2.c.ii Expand Usage of Telemedicine in Underserved Areas to Provide Access to Otherwise Scarce Services

Project Objective: This project will use telecommunication to create access to services otherwise not accessible due to patient characteristics, travel distance or specialty scarcity.

Project Description: Patients may not have access to needed healthcare services due to patient characteristics, travel distance, and/or specialty scarcity. With the emphasis that NYS has placed on EHR and HIE connectivity, as well as other advances in telehealth, these needed services can now be made available to more patients. Telemedicine is using interactive telecommunications equipment to support direct, active communication between providers and patients. This telemedicine project is meant to address home-based telemedicine for chronic disease management and/or specialty scarcity, such as services for AIDS/HIV, adult psychiatry. Implementation will is intended to meet an unmet service need; this project is not intended to be a convenience service for the member or provider where access is otherwise available.

Telemedicine capabilities have been used to increase primary care provider and other medical personnel's expertise through programs such as Project Echo (echo.unm.edu). Modeling of Project Echo, where appropriate, is encouraged.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Implement telemedicine services, aimed at reducing avoidable hospital use by increasing patient access to services not otherwise available and/or increasing specialty expertise of primary care providers and their staff in order to increase availability of scarce specialty services.
2. Provide equipment specifications and rationale for equipment choice (including cost of acquisition, maintenance and sustainability of service).
3. Define service area and participating providers, with clear delineation between telemedicine hub sites versus spoke sites.
4. Procure service agreements for provision of telemedicine services such as specialty services, participating primary care and nurse triage monitoring.
5. Develop standard service protocols, as well as consent and confidentiality standards meeting all federal and state requirements.
6. Coordinate with Medicaid Managed Care Organizations to develop and ensure service authorization and payment strategies are in place to support sustainability of patient care uses.
7. Use EHRs and other technical platforms to track all patients engaged in the project.

Project Response & Evaluation (Total Possible Points – 100):

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

Access to care was the answer 30% of the time to the CNA patient survey question "what do you believe is the most critical need for health care service in your community." Telemedicine will be employed to address two manifestations of this gap reported in the CNA. The first is shortages of specialty care physicians and the second is access to care exacerbated by transportation issues. The CNA reports "capacity is a key issue across primary care, specialist care, and mental and behavioral health care" and shortages of specialty care physicians in Western New York (WNY) are a significant barrier to access in both urban and rural areas. The CNA concludes that telemedicine "was noted in rural focus groups as an opportunity to expand access to a limited rural provider network." The CNA says, "areas with the most severely low proximities to specialty care providers lie within rural counties." According to the CNA, four acute care facilities outside the Buffalo metropolitan area agree that if shortages in certain specialties could be met remotely using telehealth, care delays will be reduced and local coordination of care will improve. This will reduce total costs and readmission rates. The specialty fields most often cited in the CNA with shortages are Intensivists, Behavioral Health, Neurology and Infectious Disease; others include vascular, cardiology, endocrinology, and maternal fetal medicine. To address this gap the telemedicine project will provide remote consults with specialty physicians initially focused on the ICUs of rural acute care facilities, as well as, emergent behavioral health for participating acute care facilities. The CNA says inadequate transportation has a negative impact on access to care and is "a pervasive issue for people seeking health care" that results in patients often not getting the primary care and follow-up care they need. Further, the CNA reports, by comparison to other areas of the state, outside of NYC, WNY has a greater percentage of households without a vehicle and that concentrations of poverty and patients who lack access to transportation are in both urban and rural areas. To mitigate this gap, telemedicine technologies will "co-locate" specialty care with primary care reducing the need for multiple appointments. The project will also employ telemonitoring and mobile health tools to monitor targeted patients in their homes, rapidly identifying sudden changes in health and reminding them of appointments or treatment plan components, including medication regimens. The acute care component will benefit 720 attributed beneficiaries with 828 teleconsults, plus additional patients not attributed to the PPS and other non-Medicaid patients in year one. The non-acute setting component of the project will become operational in year two and is expected to benefit 6,000 beneficiaries by year five.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease

type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

In acute care environments, this project will benefit patients: ● admitted to the ICU of each of the five PPS partner hospitals in Cattaraugus, Chautauqua, Niagara, and Orleans counties; ● Medicaid patients who present at any of 11 PPS partner emergency rooms in need of behavioral health services; ● Medicaid inpatients at a PPS partner facility in need of behavioral health services, including patients for whom behavioral health is a primary diagnosis and those with comorbid conditions. It will include patients currently attributed to this PPS and the community in general. The primary care and remote monitoring component of the project will focus on patients with conditions representing the highest rates of preventable hospitalizations and the highest number of ER visits among the Medicaid population for the PPS acute care providers in 2013, as reported in the CNA, including diabetes, COPD, asthma, congestive heart failure, and/or behavioral health needs. Focus on these chronic illnesses is informed by the Salient NYS Medicaid System data regarding Medicaid chronic conditions which shows disproportionate representation among beneficiaries attributed to the PPS compared to the general Medicaid population. The focus will be directed to beneficiaries receiving services at one of six large primary care facilities in the PPS including 9th Street Clinic in Niagara Falls, St. Vincent Health Center and Mercy Comprehensive Care Center in Buffalo, Orleans Community Health Primary Care in Albion, Springville Primary Care, and WCA PCC.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

All acute care Community Partners of WNY partners have participated in an FTC grant to develop a dedicated healthcare high speed secure broadband network which will be deployed to support this project. This project will leverage established local relationships of the Community Partners of WNY partners and incorporate specialty care expertise from turnkey national vendors to meet local gaps through a collaborative and flexible “hub and spoke” model providing remote care consultations. This will include accessing needed expertise from among over 750 CMP specialty physicians. In addition, the project will leverage the already established behavioral health programs of PPS partner, WCA Hospital. The projects mobile health component will utilize existing community resources of PPS partners including developed home care programs of Catholic Health, patient transportation services of MASH and EMS organization, Rural Metro, to leverage combined clinical and logistical expertise. The mobile health program will require the acquisition of and training on telemonitoring equipment for both patients and clinicians to monitor chronically ill patients remotely from a central location and dispatch the appropriate level clinician when needs arise. This will require a team to support operations, deployment and training, as well as, field support (total of nine in the first year and 13 in year five) and Medical Triage Teams (four NPs in year one to seven in year five, 42 LPN/Paramedics in year one to 70 in year five). It is anticipated that some of these needs will be met by redistribution and retraining of currently employed personnel. Our plan to augment the call center program will require evaluation and implementation of cell phone and home computer applications that will enhance patient compliance with medication regimens, physician appointments and other recommended care. This will use the same support, deployment and training resources noted above.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

The challenge to assess technology and compatibility issues; will be mitigated, in the acute care environment, by incorporating the services of turnkey vendors, and using equipment owned & maintained by the vendors who will provide remote consultations to supplement local providers. High per consult charges for individual PPS partners is a challenge given relatively low volumes. Consult volume will be aggregated for the PPS leading to volume discounts. Provider resistance to telemedicine may be a challenge addressed by engaging them in conversations that identified telemedicine as a solution to a community need. We will develop protocols requiring utilization of available local physicians before using vendor physicians & will use a hybrid model so local physicians can choose to join vendor's panel of experts. Vendor physicians will provide consultation & care recommendations while patients will be under the care of local physicians. The challenge of physician licensure/credentialing will be addressed by choosing a vendor that handles these issues. The challenge of needing standard protocols will be met by having PPS partners approve the standard service protocols of the vendor and their consent and confidentiality standards to meet gov't requirements. The mobile health program will require a physical center, hiring/training of staff and evaluating/acquiring equipment. It will require training providers and patients. Integrating Community Paramedicine will require changes to NYS Community Paramedicine regulations. To help, PPS partners will work together to leverage our expertise: those with established home care for working with patients at home; those with displaced health professionals who could be redeployed; our EMS partner for dispatch expertise and to facilitate regulatory changes. We have addressed issues of defining participating providers & delineating hub & spoke designations with an active project team of PPS partners that continues to work together to evaluate vendor proposals and develop an implementation plan. We will leverage our relationship with local Medicaid Managed Care providers to develop sustainable strategies for authorization/payment and expect that our plan to expedite implementation through use of turnkey vendors will provide greater opportunity to evaluate efficacy and produce measureable outcomes that will justify sustainability.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

No other PPS in our service area has proposed a telemedicine project so no direct coordination for program design and delivery is required. Coordination benefitting Medicaid patients will occur because patients are targeted by health status and facility where they seek services, not by the PPS to which they are attributed. Therefore, coordination will occur for reporting and funding of services provided to patients not attributed to our PPS.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the

application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

3. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

4. <u>Project Resource Needs and Other Initiatives</u> (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

The capital funding required to build and support the telemedicine program is directly linked to: (a) supporting the workforce outlined in this application, and (b) building the information technology architecture enabling the effective use of telemedicine technologies featured in this program. Workforce Office Infrastructure: The Medical Triage Team program requires a centralized call center supported by software similar to EMS dispatch capabilities. The capital required to construct the physical space accommodating between 20 to 30 personnel is estimated at $200,000 including workstations, telephones, headsets, computers, cabling, etc. The operating budget for leased office space of approximately 4,500 square feet is estimated at $136,000 per year including CAM, janitorial, and utilities. The cost of the medical triage call center system is estimated at $100,000 and is based on a typical Medtronic EMS dispatch system that would be customized for our purposes. Enabling IT Architecture – To be developed in conjunction with PPS and vendor partners.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☐	☒

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

5. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards <u>scale of project implementation,</u> <u>completion of project requirements</u> and <u>patient engagement progress</u> in the project.

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed

and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.