

## **A Baseline on the State of Telemedicine in Michigan: Practical Considerations**

By Monica P. Navarro<sup>1</sup>

Telemedicine is a hot topic these days, but one that has not enjoyed wide coverage in legal writings in Michigan thus far.

In 2010, I was the co-author on an article on Telemedicine entitled “**A Baseline on the State of Telemedicine in Michigan: Where We Are Now and Where We Are Headed**” which was the first of its kind in Michigan. That article sought to provide some basic guidance to Michigan practitioners on salient yet mostly unresolved issues in telemedicine, including the physician-patient relationship; the use of online or “e-prescribing” practices, licensing as it related to practicing telemedicine across state lines; privacy; and reimbursement. The first **Baseline** article was updated in 2012 to reflect the passage of two major pieces of legislation in Michigan in June of 2012, which required Blue Cross Blue Shield and other private insurers to provide coverage (subject to certain restrictions) for care rendered via telemedicine utilizing real-time video and/or interaction.

Since 2012, there have been no major legal developments in the world of telemedicine. The Michigan Legislature has not passed any other legislation and the State Boards have issued no guidance. Notwithstanding, in 2014, the Michigan Institute of Continuing Legal Education in Health Law featured for the first time in its Annual Institute a panel on the development of telemedicine, evidence that telemedicine has “arrived” into the mainstream of the healthcare space.

In the meantime, telemedicine, or at least pilot projects in telemedicine, have continued to explode. This explosion is not surprising, given the hundreds of evaluative studies related to telemedicine uniformly endorsing the cost effectiveness of telemedicine.<sup>2</sup> Thus, widespread adoption of telemedicine beyond pilot projects appears imminent.

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<sup>2</sup> Most of the peer-reviewed research based on large sample sizes and following sound scientific rigor are relatively new, many emerging in the past two years. However, these studies are consistent in finding that telemedicine saves the patients, providers and payers money when compared with traditional approaches to providing care. See Appendix A, from <http://www.capsil.org/files/Telemedicine%20and%20Telehealth%20Outcomes%20Research.pdf>, which presents examples of research studies about various applications of telemedicine showing cost effectiveness, quality of care and patient acceptance.

This article - the third of what has now become a Telemedicine series - seeks to give practitioners advising clients on telemedicine acquisitions with a list of quasi-legal, mostly practical, factors that should be considered in the purchase and adoption of telemedicine.

Readers should keep in mind that this article is not legal advice, but simply a starting point for beginning to think about telemedicine acquisitions and telemedicine contracting generally.

### **Begin with Client Needs Assessment and Goals:**

The telemedicine systems available in the marketplace are quite diverse. Therefore, you should start by assessing the scope of the medical services and the needs of the practitioner's particular patient population.

In general, a telemedicine system consists of at least two portals (one at the physician location and one at the patient location) which, together, create a virtual clinic environment, meaning that the practitioner and patient coordinate and allow the practitioner to conduct most of the check-up virtually. Beyond the portal units, which allow the capture of data at the patient's end and the receipt of the data at the practitioner's end, the telemedicine capabilities of the system depend on the type of peripheral equipment that is acquired. Peripheral equipment usually includes stethoscopes, glucometers, blood pressure tools, weight scales, ECG recorders, pulse oximeters, spirometers, HNC/PT/INR monitors, proscopes, horoscopes, ultrasound and others. In sum, there are telemedicine products and solutions for a wide variety of functions and problems.

Accordingly, the acquisition of telemedicine must necessarily begin with the practitioner's assessment of the challenges that are sought to be addressed by incorporating telemedicine into a practice.

Thus far, telemedicine has commonly been used to improve access to essential health services in remote or rural areas; for preventive treatment at public health centers; to address gaps in emergency services at all levels; to monitor the quality of health services delivered; for post-op recovery (to promptly identify changes in patient condition that can result in readmission); for second opinions; to improve access to specialists in rural/remote areas; to train health work force; for emergency and disaster management; and other reasons. Thus, there are custom telemedicine solutions to address almost every patient/practitioner need.

Often times, a practitioner's needs assessment requires input from the vendors, who are most adept at identifying efficiencies that can be attained through particular telemedicine products. In fact, many vendors offer audits of a practitioner's operations for the purpose of identifying practice challenges that present opportunities for telemedicine solutions through the deployment of telemedicine products that can streamline medical functions and shave costs from the practitioner's bottom line.

### **Assess Quality of Vendors:**

Once the client has identified the needs and goals sought to be served by telemedicine, it is extremely important to ensure that the client selects quality vendors with an extensive track record and the financial ability to stand behind their product. As subsequently discussed, warranties and client support assurances do not mean much if the vendor goes out of business.

Beyond the telemedicine company vendor, practitioners and their clients must consider the quality of any other companies which provide parts of the integrated telemedicine solution. For example, a vendor that uses a widely adopted commercial product and data analytics will inherently carry less risk than a vendor which relies on start-up technology.

### **Consider Functionality/Interfacing with Existing Practice Models/Data Analytics:**

Telemedicine products capture, secure, and retrieve patient data/physiologies wherever the patient is located and transmit that data wherever the physician (or other healthcare provider) is located real time. The two locations make up a virtual exam room. The product used, therefore, must be capable of integrating with hardware devices that facilitate the patient-doctor interaction outside and inside the confines of the traditional care delivery model of the medical facility. Consequently, the telemedicine products must interface seamlessly with EHR/EMR in order to feed into any other functions or communities that are maintained by the clinical provider. Further, the telemedicine system must not only support the patient's connection to the physician, but also the physician's connection to the hospital, to life sciences and research, to health information exchanges, to payors, to public health, to health authorities, and to any other relevant functions/communities. Finally, the telemedicine system must provide

data analytics that support care management and the ability to measure and report performance outcomes.

### **Don't Ignore Privacy/Security/Record Retention:**

It can be assumed that any practitioner sophisticated enough to incorporate a telemedicine solution into its practice is a HIPAA-covered entity. Therefore, the telemedicine process must be HIPAA/HITECH compliant. Robust encryption is a must. Further, the telemedicine product must offer complete record retention and back up of computerized patient data. Additionally, virtual video should be capable of being recorded and stored for future reference and second opinion consultations.

### **Understand Product Quality/Liability/Insurance:**

Telemedicine products do not substitute practitioners in clinical decision making, so adoption of telemedicine should not require a change in malpractice insurance. However, a consultation with the malpractice carrier should clearly be a part of the equation.

What telemedicine products do is provide a conduit for capturing and transmitting medical information that practitioners then use to make clinical decisions in accordance with the standard of care. As such, telemedicine products do carry the risk of malfunction as any other medical product that relies on on-site technology, as opposed to remote technology. With that said, telemedicine products are medical devices which, like any other device of the same type, should be FDA registered.

### **Don't Forget About Warranty/Support:**

Because telemedicine products, like any other new technology, require deployment and integration with existing systems which lag in time from the purchase of the product, it is extremely important to secure a warranty that is commensurate with the scope and length of deployment and the length of the product reaching full operational functionality. The warranty should be no shorter than one year on all hardware and software.

Further, purchase of the telemedicine product should include some level of service/support throughout the deployment phase of the product. If the vendor

offers additional optional warranty and support services that can be purchased at an additional cost, that should be strongly considered.

### **Appreciate the Importance of User Friendliness:**

In selecting telemedicine products, the practitioner has to be confident that patients will adopt the technology. Thus, user friendly telemedicine platforms are crucial.

In general, platforms that mimic modalities common in the marketplace, such as icons and touchscreens, are most likely to be embraced by patients.

### **Insist on Confirming the Track Record of Telemedicine Product/Solution:**

Where possible, it is important to know the track record of success thus far enjoyed by the telemedicine product or solution that is being acquired. Absent competitive interests, previous customers may be willing to share their experiences with the products and vendor. Thus, practitioners should not hesitate to ask for information regarding previous deployments and references.

## **Conclusion**

Given the consistent success and sheer number of telemedicine pilot projects in a wide array of healthcare settings, it is reasonable to predict that wide adoption of telemedicine is inevitable. As such, legal practitioners can expect to receive more inquiries from their clients in connection with the acquisition of telemedicine products. There are numerous legal considerations in the acquisition and roll out of telemedicine solutions into any practice. However, all such acquisitions and legal considerations necessarily will begin with the assessment of initial factors, as laid out in this article.

## **APPENDIX A**

## **Telemedicine and Telehealth Outcomes Research**

Over 40 years of research has yielded a wealth of data about the cost effectiveness and efficacy of many telemedicine applications. Over 1,000 evaluative studies related to telemedicine have been published in the two leading journals devoted to telemedicine. Medline lists over 10,000 citations of published works related to telemedicine or telehealth. Presented here are examples of research studies about various applications of telemedicine showing cost effectiveness, quality of care and patient acceptance.

### **COST EFFECTIVENESS OF TELEMEDICINE**

Studies of the cost effectiveness of telemedicine assess specific applications rather than a broad overview of all aspects of remote health care. Most of the peer-reviewed research based on large sample sizes and following sound scientific rigor are relatively new, many emerging in the past two years. However, these studies are consistent in finding that telemedicine saves the patients, providers and payers money when compared with traditional approaches to providing care.

#### **The Value of Provider-to-Provider Telehealth Technologies** Center for Information Technology Leadership Partners HealthCare System, Inc, 2007

This study examined several specific telemedicine applications and used a rigorous approach to define both costs and financial benefits to the nationwide implementation of each application. For the use of telemedicine to join emergency rooms - the cost to equip all US emergency departments with hybrid telehealth technologies could easily be covered by savings from a reduction in transfers between emergency departments. From a baseline of 2.2 million patients transported each year between emergency departments at a cost of \$1.39 billion in transportation costs, hybrid technologies would avoid 850,000 transports with a cost savings of \$537 million a year.

For the use of telemedicine in correctional facilities - Correctional facilities could cover their costs of hybrid telehealth equipment by savings from a reduction in transporting patients to emergency departments and to physician offices, and by avoiding the costs of the emergency department visit. From a baseline of 94,180 transports made annually from correctional facilities to emergency departments at a cost of \$158 million in transportation and visit costs, hybrid technologies could avoid almost 40,000 transports with a cost savings of \$60.3 million a year. Further, hybrid technologies could avoid visits to physician offices. From an annual baseline of 691,000 physician office visits at a cost of \$302 million, hybrid technologies could avoid 543,000 inmate transports with a cost savings of \$210 million.

For the use of telemedicine in nursing homes - the costs of implementing hybrid telehealth equipment in nursing homes could be covered by savings from a reduction in transferring residents to emergency departments and physician offices, and by avoiding the costs of the emergency department visit. From a baseline of 2.7 million transports made annually from nursing facilities to emergency departments at a cost of \$3.62 billion in current transportation and emergency department visit costs, hybrid technologies could avoid 387,000 transports with a cost savings of \$327 million. In addition, of the 10.1 million physician office visits made annually from nursing facilities at a cost of \$1.29 billion for in-person physician office visits and transportation, hybrid technologies could avoid 6.87 million transports with a cost savings of \$479 million.

#### **Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions**

Adam Darkins, Patricia Ryan, Rita Kobb, Linda Foster, Ellen Edmonson, Bonnie Wakefield, Anne E. Lancaster *Telemedicine and e-Health*. December 2008, 14(10): 1118-1126.

The Veterans Health Administration (VHA) introduced a national home telehealth program, Care Coordination/Home Telehealth (CCHT), in 2003 to coordinate the care of veteran patients with chronic conditions and avoid their unnecessary admission to long-term institutional care. CCHT patients increased from 2,000 to 31,570 (1,500% growth) between 2003 and 2007. CCHT is now a routine noninstitutional care (NIC) service provided by VHA to support veteran patients with chronic conditions as they age. Routine analysis of data obtained for quality and performance purposes from a cohort of 17,025 CCHT patients shows the benefits of a 25% reduction in numbers of bed days of care, 19% reduction in numbers of hospital admissions, and mean satisfaction score rating of 86% after enrollment into the program. These results demonstrate a dramatic reduction in costs and an equally dramatic increase in quality.

**A Systematic Review of the Key Indicators for Assessing Telehomecare Cost-Effectiveness** Stephanie Vergara Rojas, Marie-Pierre Gagnon. *Telemedicine and e-Health* November 1, 2008, 14(9): 896-904.doi:10.1089/tmj.2008.0009.

This careful review identified 5,219 reports on telehomecare published between 1997 and 2007. Of all these, 23 were appropriate for comparison of cost in various ways. Of these, 70% were in the United States, 15 of 23 were randomized control trials, and 48% were published between 2003 and 2007. Teleconsultation was about equal to telemonitoring in the services. Total cost, cost per patient, and cost per visit were all reduced by telehomecare. The report also concluded that standardization of cost outcomes should be implemented in order to help funding agencies better understand the importance of telehomecare.

**Economic Impact of eICU Implementation in an Academic Surgical ICU** Benjamin A Kohl, Frank D Sites, Jacob T Gutsche, Patrick Kim, Anesthesiology and Critical Care, University of Pennsylvania, Philadelphia, PA Crit Care Med. 2007;35(12):A26.

Introduction: We have recently shown an improvement in mortality and length of stay after implementing eICU (VISICU, Baltimore, MD) in a large academic surgical ICU. The purpose of this study is to measure the economic impact of this transition.

Hypothesis: Implementation of eICU in an academic surgical ICU, allowing round-the clock intensivist oversight, will decrease ICU and hospital costs.

Methods: We retrospectively compared a random sample of 189 patients pre-eICU to 2,622 patients 3 years post eICU using a multiplier of 13.87 to normalize populations. Assumptions based upon published literature include an average surgical ICU cost per day of \$1,500-\$2,000 and an average daily cost on a general floor of \$500-\$600. Because of the disparate sizes in populations a multiplier of 13.87 was used to standardize the numbers. There was no significant change in practice paradigm during the time period. APACHE III scores were used to calculate predicted length of stay in ICU and hospital.

Results: An almost 10% reduction in ICU stay and 20% reduction in floor stay occurred after implementation of eICU. This translated into a savings of \$706,272-\$941,697 for the ICU and \$2,134,339-\$2,842,940 for the floor.

Conclusions: Implementation of an eICU in an academic SICU resulted in significantly reduced costs.

**Cost-Utility Analysis of Telemedicine and Ophthalmoscopy for Retinopathy of Prematurity**

**Management** Kevin M. Jackson, OD, MPH; Karen E. Scott, MD, MBA; Joshua Graff Zivin, PhD; David A. Bateman, MD; John T. Flynn, MD; Jeremy D. Keenan, MD, MPH; Michael F. Chiang, MD Arch Ophthalmol. 2008; 126(4):493-499.

Objective To evaluate the cost-effectiveness of telemedicine and standard ophthalmoscopy for



retinopathy of prematurity (ROP) management.

Methods Models were developed to represent ROP examination and treatment using telemedicine and standard ophthalmoscopy. Cost-utility analysis was performed using decision analysis, evidence-based outcome data from published literature, and present value modeling. Visual outcome data were converted to patient preference-based time trade-off utility values based on published literature. Costs of disease management were determined based on 2006 Medicare reimbursements. Costs per quality adjusted life year gained by telemedicine and ophthalmoscopy for ROP management were compared. One-way sensitivity analysis was performed on the following variables: discount rate (0%-7%), incidence of treatment-requiring ROP (1%-20%), sensitivity and specificity of ophthalmoscopic diagnosis (75%-100%), percentage of readable telemedicine images (75%-100%), and sensitivity and specificity of telemedicine diagnosis (75%-100%).

Results For infants with birth weight less than 1500 g using a 3% discount rate for costs and outcomes, the costs per quality-adjusted life year gained were \$3193 with telemedicine and \$5617 with standard ophthalmoscopy. Sensitivity analysis resulted in ranges of costs per quality-adjusted life year from \$1235 to \$18 898 for telemedicine and from \$2171 to \$27 215 for ophthalmoscopy.

Conclusions: Telemedicine is more cost-effective than standard ophthalmoscopy for ROP management. Both strategies are highly cost-effective compared with other health care interventions.

#### **Can Telecommunications Help Solve America's Health Care Problems? Arthur D. Little, January 1993**

A.D. Little conducted a study to assess the cost reductions associated with four telemedicine applications. The study concluded that the use of videoconferencing for professional training and remote medical consultations will reduce costs by more than \$200 million. While this early study did not include the cost associated with implementation of the applications the results are illustrative of the size and scope of potential for the use of telemedicine nationally.

#### **TELEMEDICINE AND QUALITY OF CARE**

The current and recent past peer reviewed scientific literature includes many studies indicating that there is no difference in the ability of the provider to obtain clinical information, make an accurate diagnosis, and develop a treatment plan that produces the same desired clinical outcomes as compared to in-person care when used appropriately. The peer reviewed *Journal of Telemedicine and e-Health* is full of empirically grounded studies that conclude diagnostic accuracy and the ability to treat and produce evidenced based outcomes via telemedicine is no different than in-person care. Many other peer reviewed medical journals indicate the same results from empirical studies. A few are listed below:

#### **Home-based telehealth: a review and meta analysis Dellifrairie JL, Dansky KH. J Telemed Telecare. 2008;14(2):62-6**

Department of Health Policy and Administration, The Pennsylvania State University, Pennsylvania 16802, USA. We conducted a systematic review to identify studies on the effect of home telehealth on clinical care outcomes. The search was restricted to peer-reviewed publications (published between 2001 and 2007) about studies conducted in home or residential settings. The search yielded 154 potential articles and dissertations. A total of 29 articles met the inclusion criteria and were included in a meta-analysis. The weighted mean effect size for the overall meta-analysis was 0.50, and the z-statistic was 3.0, indicating that telehealth had a moderate, positive and significant effect ( $P < \text{or} = 0.01$ ) on clinical outcomes. Sub-analyses also indicated positive significant effects of telehealth for some disease categories (heart disease and psychiatric conditions), but not others (diabetes), patient populations and telehealth interventions. Overall, the meta-analysis indicated that telehealth positively affects clinical outcomes of care, even in different patient populations.

**Janca, 2000. Telepsychiatry: an update on technology and its implications. *Curr Op in Psych* 13: 591-7.**

This study/article concluded that even “early research demonstrated that the psychiatric interview conducted over videoconferencing is reliable for diagnostic assessment and treatment recommendations.” In addition, a retrospective review of medical records comparing clinical outcomes of patients seen by [interactive TV] (IATV) and those in-person showed no significant difference found in the percentage of change in Global Assessment of Functioning (GAF) between the two groups suggesting clinical outcomes were not affected by the use of IATV.

**Young TL, Ireson C. Effectiveness of school-based telehealth care in urban and rural elementary schools. *Pediatrics*. 2003 Nov;112(5):1088-94.**

Telehealth technology was effective in delivering pediatric acute care to children in [these] schools. Pediatric providers, nurses, parents, and children reported primary care school-based telehealth as an acceptable alternative to traditional health care delivery systems.

**Leggett PF, Graham L, Steele K, Gilliland A, Stevenson M, O'Reilly D, Wootton R, and Taggart A (Sep 2001) Telerheumatology: Diagnostic accuracy and acceptability to patient, specialist, and general practitioner. *British Journal of General Practice* 51(470) : 746-8.**

This study examines the diagnostic accuracy and acceptability of telemedicine in the field of rheumatology. One hundred patients had a telephone and televisual consultation and the results were compared with a face-to-face consultation. While the telephone consultations were often unsatisfactory, the televisual consultations were highly accurate (97%) and acceptable to patients, general practitioners, and specialists.

**Loane, M.A., Corbett, R., Bloomer, S.E., Eedy, D.J., Gore, H.E., Mathews, C., Steele, K., and Wootton, R. *Journal of Telemedicine and Telecare* 4(2): 95-100.**

**Diagnostic accuracy and clinical management by real-time teledermatology: results from the Northern Ireland arms of the UK Multicentre Teledermatology Trial (1998).**

The results indicate that a high proportion of dermatological conditions can be successfully managed by real-time teledermatology.

**Jerant AF, Azari R, Martinez C, Nesbitt TS. A randomized trial of telenursing to reduce hospitalization for heart failure: patient-centered outcomes and nursing indicators. *Home Health Care Serv Q*. 2003;22(1):1-20.**

Patient self-care adherence, medications, health status, and satisfaction did not significantly differ between groups. Telenursing can reduce CHF hospitalizations and allow increased frequency of communication with patients.

**Belmont JM, Mattioli LF. Accuracy of analog telephonic stethoscopy for pediatric telecardiology. *Pediatrics*. 2003 Oct;112(4):780-6**

In pediatric patients, a narrow-bandwidth telephonic stethoscope can accurately distinguish between functional and organic murmurs and thus can detect heart disease. Accuracy is greatest when the instrument is used by an experienced examiner with patients at least 5 years of age.

**Ermer D.J., 1999. Child and adolescent telepsychiatry clinics. *Psych Services* Jul 29(7): 409-14.**

This study concluded that severely disturbed children can be adequately assessed and treated, the range of expressed emotion and the quality of clinical interaction appear similar in TelePsychiatry and [inperson] interactions, and children in crisis can be safely assessed and treated [via telepsychiatry].

**Arizona telepsychiatry project gains national attention, patient approval, 1998. *Mental Health Weekly*, Jan 19, 8(3): 4.**

Main purpose of the project was to facilitate mental health in the region with the use of telehealth technology – role of simplifying case management and prior authorization. Program instituted by the Northern Arizona Regional Behavioral Health Authority.

**Craig J, et. al. 2000. The cost-effectiveness of teleneurology consultations for patients admitted to hospitals without neurologists on site. *Journ of Telemedicine and Telecare* 6 (suppl 1): S1: 46-9.**

Comparison of outcomes of patients admitted to two small. One hospital received neurological services by telehealth, the other in-person. Neurological services were provided via Telemedicine. Comparing case-mix, process of management, and outcomes for all patients using ICD-10 codes with a final diagnosis of neurological condition there were no appreciable differences noted between the clinical outcomes and the length of stay between patients receiving services in-person and those who received services via telehealth.

Warsi A et. al, *Arch of Int Med*, Vol 164, Aug 9.23, p. 1641-1649

A systematic review and methodological critique of the literature done by Warsi et. al. (2004) provided insight into self-management programs and the efficacy of patient self-management education for chronic disease. Seventy-one trials of self-management education were included in the analysis. In the study, diabetic patients involved with self-management education programs demonstrated reductions in HbA1c levels, and improvements in systolic blood pressure. Another study conducted at Johns Hopkins University by Gary et. al., (2003), indicated that educational and behavioral modification programs in type 2 diabetes produced modest improvements in glycemic control and weight (Gary et al. *The Diabetes Educator*, Vol 29, No 3, 488-501, 2003).

Dimmick et. al. *Telemed Journal and e-Health*, 9(1): 13-23

Dimmick et. al. (2003) conducted a study of patients receiving care over a telemedicine network that linked three hospitals and an FQHC with six sites, a dental clinic, and patient homes. Outcomes from the disease management programs conducted over telemedicine for the diabetes group showed that the diabetes disease management program increased the number of diabetics who brought their blood sugar under control.

## **PATIENT SATISFACTION WITH TELEMEDICINE**

Patient satisfaction with the use of telemedicine to access care and the use of telecommunications technologies to connect with specialists and other health care providers in order to meet unmet medical needs has always been very high. Degrees of satisfaction may vary slightly with the specialty accessed through telemedicine, but overall satisfaction remains high. The source of satisfaction for most patients is the ability to see a specialist trained in the area most closely related to the patient's condition, the feeling of getting personalized care from a provider who has the patient's interest in mind, and the ability to communicate with the provider in a very personal and intimate manner over the telecommunications technologies. The current peer reviewed literature on patient satisfaction with accessing health care via telecommunications technologies including interactive video over high and low bandwidths, store-and-forward teleconsultations, remote monitoring, and telephone consultations should undisputable evidence that patients are very satisfied with care provided via telecommunications technologies. A few of the peer reviewed scientific studies are listed below:

**Gustke, S.S., Balch, D.C., West, V.L., and Rogers, L.O. 2000. Patient satisfaction with telemedicine. *Telemedicine Journal* Spring 6(1): 5-13.**

Patient satisfaction was examined in relation to patient age, gender, race, income, education, and insurance. Overall patient satisfaction was found to be 98.3%.

**Janca, 2000. Telepsychiatry: an update on technology and its implications. *Curr Op in Psych* 13: 591-7.**

In this study, results indicated that “most consumers found that a video link with a psychiatrist moderately or greatly helped them in managing their treatment, with 98% of the preferring to be offered videoconferencing in combination with local services.”

**Brodey et al, 2000. Satisfaction of forensic psychiatry patients with remote telepsychiatric evaluation. *Psych Services: Oct* 51(10): 1305-7.**

This study indicated that satisfaction did not differ significantly between video and in-person consultations for incarcerated patients.