EVISITS INSURE CONTINUOUS CARE, EMPOWER PATIENTS

A recent study from Deloitte predicts that in 2014, there will be 100 million eVisits globally. Deloitte also estimates that this could involve a potential $5 billion savings in healthcare costs when compared to the current cost of in-person doctor visits.

An eVisit is an interaction between a clinician and a patient that happens online, is based on an established patient/clinician relationship, and deals with non-emergency issues. Some eVisits are done in real- time on a secure portal where the patient and the clinician are communicating virtually and asynchronously, as though they were face to face.

Deloitte defines the eVisit as “an interaction where a patient fills out forms and questionnaires and provides photographs where appropriate.” This information is sent by the patient to the clinician on a secure portal, via a closed email system or using a kiosk. A diagnosis is made and communicated to the patient along with a prescription for whatever treatment is needed.

The Deloitte report concludes that while complex diagnoses and treatments are likely to remain part of a face-to-face encounter, the eVisit will become more common for minor ailments and routine matters including dermatology consults.

The eVisit has been around for a long time. First introduced by RelayHealth in 1999, as a way to improve care coordination between patients and their clinicians, the RelayHealth secure web-based portal platform includes a formalized questionnaire that invites patients to choose from a menu of symptoms and answer a series of questions related to their specific condition. This information then is sent to their clinician who responds with treatment recommendations or comments.

Last year Kaiser Permanente conducted 10.5 million patient/doctor (eVisits) visits via email, telephone or video tools. One of the reasons patients give for favoring these visits is that they do not need to miss time from work or school for minor problems. The eVisits are ideal for addressing allergies, minor infections, earache, GI upset, colds, low back pain, poison ivy, and more.

Other institutions that engage patients and clinicians with eVisits through their secure portal include the Mayo Clinic, the Veterans Administration Hospitals, Decatur Memorial Hospital in Central Illinois, the University of Wisconsin Health System and the Henry Ford Health System in Detroit, and many others. For some of these institutions the eVisit is a way to reach out via a secure HIPAA compliant network to patients who live in rural areas, as well as to help patients everywhere manage chronic conditions.

Reinforcing the validity and usability of the eVisit, CMS ruled in 2009 that clinicians would be allowed to bill Medicare for eVisits that occur after the patient has had an in-office patient consultation. The telehealth consultations would include monitoring a patient's progress, recommending care-management changes or providing a new plan of care. The e-visits would be performed in real- time with interactive communications systems in all states except for Alaska and Hawaii, where store and forward technology is being used in Federal telemedicine demonstration projects. Several insurance companies are also reimbursing eVisits on the premise that they will save money and provide better coordination of care.

In 2013 **JAMA Internal Medicine** did a study that looked at results from office visits vs. eVisits for two conditions: sinus infections and urinary tract infections (UTIs).The study was conducted at four primary care practices in Pittsburgh and revealed that although over 90% of the interactions between patients and doctors were in-office visits, there was no difference in outcome of those who engaged in an eVisit for the same condition, except that the eVisit patients were prescribed more antibiotics than the office visit patients. Even with that difference in prescribing, the study concluded that treating each patient with a UTI cost an average of $74 per e-visit as opposed to $93 for an office visit.

Extended care eVisits are also used to enable physicians to consult with nursing home patients without having to physically make routine on site calls. Over 1.5 million people currently live in nursing homes—a number that will only increase as baby boomers enter this age The

extended care eVisit addresses the primary care physician shortage challenge by providing 24/7 coverage with voice and/or videoconference functionality, connecting a physician hub to nursing home residents at their bedside and improving care for this patient population at minimal cost.

The **American Academy of Family Physician**s (AAFP) supports the eVisit which AAFP defines as “an evaluation and management service provided by a physician or other qualified health professional to an established patient using a web-based or similar electronic-based communication network for a single patient encounter.”

AAFP has established their own guidelines for e-Visits as follows:

1. eVisits are only available to patients who have an established relationship and who have previously received care from the physician’s practice.
2. The process is initiated by the patient who has to provide a signed agreement regarding privacy policies, service terms, and a commitment to pay the associated charges for this service.
3. eVisit communication must occur over a HIPAA-compliant secure connection.
4. Clinicians must appropriately document the eVisit in the patient’s medical/health record
5. The physician or other qualified health professional has a defined period of time to respond to an e-visit request.
6. An eVisit should be a payable visit.

Along with retail clinics, house calls, community health centers, and urgent care centers, eVisits are another way to serve, engage and empower patients, coordinate care for non-emergency situations, provide, efficient, and cost-effective communication and interaction among large patient populations and providers, and resolve the issue of how to get appropriate ongoing care to those patients whose access to care is limited.

Patient initiated dialogue and advocacy is needed to urge more provider groups and healthcare institutions to build the infrastructure to make this happen.