ACO’s, Care Collaboration, Patient Centered Care and Collaborative Video Solutions

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## History: Collaborative Video for Healthcare

- **Multi Million dollar PACS**
- **Early Telemed Adopters**
- **T1 lines**
- **Expensive Equipment**
- **Spotty coverage**
- **Quality sketchy**
- **License & Reimbursement issues**

- **Move to IP and WEB based**
- **Browser based PACS 500K**
- **Expansion of grant based telemedicine**
- **Chronic DZ monitoring pilots**

- **Economy tanks**
- **Baby Boomer Age**
- **Doc shortage**
- **Stimulus PKG**
- **Affordable Care Act**
- **2 Billion to CHC**
- **Billions from ONC**
- **7.2 Billion for Broadband**
- **EHR**

- **PCMH**
- **CMS Telemedicine Codes Expanded**
- **Grant funding for collaboration**
- **11.5 Billion CHC**
- **Accountable Care**

- **Peer to Peer**
- **Mobility**
- **Cloud**
- **2-10 billion Innovation**
- **Prevention Wellness**
- **ACO**
- **RE-Admits**
- **Care Coordination**
- **Payer/Provider**

### Milestone

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
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<tbody>
<tr>
<td>1990s</td>
<td>Large Room Based Sys</td>
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<tr>
<td>2000s</td>
<td>HD, RMX, DMA</td>
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<tr>
<td>2010-2012</td>
<td>CMA 100k licenses 1st month</td>
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<tr>
<td>2011-2013</td>
<td>Video where and when you need it, desk, room, home, on the go</td>
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**Polycom Tablet, CloudAxis**

- **Polycom Open, Standards Based, Scalable, Most Cost Effective, Customer focused**

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HC Reform

- ACO’s (Accountable Care Organization’s)
  - Medicare Model, Private Model, New Payment Models
- Care Coordination
  - Prevention and Wellness, Population management, Decreasing Readmits
- Patient Centered Care
- All Require Collaboration/Coordination
ACO’s (Accountable Care Organizations)

• Newly formed collaborative business model that focuses on population management, and new payment models

• Comprised of Providers, Payers, Public Health, Health systems, Community members, Long Term Care, Patients, and families

• Goal is to keep patients healthy and to reduce cost of care and reward practitioners for best practices and patient outcomes

• Challenge is to collaborate across businesses, and geographic locations to optimize resources, including knowledge, expertise, and the power of peer to peer, face to face influence.
ACO’s (Accountable Care Organizations)

- Payment Models

- Recent Health Innovation Grants:
  - 2012 Billion dollars for innovation: focused on inpatient, and heavy focus on reducing emergency room visits, and enabling models similar to Coaching model
  - 2013 Billion dollar innovation grant: focused on outpatient, new payment models, and prevention and wellness
  - Future 8 billion more? Are you ready? Reach out now, line up your relationships now

- Some thoughts:
  - Payers and providers partnering: predictive analytics and population management, outreach, transitions of care, care coordination, telehealth
  - Payers offering bonuses for better patient health, and outcomes
  - Payers and providers partnering for population management
Care Coordination

- Coordination/collaboration across
  - Specialists
    - Tumor Boards, Multi-disciplinary teams
  - Organizations
    - Hospitals, Primary Care Groups, Specialists Groups, Payers, Labs, Community Centers, Long Term Care, Public Health, Centers of Excellence
  - Communities
    - Schools, Community Centers, Churches,
  - Populations
    - Chronic disease, aging in place
  - Care Teams
    - Home care, Case Management, Discharge Planning, Hospice

• Benefit: better outcomes, more cost effective utilization of resources, decreased unnecessary readmits
Care Coordination Goals

• Prevention and Wellness
  – Target chronic disease
  – Patient enablement
  – Population management and outreach
  – Avoid unnecessary costs

• Decreasing Readmits
  – Regionalization of resources
    – Case managers
  – Education and safety programs
  – Transitional care

• Better resource utilization
  – Practitioners, Case Managers +
Prevention and Wellness: Community/Patient Education

Populations Management
- Disease Management
  - Diabetes
  - CHF
  - COPD
  - Mental Health
- Nutritional Education
  - Childhood Obesity
  - BP, HTN
- Public Service Updates
  - Cardiac and Pulmonary Education
  - Smoking Cessation
Decreasing Readmissions

- Law went into effect Oct 1, 2012
- “About two-thirds of the hospitals serving Medicare patients, or some 2,200 facilities, will be hit with penalties averaging around $125,000 per facility this coming year, according to government estimates” (1).
- Year 2 2%, Year 3 3%
- Hearing that more conditions will be introduced, stroke?

(1) RICARDO ALONSO-ZALDIVAR | October 1, 2012 04:27 AM EST | Associated Press
Re-Admits, Why are they high?

• An avoidable re-admit could have been prevented by:
  – (1) the provision of quality care in the initial hospitalization
  – (2) adequate discharge planning
  – (3) adequate post-discharge follow up
  – (4) improved coordination between inpatient and outpatient health care teams. (1)

Re-Admits, Why are they high?

- Medicare Hospital Readmissions: Issues, Policy Options and PPACA (1) lists:
  - An inadequate relay of information by hospital discharge planners to patients, caregivers, and post-acute care providers
  - Poor patient compliance with care instructions
  - Inadequate follow-up care from post-acute and long-term care providers
  - Insufficient reliance on family caregivers
  - The deterioration of a patient’s clinical condition
  - Medical errors

(1) Medicare Hospital Readmissions: Issues, Policy Options and PPACA Julie Stone, Specialist in Health Care Financing Geoffrey J. Hoffman, Analyst in Health Care Financing September 21, 2010
Collaboration is Key, B-to-B, B-to-C

- **Case Management**
  - Bring everyone to the table
- **Discharge Planning**
  - Live video discussion, written plan + video tips, video recorded supportive education
- **Post Acute Care**
  - Live video to Case Manager or coach once home
  - Follow up with Primary Care over live video
  - Tablet accessible educational material on web portal
- **Prevention and Wellness Programs**
  - Live multipoint, interactive peer to peer educational sessions
  - Stored version available
  - Support patient wellness programs
Healthcare Collaboration

**ONE-TO-ONE**
- Case Mgr to Patient
- Peer to peer
- Patient to family member
- IT to End User

**ONE-TO-MANY**
- Community health education
- Specialist to many patients

**MANY-TO-MANY**
- ACO meetings
- Community center to community center
- Hospital to hospital group meetings

**AD-HOC**
- Virtual HC teams
- Discharge Planning
- Follow up calls
- Transition support
- IT to End User
Making Collaboration Available to Everyone

All have a secure high quality experience

Diabetes Exercise
Solution: Collaborative Video for Healthcare
Collaborative Video for Healthcare

RealPresence CloudAXIS

IT

PACS

Remote Medical Specialists

Mobile

Telepresence

Physicians Office

Desktop

Community Health Center

Practitioner Cart

Rural Treatment Center

Room based
Summary:

• ACO Operation and prevention and wellness programs can be enabled with collaborative video.

• Collaborative ubiquitous video can support continuum of care, case management, and discharge planning to extend care to the patient as they transition back to long term care or home and reduce Re-admits

• Collaborative video solutions enable continuous patient centered care, and assist in reducing the cost of healthcare
Thank You

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