Expert discusses the evolution of health care during the COVID-19 pandemic

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"Health care in [community health centers] has been turned upside down by the coronavirus pandemic," says Jeffrey Harris, physician and MIT economist. "Patients with chronic conditions are being dissuaded from coming in. Instead, telehealth service has become the new form of care." Credit: Department of Economics

Jeffrey E. Harris is a physician and a professor in MIT's Department of Economics. He served as an internist at Massachusetts General Hospital for more than 20 years and continues to practice medicine today at community health centers. Harris is currently working on a new health economics textbook based on medical case studies. SHASS Communications spoke with him recently about the Covid-19 pandemic.

Q: As a doctor on the front lines of the Covid-19 pandemic, can you provide a glimpse of what is going on today inside our increasingly burdened health care facilities? How are electronic health or "telehealth" services being employed to ease the burden on in-person providers during this crisis?

A: Since 2005, I have been working exclusively in community health centers, taking care of the neediest patients. Health care in these facilities has been turned upside down by the coronavirus pandemic. Patients with chronic conditions are being dissuaded from coming in. Instead, electronic health or "telehealth" service has become the new form of care. Large general hospitals are preparing for the worst. Elective surgeries have been canceled.

Many hospitals have record-low inpatient counts, having reserved separate floors for Covid-19 patients. Clinics have likewise created separate areas for patients with respiratory symptoms. Health care providers' work shifts have been reconfigured to reduce stress and potential exposure. In intensive care units, some attending physicians see patients only once daily to reduce risk.

Telehealth is no longer evolving. Instead, it is being revolutionized. Patients are being asked to download videoconferencing apps on their phones. Nurses are being trained and recruited to make home visits using devices such as electronic stethoscopes that can transmit heart and lung sounds, electronic otoscopes to transmit magnified images of the ear canal, telemetry-capable electrocardiograms and portable ultrasound devices. Even after the Covid-19 pandemic passes, these will be permanent fixtures of our health-care system.

Q: Does the Covid-19 pandemic pose special challenges for patients with few resources?

A: Absolutely. Here's an example of the challenges that health-care providers face every day: A patient calls into the health center reporting fever, lethargy, and a cough, but no shortness of breath. Following current triage guidelines, I counsel the patient to seek care if her breathing gets worse, but otherwise to stay home and isolate herself from household members for two weeks.

"Can you stay in your own bedroom?" I ask in Spanish. The response is no. Family members

have to share the same bedroom. I ask her whether she could use her own bathroom. Same response. She inquires whether the self-isolation period could be reduced to just one week, as she has to get back to work. I am reluctant to say yes, but one-week isolation is still better than none.

The patient then informs me that she will have to take two buses to get to work. I know that public transportation may have been the fuse that lit the epidemic explosion in New York and other dense metropolitan areas, but at best I can only counsel her to maintain her distance as much as possible from other passengers, wear a mask if she can get one, and wash her hands thoroughly when she gets to work.

Q: Six Massachusetts medical leaders recently called for a comprehensive program to triage and safely support Covid-19 patients at home or in community-based venues. Can you comment on whether this plan is similar to the system of testing, contact tracing, quarantine, and isolation/treatment that has been successful in several Asian countries?

A: We need a comprehensive response that's tailored to our own health care system. That's where new telehealth capabilities become absolutely critical. With expanded channels of communication, primary care providers can steer patients to testing resources, advise them on home isolation, and help with contact tracing. If people with symptoms or questions can't get access to primary care providers, they'll end up in emergency rooms.

But the financial viability of primary care providers will depend on adequate insurance reimbursement for phone and video visits. Some progress has been made in realigning financial incentives, but bureaucratic rigidity remains the rule. Here's an example: A federally qualified health center can bill Medicare for a telehealth visit only if the visit is for a condition unrelated to an evaluation/management [E/M] service provided by the health center within the previous seven days and does not lead to an E/M service or procedure within the next 24 hours or soonest available appointment. This is an unnecessary barrier to care at a time when flexibility is absolutely essential.