

THE Physicians Report

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8 Remote Patient Monitoring: How to Make It Work for Providers and Patients

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Navigating Telemedicine in a Hybrid World

The Future of Telemedicine Depends on Us

One of the offshoots of the coronavirus pandemic has been a surge in both awareness and use of telemedicine services. Published estimates suggest that the use of telemedicine during the early days of the outbreak in the United States soared to anywhere from 20 to nearly 80 times what it had been during comparable time periods the year before. This boom was aided by federal regulatory waivers that expanded physician reimbursements for Medicare-related telemedicine services and temporarily suspended penalties for failing to adhere to certain telemedicine protocols. While those numbers have subsequently declined, telemedicine usage remains significantly higher than in pre-pandemic days, and will likely continue to grow, in part due to ongoing government activity in this area.

Even before COVID-19 hit our shores, federal regulatory and legislative efforts had been focused on increasing access to telemedicine services. The Centers for Medicare & Medicaid Services (CMS) routinely expanded the list of telemedicine services for which reimbursements would be provided in the annual Physician Fee Schedule update. In addition, Congress regularly takes steps to increase access to specific services via telemedicine. In 2018, for example, legislation was enacted to allow telemedicine to be better utilized for treating substance abuse, another bill was signed into law to increase telemedicine treatments for stroke victims, and yet another bill was passed to waive state licensure requirements for Veterans Administration physicians treating patients across state lines.

While undoubtedly providing a valuable benefit to many Americans, this expansion of telemedicine does not come without

risks, especially when the interstate provision of telemedicine is involved. Questions remain about how health professional licensure and scope-of-practice requirements are to be enforced, what liability laws apply, and who is responsible when technology issues hinder telecommunications on either side of the patient-physician interaction. Thus far, Congress has failed to address any of those issues—and not because they are unaware of them. The Medical Professional Liability Association has repeatedly raised these concerns in individual meetings with members of Congress, before congressional hearings, and with the Congressional Telehealth Caucus, and we will continue to do so as federal legislators take additional steps to address telemedicine issues.

The expansion of telemedicine services is a win-win for both patients and healthcare professionals. Whether it remains that way will depend on what steps our elected leaders take to address the numerous questions that expansion entails. Regardless of whether the issue is reimbursement, liability, or access, it will be critical for healthcare stakeholders to remain informed and engaged so that those leaders are held accountable for their acts (or failure to act) regarding the future of telemedicine.



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Telemedicine Is Here to Stay. Are You Ready?



Seven Operational Strategies That Will Pay Off Now and in the Future

When demand for telemedicine skyrocketed during the first few months of the COVID-19 pandemic, healthcare leaders scrambled for solutions. Organizations that hadn't seriously considered telemedicine before were suddenly making it a priority; they jumped in with teleconferencing platforms, promoted their services to the public, and urged physicians to get on board. State legislatures passed payment-parity laws to ensure greater access and reimbursement.

Stuck at home but still needing medical care, patients responded enthusiastically to telemedicine. In February 2020, telemedicine usage for primary-care visits in the United States accounted for a sleepy 1 percent of all visits. By April 2020, it had ballooned to 43.5 percent. When outpatient clinics reopened in May and June, patients returned to their doctors' offices for check-ups and episodic care—but telemedicine

remains an attractive option for many. According to a recent McKinsey report, utilization has stabilized at a level 38 times higher than before the pandemic.

New COVID-19 variants and vaccine hesitancy have since created new uncertainty within the healthcare ecosystem. But it doesn't take a crystal ball to see that telemedicine—with its convenience, widespread acceptance, and potential for continued reimbursement—is here to stay.

What does your organization need to do to survive and thrive as you weather the challenges ahead? In this article, we'll take a look at seven key strategies that will help you create a sustainable telemedicine program that benefits patients, providers, and your organization as a whole.



“Only half of the counties in the state of Washington have a psychiatrist—some patients would have to drive two hours to see one. We need to be flexible in those situations because, for these patients, the choice may be telemedicine care or no care.”

DR. JOHN SCOTT, MEDICAL DIRECTOR OF DIGITAL HEALTH AT UW, SEATTLE, WA

ASSESS YOUR INFRASTRUCTURE

In the pandemic's early days, the spike in telemedicine was a stress test for many health systems' information-technology infrastructure. It also tested the digital capabilities of telemedicine vendors, and not all of them passed with flying colors. Inadequate data storage, slow servers, unreliable broadband connections, and weak security can sink a telemedicine program in a hurry; so can a telemedicine vendor whose software won't integrate with your current information-technology landscape. In its “Telehealth Implementation Playbook,” published in 2020, the American Medical Association recommends that organizations work with their IT department and a telemedicine vendor to:

- Ensure that the telemedicine platform seamlessly integrates with your organization's electronic medical record

- Assess the platform's impact on your internet and local network usage
- Capture data important to patients and providers and make it available to patients as appropriate
- Allow customization based on patient and provider preferences
- Ensure the ability to maintain patient identity across platforms, if applicable
- Establish patient geolocation for licensure purposes
- Connect remote patient-monitoring and biometric devices to the platform
- Offer a dedicated help desk for providers and patients facing technical challenges

EXPAND INTO SPECIALTY CARE—WHEN APPROPRIATE

Primary-care visits were the main attraction for telemedicine

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“Telemedicine can work well for patients with chronic diseases such as hypertension and diabetes—as long as they use at-home medical devices to monitor and report biometric information such as blood sugar and blood pressure.”

DR. JOHN SCOTT, MEDICAL DIRECTOR
OF DIGITAL HEALTH, UW, SEATTLE, WA



(Telemedicine Is Here to Stay, continued from page 5)

users during the height of the pandemic. Now, health systems are expanding video visits to include multiple specialties. Real-world experience is helping leaders identify which specialties are appropriate for telemedicine and which ones make more sense for in-person appointments. (See “Liability Implications and Recommendations for Telemedicine,” pg. 28.)

UW Medicine in Seattle has been grappling with this question and developing best practices for its clinics, says Dr. John Scott, medical director of digital health at the University of Washington. “We are finding that in-person visits are most appropriate for patients with eye complaints, since ophthalmologists use specialized equipment to view the retina,” he

explains. “The other two in the ‘in-person’ category include patients with abdominal pain and medically complex patients who tend to be brittle and need routine blood tests.”

He adds that telemedicine can work well for patients with chronic diseases such as hypertension and diabetes—as long as they use at-home medical devices to monitor and report biometric information such as blood sugar and blood pressure.

Mental-health services can be effective in the virtual and in-person setting; Dr. Scott says UW Medicine leaves it up to providers to decide which they employ. “Only half of the counties in the state of Washington have a psychiatrist—some patients would have to drive two hours to see one,” he says. “We need to

be flexible in those situations because, for these patients, the choice may be telemedicine care or no care.”

Dr. Scott, an infectious-disease specialist, has long been a proponent of telemedicine. In 2008, he launched Project ECHO at UW Medicine. This innovative telehealth platform helps clinicians in rural and underserved areas treat chronic diseases. Dr. Scott began using Project ECHO to treat patients with Hepatitis C, and the program has since expanded at UW Medicine to include other conditions.

SEEK INNOVATION

As telehealth gains wider acceptance among patients and providers, investors are taking notice. According to Rock Health, total venture-capital investment in the digital space in the first half



Stay Up to Date

on Best Practices and Telemedicine Legislation with These Helpful Resources

- American Telemedicine Association (AmericanTelemed.com)—Resources and information to help providers ensure access to safe, appropriate care.
- Center for Connected Health Policy (CCHPCA.com)—The CCHPCA is the federally designated National Telehealth Policy Resource Center. It works to maximize telehealth’s ability to improve health outcomes, care delivery, and cost-effectiveness.
- MHealthIntelligence (MHealthIntelligence.com)—This media website connects with leading subject-matter experts to provide news, featured stories, and emerging trends in mobile health, telemedicine, remote patient monitoring, and connected health for providers.
- Northwest Regional Telehealth Resource Center (NRTRC.com)—Assists healthcare providers, organizations, and networks in seven Northwest states in implementing cost-effective telehealth programs to serve rural and medically underserved areas and populations.

Depending on your state, state medical boards can be a valuable resource. The UW’s Cindy Jacobs encourages providers to reach out to medical board staff about issues affecting telemedicine, attend public board meetings (particularly when the board is proposing telemedicine-related regulations), and sign up for the organization’s newsletter, if available.

of 2021 totaled \$14.7 billion, more than twice the investment in 2019. That puts pressure on virtual health companies to innovate—which is good news for health systems that want to provide cutting-edge technology for their patients.

Some health systems, such as UC San Diego Health, have launched centers for innovation to develop telehealth devices and platforms. “Doctors, nurses, and medical teams know best where there are existing technology gaps in patient care,” Dr. Christopher Longhurst, the health system’s chief information officer, said in a press release. “Our in-house teams of clinicians and scientists will innovate solutions that lead to things like lower blood pressure with longer-term goals, like reduced number of hospitalizations and a longer life. With

our proximity to the health and biotech sector as well as to the cross-border region, the number of collaborative opportunities is immense.”

Your organization may not have the resources to develop the next big thing in telemedicine—but you can partner with vendors who do. Take it from Deb Muro, chief information officer at El Camino Health in northern California. Her team works with a telemedicine vendor that is launching closed-captioning and translation services for patients. (See “Lessons Learned by an Early Telehealth Adopter,” page 12.)

STREAMLINE OPERATIONS

If your organization cobbled together a telemedicine solution during the pandemic, you likely used multiple platforms that didn’t necessarily play

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Remote Patient Monitoring

How to Make
It Work for
Providers
and Patients

There's no place like home.

No matter how much providers and staff work to make a hospital stay or office visit pleasant for patients, there's nothing like being in your own surroundings, with your own creature comforts.

Healthcare providers are increasingly finding ways to keep patients at home when they might otherwise have needed to be at the doctor's office or in the hospital—particularly those patients who have chronic conditions that require frequent checking, or even those with acute conditions who are able to be discharged. Providers are accomplishing this with emerging remote patient monitoring programs that improve patient outcomes and overall quality of life, as well as reduce costs to providers.

Like much in the telehealth and telemedicine arenas, the development of remote patient monitoring (RPM)—even to the extent of “hospitals at home”—has accelerated dramatically because of the pandemic and the need to keep patients—especially vulnerable ones—safe from exposure to COVID, reduce exposure for healthcare professionals, and free up hospital beds. Also, prior to the pandemic, reimbursement of RPM was limited—but since COVID, Medicare coverage of RPM services has expanded, furthering its growth.

RPM Defined

Remote patient monitoring, sometimes called remote patient management or abbreviated as RPM, is a means of delivering healthcare using technology—usually through wireless mobile devices—to capture and transmit patient data, either from a remote healthcare location or outside of traditional healthcare settings altogether—that is, in the patient's home. Providers remotely monitor and assess the gathered data and give recommendations and directions. Usually RPM is managed by nurses or physicians' assistants—or contracted third-party RPM administrators—and escalated to a doctor when that's warranted by a change in the data.

RPM is most commonly used to check on patients with conditions like high blood pressure, diabetes, and obesity. Providers can use RPM to collect a range of health data, including blood pressure, heart rate, weight, and blood sugar levels, via devices like blood-pressure monitors, weight scales, and blood-glucose meters. Medication compliance can even be monitored when patients wear a patch that detects when they take their medications and relays that information to providers. Patients may also be given tablets for video calls with providers, or in order to fill out answers to questions about their symptoms.

“Hospital at home” care is next-level RPM for patients with acute conditions such as pneumonia, congestive heart failure, or even moderate COVID, managed via devices such as spirometers and ECG machines. These patients require more frequent remote monitoring and perhaps also regular home visits by medical providers.

How Did It Start?

Mark VanderWerf, a telehealth and telemedicine advisor and consultant in Worcester, Massachusetts, has seen the evolution of remote patient monitoring over the last three decades. A recognized leader in telemedicine and related technologies from the points of view of technology providers, service providers, and healthcare provider executives, VanderWerf has built successful telehealth programs and founded telemedicine companies. RPM began with clinician-to-clinician applications, he says—for example, a patient in a rural area would be connected remotely, through the primary-care physician they saw in person, to a specialist elsewhere for treatment.

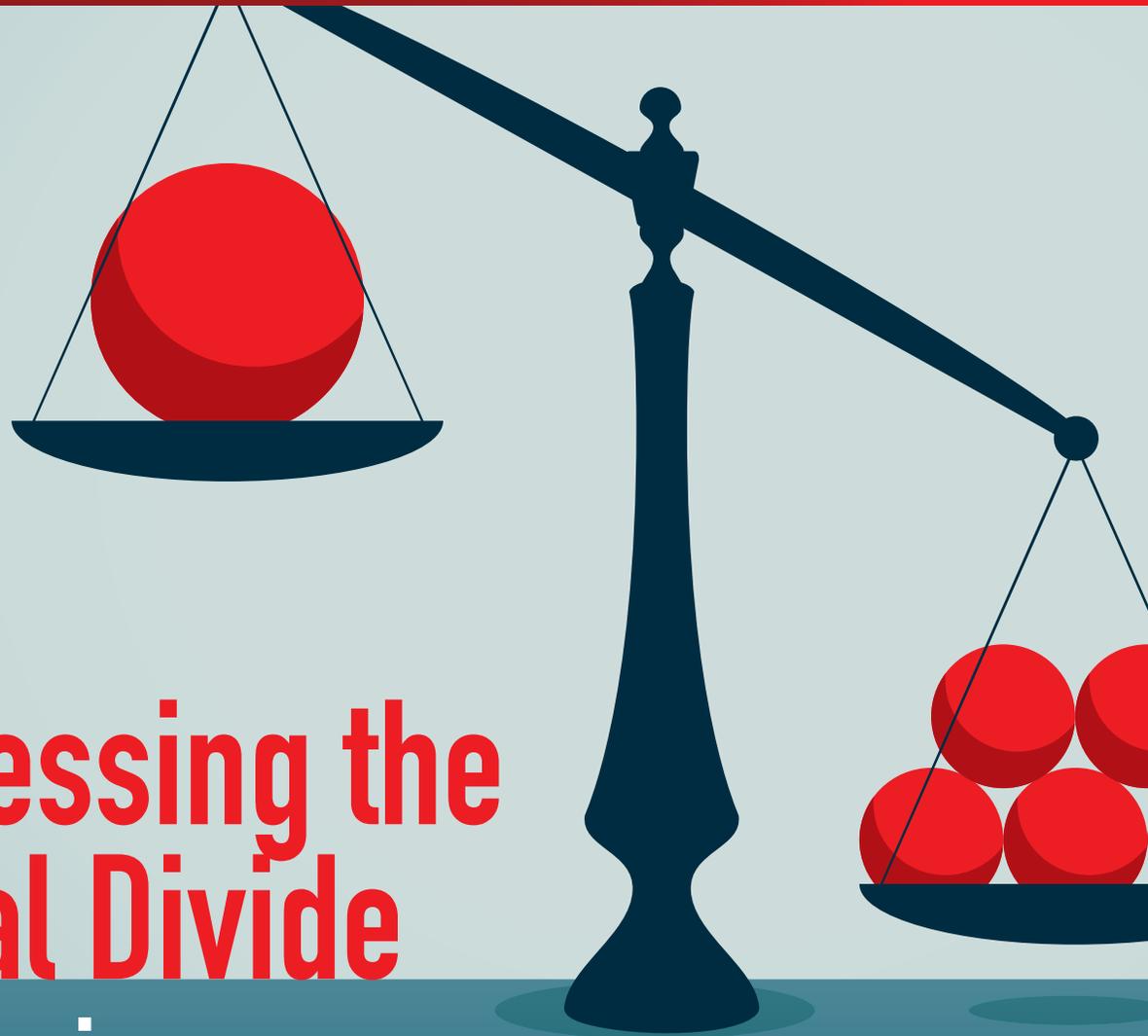
This type of application has developed in many specialty areas; one where dramatic success has been seen is stroke

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“You can create an ICU anywhere.”

MARK VANDERWERF, FATA,
TELEHEALTH AND TELEMEDICINE
ADVISOR/CONSULTANT,
WORCESTER, MASSACHUSETTS, MA



Addressing the Digital Divide

Overcoming Telehealth Inequities

The explosion of telehealth catalyzed by the pandemic is changing healthcare forever.

A hybrid model of care that includes both in-person and telehealth visits has emerged, and it's here to stay. But a very real digital divide is threatening to exacerbate health equity gaps, and it's up to healthcare providers to understand and address those disparities now, during telemedicine's nascent stage.

Here are some startling facts about Internet access. According to Pew Research, 26 percent of Americans earning less than \$30,000 rely exclusively on smartphone Internet access, and although most without Internet access live in rural areas, digital barriers also affect urban dwellers. For example,

in New York City, almost 50% of low-income households lack internet access, according to the mayor's office. All told, anywhere between 21 and 42 million Americans lack high-speed Internet access, according to the Federal Communications Commission. Nearly half of Americans without at-home Internet were in Black and Hispanic households, according to the *Harvard Business Review*. The American Medical Informatics Association (AMIA) has urged the federal government to recognize broadband access as a social determinant of health.



“Healthcare providers are encountering, and will continue to encounter, obstacles in telehealth. But we are learning a lot, fast, and finding solutions.”

DR. JOHN SCOTT, MEDICAL DIRECTOR
OF DIGITAL HEALTH, UW, SEATTLE, WA

In addition, even among those who are using telehealth, *The Los Angeles Times* recently reported that many who are not fluent in English do not get telehealth in their preferred language—especially those who do not speak Spanish, according to research by the California Pan-Ethnic Health Network. Its surveys also found that Asian respondents were less likely to have a private place for a telehealth appointment, and that Latinx respondents were most likely to report technological barriers such as an unreliable Internet connection.

As daunting as these challenges sound, John Scott, MD, Medical Director of Digital Health for UW Medicine, urges healthcare providers not to become overwhelmed by the digital divide.

Dr. Scott is an early telehealth pioneer and currently oversees the development of new telehealth applications throughout the Pacific Northwest. He’s seen the gradual development of telehealth as technology became more affordable, cloud-based videoconferencing took hold, and people began using these technologies in their personal lives. He’s seen what once seemed impossible become everyday practice. As healthcare moves into the brave new world of telehealth possibilities and challenges, he’s already seeing providers find solutions to barriers—at warp speed, no less—and knows it’s a harbinger of more to come.

“Healthcare providers are encountering, and will continue to encounter, obstacles in telehealth,” he says. “But we are learning a lot, fast, and finding solutions.”

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Lessons Learned by an Early Telehealth Adopter

By Deb Muro, Chief Information Officer at El Camino Health

When the need for telemedicine surged

during the pandemic, many healthcare leaders probably thought the same thing: Oh no! But for people like me who have been promoting telemedicine for years, it was more like: Finally!

My interest in telemedicine goes back to my days as a nurse, when I was asked to lead the implementation of a new bedside computer system to help care for inpatients. I was captivated by technology's potential to assist clinicians in their daily work. I eventually left nursing and became a healthcare tech professional, and in 2014 joined El Camino Health, a system that includes two not-for-profit acute-care hospitals in Los Gatos and Mountain View, California.

For the next five years, my teams worked with various departments to introduce telehealth initiatives, such as remote monitoring and psychiatry consults. We launched video visits, too—but up until early 2019, those only represented 1 percent of all clinic visits in the industry.

I was eager to do more with telemedicine and started digging into what it would take to expand our video-visit platform. I saw video visits as a way for physicians to ensure that patients were doing well between episodes of care. It took time to convince our organization of this new tool's capability, and progress was slow. In late 2019, we selected a vendor who could staff and provide on-demand video visits 24/7 and help us deliver video visits with physicians in our clinics. That hybrid approach was important to us. We want to be available for patients 24/7, but we cannot staff a service like that from within.

The pandemic hit just as we were planning our launch. One day early in the crisis, my team was asked to ramp up a telemedicine offering to assess patients exhibiting symptoms of COVID-19. Thankfully, our vendor was able to do it in a matter of days.

The service met a vital need for people in our community who needed care during a stressful time. Soon we added primary-care and even specialty-care video visits. Now patients can use their

computer, smartphone, or tablet to schedule a virtual appointment with one of our providers, or see a provider on demand.

At El Camino Health, in Los Gatos and Mountain View, CA, we were fortunate to have a telemedicine partner in place just before the pandemic began. But we were even more fortunate to have selected a vendor who could help us ensure the platform's long-term growth and stability. If you are choosing from the hundreds of telehealth vendors out there today, I recommend looking for one who:

- 1. Is fully dedicated to healthcare,** and not serving multiple industries. A single focus on healthcare means more knowledge, expertise, and specialization.
- 2. Offers a product that will fully integrate** with your health system's electronic medical record system. This will allow doctors to conduct the visit, enter notes, view documentation, and see other data related to the patient's medical care, all in one place.

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“If patients don’t have devices, can providers send them home with devices for eight weeks of follow-up? If they don’t have Internet access at home, is there a library or a police or fire department in town that has a private kiosk set up for telehealth visits? If there is a cultural divide, how do we learn to communicate effectively and appropriately?”

NICHOLE PERISHO, BA, BSN, RN, PROGRAM DIRECTOR, NORTHWEST REGIONAL TELEHEALTH RESOURCE CENTER

(Addressing the Digital Divide, continued from page 11)

Fast being the operative word. In February 2020, about 200 UW Medicine healthcare-system providers logged about 200 telehealth visits. In May 2020, 3,800 providers in the system had 33,000 visits. And the numbers keep growing.

“The genie is out of the bottle,” Dr. Scott says. “People tried it to avoid exposure to COVID-19 and realized how convenient and easy it is. There’s no going back.”

The three drivers of future telehealth growth, he says, are increased broadband access, device access, and digital literacy. The \$1 trillion infrastructure bill that Congress passed in August will go a long way toward increasing broadband where there are deficits. Device access is being addressed in many different ways—from Medicaid providing tablets to

recipients who demonstrate need, to companies like Amazon and Microsoft giving them away as those tech giants lay the groundwork for getting into the business of healthcare themselves. Digital literacy is being tackled at a grassroots level, with opportunities for education arising at local libraries and community centers.

Where providers are concerned, he said, there are three non-negotiables for getting patients to use telehealth: it must be private, reliable, and easy to use for both patients and providers.

“You need to create an interface with as few clicks as possible,” he says. “We work hard on the back end to do that.” He says that ideally there’s no downloading of an app; rather, it’s just a link, which can be texted to the patient, where the patient logs in, sees the visit, and clicks to connect.

Dr. Scott explains that it’s important to educate the patient, before telehealth is used, about privacy and how the equipment works. One way to do that is creating a video with instructions, in the language that patients prefer.

Contracting with interpreter services ensures straightforward communication once the visits take place. Zoom does provide closed captioning, and sign-language interpreters are an option as well.

“You can have a very good experience connecting with a patient over video, but you have to make them comfortable,” Dr. Scott says. “Show them the actual room, not a background. Show them your badge, that you really are a doctor. Show them that you’re writing notes, so they don’t think you aren’t paying attention. Share your screen, and look at labs and X-rays together. Come close to the camera with your face. Use facial and body language to express caring.”

TELEHEALTH TOOLKIT

Just like patients, providers have their own digital learning curves to surmount—and help is out there.

Nichole Perisho serves as Program Director at the Northwest Regional Telehealth Resource Center (NRTRC), creating and disseminating information and resources to expand and sustain telehealth in NRTRC’s seven-state region (Alaska, Idaho, Montana, Oregon, Utah, Washington, and Wyoming). A 10-year veteran in the telehealth field, Perisho is working to develop telehealth’s critical role in achieving the quadruple aim of reducing cost, improving quality, enhancing the patient experience, and bettering the work life of healthcare staff.

Created in 2005, NRTRC is a Health Resources and Services Administration

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OVERVIEW

Telehealth's Policy Landscape



When it became apparent in early 2020 that COVID-19 would have a significant impact on our lives and particularly on the United States healthcare system, immediate action needed to be taken.

As the highly infectious virus had devastating effects on patients, we watched as national economies came to a standstill and necessary supplies became scarce. Immediately, telehealth was looked to as a tool to help combat the pandemic.

Telehealth is the use of technology to provide healthcare services from a distance, when the parties are not in the same location. It seemed an ideal tool for the time: patients could still receive healthcare services, but physical exposure could be limited and precious personal protective equipment could

be conserved. But as beneficial as telehealth was, why wasn't it already being utilized? Instead, doctors, hospitals, and clinics had to scramble to set up telehealth programs, often literally overnight. Why wasn't America ready?

Though telehealth itself has been in existence for decades, it was slow to be adopted for a variety of reasons. For one, until recently, the technology was not necessarily at a point where it could be used effectively to provide health services. Additionally, telehealth policy only began to appear on the federal and state levels in the mid-1990s. Much of the telehealth-specific policy that had evolved to that point centered around reimbursement—what and who could be paid and covered, if healthcare was delivered remotely. Existing policies were very restrictive among Medicare and Medicaid programs; the reasoning being that the technology was all very new and policymakers were uncertain about their efficacy—which, if we think about the technology available then, were justifiable concerns.



COVID-19 pushed telehealth policy forward by a decade in terms of policy and adoption—but only on a temporary basis.

Over the next quarter-century, however, the technology developed rapidly and began to quickly outpace the telehealth policy landscape. The development of telehealth policy was also uneven across jurisdictions: some states were more progressive in their development than others, and the federal telehealth policy landscape, primarily with Medicare, practically stalled after 2010. This varying landscape led to many clinics and facilities not investing in or adopting telehealth, because there was no reimbursement for it. Therefore, when the pandemic hit, the state and federal governments were in very different places on telehealth—underscoring the wide range of telehealth capabilities across the nation.

COVID-19 upended this policy landscape. Significant limitations that telehealth advocates have been urging lawmakers for years to change were waived overnight. Federal and state temporary waivers greatly expanded how telehealth could be used, by whom and where, and what would be covered, and COVID-19 pushed telehealth policy forward by a decade in terms of policy and adoption—but only on a temporary basis.

TEMPORARY COVID-19 CHANGES

Significant temporary telehealth policy changes were made on both the federal and state levels. Federally, the major policy changes centered on what was allowed to be covered and reimbursed in the Medicare program and how those

services could be delivered. Other temporary waivers included relaxation of HIPAA laws, allowing for the wider use of certain platforms, and waivers on the number of telehealth visits that could take place. On the state level, the temporary changes mirrored those seen on the federal level, but also included certain policies that are under states' purview, such as licensing, Medicaid access, and the establishment of a patient-provider relationship.

One significant, temporary change was allowing the use of audio-only appointments to deliver services (though how extensively these could be used varied from jurisdiction to jurisdiction). Pre-pandemic, most established

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(Telehealth's Policy Landscape, continued from page 15)

telehealth policies did not consider audio-only to be under the umbrella of telehealth; however, recognizing that not all segments of the population could readily and reliably access live video, audio-only appointments were allowed as an option.

One of the greatest achievements with telehealth during the pandemic was how quickly organizations were able to establish a telehealth program from scratch. There are numerous stories of community health clinics, such as federally qualified health centers or rural health clinics, which, faced with the immediate need or opportunity to provide telehealth services to their patients, transitioned into using telehealth technology in a matter of days—some as quickly as 48 hours. It is uncertain how much telehealth may have assisted in reducing the transmission of COVID-19, but its impact in this regard cannot be discounted.

In the early months of the pandemic, there was a dramatic rise in telehealth utilization. From March to June 2020, 34.5 million services were delivered via telehealth in Medicaid and CHIP.¹ This represented a 2,632 percent increase of services via telehealth compared to the same period in 2019.² Since that time, we've seen the use of telehealth dip from these higher numbers—though some types of services, such as mental and behavioral health, continue to see high utilization.³ The drop has been attributed to more patients seeking in-person visits and the “opening up” of more states as COVID-19 has appeared to recede.

Other positives that we were seeing were patient satisfaction with the services and reduced no-show rates. In one study, researchers found that between March 16 and May 1, 2020, telehealth appointments had a lower no-show rate compared to in-office

Increasingly, many believe that when the pandemic is over, we're likely to see more of a hybrid model in care delivery, with providers and institutions still providing services in-person but also utilizing telehealth to deliver some care. Which policies are made permanent will determine exactly what those models look like.

visits. In a survey of 2,000 patients conducted by the COVID-19 Healthcare Coalition that includes the American Medical Association, American Telemedicine Association, and other healthcare stakeholders, 83 percent of those surveyed thought their telehealth visit was of good quality and 78 percent felt their concerns could be addressed by telehealth.⁵

However, telehealth has not been the panacea for all problems. Every telehealth proponent will tell you that there are still things that need to be done in-person. Additionally, the fact that telehealth had been so underutilized prior to the pandemic meant institutions had to switch rapidly to using it, causing some bumps along

the way. It also meant that states with a history of more progressive telehealth policies likely had more developed and robust telehealth programs that could more easily transition into providing a higher volume of services than states with less robust programs. And lastly, as noted earlier, not everyone has access to telehealth, due to potential connectivity issues, access to equipment, or the digital literacy to engage in a telehealth interaction. Concerns have been raised on whether the use of telehealth will create inequities among certain populations.⁶ (See “Addressing the Digital Divide,” page 10.) As federal and state policymakers decide which of the temporary waivers to retain on a permanent basis, the telehealth policy landscape becomes even more diverse as different approaches are taken: rolling back to pre-pandemic policies, adopting or expanding temporary policies, etc.

Some have questioned whether the drop in telehealth utilization is indicative that telehealth has been a flash in the pan. However, the majority opinion appears to be that the genie is out of the bottle—and while we likely will not again see the high numbers that characterized the beginning of the pandemic, we also won't be reverting back to where telehealth was pre-pandemic. Increasingly, many believe that when the pandemic is over, we're likely to see more of a hybrid model in care delivery, with providers and institutions still providing services in-person but also utilizing telehealth to deliver some care. Which policies are made permanent will determine exactly what those models look like.

DECIDING THE FUTURE OF TELEHEALTH POLICY

While this article was being written, we were far from a post-pandemic world, due to the surge of the Delta

variant—but policymakers have been discussing, and in some cases deciding, which temporary telehealth policies to make permanent. As it was before the pandemic, the telehealth policy landscape continues to be a patchwork of different policies, approaches, and thinking, as policymakers in different jurisdictions make different decisions on varying timelines.

At the end of the summer of 2021, very little progress has been made on making telehealth policy permanent on the federal level. This is partially due to the fact that most of the major telehealth policy changes on the federal level would require passage of new legislation. At this stage, there have been some administrative proposals on what to make permanent—including some changes that the Centers for Medicare and Medicaid Services (CMS) can make, such as changes involving audio-only provision of mental-health services.

On the state level, the changes vary from state to state. Some states started making their policies permanent in 2020; North Carolina and Tennessee were early states to do this. However, it should be noted that these two states had very little in the way of telehealth Medicaid policies prior to the pandemic, and what they adopted had limitations. (For example, Tennessee Medicaid allowed audio-only as a service modality, but only for the delivery of mental-health services for the treatment of substance-use disorders.)

Other states are postponing this decision by extending their temporary policies for an additional year or two, citing the need to have more data and time to examine the effectiveness of telehealth.

HOW WILL THINGS LOOK ONCE THE PANDEMIC IS TRULY OVER?

Where policymakers appear to be heading is a landscape that, for the

most part, is not what it was pre-COVID-19: some temporary policy changes will be made permanent, but to a varying extent federally and from state to state. What is also likely to happen is that at least a good portion of providers will not revert to a strictly in-person model, instead adopting a hybrid in-person/telehealth model. There are several reasons this kind of model may make sense:

- The policy landscape will be such that providers can incorporate more telehealth in their practices without sustaining financial loss
- There will likely be enough demand from patients who experienced telehealth for the first time during COVID-19 to keep telehealth services available for at least some services
- All aspects of our lives have become increasing intertwined with technology, and not incorporating telehealth puts a provider at risk of being left behind
- Providers want to be ready for the next pandemic

We are still in the midst of the pandemic, and the telehealth policy landscape is still evolving. But one thing is clear: telehealth will continue to provide services to patients and be used as a valuable tool to help save lives. 



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Learn More

It's vital that providers continue to be informed and updated on these policy changes, as they will impact their practices. Additionally, providers should continue to be part of the discussion of the evolving landscape, because at the end of the day, they're the ones who will be utilizing this technology and delivering these services. To keep abreast of state and federal changes, providers can go to the Center for Connected Health Policy's website at cchpca.org and subscribe to CCHP's newsletters and alerts to let them know when major changes in telehealth policy are occurring.



GOVERNMENT RELATIONS

GOOD SAMARITAN LEGISLATION REINTRODUCED IN THE HOUSE OF REPRESENTATIVES

On Friday, September 10, 2021, Representative Raul Ruiz, MD (D-CA), and Larry Bucshon, MD (R-IN), reintroduced the *Good Samaritan Health Professionals Act* in the U.S. House of Representatives. H.R. 5239—117th Congress: *Good Samaritan Health Professionals Act of 2021* (Link: govtrack.us/congress/bills/117/hr5239) is identical to the bill that was introduced in the 116th session of Congress. Our champions in the Senate, Senator Bill Cassidy, MD (R-LA), and Senator Angus King (I-ME), plan to reintroduce a companion bill in the U.S. Senate in the upcoming weeks.

The *Good Samaritan Health Professional Act* amends the *Public Health Service Act* to limit medical liability protections to healthcare professionals who cross state lines to volunteer their time and skills to treat victims of federally declared disasters. The bill encourages medical professionals to join volunteer registries like the Emergency System for Advance Registration for Volunteer Health Professionals (ESAR-VHP) to expedite deployment and resources in the event of a federally declared disaster.

The *Good Samaritan Health Professionals Act* will ensure that victims of federally declared disasters and public-health emergencies will have adequate access to medical care following a catastrophic event. The current variations in state laws that aim to encourage medical volunteerism are ambiguous and inconsistent, especially when applied to large-scale events. Congress enacted volunteer liability protections

in the *Coronavirus Aid, Relief and Economic Security (CARES) Act* last year; however, those protections are limited to the treatment of COVID-19. The *Good Samaritan Health Professionals Act* corrects these problems by applying the same volunteer protections from the *CARES Act* to volunteers responding to future disasters or public health emergencies.

We are grateful and pleased to have bipartisan support for reintroduction, and we are working to increase support throughout the congressional community. Anne Bryant, Senior Director of Government Relations at Physicians Insurance, serves as our in-house lobbyist and chairs the MPL Association's Government Relations Committee, our national medical professional liability trade association. The Medical Professional Liability Association will be hosting a 2021 Capitol Hill Week the week of November 1, 2021, to promote opportunities for the medical community and MPL industry leaders to meet with their federal lawmakers to encourage support for the *Good Samaritan Health Professionals Act*, as well as to discuss other issues of importance to the medical liability community. ^{PR}

More Information

To learn more about our Government Relations efforts, contact: Anne E. Bryant, Senior Director of Government Relations, at anne@phyins.com.



Lessons Learned Curbside Consults

Our Risk Management team regularly monitors our members' practice trends to proactively identify potential risk exposures. This highlight of "lessons learned"—gleaned from various resources and approved by Risk Management consultants—could help reduce our members' liability and risk exposure and improve patient safety and outcomes.

WHAT CONSTITUTES A CURBSIDE CONSULT

One type of consultation that occurs in medicine is known as a "curbside" consult, which takes place when a provider informally seeks advice about a patient from another provider who is not otherwise involved with the patient. The issues are not complex, and the treating provider presents only basic details of the case. It is strictly a discussion, and

does not involve seeing the patient or reviewing medical records.

The following are **not considered characteristic of curbside consults**:

- The consultation involves a question posed to an on-call provider.
- The consultation occurs between a supervising physician and the healthcare provider being supervised.
- The consultation is rendered by a provider who has a preexisting patient-provider relationship with the patient in question, or who is covering for a provider who has that relationship.
- The consultation is for a patient in active labor, a patient who is critically ill, or a patient whose condition is rapidly deteriorating.

The situations listed previously describe **formal consultations** rather than curbside consults.

BLURRING THE LINES MAY INCREASE LIABILITY

When the dividing line between curbside and formal consults becomes blurred, greater liability concerns may arise. Traditionally, medical malpractice liability exists in the context of a provider-patient relationship, and a true curbside consult should not give rise to one because the consulting provider has not seen, treated, or cared for the patient themselves. But liability problems can arise when the dialogue moves beyond generality and into the realm of specific patient care.

In the following situations, a **formal consultation is likely more appropriate** than a curbside consult and should be considered:

- The medical situation is complex, or advice cannot be given without examining the patient or the records.
- The scope of the discussion identifies a patient and involves his or her specific medical issues.
- The treating physician returns with a second question regarding the same patient.

(Continued on page 25)

Questions?

To learn more about how we can support your goals for mitigating risk, contact our Risk Management team at (800) 962-1399 or by email at riskmanagement@phyins.com or riskmanagement@medchoicerrg.com.

Getting a Handle on Data Security Is Key in the Expansion of Telehealth



The headlines are scary about a lot of things these days—and now we can add cybersecurity to the list, especially when it comes to healthcare.

We've all heard the reports: "Ransomware attacks on the rise!" and "Healthcare organizations under siege!" Unfortunately, it's not fake news.

Healthcare providers have enormous cause for concern—for the security of their systems, for the privacy and safety of their patients, and for their liability. The expansion of telehealth during the pandemic and beyond increases vulnerabilities as healthcare delivery and technology become increasingly intertwined, and as visits take place outside clinic walls.

However, there are some practical steps providers can take to protect themselves from cyber-attacks and their repercussions.

ATTACKS INCREASING

According to a recent report from the Ponemon Institute, 67 percent of healthcare organizations have experienced ransomware attacks, and a third of those say they've had two or more. (The Ponemon Institute, a research center focused on data protection, surveyed IT professionals at nearly 600 healthcare organizations—including health systems, physician groups, and payers—that provide clinical care and rely on third-party security contractors.)

The problem is escalating. The healthcare sector accounted for 79 percent of all reported data breaches in 2020, with the rate of attacks ramping up significantly into 2021. That's more than twice the

rate seen in other industries, according to reports from Check Point and Fortified Health Security.

Last year, healthcare data breaches were caused primarily by hacking and IT incidents, which accounted for 69 percent of all breaches. Unauthorized access was the second top cause, representing 20 percent of breaches. Network server attacks were also on the rise.

Why are attackers targeting healthcare more than other sectors? For starters, healthcare organizations hold a treasure trove of sensitive, valuable information. Second, healthcare organizations have been upended by COVID on many fronts—increased patient-care demands, staffing challenges, shifts to

remote work, and finally, new telehealth systems—and attackers are trying to take advantage of the disruptions. Third, attackers believe healthcare providers are more likely to pay ransom demands because lives are at stake.

Ransomware attacks do more than breach systems and hold data hostage—they actually impact patient care and increase mortality rates, according to the Ponemon Institute report. The same report found that following ransomware attacks, nearly a quarter of healthcare providers reported increased mortality rates, and more than 70 percent of providers reported longer stays or procedural delays that led to poor outcomes. More than half of organizations also reported an increase in patient transfers, and more than a third reported increased complications from medical procedures.

They're also expensive. Ransomware attacks cost healthcare organizations \$20.8 billion in downtime in 2020, double the amount they cost in 2019, according to a Comparitech report. An IBM report found that data breaches in the healthcare industry cost an average of \$9.23 million each.

LIMITING RISK

While expanding telehealth is part of the disruptive change that hackers thrive on, most attacks haven't been specific to telehealth, says Joe Gellatly, CEO and cofounder of Medcurity. Most telehealth is delivered through third-party vendors, which are technology companies that should have greater expertise in cybersecurity.

Telehealth does create potential risk, Gellatly cautions, with care being delivered online, anywhere, on unsecured devices. The risk, though—at least on the patient-interaction level—is primarily the vendor's. "Patient devices aren't gaining any

"The vendor is where your risk starts, so make sure you're working with a great vendor. If you rushed into an arrangement to accommodate telehealth, now is the time to go back and evaluate. Remember, there's more than liability risk—there's also risk to your reputation. Your patient doesn't have a relationship with your vendor—your patient has a relationship with you."

JOE GELLATLY, CEO AND
COFOUNDER OF MEDCURITY

access to protected health information on your network," Gellatly says. But it's important for providers to protect themselves from liability caused by breaches at this level through Business Associate Agreements.

Medcurity is a cloud-based tool that helps providers meet the security and

privacy rules of HIPAA (the Health Insurance Portability and Accountability Act). The company guides clinics and hospitals and their business associates through their annual HIPAA Security Risk Analysis, with recommended remedial actions and action-item tracking via dashboards. The Medcurity platform also provides customizable policies and procedures, as well as Business Associate Agreement management through electronic signature.

The federal government waived enforcement of HIPAA penalties for good-faith use of telehealth during the nationwide COVID-19 public health emergency. But this grace period, which is renewed every 90 days (and was last renewed July 20, 2021), will eventually come to an end—likely soon—and then telehealth offerings must be HIPAA-compliant or face penalties.

The risk to the provider isn't so much in the patient-vendor connection, but rather in the vendor-provider connection. According to the Ponemon Institute report, less than half of respondents completed a risk assessment of their third-party security vendor before contracting with them. Healthcare providers need to ensure that they secure their internal networks from third-party vendors by making sure those vendors have been risk-assessed—using a tool such as Medcurity—as thoroughly as the provider's own internal network.

"The vendor is where your risk starts, so make sure you're working with a great vendor," Gellatly says. "If you rushed into an arrangement to accommodate telehealth, now is the time to go back and evaluate. Remember, there's more than liability risk—there's also risk to your reputation. Your patient doesn't have a relationship with your vendor—your patient has a relationship with you." 

Remote and Hybrid Workforces

Rethinking HR Questions



The COVID-19 pandemic has not only filled hospitals, exhausted healthcare workers, killed hundreds of thousands of people, and sickened millions—it has also caused healthcare organizations to change and rethink many human-resources questions.

What are the legal questions surrounding government vaccine mandates? What policies are needed for remote and hybrid workers? What liability questions are raised when patients receive healthcare through telemedicine?

All these changes in such a short period of time have required HR departments and legal advisors to quickly create new policies and figure out how to implement them while keeping caregivers and patients safe. And all of this is coupled with the need to keep up with new rules—just as science,



If an unvaccinated employee receives an exemption, is allowed to work, becomes sick, and infects a patient, is the healthcare organization liable? If a healthcare organization denies an exemption and fires an employee, can the organization be sued?

created an internal-facing intranet with all our policies and FAQs.

“Our response team is the vehicle for us to stay on top of everything COVID-related, large or small, for anyone in the organization who has a question,” he adds. “It helped us maneuver through telehealth, work-from-home requirements, and rules the state and CDC made for workplace safety. We’ve done well to have an in-the-moment pulse on things, to give us the best guidance to minimize the spread of COVID.”

Nearly two years into the pandemic, healthcare employers are still creating new HR policies as the situation evolves.

VACCINE MANDATES AN ONGOING CHALLENGE

One of the most challenging issues facing healthcare organizations is how to implement vaccine mandates. Not only do these mandates vary from state to state, but the federal government has issued its own as well. When the mandates were initially announced, not all details about how to implement and enforce them had been worked out, raising questions and leaving companies to interpret how to appropriately implement them. Some of the mandates allow for religious and disability-related exemptions.

Jennifer Smitrovich, an attorney with FAVROS Law in Seattle who advises healthcare organizations, calls the mandates a “hot-button issue” without specific direction on how companies should determine what qualifies for an exemption. “Employers are worried about how to implement the mandate, how to apply the exemptions,” she says. “And if an employee isn’t vaccinated, what do you do with them? Fire them?”

On top of that, there are liability questions. If an unvaccinated employee

guidance, and best practices are changing at an unprecedented pace.

COVID-19 RESPONSE TEAM KEY

Joe Smecker, director of operations with Western Washington Medical Group (WWMG), which operates 20 care sites with nearly 500 employees in Snohomish County, Washington, recalls early 2020, when some of the organization’s physicians were the first to treat a COVID-positive patient at Providence Regional Medical Center in Everett, Washington.

“It was very early when we decided as an organization to create a COVID response team, which included members of leadership, including the medical director, physician leaders, and the administrative team,” he says. “The group stays on top of the CDC guidelines and provides two-way communication between staff and patients. We communicate evolving policies, best practices, and recommendations for all of our workplaces—including masking, distancing, quarantine and exposure parameters, and incident response. We

(Continued on page 24)

"90 percent of our organization's workers never went fully remote. But WWMG nevertheless worked hard to create work-from-home policies, contracts for manager/employee expectations, and IT guidance to make sure all HIPAA rules were followed for those employees who worked remotely—mainly administrative and IT staff."

JOE SMECKER, DIRECTOR OF OPERATIONS, WESTERN WASHINGTON MEDICAL GROUP



(Remote and Hybrid Workforces, continued from page 23)

receives an exemption, is allowed to work, becomes sick, and infects a patient, is the healthcare organization liable? If a healthcare organization denies an exemption and fires an employee, can the organization be sued? "There is a lot of uncertainty, and that's making employers nervous," Smitrovich says.

The government entities that required the mandates promised additional guidance after the fact, and some lawsuits have been filed. Smitrovich advises employers to address each situation individually. "I'm telling people to keep reviewing [the guidelines] to see if there's any more guidance, additional qualifiers—work with their employees individually to determine if they actually have a basis [for an exemption]," she says. "There's no easy answer. People are struggling with it."

WWMG implemented its own vaccine mandate right before Washington Gov. Jay Inslee announced the statewide vaccine mandate for healthcare workers. Smecker's organization's mandate applies to all healthcare workers and contractors who enter a care site. When the mandate was announced, more than 85 percent of WWMG workers were already vaccinated.

A bigger issue his organization faced involved procedures for employees exposed to COVID. Any exposed employee was sent home and asked to quarantine based on CDC and other governmental guidelines. Employees were also asked to continue to do their jobs from home if possible; for example, physicians who were quarantined were asked to see patients using a telehealth system if possible.

REMOTE WORK

The question of who worked remotely and the rules surrounding remote work also had to be worked out early in the pandemic. While the majority of healthcare workers never had the choice or luxury of working from home during the pandemic, those who did not work directly with patients were able to work remotely to reduce exposure to the virus. But having some employees work from home while others stayed in the healthcare setting provided its own set of challenges.

Smitrovich says some of those challenges included onboarding new employees, training them to use specific technology, developing a sense of camaraderie and teamwork among employees who had never met or worked together in person, evaluating employees and measuring productivity,

and protecting patient privacy in a remote setting.

Securing patient-health information is especially important as remote workers use their own technology, which may not be controlled by an organization's IT staff. Smitrovich says she is especially concerned about smaller organizations that don't have large IT staff and protocols. "The employer has the burden, if they're allowing anybody to work from home, to ensure that HIPAA is complied with, that they have safeguards in place, and that they have programs that are HIPAA-compliant," she says. (See "Getting a Handle on Data Security Is Key in the Expansion of Telehealth," page 20.)

Smecker says that 90 percent of his organization's workers never went fully remote. But WWMG nevertheless worked hard to create work-from-home policies, contracts for manager/employee expectations, and IT guidance to make sure all HIPAA rules were followed for those employees who worked remotely—mainly administrative and IT staff.

A SILVER LINING

Interestingly, the pandemic allowed WWMG to implement a telemedicine system that it had faced roadblocks launching in the past. "Prior to COVID,



(Curbside Consults, continued from page 19)

- The treating physician is suspending his or her own professional judgment and is relying on the consultant's advice to determine the course of the patient's care.
- The patient has requested the consult or knows that a consultation is being obtained, and therefore, arguably, a physician-patient relationship has formed.

PRACTICAL CONSIDERATIONS

Here are some practical considerations to follow when using curbside consults:

- At the outset, the requesting and consulting provider should explain the expectations and understand that the consultation is informal.
- Generally, patient identifiers and medical records should not be reviewed during a curbside consult. The dialogue should address general issues and be relatively brief.
- The treating provider should alert the consulting physician if the consultation is being included in the medical record.
- When a physician does document a curbside consult, the note should be brief and include the nature of the consult.

To help ensure minimal risk of liability for the treating or consulting provider, it is important that providers communicate clearly and avoid common pitfalls that can create the impression of a more formal consultation. The convenience and ease of curbside consults must be balanced with the needs of the patient, and when in doubt, a formal consultation should be obtained. [PR](#)

WWMG did zero telemedicine exams because payers wouldn't reimburse," Smecker says. "During the first peak of the pandemic, 50 percent of physician visits were done via telehealth. Since then, the number has fallen as patients received vaccines and became more comfortable coming into a clinical setting. The organization will continue to offer telehealth visits as long as insurance will reimburse."

Going forward, Smecker expects WWMG to continue to use a hybrid approach when seeing patients and conducting business. Holding video meetings for staff rather than requiring everyone to meet in person saves time for clinicians spread over a large geographic area. Video meetings have also proved valuable for initial job interviews, saving time and money previously spent on flying in physician candidates for interviews early in the recruitment process.

As the COVID-19 virus continues to morph, healthcare organizations will be forced to change and evolve their policies to best serve patients. The initial learning curve has been steep and challenging. But nearly two years from when COVID first struck in the United States, healthcare practices have made significant advances and will continue to do so in the future.

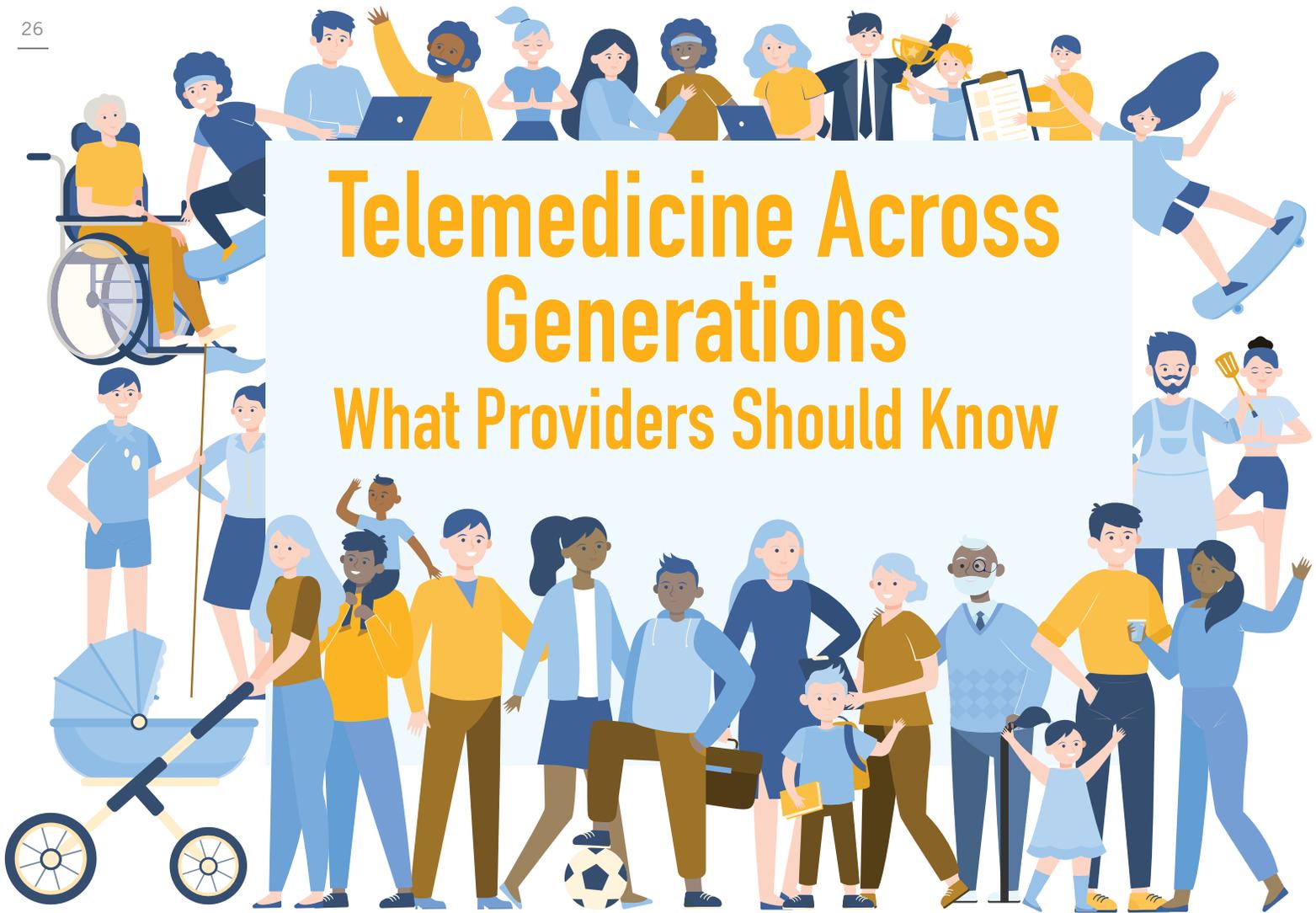
"It has been a journey, starting from hearsay about COVID and the first CDC-confirmed COVID patient being in our local community," Smecker says. "WWMG moved quickly to effectively establish best practices of masking, distancing, and testing, and propped up secure work-from-home options when appropriate. We also created a centralized COVID vaccination site, providing more than 20,000 vaccines to our employees, patients, and the greater community. The pandemic has been one of the worst things ever, but it's been an interesting time to be in our industry, and we at WWMG continue to work hard to do our part to mitigate the spread of COVID. It's been rewarding to see how we came together as an organization and as a community." [PR](#)



Jennifer Smitrovich,
Attorney, FAVROS Law,
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Joseph C Smecker,
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Medical Group



The mass adoption of telemedicine and the new technologies it incorporates affect different generations in different ways.

While it's easy to infer that younger generations have an easier time with new technologies and expect to integrate them into their lives, telemedicine is here to stay for all ages of users—and providers need to be prepared.

Before we consider the differences, here's a refresher on the birth years of each generation:

Traditionalists: 1927–1945, Baby Boomers: 1946–1964
 Generation X: 1965–1977, Millennials: 1978–1999
 Generation Z: 2000 onward

COVID-19 proved to be the tipping point for telemedicine in all of its forms. The convenience and safety afforded by telemedicine allowed many patients to continue their care regimens without overburdening healthcare facilities during the pandemic. But as we move into a post-COVID world (if there is such a thing!), will telemedicine continue its rapid rate of acceptance?

GENERALLY SPEAKING, GENERATIONAL DIFFERENCES EXIST

For providers to improve patient outcomes and ensure the best experience, it's crucial to understand the desires and needs of the various generations. According to data from a recent Healthcare Information and Management Systems (HIMSS) State of Healthcare report, 47 percent of Millennials would prefer telehealth over in-person visits once the pandemic has ended. However, most Traditionalists and Baby Boomers favored in-person visits.¹

Those statistics may not come as a surprise, but it's important to look beyond the data and understand how different generations view their healthcare.

Anna Liotta, founder of The Generational Institute and author of *Unlocking Generational CODES*, notes how the clinician-patient relationship has evolved between generations. “The Traditionalist generation expected to be with a healthcare provider for a long time, and they expected it to be a somewhat authoritarian relationship. The healthcare provider told you what to do, and you did it because they were the authority,” she says.

“Then Baby Boomers came along and also mixed in credentialing expertise,” she continues. “So they placed emphasis on advanced degrees, specialized degrees, and the status of where you went to school. Gen Xers related to their healthcare providers as an expert, but began to have less of an authoritarian relationship with them. Millennials look at their healthcare provider as a coach and a mentor—and they’re very willing to change healthcare providers if they do not feel that coaching, mentoring, engagement relationship with them.”

As generations age, of course, their healthcare needs become more complex. Liotta believes providers need to adapt their care to fit the expectations of each generation, not the other way around. And that opens the door for a telemedicine-first care plan. “For instance, Millennials and Gen Z really want concierge medicine on demand,” she says. “They have no need to physically go into a healthcare provider’s space and see them unless it’s a severe or emergent situation. So they are absolutely happy with text-led healthcare.”

KEYS TO CREATING AN EFFECTIVE CROSS-GENERATIONAL TELEMEDICINE PROGRAM

The bottom line for providers is that telemedicine across generations is here to stay. So how do you offer the best patient experience? Liotta has a few suggestions.

Develop warmth. Without the non-verbal cues of an in-person visit, emotional intelligence plays a key role in determining how comfortable patients are with telemedicine. It’s what Liotta refers to as a sense of warmth. “What we’re seeing now is that some healthcare providers are doing a great job at providing that in the telemedicine, and that will actually

Develop warmth. Without the non-verbal cues of an in-person visit, emotional intelligence plays a key role in determining how comfortable patients are with telemedicine.

keep people from having to physically come in,” she explains. “The challenge with a lot of telemedicine is that people are being more technical in delivering care, and that’s where there’s an opportunity to convert more people to telemedicine if they could learn the warmth in the modality.”

Reduce friction. Make your telemedicine accessible and easy at every touchpoint. Liotta points to an e-commerce shopper experience as a guide. “This isn’t exactly what people would want to be compared to, but everyone, to some degree, is competing with Amazon, because they have created a customer expectation of frictionless interaction,” she says. “That’s what healthcare providers should strive for.”

Tailor the offering to generational expectations. “Millennials grew up with having options as a core component of their generational code,” Liotta explains. “So there’s not even a choice to not have every option. The thing that Millennials want to know is, ‘Can you hyper-customize it to me?’ For the Gen Xers, it’s about efficiency and saving

time across the full spectrum of their family care. As for Baby Boomers, they want to know that it’s smooth, easy, and accessible, but they also want to know they’re getting premium care. Because status is still important to them.”

Consider diversity. Liotta stresses the increasing need for diverse perspectives, even when providing telemedicine options. “Physicians should ask, ‘Do I need to have young people to take care of young people?’ Patients, particularly Millennials and Gen Z, will look for signals of diversity,” she says. “When patients call in, do you have multiple languages for people to select from? Is it just Spanish and English, or are there more options? Do you make sure that if I have an elder in my family, it’s very accessible for them? Accessibility, inclusion, equity—those are all really key pieces.” 

Learn More

Once you are aware of generational issues within your organization, training is often the next step.

To learn more about training and resources available to our members, go to phyins.com or to medchoicerrg.com, and go the “Education” drop-down to search for online courses.

One course related to generational issues is:

“Clinical Express: Cultural and Age-Specific Competencies.” The goal of this course is to equip learners with knowledge of the perspectives and skills needed for providing age-specific and culturally competent care.

¹ <https://www.mobihealthnews.com/news/patients-are-looking-go-back-brick-and-mortar-post-pandemic>



Liability Implications and Recommendations for Telemedicine

As COVID-19 cases and hospitalizations rise, hospitals, clinics, and practices are once again gearing up virtual care for the Delta variant surge,¹ and the Biden administration recently announced that it is investing \$19 million into telehealth services in rural and underserved communities.²

The increase in both need and funding has caused an upsurge in telemedicine spanning all aspects of patient care. More critically ill patients during the pandemic have spurred rural areas to implement telemedicine intensive care services, where fiber optic-connected setups keep cameras trained on patients in hospital beds while off-site intensivist physicians monitor vitals in a remote command center and respond in real time to any data changes displayed on monitors.³

With the growing telemedicine demand during the pandemic, including not only for routine preventative care but urgent and critically ill patients alike, a corresponding rise in medical malpractice litigation poses potential concerns for providers and risk managers. Telemedicine raises unique legal issues, as providers forgo the benefit of a traditional hands-on

examination in favor of a virtual data exchange necessarily lacking the personal connection that often alleviates a patient's desire to sue at all in the event of an adverse outcome. Some of these telemedicine risks are known, but the growing use of novel technology, including newer aspects of telemedicine like tele-ICU care, may reveal new concerns.

We know, for instance, that missed diagnoses comprise the most common medical malpractice allegation in nearly 70 percent of telemedicine-related lawsuits, most often involving allegations that providers should have been able to virtually diagnose cancer, stroke, and infection. There are also issues arising from physicians and patients being located in states with different liability laws, statutes of limitations, and standards of care.⁴

Each state has its own medical malpractice laws generally, and telehealth laws, including licensing requirements, specifically. Providers who intend to engage in telemedicine across state lines should ensure that they are familiar with the laws in the states in which their telemedicine patients are located.

In Washington State, the question of what standard should apply to judge whether a provider is liable in a medical malpractice lawsuit arising from telemedicine has not yet been tested in the appellate courts. For example, if an intensivist remotely monitoring a tele-ICU patient does not react quickly enough to signs of systemic infection because the patient's vitals remain within acceptable limits, should that doctor be held to the same standard as an intensivist who is physically present in an ICU, able to lay hands and eyes on a patient to garner a complete impression of the patient's illness? Intuitively, the answer is no, but the concept remains to be vetted in this state.

Washington's medical malpractice statute, RCW 7.70.040, supports that telemedicine providers should be held to a unique standard reflecting the unique challenges in virtual care. The statute states that, to succeed in any medical malpractice lawsuit, a plaintiff must prove among other elements that the "health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent healthcare provider at that time in the profession or class to which he or she belongs, in the state of Washington, **acting in the same or similar circumstances.**"¹⁵ The statute itself therefore invokes protections for the healthcare provider involved in a telemedicine-related lawsuit: he or she must be judged according to what a reasonable provider "in the same or similar" circumstances, i.e., a telemedicine visit, would have done. As lawsuits from telemedicine necessarily increase with the rise in virtual care, this will certainly be a dynamic and developing legal topic to watch.

(Continued on page 30)



Telemedicine, Telehealth, and Malpractice

A comprehensive search for "telemedicine" and "telehealth" revealed no appellate decisions in Washington State that arose from allegations of medical malpractice in a telemedicine setting to date. While there may have been trial concerning telemedicine, none have yet been addressed by appellate courts.

Likewise, a comprehensive search in Oregon, Idaho, California, and Alaska appellate cases yielded few results, indicating that we are not yet seeing a major increase in telemedicine-related medical malpractice litigation regionally.

One recent lawsuit in Oregon concerned a telemedicine encounter in which a patient reported stroke symptoms but tPA was not administered due to imaging and lab results. The telemedicine provider obtained a defense verdict at trial. A California lawsuit concluded that a California court had jurisdiction

over a Colorado physician who did not have a California medical license and prescribed a drug over the Internet after reviewing a questionnaire forwarded by a Florida company from a person who identified himself as a California resident, although the doctor never communicated directly with anyone in California regarding the prescription.

Apart from these few opinions, the vast majority of appeals have occurred in California, brought by prison inmates following the California Correctional Health Care Services' significant recent expansion of telemedicine in jails, who have largely challenged whether telemedicine visits meet the constitutional requirement of adequate medical care to prisoner inmates. Thus far, these challenges have not been successful, and telemedicine in jails has been lauded as increasing access to care while saving money.



(Liability Implications, continued from page 29)

BEST PRACTICES TO LIMIT EXPOSURE

In the meantime, to help bolster the statute's protections, as a practical matter when providing telemedicine, providers must be vigilant to limit exposure to medical malpractice suits associated with telemedicine. Best practices include:

- **Educating patients** on what their telemedicine visit entails, including the limitations inherent in virtual data exchange versus an in-person examination
- **Providing informed consent**, detailing any potential risks associated with telemedicine services, as well as instructions to seek emergency care with worsening or changed conditions.
- **Thoroughly documenting encounters** and using a systematic approach in evaluations.
- **Familiarizing yourself with the prescribing laws** that apply to telehealth in the state in which you will be prescribing to help ensure that you do not engage in unauthorized prescribing.
- **Identifying the encounters** that are appropriate for telemedicine and those that are not.

GENERALLY A GOOD USE OF TELEMEDICINE:

Follow-up visit for a known or diagnosed disease or patient condition	Follow-up post-procedure with no patient complaints
Medication review for patients with known medical conditions	Telecounseling or telepsychiatry
Conjunctivitis	Radiology
Minor cuts, burns, other minor dermatologic conditions, such as contact dermatitis, shingles	Minor sports injuries, with the caveat that examination of a patient's movement and motor function is limited virtually
Urinary tract infection	Constipation

NOT RECOMMENDED USE OF TELEMEDICINE:

Any apparent or suspected emergency condition, including anaphylaxis, signs and symptoms of heart attack, shortness of breath, concerning chest pain, suspected head trauma, signs and symptoms of stroke, traumatic injuries due to fall, MVA, or other serious accident, unexplained bleeding	Anything requiring auscultation of the heart or lung sounds
	Newly recognized palpable mass
	Patient with low health literacy or poor vision or hearing, or poor Internet connection
	Where a focused exam cannot be performed visually and findings may influence initial workup or management

PROCEED WITH CAUTION WHEN USING TELEMEDICINE:

Initial primary care visit with a new patient (beyond the clinical value, many patients feel comforted by a face-to-face examination with a new PCP, building a personal connection which may be difficult in a virtual setting)	Annual physical examinations
	Well-child visits where child has not had recent weight or developmental assessments

Although an important resource to improving patient access to care, and a practice that is certainly here to stay even post-pandemic, telemedicine is simply not at this time capable of being equivalent to an in-person encounter, and along with that comes unique risk management considerations.



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- ¹ <https://www.beckershospitalreview.com/telehealth/how-hospitals-are-gearing-up-virtual-care-for-the-delta-variant-surge.html>
- ² <https://www.hhs.gov/about/news/2021/08/18/biden-harris-administration-invests-over-19-million-expand-telehealth-nationwide-improve-health-rural.html>
- ³ <https://www.avelecare.com/ecare/what-we-do/icu/>
- ⁴ While this article's focus is medical malpractice liability associated with telemedicine, other areas of liability exposure exist in telemedicine, including unlicensed prescribing and limitations in a provider's ability to ensure that federal privacy and security rules are met.
- ⁵ RCW 7.70.040(1)(a).



Online Education and Resources

The following are just a few of the wide array of resources for helping to reduce risk that are available to all of our members at no additional cost (depending on your policy type).

Visit our website at phyins.com/education or medchoicerrg.com/education. There you'll find libraries of online courses, available 24/7, on various topics and issues, including telehealth for providers and staff. Many of these courses offer CME credit.

TELEHEALTH COURSES

Improving Practice in the Delivery of Telehealth: In this 1-hour course, you will gain knowledge about building and maintaining rapport with clients remotely via telehealth. You will also learn about the strengths and weaknesses of telehealth practice, including ways to address those weaknesses.

Conducting Clinical Assessments via Telehealth: In this 1.5-hour, CME-certified course, you will learn helpful approaches for establishing rapport during the comprehensive intake and referral process, and gain information about screening assessments, interventions, and treatment referrals. Interactive exercises

and practical examples will help you incorporate these assessment strategies in your own setting.

Ethical and Legal Guidelines for Telehealth Service Delivery: The goal of this 1.25-hour course is to provide addiction professionals, behavioral-health counselors, marriage and family therapists, psychologists, social workers, and nurses in health and human services settings with strategies and information for competent and ethical telehealth practice.

Using Telehealth in Clinical Practice: In this 1-hour, CME-certified course, you will receive an overview of telehealth practices including a brief history of telehealth, current trends and research, and associated technologies. You will learn how to provide telehealth services, including potential advantages and challenges. The goal of this course is to provide psychologists, professional counselors, social workers, addiction professionals, marriage and family therapists, and nurses in health and human-services settings with current, research-based information on telehealth and guidelines for telehealth practice.

OTHER RESOURCES

RM Resource Library at phyins.com/resources or medchoicerrg.com/resources.

Searchable and sortable libraries with articles, guidance, customizable forms and letters, and more.

Some helpful resources include:

- OSHA Issues New COVID-19 Regulations—Are Your Current Prevention Practices Enough?—PYA (pyapc.com)
- On-Demand Webinar: OSHA's COVID-19 Emergency Temporary Standard—Implications and Next Steps for Healthcare Providers—PYA (pyapc.com)
- Cyber Center. An online resource offering best practices, staff training, protocols, and more to improve your cyber security
- HR Hero. An online portal offering handbooks, checklists, and staff training to reduce your risks related to Human Resources

“Patients are already choosing providers, health systems, and hospitals based on telemedicine access. CQI programs help ensure that you are offering a consistent, secure, easy-to-use platform that patients will keep coming back for.”

DR. JOHN SCOTT, MEDICAL
DIRECTOR OF DIGITAL HEALTH
UW, SEATTLE, WA



(Telemedicine Is Here to Stay, continued from page 7)

well with others. That may have worked temporarily, but long-term sustainability requires a more streamlined approach.

The key is to fully integrate your telemedicine platform with your organization's EHR. It should be noted that some hospitals may have limited ability to achieve this, as they often use a host site, and thus their ability to customize is limited. Nonetheless, doing so will mean that:

- Providers can easily document visits and refer to the patient's medical record
- Patients can self-schedule visits and pre-register online
- Visits can happen within the EHR (e.g., on MyChart)
- The system can capture insurance information and process payment
- Providers won't have to use multiple screens (e.g., Epic and Zoom) while interacting with patients

If your telemedicine platform is difficult to use or inconvenient, patients won't use it and providers won't encourage it. A streamlined offering can make a difference.

LOOK TO STATE MEDICAL BOARDS FOR LICENSING GUIDANCE

Second to reimbursement, licensure portability has been the most significant

hurdle facing telemedicine. The default presumption under state law (which controls physician licensing) is that a physician needs to be licensed in the state where the patient lives. But the particulars for out-of-state telemedicine providers vary state by state. “Most states require a full license to care for one of their citizens, but some allow telemedicine practice with a limited license,” says University of Washington School of Law Affiliate Instructor Cindy Jacobs, an expert in telemedicine legislation.

At Last Count...

- **43** U.S. states and territories require a full license to practice telemedicine
- **12** offer a specific telemedicine license (this includes both MD and DO licensing structures, so some states are counted twice in this total)
- **28** states have consultation exemptions of some kind



Jacobs adds that there are other state regulations governing out-of-state practice, and these also vary from state to state. Some states may require providers to see a patient in person before offering a telemedicine visit, for example. A very small group of adjoining states (such as Maryland and Virginia, plus the District of Columbia) have reciprocal arrangements in place.

Jacobs recommends that healthcare leaders keep tabs on applicable legislation by relying on their state medical board or policy organizations such as the Center for Connected Health Policy.

TAKE ADVANTAGE OF PROXY CREDENTIALING

Credentialing is time-consuming for any organization, but proxy guidelines can simplify the task when it comes to telemedicine. Proxy credentialing means that a hospital that uses telemedicine providers who work for a hospital outside their system (a "distant site") can rely on the other hospital's credentialing process as a proxy for full-blown credentialing. The Centers for Medicare and Medicaid (CMS) began allowing proxy credentialing in 2011.

"Proxy credentialing streamlines the work a hospital must do to bring

telemedicine in from another hospital or other entity," Jacobs says. "Not very many hospitals take advantage of it, either because they aren't familiar or because they don't trust it. But it is legitimate and worthwhile."

Jacobs adds that when using providers from a "distant site," it's important to ensure that they have received appropriate training on the telemedicine platform being used. Training can be offered either by your system or by the distant-site system in order to ensure a compliant experience for patients and providers. A written agreement meeting CMS criteria must also be in place.

INVEST IN CONTINUOUS QUALITY IMPROVEMENT

As your telemedicine platform continues to mature, a continuous quality-improvement strategy will ensure its long-term viability and value, says Dr. Scott of UW Medicine. "UW is very fortunate to have a full-time physician and staff member dedicated to telemedicine CQI," he says. "But every organization should incorporate telemedicine operations into its CQI efforts, even if they have to start on a small scale."

UW Medicine's telemedicine CQI strategy has four pillars:

- **Surveys** that collect patient feedback. Telemedicine teams use this feedback to identify issues (doctor running late, poor "web-side manner," etc.) and provide coaching to the clinical team as needed.
- **Anonymous reporting tools.** These allow providers and clinic staff to report information about patient-safety issues, enabling the telemedicine team to review incidents, conduct critical analyses, and make changes as needed.
- **Random chart reviews.** Dr. Scott and a colleague complete about 30 chart reviews every month to ensure providers are documenting each visit correctly.
- **Special projects** help the team address safety concerns, technical issues, and other problems.

"Patients are already choosing providers, health systems, and hospitals based on telemedicine access," Dr. Scott says. "CQI programs help ensure that you are offering a consistent, secure, easy-to-use platform that patients will keep coming back for." 



Cindy Jacobs,
UW School of Law
Affiliate Instructor
and telemedicine
legislation expert



(Addressing the Digital Divide, continued from page 13)

(HRSA) grant-funded program that assists healthcare providers and organizations throughout the region through technical assistance, tools, and training. It has a particular focus on telehealth programs in rural and medically underserved communities and has developed a guide on telehealth for critical-access hospitals.

“When COVID first hit, so many providers scrambled into telehealth to keep hospitals and patients safe,” Perisho says. “But now that most have been doing this for the last year and a half, it might be time to reevaluate and optimize their existing telehealth programs—and address digital divide issues.” (A provider might begin at nrtrc.org by using NRTRC’s new telehealth program assessment tool, a scorable PDF tool that helps gauge where they are in terms of telehealth maturity and what areas could be improved.)

Due to the speed with which providers had to ramp up their telehealth, “a

lot of creative wheels are turning right now,” Perisho says—and those are exciting opportunities for providers to share with and learn from each other. “If patients don’t have devices, can providers send them home with devices for eight weeks of follow-up? If they don’t have Internet access at home, is there a library or a police or fire department in town that has a private kiosk set up for telehealth visits? If there is a cultural divide, how do we learn to communicate effectively and appropriately?”

One of the ways NRTRC helps providers and clinicians navigate challenges and gain practical knowledge is by housing online telehealth training courses on its website that are open to the public and free to anyone at nrtrc.catalog.instructure.com. Offerings include:

- **Telehealth 101 Online Training**
Gain practical knowledge with this comprehensive overview, for those new to telehealth or looking for a refresher.

- **TeleBehavioral Health 101 Series**

This six-part series provides basic information and knowledge for delivering behavioral-health and mental-health services via telemedicine.

- **Connecting Care Through Telehealth: Long-Term Services and Supports**

Designed to inform and improve best practices when using telehealth and virtual services in long-term-services and support settings.

The NRTRC tracks state-level policy on telehealth in the Northwest region. They collaborate with the Center for Connected Health Policy (CCHP), a nonprofit, nonpartisan organization working to maximize telehealth’s ability to improve health outcomes, care delivery, and cost-effectiveness.

Perisho urges providers to visit the Center for Connected Health Policy’s website at cchpca.org to get to know how the laws, regulations, and Medicaid programs work in their state, and to find policies and regulations that impact them.



“Equity is giving people access to appropriate and high-quality care in the way they want it. We need to make it easy to connect with us, regardless of the modality. Education and outreach tactics should include all the ways people communicate. What is it you want, and how can we meet you there?”

MOLLY SHUMWAY, DIRECTOR, DIGITAL HEALTH, UW MEDICINE, SEATTLE, WA

Whether the various telehealth services initially reimbursed during the pandemic will continue to be reimbursed is up in the air, and the group is highlighting telehealth successes in its advocacy.

EQUITABLE ACCESS

Molly Shumway works with Dr. Scott as Director for Digital Health at UW Medicine. She has 20 years of experience in healthcare administration, all at UW Medicine, and transitioned to telehealth in January 2020—so she can certainly relate to the experiences of many healthcare providers who had to innovate when the pandemic hit.

“At UW Medicine, we had good infrastructure, technology, and partnerships and support from IT and compliance in place, but it was still a tremendous ramp-up, and we’re still moving so quickly,” she says. “We’re increasing efficiency while providing care to patients in ways that meet their needs. Telehealth is forcing healthcare to be more of a service industry, because it creates more options for patients.”

In the name of service, though, remember that not everyone who has access to telehealth necessarily wants it.

“There is a risk of implicit bias,” Shumway says. “For example, you might assume that certain patients, such as those who are older or without stable living situations, aren’t interested in telehealth, but when it’s offered, they’re thrilled to be able to use it. On the other hand, some patients prefer in-person or telephone. It’s important that these services are made available to all patients for whom it’s appropriate.” (See “Telemedicine Across Generations,” page 26.)

“Equity is giving people access to appropriate and high-quality care in the way they want it,” Shumway says. “We need to make it easy to connect with us, regardless of the modality. Education and outreach tactics should include all the ways people communicate. What is it you want, and how can we meet you there?” 



John D. Scott, MD, MSc, FIDSA, Medical Director, Digital Health Professor, Medicine University of Washington School of Medicine



Molly Shumway, Director, Digital Health, UW Medicine



Nichole Perisho, BA, BSN, RN, Program Director, Northwest Regional Telehealth Resource Center

“Even when the smoke of this pandemic clears, RPM will be significant and part of most practices. Doctors will have mixed practices of online and in-person, depending on patient preference. It’s good service and good business to offer care the way patients want to receive it.”

MARK VANDERWERF, FATA, TELEHEALTH AND TELEMEDICINE ADVISOR/CONSULTANT, WORCESTER, MASSACHUSETTS, MA



(Remote Patient Monitoring, continued from page 9)

care. “Say a patient comes into a hospital and a stroke is suspected, but there’s no stroke neurologist on staff that day, or none at all at that hospital,” VanderWerf explains. “With tele-stroke, you can instantly link to a stroke center, and a stroke neurologist can get online and assess that patient. If a clot breaker is needed, that can be administered. Those first couple of hours after a stroke are critical—tele-stroke saves a lot of lives.”

The crush of COVID faced by smaller hospitals has led to the advent of tele-ICU—the use of critical nurses in a central site to monitor patients in other

hospitals. “With remote intensivists elsewhere, a small hospital can support more ICU beds,” VanderWerf says. “You can create an ICU anywhere with this.”

Another clinician-to-clinician application of RPM that falls into the larger tele-behavioral health area is crisis intervention. “Tele-behavioral health is most often on-demand and scheduled, but when there’s an emergency where a patient needs to be stabilized immediately, a hospital or doctor can connect the patient with a remote therapist instead of leaving that patient in crisis for hours until a therapist is available,” VanderWerf says.

He adds that doctor-to-doctor RPM laid the foundation for patient-to-doctor RPM at home, which is now taking off because of the pandemic.

Why Do It?

The benefits of RPM to patients are numerous:

- Constant monitoring makes RPM just as safe as in-person care in many cases, and in fact RPM is often shown to produce better outcomes. According to VanderWerf, most RPM programs are resulting in anywhere from a 35 percent to a 55 percent reduction in hospitalizations.

- RPM gives patients a sense of control over their medical conditions and allows them to take more ownership of their health; these patients, therefore, have higher compliance rates. They can recognize the connection between changes in how they feel and changes in health data and, by extension, between their lifestyle choices and health outcomes.
- Since RPM can reduce emergency-room visits, readmissions, length of hospital stays, and frequency of office visits—nipping many problems in the bud before other care becomes necessary—it makes life less disruptive for patients and caregivers. RPM can also enable older or disabled people to live at home longer and avoid moving into nursing facilities.
- Patients and caregivers feel reassured that their health conditions are being monitored at home, lessening their stress and fear of surprises.

In addition to healthier, happier patients, RPM provides a number of benefits to healthcare providers, including reduced spending on visits, readmissions, and hospital expansions. For health insurers, the upside is lower-cost care in which quality is not sacrificed.

“In the old days, a lot of patients went home until they got sick again, and then went to the hospital again—and that was a painful and costly cycle for everyone,” VanderWerf says. “Patients want to live life as normally as possible. It’s good to know someone is watching you, can catch a problem before it becomes acute, and will prevent you from having to go in at all.”

What Are the Obstacles?

The biggest challenge to remote patient monitoring is the same as it is throughout telehealth and telemedicine: the digital divide (see “Addressing the Digital Divide,” page 10). Lack of Internet access, device ownership, and digital literacy are obstacles that must be addressed at government and grassroots levels.

Another limiting factor to at-home remote care is who lives with the patient. RPM might not be an option for those who live alone or who don’t have capable caregivers, but need a lot of help. Those who live in tight quarters with a lot of other people might be better served by getting care outside their homes, where they can enjoy rest and privacy.

From the provider’s point of view, the downside to offering RPM is the same as that in launching any new service. “You have to make sure it meets everyone’s needs—doctors, staff, patients—and integrate it into the workflow,” VanderWerf says.

He predicts that RPM will remain one of many digital services that are included in the hybrid model that’s rapidly becoming the healthcare norm. “Even when the smoke of this pandemic clears, RPM will be significant and part of most practices,” he says. “Doctors will have mixed practices of online and in-person, depending on patient preference. It’s good service and good business to offer care the way patients want to receive it.” [PR](#)



Mark VanderWerf,
FATA, Telehealth and
Telemedicine Advisor/
Consultant, Worcester,
Massachusetts, MA

(Lessons Learned by an Early Telehealth Adopter, continued from page 12)

3. Has the resources to invest in new technology to improve the patient and provider experience. The need for technical innovation in this space is limitless. Our vendor recently introduced enhanced audio/visual capabilities and technology to improve the platform’s reliability. And they are planning to roll out language translation and closed-captioning features soon.

4. Offers a flexible product that accommodates different patient needs and preferences. For example, our patients can access a video visit using MyChart or our vendor’s portal. They can schedule with their own doctor or request an immediate visit with one of our vendor’s providers, and they can pay for their visit online.

5. Will grow with you. We’re working hand-in-hand with our vendor to fill gaps in care through telemedicine. For example, our team recently identified a need for 24/7 digital lactation consults, and our vendor is helping us with this need.

A strong telemedicine program is a competitive advantage in today’s ever-changing healthcare marketplace. No matter which vendor you choose, remember: the time you spend thinking about innovation will pay off in the long term. You are essentially predicting what will happen in the future. When it arrives, your organization will be ready to meet needs that others can’t. [PR](#)



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Where Are We Now?



In fall 2014, we highlighted some of the technological advancements that were “Making Medicine Better.” In this current issue, in which we’re exploring telehealth from a variety of angles, we also checked in on some of the technology we previously highlighted, to see what advancements have been made and what difference it’s making in the delivery of care today. What follows is an update on one of those advancements.

INSYU IS NOW PART OF TEGRIA

In addition to using technology and tools to train medical staff with simulations, InSyту is now using more human actors—some connected to devices that can be programmed to replicate human vital signs. The actors do a better job than a programmable mannequin at giving doctors and

nurses practice treating patients with behavioral-health challenges.

Integrating actors and the programmable vital-signs tool are a couple of the advances InSyту has implemented over the past several years in its simulation training.

The advances are increasingly important, as more and more patients are coming into emergency rooms facing mental-health crises. “My colleagues unfortunately get assaulted at work a lot. How can we make our work life in the ED safer?” asked Ian Doten, MD, an emergency-medicine physician and medical director at Tegria, which incorporated InSyту into its suite of services in January 2021. “De-escalation training is especially important in the ED. We have more and more potentially

violent patients, and maximizing staff safety is a big deal.” Using actors allows healthcare professionals to practice reacting to a patient in crisis in a realistic but safe environment.

InSyту has also incorporated relatively low-tech ways to let healthcare professionals practice giving IV treatments and administering massive transfusion protocols on patient actors, who use an arm sleeve that accepts IV fluids and “blood” transfusions and whose vital signs can simulate hemorrhagic shock.

Doten says participants give high marks to the new low-tech actors and high-tech tools. “We measure participant confidence before and after, and we’re seeing 95-plus percent of participants feel they have very good confidence



to reliably give care after these situations,” he says.

In addition to experiencing a gradual evolution over the past few years, InSytu was forced to make changes on the fly in February 2020, when the nation’s first known COVID-19 case broke in the Seattle area. Immediately, the InSytu team started training Swedish Medical Center practitioners and clinicians through in-person simulations—and others in five states virtually—on the best ways to stay safe while treating patients with the deadly, highly contagious virus.

“It was kind of a scary time early on, when we didn’t know what we know now and people were wondering what caring for patients with COVID-19 would look like,” Doten says. “We looked at critical

processes you need to get right, such as emergency airway management in COVID, which puts caregivers most at risk.”

The team of nurses, doctors, and respiratory therapists practiced intubating patients with minimal respiratory aerosol exposure. They practiced donning and doffing Personal Protection Equipment, discovering that even the seemingly simple act of talking and listening required additional training, given the ubiquity of sound-muffling masks. “What we’ve learned in our work is that policies and technical management is one thing, but teamwork and communication keep patients safe,” Doten says.

After the initial wave of the pandemic lessened, the team continued to work with client organizations to use simulation to improve its processes for caring for patients, and partnered to improve quality and safety for OB emergencies such as shoulder dystocia and postpartum hemorrhage, sepsis and massive transfusion, and emergency airway management in the ICU setting.

Simulation training—which ideally takes place at the healthcare setting where employees work, to make it as realistic as possible—is beneficial in reducing risk, improving processes, and training workers to respond to a near miss. “We connect institutional goals around safety and quality, and ask, ‘How do we do this together?’” Doten says. “At the end of the day, physicians and nurses and other folks who take care of patients have to do difficult work. The systems are getting more complex. There’s new tech and challenges, and we have to be nimble and respond to them and adapt our systems to do things the best way that we can.” 



“What we’ve learned in our work is that policies and technical management is one thing, but teamwork and communication keep patients safe.”

IAN DOTEN, MD, EMERGENCY-MEDICINE PHYSICIAN AND MEDICAL DIRECTOR, TEGRIA



How Are We Doing?

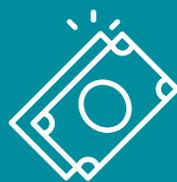
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