"Advancing Quality of Care for Nursing Facility Residents while Reducing the Spread of COVID-19 to Residents and Staff."

Final Report for CMP Request No. 2020-04-FL-0826
Executive Summary

The TRECS Institute has recently completed Civil Money Penalty Grant No. 2020-04-FL-0826 titled: *"Advancing Quality of Care for Nursing Facility Residents while Reducing the Spread of COVID-19 to Residents and Staff."*

Through this program, telemedicine services were implemented in 28 certified skilled nursing facilities across Florida. These facilities were all owned and operated and by Southern Health Care Management. Telemedicine services were provided during the day by the medical director and local physicians at each participating facility. Telehealth Solutions, a national physician practice specializing in nursing facilities, served as the covering physician practice, and provided coverage during evenings, nights, weekends, and holidays across all 28 facilities. The telemedicine carts were provided by AMD Global Telemedicine. The TRECS Institute was responsible for supporting the overall implementation, ongoing oversight, data collection and analysis, and creating the final report with findings and recommendations.

The primary goal of this 15-month program was to prevent unnecessary and avoidable nursing home to hospital admissions. A total of 7,775 calls were made using the telemedicine service during the project period. Of that total, 29.4 % or 1,910 calls were escalated to bedside virtual visits. From those virtual visits, a total of 563 or 29.8% were identified as having avoided an acute care admission as a direct result of the telemedicine intervention provided by this program. These avoided admissions generated an estimated total new revenue for the participating facilities of $1,137,271.00, which represents an average of $40,616.00 per facility or $338.47 per licensed bed and $411.16 per occupied bed of the 28 participating facilities.

The secondary goal of this program was to reduce potential exposure of residents and staff to COVID-19 and other infectious diseases. This goal was achieved as the 563 vulnerable seniors remained in their respective SNFs and avoided being transported to a local hospital and the potential of being exposed to COVID. This also prevented those same residents from potentially returning to their facilities and exposing other residents and staff to COVID or other infectious diseases. In addition, anytime the telemedicine program was utilized and replaced a physician physically entering the facility, also helped reduce exposure.

Finally, through a series of over 60 interviews with the management teams, regional managers and corporate staff of Southern Health Care Management, the operating characteristics of those facilities that effectively utilized the telemedicine program were identified. While this program clearly confirmed the quality of life and economic benefits of providing telemedicine services in skilled nursing facilities, it also suggests that facilities without the appropriate operating characteristics in place, should consider improving those factors before implementing telemedicine services for its residents.

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Overview of Project

The TRECS Institute was awarded a Civil Money Penalty Grant to implement telemedicine services in 28 skilled care facilities across Florida. TRECS submitted this application in an effort to show the importance of replacing the current accepted industry standard of using a telephone to diagnose and treat nursing facility residents when a physician in not in the facility and unable to see and evaluate the resident in person. With few exceptions, the amount of time a physician or nurse practitioner is physically present in a facility is typically limited. In addition, a large percent of the current nursing home to hospital admissions occurs during evenings, nights, weekends, and holidays when physician presence in nursing facilities is again limited.

In reality, when a nurse calls a physician explaining a change of condition in a resident, the physician has limited options. Often, it may be a covering physician who has never seen the resident. Even if it is the resident's primary care physician, they may not have seen the resident for 30 days or more. Finally, the physician is relying on the details provided by the nurse at the facility. The physician is forced to make a medical diagnosis and treatment decision often with limit details. Unfortunately, given the current legal environment within the long-term care industry physicians often make their decision on the worst-case scenario and send that resident to the hospital…just bn case it is a serious issue.

CMS has estimated that as high as 40% of all SNF to hospital transfers, when viewed in retrospect, had no justifying medical condition to warrant the hospitalization. For example, a resident complaining of chest pain. When a physician hears chest pain, his/her immediate thought is to consider a cardiac issue. In reality, a high percentage of chest pain in long term care residents is often a pulled muscle between the ribs. On the phone, a physician will often assume a cardiac issue and send that resident to the hospital. With a telemedicine visit, the physician can have the nurse place her fingers on the resident's ribs and palpitate. If it is a pulled muscle, when the nurse hits that spot, the physician will know it's a pulled muscle and not a cardiac issue.

Telemedicine gives physician the opportunity to differentiate between more serious issues that truly justify a hospital admission from less serious issues that can and should remain and be treated in the SNF.

This program was broken into three specific phases:

Phase I: Implementation and Training (1 month)

Phase II: Service Phase (12 months)

Phase III: Report Phase (1 month)

Telehealth Solution's software provided The TRECS Institute with monthly data on the use of the telemedicine program and the various diagnostic categories describing each telemedicine visit. Using that data and the findings of a two-physician review panel of the telemedicine virtual visits

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confirmed the actual number of visits classified as having avoided a hospital admission as a direct result of the telemedicine intervention.

In Phase I of the project and again in the final quarter, facility specific information was gathered from each participating facility. This information included:

- Average number of days residents stay in hospital by payer
- Average LOS for short stay patients
- Percent of residents who do not return to the SNF
- Percent of Medicaid residents who return from hospital with Medicare skilled days
- Average number of Medicare skilled days for Medicaid residents after returning from the hospital to the SNF
- Average daily rate for Medicaid residents
- Average daily rate for Medicare and Managed Care

These variables were applied to the number of avoided hospital admissions generated for each facility. Those avoided admissions were further divided by Medicare and Medicaid residents.

Finally, throughout the project, video interviews were held with the management teams of each of the participating facilities to better understand how the telemedicine program was working, what concerns or issues they were experiencing, and what recommendations they had to make the program stronger.

Findings

This program was successful in achieving the primary and secondary goals set forth in the application. The primary goal was to prevent unnecessary and avoidable SNF to hospital transfers. The secondary goal was to help prevent the spread of COVID and other infectious diseases to nursing facility residents and staff.

These are the overall findings from this program based on twelve months of telemedicine services across all 28 participating skilled nursing facilities:

A total of 7,775 audio calls were received during the 12 months of the program

- Of those, 5,865 (75.4%) were audio only
- Of those, 1,910 (24.6%) were escalated to video calls between the physician and resident
- Of those video calls, 563 (29.4%) of video calls and 7.2% of total calls were classified as having avoided a hospital admission as a direct result of the telemedicine intervention.
- The 563 avoided admissions generated an estimated $1,137,271.00 net new revenue for the 28 participating facilities, based on facility specific economic data
- The net revenue is the difference between the positive impact of preventing Medicare residents from being hospitalized and the negative impact (lost opportunity cost) for facility when Medicaid residents remain in the facility.
- The average new revenue per facility was estimated at: $40,616.00
- The average new revenue per occupied bed was $411.16

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- The range of new revenue was as high as $133,984.00 and as low as $1,656.00
- In addition, Southern Health Care Management was able to bill Medicare for the originating fee for telemedicine visits. Based on 1,910 telemedicine visits and approximately $20 per visit, this generated an additional $38,200 for SHCM.
- The cost to continue the telemedicine service after the grant is $850 per facility/month
- Of the 28 facilities in the program, all 28 showed a positive economic impact when the telemedicine fees were paid for by the grant funding.
- At the termination of the grant funding, only 2 of the 28 facilities (7.1%) showed a negative economic impact by continuing the program,
- Southern Health Care Management has made the commitment to continue the program across all 28 facilities after the grant funding terminated

The interviews conducted throughout the program provided valuable information especially in identifying the operational characteristics of those facilities that were the most successful with the telemedicine program and the operational characteristics of those with poorer performance.

- Based on the 563 avoided admissions, the Medicare Program saved an estimated $6,756,000 based on an average estimated cost of $12,000 per SNF to hospital admission.
- Based on the 28 participating SNFs, Medicare saved an average of $241,285.00 per facility
- Applying this savings to just half of the approximately 15,000 skilled nursing facilities across America, suggests a potential savings to the Medicare Program in excess of $1.8 billion dollars across a 12-month period.
- The effective use of the telemedicine program during the first few months was not as strong as anticipated. Unfortunately, facilities were still dealing with challenges of COVID and it was difficult getting facilities to prioritize this program. During the second quarter, the corporate office, through its regional directors, launched a significant effort to raise the priority level of the telemedicine program and it resulted in a significant increase in not just overall calls but the number of identified “avoided admissions”.
- Telehealth Solutions was responsible for data collection for all telemedicine visits. The company’s data specialist left early in the program and the process for collecting data went through several alterations before arriving at a methodology that was accepted by The TRECS Institute.
- The earlier methodology attempted to identify avoided admissions based on the diagnosis and medical details recorded for each telemedicine visit. TRECS reviewed the data and expressed concerns that the number of avoided admissions generated by Telehealth Solutions was over estimated.
- TRECS requested a two-physician review of a statistically appropriate number of the medical records of residents Telehealth Solutions deemed as having avoided a hospital admission to arrive at a more accurate number. The results of the two-physician review generated 563 as the final number of avoided admissions. TRECS utilized this number in the final economic analysis for this project.
- Of the total use of the telemedicine equipment, 84.7% were with the Telehealth Solutions physician. Only 15.3% were with physicians from Southern Health Care Management.

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Key Recommendations

Throughout the program, video interviews were conducted with the management teams of all 28 participating facilities, the regional directors, and the corporate office of Southern Health Care Management. The purpose of those calls was to identify how the telemedicine program was working in their facility. Specific issues addressed in these calls included:

- Capability of the onsite management team
- Interaction and support from the medical director
- Interaction and support from the local PCPs
- Nursing staff acceptance and participation
- Issues or concerns with the telemedicine cart
- Issues or concerns with Telehealth Solutions (the physician practice providing after hour services)
- Questions, comments or issues with residents or families
- Any other issues either positively or negatively impacting this program

Based on these interviews, a series of recommendations have been developed. It is interesting to note, that one reality these interviews uncovered was that not every facility is the same. Some facilities are more capable of taking a program like telemedicine and make it successful with little outside support, while other facilities require regular and ongoing monitoring and support. That is why one of the important findings from this study is the identification of operational characteristics of those facilities that achieved excellent results from this program compared to the operational characteristics of those that performed poorly.

These operational characteristics should serve as an opportunity for any skilled nursing facility considering implementing a telemedicine program to gauge their level of readiness. While The TRECS Institute believes telemedicine services should be available in every skilled care facility across America, not every facility is capable of being successful. Using these operational characteristics to evaluate an individual facilities readiness and likelihood of success should serve as a valuable tool for the industry.

The operational characteristics of successful SNFs when implementing telemedicine were identified as having:

- A strong management team (NHA/DON) in place with daily attention to the telemedicine service including:
  - Daily review of hospital log to assure telemedicine service are being used when appropriate and not being bypassed.
  - For true emergency transfers, a review of the medical record to assure there were not clinical signs that should have triggered a telemedicine visit and potentially prevented the situation from escalating to a medical emergency requiring hospitalization.
  - One-on-one follow up with any nursing staff who are not utilizing the telemedicine service when appropriate.

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  - Implementation of a program to assure all new RN hires and all agency staff understood the telemedicine program and how and when to use it.
- Strong support from Medical Director
  - His/her support was essential in working with local PCPs to win their support.
- A strong implementation program that included:
  - The Medical Director understanding and being able to fully describe the program and the benefits, as well as training PCP's on how and when to use the telemedicine equipment.
  - The local PCPs understanding and being able to describe the program, respond to any issues or concerns, and being trained on the use of the telemedicine equipment.
  - The nursing staff being trained on how to use the equipment but also when and what kinds of conditions warranted the telemedicine service.
- Early identification of problems or concerns and seeking help and support in responding to those concerns was critical to success.
- Self-appointed nurse champions of the telemedicine service who support the management team and helped to assure that residents who could benefit from a telemedicine visit were identified and the service effectively utilized.

In contrast, the poorer performing facilities often had one or many of the following operational characteristics:

- A weak management team (NHA/DON) in place with inconsistent attention to the telemedicine program. Often the result of turnover of the NHA and/or the DON.
  - Daily review of hospital log not being completed or completed regularly.
  - Not questioning and re-educating nurses for not using the telemedicine service when appropriate.
  - Not putting into place necessary processes to assure new nurse and agency nurses knew about and were trained to not only use the telemedicine service, but also when it should have been utilized.
  - Not requiring support from the medical director.
  - Not confronting and re-educating local PCPs not utilizing the telemedicine program.
- Despite a strong implementation program, not recognizing that for any number of reasons, their facility needed additional support to be successful with telemedicine.
- Although displaying a strong belief in the need for telemedicine their unstable nursing staff with high use of agency time negatively affected training and ultimate utilization of the telemedicine program.

Based on these findings across the 28 participating facilities in this program, the key operational characteristics for a skilled nursing facility considering the implementation of a telemedicine program, should be:

#1. A strong management team (NHA/DON) that will embrace the telemedicine program and make it a priority for the facility.
#2. A strong and supportive medical director.

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#3. A stable nursing staff that will embrace the telemedicine program.
#4. Limited use of agency time and when agency must be used, a mechanism to assure adequate training on how and when to use the telemedicine program,

These operational characteristics are essential for any skilled nursing facility considering the implementation of a telemedicine program.

Other Recommendations

Additional recommendations emerging from this program include:

- Regular monitoring of the telemedicine program at the individual facility level, and at the regional or corporate level positively impacts performance.
- Detailed upfront training is essential for:
  - Medical Directors
  - Local PCPs
  - Nursing Staff
- For some facilities, the upfront training is sufficient, however, for others, repeating this training and reinforcing the basics of the telemedicine service is necessary.
- The facility's management team needs to monitor the success of the program along with issues and concerns and seek support in resolving any issues or concerns.
- Appoint one or more nurses as an "Internal Telemedicine Champion" so they can assist other RNs, the medical director, and local PCPs in the use of the telemedicine program. This is an effective way to help build and increase the use of the telemedicine program.
- Regularly monitor the use of the telemedicine program. This can be done by reviewing the "*sent to hospital log*". Residents transferred to the hospital when the telemedicine service was not used should be reviewed at staff meetings. The staff should be then educated so when future situations arise, the telemedicine service will be called when appropriate.
- For emergency hospital admissions, the resident's medical record should be reviewed for the past 12, 24, 48 hours to see if there were clinical indications in their medical record that should have triggered a telemedicine visit and could have prevented the situation from escalating to an emergency.
- At the beginning of the program and as necessary repeated throughout the project, review the fact that Telehealth Solutions was serving as the covering physician during evenings, nights, weekends, and holidays. Some physicians did not fully understand this.
- As part of the solution to the point above, Telehealth Solutions needs to improve the level of communication between the physicians providing after hour coverage and reporting necessary information back to the PCPs.
- When PCPs are unable to return calls during normal working hours, a time should be set where if a response has not been received from the PCP, the telemedicine service would be called to intervene.

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Project Phases

This was a fifteen (15) month project divided into three separate phases:

Phase I: Preparation & Training Phase (2 months long)

Phase II: The Service Phase: (12 months)

Phase III: The Report Phase (1 month)

Phase I: Preparation & Training (2 Months)

This phase took place from March 1 through April 30th, 2021. Within the first quarter report, one month of actual telemedicine services were provided. The following section is copy of the overview and key factors of that first quarter:

During this period, the following tasks, as outlined in the original proposal, were achieved:

- Historical data sheets were created, distributed to, and returned by all 28 participating SNFs. (See "Data Collection Section" of this report)
- Ongoing data collection sheets were created and returned for May 2021, the first full month of telemedicine services. (See "Data Collection Section" of this report)
- Telemedicine carts were delivered, set up and tested at each of the 28 participating SNFs before the end of April in time for the telemedicine kick off date on May 3rd, 2021.
- A series of video conference calls were held with the management trams of all participating SNFs. During the first round of small group calls, a Power Point presentation was used to describe the telemedicine program, its goals and objectives and the requirements of all parties involved in this project. (See "Implementation Documentation Section" of this report)

  Follow up calls were held with each of the participating facilities to review their facility specific situations, issues, and concerns.

Additional group calls were scheduled regularly to continue following up and addressing any questions or concerns identified. These calls continued throughout May.

- Physician training sessions were scheduled and instructional help for medical directors and local PCPs with residents in the 28 participating facilities were scheduled through Telehealth Solutions, the physician practice providing the telemedicine services.
- Video training recordings were created to help physicians learn more about the program and how to access and successfully utilize the telemedicine equipment to care for their patients. (Details on how to view these videos is found in the "Implementation Documentation Section" of this report)
- Nursing staff at each facility were also trained through a combination of onsite and virtual programs, including recorded video educational programs.

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- Letters were sent from each facility to residents or responsible parties as well as the resident and family councils introducing the program and offering individuals the opportunity to opt out of the program if they so desired. (See "Notification Section" of this report)
- Weekly calls were set up with the management team of each facility in each of the four regions identified by Southern Health Care Management to discuss progress and any issues or concerns.

The level of support provided by the corporate office of Southern Health Care Management during this phase of the project was extensive. Not only did they secure the focus of their individual facilities and the management team at each, but the Corporate Medical Director was also involved and very supportive. The regional vice presidents and clinical directors were also involved. The corporate office also made short video educational recordings for their medical directors and nursing staff.

Phase II: Service Phase (12 months)

The service phase represents the 12 months when the telemedicine services were online and being offered by all 28 of the participating facilities. This period ran from May 1st, 2021, until April 30, 2022.

Below are some of the highlights from this phase:

- All 28 participating facilities provided telemedicine services to their residents during the entire 12 months of this phase
- Throughout the 12 months of this Phase, video calls were held regularly with the NHA or DON of multiple facilities to hear their thoughts on how the program was going, issues or concerns they had and or recommendations for improvement.
- Consistent concerns were raised over the difficulty utilizing telemedicine with fluctuations in staff stability. The more agency nursing staff was required, the harder it was to effectively utilize the telemedicine program.

- Occasional issues with the actual telemedicine equipment were identified and telehealth services was immediately notified to rectify.
- Lack of or poor support from a facility's medical director was occasionally identified and those situations were reported to the corporate medical director for action.
- One facility in particular utilized the telemedicine equipment to help provide behavioral health and specialty consults to its residents. TRECS applauds the creative efforts on the part of that facility to better serve its residents. The only negative for this program is that none of those efforts were recorded because the software, allowing capture of data from each telemedicine visit only kicks in when the telemedicine software is used. This facility was only using the video two-way capabilities, which again, were excellent for their residents and practitioners, but did not capture any that data for inclusion in this report.
- Facilities that experienced change in the management team (NHA or DON) often saw a decline in telemedicine usage. On the other hand, if the replacement NHA/DON was more effective than his/her predecessor, the use of the telemedicine service often increased.

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- Looking at the total use of the telemedicine equipment, 84.7% of the usage was with physicians from Telehealth Solutions. A total of 15.3% of the usage was from Southern Health Care Management Physicians. This number was not surprising because the physicians from Southern Health Care Management are covering only daytime hours during the week. The physicians from Telehealth Solutions are covering evenings, nights, weekends, and holidays.
- Those facilities with the strongest performance had strong management teams and paid daily attention to the telemedicine program.

Phase III: The Report Phase (1 month)

The Report Phase was used to review all data, confirm the final estimate of avoided admissions, calculate the estimated economic impact on each of the 28 participating facilities along with regional and cumulative results. The results of this Phase are included in this report.

Economic Analysis

The primary economic impact on all of the 28 participating facilities by preventing unnecessary hospital admissions was their ability to bill Medicare or Medicaid for additional days those residents were cared for in their facilities. If those 563 residents saved in this program had been admitted, which would have occurred without the telemedicine intervention, the SNFs would have lost the ability to bill for those days they went to the hospital. In addition, a certain percentage of residents that are admitted to the hospital, never return. In those cases, the SNF not only loses the ability to bill for those days lost to the hospital, but also those additional days they lost by not returning. (For example, if a Medicare patient is admitted with a 14-day expected Medical Skilled LOS, and if they are admitted on day 3 and stay in the hospital 3 days, the SNF loses the ability to bill for those three days. If a particular patient does not return however, the facility loses not only the 3-day hospital stay, but also 8 days at the tail end of the stay.) When Medicare pays facilities between $500 and $600 a day, being able to prevent that admission and bill for those 11 Medicare days is a significant economic impact for the facility.

Ironically, with Medicaid residents, the economic impact is different. Preventing a Medicaid resident from being admitted unnecessarily to an acute care hospital is certainly in the best interest of the resident from a quality-of-life perspective. It is certainly the right thing to do for our health care system by not wasting approximately $12,000 to pay for an unnecessary hospital admission.

However, for an individual nursing facility, preventing a Medicaid resident from being admitted to an acute care hospital can actually result in lost revenue for that facility. The reason is simple, many (but not all) Medicaid residents admitted to the hospital return after discharge with Medicare skilled coverage in the SNF. The dollars paid and the length of their coverage under Medicare may be less than that of a rehab type resident, but it is still a higher payment then Medicaid pays.

In an effort to be as accurate as possible in the economic analysis of this program, the lost opportunity cost to each facility when Medicaid residents avoid a hospital admission as a result of

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the telemedicine program, is subtracted from the positive economic impact when a Medicare resident remains in the SNF and is not sent to the hospital.

In addition, with the goal of accurately reflecting the economic impact, each facilities specific data was collected and used in the financial analysis. These specific data elements are listed below with an example in paratheses that will be used in the formula below:

- Average number of days residents stay in hospital by payer **(3)**
- Average total LOS for short stay patients **(18)**
- % of residents who do not return to the SNF **(15%)**
- % of Medicaid residents who return to SNF with Medicare skilled days **(75%)**
- Average number of Medicare skilled days for Medicaid residents after hospital (8)
- Average daily rate for Medicaid residents **($225)**
- Average daily rate for Medicare residents **($558)**

The formula used to calculate the individual facility's positive economic impact for Medicare residents is:

((Number of avoided Medicare admissions) x (Average acute LOS) x (Average Daily Rate))
Plus
((#of avoided admission) * (% not returning to SNF) * (Days remaining after Hospital stay)

= the positive impact of a hospital admission by a Medicare resident.

For the example below, the total number of avoided Medicare residents for this sample SNF was 21. The examples in blue above were applied to the formula below to calculate the impact of Medicare residents who avoided being admitted to the hospital. would read:

(21 x 3 x $558) + (21 x 15%* 8 x 558) = $49,215.00

$35,154 + $14,061 = $49,215.00. **(New Revenue due to avoided hospital admission)**

In Table I of this report, all 28 facilities are listed with facility specific data and the calculation for the economic impact of avoided Medicare hospital admissions. For the 28 participating facilities,

the amount of new revenue for Medicare avoided admissions, using facility specific data, is $1,431,202.00.

The formula below shows how to calculate the lost revenue opportunity for Medicaid residents who avoid a hospital admission and therefore do not offer the SNF the opportunity to provide Medicare skilled days at a much higher reimbursement compared to Medicaid rates. In this example, the blue examples provided on the previous page were used along with an example of 5

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avoided Medicaid hospital admissions. To calculate the lost revenue opportunity for Medicaid residents who avoided an acute care admission, the formula is:

((# of avoided Medicaid) x (% with Medicare Days) x (Average # days) x (Medicare rate)
Minus
(# of avoided Medicaid) x (ALOS in hospital) x (Medicaid daily rate)

= the economic impact of Medicaid residents who avoided a hospital admission

Using 5 as the number of avoided admissions and the examples on the previous page, the formula reads:

(5 * 75% x 8 x $558) – (5 x 3 x $225)

$16,749 minus $3,375 = $13,375

In this example, the 21 avoided Medicare residents generated an estimated $49,215 of new revenue. The 5 avoided Medicaid residents represented a lost revenue opportunity for this SNF of $13,375. There for, the net impact for this sample SNF was:

$49,215 - $13,375 = $35,840.00 (net new revenue generated)

Although our health care reimbursement system has a negative incentive to send Medicaid residents to the hospital to secure higher paying Medicare rates upon their return to the SNF, this is not quality of care for those residents. In an effort to provide the most accurate estimate of the economic impact of using telemedicine, it was decided by TRECS that in addition to showing the positive impact of Medicare residents who avoid a hospital admission, it was necessary to recognize the lost economic opportunity for SNFs when Medicaid residents are saved from an unnecessary and avoidable hospital admission.

Table I of this report provides the full breakdown of required data and estimates of the new revenue created by Medicare avoided admissions, the lost opportunity costs for Medicaid hospital admissions and the net impact created for each participating facility.

The findings presented in Table I represent the 563 avoided hospital admissions broken into Medicare and Medicaid residents by facility. The facility specific data collected in the Preparation and Training Phase and reconfirmed/refined during the final month of Phase II, the Service Phase, were used to calculate the estimate cumulative economic impact of this program for Southern Health Care Management, for each of the four regions, and for each individual participating facility.

Interviews

Over the course of this program, over 60 interviews were conducted with members of the management team of each facility along with regional vice presidents and regional clinical

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managers. In addition, multiple interviews with members of the corporate staff at Southern Health Care Management were also conducted throughout the 15 months of this initiative.

The initial interviews by The TRECS Institute were conducted during Phase I, the Implementation and Planning Phase. The first interviews/zoom meetings were held in small groups of 4 to 5 facilities with representation from the corporate office attending. The goals of the program were reviewed and facility specific responsibilities discussed. This was a time for each facility to express any concerns or issues they felt could impact the success of the program.

Following these small group sessions, individual video calls were scheduled with each of the 28 participating facilities to review their specific details and concerns. Any issues raised were addressed often with involvement from the corporate office.

During the first four months of the project, random video interviews were conducted on a monthly basis. During that period, all 28 facilities were included in this interview process. During the final four months of the program, all 28 facilities were again interviewed. In addition, many of the regional vice presidents and regional clinical coordinators were interviewed.

The goal in conducting these video interviews was to identify any issues or concerns that could impact the success of the telemedicine program. Where appropriate, the corporate team at Southern Health Care Management and/or the leadership at Telehealth Solutions were brought into the discussion.

In addition, these calls, especially during the last few months of the project, were asking for recommendations on “How can this program be improved?” Many of the concerns and comments recorded during these interactions fell into the same categories. In terms of concerns or issues, the most common were:

- Staffing difficulties especially facilities with high agency use
- Difficulty in securing nursing buy-in for the program
- Lack of support by the Medical Director
- Problems with one or more local primary physicians not wanting to use the program
- Turnover in the administrative team
- Temporary issues with the telemedicine equipment

During the final months, TRECS was specifically requesting recommendations for improvement and validation of the success of the program. The responses also fell into several major categories such as:

- Great program for reducing return to hospital rates.
- Great marketing tool that local hospitals found extremely attractive.
- Great marketing tool for families looking for placement.
- Excellent opportunity for nurses to improve their clinical skills and confidence levels.
-

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- Several facilities also used the telemedicine equipment to bring behavior health and specialty consults to their residents. These were not intended uses of the equipment but because they brought additional benefits to the residents, they were applauded by TRECS.

In terms of recommendations for improving the success of the program, the following represent the major categories of recommendations suggested:

- Increase efforts to win the support of medical directors.
- Increase training initially and throughout the program for medical directors.
- Increase efforts initially to educate local physicians on the details of the program and how they can access the telemedicine equipment.
- Increase ongoing training for nursing staff (primarily due to turnover and use of agency nurses).
- Work with Telehealth Solutions to provide more direct interactions with medical directors and local PCPs, especially for residents with major medical issues and concerns.

All but two of the 28 participating facilities felt that the telemedicine program was helpful and should be continued after the grant funding. Both of the facilities that felt the program was not helpful admitted that the problem was not the program, but their current operational issues (primarily instability of staff and high agency usage) and therefore, they were unable to take advantage of the telemedicine program.

The regional and corporate staff also made the same recommendations.

These recommendations were extremely helpful and accurate and will be built into any future telemedicine implementation efforts.

Spreadsheets: Data Results

Attached to this report are multiple spreadsheets showing the outcomes of this initiative. They include:

- Cumulative results for all 28 participating facilities
- Regional Results
- Individual facility results
- Ranking of facilities by total calls and avoided admissions

Acknowledgements

The TRECS Institute would like to acknowledge the support of several individuals in particular who were extremely helpful in making this program a success. In particular:

1) The NHAs and DONs of the 28 participating facilities for their support in making this program a success while dealing with so many other day-to-day issues and trying their best to provide their residents with the care they need and deserve.

2) Laura Quinn
VP of Business Development
Southern Health Care Management, LTC'

For your never-ending support and commitment to make this program a success.

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