A Model for Telephonic Medical Consults

Guidelines for Decision-makers

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Executive Summary

Telephone-based medical care delivered by fully trained and qualified primary care physicians has become a staple of healthcare delivery throughout the United States. As the marketplace demonstrates its continued confidence in this mainstream model, the growing use of telephone-based consultations -- particularly for physician cross-coverage -- promotes more efficient interactions between patients and providers. Telehealth primary care doctors include family practice physicians, internal medicine physicians, and emergency medicine physicians.

Increased reliance upon this proven method for delivering health services is already generating significant cost savings for plan sponsors and benefits payers and will favorably impact access to care for individuals living in rural and urban settings. Both public and private sectors are highly receptive to the concept with accelerated adoption rates tied to the increased focus on healthcare consumerism, more timely access to services, and ongoing pressures to reduce healthcare expenditures. Currently, over 1.5 million Americans enjoy access to these services.

Historically, physicians have relied upon telephone consults as a means of communicating with patients. This applies not only to the individuals in their own practices but also those patients for whom they take responsibility in cross-coverage arrangements with medical colleagues. The modernized progressive model which focuses on patient-centric care utilizes a fully portable, continuity of care (CCR) electronic health record (EHR) which is updated before, during, and after each telephone consult. It has become evident that this robust, telephonic level of communications is particularly valuable in addressing illnesses that arise quickly and tend to run a brief course, typically 5-10 days.

Today, many non-emergent medical issues can be managed and definitively treated in this manner, providing consumers with more immediate access to clinically sound medical advice and treatment options. Studies demonstrate that users are very satisfied with the advice they receive and would recommend the service to friends, family, and business colleagues. Additionally, primary care physicians embrace the opportunity to readily facilitate cross-coverage services as well as to enhance their revenues.

The simplicity of the model, its fully transparent pricing, and the use of a freely available EHR support our national goals for streamlined continuity of patient care and the development of the medical home. Telephone medical consults support these national trends:

1. Equivalent healthcare outcomes at lower costs for participating Americans
2. Increased focus on personalized, private consultations that are high quality, affordable and readily accessible
3. Streamlined, coordinated care through the use of an open, privacy-protected and Advanced Encryption Standard (AES) 128 Bit-encrypted Electronic Health Record (EHR)
4. Widespread adoption of the medical home model and reliance upon primary care physicians
5. Timely care for rural Americans and the nearly one-in-four citizens who have problems missing work to see a physician for routine medical services
6. Consumer centric programs and empowering individuals to purchase their own healthcare
7. Relieving pressures on overcrowded, understaffed hospital emergency rooms
8. Expanded practice options for physicians

This document was developed to help decision-makers define the essential parameters of this formalized platform of telephone medical consults delivered by physicians and to better understand their role in improving the quality, accessibility and affordability of health services across the country.
Defining the Model: A Gold Standard of Care

Telemedicine programs have proven their value in a variety of healthcare specialties and settings, with ongoing achievements in the criminal justice system and home healthcare programs. They have also become an important component in the supplemental management of chronic conditions such as hypertension, diabetes, arthritis, depression, and obesity. Now, there is widespread acknowledgment of their usefulness to impact routine care for non-emergency medical problems.

Delivered on a national level, telephonic medical consults emerge as a new frontier in telemedicine -- one that offers convenient, cost-effective options for healthcare consumers and more attractive pricing for health benefits sponsors. There is growing recognition of the delivery of healthcare via telehealth as a safe, practical, and necessary practice.

The following requirements represent the Gold Standard of care for telephone medical consults, and adherence to these standards should be mandated to ensure quality and consistency of care.

Routine medical care

Telephone medical consults conducted by experienced primary care physicians appropriately address routine, acute, non-emergent, non-recurrent medical conditions with marketplace receptivity for its merits in addressing minor issues. In researching possible methods for nurse telephone triage or interventions, some large health plans have identified nearly 5000 clinical scenarios and 320 symptoms from which an intake nurse can choose. After further questions, approximately 15 ultimate scenarios may arise from any one symptom. Experience has determined that there are about 550 clinical scenarios as candidates for telemedicine consultations; 120 of these scenarios may be appropriate for physician intervention instead of or in addition to a nurse. Some examples include:

- Respiratory Infections
- Gastroenteritis
- Sinusitis
- Bronchitis
- Urinary Tract Infections
- Pharyngitis
- Seasonal Allergies
- ALSO: Prescription refills as appropriate and only for short-term of non-controlled substances

Figure 1 demonstrates the large number of commonly diagnosed and easily treated conditions.
**Patient age limits**

This model is well-suited to meet the needs of adults who can express themselves over the telephone and reliably relay information to the physician. Therefore, rules on age are an essential ingredient for ensuring quality of care. Physician telehealth programs should not enroll children under the age of ten or attempt to address the medical problems of seniors requiring treatment for chronic conditions. However, in certain specific cases, telemedicine can be quite beneficial, cost-effective, and efficient for follow-up care of patients with stable, chronic medical illness.

**Physician licenses**

All consultations should be delivered by physicians licensed in the state where the patient is presently located. Physicians should not be required to live in the same state as the patient, but they must be licensed in states where they practice.

**Telephone-based medicine should not be practiced by physician assistants (PAs), nurse practitioners (NPs) or any other licensed practitioner.**

**Prescriptions**

One of the key value points of telehealth consultations is the ability for physicians to prescribe medications. However, controls should be in place to establish limits: short-term prescriptions or refills of no more than one month and no DEA controlled substances or lifestyle drugs (generally defined as drugs taken to satisfy a non-medical or non-health-related goal). The EHR should reflect each script with an alert message (flagged) that the patient has received a refill from a telemedicine consult to prevent abuse of this benefit.

The ideal telemedicine service gives the patient, physician and the payer the following advantages:

- Easy accessibility for the patient
- Quality care that is accountable with quality assurance at every level
- Board certified primary care physicians or physicians with 15 years experience and no record of medical malpractice
- Physicians who are committed to returning consultation requests in one hour
• Affordability for the patient and the payer
• Efficiency for the patient and the physician regardless of their location
• Convenience for the patient
• High patient satisfaction
• High productivity from a healthy work force that does not leave work for a doctor’s appointment or ER visit
• Reliable searchable record of interactions that proves economic advantages
• Privacy-protected, portable and instantly accessible medical records to improve the quality of care given by the telemedicine doctor
• 24/7/365 coverage throughout the entire U.S.
• Rapid access for rural and urban populations
• Reasonable and rapid pay for incentivized physicians to work and coverage for their malpractice insurance
• Allied in principals and practices of the American primary care professional organizations and with the medical home concept

Electronic Health Records Improve Physician Cross-Coverage

As physicians go off duty, they provide information to a "cross-covering" physician who will care for patients in the interim, with the process often referred to as “taking call.” Customarily, these arrangements do not usually involve the sharing of patient charts or files since few doctors use an EHR which is accessible over the Internet. Furthermore, because privacy laws prohibit sharing of medical information without a signed release, each physician would be required to obtain permission for their patients’ medical record to be shared with the cross-covering physician. Privacy laws prohibit sharing of medical information without a signed release.

The President’s Executive Order issued April, 2004 calls for widespread use of electronic health records for all Americans. Yet adoption rates for this technology remain surprisingly low. The CDC's National Center for Health Statistics announced in the summer of 2006 that while nearly one quarter of the nation's physicians (23.9 percent) reported using full or partial electronic health records (EHRs) in their office-based practice, just one in ten physicians (9.3 percent) used EHRs with the four basic functions (e-prescribing, computerized provider order entry, automated reporting of test results, and physician documentation) considered necessary for a complete EHR system.

This leaves the covering physician at a loss for critical information regarding patient medical histories, a situation which can diminish the quality of patient encounters. Covering physicians must be aware of the patient’s previous illnesses or medical conditions, current medications, allergies and other vital data to arrive at an accurate diagnosis and recommend appropriate treatment or prescriptions. The patient's best interests must always be the physician's main concern and focal point.

The advent of the telephone cross-coverage model materializes as one of the best examples of the power of this platform to make medical care safer: physicians “cover” for one another via the telephone on a round-the-clock basis and have an electronic health record at their fingertips. It also ensures that every patient has access to a primary care physician – wherever they are located and whenever they require medical attention.

When patients register for telephone consult services, it is appropriate and accrues to their benefit and safety to provide their medical histories in order to build their own unique EHR. With access to the patient’s EHR, covering telehealth physicians are able to update the EHR with documentation of each patient encounter, creating a patient’s universal medical record and a virtual medical home.
The beauty of this process is that patients are naturally incentivized to contribute the information required for a personalized EHR, since they cannot access the benefit without it. Physicians must also use the EHR, updating the electronic medical record prior to and during every patient encounter. The patient has instant access to the updated EHR and may give it to his/her doctor at any time. This also allows the fully transparent health record to be available to the patient for evaluation.

Contrary to prevailing reports about the failure of physicians to adopt EHRs – with pushback regarding the cost of acquisition, implementation, and training – the market can expect to hear accolades from physicians about the role of EHRs in the telehealth model. They access the patient record at their desktops, review and enter new information, and proceed with an efficient, streamlined telephone encounter.

Information is easily recorded, without changing the manner in which physicians practice telehealth medicine or deliver care. To promote interoperability across the healthcare spectrum, the EHR should ideally utilize a CCR-compliant data structure and be fully portable. It should be available 24/7, provided free to both patients and physicians, and be delivered on demand worldwide.

Ubiquitous EHR availability is clearly driving the success of this model, supporting the continuity of patient care across medical entities -- including primary care physician (PCP) offices, emergency departments and hospital specialty clinics. EHRs are helping link together doctors, patients, and hospitals in seamless, digital environments, making it possible for a patient’s records to be transferred quickly and accurately and with all necessary privacy protections.

_EHRs represent a viable solution for helping Americans to receive high-quality medical care -- saving lives, reducing medical errors, and eliminating duplication of services. They are a vital component of this physician-driven telehealth model and can provide a needed boost to the widespread adoption of electronic patient records across the country._

Thus, it is essential that the creation and updating of an EHR be a requirement of any telemedicine consult program.

### Ensuring the Quality of Care

Robust oversight of all consults and a formal Continuous Quality Assurance (CQA) program conducted by physicians must be an integral part of any telehealth program, with a baseline requirement stipulating automatic review of 3-5 percent of all consultations. These CQA activities should include benchmarking of quality standards, establishing guidelines for treatment, and articulating current best practices and standards of care. All data that are collected should be available for self and outside audits, creating a simple transparent system that incorporates quality indicators for each patient record.

It will be important to monitor patient utilization of services in order to identify individuals who may be over-utilizing the system. These cases should be queued for physician review, pointing to a need for supplementary evaluations and triggering additional research as warranted to further clarify each patient’s health needs. When utilization is more frequent than would be anticipated, it will be critical to determine if the patient has a recurring or chronic illness which may need more than episodic care. Any patient who has used the telemedicine consult service for a recurrent issue or who has used the service more than twice per month, should be contacted to strongly reiterate the need to seek care from a doctor.

Once physicians are performing telephone consults, they should be reviewed on a regular basis to ensure they meet standards of care. The following tools should be in place to ensure optimal performance:

- Daily random audits to identify general medical appropriateness. Any variances outside certain pre-defined parameters are flags for further investigation and action as warranted
• Key issue audits conducted monthly to focus on specific issues of particular importance in this environment or employer-specific audits as requested
• Satisfaction survey results reporting patient satisfaction after their consults. Any issues arising from this process should be specifically investigated and appropriate actions taken
• Outcomes review of specific cases, chief complaints, and other benchmarks should also be reviewed regularly. These would be actual case-specific issues that arise and are deemed to warrant review outside the normal process described above
• Outcome studies will help to determine effectiveness of the encounter. Data should be compared on a per physician basis to assure continued quality encounters

To further ensure accountability, a mechanism should be created to solicit consumer feedback and evaluate patient levels of satisfaction with the consultation. Expect to see high ratings, since 96 percent of patients utilizing a leading telephone medical consult service consistently report a positive experience.8

Finally, rules should be established for all prescriptions written by telehealth physicians with ongoing monitoring of all prescriptions to ensure that physicians prescribe only those medications which are appropriate for the patient encounters. As a caveat, policies should be in place to prohibit physicians from authorizing multi-month refills or prescribing controlled medications -- including “pleasure drugs” (i.e., erectile dysfunction medications). Furthermore, physicians should be trained and held accountable for the correctness of the prescriptions, appropriately considering such issues as allergies, contraindications, and potential drug interactions.

Improving Access and Reducing the Cost of Healthcare

Recognizing that healthcare costs must be contained, proponents of medical telephone consults have developed fully transparent models which offer a flat rate fee schedule -- +/-$35.00 per consult – with no hidden expenses. This is approximately what an insured patient may have as a “co-pay” at the physician’s office.

This model mitigates high costs of visits to the ER, urgent care center or physician office. Determination of cost savings are possible by identifying where patients would have gone if the telehealth consultation was not available. Table 1 compares these costs.

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<tr>
<th>Place of Service</th>
<th>Average Cost</th>
<th>Total cost (range)</th>
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<tbody>
<tr>
<td>ER</td>
<td>$1029</td>
<td>$361-1262</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$194</td>
<td>$104-235</td>
</tr>
<tr>
<td>Physician Office*</td>
<td>$153</td>
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Sources: NC BlueCross BlueShield 2007-2007 Provider Economics/Wellmark

Figure 2 displays a demonstration of potential cost reduction based upon one telemedicine company’s survey.
Significant access to care benefits:

**Employees** are not forced to leave work in order to consult with physicians. With telehealth consultations they get timely treatment – resulting in reduced workforce absenteeism, decreased probability of spreading infections to other employees, and improved access for patients with pre-existing conditions who might forego receiving proper care for minor issues. Employees and employers find it especially convenient for treatment of minor illnesses.

**Rural residents** dealing with economic constraints, cultural and social differences, educational shortcomings, and the sheer isolation of living in remote rural areas can rely upon a physician telephone consult program to more rapidly deliver quality medical services at a reasonable cost. This enhances patient safety, eliminating the drive time to the nearest physician’s office. In the U.S., 25 percent of the population lives in rural areas, whereas only 10 percent of physicians practice in rural areas.9

**Travelers – for business or pleasure** – find these consumer-friendly services to be extremely convenient. Telephones are universally available at any time and from anywhere, allowing patients to access care at home, in a hotel, or in the office. People who forget to pack their medications can also take advantage of short-term prescription refills.

**Culturally appropriate care** – Programs must make a multi-lingual helpline available 24 hours a day. This will help the most culturally isolated members of our workforce obtain timely care.
TelaDoc reports that corporate acceptance of the program is even more robust, with many companies purchasing telemedicine services for their employees and making the service available during working hours. They are particularly effective for employees who travel such as truck drivers and sales staff who are often on the road and away from the state where they live.

Several large employers utilize the program to enhance their clinic operations which employ video consultation systems during their short hours of operation. The physicians conducting these clinics report using telephonic consults to meet the needs of staff who conduct business outside the office or who, for one reason or another, are unable to get to the clinic. These visits keep these employees focused on their work-related tasks and attentive to their job responsibilities.

Conclusion

As government leaders at both state and federal levels, decision-makers and regulators search for opportunities to improve access to quality healthcare at lower costs, they should increasingly embrace telephonic medical consultations conducted by qualified primary care physicians. In fact, in Missouri legislators have introduced SB1283 creating the Missouri Health Transformation Act of 2008 with the following provision:

TELEHEALTH: This act expresses the state's recognition of the delivery of health care via telehealth as a safe, practical and necessary practice in the state. By January 1, 2009, the Department of Health and Senior Services shall promulgate quality control rules to be used in removing and improving the service of telehealth practitioners. SECTIONS 191.1250 to 191.1277.
Furthermore, this platform is a viable component of the solution for all Americans -- regardless of geography or individual insurance coverage. Public and private sector health benefits payers will benefit from the transparent, straightforward pricing options which significantly impact the overall costs of care.

This is a model which complements broader initiatives for system-wide transformation, impacting stakeholders across the spectrum. It is founded upon a vision for enhanced patient safety and a more efficient approach to physician-patient interaction.

TelaDoc Medical Services was used as a model for understanding the concept of telephonic medical consults. With more than 1.2 million members, TelaDoc is one of the nation’s leading telephone-based cross coverage and convenience-based providers. TelaDoc provides a network of board certified, state licensed primary care physicians that delivers cross coverage consultations for minor medical issues 24 hours a day, 7 days a week, and 365 days a year with typical response times under 30 minutes.

Systems like the one built by TelaDoc are bringing an improved new standard of care and delivery to our ailing healthcare system. While the bullet points below are excerpted from TelaDoc documents, other free enterprise companies may be able to produce similar results.

- Rapid access to a primary care physician (via telephone). TelaDoc model has a 3 hours or it's free guarantee.
- Telephonic cross coverage should handle acute, episodic, self-limited and minor illnesses; available to individuals age 12 or above
- Fully portable Electronic Health Record (EHR) provided free to both patients and physicians, available 24/7, delivered on demand worldwide; fully CCR-compliant data structure
- TelaDoc data has demonstrated that telephone consultations are typically 10 minutes vs. national average for office visits running 3-6 minutes
- Patients with pre-existing conditions are welcome customers
- Telephone-based services provide concierge-type medicine
- Because costs are well understood, telephone consultations come with a transparent and typically low price tag. (i.e., TelaDoc is $35 per consultation)
- 96 percent of patients are happy with the service
- Physicians can make more money working inside an efficient model (refer to Table 2)

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<th>Table 2: Sample Physician Income Chart</th>
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<td>Physician 1</td>
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<tr>
<td>Physician 3</td>
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<td>Physician 4</td>
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1 Gingrich, Newt; Boxer, Richard MD; Brooks, Byron MD; Telephone Medical Consults Answer the Call for Accessible, Affordable and Convenient Healthcare; Center for Health Transformation, Washington, DC; 2008

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3 Flower, Rod. *Lifestyle drugs: pharmacology and the social agenda*; Department of Biochemical Pharmacology, The William Harvey Research Institute, Charterhouse Square, London EC1M 6BQ, UK; http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6T1K-4BSVS6X-1&_user=10&_rdoc=1&_fmt=&_orig=search&_sort=d&view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=bb2c6cdc687b258ae7f41bc97c5d842f

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9 van Dis J. MSJAMA. *Where we live: healthcare in rural vs.urban America*. JAMA 2002; Jan 2;287(1):108
About the Authors
Tommy G. Thompson
Former U.S. Secretary of Health and Human Services
Chief Executive Officer of Thompson Consulting Group
Mr. Thompson has dedicated his life and career to public service, first as a state lawmaker from his hometown of Elroy, Wisconsin, followed by an unprecedented four terms as Governor of Wisconsin and four years as the Secretary of the U.S. Department of Health and Human Services.

As Governor of Wisconsin from 1987 to 2001, Thompson repeatedly cut taxes while holding the line on state spending. Under Thompson, Wisconsin led the nation in moving tens of thousands of families off of the dependence on a welfare check to the independence of a paycheck. He also empowered students in Milwaukee by allowing them to attend schools of their choice, regardless of their socioeconomic background. He gave hard-working families access to affordable health care by expanding coverage to tens of thousands hard-working families who lacked insurance but made too much money to qualify for government health programs.

Thompson took that willingness to innovate and ability to get things done to Washington as the Secretary of Health and Human Services from 2001 to 2005. Thompson led the way in rebuilding our nation’s crumbling public health infrastructure after 9/11. He worked tirelessly to provide prescription drug coverage to our nation’s seniors once and for all. And as Chairman of the Global Fund to Fight AIDS, Tuberculosis and Malaria, he was the driving force in America’s unprecedented investment to stop the spread of AIDS, tuberculosis and malaria around the world. Thompson is now a senior partner at a Washington D.C. based law firm and heads a health care think tank.

Donald Arthur, MD
Vice Admiral, U. S. Navy, retired
35th Surgeon General of the Navy

Dr. Arthur retired from the Navy in 2007 following a 33 year career in the U. S. Navy, culminating in his role as its 35th Surgeon General. As Surgeon General, he was responsible for delivery of medical and dental services to over 700,000 active duty service members and 2.6 million retirees and family members. His oversight included 28 hospitals, 266 free standing clinics, 4 regional support offices, and 6 research centers in 4 countries.

Dr. Arthur has been the Chief Executive Officer of two medical facilities: the National Naval Medical Center in Bethesda, Maryland, and the Naval Hospital in Camp Lejeune, North Carolina. For five years, he was Chief of the Navy Medical Corps, responsible for personnel policies, recruiting, career planning, graduate medical education, research activities, and all other professional programs for the Navy’s 4100 physicians.

Other Navy assignments included service as the Deputy Surgeon General, Navy Medicine’s Chief Operating Officer, Medical Center Chief Operating Officer, Department Head for Emergency Medicine at a residency training Medical Center, Director of Medical Programs for the Marine Corps, Senior Medical Officer aboard an aircraft carrier, practicing physician in a variety of clinical settings, and researcher in the environmental sciences.

A native of Northampton, Massachusetts, Dr. Arthur received his Doctor of Medicine degree from the College of Medicine and Dentistry of New Jersey and is a member of the Alpha Omega Alpha Honor Medical Society. After a surgical internship, he completed Navy training in aviation,
Dr. Arthur is residency trained in emergency medicine and attained board certification in Emergency Medicine and Preventive Medicine (Aerospace).

Dr. Arthur is a Fellow and Past President of the Aerospace Medical Association and was President of the Association of Military Surgeons of the U.S. in 2005. He is a member of the Alpha Omega Alpha Honor Medical Society. He was also the 2002 recipient of the American College of Healthcare Executives’ Federal Excellence in Healthcare Leadership Award and 2002 Association of Military Surgeons of the U.S. Outstanding Federal Healthcare Executive Award.

Dr. Arthur has been awarded two Navy Distinguished Service Medals, four Legions of Merit, three Meritorious Service Medals, three Navy Commendation Medals, and a Navy and Marine Corps Achievement Medal in addition to unit, service, and campaign awards.

Richard Boxer, MD  
Chair of National Health Policy Council

Dr. Boxer graduated from the University of Wisconsin-Madison with honors from both the undergraduate and medical schools. He served a residency in urology at U.C.L.A., is Professor of Clinical Urology, University of Miami, Clinical Professor in the Department of Family and Community Medicine and Clinical Professor in the Department of Health Policy at the Medical College of Wisconsin, as well as Clinical Professor the Department of Surgery/Urology at the University of Wisconsin in Madison. He has written over 40 scientific articles and chapters for books, won a national award for cancer research, was awarded a Presidential Citation from the American Urological Association for excellence in Urology, patented a medical device and has lectured around the world on treatment for cancer of the prostate gland and urinary tract.

Doctor Boxer was honored as one the best urologists in Milwaukee by his peers in the only five surveys by the Milwaukee Magazine in 1987, 1991, 1996, 2000, and 2004. He was named among the top doctors in America in 1999 and 2003. He serves as Medical Director of two prostate cancer foundations, is the former Chair of Surgery at St. Michael and Mt. Sinai Hospitals, past president of the Milwaukee Urological Society, and an advisor to Medicare. Dr. Boxer was a Section Editor for Oncology Spectrums, reviews scientific articles for the Archives of Internal Medicine, Urology, The Journal of Urology, and Oncology. He has been invited to deliver over 35 keynote lectures. Dr. Boxer is presently or has been on the Board of Directors of sixteen philanthropic organizations and he is National Chairman of the National Health Policy Council.