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**

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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

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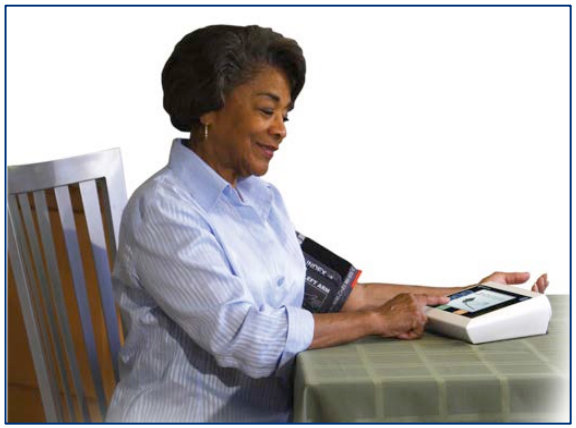
Telehealth:



A Vital Link in :

Hospital, Physician &

Home Health Patient Care Coordination Strategy

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We Are SeniorAdvocates®

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

Diseases

- Heart Failure
- COPD
- Diabetes
- Other Complex Conditions

Improve Care

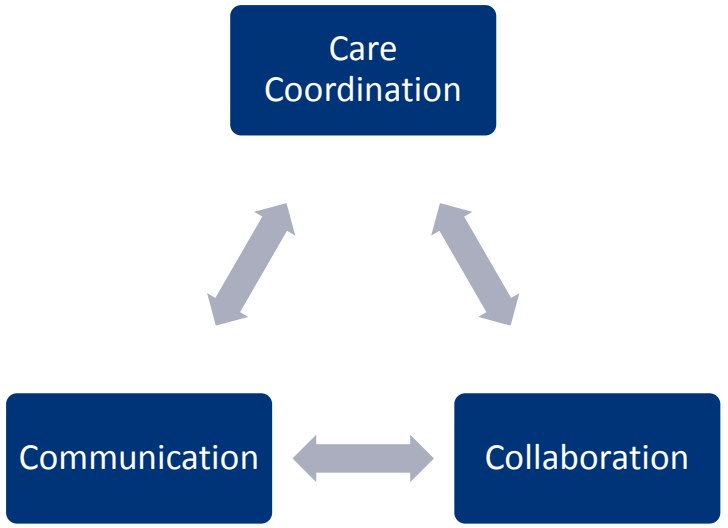
- Daily Monitoring (Care Between Services)
- Timely Intervention
- Triage Clinical Needs
- Enhanced Chronic Care Management

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**

Help Eliminate Care Silos With Three C's

Impact to Physician Partnerships

Care Coordination	Collaboration	Communication
• Reinforce treatment plan • Identify gaps/ inconsistencies in care • Detect exacerbations earlier • Monitoring between office visits	• Direct to appropriate level of care • Prescribe based on objective data • Monitor response to treatment plan changes	• Real-time objective trended reports • Integration with physician and home health

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

Success Depends on Interaction of the Whole System

Impact to Home Health

Care Coordination	Collaboration	Communication
• Daily monitoring • Means for early intervention • Reinforce treatment and discharge plan	• Targeted visits and intervention • Disease condition education • Better self-management	• Real-time objective trended reports • Improve patient satisfaction

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

National Program Overview

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

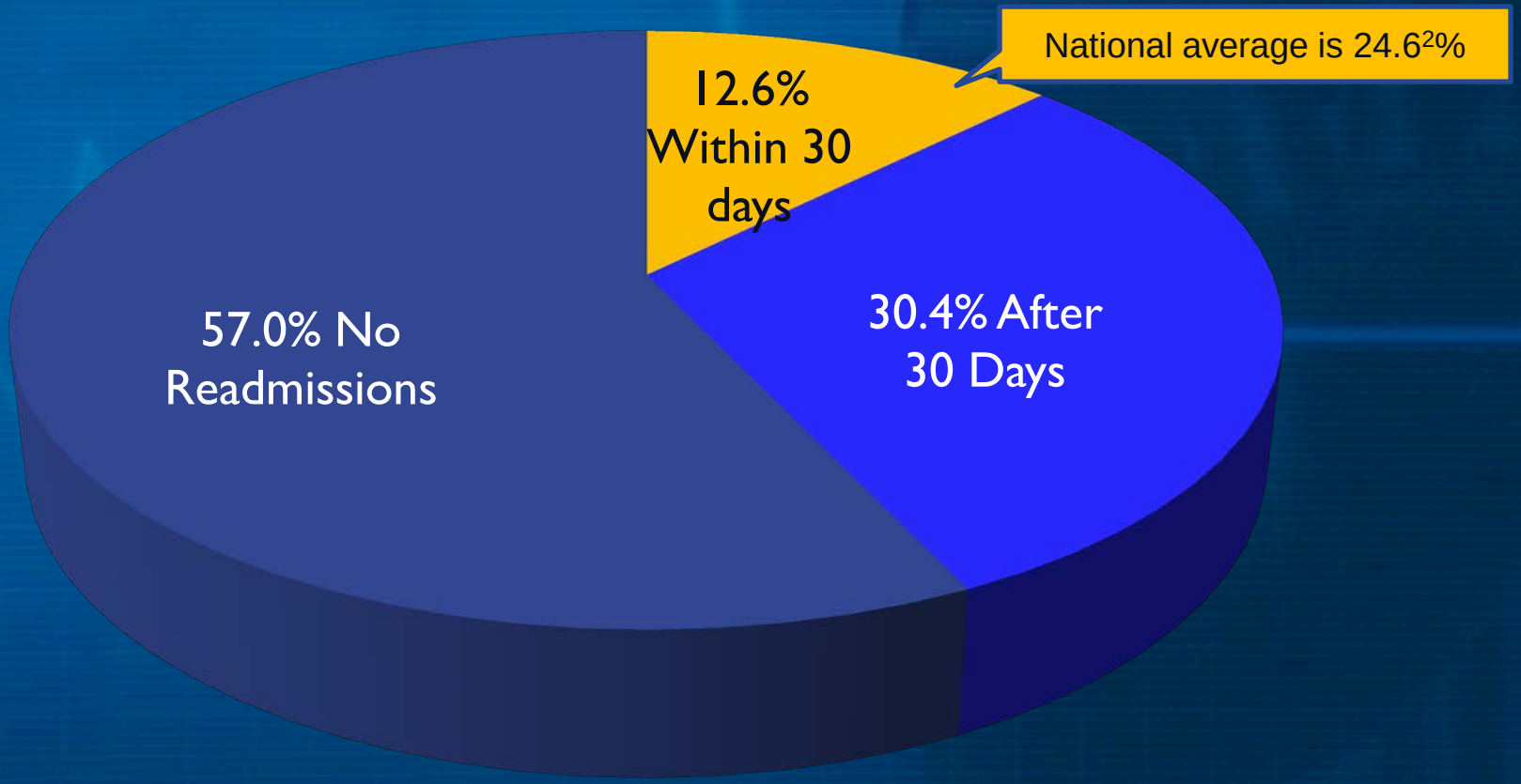
National Program Outcomes

Patient Population Overview

Metric	Total	Percentage
Total Population	566	
Gender		
Male	218	39%
Female	289	51%
Unknown	59	10%
Age		
<65	59	10%
65-74	110	19%
75-84	194	34%
>85	170	30%
Unknown	33	6%

National Program Outcomes

All Cause Readmission Rate for Patients Discharged with HF Diagnosis[1]

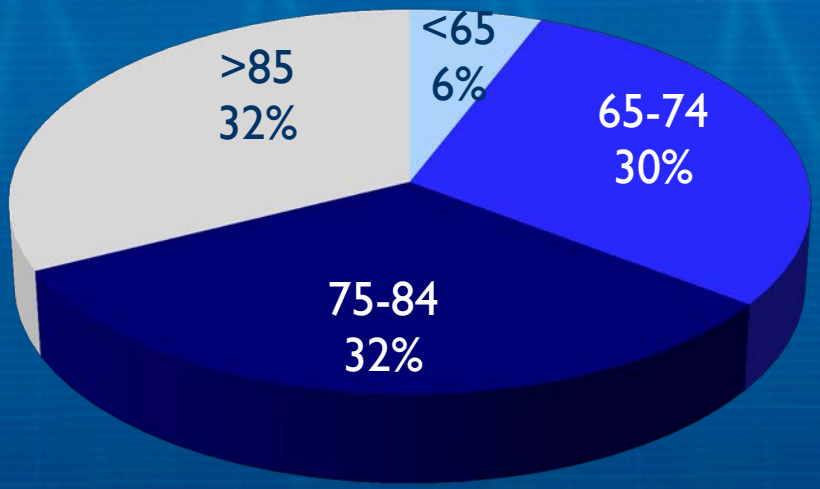


[1] Calculated by readmissions within 30 days from the date of discharge of the admission, from patients discharged from the hospital with a principal discharge diagnosis of HF

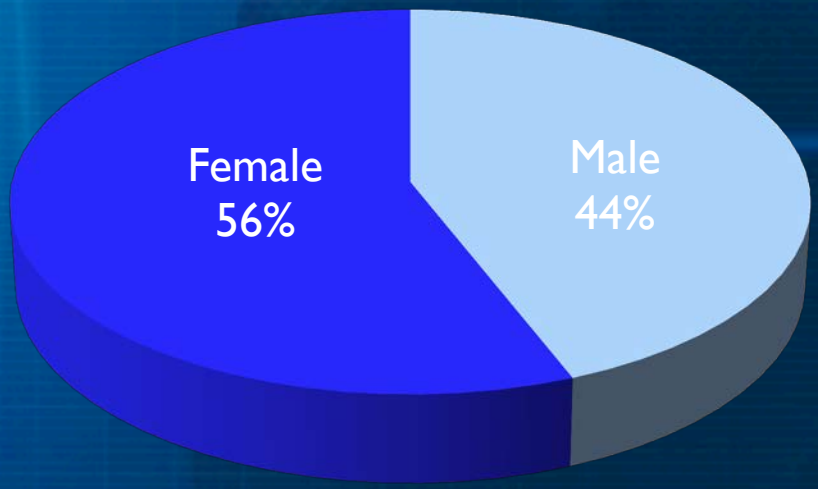
[2] www.cms.gov

National Program Outcomes

HF Hospitalizations by Age Group



HF Hospitalizations by Gender

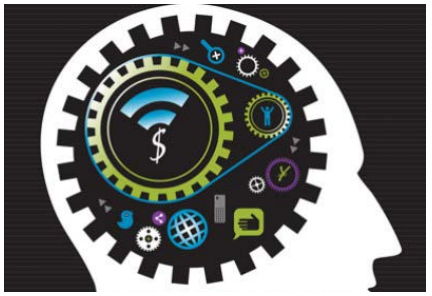


Key Building Blocks to Successful Programs

People
(Clinicians & Training)

Process
(Standardization & Clinical Best Practices)

Platform
(Right Technology)



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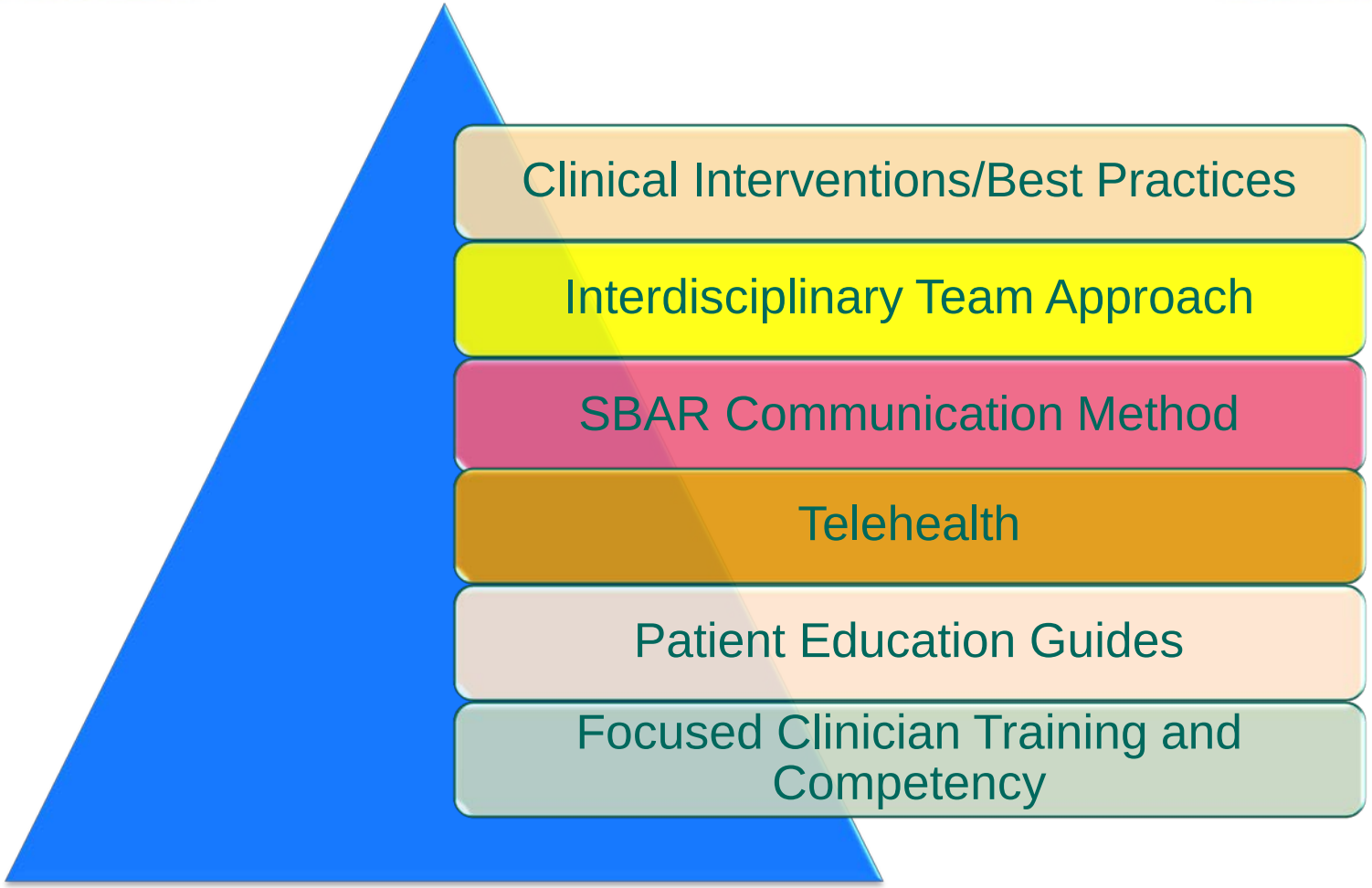
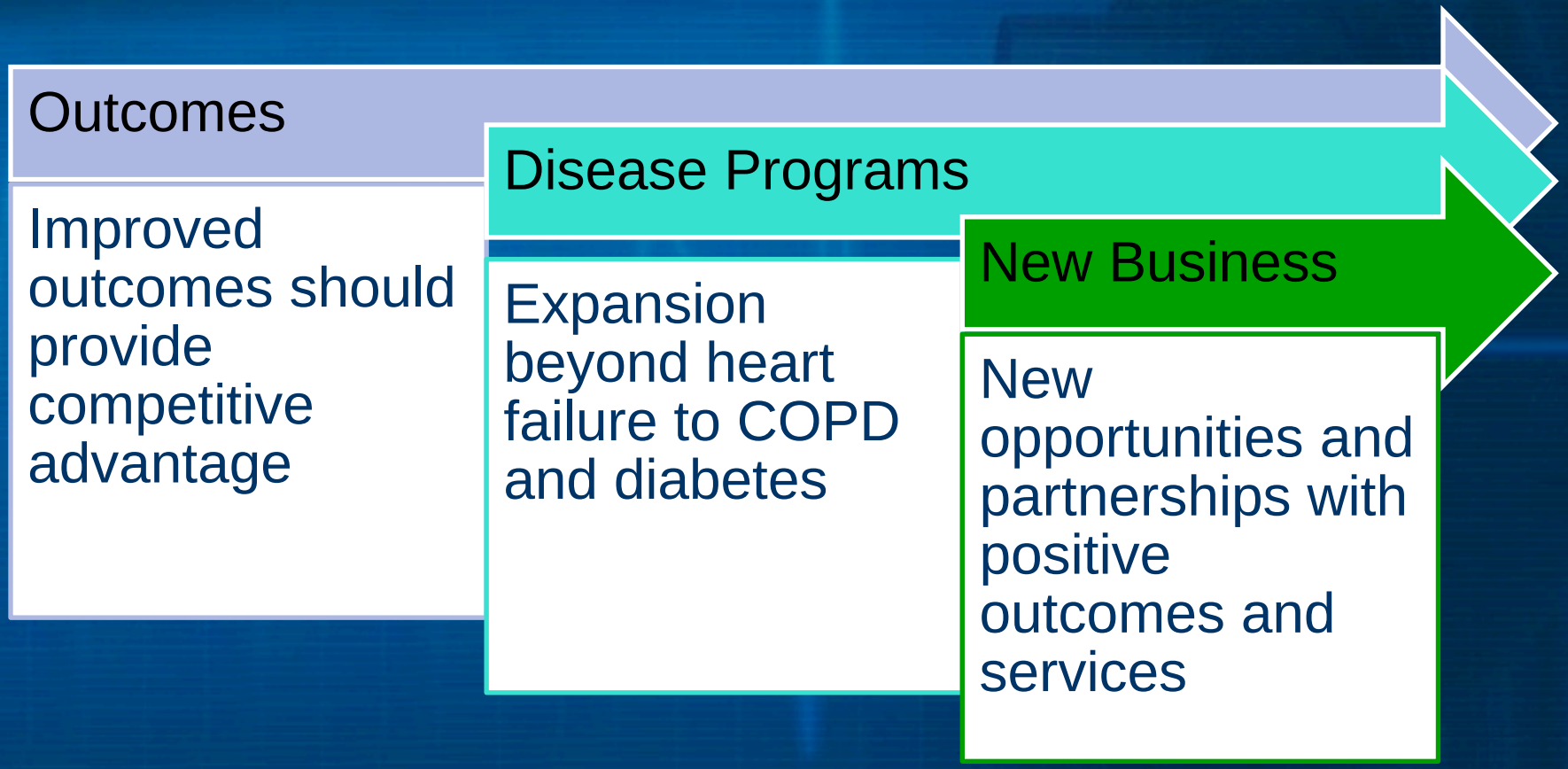
Key Features to Successful Programs



How Success Leads to Growth



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

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

Innovation in Telehealth Ideal State

Telephonic Health System	Mobile Flexibility	Remote Patient Monitoring	Two-Way Video Options
			

Patient needs and access to care changes over time

Right Technology | Right Patient | Right Length

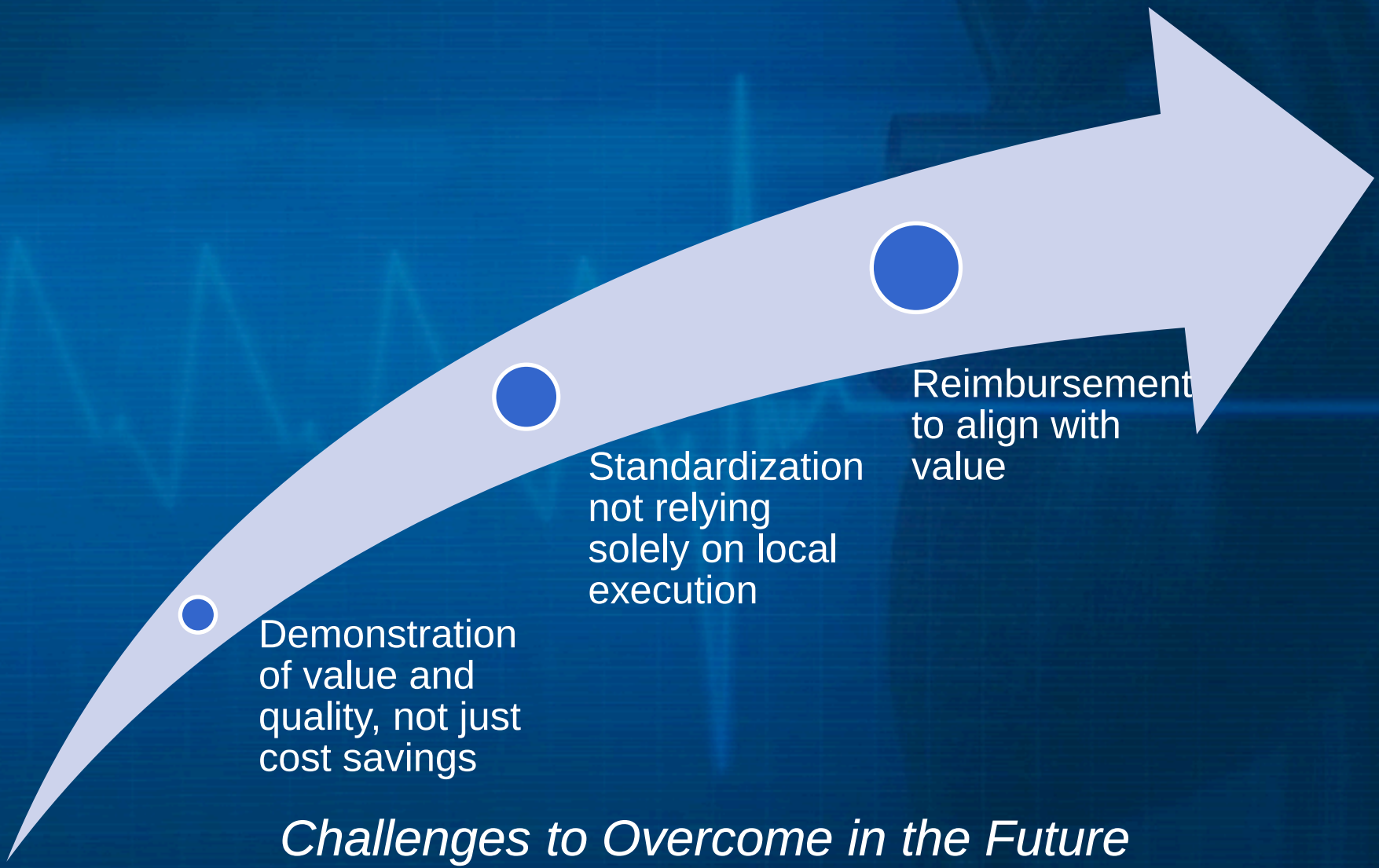
ENSURE TECHNOLOGY CAN CHANGE AND SCALE WITH NEED

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



Challenges to Overcome in the Future