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What's New in the Patient Safety World

November 2020

Telemedicine Here to Stay But Use It Safely

One of the few positive things to come out of the COVID-19 pandemic (yes, there are some positives!) is that telemedicine has flourished. As shutdowns and restrictions and fear led to significant drop-offs in office/clinic visits, telehealth and "virtual" visits began to fill the gaps and both patients and clinicians have begun to see the benefits of such visits. Since CMS (Centers for Medicare & Medicaid Services) issued emergency waivers in April 2020 to allow payment for telehealth services and many other insurers followed suit, such visits have skyrocketed. A report from McKinsey & Co. in June concluded that 46% of consumers in the U.S. were using telemedicine, up from 11% a year earlier, and estimated that with changes such as replacing 20% of emergency room visits and 25% of health-care office visits, telemedicine eventually could account for a fifth of all Medicare, Medicaid and commercial insurance spending on outpatient, office and home health care (Cortez 2020).

But not all patients are ready for or able to participate in telehealth visits. And for many, clinicians must be aware of barriers they will encounter during such visits. Lam et al. (Lam 2020) estimate that 32% to 38% of older adults in the United States may not be ready for video visits. Many are inexperienced with technology and some don't have a computer or know how to use email. In addition, those with dementia or other cognitive impairment would need assistance from a caregiver or be unable to participate at all. Some may have problems speaking or making oneself understood. Some may have difficulty seeing well enough. But, perhaps, the biggest problem is hearing impairment.

Nieman and Oh (Nieman 2020) have very practical recommendations for connecting with older adults via telemedicine:

- Assume the patient has some degree of hearing loss
- Ask them if they have on their hearing aids and are in a quiet room
- Ask them to wear a headphones or a headset
- Put on a headset yourself
- Use video and have the camera focused on your face
- Use captioning when available
- Provide a written summary of key points and instructions

- Pay attention to cues, such as nodding along or looking to a loved one, which suggest a patient may not be following the conversation
- Have a backup plan (eg. audio by landline phone)
- Ask a loved one or care partner to join in, if necessary

Practical recommendations for telehealth visits have also been made by the AMA (AMA 2020), Canadian Patient Safety Institute and Canadian Medical Association (CPSI 2020), and the British Medical Journal (Car 2020). The National Consortium of Telehealth Resource Centers) also has a wealth of resources on telehealth (TRC 2020).

The Joint Commission (Joint Commission 2020) acknowledged some additional benefits of telehealth during the COVID-19 pandemic:

- Promoting social distancing
- Aiding in monitoring the progression of home-quarantined COVID-19 patients
- Enabling providers who are quarantined but asymptomatic to provide care remotely from their homes, thus mitigating the loss of highly needed resources
- Reducing the use of personal protective equipment (PPE)
- Helping patients with transportation barriers connect with their care providers

It stressed that your telehealth visits, of course, must be done on secure systems and are subject to HIPAA and all other security and confidentiality concerns.

It's also critical to recognize that not all conditions can be appropriately or safely managed via telehealth. Patients must be informed that certain symptoms (like chest pain, or even "indigestion" which might be a sign of an MI) merit immediate attention and should not be attempted via telemedicine.

Joint Commission stresses that organizations should develop protocols for virtual care and standards for which symptoms and conditions can be managed virtually They should also pay attention to regulations on scope of practice, noting that limitations regarding different health care disciplines can vary by state. It also has recommendations regarding training, supervision, workflow, and feedback.

Gallegos (Gallegos 2020) discussed issues from malpractice cases related to telemedicine. Diagnostic errors were the most prevalent issue, particularly related to the inability to perform a physician examination on the patient. Documentation issues were also important, citing cases where documentation included things that could not have been done during a telemedicine visit (like comments about heart rhythm or symmetry of limb strength). The article has recommendations about having a template for a post-visit summary to send to the patient and key elements to include in documentation of any informed consent done during a telehealth visit. Documentation should also include any patient refusal to come in for a recommended physical examination. It also notes the importance of ensuring a quiet environment for the telehealth visit and ensuring that the patient is able to adequately hear.

Some types of interaction are ideal for telehealth visits. The annual "wellness visit", where the focus is on managing risk factors, can often be fully accomplished using telemedicine. And the annual "brown bag" medication review that is so important in geriatrics is actually easier to do via telemedicine. The patient doesn't have to bring in their "brown bag" of medications but can simply show everything in their medicine cabinet to you via these communication links. It saves all time and still allows for face-to-face interaction. For years we have recommended that clinicians provide a phone call to most patients 24-48 hours after discharge from hospitals. Better yet, do that via a telemedicine visit!

One of the drawbacks of the telehealth visit is lack of a physical exam. But that is not always the case. Back in the early 1990's we developed one of the first telemedicine systems at the Erie County Medical Center, SUNY Buffalo's major teaching facility. We had contracts to deliver medical care for inmates at Attica Prison and other New York State prisons. It was very costly for the prison system to send inmates for clinic visits (they had to send at least 2 guards with each prisoner and this led to substantial overtime costs). So, we began using telemedicine visits. A nurse practitioner or physician assistant at the prison would be able to place a stethoscope so we could audibly appreciate heart sounds, lung sounds, bowel sounds, etc. The views of the tympanic membrane we'd see from their otoscope made us all envious. We even had a special glove lined with sensors that allowed us to examine the abdomen as the on-site clinician palpated the patient's abdomen. Of course, your typical patient does not have access to all these items in his/her home. But, someday, patients with certain conditions will be supplied with stethoscopes or otoscopes or other tools that will allow parts of the physical exam to become part of the telehealth visit. Some smartphones already allow transmission of reasonable fundoscopic views. Much of the neurological exam can be appreciated by watching the patient walk and talk (it's difficult for some patients to set up their webcam to allow viewing of their gait but it's easy to transmit video of their gait by their spouse or other using a smartphone).

Telemedicine has had a substantial impact on stroke care, particularly in rural areas. Physicians in rural ED's who were previously reluctant to diagnose strokes and begin thrombolytic therapy can now interact with a neurologist via telemedicine and be better positioned to make such decisions.

Telehealth can be a godsend for certain populations. Those with significant physical disabilities that limit their ability to travel to an office or clinic are likely to benefit. Patients in rural areas may avoid long trips to get access to specialists. There is a nationwide shortage of psychiatrists, particularly child and adolescent psychiatrists, and telehealth can improve access to these. Telehealth could also reduce the long wait times patients have to see another specialist in short supply, the dermatologist (though not all dermatological problems can be diagnosed in telemedicine visits). Followups from surgery may be facilitated by telemedicine by allowing visualization of healing wounds. Our April 7, 2020 Patient Safety Tip of the Week "From Preoperative Assessment to Preoperative Optimization" discussed how prehabilitation may help reduce complications prior to surgery. That included an opinion piece (Silver 2020) in the British Medical

Journal that suggested we should use prehabilitation to prepare patients for COVID-19 infections and that these interventions can be delivered while patients are practicing social distancing or are sheltering in place and can be easily delivered via telemedicine.

There is also a "good news, bad news" feature of telehealth – death of the waiting room. The good news is that patients won't be exposed to transmissible diseases in a waiting room. The bad news is that many patients actually like the social interactions that occur in a waiting room. But there is also an important point we make over and over regarding practice management – some of the most important people in your practice are your front line staff. Patients will often confide to them things they are reluctant to reveal to the clinicians (such as that they are not taking their medications because they cannot afford them).

One nuance of telemedicine that we consider extremely important is that it forces the clinician to actually look at his/her patient! All too often in today's more typical "face-to-face" office visits, the clinician is looking at a computer screen rather than at the patient. Body language and facial expression often convey much more meaning than the spoken word. By carefully observing those in your patient, you may recognize when they are having difficulty comprehending something. Those of you who give talks or chair meetings have probably begun to appreciate that same nuance as we've moved from the "old" webcast format to the new zoom format. If we see our audience fidgeting, we know it's time for a break. Similarly, if we see some of the yawning, we know it's time to move on to something else or deliver whatever ploys you use to wake up your audience.

Lastly, don't forget about the "old-fashioned" audio-only phone call. Many payers also relaxed some of the restrictions on care by telephone when the COVID-19 pandemic began and many clinicians have been impressed with how much care can be delivered via plain old basic telephone calls (Jaklevic 2020). They are particularly valuable for people who can't access a computer or smartphone.

Telehealth and "virtual" visits are clearly here to stay. But every hospital, office, clinic, or other healthcare organization must ensure that they deliver such services securely and safely as well as conveniently.

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