URGENT PERSPECTIVES

Point–Counterpoint: Is Telemedicine Ready for Prime Time?

STANFORD COLEMAN, MD, MBA, FAAP and WILLIAM GLUCKMAN, DO, MBA, FACEP

JUCM invited two longstanding industry leaders to share their perspectives on the viability of telehealth in the urgent care setting. **Stanford Coleman, MD, MBA, FAAP**, Vice President and Chief Networking Officer for Medical Affairs and Community Relations for Righttime Medical Care in Maryland is a proponent of the use of telehealth in urgent care. He treats patients virtually through the company's RighttimeNow telemedicine service. **William Gluckman, DO, MBA, FACEP**, President and CEO of FastER Urgent Care in Morris Plains, NJ; Clinical Assistant Professor of Emergency Medicine at Rutgers New Jersey Medical School; and a member of the *JUCM Editorial Board*, is skeptical about telehealth's place in urgent care. Here's what they had to say.

WG: I have concerns about telehealth in urgent care in a number of areas, but the most significant are from a quality perspective and from a liability perspective. The quality piece has a couple of components to it: One is the ability to perform an appropriate, complete evaluation from a hands-on perspective, meaning the inability to do a real palpation of the abdomen, to auscultate the lungs, or test for instability in an orthopedic issue.

SC: Telemedicine can be and *is* being practiced multiple ways in urgent care today. A number of urgent cares do telemedicine for load-balancing and have a "virtual room" on-site staffed by medical assistants using electronic peripheral instruments such as a telestethoscope for heart and breath sounds, otoscope for examination of the ears and throat, as well as an ophthalmoscope, and video/still camera systems—all directed by the remote provider. We need to do a survey and get data, but there is anecdotal evidence to support this.

Further, the remote provider can direct the patient in self-examination, with self-palpation of the abdomen or heel tap that can provide information about abdominal pain, or observe the patient's breathing pattern, cough, and voice quality, etc.

The real issue is having providers and assistants properly trained in doing these kinds of remote physical examinations. Not every provider can be a telemedicine provider in urgent care. They should be selected based, in some sense, on how telegenic they are, how enthusiastic they are about doing telemedicine visits, and what kind of relationship they can build with a patient remotely. They clearly have to be a clinically experienced provider who can make appropriate decisions in this setting and trained to best practices.

Quality and liability in any clinical setting rest on proper documentation of clinical decision-making supported by an adequate follow-up plan. The follow-up plan is essential. Having an adequate "safety net" for follow-up is most important. At Righttime we schedule follow-up visits and call every patient after every telemedicine visit.

WG: My concern is that many other telemedicine providers operate without the diagnostic tools and POC testing you described. This is the major issue I have. If all telemedicine visits have advanced diagnostics associated with them, I would have less opposition. And about the ability to do point-of-care testing, such as for sore throat? Standard practice is to do a rapid strep test. If it's positive, great, you know it's strep, you give them antibiotics, and all is good. But if the rapid strep is negative, the general procedure is not to provide antibiotics. You may choose to do a throat culture and only if that's positive do you treat. I think it's almost a given that a patient calling in through a telemedicine visit is looking for an antibiotic. The easy thing to do is, *Well, it's a sore throat, we'll give you antibiotics*. And that goes against the current push toward antibiotic stewardship.

SC: Most patients want advice, a diagnosis, and relief from discomfort. You'd be surprised how many patients listen when

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you sincerely educate them when antibiotics would be inappropriate for them. Let me describe our process at Righttime, using sore throat as an example.

When patients call in to our call center for a visit, they're given the opportunity to have what we call a RighttimeNow visit, a telemedicine visit. We have an intermediary company that has created the ability to connect the patient to the provider through a HIPPA-compliant secure channel by using Facetime or Skype. When the visit is scheduled, I have the patient's chart. I know everything about every visit they've ever had to Righttime. If they're a new patient, I start a new chart. Either way, I can decide whether this is an appropriate telemedicine visit. If it is not, I can immediately schedule them for a face-to-face visit and get them into one of our sites.

When our call center schedules a patient for me, we ask the patient to take their temp, have a flashlight or be sitting in good lighting. I'm going to look in their eyes, their nose, and their throat and I'm going to teach them how to do a self-exam for their cervical lymph nodes. If they've had no fever, if their sore throat just began today, if no one else in the household has a sore throat, or has been diagnosed with strep, I'm not going to put them on antibiotics. There are criteria called the Centor criteria we utilize; if they don't have a temperature of 38.5° C, don't have tender lymph nodes, no exposure to strep, they don't have any exudative pharyngitis, I'm not going to put them on an antibiotic.

We are very aware of proper antibiotic stewardship at Righttime and have kept our antibiotic prescribing rate well below national averages for urgent care and will do the same for telemedicine.

WG: Clearly that's a better approach than what my perception from other providers is. If you're very comfortable that they don't meet Centor criteria or other evidence-based guidelines for use of antibiotics and you're firm with it, and you explain why they're not getting an antibiotic, that's a win-win. But beyond the testing issue, aren't the tangible benefits of face-to-face contact and a hands-on approach lost in a telemedicine visit?

SC: I'd rather look at what is *gained* for patients in terms of access, convenience, and timeliness in a telemedicine visit rather than what could be lost in not seeing them in person. I see it as an opportunity to see and satisfy more patients and to connect them to our urgent care and our values. The face-to-face interaction, eye-to-eye is still there. The patients I see are very excited, and curious about doing a videoconference visit. And they know right up front there are limitations, but they all respond positively when there is an expression of warmth, concern, and commitment to finding a solution to their medical problem.

WG: Do the patients who are excited about it tend to be the younger generation that are tech-savvy? How many seniors do you really get doing this?

SC: I would have thought it would be the young, tech-savvy people but I've had a number of elderly patients. I think it's because our system is really easy as long as they know how to use their cell phone or they know how to use their tablet or laptop. Overall, our mission is to simplify access to trustworthy medical care. So this is just another modality for us in simplifying access and providing trustworthiness.

WG: There's no doubt it can improve access, but I would still have reluctance about certain conditions. I don't know how even the best clinician would be comfortable dealing with a young female of childbearing years with a chief complaint of abdominal pain. That could be anything, from gas to an ectopic to appendicitis. Without having a pregnancy test, without having a urinalysis, without pushing on her belly, I would be reluctant to say anything other than, *Please come in and be seen by a provider*. In which case, what's the satisfaction of a patient who has a telemedicine visit and is then told, I think you need to be seen by a provider? *Hey, I thought I was getting on-demand care here and all you do is tell me to come in?*

SC: It comes down to clinical judgment. For the childbearing age female with abdominal pain, I'm going to take a very careful history to understand the quality, location, duration, and associations of the pain, her last normal menstrual period, etc., the same history that I would acquire in an in-person visit. More than likely this patient would be sent to a site for further evaluation and lab work. She and the next provider would have the benefit of my evaluation in her chart and the relationship I would have already built. She would not be charged for two visits, and I'm certain she'd realize how important she is to us and that we will not abandon her.

WG: We don't hear a lot about horrible medical-legal cases—yet—with telemedicine but I look at that as a different standard of care. Say you thought a patient had bronchitis but they ultimately turned out to have either a lung mass or maybe pneumonia. For whatever reason, they go on to decompensate and have a bad outcome. They could certainly try to challenge: *Dr. Coleman, you didn't even listen to his lungs. How could you possibly have missed this?* We haven't heard that yet, but my hairs go up thinking that's coming down the pike.

SC: You can be still be sued for missing a lung mass even when you treat a patient for bronchitis in person. What it comes down to is what kind of advice did you give the patient about follow-up, what to watch for, how soon to follow up and how well did you document the visit.

We provide diagnosis information handouts in an email to the patient, and they have access to the Righttime patient portal if they need further detailed information. So the follow-up plan is the same as if I were seeing that patient in person.

WG: By the way, I don't think there's *no* utility for telemedicine. I could see where you'd suture a wound and want to do a telemedicine visit in 2 days just to do a wound check, for example. Or you're following a skin lesion to see if it's getting worse. But I'm still having a hard time with many of the acute scenarios for first-time visits.

SC: As you've detected, I'm very enthusiastic about this. But I try to be very disciplined about it. That's one of the tenets a telemedicine provider has to sign on to, that he or she is going to fight that temptation to write a prescription just to make the patient happy, but to educate patients very carefully and take the time to explain things. That's why I have them bring a pencil and paper to the visit—because I'm going to give them many things to do. Educating patients on elements oself-care is critical to antibiotic stewardship in urgent care and in telemedicine.

WG: Hearing all this from you certainly gives me food for thought. I'm going to sit back in the wings and watch a little bit more to see what happens, though.

SC: Developing evidence-based guidelines should help. That's the next step for me in terms of growing our program. And I would love to run those past you to see if I can convert you.

WG: I think you should do some real research, write it up, and publish it in *JUCM*.

SC: That's a good point. All the innovations in medicine we practice today, that we have confidence in, have gone this way. Telemedicine has its place. But it also has its risks and therefore has to be done very carefully and thoughtfully. It is an opportunity to provide further access, convenience, and patient satisfaction. Just like urgent care.

(The views expressed by Drs. Coleman and Gluckman reflect their experiences and perspectives, and are not meant to speak for the industry as a whole.)

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