Letters of Correspondence: Telehealth, Post-Acute Sequelae of COVID-19, Lung Cancer Screening Rates

Telehealth Has Been Great for Patients. Keep the Phone Visits.

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To the Editor—North Carolina Medicaid responded quickly to the Covid pandemic by permitting reimbursement for telehealth visits by video and phone. Patients who had NC Medicaid, including pregnant women and immunocompromised patients, were able to continue to receive medical care from their providers while staying safe where they reside.

On behalf of patients and the medical community, I would like to say Thank You!

As North Carolina inches toward herd immunity and this latest wave of COVID infections (hopefully) continues to abate, there appears to be consensus around keeping reimbursement parity for telehealth at par with in-person office visits. But there is discussion around dropping phone visits. Some of the concerns are that providers are doing "quick, low-quality" phone visits and NC Medicaid and other payers are having an explosion in costs.

On the other hand, many patients have benefited from phone visits. In rural areas, particularly in the mountains, internet access does not exist or is so poor that streaming video does not work. Many patients, especially the elderly, do not have smart phones or cannot figure out how to connect to a video session despite much assistance.

I and many colleagues truly believe we are providing quality care via phone visits. Patients express gratefulness that they do not have to come to the clinic because of exposure to illness, lack of transportation, lack of money for gas, etc. Furthermore, I believe employers, especially with staffing issues, are more than happy to have an employee step away from work to spend 10 to 20 minutes on the phone with a provider versus taking a half day off to drive to a clinic.

The reality is that providers have to pay their expenses. So, if phone visits are eliminated and patients cannot do a video telehealth visit, then providers will ask the patients to come into the clinic for an in-person visit just because of the reimbursement model.

I truly hope that NC Medicaid, Medicare, and commercial insurance providers will keep phone visits as an option. NCMJ

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COVID-19's Lasting Impact on North Carolinians

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To the Editor—The long-term consequences of COVID-19 infection are increasingly recognized as a significant public health concern. Post-Acute Sequelae of COVID-19 (PASC), commonly known as Long COVID, is a collection of persistent symptoms that continue after resolution of the initial COVID-19 infection. It is estimated that this post-viral syndrome may impact 10%–30% of COVID-19 survivors [1, 2]. Given the large caseloads within North Carolina, there may be more than 150,000–400,000 survivors of COVID-19 affected by PASC in our state. The potential impact on North Carolinians, and our health care system, is substantial.

The presentation of PASC can be variable across physical, cognitive, and psychologic domains. The most common effects include fatigue, respiratory difficulties, headaches, anxiety, depression, and memory impairments ("brain fog") [3]. Those who experience mild effects may be able to continue daily activities with little interruption, but many of the moderately or severely affected survivors will be limited in their ability to attend to home, school, and work duties. These implications were recently underscored by President Biden when he announced that those with PASC may qualify for benefits under the Americans with Disabilities Act [4, 5].

Our academic health care center has responded by developing a multidisciplinary PASC clinic. The clinic structure includes panel evaluations by physicians specialized in rehabilitation medicine, internal medicine, and psychiatry; a neuropsychologist; physical and occupational therapists; and a social worker. We have found this collaborative and coordinated approach necessary due to the complex nature of patients' medical presentations and psychosocial impacts.

While we have been able to help hundreds of North Carolinians struggling with PASC, there are thousands more

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who require focused post-COVID care. We urge government and health organization leaders to consider how they can assist with the funding and delivery of equitable post-COVID care to those within our state. An integrated approach providing comprehensive evaluation and treatment is needed to mitigate the effects of PASC. Health care workers of all levels need to be educated on post-COVID conditions and equipped to treat them appropriately. Patients in North Carolina with PASC deserve knowledgeable and compassionate care. NCMJ

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Improving Low Dose Lung Cancer Screening Computerized Tomography Scan (LDCT) Enrollment Rates

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To the Editor—Dr. Tailor and colleagues report in the November/December issue about low lung cancer screening enrollment rates of 1.5%–12.5% in lung cancer screening-eligible population estimates from Durham County, North Carolina, utilizing publicly available census tract and smoking prevalence data [1]. The 2015 USPSTF guidelines recommend annual lung cancer screening with LDCT in adults aged 55–80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years [2]. The "State of Lung Cancer 2020" report from American Lung Association shows similarly low rates across the United States [3]. Improving screening rates in the eligible population could potentially reduce the lung cancer death rate by 20%, highlighting the importance of lung cancer screening [2].

Proactive eligibility screening with shared decision-making discussion is a potential area of opportunity to increase enrollment of eligible candidates. The shared decision-making discussion should focus on the potential risks and benefits of screening and ensure eligibility for curative surgery by exclusion of populations with substantial comorbid conditions, life-limiting conditions, poor functional status, or reluctance to undergo surgery [2]. Barriers such as complexity of eligibility assessment, recall bias, time constraints, and lack of resources for sharing decision-making could further contribute to low lung cancer screening rates [4–6]. Thus, moving the shared decision-making screening discussion to specialty clinics like pulmonology could help address some of these barriers. Telehealth access to specialty offices could also be a potential strategy for addressing the time constraint, provided that the time is adequately reimbursed by the payers. These barriers also highlight the need for multidisciplinary teams that include pulmonologists, respiratory therapists, nurses, and case managers to aid with shared decision-making process and follow-up. This could increase the enrollment of eligible patients while protecting the patients from unintended harm. Future studies should assess feasibility and impact of strategies addressing the barriers to LDCT screening enrollments toward improving lung cancer outcomes in high-risk populations. NCMJ

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