Balancing the Tradeoffs Between Office and Video Doctor Visits

Read the news online or in an actual newspaper? Stream a movie at home or watch in a theater? Order groceries online or pick your own produce at a nearby supermarket? When deciding between these alternatives, we weigh a set of tradeoffs—including convenience, experience, and cost—and select the option that best matches our needs and preferences at the time.

Similar tradeoffs exist between seeing the doctor in person compared with over video. Until recently, because net tradeoffs (particularly around reimbursement) strongly favored in-person health care, only a tiny fraction of encounters occurred virtually.[1] This proportion suddenly flipped with the COVID-19 pandemic, when the imposition of physical distancing, coupled with relaxed rules and expanded reimbursement, led innumerable patients and providers to experience video visits, often for the very first time. Gastroenterologists were among the highest users.[2]

But what will happen as the pandemic wanes and in-person care again feels safe? We believe that patients and clinicians will weigh a series of tradeoffs to answer this question in the coming months.

The primary driver will likely be experience. Video visits are often a convenient and low-effort way for patients to see their doctor: rather than spending an average of 2 hours attending a 20-minute office visit, they can spend just over 20 minutes, all from the comfort of their own home.[3] Conversely, some patients may find the technology frustrating and miss the interpersonal relationship and social interaction they get visiting their doctor's office, especially if the video visit requires seeing someone other than their established clinician. Studies show that when both video and in-person visits are available with the same doctor, many patients still opt for in-person care.[4]

Clinicians also may have mixed experiences. On one hand, video visits may improve their work–life balance by increasing scheduling flexibility and eliminating travel time between clinical locations, even enabling some to work from home. However, adding even more screen time may leave them feeling more fatigued and lonelier.[5] Technology glitches may frustrate them. And some tasks that are routine in the office may suddenly be much harder over video, such as informing patients when they are running late or arranging diagnostic tests.

Access will be another key variable. By allowing patients to see their clinician from their home, work, and wherever else they carry their smartphones, video visits increase access for those who cannot see their clinician in person owing to time constraints or travel barriers. Likewise, video visits may enable clinicians to reach into new geographic areas to serve more patients with the conditions they are interested in and expert at treating. Still, because from start to finish video visits require nearly the same amount of clinician time as office visits, video will not improve access if clinician availability is the key constraint, and it could cut off those who lack the technologic resources or ability to use the service.

As in-person and video visits are weighed by clinicians and patients, their relative effectiveness will come under scrutiny. Video visits enable both groups to see, hear, and talk with one another. Often this is enough to effectively evaluate and manage many health conditions.[6] Video also offers clinicians something in-person care does not: a glimpse into their patients' everyday lives, including their living conditions, family members and caregivers, cherished personal objects, pill bottles, and refrigerators. But communicating through a screen, rather than in person, may impair the human connection and rituals that are central to healing.[7] Also, it may be hard or impossible for clinicians to remotely obtain key information—such as vital signs, physical examination findings, and laboratory tests—that they need in order to accurately assess and treat certain patients. For example, during video visits primary care physicians are less likely to assess their patients' cardiovascular risk factors such as blood pressure and cholesterol,[8] and pediatricians are more likely to unnecessarily prescribe antibiotics to children with acute respiratory infections.[9]

Finally, consumers, providers, and payers will increasingly consider the relative financial value of video versus in-person visits. For patients, video visits reduce indirect costs, such as travel, parking, and time. Sometimes direct out-of-pocket costs are also lower, such as video visits from low-cost virtual care vendors, and those that avoid facility fees that would have otherwise been charged in person. However, a video visit may be less affordable if insurance does not cover it, or if it does not fully address the patient's needs and therefore leads to an in-person visit. For providers and payers, the financial tradeoffs of video versus in-person visits depend on the payment model.[10] Under value-based payment models that put the provider at risk for total cost of care, the provider is motivated to deliver the most efficient possible mix of in-person and video visits. Things are much different under fee-for-service, where net economic effects depend on relative (video compared with in-person visits) reimbursement rates, as well as the effects of video on total visit volume, the mix of visits, and downstream services. Health systems may be concerned that video visits result in fewer diagnostic tests within their facilities.[11] Likewise, payers are concerned that, because of their convenience, video visits will add to—rather than substitute for—in-person visits and raise total costs of care. Likewise, if key coverage and regulatory changes expire at the end of the public health emergency, providers may be reluctant to accept lower video reimbursement rates.

Technologic advances bring both advantages and drawbacks. Virtual care is no exception. Now that the "genie is out of the bottle,"[12] the challenge is to harness video visits in ways that balance these tradeoffs to maximally benefit all stakeholders. This means that patients must determine if a video visit can meet their health needs and whether, based on their priorities, it fits into their lives. Providers must define the role of video visits—and virtual care more broadly—in their overall practice, and then adopt the necessary technology, develop streamlined workflows, and adequately support their teams to provide them smoothly and effectively. And payers must assess the effects of video on outcomes and costs, and then implement benefit designs and reimbursement policies that promote high-value use.

Importantly, each group must be able to learn from their experience and be willing to give something up to gain something in return. For patients to enjoy the increased convenience of video visits, they may need to pay at least an equivalent amount for it, accept the risk of some redundant visits, and take responsibility for some tasks that would have otherwise been performed in the office (eg, taking blood pressure at home or getting blood drawn at an external laboratory). Meanwhile, providers who continue to offer both in-person and video visits are essentially running 2 practices and will need to continually refine how they determine which modality is appropriate for which patient needs, and may need to agree to lower payments for video visits. Finally, payers may need to accept that sometimes video visits will add to baseline care utilization, but at other times they will replace and may even deter more costly care.

Of course, video visits are just one of several virtual care channels. Virtual care may also be provided directly to patients via e-visits, remote second opinion services, and telephone visits, as well as by remotely monitoring key patient factors (such as biometrics, activity, and symptoms) and providing individualized feedback. In addition, there are several peer-to-peer virtual care options, including e-consultations, telephone consultations, and video-conferencing.[13] Ideally, all stakeholders will move to encourage the blend of in-person and virtual care channels that best matches individuals' needs and preferences, and makes care more accessible, pleasant, affordable, and effective.

Ultimately, all stakeholders will need to make a series of tradeoffs between these modes of care. We expect that with continued experience the drawbacks will lessen over time and that we will ultimately see each as a complement to the other and not mutually exclusive—much in the same way as we sometimes decide to go to see the latest movie in the theatre, and other times stay at home to watch Netflix.

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Conflicts of interest
The authors declare no conflicts.

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0016-5085/$36.00
https://doi.org/10.1053/j.gastro.2021.06.069