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Telehealth: Pivoting in a Pandemic

University of Vermont
General Internal Medicine

THE University of Vermont MEDICAL GROUP

Primary Care at UVM

- 11 Clinic sites: 4 GIM, 5 FM, 2 Peds
- ~80,000 patients (% of patients>65=19%,>75=7.7%)
- Common leadership structure: each site with MD site leader and staff supervisor
- Meet regularly to review processes/streamline communication and promote standardization
- During early pandemic met daily for primary care huddle to keep abreast with new information/changes

The Challenge for ALL of us

- ONLY EMERGENCY/ESSENTIAL VISITS
- STAY AT HOME ORDERS DECLARED
- PATIENTS ARE SCARED
- PATIENTS FEEL THEY ARE A BOTHER
- THEY'LL GET SICK IF THEY SEE US, SICK IF THEY DON'T PHENOMENON
- THE SOLUTION…. TELEHEALTH !

Telehealth: Our Choices

- TELEPHONE ONLY (AUDIO) VISITS
  - PROS: convenient, most everyone has phone, compensated
  - CONS: payment parity issues, can't visualize patient

- TELEVIDEO (AUDIO/VIDEO) VISITS
  - PROS: less travel, convenient, payment parity
  - CONS: lack of devices/connections, willingness of patients, can't "touch" patient, some potential safety issues

- E- VISITS (template for certain acute conditions)
  - PROS: convenient for patients, usually quick for provider, some $ paid for time spent doing this work
  - CONS: not a full E/M code, limited # conditions

OUR APPROACH

- All PROVIDERS and STAFF given ZOOM accounts
- Current schedules reviewed and patients converted to telehealth visits—preferred for VIDEO but AUDIO ONLY also scheduled.
  - Central patient access center made available to help troubleshoot connection issues—called patients day before
  - Staff consent patient for telehealth visit at the time of scheduling the appointment (scripted).
  - OBSERVATION: initially many patients opted to postpone visits until they could be seen “in person”, as time went on more accepted a telemedicine option. Not all providers were comfortable with this quick transition to a new workflow either.

Points to Ponder with this Transition

- How do we create a patient experience equivalent to in-person visits?
- How do we ensure quality of care?
- How do address the provider experience and joy of practice?

OUTREACH

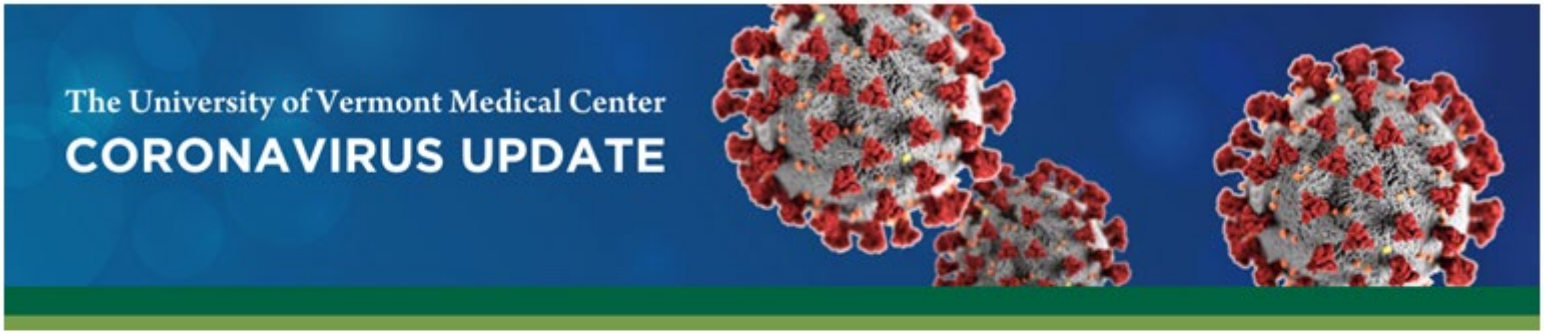
- Outreach to high risk patients---patients high risk for poor outcome if contracted COVID-19 AND those who are at high risk for poor outcomes from not accessing care.
  - Scripted calls by medical assistants: focus on asking about symptoms, support at home, food, medicines, needed help
    - If symptoms, sent to provider or RN
    - If needs help with SDOH- referral to care manager/SW
    - Follow up telehealth visit scheduled with PCP or APP
- Outreach to COVID + patients—scheduled telehealth follow up with member of care team (PCP, APP)
- What to do with those who have respiratory symptoms?

SYMPTOMATIC PATIENTS

- CENTRALIZED ACUTE RESPIRATORY CLINIC
  - Combined clinic of all of primary care (GIM, FM, Ped)
    - One adult provider, one child provider each day
    - PPE centralized, limited staff exposure
    - Patients seen outside in cars/in a tent
  - Video visit first—empiric treatment encouraged
  - If “in person” visit needed, referred to ARC

- CENTRALIZED “DRIVE BY” COVID TESTING SITE
  - for patients not needing in-person evaluation.

Curve is FLAT—TIME TO RE-EMERGE?



May 6, 2020

COVID-19 PATIENT ACTIVITY IN VERMONT

Total Tests – 17,876
Total Cases - 908
Currently Hospitalized - 6
People Being Monitored - 20
People Completed Monitoring - 841
Deaths - 52

OUR RECOVERY

- ESTIMATED $150 MILLION DEFICIT BY JUNE FOR OUR NETWORK
- NEED FOR STRICT ADHERENCE TO SOCIAL DISTANCING GUIDELINES
- NEED TO “RE-OPEN” FOR BUSINESS (OR cases etc.)
- NEED TO KEEP “SEEING” OUR HIGH RISK PATIENTS

PRIMARY CARE RECOVERY

- UNIVERSAL GUIDELINES REGARDING CLINICS
  - Keep patients 6 feet apart, everyone masked, etc.
  - No one in waiting room, immediate rooming upon arrival
  - Designated rooms for patients who are COVID suspect
- PRIMARY CARE PLAN
  - Estimate ~60% video visit, 40% in person (for those who NEED exam).
  - Coordinating schedules per exam room—set times for in person exams.
  - Swapping out schedules—considering flexing some providers as needed to evening and weekend scheduled clinics to limit # of patients/provider/staff on site.
  - Continue outreach efforts to patients, promoting team based care

TELEHEALTH PROTOCOL

- PREVISIT PLANNING
  - Staff call patient and arrange to get necessary labs done prior
  - Staff call patient and ask to have updated data per reason for visit.
    - HTN: BP, HR, weight available
    - Diabetes follow up: available blood sugars, BP, HR, weight
  - Staff ask patients to have all medication bottles available and ask patient to make note of refills needed.
  - Staff ask patient to make sure on day of video visit that they are able to be in a well lit room with ample room to move around if necessary.

TELEHEALTH PROTOCOL CONTINUED

- "ROOMING PROTOCOL"- (can be done from anywhere)
  - Staff confirm reason for visit, administer necessary screening tests (falls risk), administer necessary questionnaires (annual wellness visit, behavioral health screen, SDOH screen, etc). This can be done in advance of scheduled visit time.
  - Staff pend necessary medication refills for provider or RN to sign

- CHECK OUT- staff can "join" at end again to set up next appointment. We utilize interoffice Skype to alert staff.

Our new normal? How do we Address the Digital Divide?

- What are strategies that health systems can use to identify vulnerable populations? How can we identify potential disparities in access to our new model of care?

- Are there examples of best practices in addressing potential barriers?

NOTABLE BARRIERS/SOLUTIONS

- No device/technology/internet?
  - Ideas
    - Partner with school districts/public domains who have supplemented homes for the sake of education?
    - Lending programs?
    - Potential partnering with libraries to have “consultation rooms” available for patients to use

BARRIERS CONTINUED

- No home monitoring device (no BP cuff)
  - Can check BP at pharmacy (but do we want patient leaving house)?
  - Partnering with visiting nurses?
  - Partnering with community health workers?
  - Lending programs?

- Potential future considerations advocacy opportunity?
  - After the PHE what happens to payment parity for telephone visits?
  - After the PHE will rules go back into place regarding televideo visits?

Enhancing Virtual Care

- Ideas for Faculty Development:
  - Communication strategies for sensitive topics
  - Optimizing My Digital Presence (lighting, positioning, background, etc)
  - Directing patient exam maneuvers (abdomen, neuro, MSK, etc)
  - Directing the sensitive exam (male/female GU exam, breast exam)
- Patient Videos:
  - Preparing for their visit
  - The Patient Self-Exam (to prep patients for your exam)
- Virtual Waiting Room: Patients use waiting time productively for the visit
- Virtual Check-Out: MAs or others follow-up to ensure nothing gets dropped, and health maintenance.
- Virtual Continuity/Support: home based monitoring systems for selected patients
- Digital Lending Library: lend home based monitoring or other digital devices to vulnerable patients.
- Technology access teams: support for vulnerable patients or limited technology literacy

Tips for a more successful video visit

Telemedicine | Communication Tips

During the the COVID-19 pandemic, telemedicine is playing a key role for the UVM Health Network so that those who are symptomatic or wish to stay home can still connect with their clinicians. Below are helpful communication techniques that are unique to telemedicine encounters.

Introduction

This can be stressful and a new experience for patients who will need reassurance. It is important to orient them to the visit, setting expectations and the length of time. Also, let them know if something goes wrong you will call them back.

Environment

If you anticipate there will be expressions of strong emotions, make sure to cue the patient to be in a more private setting where they will feel comfortable expressing emotions. For example, they may not want to have the kids around.

Look into the Camera

Make sure you have your screen aligned in such a way that you can look into the camera directly, creating eye contact. Paradoxically, one trick is to use a smaller device (i.e., phone, tablet) to foster a more intimate connection. Background should be plain and without windows.

Attend to Environmental Cues

In telemedicine, we are invited into a patient's inner world. What do you notice? For example, are they in a darkened room? Are they wanting to have a more superficial conversation today? These clues can help guide your questions and emotional responses.

Conveying Emotion

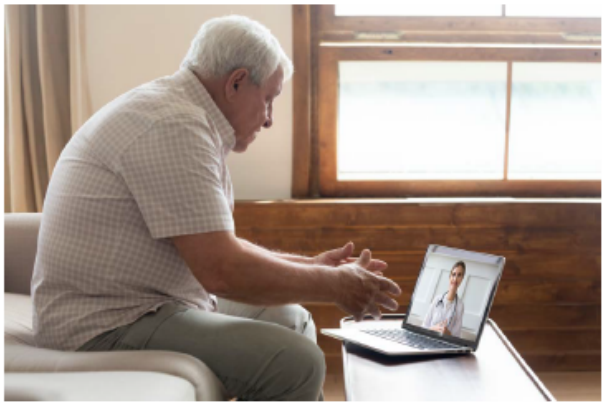
Visual gestures can convey empathy and connection such as touching your heart when expressing concern. You can also use verbal or sound cues to indicate you are listening.

Ending the Session

Ending a telemedicine session can feel very abrupt. We don't get to walk the patient to the door and say goodbye. Think about how you might want to wind things down if a patient has expressed emotions. You may want to signpost that the appointment is coming to an end.

- "I see that we have about 10 minutes left. I wonder what might be most helpful to discuss as we finish up for today?

Be sure to include next steps and what to expect after the visit.



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