Telephone Encounters Testimony

My name is Teresa Fama, and I'm a rheumatologist at Central Vermont Medical Center. I also am the Regional Physician Leader at CVMC, and the Medical Director for Specialty Care Services. I also have a background in health policy.

In these roles, I have significant knowledge of the state of eHealth, also known as telemedicine, at CVMC. Thank you for the opportunity to share my views.

One of the few benefits of the COVID pandemic was to push us to develop ways for our patients to continue to receive care during the pandemic – this was done initially via phone visits, and then more commonly with video visits as this capability was rapidly expanded. This has allowed us to continue to "see" patients despite challenges and safety concerns. From my experience in my own practice and in the administrative roles I have at CVMC, the type of visit (whether it's in-person, video or phone) is determined by the clinical scenario and the patient's circumstance and comfort level of coming to the office. Based on data from CVMC and the other community practice division hospitals in the network, phone visits were more common during early COVID days. Once we were able to initiate more widespread video capability, video has surpassed phone visits. In-person visits remain the mainstay of all visits. Specifically, <25% of all visits are TELEHEALTH (that is, video plus phone visits); this has been consistent over the past several months. Only a minority of all clinical visits (5-7%) are by PHONE. Thus, this does NOT constitute a massive utilization of telemedicine even during a pandemic.

It's imperative that we continue to have access to audio-only visits for the following reasons:

- Vermont's broad-band capabilities are poor at baseline; video conferencing is not possible in some areas of Vermont.
- Older adults tend to have less access to or capability of using video conferencing; close to 20% of VT's population is >65 years of age.
- Patient visits often begin as Zoom and, due to internet/wifi signal issues, need to be aborted (or cannot even start). These visits can either be converted to phone or else re-scheduled to in-person, and for certain specialties, such as mine (rheumatology), this means that patients will need to wait at least 3 months to see me due to access issues (with my schedule being booked out that far).

Another consideration is that Vermont's healthcare reimbursement still is predominantly a FEE FOR SERVICE model (and not value-based). My colleagues and I phone patients informally to discuss test results, to answer questions, and to triage patients' symptoms. These phone calls often happen on our own time (lunch hour, evenings, weekends). This practice has remained mostly unchanged, despite having a phone or video option with patients for patient initiated calls. However, knowing that we have the option of creating a formal visit allows us to not only get "credit" for the visit (because our compensation is based on RVU generation) but formal phone visits over informal phone conversations result in improved documentation (since the

visit is now scheduled, rather than informal), as well as improved morale since these visits happen during clinical hours, rather than non-clinical hours.

Regarding co-pays for these visits, I have yet to hear any complaints from any of my patients or of patients in our medical group.

In terms of types of visits done via phone visits, as a rheumatologist, my clinical expertise often rests on the management of pain in my patients. I have not yet ONCE encountered a request for a phone visit to accommodate narcotic prescribing. Regarding established patient visits vs. new patient visits, some specialties, including rheumatology, rely predominantly on in-person visits, with video being an option for some new patient visits. I rarely use phone visits for new patients given the nature of my specialty with needing to do a through joint and physical exam. However, for some specialties, such as psychiatry, phone visits might be an acceptable option for new patient visits.

Finally, as we spend our first full winter with having video and phone option for visits, with our last two snow storms, I was able to convert patients from in-person to video or phone, the day prior to the storm. For patients who did not have access to video, this meant that they could still receive care on the day or their originally scheduled appointment. Otherwise, as I previously mentioned, their care would be delayed by about 3 months due to my booked schedule – which is unfortunately true of several other specialties. Hearing patients express their thanks to me for this option, resulting in them not having to drive in the bad weather or reschedule the appointment was the highlight of my day. Why would we ever want to go back to what we used to do given the expansion in access and improved patient satisfaction?

Thank you.