House Health Committee

I am a retired nurse with a 40 year career. I am now 76 and have perhaps a unique view on the subject at hand. I like many older Vermonters live in a rural community. I am 35 miles from my Practitioner and it takes an hour on a good summer day to get there.
My Dentist is half that distance. My nearest pharmacy is 30 -40 mins by car. Not bad really, as I have lived in a place that allowed me to get to the hospital for work for my last 28 years. Many Vermonters are much more remote and services much more limited.
Similar to broadband, health care is not easily delivered to each of our citizens.

MY THOUGHTS FOR YOUR CONSIDERATION

1. Skill at Diagnosis and appropriate decision making

Doctors and Nurse Practitioners Dentist (Practitioner)are well trained in what we call Differential Diagnosis. That is the art and science of assembling all the information, the symptoms, natural history, acquiring relevant anecdotal evidence (history taking) and the physical presentation, then determining which of several health problems may be at work. Suggesting that the Practitioner would not be able to discern whether the visit by phone is appropriate media, is frankly absurd.

2. Challenges and Efficiency

Practitioners who have established relations with a patient will have developed the skill set necessary to elicit the information needed to create a plan of care with the patient. The buy in and compliance from the patient may actually be improved through a phone visit because the person is more relaxed when at home. These phone only visits, are limited in their scope and usefulness. Not everything is treatable by phone. However, every phone only tele health visit done by phone, better targets in office time and avoids using office time for items that are well suited for a phone visit.

Travel for the elderly can be daunting due to weather, poor mobility, use of walking aides or wheel chairs, the need to arrange a ride, the time it takes to travel, willingness of a driver to spend that time, Lack of public transportation or subsidized senior transportation which is few and far between not to mention rigidly scheduled. Imagine you live 2 hours from the oncologist at UVM last week you had blood taken at your local rural clinic. Do you have leukemia or is it in remission. What to do in either case? Would a timely phone visit from your specialist be useful or would you have to travel all that way and home again? For the past several decades, the cost of this phone call has been hidden in general operating costs of Offices and Hospitals. Let's see what it really costs? And how much more health care can be delivered.

3. Malpractice

Mistakes or mis-diagnosis will be made over the phone just as they are now in the office or in the hospital. Review of long term data will set this rate, determine best practices and reduce errors over time. We need the data, we need the time.

The term malpractice is often a trigger word used to intimidate or scare non-medical people. It is a common trope used by health insurers and medical professional organizations anytime there is a legislative attempt to broaden availability or restrict the activities of groups to protect their profits. Most recently, the Dental groups used this tactic when the needed expansion of Dental Practitioners were proposed and badly needed in under served areas. Doctors fought Nurse Practitioners and Physician Assistants for decades. Now each has at least one and sometimes several with increased quality and satisfaction and reduced errors.

4. Why it should be full price reimbursement

"It is a phone visit, it doesn't have brick and mortar costs of in office visits it should be a cost savings and be reimbursed less"
On the face of it one might think so however consider this, when a Practitioner makes a phone visit, he or she is sitting in a place with a computer, a phone, patient charts, billing software, and likely a desk and chair. The 'office' has a receptionist scheduler and/or nurse to take the initial call, schedule the phone visit after checking with the Practitioner. That is brick and mortar and I think the B&M costs for in office visits might go down because the infrastructure costs are spread out. Maybe not, again time and data will tell us that.

BC BS suggests billing the Provider rate at 55% of current. Umm, is that already at the Medicare rate which is very low or is that the rate for Practitioners that don't accept Medicare or Medicaid? The value of a Practitioner's time is based on education, skill and experience, not on whether the service is provided face to face or media. Nevermind based on the the type of media used. This phone only media works better for some right now. It will likely phase out but still be useful for some in the future. We have a long way to go for universal broadband. This is another reason to keep the tele health approach intact going forward.

5. Concern for misuse and final thoughts

Any practice has at least one caller who calls "about everything". These often are deemed nuisance calls. Since they don't cost anything why not? The Practitioner has the difficult job of redirecting the caller. A modest copay may reduce these calls but for the economically challenged will also be a barrier to access. I have no suggestion here other than to consider this carefully. The goal is to improve access by using modern methods.

I urge you to include an audit requirement that will give health care and government entities the data to drive better service, better practice and better cost for Telehealth in all its forms. In keeping, this audit must include age gender ethnicity, race data which can no longer be overlooked or left out.

I thank you for your time and considerations.

Ethel Pike
72 Brown Rd
Vershire VT 05079
802 685 38745