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Establishing Telehealth Strategic Priorities: A Guide for Development Methods, Structures, & Decision Making

North Country Telemedicine Conference

November 3, 2016

Lake Placid, New York

Presentation Agenda

- About Schumacher Clinical Partners
- Telehealth Development – Readiness & Life Cycle
- Decision Making & Telehealth Governance
- Design & Communication

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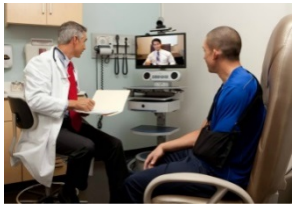
- 8M Patients
- 7,200 Providers
- 450 Hospitals/Acute/Pediatric/Specialty/CAH/LTAC
- 32 States
- Consulting Services
  - Telehealth
  - Revenue Cycle
  - Integration
  - Technology

Our Telehealth Experience

Experienced Thought Leaders, Vertically Focused in Telehealth



- Consulting team averages over 18 years healthcare and Telehealth consulting experience
- Deep specialty in Telehealth consulting services for client needs from planning through implementation and interim leadership:
  - Telehealth Business Plan
  - Service Line Solution Design
  - Vendor Analysis and Selection
  - Implementation and Program Management
- We help clients strategically leverage existing clinical strengths to build new care programs that drive improved care, better managed patients, and new revenue
- Invited as industry thought leaders to speak at many national and regional conferences
- Active in research oriented journals to advance Telehealth best practices across the healthcare industry

HIMSS transforming healthcare through IT

ATA American Telemedicine Association

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Our Telehealth Services

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Telehealth Development

Readiness & Life Cycle

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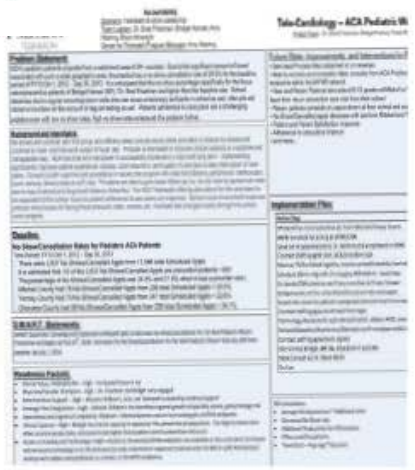
Rapid Telehealth Development Life Cycle

Key Stakeholders for each step include Provider Champion(s), Executive Champion(s), IT, IP or OP Medical Director for Telehealth, and the Center for Telehealth Facilitates.

1. Brainstorm and Readiness Factors
2. White Board Process Mapping
3. Exec or Steering Review Workplan



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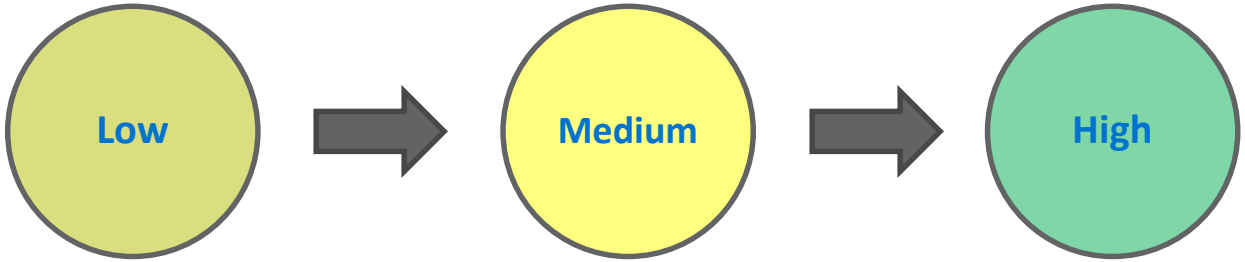
Telehealth Readiness Factors

Readiness Factors:

1. Clinical Value
2. Physician/Provider Engagement
3. Administrative Support
4. Strategic Plan Congruence
5. Clinical Capacity
6. Operational & Logistical Complexity
7. Access to Funding & Technology

3 Readiness Levels:



Low = Barriers exist, meets few/no criteria

Med = Some barriers, meets most criteria

High = No barriers, meets all criteria

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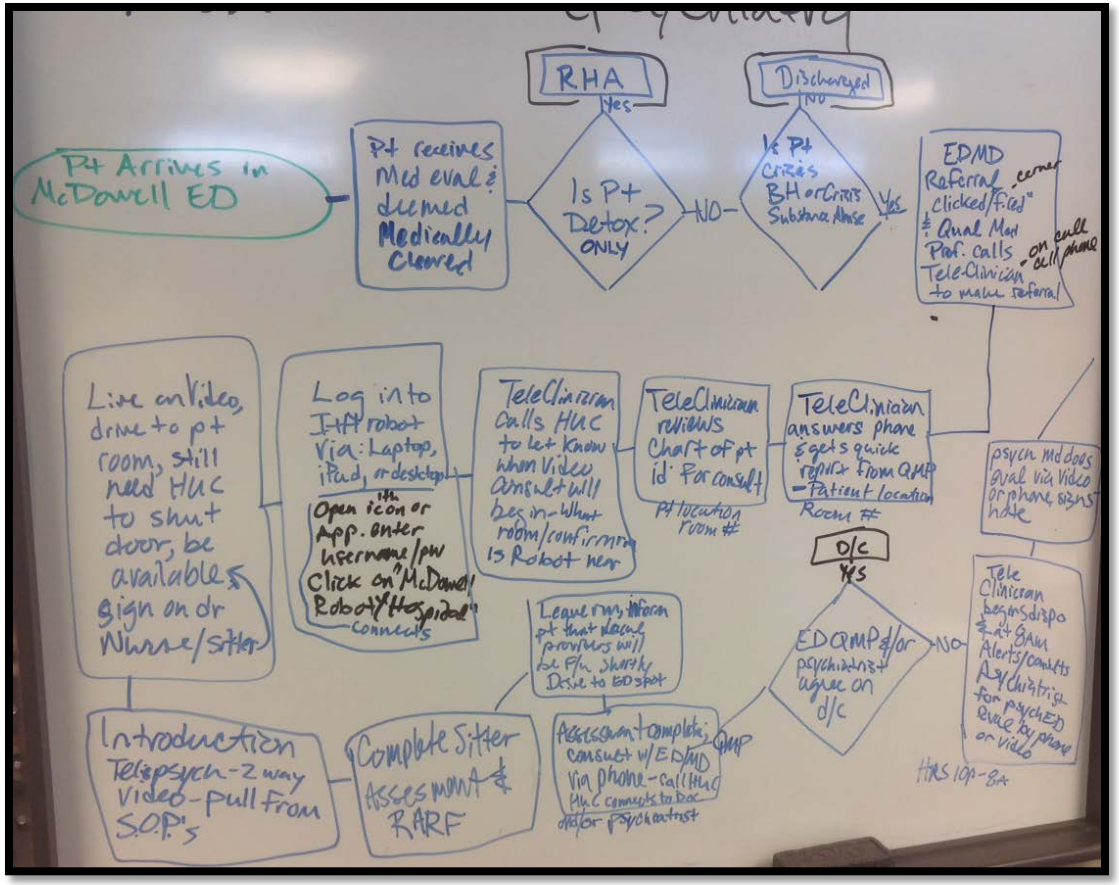
Readiness Factors: (definitions)

- **Clinical Value** – Implementing the Telemedicine application significantly improves the Patient Experience/Access, reduces Cost, & improves Quality. Is it Cognitive or Procedural in nature?
- **Physician/Provider Engagement** – Is a Physician/Provider Champion candidate present with significant buy-in from others in medical discipline (strong team & team lead & team lead backup)?
- **Administrative Support** – Does senior leadership support/validate physician champion & clinical discipline's strength to implement successfully? Has Legal Counsel been sought?
- **Strategic Plan Congruence** – Does the clinical discipline align with the Enterprise Strategic Plan (crossover, invest/grow or strengthen/defend area)?
- **Access to Funding & Technology** – Does the clinical discipline have access to research grant funding (Federal/Industry/Foundation/Association), organizational funds, capital, or other? And does clinical discipline have access to technology (is technology existing or require new investment)? Is the initiative reimbursable?
- **Clinical Capacity** – Does the clinical discipline have capacity (time & manpower) to begin implementing successfully in the short and long term (1,3, & 5 years)? Will implementing significantly impact capacity for the clinical discipline in a positive & manageable way?
- **Operational & Logistical Complexity** – Ease of implementation, are there significant barriers that exist? Has any pre-work been accomplished to date?

White Board Process Mapping



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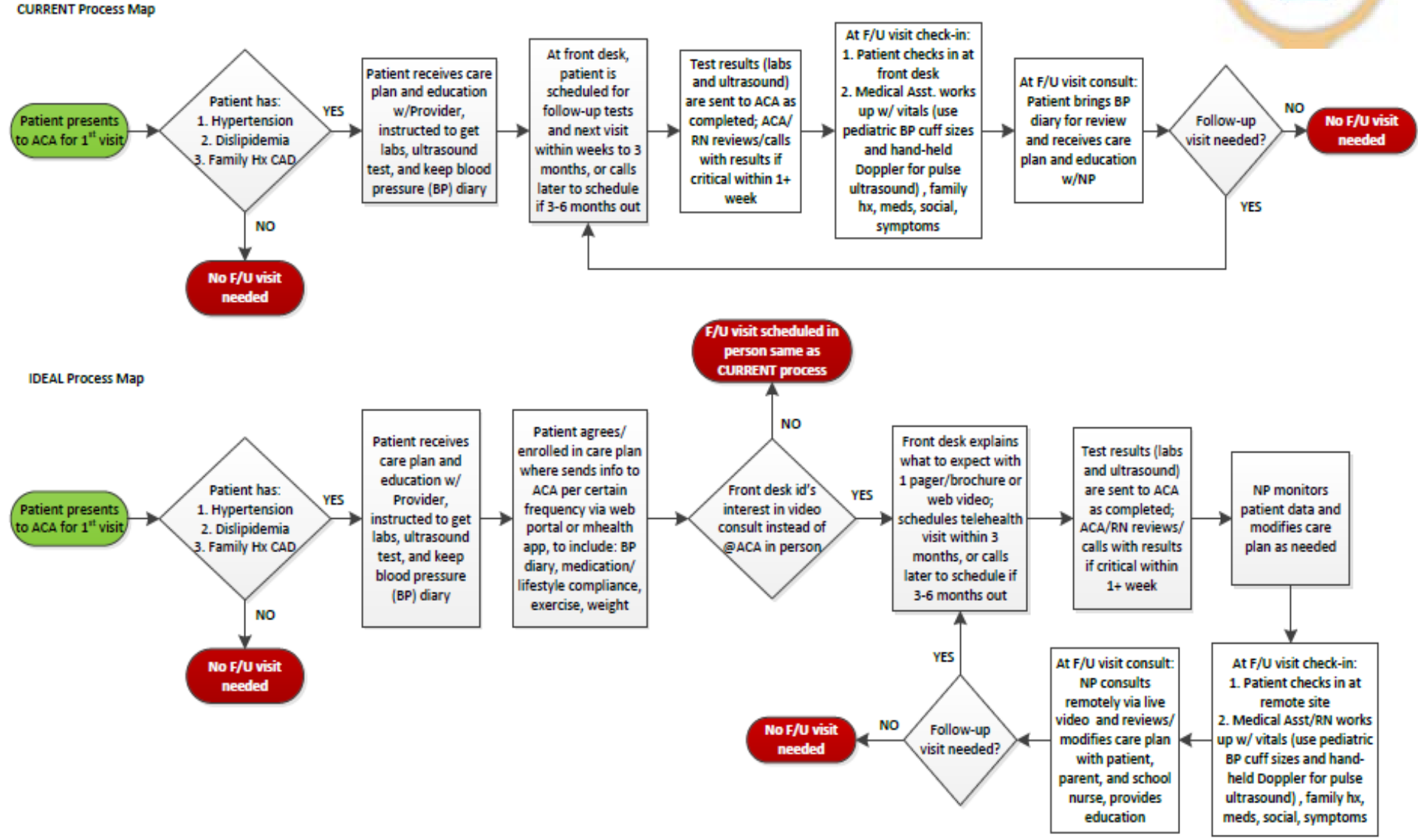
White Board Process Mapping

White Board Process Mapping, cont.



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Workplan

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Accountability:

Program Name:

Project Team:

Problem Statement:

Mission Health is focused on being a great place to work and practice. Employees of Mission Health have varying access to care based on their primary place of appointment, for example employees of Blue Ridge Hospital do not have a nearby Mission urgent care center or employee health/staff health clinic. Access to quality, Mission Health providers is limited to the ED in some locations depending on the date and time of day. Telehealth is a viable way to offer employees urgent care and staff health related care.

Background and Importance:

One of the most significant ways in which Telehealth results in cost savings for both employers and employees is the redirection of non-emergent medical care from the emergency department or an urgent care facility to a less expensive setting. There is opportunity to provide a quick proof of concept for employer telehealth by providing a Telehealth Endpoint at Blue Ridge Hospital for either Staff Health in Mission-Asheville and/or McDowell Urgent Care.

- Provide through Staff Health, McDowell Urgent Care, or hybrid to provide extended coverage 7a-11p
- After successful proof of concept, expand to Mission members and employers (i.e. Baxter)
- Great Place to Work & Practice, Employee Satisfier for convenience
- Health Plan Utilization, transferring ED visits more appropriately to urgent care or office visits saves $$$'s
- Revenue generating through reimbursement, possible increase in referrals to specialists.
- Population Health
- Grow, Grow, Grow

Baseline:

Mission DATA from entire Health System, a REAL EXAMPLE (FY13 Data):

The Diagnosis Code **784.0 Headache, unspecified** had the following Statistics in FY 13:
-230 Office Visits for total amount paid of $17,243 or $75 per visit Average Cost to Mission
-14 Urgent Care Visits for total amount paid of $1,771 or $126 per visit Average Cost to Mission
-74 ED Visits for total amount paid of $123,017 or $1,662 per visit Average Cost to Mission

- The Diagnosis Code **789.00 Abdominal Pain, colic, unspecified** had the following Statistics in FY 13:
  -220 Office Visits for total amount paid of $16,495 or $75 per visit Average Cost to Mission
  -2 Urgent Care Visits for total amount paid of $240 or $120 per visit Average Cost to Mission
  -30 ED Visits for total amount paid of $50,418 or $1,939 per visit Average Cost to Mission

Blue Ridge Only, Top 50 TelaDoc Diagnosis Codes in Total

- 302 Office Visits for total amount paid of $25,044 or $83 per visit Average Cost to Mission
- 3 Urgent Care Visits for total amount paid of $334 or $111 per visit Average Cost to Mission
- 21 ED Visits for total amount paid of $24,546 or $1,169 per visit Average Cost to Mission

S.M.A.R.T. Statement:

SMART Statement: Implement a telehealth video consult proof of concept pilot & endpoint at Blue Ridge Hospital for Mission Employees to get urgent care and/or staff healthcare 7a-11p by or before June 10, 2014. Go live and complete at least 2 telehealth video consults per week from pool of 302 Health Scope Claims in last FY. Track all results for 6 months & reassess.

Future State and Improvements:

1. Offered at all system hospitals
2. Dovetails into Direct to consumer medium for care delivery, could use same providers
3. Eventually begin to offer to area employers

Readiness Factors:

- **Clinical Value** – HIGH – significantly improves the Patient & Employee Experience/Access. Visits are cognitive and procedural in nature
- **Physician/Provider Engagement** – HIGH – Strong team (Dr. Westle and Dr. Lowery) Staff Health is ramping up increased service offerings across the board and adding staff and capacity as well.
- **Administrative Support** – HIGH – Dr. Westle, Kathy Bumgarner, Jonathan Bailey
- **Strategic Plan Congruence** – HIGH – Does the clinical discipline align with the Enterprise Strategic Plan? – Yes, primary care efficiency a system goal. Managing Population Health and risk by 2016 and Grow, Grow, Grow directly align.
- **Access to Funding & Technology** – HIGH – Equipment available for use at Blue Ridge. Cisco MX200 is ready for use, jabber is working with free and enterprise versions, providers each have a laptop with video consult capabilities and/or an ipad with video consult capabilities.
- **Clinical Capacity** – HIGH – Does the clinical discipline have capacity (time & manpower) to begin implementing successfully in the short and long term (1,3, & 5 years)? Will implementing significantly impact capacity for the clinical discipline in a positive & manageable way? Yes, will increase productivity, decrease no-shows, and should be able to capture billing/revenue not currently being captured. Will also shift healthcare utilization from the ED.
- **Operational & Logistical Complexity** – MED - No significant barriers, need to figure out staffing physician coverage.

Implementation Plan:

Team Reviews this draft, edits/changes	7	4/23/2014	Team
Triage and Consult Process Mtg	7	4/21/2014	Dr. L & Team
Scope out & Select BR site by ED	7	4/22/2014	Dr. N, Lynn, GH
OK'd to Move MX200 from 1 HD	7	4/30/2014	BA/AH
Forward Draft to Docs &/or schedule mtg to review	7	4/30/2014	AW &/or BA
Staff identified & Train Docs & ED personnell	14	5/30/2014	Project Team
Go-Live, 1st patient seen!	1	5/30/2014	Project Team
Peripherals bought/installed	7	5/15/2014	BA/AH/SKC
Pricing Meeting w/ Susan & Kathy	7	4/26/2014	BA/CH
Credentialing Meeting w/ MS office	7	4/30/2014	BA/AH

Outcomes:

Measures of success include:

- Time it takes to see patient
- Patient Satisfaction
- Provider Satisfaction
- Practice Efficiency,
- No-Show/Cancellations
- Health Plan Utilization
- Other……

Cost and ROI Calculation:

Cost of MX200 – $0 (provided from 1HD,after pilot, $10K)

Cost of Jabber for each provider = Minimal, System sunk expense, cost of jabber to patient = $0

Cost of Provider Time = Same calculation, but anticipate shorter time with patient, need to define

New billable time? = define and calculate based on:

-Medicaid CPT OP & Level II Consults 99201-99205, 99211-99215, 99241-99245, 99251-99255, 90801, 90804-90809, 90862

-BCBSNC CPT OP & Office Consults 99201-99215, 99241-99245, 90801, 98966-98969, 99441-99444, Diabetes OP Self-Management = G0108, G0109

Decision Making & Telehealth Governance

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Decision Making – Telehealth Governance

Telehealth Executive Committee (8-10)

- Strategy Focused
  - Health System CIO (Exec Champion), VP Operations, Chief Innovation Officer, SVP Patient Care, VP Marketing, IP Medical Director for TH, OP Medical Director for TH, TH Director

Telehealth Steering Committee (20+)

- Operations Focused
  - CMO, Legal, IT, Nursing, Marketing, Physicians, Foundation, Innovation, Care Management, Revenue Cycle, Human Resources

(Each Group Meets Monthly & Receives Regular / Ongoing Communication Every 2 Weeks)

Beyond The Workplan: Key Design Models

Key Focus Areas

1. ***Clinical Model:*** Addresses the clinical approach, workflow, and potential barriers to the delivery of quality care.

2. ***Operational Model:*** Addresses *how* the Clinical Model is operationalized, including practical issues and programmatic needs (e.g., space, location, organization, governance, support, licensing, new resources, billing, reimbursement, etc.).

3. ***Financial Model***: identifies the costs, revenue, margin, and ROI.

4. ***Technical Model***: technical solution design (mobile carts, video conferencing, peripherals, network adequacy and reliability, EMR access, etc.).

Beyond The Workplan: Communication (Implementation)

Telehealth Intelligence; sent every 2 Weeks

Project & General Updates

Telehealth Data / Business Intelligence

Local Market Intelligence

National & International News/Trends

Feedback Link allows *Push* & *Pull* of Telehealth Information

TELEHEALTH INTELLIGENCE : [redacted]

Mission Center for Telehealth Updates

1. Mission's Telestroke Network featured in ABC News 13 Health Alert, Dr. Taylor & McDowell Hospital Featured
2. Go Live planned 2/14 for Pediatric Cardiology w/ 14 School Based Telehealth (My Health-e-Schools) locations
3. Go Live planned 2/5 for Pediatric Psychiatry w/ 14 School Based Telehealth (My Health-e-Schools) locations
4. BH Retreat F/u meeting on 2/19 & a Telepsychiatry Sub group will meet 2/7, if interested click here
5. St. Louis Based Mercy Health System will have leaders visiting Mission on 2/3, incl's reps from Mercy TH Program
6. Mission Center for TH hosted Asheville STEM School to record various TH Technologies for a future Video

Mission Center for Telehealth Activity

7. TH Volumes for Calendar year end 2013 = 2,163 Video Consults! (2011=68 consults, & 2012=655 consults)
8. FY14, Qtr 1 (Oct-Dec) Telestroke Network records lowest Physician Response Time to date =15 mins, goal= 30 mins
9. FY14, Qtr 1 (Oct-Dec) Telestroke Network records best tPA admin rate to date =48.4% , Natl avg= 3%
10. Averages for Telestroke Network since June 2011 Launch = 18 min response time & 37.2% tPA admin rate

Local & State Intelligence

12. NC Statewide Telepsychiatry Advisory Group (NC-STeP) had first meeting on 1/21 at NCDHHS Hdqtrs
13. Novant's Telestroke Network is at 13 & #14 going live soon, last go live= Ashe, who switched over from WF
14. Novant uses Specialists on Call (SOC) for their Telestroke Network
15. Other NC hospitals using SOC for Telestroke = Central Carolina, New Hanover Regional, Outer Banks, Rockingham Co., Annie Penn, & Alamance Regional
16. Alamance Reg. also uses SOC for Telepsychiatry; service & quality cited as subpar, switching to state program
17. Duke Telestroke Network at 3 hospitals; Nash General, Maria Parham, & Memorial Hospital of Martinsville, Va
18. Wake Forest Telestroke Network at 11 hospitals (2 of 11 they are 24/7 coverage only & do not get transfers)

National & International News/Trends

19. Intel & GE sign Joint Venture with Univ. of Mississippi Telehealth Program, focus= underserved Diabetes pts
20. MD Live (Miami, FL) & Sutter Health System (CA) part of $50M funding/growth Strategy, also includes Virginia based Sentara Health System. Related News, Sentara now Active in NC; Acquires Albemarle Hospital

Feedback, Follow Up, News, or Ground Intelligence to report for next update, submit here

Opt in/out to distribution here

Closing Thoughts

Closing Thoughts / Recap

- About Schumacher
- Telehealth Development – Readiness & Life Cycle
- Decision Making – Telehealth Governance
- Beyond the Workplan: Design & Communication

Questions / Discussion

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Appendix

Telehealth Stages of Maturity

Use of Telehealth is rapidly evolving from independent, single service solutions to more advanced stages of maturity. Organizations that focus development of their Telehealth program on Stage 4+ will realize greater Telehealth value and benefit.

Telehealth Stages of Maturity

Stage 1 Single Service Focused	Stage 2 Multi-Service Focused	Stage 3 Program Focused	Stage 4 Market & Care Delivery Focused	Stage 5 Consumer Focused
• Single service deployed to address a need • Silo'ed clinical delivery care model • Limited business and clinical benefits • No org structure or governance. Department sponsorship	• Multiple independent clinical services to primarily extend care. • Silo'ed clinical delivery care model • Some tangible business benefits • No org structure, limited governance and departmental sponsorship	• Multiple services aligned with top specialty areas focused in local/regional market • Services have limited integration within care delivery models • Program has measurable value, and provides local market differentiation • Central org structure, services-driven governance and sponsorship	• Market-driven portfolio of services that flex and extend beyond local/ regional markets • Services are integrated within care delivery models • Self-sustaining as a business with metrics-driven clinical outcomes and financial results • Central organizational structure, enterprise-level governance and sponsorship	• Broad and flexible portfolio of services addressing needs within/outside U.S. borders • Expands beyond provider markets directly to consumers • Services can be integrated within any clinical delivery model • Services are productized to be sold to any health organization or consumer • Opportunities to monetize data

High Percentage of Today's Market

Current Market Focus

Targets for the Leading Health Providers

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