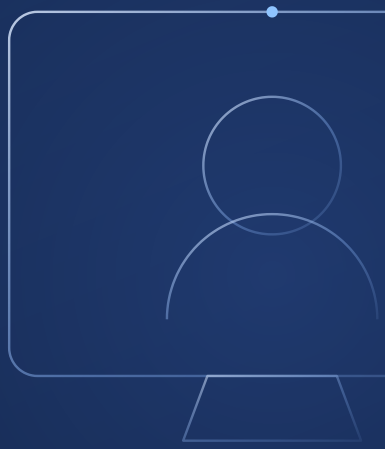
PITON Global

EXECUTIVE WHITE PAPER · WP-63

TELEHEALTH & HEALTH-TECH SUPPORT · PHILIPPINES

# The virtual front desk: the executive economics of telehealth support outsourcing to the Philippines.



An analysis of clinician-hour economics, patient access and visit-rescue operations, RPM support, the clinical-adjacency boundary, and vendor-selection discipline for telehealth platforms and digital-health companies sourcing in the Philippines.

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# Contents



**ABOUT THIS SERIES**

Where WP-62 examined the administrative machinery of healthcare — claims, billing, revenue cycle — this volume examines its newest front door: the virtual visit and the operations that keep it open. The instruments are the series' constants: verified costs, audited benchmarks, an honest census of the qualified provider field, and the governance record of a quarter century of buyer-side engagements.

THE PITON-GLOBAL LEADERSHIP TEAM

# About the authors

## John Maczynski

Chief Executive Officer

Health-plan and care-adjacent programs recur throughout John's thirty-plus years of running outsourced operations for major US corporations — work that taught him the discipline this vertical demands: every process touching a patient must be designed twice, once for efficiency and once for the day

## Ralf Ellspermann

Chief Strategy Officer

Health services have anchored a substantial share of the delivery organizations Ralf has built and advised across twenty-plus Manila years — floors where HIPAA discipline, nurse-adjacent escalation, and patient empathy were daily operating requirements, not slideware. That operating history

something goes wrong. He leads every PITON-Global engagement personally, and telehealth clients get both designs, from requirements through the launch that proves them.

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is why the diligence protocols in this volume inspect what they inspect; the provider dossiers and benchmark models behind the series remain his ongoing work.

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PITON Global

**ABOUT PITON-GLOBAL**

Twenty-five years of continuous, single-market focus have made PITON-Global something rare in professional services: an advisor whose knowledge asset is verifiably deeper than any vendor's sales narrative. The Manila-based firm — honored repeatedly across its industry — works exclusively for outsourcing buyers: it scopes the requirement, tests the thousand-plus-provider field against evidence, referees the competitive process, and remains embedded until the program performs to contract. Tripadvisor, TSYS, Garmin, HealthPartners, Yetipay, Workrise, and Norman Disney & Young are among the companies that have built Philippine operations with the firm.

SECTION 01

# Executive summary

**-63%**
Fully-loaded cost vs. US onshore, blended program

**-32%**
Appointment no-show rate at vetted providers

**84%**
Visit-rescue rate on pre-visit technical issues

**5.5×**
First-year ROI, reconstructed platform case (Section 6)

Telehealth's scarcest input is the clinician hour, and its operations exist to protect it. Every no-show is a wasted clinical hour a platform already paid for; every visit that dies on a camera permission is revenue, care, and often a patient lost together; every scheduling call a clinician's staff handles is licensed time doing unlicensed work. Virtual care solved medicine's distance problem and inherited a logistics problem — one that behaves exactly like the operational challenges this series has priced in fifteen other verticals.

The Philippine market meets it with an unusual double inheritance: the HIPAA-governed delivery discipline documented in WP-62, and the technical-support machinery documented in WP-04 — combined in floors staffed by clinically literate, empathetic English speakers, many from the country's vast allied-health talent pool. Five findings frame the volume:

1. **The no-show is the unit of waste.** At $150–300 of loaded clinician time per missed virtual visit, a platform running 18% no-shows is burning its margin on empty screens. Confirmation cadences, barrier-removal calls, and same-day rebooking cut the rate by a third — Section 3 shows the machinery.

2. **The saved visit is telehealth's truck roll.** A tech check fifteen minutes before the appointment — camera, audio, connection, app state — rescues 84% of would-fail visits, the same remote-resolution economics WP-73 priced for dispatch avoidance.

3. **The clinical-adjacency boundary is the design document.** Scheduling, logistics, tech rescue, and device support move; symptoms, advice, and triage judgment never do — with warm-transfer escalation paths to licensed staff drilled like fire exits. Programs that draw this line in the SOW run for years without incident.

4 **RPM lives or dies on its support desk.** Remote-monitoring programs churn when devices confuse patients and alerts drown staff. A desk that onboards devices patiently, triages data alerts on protocol, and chases disconnected patients keeps enrollment — and its reimbursement — alive.

5 **The qualified field is narrow where it matters.** Of 1,000+ Philippine operations, PITON-Global's mapping confirms genuine telehealth depth — HIPAA-grade floors with technical benches and clinical-escalation machinery together — at roughly eighteen. Either half alone is common; the combination is the scarcity.

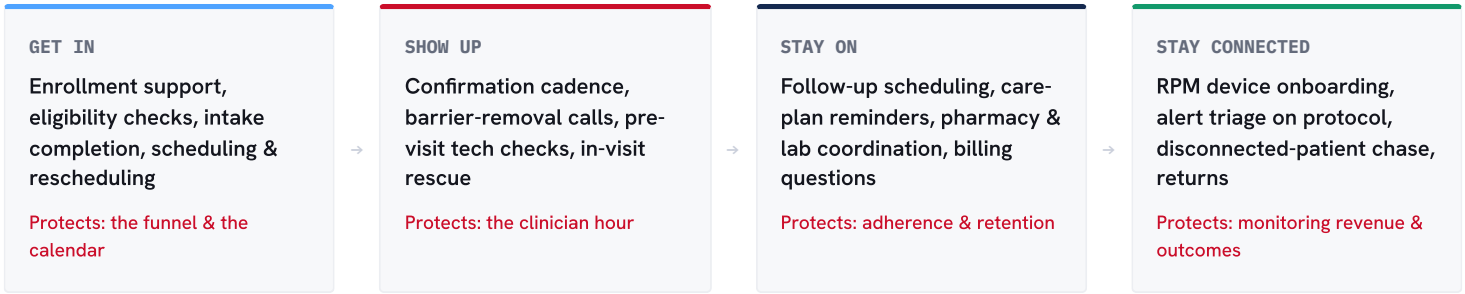
The intended reader leads operations, patient experience, or finance at a telehealth platform, digital-health company, RPM provider, or health system building virtual care. Sections 2–4 supply the evidence; sections 5–7, the method and the proof.

SECTION 02

# The clinician-hour problem: virtual care's economics and the work that moves

Figure 1 maps the outsourced telehealth work along the patient journey — every station of it existing to keep clinician hours full and patients moving.

FIG. 1 — THE OUTSOURCED VIRTUAL-CARE JOURNEY




Composite of PITON-Global telehealth engagements, 2024–26 — platforms, digital-health companies, and RPM providers.

Reading the journey as clinician-hour protection reorders the investment case. The "show up" station carries the highest yield per seat of anything in this volume: a patient-access desk that runs confirmation cadences and pre-visit tech checks converts empty calendar slots into delivered — and billed — care. The "stay connected" station carries the compliance-revenue stakes: RPM reimbursement depends on transmission days, and a desk that keeps devices paired and patients engaged is defending a revenue stream measured per patient per month.

Everything on the map is HIPAA-governed, and the perimeter machinery of WP-62 applies without amendment: BAA, delivery-unit certification, minimum-necessary access, inspected floors. What telehealth adds is the technical dimension — agents who can walk a seventy-year-old through camera permissions with grace, diagnose a bad connection in ninety seconds, and know the app's failure modes release by release. The vetting problem, correspondingly, is finding both disciplines in one provider.

SECTION 03

# The saved visit: no-show economics and the clinical-adjacency boundary

Figure 2 reconstructs the machinery that moves a no-show rate: a timeline of touches, each with its measured contribution.

**FIG. 2 — THE SAVED-VISIT TIMELINE: FROM BOOKING TO DELIVERED CARE**

| | | |
|---|---|---|
| T−72 HRS | Confirmation touch with one-tap reschedule — the patients who can't make it move now, into slots that refill | no-show −9 pts |
| T−24 HRS | Barrier-removal call on flagged cohorts — first visits, prior no-shows, new devices: "anything in the way of tomorrow?" | no-show −4 pts |
| T−15 MIN | Pre-visit tech check — camera, audio, connection, app state — with live rescue for the 1-in-6 who need it | 84% of failing visits saved |
| IN-VISIT | Standby rescue line for mid-visit failures; clinician never troubleshoots, patient never dangles | clinician hrs protected |
| MISSED ANYWAY | Same-day outreach and rebooking while the reason is fresh — the slot refills, the patient stays in care | 61% rebooked ≤48 hrs |

Touch contributions from PITON-Global telehealth engagements, 2024–26; baseline no-show rates 16–20% across behavioral, chronic-care, and primary virtual programs.

Every touch on the timeline is non-clinical — and that is the design point. The **clinical-adjacency boundary** runs through this vertical the way UPL ran through WP-33 and licensing through WP-59: support staff schedule, remind, troubleshoot, coordinate, and rescue; they never interpret a symptom, adjust an expectation of care, or answer "should I worry about this?" with anything but a warm transfer. Vetted floors drill the escalation the way airlines drill evacuations — scripted recognition cues, one-touch transfer to licensed staff, documentation of every handoff — and QA samples for boundary discipline as heavily as for accuracy.

Drawn correctly, the boundary is what makes the economics available at all: it moves the 80% of patient-facing volume that requires no license to a $11.60 blended hour, while concentrating licensed staff on the work only they can do. Drawn sloppily — or left to habit — it is a regulatory and clinical risk no rate card can compensate. Step 1 writes it; Step 4 audits it; the quarterly boundary review keeps it honest.

SECTION 04

# Cost and performance: role-band economics and top-tier

# benchmarks

**TABLE 1 — FULLY-LOADED COST PER PRODUCTIVE HOUR BY ROLE BAND (US$, 2026)**


Basis: PITON-Global telehealth engagement pricing 2025–26; fully loaded and net of shrinkage, as defined in Methodology & notes. Coverage follows the visit calendar, including evenings and weekends at flat rates.

**TABLE 2 — TELEHEALTH OPERATING BENCHMARKS, VETTED VS. BASELINE (2025–26)**

| METRIC | VETTED TOP TIER | BASELINE | EXECUTIVE READING |
|---|---|---|---|
| **Appointment no-show rate** | **–32%** | reference | Clinician hours filled, not burned |
| **Visit-rescue rate (pre-visit tech issues)** | **84%** | ~50% | The visit happens |
| **Missed-visit rebooking ≤48 hrs** | **61%** | ~35% | Patients stay in care |
| **RPM transmission-day compliance** | **87%** | ~68% | Monitoring revenue defended |
| **Patient CSAT / boundary-discipline QA** | **92 / 99%+** | ~84 / unmeasured | Experience and safety, both audited |
| **Annual attrition, telehealth programs** | **20–28%** | 40–55% | Protocol fluency stays in seat |

Source: PITON-Global telehealth engagement data 2025–26; baseline = client pre-engagement and onshore/commodity-offshore averages.

The machinery is the series constant — calibrated QA, certification gates, tenure economics — with two telehealth-specific engines: **release-synchronized training** (the desk knows the app's new failure modes before patients meet them, the same discipline WP-04 documented for SaaS) and **cohort-tuned outreach** — confirmation cadences and barrier calls weighted by no-show risk, so effort lands where the waste was. Both are visible in diligence; neither survives a provider who treats patient access as a generic queue.

SECTION 05

# Sourcing discipline: the 7-Step Vendor Vetting Framework, applied to telehealth

Telehealth compresses the funnel on a conjunction: providers must clear WP-62's compliance bar *and* WP-04's technical bar on the same floor. Most clear one. The counts below are representative of a platform search.

FIG. 3 — THE 7-STEP FRAMEWORK AS A TELEHEALTH FUNNEL

| | STEP | WHAT IT ELIMINATES IN A TELEHEALTH SEARCH | FIELD REMAINING |
|---|---|---|---|
| 1 | **Requirements definition** | Unwritten boundaries: fixes the clinical-adjacency split, visit-calendar coverage, volumes by station, systems (EHR, scheduling, video stack, RPM platforms), escalation paths with clocks | 1,000+ |
| 2 | **Market mapping** | Providers without healthcare-governed delivery units in the required scale band | ~55 |
| 3 | **Capability screening** | Single-discipline shops: patient-access floors with no technical bench, tech desks with no healthcare governance — both evidenced, together | ~18 |
| 4 | **Compliance & security audit** | Anyone failing the WP-62 PHI perimeter on the actual floor — BAA readiness, HITRUST/SOC 2 on the unit, access architecture — plus boundary-discipline training records | ~11 |
| 5 | **Operational diligence** | No-show and rescue claims that fail export sampling; escalation drills that exist on paper; attrition that churns protocol fluency | 5–8 |
| 6 | **Competitive RFP & negotiation** | Generic seat pricing; finalists bid per productive hour with no-show, rescue-rate, and transmission-day credits on identical scenarios | 2–3 |
| 7 | **Transition & launch governance** | Boundary decay after go-live: PITON-Global stays embedded buyer-side to certified steady state — including a live escalation drill — then hands over | 1 |

Field-remaining counts represent a telehealth-platform search (30–90 seats), PITON-Global engagements 2024–26.

The guarantees hold, sixteenth statement: **vendor neutrality** — no capacity sold, no placement economics, shortlists answering to floor inspections and export sampling alone; **right-sizing** — a 55-seat platform program inside a hyperscale healthcare BPO queues behind national payers, while the framework surfaces specialists for whom the platform's visit calendar becomes the floor's heartbeat. Five to eight genuinely qualified providers, within 48–72 hours, free to the buyer, competing through a fully transparent, fair, comprehensive, and highly competitive RFP.

SECTION 06 · ANONYMIZED CASE STUDY

# Filling the calendar: a 55-seat telehealth-platform program, reconstructed

Engagement TH-026 is a US virtual-care platform — roughly 1.1 million registered patients across behavioral health and chronic-care lines — whose growth had outrun its front desk: no-shows at 19% against clinician capacity already sold, a support queue where a camera problem waited behind a billing question until the visit window closed, and an RPM program losing enrolled patients to device frustration faster than marketing could replace them. Clinician recruiting was the board's obsession; clinician waste was the actual problem. Identifying details are anonymized under NDA.

### SELECTION (WEEKS 0–9)

Requirements fixed a 55-seat scope — 26 patient access, 17 visit tech support with the T–15 check, 12 RPM and device support — on the platform's EHR, scheduling, and video stack, with the clinical-adjacency boundary documented station by station and escalation clocks to licensed staff in the SOW. Mapping yielded 52 claimants; dual-discipline screening left 16; the PHI-and-boundary audit left 10. Export-verified diligence produced a shortlist of 6. A Manila healthcare-and-technical specialist won at $11.60 per productive hour, with no-show, rescue-rate, and transmission-day credits.

### TRANSITION (WEEKS 10–24)

BAA and floor validation preceded data access. Patient access certified in first with the confirmation cadence; the tech desk followed with release-synchronized training and the T–15 check piloted on the behavioral-health line, where failed visits hurt most. RPM support launched last, with device-onboarding scripts rebuilt around the three most-returned devices. A live escalation drill — simulated symptom disclosure mid-tech-call — passed in week 19. PITON-Global chaired buyer-side governance to certified steady state in month 6, then handed over on documented criteria.

**TABLE 3 — TH-026 FIRST-YEAR VALUE BUILD-UP (US$)**

| VALUE COMPONENT | YEAR 1 | BASIS |
|---|---|---|
| Labor & overhead arbitrage | $2.03M | 103k productive hrs × ($31.30 − $11.60) |
| Clinician hours recovered (no-show 19%→13%) | $0.55M | Recovered visit slots × loaded clinician cost, refill-adjusted |
| Visits rescued (pre-visit + in-visit tech saves) | $0.28M | Saved visits × visit contribution margin, conservatively factored |
| RPM revenue defended (transmission compliance 66%→86%) | $0.18M | Billable monitoring months retained × per-patient reimbursement margin |
| **Gross value created** | **$3.04M** | |
| Less: engagement & transition costs | ($0.55M) | Transition, security validation, cadence and script builds, escalation drills, governance overlay; advisory fee $0 (provider-paid model) |
| **Net value ÷ cost = first-year ROI** | 5.5× | $3.04M ÷ $0.55M |

Figures rounded; recovery, rescue, and RPM effects conservatively factored. Method in Methodology & notes.

Sixty-seven percent arbitrage, thirty-three percent operational value — the series ratio, sixteenth appearance, and once again the operational lines are the ones leadership quoted upward: the no-show recovery equaled hiring four clinicians without recruiting one. The

COO's handover summary: "We spent two years trying to buy more clinician hours. It turns out we owned them already — they were just sitting in empty video rooms."

SECTION 07

# The executive playbook: governance for the first 180 days

Telehealth governance answers to three authorities at once — the visit calendar, the compliance office, and the clinical leadership whose license the boundary protects. The sequence below serves all three, client in command throughout.

| | |
|---|---|
| **DAYS 0–30**<br>**Write the boundary, wire the perimeter** | Document the clinical-adjacency split station by station, with escalation paths and clocks clinical leadership signs. Execute the BAA; validate the floor against the WP-62 perimeter in person. Contract per productive hour with no-show, rescue, and transmission-day credits. |
| **DAYS 30–90**<br>**Certify stations, drill the escalation** | Gate each station on your own QA rubric — boundary discipline sampled as heavily as accuracy. Pilot the T−15 tech check on the line where failed visits cost most. Run the live escalation drill before month three; an undrilled warm transfer is a script, not a safety system. |
| **DAYS 90–180**<br>**Tune the cadences, then widen the scope** | With the calendar stable, tune outreach by no-show cohort and feed failure-mode data to product weekly. Expand to the second wave — RPM growth lines, billing support, care-plan reminders — on the same gated pattern. Certify steady state; hand over on dated criteria; keep the quarterly boundary audit standing. |

**THE FIVE FAILURE MODES WE ARE HIRED TO PREVENT**

Leaving the clinical boundary to agent instinct · buying a patient-access desk with no technical bench (or the reverse) · accepting corporate HIPAA letters for floor-level PHI risk · measuring the desk on handle time while clinician hours burn in empty rooms · discovering the escalation path during a real disclosure. All five are settled at selection and design.

Virtual care's promise was medicine without waiting rooms; its economics turn on an operations layer most platforms built last and staffed thinnest. The Philippine market offers that layer whole: HIPAA-governed, technically fluent, empathetic at the moments care depends on, and 63% below onshore cost. Eighteen providers genuinely qualify. The method in these pages — a written boundary, an inspected floor, export-verified diligence, and a fully transparent, fair, comprehensive, and highly competitive RFP — finds the right ones, and gives every clinician hour a patient on the other end of it.

METHODOLOGY & NOTES

## How the numbers were built

**Operating benchmarks** (no-show reduction, visit-rescue rate, rebooking, RPM transmission compliance, CSAT, boundary-discipline QA, attrition) derive from PITON-Global telehealth engagements active 2025–26, measured on scheduling platforms, video-stack telemetry, RPM dashboards, and QA systems, validated in client governance. Baselines combine client pre-engagement data with onshore and commodity-offshore averages.

**Cost figures** are fully loaded — wages, benefits and statutory charges, facilities, technology and security stack, management and QA overhead, attrition-driven recruiting and ramp — net of shrinkage, at flat rates across visit-calendar coverage including evenings and weekends. US baselines reflect Tier-2 metro patient-access and technical-support labor; Manila figures reflect 2025–26 engagement pricing.

**The case study** (TH-026) is anonymized under NDA; patient counts, service lines, and platform details are generalized, figures rounded. Value factors are conservative: recovered clinician hours are refill-adjusted (not every emptied slot rebooks); rescued visits count contribution margin, not revenue; RPM defense counts billable months actually retained. ROI = net first-year value ÷ all engagement-related client costs. PITON-Global's advisory fee is provider-paid and appears at $0 in the client cost base; neutrality safeguards are documented at piton-global.com.

**Market context** draws on IBPAP reporting and PITON-Global's proprietary provider mapping (1,000+ operations; telehealth capabilities re-verified July 2026). Nothing in this paper is clinical, legal, or compliance advice; boundary designs should be reviewed by the client's clinical and compliance leadership. Estimates and projections are PITON-Global analysis and should be cited as such.

## Which telehealth-support providers belong on your shortlist?

Thirty minutes with John will tell you. Free to buyers, strictly vendor-neutral — a boundary-vetted shortlist within two to three business days.

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