

Hands Down, COVID-19 Will Change Medical Practice

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As the burden of coronavirus disease 2019 (COVID-19) grew and New York City introduced increased social distancing regulations, New Yorkers came to their windows at 7 PM each night to clap and cheer for the essential workers—not just doctors and nurses but also grocery store employees, transit staff, and others. This communal celebration is welcomed because, with no more high-fiving or shaking hands, and recognizing colleagues only by their eyes peering over a mask, we all need this act of bonding. As we have passed our first wave in New York City and we have begun to renormalize our social behaviors, the clapping has faded. In its wake, we must find ways to continue to engage as a community. Just as COVID-19 has changed daily routines, our health care delivery system has been upended. We continue to care for patients during this difficult time, only differently. Now we must think through which of these changes are worth preserving as we move forward.

Medicine has historically been very attached to in-person interactions, yet COVID-19 has forced us to limit these encounters to only the most urgent, even suspending certain types of care and procedures. It has challenged us to incorporate technology as a means to engage, interact with, and care for our patients, using televisits and video conferencing in ways that previously were resisted or derided.

Although telemedicine has been heralded as the future of medicine, some physicians have viewed it as something for either science fiction or an ill-defined future. Just in February, some of the authors published a paper in the *Society of General Internal Medicine Forum* titled “Can We Live-Stream Primary Care? Challenges in the Adoption of eConsults and Video Visits.”¹ We discussed that although patients were often ready for telemedicine, providers were not. One physician said that we were killing the physical exam by promoting telemedicine at a Medical Grand Rounds presentation.

My, how times have changed! Those same doctors are now clamoring to be on-boarded onto our video visit platform. The Department of Medicine at Mount Sinai Beth Israel has increased video visits 100-fold since we have had to reduce and, in some practices, eliminate on-site visits. Our residency program has

TAKEAWAY POINTS

Upon reflecting on how coronavirus disease 2019 (COVID-19) has forced us to change our practices and heavily rely on technology as a means to care for our patients, we look into the next phase of this pandemic. In New York City, our number of COVID-19 cases has declined. Although we are in a period of relative stability, other parts of the country have seen and are seeing rising COVID-19 numbers. For those of us past the first wave, now is the time to plan for a new normal that includes social distancing and setting limits on indoor occupancy. Each institution has its specific needs, but we can incorporate the following practices into our everyday routines and decisions:

- ▶ preserving scheduled telemedicine time for every provider;
- ▶ reducing the technological burden associated with telemedicine; and
- ▶ encouraging the evolution of regulation, payment, and legislation to allow broad application of these technological tools.

embraced video visits, which it was piloting before the pandemic, and has rolled out precepted televisits with a much deeper pool of engaged faculty. Our medical students, whose in-person classes were canceled, have helped by calling patients to ensure access to the patient portal and troubleshooting issues, including obtaining appropriate devices, downloading and activating the MyChart app to conduct the visit, and connecting to Wi-Fi.

CMS and private insurance companies have also adapted to this changing landscape. Medicare now reimburses urban area video visits, which has allowed us to maintain appointments with our most vulnerable and elderly patients, keeping them out of crowded waiting rooms at doctors' offices. Barriers prohibiting practicing across state lines have been lowered, enabling greater access to remote care visits to keep patients sheltered at home in the highly populated tristate area around New York (encompassing New York, New Jersey, and Connecticut) and for those patients who have decamped to areas farther from what was the epicenter. Telephone visits are now a billable code, as well, allowing those without access to video technology to be cared for remotely, which helps enable access for some elderly patients and those who are on limited data plans or unable to afford Wi-Fi.

The need for social distancing led us to reconsider which management meetings were really essential and which could be replaced by emails, videoconferencing, or other text chatting features. Although we lost the ability to have colleagues in 1 room, we have been able to have brief check-ins of 100 or more doctors across many hospitals in our system with very little effort. This is critical for sharing information among practitioners over a wide geographic area who are rarely in the same space together. We have also moved our academics to a virtual platform. By late March 2020, we canceled Grand Rounds and other academic conferences. Prior to that, in the first few weeks of the pandemic, we were able to hold Grand Rounds virtually via Zoom. This change accomplished 2 key goals that we had been working on for several years before the pandemic. First, it enabled faculty and trainees to watch Grand Rounds regardless of whether they were in the hospital, in the outpatient center, on vacation, or post call. Second, tele-Grand Rounds enabled us to have speakers from distant places, which historically had been limited by budgetary constraints and travel schedules.

With any luck, the COVID-19 pandemic will start to decline nationally and further hot spots will not emerge. Perhaps effective treatments or a vaccine will be available, allowing for a safe reopening of society. Even then, COVID-19 will leave behind many changes in the world. We hope that among these there will be a change to the way our hospital and department conduct business, as well as the way people see and value connectedness among the larger community. Now is the time to capitalize on this momentum and incorporate what we have learned into this next phase.

Even as we reopen our practices, we must preserve scheduled telemedicine time for every provider. We need to work together to improve access by reducing the technological burden and to study and reduce health care disparities. How can we improve telehealth

through wearables, ambulatory blood pressure monitoring, home finger sticks, and other home point-of-care testing? Educationally, we need to formalize and expand training for both our faculty practices and our residency programs. Politically, we need to encourage the evolution of regulation, payment, and legislation to allow broad application of these technological tools across diverse populations and preserve some of the changes we have gained, like the funding of telephone visits and the simplification of cross-state licensing. We can preserve what is best about teleconferencing: having regular check-ins across the city, allowing folks who can work from home to have the ability to do so, and hosting educational lectures from the best in the business, regardless of geography.

By taking these lessons and implementing them broadly, we will all have something to applaud. ■

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