`

The TRECS Institute

ACHA Grant No. GFA061

Final Report

June 11, 2018

Executive Summary:

This report outlines the findings and recommendations of GFA061, a Civil Money Penalty Grant designed to evaluate the ability of utilizing telemedicine in four urban skilled nursing facilities during evenings, nights, weekends and holidays to reduce avoidable readmissions and initial admissions as well as the estimated financial impact of this program on the Medicare Program and the individual participating nursing facilities.

Based on the findings of this study, with just four participating nursing facilities, the annualized Medicare savings achieved exceeded $1.3 million. The four facilities utilized a total of 521 virtual physician visits and 137 (26.2%) of those residents evaluated where classified has having avoided a hospitalization as a direct result of the intervention provided through this virtual physician service.

This study also looked at the impact on Medicare spending if Medicare paid for the 521 virtual physician visits as is currently allowed in rural nursing facilities. The monthly fee applied in this grant was $4,500 per facility. Annualized, this totaled $54,000 per facility or $216,000 total for all four. If Medicare allowed for Medicare Part B billing for the same number of physician visits that were recorded in this study, the total cost to Medicare would have been $52,200 representing a savings more than 70% compared to paying for the services as was done in this study.

If Medicare would allow physicians to bill for virtual services in urban areas, it would eliminate the financial risk and dramatically accelerate the adoption of telemedicine in skilled nursing facilities. It would also dramatically increase the amount of savings for Medicare by further reducing the number of avoidable SNF to hospital transfers. This is the key finding of this study and one worthy of CMS's attention.

In addition to proving the ability and value of utilizing telemedicine to reduce avoidable SNF to hospital transfers, another goal of this study was to identify the operational characteristics a skilled nursing facility should have to be successful in telemedicine. While a range of factors where identified, the most critical are:

1) Gaining the support of the facility's medical director and PCPs
2) Gaining the support of the key facility staff including the Director of Nursing and charge nurses
3) Identifying an "internal champion" at the facility level who will keep the telemedicine program a high priority despite the many competing priorities that constantly come forward within the nursing home environment

`

This study was also designed to identify the key success characteristics of a virtual physician service that SNFs can use in evaluating a potential company to service their residents. These characteristics can serve as a screening guide and include the following:

1) Does the company hire physicians that are skilled and experienced in nursing home care and are comfortable treating appropriate residents in the SNF and not locked into the industry standard of sending residents to the hospital when a change in medical condition occurs?
2) Do the physicians have solid communication skills and can they interact well not only with the resident, but also the facility's medical staff and most importantly of all, the nursing staff of the facility?
3) Is the equipment telemedicine equipment easy to use?
4) Does the company have an effective plan in place to repair or replace the equipment in a timely manner? (It is technology and technology does break from time to time)

Perhaps the most striking finding of this study was that three of the four SNFs were not able to generate sufficient additional revenue to cover the cost of the physician services if the grant had not covered that cost. This was not an issue with the programs design, but rather an issue with the level of acceptance and utilization of the service at all three facilities. The inability to generate the added revenue was not because the residents were not there or because the virtual physician was not able to care for them. Unfortunately, it was a direct result of the facilities not fully embracing the benefits the telemedicine program could offer. What this suggests is that telemedicine is not appropriate for all SNFs. Unless there is buy in from the facility's physicians, the administrator, Director of Nursing as well as and the nursing staff, telemedicine will likely not be successful. Applying these characteristics should be part of the screening process every SNF should apply if considering a telemedicne program.

Attached to this report is a PowerPoint Presentation including screening criteria both for nursing facilities to apply to themselves, but also a set of screening criteria that can be used in evaluating virtual physician services to determine if they would be right for your program.

Despite the limited economic results for three of the four participating facilities, Medicare realized a robust savings across the board ranging from a low of $90,000 to a high of $670,000.

Under the current reimbursement structure where physician visits to urban nursing facilities is not permitted, the number of SNFs willing to assume the financial risk of implementing a telemedicine program will be significantly restrained. Allowing physician visits to residents of urban SNFs to be billed to Medicare Part B however will result in a dramatic increase in the number of SNFs implementing telemedicine which in turn, will result in additional avoided admissions and the savings they generate for the Medicare Program.

In addition to the obvious economic benefits of telemedicine, we must not lose sight of the incredible impact this can have on the seniors being served through telemedicine. Anytime we can prevent a vulnerable senior from being admitted to the hospital when they don't need to go is a quality of care and a quality of life improvement.

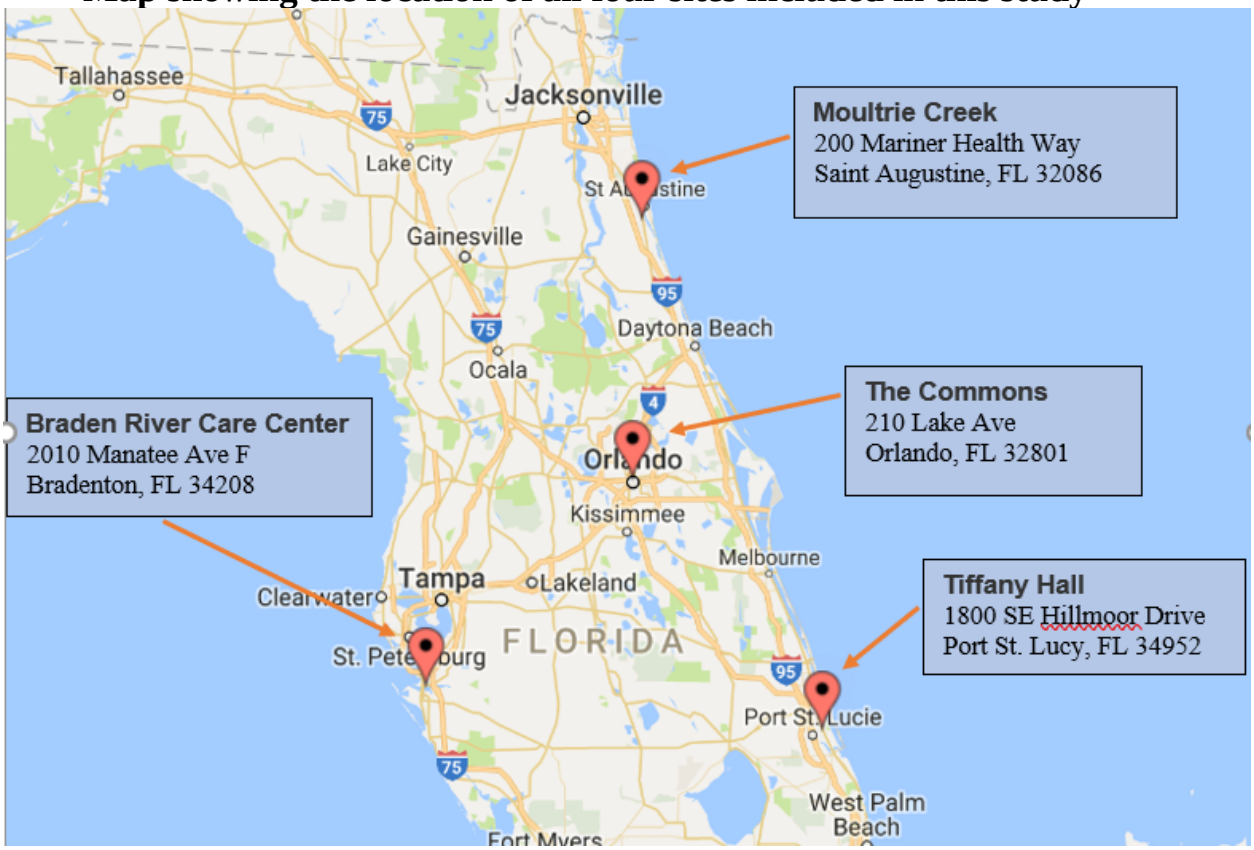
Based on the findings of this study, the benefits of offering telemedicine services to nursing facility residents is unquestionable and the positive economic implications for Medicare should make the expansion of telemedicine across America's skilled nursing facilities a high priority for

`

CMS. This could best be accomplished by expanding physician's ability to bill for Medicare services in urban areas the same they can now do in rural markets across the county.

Data and Financial Analysis: This study included four separate skilled nursing facilities located in Florida and identified in the map on the next page. Three of the four facilities were served by one telemedicine company called TripleCare while the forth facility was services by a separate company called Docs Connect. Due to some initial start-up issues detailed in the **Success and Barriers** section of this report, two of the facilities, Braden River and The Commons operated from April through December 2017. The second two facilities, Tiffany Hall and Moultrie Creek operated from August 2017 through April 2018.

Map showing the location of all four sites included in this study



Each of the facilities operated for a full eight months and the actual data from those months was used to annualize the results. The virtual physician when called for a visit during evenings, nights, weekends and holidays would classify the visit into one of the following categories:

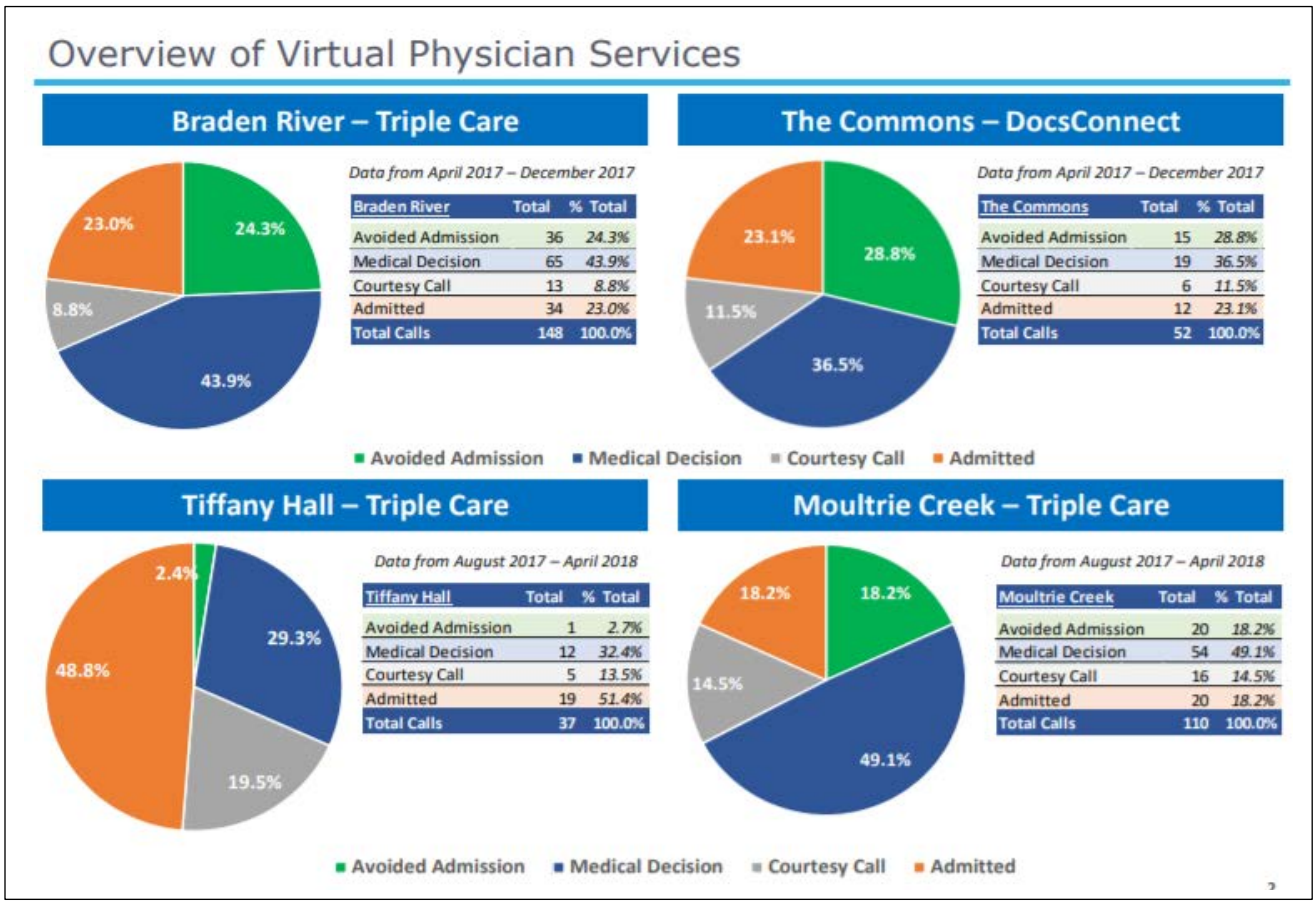
- **Treated in Place (TIP)**
  - **Avoided Hospitalization:** The intervention by the virtual physician prevented an acute care admission
  - **Clinical Decision:** The physician provided medical guidance but without it, the resident would not have gone to the hospital
  - **Courtesy Call:** A call with family or staff for clarification and support
  - **Total TIP (Treated in Place)** The number of residents seen that remained in the SNF and were not sent to the hospital.

`

- **Sent to the Hospital:**
  - **Clinical Need:** The resident's medical condition justified hospitalization
  - **Facility Readiness:** Facility could not meet the needs even though they did not justify hospitalization
  - **Patient/Family Request:** Responding to patient or family request
  - **Attending Request:** Resident's PCP requests hospitalization
  - **Procedure:** Sent to the hospital for a specific procedure and returns to the SNF
  - **Total ED:** Resident sent to the emergency room for a medical need and returns to the skilled nursing facility

The category of greatest interest is obviously the "Avoided Hospitalization." The following chart represents the actual results from eight months of service.

These numbers are slightly different than what was reported in the monthly reports. In preparing the final report it was discovered that several the virtual visits that occurred throughout the study period were not being recorded properly and therefore, the monthly numbers were slightly understated. A painstaking review of all virtual physician visits completed during the eight months of the project was undertaken and the numbers show below represent the actual visits that took place.



`

During the evaluation of the results, it was determined that a reasonable number of the virtual visits classified as “sent to the ED” were indeed “avoided admissions.” Without the virtual physician calling ahead to the ED and explaining the resident’s needs and that the SNF was expecting those residents to return to the facility, a significant percentage would have been hospitalized. Based on input from the virtual physicians, it was determined that at a minimum, 25% of those residents sent to the ED could be realistically considered an “Avoided Admission.”

This is considered a conservative estimate of the number of ED visits that could be converted to “avoided admission” category. This conservative number was agreed upon as a way of compensating for the fact that those residents classified as avoiding admission, yet having gone to the emergency room, would not be generating the same amount of savings for Medicare as a resident who did not go to the emergency room.

To simplify the analysis process, the data was then annualized using the first eight months of actual data as the base. The resulting annualized data was used in all calculations as shown on the next table. On the following page, a pie chart is also provided showing the anticipated annual results for each participating SNF.

Please see attachments I through IV for a full economic breakdown of each of the four facilities based on the final data generated by TripleCare and Docs Connect and presented in this table and the graph on the following page. The various data points used in this analysis (Medicare days, daily reimbursement rates, percent of residents sent to the hospital that do not return, etc., were generated with input from each facility and the corporate office.

This document along with a legend can be found as Attachment V

The TRECS Institute

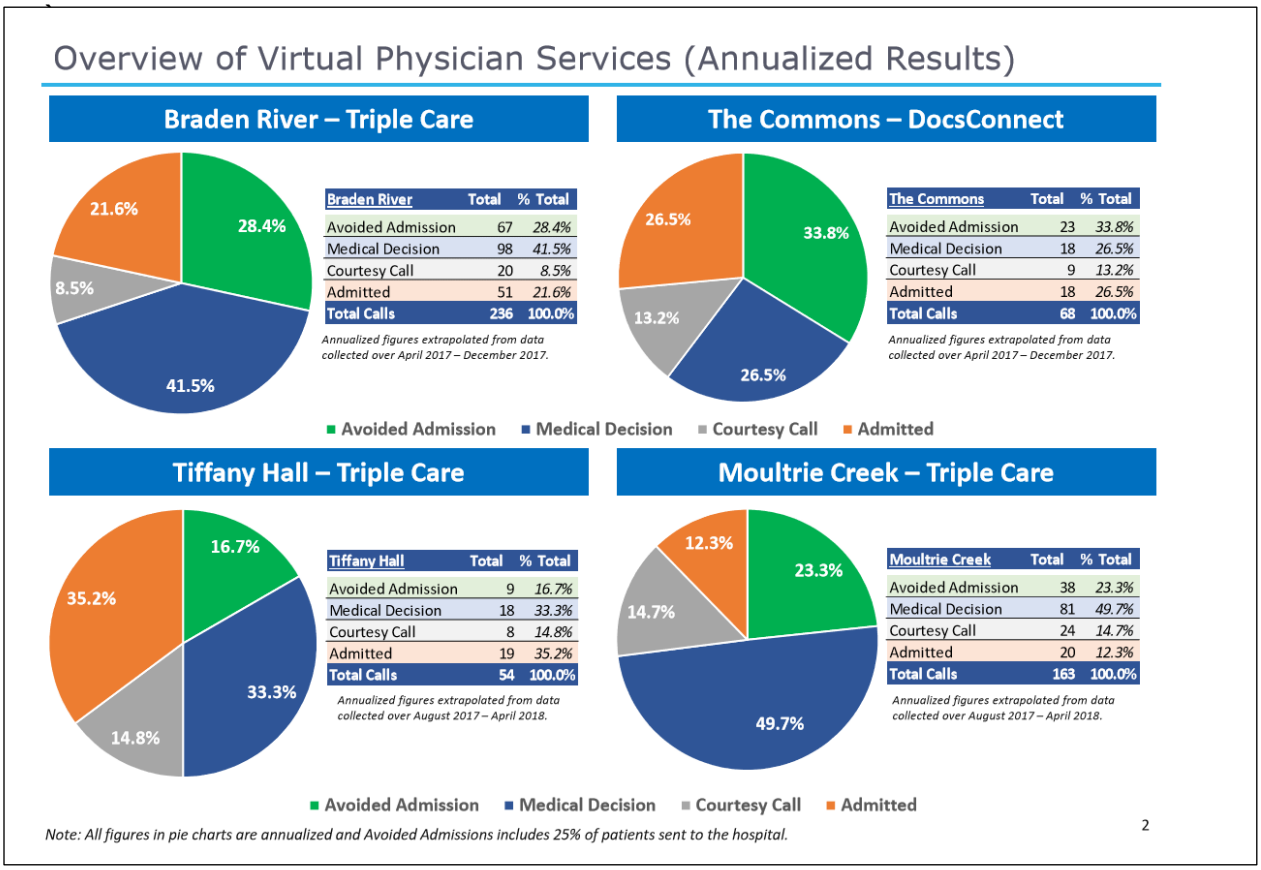
Telemedicine Grant- Overview of Findings

AHCA Grant No. GFA061

Projected Annualized Impact on Participating SNFs and Projected Medicare Savings

Facility	Visits(1)	Avoided(2)	Impact on SNF Before Cost(3)	Cost of Service(4)	Gain or Loss(5)	Gross Benefit to Medicare (6)	Medicare Cost for physician services(7)	Less Payment to Medicaid(8)	Net Impact to Medicare(9)	Impact on SNF without fee (10
Braden River	222	67	104588	60000	$44,588	$670,000	$22,300	$34,188	$613,512	$104,588
Tiffany Hall	56	9	14560	60000	-$45,440	$90,000	$5,600	$4,884	$79,516	$14,560
Moultrie Creek	165	38	55267	60000	-$4,733	$380,000	$16,500	$21,164	$342,336	$55,267
The Commons	78	23	32719	60000	-$27,281	$230,000	$7,800	$13,024	$209,176	$32,719
	521	137				$1,370,000	$52,200	$73,260	$1,244,540	

Note: Attachment V provides a full legend for each of the main items on this table.



From a financial analysis perspective, it is interesting to not that three of the four SNFs would have lost money if the grant had not covered the cost of services during the first eight months. Those loses ranged from $4,733 to $45,440. A direct correlation can be made between the number of virtual visits that took place and the level of loss identified… the fewer visits, the higher the loss.

It is also interesting to note that the Medicare Program saved dollars on each of the four facilities ranging from $90,000 at Tiffany Hall where they had only 9 avoided admissions, less than on per month and yet they saved Medicare significant dollars. Braden River however, which was the most successful of the four facilities with 222 visits, generated some $670,000 of avoided spending for Medicare.

The most important finding from this study is that …***if Medicare started paying for virtual physician coverage in urban skilled nursing facilities as it currently does in rural areas, it would virtually eliminate the risk for skilled care providers to become involved and the nation would see significant growth in the number of SNFs offering telemedicine and that growth would come in an accelerated manner.***

In the table above, utilizing the actual number of visits per facility, and a $100 reimbursement rate per visit (a blended rate between both new visits and follow up visits) would cost Medicare a total of $52,200 and still net Medicare over $1.3 million in savings!

Finally, it should be noted that when a long-term care resident is sent to the hospital, the Medicaid Program stops paying. Therefore, if telemedicine prevents LTC residents from being admitted to the hospital, while Medicare is saving, Medicaid is paying. The column above marked “Less Payment to Medicaid (8)” it is referring to those added expenditures for the Medicaid Program. Based on the savings available to Medicare, I would recommend that a small portion of those savings be given back to the Medicaid Program to make it whole. For the four

`

facilities in this study, the repayment to Medicaid would amount to just over $73,000 and represents approximately 330 additional Medicaid days as a direct result of the estimated 137 Avoided Admissions generated by the four facilities in this study.

Successes and Failures of this Project: There have been many successes and failures during this project but mainly lessons learned. It is my goal to share those now and translate them were possible into positive learning opportunities. I will use a two-panel presentation with the successes, difficulties and or failure on the left and the recommendation or lesson learned on the right.

Difficulty:	**Lesson Learned:**
Nursing Home Selection Process: This has been a difficult project from the start. I first submitted the CMP application in 2014 and identified a nursing home company that had agreed to move forward with this project once approved. Several months later, when the application was approved, the nursing home company was unable to participate because of new operational priorities that had recently been implemented. The Agency would not let me select a new nursing home company but rather required me to resubmit the application. When the second application was approved I went back to the bigger company I had selected only to find that they too were having operational difficulties and were unable to participate. I went to CMS and they allowed me to go through a selection process at that point. After careful evaluation, four SNFs were selected. We started the kick off process, completed INTERACT Training, completed the IT evaluations of each facility and a week before the kick off date, two of the facilities (from the same chain) were unable to go forward. We started with the two and added two later however they ran on a different time line.	**Lesson Learned:** The nursing home industry is a rapidly moving industry and operational changes can happen quickly and without notice. To help assure this didn't happen again, I carefully selected a company that I thought was big enough with significant infrastructure to prevent a recurrence happening… I was wrong! When the grant was approved for the second time, the company who had agreed to be part of the study was unable to do so. A detailed search was started and with the help of the FHCA, multiple applications from interested SNFs were received. Despite the good intentions and what I thought was good upfront evaluations of these facilities, based on the actual process and performance of the final four selected, I offer the following recommendations: 1) Do not preselect… when funding is available start looking for your SNF partners 2) Expand the screening process to include interviews with the medical director, DON and key medical staff to assure they are all ready and willing to participate 3) Monitor continuously 4) Communicate regularly

`

Difficulty:

Equipment Breakdown: There was equipment breakdown with both services. While this is technology and the potential for equipment breakdown always exists with technology, both virtual companies had difficulty responding to breakdowns and need to develop more timely and effective efforts to assure a quick response and minimal down time when there is equipment breakdown.

TripleCare's On Site Equipment

Staff Surveys: The original intent was to do a staff survey at the beginning of the program, half way through and at the completion. The first survey was completed however, due to staffing changes (so common in SNFs) it was determined that repeat surveys would have little value from a comparison standpoint and therefore were not redone later in the study.

Physician Buy In: Dealing with physicians that do not understand and do not want to learn about the benefits of telemedicine. This was experienced in several facilities and negatively impacted on the level of success at two facilities.

Lesson Learned:

Lesson Learned: While the physician at the other end of the equipment is the most important factor, do look at the equipment and make sure its tried and tested. Also, make sure the company has a repair/replace plan in place that assures the least amount of down time as possible.
Make sure the equipment is as simple to use as possible. The easier to use the better.

DocsConnect On Site Equipment

Lesson Learned: In lieu of the follow up surveys, a series of phone calls were held the facility staff and corporate representative to gain input into the thinking on the staff. Given the time restraints of nursing staff, the corporate staff preferred that we not conduct the follow up staff surveys.

Lessons Learned: Part of the selection process must be an in-depth review of the medical director and key medical staff of the facility to assure they understand that telemedicine will help their residents and will help them. It is not competitive although many physicians believe it is. This up-front evaluation of the level of acceptance is critical to the success of any program.

`

Difficulty	Lesson Learned:
Staff Buy In: While extensive phone interviews were conducted of the nursing facility administrator, the DON was not carefully evaluated for his/her level of acceptance. Without the DON on board, the program will struggle. This was the primary issues at Tiffany Hall.	**Lessons Learned:** Part of the selection process must be an in-depth review of the medical director and key medical staff of the facility to assure they understand that telemedicine will help their residents and will help them. It is not competitive although many physicians believe it is. This up-front evaluation of the level of acceptance is critical to the success of any program. Therefore, it is recommended that the initial interviews be expanded beyond the NHA to include the DON, key nursing staff and medical staff to assure acceptance of the telemedicine concept.
Data Collection: Despite carefully executed instructions of the data keeping requirements, for the participating SNFs and the telemedicine companies, accurate data collection was an issue, especially at the end of the project. Both telemedicine companies had data collection problems due to their physicians not accurately recording data and required extensive retrospective reviews that were unnecessarily time consuming and difficult	**Lessons:** Review the data collection process up front with the telemedicine company and monitor regularly to assure all data is being captured in the timely and accurate manner needed to generate credible findings.
Physician Selection for Telemedicine Companies: While the actual hiring of physicians is the job and responsibility of the telemedicine companies, careful monitoring of those hired and the job they are doing can help identify possible problems early. For example, the one company hired a local physician who was not well respected by the physicians caring for the residents of the facility in the project. Turns out they were also concerned that this physician might try and "steel" their patients. As one can imagine, the local physicians were unlikely to buy into the program and let this potential competitor see their patients. This problem continued for several months before the real reason for little or no calls was shared.	**Lesson:** Aggressively monitor each facility's utilization of the telemedicine service. If there are significant differences between facilities, accounting of course for bed size, dig deep to find out why some facilities are more successful than others. Look at details such as when residents are being sent to the hospital. If they are being admitted to the hospital during the hours the telemedicine service in serving as the covering physician, it could mean one of several things. For example: • The telemedicine program is being called too late to successfully intervein (i.e., they should be called when a resident's temperature is 99.5 and not when it reaches 103. • The staff is calling the residents doctor and not the telemedicine program • The telemedicine physician hired may lack the experience of working with nursing facility residents or the communication skilled needed to work with staff and families.

`

Difficulties:	Lessons Learned:
Telemedicine Physicians and how they interact with the nursing staff: After evaluating why one facility's numbers were so low, it was discovered that the telemedicine physician hired not only created competitive concerns with the physicians but that that same physician would sometime yell at the nurses when they called for him to see a resident. When this was discovered by TRECS, the telemedicine company had already replaced that physician. This is totally unacceptable behavior in any setting but especially in telemedicine where the nurse is the key for generating calls. If you treat the nurse without the highest level of respect, he/she will not call you for future visits. It's not only the right thing to do, its just plain Business 101 as well!	**Lesson Learned:** Monitor the physicians from any telemedicine company. Ask both staff and patients/family that have experienced the virtual physician to monitor how effective the physician is being and if not, aggressively seek to remove him/her as soon as possible.
Staff Surveys: While the original project design called for several surveys during the project, the difficulties in implementing, the delays and lost site visits as well as changes of staff at the facility level made this impossible to coordinate. Two major positive responses from staff about the telemedicine program were: 1) "The doctor answers the phone directly when I call… no answering machine, no call service… I get the doctor and don't have to wait long time frames while my patient needs care." 2) "It's so nice having someone else to call and talk to, especially about difficult situations where my first instinct, for the safety of the resident, is to send them to the hospital."	**Lesson Learned:** Communicate regularly with nursing staff to find out what is working well and where help or support is needed. Open communication is key. Also, challenge staff to be thinking of opportunities to more effectively utilize the telemedicine service. What kinds of resident conditions can we improve by making the virtual physician available.

Final Thoughts and Recommendations:

First and foremost, based on the findings of this project, nursing home residents who are treated at their bedside by a virtual physician service and avoid an unnecessary and unsafe hospital admission, is a tremendous benefit to the resident, to the facility and to the Medicare Program. This simple fact should be a call to action for CMS to expand Medicare reimbursement for telemedicine services for urban skilled nursing facilities as it now does for rural facilities. That said, telemedicine is not right for every skilled nursing facility.

To be successful, a skilled nursing facility must have its physicians and key management team on board and ready to make this program successful. Without the support and buy in from a facility's medical director and other key physicians servicing the residents of a facility, as well as the director of nursing and the administrator, the program will struggle at best.

`

Selecting the right telemedicine service is also a critical success factor. While equipment is important (large monitor, digitally enhanced stethoscope, zoom camera as a minimum) the simplicity of the equipment is key. Avoid login requirement and passwords… the easier the better. The key however is the virtual physicians. Look for physicians with experience in treating nursing facility resident in place. Look for physicians that cover for a full week at a time so there is consistency. Look for physicians that are not only medically strong, but have excellent communication skills in dealing with residents, families, the nursing staff and other physicians.

Once in place, monitor the program regularly. Follow the number of visits. Monitor the residents that went to the hospital and evaluate if an earlier intervention by the virtual physician could have prevented the admission. Utilize the service for end of life discussions with family and residents. ***Work aggressively with your staff to change decades of thinking that historically has leaned heavily towards "sending the resident to the hospital."***

Market your program aggressively… to new families evaluating your facility and to your local hospitals and physicians. Show them you are committed to preventing avoidable readmissions. And finally, encourage your Associations and legislators to allow for physician billing for telemedicine services provided to nursing home residents in both rural and non-rural markets.

Based on this study and other ongoing research, The TRECS Institute strongly believes that in the next few years, any nursing facility that wants to be competitive in its market will have to offer telemedicine services to its residents.

Respectfully submitted;

John Whitman, MBA, NHA
Executive Director
The TRECS Institute

`

ACHA Grant No. GFA061

Final Report
June 11, 2018

Attachments Supporting this Report

Attachment I	**Braden River's Financial Analysis**
Attachment I-A	**Braden River's Visits by Category**
Attachment II	**Tiffany Hall's Financial Analysis**
Attachment II-A	**Tiffany Halls Visits by Category**
Attachment III	**Moultrie Creek's Financial Analysis**
Attachment III-A	**Moultrie Creek's Visits by Category**
Attachment IV	**The Commons Financial Analysis**
Attachment IV-A	**The Commons Visits by Category**
Attachment V	**Projected Financial Impact by SNF and for Medicare**
Attachment VI	**Overview Graph of Actual Visits per Facility (for all eight months of service)**

Attachment I

Financial Performance of Braden River in Telemedicine Grant
AHCA Grant No. GFA061

Braden River's Annualized Financial Performance
(April through December 2017)

Medicare Patients			
Gained revenue when resident is not sent to the hospital			
Total number of Medicare avoided readmissions		**36**	
Average number of lost billable days when hospitalized	4 Days	4 days	
Average Medicare per diem lost	$539	$539	
Estimated gained revenue per patient not hospitalized	$2,156	$77,616	
Additional gained revenue from resident who would not have returned			
The percent of residents who do not come back from hospital	5%	1.80	
Average number of billable days lost	8	8	
Average per diem billing lost	$539	$539	
Estimated gained revenue per patient not hospitalized	$215.60	$7,762	
Total gained revenue/patient by avoiding Medicare readmissions =	**$2,371.60**	**$85,378**	
Private Pay Patients			
Gained revenue when resident is not sent to the hospital		10	Note (1)
Average number of lost billable days when hospitalized	5	5	
Private daily rate lost	$260	$260	
Estimated gained revenue per resident not hospitalized	$1,300	$13,000	
Additional gained revenue from resident who would not have returned			
The percent of residents who do not come back from hospital	5%	0.50	
Average number of billable days lost	30	30	
Average per diem billing lost	$260	$260	
Additional gained revenue per patient not hospitalized	$390	$3,900	
Total gained revenue per patient not hospitalized	**$1,690**	$16,900	
Medicaid Patients			**Medicaid Impact (2)**
Gained revenue when resident is not sent to the hospital		21	
Average number of lost billable days when hospitalized	5 Days	5	105
Average Medicaid per diem rate	$220	$220	
Estimated gained revenue per patient not hospitalized	$1,100	$23,100	
Additional gained revenue from resident who would not have returned			
The percent of residents who do not come back from hospital	5%	1.05	
Average number of billable days lost	8	8	8.4
Average per diem billing lost	$220	$220	
Additional gained revenue per patient not hospitalized	$88	$1,848	
Lost opportunity Cost of potentail Medicare Skilled days			
Percent of Medicaid residents returning as Medicare skilled	25%	5.25	42
Average number of skilled days	8 days	8	
Average Medicare Skilled per diem	$539.00	$539	
Lost opportunity cost per Medicaid resident	$1,078	$22,638	
			155.4
Total net revenue for Medicaid residents not sent to the hospital		$2,310	**$34,188**
Total net Impact to SNF for providing telemedicine services for its residents		$104,588	

Note #1: Includes 3 hospice patients because the economic impact closely matches that of private pay patients
Note #2: When a Medicaid resident avoids a hospitalization, it adds additional days and costs to the Medicaid Program

Annualized savings to Medicare Program: (67 avoided admissions at $10,000 savings per admission)	**$670,000**
Less added cost to Medicaid Program:	**$34,188**
Cost to Medicare if physician reimbursement available as in rural SNFs: (223 visits reimbursed at $100 per visit which represents a blend between new and f/u visits)	**$22,300**
Net financial impact to Medicare:	**$613,512**

Annualized financial impact on SNF:	**$104,588**
Cost of Virtual Company if not paid for by this Grant:	**$60,000**
Net Benefit to SNF:	**$44,588**

Attachment I-A

The TRECS Institute

Virtual Visits by Category for Telemedicine Grant

AHCA Grant No. GFA061

Braden River's Visits by Category

(April through December 2017)

Study month	Total	Avoided	Clin Dec	Court Call	Total TIP	Clin Need	Fac Read	Pt/Fam	Attend	Proc	Total ED
2017 Apr - May	22	7	9	4	20	2	0	0	0	0	2
2017 May - June	7	0	3	2	5	1	0	1	0	0	2
2017 June - July	11	4	4	0	8	3	0	0	0	0	3
2017 July - Aug	13	4	5	1	10	3	0	0	0	0	3
2017 Aug - Sept	20	2	11	0	13	5	0	1	0	1	7
2017 Sept - Oct	20	6	9	2	17	3	0	0	0	0	3
2017 Oct - Nov	23	6	11	3	20	2	0	0	0	1	3
2017 Nov - Dec	32	7	13	1	21	8	2	0	0	1	11
Thru 12/17	**148**	**36**	**65**	**13**	**114**	**27**	**2**	**2**	**0**	**3**	**34**

Based on discussions with the virtual physicians it was estimated that without them calling the emergency room and specifically requesting what was to be done and that the residents be returned to the SNF, at least 25% would have been admitted. For this reason, 25% of those classified as ED visits have been added to the "Avoided Hospitalization" category

Add 25% of ED		**8.5**									
New 8 month Total		**44.5**									
Annualized	**222**	**67**	**97.5**	**19.5**	**171**	**40.5**	**3**	**3**	**0**	**4.5**	**51**

	Avoided by Payor (8 months)		8 Month Percentages	12 Month Patients
	Med A	19	53%	35
	Medicaid	11	31%	20
n	Pvt Pay	4	11%	7
	Hospice	2	6%	4
	Total	**36**		**67**

Attachment II

The TRECS Institute

Financial Performance of Braden River in Telemedicine Grant

AHCA Grant No. GFA061

Tiffany Hall's Annualized Financial Performance

(August 2017 through April 2018)

Medicare Patients			
Gained revenue when resident is not sent to the hospital			
Total number of Medicare avoided readmissions		6	
Average number of lost billable days when hospitalized	4 Days	4 days	
Average Medicare per diem lost	$539	$539	
Estimated gained revenue per patient not hospitalized	$2,156	$12,936	
Additional gained revenue from resident who would not have returned			
The percent of residents who do not come back from hospital	5%	0.30	
Average number of billable days lost	8	8	
Average per diem billing lost	$539	$539	
Estimated gained revenue per patient not hospitalized	$215.60	$1,294	
Total gained revenue/patient by avoiding Medicare readmissions =	**$2,371.60**	**$14,230**	
Private Pay Patients			
Gained revenue when resident is not sent to the hospital		0	
Average number of lost billable days when hospitalized	5	5	
Private daily rate lost	$260	$260	
Estimated gained revenue per resident not hospitalized	$1,300	$0	
Additional gained revenue from resident who would not have returned			
The percent of residents who do not come back from hospital	5%	0.00	
Average number of billable days lost	30	30	
Average per diem billing lost	$260	$260	
Additional gained revenue per patient not hospitalized	$390	$0	
Total gained revenue per patient not hospitalized	**$1,690**	$0	
Medicaid Patients			**Medicaid Impact (1)**
Gained revenue when resident is not sent to the hospital		3	
Average number of lost billable days when hospitalized	5 Days	5	15
Average Medicaid per diem rate	$220	$220	
Estimated gained revenue per patient not hospitalized	$1,100	$3,300	
Additional gained revenue from resident who would not have returned			
The percent of residents who do not come back from hospital	5%	0.15	
Average number of billable days lost	8	8	1.2
Average per diem billing lost	$220	$220	
Additional gained revenue per patient not hospitalized	$88	$264	
Lost opportunity Cost of potentail Medicare Skilled days			
Percent of Medicaid residents returning as Medicare skilled	25%	0.75	6
Average number of skilled days	8 days	8	
Average Medicare Skilled per diem	$539.00	$539	
Lost opportunity cost per Medicaid resident	$1,078	$3,234	
			22.2
Total net revenue for Medicaid residents not sent to the hospital		$330	**$4,884**
Total Net Impact to SNF for providing telemedicine services for its residents:		$14,560	

Note #1: When a Medicaid resident avoids a hospitalization, it adds additional days and costs to the Medicaid Program

Annualized savings to Medicare Program: (9 avoided admissions at $10,000 savings per admission)	**$90,000**
Less added cost to Medicaid Program:	**$4,884**
Cost to Medicare if physician reimbursement available as in rural SNFs: (56 visits reimbursed at $100 per visit which represents a blend between new and f/u visits)	**$5,600**
Net financial impact to Medicare:	**$79,516**

Annualized financial impact on SNF:	**$14,560**
Cost of Virtual Company if not paid for by this Grant:	**$60,000**
Net Benefit to SNF:	**($45,440)**

Attachment II - A

The TRECS Institute

Virtual Visits by Category for Telemedicine Grant

AHCA Grant No. GFA061

Tiffany Hall's Visits by Category

(August 2017 through April 2018)

	Total	Avoided	Clin Dec	Court Call	TIP	Clin Need	Fac Read	Pt/Fam	Attend	Proc	Total ED
2017 Aug - Sept	5	0	2	0	2	3	0	0	0	0	3
2017 Sept - Oct	3	0	2	0	2	0	0	1	0	0	1
2017 Oct - Nov	1	1	0	0	1	0	0	0	0	0	0
2017 Nov - Dec	3	0	2	0	2	1	0	0	0	0	1
2017 Dec - Jan	14	0	4	2	6	6	0	1	0	1	8
2018 Jan - Feb	7	0	1	2	3	4	0	0	0	0	4
2018 Feb - Mar	3	0	1	0	1	2	0	0	0	0	2
2018 Mar - Apr	1	0	0	1	1	0	0	0	0	0	0
Thru 4/17	**37**	**1**	**12**	**5**	**18**	**16**	**0**	**2**	**0**	**1**	**19**

Based on discussions with the virtual physicians it was estimated that without them calling the emergency room and specifically requesting what was to be done and that the residents be returned to the SNF, at least 25% would have been admitted. For this reason, 25% of those classified as ED visits have been added to the "Avoided Hospitalization" category

Add 25% of ED Visits		5									
New 8 month Total		6									
Annualized	**56**	**9**	**18**	**7.5**	**27**	**24**	**0**	**3**	**0**	**1.5**	**28.5**

Avoided by Payor (8 months)		**8 month Percentages**	**12 month Patients**
Med A	1	100%	6
Medicaid	0	0	3
Pvt Pay	0	0	0
Hospice	0	0	0

Note: Because the performance of this facility was so poor, there was not enough volume in any payor group to accurately project where the addition patients from the ED or from annulaizing the numbers would go to. The distribution above is the researcher's best quess of payor group distribution.

Attachment III

The TRECS Institute

Financial Performance of Braden River in Telemedicine Grant

AHCA Grant No. GFA061

Moultrie Creek's Annualized Financial Performance

(August 2017 through April 2018)

Medicare Patients			
Gained revenue when resident is not sent to the hospital			
Total number of Medicare avoided readmissions		17	
Average number of lost billable days when hospitalized	4 Days	4 days	
Average Medicare per diem lost	$539	$539	
Estimated gained revenue per patient not hospitalized	$2,156	$36,652	
Additional gained revenue from resident who would not have returned			
The percent of residents who do not come back from hospital	5%	0.85	
Average number of billable days lost	8	8	
Average per diem billing lost	$539	$539	
Estimated gained revenue per patient not hospitalized	$215.60	$3,665	
Total gained revenue/patient by avoiding Medicare readmissions =	**$2,371.60**	**$40,317**	
Private Pay Patients			
Gained revenue when resident is not sent to the hospital		8	**(Note #1)**
Average number of lost billable days when hospitalized	5	5	
Private daily rate lost	$260	$260	
Estimated gained revenue per resident not hospitalized	$1,300	$10,400	
Additional gained revenue from resident who would not have returned			
The percent of residents who do not come back from hospital	5%	0.40	
Average number of billable days lost	30	30	
Average per diem billing lost	$260	$260	
Additional gained revenue per patient not hospitalized	$390	$3,120	
Total gained revenue per patient not hospitalized	**$1,690**	$13,520	
Medicaid Patients			**Medicaid Impact (2)**
Gained revenue when resident is not sent to the hospital		13	
Average number of lost billable days when hospitalized	5 Days	5	65
Average Medicaid per diem rate	$220	$220	
Estimated gained revenue per patient not hospitalized	$1,100	$14,300	
Additional gained revenue from resident who would not have returned			
The percent of residents who do not come back from hospital	5%	0.65	
Average number of billable days lost	8	8	5.2
Average per diem billing lost	$220	$220	
Additional gained revenue per patient not hospitalized	$88	$1,144	
Lost opportunity Cost of potentail Medicare Skilled days			
Percent of Medicaid residents returning as Medicare skilled	25%	3.25	26
Average number of skilled days	8 days	8	
Average Medicare Skilled per diem	$539.00	$539	
Lost opportunity cost per Medicaid resident	$1,078	$14,014	
			96.2
Total net revenue for Medicaid residents not sent to the hospital		$1,430	**$21,164**
Total Net Impact to SNF for providing telemedicine services for its residents:		$55,267	

Note #1: Includes 4 hospice patients because the economic impact closely matches that of private pay patients

Note #2: When a Medicaid resident avoids a hospitalization, it adds additional days and costs to the Medicaid Program

Annualized savings to Medicare Program: (38 avoided admissions at $10,000 savings per admission)	**$380,000**
Less added cost to Medicaid Program:	**$21,164**
Cost to Medicare if physician reimbursement available as in rural SNFs: (165 visits reimbursed at $100 per visit which represents a blend between new and f/u visits)	**$16,500**
Net financial impact to Medicare:	**$342,336**

Annualized financial impact on SNF:	**$55,267**
Cost of Virtual Company if not paid for by this Grant:	**$60,000**
Net Benefit to SNF:	**($4,733)**

Attachment III - A

The TRECS Institute

Virtual Visits by Category for Telemedicine Grant

AHCA Grant No. GFA061

Moultrie Creek's Visits by Category

(August 2017 through April 2018)

	Total	Avoided	Clin Dec	Court Call	TIP	Clin Need	Fac Read	Pt/Fam	Attend	Proc	Total ED
2017 Aug - Sept	5	2	2	0	4	0	0	0	0	1	1
2017 Sept - Oct	12	2	4	3	9	1	0	0	0	2	3
2017 Oct - Nov	15	1	7	2	10	0	0	0	0	5	5
2017 Nov - Dec	20	6	8	0	14	5	0	0	0	1	6
2017 Dec - Jan	18	2	12	1	15	1	0	1	0	1	3
2018 Jan - Feb	20	4	10	4	18	2	0	0	0	0	2
2018 Feb - Mar	8	2	3	3	8	0	0	0	0	0	0
2018 Mar - Apr	12	1	8	3	12	0	0	0	0	0	0
Thru 4/17	**110**	**20**	**54**	**16**	**90**	**9**	**0**	**1**	**0**	**10**	**20**

Based on discussions with the virtual physicians it was estimated that without them calling the emergency room and specifically requesting what was to be done and that the residents be returned to the SNF, at least 25% would have been admitted. For this reason, 25% of those classified as ED visits have been added to the "Avoided Hospitalization" category

Add 25% of ED Visits		5									
New 8 month Total		25									
Annualized	**165**	**38**	**81**	**24**	**135**	**13.5**	**0**	**1.5**	**0**	**15**	**30**

Avoided by Payor (8 months)		**8 month Percentages**	**12 month Patients**
Med A	9	45%	17
Medicaid	7	35%	13
Pvt Pay	2	10%	4
Hospice	2	10%	4
Totals:	**20**		**38**

Attachment IV

Financial Performance of Braden River in Telemedicine Grant
AHCA Grant No. GFA061

The Commons' Annualized Financial Performance
(April through December 2017)

Medicare Patients			
Gained revenue when resident is not sent to the hospital			
Total number of Medicare avoided readmissions		**12**	
Average number of lost billable days when hospitalized	4 Days	4 days	
Average Medicare per diem lost	$539	$539	
Estimated gained revenue per patient not hospitalized	$2,156	$25,872	
Additional gained revenue from resident who would not have returned			
The percent of residents who do not come back from hospital	5%	0.60	
Average number of billable days lost	8	8	
Average per diem billing lost	$539	$539	
Estimated gained revenue per patient not hospitalized	$215.60	$2,587	
Total gained revenue/patient by avoiding Medicare readmissions =	**$2,371.60**	**$28,459**	
Private Pay Patients			
Gained revenue when resident is not sent to the hospital		2	
Average number of lost billable days when hospitalized	5	5	
Private daily rate lost	$260	$260	
Estimated gained revenue per resident not hospitalized	$1,300	$2,600	
Additional gained revenue from resident who would not have returned			
The percent of residents who do not come back from hospital	5%	0.10	
Average number of billable days lost	30	30	
Average per diem billing lost	$260	$260	
Additional gained revenue per patient not hospitalized	$390	$780	
Total gained revenue per patient not hospitalized	**$1,690**	$3,380	
Medicaid Patients			**Medicaid Impact (1)**
Gained revenue when resident is not sent to the hospital		8	
Average number of lost billable days when hospitalized	5 Days	5	40
Average Medicaid per diem rate	$220	$220	
Estimated gained revenue per patient not hospitalized	$1,100	$8,800	
Additional gained revenue from resident who would not have returned			
The percent of residents who do not come back from hospital	5%	0.40	
Average number of billable days lost	8	8	3.2
Average per diem billing lost	$220	$220	
Additional gained revenue per patient not hospitalized	$88	$704	
Lost opportunity Cost of potentail Medicare Skilled days			
Percent of Medicaid residents returning as Medicare skilled	25%	2	16
Average number of skilled days	8 days	8	
Average Medicare Skilled per diem	$539.00	$539	
Lost opportunity cost per Medicaid resident	$1,078	$8,624	
			59.2
Total net revenue for Medicaid residents not sent to the hospital		$880	**$13,024**
Total net Impact to SNF for providing telemedicine services for its residents		$32,719	

2

Note #1: When a Medicaid resident avoids a hospitalization, it adds additional days and costs to the Medicaid Program

Annualized savings to Medicare Program: (23 avoided admissions at $10,000 savings per admission)	**$230,000**
Less added cost to Medicaid Program:	**$13,024**
Cost to Medicare if physician reimbursement available as in rural SNFs: (78 visits reimbursed at $100 per visit which represents a blend between new and f/u visits)	**$7,800**
Net financial impact to Medicare:	**$209,176**

Annualized financial impact on SNF:	**$32,719**
Cost of Virtual Company if not paid for by this Grant:	**$60,000**
Net Benefit to SNF:	**($27,281)**

Attachment IV- A

The TRECS Institute

Virtual Visits by Category for Telemedicine Grant

AHCA Grant No. GFA061

The Commons Visits by Category

(April through December 2017)

	Total	Avoided	Clin Dec	Court Call	TIP	Clin Need	Fac Read	Pt/Fam	Attend	Proc	Total ED
2017 Apr - May	6	0	3	0	3	3	0	0	0	0	0
2017 May - June	5	0	3	0	2	3	0	0	0	0	0
2017 June - July	7	0	3	0	4	3	0	0	0	0	0
2017 July - Aug	0	0	0	0	0	0	0	0	0	0	0
2017 Aug - Sept	9	4	0	3	9	0	0	0	0	0	0
2017 Sept - Oct	7	1	1	1	6	1	0	0	0	0	0
2017 Oct - Nov	8	4	1	2	7	1	0	0	0	0	0
2017 Nov - Dec	10	6	1	0	9	1	0	0	0	0	0
Thru 12/17	**52**	**15**	**12**	**6**	**40**	**12**	**0**	**0**	**0**	**0**	**0**

Based on discussions with the virtual physicians it was estimated that without them calling the emergency room and specifically requesting what was to be done and that the residents be returned to the SNF, at least 25% would have been admitted. For this reason, 25% of those classified as ED visits have been added to the "Avoided Hospitalization" category

Add 25% of ED Visits		0									
New 8 month Total		15									
Annualized	**78**	**23**	**18**	**9**	**60**	**18**	**0**	**0**	**0**	**0**	**0**

Avoided by Payor (8 months)		**8 month Percentages**	**12 month Patients**
Med A	8	53%	12
Medicaid	5	33%	8
Pvt Pay	2	13%	3
Hospice	0	0%	0
Totals:	**15**	**100%**	**23**

Attachment V

Telemedicine Grant- Overview of Findings
AHCA Grant No. GFA061

Projected Economic Impact on Participating SNFs and Gross Medicare Savings with Adjustments for Cost of Virtual Physician Visits and Repayment to Florida's Medicaid Program

Facility	Visits(1)	Avoided(2)	Impact on SNF Before Cost(3)	Cost of Service(4)	Gain or Loss(5)	Gross Benefit to Medicare (6)	Medicare Cost for physician services(7)	Less Payment to Medicaid(8)	Net Impact to Medicare(9)	Impact on SNF without fee (10
Braden River	222	67	104588	60000	$44,588	$670,000	$22,200	$34,188	$613,512	$104,588
Tiffany Hall	56	9	14560	60000	-$45,440	$90,000	$5,600	$4,884	$79,516	$14,560
Moultrie Creek	165	38	55267	60000	-$4,733	$380,000	$16,500	$21,164	$342,336	$55,267
The Commons	78	23	32719	60000	-$27,281	$230,000	$7,800	$13,024	$209,176	$32,719
	521	137				**$1,370,000**	**$52,100**	**$73,260**	**$1,244,540**	

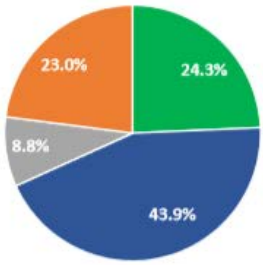
Note #1: Visit refers to the total number of telemedicine calls/bedside visits based on 8 months of actual data and annualized
Note #2: Avoided refers to the annualized number of "avoided admissions" recorded and confirmed during the 8 months of actual services
Note #3: The gross added revenue the participating SNFs generated by preventing avoidable admission and being able to bill for days that otherwise would have been lost
Note #4: Cost of Services refers to the actual cost to the SNF to purchase the telemedicine services without the grants support. A cost of $5,000 was used in this calculation
Note #5: The SNF gain or loss refers to the economic impact generated by avoided admissions less the cost of purchasing the telemedicine services
Note #6: Refers to the number of avoided admissions for each SNF multiplied by $10,000, the estimated cost of a nursing home admission to the hospital
Note #7: Refers to the cost to Medicare if the virtual physician visits were paid my Medicare as they are in rural SNFs. A $100 per visit was estimated which roughly approximates the average between reimbursement for new visits and follow up visits under Medicare Part B
Note #8: When a Medicaid resident is treated with telehealth and avoids a hospital stay, the Medicaid Program spends more money. Those days the resident would have been in the hospital and any Medicare skilled days they might have qualify for would have been days where Medicaid didn't pay. By preventing the admission to the hospital, Medicaid continues to pay. This study estimated the additional Medicaid payments made as a result of preventing the hospital admission.
Note #9: The Net Impact to Medicare is the total gross benefit identified (total avoided admissions times $10,000) less the cost if Medicare were to pay for physician visits as is currently done in rural SNFs as well as repaying the Medicaid Program for additional spending incurred when the resident remains in the SNF
Note #10: The Impact on the SNF is the actual economic impact on each SNF based on the added revenue they generated but without the cost to the telemedicine program assuming the physician visits would be paid by Medicare under Medicare Part B as they currently are in rural SNFs

Attachment VI

Utilization of Virtual Physician Services by All Participating Facilities

Overview of Virtual Physician Services

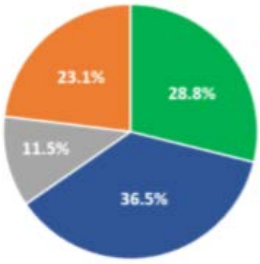
Braden River – Triple Care



Data from April 2017 – December 2017

Braden River	Total	% Total
Avoided Admission	36	*24.3%*
Medical Decision	65	*43.9%*
Courtesy Call	13	*8.8%*
Admitted	34	*23.0%*
Total Calls	148	100.0%

The Commons – DocsConnect

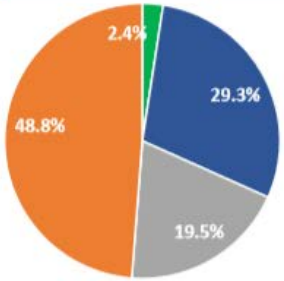


Data from April 2017 – December 2017

The Commons	Total	% Total
Avoided Admission	15	*28.8%*
Medical Decision	19	*36.5%*
Courtesy Call	6	*11.5%*
Admitted	12	*23.1%*
Total Calls	52	100.0%

Avoided Admission ■ Medical Decision ■ Courtesy Call ■ Admitted

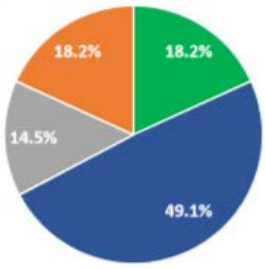
Tiffany Hall – Triple Care



Data from August 2017 – April 2018

Tiffany Hall	Total	% Total
Avoided Admission	1	*2.7%*
Medical Decision	12	*32.4%*
Courtesy Call	5	*13.5%*
Admitted	19	*51.4%*
Total Calls	37	100.0%

Moultrie Creek – Triple Care



Data from August 2017 – April 2018

Moultrie Creek	Total	% Total
Avoided Admission	20	*18.2%*
Medical Decision	54	*49.1%*
Courtesy Call	16	*14.5%*
Admitted	20	*18.2%*
Total Calls	110	100.0%

Avoided Admission ■ Medical Decision ■ Courtesy Call ■ Admitted

2

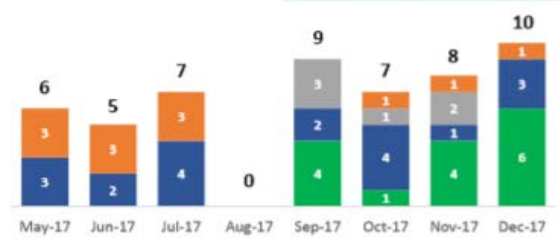
Overview of Virtual Physician Services

Braden River – Triple Care

Total Avoided Admissions = 36

The Commons – DocsConnect

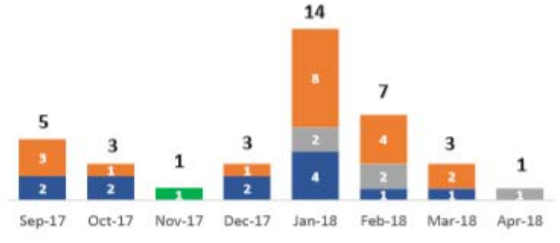
Total Avoided Admissions = 15



Avoided Admission ■ Medical Decision ■ Courtesy Call ■ Admitted

Tiffany Hall – Triple Care

Total Avoided Admissions = 1



Moultrie Creek – Triple Care

Total Avoided Admissions = 20

Avoided Admission ■ Medical Decision ■ Courtesy Call ■ Admitted

3