How to Enhance Care and Reduce Costs through Telehealth Programs

Linda Chambers MBA, PT
Terese Higgins MSN, RN

Objectives

1. Describe steps necessary to develop a telehealth program that spans the care continuum.

2. Define the intensive home care model from hospital to home.

3. Identify opportunities to expand the program.
Objective 1: Describe steps necessary to develop a telehealth program that spans the care continuum.

- Identify population trends including admissions and claims data.
- Identify acute care and post acute care partners.
- Create communication and implementation plan.

Historical Perspective

- Telehealth – not a new modality in home care
- Impact of telehealth on patient satisfaction and hospital readmission rates
- Substitutive model of care
- Enhanced home care delivery system
Population Trends

Population 65+ by Age: 1900-2050

Source: U.S. Bureau of the Census

Population Trends

Segmentation based on healthcare spending

5%
5-15%
15-50%
50-100%

Percentage of total expenditure

51%
24%
23%
3%

15% of the patient population equals 75% of expenditure

Source: AHRQ
Population Trends

Medicare Average Cost


Select Telehealth Vendor

- Explore options available in your service area
- Equipment demonstrations
  - Connectivity
  - Ease of use
    - Patient Monitoring clinician
  - Report/data extraction
- Interview current clients
- ROI
Review Admission and Claims Data

- Claims data from payer
  - Annual data by age group and diagnosis
    - Emergency Room visits
    - Hospital observation stays
    - Hospital admissions

- Hospital discharge data sorted by age and diagnosis

- Emergency room visit data sorted by age and diagnosis

Establish Program Admission Criteria

- Target Population
  - Age
  - Payer
  - Hospital

- Target Diagnoses

- Admission checklist

- Screening tool

- Inclusion and Exclusion criteria
Determine Process Workflows

- Staffing plan
  - Program Coordinator
  - Telehealth Nurse
  - Telehealth Support Coordinator
  - Field clinicians

- Communication needs:
  - ER Team including nurses and physicians
  - Patient and family
  - Primary Care Physician
  - Specialist
  - Home Care intake department
  - ER2Home field team
  - ER2Home installation and monitoring team

Determine Process Workflows

- Mechanism of communication
- Investigation of adverse events
- Method of program awareness if patient has an ER visit or in-patient admission
- Weekly progress
- Discharge needs
- Discharge summary
ER2HOME PROCESS FLOW

1. **Patient Selection**: Patient presents to the Emergency Department.
2. **Patient Treatment**: Patient is treated and stabilized by ED Staff.
3. **Program Coordinator**: Reviews chart and meets with patient.
4. **Program Coordinator Determination**: Admits patient based on ED criteria and reviews admission eligibility with program criteria.
5. **Communicate to Coordinate**: ED discharge patient transported home.
6. **Monitor Care Integrate Services**: Home care admission within 4 hours of ED discharge. ANP contact within 72 hours of HC admission.
7. **TeleHealth RN**: Monitors TH sessions within central monitoring station.
8. **Home Care Provider**: Provides patient care per program protocol.
9. **Home Discharge**: Patient is discharged from ER2Home program on Day 30.

**Establish Measures of Success**

- Number of admissions
- Timeliness of admissions
- Number of discharges
- Number of early discharges
  - Reason for early DC
- Adverse events
  - ER visits
  - Hospital admissions
- Patient satisfaction
- MD satisfaction
- Cost
- System impact
Identify Acute Care Partners

- Manageable population size
- Geographic area
- Administrative Support for the program
  - Executive Leadership
  - Medical Staff
  - Nursing Staff

Communication and Implementation Plan

- Develop a comprehensive project plan for communication, implementation and rollout
- Establish a program steering committee
- Program name
  - Involves legal for program branding and registration
- Compliance department review
Communication and Implementation Plan

- Marketing needs
  - Web-based advertising
  - Printed materials
  - Internal newsletter and communication vehicles
  - External press

- Communication needs
  - Internal audience
  - External audience

Patient Education

- Video created

[Image of a video titled "telehealth video.wmv"]
Objective 2: Define the intensive home care model from hospital to home.

- ER2Home
- Transition2Home
- Success Stories
- Lessons Learned

ER2Home

- 30-day enhanced home care telehealth program.
  - Monitor blood pressure, heart rate and weight
  - Additional monitoring of oxygen level, ZOE fluid monitor and single lead ECG available

- Goal is to prevent a hospital admission and maintain the patient in their home for the 30 day episode of care.
ER2Home

- Chronic Diseases targeted: COPD (Chronic Obstructive Pulmonary Disease) and HF (Heart Failure).
- Acute Diseases: Pneumonia, Urinary Tract Infection and will consider VTE (venous thromboembolism).
- Admission screening completed by Program Coordinator.

ER2Home Protocol

- Admission visit by RN within 4 hours of ER discharge.
- ANP to make contact with patient within first 72 hours of care and consultation as necessary.
- Week 1: 2 TH sessions/day by 10am and 3pm; daily phone calls from TH RN.
  - 3–4 RN visits to the home
  - ANP visits as needed
- Week 2: 1 TH session/day by 10am; three a week calls from TH RN.
  - 2–3 RN visits to the home
  - ANP visits as needed
- Weeks 3–4: 1 TH session/day by 10am; weekly calls from TH RN.
  - 1–2 RN visits a week
  - ANP visits as needed
Transition2Home

› 30-day enhanced home care telehealth program.

› Focus is to prevent a 30 day readmission.

› Goal is to decrease the length of hospital stay by 1 day.

Transition2Home

› Targeted Diagnoses: COPD and HF

› Screening for appropriateness done by referral coordinator and admission nurse
Transition2Home Protocol

- Intake nurse contacts patient within 4 hours and admission visit by RN within 24 hours of hospital discharge.
- ANP to make contact with patient within first 72 hours of care and consultation as necessary.
- Week 1: 2 TH sessions/day by 10am and 3pm; daily phone calls from TH RN.
  - 3–4 RN visits to the home
  - ANP visits as needed
- Weeks 2–4: 1 TH session /day by 10am; weekly calls from TH RN.
  - 1–3 RN visits a week
  - ANP visits as needed

Home Care Resources

- Program Coordinator
- Telehealth nurse
- Advanced Nurse Practitioner (ANP)
- Visit nurse
- Telehealth Support Coordinator
Documentation

- Discharge planning: at the end of 30 days, evaluate need for continued skilled services or telehealth monitoring. Discuss with Telehealth Coordinator.

- Weekly progress reports will be sent to Insurance Case Manager and PCP during this program. Communication between field staff and Telehealth Coordinator is essential.

ER2Home case statistics April–July 2014

- 7 patients identified for the program.
- 2 were not admitted: 1 had cognitive issues and the second refused home care.
- 5 successfully completed the 30 day program
- 1 patient did end up being admitted to the hospital for insertion of a pacemaker during the 30 day program.
- The rest were successfully maintained at home with no admissions.
Transition2Home Statistics May–July 2014

- 46 patients admitted to the program to date
- 4 did return to the hospital in the 30 day program for re-admission rate of 11%

Success stories

- M.B. is a 53 y.o male with a new diagnosis of HF.
- Blood Pressure range 191/112 → 102/76
- Weight range 219 → 207
Success stories

- D.M. is a 78 y.o admitted to hospital with HF. On continuous oxygen.
- Placed in T2Home program at discharge.
- Blood Pressure range 170/83 → 110/60
- Weight range 211 → 209
- Weaned from oxygen use by discharge from home care.

Success stories

- J.R. is a 73 y.o. with hx end stage COPD.
- Frequent ER admissions due to anxiety
- Blood pressure range 159/78 → 124/71
- Weight stable at 140
Lessons Learned

- Palliative Medicine consults
- Education
- Communication
- Home care oversight
- Census
- Physician buy-in

Objective 3: Identify opportunities to expand the program.

- Expand program within the system and to other entities not within your system.
- Investigate alternative diagnoses that could benefit from enhanced telehealth home care programs.
- Collaborate with insurance payers to manage population health.
Expansion of Program

- Expand the pilot to other hospitals within the system
- Educate physicians/office practice groups to use ER2Home / enhanced home care models
- Other hospital systems
- Skilled nursing facilities

Alternative Diagnoses

- Diabetes
- Behavioral Health
- Pre-eclampsia
Collaboration Opportunities

- Insurance payers for population health management
- Collaborate with heart failure clinics

Questions
Contact Information

Linda Chambers MBA, PT
linda.chambers@promedica.org
419-824-7510

Terese Higgins MSN, RN
terese.higgins@promedica.org
419-824-7517