

# The Health Care Spectrum: Aging at Home, A Role for Telemedicine

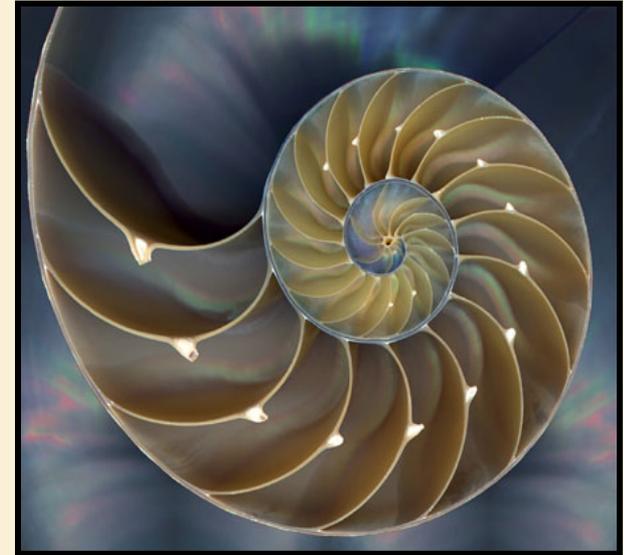
Presented by EdithForge/Welcome Home Health  
2 October 2013



***Welcome Aboard!***

# Who We Serve:

- Regional Health Care System
  - 10+ remote sites
- Health Care Networks
  - FCC broadband pilots
  - Regional HIE networks
- Corporate Health Care
- Physician's Groups
- Health Plans
  - Telemedicine development
  - PCMH implementation
- For-profit Telemedicine Services



Will Telemedicine Help Americans Age in Place?

# Aging In America

## Common Health and Safety Factors Affecting Seniors Transitioning Through Aging Lifecycles:

- They are often at higher risk for readmission “bounce-backs”
  - They are at higher risk for a fall
  - They report confusion about who to call when they need help .....
- AND ....**
- 90% of senior prefers to remain in their own home

# What We Know

## DATA:

- There is little research in longitudinal care concerning the cost/ value of seniors aging in place
- 26% of grandparents use electronic communications including email, text and videoconferencing to connect with their grandchildren

# What We Know

## DATA:

- VA Health Care System has reported 50% reduction in readmissions in their remote home health monitoring programs that include video visits
- CDC reports between 10-20% patients acquire an infectious disease when in hospital or nursing home costing between 4.5 and 11B annually

# Infrastructure

## In the Past 25 Years:

The US has developed broadband and cellular infrastructure into most rural and frontier communities

# Infrastructure

The federal government has supported the development of telemedicine programs and networks across the US for the past 20 years

The VA Health Care System has been developing and using remote telehealth programs since the mid 90's

# What We Know

## The VA Programs have Taught us Two Things We Know for Sure:

1. Telemedicine and telehealth services increase access to care, enhances quality and reduce costs (Triple Aim)
2. Seniors are willing to incorporate telemedicine into their lives.

Existing Health Care Delivery Model :

What's Missing?

# Health Care in America

- Health care services are delivered in an episodic manner
- Patients seek/secure health care services as required
- 80% of all health care services are used by Seniors age 65+
- Most elderly are cared for by a family member or caregiver
- There is little to no coordination of longitudinal care for seniors

# Who is Working on Solutions?

- Entrepreneurs, innovators and early adopters
- Many are not from health care
- Consortiums- Ascension Health Ventures
- Insurers- Aetna, United Healthcare, Blue Cross, WellPoint and Kaiser. (not exclusive)
- Venture capital firms

# Emerging Services and Products

- Health monitoring devices
- On-line personal health records connected to EMR's
- Security and surveillance services
- Hybrid call center with visiting nurses
- Smart phone video chats with providers
- Video call centers
- Bracelets with video and audio call back



**GSM Elderly Guarder**  
Peace of Mind for Your Family

100% SATISFACTION GUARANTEED

**Help** Push to Talk

Store No: 206336

Live Safe Live Free Enjoy Life

**Longitudinal Care:**

Can Transitions in Care Open the Door?

# Care Transitions

One place to review how new companies and innovations are hitting the marketplace is to look at the care transition

## Hospitalization to End of Life Care

Again.. This remains episodic .. However... its beginning to line up

# Post-Discharge Care Continuum

## Patient Transitional Care Continuum

<i>Care Model</i>	Care Transitions	Care Transitions Remote Monitoring	Chronic Care Home Monitoring	Supported Care
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# Post-Discharge Care Continuum

## Patient Transitional Care Continuum

<i>Care Model</i>	Care Transitions		Care Transitions Remote Monitoring	Chronic Care Home Monitoring	Supported Care
<i>Service Model</i>	Full Service	Internal Support Models	Provider Call Center Models	External Support Models	Home Health/Assisted Living/SNF Nursing Home/Hospice

# Post-Discharge Care Continuum

## Patient Transitional Care Continuum

<i>Care Model</i>	<b>Care Transitions</b>						<b>Care Transitions Remote Monitoring</b>			<b>Chronic Care Home Monitoring</b>				<b>Supported Care</b>	
<i>Service Model</i>	<b>Full Service</b>	<b>Internal Support Models</b>					<b>Provider Call Center Models</b>			<b>External Support Models</b>				<b>Home Health/Assisted Living/SNF Nursing Home/Hospice</b>	
<i>Services</i>	WHH	Care Transitions-CMS Models	CHAMP	AIM	INTOUCH	Emerge MD	Kaiser Regional Call Centers	Specialists on Call	Nuphysicia	Honey Well	Care Innovations/GE/Intel	Vivify Health	Viterion	Phillips	AMC Call Centers

# Coordinating Longitudinal Care:

A Case Study

# Case Study

## Integrated Health System

- 40 hospitals across 4 states
- Multiple ACO's groups insuring 50K-400K
- Each group approached telemedicine director to request a single point of contact call center to support patient panels
- Significant number of patients over 65+

# Common Core Requirements

- Ongoing support for chronic care patients
- Reduce preventable readmission “bounce-backs”
- Incorporate CMS Care Transition best practices
- Provide a step-down environment for patients requiring fewer nurse home visits, phone or video calls, home monitoring, yet remain in need of health grade “attention”
- Need a single resource to contact –  
a Coordinated Care “Eco-System”

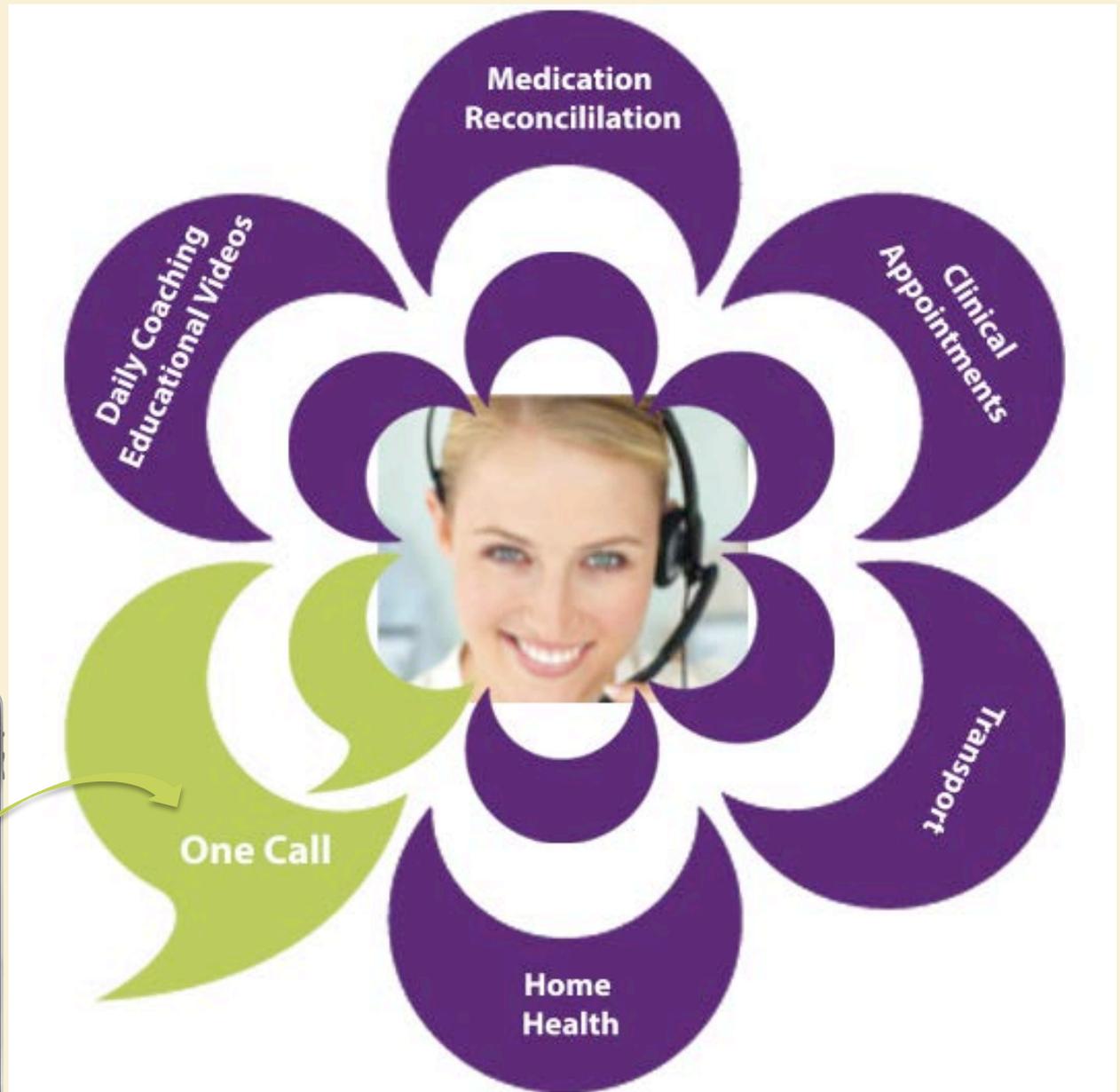
A close-up photograph of an older man with grey hair, smiling broadly while talking on a black mobile phone. He is wearing a light blue, vertically striped button-down shirt. The background is a soft-focus indoor setting with a white wall and a framed picture. The overall lighting is warm and natural.

**Welcome Home Health:  
Expands the Care Transition Model**

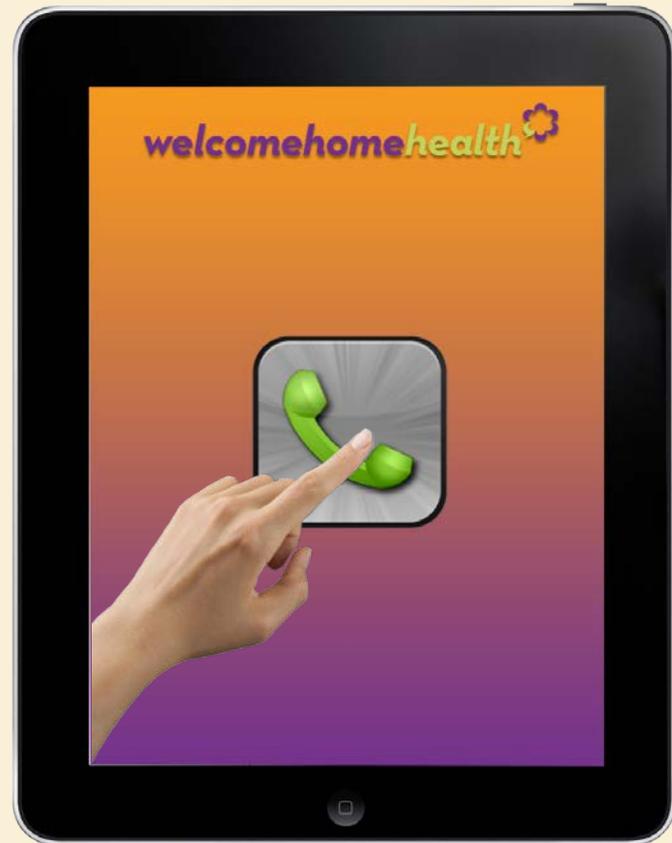


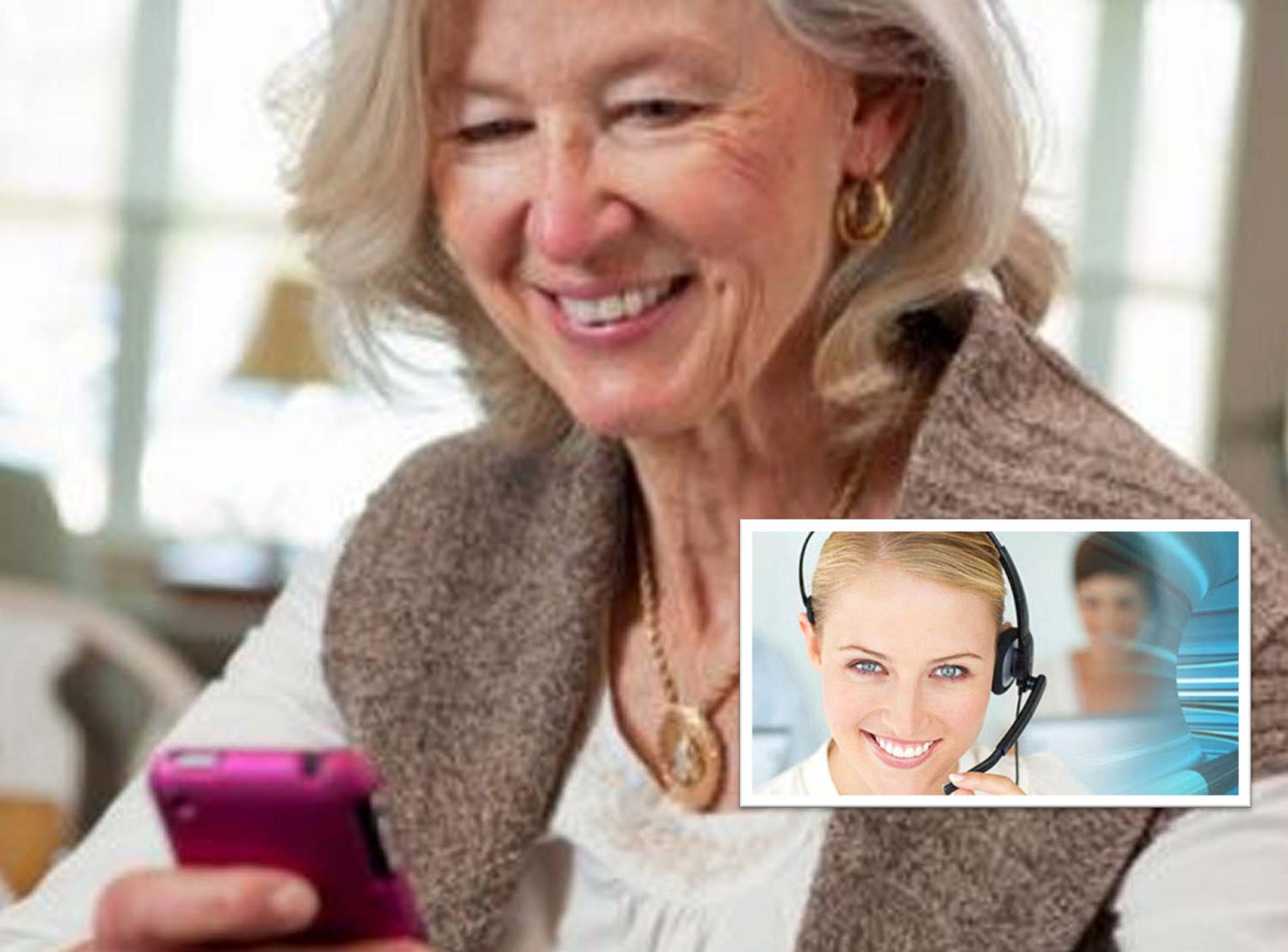
**Patient Receives Video  
Enhanced Tablet at Discharge**

# Single Point of Contact



# One Button Push!





# Reduce Preventable Readmissions

## Care Transitions: “Healthy at Home” Service

- Patients supported first 30 days post-discharge
- Additional services included:
  - Home safety visit by EMT
  - Non emergent transport
  - Meals on wheels
  - Home Health Monitoring when required

# Reduce Preventable Readmissions

## Step Down- One Call

- 24/7 Access to video health advocate and 911 services
- Additional services included:
  - One health coaching call per week with video health advocate
  - Continued scheduling of medical appointments with reminders
  - Scheduled medicine alerts with 2x per year video pharmacist reconciliation
  - Home Health Monitoring when required

# Reduce Preventable Readmissions

Care Transitions “Healthy at Home” Service

**\$3.27 per patient/pm**

Step Down- One Call

**\$2.25 per patient/pm**

Water for good

**America: Aging at Home**

**- It's Just Integration!**

# *Requiring Orchestration!*



# Trends

## American Telemedicine Association

- 73M patients (¼ of all Americans) are now covered under a Managed Care Health Insurance Plan
- Telemedicine is emerging as a standard of care
- Emergence of independent remote clinical enterprises
  - Clinical consultations
  - Remote pharmacist support
    - After-hours and critical access hospitals

# Trends

## American Telemedicine Association

- Re-admission reduction patient support services-
  - Hot spotter models
- Chronic care home health management services
  - The rise of virtual medical clinics and centers
  - Mobile Health- consumer friendly (mHealth)
  - Programs vs Network for multi-site Telemedicine operations

# Survey

## Health Care Executives:

- 89% believe telehealth technology will transform health care in the next 10 years
- Many said it will lead to better patient care and lower costs
- If not currently using telehealth technology, half plan to implement it within the next year







# Results

**Movement Toward  
Meeting Triple Aim  
and  
Meaningful Use Goals**

Discussion

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