MDINTEGRATIONS

2026 Report

The State of DTC Telehealth

The Systems Behind Sustainable Virtual Care

Why demand is no longer the limiting factor, and what shapes scalability

Letter from the CEO

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CEO & Founder MD Integrations

Demand is no longer the primary constraint in direct-to-consumer ("DTC") telehealth. What increasingly determines whether programs scale is how care is executed once demand arrives.

Across specialties, patients are engaging consistently and often outside traditional clinic hours. Clinicians are practicing nationally. Follow-up care now represents a meaningful share of volume. Virtual care has moved beyond experimentation into a durable access layer within the healthcare system.

As this shift takes hold, the sources of friction have changed. Awareness and adoption are no longer the dominant challenges. Instead, scalability is shaped by structural realities: how clearly patients are guided into care, how clinician workflows preserve judgment at volume, how multi-state operations remain coherent, and how continuity is supported as care becomes ongoing rather than episodic.

This report offers a grounded view of DTC telehealth in 2026, based on what can be directly observed at the clinical and operational layer. Through a set of aggregated and anonymized data, it examines how patient behavior, intake workflows, clinician capacity, licensure depth, asynchronous coordination, and implementation choices interact as programs mature.

The findings do not rank platforms or predict winners. They surface the operational signals that increasingly determine whether virtual care programs can sustain quality, consistency, and trust at scale.

Taken together, these signals point to a clear conclusion: the next phase of DTC telehealth will be defined less by generating demand and more by executing reliably once demand is present. Programs designed for clarity, predictability, and continuity are better positioned to endure as virtual care becomes a permanent part of the healthcare landscape.

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Section 1

Introduction

For much of the last decade, telehealth was evaluated on whether it could expand access.

Virtual care reduced friction in obvious ways: after-hours coverage, faster consultations, and alternatives to long waits or limited specialist availability. These early models proved that patients would engage and that clinicians could deliver care remotely.

That phase of the market is largely behind us.

Across the programs observed in this report, indexed consult activity increased more than sixfold between late 2022 and the end of 2025, reflecting sustained growth rather than episodic adoption. This growth provides a useful lens for examining how virtual care systems behave once scale is no longer theoretical.

As specialty virtual care becomes commonplace, the question has shifted from *whether* patients will engage to *how care delivery holds up once engagement becomes consistent*. Volume exposes weaknesses that early traction often masks. What works at launch does not always scale cleanly.

This shift changes what it means to succeed in DTC telehealth. Speed to launch still matters, but durability increasingly depends on execution: how patients are guided into care before clinical review, how clinician workflows support judgment under load, how programs operate across jurisdictions, and how continuity is handled as care becomes ongoing rather than episodic.

Supporting physician-led care across specialties and states places MD Integrations at the clinical and operational layer where these dynamics are most visible. From this vantage point, it is possible to observe not just adoption, but behavior: when patients seek care, how clinicians work, where friction appears, and which structural choices enable programs to sustain scale.

The sections that follow examine these patterns as they appear in practice, not as theory, but as operational reality.

Section 2

Market Context

Key Forces Shaping Specialty Virtual Care

The signals surfaced in this report do not exist in isolation. They reflect broader shifts in how care is accessed, delivered, and regulated across the healthcare system.

Over the past several years, digital health has moved beyond general-purpose telehealth toward more specialty-focused virtual care models. Patients increasingly seek services that address specific clinical needs while reducing friction inherent in traditional care pathways, including long wait times, limited specialist availability, geographic inconsistency, and schedules that do not align with daily life.

This evolution is not driven by novelty. It reflects structural changes in access, expectations, and care delivery that continue to reshape how and when care is sought.

Demand is consolidating around use cases with structural fit

Across the digital health landscape, demand has increasingly concentrated in areas where virtual care offers durable advantages: conditions with predictable diagnostic inputs, recurring management needs, or access barriers that discourage in-person care.

In these contexts, virtual care functions less as a substitute for office visits and more as a practical entry point into the healthcare system. As these use cases mature, expectations shift away from convenience alone toward consistency, clinical rigor, and continuity.

Access constraints remain persistent

Workforce shortages, specialist bottlenecks, and uneven geographic distribution continue to shape care-seeking behavior. These constraints are compounded by work schedules, family obligations, and the reality that symptoms often arise outside traditional clinic availability.

Virtual care adoption reflects these pressures. It expands access where in-person models struggle to scale, rather than merely offering an alternative channel.

Regulatory expectations are converging

As virtual care expands, regulatory oversight has become more defined. Across jurisdictions, expectations increasingly emphasize documentation quality, appropriate clinical inputs, physician involvement in decision-making, and license-based routing of care.

While requirements vary by state, the directional trend is consistent: virtual care is expected to meet the same standards of safety, accountability, and clinical rigor as in-person care.

Why this moment matters

What distinguishes the current moment is not demand alone, but visibility. Multi-state physician networks, maturing workflows, and refined operating models now make it possible to observe how virtual care performs once programs reach meaningful scale.

The sections that follow examine how these forces manifest in practice, not as theory, but through observed patient behavior, clinician workflows, and operational design at the clinical infrastructure layer.

Section 3

How Virtual Care Is Actually Being Used

Behavioral Patterns, not Demographics, are the Clearest Signal in Today's DTC Telehealth Landscape

Patients are not using virtual care as a one-to-one substitute for traditional office visits. They are using it to access care in moments where in-person care is difficult, inefficient, or simply unavailable.

Across specialties, engagement concentrates in the margins of the day and week, after traditional work hours, following weekends, and during short windows of high intent that would be impractical to accommodate through scheduled, in-person appointments.

Mobile devices dominate access, reflecting how virtual care fits into daily life rather than being planned around it.

This pattern highlights a structural shift: virtual care is not replacing the doctor's office. It is creating access points that didn't previously exist.

Day of Week

+33%

more patient encounters on Monday and Tuesday compared to averages for Saturday and Sunday

Time of Day

10:00 AM – **4:00** PM

when most patient encounters begin (CST)

Section 3

How Virtual Care Is Actually Being Used

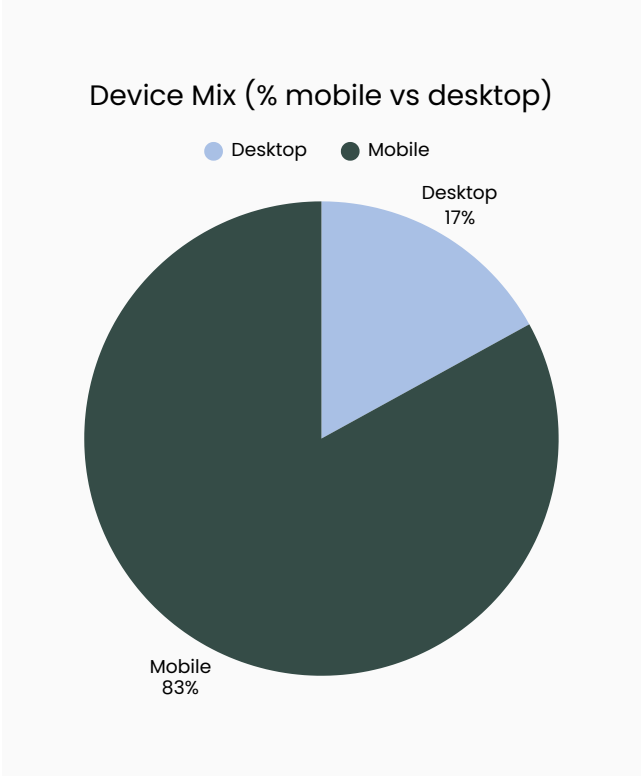
When patients engage matters more than who they are

Activity levels peak during traditional working hours following weekends, with sustained engagement throughout evenings and non-clinic times. This aligns with the reality that many patients are addressing care needs in between responsibilities, not setting aside time for appointments, travel, and pharmacy visits.

The dominance of mobile access (83% of traffic) reinforces this behavior.

Patients are initiating care from wherever they are, often while managing work, family, or other obligations. Virtual care compresses what would otherwise require multiple steps, scheduling, travel, waiting rooms, and prescription pickup, into a single, asynchronous interaction.

In this sense, virtual care is functioning less as a digital clinic and more as a time-saving access layer.



Section 3

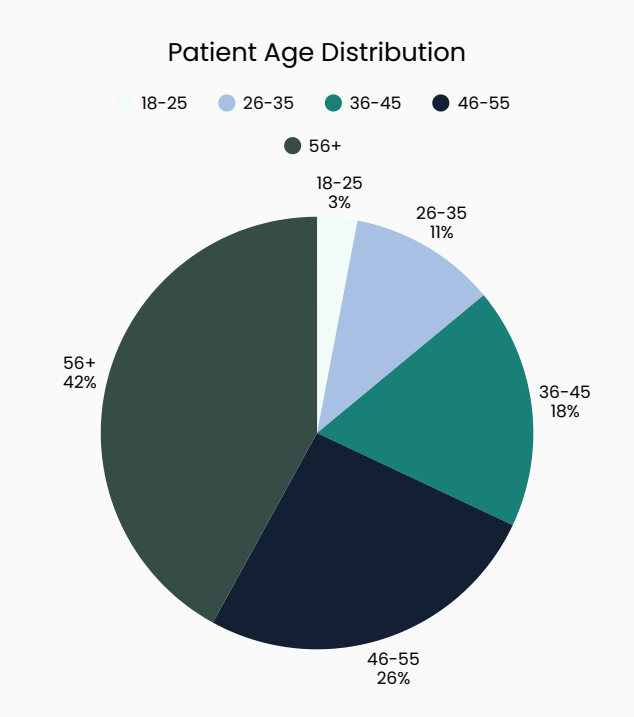
How Virtual Care Is Actually Being Used

Age Distribution Reflects Conditions, Not Adoption Curves

Patient engagement spans age groups, with the largest share concentrated among adults over 45. This distribution is best understood in the context of the conditions being treated, many of which disproportionately affect mid-career and older populations.

This does not contradict established technology adoption patterns, where younger users are often early adopters. Rather, it reflects that virtual care has matured into a practical delivery model for real medical needs, not a novelty channel driven by experimentation.

In other words, age distribution here signals clinical relevance, not technological curiosity.



68%

of patients are over the age of 46

58%

of patients identify as female

42%

of patients identify as male

Section 3

What This Means for Care Delivery Models

These behavioral patterns point to a growing mismatch between patient behavior and care models built around:

- Fixed office hours
- Synchronous availability
- Appointment-centric workflows

Patients are seeking care in ways that prioritize flexibility, efficiency, and minimal disruption to daily life.

Designing Care Around When Patients Actually Seek It

Patient behavior indicates that virtual care is most valuable when it aligns with real-world timing rather than traditional clinic availability. Engagement patterns concentrated outside appointment-based norms, combined with mobile-first access, create an opportunity for care models built around asynchronous intake, predictable review windows, and distributed clinician coverage. Programs that design workflows around when patients initiate care, not when appointments can be scheduled, are better positioned to capture demand efficiently while reducing friction across the patient journey.

Section 4

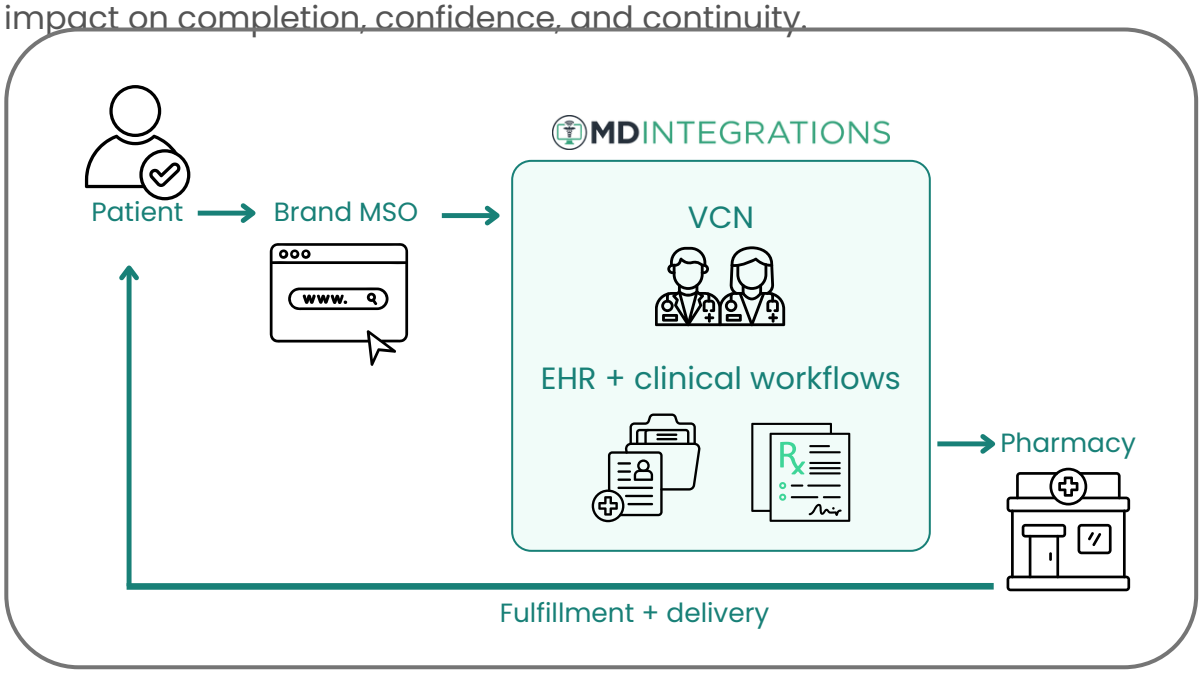
From Intake to Completion and Where Workflow Shapes Outcome

Demand Alone Does not Determine Whether Virtual Care Scales

What matters just as much is how effectively the patient journey is designed before a clinical encounter ever begins.

From the patient's perspective, intake is the virtual waiting room. It is the moment where intent is either sustained or lost, not because care is unavailable, but because uncertainty, friction, or delay interrupts momentum.

From the brand's perspective, this stage represents the primary handoff between the MSO-led experience and the physician or clinical network that delivers care. How clearly that handoff is structured has a direct impact on completion, confidence, and continuity.



Section 4

From Intake to Completion and Where Workflow Shapes Outcome

New vs. Returning Patients: Why Time Differences Are Expected

New patient journeys take materially longer than those of returning patients. This is not a signal of inefficiency. It reflects the work required to establish a baseline: identity verification, medical history, eligibility, and the creation of an initial patient chart.

Once that foundation exists, follow-up care moves more quickly. Returning patients benefit from prior context, reduced uncertainty, and fewer required inputs. Shorter completion times for follow-ups are therefore an expected and healthy pattern, not an optimization failure.

Understanding this distinction is important. Attempts to compress first-time intake too aggressively can undermine confidence and accuracy, while well-designed workflows balance clarity with completeness.

14 minutes

Average Time to Complete Intake
(all new intakes)

~3.5 hours

Average Encounter Completion Time for New Intakes
(vs follow-up, renewal)

Section 4

From Intake to Completion and Where Workflow Shapes Outcome

Where Abandonment Actually Occurs

Across programs, abandonment is most concentrated early in the intake process, with **19% of patients never completing intake**. However, once cases are routed to clinicians, **completion exceeds 96%.**

Case completion includes all clinically resolved outcomes, treatment provided, determination that no treatment is needed, denial of treatment, and patient-initiated cancellations. In other words, once patients reach clinical review, cases are overwhelmingly resolved.

This gap makes clear that the primary constraint on scale is not physician follow-through. It is upstream workflow clarity: how eligibility is signaled, how expectations are set, and how confident patients feel while waiting for clinical review.

96%

Consultation Completion Rate
% completed by patient vs requested

81%

Intake Completion Rate
% patients that complete intake

Intake Abandonment as a Design Signal

When patients disengage during intake, it is tempting to attribute the behavior to lack of interest or weak demand. The data suggests otherwise.

Abandonment at this stage behaves much like a physical waiting room. When the process feels unclear, overly complex, or unpredictable, patients pause, even if they still want care.

Because intake design and experience sit squarely within the brand's control, this stage represents one of the most meaningful opportunities to improve conversion without increasing acquisition spend. Small changes to workflow sequencing, expectation-setting, and communication can materially affect follow-through.

As DTC telehealth matures, intake is no longer a tactical detail. It is a strategic lever that shapes:

- conversion from intent to delivered care
- patient confidence before clinical review
- the efficiency of downstream clinician workflows
- continuity across follow-up visits

Programs that treat intake as a core part of the care experience, rather than a form to be completed, are better positioned to scale without eroding trust or increasing operational drag.

These intake dynamics help explain why predictability and expectation-setting become more important than speed as programs scale.

Section 5

Clinician Capacity and Why Workflow Design Matters Most

As Virtual Care Scales, the Limiting Factor Shifts

Demand continues to grow. Intake can be optimized. Conversion can improve. Eventually, however, the primary constraint becomes clinician capacity, not in absolute numbers, but in how clinical work is structured, supported, and sustained. Virtual care operates sustainably only when clinician workflows preserve medical judgment while remaining efficient under real-world demand.

Between 2023 and 2025, the active physician network supporting these programs grew by 121%.

This expansion did not precede demand; it followed sustained increases in patient volume, specialty breadth, and follow-up care. As programs moved from episodic use to consistent, multi-state delivery, network growth became a prerequisite for maintaining reliability rather than a lever for accelerating growth. At this scale, expanding clinician capacity reflects operational necessity: preserving coverage, predictability, and clinical judgment as volume and complexity increase.

121%

growth of clinical network
active physicians between 2023-2025

Section 5

Clinician Capacity and Why Workflow Design Matters Most

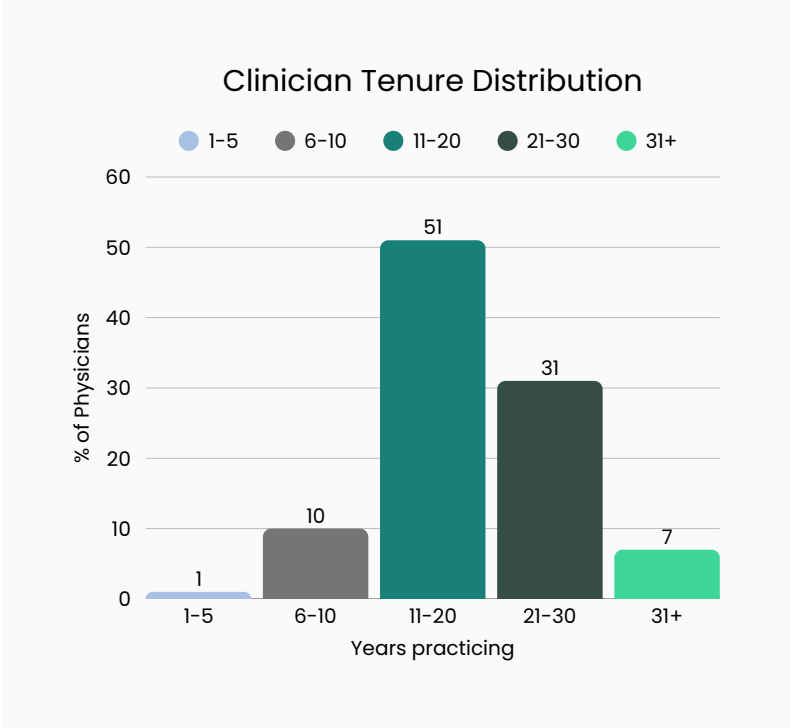
Clinical Experience, not Novelty, is Driving Scale

A common assumption in virtual care is that adoption is driven primarily by early-career clinicians, recent graduates who are more comfortable with new technology.

The data tells a different story.

Across this clinical network:

- 81% of physicians have been practicing between 11 and 30 years
- Over half (51%) fall in the 11–20 year range
- Fewer than 12% have been practicing fewer than 10 years



82%

of MDI's physician network has been practicing between 11 and 30 years

Section 5

Clinician Capacity and Why Workflow Design Matters Most

Responsiveness Reflects Workflow Design, Not Individual Effort

Median clinician responsiveness remains strong:

- 41 minutes to pick up a new case
- 1 hour 8 minutes to complete a case

These figures are not driven by clinicians working faster at all costs. They reflect workflows designed to support efficient review without compromising documentation or decision-making.

Average completion times are meaningfully higher than medians, indicating a long tail of cases that require additional context, follow-up, or clinical discretion. This variability is not a failure mode; it is a natural feature of real medical care. Sustainable programs are therefore optimized around predictable review windows, not extreme speed guarantees. When clinicians are supported with clear intake context, structured workflows, and discretion over pacing, both efficiency and completion remain high.

<1 hour

New case pickup by physician
Median time between patient intake form and start of physician encounter

~1 hour

Time to complete case
Median time of clinical encounter from physician pickup to case resolution

~4 hours

Average time to complete case

Section 5

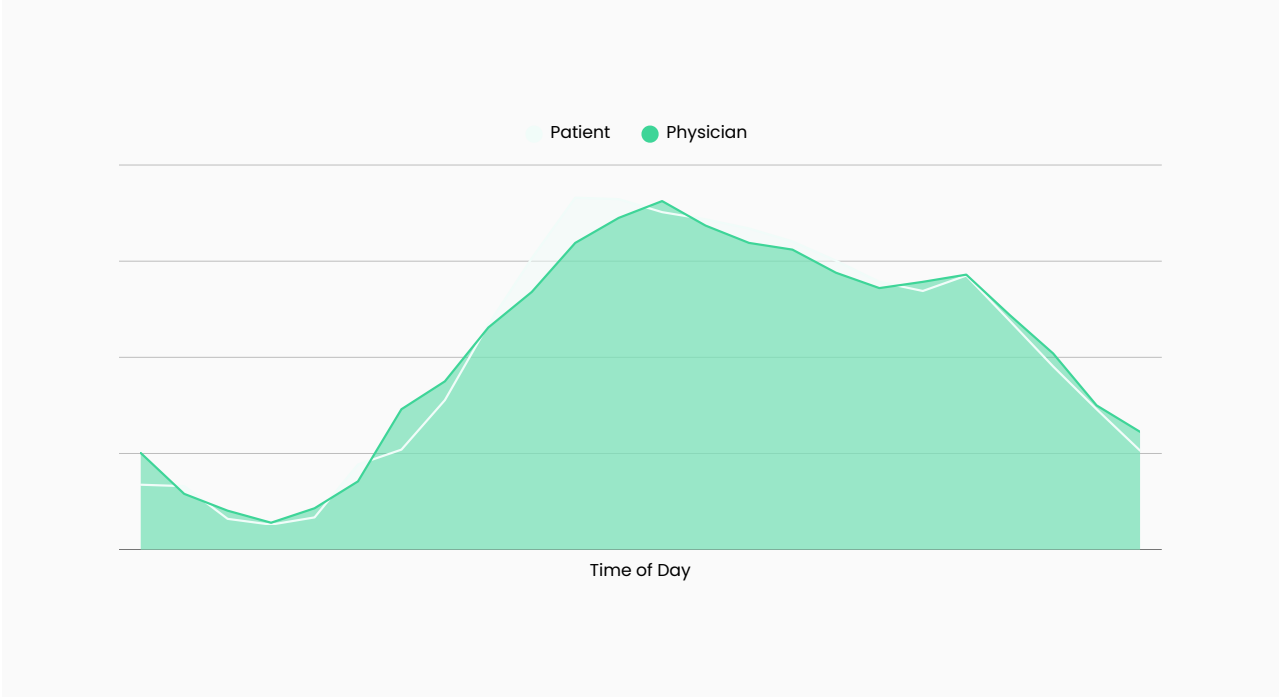
Clinician Capacity and Why Workflow Design Matters Most

On-Demand Care Mirrors Patient Behavior, Not Office Schedules

Clinician activity closely mirrors patient demand patterns.

Engagement extends beyond traditional clinic hours, with meaningful activity occurring during evenings and across the workweek. This alignment reinforces a core advantage of virtual care: care is delivered when patients seek it, not when offices are open.

This model is fundamentally incompatible with in-person scheduling paradigms. On-demand access at this scale is only possible when clinical workflows are asynchronous, physician-led, and designed for distributed coverage rather than appointment blocks.



Section 5

Clinician Capacity and Why Workflow Design Matters Most

Once in Clinical Workflow, Resolution Is the Norm

Once patients enter the clinical workflow, the system performs consistently. **Consultation completion rates exceed 96% once cases are routed to clinicians.** Completion includes all clinically resolved outcomes, treatment provided, determination that no treatment is needed, denial of treatment, or patient-initiated cancellation.

This reinforces an important distinction: scale constraints arise primarily before clinical review. Once physicians are engaged with sufficient context, cases are overwhelmingly resolved.

Approximately 4% of cases do not reach completion due to a range of routine resolution outcomes rather than clinical failure. These include patient inactivity, duplicate or already handled requests, time limits being exceeded during intake, clinician rejection when care is not clinically appropriate, patient-initiated cancellations, and instances where required follow-up information is not provided. Together, these outcomes reflect normal safeguards and decision points within virtual care workflows, ensuring cases are resolved appropriately even when treatment does not proceed.

96%

Consultation Completion Rate
completed vs requested

Section 5

Clinician Capacity and Why Workflow Design Matters Most

Workforce Design Is the Real Constraint on Scale

These signals point to a structural shift in virtual care.

The question is no longer how to schedule more appointments or compress response times. The question is how to design clinician workflows that:

- respect medical judgment
- accommodate case complexity
- remain predictable under variable demand
- sustain experienced physicians over time

As DTC telehealth matures, workforce and workflow design, not scheduling tactics, become the primary determinant of scale.

These clinician dynamics help explain why predictability, not raw speed, becomes the defining advantage as programs move from launch to sustained scale.

Section 6

Multi-State Practice Is Table Stakes, Consistent Operations Are the Challenge

National Reach Is Largely Solved

The physician workforce supporting DTC telehealth is increasingly organized around national reach, specialty alignment, and flexibility. Broad licensure coverage enables programs to meet distributed patient demand, but coverage alone no longer determines whether care can be delivered reliably at scale. The constraint has shifted from where clinicians are licensed to how multi-state care is operated.

Within this clinician cohort:

- 45% maintain licensure across 34 or more states
- An additional 20% are licensed in 11–25 states

This distribution reflects a workforce already built for national delivery. Multi-state licensure is no longer a differentiator; it is the baseline required to participate meaningfully in DTC telehealth.

As a result, the competitive challenge is no longer geographic reach. It is the ability to operate consistently and compliantly across jurisdictions as volume, case complexity, and follow-up care increase.

Section 6

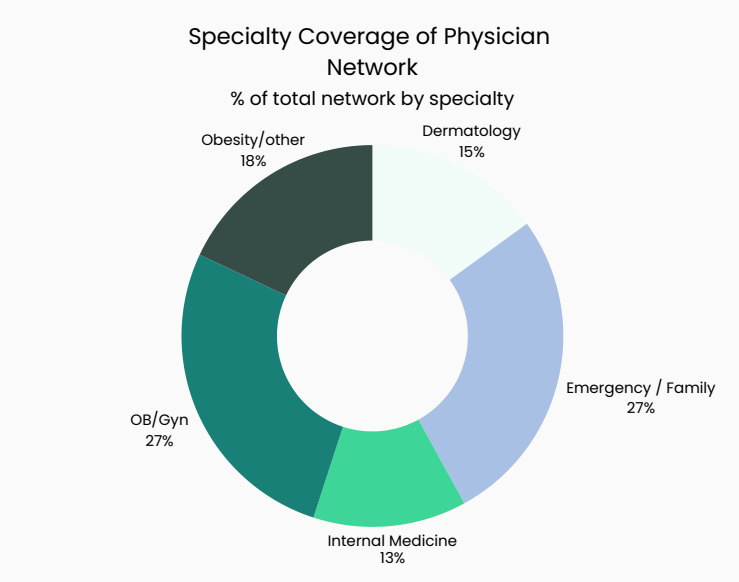
Multi-State Practice Is Table Stakes, Consistent Operations Are the Challenge

Specialty Alignment Increases the Operational Bar

As programs mature, reliance on board-certified clinicians aligned to specific conditions deepens. This specialization improves care quality but also raises the operational bar.

Routing accuracy, documentation standards, and jurisdiction-specific requirements must remain consistent across states and specialties. Small misalignments, in intake context, handoffs, or workflow logic, compound quickly at scale.

In this environment, multi-state practice is not just a licensing problem. It is a systems problem.



Section 6

Multi-State Practice Is Table Stakes, Consistent Operations Are the Challenge

Clinician Experience Becomes a Scaling Lever

As shown in Section 3, experienced physicians are central to sustaining quality and judgment at scale. Supporting those clinicians across dozens of jurisdictions requires more than coverage maps. It requires:

- workflows that account for regulatory variation without fragmenting experience
- intake and routing logic that delivers sufficient context at first review
- predictable review windows that remain achievable across states and specialties

Physician experience design, how clinicians interact with cases, context, and compliance, is increasingly a determinant of network depth, retention, and long-term scalability.

The Shift From Coverage to Coherence

Multi-state practice enables access. Operational coherence sustains it.

Programs that treat national reach as the finish line often struggle as complexity grows. Those that invest in consistent workflows, clear handoffs, and clinician-centric experience design are better positioned to scale without introducing friction for patients or providers.

Section 7

Asynchronous Care as the Coordinating Layer

Async Enables Judgment, Not Just Speed

Asynchronous care is no longer best understood as an efficiency mechanism. It has become the coordinating layer that aligns patient behavior, clinician capacity, and multi-state operations.

Earlier sections show that patients initiate care outside appointment-based norms, clinicians engage across distributed time windows, and national programs require consistent workflows across jurisdictions. These pressures do not resolve through faster scheduling or more synchronous touchpoints.

They resolve through systems that allow care to be reviewed, escalated, and resolved without requiring real-time alignment at every step.

Asynchronous workflows allow clinicians to:

- prioritize cases based on clinical need
- manage variability without compressing judgment
- maintain documentation and compliance standards under load
- Importantly, async does not replace synchronous care. It reframes it.

Live encounters increasingly function as escalation paths, not default entry points. This structure preserves access while protecting clinician discretion, an increasingly critical balance as complexity and follow-up volume grow.

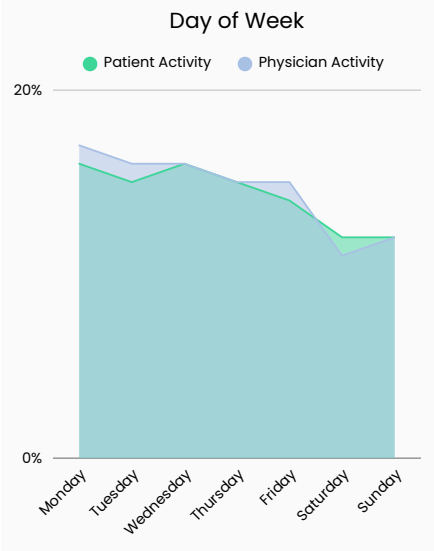
Section 7

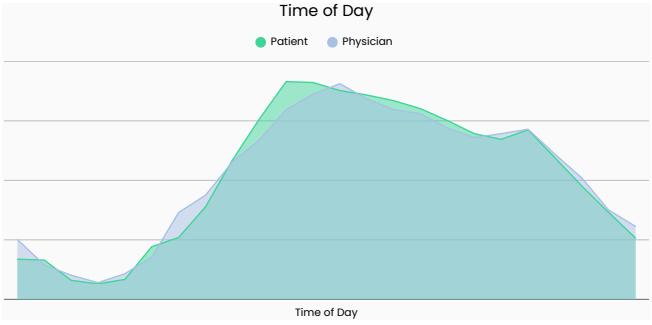
Asynchronous Care as the Coordinating Layer

Alignment, Not Availability Drives Efficiency

Overlaying patient initiation patterns with clinician review activity reveals alignment without simultaneity. Patients and clinicians do not need to be active at the same moment for care to move forward.

This is the structural advantage async provides coordination without scheduling





Programs that treat async as an operating layer, rather than a workaround, are better positioned to absorb demand volatility, clinician variability, and regulatory complexity simultaneously.

Section 8

Continuity Emerges When Systems Are Built to Sustain It

DTC Telehealth is Often Framed as Transactional by Design

The data suggests otherwise, not because brands are explicitly building longitudinal care programs, but because patient behavior and system design increasingly support continuity by default.

Returning patients complete intake more efficiently and engage more reliably than first-time users. This reflects established clinical context, clearer expectations, and reduced uncertainty, not simply familiarity with technology.

Follow-Ups Change the Operating Equation

Follow-up visits account for **50%** of all cases in this dataset.

Notably, follow-up completion times are not uniformly faster than new patient visits. In many cases, they require additional review time as clinicians evaluate treatment response, adjust care plans, or determine next steps.

This reinforces an important distinction: **continuity increases clinical depth, not operational simplicity.**

Systems optimized only for first-visit efficiency struggle as follow-up volume grows. Longitudinal care requires workflows that preserve context, clinician consistency, and decision continuity over time.

Section 8

Continuity Emerges When Systems Are Built to Sustain It

Continuity Is an Outcome of Infrastructure Choices

Continuity does not need to be forced through more touchpoints or heavier engagement tactics. It emerges when:

- intake establishes a durable clinical baseline
- workflows preserve context across encounters
- clinicians are supported to manage ongoing care without fragmentation

In this sense, continuity is not a feature. It is a byproduct of infrastructure that scales responsibly.

Section 9

Implementation Choices Reflect Program Intent

How a Virtual Care Brand Integrates Clinical Infrastructure is More Than a Technical Decision

It reflects how the business expects to operate, both at launch and as complexity increases.

Across programs, implementation approaches vary in speed, flexibility, and depth. Each carries tradeoffs that become more pronounced as volume, specialty scope, and continuity grow.

How Brands Are Choosing to Implement

Among net-new programs launched in 2025, implementation choices clustered clearly:

- 80.79% adopted a full API integration
- 13.91% launched via a white-label approach
- 5.30% used an eCommerce plug-in model

These distributions suggest a shift in how brands approach virtual care infrastructure. Rather than optimizing solely for the fastest time to launch, most programs are selecting integration models that support greater workflow control, adaptability, and long-term operating flexibility.

Section 9

Implementation Choices Reflect Program Intent

Implementation as a Signal, Not a Feature

Faster implementation paths can reduce initial lift and accelerate early traction. Deeper integrations, while requiring more upfront coordination, tend to better support:

- specialty-specific workflows
- nuanced intake and routing logic
- continuity across follow-up care
- alignment between brand experience and clinical delivery

As programs mature, these structural differences matter more than launch speed alone.

Why This Matters in Context

Earlier sections of this report show that scale is constrained less by demand than by execution, intake design, clinician workflows, predictability, and continuity.

Implementation choice influences how easily brands can evolve across each of these dimensions. What begins as a technical decision often becomes an operational one.

As the market matures, implementation strategy is increasingly a long-term business decision, not merely a launch tactic.

Section 10

What These Signals Point to in 2026

DTC Telehealth has Entered its Next Phase

The question is no longer whether virtual care can attract patients or support growth. The question is whether programs are built to function reliably once growth becomes sustained, variable, and clinically complex.

Across the signals examined in this report, a consistent pattern emerges. Constraints arise less from demand and more from execution: intake workflows that interrupt momentum, clinician systems that strain under variability, multi-state operations that lack coherence, and infrastructure choices that limit adaptability over time.

The expansion required to sustain this execution is non-trivial. Between 2023 and 2025, active physician participation more than doubled, reflecting the infrastructure required to support consistent care delivery as virtual programs mature. Growth at this layer underscores a central finding of this report: scale in DTC telehealth is not achieved by demand generation alone, but by the systems and workforce design required to reliably meet that demand over time.

At the same time, the data points toward what endures. Programs that treat intake as part of the care experience, design clinician workflows around judgment rather than speed, coordinate care asynchronously, and support continuity by default are better positioned to scale without eroding trust or quality.

These outcomes are not driven by any single feature or tactic. They are the result of deliberate structural choices around how care is routed, reviewed, escalated, and sustained across time, specialties, and states.

As virtual care becomes a permanent access layer within healthcare, advantage will accrue to programs designed for predictability, coherence, and clinical depth. Demand may bring patients to the door. Execution determines whether care is delivered consistently, responsibly, and at scale.

Section 11

Methodology

This report is based on aggregated, anonymized clinical and operational observations drawn from MD Integrations–supported virtual care programs operating across multiple states and specialties.

The dataset reflects patterns in patient engagement behavior, intake progression, clinician workflows, licensure distribution, asynchronous review activity, and implementation approaches. All clinical decisions represented in this dataset were made independently by licensed physicians exercising their professional medical judgment within the context of their respective clinical engagements.

The insights presented are directional and intended to surface structural and operational patterns observed at scale. They are not benchmarks, performance rankings, or evaluations of individual brands, clinicians, or programs. No patient-identifiable information, brand-specific results, revenue data, or prescribing outcomes are included.

Where referenced, external research is used solely to contextualize broader system-level dynamics affecting virtual care delivery and access. All conclusions are derived from observed behavior at the clinical and operational layer rather than modeled forecasts or self-reported survey data.

Section 11

Sources & Further Reading

Selected external resources that inform the broader context of telehealth access, regulation, clinical quality, and healthcare consumer trends.

Telehealth Utilization & Market Evolution

- *McKinsey & Company: Virtual Care & Telehealth Insights*
- *FAIR Health: Monthly Telehealth Tracker*
- *American Medical Association: Digital Health Research*

Care Access, Wait Times & Consumer Cost Pressure

- *AMN Healthcare / Merritt Hawkins: Physician Appointment Wait Times Reports*
- *Kaiser Family Foundation (KFF): Health Care Affordability & Cost Barrier Reports*
- *Gallup: Healthcare & Wellbeing Surveys*

Clinical & Asynchronous Care Research

- *JAMA Dermatology: Teledermatology Research*
- *PubMed / NCBI: Telehealth & Asynchronous Care Studies*

Regulatory & Policy Guidance

- *Center for Connected Health Policy (CCHP): State Telehealth Policy Navigator*
- *DEA: Telemedicine & Prescribing Guidance*
- *Federation of State Medical Boards (FSMB): Policy Documents*
- *Pew Trusts: State Telehealth Policy Analyses*
- *Brookings Institution: Digital Health & Healthcare Policy*

Physician Workforce & Licensure Trends

- *Federation of State Medical Boards (FSMB): Physician Workforce Report*
- *Interstate Medical Licensure Compact (IMLC): Participation, Rules & Updates*

About MD Integrations

MD Integrations (MDI) powers today's most trusted digital health brands with the technology and physician network needed to launch and scale compliant virtual care. Built on a 50-state, board-certified physician network, MDI provides configurable workflows, APIs, and nationwide coverage that help organizations operate leaner, move faster, and deliver physician-directed care without building clinical operations in-house.

Founded by Dr. Marc Serota, a quadruple board-certified physician and telehealth leader, MDI is defining the next generation of telehealth technology, connecting doctors, patients, and brands through scalable, compliant virtual care.

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