https://doi.org/10.30953/tmt.v2.31

TMT Interview: Robert Abel, MaineHealth Care at Home

Editor's note: On March 16th and 17th, 2017, Telehealth and Medicine Today *convened a national conference of opinion leaders to discuss and debate "Technologies and Tactics Transforming Long-term Care." What follows is an interview with Robert Abel, who is the Chief Nursing Officer and Director of Palliative Care for MaineHealth Care at Home, a member of the MaineHealth system.*

TMT: Fill us in on the background of MaineHealth. *[00:00]*

Mr. Abel: We are a fairly large hospital system; 12 hospitals. Three rehab hospitals are affiliated, as well as some nursing homes. Our own health agency has an average daily census of about 1500 patients. It's a pretty large home health agency—one of the largest in New England.

TMT: At MaineHealth what does sustainability mean? [00:21]

Mr. Abel: Sustainability, I call a trigger word. It's so popular that people have all sorts of definitions for it. I'm more inclined to use words like outcomes, and can we have sustained outcomes over time; and I think that happens because you give great care. And technology is one of the tools that you use to give great care.

TMT: What are the components of the sustainable program that result in great care? [00:45]

Mr. Abel: Sustainability from my perspective has two pieces to it: that is, good health care and that we can show some outcomes. And the second piece is that we have technology that we're using that has some future to it. I think one of the mistakes, at least that health agencies and community based agencies make, is using technology that quickly becomes outdated.

TMT: How do you make the decision that a technology will be sustainable? [01:16]

Mr. Abel: What we looked at is, “What are we going to use the technology for?” There's many many products in our particular case.

Some things that urban home health agencies may not think about. One of those things was can we provide virtual care; and if we can, how are we going to do that? We needed to have some sort of technology that we could provide virtual care. So, we ended up with tablets that have cameras, and screens, and educational materials, and actual delivery of the information. Will technology be adaptable as we change programs?

TMT: How do education and training fit into the sustainability of the program? [01:58]

Mr. Abel: The technology isn't going to solve anything. It's how you train people to use that technology as an additional tool; and it needs to be evidence-based care that's enhanced by the technology that we're using.

TMT: What did you at MaineHealth do to gain buy-in from healthcare professionals? [02:18]

Mr. Abel: I think there's two groups of people: groups of people delivering the care and the groups of people who are ordering or requesting the care. I’m kind of taking the patients out of the mix for the moment.

The first piece was how do we teach, train, educate, engage staff to understand that this is a new tool. That's largely nursing staff, although there is some therapy involved. And the second piece was how are we going to engage providers to understand that we have valid outcomes. And I think that second piece is the one people miss. Somehow, they think they're just going to throw telemonitoring equipment or something they're calling a telehealth program at a provider, and they're going to jump on the bandwagon without demonstrating results, without demonstrating outcomes. The third piece is for patients to see that it’s valuable and really engage in whatever the program is.

I think it's hands-on people in the field; for them to really understand what the technology can do, that it's not be replacing what they're doing, that it's enhancing what they're doing; and it is going to help them provide care in a different way.

And so, we were like every other agency that does telehealth. We had a bunch of equipment out there that we were kind of just randomly assigning to patients. And, you know, the new way I talk about that is we were doing telemonitoring we were not doing telehealth. We basically recorded vital signs, entered them into the record, and thought that magically something was going to change.

And it wasn't until we really sat down with clinicians and said, “Here's what you could do with this equipment and here is how we can help you do your job,” that things began to change.

The other thing that we did was we said we weren't going to do telehealth without provider orders; and that dramatically changed what we did because then providers at least were aware we were doing it—implicitly I guess you could say—and that there was a value to it.

TMT: To what extent did you modify protocols in order to gain buy-in from physicians? [04:25]

Mr. Abel: The environment that we work in is practices. For example, in our flagship hospital we have a very large heart failure clinic with multiple providers—both physicians and nurse practitioners. The clinic has a protocol that it approved for all the providers in that clinic. There is one approved for that site.

Our diuretic protocol, for example: There's a whole body of evidence to support that protocol, whether you want your patient to have potassium levels run every fourth day or every sixth day, can be flexible. How much diuretic you want in the first day can be flexible; but basically, the general outline is well researched.

TMT: Is flexibility the key to success, or is there something else to consider? [05:19]

Mr. Abel: I definitely think flexibility was vitally important; and I think it still is, both for us internally, as well as for providers. And the reason I'm saying that is we have just been embarked, in the last couple weeks on a new COPD (chronic obstructive pulmonary disease) telehealth program. And we've obviously had to change our internal sort of way we deal with our patients because it's a different disease process.

We have the same nurses that are going to be providing the care to our heart failure patients, but it's not the same here. It's going to be different. They had to go and get different education and learn different parameters. So, it kind of works internally and externally, having that flexibility, understanding that you know nothing specifically. There's no such thing as empirical heart failure or empirical COPD. They're co-morbid to many other conditions.

TMT: Is additional training always part of the process you follow when new disease states are added to the telehealth program? [06:23]

Mr. Abel: I would say yes. And part of the reason for that is that we want there to be standard care.

One of the commitments we've made to our system is that we're going to reduce variation across the system. So, a heart-failure patient in the southern part of our region at one of our community hospitals is going to get the exact same care as a patient in our coastal region is going to receive.

Now, a physician can alter the orders and adjust them according to their preference. But the care that the agency provides, in other words how many nursing visits they would get, how we do the telemonitoring, how we do the education with the patient would be the same. And in order to do that with a new disease process you almost have to sit down; and we spent quite a bit of time doing the COPD one, several months, so that we could agree with our flagship hospital on how are we going to hand this off to home care, and what was that going to look like, and what was their expectation.

TMT: Who are the members of your governance team? [07:33]

Mr. Abel: Being a home health agency we have a professional advisory board, which is people who don't work for the agency from various disciplines, including community representatives, so sort of big picture initiatives. They know about the clinical aspects on our board of directors, obviously the financial and governance piece of that.

Sort of more practically internally our senior leadership team, there's eight of us on that team who have various backgrounds and disciplines: finance, rehab, quality, nursing. There's no physicians on that group, but there are physicians on both our governing body, as well as our advisory board.

Actual, sort of day-to-day policy, I have a nursing leadership group, and we have a rehab leadership group to participate in the program development conversations and policy and procedure development process.

TMT: Please share with us an example of the economic benefits that were not present before telehealth. [08:38]

Mr. Abel: Here's the thing where telehealth starts becoming this gray area and in my mind. If a freestanding community agency is going to try and get into telehealth because they see it as a revenue stream, that's not going to work, at least in the current environment.

If on the other hand, if you're part of a big system like we are, and the system values cost savings in some area, then the program begins to work. And there are some small gains that an independent agency can gain if they're really good by reducing things like cost per visit or the frequency that nurses see patients. But that's a really difficult one to measure.

The old model that we had, patients would go to an infusion clinic, the ER (emergency room), or they would be admitted to the hospital for the four days of the diuretic protocol, or part or any number of those days depending on their response. So, when the system analyzed kind of what was the savings or the efficacy of this and started putting dollars to that, there were three groups of people that we compared. We compared the home care patient, the people that went to the emergency room, had their

treatments and went home, and the people that were admitted to the hospital for four days.

What we realized in the review of that is the care they received is essentially the same. Just because they went to the hospital didn't mean they were getting any additional skilled services. They were basically getting IV diuretics and lab work just like they are at home.

To put a number to that, for someone to have four days of the diuretic protocol at home, including nursing, telehealth, the cost of the medication, the IV kit, the cost of the lab work was about $1150.

But to have that same person to go to the emergency room; over 1000 patients we looked at, was $3272. And for those patients to be admitted to the hospital, the hospital charges were $39,900. The system was saving $40,000 every time we didn't admit, because we had such a large ACO (Accountable Care Organization), it was significant (Table 1). When an ACO case gets admitted to the hospital, basically the ACO loses control of that cost.

Table 1. Just because patients go to the hospital doesn't mean they get additional skilled services (see text for more information). ED: emergency room; HDP: home diuretic program; HF: heart failure; MMC ER: Maine Medical Center Emergency Room

HDP

	Baseline	Day 1	Day 2	Day 3	Day 4
telehealth	$30.00	$30.00	$30.00	$30.00	$30.00
nurse visit	$162.95	$162.95	$162.95	$162.95	$162.95
labs	$31.95	$31.95	$31.95	$31.95	$31.95
IV kit	$25.00	$0.00	$0.00	$0.00	$0.00
IV diuretic	$0.00	$0.00	$0.00	$5.00	$0.00
total	$249.90	$224.90	$224.90	$229.90	$224.90
cumulative		$474.80	$699.70	$929.60	**$1,154.50**

Comparison Group

	Baseline	Day 1	Day 2	Day 3	Day 4
telehealth	$30.00	$30.00	$30.00	$30.00	$30.00
nurse visit	$162.95				$162.95
total	$ 192.95	$ 30.00	$ 30.00	$ 30.00	$ 192.95
cumulative		$ 222.95	$ 252.95	$ 282.95	**$ 475.90**

MMC ER and Hospitalization for HF Jan-Mar 2015

	all (1025)	discharged (728)	admitted (279)
Avg ED charges	$2,837.00	$1,644.00	$3,272.00
Avg hospital charges	$30,632.00	$5,493.00	$39,900.00
total		**$7,137.00**	**$43,172.00**

TMT: How do you get reimbursed for service? [11:12]

Mr. Abel: Our regular reimbursement is Medicare, for the most part.

We do not get reimbursed for the telehealth. We do two things with the telehealth. We get grant money from the federal government for some of our rural areas that pays monthly costs of the equipment, and we have gotten good at reducing the cost of care by reducing the visit frequency. So, we actually do a fair amount of virtual visits with our patients.

To be clear, we're talking about a very specific cohort of patients. And we're going to know in another six months if this bears out for another diagnostic group that we're talking about with one of our hospitals—those charges are specifically at our hospital in Portland. And it is the group of patients that met this criterion—that they had heart failure and needed to be on this diuretic protocol.

TMT: What is the most important advice you might offer to an organization contemplating incorporating telehealth into their system? [12:12]

Mr. Abel: Technology doesn't work without clinical expertise; our nurses are highly trained in heart failure care. Telehealth is one of the tools they use to provide that care.

Robert Abel, MSN, RN, CHPN, CMC, CCM, *is the Chief Nursing Officer for MaineHealth Care at Home. He has responsibility for the agency's telehealth program and involved in several system-wide initiatives to implement telehealth programs in areas such as heart failure, palliative care, and pediatrics. Mr. Abel previously worked with interdisciplinary clinical programs that used telehealth for decentralized, team-based, disease-driven care models.*

Tags: Robert Abel, COPD, economics of telehealth, governance, heart failure, home care, MaineHealth, Medicare, nursing care, sustainability, telehealth