SPECIAL ISSUE

brief

FALL 2020

Telemedicine

TRANSFORMATIONAL INNOVATION

AMERICAN SENIORS HOUSING ASSOCIATION
Living Longer Better

GLENAIRE HEALTHCARE, LLC

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Telemedicine

TRANSFORMATIONAL INNOVATION

INTRODUCTION

"Never allow a good crisis go to waste. It's an opportunity to do the things you once thought were impossible."

This rallying cry from the White House during the height of the Great Recession resonates resoundingly today as senior living operators meet the COVID-19 crisis head on by adroitly adopting transformational innovation.

Telemedicine, now a vital breakthrough in battling the outbreak, is a prime example of how communities have turned to emerging technology to deliver more intensive health care services that maintain and extend continuity of care. It also protects residents by avoiding potential exposure to the virus in physician offices and hospitals, while prolonging length of stays.

In fact, virtual provider visits have proven so successful during the coronavirus pandemic that telemedicine is opening the way for senior living going forward to significantly expand its health care options, giving residents greater access to more services. This, in turn, positions communities for a more prominent role in the integrated care delivery movement.

And with telemedicine's tremendous growth, this is the link that promises to heighten senior living's role in health care by bridging the gap separating private pay services from the innumerable services covered by Medicare. Telemedicine connects both sides of this payor equation.

When the COVID-19 outbreak erupted into a full-blown public health emergency throughout the Spring, telemedicine immediately moved from a promising, but early stage virtual technology to the forefront of delivering care, whether it was from physicians, nurse practitioners, physician assistants, physical, occupational and speech therapists, or mental health specialists.

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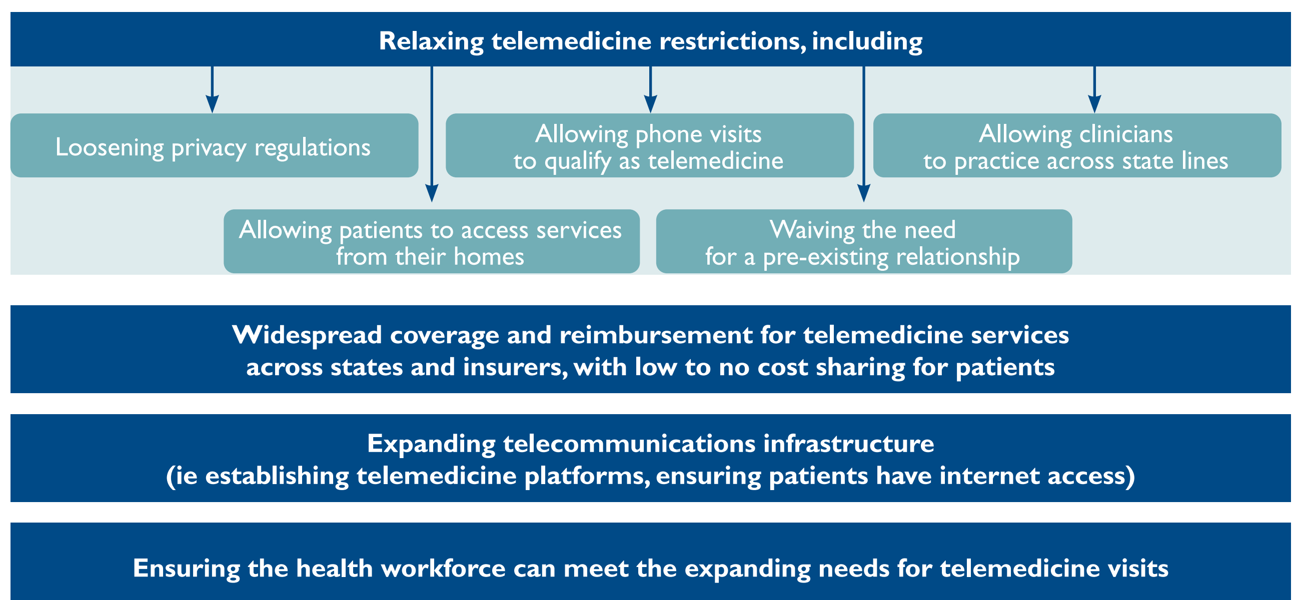
Telemedicine platforms and remote patient monitoring technology have been responsible for over 9 million Medicare beneficiaries receiving services from mid-March through mid-June. Prior to the public health emergency, approximately 13,000 beneficiaries in fee-for-service Medicare received telemedicine in a week. In the last week of April, nearly 1.7 million beneficiaries received telehealth services.

Examples of remote access that improve outcomes by delivering acute, chronic, primary and specialty care include:

- Screening patients who may have symptoms of COVID-19
- Providing low-risk urgent care and identifying those who may need additional medical consultation or assessment, and referring as appropriate
- Accessing primary care providers and specialists, including mental and behavioral health, for chronic health conditions and medication management
- Participating in physical therapy, occupational therapy and other modalities as a hybrid approach to in-person care for optimal health
- Monitoring clinical signs of certain chronic medical conditions (e.g., blood pressure, blood glucose, respiratory rate, heart rate and other remote assessments)
- Engaging in case management
- Following up with patients after hospitalization
- Delivering advance care planning and counseling to patients and caregivers to document preferences if a life-threatening event or medical crisis occurs

Actions to Expand Telemedicine Availability During the COVID-19 Pandemic



SOURCE: Kaiser Family Foundation

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Prior to the pandemic, Medicare limited coverage of telemedicine to those receiving the service in designated rural areas and when patients left their homes to go to clinics, hospitals and other locations for access to remote visits.

But as the crisis unfolded, the Centers for Medicare and Medicaid Services (CMS) temporarily expanded the scope of Medicare telemedicine to allow beneficiaries across the country — not just in rural areas — to receive telehealth services from any location, including their homes.

CMS also added 135 allowable services, more than doubling the number of services that beneficiaries could receive via telehealth. And physicians are now being paid for telehealth services under this temporary expansion at the same payment rate as they would receive for in-person services.

Noteworthy changes for Medicare fee-for-service telemedicine coverage during the COVID-19 emergency include:

- Allowing beneficiaries living in any geographic area to receive telemedicine services
- Allowing beneficiaries to access telemedicine visits from their homes
- Allowing telemedicine videoconference visits to be delivered via smartphone
- Removing the requirement for a pre-existing relationship between patient and provider
- Allowing some services to be delivered via audio-only phone

Key Changes to Coverage Restrictions for Medicare Fee-for-Service During the COVID-19 Emergency

Note: Changes enacted as part of the Coronavirus Preparedness and Response Supplemental Appropriates Act and the CARES Act.

SOURCE: Centers for Medicare and Medicaid Services (CMS), Medicare Telemedicine Health Care Provider Fact Sheet, March 2020. CMS Press Release. March 30, 2020

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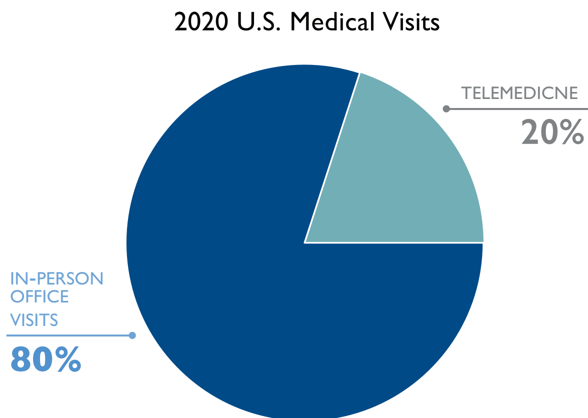
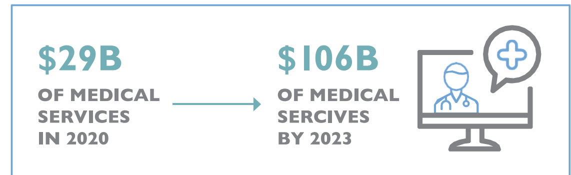
A group of bipartisan lawmakers has introduced a bill in the U.S. House to permanently enact Medicare telemedicine expansions that were made during the coronavirus pandemic. Meanwhile, the White House is expected to back legislation that would give telemedicine a broader role under Medicare.

According to telemedicine research conducted by Doximity, over 20 percent of medical office visits in 2020 are expected to be conducted via telehealth, representing $29 billion in medical services. Furthermore, the firm's projections indicate Medicare, Medicaid and privately insured office visits conducted via telemedicine in 2023 will account for upwards of $106 billion.

Impact of COVID-19 on Telemedicine Adoption





SOURCE: Doximity

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TELEMEDICINE IN SENIOR LIVING

Given telemedicine's immense, pandemic-driven surge in delivering health care virtually, some senior living operators continue to adjust as they learn more about gearing up for remote access to health care professionals, while others were well-positioned to immediately participate.

Telemedicine's role in senior living has largely revolved around:

- On-call, after-hours emergency response to avoid emergency room visits and unplanned hospitalizations
- Assessing changes in condition
- Addressing behavior issues such as agitation and aggression to minimize use of drug therapy
- Managing medications and prescribing electronically
- Accessing specialists
- Routine check-ups
- Provider consultations that bring residents, staff and families together

Operators deliberating how telemedicine can most effectively interface with their communities' clinical capabilities face a number of considerations. These include achieving quality outcomes remotely for primary care delivered to residents with complex, multiple chronic conditions, assessing the value of various third-party virtual care platforms versus developing an in-house solution, and determining how telemedicine can interact with electronic medical records.

But the overriding question is how to efficiently support telemedicine with community staff, who often spend a considerable amount of time with residents during virtual visits, leading to higher labor costs. The health care professional on one end of the virtual visit is being reimbursed, but time for staff assisting residents throughout their visits often is not.

One operator confided "it's not like you can drop off a tablet in the resident's room and say here's your doctor. It's taking somebody off the floor, which is a time commitment for our clinicians. We certainly want to do what's best for our residents, so it's a trade-off right now."

Brookdale Senior Living, with service lines reaching across seniors housing, skilled nursing, home health care and hospice, is building upon its experience with telemedicine.

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For home health care, Brookdale works with a vendor to connect patients' electronic devices with an app that interfaces with the company's electronic health records. The app allows Brookdale associates in HIPPA-compliant interactions to conduct virtual visits with patients, while staying in touch with the organization's support network.

On the skilled nursing side, Brookdale utilizes a different telemedicine solution to help prevent hospitalizations.

Meanwhile, several telemedicine pilot programs have been conducted for assisted living. "We've tried different platforms, but something else always seems to come along that is better than the last," said Kim Elliott, Brookdale's senior vice president of clinical services.

"During COVID, we've used the technology we have. We've had iPads, so we still have access to physician groups to get residents the care and services they need. I can give you an example," she continued. "We had a community in the New Jersey area early-on where the hospital groups said, 'Do not send them to the hospital. We're not going to be able to accept them.'

"We were immediately concerned about what would happen if there's a change in condition. We've got to get them in front of a doctor. So, we deployed iPads and then worked with our physicians so we had immediate access to them, knowing that there were going to be restrictions on any discharges to the hospital," Elliott explained.

Benchmark Senior Living has also been piloting telemedicine platforms. "We're looking at urgent care, off-shift and other options," said Denise McQuaide, president and COO of Benchmark Wellness Management, an affiliate overseeing health care initiatives.

"But I can tell you we're very much in the throes of a strategic plan, looking at software apps that interface with our electronic health record," she said. "We're assessing what happens when you have a physician group or a health system that has its own platform and provides a lot of the medical care for our residents. Do you go with them, or do they have to go with your platform and your software?

"And do we really need one telehealth system, or do we have a telehealth system just for urgent care? If I were an ACO or even a Medicare Advantage plan, do I want to pay another provider to do an urgent care visit, or do I want them to use the system I've set up? I certainly want to avoid sending residents off to an ER.

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"These telemedicine groups all do similar things, in that they see the patients, they instruct the other person in the room to touch, report, whatever. They get vital signs sent to them. They can order labs. They can order medications. In assisted living, it is resource-intensive to manage these telehealth visits for both urgent care and primary care visits where staff are much leaner than in skilled nursing facilities. We have one community that received much of its primary care during COVID via telehealth and it took a staff memeber a full day to prepare, then a full day to manage the visits and follow up on all orders. How do you sort through all this with various health systems or doctor groups? That is political, it's sensitive, and it's non-traditional for seniors," McQuaide commented.

RESPONDING TO MULTIPLE, COMPLEX CONDITIONS

ALG Senior, formerly known as Affinity Living Group, participated in telemedicine prior to the COVID-19 pandemic, but significantly increased the volume of virtual visits following the outbreak. All of its 140 assisted living communities, which are located primarily in the Southeast, have computer tablets so residents can interact with providers via HIPPA-compliant video conferencing sites.

Responding to changes in condition and behavioral issues are two of the foremost events that bring telemedicine into the mix at ALG.

"Say someone suddenly spikes a fever or develops delirium," explained Kevin O'Neil, MD, chief medical officer at ALG. "Often older adults with heart attacks and infectious diseases may not necessarily present with typical symptoms.

"The ability to access and talk to somebody through a telehealth application can avoid unnecessary ER visits and hospitalizations. You can save a significant amount of money if we can keep people out of the ER and out of the hospital. I'm a geriatrician. And one of the basic tenants of geriatrics is the hospital is a dangerous place to be for our population, given potential exposure to infections.

"Some of the digital technology that's evolved has been extraordinary, because we can now listen with a digital stethoscope, and we can use pulse oximetry. All of this can be done remotely," he pointed out. "We can do an EKG. We can actually hear what the nurse is hearing at the bedside. There's just so much that can be done with telehealth that could potentially obviate the delay that might occur if a doctor had to drive to get to a community and actually see that resident."

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O'Neil noted that behavioral issues often arise in assisted living, "because the majority of residents have some either cognitive or functional impairments. Especially now as people are isolated more and more because of the pandemic, we've seen an increase in some of the behaviors with agitation and aggression. This is where the mental health teams we work with through telemedicine can provide guidance on how to de-escalate the situation without resorting to drug therapy."

ALG recognizes that the growing prevalence of multiple, complex medical conditions among its residents requires broader access to health care services. And telemedicine is critical in increasing provider participation.

"We call it an integrated care model with a preferred provider network," he said. "We've put together a list of provider expectations. And one is that they will do all of their prescribing electronically. We're not going to accept doctors writing orders on Post-It notes or faxes back and forth. And they must share their quality metrics with us on a regular basis. We'll periodically review performance, customer experience and so forth. We're also going to insist on an interoperable electronic health record.

"Eventually we'd like to improve care coordination by having a limited number of health care providers. They could be physicians, but they could be nurse practitioners and physician assistants working with physicians. We also want to limit the number of home health and hospice agencies that we work with so they step to the plate and help us coordinate together. This is because one of the biggest vulnerabilities for an older adult is through care transitions, or when you're dealing with multiple providers. If they're not communicating with each other and don't share information, that creates problems," O'Neil asserted.

He added that "one of our goals will be reducing clinical and operational variation, because if you have different providers doing things different ways, it impacts the workflows of your staff, and the potential for error increases tremendously. Everything shouldn't be a regimented cookbook, but there aren't hundreds of ways of managing heart failure or hypertension. How can we work together to help create some guidelines and standards related to care?

"I'm actually working on stratifying the risk of our population, because we can't treat every single person in assisted living the same way," O'Neil acknowledged. "We know that at least five to 10 percent of them are very high risk in terms of ER admissions and hospitalizations. We want to

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determine who is in that high risk, high cost population and focus more on care management efforts. We'll have wellness programs to address the needs of the less acute folks, but you need to identify who's in that high risk, high cost group."

THE CONFLUENCE OF TECH, HEALTH CARE

Technological advancements such as telemedicine are a major force driving health care's growing role throughout senior living. A prime example of this confluence between tech and health care is the allicance underway with operator Senior Resource Group, insurer Anthem and its CareMore Health affiliate that delivers integrated, multi-disciplinary clinical care.

Anthem offers Medicare Advantage (MA) I-SNP plans to assisted living residents, while CareMore employs multi-disciplinary care teams that serve residents participating in Anthem's MA plans, as well as those enrolled in other insurers' MA plans.

CareMore Senior Living Solutions serves over 160,000 Medicare and Medicaid patients across nine states: Arizona, California, Nevada, Colorado, Texas, Connecticut, Virginia, Tennessee, Iowa and the District of Columbia. It interacts with approximately 600 assisted living communities managed by both large national operators and smaller local, regional operators.

"We employ the staff that actually goes out and cares for the residents," CareMore Vice President Jim Lydiard reported. "Because CareMore's model is designed to bridge care across settings, we also support the residents beyond assisted living. If a resident needs to go to the hospital, we send them to our network contracted hospital. If a resident needs specialists, they can go to our care centers or our network of specialists.

"All of our providers speak seamlessly to one another and give these residents the member experience that keeps assisted living folks out of wasteful hospitalization settings. We have the electronic health records and case management, so it's basically an integrated care network," he observed.

Turning to CareMore's experience with telemedicine, Lydiard said that at the outset of March before the COVID-19 outbreak exploded, about five percent of its interactions with patients were through telehealth, and it was predominantly texting and phone calls. As April got underway, that soared to approximately 95 percent telehealth outreach, with about 50 percent of those visits conducted via video.

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"There is no substitute for an in-person clinical exam for very frail patients, so we have started to shift back to more in-person visits. I believe we'll level off after the next couple of months to maybe 75 percent of our senior living community visits being in-person, 25 percent of our senior living community being telehealth," he predicted.

"The dominant telehealth modality is video, where we can actually see what's going on if it's a rash, if there's a laceration, if there was a fall," he continued. "We can triage and coordinate thereafter with any of our other mobile ancillary contractors. If the patient needs an x-ray, if the patient needs a lab to come out, if we need to change a prescription and have a pharmacy make the delivery, we oversee all of this.

"Today, about half of our telehealth visits are proactive in nature. We're scheduling time with the patient and the community to connect to our platform and check on the patient and the community as a whole. The other 50 percent are emergency visits.

"As we move back to more and more in-person encounters for our proactive visits," he said, "the greater degree of telehealth utilization will be emergency services, where something occurs during the day, night, weekend, holiday, or whatever it may be. They just can't wait for our next routine in-person visit, nor should they. We want them to call us."

Working with CareMore throughout the pandemic by expanding the use of virtual health care visits has opened new opportunities to deliver a greater range of services for Senior Resource Group (SRG) residents.

One of telemedicine's primary benefits "during these unprecedented times is filling the gap while many traditional health care delivery systems have struggled," noted Jason Rich, SRG's vice president of operations. "The convenience and reassurance to families that they can join in discussions about their loved one's care and a specific diagnosis without having to physically be there will now be part of the new normal. In addition, the increased care coordination between our communities and the resident's physician will continue to lead to better outcomes and ultimately better patient experiences.

"The biggest change is the increase in patient information the provider is able to access and the ability to coordinate residents' care," he pointed out. "Our nursing staff can directly upload a report with recent patient history as well as changes in condition, establishing a baseline from which the provider can work. Most labs can be ordered and performed on-site, increasing the speed of diagnosis and ultimately the response to the patient."

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Thanks to providers' ability to quickly intervene through telemedicine when a resident's condition changes, "the speed at which one our residents can receive care has increased," according to Rich. "Previously, a resident with a suspected UTI and dehydration would need to leave the community to see their provider, who would review their condition based on information and timelines from the resident, then order labs, review the labs, make a diagnosis and order a prescription.

"Now, our team can set up a telemedicine consult while simultaneously running labs and providing a change in conditions report from our nursing staff, allowing the care provider to render a diagnosis and send in a prescription. Instead of being in discomfort and travelling to appointments, the medications are delivered to the community, and the resident is able to start their regime faster and easier.

"In addition, the amount of patient information has increased as care providers not only interact directly with their patient, but they also have the changes in conditions report and recent history provided by the community. The coordination of the response and care has increased, because the CareMore nurse practitioner is working directly with the care team at the community. They are all focused on a better outcome for the patient," he added.

A PHYSICIAN'S PERSPECTIVE

Payam Parvinchiha, MD, CareMore regional medical director, shared his perspective on why telemedicine has quickly become an integral part of caring for assisted living residents.

"Those that live in assisted living with care needs require frequent touches from clinicians. We always fostered this idea that when you're 85, you might be as healthy as you can be and living in senior living and doing well. But at 85 you can go from being low-risk to high-risk in a matter of hours," he said.

"With COVID, telemedicine incentives aligned. Seniors needed care, the communities in the beginning didn't want doctors and nurse practitioners coming into the building out of fear of COVID entering," Parvinchiha continued, "and we equally didn't want to send our clinicians, because we were worried about them and were worried about introducing the virus into communities as obviously the worst-case scenario.

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"During that time, the crisis became a substrate for innovation. Beyond the typical telemedicine appointments, we've been able to come up with new engagements with patients via virtual visits that actually are enhancements of in-person visits," he noted.

These enhancements with greater provider access via telemedicine may well lead to advances such as community-based virtual health clinics, where a clinical room can be equipped to accommodate the delivery of virtual health care by multiple providers.

"I see that space having various devices like heart rate monitors, virtual stethoscopes, things like that so patients can interact with the doctor up on the screen, along with family members. The more time seniors spend in the community they live in, the better. Going to the doctor's office can be a nuisance, whether it's because it takes time and energy from the staff at the assisted living community, or takes time and energy from the family member who has to leave work to take the patient to the office," Parvinchiha commented.

The "sweet spot" for meeting the health care needs of assisted living residents "will be virtual health coupled with responsive in-person support," he predicted. "When the virtual appointment is done and an infection or heart failure exacerbation is identified, a physician can quickly mobilize to deliver the needed intervention in the assisted living community.

"One of the problems with virtual health is you're limited in terms of intervention. If you have pneumonia, we're trying to avoid going to the ER. So, we want to connect you with our primary care support so antibiotics can be delivered immediately. We want to avoid going to the next step of increased medical exposure," he emphasized.

To illustrate how telemedicine is being deployed by CareMore in assisted living, Parvinchiha shared the following examples.

Mr. Jones was an 81-year-old who moved into assisted living, due to worsening dementia. His family had moved away for work. He started falling, had one incident with head trauma and was sent to the emergency room, where he was found to have normal pressure hydrocephalus, a condition that is potentially treatable with neurosurgical intervention.

However, since his family lived out of state, it was difficult to arrange a consultation.

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CareMore's nurse practitioner coordinated a virtual visit with her at bedside, along with the neurosurgeon and the family. The surgeon reviewed the imaging from ER, the nurse practitioner helped with a physical exam, and the options were reviewed.

A procedure was offered, but given the potential risk the family chose hospice, which the assisted living staff agreed to, allowing the patient to continue living in the community.

Ms. Jensen had severe peripheral artery disease and worsening kidney disease. Weekly virtual visits allowed for coordination of home health services to provide wound care. However, her condition deteriorated.

She had four children in different states who had differing opinions about her treatment plan. Invitations for weekly group virtual visits were extended to each of her children, the patient, CareMore's nurse practitioner, community staff, and Dr. Parvinchiha.

During one visit, a nephrologist was included to give advice about her kidney disease. During another virtual visit, a vascular surgeon gave a prognosis regarding her vascular disease. After five weeks of visits, there was consensus not to pursue aggressive care. All the daughters and community staff were in agreement.

A care plan was developed, and she continues to live at the community with the understanding that when her condition declines further, she will enroll in hospice.

ABOUT THE AUTHOR

Jim Bowe is Principal of GlenAire HealthCare, LLC, a strategic planning and business development firm that specializes in post-acute care and senior living engagements. GlenAire HealthCare partners with health care networks to help realign the continuum of care with an emphasis on rewarding quality outcomes and cost efficient operations. The firm advises and guides clients on how to optimally develop, expand and reposition post-acute care and senior living businesses.

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