

Physician Attitudes About Veterans Affairs Video Connect Encounters

Marco Proano, MD^a; Eyerusalem Akpan, MD^{a,b}; Kimberly Reiter, MD^b; Vimla L. Patel, PhD^c; Vishal Vashistha, MD^{d,e}

Background: The US Department of Veterans Affairs (VA) launched the VA Video Connect (VVC) video conferencing platform to connect veterans with VA clinicians in 2018. We assessed practices, concerns, and perceptions toward VVC encounters among physicians within the VA New Mexico Healthcare System (VANMHCS).

Methods: Medicine Service Physicians of VANMHCS who had previously completed ≥ 1 VVC encounter were invited to semistructured interviews. Questions were constructed to assess the following domains: overarching views of video telehealth, perceptions of the VVC application, and barriers to the broad implementation of video telehealth. Interviews were assessed using a qualitative, open-coding approach. Themes were constructed both deductively, through direct responses to interview questions, and inductively, by identifying emerging patterns in the data.

Results: Of the 64 physicians invited to participate, 13 (20%) were

interviewed. Of those interviewed, 9 (69%) were female, 10 (77%) were specialists, 8 (62%) had been practicing for ≥ 10 years, and 7 (54%) completed ≥ 5 VVC visits. Interviews ranged from 10 to 25 minutes. Five themes were observed: (1) VVC software and internet connection issues affected implementation; (2) patient technological literacy affected both veteran and physician comfort with VVC; (3) integration of supportive measures is desired; (4) clinical video telehealth (CVT) services may increasingly enhance access to care; and (5) in-person encounters provided unique advantages over CVT.

Conclusions: Physicians believe VVC could lead to improved access to care for veterans facing geographical challenges. Efforts should focus on improving VVC user interface and addressing technological issues, educating veterans/physicians on the use of CVT, and integrating supportive measures for successful VVC encounters.

Author affiliations can be found at the end of this article.

Correspondence:

Marco Proano
(marcolproano@gmail.com)

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Prior to the COVID-19 pandemic, health care systems had been increasingly focused on expanding care delivery through clinical video telehealth (CVT) services.¹⁻³ These modalities offer clinicians and patients opportunities to interact without needing face-to-face visits. CVT services offer significant advantages to patients who encounter challenges accessing traditional face-to-face services, including those living in rural or underserved areas, individuals with mobility limitations, and those with difficulty attending appointments due to work or caregiving commitments.⁴ The COVID-19 pandemic accelerated the expansion of CVT services to mitigate the spread of the virus.¹

Despite its evident advantages, widespread adoption of CVT has encountered resistance.² Physicians have frequently expressed concerns about the reliability and functionality of CVT platforms for scheduled encounters and frustration with inadequate training.⁴⁻⁶ Additionally, there is a lack of trust in the technology, as physicians are unfamiliar with reimbursement or workload capture associated with CVT. Physicians have concerns that telecommunication may diminish the intangible aspects of the “art of medicine.”⁴ As a

result, the implementation of telehealth services has been inconsistent, with successful adoption limited to specific medical and surgical specialties.⁴ Only recently have entire departments within major health care systems expressed interest in providing comprehensive CVT services in response to the challenges posed by the COVID-19 pandemic.⁴

The Veterans Health Administration (VHA) of the US Department of Veterans Affairs (VA) provides an appropriate setting for assessing clinician perceptions of telehealth services. Since 2003, the VHA has significantly expanded CVT services to eligible veterans and has used the VA Video Connect (VVC) platform since 2018.⁷⁻¹⁰ Through VVC, VA staff and clinicians may schedule video visits with patients, meet with patients through virtual face-to-face interaction, and share relevant laboratory results and imaging through screen sharing. Prior research has shown increased accessibility to care through VVC. For example, a single-site study demonstrated that VVC implementation for delivering psychotherapies significantly increased CVT encounters from 15% to 85% among veterans with anxiety and/or depression.¹¹

The VA New Mexico Healthcare System (VANMHCS) serves a high volume

of veterans living in remote and rural regions and significantly increased its use of CVT during the COVID-19 pandemic to reduce in-person visits. Expectedly, this was met with a variety of challenges. Herein, we sought to assess physician perspectives, concerns, and attitudes toward VVC via semistructured interviews. Our hypothesis was that VA physicians may feel uncomfortable with video encounters but recognize the growing importance of such practices providing specialty care to veterans in rural areas.

METHODS

A semistructured interview protocol was created following discussions with physicians from the VANMHCS Medicine Service. Questions were constructed to assess the following domains: overarching views of video telehealth, perceptions of various applications for conducting VVC encounters, and barriers to the broad implementation of video telehealth. A qualitative investigation specialist aided with question development. Two pilot interviews were conducted prior to performing the interviews with the recruited participants to evaluate the quality and delivery of questions.

All VANMHCS physicians who provided outpatient care within the Department of Medicine and had completed ≥ 1 VVC encounter were eligible to participate. Invitations were disseminated via email, and follow-up emails to encourage participation were sent periodically for 2 months following the initial request. Union approval was obtained to interview employees for a research study. In total, 64 physicians were invited and 13 (20%) chose to participate. As the study did not involve assessing medical interventions among patients, a waiver of informed consent was granted by the VANMHCS Institutional Review Board. Physicians who participated in this study were informed that their responses would be used for reporting purposes and could be rescinded at any time.

Data Analysis

Semistructured interviews were conducted by a single interviewer and recorded using Microsoft Teams. The interviews took place between February 2021 and December 2021

TABLE. Interviewee Demographics (N = 13)

Characteristic	No. (%)
Sex	
Male	4 (31)
Female	9 (69)
Specialty	
Cardiology	1 (8)
Endocrinology	1 (8)
Hematology	1 (8)
Infectious disease	1 (8)
Internal medicine/primary care	3 (23)
Nephrology	2 (15)
Palliative care	1 (8)
Critical care	1 (8)
Pulmonary	1 (8)
Sleep medicine	1 (8)
Time in practice	
1 to 9 y	5 (38)
10 to 19 y	3 (23)
≥ 20 y	5 (38)
Video visits completed, No.	
1–4	6 (46)
5–20	4 (31)
21–49	2 (15)
≥ 50	1 (8)

and lasted 5 to 15 minutes, with a mean duration of 9 minutes. Verbal informed consent was obtained from all participants before the interviews. Interviewees were encouraged to expand on their responses to structured questions by recounting past experiences with VVC. Recorded audio was additionally transcribed via Microsoft Teams, and the research team reviewed the transcriptions to ensure accuracy.

The tracking and coding of responses to interview questions were conducted using Microsoft Excel. Initially, 5 transcripts were reviewed and responses were assessed by 2 study team members through open coding. All team members examined the 5 coded transcripts to identify differences and reach a consensus for any discrepancies. Based on recommendations from all team members regarding nuanced excerpts of transcripts, 1 study team member coded the remaining interviews. Thematic analysis was subsequently conducted according to the method described by Braun and Clarke.¹² Themes were developed both deductively and inductively by reviewing the direct responses to interview

questions and identifying emerging patterns of data, respectively. Indicative quotes representing each theme were carefully chosen for reporting.

RESULTS

Thirteen interviews were conducted and 9 participants (69%) were female. Participating physicians included 3 internal medicine/primary care physicians (23%), 2 nephrologists (15%), and 1 (8%) from cardiology, endocrinology, hematology, infectious diseases, palliative care, critical care, pulmonology, and sleep medicine. Years of posttraining experience among physicians ranged from 1 to 9 years ($n = 5$, 38%), 10 to 19 years ($n = 3$, 23%), and ≥ 20 years ($n = 5$, 38%). Seven participants (54%) had conducted ≥ 5 VVC visits, with 1 physician completing > 50 video visits (Table).

Using open coding and a deductive approach to thematic analysis, 5 themes were identified: (1) VVC software and internet connection issues affected implementation; (2) patient technological literacy affected veteran and physician comfort with VVC; (3) integration of supportive measures was desired; (4) CVT services may increasingly be used to enhance access to care; and (5) in-person encounters afforded unique advantages over CVT. Illustrative quotes from physicians that reflect these themes can be found in the Appendix.

Theme 1: VVC software and internet connection issues affected its implementation. Most participants expressed concern about the technical challenges with VVC. Interviewees cited inconsistencies for both patients and physicians receiving emails with links to join VVC visits, which should be generated when appointments are scheduled. Some physicians were unaware of scheduled VVC visits until the day of the appointment and only received the link via email. Such issues appeared to occur regardless whether the physicians or support staff scheduled the encounter. Poor video and audio quality was also cited as significant barriers to successful VVC visits and were often not resolvable through troubleshooting efforts by physicians, patients, or support personnel. Given the limited time allotted to each patient encounter,

such issues could significantly impact the physician's ability to remain on schedule. Moreover, connectivity problems led to significant lapses, delays in audio and video transmission, and complete disconnections from the VVC encounter. This was a significant concern for participants, given the rural nature of New Mexico and the large geographical gaps in internet service throughout the state.

Theme 2: Patient technological literacy affected veteran and physician comfort with VVC. Successful VVC appointments require high-speed Internet and compatible hardware. Physicians indicated that some patients reported difficulties with critical steps in the process, such as logging into the VVC platform or ensuring their microphones and cameras were active. Physicians also expressed concern about older veterans' ability to utilize electronic devices, noting they may generally be less technology savvy. Additionally, physicians reported that despite offering the option of a virtual visit, many veterans preferred in-person visits, regardless of the drive time required. This appeared related to a fear of using the technology, which led veterans to believe that virtual visits do not provide the same quality of care as in-person visits.

Theme 3: Integration of supportive measures is desired. Interviewees felt that integrated VVC technical assistance and technology literacy education were imperative. First, training the patient or the patient's caregiver on how to complete a VVC encounter using the preferred device and the VVC platform would be beneficial. Second, education to inform physicians about common troubleshooting issues could help streamline VVC encounters. Third, managing a VVC encounter similarly to standard in-person visits could allow for better patient and physician experience. For example, physicians suggested that a medical assistant or a nurse triage the patient, take vital signs, and set them up in a room, potentially at a regional VA community-based outpatient clinic. Such efforts would also allow patients to receive specialty care in remote areas where only primary care is generally offered. Support staff could assist

with technological issues, such as setting up the VVC encounter and addressing potential problems before the physician joins the encounter, thereby preventing delays in patient care. Finally, physicians felt that designating a day solely for CVT visits would help prevent disruption in care with in-person visits.

Theme 4: CVT services may increasingly be used to enhance access to care. Physicians felt that VVC would help patients encountering obstacles in accessing conventional in-person services, including patients in rural and underserved areas, with disabilities, or with scheduling challenges.⁴ Patients with chronic conditions might drive the use of virtual visits, as many of these patients are already accustomed to remote medical monitoring. Data from devices such as scales and continuous glucose monitors can be easily reviewed during VVC visits. Second, video encounters facilitate closer monitoring that some patients might otherwise skip due to significant travel barriers, especially in a rural state like New Mexico. Lastly, VVC may be more efficient than in-person visits as they eliminate the need for lengthy parking, checking in, and checking out processes. Thus, if technological issues are resolved, a typical physician's day in the clinic may be more efficient with virtual visits.

Theme 5: In-person encounters afforded unique advantages over CVT. Some physicians felt in-person visits still offer unique advantages. They opined that the selection of appropriate candidates for CVT is critical. Patients requiring a physical examination should be scheduled for in-person visits. For example, patients with advanced chronic kidney disease who require accurate volume status assessment or patients who have recently undergone surgery and need detailed wound inspection should be seen in the clinic. In-person visits may also be preferable for patients with recurrent admissions, or those whose condition is difficult to assess; accurate assessments of such patients may help prevent readmissions. Finally, many patients are more comfortable and satisfied with in-person visits, which are perceived as a

more standard or traditional process. Respondents noted that some patients felt physicians may not focus as much attention during a VVC visit as they do during in-person visits. There were also concerns that some patients feel more motivation to come to in-person visits, as they see the VA as a place to interact with other veterans and staff with whom they are familiar and comfortable.

DISCUSSION

We conducted interviews among VAN-MHCS physicians, which serves veterans across an expansive territory ranging from Southern Colorado to West Texas. About 4.6 million veterans reside in rural regions, constituting roughly 25% of the total veteran population, a pattern mirrored in New Mexico.¹³ Medicine Service physicians agreed on a number of themes: VVC user-interface issues may affect its use and effectiveness, technological literacy was important for both patients and health care staff, technical support staff roles before and during VVC visits should be standardized, CVT is likely to increase health care delivery, and in-person encounters are preferred for many patients.

This is the first study to qualitatively evaluate a diverse group of physicians at a VA medical center incorporating CVT services across specialties. A few related qualitative studies have been conducted external to VHA, generally evaluating clinicians within a single specialty. Kalicki and colleagues surveyed 16 physicians working at a large home-based primary care program in New York City between April and June 2020 to identify and explore barriers to telehealth among homebound older adults. Similarly to our study, physicians noted that many patients required assistance (family members or caregivers) with the visit, either due to technological literacy issues or medical conditions like dementia.¹⁴

Heyer and colleagues surveyed 29 oncologists at an urban academic center prior to the COVID-19 pandemic. Similar to our observations, the oncologists said telemedicine helped eliminate travel as a barrier to health care. Heyer and colleagues noted difficulty for oncologists in performing virtual physical examinations,

despite training. This group did note the benefits when being selective as to which clinical issues they would handle virtually vs in person.¹⁵

Budhwani and colleagues reported that mental health professionals in an academic setting cited difficulty establishing therapeutic relationships via telehealth and felt that this affected quality of care.¹⁶ While this was not a topic during our interviews, it is reasonable to question how potentially missed nonverbal cues may impact patient assessments.

Notably, technological issues were common among all reviewed studies. These ranged from internet connectivity issues to necessary electronic devices. As mentioned, these barriers are more prevalent in rural states like New Mexico.

Limitations

All participants in this study were Medicine Service physicians of a single VA health care system, which may limit generalizability. Many of our respondents were female (69%), compared with 39.2% of active internal medicine physicians and therefore may not be representative.¹⁷ Nearly one-half of our participants only completed 1 to 4 VVC encounters, which may have contributed to the emergence of a common theme regarding technological issues. Physicians with more experience with CVT services may be more skilled at troubleshooting technological issues that arise during visits.

CONCLUSIONS

Our study, conducted with VANMHCS physicians, illuminated 5 key themes influencing the use and implementation of video encounters: technological issues, technological literacy, a desire for integrated support measures, perceived future growth of video telehealth, and the unique advantages of in-person visits. Addressing technological barriers and providing more extensive training may streamline CVT use. However, it is vital to recognize the unique benefits of in-person visits and consider the benefits of each modality along with patient preferences when selecting the best care venue. As health care evolves, better understanding and acting upon these

themes will optimize telehealth services, particularly in rural areas. Future research should involve patients and other health care team members to further explore strategies for effective CVT service integration.

Author affiliations

^aUniversity of New Mexico Health Sciences Center, Albuquerque

^bRaymond G. Murphy New Mexico Veterans Affairs Medical Center, Albuquerque

^cThe New York Academy of Medicine, New York City

^dIowa City Veterans Affairs Medical Center, Iowa

^eUniversity of Iowa Hospital and Clinics, Iowa City

Author disclosures

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Ethics and consent

This article was not reviewed by an institutional review board.

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APPENDIX. Physicians Feedback and Survey Responses

Theme	Quote
VVC software and internet connection issues affected implementation	<p>Internist/primary care practitioner practicing 1-9 y with 21-49 video visits: "[The scheduling] is terrible. Firstly, a patient can schedule themselves a video visit. However, they...can't generate themselves a video link...We don't get notified that they need a link so we don't know until we just happen to look at their appointment, either because it's time, [we're charting,] or because they have a question. That's problem No. 1. Problem No. 2 is when our own staff scheduled him. They don't often...get a video visit link. [But] even if they generate the link, neither the residents or I [get] copy of [the link]... There's no plan."</p> <p>Pulmonologist practicing 10-19 y with 1-4 video visits: "Doximity was a lot easier...the main reason for this was that Doximity sent the patient a text message...[which send them a link] on their phone. [If they click it,] it will automatically bring up the video. So I had much more success with doximity, but that's just because patients were having difficulty getting their email on the device...being used for the visit."</p> <p>Hematologist practicing ≥ 20 y with 1-4 video visits: "There were...technical issues in having sound...in spite of help from the experts who set up this system...Whether this was a problem on my end or on the patients, I don't know."</p> <p>Palliative care physician practicing 1-9 y with 1-4 video visits: "[When I am having technical issues,] I'll usually end up spending about 15 to 20 minutes. It's completely inefficient. And then I have to convert...to a telephone call and...get our scheduler to convert the visit to a telephone visit so that it can bill appropriately and document that note. So I can't start documenting while I'm talking to them...[because] it'll mess up the billing."</p> <p>Internist/primary care practitioner practicing 1-9 y with 5-20 video visits: "Some patients...live...in rural areas and they don't have either internet connection or a device to use."</p>
Patient technological literacy affected veteran and clinician comfort with VVC	<p>Endocrinologist, practicing 1-9 y with ≥ 50 video visits: "[Barriers that I faced when completing virtual care manager visits are the] technical aspects on patients for sure. The assumption that patients know how to even log in or turn the camera on or the microphone is not always true."</p> <p>Cardiologist practicing ≥ 20 y with 21-49 video visits: "The biggest problem I run into is the veterans not being able to access the video...They get an iPad. They only use it once every couple of months...They forget the password to get in...and they can't get into virtual care manager or if they're using the computer they have the same issues."</p> <p>Internist/primary care practitioner practicing 1-9 y with 5-20 video visits: "I've had several [visits] where I had to convert to [phone] visits because the patient had the iPad and I wasn't familiar enough with the iPad to walk them through...for setting it up or getting the video to work."</p> <p>Palliative care physician practicing 1-9 y with 1-4 video visits: "We're offering [virtual visits] and a lot of them don't want to try it...That's really important that the VA is offering a choice. I don't know what it might take to help them get over the fear of using the technology or whatever, but that's definitely an issue."</p> <p>Internist/primary care practitioner practicing 1-9 y with 5-20 video visits: "I think there are 2 main barriers limiting implementation of video care manager that I have noted. The first is...that not all of my patients are able to maximize the use of whatever smart device they currently have. The second barrier, is this overall perception [by patient] that a televisit does not provide the same quality of care as an in-person visit."</p>

3. Integration of supportive measures is desired	<p>Nephrologist practicing 10-19 y with 5-20 video visits: "I wish that there was a way...that if a veteran is really interested...[the patient or their caretaker] could have some sort of training on how to log in or things like that. I think because I have select patients that I routinely use [virtual visits] on. They know how to use it but there are patients that still have difficulty even after I walked him through it. So maybe having some sort of like pictures...to walk them through, [or] like a piece of paper instructions to give them."</p> <p>Palliative care physician practicing 1-9 y with 1-4 video visits: "More training on our end of how to resolve things that are happening, like a frequently encountered issue or platform use."</p> <p>Internist/primary care practitioner practicing ≥ 20 y with 5-20 video visits: "Figuring out the communication of a video visit [is difficult]. Some get an email way in advance but how do you keep track of that? A reminder system the day before so you know these are your video visits [would be helpful]. What would be ideal would be to have a screen [with all the telehealth visits] or start the visit and then transfer it over to [the clinician] similar to how they would screen an in person visit [with] somebody to assist me."</p> <p>Infectiologist practicing 10-19 years with 1-4 video visits: "[To utilize virtual care manager more frequently] it's going to require...a nurse or MA...virtually [setting up] the patient so that the doctor is not sitting there trying to figure out the technology or help the patient figure out the technology and then wasting...time and making clinic inefficient. I think that would be the only way that it could work and that's how we did it at Kaiser...The nurse or the MA virtually room the patient and have them ready ahead of time."</p> <p>Nephrologist practicing 1-9 y with 1-4 video visits: "I deliberately schedule any telehealth on a separate day from my face-to-face clinic days so it doesn't disrupt my clinic days when I have face to face [appointments]."</p>
4. CVT Services may increasingly be used to enhance access to care	<p>Endocrinologist practicing 1-9 y with ≥ 50 video visits: "[Certain] patients are a good fit for video visits, especially patients living with diabetes and if they use technologies like insulin pumps."</p> <p>Internist/primary care practitioner practicing 1-9 y with 21-49 video visits: "[Video care manager is] most beneficial [for]... people who live far away. . . We have [VA patients], all over the state who need frequent care, but often are short checked...Like the heart failure patient who we need to know their weight in a week...Diabetics, who need insulin adjustment, hypertensive [patients] with med adjustment. Then, the acute care [visits where] something has happened, and they just need to check and see like do I need to come in or can this be dealt with [virtually]. So, I would say those quick turnover type."</p> <p>Palliative care physician practicing 1-9 y with 1-4 video visits: "Virtual visits for palliative care is pretty ideal in general because a lot of our visits are more having conversations with them about their goals... values... and wishes.... A lot of times our patients are really sick or it's really hard for them to physically get into the hospital."</p> <p>Pulmonologist/intensivist practicing 1-9 y with 1-4 video visits: "I think it's helpful for people who may not be able to come into the hospital. . .due to transportation issues or medical issues. I think it's also good for New Mexico in particular because it's such a rural state and we cover such a broad geographic area."</p> <p>Internist/primary care practitioner practicing 1-9 y with 5-20 video visits: "Video... has been... a little bit more efficient than... in person because the video visit allows for basically just the encounter to end vs [when] in-person you have to... account for the time the patient is going to get up, put their coat on and then leave. Video visits really allow you to kind of just optimize the actual provider patient time."</p>
5. In-person encounters afforded unique advantages over CVT	<p>Nephrologist, practicing 1-9 y with 1-4 video visits: "[Patients with] more advanced chronic kidney disease like Stage 5. They probably would not do well with video connect because you have to examine them. . .each visit."</p> <p>Somnologist practicing ≥ 20 y with 5-20 video visits: "If I was a surgeon. . .being able to look at the wound and see that it is healing properly might be a good thing. But for [somnologists], having the video component [compared to phone visits have] really had no added value in terms of what we do clinically."</p> <p>Cardiologist practicing ≥ 20 y with 21-49 video visits: "There are those times that I just have to see [my patients] in person. It can't all be done over the phone because patients will tell me one thing and when you get him in the office it's completely different than what they've [told you previously]."</p> <p>Nephrologist practicing 1-9 y with 1-4 video visits: "[Many older veterans have] distrust of [video] technology. Another thing is that some of these veterans still believe in face-to-face care because that's how they communicate. . .So they don't like. . .virtual care as much because they feel like you are not paying attention compared to if they were in the room with you."</p> <p>Infectious disease specialist practicing 10-19 y with 1-4 video visits: "A barrier (limiting the implementation of video care manager) to a small extent, is that a lot of patients actually like to come in and be physically seen. I think for the veterans it's kind of. . .a social event for them to come up here and talk with other veterans."</p>

Abbreviations: CVT, clinical video telehealth; MA, medical assistant; VA, US Department of Veterans Affairs; VVC, VA Video Connect.