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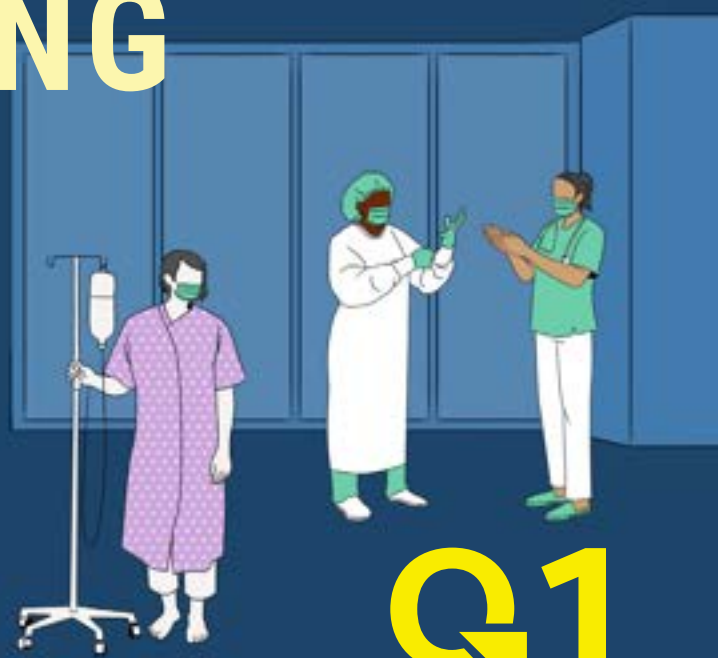
CME

HEALTH CARE ON HOLD: ADULT PREVENTATIVE CARE DURING COVID-19



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- **Closed claim: Failure to communicate and to properly administer warfarin**
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Q1

Quarter 1, 2021

CME - HEALTH CARE ON HOLD: ADULT PREVENTATIVE CARE DURING COVID-19

by Wayne Wenske, Senior Marketing Strategist

OBJECTIVES

Upon completion of this course, the physician will be able to:

1. discuss the impact of COVID-19 on preventative care;
2. describe accepted guidelines for preventative medicine in adult patients; and
3. explain the need for preventative care with patients at high risk for severe COVID-19 infection.

COURSE AUTHOR

Wayne Wenske is the Senior Marketing Strategist at Texas Medical Liability Trust (TMLT).

DISCLOSURE

Wayne Wenske has no commercial affiliations/interests to disclose related to this activity. TMLT staff, planners, and reviewers have no commercial affiliations/interests to disclose related to this activity.

TARGET AUDIENCE

This 1-hour activity is intended for physicians of all specialties who are interested in practical ways to reduce the potential for medical liability.

CME CREDIT STATEMENT

The Texas Medical Liability Trust is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Texas Medical Liability Trust designates this enduring material for a maximum of 1 *AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

PRICING

A fee of $75 will be charged when accessing this CME course online at http://lonestara.inreachce.com.

ETHICS CREDIT STATEMENT

This course has been designated by TMLT for 1 credit in medical ethics and/or professional responsibility.

TEST

To receive CME credit, physicians should complete the test questions that follow the activity. A passing score of 70% or better earns the physician 1 CME credit.

INSTRUCTIONS

the Reporter CME test and evaluation forms must be completed online. After reading the article, go to https://lonestara.inreachce.com. Follow the online instructions to complete the forms and download your certificate. Questions about the CME course? Please call TMLT Risk Management at 800-580-8658.

ESTIMATED TIME TO COMPLETE ACTIVITY

It should take approximately 1 hour to read this article and complete the questions and evaluation form.

RELEASE/REVIEW DATE

This activity is released on March 15, 2021 and will expire on March 15, 2024.

Please note that this CME activity does not meet LSA's discount criteria. Physicians completing this CME activity will not receive a premium discount.

INTRODUCTION

Preventative health care is often the first step physicians take when managing the overall condition of their patients. Regular exams and testing may lead to the early detection of disease, minimize negative outcomes, and create more treatment options.

Even in the best of times, patient compliance with preventative or routine care can be challenging. Missed appointments, busy schedules, lack of insurance, and "white coat syndrome" contribute to patients avoiding proper preventative care. But add a global pandemic to the mix, and physicians may see more patients developing chronic conditions or advanced disease and higher patient mortality.

To facilitate continued care for patients during the COVID-19 pandemic, physicians have adapted in unforeseen ways. Using telemedicine, managing patient spaces, reducing the number of daily appointments, increased cleaning of communal spaces, and testing and tracking of patients infected with COVID-19 have all minimized the risk of infection for both patients and physicians.

Yet the impact of COVID-19 on preventative care has been demonstrable, and how it will ultimately affect patient care and mortality is unknown. This article provides an overview of what is currently known about the effect of COVID-19 on preventative care, current preventative care guidelines for adult care, and how physicians can encourage patients to comply with these guidelines.

THE IMPACT OF COVID-19

Several studies have identified a substantial drop in the number of patients seeking health care services in 2020. Last year, many medical offices closed or reduced operations, and patients generally avoided interacting with the health system due to fears of COVID-19.

According to a report published in September 2020 by the Centers for Disease Control and Prevention (CDC), an

estimated 41 percent of adults in the U.S. have avoided medical care due to concerns about contracting COVID-19. Of these patients, 12 percent avoided urgent or emergency care and 31.5 percent avoided routine care.[1]

These findings are consistent with reports of declining emergency department visits and hospital admissions for heart attack, stroke, and hyperglycemic crisis.[1]

Avoidance of health care was higher among adults aged 18 to 24 years, African Americans, and Hispanics. Others who avoided care in significant numbers were persons with disabilities and persons with underlying medical conditions. Unfortunately, these patients are more likely to require continued care to monitor and treat the very conditions that put them at higher risk for severe COVID-19 disease. Severe COVID-19 illness is defined as hospitalization, admission to the ICU, intubation or mechanical ventilation, or death.[2]

Another group that reported avoiding care in high numbers were unpaid caregivers for adults, such as family members or friends of patients at high risk for severe COVID-19 disease.[1]

The report also pointed out the disparity of COVID-19-associated mortality between Black and Hispanic patients versus White patients. "COVID-19 hospitalization rates are approximately five times higher among Black persons and four times higher among Hispanic persons than those among White persons." [1]

Factors that may contribute to these racial disparities in health care include health insurance status; health care access; work and living circumstances, such as poor nutrition or use of public transportation; and essential worker status.[1]

Another study reviewed health care claims and found significant declines in 2020 compared to 2019. This study showed that "mammograms and Pap smears were down nearly 80 percent in April 2020 compared to 2019 . . . colonoscopies, down almost 90 percent at one point in mid-April 2020 compared to 2019, are as of November 2020 still down about 10-15 percent compared to last year." [3]

In another recent national survey, 38 percent of primary care physicians believe "there will be non-COVID-19 related deaths among their patients after the pandemic ends due to diverted or avoided care." In the same study, more than 60 percent of these responding physicians believe that "some of their patients will experience avoidable illness due to diverted or avoided care." [4]

PREVENTATIVE CARE SCREENING GUIDELINES

Editor's note: The following guidelines should not be interpreted as establishing a standard of care, being comprehensive of all proper preventative care methods, or used as a substitute for clinical decision making. Guidelines are frequently updated. Please consult your specialty society, state medical board, and the United States Preventative Services Taskforce (USPSTF) often for updates. Patients are best served by an individual evaluation of their medical history by their physician and shared decision-making on treatment. The following guidelines reflect minimum screening protocols in effect at the time this article was written. If a patient's history and condition indicate that additional care or testing is necessary, it is not recommended to limit preventative care to these recommendations.

The following guidelines are for all adult patients 18 years and older. These guidelines are listed alphabetically, per recommended test or screening.[5, 6, 7, 8, 9, 10]

Blood pressure screening

Encourage patients between the ages of 18 and 64 to have their blood pressure checked at least once every two years. If a patient's reading is anywhere from 120 to 139 (systolic number) over 80 to 89 (diastolic number) mm Hg, the screening should be annual.

For patients with a systolic reading of 130 or more or a diastolic reading of 80 or more, consider methods to reduce the patient's blood pressure (medication, diet, exercise). Discuss with the patient the best, most realistic approach(es) he or she will take to ensure adoption of these measures.

Patients with certain conditions, such as diabetes, heart disease, or kidney problems should be screened more regularly. These patients should be scheduled for annual screenings, at minimum.

Cholesterol screening and heart disease prevention

Testing is recommended for patients at different times within the 18 to 39 age group, depending on the patient's risk factors for high cholesterol or heart disease.

Risk factors for high cholesterol may include obesity; lack of exercise; eating a poor diet high in saturated fat, trans fat, red meat, or full fat dairy products; smoking; and diabetes. Risk factors for coronary heart disease may include high blood pressure, diabetes, smoking, high LDL cholesterol, low HDL cholesterol, obesity, and family history.

For patients who exhibit or inform you of risk factors for coronary heart disease, testing is recommended beginning

at age 20. For men without known risk factors, testing is recommended beginning at age 35. For women without known risk factors, testing is recommended beginning at age 45.

Patients with normal cholesterol levels do not need to be tested for another 5 years. Repeat testing sooner if risk factors change, such as significant weight gain. Again, patients with certain conditions, such as diabetes or kidney problems, should be screened more often.

Colorectal cancer screening

Patients between 50 and 75 years old should be screened for colorectal cancer. Patients under the age of 50 with a strong family history of colon cancer or polyps or a personal history of inflammatory bowel disease or polyps should be strongly encouraged for screening.

A patient may require more frequent colonoscopies if they have risk factors for colorectal cancer such as ulcerative colitis, personal or family history of colorectal cancer, or a history of adenomatous polyps.

Dental and eye exams

Patients between the ages of 19 and 69 should be encouraged to go to the dentist once or twice a year for an exam and/or cleaning.

Routine eye exams should occur every 2 years. Patients between the ages of 55 and 64 should be examined every 1 to 3 years. Patients at risk for glaucoma should be seen more often.

Patients with diabetes should have an annual eye exam.[11]

Diabetes screening

Patients should be screened if the following conditions are present:

- blood pressure is 130/80 mmHg or higher;
- body mass index (BMI) is greater than 25 (overweight);
- BMI is greater than 20 and the patient is Asian-American between the ages of 19 and 39; BMI is greater than 23 and the patient is Asian-American between the ages of 40 and 69; and
- the patient exhibits or informs you of additional risk factors for diabetes.

Risk factors for diabetes include having a first-degree relative with diabetes, obesity, fat distribution concentrated around the middle, history of heart disease, high blood pressure, high cholesterol, and ethnicity. There is an increased risk of diabetes for Hispanics, Asian-Americans, and African Americans.

Patients over the age of 44 should be screened for diabetes every 3 years.

Immunizations and vaccinations

In addition to an annual flu shot (and possibly annual COVID shots in the future), patients should be immunized as follows:

- at or after age 19, the patient should have a tetanus-diphtheria and acellular pertussis (Tdap) vaccine once, as part of the tetanus-diphtheria vaccines if not received as an adolescent;
- a tetanus-diphtheria booster every 10 years; and
- two doses of varicella vaccine, if the patient has never had chickenpox or the varicella vaccine.

Consider a herpes zoster (shingles) vaccination for patients who are 50 years or older.

According to the CDC, pneumococcal vaccines are recommended for all patients younger than 2 years old and older than 65 years old.[12]

If the patient is not immune to measles, mumps, and rubella (MMR), the patient should receive one to two immunizations for MMR.

If a patient is between the ages of 19 and 26, consider immunizations for human papilloma virus (HPV) if the patient has not received HPV immunization in the past or finished the full HPV vaccine series.

Infectious disease screening

Per the CDC, all adults aged 18 and older should be screened once for Hepatitis C, except in settings where the prevalence of Hepatitis C infection is less than 0.1 percent.[13]

Routine periodic testing is also recommended for patients with ongoing risk factors, such as patients who inject drugs, share needles, syringes, or other drug preparation equipment, and patients with certain medical conditions, including those who have ever received maintenance hemodialysis.[13]

Based on what you know about a patient's medical history, lifestyle, and behaviors, consider screening for sexually transmitted infections, such as syphilis, chlamydia, and HIV.

Lung cancer screening

According to the U.S. Preventative Services Task Force (USPSTF), an annual screening for lung cancer is recommended for all patients ages 50 to 80 who have a 20 pack-year smoking history and who still smoke or have quit within the past 15 years. These new recommendations were published in March 2021.[14]

This new guidance replaces previous recommendations that recommended annual lung cancer screenings for adults aged 55 to 80 years with a 30 pack-year smoking history and who currently smoke or have quit smoking within the past 15 years.

Osteoporosis screening
Consider screening your patients for osteoporosis if they are between the ages of 50 and 70 and exhibit risk factors, such as long-term steroid use, low body weight, smoking, heavy alcohol use, having a fracture after the age of 50, and a family history of osteoporosis.

Physical exam
During every patient encounter, check the patient's height, weight, and BMI.

Ask patients during a physical exam about the quality of their diet, the frequency and method of physical exercise or activity, alcohol, tobacco, or recreational drug use, and if they are experiencing any signs of depression. It is also important to reconcile all medications with your records, to check for risk of drug interactions or contraindications.

If you encounter a patient at high risk for skin cancer, encourage him or her to seek an annual skin exam with a dermatologist. High risk patients have a family history of skin cancer, moles, a weakened immune system, have had skin cancer before, or have a lifestyle in which they are often in the sun. If at lower risk for skin cancer, annual dermatology exams should occur beginning when the patient is in his or her twenties.

All patients 65 or older should be examined once a year. For this patient population, consider asking if the patient has experienced any falls or balance issues.

While falls may simply be a result of an overall decrease in vision, muscle and bone strength, and brain function, falls may also indicate damage to the central nervous system, such as decreased blood flow to the brain due to stroke, traumatic brain injury, multiple sclerosis, Parkinson's disease, hydrocephalus, neurological disorders, or other conditions. Any disease or condition that interferes with the proper function of the central nervous system can also cause balance issues, such as abnormal heart rhythms, congestive heart failure, diabetes, dehydration, anemia, and thyroid disorders.[15]

Falls can also indicate trauma to the inner ear or head. Other causes could be Meniere's disease, medication interaction, inner ear disorders, and vestibular neuronitis.

PREVENTATIVE CARE FOR WOMEN

The following guidelines are specific for women beginning at the age of 18. Guidelines are provided alphabetically per recommended test or screening.

Breast cancer screening
The American Cancer Society (ACS) recommends women aged 40 to 44 years with average risk for breast cancer have "the choice to start breast cancer screening once a year with mammography if they wish to do so. The risks of screening as well as the potential benefits should be considered. Women aged 45 to 49 years should be screened with mammography annually."[16]

ACS guidance also includes the following guidelines for patients with an average risk of breast cancer:

- Women aged 50 to 54 years should be screened with mammography annually.
- Women aged 55 years and older should be screened with mammography once every two years or once a year.
- Women aged 55 years and older should transition to biennial screening or have the opportunity to continue screening annually.
- Among average risk women aged 50 to 74 years, clinical breast examination to screen for breast cancer is not recommended.
- Women aged 75 and older should continue screening with mammography as long as their overall health is good and they have a life expectancy of 10 years or more.
- According to the ACS, "evidence is insufficient to recommend for or against yearly MRI screening" for women with dense breasts.[16]

Patients with the following conditions are at a higher risk for breast cancer:

- getting older, most breast cancers are diagnosed after age 50;
- smoking and drinking alcohol;
- sedentary lifestyle;
- being overweight or obese after menopause;
- inheriting genetic mutations to certain genes, such as BRCA1 and BRCA2;
- having a history of early menstruation (before age 12) or late menopause (after age 55);
- having dense breasts, with more connective tissue than fatty tissue;
- personal history of breast cancer or certain non-cancerous breast diseases;
- family history of breast or ovarian cancer;
- history of radiation therapy to the chest or breasts before age 30;

- history of taking the drug diethylstilbestrol (DES) either personally or if the patient's mother took the drug while pregnant with the patient; and
- additional factors such as taking hormone replacement therapy during menopause; taking certain oral contraceptives; or being exposed to cancer-causing chemicals.[17]

The American College of Obstetricians and Gynecologists (ACOG) offers guidelines that constitute a more collaborative approach with patients. These guidelines are as follows for patients at average risk of breast cancer:

- Women aged 40 to 49 should be offered mammography once a year or once every two years, and clinical breast exams may be offered once a year after counseling. (This recommended age differs from the ACS guideline.) After appropriate counseling, decisions about whether to screen once a year or once every two years may be reached through shared decision-making between the physician and patient.
- Women aged 50 to 74 should be encouraged to undergo screening with mammography once a year or once every two years. "Decisions between screening with mammography once a year or once every two years should be made through shared decision-making after appropriate counseling. Clinical breast exams may be offered annually. Clinical breast exams should be offered in the context of a shared, informed decision-making approach that recognizes the uncertainty of additional benefits and harms of clinical breast examination beyond screening mammography."
- For women aged 75 or older, ACOG recommends physicians and patients make a shared decision of when to stop screening based on a discussion with the patient about the patient's health status and longevity.
- For patients with dense breasts, ACOG recommends that health care providers "comply with state laws that may require disclosure to women of their breast density as recorded in a mammogram report." ACOG also does not recommend the routine use of "alternative or additional tests" other than mammograms.[18]

Cervical cancer screening

For early detection of cervical cancer, patients should be screened using a Pap test and a human papillomavirus (HPV) test at the following ages.[5, 19]

- Patients between the ages of 21 and 29 should receive a Pap test every three years. If a test is normal, the patient can wait three years before the next test.
- Patients between the ages of 30 and 65 should be evaluated whether they need a Pap test, an HPV test, or both (co-test). If the test results are normal, the patient can wait another three years before the next Pap test; another five years before the next HPV test; and another five years before the next co-test.
- Patients "who have been treated for precancer (cervical dysplasia) should have Pap tests for 20 years after treatment or until age 65, whichever is longer."
- Individual patients older than 65 may not require testing, if screenings were normal for several years

or if the patient's cervix was removed as part of a total hysterectomy for non-cancerous conditions.
- Patients who have had a total hysterectomy and have not been diagnosed with cervical cancer do not need to have Pap tests.

Infectious disease screening
In addition to the infectious disease guidelines previously discussed, the USPSTF recommends that women under the age of 25 who are sexually active should be screened for chlamydia and gonorrhea. Women 25 years and older should be screened if they are at high risk.

All pregnant women should be screened for hepatitis B, HIV, and syphilis. Pregnant women under the age of 25 and all women at increased risk also should be screened for chlamydia and gonorrhea.[20]

Osteoporosis screening
In addition to following the guidelines in the previous section, it is recommended to provide a bone density test to women over 50 who have experienced a bone fracture, or women under 65 who are at high risk for osteoporosis. All women over 65 should receive a bone density test.

Risk factors for osteoporosis include, but are not limited to:
- being a woman;
- being White or of Asian descent;
- excessive alcohol and tobacco use;
- a family history of osteoporosis;
- low estrogen levels;
- overactive thyroid;
- long-term use of corticosteroid medications;
- sedentary lifestyle; and
- history of cancer, celiac disease, inflammatory bowel disease, lupus, multiple myeloma, and rheumatoid arthritis.

Well-woman exam
In addition to the physical exam guidelines described in the previous section, women are encouraged to have an annual well-woman exam or visit annually. This exam is a preventative screening of breast and gynecological diseases. Reproductive health and pre-pregnancy counseling are also a component of this exam.

Well-woman visits typically consist of a breast exam; pelvic exam to screen for uterine or ovarian abnormalities and screen for cervical cancer; mammogram or bone density screening based on age or risk factor; Pap test; and possibly an HPV test depending on age.[21]

These individual screenings, and when they are recommended, were previously discussed in this article.

PREVENTATIVE CARE FOR MEN
The following guidelines are specific for men beginning at the age of 18. Guidelines are provided alphabetically per recommended test or screening.

Abdominal aortic aneurysm screening
Men with a history of smoking between the ages of 65 and 75 should be encouraged to have an ultrasound to screen for abdominal aortic aneurysm.[22]

Physical exam
If a patient is between the ages of 15 and 40, a testicular exam should be conducted during a patient's physical exam, or at any age if the patient reports pain or swelling in the testicles or a feeling of heaviness or aching in the lower abdomen.[23]

Prostate cancer screening
It is not generally recommended to screen patients age 55 or younger or age 70 or older for prostate cancer, unless they are at higher risk. Risk factors include a family history of prostate cancer (especially a father or brother) and being African American. Prostate examinations are no longer routine for male patients without symptoms of prostate cancer.[24]

If a patient is between the ages of 55 and 69, discuss symptoms of prostate cancer to determine if a screening is advisable. Symptoms include, but are not limited to:
- frequent and sometimes urgent need to urinate, especially at night;
- difficulty starting or holding back urination;
- weak, dribbling, or interrupted urine flow;
- painful or burning urination;
- blood in urine or semen;
- difficulty in having an erection;
- painful ejaculation; or
- pain or stiffness in the lower back, hips, pelvis, or thighs.[25]

IMPROVING PARTICIPATION IN PREVENTATIVE CARE
Encouraging follow up and preventative care takes on even greater importance during the current public health crisis. Consider the following strategies to help patients maintain follow-up appointments, testing, and preventative care during the pandemic.

- Engage patients in their own care and treatment plan by educating them about the importance of follow up tests, lab work, or appointments. Encourage them to follow through with the treatment plan and to discuss with you any reasons or fears they may have about doing so. This may include voicing fears about coronavirus infection.

Attempt to allay their fears of coronavirus infection during an appointment by informing them of the measures you have taken to protect patients. Document these conversations or communications and any educational materials you may provide in the patient's record.

- Documenting patient communication should include what was discussed, decisions for treatment, changes to the treatment plan, participants in the discussion, and referrals made. Include the date, location, and time.

- Consider creating official communications directed at patients to inform them of the safety protocols your office or hospital has adopted to reduce risk of coronavirus spread. These messages could be distributed via email, website, social media, phone message, posted flyers in your office, direct mail letters, or even a short video posted on your website or social media channels.

  The messaging could describe your safety protocols, such as required face mask protocols for patients, physicians, and staff; enforced social distancing, hand washing, and hand sanitizing; adjusted furniture in common areas to promote social distancing; and what patients may expect when they arrive for an appointment, such as mandatory temperature checks and limited non-patient visitors in your office.

- Schedule follow-up or preventative care appointments while the patient is still in the office and before he or she leaves. Encourage the patient to keep all follow-up appointments and appointments for testing.

- Likewise, when ordering tests, schedule the follow-up appointment for results review at the time of the office visit with the patient. Use a tracking system to ensure test results are received by your office in a timely manner.

- Ask testing facilities or a consulting specialist to inform you if the patient does not come to a scheduled appointment. Document that the patient was a "no show" and why, if you have that information.

- If the patient chooses not to have a test performed, discuss the test's importance with the patient and your reasoning for ordering it. Again, document this conversation and any educational materials given to the patient in the progress notes.

- If the patient regularly fails to return to your office or has a medical condition or test results that requires follow up, you may choose to contact the patient in writing.[26]

- Schedule telemedicine appointments for high-risk patients to ensure their continuity of care. The standard of care is the same for telemedicine as it is for in-person visits. Documentation standards are also the same. Additional standards for patient care using telemedicine are found on the Texas Medical Board website for Texas physicians. If you are practicing outside of Texas, check with your state's medical board.[27]

In addition, encourage any patient who may be at increased risk for severe COVID-19 illness to:

- continue to follow his or her treatment plan as directed;
- contact you if they wish to make any changes to their treatment plan;
- continue to take medications as directed;
- maintain a 30-day supply of prescription and non-prescription medication (consider increasing the number of allowable refills for non-opioid or other medications during this time);
- contact you if they experience any new or troubling signs or symptoms of illness;
- receive recommended vaccinations against influenza and pneumonia; and
- call 911 without delay if he or she needs emergency care or thinks they may have COVID-19.[2]

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Wayne Wenske can be reached at wayne-wenske@tmlt.org.

Thank you

We are deeply grateful for your strength and dedication during this extraordinary time.

We are humbled and heartened when we hear about the everyday acts of courage and humanity being carried out by physicians during the COVID-19 pandemic. As vaccine administration continues across the United States and we cautiously look to the future, we are proud to support you in 2021 and beyond.

LONE STAR ALLIANCE

A RISK RETENTION GROUP

REMOTE PATIENT MONITORING: RISK MANAGEMENT CONSIDERATIONS

by Tanya Babitch, Director, Risk Management; and Robin Desrocher, BSN, RN, CPHRM, Director, Risk Management

Remote patient monitoring (RPM) allows a patient to use a mobile medical device to perform routine tests and send test results to a physician in real-time without visiting the office. The physician can then review the information and adjust the patient's treatment plan as needed. RPM can help physicians manage patients with chronic conditions — high blood pressure, COPD, diabetes — and patients with implanted pacemakers or defibrillators. RPM also includes the use of wearable electronic devices designed for consumer or medical use.

RISK MANAGEMENT CONSIDERATIONS

Here are factors to think about when considering the use of RPM.

- Providers using telemedicine in any capacity — including RPM — should develop a comprehensive set of protocols that defines hours of availability and describes the operation of telemedicine services. The protocols should describe when, how often, and who reviews the data. If the designated person is unavailable, who covers for them? The protocols should also include guidelines for physician notification.

- Consider which of your patients are good candidates for RPM. You may decide not to use these technologies with patients who are not engaged in their own health care, do not have reliable access to an internet connection, or senior patients who may have difficulty using technical devices.

- Patients who are good candidates for RPM should be fully educated (and possibly sign an acknowledgment) about how to use and maintain the device, physician/provider "available hours" for consult, and the limitations of remote monitoring. Similar to emailing a practice with questions or issues, the patient must understand that there are limitations on remote monitoring, and that review of the data will occur during certain hours and within a certain timeframe.

- Patients should be educated about what constitutes an emergency reading, and how to respond (i.e., call 911, go to the emergency department, etc.).

- Patients should be educated on the risks of a remote device failing or malfunctioning, and the risks of malware compromising the effectiveness of the device and patient privacy.

- These education elements should be documented in the medical record, either via written acknowledgment or documentation of discussion. A written acknowledgment should reference patient education about how remote monitoring works, the limitations, and warnings.

- Some telemedicine platforms allow providers to set the times when patients can transmit data to the provider. Others allow providers to tailor the timing of transmissions for each patient to avoid random submissions when providers are not available to monitor the data. If patients will be allowed to transmit information 24/7, the providers would be responsible for developing and implementing a process to evaluate this data in a timely manner to avoid any delays in treatment.

- Incorporate reference to telemedicine/remote monitoring technologies into your Notice of Privacy Practices.

- Include telemedicine equipment in your organization's Security Management Plan and annual Security Risk Assessment. Ensure that all employees who participate in telemedicine/remote monitoring services have received telemedicine-specific health care privacy and security training.

- Determine the need for Business Associate Agreements. Evaluate all parties, including any vendors involved in the provision of services, for compliance with federal and state privacy and confidentiality regulations. Require the ability to provide proof of compliance if asked; and require telemedicine vendors to hold their subcontractors accountable as well.

- Ensure that all of your medical devices are safeguarded against data breaches, viruses, or malware. Per HIPAA, physicians must take reasonable steps to protect patient health information from unauthorized access by cyber criminals. Do not rely only on RPM device manufacturer security features. Be diligent in keeping all of your own encryption and security software up to date when using RPM technologies.

- Texas physicians may use telemedicine to treat or see patients within Texas. However, to treat patients outside of Texas using remote technologies, you must be licensed in the state the patient is located. If you practice outside of Texas, check your state medical board for your local telemedicine rules and limitations.

Contact your medical liability carrier to discuss any change in your practice related to telemedicine. TMLT policyholders should contact the TMLT Underwriting and Business Development Department at www.tmlt.org/contact/underwriting.

ADDITIONAL RESOURCES

- "How to mitigate the risks of remote patient monitoring" on The Doctor Weighs In website, available at https://thedoctorweighsin.com/remote-patient-monitoring-risks/.
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- "Pros and cons of remote patient monitoring" on the Health IT Outcomes website, available at https://www.healthitoutcomes.com/doc/pros-and-cons-of-remote-patient-monitoring-0001.
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- "Remote patient monitoring brings mHealth care management into the home" on the mHealth Intelligence website, available at https://mhealthintelligence.com/features/remote-patient-monitoring-brings-mhealth-care-management-into-the-home.
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- "How to avoid the legal risks of telemedicine" on the Medical Economics website, available at https://www.medicaleconomics.com/view/how-avoid-legal-risks-telemedicine. Accessed February 5, 2021.

- "Remote patient monitoring opportunities and risks for technology vendors and providers" on the JD Supra website at https://www.jdsupra.com/legalnews/remote-patient-monitoring-opportunities-54912/.
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- "Safely incorporate remote patient monitoring into your practice" on the Texas Medical Association (TMA) website. Portions of TMLT's risk management advice found in this article also appears here. Available at https://www.texmed.org/Template.aspx?id=53660&terms=remote%20patient%20monitoringpresents."
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Tanya Babitch can be reached tanya-babitch@tmlt.org.

Robin Desrocher can be reached at robin-desrocher@tmlt.org.

FAILURE TO COMMUNICATE AND TO PROPERLY ADMINISTER WARFARIN

by Wayne Wenske, Senior Marketing Strategist

PRESENTATION

In November 2010, an 80-year-old man moved into an assisted living facility. He had a pacemaker and a history of three cerebrovascular accidents (CVAs). The patient's medications included daily warfarin, which required daily international normalized ratio (INR) checks.

The facility employed an outside home health care vendor to provide care for its residents. Employees of the facility regularly administered medication to residents, based on the vendor's orders.

Upon the patient's admission, a family medicine physician employed by the vendor became the patient's physician. This physician typically communicated her medication orders first to the home health vendor. The home health vendor would then inform the facility, and facility employees would administer medication to her patients.

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PHYSICIAN ACTION

On March 30, 2011, the patient's INR level was measured as low. The family physician sent an order to the health care vendor to increase the patient's warfarin dosage to 3 mg per day and to recheck the INR in three days. The vendor communicated this order to the facility. The facility misinterpreted the order as being to discontinue the warfarin in three days.

On April 2, the patient's INR levels were again too low. The family physician gave a phone order to an advanced practice provider (APP) from the health care vendor to continue warfarin at 3 mg daily and to check the INR levels on April 4. The APP never communicated this order to the facility.

On April 4, the family physician gave another phone order to the same APP to increase the warfarin to 5 mg daily and to repeat the INR check on April 7.

On April 7, the patient had an acute embolic CVA after not receiving warfarin for at least one week. On this same day, the APP documented the April 4 phone order.

The patient died a few months later.

ALLEGATIONS

The patient's family filed a lawsuit against the family physician, the APP, the health care vendor, and the assisted living facility. The lawsuit alleged that the failure to timely and correctly administer warfarin caused the patient's CVA and death.

LEGAL IMPLICATIONS

Experts for the plaintiff were critical of the care provided to this patient. One of the experts was critical of the family physician for not taking the appropriate steps to ensure the providers received her orders. This expert also noted that the APP failed to conduct a telephone read back with the family physician of the April 2 warfarin order and then failed to deliver the order to the facility.

The facility was also criticized for failing to accurately transcribe the orders they received on March 30 from the vendor. The facility also failed to document when the patient received warfarin.

These actions were all deemed by the plaintiff's expert as breaches to the standard of care that caused the patient's acute embolic CVA and eventual death. Another expert for the plaintiff argued that the family physician should have ordered the use of heparin when the patient's INR continued to fall.

Family physician and geriatrics consultants for TMLT were more supportive of the defendant family physician. They both felt that the outcome of this case was primarily due to a system failure by the staff members of the health care vendor, including the APP, and the assisted living facility. The geriatrics consultant felt this patient should have been in a nursing home, as opposed to an assisted living facility, where he would have received more appropriate care for his condition.

DISPOSITION

Due to the administrative errors and miscommunication that resulted in the death of the patient, this case was settled on behalf of the family physician. The cases against the APP, health care vendor, and assisted living facility were also settled with the plaintiff.

RISK MANAGEMENT CONSIDERATIONS

Effective communication between physicians and staff members is critical for quality patient care. This case demonstrates a communication breakdown between all parties involved. In this scenario, physician orders for medication, lab studies, tests, procedures, and follow-up appointments with the facility's residents should have been documented using a well-maintained system to ensure that clear, consistent communication existed between the four entities involved (physician, patient, care vendor, and facility administrators).

Every practice requires a process to ensure physician orders are received, reviewed, and acted upon in a timely manner. These processes ensure quality continuity of care. Maintaining and following written policies and procedures for patient care can help ensure that each staff member understands his or her responsibilities. When training materials or process guidelines are developed or updated, it is helpful to have staff members sign and date the materials or guidelines as acknowledgment that they have read and understand the policies and responsibilities of every staff member.

Another weakness in this case was the lack of clear, comprehensive, and contemporaneous documentation. From the notes maintained by the assisted living facility, it was unclear if the patient received any of the medication ordered by the family physician. There is also no record of the patient requesting his medication, which brings up questions of how clear the family physician was with the patient on what medications were ordered and required for his continued care.

Follow up care can be improved by recruiting and engaging patients in their own care. Had the family physician discussed her rationale for increasing the warfarin dosage with the patient, the patient may have better understood his care needs and become more active in seeking treatment from the facility.

It is also important to immediately document phone calls, including any instructions received for patient care or instructions given out to patients. This is critical, as it may become difficult to remember a phone discussion over time or what instructions or orders were given. In addition to facilitating continued quality care, comprehensive and up-to-date documentation can become valuable in defending a medical liability claim.

Wayne Wenske can be reached at wayne-wenske@tmlt.org.

RETAINED FOREIGN BODY AND ALTERATION OF MEDICAL RECORD

by Gracie Awalt, Marketing Associate

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PRESENTATION AND PHYSICIAN ACTION

On December 14, an otolaryngologist performed a revision endoscopic sinus surgery on a 50-year-old man. The patient had previously been diagnosed with pansinusitis with contents that indicated allergic fungal sinusitis.

The patient had a history of sinus surgeries for polyps and chronic sinusitis over the past four years. The patient's history also included fibromyalgia, asthma, hypertension, hypothyroidism, and migraine headaches.

At the first postoperative visit on December 18, the otolaryngologist removed the patient's nasal packing and purulent drainage was present. On December 22, the patient reported a worsening headache and additional nasal packing was removed from his left frontal duct. The dosage of the patient's antibiotic prescription was increased.

The next day, the patient underwent a CT scan of the brain. The results showed pansinusitis with abscess within the inferior right frontal lobe. The scan also showed an enlarging right-sided subdural hematoma with a secondary mass effect with a 9 mm right to left midline shift.

A sinus CT scan showed a deficient right cribriform plate measuring 3.4 mm. The otolaryngologist concluded that this was the site of the intracranial extension of the sinus infection. The patient was diagnosed with an intracranial abscess.

On December 24, the patient was taken to surgery for a right-sided craniotomy to evacuate the subdural empyema with cranialization of the frontal sinus. During the procedure, a foreign object was removed from the patient's left ethmoid sinus. Although initially thought to be cotton, a pathologic examination of the object revealed it to be Surgicel.

On December 28, the patient died from complications of septic thrombophlebitis infection, that resulted from the sinus surgery.

Three years later, the otolaryngologist added operation notes to the patient record upon receiving notice of the claim. She stated that she made amendments to the record to clarify what occurred during the December 14 surgery.

ALLEGATIONS

A lawsuit was filed against the otolaryngologist. It was alleged that during the sinus surgery, the otolaryngologist created a defect in the right ethmoid sinus wall, which exposed the dura and created a pathway for infection. This led to brain infection and swelling, septic clotting, strokes, and death.

LEGAL IMPLICATIONS

The majority of TMLT consultants who reviewed the case were not supportive of the otolaryngologist's actions. It was suggested that an image-guided operation system should have been used during the procedure because the patient's previous surgeries may have caused anatomic changes, making the December 14 procedure difficult. Using such a system could have potentially prevented the cribriform plate and dura defects.

One consultant believed the intracranial infection occurred due to a defect in the cribriform plate, allowing the ethmoid sinus contents to spread to the intracranial area. Another consultant noted that the "veins in the middle third of the face and within the skull do not have valves, which cause the infection to ascend and disseminate causing septic thrombophlebitis, leading to arterial compromise and intracerebral bleeding."

Another consultant noted the severity of the patient's sinusitis and the extensive surgery. He believed the otolaryngologist should have been familiar with post-surgical anatomic landmarks of the patient, since she had operated on the patient two times before. Another consultant believed there was enough bleeding to justify using Surgicel on the operative site, and that this was a common risk for sinus surgery.

A treating neurosurgeon noted that the right medial wall of the maxillary sinus was absent when they performed emergency surgery on the patient; however, an expert for the plaintiff said this was not significant.

The plaintiff's expert believed the otolaryngologist should have removed all remaining packing material when the purulent drainage was found. Failure to do this was a breach in the standard of care, and led to the intracranial abscess, stroke, and death.

The otolaryngologist explicitly mentioned that she does not perform CT scans on patients with postoperative complications. A defense consultant criticized this statement and maintained that if the patient had received a CT scan sooner, he may have had a greater chance of survival.

The defense of this case was also complicated because the otolaryngologist dictated changes to her operative notes in the patient's record three years after the procedure.

DISPOSITION

This case was settled on behalf of the otolaryngologist.

RISK MANAGEMENT CONSIDERATIONS

In this case, it was strongly advised that the physician use an image-guided system or computer-assisted navigation system due to the anatomic complexity and the high risk for error during endonasal surgery.[1]

The otolaryngologist was also criticized for updating the patient's medical record three years after the surgery. For physicians in Texas, the Texas Administrative Code states that each licensed physician "shall maintain an adequate medical record for each patient that is complete, contemporaneous and legible." When documentation is not completed contemporaneously, it can be difficult for physicians to recall detailed information from a patient encounter. [2]

The Code continues that any late changes made to a medical record "shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction." Physicians practicing outside of Texas should refer to their own state regulations on medical records. [2]

According to the American Academy of Professional Coders, documentation into the patient's record should not occur more than 48 hours after last seeing the patient. Within that time frame, physicians can clarify, correct errors, or add additional information to the record.

Physicians should not alter or correct a medical record after being notified of a claim. Doing so can lead to accusations that the physician made mistakes and is trying to conceal them. This can make the claim more difficult to defend.

If there is no notice of a claim and an addendum must be added to the patient's record, it is appropriate to amend a record but only if the physician clearly states the reasons for the amendment and signs the addendum. When making an addendum, the following information should be documented in the patient record: [3]

- the date the record is being amended;
- details of the amended information including the reason for making the addendum;
- clearly noting that the added information is an addendum; and
- the signature of the physician.

Even when done in a timely manner, amending patient records should be avoided and not become a routine occurrence.

To protect the integrity of the medical record once you are notified of a claim, place your original medical records in a secure place for future reference. Do not make any additions, deletions, or any other type of alteration to the medical records. Secure any other pertinent information or items in your possession, such as billing records, x-rays, hospital charts, etc.

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Gracie Awalt can be reached at gracie-awalt@tmlt.org

the REPORTER

LONE STAR ALLIANCE RRG
P.O. Box 160140
Austin, TX 78716-0140
844-595-8866
www.lonestara.com

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