



MUHAMMADIYAH HEALTHCARE FACILITIES READINESS IN TELEMEDICINE IMPLEMENTATION

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ABSTRACT

Background: Telemedicine is the use of electronic devices by healthcare practitioners to interact with patients and with one another, including patient consultations, diagnosis, and appointment scheduling. Telemedicine not only improves provider-patient interactions, but it also strengthens the network of healthcare professionals. The capacity and willingness of an organization to modify its present operating model is referred to as organizational readiness. It may also refer to being informed of the existing situation of the organization before moving to a new change. Organizations that successfully implement a telemedicine program have the internal capability and willingness to move in new directions, a focus on the ability to acquire the new skills required to successfully implement change, and a willingness to focus on the organization's and its employees' desire to change. Because telemedicine has not been completely established in Muhammadiyah/Aisyiyah health institutions, it is vital to examine their preparedness to carry out telemedicine. The goals of this study are to determine and examine the readiness of health facility management to undertake telemedicine. The research method used will be quantitative with a cross-sectional approach. Because it has health facilities all around Indonesia, the Muhammadiyah organization was picked. Organizational readiness to deploy telemedicine is influenced by factors such as change attributes, leadership support, organizational situation, and organizational member mood. However, organizational assistance had no discernible impact on organizational readiness in the long run. They do, however, have a cumulative effect of 73,8 percent on organizational preparedness to implement telemedicine.

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INTRODUCTION

Background

Telemedicine is the use of electronic devices by healthcare providers to communicate with patients and with one another, including performing patient consultations, making diagnoses, and scheduling follow-up appointments. Telemedicine may also include patient self-care and self-monitoring regimens in the patient's home. Telemedicine has become an integral aspect of health care delivery in a number of nations, including the United States of America, the United Kingdom, and parts of continental Europe. In the United States of America, 72% of hospitals and 52% of physician groups have telemedicine programs, and 74% of big businesses provide telemedicine to their employees as part of their healthcare benefits. The Obama administration promoted telemedicine as part of its 'Obamacare' policies, which paid healthcare providers for reducing hospital admissions and in-person medical consultations. The National Health Service of the United Kingdom is also pursuing expansion of telemedicine initiatives. The Australian government recently launched the Health Care Homes concept, which will encourage patients with chronic and severe illnesses to utilize digital self-care,

medical management, and telemedicine technology at home (Lupton and Maslen, 2017).

Telemedicine has advanced significantly during the last two decades. While the sector has changed dramatically in recent years, its primary objective has remained constant: to provide access to care. While numerous parts of our present health care system require improvement, the urgency of enhancing access to medical care remains important. To overcome access hurdles, resourcefulness and smart creativity will be required (Barbosa *et al.*, 2021).

One of the current hurdles is a global pandemic driven by the coronavirus responsible for severe acute respiratory syndrome is providing a historic challenge to health care workers, patients, and societies worldwide. Hospitals are rapidly expanding their intensive care capacity in an effort to contain the pandemic's consequences. Staffing, technological, and infrastructural constraints, on the other hand, are hindering progress in this area. With an estimated 5% rate of critical care unit (ICU) hospitalization, the pandemic swiftly surpassed global hospital capacity. New techniques are urgently needed to avert a medical crisis in reaction to the issue. Diverse telemedical approaches have been integrated into regular

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patient care globally, in both the ambulatory and hospital sectors (from the home environment to admission, treatment, and discharge), with adaptations established for each use case (Peine *et al.*, 2020).

Telemedicine is not only effective for provider-patient interactions but also creates a more connected network between healthcare professionals. The specialties that were reported to most frequently use telemedicine to communicate with other health workers were emergency department (38.8%), pathology (30.4%), and radiology (25.5%). With the growing need for a multidisciplinary approach to patient care and provider partnerships, telemedicine has helped to further strengthen relationships between patients, healthcare providers, and other stakeholders. In the face of the COVID-19 pandemic, the relevance of telemedicine is becoming more acute. The use of telemedicine is rapidly being promoted, and laws regarding its scope are changing rapidly (Hyder and Razzak, 2020).

Telemedicine approaches can be seen in a form of telehealth. Recently researched telehealth based care for pregnant women mental health and antenatal care show that their implementation show great benefits. Telehealth can aid in the monitoring of pregnant women's health, especially mental health. The use of tracking on mobile phone applications can assist pregnant women and health care providers in determining whether or not they are experiencing mental health issues. Pregnant women could monitor their own health and blood pressure, fetus movement, uterus contractions, and boost their ability to handle stress connected to mother-fetal health while using Web-Based antenatal care (Tendean *et al.*, 2021).

In 2013, there were about 4 neurologists per 100,000 people in the country, having treated more than 700,000 strokes per year. To overcome the shortage of neurologists, some hospitals and offices implement special telemedicine measures for the treatment of stroke, or telestroke. Telestroke is a common method used in emergency departments to contact specialist neurologists, reducing the need for specialists at a single health facility. Using telemedicine, neurologists can communicate remotely with emergency physicians and patients with stroke and recommend treatment faster than previously available (Aita *et al.*, 2013).

Telemedicine is also very useful in radiology, because almost all radiological examinations produce digital content, which is called teleradiology. In 2014, teleradiology reportedly accounted for more than half of all telemedicine services performed in the United States. Images and reports collected from in-person or telemedicine examinations can be sent to a remote radiologist, whose reports can be sent to the patient's doctor or other health care provider. Especially in areas where there is a shortage of radiologists (Weinstein *et al.*, 2018).

Fields that rely on face-to-face communication, such as psychiatry, have been able to provide care of a quality comparable to using telemedicine. In 2016, 43.1% of the 44.7 million Americans with any type of mental illness had used mental health services in the United States. Service providers only need to send a request for a patient visit via computer, and the request is answered by a specialist at the university. The program used is very simple, consisting of an iPad for service providers and a video camera for patients. Nurses can also use the program to record videos of anxious patients and

safely send those videos to specialists who can use the videos and the patient's medical records to recommend treatment techniques and how to calm the patient (Hasselberg, 2020)

Organizational readiness is the ability and willingness of an organization to change its current way of operating. Organizations that successfully implement a telemedicine program have the internal ability and willingness to move in new directions, focus on the ability to acquire the new skills needed to successfully implement change, and a readiness to focus on the desire of the organization and its employees to change. The activity of assessing organizational readiness will identify any key challenges that could delay or prevent the success of the new program. Organizational strengths can be harnessed to assist in program development and acceptance (Shaw *et al.*, 2013).

Organizational readiness for change is considered an important capital for the successful implementation of complex changes in the healthcare sphere. Some experts consider that failure to establish adequate organizational readiness accounts for more than half of failures in large-scale organizational change efforts. Change management experts have proposed various strategies for creating readiness by changing existing mindsets and creating motivation for change. This strategy includes noticing the difference between current and desired performance levels, eliciting dissatisfaction with the situation remaining unchanged, creating an attractive vision of the future, and fostering confidence that future goals can be achieved (Weiner, 2009).

Assessment of the readiness of health facilities in implementing telemedicine can be assessed starting from organizational readiness which is defined as psychological readiness and behavior of organizational staff. This includes their willingness (commitment to change) and ability (change efficacy) to initiate and sustain change. Change commitment and motivation to take action arise when staff feel that they want, and value change. It's not when they feel compelled that they have no choice and are obligated to take action. To motivate staff to change, they must be dissatisfied with the current state of affairs and understand or be convinced of the benefits to be gained. Change efficacy i.e., organizational staff's belief in their ability to carry out change actions or the possibility of successful change, as evidenced by success stories from similar organizations that rely on staff understanding and assessment of job demands and available resources (Kabukye *et al.*, 2020).

Currently, the Muhammadiyah Central Executive has health charities at the primary and advanced levels spread throughout Indonesia. The number of health facilities belonging to the Muhammadiyah Central Executive based on 2019 data is 317. It consists of 102 Muhammadiyah and Aisyiyah hospitals, as well as 215 Muhammadiyah and Aisyiyah clinics. Telemedicine has not been fully implemented in these health facilities, therefore it is necessary to assess the readiness of these health facilities to carry out telemedicine.

Objectives

This research objectives are find out and analyze the readiness of health facilities management to conduct telemedicine.

METHOD

Study Design

The type of research that will be used is quantitative research with a cross sectional approach. This method was chosen with the aim of collecting data related to the independent and dependent variables at one time. This study will not intervene on research subjects. The data obtained will go through an analysis process on the basis of the theory that has been stated previously so that it can present information for further conclusions about the relationship between variables.

Setting

This study takes place online using Google form-based questionnaire which shared among every manager on Muhammadiyah/Aisyiyah clinics in Indonesia.

Participant

The subjects of this study were the managers and staff of health workers and non-nurses at primary level health facilities. The selected health facilities are health business charity health facilities owned by the Muhammadiyah Central Executive. The Muhammadiyah organization was chosen because it has health facilities spread throughout Indonesia. The object of this research is the organization's readiness for change in implementing telemedicine which includes change attributes, leadership support, organizational situation, change target attributes

Variables

This study has 4 independent variables and the dependent variable. The variables contained in this study are as follows:

- A. Independent Variable
 - Change Attribute
 - Leadership Support
 - Organizational Situation
 - Sentiments of Organizational Members
- B. Dependent Variable: Organizational Readiness

Measurements

The research instrument used in this study was a questionnaire based on the Organizational Readiness for Change conceptual model developed by Paré (Paré *et al.*, 2011) to measure organizational readiness in implementing Electronic Medical Records and modified to measure organizational readiness in implementing telemedicine. The process of adaptation and modification begins with translation into Indonesian.

1. Attributes of Change Variable will be assessed with questions numbered 1-10, consisting of subscales of clarity of change, suitability of changes, and efficacy of changes, each of which consists of 4 question items.
2. The Leadership Support Variable will be assessed with questions numbered 11-16 consisting of 4 top-management support questions and 3 questions regarding the presence of a project leader.
3. Organizational Situation Variables will be assessed with questions numbered 17-27 consisting of 4 questions each regarding the history of change in the organization, conflicts within the organization, and organizational flexibility.
4. Change Target Attribute Variable will be assessed by question number 28-31 which consists of 4 question items.

5. Finally, questions number 32-35 and the description at the end of the questionnaire are added to outline managers' perceptions of their organizational readiness.

The data obtained is the total score of the Likert scale that has been determined in the research instrument. Furthermore, each variable is searched for the average value of the total score and then compared between the independent variables and the dependent variable to determine the relationship between these variables. Data processing using SPSS with linear regression method to determine the correlation between variables.

Study size

The population of this research is the managers and staff of health workers and non-nurses of health business charities owned by the Muhammadiyah Central Executive at the primary level throughout Indonesia. The number of health facilities belonging to the Muhammadiyah Central Executive based on 2019 data is 317. It consists of 102 Muhammadiyah and Aisyiyah hospitals, as well as 215 Muhammadiyah and Aisyiyah clinics.

The sample size calculation was carried out on a population of 215 clinics belonging to Muhammadiyah leadership with a confidence interval of 99% and a margin of error of 15%. The calculation results obtained as many as 50 health facilities. Each health facility will require at least 1 manager. The staff at these health facilities can also fill out a questionnaire if needed.

The sampling method that will be used is non-probability sampling, with quota sampling technique. After the number of samples are considered sufficient, no more samples are going to be included.

Quantitative variables

For the analyses, the independent variables are measured their correlation toward dependent variable. We are using univariate and multivariate approach to see whether their independent variables are independently and consecutively affect dependent variable.

Statistical Method

Based on our objective to find out how the independent variables are influencing dependent variable, we used Pearson Correlation model to determine which independent variables are significantly affect dependent variables. Furthermore, we see the model summary to determine how strong are the influence of independent variables toward dependent variable. Finally, we measure how the independent variables consecutively influence the dependent variable using linear regression. All the statistical analysis are done using IBM SPSS Statistic program.

RESULTS AND DISCUSSION

Participants

In this study there were 114 respondents from 50 different clinics. The profile of the respondents in this study included age, gender, education level, profession, position, and length of service at the clinic. Respondent profiles are described in the following table:

Table 1 Participants Characteristics

No	Profile	f	%	No	Profile	f	%
1.	Age			5.	Profession		
	<=30	45	39,5		Doctor	38	33,3
	31-40	50	43,9		Nurse	28	24,6
	41-50	14	12,3		Administration	14	12,3
	>=51	4	3,5	Midwife	14	12,3	
2.	Gender			Dentist	9	7,9	
	Female	75	65,8	Analyst	5	4,4	
	Male	38	33,3	Pharmacist	4	3,5	
3.	Education			6.	Year of experience		
	JHS	35	30,7		<=1	20	17,5
	Diploma	61	53,5		1-5	47	41,2
	Undergraduate	11	9,6		6-10	29	25,4
	Postgraduate	7	6,1	>10	18	15,8	
4.	Position						
	Head of Clinic	33	28,9				
	Manager	12	10,5				
	Staff	69	60,5				

Based on gender, it can be seen that most of the respondents are women. The number of female respondents was 75 respondents covering 65.8% of all respondents. The age range of respondents is dominated by respondents aged 30-41 years as many as 50 respondents covering 43.9% of the total respondents. Furthermore, when viewed from the educational background, most of the respondents have an educational background at the undergraduate level as many as 61 respondents which cover 53.5% of the total respondents. Then based on the position, most of the respondents were staff as many as 69 respondents covering 60.5% of the total respondents. When viewed from the profession, most of the respondents are doctors, totaling 38 respondents, this number covers 33.3% of the total respondents.

Table 2 Descriptivedata

Question Item	Mean	Std. Deviation
VC1	3.10	.441
VC2	3.11	.456
VC3	3.05	.396
VC4	3.21	.470
CA1	3.20	.464
CA2	3.05	.546
CA3	2.92	.551
CA4	2.89	.576
CE1	3.09	.389
CE2	3.08	.402
TMS1	2.95	.458
TMS 2	2.87	.507
TMS 3	2.81	.513
TMS 4	2.88	.482
PM1	2.79	.587
PM2	2.89	.504
PM3	2.87	.507
OHC1	2.85	.552
OHC 2	2.87	.451
OHC 3	3.09	.452
OC1	3.16	.472
OC2	3.22	.621
OC3	3.00	.665
OC4	2.16	.472
OF1	2.75	.545
OF2	1.99	.282
OF3	2.32	.617
OMS1	2.88	.482
OMS2	2.82	.472
OMS3	3.00	.441
OMS4	2.83	.579
Organizational Readiness1	2.96	.398
Organizational Readiness2	2.88	.551
Organizational Readiness3	2.83	.440
Organizational Readiness4	2.99	.431

Finally, based on the length of work at the current clinic, most of the respondents have experience of 1-5 years at the clinic with a total of 47 respondents which covers 41.2% of the total respondents.

The validity test of the questionnaire items was carried out using the IBM SPSS 21 program using the Pearson correlation method on each part (variable) by comparing each question item score with the total score of the variable. The results of the validity test can be seen in the following table. Based on the test results, it was found that question items no. 9, 10, 18, and 25 were invalid because they had a significance of more than 0.05, so the four items were deleted and not used in data collection.

The reliability test of the questionnaire items was carried out using the IBM SPSS 21 program after using the Pearson correlation method. The results of the reliability test can be seen in the appendix. Based on the test results, it was found that all question items are reliable and can be used in data collection because they have a Cronbach alpha value of 0.958.

Based on descriptive data, it can be seen from each variable represented by attributes and sub-attributes of the questionnaire. Variable attribute of change (AC) which consists of sub-attributes vision clarity (VC), change appropriateness (CA), and change efficacy (CE). Variable leadership support (S) which consists of sub-attributes top management support (TMS) and the existence of a project manager (PM). Variable organizational situation (OS) which consists of sub-attributes history of change (OHC), organizational conflict (OC), and organizational flexibility (OF). The change target attribute variable (CTA) was assessed by sub-attribute organization member sentiment (OMS). Organizational Readiness (OR) with the same name.

Main results

Pearson Correlation

Table 3 Pearson Correlation

	Organizational Readiness	Attributes of Change	Leadership Support	Organizational Situation	Change Target Attribute
Organizational Readiness	1.000	.592	.561	.212	.571
Attributes of Change	.592	1.000	.660	.096	.338
Leadership Support	.561	.660	1.000	.022	.289
Organizational Situation	.212	.096	.022	1.000	.325
Change Target Attribute	.571	.338	.289	.325	1.000

Pearson correlation test will show the effect of each independent variable on Organizational Readiness. It can be seen from the table that each independent variable has an influence on the knockouts variable. The Attributes of Change variable has an effect of 0.692 on Organizational Readiness. The Leadership Support variable has an effect of 0.561 on Organizational Readiness. The Change Target Attribute variable has an effect of 0.571 on Organizational Readiness. The Organizational Situation variable has an effect of 0.212 on Organizational Readiness where this variable has the smallest effect when compared to other independent variables.

Hypothesis testing

Table 4 Hypothesis testing

	Organizational Readiness	Attributes of Change	Leadership Support	Organizational Situation	Change Target Attribute
Organizational Readiness	.	.000	.000	.012	.000
Attributes of Change	.000	.	.000	.155	.000
Leadership Support	.000	.000	.	.407	.001
Organizational Situation	.012	.155	.407	.	.000
Change Target Attribute	.000	.000	.001	.000	.

H1. Change Attributes affect Organizational Readiness
 H01: Attribute Change does not affect Organizational

Readiness

H11: Change Attributes Affect Organizational Readiness
 According to the results of the analysis in this study, it shows the effect of Attributes of Change on knockouts with a p value of 0.00 (<0.05). This means that H01 is rejected and H11 is accepted.

H2. Leadership Support affects Organizational Readiness
 H02: Leadership support does not affect Organizational Readiness

H12 : Leadership support Affects Organizational Readiness
 According to the results of the analysis in this study, it showed the effect of Leadership Support on knockouts with a p value of 0.00 (<0.05). This means that H01 is rejected and H11 is accepted.

H3. Organizational Situation affects Organizational Readiness
 H03 : Organizational situation does not affect Organizational Readiness

H13: Organizational Situation Affects Organizational Readiness

According to the results of the analysis in this study, it showed the effect of Organizational Situation on knockouts with a p value of 0.012 (<0.05). This means that H01 is rejected and H11 is accepted.

H4. Organizational Member Sentiments affect Organizational Readiness

H04: Organizational Member Sentiment does not affect Organizational Readiness

H14: Sentiments of Organizational Members affect Organizational Readiness

According to the results of the analysis in this study showed the effect of Change Target Attribute on knockouts with a p value of 0.00 (<0.05). This means that H01 is rejected and H11 is accepted.

Model Summary

Table 5 Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.738 ^a	.545	.528	.23807

When referring to the model summary table, it is known that the R value is 0.738. This means that the variation of all independent variables can affect the change in the knockouts variable by 73.8%. Meanwhile, 26.2% of changes in the knockouts variable were influenced by other variables outside of this study.

This means that the attributes of change, management support, organizational situation, and change target attributes together affect organizational readiness by 73.8%.

Linear Regression

Table 6 Linear Regression

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B	
	B	Std. Error	Beta			Lower Bound	Upper Bound
(Constant)	.131	.398		.329	.743	-.658	.919
Attributes of Change	.268	.083	.285	3.244	.002	.104	.432
Leadership Support	.230	.076	.261	3.014	.003	.079	.381
Organizational Situation	.112	.139	.055	.807	.422	-.164	.388
Change Target Attribute	.346	.066	.382	5.248	.000	.215	.477

Based on the results of the table, it can be seen that the value of the constant coefficient is 0.131 with a significance of 0.743 (> 0.05). This means that if the Attributes of Change, Management Support, Organizational Situation, and Sentiment of Organizational Members are 0, the Organizational Readiness is 0.131. However, this result is not significant because the p value > 0.05.

The coefficient value of the Attribute of Change constant has a value of 0.268 with a significance of 0.002 (<0.05). This means that assuming the variables Leadership Support, Organizational Situation, OMS are fixed or unchanged, every 1 unit increase in Attribute Change will increase organizational readiness by 0.268. This result is significant with a significance value of 0.002 (<0.05).

Leadership Support constant coefficient value has a value of 0.230 with a significance of 0.003 (<0.05). This means that assuming the variables Attributes of Change, Organizational Situation, OMS are fixed or unchanged, every 1 unit increase in Management Support will increase organizational readiness by 0.230. This result is significant with a significance value of 0.003 (<0.05).

The coefficient value of the Organizational Situation constant has a value of 0.112 with a significance of 0.422 (>0.05). This means that assuming the variables Attributes of Change, Leadership Support, OMS are fixed or unchanged, every 1 unit increase in Organizational Situation will increase organizational readiness by 0.122. However, this result is not significant with a significance value of 0.422 (> 0.05).

Organizational Member Sentiment constant coefficient value has a value of 0.346 with a significance of 0.000 (<0.05). This means that assuming the variables Attributes of Change, Leadership Support, Organizational Situation are fixed or unchanged, every 1 unit increase in Organizational Member Sentiment will increase organizational readiness by 0.346. This result is significant with a significance value of 0.000 (<0.05).

DISCUSSION

Key results

Attribute of change, leadership support, organizational situation, and organizational member sentiment are significantly influence organizational readiness to implement telemedicine. But consecutively the organisational support gave no significant influence on organizational readiness. However, they consecutively affect organizational readiness to implement telemedicine by 73,8%. This result considered high, although the remining 26,2% influence from another factors are still unknown.

Limitation

This study are limited on Muhmmadiyah/Aisyiyah clinics in Indonesia. Our variables are measuring indogenous factor that lies on the organization.

Interpretation

Attribute of Change

This variable is assessed by 3 sub-attributes. The mean of Attributes of Change variable is the highest when compared to other variables. This is supported by the highest value found in the CV sub-attribute and the lowest in the CA sub-attribute. When viewed from each questionnaire item, the question item VC4 has the highest value while CA4 has the lowest value among other items in this variable. Item VC4 asks the need for telemedicine to improve clinical services. Meanwhile, item CA4 asks that the application of telemedicine is the best choice. Based on the results of the analysis, this variable independently or together with other independent variables has a positive and significant influence on organizational readiness to implement telemedicine.

Leadership Support

This variable is assessed based on 2 sub-attributes in it. The highest average value is found in the TMS sub-attribute and the lowest is in the PM sub-attribute. When viewed from each questionnaire item, the question item TMS1 has the highest value while PM1 has the lowest value among other items in this variable. Item TMS1 asks the manager's commitment to implementing telemedicine. While item PM1 asks that there are figures who are actively promoting the implementation of telemedicine. Based on the results of the analysis, this variable independently or together with other independent variables has a positive and significant influence on organizational readiness to implement telemedicine.

Organizational Situation

This variable is assessed by 3 sub-attributes. The mean of Organizational Situation variable is the lowest when compared to other variables. This is supported by the lowest average value found in the OF sub-attribute. When viewed from each item of the questionnaire, the question item OC2 has the highest value among other items in this questionnaire, while OF2 has the lowest value among all the question items in the questionnaire. The OC2 item asks about the changes that were made because of political interests. While the OF2 item asks that any changes made take time and a long process. Based on the results of the analysis, this variable independently has an influence on the readiness of the organization to implement telemedicine. However, together with other independent variables, it has a positive but not significant effect on organizational readiness to implement telemedicine.

Change target attribute

This variable is only assessed by 1 attribute, namely OMS. When viewed from each questionnaire item, the question item OMS3 has the highest score while OMS2 has the lowest score among other items on this variable. The OMS3 item asks the computer usage habits of the staff. While the OMS2 item asks that staff will quickly adapt to the use of telemedicine. Based on the results of the analysis, this variable independently or together with other independent variables has a positive and significant influence on organizational readiness to implement telemedicine. In contrast to similar previous studies, in this

study this variable had a small effect and the most constrained on the health workers' proficiency in operating the computer (Kabukye *et al.*, 2020).

This variable is only assessed by 1 attribute, namely Organizational Readiness. When viewed from each questionnaire item, the question item KO4 has the highest score while KO3 has the lowest value among other items in this variable. Item KO4 asks that health facilities sap with changes. Meanwhile, item KO3 asks that the implementation of telemedicine will be achieved on time. Based on the results of the analysis, this variable is significantly influenced by the four independent variables in this study. However, there are Organizational Situation variables that are not significant in influencing organizational readiness. This is supported by the low score on the sub-attributes in the variable which states that implementing new things will take a long process and time.

CONCLUSIONS AND SUGGESTIONS

Conclusion

Based on the results of research and discussion in the previous chapter, it can be concluded that:

1. Attribute of Change, Leadership Support, Organizational Situation, and Change Target Attribute has an important role in assessing the readiness of health facilities to apply Telemedicine in a meaningful way
2. The Organizational Situation variable does not have a significant effect on Organizational Readiness
3. There are still other factors that affect the readiness of health facilities to implement Telemedicine.

Suggestion

For Primary Health Care Facilities that will Implement Telemedicine

1. The management of the health facilities can assess how prepared each member is with the instruments used in this study. The results of the assessment will show the dimensions in which health facilities have strengths and weaknesses.
2. Management can begin to consider whether the application of telemedicine is important and beneficial for them at this time.
3. Management appoints leaders to be able to initiate the implementation of telemedicine

For Further Research

For further research, the population of all health facilities in Indonesia can be used to see the readiness of health facilities in Indonesia as a whole. Furthermore, it can also consider other factors that have a major influence on organizational readiness.

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Conflict of Interest Statement

There are no possible conflicts of interest with respect to the authoring and publishing of this work, according to the authors.

Suggest Reviewers

Authors will be required to include the names, institutions, e-mail addresses, and research specialties of persons outside the author's institution who have not collaborated with the author(s) in the past 5 years and who are qualified to referee the paper. The present address of any author, if different from that where the work was carried out, should be supplied in a footnote.

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