CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

"Using Technology to Improve Care for Patients with Chronic Conditions" Learning Collaborative

KICK OFF MEETING: FEBRUARY 10TH, 2021

7:30 – 9:00 AM

Agenda

10 min	Welcome and Thank you - UnitedHealthcare	Susanne Campbell
20 min	Introduction of Practices	Group
30 min	Getting Started with Telehealth – Pearls and Pitfalls	Lisa Levine, MD
15 min	Introduction of Practice Facilitators, NETRC Review nuts & bolts of program	Sue Dettling
10 min	Questions & Answers	Group
5 min	Next Steps /Evaluation	Sue Dettling

Funded by UnitedHealthcare and State of RI Cares Act Funding

UnitedHealthcare®

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Meeting will be recorded; Please keep your microphone on mute

Telehealth Learning Collaborative

Objectives

- Improve access to care and patient experience for patients who have physical distancing requirements during COVID-19;
- Improve clinical outcomes for patients with chronic conditions;
- Improve engagement of under-served patients experiencing barriers to care and health disparities with respect to using technology to improve chronic illness outcomes;
- Improve access to peer learning opportunities as well as customized quality improvement and content expert technology support.

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Telehealth Learning Collaborative

"Using Technology to Improve Care for Patients with Chronic Conditions"

Practice Type	Chronic Conditions of Focus
Adult	Heart Failure Diabetes Hypertension COPD
Family Medicine	Heart Failure Hypertension Obesity Asthma
Pediatrics	Mental Health (Depression, Anxiety, ADHD) Social Determinants of Health Asthma Diabetes Hypertension Liver Enzymes Obesity

Meet the Practices

Introductions:

- One person to introduce themselves, their practice, and answer the question:

- "What do I hope to get out of the Telehealth Learning Collaborative?"

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Meet the Practices

Adult	Pediatrics
1. Anchor Medical Associates (Lincoln, Providence, Warwick) (C2)	7. Anchor Lincoln Pediatrics (C2)
2. CharterCare Medical Associates – Blackstone (C1)	8. Barrington Pediatrics (C1)
3. Coastal Medical (Adult Primary Care, Cardiology, Pulmonary) (C1)	9. Encompass Pediatrics (C1)
4. Medical Associates of RI (Bristol, East Providence) (C1)	10. Hasbro Children's Hospital Pediatric Primary Care/ Hasbro Medicine Pediatrics Primary Care (C1)
	11. Kingstown Pediatrics (C2)
Family Medicine	12. PRIMA Inc. (C1)
5. A to Z Primary Care (C1)	13. Richard Ohnmacht, MD (C1)
6. Barrington Family Medicine (C1)	14. Santiago Medical (N. Providence, Pawtucket) (C2)

"What do I hope to get out of the Telehealth Learning Collaborative?"

C1 = Cohort 1; C2 = Cohort 2

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Getting Started with Telehealth – Pearls and Pitfalls

Care Transformation Collaborative of R.I.

USING TECHNOLOGY TO IMPROVE CARE FOR PATIENTS WITH CHRONIC CONDITIONS

FEBRUARY 10, 2021

LISA BARD LEVINE, MD, MBA

Key Note Agenda

- Introduction
- Telehealth landscape
- Planning for success

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Introductions

- Former CEO of The MAVEN Project (Sr. Advisor to CEO now)
- National telehealth nonprofit dedicated to expanding access to comprehensive, compassionate medical care and supporting primary care providers (PCPs) via telehealth
  - Expert volunteer physicians (51 specialties)
  - Virtual network of provider-to-provider support:
    - Education
    - Medical consults and advice
    - 1:1 Mentoring
- Bring expertise where, when, how needed while supporting PCPs in the CHCs across the US; virtual multispecialty group
- Art & science of medicine; provider wellness

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Recent Experience

- Selected, customized, deployed telehealth platforms
- Designed and optimized operations
- Identified requirements for success
- Designed and collected data to demonstrate impact
- Trained end users
- Scaled model, taking local/national telehealth landscape
  - COVID-19 impact on policy/reimbursement
- Advocated for policy (state/national)
- Gained pearls from successes and challenges
- Shared our story via publications, podcasts etc.

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MAVEN Project Impact

Recent impact of consults: (select stats)

- **69% Referrals Saved** (not need to see a specialist based on consult)
- **98% Consults provided education** which can apply to future patients
- **Multiplier effect - sustainable learning (McKinsey)**
  - 1 encounter provides knowledge that can be applied to up to 19 patients that year

Sample case study:

- Free clinic in Miami Dade county serving uninsured population
  - PCP to pulmonologist virtual medical consult
  - Stopped cycle of recurrent ED/ICU visits, days missed from school for an 11-year-old asthmatic boy by adjusting medications

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In The News (select recent)

- Telehealth PSA (Dec 2020 with NETRC)
- Medicaid Transformation Podcast (Oct 2020)
- Signal Group DC (Oct 2020)
- NEJM Perspective (Sept 2020)

And many more including PBS NewsHour, O Magazine!

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Telehealth Acceleration: COVID-19

- Necessity – accelerator of innovation:
  - Availability, access, answers
  - Takes on many forms (phone, text, email, video)
- Creates access and support to needed care while maintaining physical distance
  - Extends reach of care where most needed
  - Creates mechanism for connection
  - Doesn't require specialized tech/equipment
- Historically – way to democratize medicine but adoption low
- Right-sizes where and how care is accessed
  - Improves care and health outcomes (i.e. managing chronic conditions)
  - Decreases cost, burden, stress
  - Supports and empower providers, can decrease burnout

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Telehealth Solutions

- **Patient-Provider**
- **Provider-Provider**
- **Remote Patient Monitoring (RPM)**

Also:

- **Live vs. asynchronous/store-and-forward**
- **Video/phone/text/email**

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RI & National Telehealth Landscape

- **Understanding reimbursement and policy (temp and perm) may impact your solution and how you implement**
- Reimbursement varies
  - By payer
  - By modality (e.g. live video vs. store-and-forward vs. phone vs. RPM)
  - PHE has tried to equal the playing field for now
- PHE thru April 2021; policy advocates believe it will be in place for all of 2021
- Watch Biden administration

Planning For Success (and Failures)

High Level Pearls:

- Understand what problem you are solving for
- Clearly define success and how you will measure progress
- Align incentives to drive adoption
- Identify IT requirements
- Plan for implementation…..including training…..and everything breaking
- Communicate often and transparently
- Don’t give up – learn from challenges – it makes you stronger!

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Needs Assessment is Critical

- Understand what problem you are solving for
  - Leverage surveys, interviews, data to inform
- Ensure your problem is a problem
  - Confirm with data
  - Understand who is impacted by what issue(s)
  - If it's not, end users won't feel compelled to use your technology!
- History can help avoid future pitfalls
  - Was something tried and failed in the past?
- Understand tech literacy of end users
  - Identify needs and explore partnerships that can help bridge caps
- Understand pain points and current barriers

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What Does Success Look Like?

- What impact are you looking to make?
  - For what population(s)?
- What outcomes will indicate you have achieved your goal(s)?
- How will you capture data? Survey? Claims? Medical Records?
- Collect data to demonstrate impact and identify issues to address – how do you know it's working?
  - **Activity data** - # activities accomplished, process data
  - **Performance data** – how well you accomplished them
  - **Impact/outcome data** – what impact did you make
  - **Case studies** - humanize

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Example: RPM for Diabetes

- Continuous Glucose Monitoring (CGM)
  - Compact medical technology that continuously monitors blood sugars q5min to manage diabetes (chronic condition)
  - Eliminates static readings of finger sticks
  - Transmitter allows system to send real-time readings wirelessly
  - Can alert patient when blood sugar is too high/low
    - Can help avoid dangerous complications for kids, parents, during different times of day
  - Can customize alerts
  - Data indicates significant impact on improvements in HgA1C with CGM

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Example: RPM for Diabetes

What impact are you looking to make?	Improve HgA1C for patients with poorly controlled type 2 diabetes
For what population(s)?	50-65 yo men and women with HgA1C >9 (20 patients to initiate pilot)
What outcomes will indicate you have achieved your goal(s)?	• 75% of patients learn how to use RPM after 3 mo • 10% average decrease in HgA1Cs for the target population
How will you capture data?	• Survey patients regarding comfort and use of RPM • Survey providers regarding capturing and managing data from RPM • Chart review
What data will you collect?	• Activity data: web-enabled survey • Performance data: web-enabled survey • Impact/outcomes data: chart review, survey • Case studies: interviewing patients and providers

Incentives, Reimbursement, Policy

- Understand current incentive model(s) in place
  - How does this new technology play a role provider incentives
  - What role does/can billing have in the technology implementation
  - Develop list of incentives and strategies that can help drive/align with adoption
- Understand policy and reimbursement landscape
  - Current, future
  - Anticipated longer term
- Address key issues in implementation workplan

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What Are the IT Requirements?

- **Critical to understand end users**:
  - Skills, capacity
  - Training needed
  - Firewalls, wifi, system requirements
  - Tech available or accessible
- Involve IT staff at the onset
- **Keep it simple!**
- Keep it simpler than you think
- If there's a button *anywhere*, it will be pressed…….

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Implementation Prep

- Make a thoughtful plan
  - Clear roles and responsibilities
  - Identify all aspects of operations impacting (i.e. billing)
  - Escalation protocol(s)
- **Test, test, test**
  - All types of end users, across technology systems
  - *Try to break system* – and then fix weak points
- Pilot before full blown roll-out
  - Consider “superusers”

Implementation Planning

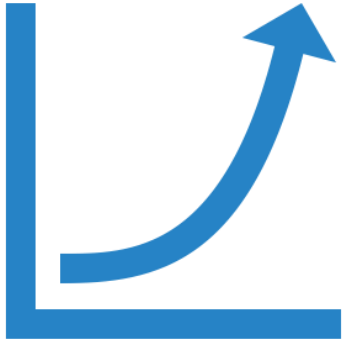
- Develop training materials for end users
  - Will vary by end user group
  - Test training with pilot team first
  - Update content on an ongoing basis (consider online to house)
- Implement with LOTS of support available
- **Anticipate lots of issues that aren't anticipated**
- Use data (timely as possible) to inform what's working and what's not (e.g. pop up surveys)
- Communicate and celebrate success

During Implementation

- Keep a running log of issues
  - Aggregate into themes to identify root causes of issues
  - System issues vs. user error
    - Solve accordingly – system vs. training vs. something else
- Address issues immediately with a person – human touch
  - Users will give tech a few tries, then give up
- Leverage peer groups – you are not alone
- Be resilient
  - Whatever can go wrong probably will
  - Anticipate and manage issues as they arise - transparently

Accelerating Adoption

- Develop a plan
- Align incentives and cultural norms
  - i.e. gamify, competition
- Make it easy to do the right thing
- Empower early adopters to engage others
- Use data and case studies to demonstrate (early) impact
- Celebrate success



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Communication

- **Critical** at every step of the way to **all stakeholders**
- Identify medium and segment by target audience
  - i.e. video, text, email, webinar
- Set and manage expectations
  - How to set the bar – make initial goal achievable (i.e. TAT)
  - Prepare to communicate fast
- Create a detailed plan with ownership and review process
- Ensure lists users exists and updated
- Create online resources – visualization (videos)
- Survey end users
- PR helps all; celebrate success; publish

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Celebrate Success

- Reach your target audience(s) and share wins
- Data, case studies, progress
- Use early adopters to build momentum and scale

To all here:

Congratulations on this incredible, critically important, and innovative collaborative opportunity! I hope you, your providers, and your patients all benefit from this initiative!

Discussion and Questions – will cover at the end with Q&As

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Meet the TLC Team

Suzanne Herzberg, PhD, MS, OTR/L
Practice Facilitator

Kelley Sanzen, PharmD
Practice Facilitator

Vicki Crowningshield, MPH, PCMH CCE
Practice Facilitator

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Project Manager/ Practice Facilitator

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Nuts & Bolts of program

Cohort 1: February 2021 – January 2022
Cohort 2: May 2021 – April 2022

- Kick-off Meeting
- Monthly – meet with your practice facilitator
- Quarterly – peer learning collaborative meetings (*include all from practice QI Team*)
- Ongoing – NETRC support, webinars (CTC-RI and community)
- Wrap up Meeting

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Nuts & Bolts of program

<u>Telehealth Learning Collaborative Toolkit:</u>

- Milestone Document
- Telehealth Project Plan
- Quality Improvement – Plan, Do, Study, Act (PDSA) template
- Resource Guide

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Start-Up Phase (months 1 - 4)

Start-Up Objectives

1. Define practice site/telehealth needs to address

2.a. Identify patients with chronic care needs

2.b. Data plan: Identify baseline data /outcome data

3. Identify technology/telehealth option

4. Estimate cost of program, staff training, workflow

5. Define Performance Improvement and Patient Support Plan (PDSA)

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Implementation Phase (mos. 5- 12)

Implementation Objectives

1. Prepare to implement

2. Implementation of technology

3. Evaluation

4. New tests of change for PDSA:
    a) Identify vulnerable, high risk patients
    b) Identify community partnerships

5. Update/submit a PDSA/plan QI Plan Storyboard

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Questions & Answers

Next Steps

Evaluation

Additional Questions: CTCTELEHEALTH@CTC-RI.ORG