

2007 What Your Peers Are Doing

Private Pay: Establishing A Telecare Program And The Challenges Of Promoting A Paradigm Shift

Company: **The Jewish Home & Hospital Lifecare System**, New York, NY

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Healthy aging has been the buzz phrase of the 21st century. The aging population is demanding a change not only in the provision of aging services but also how they expect to age; they want to stay safely and comfortably at home. Our current health care system continues to function very much in “response mode.” Following a crisis (e.g. a fracture) or a significant deterioration in function, services are traditionally provided to “assist in a return to prior functioning.” Increasingly, these types of services are provided in the home. However, these services are not what are envisioned when “Healthy Aging In My Own Home” is stated as the desire of our aging population. This vision entails optimal functioning and maximum independence (thus, healthy aging) in their home environment. So we arrive at the paradigm

long term benefits of health promotion and long term disease management models. Subsequently many of these efforts can only be provided under private pay, and they need to be utilized by a population that may be aging, but definitely do not consider themselves “sick.” At the same time, the concept that “my insurance pays for my health care needs” is also still very entrenched, so healthy aging approaches must be designed in as cost effective manner as possible.

For over 155 years, The Jewish Home & Hospital Lifecare System (JHHLS) has been meeting the needs of New York’s elders. The System provides a network of care that includes skilled nursing, rehabilitation, Alzheimer’s special care communities, senior housing and community programs such as home care and adult day healthcare along with many other

(JHHLS) developed a series of programs which focused on:

a – Supporting community residing elders to remain at home using chronic care disease management telehealth programs.

b – Extending disease management to a wellness consumer

This article will describe the telecare program, its evolution, impact and potential for private pay. The telecare program promotes healthy aging, while also establishing a link with our organization so as the need arises they have full access and knowledge to the JHHLS continuum. Our hope is that sharing this framework and our strategies to deal with the challenges of the paradigm shift will assist other organizations in their endeavors.

LESSON 1: Telecare Is A Tool That Must Be Used As Part Of An Overall Service Structure. You Need To Match The Telecare Program To Overall Clinical Goals

Our home care agency identified hospitalization rates as an area of major concern. We used performance improvement, and subsequently evidence based best practice as our service structure. This service structure will guide your telecare unit choice, your parameters, and your entire telecare structure. It is imperative to remember that telecare is a clinical component; it can enhance your care plan for the patient, but it cannot BE your care plan for the patient. It is also very much of a partnering tool; believe it or not telling a potential client “this is cutting edge technology, which is why we

ing to make it happen. What is it that you and the client are hoping to achieve ... avoid hospitalizations for CHF? Get HgbA1Cs under 7 for diabetics? Promote medication compliance? Telecare can provide data to help you and the client achieve all these things, but it is only data. What interventions should occur based on the data, what data will need drill down, what are the next steps ... all of these are based on your service structure. Starting a telecare program without this service structure will cause your program to flounder.

LESSON 2: Decisions, Decisions, Decisions ... Just Because You Can Have All The Bells And Whistles On A System, Does Not Mean That You Want (Or Need) Them All

There are so many telecare systems out there. First identify what you want to use the telecare system for – vital signs, daily monitoring, health education, care plan reinforcement, narrative interaction; some, none, or all of the above? Again, this is based on your service structure ... if you hope to design a cost effective program for diabetes disease management is a video unit more beneficial than a non video unit that provides diabetic education information?

Are you focusing on monitoring vital signs? Chronic disease management? Relating back to our home care experience, we had wanted to focus on hospitalizations. Our number one cause of acute care hospitalizations was congestive heart failure. We chose a non-video unit that had an extensive dialogue as well as the ability to collect vital signs. Time and time again, we found that dialogue responses (Yes, I had a little shortness of breath last night or No, I did not take my medication) prompted us to early deterioration before we started to see a change in the vital signs. The earlier you can catch it, and strategize between the community physician and the client on a response, the greater the likelihood that you will avoid hospitalization.

Due to the success of our congestive heart failure in 2001 (re-hospitalization rates went down to below 4%) and have

wellness program. During this expansion we have had some additional lessons. Our wellness program includes falls management, medication compliance and pain management. We had evidenced based programs on all three of these issues, which are so high risk for our aging population.^{1,2} Many of the questions we built into the non-video dialogue were the very same questions our clinicians were asking on their home visits. Yet, we found that frequently the answers were different. Clients will tell the telecare unit that they had a fall or are having problems with their meds before they will tell the clinicians. There is always the perception by some elders living at home that sharing problems could be perceived by the home care team as indication that deterioration has occurred that prohibits their remaining at home. Yet, they clearly do not feel that sharing the information with the telecare unit will result in institutionalization (hospital, sub-acute or long term).

These examples help reinforce the importance of the model choice you make. Following are some basic questions your team will need to answer:

- Video or non-video?
- Dialogue flexibility and enhancement? Some models have a fixed dialogue, some have dialogues where only the vendor can add questions which prolong the process, and some provide direct dialogue access.
- Wireless or POTs (Plain Old Telephone System)? We are located in an urban area, and certain buildings/areas have poor wireless reception. On the flip side, if it is a POTS system, will it work with the cable phone systems that so many people are switching to in their homes?
- Web based? Who will be monitoring? How will you cover the weekends and evenings as you expand?
- Purchase or lease? Operational or capital expense?
- Installation options? Will your own staff do installations? What about pick up and cleaning?
- Report capability? How easy is it to access? Are they canned reports, can you

LESSON 3: Data Overload: This Lesson Is Much Like The Bells And Whistles ... Just Because You Can Get The Data; Do You Need All Of It?

This issue will again be resolved based on your service structure (by this point you are probably recognizing a theme). When we first started with telecare, we were “going to look at everything.” Not surprisingly, we were shortly overwhelmed and having difficulty responding to key alerts. We went back to the drawing board and identified the data we would focus on and parameters we would flag, based on our evidenced based best practices and outcomes we hoped to accomplish. Answers of Yes to shortness of breath at night became a focus for our Congestive Heart Failure patients, versus whether they know that exercise is good for them. Our clinicians, who are all on laptop, also have Internet access, so they can pull up all of the data related to their specific clients, but our formalized telecare endeavors are based on our evidenced based practices and outlined in our protocols.

This lesson also ties back into reporting capabilities of the system. Asking for agency specific reports may result in a “data dump,” where you get all the data on your users. However, if you want to know if your recent pain management program roll out is having an impact, why do you want to have reports about all the clients that who reported no pain, before the intervention?

Data and how it will be handled and responded to requires guidelines. All of our telecare programs have protocols that outline expectations for the clinicians. We also have formalized our system via policies and procedures. The formalization process of your telecare program can be made simple through using the American Telemedicine Association (ATA) guidelines. The ATA has established a universal set of principles guiding the development and use of telemonitoring technology. It's important to include issues such as compliance with HIPAA regulations, standards for follow-up and documentations, policies and procedures for

LESSON 4: Telecare Implementation Realities And Budgeting

New program implementation does not happen over night or on its own. You will need to have staff devoted to program implementation. Our experience has shown that you need a team of champions – a clinician, such as a Telecare Nurse and an administrative staff member, such as a Project Manager, as well as the oversight of a senior executive. This steering group needs to create an appropriate budget for establishing and maintaining the telecare program. There are several components which need to be included in the budget such as attrition of clients, marketing, installation/unit return and staffing. Though telecare programs allow for a tie to many monitoring system, you will still need staff to assist with marketing/uptake, follow-up/communication, troubleshooting and of course, billing.

LESSON 5: Marketing Focus

Are you creating a telecare program because you want to, or because your organization feels you need to? As cited in (Brebner, Brebner and Ruddick-Bracken 2005)⁴, telehealth needs to be a needs-driven service and must have commitment for the program to succeed. Your needs assessment is critical to the success of your program. Who and how are you going to market your telecare program? How are you going to find and build relationships with referrals and resources?

This brings us back to the paradigm shift. The marketing focus needs to be on a **healthy aging service** that the client and caregiver both *deserve*. Please note the bolding ... healthy aging is not equated with illness, and we have found that potential clients are much more receptive to our wellness model than the different disease management models we have. Access to the nurse is also another large selling point, again with a healthy aging focus. The Telecare RN monitors and alerts you (or family) to areas that indicate a possible concern/early deterioration. Many of our clients and families cite the best value of the program is the sense of being connected. In satisfaction surveys

care program) over 95% consistently state that they feel telecare connects them better with their community physician.

Ethical Considerations

Cantor (2005) asks the question “How do we develop equal access when technology use presupposes some technological sophistication, skills, and basic comfort level?”⁵ Combine this concern with the paradigm shift challenge for healthy aging and the reality, at least initially, that access will be limited to those who can afford to private pay, and it is clear that the potential of this healthy aging tool being limited to an elite group is valid.

We have worked hard to make our model as cost effective as possible, user friendly and culturally appropriate (it comes in multiple languages). Yet there are still further challenges. We are working with a telecare model that has IVR (Interactive Voice Recognition) to accommodate clients with vision loss. We are exploring models that offer greater flexibility in information sharing, in order to allow us to address issues of literacy and cultural sensitivity, as well as explore different teaching modalities. Finally, we are participating in grants sponsored by NYS DOH as well as IPRO that gather data about the impact and potential of telecare with the ultimate goal that more universal coverage will occur in the near future. Ethics also addresses the value of stewardship. We believe the efficient use and allocation of resources results in providers being effective stewards.

As well as the dilemma of access, data and its use also presents quandaries. Savenstedt, Stefan, et al.(2005)⁶ ask the question “Does the desire to “keep a better watch” over aging parents actually reveal or underscore a paternalistic attitude on the part of service providers, adult children, and/or the medical establishment towards elders?”³ The very last thing we would want to happen is that the concept of “Healthy Aging” be equated with “Controlled Aging.” We have had relatives pay for the telecare units for their loved ones specifically for the piece of mind it will bring them, only to be told by the client (and subsequently by us)

is between the client, the Telecare RN and the community MD.” We have worked with some clients to place sensor devices in their homes to alert us to decreased activity and possible fall/other injury. These clients have no problem stating “I am fine if you call my daughter if you think I have a fall, but I have no desire for her to have the ability to check on what time I get up every day.” Healthy Aging brings with it a connotation of autonomy – individual decision making about where and how one lives (assuming competence). As we incorporate technology into our service packages, it is important for us to remember that this desire for freedom is not a “monitored freedom,” but instead a partnership with our clients where data is gathered and acted on for a mutually agreed upon goal, not just because we are able to do it.

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2007 Healthcare By The Numbers

viewed these incentives as a very important factor determining their compensation, the study found.

- In contrast, 44 percent of physicians subject to quality-related incentives viewed these incentives as very important to their compensation, or just 9 percent of all physicians.

- In recent years, public and private payers have explored using financial incentives through pay-for-performance programs to encourage physicians and hospitals to improve quality.

- The percentage of physicians with quality-based compensation incentives in 2004-05 was not significantly different from that in 1996-97, according to the study. The recent increase in quality-based compensation largely reversed a significant decline between 1998-99 and 2000-01, which most likely was associated with the sharp drop in capitation – fixed per patient, per month payments – during this period.

- The percentage of physicians in practices with capitated contracts with health plans dropped from 62 percent to 50 percent between 1998-99 and 2000-01. The use of capitated contracts has remained steady since 2000-01, so increased capitation cannot explain the recent rise in the use of quality measures.

“Despite the recent interest in pay for performance, quality-based physician compensation has been around for a long time,” said James Reschovsky, Ph.D.,

Healthcare Costs Increase At Lowest Rate In Five Years

Healthcare cost increases are projected to be about 11 percent in the next 12 months, representing the lowest increase in five years, according to a study conducted by Aon Consulting. Consumer-driven health (CDH) cost increases are projected to be lower than those for traditional health plans

- Surveying more than 90 leading healthcare insurers (representing more than 100 million insured individuals), the study found that healthcare costs are projected to increase by 11.4 percent for HMO (health maintenance organization) plans, 11.2 percent for POS (point of service) plans and 11.6 percent for PPO (preferred provider organization) plans.

- This compared to one year ago, when HMO cost increases were 12.9 percent, and POS and PPO increases each were 13.0 percent. Five years ago, the medical trend rate was estimated to increase about 16 percent.

- Meanwhile, CDH plans are estimated to increase by 10.5 percent, a 2.8 percent decrease from one year ago. This is lower than traditional medical plan rates and the lowest increase since 2004 when Aon began tracking CDH trend rates.

- Healthcare rate increases for retiree medical are projected to be lower than active employees, according to the study. During the next 12 months, Medicare Supplement plans are predicted to increase by 10.5 percent and Medicare Advantage plans will likely increase by 10.1 percent.

- As for prescription drugs, general pharmacy costs are expected to increase by 10.6 percent, compared to 11.8 percent one year ago. Specialty drug costs will increase by 14.9 percent, down from 19 percent at this time last year.

SOURCE: Aon Consulting.

http://www.aon.com/about/news/press_release/pr_00697117_2006_fall_hctrends.jsp
previous edition emphasize the most recent developments in the field.



HSC senior researcher and coauthor of the study. “However, incentives tied to productivity clearly continue to play a much more important role than quality

measures.”

SOURCE: Center for Studying Health System Change, January 4, 2007

<http://www.hschange.org/CONTENT/906/>

New Institute For Healthcare Improvement (IHI) Safety Effort: Protecting 5 Million Lives

Preventing 5 million patient injuries over the next two years is the aim of the new campaign initiated by the Institute for Healthcare Improvement. At the organization's National Forum in Orlando, Fla., IHI President and Chief Executive Officer Donald Berwick announced that the campaign, officially titled Protecting 5 Million Lives From Harm, will be based on five main interventions:

- Preventing pressure ulcers.
- Preventing harm from high-alert medications.
- Reducing surgical complications by implementing all of the changes recommended by the Surgical Care Improvement Project.
- Reducing methicillin-resistant Staphylococcus aureus infections.
- Delivering evidence-based care for congestive heart failure to avoid readmissions.

The 5 Million Lives Campaign will also include a Boards on Board plank that calls on hospital governance bodies to accept responsibility for reducing harm. If boards do not help to

