

Telemedicine: Developing a New Home Care Standard of Practice

HomMed Partner Meeting
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America's Health Care Dilemma

Increased Cost for Providers and Payors

-  Shortage of Health Care Employees

-  “Graying of America”

Changes in Payment System

-  Acute Care

-  Continuum

Incentive for Efficiency



Early Adopters

 Vision of the Future

 Ahead of the Market



 Pioneers Often Must Search for the Right Trail

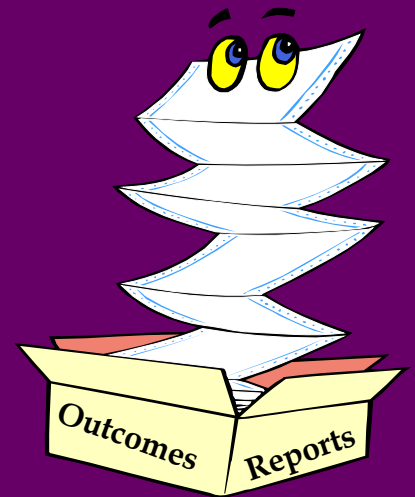
 Determination A.K.A “Pig Headedness”

 Do the Right Thing

Making Telemedicine Work In Home Health Care





Efficiency AND Efficacy

-  Management of Resource Utilization
-  Achieve Positive Patient Outcomes







Making Telemedicine Work In Home Health Care

Basic Assumptions

-  Clinicians Will Love Telemedicine
-  Nurses Will Become Our “Sales Force”
-  Physicians Will Embrace All Available Data
-  Home Care Will Function As a Data Gatherer for Patients and Physicians

Reality

-  Clinicians Have Many Reservations About Telemedicine
-  Nurses Generally Do Not Like to “Sell” to Patients
-  Physicians Have Specialized Needs
-  Data Gathering Without Analysis Is Not Useful

Barriers to Implementation

- 🖥️ Fear of Replacement by “Technology”
- 🖥️ Productivity Requirements
- 🖥️ Additional Time in the Home for Teaching
- 🖥️ Stereotype of Telemedicine Patient



Eliminating Barriers

Educate Staff





-  The Primary Goal of Telemedicine
-  Assessment and Care Management Is Key

Eliminate the “Downside”

-  Account for Monitor Placement in Productivity
-  Align Incentives As Applicable

Clinician's Tool

Telemedicine As a Standard of Care

-  Used by Nurses for ALL Patients
-  Develop a Care Plan That Includes Teaching
-  *Visits Are Made When the Patient Needs Them*
-  Increase Nursing Case Capacity

TRADITIONAL HOMECARE NURSING SCHEDULE

WITH 2 VISITS PER WEEK PER PATIENT

Total visit capacity is 6 visits per day, 5 days per week or 30 total visits per week.

Patient capacity is 15 at 2 visits per patient.

Monday	Tuesday	Wednesday	Thursday	Friday
Sally Smith	Bill Rogers	Betty Baker	Ethyl Moore	Marsha Cole
David Cooper	Myrtle Hightower	Roger Brown	Carolyn Carpenter	Sarah Miles
Susan Murphy	Ethyl Moore	Susan Murphy	Patty Peterson	Myrtle Hightower
Patty Peterson	Terrance Davis	David Cooper	Sally Smith	Roger Brown
Tommy Lewis	Marsha Cole	Sarah Miles	Terrance Davis	Bill Rogers
Tina Martin	Carolyn Carpenter	Tina Martin	Tommy Lewis	Betty Baker

NEW MODEL OF HOME CARE SCHEDULE

WITH 1 VISIT PER WEEK PER PATIENT TO 15 PATIENTS

Monday	Tuesday	Wednesday	Thursday	Friday
			Ethyl Moore	
	Myrtle Hightower	Roger Brown		Sarah Miles
Susan Murphy				
Patty Peterson	Terrance Davis	David Cooper	Sally Smith	
Tommy Lewis	Marsha Cole			Bill Rogers
	Carolyn Carpenter	Tina Martin		Betty Baker

NEW MODEL OF HOME CARE SCHEDULE

WITH 1 VISIT PER WEEK PER PATIENT TO 15 PATIENTS
AND A RATIO OF 50% REPEAT OR PRN VISITS

Monday	Tuesday	Wednesday	Thursday	Friday
		PRN Sarah Miles	Ethyl Moore	PRN Tommy Lewis
PRN Betty Baker	Myrtle Hightower	Roger Brown		Sarah Miles
Susan Murphy	PRN Bill Rogers		PRN Patty Peterson	
Patty Peterson	Terrance Davis	David Cooper	Sally Smith	PRN Carolyn Carpenter
Tommy Lewis	Marsha Cole	PRN Susan Murphy	PRN Myrtle Hightower	Bill Rogers
	Carolyn Carpenter	Tina Martin		Betty Baker

NEW MODEL OF HOME CARE SCHEDULE

WITH 15 FIXED VISITS TO 15 PATIENTS AND AN ADDITIONAL 8 PRN VISITS THE SAME PATIENTS
THE REMAINING TIME SLOTS IN THE SCHEDULE ARE FILLED WITH 7 NEW PATIENTS

Monday	Tuesday	Wednesday	Thursday	Friday
NEW PATIENT	NEW PATIENT	PRN Sarah Miles	Ethyl Moore	PRN Tommy Lewis
PRN Betty Baker	Myrtle Hightower	Roger Brown	NEW PATIENT	Sarah Miles
Susan Murphy	PRN Bill Rogers	NEW PATIENT	PRN Patty Peterson	NEW PATIENT
Patty Peterson	Terrance Davis	David Cooper	Sally Smith	PRN Carolyn Carpenter
Tommy Lewis	Marsha Cole	PRN Susan Murphy	PRN Myrtle Hightower	Bill Rogers
NEW PATIENT	Carolyn Carpenter	Tina Martin	NEW PATIENT	Betty Baker

Central Station






- 📄 Can Collect Data From up to 500 Patients
- 📄 Critical Role in Home Care
- 📄 Data Analysis and Identification of Problems or Potential Problems Is Critical
- 📄 Process for Communicating Information Is Necessary
- 📄 Process for Patient Management Is Key

Value Added Service To Physicians

- 🖥️ Educate Physicians About Telemedicine As a Standard of Your Practice
- 🖥️ Design Processes to Provide Value Added Service
 - 📁 Data Analysis
 - 📁 Patient Assessment
 - 📁 Physician Communication

Quality of Care

Focus on Positive Patient Outcomes

-  Daily Monitoring Versus Standard Visits 3x a Week
-  Assuring That the Patient Has a Visit When Needed
-  Early Intervention When Trends Are Noted
-  Decrease Re-hospitalization Rates
-  Patient Empowerment & Compliance

Utilization of Resources

- 🖥️ Will Decrease!
 - 📈 Positive Outcomes
 - 📈 Trust in System