

## Special Focus: Internet Medicine

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# A new kind of doctor's appointment

## *E-visits for stable conditions save time, money*

**By Paul C. Seel, MD, MBA**

Have you ever felt that going to the doctor's office for the follow-up of a stable condition, such as high blood pressure or diabetes, required more time than it was worth? Maybe, counting time spent driving and waiting, it took up the better part of a morning. Perhaps your physician was too busy to see you, so you had to see someone else in her office. Or perhaps there was some crucial family or work activity that you missed because you were tied up with the appointment. On top of all that, you knew what your physician would say: Nothing had changed since your last visit.

Would it surprise you to learn that your doctor feels the same way? Your physician has a limited number of appointment slots. She needs to learn how you are doing but, given that nothing has changed, seeing you in the office will have little impact on your care—as long as there's another way to exchange information. Furthermore, if she can free up an appointment slot for someone who really does need to be seen, she can potentially shorten her day. The end result is a better match of the patient's needs and the physician's, plus a more efficient use of an expensive resource—the office.

It's analogous to hitting a fly with a sledgehammer: If you can use something less intensive, everyone makes out better.

### **Another way to touch base**

One possible solution is the e-visit—Internet-based electronic communication between patient and physician. Unlike regular e-mail, the exchange has a level of security similar to on-line banking. It can be very structured through specific, logic-driven questions and can be stored in the patient's electronic medical record (EMR), where safeguards limit access to those directly involved with the patient's care.

Annual polls by the respected Harris Interactive organization show that 74 percent of patients want to be able to communicate electronically with their physicians. However, only 8 percent of patients in the United States at the time of the last poll in 2006 reported having physician access by e-mail. Some of Minnesota's larger care delivery organizations, such as Winona Health and Park Nicollet Clinic, offer e-visits, but adoption rates remain slow.

### **Change is difficult**

Although there may be multiple reasons for this gap, a primary factor is that the medical profession is focused right now on a transition from traditional paper records to EMRs. The widespread adoption of the EMR eventually will facilitate electronic communication between patients and physicians. But physicians making the transition (so far, roughly 20 percent of U.S. doctors) have their plates full with a slow, laborious, and costly adoption process—and the rest of the physician population has been spooked by the adopters' experiences. Another reason for the reluctance of physicians to embrace this technology is that it reverses the sequence of handling a patient's problem. Rather than physically seeing the patient first and then gathering information, the information is gathered first and then the physician decides whether to see the patient. This is a major procedural change, and change can be difficult to embrace.

### **How e-visits work**

Suppose you have high blood pressure, a chronic, stable health problem that requires daily medication. You feel well and are aware of no new issues. You see your physician two or three times each year for this condition.

As routine as these visits are, the information exchange is critical to the management of your chronic disease. In addition to your physician's need to know how you are doing, the anticipation of your follow-up helps keep you on task monitoring your blood pressure, taking your medications faithfully, and working on reducing your calories and increasing your exercise. Studies of patients with chronic diseases like high blood pressure show a correlation between the number of interactions with a physician and their

overall results. This interaction is not only necessary but could be done more frequently, particularly if there were an efficient alternative to the time-consuming office visit.

Enter the e-visit.

Several days prior to your scheduled clinic visit, you pull up your physician's Web site and click on the e-visit icon. You log on with a unique and secret password just as you would to transfer money from a bank account. Once you are logged on, the e-visit program leads you through questions to update things like your address, phone number, and insurance. Then it asks a series of questions that pertain to your high blood pressure. The questions are "logically driven," meaning that your answers on the early questions will determine the specific follow-up questions you will be asked. For example, mention headaches and you might get a dozen or so detailed questions exploring the nature of your headaches. Deny headaches and these questions aren't asked. It also may ask one last catch-all question: "Is there anything else of concern?"

In addition, you enter your recent blood pressure readings and specifics about how you are taking your medications. When you're done, you electronically zap the report to your physician. The entire process might take less than 20 minutes.

Your physician logs onto the system with her unique password and reads your e-visit. She composes a brief response and sends it back. In this case, it's what you anticipated: "Blood pressure looks good. Try to work a little harder on your weight and cut back on the calories."

Had the questions revealed some other symptoms—i.e., leg pains when walking—your physician might want to see you. Armed with the information from your e-visit, she may even ask you to get some diagnostic tests before she sees you, which may lead to a more efficient process and fewer trips to the office.

### **The outcome**

The end result is a successful e-visit for your high blood pressure. You're satisfied because the follow-up took about 20 minutes instead of three hours. Your physician is satisfied because she got a detailed account of how you were doing, you recorded your recent history so she doesn't need to enter the information in your chart, and the entire process took just minutes of her time with virtually no overhead expense. What's more,

she now has time to see the patient with an urgent problem. Both parties have benefited because the encounter occurred asynchronously: The patient and the physician acted separately, eliminating delays and phone tag.

Your insurance company is happy as well. Insurers understand that increasing access to health care and follow-up for chronic diseases improves results. The major insurance companies in Minnesota will pay for e-visits and are very interested in seeing how this tool can improve chronic disease management. Insurers generally pay the physician \$35. Co-payments may still apply, depending on the policy.

Let's return to the fly-and-the-sledgehammer analogy. Imagine if everyone journeyed to a hospital emergency room for every health problem. Certainly no one would have a problem that couldn't be handled. However, most patients wouldn't require anywhere near the resources that an ER has. The end result would be great and timely care for a handful, but the vast majority of patients would actually get care that was less convenient and incredibly more expensive.

Although not so extreme, seeing patients in the office who don't need to be seen is analogous. The office is an expensive and limited resource. Patients' time is valuable and rarely factored into cost-benefit analyses. The physician, meanwhile, doesn't know whom she doesn't need to see until after she's seen them. The missing ingredient is a system that gathers information so that the physician can decide in advance who actually needs to be seen. E-communication between physician and patients with an e-visit is one such tool.

### **When is an e-visit appropriate?**

For e-visits to be safe and effective, it's critical that physicians educate their patients as to what types of situations are appropriate for e-visits and what situations require a more traditional approach. The asynchronous nature of the e-visit could be detrimental in a serious or life-threatening situation. To help prevent problems, physicians can be very specific explaining what a patient can expect as far as timeliness. For example, the e-clinic site might state that no e-visits will be responded to after 3 p.m. on weekdays or when the office is closed. A good dose of common sense can also help. You wouldn't leave a message on your physician's voicemail that you were having a

heart attack. It would be equally inappropriate to handle that type of situation with an e-visit.

Nationwide, e-visits are routine in some larger practices, including Kaiser Permanente on the West Coast and the Henry Ford Health System in Detroit. One big reason for the lack of more universal acceptance is the human aversion to change. There are also specific issues for medical practices regarding just how rapidly the volume of e-visits picks up. Until the volume of e-visits reaches a certain point, a Catch-22 is created: Either more time is allotted than actually needed—and therefore wasted—or e-visits are just one more activity added at the end of an already busy day.

The bottom line, though, is that the e-visit can accomplish the rare trifecta of satisfying patients, physicians, and payers and, over time, will become commonplace.

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