COMMENTARY

Low-Tech High-Value(s) Care: No Patient Left Behind

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Telemedicine has changed how we practice medicine. The scope of this change is staggering. Between March and October 2020, more than 24.5 million patients—nearly 40% of 63 million eligible Medicare patients—completed a Medicare-covered telemedicine visit. This is 71.1% of all 2020 Medicare visits, compared with 1.2% prepandemic.[1] Furthermore, telemedicine appears to be effective. Research shows telehealth encounters are successful for older patients in resolving urgent and nonemergent needs such as upper respiratory or urinary tract infections and skin conditions in nearly 87% of cases, requiring only one telehealth visit 80% of the time.[2]

We have seen telemedicine focus on implementing video visits, rather than its less technologically sophisticated but consistently reliable alternative: the telephone (audio-only) visit. Although telephone visits provide an opportunity to connect with patients, there are good reasons behind the video push. Studies show similar efficiency and outcomes to in-person visits, and high satisfaction for both patients and clinicians.[3–8] From a quality and cost perspective, there are concerns that the lack of visual cues over the telephone leads to inferior care in some scenarios, and that they are more likely to be overused.[9] However, new data suggest that the telephone is equally effective as video at achieving visit resolution for certain common conditions such as eye infections, skin conditions, and allergies.[2]

The potential gains of high-tech video visits will not matter for patients who cannot or do not want to access them. For them, the critical issue is not if high-tech options are beneficial, but whether there are low-tech alternatives that are of high value. Does high-tech always mean high value and, if not, why not?

> *I think that senior people should have a little special consideration seeing that because of the fact that a lot of them are not technology oriented. Why [don't you] call them and tell them when they can get an appointment for the vaccine? Why do they have to go online and look for an email when they don't do computer? In particular, my dad is trying to get in line for that and he's 85. He is somewhat technically oriented, but he always say that the computer ain't working right. I think that they should reach out to those people. [Patients] shouldn't have to reach out to them.*

So opined a patient in the middle of an interview study we are conducting to gauge patient perspectives on telehealth medical visits on the South Side of Chicago. And although qualitative data analysis is still underway, it is already clear that this is a common sentiment. Clearly, in the midst of a pandemic of monumental proportions, the specter of a digital divide and its potential health implications for those left behind by an increasingly technology-oriented society has become very real. This should be a wakeup call to avoid a one-size-fits-all approach where clinicians (or schedulers) make unilateral decisions about what type of telemedicine visit is appropriate. Instead, patients should be in the driver's seat.[10]

The transition from traditional office visit models to high-tech remote care has been uneven, and the digital divide between the haves and have-nots has grown. Many factors account for this: technology access, computer literacy, privacy concerns, and reluctance to use technology, to name a few.[11–13] Studies are beginning to show technology have-nots tend to be older, nonwhite, non-English-speaking Medicare patients.[14–16] Although studies have derived important patterns of telemedicine use, there is often a chasm between generalizations and the particular needs of patients such as the one just quoted .

How can busy clinicians and health-care teams discern which telemedicine modalities will provide the best high-value care for patients? We struggle with this question and, as far as we know, it has not been explored in the literature. We believe it must be answered by meeting patients where they feel comfortable, regardless of whether that is a high-tech or a low-tech approach. In general, the definition of low tech focuses more on the technological capabilities of the clinician and less on the patient's engagement with technology. Similarly, what is high-value care in this context? It is often thought of as the best care for lowest cost, but this value

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proposition often fails to incorporate patients' viewpoints. From their perspective, professionalism of the provider is a strongly held value, achieved one conversation at a time by individual clinicians, building trust successively by making decisions with patients rather than for them.[17]

But what do low-tech, high-value approaches to communication between doctors and patients look like in practice? The following are four simple suggestions for answering this key question:

1. *Explain options and negotiate choice:* Start by ensuring that patients know they have a choice, which will vary depending on their concerns and circumstances. Negotiating visit type can be the first shared decision-making point between health-care teams and patients. How can this be done? Training! Teaching team members, including schedulers, to explain (in 1–2 minutes) different visit types and to ask about tech resources and preferences in a nonjudgmental or embarrassing manner will result in better patient experience and smoother visits.
2. *No portal? Phone only? Ask why:* If patients are using audio-only telemedicine but not video, it is important to understand—without making assumptions— why they have chosen that particular visit type. Do not assume, for example, all older adults prefer phone over video visits. Testing assumptions and inferences are practices that lie at the heart of patient-/relationship-centered care. Similarly, do not assume just because a patient asks for phone visits that they are opposed to trying video. Without being paternalistic, clinicians should inquire about visit choice, offer information about video visits, and encourage patients who seem open to exploring these options. A bidirectional, co-constructed conversation around what is right for the individual patient is a primary function of the initial screening process during which choices about modality are made. Are they choosing telephone because they do not have internet access for video visits? Do they not have a private place to do a video visit? Perhaps they are unsure about how to use the technology. Explore, at an individual level, how you and your health-care team can address barriers patients may be interested in overcoming. For example, schedulers could ask a set of questions to all patients: one to normalize the screening process and another to identify potential barriers. If challenges are identified and patients are amenable, a list of resources for low-cost technology and training could be instrumental at providing access not just to health care, but to the larger digital world.
3. *Support high-value low-tech options:* High-value care suggests an alignment between practitioner and patient on the best course of action given the context of each particular decision.[17] As a result, high-value care might translate into a "low-tech" telemedicine option, both for those who need less complex technology as a result of a lack of access, and for those who might prefer lower tech over video visits even when resources are not an issue. It can also mean supporting low-tech nonvirtual options, such as home visits, which is an important item in the menu of visit option types, particularly for patients who have dementia or other cognitive dysfunctions that may make it physically difficult if not unmanageable for them to undertake an in-person visit. Similarly, lower tech options may work well with mentally challenged patients and others who are partially or completely dependent on others for technical assistance in using a video visit platform. Given the staggering prevalence of dementia in our society,[18] in which 70% of these patients live at home and rely on family and friends for care,[19] a combination of low-tech options such as home visits (truly meeting patients where they are) *and* less-complicated phone visits may be an important bridge to meeting their care needs.[15]
4. *Lay the foundation for future high-tech adoption:* The benefits and convenience of video visits are clear, and as clinicians we should encourage, educate, and empower patients to at least try them. However, the transition to higher tech approaches may need to come *after*, not before, trust and relationships between patient and clinician are established. Patients who are overwhelmed by tech issues in the absence of a strong attachment are apt to become discouraged and abandon their efforts. Starting with telephone and/or home visits may be crucial to laying the foundation for a trusting relationship, which can then flex to something new and unfamiliar. As options are explained and choice is negotiated, it is important for those on the front lines having such conversations to know how well the patient is already connected to the clinician, as well as what kind of issue is propelling the visit. Arriving at video visits may be an achievable endpoint, but not if it is rushed or eclipses other kinds of communication.

As Epstein and Street assert, "Patient-centered care, as does evidence-based medicine, considers both the art of generalizations and the science of particulars."[20 p100] We need to educate our patients about telemedicine options, engage in shared decision-making about modalities, foster trust to invite consideration of high-tech approaches, and continue to provide low-tech options for those who want or need them. Furthermore, as the threat of phone visit reimbursement discontinuation looms,[9] it is critical to advocate that payors continue to reimburse for "low-tech" health-care modalities such as phone, snail mail, and home visits, so they remain viable options for patients who value them.

In the virtual world, as with in-person care, one size does not fit all. And even if patients are open to using new technologies (if they can overcome access and literacy barriers), they might need low-tech options as they move along to the other side of the digital divide. Making a range of options available is key to providing high-value, patient-centered telemedicine care that meets our patients where they are and is responsive to their needs. ❖

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Author Contributions

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