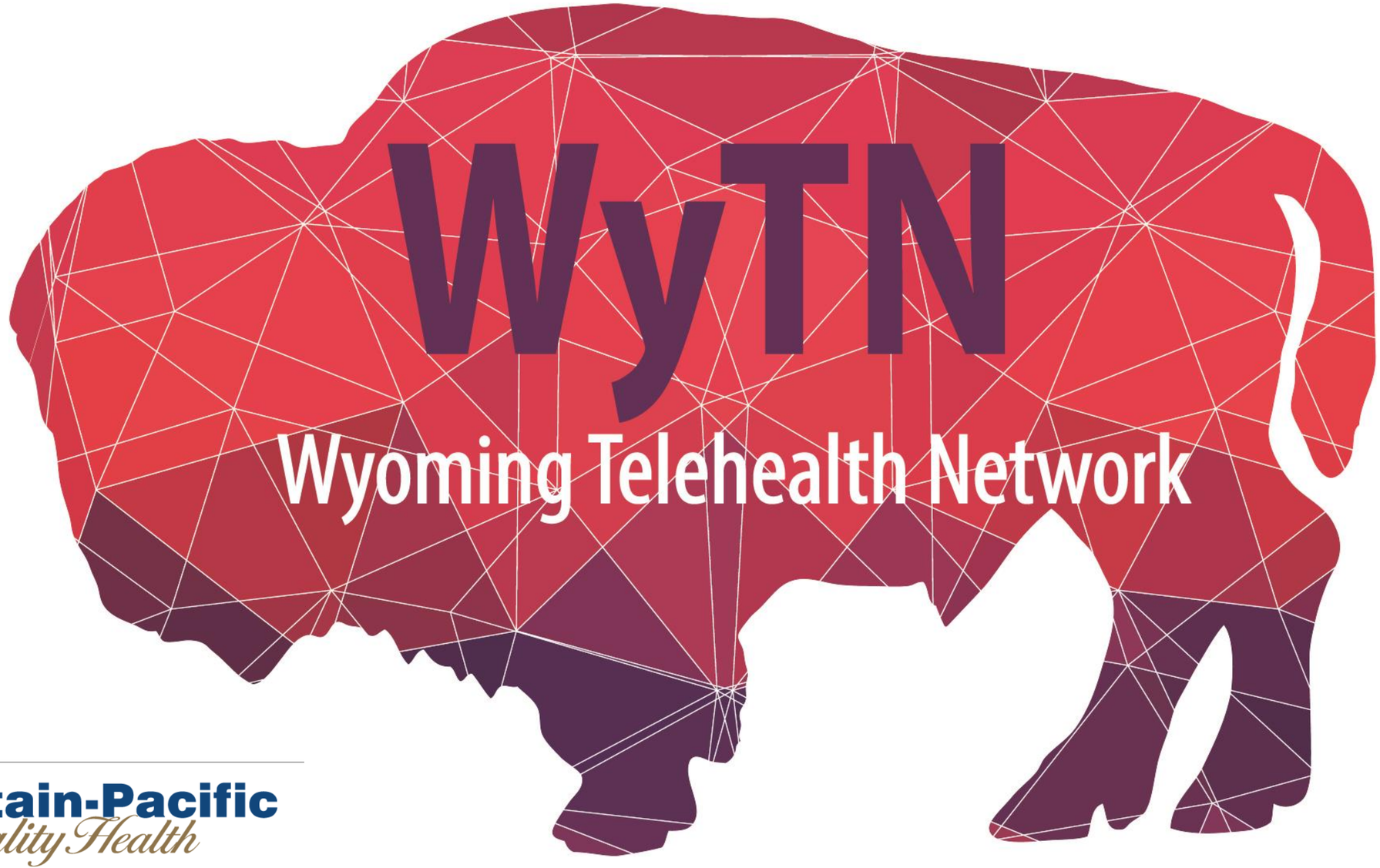
Relationship Based Telehealth:

Incorporating Telehealth into your Care Coordination Program



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Faith M Jones, MSN, RN, NEA-BC

Director of Care Coordination and Lean Consulting

Faith Jones began her healthcare career in the US Navy over 30 years ago. She has worked in a variety of roles in clinical practice, education, management, administration, consulting, and healthcare compliance. Her knowledge and experience spans various settings including ambulance, clinics, hospitals, home care, and long term care. In her leadership roles she has been responsible for operational leadership for all clinical functions including multiple nursing specialties, pharmacy, laboratory, imaging, nutrition, therapies, as well as administrative functions related to quality management, case management, medical staff credentialing, staff education, and corporate compliance. She currently implements care coordination programs focusing on the Medicare population and teaches care coordination concepts nationally. She also holds a Green Belt in Healthcare and is a Certified Lean Instructor.

Health Technology Services

Deb Anderson, Health Information Technology and Quality Improvement Consultant, Business Relationship Manager for Health Technology Services.

With 17 years health information technology (HIT) and over 30 years of general IT experience, Deb assists clinics and hospitals in the selection and implementation of Electronic Health Record software as well as helping them to achieve and attest to Meaningful Use and other Quality Reporting programs. She currently consults on regulatory programs from CMS, recommending workflow improvements for improved efficiency and data collection, leading toward improved health outcomes. Deb serves on committees for Health Information Exchange efforts in both Wyoming and Montana and provides technical assistance with interface implementations for HIE and public health registries. She serves on the board of MT HIMSS as the chapter president and the Industry Advisory Board for the Healthcare Informatics program at Montana Tech..

Objectives

Following this presentation, the participant will understand:

- The role of the care coordinator in primary care practices
- How to leverage the relationship between care coordinators and patients to facilitate the use of telehealth technologies

Changing Models

"Our goal is to recognize the trend toward **practice transformation** and overall improved quality of care, while preventing **unwanted** and **unnecessary** care"

CMS CFR 11-12-2014

"CMS's focus is on putting patients first, and that means protecting the doctor-patient relationship"

CMS Administrator Seema Verma 7-17-2018

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2018-07-17-eNews-SE.pdf

Care Delivery Models

"…new and evolving care delivery models, which feature an increased role for non-physician practitioners (often as care coordination facilitators or in team-based care) have been shown to improve patient outcomes while reducing costs, both of which are important Department goals as we move further toward quality and value-based purchasing of health care services in the Medicare program and the health care system as a whole."

Vol. 80 Wednesday, No. 135 July 15, 2015, P 226

The Provider Question

What do I have to do?

Embrace the concept of

Team Based Care

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Team Based Care

Care Coordination uses a Team Based Care Approach

Shared goals: The team—including the patient and, where appropriate, family members or other support persons—works to establish shared goals that reflect patient and family priorities, and can be clearly articulated, understood, and supported by all team members.
Clear roles: There are clear expectations for each team member's functions, responsibilities, and accountabilities, which optimize the team's efficiency and often make it possible for the team to take advantage of division of labor, thereby accomplishing more than the sum of its parts.
Mutual trust: Team members earn each other's trust, creating strong norms of reciprocity and greater opportunities for shared achievement.
Effective communication: The team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings.
Measurable processes and outcomes: The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals. These are used to track and improve performance immediately and over time.

Source: Mitchell et al., 2012

Chronic Care Management

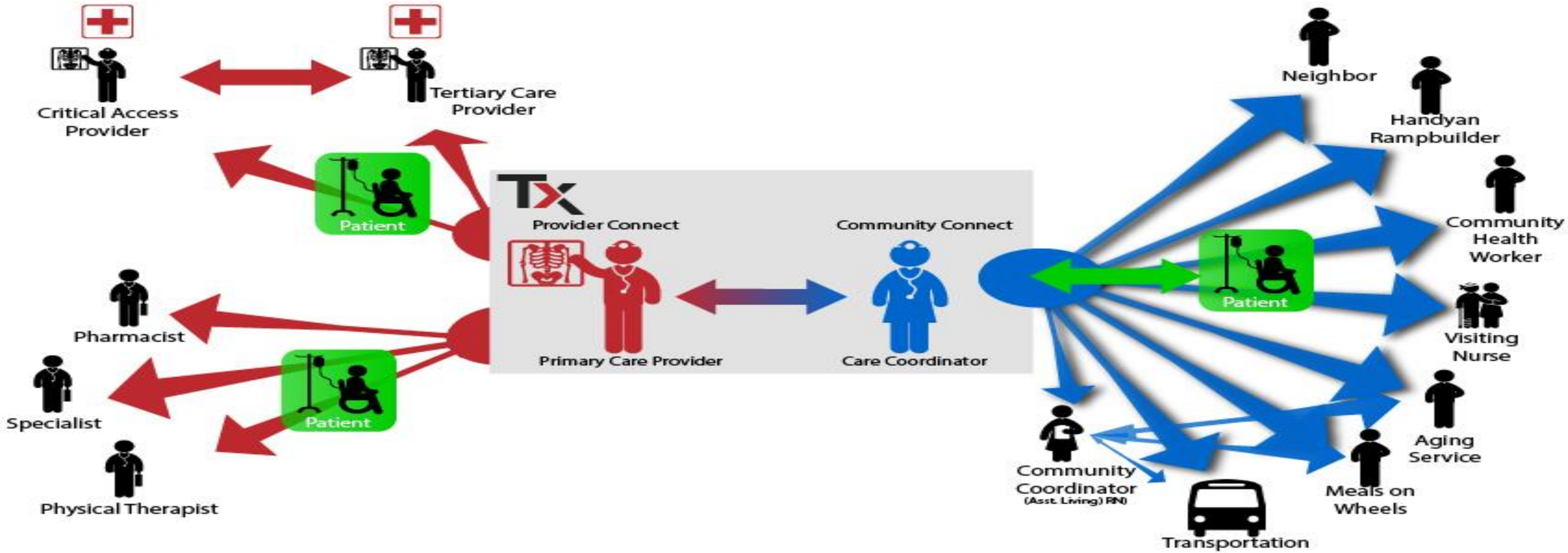
Practice/Billing Eligibility

- Qualified EHR
- After hours access
- Patient Agreement/Consent
- Care Planning
- At least 20 minutes per Calendar month

Patient Eligibility

- Medicare Patient
- Two or more chronic conditions expected to last at least 12 months or until the death of the patient
- At significant risk of death, acute exacerbation, decomposition, or functional decline without management

Expand your Reach



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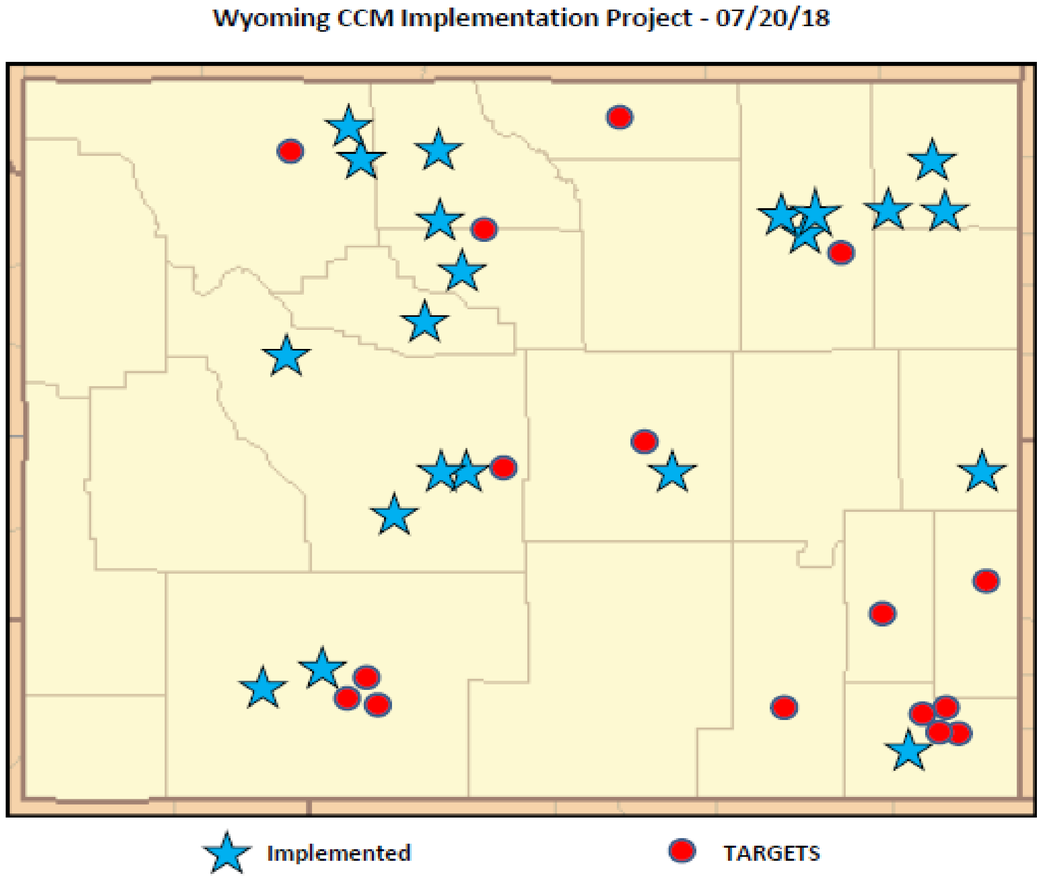
Care Coordination Growth and Development in Wyoming



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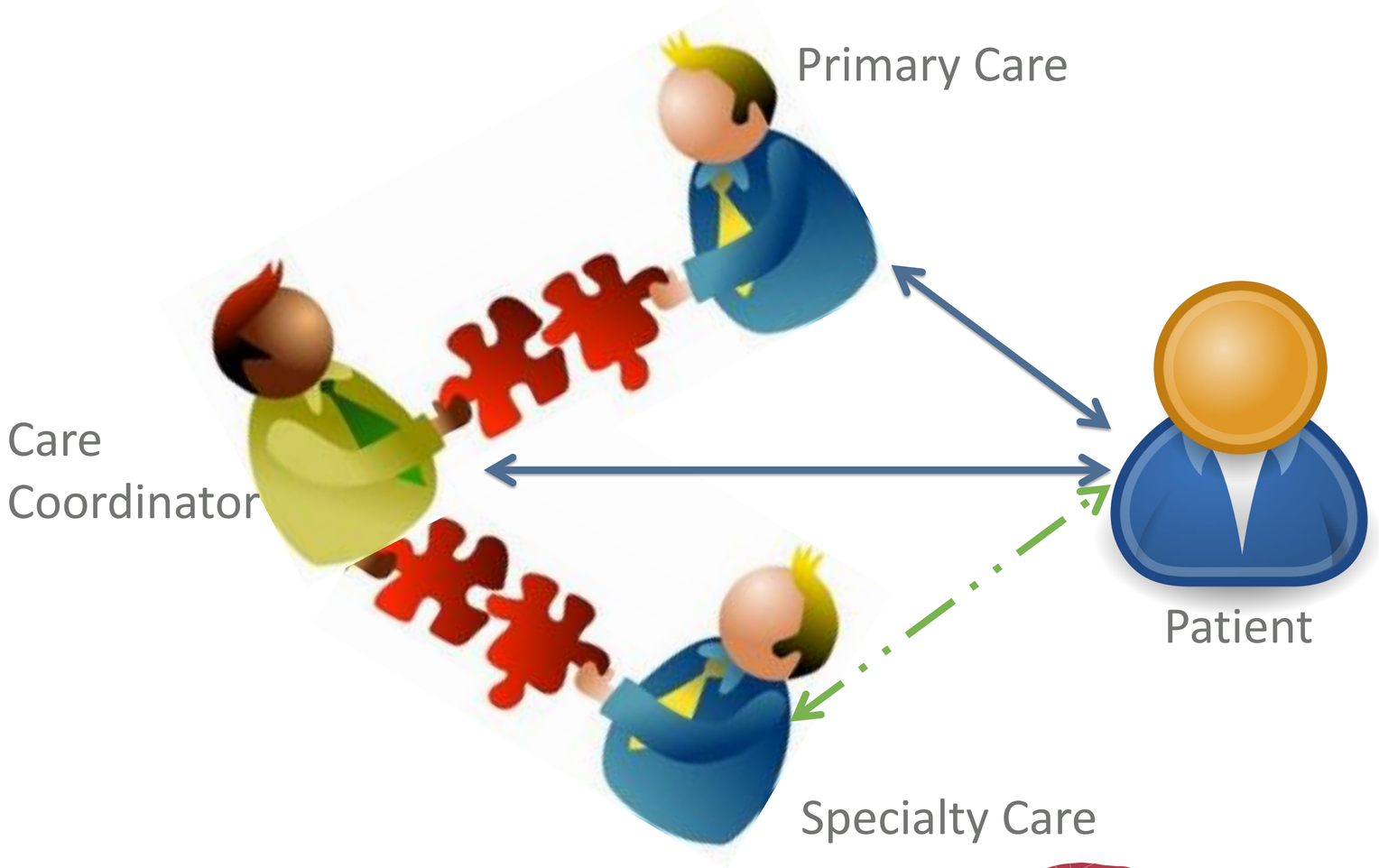
Leveraging Care Coordinator Relationships

Relationships

Relationships

Relationships

Connecting CCM Patients to Specialty Services



- Patient / Primary Care Provider Relationships
- Patient / Care Coordinator Relationships
- Patient / Specialty Provider Relationships

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Telehealth Technologies

- No longer cost prohibitive
- Easy to use across various platforms including cell phone apps
- Be secure – Use Encryption

Proposed Changes to Telehealth Billing

- Paying clinicians for virtual check-ins (brief virtual appointments via video or audio communications)
- Paying clinicians for evaluation of patient-submitted photos
- Expanding Medicare-covered telehealth services to include prolonged preventive services

Charging vs. Tracking

Billable Visit

- No Double Dipping
- Continue to bill for eligible services
- If service is billable do not track time
- Specialty Visit
- Originating Site Visit

Time Tracking

- No Double Dipping
- Track all time for non-billable services
- Do Not track time if billing for the visit
- Track time for all of the referral management and appointment set up

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Recorded WyTN Webinars

Session Date	Session Topic	Session Presentation	Session Video
June 27, 2018	Wyoming Frontier Information (WYFI): Enhancing Telehealth Through Health Information Exchange	Session presentation	Session video
May 30, 2018	Best Practices in Telehealth: Two Physicians Discuss Their Experiences	Session presentation	Session video
Apr 25, 2018	Telehealth Billing and Reimbursement	Session materials	Session video
Mar 28, 2018	Patient Centered Medical Home 101 and Telehealth's Implications	Session presentation	Session video
Feb 28, 2018	Telehealth Resource Centers: A Source for Providing Care at a Distance	Session presentation	Session video
Jan 31, 2018	Sleep Apnea: Home Sleep Testing and Compliance Monitoring	Session presentation	Session video
Nov 29, 2017	Telepharmacy: How One Wyoming Pharmacy Makes it Work	Session presentation	Session video

http://www.uwyo.edu/wind/wytn/wytn-webinars.html

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