Med-IQ FOCUS: Volume 270: Navigating Virtual Care Amid the COVID-19 Crisis

Consider

What duty do providers have to appropriately document virtual visits during the COVID-19 pandemic?

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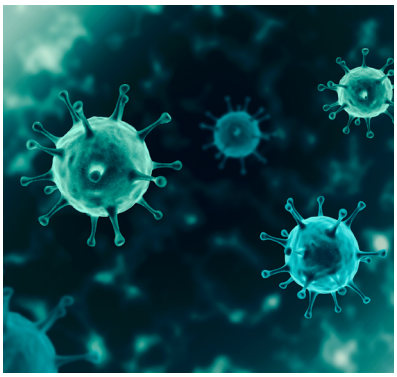


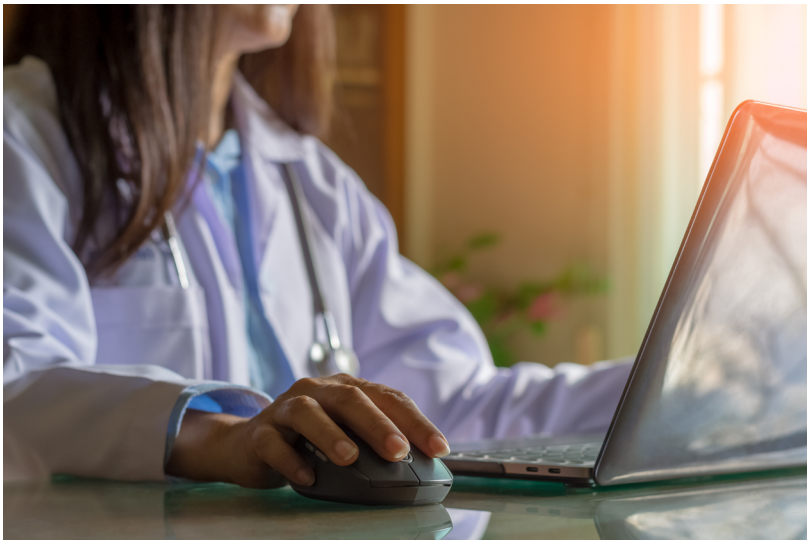
The COVID-19 pandemic has profoundly altered care delivery and access for patients and providers across the country. No specialty or care setting has gone unaffected. In this evolving context, it is important to acknowledge the unprecedented challenges and risks that the provider community currently faces and recognize the incredible work providers across the country are doing to serve and protect patients in the midst of this pandemic.

For many providers, the COVID-19 pandemic has resulted in a rapid shift to virtual care delivery to minimize the risk of transmission in healthcare settings.1,2 This Focus highlights some of the challenges and opportunities for virtual care delivery during the COVID-19 pandemic.

Pre-COVID	Intra-COVID
Virtual care deployed with sufficient training and support	Unprecedented virtual care volume and demand for services
Scope of virtual care aligned with provider/patient comfort and preference	Increased scope of virtual care demand and delivery of services
Availability of face-to-face evaluation and physical evaluation if needed	Potential disruptions in face-to-face care access (clinical service delivery realignment)
Face-to-face encounters prioritized in organizations of clinical service delivery	Increased risk fo COVID-19 transmission with face-to-face access
Stable regulatory framework	Limited access to on-site support for virtual care delivery
	Increased scope of virtual care demand and delivery of services
	Potential disruptions in face-to-face care access (clinical service delivery realignment)
	Increased risk of COVID-19 transmission with face-to-face access

In this special edition Focus series, we will begin by addressing the documentation of virtual visits in a high-volume practice during (and beyond) the COVID-19 crisis. It is too early to tell how lawsuits will spring forth from this crisis. Some states are expanding Good Samaritan statutes to address crisis-related events. Regardless, documenting visits appropriately is always required and prudent.

Documenting Virtual Visits and COVID-19 Test Denials



Dr. S is a PCP working in a large integrated healthcare system. Before the COVID-19 pandemic, she had "dabbled' in virtual care. She is an avid user of her healthcare system's patient portal and regularly conducts telephone visits with her patients. However, with the onset of the COVID-19 pandemic, Dr. S's schedule was converted to almost exclusively virtual care. She was provided a video platform to use in conjunction with her healthcare system's EHR. As she started to use the video platform, she found that there was an adjustment period for both her and her patients. Because her schedule was packed with virtual appointments and she struggled with managing the virtual platform and the EHR, she often neglected to document her shorter virtual encounters in her healthcare system's EHR. She rationalized that, because these were virtual visits, it probably wasn't necessary to document them.

A 43-year-old man, Mr. F, presented to Dr. S virtually. Mr. F was a physical therapist in the community and, although Dr. S was his PCP, she had only seen him once in the last 5 years. Mr. F reported having a mild cough, body aches, and congestion. He denied any fevers or shortness of breath. As a physical therapist, Mr. F requested that Dr. S order testing for him.

Based on current guidelines, Mr. F did not meet the criteria for testing—despite being a healthcare worker—because he did not have a fever. Dr. S informed Mr. F that he did not qualify. Mr. F became quite agitated with Dr. S, stating that he was a healthcare worker and needed a test to go back to work. Dr. S was adamant that she could not order the test unless Mr. F met the clinical criteria, which—at that time—required a fever. She counseled Mr. F on self-isolation, symptomatic management, and the "red flags" that should prompt Mr. F to go to the ED. Mr. F curtly told Dr. S that he would seek care elsewhere if she would not order the test for him, and he ended the visit abruptly.

Dr. S was quite busy learning the new platform and, because there were no orders from the encounter with Mr. F, she only documented that a video visit has occurred with Mr. F in her EHR.

One week later, Mr. F presented to a local hospital with respiratory distress and tested positive for COVID-19. He was intubated in the ED and transferred to the ICU. Although he recovered, he spent 11 days in the ICU on a ventilator. His wife also tested positive for COVID-19, as did several of his clients. In reviewing Mr. F's admission note, Dr. S noticed that Mr. F reported that he had been denied a test by his PCP despite reporting a fever, cough, and shortness of breath. The note mentioned that Mr. F had not been instructed to self-isolate by his PCP and had returned to work. Dr. S distinctly recalled counseling Mr. F that he should isolate himself and should not return to work for 72 hours. However, when she checked his chart, there was no documentation of recommendations for isolation because she had not completed a note related to the video visit.

Takeaway

Physicians and other healthcare professionals need to document telehealth patient encounters just as they would document in-person encounters. The telehealth format does not negate a provider's responsibility to comprehensively document the care provided.

The Secretary of Health and Human Services waived certain Medicare telehealth restrictions during the COVID-19 public health emergency, including the telehealth originating site requirement, and issued recommendations to all US governors regarding the need to shield healthcare professionals from medical liability during this time.[3,4,5,6] This does not negate the need for appropriate and necessary documentation for telehealth patient encounters that may take place because of social distancing. Documentation for a telehealth patient visit should contain all of the same essential elements as the documentation of an in-person patient visit, so far as possible.

Best practices for telehealth patient encounter documentation include[7,8]:

☑ **Documentation that the patient has consented to receive telehealth services, specifically.**

This should follow the same process as other informed consents, with documentation by the clinician that the risks, benefits, and alternatives were discussed and that the virtual visit is being conducted as a response to the COVID-19 pandemic. These elements should be written out as discussed with the patient and include the patient's responses. Although a paper consent form is not feasible, the clinician must document the informed consent process and the patient's consent for the virtual modality.

☑ **Documentation of details about a patient's symptoms, disease course, and prior treatment.**

Be sure to document what the patient reports in the subjective portion of the documentation. Limit objective input to what you see or hear via video. As you cannot directly auscultate lung sounds, you cannot accurately describe what the patient's lung fields sounded like. Instead, document what you hear when the patient speaks (eg, patient with 3-4 word dyspnea, patient with frequent dry cough, patient with hoarseness to voice, patient with moist cough). It is also prudent to describe how the patient appears to you via video, such as flushed, pale, or having a scattered red rash.

☑ **Documentation of your thought processes when determining your differential diagnosis.**

If you are sending the patient for diagnostic testing, include this in the plan and how it may modify the diagnosis. Even with a reduced risk of liability, documenting your thought process is imperative to demonstrate that you considered other illnesses, rather than committing the diagnostic error of availability for COVID-19.

☑ **Document all directives provided to the patient.**

Include the need to self-isolate, when to seek additional care (such as going to the ED), and how to protect themselves and others if referring for testing. Document the patient's response and your use of the teach-back or another method to confirm understanding.

☑ **Uploading any images submitted by the patient.**

Do not take snapshots yourself.

☑ **Organizing your workspace to avoid having to toggle between the video visit and the documentation platform.**

Virtual visits are a good way to not only triage sick patients who may expose other patients and clinic staff members, but also to continue caring for well patients who may be apprehensive about coming to a clinic during the COVID-19 pandemic. Even if the visit is virtual, the same adage holds true: if it isn't documented, it didn't happen.

Resources

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