EPISODE 19: Navigating Telemedicine

Hosts: Rebecca Gillett, MS OTR/L, and Julie Eller
Guest Speaker: Daniel Albert, MD, is a rheumatologist at Dartmouth-Hitchcock Medical Center in Lebanon, New Hampshire

While a medical necessity, health care visits can be a serious drain on energy and time – the trip to and from, the parking, the waiting, the paperwork, the missed school and work — all can make it feel downright arduous. Add the uncertainty surrounding these unprecedented times and the risk of exposure to COVID-19, and going to the doctor can make patients feel apprehensive, even scared. As a result, telemedicine is having a moment. Many health care visits can be done virtually, from the comfort and safety of your own home, and simply involve seeing a doctor or other health care provider remotely via a two-way video and/or audio connection.

In this episode, podcast hosts Rebecca and Julie — both arthritis patients themselves — explore the benefits, conveniences, costs and even challenges of using telemedicine for treating both pediatric and adult arthritis patients. Their guest expert, Daniel Albert, MD, is a rheumatologist at Dartmouth-Hitchcock Medical Center in Lebanon, New Hampshire, who has been using telemedicine for years.

Dr. Albert was the first physician to use telemedicine at Dartmouth and has more than 40 years of experience working with adult and pediatric patients with rheumatic conditions. His research interests primarily focus on epidemiology and health services research through the Dartmouth Institute for Health Policy and Clinical Practice. He is a professor of medicine at the Geisel School of Medicine, Dartmouth, and the recipient of many fellowships and awards. He is a graduate of New York University School of Medicine and Columbia University.

Tune in to get tips and insights from Dr. Albert, Rebecca and Julie on how telemedicine might work for you and how to get started.

Additional resources:

Visit the Live Yes! With Arthritis Podcast site to read the blog, get show additional notes and full episode transcripts: https://arthritis.org/liveyes/podcast.

Visit the Arthritis Foundation website to learn more about telemedicine and what it costs.

To explore more about federal and state policies and reimbursements regarding telemedicine, visit the Center for Connected Health Policy's website.

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PODCAST OPEN:

Welcome to the Live Yes! With Arthritis podcast, from the Arthritis Foundation. You may have arthritis, but it doesn't have you. Here, you'll learn things that can help you improve your life and turn No into Yes. This podcast is part of the Live Yes! Arthritis Network — a growing community of people like you who really care about conquering arthritis once and for all. Our hosts are arthritis patients Rebecca and Julie, and they are asking the questions you want answers to. Listen in.

Rebecca Gillett:
Welcome to the Live Yes! With Arthritis podcast. I'm Rebecca, an occupational therapist living with rheumatoid arthritis and osteoarthritis.

Julie Eller:
And I'm Julie, a JA patient who's passionate about making sure all patients have a voice.

MUSIC BRIDGE

Rebecca:

On today's episode, we're talking about navigating telemedicine, which was something that I don't know if any of us really knew what that is. (laughter) Julie, have you had to do any visits with any of your health care providers virtually or over the phone or using telemedicine?

Julie:

No, I haven't had to do it just yet, and mostly because I've been hoping and hoping to have an in-person visit later this summer. But we're getting to a point, with my rheumatologists, that we're going to have to transition from that in-person visit to a telemedicine one. What about you, Rebecca?

Rebecca:

Actually, yes. So, I have done a telemedicine over the phone with my rheumatologist. It was supposed to be video, but I messed that up. (laughter) I have seen my primary care physician a couple of times as well. We're monitoring hypertension issues, but, I think in those situations and with my RA, I felt comfortable because, one, I have great relationships with both of my physicians. I've been with them for, you know, especially my rheumatologist, a long time. But I think it went well. And since my disease is mostly managed well with my RA and my OA, I feel like I could do these and I don't mind them at all.

Julie:

(laughs) Yeah.

Rebecca:

I don't need an injection. I do have the advantage of being a therapist, so I kind of know how to do a physical exam and use those terms with her, you know? That gives me a little bit of an advantage.

Julie:

Yeah. I think that there are a lot of patients who, especially people in the Arthritis community who have shared with me, you know, "I feel like I've been preparing for this pandemic for years because I've always been washing my hands more vigorously, I've always been really cautious about keeping my surfaces clean and free from bacteria, and keeping my distance from folks."

And one of the things that I think folks have shared is that they just wish that they would be able to do that in the doctor's office during flu season, around the year, and now is a really great way to mitigate some of that risk through telemedicine. Telemedicine has allowed us to have access to our

providers without needing to take an extra risk for COVID, but maybe also for the rest of the year, I don't think telemedicine is going anywhere.

And that's why we're talking with Dr. Daniel Albert today, who is a rheumatologist at Dartmouth Hitchcock Medical Center in Lebanon, New Hampshire. Dr. Albert has more than 40 years of experience working with adult and pediatric patients with rheumatic conditions. And his research interests primarily focus on epidemiology and health services research through the Dartmouth Institute for Health Policy and Clinical Practice.

And one of the most exciting things about Dr. Albert for today's conversation is that he has been practicing telemedicine, not just during this pandemic, but for a number of years now. So, he's the perfect guest to talk about the promise of telemedicine and really help us understand more about how we can navigate telemedicine together.

Rebecca:

We're excited today to have Dr. Albert with us to talk about how to navigate telemedicine, something that some of us may have already been doing, or some of us are a little leery to do. So, thanks so much for joining us today, Dr. Albert.

Dr. Daniel Albert:

Thanks for having me.

Julie:

Welcome to the show. Do you want to start by telling us a little bit about your practice and the type of patients that you treat?

Dr. Albert:

So, to start, I would like to thank the Arthritis Foundation. Because the Arthritis Foundation has been with me from the beginning, from when I was a fellow with support in my fellowship and my early work in a laboratory at the University of Chicago. And even now, I run a camp for kids with arthritis during the summer, although not this year — we'll do a virtual camp. But almost all years, for the last 33 to 34 years, it's been the Arthritis Foundation that has supported it, primarily through grants to

support the tuition for the kids to come to it. So, I have undying thanks for the Arthritis Foundation and their support of our work.

Rebecca:

Well, thank you.

Julie Eller:

Wow. Thank you so much for your years of service to the Arthritis Foundation. It certainly means a lot to us every day, but especially right now as we are navigating these uncharted waters of coronavirus and all that comes with it. So, why don't you tell us a little bit about your practice and the types of patients that you treat.

Dr. Albert:

Over the last couple of years, I've transitioned from doing both adult and pediatrics to mostly pediatrics at this point in time. Most of the patients that I see were in person up until February. Patients have had a lot of apprehension to coming to the medical center, and we have transitioned to do effectively only telemedicine. I have been doing telemedicine myself for seven years.

Rebecca:

Oh, wow.

Dr. Albert:

I was actually the first person at Dartmouth to do telemedicine. We had to do it through rural hospitals. So, our sites were what are called critical access hospitals, that have very limited bed space and are in areas that are poorly served by medical care.

The preference for patients to do telemedicine was not as robust as it is now. What it is now is essentially a complete sea-change in the use of telemedicine. Before, it had been sort of a boutique sort of thing. At these rural hospitals, some patients didn't have transportation, or they just preferred to do the video, and we saw them fairly infrequently. So, I had one session a month for each of these four outlying hospitals.

Since the coronavirus epidemic, federal agencies have reduced the administrative overview of this, and so we're able to do it in a more patient-friendly fashion.

So, we do it, are doing it, with effectively any form of electronic communication that is available. So, at the bottom, it would be telephone, but after that, we use Zoom, like we're doing now.

We use, FaceTime, Google Duo, which is sort of like FaceTime, and, or we use our in-house video application called Vidyo. Sometimes the bandwidth is not great enough, but the hospital has converted from effectively all in-person encounters to about 85% telemedicine, and that constitutes over 2,000 appointments a week.

Rebecca:

Wow.

Dr. Albert:

So, that's a lot of appointments.

Rebecca:

Yeah, you are ... you have a lot of screen time right now (laughs).

Dr. Albert:

Yeah. I think that the whole idea of limiting screen time has kind of evaporated, for both us and also our patients, and especially for the kids, since they're doing everything for school online. Most of them are pretty comfortable with it, and it's remarkably effective.

Rebecca:

Yeah. So, you've found that most of your patients are comfortable with doing this telemedicine with you?

Dr. Albert:

I think the vast majority are comfortable. And as we do more and more, we get better at it.

Rebecca:

Yeah.

Dr. Albert:

Like everything else in the world, right? So, some of the things that have been difficult to do by video, like a joint exam, we're learning how to sort of circumvent that with certain physical maneuvers. So, for example, if you were concerned about inflammation of the joints in the hand, you might ask them on the video to make a fist, and then to rotate your fist and then flex and extend it. That's not bad for a joint exam of the hands.

And so those are little tricks that you learn, by doing it more and more. And sometimes, since I see kids, their parents are in the room. And I ask the parents to do certain things with them, which allows me to assess their flexibility. So, I have them bend there, turn back and kind of touch the forearm as an example of hypermobility, and things of that nature.

Rebecca:

Yeah. And I'm sure that when you do an exam in person, that's the kind of stuff that you're just doing, and it's automatic to you. And I'm an occupational therapist, and I have done telehealth myself, and I worked in early intervention. So, I worked with families and their children, and it's a whole 'nother thing to try to explain and coach somebody through it.

Dr. Albert:

Yeah, I think that's true. In the rural hospital ... critical access hospital situation, we had a nurse with the patient. We had the nurses who were going to do it come down from the rural hospital and follow us around for a day or two. And we would demonstrate joint exams to them so that they got a little bit more comfort with that.

But at home, you'd be surprised, or maybe you wouldn't be surprised, how many parents are involved directly in the physical exam of their children. I mean, they get taught exercises, and they have to help their children do the exercises. So, they're not as naive as you might expect.

Julie:

Yeah, that's right. I would say from the juvenile arthritis experience that I've had, oftentimes when we go to the exam and we're sitting with the pediatric rheumatologist, my mom could tell you the order of how they would feel my joints and where they would go and what they would be looking for. And I think if she and I were doing a telemedicine visit today, she would very gracefully navigate that appointment and know exactly how to tell you, "Oh, when she bends over this way, I can feel right here. And I know exactly that that's a swelling issue, not something that's related to a muscle issue, but a joint issue." And be able to describe it in language that I would imagine would be very meaningful to that provider.

Dr. Albert:

Yeah, I think that, as a pediatric rheumatologist, you get to depend very, very heavily on mothers.

Julie:

Yeah. (laughs)

Dr. Albert:

They have such an almost uncanny ability to relate to their children.

Rebecca:

That is a very fair assessment. Well, our brains rewire when we become moms, so it's true. I feel like for people who are probably more recently diagnosed, trying to explain their current physical status to a provider might not be as easy as someone who's more of a veteran like Julie and I, who have had it for, you know... Our arthritis is old enough to vote, is like what we always like to joke about. We're over 18 years, and so for us, it's a little bit easier for us to explain to our doctor. Is there something you would recommend to people, or how you walk people through this process of doing the telemedicine physical exam with you?

Dr. Albert:

I think that's a hard one. I mean, I have certain maneuvers that I do with patients, depending on what my suspicion of their underlying disease is. But I will tell you that when it gets to be too ambiguous on my telemedicine, I do have them come in.

A good example was a patient with polyarthralgia, meaning many joints were painful. I wasn't able to discern whether they were swollen or not. But based on what the patient showed me on the video and what his parents told me ... And I was kind of surprised, when I had him come in, because he had a fairly large knee effusion, meaning a big swollen knee, and his podiatrist father didn't recognize it.

Julie:

Yeah. It sounds having that fallback of being able to come in when you really have a symptom that you're not really sure of, being able to really see that person in person, and feel that joint and maneuver it, and understand that underlying factor, that would be really important. Is that fair?

Dr. Albert:

I think that's very fair. When it's ambiguous, we just have them come in. But still, patients really enjoy the ability to have an encounter right in their kitchen or living room. Our average time of travel for patients, because we live in a rural area, is two hours.

Rebecca:

Oh, wow.

Dr. Albert:

And if you travel two hours to and two hours from, you know, you're talking about a whole day's commitment. And many people have constraints on that that just forbid that. Or cost them salary or transportation costs or something like that.

Julie:

A day off of work, a day off of school, a trip in can be really, really burdensome like that. So, you're seeing that families who might have that commute have had an easier time accessing their care with all this telemedicine then.

Dr. Albert:

It actually can improve their care. The doctor has very little constraint because the number of visits, you know, has gone down, that you can just have the flexibility of seeing a patient in two weeks instead of in a month, or in a month instead of three months. I feel that, in some ways, I actually can generate better care for the patient.

Rebecca:

This could change the way that we manage arthritis in general and all other chronic illnesses, like you said. especially, within rheumatology, there's a shortage of specialists. Do you think this will be kind of the wave of the future to address some of that shortage?

Dr. Albert:

When I started doing this seven years ago, I thought, "Well, if you just eliminated the administrative constraints on this thing, it would explode, because it's so much better for many, many patients." The coronavirus thing just accelerated everything by reducing all the administrative barriers. The consequences are enormous. For example, we have much more clinic space than we need, and we were strapped for clinic space before. And clinic space is amazingly expensive. From an economic standpoint, less clinic space, less travel, all that stuff saves money. It saves a huge amount of money. And it saves time.

I think that there's very little evidence that there is a deficit in care. In fact, most of the evidence is in favor of it. Even when the provider is, you know, an associate provider or a nurse. I don't think that we're going to go back to where we were. The patients really like it, and there are a lot of economic and financial reasons that it should continue.

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Julie:

I think you've sold me on all the reasons, from that public health perspective, why telemedicine is an essential piece of where we move, how we innovate in the future. I still have some anxieties about it. Can you walk us through what a standard telemedicine appointment might look like?

Dr. Albert:

Well, the appointments that we have are the same scheduling framework that we had before, but there's much less pressure on the patient and the provider to hurry up through the encounter. So, I think part of the reason that you felt the comfort of having a nurse with you before was because it allowed you to voice your own concerns in a way in which was not so rigidly regimented from a time perspective.

Julie:

Yeah.

Dr. Albert:

So, I think some of that can be a benefit of telemedicine, because the encounters are not as hurried and harried. However, that doesn't mean that nurses shouldn't have a role in this, by any means. I mean, I think that we need to be very flexible in having nurse encounters as part of telemedicine.

Rebecca:

Are you having your patients check their temperature, if they're able, and blood pressure and all of that stuff that a nurse would normally do?

Dr. Albert:

It depends entirely on the circumstance. So, if the patient is there because their primary problem is what we call oligoarticular JIA, that's just juvenile arthritis of a few joints, and there's no intercurrent illness, there's really no reason to take their temperature. OK? If it's lupus and it's a flare, there is a reason to take their temperature, and you might ask the parent to do that. I don't know any parent of a kid with lupus who doesn't have a thermometer in their house.

The other thing you can do is, you know, engage the primary care physician and their involvement in the patient's care. And you can say to the patient, and you might contact the primary care doctor,

"I'm not comfortable with this patient. I want you to take a look. I think it's an intercurrent illness. I don't think it's related to the lupus, but I want you to give me your impression."

Julie:

It sounds like you're kind of targeting those steps to the patient and their specific disease, and I think that's a really heartening piece of moving this toward a more patient-centered health care system, right?

Dr. Albert:

Telemedicine allows you to involve all the other people who are involved in the patient's care: the parents, the occupational therapist, the physical therapist, the primary care physician, the primary care physician's nurse. I think that telemedicine allows you to utilize all those different resources to help the patient rather than just depending on the big, you know, mega medical center.

Rebecca:

Yeah.

Julie:

That's a very exciting thing. Can you talk a little bit about what that looks like?

Dr. Albert:

We were able to start telemedicine, in part, because we had a telemedicine group at Dartmouth. In part, because we had an IT department. Only 50% of hospitals offer telemedicine, and probably less for practicing physicians. Although, you know, when they saw their income evaporate, I think they made a very quick transition to utilizing telemedicine. But I still think that they need a lot of instruction on how to do it best.

Rebecca:

You've been doing it for seven years, and now everybody else has been kind of forced to jump on the bandwagon. Why is it that, you know, maybe physicians and health care providers weren't really using telemedicine? What were the barriers?

Dr. Albert:

So, the major barrier was that, if you were an originating site like Dartmouth, you had to have a recipient site that was approved by Medicare. So, you couldn't do it from home, you couldn't do it from a clinic. You had to do it from a very narrowly defined origin site. Contracts were very laborious. And then in addition, if it was in a different state, you had to be licensed in that state. And the difference between New Hampshire and Vermont, in most people's mind, is pretty zero. But in terms of licensure, it took me six months to get licensed in Vermont when I had an active license in New Hampshire.

Julie Eller:

Wow.

Dr. Albert:

The regulations have just been completely reversed. So, now there is no originating site. You could do it from a, a home, a nursing home, a clinic, you name it. You can use whatever software package the patient is comfortable with. The whole thing has changed.

A companion set of issues was compensation. The compensation for telemedicine was not uniform across the board, and some third-party payers paid it, and some didn't. Some Medicaid approved it and some didn't. And it didn't make any sense. For example, Medicaid in New Hampshire was OK with telemedicine. Medicaid in Massachusetts, probably the most liberal state in the country, was forbidden. So, you couldn't do telemedicine in Massachusetts and you could do it.

Julie:

Wow. So, those licenses, those emergency kind of fixes for right now, do we anticipate that they will last beyond the pandemic, or do we think that they are time limited?

Dr. Albert:

That is a really good question, and it revolves around predicting the COVID-19 pandemic, which I think nobody knows, you know?

Julie:

(laughs) That's right.

Dr. Albert:

I think there's a lot of patient sentiment in favor of continuing it. My best guess is that some form of HIPAA regulations will be reinstated, which in itself will make things much more difficult. I also think that the restrictions on originating sites and participant sites will probably go away. I think that people will be able to do it from their home. There's too much patient pressure.

Whether the compensation is as equitable as it is now ... At least in theory, compensation for all forms of telemedicine is equivalent, meaning if you don't have a computer, and there are people who don't still, the compensation for a telephone is the same. So, you know, there's a lot of equity issues. A lot of people in rural parts of the U.S. don't have internet to the extent that other places have it. And without internet, you're really stuck.

Rebecca:

From the patient perspective, how do those costs compare for telemedicine versus a traditional visit? Is the telemedicine treated differently by insurance coverage?

Dr. Albert:

Right now, telemedicine is, in theory, compensated exactly the same as it is for an in-person visit. So, from a patient standpoint, they don't lose their wages, they don't lose their transportation costs, and they don't have to pay a copay. From an institutional standpoint, I think they haven't figured out exactly how good or bad this is gonna be.

For some rural private practices and smaller institutions, their financial hit has been enormous, and they haven't been able to survive it. Local clinics around here have closed, and I also know even substantial regional hospitals that have furloughed their medical staff. I don't exactly know what that means, but I do know it's bad.

Julie:

This is, in some cases, a big science experiment where we're learning exactly how telemed can innovate health care delivery and design. And as you were talking, all of these stakeholders are hugely important to decision makers as we think about what those permanent fixes are. If we're going to pass HIPAA regulations that's going to be different, we need to make sure that we're contacting and talking to the people who are really directly involved.

If these are things that you want permanent solutions for, consider signing up to be an Advocate with the Arthritis Foundation. Because I know that this focused advocacy is going to be a big part of our future, and this is a great way to share your story to make change happen. So, sign up today.

Dr. Albert:

It's one of the few times that I've been involved in something that has been this drastic where all the different stakeholders have pulled together.

Julie:

Yes. The hospitals have, the IT departments have, the insurance companies have. The federal and local governments and the state governments have all done the right thing. It's amazing.

Rebecca:

Necessity can force change, right?

Julie:

We've all come together, and we've noticed that patient outcomes are good. Patients are appreciative of these changes. So, I feel very inspired by that. (laughs)

Rebecca:

Yeah.

Dr. Albert:

As do I.

Julie Eller:

Good.

PROMO:

Visit our special resources webpage at arthritis.org/care-connect — for more information about avoiding COVID-19, as well as tips for returning safely to school and college. Also learn about our webinars on coronavirus topics like employee rights, emotional well-being and navigating juvenile arthritis and family care. Plus, much more. Go to arthritis.org/care-connect.

Rebecca:

Recently, Dr. Albert, we've conducted some studies on how the pandemic is affecting our arthritis community. And we are hearing from some people that they're not managing their arthritis care at the level that they were. Maybe they've missed appointments, or they've canceled appointments and rescheduled elective surgeries, or they're skipping medications because they're afraid of contracting COVID. What would you suggest and recommend to those patients who are hesitant to access their care because of their fears, and in stressing the importance of managing their care?

Dr. Albert:

There's no reason to forego the medications that you are being prescribed. I mean, I think the arthritis community feels, uniformly, that that should be the case. And there's an ACR, American College of Rheumatology, position paper that does state just that. If you're on medication for your condition, then you should stay on medication unless you're specifically told that you should stop it.

In-person encounters are going to be ... constitute the minority of care in the future. Almost everything is going to be done electronically, whether it's messaging, whether it's, you know, having labs and tests done.

The only things that I think are going to prevail are the necessity of actually having an encounter of one-on-one person, if the situation dictates that. And then, of course, surgery, you cannot do it remotely. I don't think that people should be apprehensive about that. There's a lot of attention paid to co-prevention for COVID. No health care worker in our hospital has acquired it. No patient has

acquired it from some other person. So, I think people are being screened appropriately and are safe in coming to the hospital.

Julie:

That's really helpful. I can access my care safely, and in doing so, I won't be taking away care from someone else. I think that's a big factor. If you are getting to that point and you're ready to take that step — you're ready to have your first telemedicine visit — what are some things that patients should be doing to prepare to make sure that they know what to expect?

Dr. Albert:

They have to be an active participant in their own care and be up to date with the information that's relevant to the provider: medications, recent lab tests, recent imaging, things of that nature. Other diseases that might have an impact on their care for the rheumatic disease.

You have to keep everything in perspective. And I would just encourage them: Ask questions. That's your job. Our job is to try to answer them, you know, to the best extent that we can. And when we can provide data, that's even better.

Julie:

Coming with a list of questions, being curious about your disease, and allowing that curiosity to manifest is really taking an active role in your care. When it comes to getting those lab tests done or having an image taken, can you provide some guidance on how to do those things safely in the age of COVID?

Dr. Albert:

So, the way we are managing our blood draw lab is by scheduling patients to come in. So, we no longer have real walk-ins. What I tell patients is, "Where would you like to have the test done?" They identify it. I tell them, "I'm going to put the requests in, and I want you to call the lab and schedule a time for them, for you to go in to have that done."

Julie:

Yeah. I think that's a really helpful thing, to think about those steps that you can take to really manage the system. Call and make that appointment ahead of time. And when you're doing so, you can trust that there's going to be good social distancing in place. Wear your mask, bring your hand sanitizer, do those things that you would do if you were going to the grocery store. But to do so as you pursue that medical care I think is a really important thing to think about as well.

Dr. Albert:

You don't have to bring a mask. You'll be given one anyway.

Julie:

Oh, great. OK.

Rebecca:

It is important, especially when you're on the biologics, I think, to make sure you still get your labs done. And make sure that you're monitoring, because that will help your telemedicine visit go better.

Julie:

Go swimmingly. Yeah. And I think I really loved Dr. Albert's point when he said, you know, be curious and ask your questions. Use the internet, use Google to your advantage, but also, don't be afraid to call the practice and just say, "Hey, what's the situation here? How can I be best prepared so I can pursue this care and make sure that it's ... that I'm doing my part to get this done appropriately?" So, I appreciate that very much.

Rebecca:

Dr. Albert, we like to ask what your top three takeaways for patients with arthritis are in navigating telemedicine and managing their arthritis care during this pandemic. And also, in your takeaways, if you can differentiate, you know, which appointments are OK to do telemedicine and which ones we can do through an actual appointment.

Dr. Albert:

OK. Well, I think the first takeaway is: Patients shouldn't be afraid of telemedicine. That by and large, the care is as good, and in some cases a little better, than they would get as an in-person. With the following caveat: That's takeaway number two. Takeaway number two is: If you have a condition that requires a physician or a provider to examine you, then it's probably best done in person.

The third takeaway, I think, is that if you can't do conventional telemedicine, a phone encounter with your provider is almost as good as a video encounter. And so, since almost everybody has a telephone or a cell phone, then I think that you shouldn't ever miss or delay important care.

Rebecca:

On your second takeaway about getting the exam: If you think you need an exam and having an appointment, can you be specific as to give some examples of what types of things that people might want to come in and see their physician or provider?

Dr. Albert:

I think that it's very hard to know whether a joint is swollen without actually examining it. Sometimes it can be done, but by and large, it's difficult. Some rashes are easy by video, and we do accept photographs on our patient portal, and they are helpful sometimes. The third category is if the patient is sick and you don't know why. If it's a mysterious or unclear clinical situation, an in-person encounter is superior, no doubt about it.

Rebecca:

Those are some great examples, and also the suggestion of taking photos.

Julie:

Yeah. One of the other things that I've done in the past, depending on the area, the affected joint ... Sometimes I'll circle the swelling with a sharpie marker, and I'll watch it for 24 hours and see if it gets bigger than the circle that I've drawn or if it's gone down at all. And what happens if I ice it, what happens if I elevate it? Kind of create my own human science experiment. And that's been helpful in sharing some of those details out.

Dr. Albert:

And you can do it for rashes also.

Julie:

Right.

Rebecca:

When in doubt, you call your doctor's office.

Julie:

Well, this has been very helpful for me. I think I'm going to have one of my first telemedicine rheumatology appointments coming up just later this summer, so I really appreciate going into it with this prep conversation. We so appreciate you, Dr. Albert. Thank you.

Dr. Albert:

Well, thank you for having me. And again, I can't say enough about the Arthritis Foundation. Terrific organization that everybody should support.

Julie:

Thank you so much.

Rebecca:

Well, thank you, Dr. Albert. We appreciate your time.

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