



The future of telehealth: What's next for virtual care

Health systems have moved past fragmented, one-off telehealth pilots. The organizations furthest along are standardizing technology systemwide and rethinking staffing as a deliberate portfolio that intentionally and strategically includes telemedicine. The bigger question now is less about catching up and more about what's next: how far AI governance, cross-state licensure, and a handful of unresolved federal rules will reshape virtual care into 2027 and beyond.

Telehealth today: Three phases of technology

1. **The digital front door.** Patients' first touchpoint is virtual, mostly for primary care and urgent, low-acuity needs.
2. **Specialty-focused care.** Telehealth expands into tele-neurology, tele-stroke, and tele-ICU, shifting from full-time to fractional coverage (a 0.25 FTE resource in a hub-and-spoke model).
3. **Integration and workflow orchestration.** Where most sophisticated health systems operate today—virtual and on-site resources woven into hybrid physician/APP teams, with every provider practicing at the top of their license.

Staffing virtual care: A three-tier portfolio

Health systems are moving away from reactive, last-minute staffing toward a deliberate portfolio, filled in order:

1 Employed float pool

First call for virtual coverage—physicians already on staff, scheduled flexibility across sites

2 1099 & telehealth contractors

Flexible, specialty-specific coverage for demand that doesn't justify a full-time hire

3 Locum tenens physicians

Scales coverage up or down as real utilization comes in, without a permanent commitment

None of this is aspirational anymore. CHG's integrated float pool product is live, "telephysician" is its own standard locum billing category, and multi-state credentialed pools are an operating reality.

Specialist sharing across health systems

Health systems are increasingly sharing in-demand specialists with each other, rather than each recruiting full coverage independently. Sentara Health, a 12-hospital system, built one of the country's first tele-ICU programs, pairing employed intensivists with round-the-clock remote monitoring. The health system has reported a 26.4% decrease in ICU mortality and a 17% reduction in average ICU length of stay since launching the program.

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The strategic benefits of virtual care

- **Healthcare workforce shortage.** Physicians retiring were often working around 1.5 FTE, while many entering practice today want 0.5 to 0.7 FTE—telehealth helps close that gap, especially in high-shortage specialties and underserved areas.
- **Labor cost savings.** Coordinating employed, flexible, and locum coverage together can meaningfully reduce staffing costs versus defaulting to the most expensive option whenever a gap opens.
- **Increased access to care.** Telehealth remains one of the most direct ways to reach populations that lack easy access to certain specialties.
- **Reduced provider burnout.** Relief depends on staffing the program well; an understaffed telehealth service can add to burnout as easily as reduce it.

The regulatory landscape: What's ahead through 2027

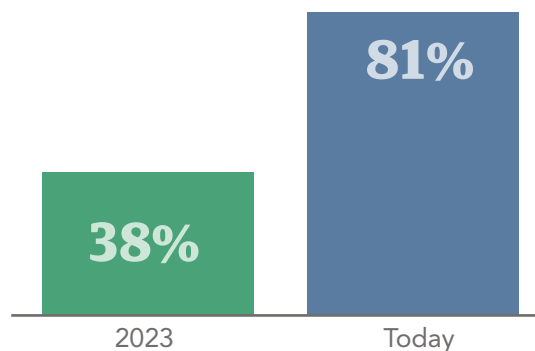
Telehealth policy is moving from temporary waivers toward durable infrastructure, but a few questions stay open heading into 2027 and beyond: a permanent DEA

framework for prescribing controlled substances via telemedicine, further progress on cross-state licensing, and where liability for AI-assisted care ultimately lands. None of them are reasons to wait—Congress has already extended key Medicare telehealth flexibilities through December 31, 2027, and telebehavioral and telemental health flexibilities are permanent.

Artificial intelligence: The biggest open question beyond 2027

Physician use of AI for clinical purposes jumped from about 38% in 2023 to more than 80% by 2026. Governance hasn't moved nearly as fast: Liability for AI-assisted decisions still defaults to the supervising physician, with no settled framework for where that responsibility ends. Worth watching: early data shows ambient AI scribes are associated with higher physician RVUs, not just saved time—a sign that reclaimed capacity isn't yet translating into more telehealth coverage.

Physician use of AI in clinical practice



Telehealth's future: Fully integrated, fully strategic

Telehealth has moved from a patchwork of disconnected tools to a deliberate staffing portfolio, from temporary waivers to durable policy, and from speculative AI use cases to a governance question health systems can no longer defer. The health systems that treat virtual care as a genuine, ongoing part of their workforce strategy—built alongside permanent hiring, float pools, and locum tenens—are best positioned to control costs, close access gaps, keep physicians engaged, and meet patient demand for virtual care as a standing option, not a pandemic-era workaround.