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CAN WE LIVE-STREAM PRIMARY CARE?: CHALLENGES IN THE ADOPTION OF ECONSULTS AND VIDEO VISITS

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"You're killing the physical exam," shouted one attending physician from the back of the Grand Rounds auditorium in response to our presentation on the benefits of incorporating video visits and eConsults into our medical practice. Given the data on the early success of this disruptive innovation, we were surprised by the vitriol in the room. Perhaps we should not have been, considering the amount of pushback even Laennec received after having invented the stethoscope.

Telemedicine encounters are capable of adding tremendous value to health care. There is an increasing amount of evidence that suggests numerous disease states can be managed successfully through video visits. Additionally, eConsults have created a collaborative work environment in which primary care providers can seek specialty guidance faster than ever before. These interventions serve the quadruple aim of enhancing the patient experience, improving population health, reducing costs, and returning joy to work for the clinical team. The reluctance of some providers to incorporate telemedicine into their clinical workflows has hindered progress for a variety of reasons. We thought it appropriate to share the common concerns and feared misconceptions raised by these providers, as well as our responses to their resistance.

"Telemedicine isn't good care." — Health care is a change-averse industry, and thus, there must be proof that the value-added is worth the change. Early data support that telemedicine is as successful as an in-person visit for some clinical issues. According to a study published in the *Journal of General Internal Medicine*, patients with well-controlled hypertension were able to be managed equally well by telemedicine.[1] Additionally, a Cochrane review from 2016 demonstrated that virtual check-ins did "not demonstrate any important differences between face-to-face and remote asthma check-ups in terms of exacerbations, asthma control or quality of life".[2]

"But my patients are too sick and need to be cared for in an in-person setting." — Yes, it is true that some patients are very sick and need in-person care to help facilitate their care plan, suggesting that telemedicine is not a solution for every patient every time. However, some of the patients we perceive to be too sick may not actually be too sick for telemedicine. Many chronically ill patients struggle to attend their medical appointments and are vulnerable to acquiring infections in the waiting room and could easily benefit from health care delivered to them at home. With the addition of specialty eConsults, we could greatly reduce the burden of the number of trips these patients would have to make to offices. In particular, these patients could utilize video visits as a means to obtain routine, periodic check-ups, and could even leverage video visits in emergency situations where their symptoms cannot be readily assessed over the phone. Many aspects of the physical examination, such as examining rashes, assessing difficulty of breathing, and even collaborating on an abdominal exam, are reproducible through telemedicine encounters. Furthermore, a virtual care delivery model would create more frequent touchpoints across all aspects of these patients' care plans.

"Virtual visits eliminate the provider-patient relationship."— Defined as providing clinical care to patients from a distance, telemedicine is often perceived to remove the humanistic element of healthcare delivery. Specifically, providers fear that the introduction

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of technology to medicine makes it impersonal as it values disruptive innovation over quality and trust. However, much of medicine today is already conducted using technology, such as phone calls, e-mails, and in-app messaging. In addition to these examples of digitalization, video visits and eConsults can actually strengthen the provider-patient relationship. Video visits create an opportunity for providers to gain a better insight into their patients' lives as they can demonstrate how they self-manage their conditions at home. Specifically, providers can see first-hand what type of food is stored in their fridges, how many pills are left in their pill bottles, and how their medications are stored and organized. As primary care providers review eConsults with specialty consultants, they are better able to explain to their patients the rationale behind their treatment plan, putting more of the conversation in the hands of the primary care team.

"My patients don't want video visits."— Throughout a number of industries, technology has created system efficiencies and heightened consumerism. Companies, such as Netflix and Hulu, introduced a streamlined and convenient way for consumers to watch television shows and movies. In many industries, including health care, change is being driven by people's desire for such speed, efficiency, and convenience. The *American Well's 2019 Consumer Survey* indicated that 66% of Americans would adopt telemedicine into their healthcare, and multiple other surveys demonstrated similar results.[3] Data shows that patients of every age are expressing an increasing interest in utilizing technology to bypass the waiting room and access convenient healthcare services from the comfort of their own home. In fact, limited data exist that state patients are amenable to video visits in certain circumstances.[4]

"Both video visits and eConsults disrupt the traditional workflow."— Video visits and eConsults are seen as adding to a provider's overall workload but should not be. In many cases, they can replace existing work in a more meaningful and often compensable way. Providers can use telemedicine as a means to triage clinical cases to appropriate sites of care. Visits, such as follow-ups of chronic illnesses, can occur during a patient-care session. After-hours telephone care for urgent illness can be transformed into a video visit to help with breathing and rash assessments or to help assess how urgently sick is a patient. Meanwhile, follow-ups requiring physical exams or provider-obtained lab specimens, like pharyngeal swabs in the office, could remain as in-person encounters. In fact, while doing so, providers can simultaneously engage with their patient and chart the visit without compromising the quality of care delivered. Thus, workflows can be enhanced both clinically and operationally when telemedicine is introduced.

"Telemedicine increases the rate of medical errors and my risk for liability."— One of the most feared misconceptions regarding the use of telemedicine is that it creates a higher risk for medical errors and provider liability. Without the traditional face-to-face medical assessment, providers believe there is an opportunity to miss clinical information, thus, leading to a suboptimal diagnosis and treatment plan for their patients. However, providers are already engaging in activities that have the potential to result in such negative outcomes. For instance, the earliest available appointment a patient can make with a specialty provider may be a month or longer away and a patient's care might get delayed. Providers attempt to address these access issues by conducting "curbside" consults. In one study of curbside consults, specialists often felt that curbside consultations left off important clinical information.[5] Perhaps creating a more structured electronic system can enhance the exchange of data.

"My practice will not compensate me for telemedicine encounters."— An increasing number of insurance companies compensate video visits at the same rate as office visits and categorize eConsults as covered expenses. However, there is an opportunity for Medicare to expand telemedicine coverage as reimbursement is only provided when this type of care is delivered to patients in rural areas. Some institutions also recognize that providers should be directly compensated for telemedicine encounters through corresponding RVU credit. In systems aimed at reducing the total cost of care, telemedicine has been used to reduce unnecessary emergency room and specialty care utilization. These cost savings are then passed along to the patient's primary care provider.

"The majority of my patients are on Medicaid and adopting telemedicine will create two-tiered care."— It is not clear that incorporating technology into healthcare further segments lower income patient populations. According to the 2018 Deloitte Survey of US Health Care Consumers, "adult Medicaid beneficiaries own smartphones (86 percent) and tablets (69 percent) at the same rates as the general adult US population (86 percent and 72 percent, respectively)".[6] These data suggest that access to technology may not be a problem for this patient population, although access to broadband internet at reasonable prices may be. In reality, uninsured patients or those on Medicaid may benefit disproportionately by avoiding the costly difficulties associated with attending medical appointments,

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such as taking time off of work and securing child care.

We need only look at the history of medicine to see the reluctance of providers to embrace technological innovations. Given the benefits to patients of telemedicine, we must demystify clinicians' concerns to shift the curve to earlier adoption of this important technology—one Grand Rounds auditorium at a time.

References

1. Levine DM, Dixon RF, Linder JA. Association of structured virtual visits for hypertension follow-up in primary care with blood pressure control and use of clinical services. *J Gen Intern Med*. https://link.springer.com/article/10.1007%2Fs11606-018-4375-0. Published April 23, 2018. Accessed January 15, 2020.
2. Kew KM, Cates CJ. Remote versus face-to-face check-ups for asthma. *Cochrane Database Systematic Rvws 2016*. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD011715.pub2/abstract. Issue 4. Art. No.: CF011715. DOI: 10.1002/14651858.CF011715.pub2. Accessed January 15, 2020.
3. American Well. Telehealth index: 2019 consumer survey. https://static.americanwell.com/app/uploads/2019/07/American-Well-Telehealth-Index-2019-Consumer-Survey-eBook2.pdf. Accessed January 15, 2020.
4. Powell RE, Henstenburg JM, Cooper G, et al. Patient perceptions of telehealth primary care video visits. *Ann Fam Med*. 2017 May; 15(3): 225–229. doi:10.1370/afm.2095.
5. Kuo D, Gifford DR, Stein MD. Curbside consultation practices and attitudes among primary care providers and medical subspecialists. *JAMA*. 1998;280(10):905–909. doi:https://doi.org/10.1001/jama.280.10.905.
6. Majerol M, Carroll C. Medicaid and digital health: Findings from the Deloitte 2018 Survey of US Health Care Consumers. *Deloitte Insights*. https://www2.deloitte.com/us/en/insights/industry/public-sector/mobile-health-care-app-features-for-patients.html. Published September 7, 2018. Accessed January 15, 2020.

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