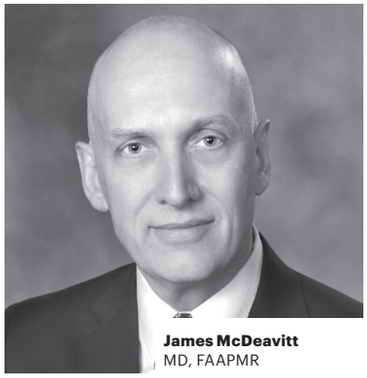
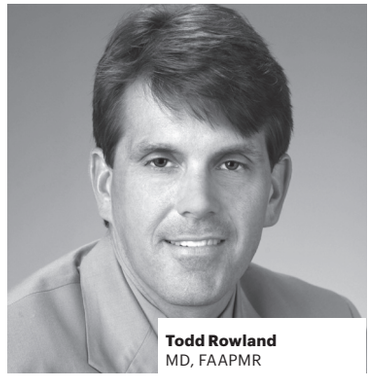
Telehealth Advancement at Baylor and What That Means for PM&R in the Future: An Interview with Dr. James McDeavitt



James McDeavitt
MD, FAAPMR



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In this issue, we had the opportunity to speak with James McDeavitt, MD, FAAPMR, Executive Vice President and Dean of Clinical Affairs at Baylor College of Medicine in Houston, TX. For the past year and a half, Dr. McDeavitt has led Baylor's COVID-19 response as the Incident Command Center Commander. The following article is based on his experience with Baylor's telehealth development and thoughts on the future of virtual care for PM&R. The interview was conducted by Todd Rowland, MD, FAAPMR, Chair of AAPM&R's Telehealth Innovation Workgroup. Responses have been edited for length and clarity.

Can you share a bit about how Baylor transitioned to telehealth at the beginning of the COVID-19 pandemic?

When you look at the Baylor practice, which is a multidisciplinary practice, it is comprised of about 800 physicians. We average roughly 8,400 patient visits a day. When the pandemic hit and we had an executive order from our governor that mandated that outpatient facilities were shut down except for the most dire of emergencies, we literally lost 80% of our business in a three-day period. A 250-billion-dollar annual operation suddenly has no revenue. That was a very critical time as it was for everybody else across the country. In our very rapid pivot to telehealth, we were partially good and partially lucky. We were lucky that we had already started down a path to invigorate our telehealth program. We truly by coincidence had worked through regulatory issues, licensure issues, and had developed an Epic interface to be able to offer telehealth services integrated into physician workflows. Within two weeks we were able to get telehealth service up and running. These virtual visits replaced half the revenue we lost due to the shutdown of our outpatient facilities. That was a critically important bridge that kept us in business as we recovered and allowed us to continue to provide critical services to patients.

At Baylor, what percentage of PM&R visits are currently being conducted via telehealth?

We have a persistent band of telehealth that has not gone away; it varies between 10-15% of our total visits with quite a bit of variability by specialty. Frankly, it is a little bit lower in PM&R. At our peak, about a quarter of PM&R visits were telehealth during the height of the pandemic. We settled in at a range of 5-7% of total PM&R visits. It was a salvation; we did not furlough staff; we did not reduce salaries. Now that the crisis has waned, it is looking more like a clinical and business innovation.

What considerations do you make to determine the right mix of virtual and in-person visits?

I think there are different use cases, and we are working on these now. There is the opportunity for virtual consultation. A teleconsultation or a televisit for an initial visit can be a screening visit, to see if you have something to offer a patient. A second use case is follow-ups. You can have a conversation with the patient; see them move online; examine postoperative incisions, which is often adequate for a follow up visit. A third use case is chronic diseases. We have talked about this in our large practice and look at diabetes as a prototypical disease. An endocrinologist might follow a brittle diabetic patient on a monthly basis, seeing them 12 times a year. Maybe half of those visits could be virtual, and half still need to be face-to-face. I think there is an opportunity to do some chronic disease management virtually, which I believe has direct applicability to PM&R. In disability management, my clinical work was mainly in traumatic brain injury. A lot of it was counseling, talking to families, exploring behavioral issues, looking at cognitive functional deficits. Much of this can be done very well online in a manner that is much more convenient for the patient and family.

How do you see telehealth shaping the future of physiatric care?

It is our new toy and people will find a way to use it.

I think it is clearly a way to expand your market. By way of example, many procedurally-oriented physicians hold seminars that are partially educational, and partially marketing. These sorts of events lend themselves to a virtual format, and perhaps even expand their scale to reach more people. If you practice in a major referral center, telehealth will expand opportunities for initial assessment of those seeking tertiary or quaternary referral.

Increasingly, it is going to be a physician satisfier in the future. If a doctor does not have to come into the clinic one or two days a week and could work-from-home, for many physicians it is probably going to be a satisfier. I think we may see partial telehealth work-from-home options become a recruiting tool as we try to compete to recruit physicians in health systems. We are trying to be thoughtful about how we establish those parameters to provide great service to patients but also to try to create some value to our physicians. In an era where burnout is such a huge issue, it is our responsibility to explore any tool that may enhance work-life balance. Telehealth is here to stay, not as a panacea for all our national health system woes, but as an important tool.

AAPM&R's Telehealth Innovation Workgroup is continuing to explore telehealth opportunities for physiatry. The Workgroup will provide additional updates regarding telehealth initiatives via the Academy website.

For more in-depth information, listen to Dr. McDeavitt's podcast on AAPM&R's online learning portal (onlinelearning.aapmr.org) and watch for more telehealth podcasts—coming soon!