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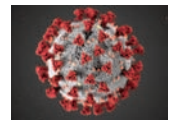
Project ECHO

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Patient-Doctor Telemedicine: Virtual Care in the Era of COVID-19 and Beyond.

Steven Zweig

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Patient-Doctor Telemedicine: Virtual Care in the Era of COVID-19 and Beyond

by Steven Zweig, MD, MSPH

Virtual visits will likely remain in place after this pandemic is over. We will need to be mindful of their advantages and disadvantages going forward.

This issue of *Missouri Medicine* includes updates on the use of telehealth techniques from experts. The use of telehealth to support long distance care and education has increased substantially.¹ Telemedicine use for behavioral/psychiatric care has been common. It has also been used increasingly to support emergency services, intensive care or stroke, particularly in rural environments.

Project ECHO started as a strategy to disseminate knowledge about the treatment of Hepatitis C in New Mexico,² but has now, as described in this issue, has become a broad-based educational strategy with 24 unique programs supported by the Missouri Telehealth Network. This spring those of us who knew nothing about telemedicine – as well as our patients – had to

quickly learn the makeshift strategies that would enable nonemergent health care to continue.

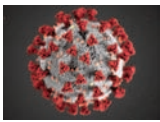
Our first experience with virtual visits was a special clinic to evaluate patients with respiratory complaints (who could have COVID-19) that enabled them to reassure the patient who clearly did not and to triage patients to either the emergency department if very sick or MU Health Care's drive-through testing center if they were not. This strategy also kept potentially contagious patients out of the clinics and physically isolated from others. The strategy used for health care surge control is called "forward triaging" which enables protections for patient, provider, and community from exposure.³

In the pre-COVID era, routine home-based patient-doctor telemedicine care was limited due to lack of reimbursement. Not surprisingly capitated systems like Kaiser Health have been the earliest adopters where 52% of the more than 100 million patients visits in 2018 were virtual ones.⁴ The COVID-19 pandemic created changes nearly overnight. Now patient and physicians were striving to reduce in-person visits for public health reasons.

In a period of two weeks, MU physicians primary care and subspecialty physicians went from none to over 4,000 virtual outpatient visits per week on a secure platform. This allowed us to take care of all of the other problems



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our patients had in spite of the pandemic. We did our best to not defer patients who would otherwise be stacked on to future schedules, miss the opportunity to have needed evaluations or refills, or worst of all become sicker from their acute or chronic illness requiring avoidable visits to emergency or hospital admissions.

The rule changes by Centers for Medicare and Medicaid (CMS) to pay for virtual visits between physician and patient helped to enable this innovation. Physicians can follow the same documentation guidelines used for in-person visits and get paid the same rate for virtual visits incorporating both audio and visual capabilities. Unfortunately, many of our patients could not operate the ZOOM platform, did not have a computer or smart phone, or did not have sufficient internet resources to enable a connection. Whereas follow-up visits by phone were equally important, reimbursement for these visits was at first much less. Not surprisingly those patients most vulnerable due to poor social resources were likely to suffer once again by even more limitations in access. Even before the COVID-19 pandemic, Missouri was among the most supportive states for telehealth reimbursement for professional services.⁵

Also, some important outpatient care does not lend itself to virtual visits. Virtual ophthalmology visits, for example, are much more difficult especially if an instrument assisted examination is required. Even in the primary care setting, we brought in patients who could not be care for virtually, such as those requiring a hands-on physical exam (e.g. abdominal pain) or a procedure (e.g. ingrown toenail excision). We felt comfortable doing this because of our comprehensive strategy to keep sick people out of the clinic (video assessment and drive through testing, keeping sick staff at home, preventing visitors, and screening all who enter the clinic with questions and temperature) knowing that we could make it safe for both our staff and our patients needing to be seen.

Virtual visits will likely remain in place after this pandemic is over. We will need to be mindful of their advantages and disadvantages going forward. While audio-visual care is likely more effective than audio only or asynchronous email consultations, there are limitations with the quality of the transmission, the stilted social interactions, potential for missing nonverbal cues, and the loss of “healing touch.”⁶ This also has implications for medical education. These past weeks students and residents have been included as third parties in the virtual visit. We will need to determine curricula that best prepare them for this change in practice.

All in all, the innovations that have come from catastrophe will help provide greater access for our patients, particularly those who are old or disabled, those with limited transportation ability, people in rural communities who need distant subspecialized care, behavioral health visits that may have been limited by stigma, and even working patients who are more likely to attend visits if they can minimize lost time from work. Elements of chronic disease care that emphasize how to help the person stay well in their home environment might be best accomplished in that environment, even virtually. How we can best provide that care and when it is a “better” substitute for in-person care will be an ongoing dynamic between physicians, patients, and probably payers in the future.

References

1. Health Resources Services Administration. Telehealth Programs. <https://www.hrsa.gov/rural-health/telehealth>. Accessed May 3, 2020.
2. University of New Mexico. Project ECHO. <https://echo.unm.edu/>. Accessed May 2, 2020.
3. Hollander JE, Carr BG. Virtually perfect? Telemedicine for Covid-19. *N Engl J Med* 2020;382:1679-1681. Duffy S, Lee TH. In-person health care as Option B. *N Engl J Med* 2018;378:2: 104-106.
4. Duffy S, Lee TH. In-person health care as Option B. *N Engl J Med* 2018;378:2: 104-106.
5. Lactman NM, Acosta JN, Levine SJ. Fifty state survey of telehealth commercial payer statutes. <https://www.foley.com/-/media/files/insights/health-care-law-today/19mc21487-50state-survey-of-telehealth-commercial.pdf>. Accessed May 3, 2020.
6. Wooliscroft JO. Innovation in response to the COVID-19 pandemic crisis. *Academic Medicine* 2020

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