Received: 31 August 2022 | Revised: 21 September 2022 | Accepted: 27 September 2022

DOI: 10.1111/jgs.18090

Journal of the
American Geriatrics Society

Telehealth with older adults: Getting it right

Telehealth has tremendous potential to improve healthcare access, efficiency, and safety; the COVID pandemic has only made this more evident. The high number of excess deaths[1] and decreased utilization of medical care early in the pandemic,[2] especially for individuals over age 65, make the case for continued utilization of telehealth in an older adult population post pandemic.

In this issue of the *Journal of the American Geriatrics Society*, Bhatia et al. share the results of a mixed methods survey of 208 individuals aged 65 and over regarding their experience of utilizing telehealth (audio only and/ or video) in place of in-person visits with their primary care provider (PCP).[3] Most respondents liked their telehealth experience and thought telehealth should remain a covered option post pandemic. Respondents appreciated the convenience and time-saving nature of telehealth. Satisfaction with telehealth visits was equally high for all age groups including people aged 75 and over. Though many acknowledged the benefits of in-person visits, a majority want telehealth visits with their PCPs to remain an option for the foreseeable future. The authors assert that these findings make a strong argument for continuing Medicare reimbursement of telehealth visits after the pandemic.[3]

Though having telehealth available for older adults has clear advantages, it is equally clear that guidelines need to be in place to facilitate its optimal deployment and use. This is especially true for complex or vulnerable older patients. The West Health Institute-supported Collaborative for Telehealth and Aging created and organized a set of such guidelines (see Figure 1) into three main categories: (1) patient-centered, (2) equitable and accessible, and (3) integrated and coordinated.[4] Each of these domains must be considered if high-quality telehealth-facilitated care will be delivered to older adults. Reviewing the results of the study by Bhatia et al., which was directed at an older adult population likely to have the best possible experience of telehealth visits, through the lens of these domains elucidates significant considerations as to how telehealth is best offered to older adults.

PERSON-CENTERED

It is imperative that what matters to patients, including their goals of care (and when applicable, the caregivers' goals) are identified and kept front and center throughout telehealth visits.[5] Consider the Bhatia et al. survey, which was directed at patients who utilized telehealth with their PCPs, with whom they presumably had preexisting relationships. Their experiences highlight many concerns about how telehealth may often not be patient centered. For example, many participants expressed concern that telehealth visits were shorter and more superficial than in-person visits. Twenty-two percent of respondents stated that their PCP was less likely to ask about multiple health problems and focus primarily on the chief complaint in a telehealth visit when compared to an office visit. Many respondents stated that they were less likely to share worries or concerns during telehealth visits than during office visits. These challenges related to going beyond a single surface concern into patients' deeper concerns and goals of care may be exacerbated when telehealth visits are not with PCPs and are instead with physicians with whom patients do not have a preestablished relationship. To provide person-centered care via telehealth it imperative that in every encounter the provider (1) has access to, and confirms, any relevant advance care planning documents, (2) takes the time needed to understand exactly why the patient is seeking care that day (what matters to the patient and/ or caregiver), and (3) at the end of each visit asks if the patient and/ or caregiver has any additional concerns they would like addressed during this visit outside of the chief complaint.

EQUITABLE AND ACCESSIBLE

The Bhatia et al. survey was directed at people who were English speaking and lived in an urban area where broadband service was unlikely to be a barrier to telehealth.

This editorial comments on the article by Bhatia et al. in this issue.

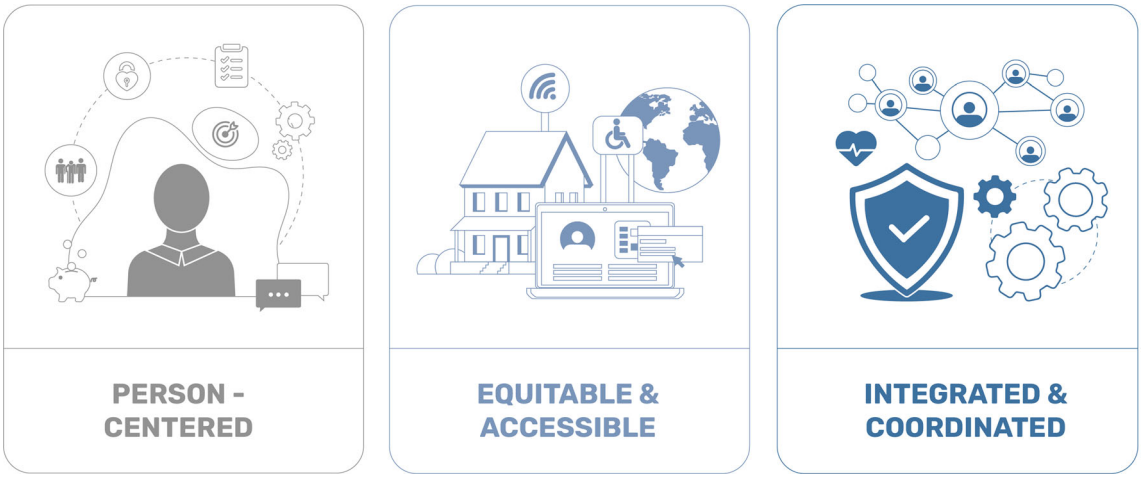

FIGURE 1 The collaborative for telehealth and aging's principles for age-inclusive telehealth

Additionally, over 90% identified as white non-Hispanic, the majority were highly educated (almost 75% with a college education and over 40% with post-graduate education), the overall population had a high annual household income, few (5%) needed help with activities of daily living, and none had identified cognitive impairment or severe psychological illness, all of which support the use of telehealth. However, even in this well-resourced population, equity and access shortcomings were evident. For example, over a quarter of those who were originally scheduled for video visits had to convert to audio-only visits due to technical difficulties, resulting in roughly half of the telehealth encounters being audio-only. The relatively few non-white participants in this survey were substantially less likely to be satisfied with telehealth visits, as were individuals with significant comorbidities. These issues and barriers would likely be more pronounced in a more representative survey population. A better understanding of disparities in the reported telehealth experiences of ethnic minorities and those with significant comorbidities will be critically important if telehealth-facilitated care is to be provided in an equitable manner. One way to do this is to ensure that every system providing telehealth tracks and reviews the demographics of patients served in order to identify underserved patient groups and address any inequities that are uncovered. Additionally, patient experience and satisfaction surveys should be incorporated into telehealth programs to track and address areas of need.

INTEGRATED AND COORDINATED

The Bhatia et al. study connected patients with their own PCPs, and, over time, these providers were able to integrate the telehealth encounter with the overall care plan of their patients. This approach of using telehealth with the patients' own existing PCP is desirable because of the preestablished doctor–patient relationship. However, telehealth visits frequently occur between providers and patients with no established relationship.[6] These providers are often not familiar with patients' overall care plans, and they often utilize technology that is not integrated with the patients' electronic health record (EHR). When telehealth is not integrated and coordinated like this, providers may not have the information they need to facilitate the best care. Beyond care plans, this information includes having an understanding of the patient's social support structure and the ability to obtain and pay for prescribed medications. At a minimum, it is imperative that all providers (telehealth or otherwise) have access to patients' care plans, including their lists of medications, allergies, and medical conditions to provide safe, effective, integrated and coordinated care. Furthermore, a record of the telehealth encounter should be forwarded to the patient's PCP for appropriate oversight and follow-up management.

PROVIDER AND PATIENT TRAINING

Simply because a provider is well-trained in supplying in-person care does not mean that the same provider is capable of providing high quality care using telehealth.[7] Thus, ongoing provider and patient training is key to the delivery of high-quality telehealth. Given that most providers have had no formal training in utilizing telehealth, and often use multiple platforms or technologies, it is not surprising that the Bhatia et al. survey identified patient concerns about lack of provider and patient training. In particular, they identified the need for training to mitigate cultural, physical or cognitive, and technical barriers, which are critical components of person-centered,

successful, and equitable telehealth care. Healthcare systems that utilize telehealth to care for their patients need regular mandatory training in best telehealth practices for their providers, and easy to access and understand patient guides to utilizing telehealth. Furthermore, training should include ways to address the unique needs of older adults.

There are many compelling reasons for ensuring that older adults continue to have access to telehealth post public health emergency (PHE) regardless of their ability to pay. The results of this study highlight that older adults perceive that telehealth is beneficial, results in improved access and efficiency, decreased risk of infectious disease spread, and that, if properly structured, can be cost effective. Additionally, if CMS restricts access to telehealth by returning to pre-PHE reimbursement limitations, CMS may further exacerbate disparities in care. The pandemic has taught us that our healthcare system is vulnerable and needs to adopt capabilities like telehealth in order to deliver safe and effective care in the future. We believe a framework that requires telehealth delivery models to provide care that is person-centered, equitable and accessible, and integrated and coordinated, along with ensuring that providers are adequately trained will be critical to ensuring that telehealth is used in a safe and efficacious manner with older adults. Without these guard rails, telehealth may further segment care thereby increasing the chances of low value care while further exacerbating health inequities. With these guardrails in place however, telehealth has the potential to realize its promise of improving access to high-value, equitable, safe, timely and convenient care to older adults.

AUTHOR CONTRIBUTIONS

All authors made substantial contributions to conception and design as well as to drafting, revising, and finalizing article.

CONFLICT OF INTEREST

Kevin Biese serves as an advisor to Third Eye Health, a telehealth provider focused in the post-acute space. None of the other authors have any conflicts to disclose.

SPONSOR'S ROLE

There was no sponsorship for this article.

Kevin Biese MD[1]
Steven M. Handler MD[2]
Liane Wardlow PhD[3]
Zia Agha MD[3]

[1]*Department of Emergency Medicine and Internal Medicine, University of North Carolina at Chapel Hill School of Medicine, Chapel Hill, North Carolina, USA*
[2]*Veteran Affairs Pittsburgh Healthcare System, Pittsburgh, Pennsylvania, USA*
[3]*West Health Institute, La Jolla, California, USA*

Correspondence
Kevin Biese, Department of Emergency Medicine and Internal Medicine, University of North Carolina at Chapel Hill School of Medicine, 101 Manning Drive, Chapel Hill, NC 27599, USA.
Email: kbiese@med.unc.edu

REFERENCES

1. COVID-19 Excess Mortality Collaborators. Estimating excess mortality due to the COVID-19 pandemic: a systematic analysis of COVID-19-related mortality, 2020–21 [published correction appears in Lancet. 2022 Apr 16;399(10334):1468]. *Lancet*. 2022;399(10334):1513-1536. doi:10.1016/S0140-6736(21)02796-3
2. Boserup B, McKenney M, Elkbuli A. The impact of the COVID-19 pandemic on emergency department visits and patient safety in the United States. *Am J Emerg Med*. 2020;38(9):1732-1736. doi:10.1016/j.ajem.2020.06.007
3. Bhatia R, Gilliam E, Aliberti G, et al. Older adults' perspectives on primary care telemedicine during the Covid-19 pandemic. *J Am Geriatr Soc*. 2022;70(12):3480-3492. doi:10.1111/jgs.18035
4. Wardlow L, Leff B, Biese K, et al. Development of novel telehealth principles and guidelines for older adults: A modified delphi approach. *J Am Geriatr Soc*. 2022. doi:10.1111/jgs.18123
5. Carbonell E, Zonsius MC, Rodriguez-Morales G, Newman M, Emery-Tiburcio EE. Addressing what matters. *Am J Nurs*. 2022;122(1):54-58. doi:10.1097/01.NAJ.0000815440.19544.ed
6. Smith SW, Tiu J, Caspers CG, et al. Virtual urgent care quality and safety in the time of coronavirus. *Jt Comm J Qual Patient Saf*. 2021;47(2):86-98. doi:10.1016/j.jcjq.2020.10.001
7. Saiyed S, Nguyen A, Singh R. Physician perspective and key satisfaction indicators with rapid telehealth adoption during the coronavirus disease 2019 pandemic. *Telemed J E Health*. 2021;27(11):1225-1234. doi:10.1089/tmj.2020.0492