Program Objectives

• Describe impact of telehealth
  – Care coordination, collaboration and communication

• How success leads to growth
  – Outcomes of a national program
  – Aligning incentives with care partners

• Explain best practices
  – Pre-launch and post-launch strategies
  – Explain natural progression of programs
  – Identify lessons learned
  – Propose what the future holds
Key Building Blocks to Successful Programs

- People (Clinicians)
- Process (Clinical Best Practices)
- Platform (Smart Technology)

Key Features to Successful Programs

- Clinical Interventions/Best Practices
- Interdisciplinary Team Approach
- SBAR Communication Method
- Telehealth
- Patient Education Guides
- Focused Clinician Training and Competency
Impact of Telehealth

Diseases
- Heart Failure
- COPD
- Diabetes
- Other Complex Conditions

Improve Care
- Daily Monitoring
- Timely Intervention
- Enhanced Disease Management

Measures
- Reduce ER Visits
- Reduce Re-hospitalizations
- Improve Quality of Life
- Promote Independence
- Supports Self-Management

Impact of Telehealth & Outcomes Goals

- Improve Patient's Ability to Stay at Home
- Reduce Need for Emergent Care
- Reduce Hospitalization
- Improve Quality of Life
- Increase Patient Satisfaction
- Reduce Total Cost of Care
Impact of Telehealth

- Impact to partnerships
  - Physicians
  - Hospitals
  - Home Health

- Enhance care coordination, communication & collaboration

- Impacts along the continuum of care

Impact to Physician Partnerships

<table>
<thead>
<tr>
<th>Care Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reinforce treatment plan</td>
</tr>
<tr>
<td>• Identify gaps/inconsistencies in care</td>
</tr>
<tr>
<td>• Detect exacerbations earlier</td>
</tr>
<tr>
<td>• Monitoring between office visits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Direct to appropriate level of care</td>
</tr>
<tr>
<td>• Prescribe based on objective data</td>
</tr>
<tr>
<td>• Monitor response to treatment plan changes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Real-time objective trended reports</td>
</tr>
<tr>
<td>• Integration with physician and home health</td>
</tr>
</tbody>
</table>

Program Success Depends on Interaction of the Whole System
Impact to Hospitals Partnerships

- **Care Coordination**
  - Reinforce discharge plan
  - Recognize key indicators for readmission
  - Support for care transition
  - Post-acute stabilization

- **Collaboration**
  - Direct to appropriate level of care
  - Appropriate follow up care
  - Reduce unnecessary readmissions

- **Communication**
  - Improve post-acute engagement
  - Build relationships with discharge planners

Program Success Depends on Interaction of the Whole System

Impact to Home Health

- **Care Coordination**
  - Daily monitoring
  - Means for early intervention
  - Reinforce treatment and discharge plan

- **Collaboration**
  - Targeted visits and intervention
  - Disease condition education
  - Better self-management

- **Communication**
  - Real-time objective trended reports
  - Improve patient satisfaction

Program Success Depends on Interaction of the Whole System
### National Program Overview

#### Background | Information
---|---
Patient Selection | • Heart Failure Primary Diagnosis
Exclusion Criteria | • Cognitively Unable or No Caregiver Assistance Available
| • Awaiting Heart Transplant
| • LVAD
Locations/Branch Offices | • 60 Branches
| • 7 States
Patients Evaluated | • 566
Program Period | • 12 Months from SOC
Average Home Care Episodes | • 3.5

#### Intervention | Detail
---|---
Telehealth Monitoring | • Biometrics: Weight, BP, Heart Rate, Pulse Oximeter & Blood Glucose
| • Telehealth for Home Care Episode
Monitoring Information | • Monitored Seven Days per Week
| • 8:00 a.m. – 4:00 p.m. of Patient Time
Post Home Care Episode Care | • Telephonic Outreach and Self Reported Information
| • Frequency: Every Two Weeks for 3 Months and then Monthly
Clinician Specialty Training | • Specialty HF Program Training & Competency
Integrate Information Into Clinical Decision Support | • Modify Care Management Practice
| • Utilization of PRN Physician Orders
National Program Outcomes

### Patient Population Overview

<table>
<thead>
<tr>
<th>Metric</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>566</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>218</td>
<td>39%</td>
</tr>
<tr>
<td>Female</td>
<td>289</td>
<td>51%</td>
</tr>
<tr>
<td>Unknown</td>
<td>59</td>
<td>10%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;65</td>
<td>59</td>
<td>10%</td>
</tr>
<tr>
<td>65-74</td>
<td>110</td>
<td>19%</td>
</tr>
<tr>
<td>75-84</td>
<td>194</td>
<td>34%</td>
</tr>
<tr>
<td>&gt;85</td>
<td>170</td>
<td>30%</td>
</tr>
<tr>
<td>Unknown</td>
<td>33</td>
<td>6%</td>
</tr>
</tbody>
</table>

National Program Outcomes

### All Cause Readmission Rate for Patients Discharged with HF Diagnosis

- **57.0% No Readmissions**
- **30.4% After 30 Days**
- **12.6% Within 30 Days**

National average is 24.6%

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1 Calculated by readmissions within 30 days from the date of discharge of the admission, from patients discharged from the hospital with a principal discharge diagnosis of HF
2 www.cms.gov
National Program Outcomes

<table>
<thead>
<tr>
<th>HF Hospitalizations by Age Group</th>
<th>HF Hospitalizations by Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;65 years</td>
<td>Female: 56%</td>
</tr>
<tr>
<td>65-74 years</td>
<td>Male: 44%</td>
</tr>
<tr>
<td>75-84 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How Success Leads to Growth

Outcomes
- Improved outcomes should provide competitive advantage

Disease Programs
- Expansion beyond heart failure to COPD and diabetes

New Business
- New opportunities and partnerships with positive outcomes and services

Growth Will Naturally Follow Success
Aligning Incentives

• Align objectives, strategies and technical plan with care partners by using telehealth as a common link in the short term and long term management

• Engaging physicians and health care providers as partners in care beyond the formal interactions with the health care system (office and hospital visits) is vital to improving health outcomes for patients

• Share risk & reward

“The Affordable Care Act (ACA) is shifting the health care system in the U.S. away from the traditional fee-for-services to a pay-for-performance system. Moreover, CMS is moving to reimburse Medicare Certified Home Health based on a value-based purchasing model instead of a Prospective Payment Model. This is starting to eliminate the misalignment of incentives inherent in traditional Medicare, Medicaid and private insurance programs. There are many provisions and models in the ACA that would benefit from, provide opportunities to cover, and consequently encourage the adoption of telehealth and RPM technologies and services. The act created the Center for Medicare and Medicaid Innovations (CMMI), which is funded and tasked with exploring new care delivery and payment models and initiatives.”

Strategies of Best Practices

Pre-Launch

- Vision & strategy
- Business goals
- Organizational readiness
- Vendor partner selection
  - Software considerations
  - Technology review
  - Program development
  - Remember the future

Post-Launch

- Engage all stakeholders
- Measure outcomes
  - Clinical
  - Satisfaction
  - Operational
  - Financial
- Program support
- Future program expansion

Focus Areas for Best Practices
Strategies of Best Practices

• Vision
  – Tool to achieve organizational goals

• Strategy
  – Align telehealth with strategic organization goals
  – Consider unique opportunities
  – Competitive advantages

Organizational Readiness

• Evaluate state of preparedness
  – High turnover
  – Short staffed
  – Appropriate leadership

• Understand time and dedication required

• Accountable and qualified resources available
  – Project team for operational planning
  – Patient management coverage
  – Inventory control
  – IT infrastructure

Visioning & Strategic Planning is a Key Foundational Step

Readiness to Initiate and Operate is Basic Step to Success
Vendor Partner Considerations

- Technology review
- Software considerations
- Access requirements
- Feedback loop for healthcare providers
- Budget considerations
- Scalability
- Program support
- Remember the future

Plan for Scalability and the Future

Operational Planning

- Program design
  - Include short and long term goals
  - Align incentives with care partners
  - Care coordination, collaboration and communication
- Incorporate program into the day-to-day operations
  - Redesign processes and workflows
  - Take advantage of technology and efficiencies
- Leadership to gain buy-in of new care delivery model
- Involve all stakeholders
- Define clear goals, timelines and deliverables

Most Successful Programs Engage All Stakeholders
Measuring Success

- Success looks different for everyone
- Ideas for goals and metrics

<table>
<thead>
<tr>
<th>Clinical</th>
<th>Satisfaction</th>
<th>Operational</th>
<th>Financial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved control of chronic conditions</td>
<td>Improved patient satisfaction scores</td>
<td>Increased staff productivity/efficiencies</td>
<td>Opportunity for new lines of business</td>
</tr>
<tr>
<td>Improved integration/care coordination</td>
<td>Improved provider satisfaction scores</td>
<td>Focused intervention and needs</td>
<td>Increased productivity</td>
</tr>
<tr>
<td>Reduction in hospitalizations/readmissions</td>
<td>Employee satisfaction and retention</td>
<td>Attracting new talents</td>
<td>Increased market share/referrals</td>
</tr>
<tr>
<td>Improved self-management skills</td>
<td>Increased trust and security in home environment</td>
<td>Positioning and market advantage</td>
<td>Decreased travel time</td>
</tr>
</tbody>
</table>

Post-Launch

- Engage all stakeholders
- Ensure baseline numbers for success measures
- Program support
  - Training support (video and audio education)
  - Key operating elements (standardization, patient and clinical education)
- Future program expansion
- Scalability
Natural Progression of Programs

New Programs
- Adoption and buy-in
- Engaging all stakeholders
- Standardization

Mature Programs
- Change in business goals
  - Clinical
  - Satisfaction
  - Operational
  - Financial
- Future program expansion
- New lines of business

Plan for Future and Scalability
Natural Progression of Programs

Business goals, programs, patient needs and access to care change over time

ENSURE VENDOR PARTNER CAN CHANGE AND SCALE WITH YOU

Lessons Learned

- Strong Clinical Champion have the best outcomes
- Hospital-Physician-Home Health integrated delivery of care approach produces the highest enrollees
- Monitoring team communication with field clinicians directly improves patient care
- Focus needs to be placed on SBAR communication, medication reconciliation and visit utilization
- Success depends on sales and operations working closely together
What the Future Holds

Requirement for All Engaged in Healthcare Delivery System:

1. Reduce Hospitalization – Hence Cost of Care
2. Use Evidence-Based Protocols to Deliver Measurable Outcomes
3. Empower Patients at Home with Improved Satisfaction, Independence & Self-Management

What the Future Holds

• Requirement to extend services outside of traditional episodes of care (Continuum of Care)
• Expansion to other partnerships & payer sources (ACO’s, Bundles, etc.)
• Reimbursement & partner opportunities moving to pay-for-performance & value-based purchasing
• More predictive higher technology solutions to prevent exacerbations of disease
• Innovative solutions for better integrated virtual care with higher touch support
Questions

Telehealth: A Vital Link in Hospital, Physician, Home Health Patient Care Coordination Strategy

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