Telehealth Role in Home Care
Convergence of Human services & Technologies

Raj Kaushal MD
Chief Clinical Officer
Almost Family Inc.
Almost Family - Who we are?

- Founded in 1976, we are the fourth largest home health provider in the US
- Seasoned senior management team with decades in home health
- $500M home health provider based in Louisville KY
- 234 branches in 14 states
Building Strategic Clinical Relationships

We believe in developing local care partnerships and we strive to identify, prioritize and develop local and regional strategic relationships with hospitals and physician practices.
**What is Telehealth?**

**Telehealth** is simply using digital information and communication technologies, such as computers and mobile devices, to manage your health and well-being.

**Telehealth**, also called e-health or m-health (mobile health), includes a variety of health care services, including but not limited to:

- Online support groups
- Online health information and self-management tools
- Email and online communication with health care providers
- Electronic health records
- Remote monitoring of vital signs, such as blood pressure, or symptoms
- Video or online doctor visits
Telehealth:

A Vital Link in:

Hospital, Physician & Home Health Patient Care Coordination Strategy
Impact of Telehealth & Outcomes Goals

1. Improve Patient’s Ability to Stay at Home
2. Reduce Need for Emergent Care
3. Reduce Hospitalization
4. Improve Quality of Life
5. Increase Patient Satisfaction
6. Reduce Total Cost of Care
Impact of Telehealth

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

Improve Care
- Daily Monitoring (Care Between Services)
- Timely Intervention
- Triage Clinical Needs
- Enhanced Chronic Care Management

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

- Impact to partnerships
  - Physicians
  - Hospitals
  - Home Health

- Enhance care coordination, communication & collaboration

- Impacts along the continuum of care

- Help deliver efficient and quality care
Impact to Physician Partnerships

Success Depends on Interaction of the Whole System

**Care Coordination**
- Reinforce treatment plan
- Identify gaps/inconsistencies in care
- Detect exacerbations earlier
- Monitoring between office visits

**Collaboration**
- Direct to appropriate level of care
- Prescribe based on objective data
- Monitor response to treatment plan changes

**Communication**
- Real-time objective trended reports
- Integration with physician and home health
**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

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*Success Depends on Interaction of the Whole System*
Impact to Home Health

Success Depends on Interaction of the Whole System

**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

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*We Are Senior Advocates*
# National Program Overview

## Background

<table>
<thead>
<tr>
<th>Patient Selection</th>
<th>Information</th>
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<tbody>
<tr>
<td></td>
<td>• Heart Failure Primary Diagnosis</td>
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<table>
<thead>
<tr>
<th>Exclusion Criteria</th>
<th>Information</th>
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<tbody>
<tr>
<td></td>
<td>• Cognitively Unable or No Caregiver Assistance Available</td>
</tr>
<tr>
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<td>• Awaiting Heart Transplant</td>
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<td>• LVAD</td>
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<table>
<thead>
<tr>
<th>Locations/Branch Offices</th>
<th>Information</th>
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<tbody>
<tr>
<td></td>
<td>• 60 Branches</td>
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<tr>
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<td>• 7 States</td>
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<table>
<thead>
<tr>
<th>Patients Evaluated</th>
<th>Information</th>
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<tr>
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<td>• 566</td>
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<thead>
<tr>
<th>Program Period</th>
<th>Information</th>
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<tr>
<td></td>
<td>• 12 Months from SOC</td>
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<table>
<thead>
<tr>
<th>Average Home Care Episodes</th>
<th>Information</th>
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<tr>
<td></td>
<td>• 3.5</td>
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## National Program Overview

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

## Patient Population Overview

<table>
<thead>
<tr>
<th>Metric</th>
<th>Total</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Total Population</td>
<td>566</td>
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</tr>
<tr>
<td><strong>Gender</strong></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>
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<tr>
<td>Unknown</td>
<td>59</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
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<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>
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<tr>
<td>&gt;85</td>
<td>170</td>
<td>30%</td>
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<tr>
<td>Unknown</td>
<td>33</td>
<td>6%</td>
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</table>

ALMOST FAMILY
National Program Outcomes

All Cause Readmission Rate for Patients Discharged with HF Diagnosis\(^1\)

- 57.0% No Readmissions
- 12.6% Within 30 days
- 30.4% After 30 Days
- National average is 24.6\(^2\)%

\(^1\) 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

HF Hospitalizations by Age Group
- >85: 32%
- 75-84: 32%
- 65-74: 65%

HF Hospitalizations by Gender
- Female: 56%
- Male: 44%
Key Building Blocks to Successful Programs

People
(Clinicians & Training)

Process
(Standardization & Clinical Best Practices)

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

<table>
<thead>
<tr>
<th>Telephonic Health System</th>
<th>Mobile Flexibility</th>
<th>Remote Patient Monitoring</th>
<th>Two-Way Video Options</th>
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<tr>
<td><img src="image1.png" alt="Image" /></td>
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<td><img src="image3.png" alt="Image" /></td>
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Patient needs and access to care changes over time

**Right Technology | Right Patient | Right Length**

ENSURE TECHNOLOGY CAN CHANGE AND SCALE WITH NEED
We are going to see more of:

- E – visits
- Personal Health Records (PHR)
- Personal Health apps
- Home health monitoring
- Physicians talking to Physicians

The Department of Health and Human Services has included greater use of technology as one of its Healthy People 2020 objectives for improving the health of all Americans.
Innovation in Telehealth Ideal State

Demonstration of value and quality, not just cost savings

Standardization not relying solely on local execution

Reimbursement to align with value

Challenges to Overcome in the Future