Patients Have Led the Way

Virtual Visits *from page 1*

Patients who have virtual visits can be billed $35 at the discretion of the physician if the visit required medical decision making. If the condition cannot be managed online, and an in-office visit is required, there is no charge for the virtual visit, he said.

Even at that relatively low fee, the profit margin on virtual visits is better than those for any other service the clinic provides because overhead costs are so low. "We are literally being paid to think, which allows us the opportunity to have a profit margin that contributes to our overall mission," he said.

Dr. Eads, who charges $50 for a virtual visit, makes less profit on virtual visits, compared with office visits, because her overhead costs are already very lean. In her experience, insurance companies have paid her at about half her rate. But it's still worth it, she said, because providing virtual visits boosts the efficiency of her part-time schedule so she spends time seeing only those patients who truly need face-to-face visits.

Many insurance companies are now paying for virtual visits under new CPT code 99444, however, reimbursement rates are still variable. Dr. Eads observed that the issue of reimbursement is evolving, but more insurance companies are likely to step up to cover the service as demand increases.

Dr. Eads, who worked with Medfusion to design her Internet platform, spent $2,000 on start-up costs for software and the Web site and pays an annual fee of $500.

To offset Mayo's development costs, the goal is to register 10,000 patients in 3 years, a target Dr. Bachman says they will easily be able to meet. Currently "we are at 1,450 patients after 5 months with a soft start."

Dr. Bachman said that he views such portals as a means for primary care practices to compete head to head with retail health clinics. "Our community has five retail nurse practitioner clinics. Often patients will bypass providers even if they have openings because of convenience. The online office visit provides a level of service that competes well with the retail clinics."

Interestingly, a driving force behind the decision to start a patient portal was the telephone. "Telephone triage is inefficient and often results in phone tag or waits for patients and providers."

Buy in from the staff has been varied. "There are still doctors who have not made the shift to providing online services," he noted. In addition, "we have had issues with some of the work flow related to doing online work." In addition, the prescription function has not worked well.

Among the portal's many favorable aspects, Dr. Bachman noted that it increases physician-patient direct interaction, which in turn promotes continuity of care. As a result, "our physicians are more comfortable suggesting to the patient 'let's try X for 48 hours and, if this doesn't work, then come in.' " This comfort level helps keep many people from needing an office visit.

Dr. Eads and Dr. Bachman said they are assured by the fact that very few patients treated online end up requiring an office visit. By providing care online, "We are not merely stalling patients," Dr. Bachman said.

In addition to the straightforward diagnoses such as UTI, influenza, sinusitis, and backaches, virtual visits also are an ideal way to manage patients with well-controlled chronic conditions such as hypertension or diabetes. If the patient is taking their own measures and everything is under control, "we are able to make a lot of treatment decisions online," he said.

From the patient's perspective, virtual office visits are much easier. No longer do they have to call in, explain their symptoms to a nurse, make an appointment, take time off from work, drive to the office, and wait to see the physician.

"We have patients sending us pictures of their rashes, sending us blood pressure [readings], and doing online scales for disorders, and clinicians are finding they can provide excellent quality to the patient that includes Web links to education and prescriptions faxed to their pharmacy," he said.

The project also has revealed a pleasant surprise: "We are seeing many elderly patients taking advantage of online services. They may use a surrogate such as a family member to help them type, but it's a lot easier for many of our frail patients to have virtual visits then to come in person," Dr. Bachman said. "The fact is, we need to get out of our patients' way because in many respects they are the ones teaching us the benefits of using this technology. It's not the other way around."

Neither Dr. Bachman nor Dr. Eads reported any conflicts of interest. ■

AAFP Set Ground Rules for e-Visits

The American Academy of Family Physicians has issued the following guidelines aimed at defining some key parameters for e-visit patient encounters:

- ► Electronic visits should be available only to established patients who previously have received care from the physician's practice.
- ► The patient initiates the process and agrees to e-visit service terms, privacy policy, and charge for receiving asynchronous care from a physician or other qualified health professional.
- ► Electronic communication occurs over a HIPAA-compliant online connection.
- ► An e-visit includes the total interchange of online inquiries and other communications associated with this single patient encounter.
- ► The physician appropriately documents the e-visit, including all pertinent communications related to the encounter, in the patient's medical/health record.
- ► The physician or other qualified health professional has a defined period of time within which responses to an e-visit request are completed.
- ► E-visits should be a payable physician service.

Source: The American Academy of Family Physicians

Policy & Practice

Ga. Docs Collaborate on EHRs

Georgia physicians are collaborating with the state's Department of Community Health on adoption of Medicare electronic health records, the department said. The department intends to apply to the Centers for Medicare and Medicaid Services to participate in an EHR demonstration project, and department officials said they met with Georgia physicians in March to develop the program. Over a 5-year period, the demonstration project will provide financial incentives to small- and medium-size physician groups using certified EHRs to meet certain clinical measures. Bonuses will be provided each year, based on a physician group's score on a standardized survey that assesses the specific EHR functions a group employs to support the delivery of care.

Consumer-Directed Enrollment Low

More employers are offering consumer-directed health plans in efforts to shift greater responsibility to workers for health care costs, lifestyle choices, and treatment decisions, according to a new survey on the plans. However, enrollment still constitutes only a small percentage of those enrolled in all employer-sponsored health plans, because large employers have not yet structured their premium contributions to favor the consumer-directed options, said the survey from the Center for Studying Health System Change. While survey respondents were optimistic that consumer-directed health plans would become more prominent in health benefit offerings, the report said plans and employers seeking to foster greater enrollment may need to make health savings accounts and health reimbursement arrangements more appealing to enrollees.

MA, Part D Changes Announced

The out-of-pocket threshold for a beneficiary enrolled in a standard Medicare Part D drug plan will rise from $4,050 to $4,350 next year, while the initial deductible rises from $275 to $295, CMS announced. The out-of-pocket threshold is the point at which the Part D "doughnut hole" is satisfied and Medicare begins paying for most drug expenses, minus 5% copayments. At the same time, health insurers running Medicare Advantage plans will see average increases of about 3.6% in capitation rates in 2009, CMS said. This increase in capitation rates is slightly lower than the estimated 3.7% Medicare growth trend for 2009, CMS said. In addition, CMS said it will audit records from a sample of Medicare Advantage plans in an effort to determine if the plans are reporting diagnosis code information correctly. Diagnosis code information is used in setting capitation and payment rates for the plans.

Side Effects Underreported

One in six Americans who have taken a prescription drug experienced a side effect serious enough to send them to the doctor or hospital, but only 35% of consumers said they know they can report these side effects to the FDA, according to a Consumer Reports poll. Additionally, 81% of respondents said they had seen or heard an ad for prescription drugs within the last 30 days, almost all on television. Consumers Union, the nonprofit publisher of the magazine, gave the FDA a petition signed by nearly 56,000 consumers asking that a toll-free number and Web site be included in all television drug ads so people can easily report their serious side effects. "What better way for the FDA to let consumers know how to report serious problems with their medications than putting a toll-free number and Web site in all those drug ads we're bombarded by each day?" asked Liz Foley, campaign coordinator with Consumers Union, in a statement.

AAMC Adopts Medical Home

The Association of American Medical Colleges has adopted a formal position stating that every person should have access to a medical home. "We believe the medical home model holds great promise for improving Americans' health by ensuring that they have an ongoing relationship with a trusted medical professional," said Dr. Darrell Kirch, AAMD president and CEO, in a statement. The AAMC position also said that further research and evaluation of the medical home model is needed and more evidence must be gathered on how the model is best implemented. In addition, payment for the model should "appropriately recognize and reward providers for prevention, care delivery, and coordination," and "health care providers should be trained to understand and implement the medical home model within a team environment," the AAMC said.

Gaps in Child Well-Being

Where a child is born and raised in the United States can make a huge difference to his or her chances of health and survival to adulthood, according to a report by the nonprofit, nonpartisan Every Child Matters Education Fund. Those born in the lowest-ranked states are twice as likely to die in their first year of life as are those born in the highest-ranked states, three times more likely to die between the ages of 1 and 14 years, and five times more likely to have mothers who received late or no prenatal care. They also are three times more likely to live in poverty and five times more likely to be uninsured, the report said. "It should no longer be politically acceptable to permit—or simply ignore—the vast differences in life chances that exist for children today," said report author Michael Petit. The bottom 10 states included Louisiana, Mississippi, New Mexico, Oklahoma, Texas, South Carolina, Arkansas, Nevada, South Dakota, and Arizona. Vermont, Massachusetts, Connecticut, Rhode Island, and New Hampshire were the top five states.

—Jane Anderson