Telemedicine: When to embark on an alternate care delivery model?

Exploratory Paper

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As medical practices move from a fee-for-service reimbursement environment to fee-for-value reimbursement it is increasingly important for the financial health of the organization to be able to optimally manage the health of the practice’s patient population in a cost-effective manner. Leveraging technology to connect patients with providers via video teleconferencing has been employed for many years to reach rural populations. More widespread adoption of this care delivery model has gained traction over the past several years as individual states have passed legislation permitting coverage for services provided through a telemedicine platform. Subsequently, many commercial insurance payers have endorsed telemedicine and view this delivery offering as a key strategy in lowering the total cost of care. For a physician practice, the decision to offer medical services virtually, however, does not come without significant organizational commitment and investment cost. From a clinical perspective, virtual care requires physician acceptance of a paradigm shift in how a relationship is established between patient and physician. From a financial perspective, key areas of concern are: 1) evaluating the adverse impact (if any) that can be expected to current office volume (cannibalization); 2) return on investment projections; and 3) the potential implications of not offering a telemedicine solution. This exploratory paper seeks to provide a review of existing literature on the topic of telemedicine with a focus on synchronous virtual encounters in primary care, evaluate experiences of member Medical Group Management Association (MGMA) practices through a survey, and, ultimately, provide additional knowledge to assist practice administrators and key stakeholders in decision-making and strategic planning as it relates to the value of telemedicine to the future of their organization.
Overview

Evolution of virtual medicine technology

The remote transmission of data and the development of medical devices to monitor care virtually have evolved and been accepted as a standard of care since the late 1990’s. Medicare has been reimbursing for physician encounters provided virtually in rural areas for many years as a solution to meeting the needs of populations in geographical areas lacking sufficient medical providers. The maturation of electronic health records (EHRs) to assist in decreasing the fragmentation of care accompanied by enhanced mobile technologies have positioned telemedicine, or virtual care, to assist as a solution to increasing demand for services (Vockley, 2015; see also Kilbridge, 2015, July 12; McGee, 2012).

Enhancements in high-quality, real-time video conferencing capabilities have made it possible to seamlessly integrate virtual care in a very convenient and cost effective delivery model eliminating wait and travel times for patients. Telemedicine can also provide enhanced flexibility for health care providers by expanding geographic reach and allowing expanded access for their patient panel while eliminating the cost of brick-and-mortar overhead for the time working virtually. The delivery of medical care is slowly transforming to incorporate the addition of telemedicine as an option, either by independent virtual providers or including as an alternative in the patient’s physician practice as an additional service line (Deloitte, 2016; McGee, 2012).

With the rapid proliferation of virtual consultations some researchers attest that close to 70% of all patient visits do not require face-to-face interaction and would be eligible for safe delivery virtually (Rosenzweig & Baum, 2013). Partnerships have been borne, such as the initiative announced recently between Tampa General Hospital (TGH) and American Well, to connect patients 24/7 to receive the care they are seeking within the TGH system (Miller, 2016). The American College of Physicians released a position paper in 2015 endorsing telemedicine as “holding the promise to improve access to patient care, improve patient satisfaction, and reduce costs to the health care system” (Daniel, 2015, p. 787). According to Tim Harbison, Director of
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National Accounts at Horizon Blue Cross Blue Shield of New Jersey, “Horizon’s strategy is to increase the bandwidth of current Horizon providers to evolve telehealth into another arm of their practice” (personal communication, May 31, 2016).

Defining the terminology: Telemedicine vs telehealth

There has been significant confusion regarding the use of the terms “telemedicine” as opposed to “telehealth”. For the purposes of this paper, we will use the following accepted definitions. Telehealth, as defined by the U.S Department of Health and Human Services, is the use of telemedicine technologies and electronic health information to support long-distance healthcare; telehealth has a very broad scope including both clinical services and nonclinical such as health education and training, public health and health administration. Whereas, telemedicine, as defined by the American Telemedicine Association, is the use of technology to communicate clinical information using the internet, wireless, satellite, and telephonic devices and focuses on the narrower scope of virtually delivering clinical services (Vockley, 2015).

Industry overview of virtual service model options

Synchronous videoconferencing. Synchronous, or real time, secure videoconferencing connects a patient with a provider virtually using live video and audio technology permitting direct communication, visualization and enhanced history-taking and physical assessment for the purposes of diagnosis and treatment. Indications for this type of telemedicine encounter include non-urgent primary care, behavioral health and chronic disease management. Synchronous encounters are the most favorably reimbursed form of telemedicine (Walsh, 2016).

Asynchronous messaging. In this model, a patient uses an online platform to connect with a provider without real time video conferencing. Through the application the patient indicates the chief complaint, answers questions with a diagnostic logic tree applied and this information is submitted to a provider who reviews within a defined period of time and responds with an assessment and plan of care directions. Asynchronous messaging, or store-and forward messaging, is also used similar to email communications between patient and provider in a secure
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platform and has been noted to be more time efficient for the provider (Kilbridge, 2015, July 12). This type of interaction saves approximately 10 minutes per patient allowing a provider to address patient concerns in a timely fashion but is not typically reimbursable.

**Technology to promote engagement and education.** Regular contact, relationship building and engagement are key to being able to optimally manage the health of a patient population resulting in optimal outcomes with good resource utilization. Telemedicine platforms are being used to assist clinical staff in providing enhanced support and education to assist in promoting self-management skills, providing guidance with challenging clinical dilemmas and lifestyle recommendations and connecting with community support as indicated (Deloitte, 2016). Vockley (2015) opines that telemedicine allows for “expanding from patient care to wellness care, with a focus on keeping people healthy” (p. 306).

**Remote monitoring and care coordination.** Clinical applications aligned with remote monitoring devices have for many years allowed for the monitoring and education of patients with chronic diseases such as heart failure, chronic obstructive pulmonary disease, hypertension and diabetes from a distance. These devices and how patients connect with them are continually improved upon.

**Scope of paper.** For the purpose of this paper, the scope will be limited to synchronous e-visits specific to acute episodic non urgent primary care complaints. Examples of conditions that have been shown to be able to be assessed and treated effectively through video-conferencing technology with a provider include uncomplicated cases of allergy/asthma, cough, conjunctivitis, pharyngitis, otitis, rash and urinary tract infections (Gough, et al., 2015).

**Market forces**

**Advances in technology**

Over the past decade, patients have increasingly gained a comfort level with health information-seeking via the internet. It is not unreasonable to anticipate that acceptance to receive actual medical care virtually will continue to grow as the physician-patient relationship evolves.
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(Roetti, Bidmon, & Terlutter, 2016). American Well has recently seen its mobile app downloaded 1.2 million times as compared to 20,000 times a year prior (Tahir, 2015). The Technology Acceptance Model (TAM) predicts the acceptance and use of new information technologies and is applied assessing the impact on consumer behavior and available health information. The TAM assesses two core beliefs central to adoption: 1) perceived usefulness which is the degree to which the technology will improve performance and 2) perceived ease-of-use which assesses the amount of effort required to use (Roetti, Bidmon & Terlutter, 2016). Telemedicine is aligned with these core beliefs and, therefore, more widespread adoption is predicted.

Protection and security of health information. Health care organizations have an obligation to maintain the privacy and security of their patient’s health information and use web-based or proprietary, secure platforms to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA). Additional software is employed by organizations to address the management of security using mobile devices, the patient portal and email within their system; the challenge occurs when communications leave the controlled structure of the organization, such as with external providers. In those cases, to ensure security, information needs to occur through direct fax rather than email or text.

Interface capabilities. Telemedicine technology platforms are enabled to interface with the provider’s electronic medical record (EMR) and can seamlessly be incorporated with an alternate encounter type within the patients’ record. In addition, if the patient is seen virtually the encounter can be electronically transmitted to the patient’s primary care provider (PCP) for inclusion. The challenge occurs in decision-making by a virtual provider who does not have access to the EMR and is dependent on the patient’s ability to provide a complete history in his/her development of a care plan.

Applications for smart phones and tablets. Advances in technology, such as the smartphone, iPad and tablet, with their multitude of applications and uses, have been embraced
by consumers far and wide. These personal devices now provide a high level of functionality and connectivity allowing for ease in integration with healthcare information technology (HIT) platforms gaining the attention of technology developers in the healthcare space. As companies in other industries, such as Amazon, Netflix and online banking, introduced easy access and convenience virtually, the bar has been raised challenging physician organizations to provide a similar customer experience in the healthcare arena (Gaynor, 2015; Kasinadhuni, 2015; Kmucha, 2015, October/November).

**Consumer preferences and demands**

The physician-patient relationship has evolved to reflect more of a partnership in developing a treatment plan rather than the historical directive care plan. Patient access to medical information on the internet has been empowering in directing healthcare discussions and, at times, setting expectations and demands for care. Virtual care is gaining momentum with 76% of patients prioritizing access to care over interaction with providers (Kasinadhuni, 2015). This can potentially result in patients receiving care from multiple sources, both local and more distant, and potential fragmentation. Conversely, eVisits can serve to encourage patient communication and promote engagement assisting to identify health needs and enhance outcomes (Hickson, Talbert, Thornbury, Perin & Goodin, 2015). To further address consumer preference, American Well recently unveiled a menu of physicians allowing the patient choice in their physician (Abelson, 2016).

**Convenience.** The rise of retail clinics and urgent care centers has been a direct result of consumer demand for a convenient and time efficient care alternative. According to a Harris Poll in December 2014, 64% of adult respondents (n=2,019) were willing to see a physician using online video technology (Roetti, Bidomn & Terlutter, 2016). In a survey conducted by The Advisory Board, convenience is paramount with six of the top 10 attributes being related to access and convenience when selecting where to seek care. Virtual visits were preferred over clinics near both home and work, a surprising shift (Daugherty, 2014). In an editorial in the
Annals of Internal Medicine (2015), David Asch sees telemedicine as eliminating such assumed “costs” of traditional medical visits as travel time and parking to patients and facility and staffing costs to the practice.

**Pricing.** While varying models and pricing structures exist including some waiving co-pays to drive adoption of telemedicine, virtual visits cost generally less than half a primary care visit and a fraction of a more costly urgent care visit (Kasinadhu, 2015). This is especially meaningful to patients as we have moved increasingly towards the consumer bearing more of the cost of their healthcare with co-insurance and high deductible plans. Various business models exist for e-Visit technology. Teladoc is not direct to consumer but charges a per-member per-month fee to members of its health insurance plan partners. Whereas, a majority of vendors are direct to consumer either in partnership with or independent of a healthcare entity (Tahir, 2015). A majority of telemedicine vendors offer pay-as-you-go pricing that allows flexibility to access care when needed without a subscription requirement.

**Adoption by demographics.** Women have been found to embrace virtual visits more frequently than men and a majority of users live in a more affluent area. Households with incomes greater than $100,000 are more than twice as likely to use telemedicine. A willingness to seek care from an online provider seems to decrease with age. Adopters of telemedicine care were found to be healthier in a California Public Employees’ Retirement System analysis when offered with no co-pay as a covered benefit to its members. Adopters were found to have fewer chronic conditions and to not have sought health care in the year prior to selecting a virtual care experience (Hickson et al., 2015; Uscher-Pines, 2014).

Millenials are technology-adept and sophisticated with an expectation of immediate access to information including healthcare. Surprisingly, however, two eVisit studies have reported higher utilization among middle-age patients than their younger equivalents. Nine thousand infants are born to Millenial parents each day in the United States and we are seeing evidence of their desire for instantaneous access to answers and care and the use of social media
to voice their opinion about the experience – both positive and negative (Zuehlke, 2016). Over 40% of visits to the emergency room are of low acuity and could be shifted safely to online care (Kasinadhuni, 2015).

**Reimbursement**

**Medicare.** Policy regarding the reimbursement for telemedicine for Medicare recipients has changed very little since its inception remaining limited to rural geographic areas. However, as of early 2015, there were more than 100 pieces of legislation related to telemedicine pending in state legislatures. As states take the lead in driving change and acceptance of telemedicine as an alternative care model, Medicare will be challenged to follow suit and, in fact, have included a telemedicine waiver in a next generation accountable care organization (ACO) pilot (Neufeld, Doarn, & Aly, 2016).

**Regulatory variation among states.** Regulations vary significantly amongst states; consistently the most significant obstacle has been reimbursement for services rendered virtually. According to Dr. Albert Chan, Vice President and Chief of Digital Patient Experience at Sutter Health, even states, such as California, which has passed legislation permitting payment for telemedicine are challenged to but does not require reimbursement. This has become onerous to medical practices as it requires negotiation with each payer separately (personal communication, May 25, 2016). The practice of medicine is defined as occurring where that patient is located at the time of service (Robeznieks, 2014). Physicians are increasingly obtaining multistate licensure to afford them expanded access to a larger patient base virtually. Despite limitations related to licensure and reimbursement, trending suggests that telemedicine will be available in all states within the next five years (Kasinadhuni, 2015).

**Physician-patient relationship requirement.** A number of states, such as Texas, have included a requirement for the physician-patient relationship to be established prior to a virtual encounter. Telemedicine, therefore, cannot be used as a tool to grow their catchment area or drive new patient volume. This restriction has resulted in slow growth of virtual care in those states.
Prescribing limitations. The Texas Medical Board has received significant attention in the past year for passing legislation prohibiting the writing of prescriptions during a telemedicine encounter unless there is a pre-existing established in-person physician-patient relationship (Kilbridge, 2015, May 6).

Parity requirements. For successful growth of telemedicine, state legislation needs to include parity for Medicaid, fully insured plans, and providers of telemedicine that contract directly with a health plan. Parity requirements, however, are not applied to self-funded plans or online care groups of providers. Debbie Settle Green, Associate Director of Health and Wellness Benefits at Novartis, which has a self-funded plan, states that Novartis created a benefit design with lower co-pays than emergency room, urgent care or traditional doctor’s office visits to promote adoption of telemedicine as a care alternative (personal communication, June 2, 2016).

Medicaid. State Medicaid regulations vary widely; in many instances, Medicaid has been more progressive and telemedicine services have been offered far in advance of other payers (McGee, 2012). States may reimburse for telehealth under Medicaid provided that the service satisfies federal requirements of efficiency, economy, and quality of care. States have significant autonomy in how they administer their Medicaid program. A letter evidencing the value and cost effectiveness of telemedicine as employed by the Veteran’s Administration and Medicaid programs was crafted by a group of health systems including Scripps, Stanford Health Care and Partners Health Care and sent to the Congressional Budget Office and Medicare Payment Advisory Commission in an attempt to encourage creative payment reform as it relates to telemedicine (Wicklund, 2016, May 25).

Commercial payers. Payers are beginning to endorse reimbursement for telemedicine as they would prefer to cover a relatively low-cost telemedicine encounter as an early intervention potentially avoiding a more expensive traditional visit at a later time. It remains to be seen whether utilizing telemedicine for early intervention results in an increase of visits for issues that patients typically would not have sought care for resulting in an overall increase in costs.
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(Kilbridge, 2015, May 6). In the absence of e-Visits, patients often seek care at higher acuity centers which often results in additional ancillary testing and higher costs. According to Jason Gorevic, Teladoc CEO, brokers are now including telemedicine as a key strategic component when presenting a benefits design package to employers aimed at reducing costs (Robeznieks, 2014). This has been evidenced by Home Depot, a self-insured company, who realized an average savings of $673 per claim resulting in a 12 month savings of $5.9 million (Kasinadhuni, 2015).

Provider concerns

The patient-physician relationship is fundamental to the provision of medical care regardless of the delivery model. Many doctors view virtual care as depersonalizing and sabotaging the trust that has been a foundation of the doctor-patient relationship (Walsh, 2016). Research has shown that patients who have a long-standing relationship with their primary care physician (greater than 10 years) are least likely to switch providers to access virtual care. However, trends are demonstrating that, in many instances, convenience is trumping personal connection for episodic care; as a result, telemedicine is a factor that physicians need to pay attention to and consider. The ideal offering is to enable patients to receive care virtually from their primary care provider ensuring continuity of care.

Skepticism regarding quality of care. The Federation of State Medical Boards as well as physician professional organizations, such as the American Academy of Family Physicians, have publicly supported the clinical appropriateness of care provided virtually for primary episodic visits. It is estimated that 16-20% of primary care visits are of low acuity and are clinically appropriate for virtual visits. Data is limited but Teladoc’s virtual care delivery model has shown a 94% resolution rate allowing for early intervention with no follow up care required (Kasinadhuni, 2015; Uscher-Pines, 2014). A small pilot study conducted at Massachusetts General Hospital with Harvard Medical School demonstrated that, for certain diagnosis types, telemedicine encounters achieved satisfactory quality of care and was envisioned to expand care
options in the future (Dixon & Stahl, 2008). In 2015, the American Telemedicine Association developed guidelines for the service delivery of telemedicine which are evidence-based and endorsed by their membership of healthcare providers, faculty, administrators and policymakers (Gough, et al., 2015). Lastly, physicians fear over-utilization of prescription drugs but this has not been borne out in the evidence thus far.

**Potential for overutilization.** Critics express concern that easy access to care virtually may result in patients seeking care for complaints that currently they do not seek medical attention for and resolve without intervention. This scenario could result in additional healthcare spending (Tahir, 2015). Craig Samitt, M.D., M.B.A., Chief Clinical Officer at Anthem, has stated that even if there is an increase in utilization of services due to ease in access through telemedicine, “the incremental increase may be good…we should be embracing the use of technology faster in the industry. Our payment system should not suppress progress” (Laff, 2016).

**Impact on workload.** Telemedicine programs thus far have shown, with limited adoption, that virtual visits increase physician productivity and panel size. Physicians fear, however, that they will be burdened by a full office schedule and then will additionally be saddled with a time commitment to treat patients online.

**Compensation model.** Compensation models vary dependent on the base compensation model with enhancements providing work RVU credits for telemedicine activity as well as bonuses for panel size optimization (Reeves & Kasinadhuni, 2014). Dr. Albert Chan, VP at Sutter Health, shared that there was low interest in telemedicine by their own physicians when they launched because replacing an office visit with a telemedicine encounter resulted in a loss of physician compensation within their productivity model. As a result Sutter Health has diversified its telemedicine offerings with external partnerships, Dr. Chan ultimately believes the greatest opportunity in telemedicine is to creatively align incentives and leverage Sutter Health clinicians to provide telemedicine services (personal communication, May 25, 2016).
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Primary care physician shortage

There is a shortage of 45,000 primary care physicians to meet the needs of patients nationally. This shortage requires adjustments and innovations in managing panel size and ensuring access for patients to receive care. UnitedHealthcare referred to this access challenge in its decision in April 2015 to offer telemedicine visits to its patients enrolled in self-funded employer health plans in partnership with Doctor on Demand, NowClinic and Amwell in 47 states and Washington, D.C. (United Healthcare, 2015). A policy statement by the American Academy of Pediatrics describes the potential impact that telemedicine will have on access and physician workforces shortages. The policy statement goes further to advocate for its members and their patients to take advantage of virtual care and perceives the technology as transformative in delivering quality care in an efficient delivery model increasing communication and providing patient-centered care (Marcin, 2015).

Population health economics

Control and management of utilization and outcomes. Healthcare organizations have been challenged to meet the “triple aim” of the Affordable Care Act (ACA) which is defined as 1) improving the patient experience (quality and satisfaction); 2) improving the health of populations and 3) reducing costs. According to the American Telemedicine Association, telemedicine is well-positioned to support this mission to improve access to healthcare while maintaining quality and introducing cost efficiencies (Vockley, 2015; see also Kilbridge, 2015, July 12; McGee, 2012). Telemedicine is seen as key to the success of an Accountable Care Organization (ACO). In 2015 only 27% of ACO’s achieved metrics related to savings and quality improvements to realize financial incentives with only 20% of them currently using telemedicine. Next generation ACOs have a waiver for telehealth services which shows that CMS recognizes the value of telemedicine and is seeking to gather evidence to justify reimbursement (Walsh, 2016).
Management of rising risk patient population. As organizations move away from fee-for-service reimbursement and revenue is increasingly dependent on value-based payments and managing the total health of the patient population, telemedicine and remote monitoring initiatives offer significant opportunity to improve quality and outcomes while reducing utilization resulting in tremendous value to the organization (Neufeld, Doarn, & Aly, 2015). Organizations engaged in risk-bearing payer relationships have begun to incorporate virtual visits into chronic care management, thereby, reducing the inconvenience and expense of repeated office visits and expanding panel access. Keys to success in layering on virtual care management are to ensure appropriate selection criteria with scheduling and documentation workflows to ensure continuity of care by employing a team approach to care delivery.

Impact on bottom line – return on investment

Insufficient reimbursement was noted as the greatest barrier for virtual visit implementation by 22% of organizations surveyed, according to a survey performed by the Healthcare Intelligence Network (Reeves & Kasindhuni, 2014). In a fee-for-service world this is a show stopper; as we move into fee-for-value reimbursement telemedicine increases access and capacity allowing for better management of the population and, ultimately, receipt of increased incentives.

Beyond direct revenue. According to Tahir (2015) in an article in Modern Healthcare, “the business of offering consumers virtual visits with physicians is booming even as questions about the quality of care and cost effectiveness of those services remain unresolved” (p. 18). Investors are seeing virtual care as convenient, less expensive and equally efficacious as in-person care, especially for minor complaints. Telemedicine implementation has been noted to improve efficiency by preventing an office visit in approximately 40% of patients and resulted in a lower margin of loss from Medicaid reimbursement (Hickson et al., 2015). According to a Consumer Choice Survey conducted by The Advisory Board, capturing episodic primary care visits is increasingly important for success in the management of population health. In addition, it
can serve as a tool to attract and capture new patients for attribution. Daugherty (2014) states, “Where a consumer receives care for her sore throat will likely influence where she receives her mammogram and knee arthroscopy.”

**Cost management.** Fixed costs are a significant financial burden an organization carries with expensive underutilized capacity of uppermost concern. Consumers now have more choice and full exposure to pricing which have not historically been present in healthcare. Providing access to care is critically important in both volume-based and value-based reimbursement models. Easy, convenient, cost-effective access is requisite to maximizing patient capture and attaining the desired volume for success (Willis, 2014). Telemedicine allows for expansion of volume with minimal operating investments such as occupancy and staffing costs. Additionally, telemedicine assists in the desire to avoid high cost emergency department visits without the costly investment of outfitting urgent care centers.

**Emerging revenue streams.** Healthcare organizations are leveraging their well-respected brand and physician staff to capture volume is more distant geographic areas through telemedicine technology as evidenced by a new partnership between DuPont Nemours Florida and American Well (Abelson, 2016). Dependent on the business line structure telemedicine can either augment current physician productivity within existing business offices or can be directed to a new service line as new business development.

**Contract negotiation leverage.** Creating an organization that possesses a full continuum of services, excellent outcomes, and geographic reach is attractive to payers; access is integral to be able to provide service and manage the population and telemedicine can support that endeavor (Willis, 2014).

**Enhanced brand awareness.** Virtual consultations through a telemedicine encounter increase visibility of the physician practice and drive traffic to the practice internet Web page with the potential for additional downstream revenue and long-term patient capture. Combined
with optimal search engine optimization, a white-labeled telemedicine platform can grow brand awareness of the practice throughout the state (Rosenzweig & Baum, 2014).

**Telemedicine platform options**

**Models driving adoption**

_{Payer-vendor partnerships._} From a physician practice perspective, this model can be challenging as it offers a service (telemedicine) to a select patient population based upon insurance payer. According to Neufeld, Doarn and Aly (2016), “programs limited to seeing patients from a single payer are likely to be less scalable or financially sustainable” (p. 73) and reimbursement for telemedicine by a majority of payers in the market is likely necessary to have a better likelihood of sustainability. That being said, the following major payers offer virtual visit programs powered by a technology partner: UnitedHealth Care (NowClinic), Aetna (Relay Health), Blue Cross & Blue Shield (both Teladoc and American Well partnerships) and Cigna (MDLive). Highmark, however, discontinued its relationship with Teladoc for its fully insured members suggesting that Teladoc’s business model of per member per month pricing might need adjustment as competitors have less costly models (Grant, 2015). As evidence of the fluctuations and volatility in this active healthcare market segment, stock news in March 2016 reported Teladoc to be ahead of earnings and outperforming the market (Zacks, 2016, March 1). Nicole Grinwis, Senior Administrator of Network Innovations and Project Management at Priority Health in Michigan, reports that access to telemedicine is a key to providing member options for care at the right time and in the right place. Telemedicine is also a lever to improve access to primary care. Telemedicine is not offered widely across their network by providers, so they offer a solution to all Priority Health members - MedNow, a proprietary solution developed by a health system partner, is their primary vendor. However, “if a member sees a provider on another virtual platform Priority Health will reimburse.” Telemedicine is covered based on the codes, not the servicing provider (personal communication, May 19, 2016).
**Employer-vendor partnerships.** At Novartis, Debbie Settle Green states that they monitored the evolution of telemedicine for several years prior to the 2016 launch and that integration was key; they partnered with Horizon Blue Cross Blue Shield and American Well to create an offering that was packaged into the medical benefits design plan with encounters flowing through normal claims processing. The pitch to senior leadership to endorse the telemedicine addition to benefits focused on “expanding the access to healthcare especially to those who can’t get in to the doctor’s office during “normal” work hours” as well as increased productivity by decreasing lost time. In 2016, Novartis offered telemedicine to employees and their dependents in seven states which represented a reasonable number of employees as a pilot; the plan for 2017 is to roll out this offering in all but three states (TX, AK, .and IN) where regulatory challenges remain (personal communication, June 2, 2016). It is predicted that 71% of employers will be offering virtual visits to their employees by 2017 as an effort to lower overall claims cost while decreasing absenteeism and improving productivity (Kasinadhuni, 2015).

**Provider organization offerings.** Intermountain Healthcare recently launched its ConnectCare telehealth platform starting initially with employees as its pilot, followed by members of its insurance partner, SelectHealth, and in April 2016 began a full-fledged marketing campaign. Currently their employed providers cover 12 hours per day with an Online Care Group of physicians serving as back up for nights and daytime volume demand as necessary. The goal is to ultimately provide 100% of telemedicine encounters by Intermountain providers to ensure optimal continuity of care (Commins, 2016).

**Pharmacy/retail offerings.** The healthcare delivery model is rapidly changing from the historic physician-centric delivery model with facility strategy, technology investments and program planning all geared to physician needs and desires to a much more patient centric model. Walmart, seeing the advent of patient traffic becoming more self-directed, has joined others in opening primary care clinics. There is a continued evolution in addressing access and forecasts that everyone in the organization will need to be involved in reorienting to a consumer-centric
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strategy (Daugherty, 2014). After a pilot in California and Michigan, in November 2015 Walgreens expanded its partnership with MDLive to offer telemedicine services in an additional 20 states promoted through its robust health app direct to consumers (HIT Consultant, 2015). MinuteClinic is actually offering telemedicine to more rural locations by employing its clinic workforce to serve as its online care group. They are staffing rural locations with licensed practical nurses (LPN) who perform the intake and then connect the patient virtually to a nurse practitioner (NP) at a traditional MinuteClinic location. Peripheral devices are operated by the LPN and provide enhanced assessment capabilities. Demand will assist MinuteClinic in its strategic planning of future locations (Reeves, 2014).

Technology solution options

**Create proprietary software solution.** Building a virtual technology platform for the organization requires IT software development experience and resources to craft and support a telemedicine platform, device applications and integration with the organizations’ EMR. This is the most costly and time-consuming telemedicine platform option.

**Custom-branded (white label) solution.** Physician groups and healthcare systems are partnering with vendors who provide the telemedicine technology, and often the online care group of physicians, under an enterprise labeled solution. From a marketing perspective, this creates huge visibility as patients connect through a single practice-branded platform (mobile, PC and kiosk). Steve Sperrazza, Senior Vice President of Health System Sales with American Well, revealed a new technology offering which allows for increased flexibility in physician time commitment to augment access and fill no show appointment slots on short notice. He equated this “ask me” service with Uber’s transportation platform (personal communication, May 18, 2016).

**Technology licensing.** This is a convenient solution that provides a well-developed technology infrastructure, branded website, clinical workflows and clinicians that can either
support or supplement an organizations’ needs. This option is the most popular being cost-effective and providing the easiest from an integration perspective.

**Differentiation of platforms**

Ultimately, selection of the ideal platform for an organization will depend on decisions regarding both capital and operating investments requisite for the project. Capital investments reflect the costs for the technology platform, development or licensing, training and equipment to support virtual care. Operating investments include dedicating resources for project management, administrative oversight and marketing.

**Alignment with organization’s strategic plan**

**Goal-oriented service design**

Episodic primary care, chronic disease management, and behavioral health services have been demonstrated to have clear demand with an ability to deliver services virtually successfully. These service lines also can create strategic benefits beyond the direct revenue for the virtual visit (Reeves & Kasinadhuni, 2014). A telemedicine offering can assist with two challenges medical practices are struggling with – clinician capacity and extended hours - to drive patient loyalty and engagement but will be most successful if using the medical group’s own providers as opposed to a vendor online support group (Friedman, 2016).

**Key population targets**

A key decision in designing the telemedicine platform is understanding who the target population is. Virtual visits can assist an organization in offering enhanced 24/7 access to their current patient population which may be attributed in a value health reimbursement initiative. E-visits also offer the ability to extend reach across the state opening access to patients typically not accessible due to geographic constraints.

**Market share implications**

According to an Intuit Health survey, “59% of Millennial-generation patients and 29% of Baby Boomers would leave their PCP for one who offers online access” (Kasinadhuni, 2015).
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Trends suggest that providers who choose to not participate in an online care offering risk losing market share to emerging competitors. MultiCare entered into an exclusive vendor relationship to deliver virtual episodic care by extending PCP capacity for lower acuity visits to grow market share. They found that 50% of the virtual encounters were provided to patients that were new to the practice and of that volume 40-60% lacked a current PCP relationship. An excellent e-Visit resulted in patient retention allowing the practice to capture future downstream care and revenue (Walsh, 2016).

**Physician engagement**

Over 57% of physicians were willing to have a virtual visit with a patient using video technology, according to a large scale survey conducted by American Well using Quantia MD. Drivers for receptiveness included flexible work-life balance, opportunity for additional income, enhanced follow up resulting in better patient outcomes, retaining existing patients and attracting new patients. One of the concerns voiced was a lack of training in the clinical protocols specific to telemedicine. Physicians overwhelming saw a video encounter as more effective for diagnosis than phone or email communication modes (Modahl, 2015).

**Education regarding virtual care experience.** The quality of communication is a primary element in a successful patient-provider relationship. Bulik (2008) conducted a study identifying the following human factors as important elements to a successful telemedicine encounter which the provider has direct control over: 1) social small talk at the beginning to develop a connection, 2) forward-leaning posture to demonstrate engagement, 3) camera placement for optimal eye contact and 4) active listening.

**Clinical quality best practices and guidelines.** As telemedicine has evolved, initial concerns regarding standard of care practices have been addressed culminating in guidelines drafted by the American Telemedicine Association and endorsed by physician organizations. In addition, there is an increasing body of evidence supporting the quality of care provided and value to all stakeholders – patient, physician, healthcare organization and payer.
**Malpractice specific to telemedicine.** Professional malpractice policies exclude coverage for unlicensed activities; it is, therefore, requisite to ensure that telemedicine is lawful in the state of practice. If pursuing a telemedicine offering, it is critical to ensure that the provision of care virtually is covered under the policy as well (Kmucha, 2015, December).

**Disclaimer language regarding appropriateness of encounter.** Organizations need to include standard triage protocol language during the intake process; a statement that there is no guarantee of a prescription and that the encounter could result in a referral for an in person assessment.

**Training and support.** Whether selecting a vendor option or building from within, the success of any new service line is dependent on sufficient preparation and integration with organizational systems. Provider training must focus not only on the use of the technology but also address human factor adjustments necessary to develop a patient connection and gather necessary clinical information to determine a diagnosis and plan (Gough, et al., 2015).

**Expansion of panel size (capacity) opportunity.** Telemedicine has been shown to boost provider productivity through reduced travel time and improved operational efficiencies. Stanford Medicine’s ClickWell Care model has demonstrated nine minutes saved for each virtual encounter; 60% of follow up appointments were able to be provided virtually (Walsh, 2016).

**Survey Methodology**

This section details the approach taken to capture a sample population of practice management professionals with telemedicine exposure in their practice environment, the development of the questionnaire, and the data collection process.

**Type of research.** A descriptive study design was employed which allowed for the gathering of information and describing of behaviors of the medical practices represented by respondents. Many variables were explored; no attempt was made to correlate relationships amongst variables or to predict causality.
Sample population. The target population consisted of members of select Medical Group Management Association (MGMA) member communities as it was not possible to survey the membership in its entirety. The member communities polled were as follows: 1) the ACMPE Board Certification Network (N=832), 2) the American College of Medical Practice Executives Network (N=1,000), 3) the Board Certification Study Group Series (N=674), 4) the Business of Care Delivery (N=954); 4) the Fellowship Study Group Webinar Series (N=249), 5) the MGMA Women Leaders Network (N=559), and 6) the Multispecialty Group Executives Network (N=605). As MGMA members can be members in multiple member communities the total target population was 3,078 unique members. Members can select whether or not to be notified of postings on their member communities so it is difficult to determine how many members actually received notification of the invitation to participate in this survey. An initial posting was placed on each community on May 17 inviting participation with a follow up reminder posted on May 24. Convenience sampling was employed with the survey open and available for responses for 15 days (May 17 through May 31, 2016).

Questionnaire. A survey was designed by this author to gather information from study participants regarding experience related to telemedicine in their practice setting. Respondent demographic questions were included to provide a better understanding of the sample population and framing of responses (Appendix A). Three MGMA fellows provided peer review and feedback leading to survey revision prior to release of the final tool. The survey was delivered using SurveyMonkey software which provided a link to include in the postings placed on the member communities calling for participants.

Presentation and analysis of data.

The survey gathered a total of 80 responses with detail outlined below.

Demographics of respondents. Geographically, there was a fairly even cross-section of the United States with 23 respondents (29.11%) from the Southeast, 20 respondents each (25.32%) from the Midwest and West and 16 respondents (20.25%) from the East.
practice type, the majority of respondents indicated an independent physician-owned practice ownership type (63.75%) followed by integrated delivery systems (15.0%), hospital-owned practices (11.25%) and faculty practices (10.0%). More than 62% of respondents represented practices with fewer than 50 physicians (Figure 1). The sample represented practices by specialty type as follows: 1) primary care physician (PCP) only (20.25%), 2) single specialty (34.18%), 3) multispecialty without PCP (7.59%), and 4) multispecialty with PCP (37.97%). Seventy-one percent of respondents indicated that their position was directly involved in the decision-making, implementation and/or oversight of a telehealth project. No practice entity was represented by more than one respondent so there was no duplication of data.

**Results.** In the topic-related section, the number of responses varied by question which was in part by a logic format design. A frequency distribution or percentage is provided for each data set. Seventy-three percent of respondents (n=37) indicated that they did not have any state regulatory mandate limiting reimbursement for telemedicine at this time. Eighty percent of the sample (n=45) indicated that they do not currently offer online telemedicine encounters. Regulatory challenges and concern regarding quality of care and risk management were the factors that ranked highest as barriers to launch virtual care; whereas, physician compensation and physician resistance to change ranked lowest as the primary barrier. Forty-six percent of respondents indicated that their strategic plan includes a launch of e-visits within the next three years and another 35% are in early discussions (Figure 2).

For those respondents who have launched virtual visits (n=22), growth opportunity to extend the practice’s reach to a larger geographical area and concern about competition and potential loss of current volume to other telemedicine providers were ranked as the top driving factors. The types of online telemedicine services currently offered were evenly split with chronic disease management and behavioral health consultations (n=7) and synchronous episodic care visits and asynchronous messaging (n=6). More than half use a vendor-branded offering as their platform to deliver their telemedicine offering (Figure 3). Recognition as a leader in technology
was the primary desired attribute identified in vendor selection with pricing and client references also noted as important. Fifty percent (n=7) reported using a vendor-branded platform while 28.57% (n=4) use a practice-branded offering in partnership with a telemedicine vendor (white label) and 21.43% (n=3) of the practices developed their own proprietary software solution.

Regarding the questions related to physician participation and adjustment, the driving force for physicians to embrace virtual care delivery was concern about maintaining oversight and medical management of their patient panel in a risk environment (53.85%) and interest in expanding access and enhancing compensation (38.46%). However, 46.67% continue to struggle with delivering care virtually.

Adoption of telemedicine was noted by 33.3% to be slow and, therefore, has not cannibalized in office volume. Of the 12 respondents addressing the return on investment question, eight indicated that it continues to be a loss leader. Seventy-one percent responded that patient satisfaction has been received positively or very positively by their patient population.

**Conclusions of survey**

The purpose of this survey was to gather information from medical practice executives regarding the use of telemedicine in their practices to expand or augment care delivery. A majority of survey participants reported no barriers to reimbursement for telemedicine; however, most of the practices represented in this sample indicated not yet having begun to offer virtual encounters. This was a surprising finding as this author is from a state where limitations on reimbursement for telemedicine have been viewed as the primary barrier to growth of this service model. Perhaps the sample being primarily smaller practices resulted in this finding. Larger practices with inherent expanded resources may be better positioned to taking risk in exploring alternate pathways to delivering care. Consistent with the literature, adoption has been slow with the offering failing to break-even. Perhaps a perceived lack of demand combined with the financial investment has resulted in a dearth of practices embracing this model thus far.
Virtual medicine is noted to consistently rank as a high patient satisfier and that alone may justify the investment as we increasingly strive to enhance the patient experience with financial incentives from payers aligned with those metrics. It was surprising that the sample did not seem concerned about the impact of telemedicine on managing population health metrics. Perhaps reimbursement for these practices has not as yet evolved to risk and gain sharing contracts. It was, however, noted that physician interest in telemedicine was primarily motivated by concern about maintaining oversight and medical management of their patient panel as opposed to the financial reward of additional physician compensation and volume. I suspect that as fee for value reimbursement takes hold it will align with physician interest in managing their patient panel optimally resulting in the recognition of virtual access as being an important component of a total delivery model which combines virtual and customary physician delivery models within the medical practice to optimize access and continuity of care.

The choice of platform needs to be aligned with the strategy and outcomes expected from this new service line. If the practice were to invest in a more expensive practice-branded offering there could be an opportunity for growth and expansion of the practice’s geographical footprint limited only by state provider licensure. Telemedicine can offer significant marketing opportunities and raise awareness of the practice’s brand identity. In this survey, the lower cost vendor-branded platform was selected by a majority of respondents which allowed entry into the telemedicine space with less financial risk. We did not explore whether practices were using the vendor-supported online care group of physicians either in addition to or to supplement practice physicians which may affect program outcomes related to continuity of care, satisfaction and demand.

Limitations of survey. Methodological limitations encountered include the inability to assess the validity of the survey instrument as it was created for the purpose of this research and the use of a convenience sample survey process which is known to gather small response rates. The sample size may not be representative of the population and, therefore, limits generalization.
The structure of the survey tool directed respondents who answered that their practice did not offer online telemedicine encounters to not complete experiential questions. However, the number of answers to the experiential questions exceeded the number who should have been answering that section. As these answers appeared to share experience, this author suspects that those respondents should have answered affirmatively to the question regarding whether their practice offered online telemedicine encounters suggesting more than 20% of the sample does indeed offer this service.

Key decision factors

Identification of regulatory barriers within state of practice

Adoption of telemedicine has been slow due in large part to reimbursement challenges as many states did not include language permitting payment for virtual encounters. In addition, there was often language barring prescribing if there was not a previously established relationship. There has also been resistance from some state medical licensing boards expressing concerns about the potential impact of multi-state licensed providers. In a position paper released last year, the American College of Physicians strongly endorsed the use of telemedicine in clinical practice and urged states to address medical licensing regulations and any barriers to reimbursement with parity (Daniel & Sulmasy, 2015; Frist, 2015).

Assessment of parity in payer reimbursement

Parity, from a physician organization perspective, is necessary to justify shifting volume from a traditional encounter to a telemedicine encounter and ensure equivalent physician productivity and compensation metrics. However, as healthcare continues to evolve, the value of a lower cost telemedicine visit helping to lower the overall cost of care for a population may be able to create that same compensation in an alternate structure.

Understand provider workforce bandwidth and interest in model

There is a risk for virtual visits to cannibalize some in-person encounters. If the practice has access issues, telemedicine can result in a shift of low acuity episodic encounters being
delivered virtually expanding access for more complex patients to be seen in the office (Friedman, 2016). Providers of the practice with available capacity have an opportunity to fill their schedules and can see patients within their organization or throughout the state dependent on the platform selected.

**Assess competition for strategic positioning**

Competition for urgent care activity and concern about risk of cannibalization of in-office volume has been noted by many entities as a major driver to consider virtual care. As payment reform evolves and the moves towards value-based-purchasing, with the number of covered lives being supreme when negotiating rates, practices need to be able to minimize leakage and provide 24/7 access to succeed in those efforts (personal communication with Becky Sanders, Director of Operations at the Upper Midwest Telehealth Resource Center, May 4, 2016). In that vein, Dr. Steven Wolinsky, Senior Medical Director at Horizon Blue Cross Blue Shield of New Jersey, reports that “they are currently in early discussions with partner hospital systems regarding ways to connect with members especially those who are not currently attributed to a system. Horizon believes that telemedicine can be used as a way to attract these patients into the system, allow data capture, then do outreach to optimize health outcomes with outward bound case management follow up. Their goal is to be inclusive and have all of Horizon’s high value providers have access to provide telemedicine” (personal communication, May 31, 2016).

**Value proposition related to population health gain sharing opportunity**

Telemedicine is well-positioned to be a key in capturing gainsharing revenue in managing the health of a population with its improved access, enhanced engagement driving improved connectivity, excellent patient outcomes and satisfaction with lower overall costs.

**Target patient population aligned with strategic plan**

In addition to episodic non-urgent care, telemedicine has the potential to expand access in the behavioral health environment with additional benefits of attracting patients with privacy concerns and appealing to payers and employers by reducing care costs and absenteeism (Miller,
TELEMEDICINE: WHEN TO EMBARK ON AN ALTERNATE CARE DELIVERY MODEL?

2016). As noted earlier, telemedicine has been successfully employed for chronic disease management and can assist in a team approach for case management of those complex patients. Lastly, the strategic plan needs to determine whether geographic growth or enhanced access for the current patient population is the intended goal.

Establish physician compensation model and incentives

For an alternate care delivery model, such as telemedicine, to be successful the practice physicians delivering the care need to be compensated equitably for their time and productivity. The specific compensation model structure needs to align with the existing compensation model (guarantee with bonus, work RVU or percentage of collections) and serve as an additional personal income stream to drive interest in physician participation. The value of telemedicine in improving access and population health goals and outcome metrics also needs to be understood and potentially factored into the compensation equation.

Minimize burden on practice infrastructure

Ensure that the technology solution interfaces with the practice’s EMR and does not create additional burden. Revenue cycle activity needs to be streamlined and seamless. Clinical operations including provider scheduling needs to be achieved smoothly with dedicated project manager oversight.

Conclusion

Align with organizational strategy

A successful telemedicine service line requires champions (executive, clinical and technology) clinical leaders, a dedicated staff and budget. The organization needs to have a culture receptive to innovation and openness to change. Change management throughout the project development is critical to a telemedicine program that is successful and sustainable (Kilbridge, 2015, July 12). In designing the platform and delivery model it is important to ensure integration with the EHR and patient portal to minimize fragmentation. Programs need three critical success factors: multiple virtual access points to meet the range of consumer
communication preferences, 24/7 physician coverage to ensure quick access to care at the patient’s convenience, and a pay-as-you-go price model to appeal to budget-conscious users.

**Why now?**

In an article assessing the patient-physician relationship, authors Roetti, Bidmon and Terlutter (2016) concluded, “Telediagnosis using a combination of traditional face-to-face treatment and online treatment is on the rise and will represent a strong future trend, which has already commenced now. Nevertheless, the physicians’ quality in the patient-physician relationship will remain the most important element, independent of the medium of communication.” Peter Kilbridge (2015, May 6), a Health Care IT Advisor with the well-respected Advisory Board Company, predicts that the future telemedicine will be woven seamlessly into a fully integrated care model optimizing technology and connectivity becoming the new normal of doing business. Dr. Albert Chan at Sutter Health concurs, stating that “video is a part of the practice’s tool belt for better access” and practices must be able to “balance the load” to manage tremendous demand “using the right resource for the right need”, i.e. nurse practitioners for episodic visits (personal communication, May 25, 2016).

In conclusion, David Asch (2015) poses the question, “Do we really want to ration care by inconvenience, or do we want to find ways to deliver valuable care as conveniently and inexpensively as possible?” (p. 801).
References


TELEMEDICINE: WHEN TO EMBARK ON AN ALTERNATE CARE DELIVERY MODEL?


Roetti, J., Bidmon, S., & Terlutter, R. (2016). What predicts patients’ willingness to undergo online treatment and pay for online treatment? Results from a web-based survey to investigate the changing patient-physician relationship. Journal of Medical Internet Research, 18(2), e32. Doi:10.2196/jmir.5244


Appendix A

MGMA – ACMPE Fellowship Paper Survey

This survey is being conducted to assess decision-making and outcomes as it relates to physician practices making a decision to offer online virtual telemedicine encounters (primary focus is synchronous primary care visits).

*Demographic information will only be used for the purpose of better understanding survey respondents and avoiding duplicate representation of practices.*

**Background of Respondent:**

1. Type of practice ownership:
   a. Independent physician-owned practice
   b. Hospital-owned/leased practice
   c. Integrated delivery system
   d. Faculty practice

2. Geographic location of practice:
   a. Northeast
   b. Southeast
   c. Midwest
   d. West

3. Size of practice:
   a. Fewer than 50 physicians
   b. 51-150 physicians
   c. 151-300 physicians
   d. > 300 physicians

4. Type of practice:
   a. Primary care only
   b. Single specialty only
   c. Multispecialty (no PCP)
   d. Multispecialty with PCP

5. Name of Practice (to avoid duplication of data when collating)

_________________________

6. Are you in a position to be directly involved in the decision-making, implementation and/or oversight of a telemedicine project?
   a. Yes
   b. No

7. What is your role within the organization? _____________________________________

**Topic-Related Questions:**

8. Does your State have any limitations on reimbursement for telemedicine encounters?
   a. Yes
   b. No
9. Does your practice currently offer online telemedicine encounters?
   a. Yes
   b. No

If no to # 9, please complete questions 10 and 11 only.

If yes to # 9, skip to # 12.

10. What has been a limiting factor? Please rank if more than one.
    a. Financial investment in technology
    b. Regulatory, i.e., reimbursement issues not resolved at State or payor level
    c. Physician resistance to change
    d. Resolving physician compensation issues related to e-visits
    e. Concern about quality of care and risk management
    f. Other __________________________

11. Is telemedicine part of your strategic plan for the future?
    a. Yes, launch within next 12 months
    b. Yes, hope to launch within next 3 years
    c. In early internal discussions; not on strategic plan as yet
    d. Do not plan to offer virtual care

12. What was/were the driving factor(s) in deciding to offer virtual encounters?
    If more than one, please rank.
    a. Concern about competition and potential loss of volume as telemedicine mature
       in the market
    b. Concern about impact to Population Health metrics if patients seen by external
       virtual providers
    c. Growth opportunity – ability to extend reach to patients in a larger geographic
       area
    d. Increase brand awareness of the practice
    e. Provide increased volume to providers who have access
    f. Expand access of providers who otherwise are at full capacity
    g. Offer additional compensation opportunity to physicians
    h. Other __________________________

13. What type of online telemedicine services does your practice currently offer? Select all
    applicable.
    a. Synchronous episodic care (non urgent)
    b. Behavioral health consultations
    c. Chronic disease management
    d. Asynchronous consultations – i.e., email consultations
14. If you offer online synchronous virtual physician visits, when did you launch?
   a. Within past 12 months
   b. 13-24 months
   c. 25-36 months
   d. Greater than 36 months
   e. Not applicable

15. What type platform do you use to deliver telemedicine?
   a. Practice-branded offering in partnership with vendor (Enterprise version)
   b. Vendor-branded offering
   c. Payor-supported vendor offering (no financial investment of practice)
   d. Practice developed own technology solution

16. What was the primary reason you chose that specific vendor? Please rank if more than one.
   a. Pricing
   b. Technology leader
   c. Support and training
   d. Excellent references (clients)
   e. Endorsed by insurance plans
   f. Endorsed by major employers in market

17. How have the majority of your physicians adjusted to delivering care virtually?
   a. Enthusiastic about expansion of services and ability to reach additional patients
   b. Initially resistant but after training and performing for a few weeks are now embracing in its application
   c. Continue to struggle

18. What was the primary driver of physician participation?
   a. Mandated by organization to ensure sufficient capture of revenue to offset investment
   b. Incentivized in physician compensation plan
   c. Interest in expanding access and enhancing compensation
   d. Concern about maintaining oversight and medical management of patient panel

19. Regarding synchronous online visits, have you experienced a shift in volume of same day sick office visits to e-visits?
   a. No, adoption of telemedicine has been slow.
   b. No, if there is access, patients have continued to choose to be seen in the office.
   c. Yes, patients are opting for virtual care due to convenience.

20. Regarding return on investment, adding telemedicine as a service for our patients:
   a. Continues to be a loss leader
   b. Has attained break even
c. Drives additional profits to the practice

21. Regarding patient satisfaction, how has offering virtual care been received by your patient population?
   a. Very positively
   b. Positively
   c. Ambivalent
   d. Negatively

Thank you so much for taking the time to complete this survey. Please feel free to share any additional learnings or outcomes that can add to our body of knowledge.
List of Graphics

Figure 1

Size of Practice

<table>
<thead>
<tr>
<th>Size of Practice</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than 300 physicians</td>
<td>6</td>
</tr>
<tr>
<td>151-300 physicians</td>
<td>6</td>
</tr>
<tr>
<td>51-150 physicians</td>
<td>8</td>
</tr>
<tr>
<td>Fewer than 50 physicians</td>
<td>12</td>
</tr>
</tbody>
</table>

Figure 2

Are e-visits part of your strategic plan?

- Already launched: 18
- Launching within next 12 months: 6
- Hope to launch within next 3 years: 8
- In early discussions, not on strategic plan: 8
- Do not plan to offer virtual care: 8
Figure 3

Platform for Telemedicine Delivery

- Proprietary software solution
- Practice-branded offering in partnership with vendor (Enterprise white-label)
- Vendor-branded offering
- Payer-supported vendor offering

7
3
4