Implementing a Structured Framework for Enterprise Adoption of Telehealth Service Development and Delivery

Foundation of the American College of Healthcare Executives
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Disclosure of Relevant Financial Relationships

The following faculty of this continuing education activity has no relevant financial relationships with commercial interests to disclose:

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  - Medical University of South Carolina
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  - Administrator Center for Telehealth
  - Medical University of South Carolina

Agenda

- Telehealth Background
- MUSC Case Studies
- Leveraging MUSC assets in quality, education, and research
- Ideas for telehealth best practices: The structured framework

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Learning Objectives

- Identify the concepts and processes needed to navigate telehealth implementation
- Learn strategies to evaluate a telehealth service
- Examine the five phases of the Telehealth Service Implementation Model (T-SIM)©

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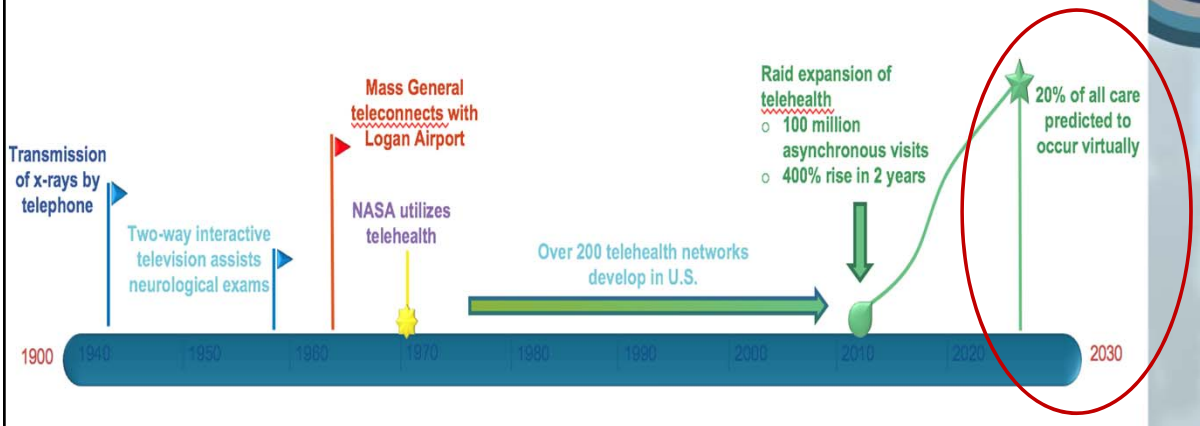
Brief History of Telehealth



Virtual Health: Aligning Solutions With Enterprise-Wide Priorities. SG2 Intelligence 2014.

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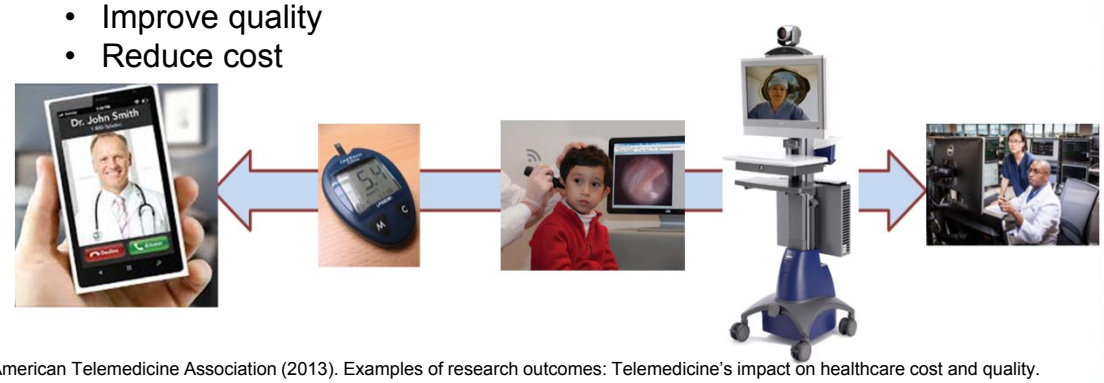
Background

- Obtaining healthcare services problematic in rural and/or medically underserved communities
- Telehealth appeal
  - Improve access
  - Improve quality
  - Reduce cost



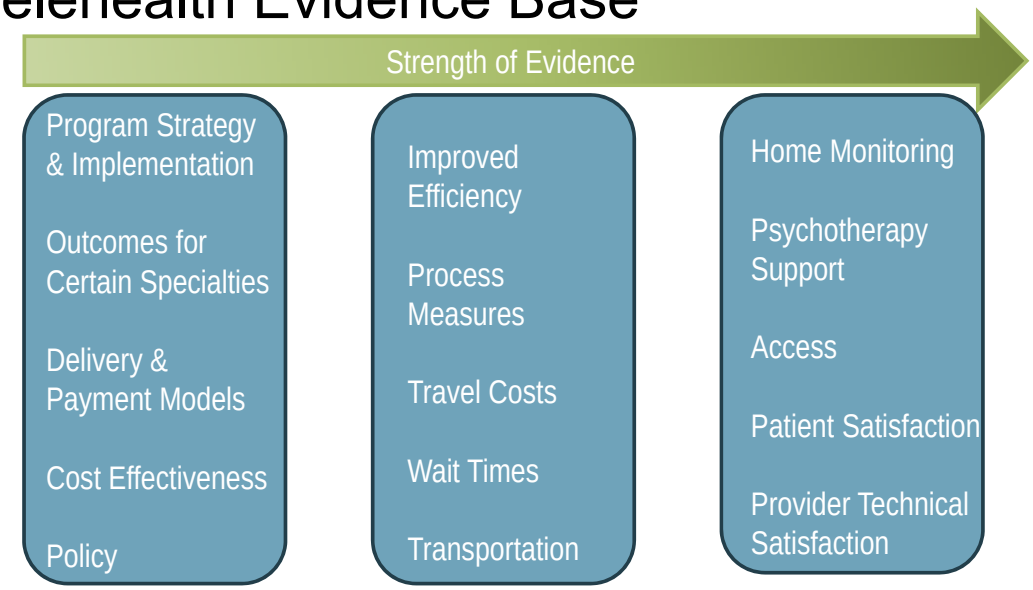
American Telemedicine Association (2013). Examples of research outcomes: Telemedicine's impact on healthcare cost and quality. https://www.amdtelemedicine.com/telemedicine-resources/documents/ATATelemedicineResearchPaper_impact-on-healthcare-cost-and-quality_April2013.pdf

Concerns

- Yet, telemedicine programs not widespread
- Small scale services poorly integrated into health systems
- Large-scale IT projects have failure rates >30%
- 75% of successful telehealth pilots not sustained

Broens, T.H., et al. (2007). Determinants of successful telemedicine implementations: a literature study. Journal of Telemedicine and Telecare, 13(6): 303-309.
Jennett, P., et al. (2003). A study of a rural community's readiness for telehealth. *Journal of Telemedicine & Telecare,* 9:259-263.
Van Dyk, L. (2014). A review of the telehealth service implementation frameworks. *International Journal of Public Health,* 11: 1279-1298.

Telehealth Evidence Base



Tuckson, R.V., Edmunds, M., & Hodgkins, M.L. (2017). Telehealth. *The New England Journal of Medicine*. 377:16, 1585-1592.
Edmunds, M., et al. (2017) An Emergent Research and Policy Framework for Telehealth. eGEMs, 5(2).

Telehealth Implementation Challenges

- Increasing Demand
- Insufficient Planning & Best Practices
- Resource Intensive
- Assessment & Evaluation

Jennett, P., et al. (2003). A study of a rural community's readiness for telehealth. *J Telemedicine & Telecare,* 9:259-263.
McIntosh, E. & Cairns, J. (1997). A framework for economic evaluation of telemedicine. *J Telemedicine & Telecare, 3(3): 132-139.*
Van Dyk, L. (2014). A review of the telehealth service implementation frameworks. *International Journal of Public Health,* 11: 1279-1298.

Telehealth Complexity

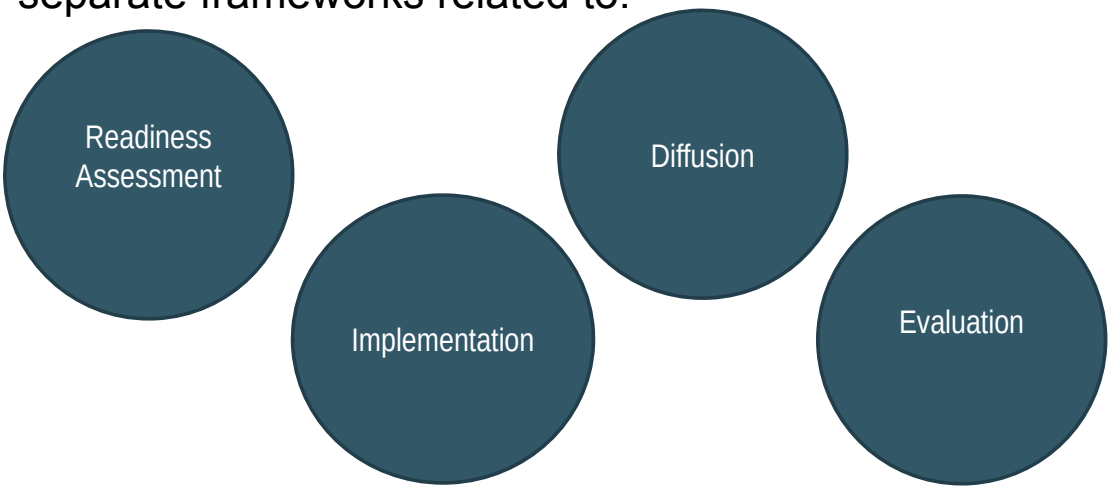
"Organizationally, telemedicine provides challenges to the traditional notions of regionalized health care systems" (Bashshur, 2000)

- Persistent problems have not been successfully addressed:
  - Relationships between traditionally competing delivery systems
    - culture, practices, business models, governance
  - Telehealth organizational structure
  - Operational system
  - Boundaries of planning regions

Bashshur, R., Reardon, T., & Shannon, G. (2000). Telemedicine: A new health care delivery system. *Annu. Rev. Public Health, 21:613-637.*

Van Dyk, L. (2014). A review of the telehealth service implementation frameworks. *International Journal of Public Health,* 11: 1279-1298.

Current telehealth literature includes multiple & separate frameworks related to:



Broens, T.H., Vollenbroek-Hutten, M.M., Hermens, H.J., van Halteren, A.T., Nieuwenhuis, L.J. et al. (2007). Determinants of successful telemedicine implementations: a literature study. Journal of Telemedicine and Telecare, 13(6): 303-309.

Van Dyk, L. (2014). A review of the telehealth service implementation frameworks. *International Journal of Public Health,* 11: 1279-1298.

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Factors that Impact Telehealth Success

- Technology
- Organizational structures
- Change management
- Economic feasibility
- Societal impacts
- Perceptions
- User-friendliness
- Evaluation and evidence
- Legislation
- Policy and governance

"A holistic implementation approach is needed"

Van Dyk, L. (2014). A review of the telehealth service implementation frameworks. *International Journal of Public Health,* 11: 1279-1298.

Sustainable Telemedicine: Designing and Building Infrastructure to Support a Comprehensive Telemedicine Practice

(Mayo Clinic Experience)

Analysis:

1. "Strategy…not clearly articulated"; priorities and scope not maintained
2. Services created from different practice areas resulted in variation, creating further challenges in providing operational support across the enterprise
3. Numerous stakeholders and competing priorities negatively impacted service development
4. Fragmented technology; no clear operational procedures

Beth L.H. Kreofsky, R. Nicole Blegen, Troy G. Lokken, Susan M. Kapraun, Matthew S. Bushman, and Bart M. Demaerschalk.Telemedicine and e-Health2018. http://doi.org/10.1089/tmj.2017.0291

Telehealth Cardinal Sins

1. Setting up a telehealth program without provider engagement & availability
2. Setting up a telehealth program without a clear path from patient to technology
3. Setting up a telehealth program without an evaluation plan
4. Setting up a telehealth program untethered from organizational strategy

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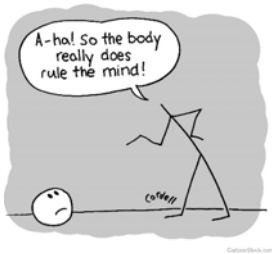
Telehealth Industry Engagement Paradox

Healthcare

Delivery | Infrastructure | Business Model

Industry

Technology | Manpower | Payment Models



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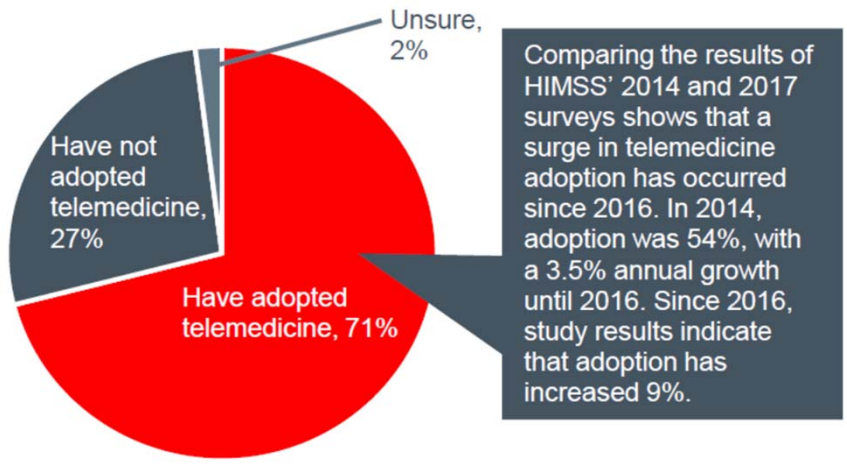
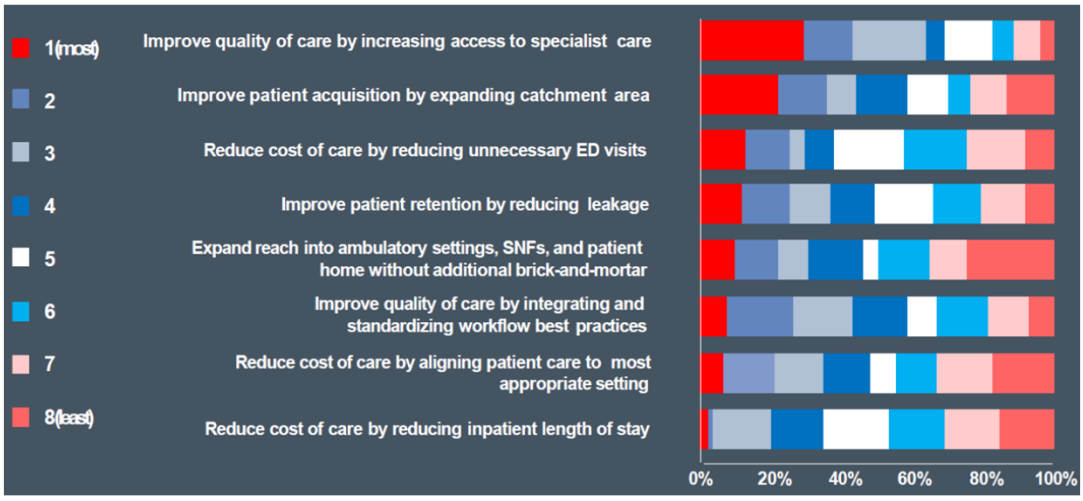
US Telehealth adoption, 2017 (n=138)



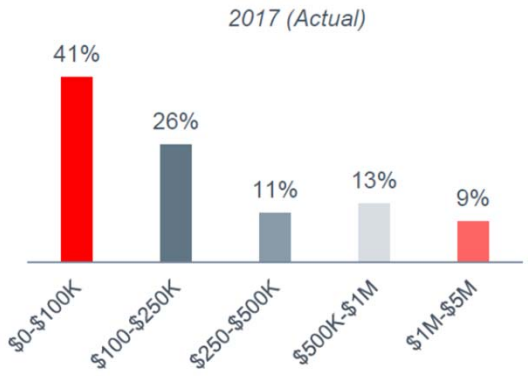
2017 Inpatient Telemedicine Study. HIMSS Analytics 2017; available at: http://www.himssanalytics.com

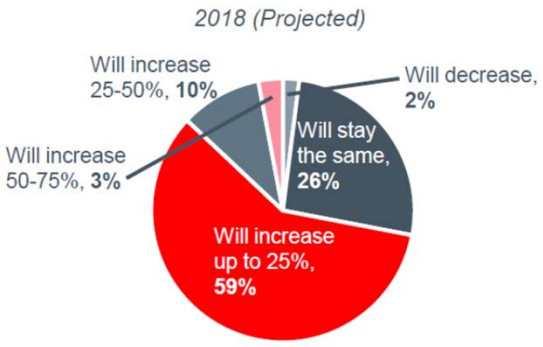
Reasons for Telehealth Adoption (n=98)



Sage Growth Partner. Defining Telemedicine's Role: the View from the C-Suite 2018; available at: http://www.sage-growth.com

Health System Telehealth Budgets (n=98)





Sage Growth Partner. Defining Telemedicine's Role: the View from the C-Suite 2018; available at: http://www.sage-growth.com

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History of MUSC Telehealth

- Physician, grass roots driven
- 2005 – maternal fetal telemedicine
- 2008 – telestroke
- 2009 – critical care
- 2010 – SE-VIEW
- 2011 – 'strategy B4'…

James B. Duke
THE DUKE ENDOWMENT

SCTR
South Carolina Clinical & Translational Research Institute

NIH National Institutes of Health

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History of MUSC Telehealth

2013 – SC Legislature takes note…

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2017 Federal Telehealth Center of Excellence Award

Health Resources & Services Administration

Criteria:

- Telehealth expertise
- Financially sustainable models
- Service to rural and underserved communities

NATIONAL TELEHEALTH CENTER of EXCELLENCE

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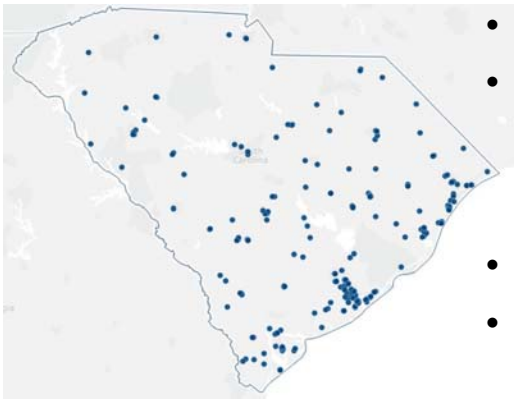
Telehealth Expertise



MUSC telehealth breadth & depth:

- 77 unique services
- 275 sites
  - 40 hospitals; 126 community clinics; 92 other sites including 80 schools
- 40 SC counties
- >90% are non-MUSC sites

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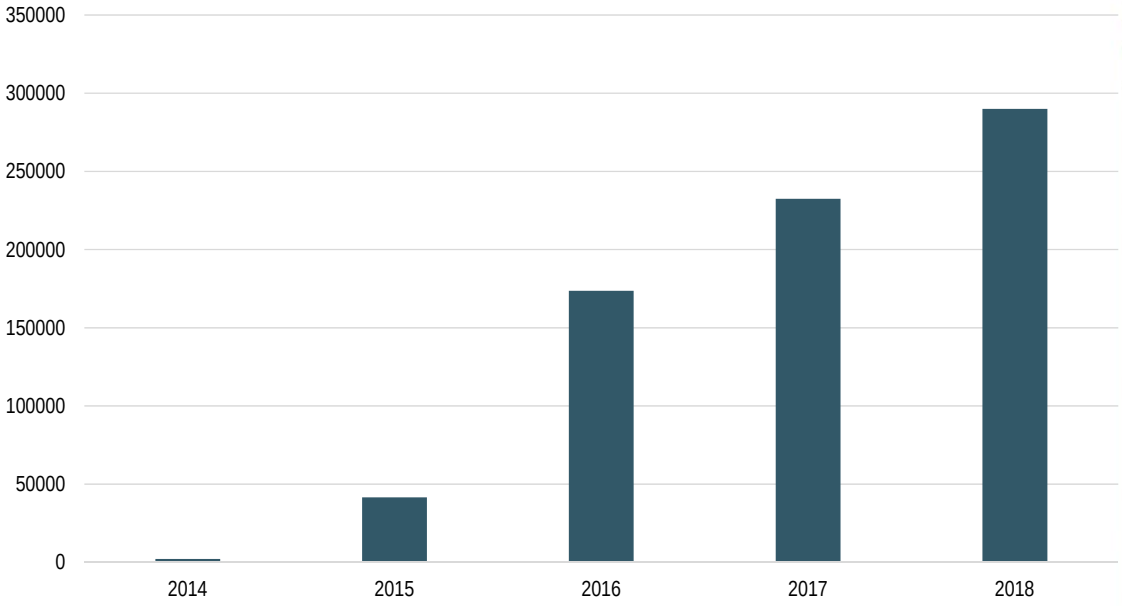
Volume of MUSC Telehealth Interactions



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Financial Sustainability

- SC ‘non-parity’ state
- Current financial models:
  - Direct negotiation with payers
  - Supply-demand model with participation fee
  - Sustainability through scale and volume
  - Corporate partnerships

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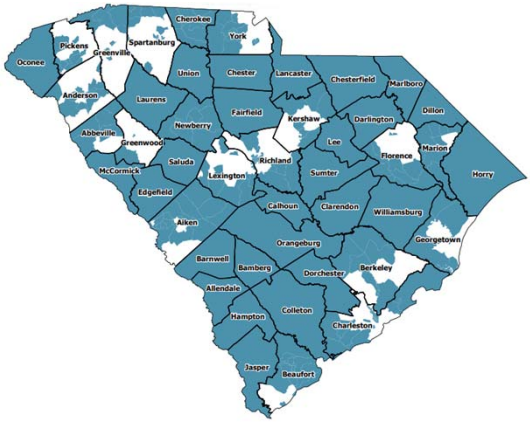
Service to Underserved Areas

- Blue = fully or partially medically underserved

78% of services in completely or partially medically underserved regions



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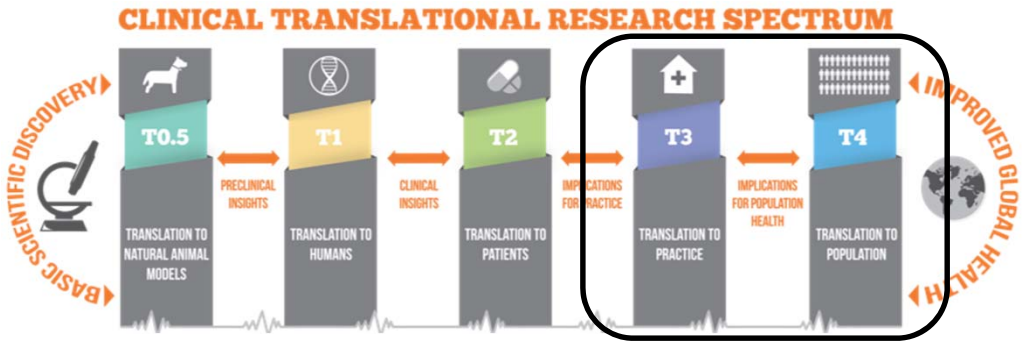
MUSC Telehealth COE Objectives

- Apply rigorous, team science to characterize telehealth best practices
- Develop materials and programs to facilitate 'next level' telehealth



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Research Strategies for Telehealth

Rapid Literature Review
- Include grey lit
- Focus key & recent info
- Nomination

Environmental Scan of Practice
- Lessons learned
- Snowball networking

Evaluability Assessment
- Cost
- Context
- Technology

Small rapid studies
- A-B
- N of 1
- Fractional factorial
- Program changes
- Version X1, X2

Application Test Diverse Settings
- Stepped wedge
- Pragmatic
- CER
- RCT's

Dissemination
- Ongoing monitoring
- Communities of practice
- Alerts
- CQI

Russell E. Glasgow, Siobhan M. Phillips, Michael A. Sanchez. International Journal of Medical Informatics 2014; (83): e1-e11.

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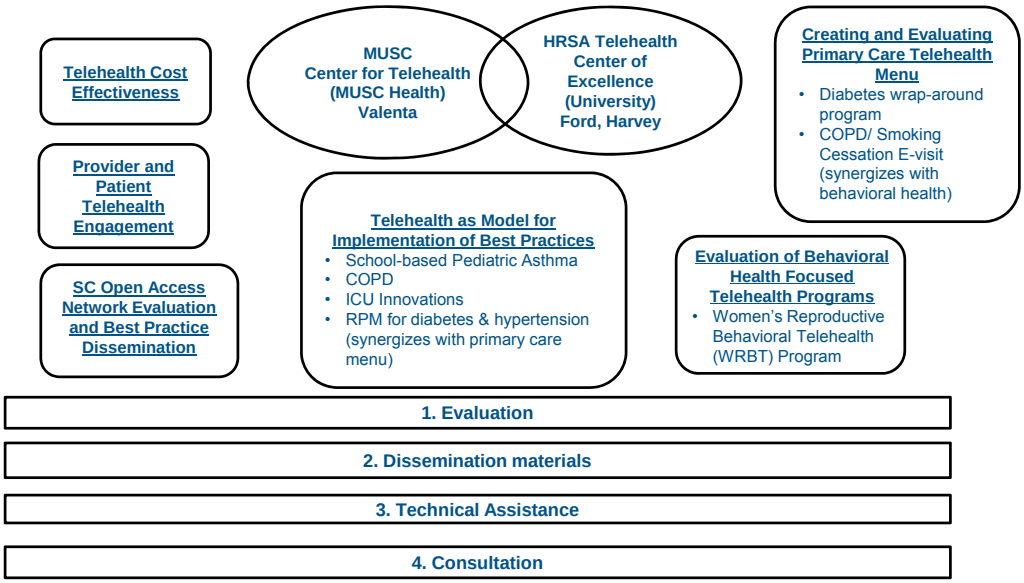
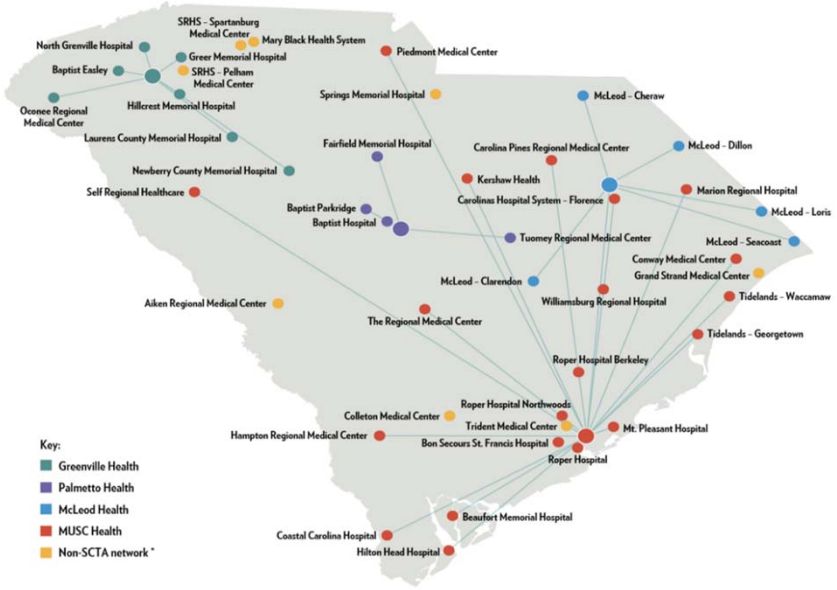
MUSC Telehealth COE Project Profiles



Criteria for Cost-Effectiveness Evaluation

1. Mature telehealth program with identifiable cohort
2. Data available in 12 month windows
3. Data sufficiently robust to measure cost and benefit differences
4. Little "leakage" of care
5. Utilization at scale to power cost effectiveness analysis

Case Study 1: Telestroke



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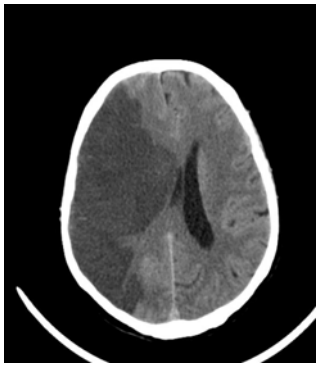
Telestroke History

- Telestroke 2008
  - 5 partners
  - 87 consults
  - 0 Primary Stroke Centers
- Telestroke 2018
  - 28 partners
  - 4,818 consults
  - 15 Primary Stroke Centers



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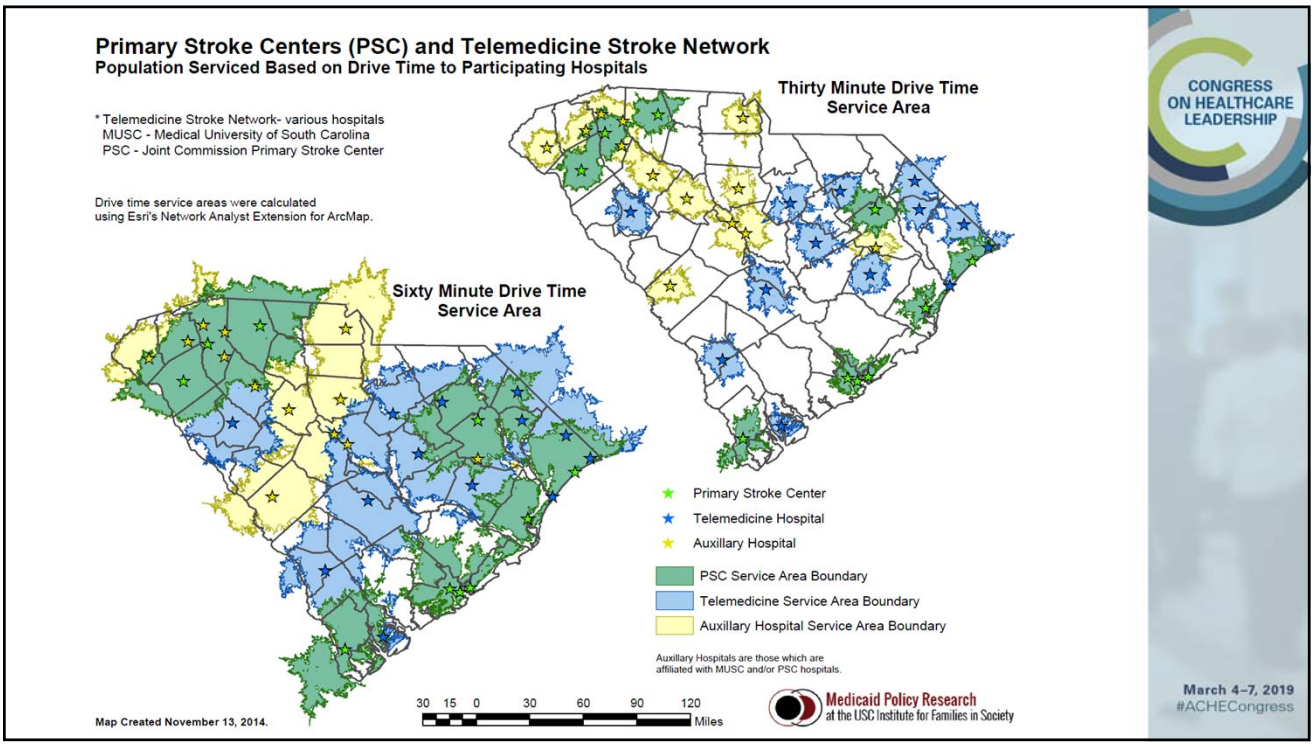
Primary Stroke Centers (PSC) and Telemedicine Stroke Network
Population Serviced Based on Drive Time to Participating Hospitals
* Telemedicine Stroke Network- various hospitals
MUSC - Medical University of South Carolina
PSC - Joint Commission Primary Stroke Center
Drive time service areas were calculated using Esri's Network Analyst Extension for ArcMap.
Thirty Minute Drive Time Service Area
Sixty Minute Drive Time Service Area
Primary Stroke Center
Telemedicine Hospital
Auxillary Hospital
PSC Service Area Boundary
Telemedicine Service Area Boundary
Auxillary Hospital Service Area Boundary
Auxillary Hospitals are those which are affiliated with MUSC and/or PSC hospitals.
30 15 0 30 60 90 120
Miles
Map Created November 13, 2014.
Medicaid Policy Research
at the USC Institute for Families in Society
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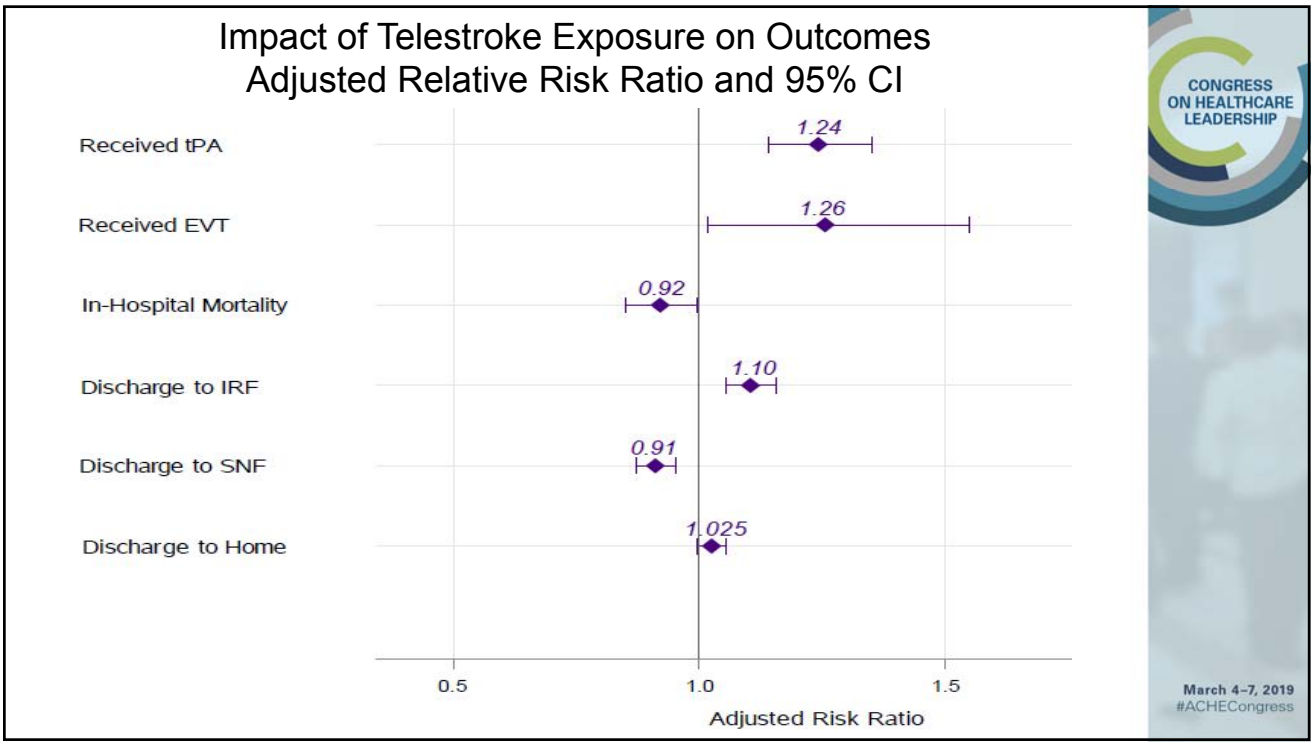
Impact of Telestroke Exposure on Outcomes
Adjusted Relative Risk Ratio and 95% CI
Received tPA
Received EVT
In-Hospital Mortality
Discharge to IRF
Discharge to SNF
Discharge to Home
1.24
1.26
0.92
1.10
0.91
1.025
0.5
1.0
1.5
Adjusted Risk Ratio
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Case Study 2: School Telehealth

- 2015
  - Precision public health: target counties with ↑ asthma
  - 7 SC counties with school telehealth
  - Williamsburg County: only county with 100% penetration (11 schools)
- Program structure
  - School nurses access MUSC pediatricians & NP's via tele
  - Focus on acute and chronic disease management

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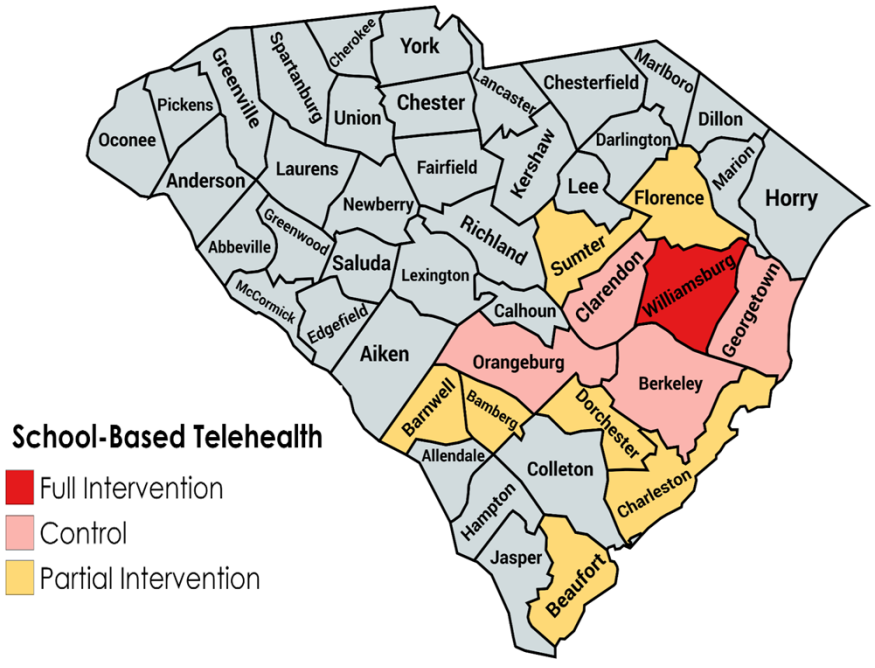

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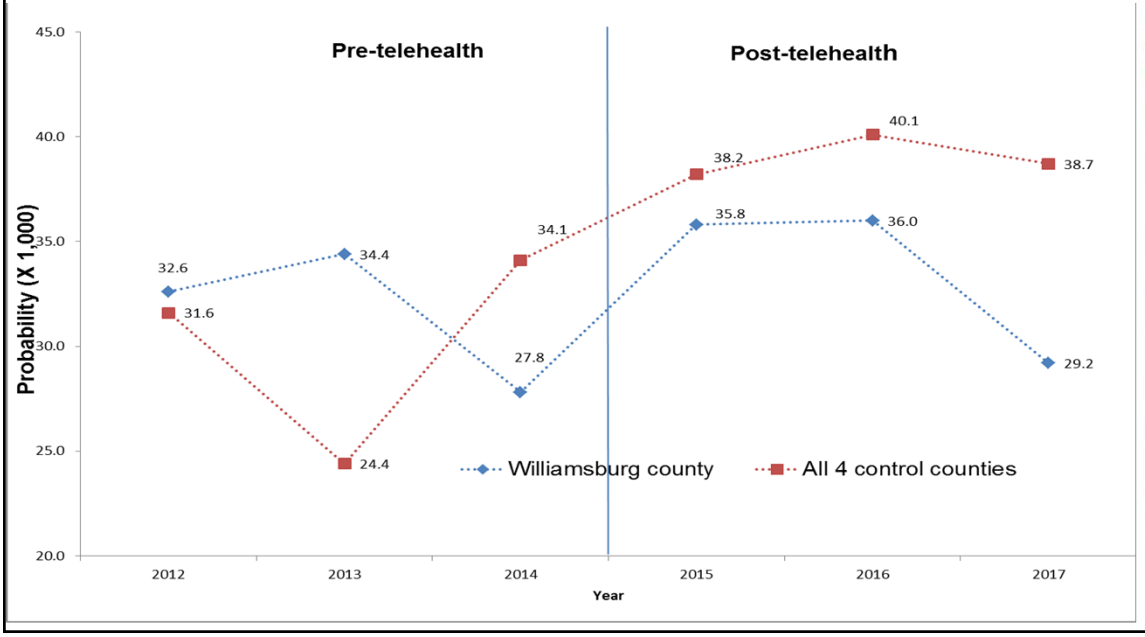
Epidemiologic Approach

- 2012-2017 SC Medicaid data age 3-17

- Key information
  - Enrollment status
  - Demographics (age, gender, race/ethnicity)
  - Primary/secondary dx

Average Probability of ED visit, 2012-2017



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Estimates from Linear Probability Models, County and Time Fixed Effects

	Model 1				Model 2			
Sample size	258752							
	Estimate	*95% CI*		*P-value*	*Estimate*	*95% CI*		*P-Value*
Overall effect of the telehealth	-6.89	-11.84	-1.94	0.0064				
Varying effects of the telehealth								
Year 2015					-4.16	-11.21	2.90	0.2482
Year 2016					-6.01	-13.46	1.44	0.1138
Year 2017					-11.07	-18.12	-4.02	0.0021
Age								
Age 3-7 (ref)								
Age 8-12	-6.28	-7.86	-4.70	<.0001	-6.27	-7.85	-4.70	<.0001
Age 13-17	0.12	-1.75	2.00	0.8968	0.13	-1.75	2.00	0.8944
Male	1.03	-0.39	2.45	0.1565	1.03	-0.39	2.45	0.1543
Race/ethnicity								
Black (ref)								
White	-6.19	-7.85	-4.53	<.0001	-6.18	-7.84	-4.52	<.0001
Others	1.52	-0.74	3.77	0.1878	1.52	-0.74	3.78	0.1873

Note: Standard errors adjusted for heteroscedasticity.

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Initial MUSC Telehealth Goal

"Everything we do within our walls, we should do outside our walls"

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Case Study 3: Inpatient Pediatric GI

- Single provider
- 'Customized' workflow
  - Not consistent across comparable services
  - Not mapped out
  - Confusion re: roles/responsibilities
- Poor communication with partner sites
- Inadequate training at partner sites
- No formalized evaluation plan

Low utilization
Low satisfaction

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Case Study 4: Outpatient Transplant Nephrology

- Lack of provider champion engagement
- Workflow
  - Everything to everybody = multiple changes to workflow
  - Not formally mapped out
  - Confusion re: roles/responsibilities
- Service goal a moving target = delay and frustration
- No formalized governance
  - Response to partner site & internal providers = multiple tech change
- High provider/staff turnover
- No pro forma & unrealistic volume expectations

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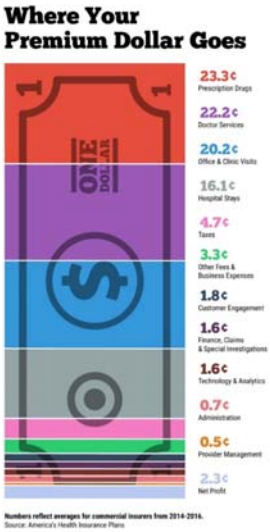
Not another dollar in the system…



MUSC Mission: Telehealth for efficient, effective care…

$$V\ (\text{VALUE}) = \frac{Q\ (\text{QUALITY}) + S\ (\text{SERVICE})}{\$\ (\text{COST})}$$

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MUSC Telehealth Value Strategy

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	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	Vision	Strategy Champion	Strategy Value Equation Template	Service	Service Champion	Service Value Equation	Primary Utilization Outcome	Primary Effectiveness Outcome	Primary Cost Outcome	Calculated Value	Q1 Goals	Q2 Goals	Q3 Goals	Q4 Goals
2	Within the next 5 years, the hospital contract services value strategy will be comprised of acute care hospital networks participating in the included programs. Network success will be measured through a combination of improved access to the specific programs' specialty services, quality of care measures, and positive financial margins for both MUSC and participating SC hospitals.	Dee Ford	Hospital outcome/cost to hospital	Tele ICU	Ford/ Nandita Nadig	lives saved for all hospitals/total cost to hospitals	*annual admissions (9680)*	*lives saved per year (600)*	*cost for all hospitals ($768*9680 admissions = $7,434,240)*	Every $12k invested saves a life	see KPI reporting	see KPI reporting	see KPI reporting	see KPI reporting
3				Stroke	C. Holmsteadt	consults/cost to hospital	Total number of consults for program annuall	quality metric per patient per 5000 ED visits	Total cost of program paid by hospitals annually	$570 per consult	see KPI reporting	see KPI reporting	see KPI reporting	see KPI reporting
4				Neurology	C. Holmsteadt	consults/cost to hospital	Total number of consults for program annuall	quality metric per patient per 5000 ED visits	Total cost of program paid by hospitals annually		see KPI reporting	see KPI reporting	see KPI reporting	see KPI reporting
5				EEG	Jon Edwards	consults/cost to hospital	Total number of consults for program annuall	quality metric per patient per 5000 ED visits	Total cost of program paid by hospitals annually		see KPI reporting	see KPI reporting	see KPI reporting	see KPI reporting
6				Inpatient Psychiatry	Jeff Cluver	consults/cost to hospital	Total number of consults for program annuall	quality metric per patient per 5000 ED visits	Total cost of program paid by hospitals annually		see KPI reporting	see KPI reporting	see KPI reporting	see KPI reporting
7				ID	Amanda Parks	consults/cost to hospital	Total number of consults for program annuall	quality metric per patient per 5000 ED visits	Total cost of program paid by hospitals annually	TBD	TBD	TBD	TBD	TBD
8				Telepathology	David Lewin	TBD/averaage cost to hospital	Average consults per hospital	quality metric per patient per hospital	average cost to hospital	TBD	TBD	TBD	TBD	TBD

Evolution of MUSC's Telehealth Services

- Created a lot of pieces to service development (e.g. checklists)
- Experienced many growing pains
- "Concentration risk"

2005
Maternal Fetal Telemedicine

2008
Telestroke

2009
ICU Telepsych

2013
State telehealth funding infused by SC Legislature

2014-Present
MUSC Center for Telehealth charged with accelerated growth of telehealth services

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Processes to be Navigated in Telehealth Service Development

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Discovered ITIL
(Information Technology Infrastructure Library)

- Created by UK in 1980's
- Detailed practices for IT service management
- Aligns services with business needs
- Used worldwide:
  - US Governments (States, Navy, Army)
  - Industry (Disney, Honda, Visa)

ITIL image retrieved from https://consultantsfactory.com

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Created Telehealth Service Implementation Model: T-SIM™

"Telehealth is a clinical service delivered over an IT service"

- Provided terminology and a standard framework
- Highlighted strengths & weaknesses

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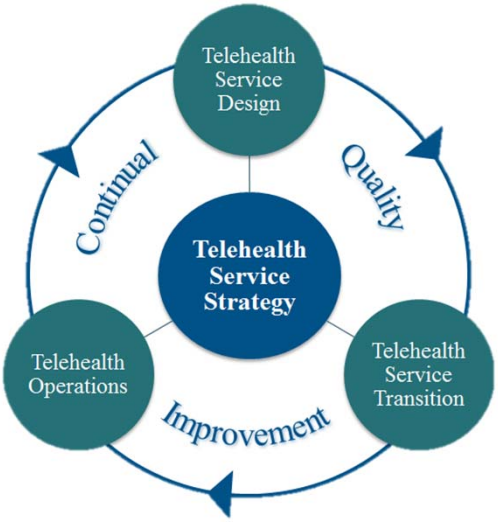
Telehealth Service Implementation Model: T-SIM™



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Telehealth Service Strategy

- Defines scope of the service
  - Condition(s)
  - Location of patients
  - Type of providers
  - **What problem is being solved?**

Key Processes:
- Strategy Management
- Demand Management
- Portfolio Management
- Financial Services Management
- Business Relationship Management (BRM)

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Slide 52

JKO1 I would suggest changing the diagram to enlarge or highlight the section you are discussing beyond the red circle, which doesn't stand out well
Jan Oldenburg, 1/2/2019

JKO2 Also, I changed your line spacing to be .8 so you didn't smush them so much
Jan Oldenburg, 1/2/2019

Thinking beyond "replicating care over distance"

MUSC Mission statement: "**Telehealth for efficient, effective care"**

Assess the impact on stakeholders:

1) Patients
2) Referring providers
3) Consulting providers
4) Payers
5) Health system (as a whole)

Prioritize services that:

- Add efficiency to care teams
- Add value to care over the continuum
- Mitigate time and distance barriers to care

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Telehealth Standardized Scoring Tool

Support of implementation

- Physician champion
- Provider capacity
- Strategic alignment

Potential impact

- Quality
- Cost
- Access to care

Growth opportunity

- Market size
- Saturation
- Demand

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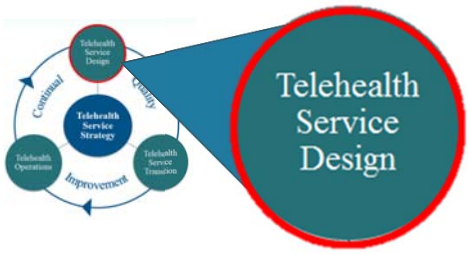
Telehealth Service Design

- Implement a **common architecture**
- Understand each "site of care" has different rules
- Draft clinical and operational protocols
- Customize test scripts
- Identify KPI's
- Navigate compliance, legal, credentialing and EHR issues and processes



Key Processes:
- Design Coordination
- Availability Management
- Capacity Management
- Information Security Management
- Training Management (internal staff, providers, sites)

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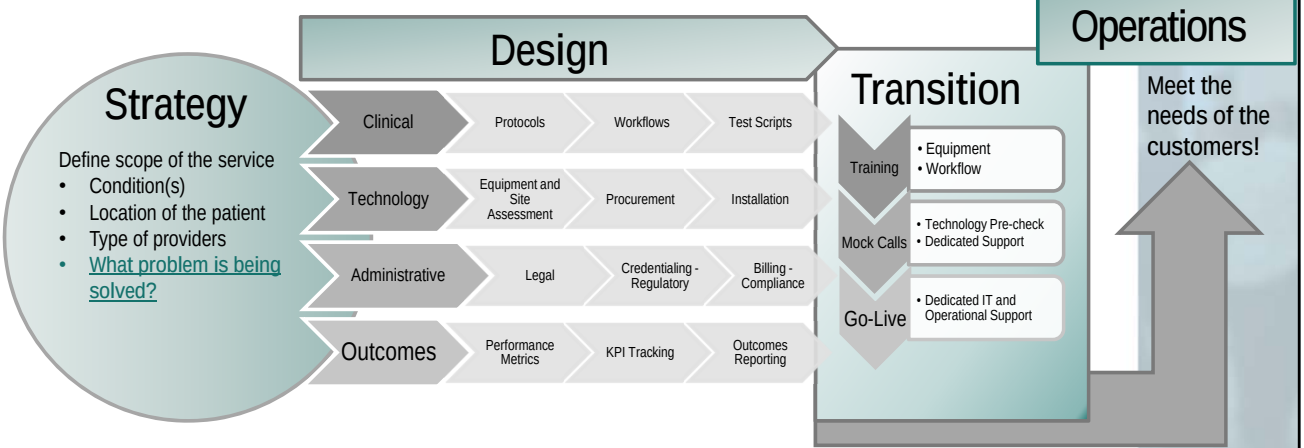
Design Coordination

- services are developed through a common architecture



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RACI matrix through the common architecture

Responsible	• The person who actually carries out the process or task assignment • Responsible to get the job done
Accountable	• The person who is ultimately accountable for process or task being completed appropriately • Responsible person(s) are accountable to this person
Consulted	• People who are not directly involved with carrying out the task, but who are consulted • May be stakeholder or subject matter expert
Informed	• Those who receive output from the process or task, or who have a need to stay informed

Telehealth Service Transition

Telehealth Service Transition

*Movement from **test to go-live***

- Training – tech and workflow
- Mock calls (alpha – internal testing, beta – partner site testing)

Key Processes:
- Transition Planning & Support
- Data & Knowledge Management
- Change Management

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Telehealth Service Operations

- High quality, reliable services
- Processes to manage **"incidents"**
  - any unplanned event that has a negative impact on normal operations

Key Processes:
- Incident Management
- Problem Management
- Access Management

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Continual Quality Improvement

- Striving for high-reliability
  - Preoccupation with failure
  - Reluctance to simplify interpretations
  - Sensitivity to operations
  - Commitment to resilience
  - Deference to expertise

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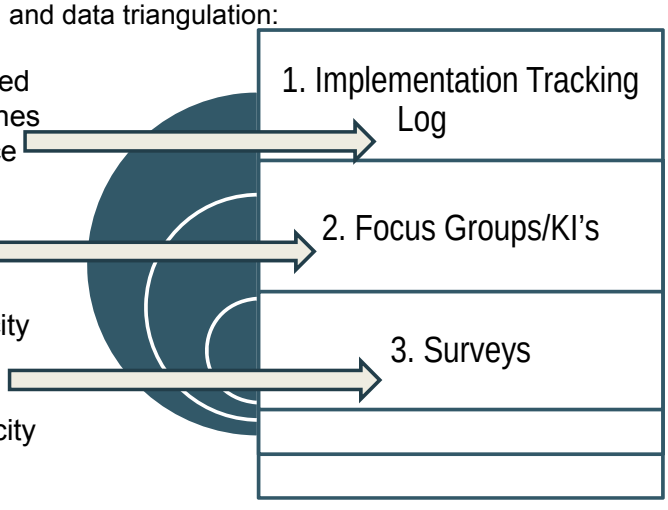
Evaluating the T-SIM™ Framework

Mixed methods approach and data triangulation:

- Services implemented
- Time to key milestones
- Fidelity to the service
- Telehealth uptake

- Program fidelity
- Uptake process
- Sustainability capacity

- Team engagement
- Sustainability Capacity



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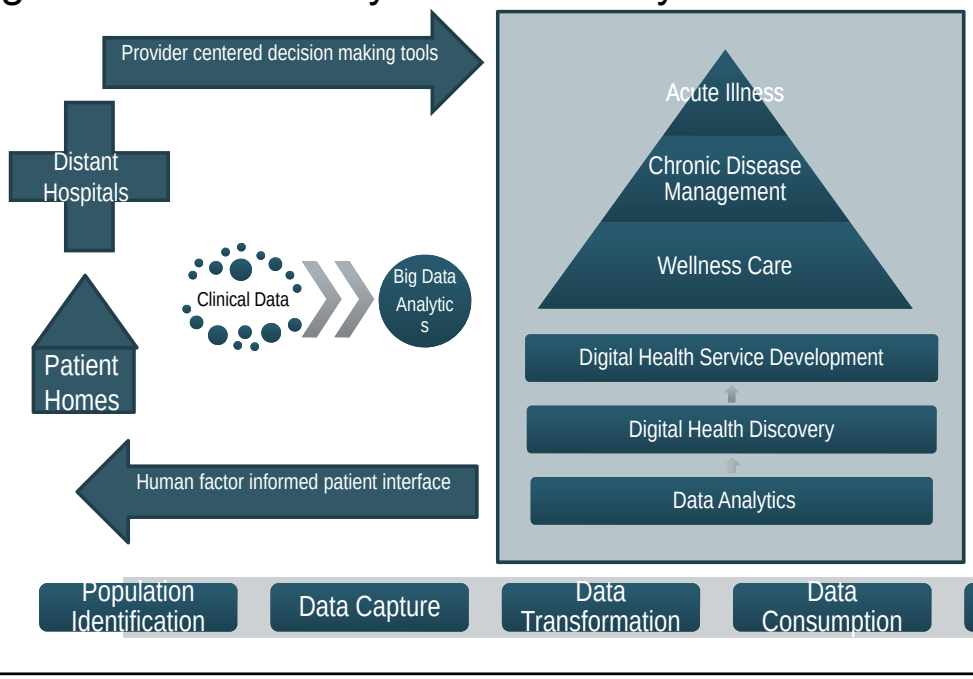
Digital Health Delivery and Discovery Institute



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Summation

- Telehealth journey is complex
- Success is achievable
- Structured implementation framework is major catalyst

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Questions?

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Jillian Harvey, MPH, PhD

Jillian Harvey is an Associate Professor in Healthcare Leadership and Management at the Medical University of South Carolina (MUSC) and the Director for the Doctor of Health Administration Division. She received a Master of Public Health from Oregon State University and a PhD in Health Policy and Administration from the Pennsylvania State University. Her research experience includes program evaluation, healthcare quality improvement, and mixed methods research approaches. Dr. Harvey is a Co-Investigator for the MUSC HRSA's funded Telehealth Center of excellence and the Evaluation Director for MUSC's NIH funded Clinical and Translational Science Award (CTSA). Her current research focuses on evaluating the development and implementation of telehealth programs and the impact on healthcare outcomes.

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Dee Ford, MD, MSCR

Dee W. Ford, MD, MSCR, is a tenured Professor of Medicine in the Medical University of South Carolina's (MUSC) Division of Pulmonary and Critical Care. She is a physician scientist and physician leader with expertise in health services research, health professional education, and quality improvement. She received her BS in biology from the University of South Carolina where she was inducted into Phi Beta Kappa. She received her MD from Johns Hopkins and was inducted into the Alpha Omega Alpha honor society. Dr. Ford completed her internal medicine residency training at the Johns Hopkins Hospital and her pulmonary/critical care fellowship training MUSC. She is known for initiating, leading, and evaluating novel programs in the context of highly effective multidisciplinary teams. She serves as Medical Director for MUSC's Tele-ICU and ICU Innovations Outreach Programs and is the Program Director for MUSC's Federal Telehealth Center of Excellence.

MUSC

Shawn Valenta, RRT, MHA

Shawn Valenta is the Administrator of Telehealth at the Medical University of South Carolina (MUSC Health) in Charleston, South Carolina. With over 17 years of clinical and health care leadership experience, Shawn has a demonstrated record in successfully achieving results with a focus on quality improvement and cost-efficiency.

Shawn oversees the strategic initiatives and operations of the MUSC Center for Telehealth, a HRSA-designated National Telehealth Center of Excellence. He is the administrative leader for the operations of telehealth services that range from the ICU to the home, including a 28-hospital telestroke network and one of the fastest growing school-based telehealth networks in the country. Shawn has developed and managed the budget for over $100 million of state-invested telehealth funds for South Carolina and has successfully executed contracts for over 200 South Carolina telehealth sites. Shawn works collaboratively in statewide strategic planning and furthering the health of South Carolinians with telehealth technology through the South Carolina Telehealth Alliance.

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