MARYLAND HEALTH CARE COMMISSION

Telehealth Symposium: Remote Monitoring and Chronic Care Management of High Risk Children, Adults and Elderly Patients

Monday, February 22, 2016

Sponsored by:

Anne Arundel Medical Center

CircleLink HEALTH

Lorien Health Systems

Telehealth Projects

In June 2015, the Maryland Health Care Commission (MHCC) awarded three telehealth grants to study the impact of remote patient monitoring on hospital re-admission in various settings to reduce hospital encounters. Telehealth is the use of electronic information and telecommunications technologies such as video-conferencing to support clinical health care, patient and professional health-related education, public health, and health administration. The MHCC believes the expanded telehealth capability to improve care coordination and chronic disease management will reduce hospital emergency department visits, inpatient admissions, and readmissions; enable the early provision of appropriate treatment; improve access to care; and provide cost savings to patients and providers. A total of $80,000 was awarded in grant funds, and a 2:1 match is required of each grantee. In addition to telehealth technology, the grantees are required to use a nationally certified electronic health record and services of the State-Designated Health Information Exchange, the Chesapeake Regional Information System for our Patients (CRISP). The work of the telehealth projects, including lessons learned and best practices, will inform telehealth activities more broadly in the State. The telehealth projects are scheduled for completion in the summer of 2016. A summary of each of the three projects and the current status is below:

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Telehealth Symposium: Remote Monitoring and Chronic Care Management of High Risk Children, Adult and Elderly Patients

Agenda

Monday, February 22, 2016

Anne Arundel Medical Center, The Doordan Health Sciences Institute-7th Floor
2000 Medical Parkway
Annapolis, MD 21401

4:00PM – 6:30PM

I. INTRODUCTORY REMARKS *(5 minutes)*

Ben Steffen, *Executive Director, MHCC*

- *MHCC's health IT initiatives and their value on health care reform at Maryland Health Care Commission*
- *MHCC's efforts to diffuse telehealth*

II. *OVERVIEW OF THE TELEHEALTH GRANTS* (15 minutes)

Angela Evatt, *Chief of Health Information Exchange*

III. KEYNOTE SPEAKER *(20 minutes)*

Lois Freeman, Doctor of Nursing Practice, Veterans Affairs (VA) Maryland Health Care

- *Sharing outcomes and lessons learned from implementing VA Care Coordination Home TeleHealth Program in Maryland since 2007.*

IV. TELEHEALTH PROJECT PARTICIPANTS:

Lorien Health Systems *(25 minutes)*

Wayne Brannock, Vice President of Clinical Affairs

Tracy Carroll – Director Operations, Lorien At Home

Susan Carroll, RN. CDON/NADON, CM/DN, CNE – VP Clinical Services, Lorien Health Systems

Telehealth use in combination with adjusted treatment protocols and care coordination to reduce re-admissions and admissions to acute care post discharge from a short-term skilled nursing facility stay.

- *Overview of project including client selection and engagement, clinical measures, treatment protocols and telehealth system capabilities.*
- *Program outcomes to date including, successes, and lessons learned*
- *Plans for sustainability*

Union Hospital Cecil County (*25 minutes)*

Anne E. Lara, Ed.D., RN, CNE, CPHIMS

Chief Information Officer and Cancer Program Administrator

The Union Hospital Telehealth Journey: Using telehealth to address several hospital Prevention Quality Indictor conditions including diabetes, chronic obstructive pulmonary disease, hypertension, heart failure, and asthma among patients discharged from the hospital to home.

- *Pilot program experience including client selection and engagement, clinical measures and treatment protocols and technology system.*
- *Program outcomes to date including, successes, and lessons learned.*
- *Future program strategies*

Crisfield Clinic *(25 minutes)*

Kerry Palakanis, Family Nurse Practitioner, Crisfield Clinic

Nivea Taylor, Program Manager

Telehealth program using mobile phone application to assist with case management of children with chronic conditions including asthma, diabetes, childhood obesity, and behavioral health issues.

- *Chronic care issues in pediatric population*
- *Choice and use of technology system in implementing remote patient monitoring for pediatric population*
- *Challenges and lessons learned in implementing program to date*
- *Plans for future projects*

V. CAREFIRST BLUECROSS BLUESHIELD TELEHEALTH EFFORTS *(5 minutes)*

Hosanna Asfaw-Means, Grants Program Manager, Community Affairs

- *Telehealth projects underway*
- *Telehealth grants being considered*

VI. PROFESSIONAL LIABILITY COVERAGE (5 minutes)

Linda Jones, Managing Director Health Care Practice, RCM&D

- *Professional Liability Coverage Considerations for telehealth practitioners*

VII. CLOSING SPEAKER *(15 minutes)*

Gary Capistrant, Chief Policy Officer, American Telehealth Association

- *Key policy considerations for impacting implementation of remote patient monitoring*
- *Federal Legislation to expand Medicare reimbursement for Telehealth services*

VIII. CLOSING REMARKS *(10 minutes)*

Fermin Barreto, Jr. M.D., University of Maryland, Upper Chesapeake Medical Center

Telehealth Symposium Speaker Biographies

Drafted by MHCC

Hosanna Asfaw-Means is the Grants Program Manager at CareFirst BlueCross BlueShield (CareFirst). She is a seasoned public health professional with more than 10 years of experience working in the public health arena. At CareFirst, Ms. Asfaw-Means is responsible for managing more than 100 active grants and coordinates the review and recommendations for funding for all grant applications. Prior to joining CareFirst, she managed the Lead Prevention Program with the Baltimore City Health Department, a home-visiting program geared to prevent lead poisoning to Baltimore City residents. In addition, Ms. Asfaw-Means worked at the American Legacy Foundation where she served as a research fellow and senior program manager. Ms. Asfaw-Means received her public health master's degree in health promotion / disease prevention from The George Washington University, and her undergraduate degree in organizational studies from the University of Michigan, Ann Arbor.

Fermin Barrueto Jr., M.D. is double-boarded in Emergency Medicine and Medical Toxicology. He is a Clinical Associate Professor for the University of Maryland School of Medicine Department of Emergency Medicine where he teaches the Toxicology curriculum for Emergency Medicine Residents. He is also Regional Director and Chairman for the Department of Emergency Medicine at the University of Maryland Upper Chesapeake Health which is a 2-hospital community system. Since 2008, Dr. Barrueto has overseen the Emergency department of University of Maryland Upper Chesapeake Medical Center and University of Maryland Harford Memorial Hospital. Dr. Barrueto has over 25 peer-reviewed publications and over 50 different textbook chapters. He has presented research from medical toxicology as well as Emergency Department operations both nationally and internationally. He has lead various new population health initiatives including assessing clinical variation among EM physicians, instituting a low risk chest pain protocol and developing a highly effective high risk care plan program.

J. Wayne Brannock, CPHQ, CPHRM has been with Lorien Health Systems for over 15 years serving as Vice President for Clinical Services and most recently Chief Operating Officer. Wayne brings over 45 years of clinical and health care management experience in both the acute and post-acute, long term care venues. Wayne also has had an extensive career working in acute care in Maryland, Wisconsin, and Texas as a clinician, manager, educator, and department director in respiratory care, cardiology, and pulmonary diagnostics. A nurse and Respiratory Therapist by education, Wayne has also held AHA certification as a Certified Professional in Health Care Risk Management and NACQ certification as a Certified Professional in Health Care Quality.

Gary Capistrant's expertise in health policy is based on over 30 years experience with Medicare, Medicaid, and national health reforms. Mr. Capistrant's knowledge of health policy has lead him to become a trusted advisor to associations, innovative health providers and Wall Street investment analysts. He is also the former Director of Congressional Relations for the American Health Care Association, Staff Director of the State Medicaid Directors Association and Health Legislative Assistant for former Rep. Jim

Corman. Mr. Capistrant earned a MA in Public Affairs from the Humphrey Institute at the University of Minnesota and he also earned a BA from the same University.

Susan Carroll, RN. CDON/NADON, CM/DN, CNE serves as the Vice President of Clinical Services for Lorien Health Systems and the RN Administrator of Lorien at Home. Miss Carroll has held various clinical management leadership positions in post-acute care as a Unit Manager and Director of Nursing. Miss Carroll is a Certified Director of Nursing, Delegating Nurse and a Certified Nurse Executive.

Tracy Carroll serves as Director of Operations for Lorien At Home. Ms. Carroll is responsible for the daily oversight and organization of the agency with emphasis on program development, marketing and human resources. Since joining Lorien Health Systems she has served as Director of Admissions and as Human Resource Director. Ms. Carroll brings over 25 years of professional industry experience in management, operations and sales leadership.

Angela Evatt serves as Division Chief for Health Information Exchange at the Maryland Health Care Commission's (MHCC) Center for Health Information Technology and Innovative Care Delivery. Ms. Evatt manages the 45 member health information exchange (HIE) Policy Board and played an integral part in drafting the State's HIE Privacy and Security regulations. In her position, Ms. Evatt coordinates various health information technology regulatory and research initiatives of the MHCC to advance secure health information exchange and widespread adoption and use of electronic health records and telemedicine. Prior to joining the MHCC, Ms. Evatt served as Provider Training Coordinator and Analyst for Automated Health Systems as they implemented a new Medicaid hybrid managed care program for the state of Illinois. Ms. Evatt completed her dual masters from the University of Chicago, in Social Service Administration and Public Policy. During her time at University of Chicago.

Lois Freeman DNP CRNP-BC, CCRN, is a 1976 diploma graduate of the Helene Fuld School of Nursing, Provident hospital. She then went on to graduate with a Bachelor's Degree in Nursing from University of Maryland 2000 and MSN in 2001. Dr. Freeman received her Doctorate of Nursing Practice(DNP) from Chatham University in Pittsburg, PA in 2011. Her extensive nursing career includes positions within the Baltimore Metropolitan area and6 years in critical care nursing at several Baltimore hospitals and the Director of Nursing at several long-term–care facilities. Dr. Freeman served the West Baltimore community while being at One Heart Cardiology, from 2002-2007 with her mentor, Dr. Athol Morgan, Chief of Cardiology at Bon SeCour Hospital. Dr. Freeman has been employed a Nurse Practitioner in Home Telehealth at Maryland VA Healthcare System since 2007 and is the sole provider in the Home Telehealth program there. She Chairs the VA Advanced Practice Nursing Council and has been a guest lecturer at Coppin State University School of Social Work. She is an evaluator for the Commission on Collegiate Nursing Education (CCNE) and was recently selected to be a test question writer for the NCLEX examination by the National Council of State Boards of Nursing.

Linda Jones has been a member of the RCM&D team for more than 19 years advancing from her role as a health care risk management and claims consultant into her current role as the Managing Director of Healthcare and COO of Self-Insured Services Company, Inc. (SISCO), a subsidiary of RCM&D. In this role, Ms. JonesLinda manages the brokerage and consulting staff and services and has developed and implemented the liability claims service line and consultative claims services for RCM&D and SISCO.Ms Jones has been a frequent guest lecturer at numerous national and regional conferences and universities on subjects such as cyber liability exposures and risk management education. Additionally, her articles have been published in leading industry journals. Prior to joining RCM&D, Ms. Jones held several executive positions and a teaching appointment at Johns Hopkins University in the School of Hygiene and Public Health, in the department of Health Policy and Management. Ms. Jones is a graduate of the University of Maryland with a BS in Business Administration and earned an MS from George Washington University in Health Services Administration. She is also a Board Member of the University of Maryland System Foundation.

Anne E. Lara Ed. D., RN, CNE, CPHIMS is currently the Chief Information Officer at Union Hospital of Cecil County, MD. In addition, she is a registered nurse with over 35 years of healthcare experience in not only clinical settings, but also in the information technology industry. Previously, she was the VP of Regulatory Affairs and Quality Systems with WellDoc, a mobile health information technology company. In other roles, Dr. Lara was the Director of Quality System Management and the Director of Product Management /Engineering with Siemens Healthcare. Before working with Siemens, she was the Administrative Director of Radiation Oncology for the Christiana Care Health System, DE and an Oncology Clinical Nurse Specialist for Main Line Health, PA. Dr. Lara has been responsible for the development and market launch of software to support clinicians in the areas of critical care, cardiology, oncology, medicine, and the operating room. Her research has focused on the quality of life of cancer patients, competency management, and leadership development. Dr. Lara holds Bachelor and Master's degrees in Nursing from the University of Delaware and a doctoral degree in Innovation and Leadership from Wilmington University.

Kerry Palakanis, DNP, NP-C has been a family nurse practitioner for over 25 years and has worked in a variety of rural and underserved primary care settings. In 2012 she founded the Crisfield Clinic, a family practice in Somerset County which services one of Maryland's poorest and most underserved areas. Dr. Palakanis has consulted with CircleLink health in the development of a chronic disease management software program that is deployed throughout the United States. In 2014, Dr. Palakanis received a USDA DLT grant to purchase eight telemedicine systems targeted for placement in Smith Island, Crisfield and Somerset County Schools. She is active in multiple organizations and arenas in telemedicine and is advocating in our state to improve access to telemedicine for primary care.

Ben Steffen serves as the Executive Director of the Maryland Health Care Commission. The MHCC is an independent regulatory agency whose mission is to plan for health system needs, promote informed decision-making, increase accountability, and improve access to

health care and health care coverage in Maryland. Prior to assuming this position, he served as the Director of the Commission's Center for Information Services and Analysis. This Center has analytic and operational responsibilities for health care practitioner initiatives in the state including development of an All Payer Data Base and the Patient Centered Medical Home Program. Mr. Steffen serves as a spokesperson for the Commission at state and national levels on State health care expenditures, physician work force, physician uncompensated care, and information security. Before joining the MHCC, he served as a budget analyst in the Health, Housing, and Income Security Division of the Congressional Budget Office, among activities he worked on the modeling that produced the estimates of reforms that ultimately led to the Medicare Prospective Payment System. Mr. Steffen holds a Master's Degree from American University and has completed post-graduate work at the University of Michigan. He is a former Peace Corps volunteer to Nepal.

Nivea Taylor is a lifelong resident of Crisfield, Maryland who after being employed at the Crisfield Clinic for two years as a medical assistant was promoted to the role of clinical manager and then program director for the clinic's chronic disease management and telemedicine program. Ms. Taylor has recently completed her certification as a Community Health Worker and will be launching the program design for Crisfield Clinic where community health workers are paired with telemedicine in order to increase access to care in underserved areas.

Advancing Telehealth in Maryland

Overview of the Telehealth Grants

The MARYLAND HEALTH CARE COMMISSION

MHCC Grants

- Maryland law, established in 2014, authorizes MHCC to directly award grants to non-profit organizations and qualified businesses
- Diverse use cases provide an opportunity to test the effectiveness of telehealth with various technology, patients, providers, clinical protocols, and settings
- Total telehealth grants: $257,888
- Total matching funds: $610,180

2

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Challenges

- Reimbursement is available from commercial payors, Medicare and Medicaid, but little incentive exists for providers to move away from traditional models of care delivery
  - Only one-half of acute care hospitals and less than 10 percent of physicians participate in telehealth
- Limited widespread awareness about how to incorporate the effective use of telehealth into existing practice workflows
- Lack of innovative use cases that demonstrate the value of telehealth on hospital encounters and in improving access to care
- Medical liability insurance for services delivered through telehealth is not always offered

3

The Value of Telehealth Grants

- Diverse telehealth use cases provide an opportunity to test the effectiveness of telehealth with various technology, patients, providers, clinical protocols, and settings
- Challenges and successes from each round of projects are shared with the next – building on successes
- Lessons learned from these projects will inform
  - Better practices and industry implementation efforts
  - Potential policies to support the advancement of telehealth
  - The design of larger telehealth programs and projects across the State

4

Round One Grants: Oct 2014 - Oct 2015

Goal: Demonstrate the impact of using telehealth on coordinating care delivery between a comprehensive care facility and a general acute care hospital			
Name	***Use Case***	***Grant Award***	***Grantee Match***
Atlantic General Hospital (Worcester County)	Video consultations between the Emergency Department (ED) and Berlin Nursing and Rehabilitation Center (BNRC) to reduce ED visits and hospital admissions of patients residing in a long term care facility (LTC).	$30,000	$87,922
Dimensions Healthcare System (Prince Georges County)	Laurel Regional Hospital and Prince Georges Hospital use mobile tablets to conduct video consultations with patients residing at two LTCs, Sanctuary of Holy Cross and Patuxent River Health and Rehabilitation Center to reduce unnecessary hospital transfers.	$30,000	$42,316
University of Maryland Upper Chesapeake Health (Harford County)	Remote telemedicine examinations and consultations between hospital and a fully equipped exam room and lab located at Lorien, Bel Air facility. Technology provides EKG monitoring, sonogram and multiple cameras.	$27,888	$45,633
	Total	**$87,888**	**$175,871**

5

Round Two Grants: June 2015 – Nov 2016

Goal: Demonstrate the impact of remote patient monitoring on hospital re-admission in various settings to reduce hospital encounters			
Name	***Use Case***	***Grant Award***	***Grantee Match***
Crisfield Clinic, LLC (Somerset County)	Rural health clinic provides mobile devices for middle school and high school aged patients to assist them in managing chronic conditions including asthma, diabetes, childhood obesity, and behavioral health issues.	$20,000	$93,983
Lorien Health Systems (Baltimore & Harford Counties)	Skilled nursing facility and residential service agency use devices installed in patients' home to monitor chronic conditions including uncontrolled diabetes, congestive heart failure, and hypertension and providing clinical support to improve care and avoid hospital admissions.	$30,000	$63,600
Union Hospital of Cecil County (Cecil County)	Hospital provides chronic care patients with mobile tablets and peripheral devices to capture blood pressure, pulse, and weight, and provide patient education to facilitate patient monitoring.	$30,000	$60,000
	Total	**$80,000**	**$217,583**

6

Round Three Grants: December 2015 – May 2017

Goal: Demonstrate the impact of using telehealth technology to improve the overall health of the population being served and the patient experience			
Name	***Use Case***	***Grant Award***	***Grantee Match***
Associated Black Charities (Dorchester & Caroline Counties)	Community association that assists minority and rural communities with navigating the health care system will utilize mobile tablets to facilitate primary care and behavioral health video consultations with a licensed nurse care coordinator from Choptank Community Health System.	$30,000	$90,000
Gerald Family Care, LLC (Prince George's County)	Patient Centered Medical Home practice will implement telehealth video consultations and image sharing services between patients at three family practice locations, and Dimensions Health System specialists providing gastroenterology, orthopedics, neurology, and behavioral health services.	$30,000	$66,726
Union Hospital of Cecil County (Cecil County)	Builds upon the original grant providing chronic care patients with mobile tablets and peripheral devices to capture blood pressure, pulse, weight and glucose levels to facilitate patient monitoring, which will support data sharing with primary care and Emergency Department providers.	$30,000	$60,000
	Total	**$90,000**	**$216,726**

7

Thank You!

Angela Evatt

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MARYLAND

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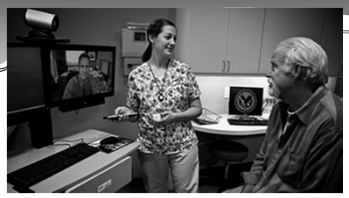
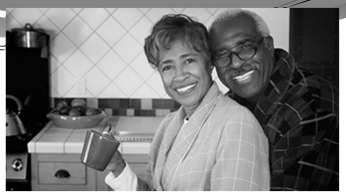




Telehealth

An adjunct to Managed Care
Linking patients and improving access to Care
Lessons learned

Lois Freeman DNP, CRNP-BC, CCRN

I have no financial disclosures.

OBJECTIVES

1. At the conclusion of this program the learner will be able to discuss the benefits of enrolling patients in Telehealth monitoring programs
2. At the conclusion of this program the learner will be able to identify the patient disease processes that may benefit from daily monitoring in Telehealth
3. At the conclusion of this program the learner will be able to discuss lessons learned in development of Hometelehealth

Core principles of Telehealth

- Should be physician or APN managed
- Must be integrated into established clinical operations and routines
- Primary care provider-patient relationships must be preserved
- Relationships are established between nurse coordinators in Hometelehealth and patients/families

The Problem

- 2012 > 41.5 million U.S. citizens over age 65
- 2020 > Projected to top 65 million
- Chronic disease affects approximately 133 million Americans
- By 2020, patients with chronic disease is projected to grow to an estimated 157 million, with 81 million having multiple conditions.
- **Today < 500,000 chronically ill citizens in the U.S. are receiving monitoring services on a daily basis**

Nationally VA Telehealth

- 2011 over 380,000 Veterans used its clinic-based Telehealth services.
- Another 100,000 patients nationwide were enrolled in VA's Home Telehealth program

The Rationale & expansion

- Just-in-time Care
- Telehealth in VA helps ensure veteran patients get the right care in the right place at the right time.
- Patient demand, access & increased satisfaction
- Better Professional Communication
- Enlarged Catchment Area
- Improved Quality &Efficiency
- Cost Savings?

Home Telehealth- expansion of services

- Not Home Health – but patient may benefit may overlap
- Telehealth Equipment/Nursing/case management
- Use nurses with the ability to monitor veterans with chronic diseases (COPD, DM, HTN,, CHF, and Diabetes)
- Use social workers to manage MH (Depression, PTSD, etc.)
- Use nutritionist to manage MOVE (Weight management) and assist with heart failure and diabetes
- Smoking cessation
- Chronic Kidney disease/Transplant
- Etc.…….find the best fit!

Patient Selection:

- Frequent Users/Frequent Callers?
  - Living in remote, rural or urban areas where travel to the clinic is often difficult and unreliable?
- Limited in their Ability to Access Care?
  - Without adequate caregiver support?
  - At risk for nursing home placement?
- In Need of Transitional Care?
  - In need of Specialty Care?
  - High risk and high cost to the system?

If you Answered "yes" to any of these, then Care Coordination Home Telehealth may be the right choice.

Use your Data warehouse to identify patients. Primary providers may not refer. *******

Patient Selection - Home Telehealth

o Patients at higher risk

o Need for more frequent biometric monitoring:

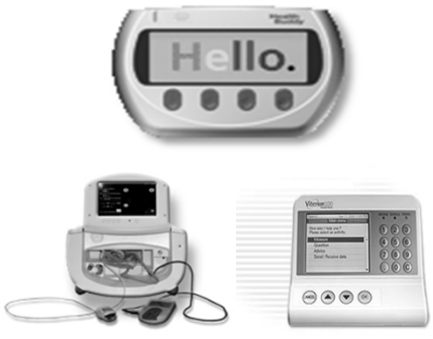
- Frequent fliers to emergency room
- Frequent readmissions
- Distance/travel problems
- Medication compliance issues
- Educational gaps

Conditions effectively monitored

- Heart Failure
- Pneumonia, COPD
- Acute Myocardial Infarction, arrhythmias
- Diabetes
- Hypertension
- Post Surgical, Spinal cord injuries
- Mental Condition … PTSD, Bipolar, Substance Abuse, Depression, etc.
- Cigarette Smoking Cessation
- Dermatological
- Substance Use Disorder, Smoking cessation
- Chronic kidney disease, Hepatitis C
- SCI, Multiple sclerosis, palliative care, Mild TBI, Dementia
- Weight Management
- Future DMP's are under consideration or development

HT -Messaging Devices in Veterans' Homes for Health Information

- Includes VHA-Approved Disease Management Protocols (DMPs) & Peripheral Monitoring Devices (wired/wireless)
  - BP Monitor
  - Weight Scale
  - Pulse Oximeter
  - Glucose Monitor
  - Stethoscope



PATIENT CARE SERVICES

Remote Health Monitoring …
Collecting Useful Data From the Patient Home

Vital Sign Data Collection:

- Blood Pressure
- Weight
- Pulse
- Glucose Levels
- O2 Level
- Temperature
- Etc.

Other Data Collection Types:

- Medication Adherence
- Motion Sensing
- Activity Tracking
- Fall Detection
- Surveys:
  - Symptoms
  - Preventative health exams
  - Nutrition

retinal exams
Podiatry exams
Mental health

The Role of the HT Care Coordinator

Case managers as Care Coordinators provide continuity of care, not novice

- Monitor patient data daily from telehealth devices
- Triage data: biometric data, symptoms, question responses
- Contact patients with high risk responses and/or significant changes
- Experienced nurses can identify and intervene as clinically indicated for:
  - Just In Time care in primary care clinic, ER/urgent care, community
  - Medication adherence, refills, facilitate renewals, note discrepancies
  - Provider directed interventions
  - Protocol-based interventions
  - Education-disease specific, diet, activity, behavior
  - Assist with appointments and set appropriate Smart goals

The Role of the HT Care Coordinator

- Triage calls and concerns of patient/family, resolve those within scope and route others to primary care staff or others as indicated
- Extend primary care inter-visit interval
- Provide communication and data exchange with community-based providers when there is co-managed care
- Provide psychosocial support to patients
- Provide interdisciplinary consultation and interventions (HBPC, social work, pharmacy, nutrition, specialty care etc)
- Reduction of ER visits/inpatient bed days of care/lapsed prescriptions
- Increased completion preventative screenings

The Role of the HT Care Coordinator

- Identify patients' knowledge, health factors, skills, behaviors that support self management and identify gaps
- Provide health care coaching, patient education
- Communicate with provider regarding progress to goals; patterns or trends of data, symptoms or findings; concerning findings; need for provider assessment or interventions
- Facilitate and communicate treatment changes directed by the provider and provide follow up evaluation of the patient
- Reduce the burden of non-emergent calls and visits for the primary provider

The Role of the HT Care Coordinator

- Provide linkages to community services and resources.
- Provide support to patients' caregivers.
- Assess medication adherence.
- Provide periodic reassessments and summary data to providers, including evaluation of progress to goals
- Recommendations to disenroll as appropriate.
- Provide transition management for patients across the continuum.

Outcome Data by Condition Reductions in Utilization

Condition	Number Of Patients	%Reduction
• Diabetes	8,954	20.4%
• HTN	7,477	30.3%
• CHF	4,089	25.9%
• COPD	1,963	20.7%
• Depression	337	56.4%
• PTSD	129	45.1%
• Other mental health	653	40.9%
• Single condition	10,885	24.8%
• Multiple conditions	6,140	26.0%

Darkins A, Ryan P, Kobb R, Foster L, Edmonson E, Wakefield B, Lancaster B. Care coordination/home telehealth: The systematic implementation of health informatics, home telehealth, and disease management to support the care of veterans with chronic conditions. Telemed J E Health 2008;14:10, 1118-1125

Hometelehealth

- Adjunct to Pact team or private practice
- Increases patient self-management skills
- Improves patient medication adherence and refills
- Reduces emergency room visits and readmission
- Makes patient a participant in their own care
- Titration of medications between clinic visits
- Supplies patient with continuous education
  - Verbal counseling
  - DMP-disease management protocols
  - Liaison between patient and provider

CCHT National Aggregate Outcomes Data

- **HT reduces bed days of care (BDOC)**
- **HT reduces admissions**
- **HT reduces improves patient satisfaction**

	2007	2008	2009
Reduction (-) in Admissions	18%	19%	26%
Reductions (-) in BDOC	19%	25%	47%
Satisfaction (+)	87%	86%	85%

2015 VA Benefit

VA Telehealth Services

FY15 Telehealth Services Provided:

- 2.14 million episodes of care to 677,000 VA patients
  - **282,000** patients used **clinical video telehealth** between VA clinics
  - **4,000+ received clinical video telehealth** visits directly into their homes
  - **156,000** patients case-managed by **home telehealth**
  - **297,940** used **store and forward telehealth technology**
- 45% of these patients live in rural areas

OUTCOMES

Home Telehealth
- 58% reduction in bed days of care
- 35% reduction in hospital admissions

Clinical Video Telemental Health
- 28% reduction in acute psychiatric bed days of care

86

Patient Care Services

Virtual Care Report

Version 3.5

Data Definitions

Help Desk

-- All VISNs

-- All Facilities

onthly data ** NOTE: Modalities canNOT be summed.

Measure	% of Population
Telehealth Use (Tele1)	4.96 %
Home Telehealth (Tele2)	1.77 %
Clinical Video Telehealth (Tele3)	2.08 %
Store and Forward Telehealth (Tele4)	1.34 %
eConsult (SC10)	2.09 %
SCAN ECHO (SC20)	0.01 %

Measure	% of Population
My HealtheVet Registration (MHV1)	59.11 %
Secure Messaging (SM10)	28.60 %

Adjust your enrollment goals annually

Patient Care Services

Build on your successes

- The VA started with Hometelehealth only
  perfect issues needed with bandwidth
  what kind of staff needed for population
  panel size

Panel size:

- Registered nurses 70-100
- Dieticians 80-120
- Social worker 80-100

Build on your successes

- Next came clinical video based telehealth
- Secured messaging/ MyhealtheVet
- CVT to the home

Equipment/Vendors

Use more than one vendor
Encryption
Licensing across state lines
Process for Quality Issues, mismatched socials/MR numbers or like names, emergencies, high risk patients, dementia, no PCP, non-responders

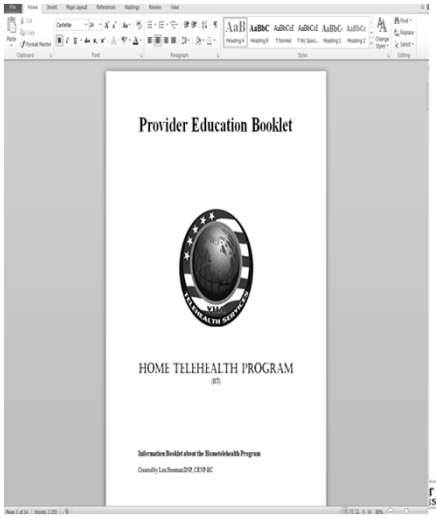
- Promote your programs

TV
Flyers in each Point of Contact
Patient newsletters
Provider education
Databases

Promote your program

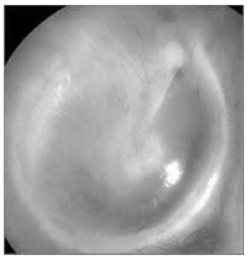
Patient newsletter

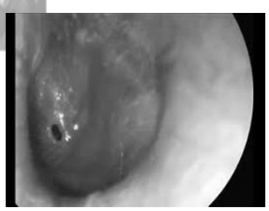
Provider Handbook

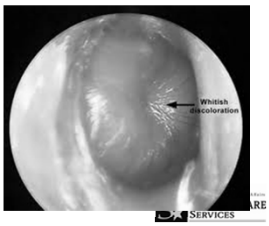


Video-conferencing Equipment

- Electronic Otoscope

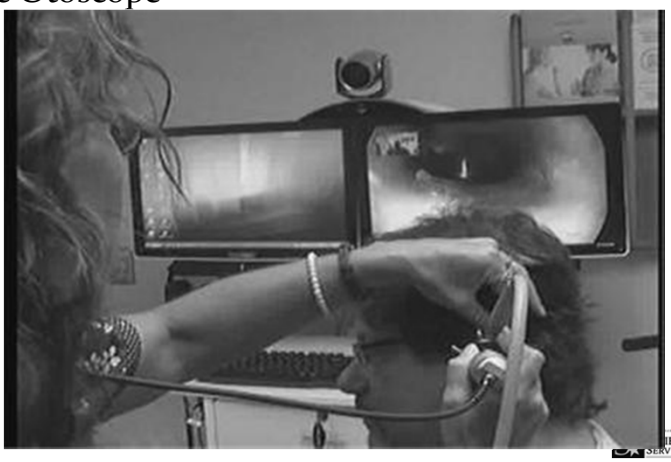






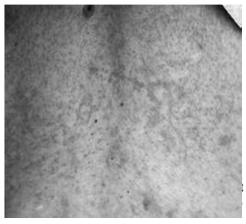
Video-conferencing Equipment

- Electronic Otoscope



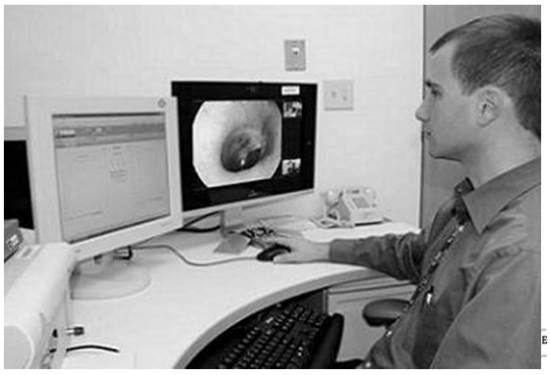
Video-conferencing Equipment

- Electronic Hand Held Camera
- Oral
- Skin lesions
- Wounds
- Neck Veins



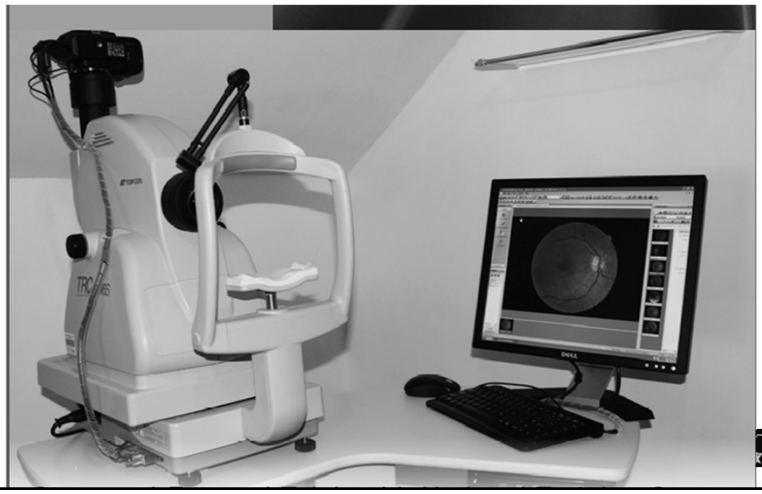
Store & Forward - Telehealth

- Diabetic Retinal Screening
- Dermatology
- Wound Care
- Podiatry



Telehealth - Store & Forward

- Tele - Retinal Equipment



Video to Home - Telehealth

PATIENT CARE SERVICES

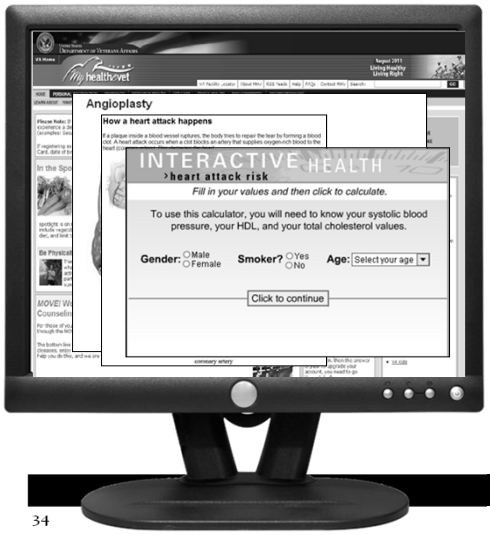
Video to Home - Telehealth

- Real time care in the home
- Barriers to overcome - Privacy issues
- Patient equipment and internet access
- Knowledge
- Technical support

PATIENT CARE SERVICES

My HealtheVet - Telehealth

My Health*e*Vet Research Health



- **Healthy Living Centers**
- **Disease and Condition Centers**
- **Mental Health Resources**
- **Medical Libraries**
- **Service Related Conditions**
- **MedlinePlus®**
- **My HealtheVet Learning Center**
- **Monthly feature articles**

34

My Health*e*Vet Pharmacy

- **VA Prescription Refills**
- **VA Prescription Refill History**
- **Self-entered medications, herbals, over-the-counters (OTCs), and supplements**
- **VA Medications List***
- **My Complete Medications List (VA and self-entered)***

Over 27.5 million VA prescription refill requests since launched in August 2005

35

*requires authenticated account

My Health*e*Vet Secure Messaging*

- eHealth Clinical Service for non-urgent communication with patient's health care team
- Veterans can request appointments, prescription ewals, ask health and/or inistrative questions, etc.

*requires authenticated account

36

Benefits of Telehealth

- Increased access to care
- Increased ability to self-manage, partner in care
- Increased renewal/refill of medications
- Increased referral to supportive clinics
- Increased patient education
- Real time med management
- More involved patients
- Decrease in number of managed care appointments
- Decrease emergency room visits
- Decreased inpatient bed days of care
- Decrease travel cost for patients

Using Telehealth to Manage Hospital Prevention Quality Indicators

Lorien Health Systems/Lorien Mays Chapel
Lorien At Home/Grand Care

Presenters

- **J. Wayne Brannock**
  COO, Lorien Health Systems
- **Susan Carroll**
  VP Clinical Services, Lorien Health Systems
- **Tracy Carroll**
  Director of Operations, Lorien At Home

Project Participants

- Lorien Health Systems
  - Maryland Provider
    - Nine Skilled Nursing and Five Assisted Living
- Lorien Mays Chapel
  - Continuing Care Facility (CCF)/(93 Bed SNF)
- Lorien At Home
  - Level III Residential Service Agency
- GrandCare Systems
  - Telehealth Technology Vendor

Overview

- Project, Objectives, Goals and Current Status
- Technology Overview & Clinical Enhancements
- Clinical Workflow Integration
- Challenges, Successes & Case Study
- Key Takeaways

Project Overview

- **Project**
  - Combine treatment protocols, care coordination and telehealth technology to reduce re-admissions and admissions to acute care post discharge from a short-term Skilled Nursing Facility stay.
- **Target Specific Diagnosis**
  - Uncontrolled Diabetes
  - Chronic Heart Failure
  - Hypertension

Clinical Measures

- **Uncontrolled Diabetic clients:**
  - Reduce and/or maintain Glycohemoglobin A1c lab value less than 6.5%.
- **Congestive Heart Failure clients:**
  - Reduce and/or maintain CHF classification by NYHA Functional Classification System
- **Hypertension clients:**
  - Reduce and/or maintain hypertension score as defined by JNC7 (7th Report of the Joint National Committee on Prevention, Detection and Treatment of High Blood Pressure)
- **Hospital Admission Rate for All Clients**
  - Reduce and/or eliminate acute admissions related to specific diagnosis
  - LACE index scale (1-19). Current average 12.8

Current Status

- Program implemented 6/1/2015 with on-going utilization
- Continuous monitoring and case management for target number of 15 clients.
- Weekly Utilization Review
- Total of 19 installations with 15 on currently.
- Of 15 clients:
  - 4 Uncontrolled Diabetes
  - 5 CHF
  - 13 Hypertension

Telehealth Capabilities with Grand Care

- Remote Monitoring
  - Blood Pressure
  - Pulse Oximetry
  - Blood Sugar
  - Weight
  - Temperature

Telehealth Capabilities with GrandCare

- Remote Coordination
  - Medication management
  - No-touch Video chat
  - Motion and door alerts and sensors
  - Shared calendar
  - Wellness surveys
  - Instructional and educational videos
  - Socialization tools
  - Family engagement
  - Secure e-mail

New Clinical Capabilities

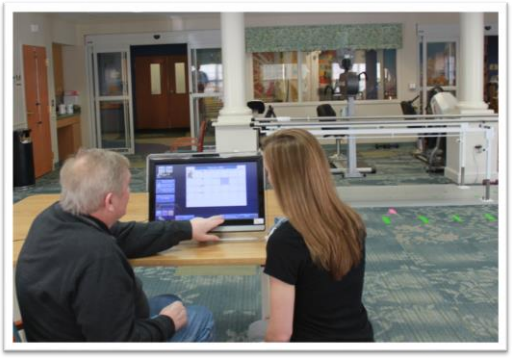
- Protocols
  - 24/7 Monitoring, Alerts, Response
  - Assessment
  - Care Strategies
  - Telemonitoring Equipment
  - Follow-up
  - Expected Outcomes
- Lorien Link plus peripherals
  - Chronic Heart Failure – BP cuff, weight scale
  - Uncontrolled Diabetes – glucometer
  - Hypertension – BP cuff

Supporting Clinical Information

- Electronic Medical Record Access
  - CRISP (Health Information Exchange)
    - Query and Encounter Notification
  - Point Click Care (EMR)
  - Grand Care (Lorien Link)

Pilot Program Challenges

- Client acceptance
- Use of Telehealth equipment
- CRISP Integration
- Primary Care engagement



Pilot Program Successes

- Equipment installations in variety of settings
- Client and family engagement
- Client and family education
- Utilization of CRISP Query and ENS

Pilot Program Success Continued

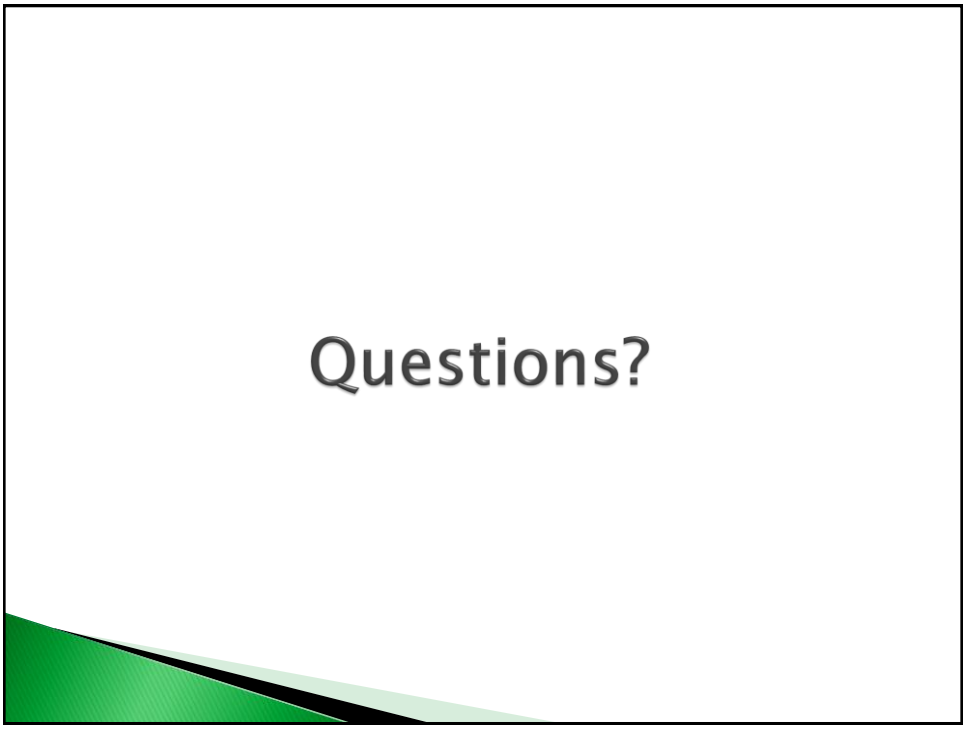
- Preliminary Findings
  - **Uncontrolled Diabetes**
    - 100% maintained or improved upon baseline A1c
    - 40% A1c improved
  - **CHF**
    - 90% maintained or improved upon classification score
  - **Hypertension**
    - 70% maintained or improved upon classification score
    - 17% improved classification score
  - **Hospitalizations**
    - Successfully avoided hospital activity for multiple patients (preventable admissions). One admission in eight months related to chronic condition.

Case Study

Pam's Story

Key Takeaways

- Value of real time alerts and intervention
- Technology enhancements
- Client and care manager relationship
- Need for reimbursement


Questions?

Lorien Link

Lorien Link is our Remote Communication System. This unique, state of the art technology provides ongoing wellness and safety monitoring. Lorien Link is placed in the home which allows clients to communicate with Care Coaches and family members at the push of a button.

Lorien Link Technology Includes:

- Lorien Link – Hardware
- Medication Reminders
- Family & caregiver communication
  - Video call
  - Secured e-mail & messages
  - Caller ID
  - Photo sharing
- Video Calling
  - Live caregiver alerts
- Customizable Technology
  - Music
  - Secured websites
  - Video
  - Games & trivia

- **Remote patient monitoring**
  - Wireless wellness devices
- Blood Pressure
- Weight Scale
- Pulse Oximeter
- Glucometer readings
- Thermometer
- Motion Sensors

Lorien at Home
Care for today.
Plan for tomorrow.

UNION HOSPITAL

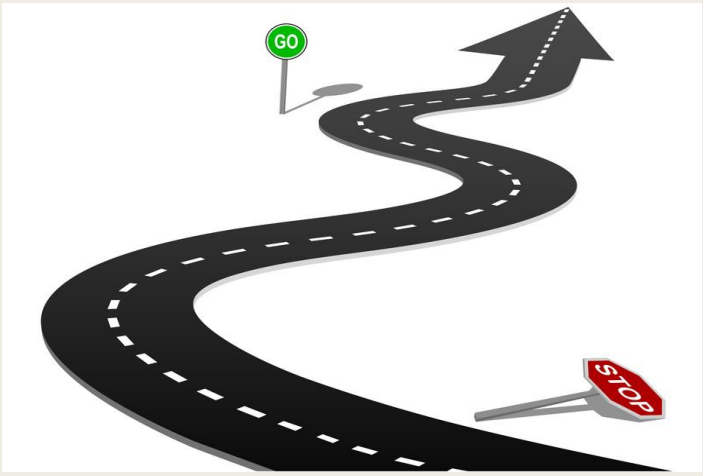
Our Values
Caring & Compassion • Integrity • Leadership • Shared Learning

THE UNION HOSPITAL TELEHEALTH JOURNEY

February 22, 2016

Our Journey

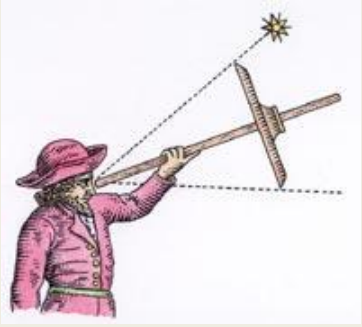
- Project Overview
- Clinical Measures
- Challenges
- Successes


GO
STOP


UNION
HOSPITAL
vivify

Project Overview

- Three phases
  - *Pilot*
  - *Round 2 funding*
  - *Round 3 funding*
- Patient Selection Criteria
  - *Chronic conditions*
  - *High-utilizer*
  - *Willingness to participate*



Clinical Measures

- Readmission rates
- PQIs
- CRISP utilization

Challenges

- Compliance
- Technology
- Logistics
  - *Kit return*
  - *Kit component return*
- Measure reporting
  - *PQIs*

Successes

- Patient outcomes
  - *Only 1 of original cohort of patients was readmitted*
  - *Only 1 of round two patients was readmitted*
  - *Patient with low oxygen saturation obtained portal oxygen at home*
- CRISP utilization increased
- Recognition of positive impact of program on patient outcomes
- Participation in the program increased from 30 to at least 60 days
- *Positive patient satisfaction scores*


why
when
who
where
what
why
QUESTIONS
who
how
where
who
what
how
how

Chronic Health Condition Management in the School-age Population using mobile health (m-health) devices

Crisfield Clinic – Crisfield, MD

Dr. Kerry Palakanis
Nivea Taylor, CHW

Somerset County Statistics

- One of only five counties in MD designated as 100% medically underserved.
- Compared to other MD Counties ranks
  - Obesity prevalence (24/24)
  - heart disease mortality (24/24)
  - Hypertension (23/24)
  - Diabetes (23/24)
  - High Cholesterol (23/24)
  - Asthma (22/24)
- Childhood obesity (21.3%) is rising and almost twice the state rate (11.6%).
- Population % living in poverty (24/24)

Chronic Care Issues and Children

- Academic achievement and education are critical determinants of health across the life span and disparities in one contribute to disparities in the other.

- Health and achievement are bidirectional – children with chronic health issues:
  - Attain lower academic achievement
  - More likely to have morbidities as adults
  - More likely to have premature mortalities

Program Overview

- Project Goal - to use mobile health devices to improve patient data metrics, reduce lost school days, reduce emergency room visits and improve the patient's self perception of their health.

- Targeted population- school aged children with Asthma, Obesity, Diabetes and any mental health condition (ADHD, Depression, etc.)

- Community Health Worker (CHW) Role - to keep in contact with patients, collect and analyze data from mobile health devices. Contact patients if data is not within normal range

Clinical Protocols

Obesity

- Monitor weight and BMI
- Journal dietary intake
- Monitor exercise

Asthma

- Monitor medication adherence
- Peak flow testing

Mental Health

- Monitor medications adherence
- Daily mood monitor
- Encourage activity

Clinical Measures

The Community Health Worker plays an important role in the collection of data for each chronic condition

- Data Input manually or remotely
- BMI and weight change
- Steps/Activity
- Missed school days
- Emergency room visits
- Peak flow variations
- Medication adherence and prn use
- Monitor appointment adherence with other care team members
- Self-reported mood status

CircleLink

- CircleLink - Mobile Health technology
  - low cost,
  - automated remote patient engagement platform
- Uses communication and information technologies
  - to boost patient compliance
  - reducing provider and payer costs
- Most suited for most chronic care situations,
- Designed to be :
  - highly scalable,
  - low cost
  - easily deployed
- CarePlanManager reminds, manages and automatically intervenes with patients that require continuous or preventative care.

Community Health Worker

- Frontline public health workers who have a close understanding of the communities they serve.
- Provide outreach, education, referral and follow ups, case management, advocacy and home visiting services to those who need an advocate to help them navigate the healthcare system.
- Assist individuals and families in developing the necessary skills and resources to improve their health status and self-sufficiency.

Case Study

- Age 18 – diabetic since age 15
- Had formal diabetes education in 2013 at Mt Washington Hospital
- Low self esteem and has always struggled with weight
- Started program, but did not put forth effort causing weight to fluctuate and poor diabetic control
- Kept track of weight, but did not diet and exercise
- Had change of heart and decided she does care about her health
- Has started watching what she eats, monitoring blood sugar and drinking protein shakes

Current Project Status

- 28 students enrolled
  - 14 Obese
  - 8 Asthmatics
  - 6 Behavioral Health children
- Ongoing recruitment of patients
- Students excited about the program and are expected to reach their goals within 1 year
- Positive response from family and interest for participation by adult family members

Challenges

- School System/Telehealth Legislation Issues
- Syncing Difficulties
- Recruiting and retaining participants
- Appointment compliance
- Lack of public exercise facilities

Successes

- Students are becoming more self aware of their chronic conditions, and are often reminding their parents of what they have to do.
- Students are using their mobile health devices by themselves with encouragement from their families and CHW.
- Increasing community awareness for chronic health condition monitoring

Lessons Learned

- Have a back up plan
- Individualize approach
- Low interest level in teens
- Parent participation = success

Future Projects

- Telemedicine cart deployment on Smith Island, public housing authority and in six schools
- Community Health Worker in chronic care
- M-health all ages
- 24/7 call center

February 22, 2016

Crisfield Clinic Family Practice

The Crisfield Clinic is now recruiting area children aged 5-18 years old who have asthma, depression, diabetes, are overweight or smoke cigarettes to participate in a free mobile health program. Contact us at 410-968-1800 to enroll today.




Our Services

- Primary Family and Preventive Care
- Same day Sick and Injury Visits
- Onsite Laboratory Draw & Testing
- Well Child Exams
- Well Woman Examinations
- DOT Physicals
- Sports and Camp Physicals
- Adult and Pediatric Immunizations
- Allergy Shots

Meet Our Staff

We are a staff of Healthcare Providers, medical assistants and administrative assistants that base our success on our patients' long-term good health.
We believe in personalized care based on your health concerns. Read More

IMPROVING CHRONIC CARE OUTCOMES

a practical solution from CircleLink Health

The Challenge

Providing quality chronic care management (CCM) is hard. Patients rarely follow their prescribed care plans, leading to low adherence, and the time and effort required by you and your staff can be exhausting. Until recently, there was little to no financial reward for all the effort involved.

The Change

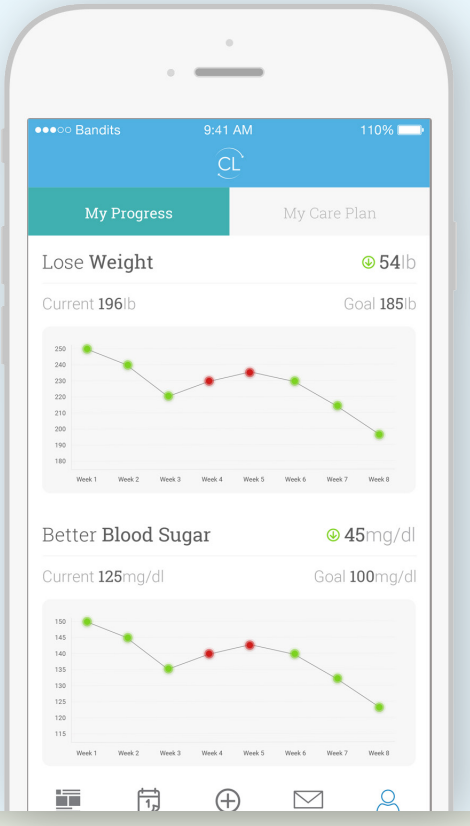
Medicare now provides CCM reimbursement...

$150,000/YEAR FOR A TYPICAL FAMILY PHYSICIAN

...and CircleLink Health makes it easy to put your CCM plan into action.

CALL OR EMAIL FOR A QUICK DEMO

203-847-5890 (ext. 3) *or*
sales@circlelinkhealth.com



A Practical Solution - Works with any Phone!

CircleLink Health uses a clinical call center and/or patients' mobile devices to monitor and promote behavioral change while helping providers easily manage patients' chronic conditions 24/7.

The CircleLink Health solution was developed with you, the healthcare professional, in mind. With next to no effort by you or your staff, CircleLink Health provides a simple way to achieve clinical and financial benefits.

CircleLink Health Benefits

Improved Outcomes:

- Empowers patients to be more active in their care
- Improves compliance to your prescribed care plan
- Provides automatic feedback and reporting

Practice Efficiency:

- Simplifies Medicare reimbursement process
- Integrates with existing EHR systems
- Increases practice revenue without extra effort by you
- 24/7 care center can deliver the 20 minutes of care

How It Works

MD approves care plan → Custom patient reminders and prompts → Vital data collected via call center and/or mobile app → Alerts and reports auto-generated → Patient outcomes improve; practice gets reimbursed

CircleLink HEALTH

CircleLink Health
1234 Summer Street, 6th Floor
Stamford, CT 06905
203 847 5890
info@circlelinkhealth.com

Ask us about our chronic care experience at:

Yale-New Haven Hospital · verizon foundation · Vanderbilt School of Medicine · Tulane University School of Medicine · University of Pittsburgh · Emory Healthcare · Montefiore Inspired Medicine · The Founding Campus · Johns Hopkins Medicine · Henry Ford Health System

CareFirst

2016 MHCC - Telehealth Symposium

February 22, 2016

Hosanna Asfaw-Means, MPH
Grants Program Manager

CareFirst

Who we are…

We are:

- Mid-Atlantic Region's largest health care insurer, serving more than 3.2 million members in Maryland, Washington, DC and portions of Northern Virginia.
- A not-for-profit organization committed to funding programs that catalyze improvements in quality, health care access, and health outcomes in the communities it serves.
- CareFirst has dedicated nearly $493 million to worthwhile programs and organizations since 2005.
- CareFirst has been supporting telemedicine efforts since 2013.

CareFirst and Telemedicine

Why Telemedicine?

- The need is great. Telemedicine can be used to address disparities in medical care for CareFirst members and in medically underserved and under-resourced communities.
- Many providers in rural *and* urban sites can use telemedicine for consultations and patient encounters.
- Patients and providers are ready. Technology is now pervasive in the medical setting.

CareFirst and Telemedicine

2013 RFP

Goal:

- Fund development, implementation and evaluation of programs that creatively use telemedicine strategies in public or private nonprofit settings to produce measurable improved outcomes in behavioral health, including those with substance use disorders

Available Funds:

- Up to $1.5 million (total) in grants over three years.
- **Funded $1.3 million over three years**

Funded Grants:

• Associated Catholic Charities:	MindCare for Marylanders – Increasing Access to Psychiatry through Telemedicine
• Atlantic General Hospital:	Expanding Access to Care of Pediatric Developmental, Learning and Autistic Spectrum
• La Clinica del Pueblo:	Telemental Health Initiative
• Sheppard Pratt Health System:	TeleBehavioral Health Integration in Rural Medical Centers in Maryland

CareFirst

CareFirst and Telemedicine

2015 RFP

Goal:

- Utilize telemedicine to address disparities in medical care in medically underserved and under-resourced communities.
- Increase efficiency and patient utilization of services.

Available Funds:

- Up to $3 million (total) in grants over three years.
- Received 31 applications requesting more than $16 million.

Funded Grants:

- TBA

RCM&D | MUCH MORE THAN A BROKER

Telehealth Symposium

Insurance and Risk Management

Linda E. Jones, MHA, CPCU
Managing Director

February 2016

RCM&D

Professional Liability Coverage Considerations

- There are insurance coverage options available
- Coverage for individuals and entities
- Not all carriers will write this exposure
- Licensing and coverage confirmation are important
- Various jurisdictions may encourage “venue shopping” by injured plaintiffs

RCM&D

Professional Liability Coverage Considerations

- Practicing across state lines?
- Are physicians licensed in all states where they may provide services?
- Do you have access to policies with pricing flexibility to base premium on exposures (# of reads or revenue)?
- Lack of portability of coverage and “tail” issues for departing physicians
- Inflexibility in the underwriting requirements for preapproval of new or last minute physicians

RCM&D

Questions to ask your Insurance Advisor:

- Does your current policy allow for additions of employed or contracted physicians automatically or with a minimum amount of information about them up front?
- Does your policy cover contracted services provided in any state?
- Does your current policy have continuous coverage for terminated/departed physicians after they leave the group?
- Does your current policy provide individual limits for each employed or contracted physician?

RCM&D

How is Telemedicine Regulated?

- Food and Drug Administration ("FDA")
- Centers for Medicare & Medicaid Services ("CMS")
- State health codes, medical boards, etc.
- HIPAA

RCM&D

How Does the FDA Regulate Telemedicine?

- When equipment or software is intended for use in the diagnosis or treatment of a disease or other condition, the FDA considers the equipment or software to be a medical device.
  - ***Example***: Remote Holter monitoring
- FDA regulates the software used in *telehealth* systems.
  - ***Example***: The software that "reads" and "interprets" the Holter data; the software that transmits the remote retinal images, etc

RCM&D

FDA Now Oversees Mobile Medical Apps

As of September 25, 2013, the FDA regulates mobile medical apps that:

- Are used as an accessory to an FDA-regulated medical device.
- Transform a mobile platform into a regulated medical device.

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How does CMS regulate Telemedicine?

- Requires hospitals receiving telemedicine services to privilege each physician or practitioner providing services to its patients, as if the practitioner worked on site.
- While current regulations permit use of third-party credentialing verification organizations, the hospital's governing body retains responsibility for all privileging decisions.

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The Hospital Must Ensure:

- The distant-site hospital providing the telemedicine services is a Medicare-participating hospital.
- The distant-site practitioner is privileged at the distant-site hospital providing telemedicine services.
- The distant-site physician or practitioner holds a license issued or recognized by the State in which the hospital, whose patients are receiving the telemedicine services, is located.

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State Licensure

- Most states have enacted legislation requiring providers using telemedicine technology across state lines to have a valid state license in the state where the patient is located.
  - 9 states have a special telehealth, conditional or special purpose license for the practice of telemedicine in their states
  - 45 states and DC allow exemptions for “infrequent” or “occasional” provider-to-provider consultations by out-of-state physicians.

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States with Telemedicine Licensure

1. Alabama
2. Louisiana
3. Minnesota
4. Nevada
5. New Mexico
6. Ohio
7. Oregon
8. Tennessee
9. Texas

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Risk Management Considerations

- Ensure you have emergency contact information for the patient.
- Privacy may be a concern if working remotely or using "Skype"
- Provide patients with reliable and accurate sources of health care information.
- Engage patients in their health care.
- Utilize the informed consent process.

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Risk Management Considerations: E-Prescribing

- Understand state-specific and federal prescribing rules related to:
  - Licensure
  - Establishment of a physician-patient relationship
  - In-person physical exam requirements
    - How is it defined?
  - Standard of Care
  - Prohibitions on certain drugs, i.e., controlled substances
    - Ryan Haight Act
  - Prohibitions on questionnaires alone

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Risk Management Considerations: Video Chat Applications

- Consumer video chat apps, such as Skype, were not designed for mHealth purposes
  - Not HIPAA-compliant
    - Encryption
    - BAAs
    - Documented Security Breaches
      - Viruses
      - Surveillance recording
      - IP address tracking
      - Storing messages and voicemails

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Telemedicine Standard of Care

- Standard of care when practicing via telemedicine is the same as if practicing in-person.
- Telemedicine providers need to account for continuity of care and patient abandonment issues.
- If telemedicine consult is not sufficient for diagnosis, provider should refer the patient to alternate providers for in-person care.

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Resources for Telemedicine

- American Telemedicine Association ("ATA")
  - Standards & Guidelines
    - Core Standards for Telemedicine Operations
    - Practice Guidelines by Specialty
- Mid-Atlantic Telehealth Resource Center
- Center for Telehealth and e-Health Law

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Questions?

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February 22, 2016

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RCM&D is ranked among the top independent insurance advisory firms in the United States. Our specialized teams provide strategic solutions and consulting for risk management, insurance and employee benefits. Leveraging 130 years of experience and strong local, national and global reach, we partner with you to meet all of your business objectives.

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- Professional Liability
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Health Care Anywhere Anytime

Gary Capistrant
February 22, 2016

Barriers

Remove and oppose artificial government barriers

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Major Government Roles

- Rendering
- Reimbursement
- Regulation
- Research
- Resources
- Readiness and recovery

Major Public Payors

Medicare - NO
- 1834(m)
- Physician services
- CMMI

Medicaid - GO
- No federal law or reg restrictions
- Common requirements
  - Statewideness
  - Comparability

Medicare FFS Barriers

Limited live video
- Only rural counties (20% of beneficiaries)
- Limited originating sites – not a home
- Limited providers – not RT
- Only specific procedures

No "store & forward" (recorded)

No phone, fax, email

No remote patient monitoring for chronic conditions

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Medicare Bills

CONNECT for Health Act
- S. 2484: Sen. Brian Schatz (D-HI)
- H.R. 4442: Rep. Diane Black (R-TN)

Telehealth Enhancement Act
- H.R. 2066: Rep. Gregg Harper (R-MS)

Medicare Telehealth Parity Act
- H.R. 2948: Rep. Mike Thompson (D-CA)

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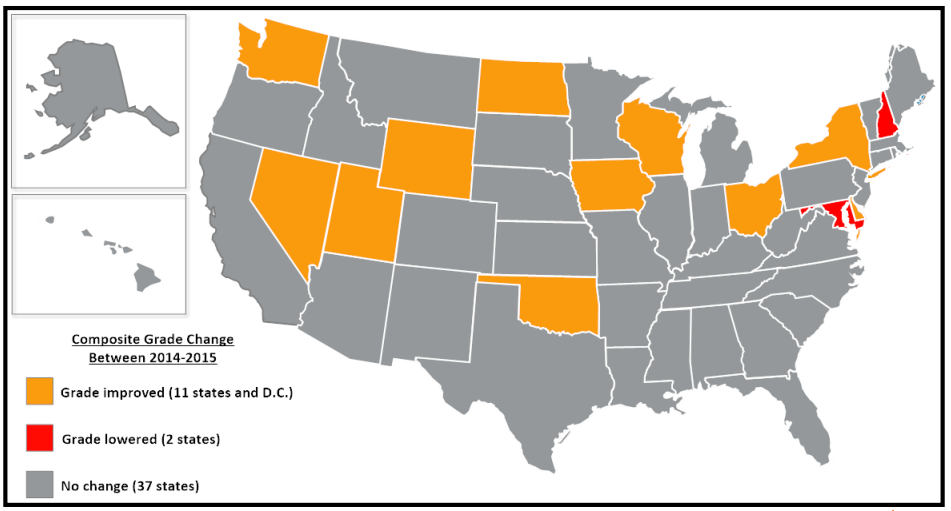
States' Overall Coverage



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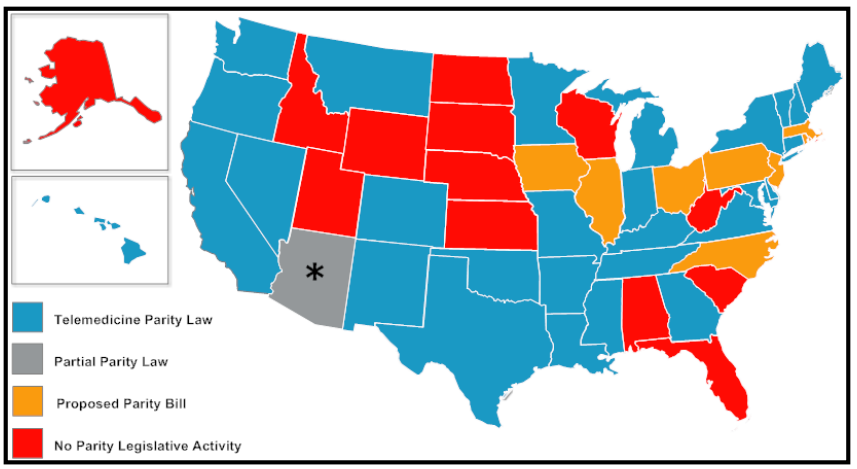
Parity for Private Insurance



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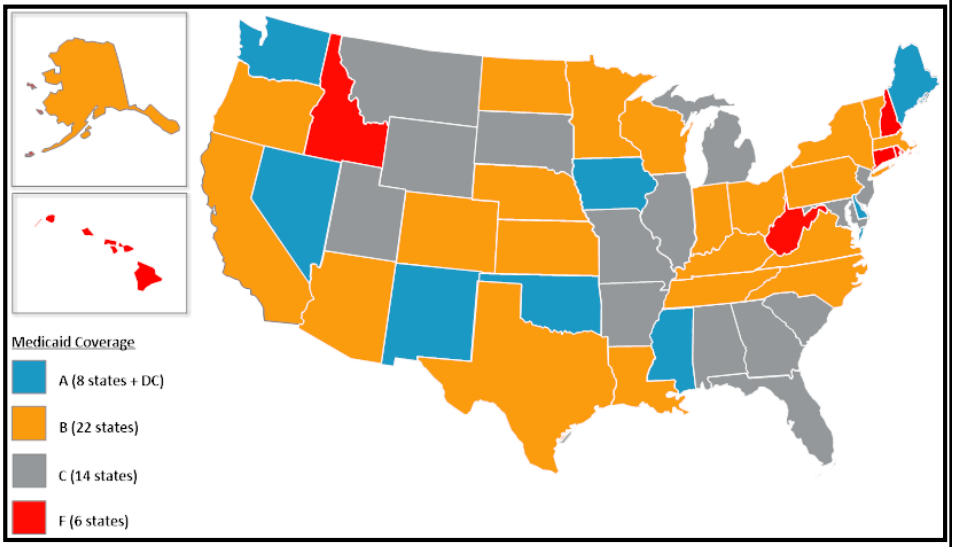
States' Medicaid Coverage



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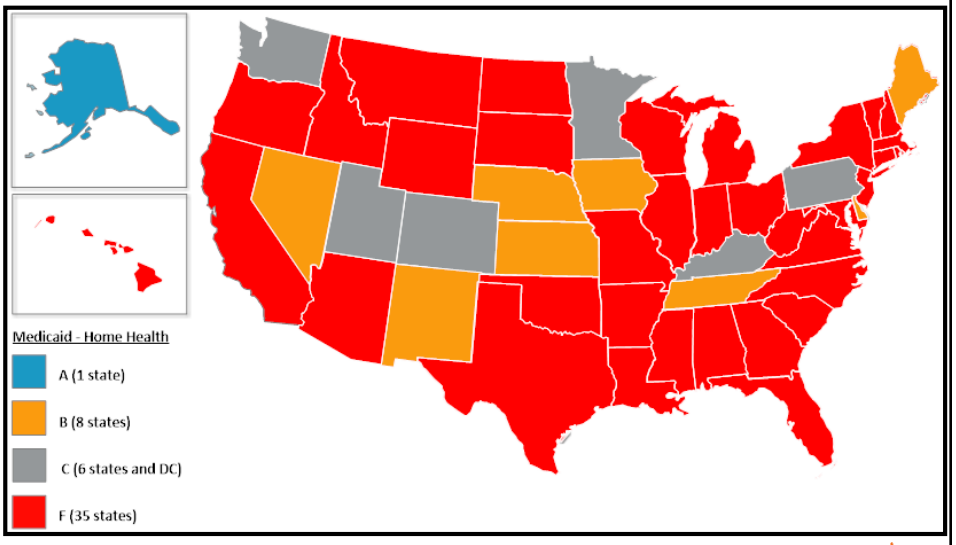
States' Medicaid Home Health Coverage



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Delivery Problems

Address care delivery problems

Cost, access, quality, productivity

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Some Problems Addressed

Barriers of time and distance
Professional shortages
Disparities in access to care
Quality of care
Hospital readmits, ER overuse
Costs of delivery
Convenience and patient choice

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Opportunities

Increase patient choice, outcomes, convenience, satisfaction

Promote "value-based" innovative payment and service

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Innovative Pay Models

Tweaks

- Value-based purchasing
- Pay for performance

Reforms

- Bundling (services, time)
- Case-mix
- Sharing (risk, savings, gains)
- Salary-based
- Reference pricing, indemnity

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Medicare Prospects

Payment innovations

- ACOs, bundles, medical homes
- Medicare Advantage
- Community health centers

FFS

- Stroke
- Chronic care

Medicaid Prospects

Parity

- Urban
- Homes

Managed care flexibility

Remote patient monitoring

Focused initiatives

- Specialty – at-risk pregnancies, autism
- Chronic - health homes
- Sites – school-based

AmericanTelemed.org
ATAwiki.org

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