

Your Patient Is Logging on Now:

THE RISKS AND BENEFITS OF TELEHEALTH IN THE FUTURE OF HEALTHCARE



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INTRODUCTION

Long before the COVID-19 pandemic struck, telemedicine was part of the standard delivery of care in the U.S., but used very rarely. By the end of April, telemedicine visits had skyrocketed to nearly one million visits per week.¹

Many patients and physicians have discovered that they appreciate the conveniences of virtual healthcare, and its support of the physician-patient relationship.² They've considered how telemedicine increases access to care (for some patients) while decreasing infection risk, not only in a pandemic but during routine flu season or for immunocompromised patients. Though telemedicine's near future is clouded by uncertainties regarding reimbursement,³ state-to-state licensing hassles, and privacy issues, for the long haul, telemedicine is here to stay.

Sweeping benefits from telehealth are still emerging—and so are its risks. Reduced infection risk and increased access to care are possible with recognition that telemedicine is not a panacea: Telemedicine is a helpful adjunct to in-person care, when supported by best known practices.

DEFINITIONS

Telemedicine consists of live remote visits with a clinician, as opposed to **telehealth**, which is a broader term encompassing telemedicine plus remote monitoring, asynchronous data collection, and a variety of other incorporations of technology into nonclinical patient and professional health-related areas.

EXECUTIVE SUMMARY

By **David L. Feldman, MD, MBA, CPE, FAAPL, FACS**

Chief Medical Officer of The Doctors Company Group

A study released by the American Medical Association (AMA) in February 2020, just before the pandemic hit the U.S. hard, reveals that telemedicine visits with physicians had already doubled from 2016 to 2019.⁴ Still, the pandemic has led to an unprecedented spike in usage. Telemedicine is here to stay, but exactly how it will be incorporated into evolving community standards of care is the question driving discussion and argument within many specialties.

“The business case needs to catch up to the clinical case. The key in making further progress is to continue to wipe away old assumptions about what will and won't work.”

—**Til Jolly, MD, FACEP**

Telemedicine Lead, COVID-19 Health Care Resilience Work Group
supporting the Department of Health and Human Services

FORESEEABLE MAJOR BENEFITS:

- ▶ **Increases access to care for most patients**, including many patients in rural locations, patients who struggle to cover the peripheral costs of an in-person visit (transportation, childcare, time away from work, etc.), and patients with chronic conditions.
- ▶ **Enhances the ability to manage chronic conditions** by making more frequent contact easier. This management is already supported by at-home devices that record blood pressure, blood sugar, and other essential data points.
- ▶ **Reduces infection risks**, not just for COVID-19, but for post-op patients, patients who are immunosuppressed, etc.

FORESEEABLE MAJOR RISKS:

- ▶ **The remote exam's inherent limitations** mean physicians must know when to ask patients to come in to avoid missed diagnoses.
- ▶ **Increases cyber liability**, especially when providers are seeing patients from a variety of devices in a variety of locations.
- ▶ **Privacy issues** come in high-tech forms: Is the video visit interface HIPAA compliant? And in low tech forms: Conversations may be interrupted by household members at either end.
- ▶ **Decreases access to care for some patients:** Half of U.S. seniors do not have internet access.⁵ On the other hand, some hospitals serving low-income populations have found that when remote visits are available via mobile device, and don't require a computer, a surprising number of patients can access telemedicine visits.⁶ That said, many communities do not have sufficient internet bandwidth; some patients are prevented by a language barrier or lack of technological savvy from accessing a telemedicine portal.
- ▶ **Reimbursement is uncertain:** Pre-pandemic, "Low reimbursement for telehealth was viewed as a critical disincentive," say the authors of an opinion piece in *JAMA*, because "Without payment, it would be difficult for clinicians to afford to provide the service, despite data from previous studies suggesting clinicians were broadly supportive about its use."⁷ As telemedicine expert Til Jolly, MD, FACEP, puts it, "The business case needs to catch up to the clinical case. The key in making further progress is to continue to wipe away old assumptions about what will and won't work."

▶ Remote exam strategies

The term *examination* may soon change—meanwhile, the exam itself has already changed. Remote triage strategies are now circulating: For instance, risk-stratifying patients with abdominal symptoms by, among other things, watching the patient jump up and down.⁸

▶ Telemedicine is medicine

Telemedicine relies on a physician's best judgment. Patients may present with concerns that cannot safely be evaluated from a distance, even with remote-exam strategies. The physician can request that the patient come in to be seen in person—and can share with the patient the risks of delaying care. In other words, one of the secrets of practicing telemedicine is knowing when not to practice telemedicine.

ACCESS TO CARE

By Dr. Til Jolly

*Telemedicine Lead, COVID-19 Health Care Resilience Work Group
Supporting the Department of Health and Human Services*

We frequently think of telemedicine as a system whereby a patient picks up a smartphone, presses an app, and gets a doctor on the screen for an urgent care visit or a more routine problem. The evolution of telemedicine, which accelerated rapidly due to COVID-19, has resulted in many more access stories to tell:

- ▶ **In ambulatory care** the access benefits both patients and physicians. Patients have been able to maintain chronic care, and physicians have been able to keep their practices open at a time of great stress on the system. Moreover, patients maintain continuity of care.
- ▶ **In hospitals**, applications of telemedicine are stretching from ICUs, to hospital floors, to teletriage in the emergency department (ED), and to the care locations in convention centers and other surge alternate care sites. These methods allow health systems to use technology to distribute their physician workforce effectively and efficiently without regard to geography.
- ▶ **Cities** such as Houston; Memphis; New Orleans; Washington, D.C.; and New York all either had in place or rapidly developed telemedicine programs that allow overburdened EMS systems to respond to 911 calls, screen patients remotely, and refer nonemergent patients to other community resources or directly to telemedicine partners. This gets patients the care they need when they believe their only access is a 911 call, and keeps many patients out of clogged emergency departments. Much of this system will work post-COVID, as long as payment systems keep pace with reality on the ground.

PROS OF TELEHEALTH

Increases Access to Care for Most Patients

Cell phones vs. laptops: NYC Health + Hospitals is the largest safety net healthcare delivery system in the United States. When the COVID-19 pandemic struck, they were keenly aware of how practicing by telemedicine can deny access to the non-tech-connected.

“Contrary to popular opinion concerning safety-net patients,” said leaders at NYC H+H, “the majority of patients had access to mobile devices”—if not home computers—“and expressed an interest in receiving telehealth services.”⁹

Age and access: Many physicians have been surprised by how quickly their older patients can master new technology—and how much they value the telemedicine option. During a web-based panel discussion, Orit Markowitz, MD, a dermatologist at Mount Sinai, said she has found that with instruction, her older patients progress “by leaps and bounds.”¹⁰

Promotes Patient Satisfaction

Pre-pandemic, patients who had tried telemedicine visits reported high levels of satisfaction,¹¹ and demand for remote physician encounters will only increase.¹²

Meanwhile, telemedicine detractors have long pointed to the doctor-patient relationship as something that cannot be maintained via telemedicine, since major online platforms direct patients to the first available telemedicine provider. In a world in which most patients had ready access to their physician, that detraction might hold up.

However, since most patients face a wait to see their physician, the balance shifts. The authors of a blistering rebuttal of telemedicine myths in *NEJM Catalyst* say it’s a myth that “patients prioritize existing relationships with their provider over transactional episodic care” because “the data argues otherwise: The majority of times, patients just want care.”¹³

Enhances Safety via Minimizing Infection Risks

Flu season. Pregnancy. Immunocompromising conditions. Postoperative wound care. In many situations, reducing infection risks is a benefit. For many of these same situations, telemedicine cannot replace in-person care. That said, the option to reduce—not eliminate, but reduce—the number of in-person visits for those most at risk of infection can offer patient safety benefits.

Eases Management of Chronic Disease

Converting some consultations to telemedicine visits can enable more frequent check-ins with less life disruption and expense (time off work, parking or bus fare, childcare, etc.).

Scheduling

For scheduling, telemedicine is a mixed blessing. On the one hand, it reduces no-shows and cancellations. That said, introducing telemedicine into a practice's workflow requires some significant rerouting of routines and retraining of staff.

Privacy

Often privacy is placed in the risks category for telemedicine, but remote visits have their privacy benefits too. For instance, patients may find it socially uncomfortable to arrive at a crowded waiting room when they are recovering from surgery with conspicuous physical issues.

TELEMEDICINE AT MOUNT SINAI

With I. Michael Leitman, MD, FACS

Dean for Graduate Medical Education, Designated Institutional Official, Professor of Surgery, and Professor of Medical Education, Icahn School of Medicine at Mount Sinai

When the pandemic hit, Mt. Sinai's telemedicine visits shot up from a few hundred per month to their April-to-May 2020 peak of 20,000-plus visits per month.

When Dr. Leitman and team launched their telemedicine program a couple of years prior, they focused on opportunities within telemedicine-friendly specialties like dermatology, ophthalmology, and psychiatry. As they expanded, they considered telemedicine's potential benefits for outpatient care and consultation with specialists, and kept a close eye on regulatory compliance, billing matters, and the supervision of residents.

"Providers need to be cautious of making decisions based on partial information."

—I. Michael Leitman, MD, FACS

Dr. Leitman has found that regardless of specialty, the type of visit best suited to telemedicine is "a very focused patient evaluation" for a specific problem that can be evaluated mostly by question and answer, something that doesn't require a sophisticated physical exam—even with the workarounds that many physicians are learning. He warns, "Providers need to be cautious of making decisions based on partial information."

Dr. Leitman speaks from experience, having learned that diseases can look different in person than on camera. Dr. Leitman was once convinced he needed to operate on an infected skin lesion that turned out to be minor and easily handled in the office. This and similar experiences provided his personal "a-ha moments" that there is no substitute for seeing a patient in person.

CONS OF TELEHEALTH

KNOWN MALPRACTICE RISKS:

- ▶ **Physician-patient relationship:** Telemedicine offers an adjunct to in-person care and a continuation of the existing relationship, but is not a replacement for in-office visits. Anyone who has ever participated in a web consult knows how even occasional glitches or delays in sound or video can impede the normal flow of conversation—a diagnostic risk, as well as a relational one.
- ▶ **Confidentiality and the patient's environment:** Housemates or family members may be nearby, so proactively ask who else is in earshot. Assure the patient that their conversation with their physician is confidential. Even if the patient doesn't seem terrifically concerned with privacy now, to mitigate the physician's own liability protection, it's best to prioritize privacy—many have a favorite anecdote about a patient beginning their appointment in an unexpected location, such as their local grocery store.
- ▶ **Suboptimal diagnosis and treatment, failure to refer:** As always, clinicians should trust their best judgment—and let patients know if they cannot make an adequate evaluation by video consult. Ending a telemedicine visit by asking a patient to come in may seem like time wasted, but letting patients know why it's important to be seen in person may prevent a dangerous delay in care. Physicians should see in person what they need to see in person.
- ▶ **Rx prescribing:** By law and by common sense, a physician-patient relationship is required before prescribing a controlled substance. But is an in-person visit required to create a relationship? Many states have eased restrictions around prescribing to online-only patients—but the future status of those restrictions remains to be seen.

Therefore, providers must stay on top of updates as conditions change. The Center for Connected Health Policy offers a state-to-state guide to telehealth laws that includes prescribing,¹⁴ but ultimately, routine checks of the state's medical board website are a provider's best protection against fines, professional censure, and civil or even criminal liability.

Harvard Professor of Dermatology Joseph Kvedar, MD, a physician leader who describes himself as a “telehealth evangelist,” has studied telemedicine-related claims. He flags prescribing controlled substances to a patient known only online as one of the likeliest scenarios to result in legal action against the physician.¹⁵

A Note on Webisode Manner



The pandemic has given millions of professionals a crash course in maintaining a professional appearance during a video conversation. For healthcare, Kathleen Stillwell, senior patient safety risk manager with The Doctors Company, says that patients report the greatest comfort with a provider wearing a clean white lab coat or scrubs.

Also recommended is professional workwear that avoids complex patterns, which can “rainbow” on camera.

Above all, Stillwell says, maintain situational awareness: Stillwell has heard from multiple physicians who had been assured by staff that a visit was audio-only—only to find out that the camera was on. One doctor was surprised by a patient’s question about the paper hat he was wearing, which had been made by his son. Act as if the camera is on, even if you think it isn’t.

CASE STUDY: Failure to Diagnose and Treat

Events

- ▶ 62-year-old obese patient with ankle injury
- ▶ ER surgical consult, cast applied
- ▶ Three weeks later, contacted physician for telemedicine visit
- ▶ New swelling of leg
- ▶ Advised to elevate leg and see orthopedic surgeon within 24 hours
- ▶ MD ordered Doppler ultrasound for 12:30 that afternoon
- ▶ EMS called at noon
- ▶ Patient unresponsive, full arrest
- ▶ Patient died

Allegations

- ▶ Failure to diagnose and treat DVT
- ▶ Patient should have been referred for care immediately
- ▶ MD should have ordered STAT study

Legal Outcome

- ▶ Case settled

Unknown Risks of Telemedicine Will Emerge

Malpractice risks: As a component of claims, telemedicine has increased in the last 15 years (as its adoption has increased), but its footprint within our claims database remains small. Of the telemedicine claims we have seen, the most common allegation has been missed diagnosis, and the most commonly missed diagnosis was cancer.

That said, the pandemic has called for a massive number of physicians and patients to use telemedicine differently than they ever had before. This may result in claims of types we have not yet seen; the results of those claims will take years to emerge.

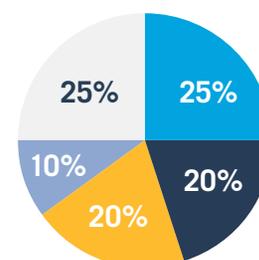
For now, physicians should protect their patients and themselves through education in remote exam techniques like the Ottawa knee and ankle rules,¹⁶ or the Roth score for preliminary assessment of shortness of breath, which simply asks the patient to take a deep breath and count out loud to 30—potential COVID-19 patients may be unable to get past seven. Many medical societies have begun offering education on remote exam techniques specific to their specialties.

Cyber risks: A single breach combines patient privacy risks with risks that the system or practice's whole network could shut down for days, leading to massive business interruption, substantial fines, the potential for lawsuits in which patients allege they were harmed by delays in care, etc. Be aware that security risks and regulatory risks overlap in cyberspace, because even in states that have temporarily relaxed restrictions around non-HIPAA-compliant platforms, use of a compliant platform is recommended; this prevents nightmare scenarios such as a patient's visit being "Zoombombed" by uninvited guests.

Licensure risks: When practicing across state lines, those new to telemedicine confront a tangle of professional, insurance, and legal risks. Although almost all states have relaxed their state-to-state restrictions for telehealth in order to ease care during the pandemic, the future prospects for state-to-state care remain uncertain.¹⁷ The Interstate Medical Licensure Compact offers assistance with state-to-state care, and physicians are advised to remain aware of updates from their state's health authority as conditions change.

Revenue risks: Even with so many affordable technology options available, for smaller practices, telemedicine adoption can present challenging expenditures, right up front—not only in terms of the purchase price of some of the more integrated technology solutions, but in the staff hours to retrain the team, redesign scheduling, and retool the overall workflow.

Allegations of Missed Diagnoses in Telemedicine



- Cancer:** 25 percent of claims
- Stroke:** 20 percent of claims
- Infection:** 20 percent of claims
- Orthopedic concerns:** 10 percent of claims
- Uncategorized:** 25 percent of claims

Uncertainty around the future of reimbursement from both public and private payers contributes to low telemedicine adoption rates, even among physicians who would like to make greater use of telemedicine technologies.¹⁸

Amid this uncertainty, it is worth distinguishing payment parity from payment equity. With payment parity, payment is the same for an in-person or online visit. With payment equity, payment is proportional, recognizing that while some things can't be done virtually, for the same basic amount of work—however that is defined—payment should be the same.¹⁹

Dr. Jolly says, “We will know we have succeeded when financial measures, quality metrics, and patient preferences align to create a seamless system where telemedicine is seen as just a normal part of healthcare delivery—used when it is the best method for the patient.”

Administrative risks of missed consent: Staff members still need to confirm the patient's identity, complete medication reconciliation, inquire about new allergies, and so on, but now they need to complete those tasks as part of onboarding the patient to the telemedicine visit—and they need to also receive the patient's specific consent to retrieve treatment via telemedicine.

AUTOMATING THE PROCESS

With Ashish Atreja, MD, MPH

Chief Innovation Officer of Medicine and Head of Mount Sinai's AppLab

“The video visit is the smallest part of telemedicine,” says Dr. Atreja. Creating technology access and providing training for physicians, allied health practitioners, support staff, and patients is the real challenge.

As telemedicine visits surged during the pandemic, Dr. Atreja saw the benefits of a platform that provides a “digital route” for the patient, something that tells them what to click and when, and gives them instructions to follow. Otherwise, each patient requires a pre-visit setup call from staff.

When the inevitable tech glitches strike, “You can at least call a patient,” he says. Phone triage, if the alternative is a missed visit, reduces patient frustration, increases patient safety, and mitigates physician liability. After all, the video visit variety of telemedicine “is a natural extension of phone calls,” Dr. Atreja says.

Of course, “When a patient is really sick, you may need to do a physical exam or a procedure”—and then the focus becomes explaining to the patient why they do need to come in. Like most telemedicine enthusiasts, Dr. Atreja envisions telemedicine as an addition to in-person care, not a replacement.

A Note on Documenting Refusal of Care



Senior Patient Safety Risk Manager Kathleen Stillwell often hears from physicians who have asked a patient to come in for further evaluation—but the patient refuses to do so, whether from fear of COVID-19 or for some other reason. For instance, a dermatologist reviewed a photo of an area of concern on an older patient’s back. The physician asked the patient to come in for a biopsy, but the patient refused, even when the potential risks were clearly explained. The patient insisted: “I’m not coming in.”

Such situations call for a **Refusal of Care Form**, says The Doctors Company attorney Richard Cahill. Even if the patient will not sign this document, if the physician signs it with a staff member as a witness, this mitigates liability in case of an adverse event.²⁰

FOCUS ON CYBER LIABILITY

With Rachel Patrizzo

Vice President of Cyber Liability Underwriting, TDC Specialty Underwriters

“Healthcare wears a target,” says Rachel Patrizzo, because healthcare providers handle patients’ private health information, which is highly valuable to a hacker.

What could go wrong? Without the proper security controls in place, a provider’s private conversation or exchange of information with a patient could be found via a Google search. A hacker could shut down a network after pocketing a provider’s cell phone. Patient information could be stolen through a network device with minimal security controls. Any device connected to the network can provide an entry point—physical access to the practice is not required.

What to do next? Practices should review their insurance coverage to confirm they are adequately protected in the event of a cybersecurity attack and possible business interruption. The costs involved with an attack can be staggering. In terms of prevention, Patrizzo offers the following advice to small practices and large systems:

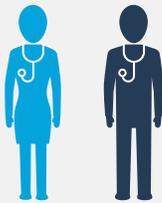
For large systems or hospitals: Consider running continuous vulnerability scans, as daily scans may no longer be enough. If 80 percent of patient visits are being conducted virtually via remote access, think about how many patient records could be accessed in 24 hours if that connection is not completely secure. The sooner a vulnerability is detected, the faster it can be secured.

For small practices: Patrizzo recommends that practices operating in a Microsoft Office environment run an O365 scan to monitor settings. Many small practices may not be utilizing some of the built-in security features. For example: Is the multifactor authentication setting turned on? Before practices purchase new technology or pursue new projects, they should

pause and access security controls and settings in existing technology. That includes mobile devices like cell phones and tablets. Remember to check the settings in the practice's videoconferencing platform. In some platforms, the *default* setting could be public and thus noncompliant. The practice will need to actively turn on security settings for even minimal privacy protection.

Patrizzo suggests that practices seek expert assistance from organizations they are already connected to: Many cyber insurance carriers and electronic health record (EHR) providers offer online and printed guides or phone help lines to assist.

Spotlight on Specialties



Cardiology

Cardiologists were early adopters of remote care opportunities, and they continue to innovate in the remote care space. For instance, the American College of Cardiology (ACC) has now partnered with Heartbeat Health to promote comprehensive virtual care by launching a telehealth platform for cardiologists. The goal is to better incorporate clinical data into communications with patients.²¹

Dermatology

Dermatology is considered a relatively telehealth-friendly specialty. Orit Markowitz, MD, associate professor at the Icahn School of Medicine and Mount Sinai's director of pigmented lesions and skin cancer, was relatively new to telehealth when COVID-19 struck but has become an enthusiastic adopter. In an online panel,²² she said the key to success with video visits is training patients about how to take photos: The "biggest pearl," she says, is to teach patients to take a photo using natural light, since daylight mimics the polarized light preferred by dermatoscopists, and while facing a window, not with the light behind them.

Hospital Care

Dr. Leitman of Mount Sinai notes that intensivists and hospitalists collaborating on telecritical care can provide enormous benefits when a very sick patient needs a higher level of care than can be immediately provided on site. And in any hospital circumstance where one might want an attending at bedside in the night, he says that telemedicine can help the attending immediately "put eyes on a patient" to "get a gestalt" that is not available by phone.

Family Practice

By volume, family practice is the top specialty using telemedicine. Family practice has enormous potential to implement what Adrienne Boissy, MD, chief experience officer at Cleveland Clinic Health System, calls "empathy at an operational scale," which she defines as "making life easier for patients, reducing suffering, reducing time spent

waiting.”²⁴ With broad knowledge of remote exam techniques, a skilled practitioner can provide the benefits of completing many visits remotely—while remembering the always-critical value of taking a thorough history and referring to a specialist as needed.

Pediatrics

By volume, pediatrics is one of the top four specialties using telemedicine.²⁵ The home setting may offer the benefit of speaking with multiple caregivers, and many pediatricians appreciate the potential to directly evaluate the safety of a baby’s crib or other aspects of the home environment.

PLATFORM TYPES AND PRICING

Bill Riley, director of sales operations and marketing at Medical Advantage Group, which provides support for telehealth implementation and training services nationwide, divides platform types into three categories:

1. Stand-Alone Solution

This is a sidecar to the EHR, also known as a “dual connect” solution. The physician is speaking to the patient via one monitor while documenting in the EHR in another. While offering the lowest amount of integration, in terms of patient workflow or connectivity to the practice EHR, this option presents the lowest cost and greatest ease of access for physicians.

2. Partial Integration

This add-on to a practice’s EHR is purpose-built for virtual patient visits, providing the same audio and live video communications as stand-alone solutions, but improving the patient’s experience through features such as automation of pre-visit authorization paperwork and a virtual waiting room. While most vendors in this category allow the practice to document in a version of a progress note, many practices do their documenting directly in the practice EHR to avoid any loss of data.

3. Fully Integrated Solution

Riley describes full integration as the “most elegant” solution, but also potentially the most expensive. The video visit portal is right there within the EHR, with scheduling, pre-visit questionnaires, technology and bandwidth test, and the patient portal integrated. A virtual waiting room will be included, and all documentation flows into the practice’s main EHR.

A SERIES OF LIGHT TOUCHES ON THE SHOULDER

With **Milton Chen, PhD**

CEO of VSee

Milton Chen has worked with many small practices and large systems to implement telehealth and telemedicine services. He says that the most common mistake is to think that the telemedicine visit is a meeting. Rather, Dr. Chen encourages those new to telemedicine to picture the busy hallway of a typical in-person practice, in which members of the care team may be asking each other to take one patient's vital signs, to send another patient to the lab, and so on. Imagining this in-person collegial environment, he encourages healthcare providers to think of movement through the telemedicine space as a well-orchestrated series of light touches on the shoulder.

Achieving this vision calls for an electronic “front desk hub.” Whatever platform a practice is using, practices need a workflow solution that allows for scheduling, for staff members to “shield” the physician from becoming information technology (IT) support by performing pre-visit technology checks with patients, and for managing all the satellite administrative matters that orbit the central interaction of the conversation between the physician and the patient.

NEW TECH: WHAT'S WELL ADOPTED, AND WHAT'S NEXT?

Apps

Dr. Leitman of Mount Sinai says that to date, the most widely accepted at-home devices to support telemedicine have been apps that monitor symptoms. For instance, apps that ask patients if they have certain red-flag COVID-19 symptoms, or those that gather data regarding heart rate or blood pressure via patient inputs.

Patient Monitoring

Many patient monitoring devices focus on blood measurements, such as glucose monitors, or blood monitors to support anticoagulant medications.

Cardiology as a field has, by its nature, been active early and often within the patient monitoring space, and new offerings continue. Some new services purport to not only collect data for a patient's physician, but to give patients more access to their own health data. For instance, KardiaCare is a new digital subscription service that collects ECG data, then creates a monthly “heart report” for the member to share with their physician. It also connects the user to a cardiologist for review every 90 days.²⁶

Devices

We are already witnessing an explosion of at-home devices to accompany apps to support telehealth. For example:

- ▶ A patient can already complete an ultrasound using an app on their phone, but soon, it will be possible to complete a remote ultrasound exam, where a device connected to the patient's phone is controlled by a provider elsewhere.
- ▶ For pediatrics, the paired TytoPro (used at the clinician's office) and TytoHome (used by the parent at home) provide an all-in-one digital stethoscope, otoscope, digital thermometer, and camera for remote exams.²⁷

The benefits of at-home data collection are obvious when it comes to easing the management of chronic disease and improving safety for immunocompromised patients. Moreover, devices don't have to be at-home, and can increase access to care: Barbershops in Cleveland and elsewhere have begun partnering with telehealth companies to test patrons' blood pressure and screen for hypertension among community members who may not be seen otherwise.²⁸

The risks of at-home data collection are also easy to imagine: user error, inaccurate results from subclinical devices, incompatibility hassles, etc.

Dr. Leitman describes the proliferation of at-home devices as a trade-off in which, on the one hand, one creates greater comfort and ease—and therefore compliance—for the patient. On the other hand, one is examining data, not the whole patient: "It's not better, it's not worse," he says. "It's just different."

CONCLUSION: EMBRACING TELEMEDICINE—WISELY

Believe it or not, telemedicine is descended from methods originally developed to treat astronauts in space.²⁹ It has since been helpful for various circumstances when treatment needs to cross distance, such as when patients in rural areas need to see a specialist. On other occasions, a surgeon who has performed high volumes of a certain procedure may remotely advise another surgeon who is actually performing the procedure. Some hospital systems were actually designed for regular remote advising via a spoke-hub model: For instance, providers in the emergency department at Alice Peck Day Memorial Hospital in New Hampshire can access advice from the tele-emergency hub at Dartmouth-Hitchcock Medical Center.³⁰

The first wave of the COVID-19 pandemic, which has highlighted telemedicine's virtues as well as its risks, caused a spike in telemedicine adoption that accelerated the existing trend toward increasing telemedicine usage.

As we proceed into the uncertainties of the future, key telemedicine takeaways include:

Train staff: Incorporating telemedicine doesn't just mean having a video meeting every now and then. It's a new workflow for the practice, which means new roles and duties for staff.

Educate patients: As Dr. Atreja says, the challenge is “not the video visit. It's getting patients there.” Whether practices access a platform that guides patients through the tech check, or whether a staff member calls patients before their first telemedicine visit, setting aside resources for preparing patients prevents healthcare practitioners from performing IT support at the expense of the clinical conversation.

Document visits: Be aware of how documentation of telemedicine visits does or does not integrate with the EHR.

Secure information: Many practices may be surprised by how many cybersecurity controls are available within their existing technologies, but not turned on. If needed, contact service providers for a printed guide or phone/email assistance, but do not leave valuable private healthcare information unguarded.

See in person what you need to see in person: Telemedicine is medicine. All the usual rules still apply. Taking a thorough history and seeking more information when needed—whether by lab tests or by an in-person visit—is just as essential as always. Used wisely, telemedicine does support the physician-patient relationship, but there's no replacement for what Howard Marcus, MD, calls “the privilege of touch.”³¹

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