Over the prior 12 months, the adoption of telehealth technology has surged to an all-time high—you’ve seen it, whether you are on the payer side, the health delivery side, in a group practice, or an employer, broker, or a government agency. The reality is that telehealth has broken new ground in the last few months. According to some statistics, the adoption of telehealth technology has rocketed to the top of any other technology in healthcare, beating the adoption of electronic medical records (EMRs), e-prescribing, and some of the household names in diagnostic product and devices.

But the breakneck speed in the adoption of telehealth has come with a side-effect. The proliferation of knowledge on how telehealth can best serve the healthcare industry, in a safe way and in a way that delivers meaningful value in financial returns, has been lagging behind the “sparkly object,” which is the video conferencing, which everybody knows and loves. The result is that many of the entities that have recently embarked on telehealth have been finding themselves disappointed, or not knowing what is right and wrong for them in terms of adopting telehealth.

The reality is that nearly every healthcare enterprise is thinking about making telehealth part of the way that they do business, but many of the assumptions that now guide the adoption of telehealth are in fact questionable. These are some of the most popular misconceptions.

Myth Number 1
This is the notion that telehealth is essentially equivalent to the apps that people have on their phones that allow a person to quickly—within a couple of minutes—reach and interact with a live clinician, usually via video, although there are other modalities as well. And because of the “blind date” nature of this interaction, it is usually limited to what most people consider very basic primary care services.

The reality is that the technology that is running telehealth is actually at the core of three different vertical applications of this technology. It is important, when you’re getting into telehealth, to know what this technology can actually do. One type is direct-to-consumer acute care, primarily on demand, 24 hours a day, in all 50 states. What makes it successful is a remarkable consumer experience: the ability to get healthcare very quickly from the comfort of your own home. There are a couple of companies that participate, large scale, in this area.

What is less well known is that the same technology is also serving in significant ways in follow-up care. Clinicians are using this technology with their own patients. This is being adopted because the providers may be deemed to be responsible for the well-being of a patient, even when that patient is not in front of them.

The third way this is being used is in connecting providers with themselves, as in tele-stroke or tele-ICU. It is utilizing this technology to find a skill set to treat the patient. There is another set of companies that are doing that.

In fact, telehealth is working in more than 140 different applications, including the arrival of telehealth into retail and other sites.

It has been incorporated into physical devices. One example lets any owner of an Apple watch become part of a study that monitors their heart rate, and indicates if they show signs of atrial fibrilla-
tion. When that happens, a physician shows up on their phone—literally, within minutes. This too is telehealth. When healthcare providers think about building telehealth into their systems, these are the sorts of things they need to consider.

These kinds of applications are actually growing at amazing speeds. The growth of telehealth for chronic care has grown six-fold, in one year. This is a breakneck speed not previously seen in any technology within healthcare.

Myth Number 2
The second myth pertains to the return on investment with telehealth. The assumption has been that the amount you make with telehealth is simply a multiple of the number of patients you connect with, and the financial margin that each generates. But this is a tough formula to follow. If you look at the general calculation, most of the urgent care telehealth visits are generating $15 to $20 margin per visit. This is, when you take the cost to the consumer and deduct the cost of the physician. And then on top of that, you have to pay for the telehealth infrastructure.

So you have to do nearly 2,000 visits every month in order to break even. That is for urgent care. For chronic care, in sharp contrast, it takes only two patients per month, if telehealth is used appropriately within the organization, to break even with the application of telehealth.

If you add into this all of the different ways that telehealth is operating around the country, you begin to see that the application of telehealth is far more widespread than originally assumed. In fact, telehealth can best be considered as a distribution mechanism for healthcare services—all of it. As such, it becomes essential for healthcare entities operating in the next decade.

Myth Number 3
Myth number three is that the way to do telehealth is to buy a system from a tech company, and then, literally, put your physicians on it. The reality is that that’s a far cry from what is actually happening.

In fact, most systems have their physicians operating at a relatively high level of efficiency. Most of them don’t have the time to begin to offer telehealth—especially not urgent care. Most systems are instead using clinicians from the telehealth vendors they work with. It is only roughly three years after initial deployment of telehealth that you see systems using their own clinicians.

Delivering 24/7 services is very hard, and also, clinicians need to be trained to deliver telehealth specifically.

Myth number 4
This one pertains to marketing. Healthcare systems frequently assume that they can use their usual means to sell telehealth services. That is not the case: most of these standard marketing programs address a local audience. With telehealth, your audience is fundamentally digital, and these individuals respond to a completely different way of communicating. It is a completely different art form from what is needed to communicate with a local audience.

Ads on Google or Facebook may be considered more appropriate. But the reality is that digital marketing is much more ferocious than that. When you are spending money on a digital campaign, there needs to be a second-by-second feedback loop that allows the telehealth product to sense where patients are coming from, correlate that with which digital channels the healthcare system has invested in, and then alter the investing accordingly.

Of course, the competition is greatly expanded too. Your telehealth enterprise is competing with every national service.

Myth number 5
How do you get paid for telehealth? In this regard, it is very different from traditional in-person medicine. There is a wide diversity of ways that claims for this service must be submitted. The telehealth system put in place has to have the capability of handling all of them.

Myth number 6
Many realize that the telehealth visit record needs to be recorded in the EHR. This is true, but it actually requires a significantly higher level of integration. Patient identities have to match between telehealth and the EHR. The staff has to manage the patient flow that’s coming via telehealth, just as if they were in the office. Paying and billing have to be synchronized; all of the data need to be communicated in the same format.

Myth number 7
It is a common assumption that telehealth is very young, that it is still forming itself. So many presume that it would make sense to just stand on the sidelines now, and let it become better—and then jump in. But that couldn’t be further from the truth. The time is now; in many markets, the time may have already passed. In fact, a recent survey revealed that one in five patients would actually switch clinicians to gain the convenience of telehealth. That translates to 50 million Americans.

By 2024, it has been forecasted, there will be more telehealth visits than in-person interactions. Healthcare systems need to prepare for that eventuality.

This article is based on a presentation by American Well.