Senate Health and Welfare / House Health Care joint meeting on telemedicine May 5, 2020

I am grateful for the chance to present today on the importance of telemedicine now and moving forward in clinical practices. I am speaking on behalf of myself, many other doctors with whom I talk with around the state, and also as a member of the Vermont Medical Society. I support keeping the flexibilities under the COVID emergency bill H.742 at least for the next year, and also to ask to formally require reimbursement for phone-only services.

I would like to quickly tell you what things looked like for us in the weeks before telemedicine was approved, and then how telemedicine has really benefitted our community, especially providing opportunities for our highest risk patients. In short, accessing telemedicine has been one of the silver linings of the COVID-19 experience.

I work for Community Health Services of Lamoille Valley, a FQHC (Federally Qualified Health Center) that serves 25,000+ people of all ages in Lamoille County. In mid-March, our office visit numbers dropped down to 50% of normal. Pay cuts and furloughs were necessary at a time when the community needed us most. Our daily phone calls, usually around 400 surged to 1,500. Patients were afraid to come in, staff were afraid to be there, and the rules changed daily.

But, through this overwhelming stress, ever changing policies and fear for personal safety, we continued to serve our patients. We answered every call, from the worried well, to the truly ill, to those who are on the verge of breakdown. Many issues we could manage over the phone, but for some they just had to be seen and we asked them to come in for a visit. Some did. But in an 8-hour day when I might normally see 22 patients, I was seeing maybe 6 and spending the rest of the time on the phone, for free.

Since televisits have been implemented, we have the capacity to use Fuze, a HIPAA compliant platform for both video and audio link, and when that fails or the patient does not have internet, we will just talk with them over the phone. This has been such a game changer – both a life saver for our patients and also the organization.

There are certain medical needs that just must be seen in person. A fracture, a laceration, an IUD insertion, a child who needs their important vaccinations. But so many things can be managed competently over the phone or via telemedicine. Our nurses are becoming experts on triaging the calls into the appropriate category. Currently we are seeing about 2/3 of visits with telehealth, and the populations benefiting the most are our most vulnerable: the elderly, the underserved, patients with mental health needs, and the sick. I will talk about each group quickly here:

1) The elderly. We have patients with diabetes and hypertension who are sure they will die of COVID if they come to the office, but are more likely to have a stroke by deferring basic medical care. Telemedicine has provided a bridge to those patients (appropriately) insistent on staying home and is very effective especially if the patient can give us readings from a home blood pressure monitor or glucometer. For many chronically ill patients, with emphysema or cancer, managing their care in the safety of their own home is the right thing to do. Since many of our Medicare patients do not have internet, a video call is often impossible, and we continued to provide care via phone. We are grateful that changes are in place to make these calls reimbursable as well.

Also, potentially more vulnerable to COVID, our “snowbird” patients are beginning to return to Vermont from the South. With telemedicine we can both manage their care while away, providing consistency and negating the need for other doctors in other states, but we can also virtually check in on them during their 14 day quarantine when they re-enter the state. We are hoping that they do abide by these recommendations.

2) The underserved. Many of my patients drive an hour to the clinic, scrambling to pay for gas, or are single parents with young children at home. Rural poverty overlaps significantly with my MAT (Medication Assisted Treatment) patients, who are seen at least monthly in the office. With the stressors of unemployment and homeschooling, we have been able to provide telehealth services to most of our MAT patients, with a great sigh of relief from them. They visit with us from their homes, or on a break at work, we hear about their lives, their stressors, check in on their counseling (which is also being done via televisits) and fill the prescriptions using my remote FOB number. It is a pretty seamless process. Of course, some patients are newer to recovery and may need more supervision or in-house visits for testing, and that is fine. But, for the single mom with three kids under 4, she would probably just stop treatment if I required her to come in every month right now. It’s just too hard.

3) Mental health. As noted above, our MAT patients also meet with counselors using telemedicine, and our entire Behavioral Health and Wellness group has been doing 100% of their work online. Again, both for safety and convenience reasons, the patients are getting great care when they need it more than ever. In the past several weeks we have more patients relapsing and considering suicide than usual, and their need for immediate intervention is critical. At an office visit the other day, I was meeting face to face with a patient, actually in health care, who revealed plans for self-harm. I was able to bring up one of our behavioralists on my computer to take part in our visit. She was working from home, and with just a few clicks was sitting right in front of us. Again, lifesaving.

   Similarly, I have a young patient who was in college out of state, unable to come home, struggling with depression. With televisits, we have been able to frequently visit, and assess her local options for care and support. These are complex and high-risk visits, often taking an hour of my time. I would do them for free, as we always have, but to be able to turn it into a reimbursable televisit just makes sense. As a family doctors, my office has 8,000 patients to whom we promise 24/7 care. I have taken many calls at 2 am, on Christmas morning and on my own kid’s birthdays. We will take care of our patient’s needs, no matter what, even without telemed. Because that is just what we have always done. But for complex, time consuming calls I feel that telemed has opened up an avenue for us to be reimbursed for the care we are providing, regardless of where we or our patients are located.

4) Finally, the actually ill. We have managed to keep all of our COVID cases in their homes. With frequent calls and televisits, we check in daily if needed to determine if they are stable, worsening, or in need of more care. A video connection, thermometer and pulse oximeter are valuable tools in this setting. Our local critical access hospital, therefore, has not has to admit a single COVID positive patient. Again, these phone calls or televisits require a high level of decision making and time, but we are glad to do it, knowing that we are keeping COVID out of the hospital when safely possible, decreasing the chance of further spread.

Here's the unfortunate news. COVID cases are down in Vermont but will likely wax and wane for months to years, until there is a vaccine or widespread immunity. The future is unclear on this. We need to be prepared to continue to use all tools possible to serve our patients. Televisits are certainly useful tools that I wish we had long before all of this started. The learning curve is not always comfortable, and we have some providers and patients who aren't happy with it – the lack of human touch, the terrible bandwidth of rural towns, the dropped calls. It is not perfect, but we have only been doing this for a few weeks. We are learning that our front desk staff really need to troubleshoot the connection, the nurses get the patients "virtually roomed" and ready for the provider, and if all else fails, we just talk on the phone or have them come in for a real visit. Bottom line, it is far better than no care, especially in a country with so much chronic disease and mental health needs. Our patients need access, and this has really helped bridge the gap.

To close, we are all worried – both about the economic, physical and emotional health of our community. Primary care offices are at ground zero of this, and the rural primary care workforce shortage that I testified about a few months ago is still a looming crisis. I'm happy to readdress that issue anytime again with you, and I worry it will worsen with this blow. Private practices will close, medical providers will burnout, patients will be left without basic care - if we do not make meaningful change to support them.

Continuing telemedicine coverage is just a start in the right direction. It helps the most vulnerable patients access care, it helps to save our organizations from closure, and it is probably environmentally friendly as well. Thank you for listening.

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