Customer for the Ethics Advisory Group
The customer for the November 20th meeting was Tom Hawkins, MD, MPH, director of e-Health strategy.

Background
HPHC is about to launch a pilot program in which physicians in the Hitchcock Medical Group in New Hampshire will be reimbursed for “e-visits” with their patients. At the November 20th Ethics Advisory Group meeting the EAG was asked to propose a values framework for use by those at HPHC who are responsible for overseeing this potential component of becoming an eHealthPlan.

In advising about values considerations pertinent to supporting the use of e-mail in clinical practice the EAG does not have to work in a vacuum. There are three especially significant pieces of background for the November 20th meeting:

a) In 1998 the American Medical Informatics Association (not part of the American Medical Association) published an excellent white paper – “Guidelines for the Clinical Use of Electronic Mail with Patients”. The white paper, which is available at: http://www.jamia.org/cgi/reprint/5/1/104, defined its scope as follows:

Patient-provider electronic mail is defined as computer-based communication between clinicians and patients within a contractual relationship in which the health care provider has taken on an explicit measure of responsibility for the client’s care. This guideline does not address communication between providers and consumers in which no contractual relationship exists, as in an online discussion group in a public support forum. (Journal of the American Medical Informatics Association 5(1), 1998, p 104.)

The AMIA guidelines focus on two areas: a) effective communications between clinician and patient and b) liability concerns. The recommended communications practices include: establishing turnaround times for messages; specifying the types of transactions that are appropriate (e.g. prescription refills, appointment scheduling, test results, non-urgent clinical questions) and inappropriate (e.g. urgent care, possibly highly sensitive issues such as HIV treatment) for e-mail; and, mutually understood privacy procedures. The recommended risk management practices include: adequate documentation of informed consent; indemnity for network failures (e.g. system crashes, power outages); adequate encryption (or waiver); and, prevention of human errors, as through password protected screen savers and precautions with regard to out-of-office email access.
b) In 2002, at the request of the Young Physicians Section, the AMA promulgated its own “Guidelines for Physician-Patient Electronic Communications” (available at: http://www.ama-assn.org/ama/pub/printcat/2386.html). The AMA guidelines are essentially the same as in those in the 1998 AMIA white paper, but carry more weight in the medical community and public arena because they represent official AMA policy. Not surprisingly the AMA recommends as policy “that physicians should uniformly be compensated for their professional services, at a fair fee of their own choosing, for established patients with whom the physician has had previous face-to-face professional contact, whether the current consultation service is rendered by telephone, fax, electronic mail or other form of communication.”

c) In 2003 the American College of Physicians published a policy paper containing its “analysis and recommendations to assure fair reimbursement for physician care rendered online” (appended to the case). The report is very positive about the trend towards using e-visits as part of ongoing care:

Patient demand for online access to their physicians is strong and growing, and there is now solid evidence…that care rendered in this manner can yield tremendous benefits for consumers, physicians, and the health care system at large. These benefits include reducing unnecessary office visits; serving patients’ medical needs without the necessity and cost of an office visit; avoiding sick days and lost worker productivity; improving the efficiency of care provided in the office and lessening waiting times for appointments and in the office; helping physicians perform follow-up care; making oversight of chronic care patients easier and more effective; ensuring that care provided face-to-face is reserved for the patients most in need; and generally lowering the cost of ambulatory care by screening out patients who do not require a costly office visit and by being able to pay physicians for e-mail consults with established patients at a rate that is fair, but that is significantly less than an office visit. (page 13)

Although “e-visits” are not yet widely disseminated, the practice is rapidly gaining momentum. On March 6, 2003, RelayHealth, a provider of secure online healthcare communications services founded in 1999, announced that Blue Cross Blue Shield of Massachusetts would start a pilot project to reimburse physicians for on-line visits (accessible via: http://www.relayhealth.com). On September 9, 2003, the Boston-based Institute for Healthcare Improvement began a program on “Alternatives to One-on-One Doctor Visits,” a series of six 90 minute audio conferences in which the first two focus on e-mail. And, on a personal note, in my own mental health practice at Harvard Vanguard Medical Associates I find that my patients are increasingly requesting e-mail access and using e-mail in ways they and I find useful, mutually convenient and innovative.

Questions for the Ethics Advisory Group
Tom Hawkins asked the EAG to contribute to HPHC’s planning for e-visits and other related opportunities that will emerge as current technologies evolve and new ones
appear. In this sense, the EAG’s deliberation about the values dimensions of e-visits can contribute to the strategic planning process. It will be helpful for Tom Hawkins and his colleagues to receive the EAG’s perspectives on the ways in which e-visits can promote important values and the areas of values that might be put at risk by e-visits.

The questions Tom asked the EAG to consider included:

- What values does the EAG see as especially relevant for the policies HPHC develops about reimbursing physicians for e-visits?
- Can the EAG suggest a values framework to help HPHC in its planning for overseeing the quality of care its members receive via e-visits?
- From the perspective of values, does the EAG identify areas of potential risk that e-visits might create?

**Relevant precedents**

a) On February 10, 2000 Charlie Baker and Bruce Bullen asked the EAG to develop an “inventory” of values that it believed should be considered as part of the decision making process during the financial crisis. The fourth item in the “inventory” reads as follows:

> HPHC can only improve the health of its members through its provider partners. Consequently, in situations that require trade-offs among values, sustaining collaborative and trusting relationships with provider partners should be given high priority.

The elements of the turnaround plan that involve ensuring prompt, accurate payment to providers and reliable clinical management information were seen as especially important for long term trust. For HPHC to be a respected partner with providers, we must be able to support them with timely claims payments and timely and accurate reports about individual Local Risk Unit’s utilization and expenditure patterns. In addition, providers also want to understand what kinds of values HPHC is following. Charlie Baker’s weekly emails were cited as models for the kind of communication that is ideal for provider partners as well.

While the use of e-visits is in a relatively early stage, it represents the leading edge of what could be a very significant evolution in the use of technology to support and reconfigure medical practice. The very basic values statement from February 2000 points to the importance of HPHC working closely with providers to shape all aspects of policy with regard to e-visits.

b) On February 28, 2001 the EAG discussed “HPHConnect: how can HPHC use the web to make health care management easier for its key constituents and address confidentiality concerns at the same time?” The values the EAG identified as “especially pertinent to the ethics of HPHConnect and confidentiality” would seem to be equally important for development of policy with regard to e-visits:

The EAG identified four values as especially pertinent to the ethics of HPHConnect and confidentiality. First, all parties need **clarity** about the facts about
HPHConnect. What kinds of information are available to what parties with what security features? There is a lot of ignorance, confusion, fantasy and fear about web-based activities. HPHC needs to work diligently to inform members, providers and purchasers what the facts are about HPHConnect and the possibilities it creates and to learn about their fears and concerns. Second, going by the focus group findings and the EAG discussion, individuals want to have **control** of personally important information, and **choice** about who will have access to it. Finally, the team needs plan for **coordination** of access to information.

c) On May 16, 2002 the EAG addressed “Becoming an e-HealthPlan: the Ethics of “high touch/high tech.” While the topic was educational outreach, the following considerations would appear to be relevant to e-visits as well:

*Outreach to members – like outreach to providers – should be done with maximum feasible collaboration with members. The EAG was happy that member responses to outreach – positive as well as negative – were being carefully followed. Each outreach program provides data about member reactions. Consumer members of the EAG would be pleased to look at materials in development from the consumer perspective. Members should be able to become actively involved once they receive outreach materials, as by choosing to “opt out” if they wish but also by having opportunities to request other materials or to express suggestions regarding future efforts. Careful attention to privacy and maximum personal control are especially important values to members.*

**EAG DISCUSSION/RECOMMENDATIONS**

Jim Sabin opened the meeting by presenting a series of questions from Dr. Joseph Bisordi, Associate Chief Medical Officer at the Geisinger Health System in Pennsylvania. Jim had circulated the case to Dr. Bisordi via Dr. Joe Dorsey. When the Geisinger group considered the question of how to deal with e-visits, the following questions arose for them:

1. How does the value of email communication differ from other forms of communication and care that are not reimbursable, such as telephone and regular mail?
2. How will third party reimbursement affect perception of the value of email as seen by patients and providers?
3. Will increased use of e-visits widen health disparities?
4. Given the lack of research evaluating the quality of care delivered by email, is it ethical to charge for the service?
5. Email is a new channel of communication. How do its distinctive characteristics impact on quality of care? What are its optimal uses and when is it the wrong modality to use?

EAG discussions are always lively, but the topic of e-visits elicited an even greater level of debate than usual. The group found the topic deeply engaging. The wide-ranging discussion can be summarized under
1. **Using email in clinical practice could diminish the “tyranny of the visit.”** A combination of payment systems and habit have created what Don Berwick and others have called “the tyranny of the visit,” under which patients and providers must meet in person in circumstances where other modes of communication could be more efficient and effective for both parties. EAG members placed a high value on “opening up the doctor-patient relationship” and “expanding the channels of communication.” Group visits were cited as another form of “opening” that – used rightly – could also enhance efficiency and effectiveness.

The EAG encouraged HPHC to frame the pilot with e-visits as one piece of a larger effort to promote more flexibility, efficiency and choice within the doctor-patient relationship.

2. **The underlying ethical issue is using the opportunity of e-visits to enhance quality of care.** The EAG suggested that the central value for guiding payment policy with regard to e-visits should be supporting improved quality of care. Use of email appears to offer significant promise, but like new treatments there is a learning curve for patients, providers and health plans in discovering how to use it wisely and well. Several members commented on the ways in which e-visits are different, including asynchrony of communication and the absence of visual (body language, facial expression) and auditory (voice tone) content. For patients and providers for whom written language functions well e-visits could allow for richer and deeper communication. For those for whom this channel was less comfortable there could be greater risk of misunderstanding and diminished trust.

The EAG felt that creating a pilot e-visit project is the ideal approach. Numerous participants emphasized the importance of learning about the clinical nuances of e visits, evaluating quality and cost parameters, and developing guidelines for optimal use of the email channel based on experience in the HPHC pilot and at other sites.

3. **Paying for e-visits has risks – it could a) increase health disparities, b) create paradoxical incentives that could distort patterns of care and c) “flood” providers with increased demands on their time.**

   a) E-visits require literacy skills and access to the Internet. If e-visits are used with patients for whom reading and writing is more difficult than verbal communication those patients could suffer. And, since Internet access tends to correlate with educational and economic level, widespread use of email in clinical practice could inadvertently widen the gap between the haves and the have-nots.

   b) Several EAG members questioned why e-visits should be paid for while telephone visits were not. The consensus view was that not paying for the telephone is a “cultural legacy” and did not reflect a systematic difference between email and telephone that called for reimbursement of one channel and not the other. There was widespread nostalgia for prepayment and capitation, as these payment mechanisms were seen as mechanisms that encourage patient and provider to find and use the communication channels that work best in the particular situation.
One EAG member asked if there could be a “lump sum payment for non face-to-face communication” rather than a new fee for e-visits alone. The group feared that paying for e-visits only might inadvertently encourage providers and patients to use that channel and move away from uncompensated channels like the telephone, even if email were not the best choice from a clinical perspective.

c) Interestingly, consumer members of the EAG were especially active in voicing concern that opening the email channel could “flood” already harried primary care physicians. One EAG member commented that “increasing access and channels of communication is basically a good thing, but the flip side of easier access could be increased demand and a sense of entitlement.”

4. E-visits add momentum to a major cultural shift in health care. Health care, like many other segments of modern society, is becoming more consumer-centric over time. The EAG felt that increased use of the Internet in the doctor-patient relationship would accelerate that trend. Computer literacy and familiarity with the Internet are increasing rapidly, which means that more and more patients (and providers) see email and the Internet as user friendly, familiar tools. Computer users shop, date and Google via the Internet. As their relationships with providers move on line they will expect to be able to do more and more – retrieve laboratory test results, make appointments, arrange consultations, receive information and more. The culture of the Internet is one of consumer choice and individual control, and these values will come to bear on the patient-health system relationships very powerfully.

The EAG saw these changes as fundamentally a good thing, but it again emphasized the importance of treating the e-visit pilot as an opportunity for all stakeholders to become more skillful at using the new IT capacities.

Summary The EAG found the issue of e-visits deeply engaging. The group saw e-visits as part of a large and very important opportunity – to expand channels of communication between patient and doctor and to broaden our concept of what constitutes a “visit” itself. The current reimbursement environment requires attention to the question of whether e-visits should become billable services. The EAG saw e-visits as potentially very valuable, but it noted that paying for e-visits could inadvertently skew care delivery away from other modalities, such as the telephone, which are not billable. Ideally a payment system would reward quality (effective, efficient communication) without distorting care by arbitrarily favoring one mode over others.

The EAG strongly endorsed the wisdom of conducting a pilot program. There is a significant learning curve for patients, providers and health plans with regard to achieving the potential of e-visits and avoiding the risks. Since e-visits appear to have potential for increasing consumer choice and control in ways that could, if managed skillfully, address provider and payer concerns as well, the EAG saw the pilot exploration as a valuable HPHC initiative.

Jim Sabin