



A collaboration between the Department of Family and Community Medicine, University of California, San Francisco, and The Permanente Medical Group
Primary Care e-Letter August 2009, Issue 21

We are sending you a new Primary Care e-Letter on the issue of e-mail visits with patients in safety net clinics. Even though lower-income families have less access to e-mail than families with higher incomes, the amount of e-mail use is quite substantial and growing among patients who use safety net clinics. A number of clinics have started to offer e-mail encounters. Dr. Joe Scherger, a national expert on e-mail encounters with patients, provided much of the information for this e-Letter.

The time has arrived: e-mail visits with patients in safety-net clinics

By Joe Scherger, Clinical Professor,

Department of Family & Preventive Medicine, UCSD, and

Tom Bodenheimer, UCSF Department of Family and Community Medicine

Many interactions in primary care do not require a face-to-face visit. Patients with minor upper respiratory symptoms or uncomplicated dysuria, people with diabetes or hypertension who regularly check their sugars or blood pressures at home, healthy people due for preventive care, patients with a question for their clinician. The list goes on and on. Yet we clinicians persist in making face-to-face appointments for patients, not giving them the choice, when medically appropriate, to communicate with us by e-mail. It takes less time for us, and it rescues patients from having to miss work, arrange childcare, figure out transportation, and wait in our waiting rooms.

Primary care practices in integrated delivery systems with robust patient portals have moved to email encounters, based on medical appropriateness and patient preference. At one clinic within Group Health Cooperative in Seattle, one-third of primary care encounters are face-to-face, one-third scheduled phone visits, and one-third e-mail. Kaiser Permanente is moving in a similar direction.

Too many of us working in safety net clinics feel that e-mail encounters with patients are a middle-class phenomenon: the clinics don't have HIPAA-compliant secure

messaging software and low-income patients don't have access to computers. It's true, e-mail encounters in the safety net are more challenging, but it's time to take up the challenge and do it.

Does the population using safety net clinics have access to e-visits? A 2008 survey by Parks Associates found that only 18% of US households are without Internet access. 21% of heads of households have never used e-mail, over half of those are over 65 and over half have had no schooling beyond high school. 56% of Latinos use the internet, a number that declines as the educational level drops. Within these figures are large numbers of individuals, or their children, who could access e-visits with us, their clinicians. Of course the entire panel of patients is not e-connected, but we may be surprised how many of our patients are able and anxious to communicate with us via e-mail. E-mail would be particularly useful for low-income people who have a harder time missing work, arranging childcare and securing transportation. Offering e-mail encounters is more urgent in the safety net than anywhere else.

How would a safety-net clinic get started? First, the clinic staff needs to discuss this innovation and a clinic team needs to try it out with a few patients. Ask some patients if they want to try it, and have them consent to a statement appearing on each e-mail such as "I accept the level of privacy of regular e-mail, and I am aware that _____ Health Center will treat all e-mail messages from patients as confidential and not forward them to anyone outside the health center without my consent." After doing some PDSAs, figure out how to put e-mail encounters on the clinician's template. E-mail should take the place of face-to-face visits rather than add to those visits; the idea is to care for more patients with less work. When these initial steps have been completed, then it's time for giant steps forward: 1) getting a secure e-mail system, and 2) working with the major health plans insuring the clinic's patients to get reimbursed for e-mail encounters. Failing to get reimbursed should not stop the process, but the reimbursement discussion with health plans should get going; ultimately it is likely to prove successful. How can a clinic get a secure e-mail system? One such system is Relay Health, and others are available. "Guidelines for the Clinical Use of Electronic Mail with Patients" can be found in the Journal of the American Medical Informatics Association, Volume 5, Number 1, Jan/Feb 1998.

Does a clinic need an EMR to offer e-mail encounters to your patients? That makes it easier because the e-mails can go directly into the EMR for documentation. Otherwise, e-mails can be printed and put into paper charts.

Will e-mails overwhelm us, the clinicians? In general, time spent on patient email is predictable: about 40 per week if 1000 patients are using e-mail communication.

How does the daily schedule look with e-visits? *The old way*: 12 visits in the AM, 12 visits in the PM, and 12 phone calls; that means caring for 36 patients and going home at 7 PM. *The new way*: 15 e-mails in the AM followed by 6 patients and 4 phone calls; the same in the PM. 50 patients cared for, home at 6 PM.

Most safety net clinics, in fact most primary care practices in general, experience a demand for clinician visits that exceeds the capacity of the clinic to provide those visits. e-Visits make it possible to reduce the demand for face-to-face physician visits by offering patients the opportunity, if medically appropriate, to interact with their clinicians via e-mail. This leap forward can be transformative for clinics, their clinicians, and their patients.