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6 Common Misconceptions about Telehealth



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By Christian Milaster
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Over the years that I've been working with health systems on telehealth service strategy, design and implementation I've come across a number of misconceptions. As telehealth these days seems to be really taking off now, these misconceptions may be some of the reasons why many telehealth implementations that I hear about have disappointing results.

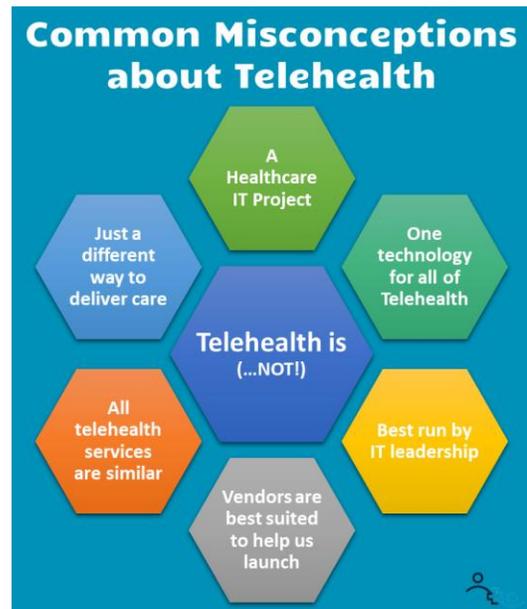
My intent with this series of articles is to raise awareness and bring clarification, so you can structure the launch of your telehealth services (even) more successfully. As readers of my article and past clients know, I'm very fond of Don Berwick's often-used quote that "Every system is perfectly designed, to get the results it gets". And in my definition, misconceptions are part of "the system". They are simply, beliefs and perceptions that people have adopted, oftentimes without questioning them (and why would they?).

Here are the six most common misconceptions about telehealth, my description of the reality and some tactics you can use to take advantage of your new understanding of the reality to launch telehealth services (even) more successfully.

1. Telehealth is a Healthcare IT Acquisition and Deployment Project
2. There is one technology solution for telehealth that everyone will use.
3. Our IT staff is best suited to run our telehealth program.
4. Telehealth Vendors will help us to properly set up our telemedicine services.
5. Once we've established one telehealth service, we can quickly roll it out to others.
6. Telehealth is just a different way to deliver care.

As you can see from the list, many of the misconceptions (in fact, the first four) focus on the "tele-" aspect of telehealth, the technology. As I've

written before, [telehealth is not about the technology](#). It's about people (such as patients, provider, nurses, MAs, etc.) and processes (such as scheduling, syncing, billing, etc.).



Let's start with an overview of the misconceptions and the reality.

Misconception #1: Telehealth is a Healthcare IT Acquisition and Deployment Project

Reality: Telehealth is the design, development and launch of new clinical service offerings. (that includes the acquisition and deployment of technology)

Misconception #2: There is one technology solution for telehealth that everyone will use.

Reality: Telehealth encompasses interactive patient care (live audio/video), remote physiological monitoring, store & forward diagnosis, TeleEducation and all features accessible through the Patient Portal, such as reviewing lab results, clinical notes, immunization records or scheduling appointments.

Misconception #3: Our IT staff is best suited to run our telehealth program.

Reality: Technology contributes only 10% to the successful creation of a telehealth service. The other 90% are workflow and organizational change management

Misconception #4: Telehealth Vendors will help us to properly set up our telemedicine services.

Reality: Great vendors are involved in ensuring the proper configuration and training of users. They are not positioned to define work-flows, policies, billing, licensing, etc.

Misconception #5: Once we've established one telehealth service, we can quickly roll it out to others.

Reality: One swallow does not a summer make. If you've established one telehealth service, you've established one telehealth service. Every new service requires a new launch.

Misconception #6: Telehealth is just a different way to deliver care.

Reality: Telehealth is becoming *the way* to deliver care. Leading organizations use it strategically to drive their strategic objectives.



**Misconception #1:
Launching Telehealth is a Healthcare IT
Acquisition and Deployment Project**

As described in the introduction, Telehealth is the design, development and launch of new clinical service offerings (that includes the acquisition and deployment of technology).

Over the past decades, the most Health IT projects have been about finding the best vendor and then deploying the solution, including the training of the users. Oftentimes, solutions were limited to a single clinical department (e.g., a radiology image management system), or occasionally they'd affect all clinical areas (e.g., in the case of an EHR implementation). In most cases, the technology sat "on top" or "in between" the existing workflows.

By comparison, the launch of a new telehealth service offering is more akin to the launch of a completely new clinical service line, with all the complexities and activities that such an endeavor requires.

The reasoning about this misconception seems to go something like this: "We already know how to deliver care and in order for us to that remotely, virtually, or at a distance, we simply need some (video) technology to connect the patients with our clinicians."

Telehealth, when understood as a new clinical service offering, however, reveals itself to be much more complex than just the technology to conduct the visit.

Due to the separation of the patient and provider in two different physical locations and since payors treat telehealth differently than a regular in-person visit, the effort involved in launching a new telehealth service is much more similar to launching a new clinical service offering than a simple technology installation.

As with any new clinical service offering (i.e., a new business line), you have to first **verify** that the new service is (1) strategically important, (2) has an underlying economically viable business case, and is (3) clinically proven. I.e., you wouldn't want to invest time, money and staff on an initiative that does not advance the most important strategic goals, is not financially sustainable and may not even clinically be good medicine.

Once the viability of the new service offering has been established, the team needs to **define** the various workflows that together comprise the service offering – from determining patient eligibility for telehealth and scheduling appointments to ensuring proper documentation in the EMR and the policies and procedures for billing.

Typically, there are at least half a dozen workflows that need to be defined. It is those workflows that create the requirements of what the telehealth technology needs to accomplish. Ideally the technology is selected after the workflows have been defined and the technology requirements been identified.

Prior to the **implementation** across multiple clinicians and patient locations, it is my best practice in my work with healthcare organizations to launch telehealth first as a proof-of-concept to **validate** all assumptions and to optimize the various workflows, policies and technology configuration.



Only after the various workflows have been tested and optimized and after the lessons learned about the technology have been documented is it time to deploy the workflows and technology across a broader set of providers and locations.

Thus, the launch of a new telehealth service is much more than simply the acquisition and deployment of a technology solution.



Misconception #2: Telehealth Requires Multiple Technology Solutions

When I come across a new misconception, I'm always curious as to where a particular misconception originated. Oftentimes it is the result of "lazy thinking", taking something, you already

know and applying it to the new circumstances without questioning it or without looking deeper.

Such is the case with the second of the six misconceptions about telehealth which is the notion that **a single technology solution (or at least one vendor's solution) is all that is needed to implement telehealth.**

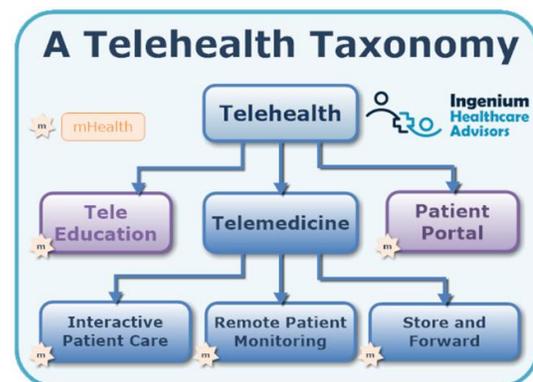
This misconception stems from healthcare's (and specifically health IT's) experience of using technology in healthcare. There is (or should be) one EMR. There is one PACS system. There is a standard for BI tools, for email, for time keeping, etc. Due to an uncontrolled wild growth in the 1990s of different technology solutions being used that essentially did the same thing, IT departments established strong policies to prevent such an explosion of solutions.

And rightfully so:

- multiple solutions take more time to support
- most solutions do not stand alone but eventually need integration with other applications,
- employee skills with one solution are not transferable
- negotiations for support (or innovative feature requests) from the vendor take more resources if you are using different solutions just to name a few.

Telehealth, on the other hand, is quite different.

The [definition of telehealth](#) is "the delivery of care at a distance" and just as there are dozens of different ways to deliver care (just think of all the different specialties) there are at least a dozen different ways to practice telehealth.



First off, my definition of telehealth not only includes telemedicine ([“practicing medicine at a distance”](#)) but also tele-education and the patient portal – both requiring vastly different sets of solutions to deliver those telehealth services.

Telemedicine further breaks down into interactive patient care, remote physiological (or patient) monitoring, and store & forward.

And within each subset of telemedicine, there are numerous solutions, especially within the category that most people think off when they think of “telehealth”: live video visits with a physician, where in my assessment at least half a dozen different technologies are justified.

“You are Here”

First off, the location of the patient plays an especially important role in the selection of the technology solution. If the patient is in a health-care environment (e.g., a rural clinic, a skilled nursing facility, an emergency room, etc.) the technology will look quite different than if the patient is at home or connecting from their place of work.

In a healthcare environment, healthcare staff has more control over the patient’s experience, and it becomes an “internally used” solution, that is optimized for the mindset and workflow of the medical staff vs. that of the patients.

For example, for specialty visits in a rural clinic environment I often use a basic, secure video chat solution that would not be optimal for patients accessing it directly (as it would require an install and configuration and a slightly awkward way of connecting with the physician).

A direct-to-patient solution, however, needs to offer a smooth, configuration-less, one-click experience that works on any consumer-grade device such as a smartphone, tablet, laptop, or desktop.

“Timing is Everything”

The next consideration is the timing of the telehealth visit. Is it going to be pre-scheduled, or is it ad hoc, i.e., allowing patients to spontaneously request their visits? Support for consumer-facing ad hoc visits requires a set of sophisticated solutions that include the management of request queues, allocating available physicians to

requesting patients, support for electronic handoffs from triage to specialists, etc. – just to name a few.

“To Exam or not Exam, that is the question”

A third dimension that justifies the use of different technologies for different types of telehealth visits is whether the telehealth visit will include the use of exam tools – whether that is a pan-tilt-zoom camera used to precisely assess the patient’s facial drooping in telestroke, exam cameras such as otoscopes, dermascopes, or telescopes (just kidding ;-), or digital stethoscopes to assess patients’ heart and lung sounds.

Contrast that with consult-only scenarios such as follow-up visits to review the patient’s test results or televisits in behavioral health.

| Clinical Specialty | Telehealth Modality | Patient Location | Expertise/Direction | Scheduling Type |
|---|---|---|---|---|
| <ul style="list-style-type: none"> Behavioral Health Primary Care Pediatrics Urgent Care Critical Care Infectious Disease Neurology Cardiology Endocrinology Dermatology Ophthalmology Rheumatology Etc. | <ul style="list-style-type: none"> Interactive A/V TeleVisit TeleExam Remote Physiological Monitoring Store & Forward TeleEducation Patient Portal | <ul style="list-style-type: none"> Clinic Emergency Rm. Hospital Home Work School College Skilled Nursing Assisted Living Hospice Out of State Abroad Etc. | <ul style="list-style-type: none"> Internal: Our MDs to Our Patients External: Contracted MDs to Our Patients Outbound: Our MDs to Others’ Patients Inbound: Specialist MDs to Our Patients | <ul style="list-style-type: none"> Prescheduled Same-day (semi ad hoc) Ad Hoc/ On Demand |

12 x 6 x 12 x 4 x 3: >10,000 interactive patient care services

From this exploration of the most common scenarios just in “interactive patient care” the need for allowing and supporting different technologies to practice telehealth is pretty obvious. And even for seemingly similar use cases (e.g., prescheduled behavioral health visits and prescheduled primary care follow-up visits) different technologies may be justified, to create the optimal workflow for a great experience for both, providers and patients.

Not without precedent in healthcare

Historically, different healthcare services, even in common lines such as outpatient services or surgery, require different approaches. Different surgical specialties need different surgical tools – orthopedists may use a bone saw, but vascular surgeons may not. Cardiologists need EKS, but Podiatrists may typically have no use for them.

The same it is with telehealth – the tool, the technology should fit the task on hand.

The tail should not wag the dog. And one technology cannot support all types of use cases.



Misconception #3: Our IT staff is best suited to run our telehealth program.

“Telehealth is about technology, right? Without technology, there is no “tele”! And we do need a vendor and some software so we can connect patients with physicians. So let’s ask IT to find some software and roll it out.”

In my experience, this line of thinking among healthcare or physician leaders has happened many times over the past years and is still going on. As I’ve written about before, the launch of a telehealth service is [not a Health IT project](#), but rather the launch of a new clinical service.

Yet even if people understand that notion, the temptation still seems to be high to assign most of the work to the IT Staff, including the project management of the overall service design, not just of the technology acquisition and deployment.

Misconception #3: Our IT staff is best suited to run our telehealth program.

Reality: Technology contributes only 10% to the success of the successful creation of a telehealth service. The key success factors are the design on the right workflow (40%) and conscious organizational change management (50%).

It’s not about the Technology

It has been my repeated experience that well over 90% of the problems with telehealth have nothing to do with the technology itself. Occasionally the technology may be cumbersome to use or problems arise from a lack of bandwidth or cell phone reception.

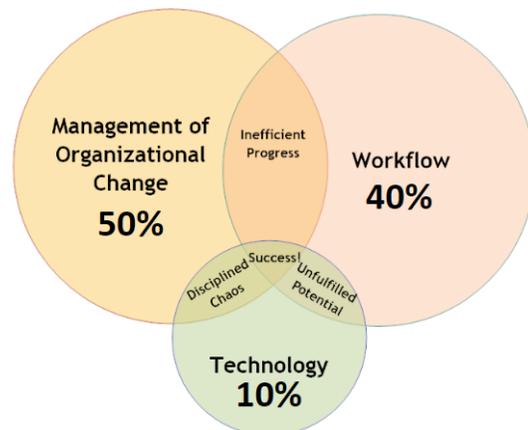
Typically, though, there is not a technology problem that a well-designed process (including training) cannot prevent, circumvent, or fix.

Now, granted, with the telehealth technology of the 1990s and early 2000s that definitely was not the case. Back in the early days, technology was a fickle friend and required a lot of finagling and finessing to get it to work just right.

But for the past 10 years or so, technology really has not been an issue.

Rather, the challenge mostly lies in getting people (including patients) to use the new technology, the new processes, the new service. There is resistance from physicians as it occurs to them as another technology put between them and the patient. There is confusion across all sorts of roles - from the billing staff to the check-in person to the IT help desk staff that didn’t know anything about the new telehealth service.

The secret to telehealth success lies in the joint design of comprehensive workflows that not only handle the “happy day scenario” (when things go the way they are supposed to) but also the times when things go wrong (predictably) or awry (unfathomably).



Thus the challenge in assigning IT staff to the design and launch of a new telehealth service lies in their lack of experience designing service workflows - especially clinical workflows. Furthermore, oftentimes IT project managers can communicate well with the IT staff and facilities etc. to get the hardware and software installed and configured, but are not as experienced in working with the clinical, administrative and operational

staff [that are required](#) to design and launch and deploy the new clinical service.

Delegating the ownership of telehealth to the IT department thus creates a triple challenge:

1. **Fumbling:** given that the skills needed to design and launch a new clinical service are outside the realm of IT, any assigned staff will, despite their best efforts, to some extent fumble. While healthcare staff (especially nurses) are highly supportive, the complexities of billing, credentialing, consent, scheduling etc. are beyond the typical experience of an IT staff (with nursing informatics staff being the laudable exception). And this fumbling leads to frustration (especially with physicians) that can prevent the successful roll out of this and future telehealth services.
2. **Opportunity Cost:** Given the inefficiency of fumbling, the extra time spent on getting the telehealth service is time that taken away from the IT staff to do the job that they are very qualified to do.
3. **Poor job satisfaction:** Given the many demands on IT -- our whole healthcare seems to be running on electrons these days -- it can be very frustrating to be given yet another assignment and, more importantly, one that is causing resistance and frustration in the physicians and other staff. This experience leaves IT staff equally frustrated and dissatisfied, with all the repercussions of a low job satisfaction.

So, who IS best suited?

With the premise that telehealth is a clinical service and not a tool or a clinical specialty, the best owner of a new telehealth service is truly all of the staff in the department that is responsible for delivering the telehealth service which includes all of the staff involved in the scheduling, preparation, documentation and billing. Yet this staff is also not adequately prepared in the design and launch, though their involvement as subject matter experts is absolutely critical.

When it comes to the design and launch of a new telehealth service, most healthcare organizations typically do not have the qualified staff experienced in the design of clinical services and

the effective management of the organizational change. Some larger organizations have created project management positions and business analysts at the enterprise level (i.e., outside of IT) that are perfectly suited to manage a project like this. Organizations without access to these expertise either need to create this position or look for temporary outside expertise to assist in the launch of a new telehealth service.

Ultimately, of course, the IT staff has to be involved and should be involved as early as possible, but they should not be the ones doing the heavy lifting.

Because you only have one chance to make a first impression and it should be an extraordinary one!



5 Things your Telehealth Vendor cannot do for you

Misconception #4: 5 Things your Telehealth Vendor cannot do for you

Whether you're building a new house or renovating - you'll typically rely on a multitude of different trades to help you get all the things done that need to be completed. The plumber, the electrician and the painter, just to name a few.

And you wouldn't ask your HVAC guy to hang your sheet rock or your electrician to hook up your sink (unless you have a fancy, motion-activated faucet).

Yet somehow the perception seems to pervasive that telehealth is simply about choosing the right vendor with the right technology and that the vendor (and maybe your CIO) is all you need to launch a new telemedicine service.

Which brings us to the 4th misconception about telehealth in our series of the [six most common misconceptions](#) about telehealth:

Misconception #4: Telehealth Vendors will help us to properly set up our telemedicine services.

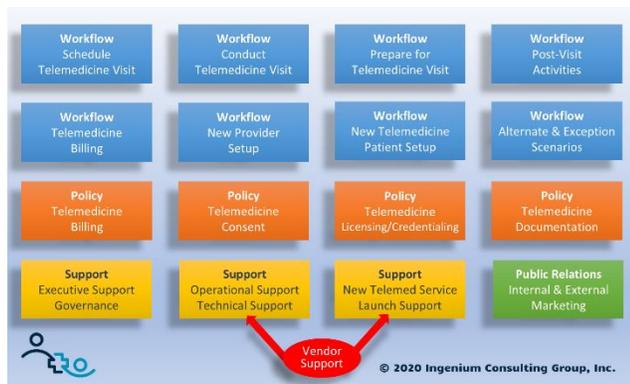
Reality: Great vendors are involved in ensuring the proper configuration and training of users. They ([including your IT staff](#)) are not positioned or qualified to define all of the workflows, write the policies, figure out the billing, licensing & credentialing and manage the marketing and the organizational change that launching a telemedicine service requires.

What telehealth vendors are (or, at least should be) good at is two things:

1. to provide you with a user-friendly, reliable, secure solution that will enable you to launch and operate your telemedicine service smoothly
2. to provide prompt, friendly and knowledgeable support if things do not work as intended or desired

As we explored before, [it takes a village](#) to launch a telemedicine service and technology is but one small part.

As the following graphic illustrates, launching telemedicine requires the definition of about a dozen of workflows, the definition of a variety of policies, defining and setting up support and promoting the service internally to the staff and externally.



And vendor support, as shown in the graphic, only addresses a small portion of the variety of activities necessary to launch a new telemedicine service.

Rather than relying on the vendor you will have to coordinate and synchronize the activities of a whole host of parties across the organization from the schedulers to the coders, from compliance to

public relations, from the CEO, CFO, and COO to the CMO and CIO.

And preferably have it all coordinated and managed by someone who's an expert in designing and launching clinical and telehealth services.

Then your telehealth technology vendor will fit right in and can do what they do best: provide you.



Misconception #5: All Telehealth Services are similar to each other

Or stated in other words: Once we've established one telehealth service, we are doing telehealth.

The reality is, that "[One swallow does not a summer make](#)". If you have established a single telehealth service, you have simply established a single telehealth service.

There are a great number of differences between the dozens or even hundreds of different types of telehealth services. And even if most things stay the same (same organization, same patient demographics, same geographic area), just moving from behavioral health to primary care or from pediatrics to behavioral health changes a lot of the key elements that make out a telehealth service, such as the workflows, policies, and the technology.

Most health systems will over the next months and years launch about 50-60 different telehealth services with smaller practices or rural community health centers looking at launching about a dozen different services.

Yet many organizational leaders and staff believe that since they launched one telehealth service, they are already “doing” telehealth, when in reality what they have is one or two telehealth services launched.

The Big World of Telehealth

Figuratively speaking, there are thousands of different telehealth use cases based on the permutation of the various characteristics of a telehealth visit.

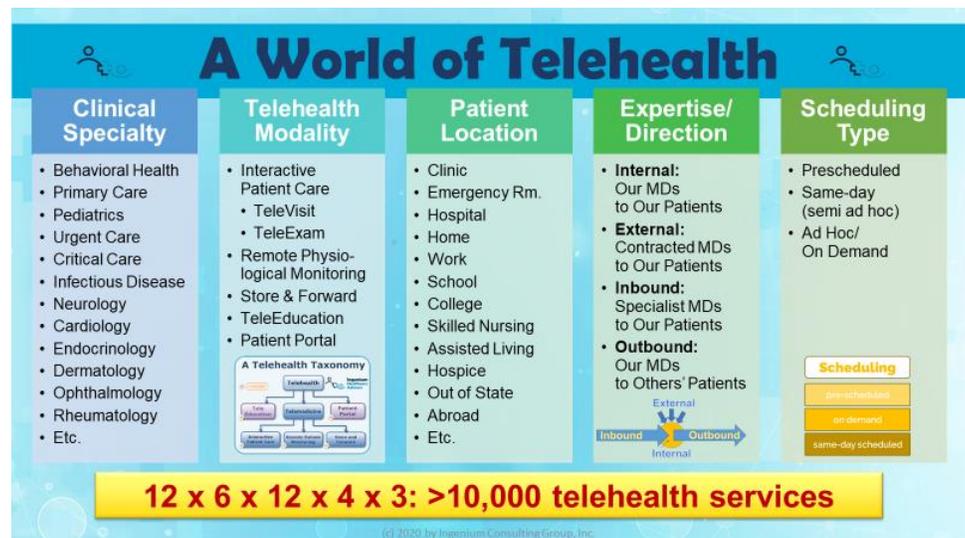
Which specialty is the service for? Is it a visit or does it include a virtual exam? Is the patient at home, at work, or in a clinic? Are our physicians providing the services? Are the appointments prescheduled, ad hoc, or same day appointments?

Telehealth is delivering care at a distance and by that definition covers the *complete* spectrum of care delivery — across all clinical specialties, across the various stages of care (from preventive to acute to chronic), to the many different locations (e.g., home, work, SNFs, ERs, rural clinics, etc.). There are dozens if not hundreds of different “use cases” for telehealth that require different business models, different technology, different workflows and also differ in their clinical efficacy.

- A **TeleStroke** service requires different equipment, different billing and reimbursement and very different workflows than a **TelePsychiatry** visit with a patient at a rural clinic.
- A **Televisit** to a patient’s home requires a different software than a Televisit with a patient presenting at a remote clinic.
- **TeleExams** for specialties such as cardiology or pulmonology require different tools than TeleExams for primary care.
- **Remote Patient Monitoring** for the purpose of preventing readmissions is a different service, than managing the high utilization of COPD patients through Remote Patient Monitoring.

Taken together (and multiplied) this graphic gives you an idea on how complex the world of telehealth can be and how the workflows and the technology will vary from use case to use case.

The difference across the different flavors of telehealth is not limited to the technology or workflows. Scalability, staffing models and business models are additional aspects of telehealth that vary from use case to use case. In addition, with the mounting competition challenging the incumbent healthcare delivery



structure, it will become imperative to leverage telehealth as a key business tool for new business models.

Misconception #6: Telehealth is just a different way to deliver care.

The final misconception stems from the fallacy that telehealth is all about putting a webcam between a physician and a patient, thereby failing to understand the complexities as well as the opportunities that lie with telehealth.

The reality is, as the Covid-19 health crisis has shown, that telehealth is becoming *the way* to deliver care. The forward thinking leaders of many organizations are already using telehealth to strategically drive their strategic goals.

Telehealth as the Core Strategy for the Delivery of Care

Rather than thinking about telehealth as a temporary solution while we are waiting for the lifting of physical distancing restrictions, the best leaders are already thinking about 2021 and beyond when telehealth will become a mainstay in the arsenal of care delivery tools.

Just like it takes a village to launch telehealth, telehealth conversely also directly impacts a multitude of a healthcare organization's strategic objectives, including

- **lowering the cost of care** by keeping people away from the ER and preventing readmissions
- **growing market share** by offering convenient access across a wider geographic area.
- **improve patient satisfaction** through convenience and fostering independence
- **fostering patient safety** during the outbreak of a viral pandemic
- **improve your standing in the community** by bringing more diverse services, etc.

The following graphic illustrates the various benefits that telehealth can provide to healthcare organizations, to help them accomplish their strategic goals.

| Telehealth: A Strategic Tool | | |
|---|--|---|
| Service | Quality | People |
| Improved Convenience "One-stop shopping" Additional Service Lines | Timelier Access Improved Care Transitions Improved Continuity of Care | Attract and Retain Talent Practice on Top of License Work Schedule Flexibility |
| Finance | Growth | Community |
| Increased Revenue Reduced Cost (e.g., ReAdx) Reduced Penalties | Expanded Geographic Reach Competitive Advantage Increased Pt. Retention | Reduced Travel Chronic Dx Management Health Education |

About Christian Milaster

Christian Milaster is an expert in optimizing the delivery of care through Digital Health & Telehealth.

Christian is the founder and president of Ingenium Digital Health Consulting and the Executive Director of Healthcare Shapers USA. Born, raised and trained in Germany as an Engineer, Christian has worked at IBM Global Services and studied healthcare delivery for 12 years at the Mayo Clinic in Rochester, Minnesota. Since 2012 he has been a strategy, design, and implementation advisor at the intersection of Care Delivery and Technology to numerous health systems, behavioral health agencies, community health organizations, urgent care organizations, federally qualified health centers, etc.

The Common Misconceptions, debunked.

Misconceptions often arise from a limited understanding of complex subject matter without realizing it, often succumbing to the Dunning-Kruger effect.

The facts, however, are:

1. That the launch of telehealth is not an IT project but rather the launching of a new clinical service offering, initiated and supported by the executive and clinical leadership.
2. That many different technologies have their place in a variety of different telehealth use cases and there truly is no single technology or even vendor that can cover the whole diverse spectrum of telehealth.
3. That telehealth launch is best run by telehealth experts who have done it before and that IT has a crucial role, but must not be the leader.
4. That telehealth vendors can offer great solutions but are not suited nor interested in helping organizations to figure out how to make telehealth work.
5. That there are dozens of different telehealth use cases which all require variations on the workflows, policies, technology, marketing, etc.
6. That telehealth is now definitely a force to be reckoned with, that telehealth is here to stay and a very versatile strategic tool that can generate revenue, improve patient outcomes, lower cost and improve physician and staff satisfaction.



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