

## ARTICLE

# Rapidly Converting to “Virtual Practices”: Outpatient Care in the Era of Covid-19

Ateev Mehrotra, MD, Kristin Ray, MD, Diane M. Brockmeyer, MD, Michael L. Barnett, MD, Jessica Anne Bender, MD

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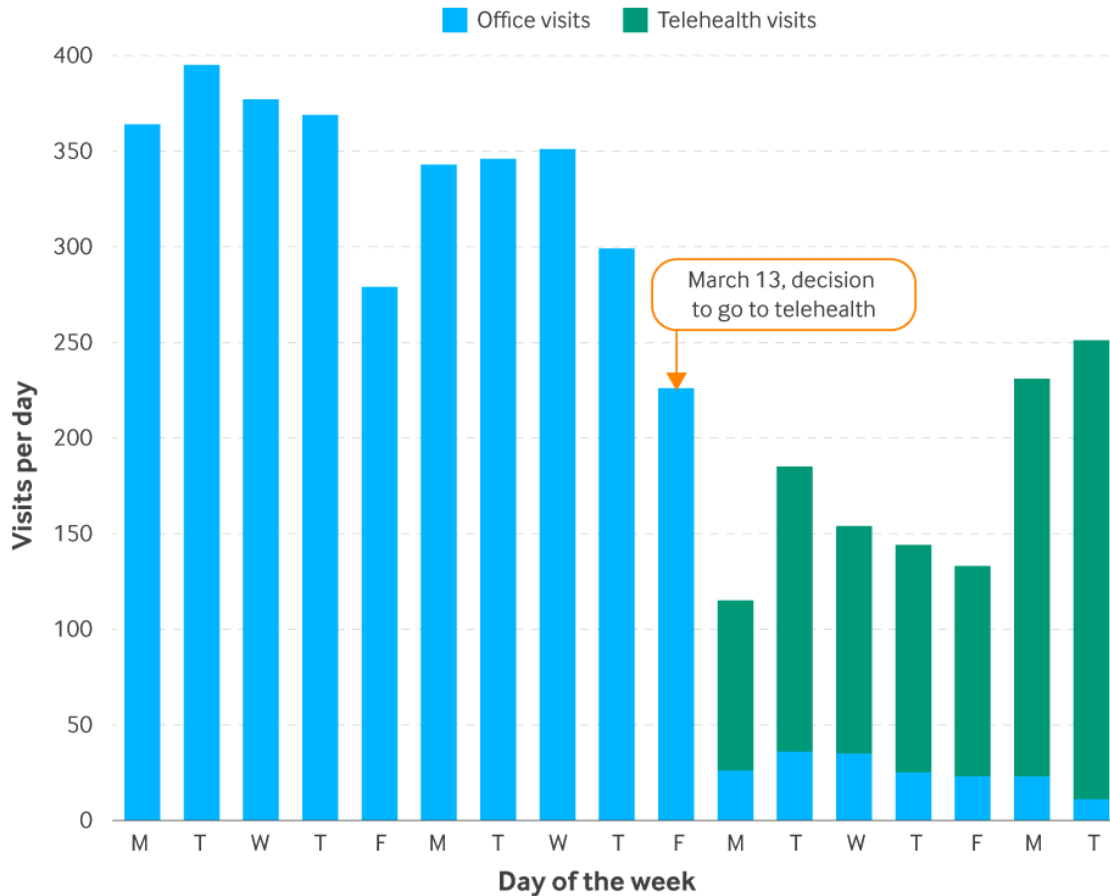
In the midst of the Covid-19 pandemic, physician practices are turning to telehealth. Across four primary care practices, we describe our experiences in trying to become “virtual practices,” challenges we have faced, and our goals for the coming weeks.

In just 2 weeks, Covid-19 has driven a rapid and radical transformation from in-person care to telehealth in primary care practices. To inform others who are making this transition, we describe our experiences across four physician practices from different regions of the United States. While each practice went through this process independently, there are many commonalities in the challenges we have faced.

The speed of the transition has been dizzying. Changes that would typically encompass months of planning, pilot testing, and education have been compressed into days. At one extreme, one of our clinics made the decision to go fully virtual on a Friday afternoon with a scheduled start date the following Monday (Figure 1).

FIGURE 1

## Number of Visits per Day in Transition to Telehealth at One Primary Care Practice



Source: The authors

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The potential benefits of virtual practices are clear. For patients concerned they have Covid-19, telehealth can address questions, coordinate testing, and triage clinical needs. It can also be used to provide care for individuals in quarantine or recently discharged to home. For patients who have non-Covid-19 issues, telehealth can allow them to receive care without the risk of exposure — a critical concern for older adults and those with chronic conditions. The net effect is reduced exposure to patients and clinicians and a limit on demands of emergency departments. Many of our clinicians are themselves quarantined or must stay at home to care for children; telemedicine has allowed them to continue to provide care.

Before the pandemic, telehealth played a relatively minor role in our practices. All had patient portals with patient-to-clinician messaging capability, but many patients had not signed up. One practice used e-visits,<sup>1</sup> a form of asynchronous telemedicine that could be obtained on the portal,

and others were using e-consults,<sup>2</sup> a mechanism to electronically obtain specialty input clinician-to-clinician, but utilization of these modalities was low. All practices were considering video telemedicine visits, but none had made the leap.

## Becoming Virtual

In rapidly adopting telehealth, our goal is to minimize the number of patients who come in. We have dramatically reduced the number of nurses and physicians who physically staff the office, while other staff provide care from their home or “clean” office space. In one of our practices, we have asked only one physician and nurse to come in per day, and we limit in-person care to two visits an hour across the entire practice.

Simultaneously, we are ramping up telehealth modalities, including electronic messaging, within the patient portal, telephone calls, and video visits. To make this transition, physicians are reviewing scheduled appointments and making triage decisions for in-person visits, telehealth visits, or deferred appointments. Our clinics have developed protocols for front-office staff on which visits can be deferred for several months (e.g., annual physicals for adults) or should remain scheduled (e.g., early infancy immunization visits), but most of the triage decisions still require clinician input. Once decisions are made, our offices are calling patients to transition visits where appropriate. An unanticipated complexity is that when physicians call to plan a future virtual visit, this initial call often has turned into an immediate telephone care, resolving the need for a telehealth visit.

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In our new virtual practices, we find that telephone care is the current telehealth mainstay; video visits are taking time to ramp up. In some practices the goal is to make video visits the norm (rather than telephone) to better approximate in-person care and to increase likely payment, while other practices are embracing telephone visits alone. Ongoing barriers to video visits include training clinicians, explaining arrival procedures to patients, using interpreter services, and getting video equipment to clinician’s homes. Some attempted video visits unfortunately have had to be switched to the telephone or less HIPAA-compliant platforms such as FaceTime and Skype. While neither of those platforms is compliant with privacy regulations, the U.S. Department of Health & Human Services has recently declared it will not enforce compliance rules in this time of crisis.<sup>3</sup>

Given varying levels of Internet capacity, some video visits have been plagued by dropped calls, poor image quality, and lags. Clinicians are quickly disseminating best practices for “Web-side” manner, including having the camera at eye level, which clothes work best on a video screen, ensuring our badges are visible to the patient, and removing visual distractions from behind the clinician.<sup>4</sup> We have created macros in our electronic health records to ensure we document patient consent for a telehealth encounter, discuss confidentiality barriers, and document time spent in the visit.

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Despite these barriers and limitations, the patient response has almost universally been one of relief. When we connect with patients, we hear they were scared to come into the office and unaware that telehealth was a possibility. Clinicians are also surprised by the scope of care that can be provided remotely through telehealth.

## **The Unknowns of Virtual Practice**

The rules on telehealth payment and regulations are changing by the day. Last week Medicare implemented [temporary rules](#) allowing clinicians to bill videoconference visits into any patient’s home (or any other site) anywhere in the country. Medicare is also paying for telephone care and e-visits and waiving out-of-pocket costs. Private insurers and some state Medicaid programs are moving in a similar direction. For example, Massachusetts has declared that all telephone and video visits should be covered. However, in other states and with other payers, there remains substantial uncertainty about or limitations to payment. Pediatric practices in particular need state Medicaid programs to rapidly adopt Medicare’s evolving positions.

During this crisis, the general attitude among our health systems’ leadership is to prioritize caring for our patients, but concerns about practice revenue will escalate as social distancing continues. Our practices are part of large academic systems with financial resources, and we recognize that these concerns are graver still for our colleagues in independent practice and those who work in the safety net.

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Our newly minted virtual practices are evolving by the day. The goals for the coming weeks are developing better systems for triaging patients to the appropriate level of care, becoming more facile with video visits, and enrolling more patients in our patient portals. Communicating new modes of access to patients is also an urgent need, for which we are using our phone systems, websites, social media, and portal messages. Given the modeling projections on the upcoming wave of Covid-19 cases, we worry that at some point even our virtual health visits will need to be rationed to only those at high risk for illness, and we are already considering protocols on which patients should take priority.

Longer-term strategies we are considering include ensuring that our high-risk patients have technologies at home to track vital signs and other data, and increasing use of e-consults (when available) so that clinicians can virtually incorporate input from specialty colleagues. In the backs of our minds, we worry about the longer-term financial impact of this transition on our practices, how

we will accommodate the “catch-up” care we are deferring now, and how this transition to virtual care now will change our practices in the long term. For now, however, virtual practice allows us to meet our patients’ needs and prepare for the surge of illness to come.

**Ateev Mehrotra, MD**

Associate Professor, Harvard Medical School, Beth Israel Deaconess Medical Center

**Kristin Ray, MD**

Assistant Professor, Children’s Hospital of Pittsburgh

**Diane M. Brockmeyer, MD**

Assistant Professor, Beth Israel Deaconess Medical Center

**Michael L. Barnett, MD**

Assistant Professor, Harvard University TH Chan School of Public Health

**Jessica Anne Bender, MD**

Clinical Instructor, University of Washington Department of Medicine

*Disclosures: The authors are presenting their experiences at their respective medical centers. They are employed by those medical centers.*

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