On the Front Lines of Primary Care during the Coronavirus Pandemic

Shifting from office visits to telephone triage, telemedicine

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In the midst of a global pandemic, we are overwhelmed with reports and stories of the COVID-19 crisis, the mounting death rates in Italy and Spain, and the growing number of cases in New York and nationwide, threatening to overwhelm existing hospital resources and staff. We have genuine concerns for the health and well-being of our friends and colleagues and all healthcare providers in Emergency Departments throughout the country. At the same time, we try to be reassured by the assertions that this will be a mild flu-like illness for upwards of 80% of patients. So where does that leave us on the front lines of primary care? After all, we are going to have to deal with this vast majority of patients and many others who have been referred to as the "worried well."

Within the short span of a few weeks, many practitioners have made the transition from office visits to telemedicine (TM) and telephonic visits. This has been driven by the necessity of social distancing, facilitated by an abrupt change in CMS policy that will now reimburse for TM visits and by the sheer volume of patient calls. In my recent experience, most of these calls average about 10 minutes and involve another 5–10 minutes for documentation. The patients have accepted this willingly. No one is demanding to see the doctor. In fact, they are afraid to come to the office (or the ED) for fear of being exposed to "sick" patients in the waiting room. It's easier for many of them not to have to travel or to wait to see the practitioner. Right now, this is also safer for patients who really need to be seen and for the providers and staff as well. It is most likely that this will become the new norm long after this pandemic has passed.

Cardiology consults

I have done several recent telemedicine cardiology consultations, including one elderly woman with a patch monitor showing rapid atrial fibrillation. Having seen her in the office a few weeks earlier and reviewing her echo and lab results, it was a relatively easy discussion to start her on metoprolol and a NOAC. Then there is the 55-year-old man with non-ischemic congestive cardiomyopathy. We have been speaking by phone every few days and adjusting his diuretic regimen as his orthopnea and chest pressure improve. He will have follow-up lab testing this week. Clearly, some patients will still need to be seen, but much of what we have previously done in an office setting can now be accomplished quite easily and effectively over the phone.

Telemedicine Triage

In the setting of the current pandemic, many patients call with flu-like symptoms that they would have previously

just managed at home. And many of them having been trying to do just that for a week or so. But now when they are not getting better, and with the COVID-19 information overload, they are afraid, perhaps rightly so, and they want to be tested.

At a Federally Qualified Health Center (FQHC) where I am helping out with TM triage, the typical patient presents with a week or two of low-grade fever, sore throat, dry cough, maybe some chills and body aches. A few have diarrhea and last week patients were reporting changes in their sense of taste and smell (so much for the power of Google Doc). The vast majority have not recently traveled outside the US and have no known contacts with COVID-19-positive patients. And the vast majority do not meet current criteria for COVID-19 testing.

But their individual stories are compelling and perhaps one previously unrecognized benefit of TM is that we have more time, without other distractions, to just listen to those stories, to commiserate and to provide reassurance. One patient was a 50-year-old woman, a housekeeper at an elderly living facility, who was sent home from work with a cough and told not to come back until she had a doctor's note saying she did not have coronavirus. Certainly, appropriate for her to home-quarantine and not pose a threat to a very high-risk population (ie, Seattle). But in the absence of fever or shortness of breath and with no concerning contacts, she did not meet strict testing criteria. At this point, she was less concerned about her cough and worried more about when she can get back to work. I promised to follow up with her in a few days.

Another patient I spoke with was a 45-year-old man who had a 6-day history of sore throat, chills and sweats, diarrhea for the past 24 hours and now a salty taste to everything (like he read on the Net). His wife and daughter had similar symptoms. He wanted to be tested for coronavirus. And oh by the way, he had been having severe chest pain and shortness of breath for the last few hours. He had several coronary risk factors and I recommended that he go to the ED for a cardiac evaluation. He thought that was what I would say and was very reluctant, afraid that he would be exposed to coronavirus in the ED. I persisted, explaining that he was more likely to die from a heart attack than from coronavirus and went so far as to suggest that while he was there they might even test him for coronavirus as well. Ultimately, he agreed.

COVID-19 Testing

In a primary care environment where rapid strep and rapid flu swabs, finger-stick glucose and HgA1c, and urine dipsticks are commonplace, the lack of available COVID-19 testing is frustrating to say the least, and difficult for patients to understand. Telling patients that even if they test positive, it will not significantly change their course or their treatment, and they will still need to self-quarantine, is just not enough. Patients need to and have the right to know and so do their healthcare providers. One way or the other, it takes some of the uncertainty out of their individual situations and allows some sense of control in this chaotic time. I called one patient to tell him his coronavirus test was undetectable and he was relieved but also said he wished it were positive so he wouldn't have this threat looming over him. If it were up to me, at this stage, I would test everybody and have been trying to do that as much as possible. In fact, the FDA last week issued two emergency-use authorizations: 1) a point-of-care COVID-19 diagnostic for the Cepheid Xpert Xpress SARS-CoV-2 test and 2) Abbott Laboratories molecular point-of-care test for the detection of COVID-19, delivering positive results in as little as five minutes. We will see how quickly and how widely available both of those efforts will be, but it would certainly be a big step forward.

In the midst of this growing pandemic, we all need reassurance, and reassurance based on facts. That is why, for so many of us, Dr. Anthony Fauci's evidence-based approach and his calming measured presence are so important right now. Paraphrasing hockey great Wayne Gretsky, he recently said "…It's not where the puck is, it's where the puck is going to be…" ❖

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