Vision:
“Telehealth will be fully integrated into Delaware’s healthcare system so that all residents will have equitable access to affordable, world-class, patient-centered healthcare throughout the state.”

Goal:
A three-year strategic action plan for facilitating the use of telehealth technologies to improve: 1) access to behavioral health services; 2) access to specialty care; and 3) the management of chronic disease.
Acknowledgments

The Delaware Telehealth Roundtable Strategic Action Plan is the product of a partnership between the Mid-Atlantic Telehealth Resource Center, the Delaware Department of Health and Social Services (DHSS), the Delaware Telehealth Coalition (DTC), and the following members of the Delaware Telehealth Roundtable Planning Team: Carol Morris (DHSS, Division of Services for Aging & Adults with Physical Disabilities), Bill Love (DHSS, Division of Services for Aging & Adults with Physical Disabilities); Gerard Gallucci (Delaware Health & Social Services), Ingrid Pretzer-Aboff (University of Delaware), Brian Olson (La Red Health Center, Inc.), Kathy Collison (DHSS, Division of Public Health); Jonathan “Kevin” Massey (DHSS, Division of Public Health), Lisa Schieffert (Delaware Healthcare Association), and Betsy Wheeler (Wheeler & Associates Management Services).

This plan would not have been possible if it were not for the invaluable expertise, experience and commitment of a large number of individuals, government officials, healthcare providers, advocates and citizens who are dedicated to improving the quality of life, health and health care services for all Delawareans.

And for the many who will continue to partner over the next two to three years to ensure timely and accurate implementation, guidance and benchmarking – please accept our gratitude in advance for your time, energy and resources.
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Executive Summary

The Mid-Atlantic Telehealth Resource Center (MATRC) is funded by the U.S. Department of Health and Human Service’s Health Resources and Services Administration (HRSA) Office for the Advancement of Telehealth, which is part of the Office of Rural Health Policy. Nationally, there are 14 telehealth resource centers (TRCs). This includes 12 Regional Centers, all with different strengths and regional expertise, and two National Centers, one focusing on Technology Assessment and one on Telehealth Policy. TRC’s have a mission to serve as a focal point for advancing the effective use of telehealth and support access to telehealth services in rural and underserved communities. The MATRC is a regional TRC that focuses on providing technical assistance and resources to the following Mid-Atlantic States: Delaware, Kentucky, Maryland, North Carolina, Pennsylvania, Virginia, West Virginia and the District of Columbia. As part of the MATRC’s Technical Assistance efforts, each grant year (September 1 – August 31), MATRC is able to provide up to two states, on a first-come first-serve basis, the resources needed to hold a full day facilitated strategic planning retreat/roundtable.

The purpose of the state roundtables is to bring together key stakeholders around one or two priority health needs, with the end goal of developing consensus and establishing a 2 – 3 year strategic action plan for advancing the adoption and utilization of telehealth as a mechanism for meeting the identified priority health need(s).

With leadership provided by the Delaware Department of Health and Social Services (DHSS) and the Delaware Telehealth Coalition (DTC), a core planning team was pulled together in June 2013 to begin planning for a Delaware Telehealth Roundtable. The planning team took on the task for identifying a date, location and venue for the event; gathering needs assessments, reviewing and then prioritizing health needs; and identifying and engaging key stakeholders from a variety of sectors to participate in the event.

The full day event was held on Wednesday December 4, 2013 at the Delaware Technical and Community College Charles L. Terry Jr. Campus Conference Center in Dover, DE. Of the 85 individuals who were invited to participate, 59 had registered and at least 55 were in attendance representing 34 different agencies and organizations.

Section A contains the policy recommendations resulting from the Delaware Telehealth Roundtable. From the list of identified barriers and challenges (pages 2-5), those requiring a policy-related solution were identified (*) and immediately moved to a separate section related to policy issues that need to be addressed. The policy related issues are among the first set of recommended action steps. Other identified barriers and challenges were then categorized and participants were asked to envision and identify telehealth enabled solutions.

A. Policy and Advocacy: The advancement of the Delaware Roundtable Telehealth Strategic Action Plan and its recommendations are heavily dependent upon quality and effective public policies, advocacy and favorable legislation. These recommended action items are policy and/or policy-related in nature and would benefit the overall telehealth environment in Delaware:

A.1. Credentialing
   a. The lengthy credentialing process (6 months+) for hospitals and for inclusion in insurance panels needs to be addressed, particularly for provider types where there are provider shortages.
   b. More favorable policies are needed to allow telehealth practice across state lines.
A.2. **Electronic Medical Records/Patient Information**
   a. It is recommended that the Delaware Health Information Network (DHIN) establish the capacity for providers to access behavioral health records.
   b. It is recommended that the DHIN identify ways to address the cost of participation and better engage the smaller and more remote practices.
   c. A mechanism is needed to track referrals in the medical record.
   d. A mechanism is needed to provide patient “verification” for telehealth encounters.
   e. Clear written guidance is needed on how to share information between providers.

A.3. **Legal Liability/Responsibility**
   a. Clear written guidance is needed to address the question “who is the provider” and “who is liable”? This is particularly needed in the case of out-of-state consults, but also for local/in-state consults.
   b. Memorandums of understanding (MOUs) and contracts for telehealth between institutions and providers are complicated and require a lengthy legal process. The development of a standard telehealth template is needed to facilitate this process.

A.4. **Licensure**
   a. The lengthy licensure process needs to be addressed, particularly for provider types where there are provider shortages.
   b. More favorable policies are needed to allow telehealth practice across state lines (e.g., interstate compacts across the region).

A.5. **Practice Guidelines**
   a. Advocacy is needed at the federal level to ensure that limitations on therapy/number of sessions for Parkinson’s disease are lifted.
   b. Policies related to restrictive involuntary treatment need to be assessed to ensure they are not creating barriers to needed care. For example, policies facilitating telehealth services may be useful in reducing the need for involuntary treatment due to lack of access to psychiatric consultation.
   c. Clear written policies are needed to help providers understand best practices, standards of care and efficacy/outcomes data pertaining to telehealth.
   d. Policies and/or incentives are needed to improve implementation of patient centered medical homes (PCMH). The PCMH emphasizes comprehensive and continuous care with a focus on care coordination and communication in order to improve patient health outcomes with the potential to lead to higher quality and lower costs while improving the experience of care for both patients and providers. Some financial incentives may be offered by health plans, employers, federal and state-sponsored pilot programs with potential for the PCMH to qualify for additional bonuses and payments. Telehealth helps to facilitate many of the required elements of the PCMH model for all practices, and is critical for rural practices.

A.6. **Reimbursement**
   a. Clear written policies are needed regarding reimbursement methodologies for telehealth.
   b. Clear written policies are needed regarding pre-authorization requirements for telehealth.
c. Policies need to be assessed and modified to address the issue of “siloed” insurance billing processes between providers (e.g., behavioral health and primary care) as these processes create a barrier to integrated and coordinated care.

d. More favorable policies regarding reimbursement for store and forward services are needed. Reimbursement for store and forward applications of telehealth would allow providers to provide telehealth consults at the time of their choosing, thus not cutting into clinic hours.

e. Reimbursement policies need to be examined to ensure that telehealth reimbursement is on the same level as face to face reimbursement for both in and out of state providers.

A.7. Technology Standards
   a. Clear written guidance is needed regarding technology interoperability and privacy/HIPAA standards.

A.8. Health Resources Planning and Coordination.
   a. The DTC has been identified as the lead for the majority of the action items to follow in this document. The DTC is comprised of volunteer leadership and membership. The successful implementation of this Strategic Action Plan will be highly dependent on the ability to identify State and other resources needed to ensure adequacy of staffing for the DTC to assume this planning and coordination function.

Immediate Next Step: Delaware Telehealth Coalition will work with DHSS leadership to devise a short-term and long-term structure that provides sufficient staff support to facilitate the implementation of the Delaware Telehealth Strategic Action Plan and the overall work of the Delaware Telehealth Coalition.

Followed By: Delaware Telehealth Coalition to identify and convene policy makers and appropriate others to initiate discussion on each of the policy issues above.

After categorizing barriers and challenges and identifying telehealth enabled solutions, participants were asked to prioritize those categories based on which ones they felt would make the greatest contribution in a two-to-three year time frame. The top five priority areas included (bold red print in the tables on pages 5-8) and are included in Sections B through F with one to three action items in each category identified as priorities for the implementation period:

1) Cost (Start Up)
2) Fragmentation/Gaps in Service (Care Transition/Coordination)
3) Fragmentation/Gaps in Service (Caregiver and Patient In-Home Support)
4) Workforce (Lack of Providers/Specialists/Interdisciplinary Teams)
5) Workforce (Provider Buy-In and Training)

B. Cost (Start Up): The cost of infrastructure and equipment for smaller practices was identified as one of the most important barriers to overcome that would enable telehealth to be more fully integrated into Delaware’s healthcare system. The following recommended action items are related to start-up costs:
B.1. Establish a value of telehealth that can be quantified. Then either through appropriations legislation or blending of agency resources, support integrative telehealth practice.

Immediate Next Step: Delaware Telehealth Coalition to develop a compendium of studies/research that summarizes telehealth use cases that have outcomes with both cost savings and improved health outcomes (e.g., reduced length of stay).

Followed By: Delaware Telehealth Coalition to convene policy makers and appropriate others to share identified use cases that result in both cost savings and improved health outcomes. The convened group should identify what existing resources they are able to contribute to support starting up of these projects.

At a minimum, who needs to be at the table? Hospitals, long term care facilities, Health Care Commission, major insurers, Medicaid, Cabinet Secretaries

B.2. Identify/make available funding opportunities through the state or other sources for the purchase of telehealth equipment which is standards based and interoperable.

Immediate Next Step: Delaware Telehealth Coalition to convene a meeting to discuss and research sources of funds and to develop grant application criteria, etc.

At a minimum, who needs to be at the table? DHSS, Budget Office, Office of Economic Development, Department of Justice (DOJ), Corrections

C. Fragmentation/Gaps in Service (Care Transition/Coordination): The ability to provide improvements in care transitions/care coordination was identified as one of the most important barriers to overcome to allow all residents to have more equitable access to affordable world-class, patient centered behavioral health, specialty care and chronic disease management services throughout the state. The following recommended action items are related to care transition/coordination:

C.1. Establish remote patient monitoring/care coordination centers.

Immediate Next Step: Delaware Telehealth Coalition to identify successful models and best practices related to remote patient monitoring/care coordination centers.

Followed By: Delaware Telehealth Coalition to convene policy makers and appropriate others to share identified successful models and best practices related to the provision of remote patient monitoring/care coordination. The convened group should decide on action steps needed to replicate these successful models and best practices in either a pilot program or on a larger scale.

At a minimum, who needs to be at the table? Medical Home Teams, Payers

C.2. Use telehealth to provide mental health consultations within primary care practices/medical homes.

Immediate Next Step: Delaware Telehealth Coalition to identify successful models and best practices related to the provision of mental health consultations within primary care practices/medical homes.
Followed By: Delaware Telehealth Coalition to convene policy makers and appropriate others to share identified successful models and best practices related to the provision of mental health consultations within primary care practices/medical homes. The convened group should decide on action steps needed to replicate these successful models and best practices in either a pilot program or on a larger scale.

At a minimum, who needs to be at the table? Primary care providers, mental/behavioral health providers (includes substance abuse), patients/consumers, Medical Society of DE (MSD), Division of Public Health (DPH) - Maternal and Child Health Bureau, all payers

D. Fragmentation/Gaps in Service (Caregiver and Patient In-Home Support): The ability to provide caregiver and patient support in the home setting was identified as one of the most important barriers to overcome to allow all residents have more equitable access to affordable world-class, patient centered behavioral health, specialty care and chronic disease management services throughout the state. The following recommended action items are related to caregiver and patient in-home support:

D.1. Enable delivery of health services through telehealth in the home – including evaluation, treatment, follow-up, care coordination and education and support.

Immediate Next Step: Delaware Telehealth Coalition to identify successful models and best practices related to home telehealth.

D.2. Develop more favorable policies regarding reimbursement for home based services in order to support D.1. This includes reimbursement for home health services, remote patient monitoring, and using the home as the originating site of care.

Immediate Next Step: Delaware Telehealth Coalition to convene policy makers and appropriate others to share identified successful models and best practices related to home telehealth. Convened group should assess current practices and identify obstacles to implementation of successful models and best practices related to home telehealth.

At a minimum, who needs to be at the table? Payers (i.e., CMS/Medicare, Medicaid, private), State agencies, advocates, community support network, providers, patients, families, policymakers, legislators, technology experts

E. Workforce (Lack of Providers/Specialists/Interdisciplinary Teams): The ability to increase the availability of providers, specialists and interdisciplinary teams was identified as one of the most important barriers to overcome to allow all residents to have more equitable access to affordable world-class, patient centered behavioral health, specialty care and chronic disease management services throughout the state. The following recommended action items are related to increasing the availability of providers, specialists and interdisciplinary teams:

E.1. Emulate or adopt Project ECHO (Extension for Community Healthcare Outcomes). Programs like Project ECHO allow providers to share challenging cases with specialists thereby building capacity to safely and effectively treat chronic, common and complex conditions in rural and underserved areas. Collaboration between primary care providers and specialists enables patients to receive state-of-the art healthcare from the professionals they know and trust in their own communities. For providers, the model brings added depth and technical
competencies and reduces professional isolation. With continued involvement, providers become highly skilled in the treatment of these chronic and complex diseases, thus creating a center of excellence in their community. (Note: this action step is already in progress in Delaware.)

E.2. Inventory existing resources and create a database/statewide directory of specialists who can provide telehealth.

E.3. Find other organizations that have the capacity to provide services through telehealth.

Immediate Next Step: Delaware Telehealth Coalition to work with the MATRC to identify what information is already available for the last two recommended action steps.

Followed By: Delaware Telehealth Coalition to reach out to: national certification/licensure boards, medical schools, 211/United Way, health provider professional associations, University of Delaware Center for Demography & Survey Research and University of Delaware Health Sciences Alliance.

F. Workforce (Provider Buy-In and Training). The ability to increase provider buy-in for telehealth through access to training was identified as one of the most important barriers to overcome to allow all residents to have more equitable access to affordable world-class, patient centered behavioral health, specialty care and chronic disease management services throughout the state. The following recommended action items are related to provider buy-in and training:

F.1. Research existing telehealth curricula and encourage adoption of such curricula in health professions education programs throughout Delaware.

Immediate Next Step: Delaware Telehealth Coalition to work with the MATRC to identify existing training curricula/programs.

Followed By: Delaware Telehealth Coalition to meet with administrators of training and educational programs including the P-20 Council, an inclusive organization designed to align Delaware’s education efforts of publicly-funded programs across all grade levels through higher education, to discuss health professions education programs and next steps to integrate telehealth into these education/technical training programs.

The DHSS will be partnering with the DTC to provide leadership for plan implementation. In order to support the vision driving this Strategic Action Plan, Delawareans must collaborate to implement the recommendations found in this document.
Delaware Telehealth Roundtable Strategic Action Plan

Introduction

The Mid-Atlantic Telehealth Resource Center’s (MATRC) is funded by the U.S. Department of Health and Human Service’s Health Resources and Services Administration (HRSA) Office for the Advancement of Telehealth, which is part of the Office of Rural Health Policy. Nationally, there are 14 telehealth resource centers (TRC’s). This includes 12 Regional Centers, all with different strengths and regional expertise, and two National Centers, one focusing on Technology Assessment and one on Telehealth Policy. TRC’s have a mission to serve as a focal point for advancing the effective use of telehealth and support access to telehealth services in rural and underserved communities. The MATRC is a regional TRC that focuses on providing technical assistance and resources to the following Mid-Atlantic States: Delaware, Kentucky, Maryland, North Carolina, Pennsylvania, Virginia, West Virginia and the District of Columbia. As part of the MATRC’s Technical Assistance efforts, each grant year (September 1 – August 31), MATRC is able to provide up to two states, on a first-come first-serve basis, the resources needed to hold a full day facilitated strategic planning retreat/roundtable.

The purpose of the state roundtables is to bring together key stakeholders around one or two priority health needs, with the end goal of developing consensus and establishing a 2 – 3 year strategic action plan for advancing the adoption and utilization of telehealth as a mechanism for meeting the identified priority health need(s).

Background and Purpose

With leadership provided by the Delaware Department of Health and Social Services (DHSS) and the Delaware Telehealth Coalition, a core planning team (see Appendix A) was organized in June 2013 to begin planning for a Delaware Telehealth Roundtable. In addition to identifying a date, location and venue for the event, the team built upon the vision, mission and work of the Delaware Telehealth Coalition (DTC - see Appendix B) and took on the task of identifying and gathering all health and health-related needs assessments that have been done in Delaware within the past five years (see Appendix C). Thirty-three needs assessments, reports and presentations were collected, including the Delaware Telehealth Coalition Issues List of May 2013. The planning team reviewed and then prioritized Delaware’s health needs based on the common threads that ran across the majority of the reports. These included the need for Delaware to improve:

1) access to behavioral health services;
2) access to specialty care; and
3) management of chronic disease.

In addition, the planning team felt it would be important to identify technology infrastructure and training needs in order to enable providers to use the technology for both clinical and educational purposes.

Finally, the planning team identified and engaged key stakeholders from a variety of sectors to participate in the event. Eighty-five individuals were personally invited by Secretary Landgraf to attend the event. The full day event was held on Wednesday December 4, 2013 at the Delaware Technical and Community College Charles L. Terry Jr. Campus Conference Center in Dover, DE (see Appendix D for agenda). Of the 85 individuals who were invited to participate, 59 had registered for the event, and at least 55 were in attendance representing 34 different agencies and organizations (see Appendix E).
Vision for Telehealth in Delaware

The Delaware Telehealth Roundtable was guided by the vision for telehealth in Delaware as delineated by the Delaware Telehealth Coalition:

“Telehealth will be fully integrated into Delaware’s healthcare system so that all residents will have equitable access to affordable, world-class, patient-centered healthcare throughout the state.”

Mission of the Delaware Telehealth Coalition (DTC)

The Strategic Action Plan developed as a result of the Delaware Telehealth Roundtable was shaped with the mission of the Delaware Telehealth Coalition in mind:

“To facilitate the use of telehealth to improve access to high quality healthcare throughout Delaware.”

Strategic Focus of the Delaware Telehealth Roundtable

To improve:

- access to behavioral health services;
- access to specialty care; and
- management of chronic disease.

To identify:

- technology infrastructure and training needs in order to enable providers to better utilize technology for both clinical and educational purposes.

Barriers and Challenges

Behavioral Health Services. The following barriers and challenges were identified in response to the question, “What is preventing all residents from having equitable access to affordable, world-class, patient-centered behavioral health care services throughout the state right now?”

<table>
<thead>
<tr>
<th>Fragmentation/Gaps in Services</th>
<th>Lack of preventive, early diagnosis and early intervention infrastructure</th>
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<tr>
<td></td>
<td>Inadequate crisis intervention services, to include suicide intervention, drug overdose, and mental health crises</td>
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<tr>
<td></td>
<td>Challenges related to restrictive involuntary treatment*</td>
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<td></td>
<td>“Marginalized” populations have a harder time accessing care, to include:</td>
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<tr>
<td></td>
<td>- Individuals with cultural/linguistic needs – lack of interpreters and culturally competent providers</td>
</tr>
<tr>
<td></td>
<td>- Individuals with development disabilities</td>
</tr>
<tr>
<td></td>
<td>- Individuals with dual diagnoses</td>
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### Specialty Care

The following barriers and challenges were identified in response to the question “What is preventing all residents from having equitable access to affordable world-class, patient centered specialty care throughout the state right now?”

<table>
<thead>
<tr>
<th>Category</th>
<th>Challenges</th>
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<tbody>
<tr>
<td>Legal Liability</td>
<td>Lack of understanding regarding who is liable during telemedicine encounters*</td>
</tr>
<tr>
<td>Medical Records/ Patient Information</td>
<td>Lack of access to medical records*</td>
</tr>
<tr>
<td></td>
<td>- Lack of integration into DHIN for small practices - Cost of DHIN</td>
</tr>
<tr>
<td></td>
<td>- No mechanisms for referral tracking</td>
</tr>
<tr>
<td></td>
<td>- No access to necessary medical information (e.g., informed consent)</td>
</tr>
<tr>
<td></td>
<td>- Lack of full participation in DHIN, especially by remote providers</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>Lack of understanding regarding reimbursement methodology for telehealth.*</td>
</tr>
<tr>
<td></td>
<td>Confusion regarding pre-authorization requirements and its complexities*</td>
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<tr>
<td>Social Determinants</td>
<td>Lack of transportation</td>
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<td></td>
<td>Lack of insurance</td>
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<td></td>
<td>Population density/rurality</td>
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<td>Workforce</td>
<td>Lack of provider buy-in for using telehealth</td>
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<td></td>
<td>Lack of large academic teaching medical centers/medical schools</td>
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<td></td>
<td>Credentialing and licensure issues (especially across state lines)*</td>
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</table>
**Chronic Disease Management.** The following barriers and challenges were identified in response to the question “What is preventing all residents from having equitable access to affordable world-class, patient centered chronic disease management throughout the state right now?”

<table>
<thead>
<tr>
<th>Fragmentation/Gaps in Services</th>
<th>Lack of coordination across disciplines and across lifespan</th>
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<tbody>
<tr>
<td></td>
<td>Lack of in-home support for individuals and families</td>
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<td></td>
<td>Lack of prevention and disease education</td>
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<td></td>
<td>Inadequate ongoing management</td>
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<tr>
<td></td>
<td>Inadequate screening</td>
</tr>
<tr>
<td>Legal Liability</td>
<td>Lack of understanding regarding who is liable during telemedicine encounters*</td>
</tr>
<tr>
<td>Medical Records/ Patient Information</td>
<td>Lack of sharing of data/integration of data*</td>
</tr>
<tr>
<td></td>
<td>Lack of patient’s personal EHRs*</td>
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<tr>
<td>Public Perception/ Awareness</td>
<td>Lack of willingness to accept new models of care</td>
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<td></td>
<td>Lack of consumer engagement in their own care</td>
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<tr>
<td>Reimbursement</td>
<td>Lack of reimbursement for home based services*</td>
</tr>
<tr>
<td></td>
<td>High cost of medications*</td>
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<tr>
<td>Social Determinants of Health</td>
<td>Lack of insurance</td>
</tr>
<tr>
<td>Workforce</td>
<td>Lack of specialists/multidisciplinary teams (labor intensive)</td>
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<tr>
<td></td>
<td>Reticence of specialists to engage in telehealth</td>
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<td></td>
<td>Lack of understanding and transparency of outcome measures/data *</td>
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<td></td>
<td>Lack of tech savvy and access to equipment</td>
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<tr>
<td></td>
<td>Inadequate implementation of patient centered medical homes*</td>
</tr>
<tr>
<td></td>
<td>Credentialing and licensure issues*</td>
</tr>
<tr>
<td></td>
<td>Inadequate understanding of policies/standards</td>
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<td></td>
<td>Inadequate assessment tools</td>
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**Technology Infrastructure and Training.** The following barriers and challenges were identified in response to the question “Why is telehealth not fully integrated into Delaware’s healthcare system?”

<table>
<thead>
<tr>
<th>Cost</th>
<th>Lack of money for startup (cost prohibitive for small practices)</th>
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<tbody>
<tr>
<td></td>
<td>Inadequate models/understanding as to who should be paying for it</td>
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</tbody>
</table>
Inadequate reimbursement*  
Legal Liability  
Malpractice concerns*  
Medical Records/  
Patient Information  
Lack of system for patient verification*  
Inadequate sharing of data*  
Public Perception/  
Awareness  
Lack of patient buy-in/demand  
Lack of public marketing/education  
Concerns about privacy of information/data  
Systems  
Lack of infrastructure  
Lack of interoperability  
Workforce  
Credentialing and licensure issues*  
Resistance to change/lack of buy-in  
Lack of integration in health professions education  
Lack of training on how to implement/lack of technical competence  
Lack of awareness/understanding of standards and guidelines and technology standards/best practices  
Lack of understanding about how to use technology within HIPAA environment/concerns about security*  

*From the list of identified barriers and challenges, those requiring a policy-related solution were identified (*) and immediately moved to a separate section related to policy issues that need to be addressed. The policy related issues are among the first set of recommended action steps found later in this report. Other identified barriers and challenges were then categorized and participants were asked to envision and identify telehealth enabled solutions.

### Envisioning Telehealth Enabled Solutions to the Barriers and Challenges

| Costs (Start Up) | Offer grants similar to electronic health records  
| Offer businesses credits for investment  
| Pursue current array of grant funded sources  
| Consider select pilot-projects funded by insurers, government entities, etc., to demonstrate cost savings such as in readmissions  
| Identify and leverage resources – use economies of scale, especially for smaller practices  
| Establish a value of telehealth that can be quantified. Then, either through appropriations legislation or blending of agency resources, support these integrative telehealth practices.  
| Make available non-competitive grants through the State for the purchase of telehealth equipment which is standards based and interoperable.  
| Provide start-up funding through insurers or Medicaid to incent participation of providers.  
| Create a database of grant sources for telehealth and distribute information  
| Fragmentation/Gaps in Service (Caregiver and Patient In-Home | Provide funding for in home technology/Provide tablets for everyone/Use TV technology instead of computer so that everyone has access  
| Enable delivery of health services through telehealth in the home – including
Support) | evaluation, treatment, follow-up, care coordination and education and support. Provide case management via web-based telehealth and provide support in the home through regular check-ins and other services. Establish telehealth services to manage chronic disease from the home. Use telehealth to have physicians do evaluations and exams remotely...and get adequately reimbursed!  
Connect families to other families via telehealth/Internet who can share resources and information  
Recognize the need and fund additional respite and support services for caregivers  
| Fragmentation/Gaps in Service (Care Transition/Coordination) | Implement remote patient monitoring/care coordination centers  
Use telehealth to provide mental health consultations within primary care practices/medical homes  
Provide tools for maximizing the telehealth opportunities (i.e., forms, evaluations, records, assessments, etc.)  
Facilitate care coordination through shared consults with interdisciplinary teams using telehealth  
Use telehealth to facilitate “warm hand offs” between specialists and providers  
Fragmentation/Gaps in Service (Crisis Intervention) | Offer telehealth follow up counseling services for patients released for suicide attempts and drug overdoses from hospital systems  
Implement programs between MH facilities and schools and other organizations that provide prevention methods for clients identified as high risk  
Develop telehealth apps for phones and heavily advertise as easy to use “Doc/crisis team in your pocket”  
Develop memorandums of understanding (MOUs) between middle/high schools and crisis intervention specialists to work with/in emergency crisis school situations  
Attach crisis hot lines to telehealth – enable connectivity to a broader network of first responders and other help sources  
Fragmentation/Gaps in Service (Cultural/Linguistic Needs) | Contract with medical interpreters, ASL interpreters to link in 24 hours to interpret via telehealth  
Use telehealth services to identify and use medical/mental health providers who speak the same language and understand the culture of the patient in need of the services  
Build apps that have built in translation features  
Use telehealth to increase training around culturally competent service delivery for providers, including connecting experts in the field to share educational resources via grand rounds, etc.  
Fragmentation/Gaps in Service (Disease Education) | Develop online resources/distance learning series  
Provide ongoing check-ins via telehealth with disease educators to promote compliance  
Provide online real time telehealth support groups  
Use mobile apps/games to educate people about diseases  
Use telehealth technology to connect experts in the field to attend/share educational resources (e.g., grand rounds)  
Fragmentation/Gaps in Service (Institutionalization) | Promote the use of telehealth in all long term care facilities  
Use telehealth for diagnosis of communicable diseases in correctional facilities.  
Triage transport cases versus treatment that can be delivered within the
<table>
<thead>
<tr>
<th><strong>DELAWARE TELEHEALTH ROUNDTABLE STRATEGIC ACTION PLAN 2014 - 2016</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>机构系统。</strong></td>
</tr>
<tr>
<td>实施远程医疗服务计划，为管理和疾病（例如，糖尿病、高血压、心脏病）提供管理服务，以减少交通费用和服务</td>
</tr>
<tr>
<td>提供远程医疗服务到设施</td>
</tr>
<tr>
<td>使用远程患者监测为设施居民提供服务</td>
</tr>
<tr>
<td><strong>碎片化/服务缺口</strong></td>
</tr>
<tr>
<td><strong>预防</strong></td>
</tr>
<tr>
<td>使用远程医疗来提供预防教育和基于证据的干预措施，针对服务不足的社区/并提供资金，以便患者可以访问项目在“Y”通过远程医疗</td>
</tr>
<tr>
<td>使用团队方法，让患者有一种机制可以在一个时间通过远程医疗接收所有服务</td>
</tr>
<tr>
<td>使用远程医疗来监测进度并定期与患者进行交互，从而与健康教练通过远程医疗提供教育/支持/指导</td>
</tr>
<tr>
<td>将心理健康提供者与初级医疗团队联系起来，通过在所有心理健康诊所提供远程医疗</td>
</tr>
<tr>
<td><strong>公众意识</strong></td>
</tr>
<tr>
<td>发展公共服务公告，展示远程医疗的实际应用和它有多么有益（在电视、电台、等）</td>
</tr>
<tr>
<td>解释服务的可用性以及高质量</td>
</tr>
<tr>
<td>建立“远程医疗办公室”帮助推广远程医疗到公众和提供者——一个一站式的资源，以获得访问并保持势头</td>
</tr>
<tr>
<td>训练图书馆工作人员，并将远程医疗信息整合到图书馆环境</td>
</tr>
<tr>
<td>主要医疗提供者应推动远程医疗的使用，作为特殊护理的途径</td>
</tr>
<tr>
<td>提供通过社区组织的培训</td>
</tr>
<tr>
<td>使用社交网络如Twitter来宣传远程医疗的优势</td>
</tr>
<tr>
<td><strong>工作队伍（激励吸引提供者）</strong></td>
</tr>
<tr>
<td>提供通过远程/远程学习方式的继续教育，作为留在农村/偏远地区的方式</td>
</tr>
<tr>
<td>提供还款选择给提供远程医疗的提供者，要求时间留在DE</td>
</tr>
<tr>
<td>减少通过提供远程医疗的教育机会带来的隔离（例如，继续教育）</td>
</tr>
<tr>
<td><strong>工作队伍（提供者/专家/跨学科团队）</strong></td>
</tr>
<tr>
<td>提供远程医疗访问，否则将不可用</td>
</tr>
<tr>
<td>探索远程医疗的实施，以便有效地促进提供远程医疗与临床学科的整合</td>
</tr>
<tr>
<td>联系国家认证机构创建资源数据库</td>
</tr>
<tr>
<td>存档现有的资源并创建资源数据库/州目录的专家，为远程医疗提供远程医疗</td>
</tr>
<tr>
<td>同意或采用远程医疗（远程医疗效能的靶标）程序。像远程医疗这样的程序允许提供者分享具有挑战性的情况与专家，从而安全有效地治疗慢性、常见和复杂的条件在农村和未服务地区。初级医疗提供者和专家之间的合作让患者能够从他们知道和信任的专家那里获得最先进的医疗服务</td>
</tr>
</tbody>
</table>
trust in their own communities. For providers, the model brings added depth and technical competencies and reduces professional isolation. With continued involvement, providers become highly skilled in the treatment of these chronic and complex diseases, thus creating a center of excellence in their community.

| Share services with other organizations via telehealth |
| Videoconference multiple specialists to coordinate care and develop interdisciplinary teams |
| Conduct needs assessments at the community level to determine needed services and then match availability of telehealth providers to those needs |
| Limit malpractice liability for telehealth providers |
| Find other organizations that have the capacity to provide services through telehealth |

**Workforce (Provider Buy-In and Training)**

| Provide examples of how telehealth is working in other states and within the federal government |
| Provide outcomes data to illustrate success stories |
| Have providers and patients/clients provide testimony of how it has worked for them |
| Provide tax incentives or state innovation grants for the purchase of telehealth equipment for provider offices |
| Provide education on the systemic benefits telehealth can offer through the institutions they work for or through outside agencies |
| Provide financial incentives to use telehealth |
| Provide standardized equipment that is efficient and easy to use…and provide free or low cost training/purchase the needed technology/equipment for providers |
| Make things easy for providers – make standards, guidelines, etc...readily available |
| Have mentors who are super users |
| Mandate training at least annually |
| Research existing telehealth curricula and encourage adoption of such curricula in health professions education programs throughout Delaware. |
| Research and provide training on assessment tools for chronic disease management |
| Create practice guidelines specific to telehealth and embed educational content into practice guidelines |
| Provide training/seminars to providers and consumers on how to use telehealth equipment |
| Have trainings and meetings done virtually/use telehealth to offer a virtual classroom so that the workforce can do training at any location |
| Provide CEUs |
| Provide practices with an IT specialist who also understands telehealth to help them |
| Reduce state licensure fees for participating in telehealth training |
| Set up Avatar for virtual reality scenarios to train and provide opportunities for experiential learning |
| Evaluate where shortages for specialty services exist then work with the University systems to review/advance curriculum |
After categorizing barriers and challenges and identifying telehealth enabled solutions, participants were asked to prioritize those categories based on which ones they felt would make the greatest contribution in a two-to-three year time frame. The top five priority areas included (bolded and highlighted in the table above):

1) Cost (Start Up)
2) Fragmentation/Gaps in Service (Care Transition/Coordination)
3) Fragmentation/Gaps in Service (Caregiver and Patient In-Home Support)
4) Workforce (Lack of Providers/Specialists/Interdisciplinary Teams)
5) Workforce (Provider Buy-In and Training)
Recommendations

For each of the top five categories of barriers and challenges with identified telehealth enabled solutions, participants were asked to identify those solutions that they felt would make the greatest contribution in a two-to-three year time frame. These solutions (along with the policy issues described earlier) collectively make up the set of recommended action items. Participants of the Delaware Telehealth Roundtable felt strongly that these recommended action items, if fully supported and funded, will lead to significant advancements in telehealth and ultimately improvements in the health and well-being of Delawareans.

A. Policy and Advocacy: The advancement of the Delaware Roundtable Telehealth Strategic Action Plan and its recommendations are heavily dependent upon quality and effective public policies, advocacy and favorable legislation. These recommended action items are policy and/or policy-related in nature and would benefit the overall telehealth environment in Delaware:

A.1. Credentialing
   a. The lengthy credentialing process (6 months+) for hospitals and for inclusion in insurance panels needs to be addressed, particularly for provider types where there are provider shortages.
   b. More favorable policies are needed to allow telehealth practice across state lines.

A.2. Electronic Medical Records/Patient Information
   a. It is recommended that DHIN establish the capacity for providers to access behavioral health records.
   b. It is recommended that DHIN identify ways to address the cost of participation and better engage the smaller and more remote practices.
   c. A mechanism is needed to track referrals in the medical record.
   d. A mechanism is needed to provide patient “verification” for telehealth encounters.
   e. Clear written guidance is needed on how to share information between providers.

A.3. Legal Liability/Responsibility
   a. Clear written guidance is needed to address the question “who is the provider” and “who is liable”? This is particularly needed in the case of out-of-state consults, but also for local/in-state consults.
   b. MOUs and contracts for telehealth between institutions and providers are complicated and require a lengthy legal process. The development of a standard telehealth template is needed to facilitate this process.

A.4. Licensure
   a. The lengthy licensure process needs to be addressed, particularly for provider types where there are provider shortages.
   b. More favorable policies are needed to allow telehealth practice across state lines (e.g., interstate compacts across the region).

A.5. Practice Guidelines
   a. Advocacy is needed at the federal level to ensure that limitations on therapy/number of sessions for Parkinson’s disease are lifted.
   b. Policies related to restrictive involuntary treatment need to be assessed to ensure they are not creating barriers to needed care. For example, policies facilitating telehealth services may
be useful in reducing the need for involuntary treatment due to lack of access to psychiatric consultation.

- Clear written policies are needed to help providers understand best practices, standards of care and efficacy/outcomes data pertaining to telehealth.
- Policies and/or incentives are needed to improve implementation of patient centered medical homes.

A.6. Reimbursement
- Clear written policies are needed regarding reimbursement methodologies for telehealth.
- Clear written policies are needed regarding to pre-authorization requirements for telehealth.
- Policies need to be assessed and modified to address the issue of "silod" insurance billing processes between providers (e.g., behavioral health and primary care) as this creates a barrier to integrated and coordinated care.
- More favorable policies regarding reimbursement for store and forward services are needed. Reimbursement for store and forward applications of telehealth would allow providers to provide telehealth consults at the time of their choosing, thus not cutting into clinic hours.
- Reimbursement policies need to be examined to ensure that telehealth reimbursement is on the same level as face to face reimbursement for both in and out of state providers.

A.7. Technology Standards
- Clear written guidance is needed regarding technology interoperability and privacy/HIPAA standards.

A.8. Health Resources Planning and Coordination.
- The Delaware Telehealth Coalition (DTC) has been identified as the lead for the majority of the action items to follow in this document. The DTC is comprised of volunteer leadership and membership. The successful implementation of this Strategic Action Plan will be highly dependent on the ability to identify State and other resources needed to ensure adequacy of staffing for the DTC to assume this planning and coordination function.

Immediate Next Step: Delaware Telehealth Coalition will work with DHSS leadership to devise a short-term and long-term structure that provides sufficient staff support to facilitate the implementation of the Delaware Telehealth Strategic Action Plan and the overall work of the Delaware Telehealth Coalition.

Followed By: Delaware Telehealth Coalition to identify and convene policy makers and appropriate others to initiate discussion on each of the policy issues above.

B. Cost (Start Up): The cost of infrastructure and equipment for smaller practices was identified as one of the most important barriers to overcome that would enable telehealth to be more fully integrated into Delaware’s healthcare system. The following recommended action items are related to start-up costs:

B.1. Establish a value of telehealth that can be quantified. Then either through appropriations legislation or blending of agency resources, support integrative telehealth practice.

Immediate Next Step: Delaware Telehealth Coalition to develop a compendium of studies/research that summarizes telehealth use cases that have outcomes with both cost savings and improved health outcomes (e.g., reduced length of stay).
Followed By: Delaware Telehealth Coalition to convene policy makers and appropriate others to share identified use cases that result in both cost savings and improved health outcomes. The convened group should identify what existing resources they are able to contribute to support starting up of these projects.

At a minimum, who needs to be at the table? Hospitals, Long Term Care Facilities, Health Care Commission, Major Insurers, Medicaid, Cabinet Secretaries

B.2. Identify/make available funding opportunities through the state or other sources for the purchase of telehealth equipment which is standards based and interoperable.

Immediate Next Step: Delaware Telehealth Coalition to convene a meeting to discuss and research sources of funds and to develop grant application criteria, etc.

At a minimum, who needs to be at the table? DHSS, Budget Office, Economic Development, DOJ, Corrections

C. Fragmentation/Gaps in Service (Care Transition/Coordination): The ability to provide improvements in care transitions/care coordination was identified as one of the most important barriers to overcome to allow all residents to have more equitable access to affordable world-class, patient centered behavioral health, specialty care and chronic disease management services throughout the state. The following recommended action items are related to care transition/coordination:

C.1. Establish remote patient monitoring/care coordination centers.

Immediate Next Step: Delaware Telehealth Coalition to identify successful models and best practices related to remote patient monitoring/care coordination centers.

Followed By: Delaware Telehealth Coalition to convene policy makers and appropriate others to share identified successful models and best practices related to the provision of remote patient monitoring/care coordination. The convened group should decide on action steps needed to replicate these successful models and best practices in either a pilot program or on a larger scale.

At a minimum, who needs to be at the table? Medical Home Teams, Payers

C.2. Use telehealth to provide mental health consultations within primary care practices/medical homes.

Immediate Next Step: Delaware Telehealth Coalition to identify successful models and best practices related to the provision of mental health consultations within primary care practices/medical homes.

Followed By: Delaware Telehealth Coalition to convene policy makers and appropriate others to share identified successful models and best practices related the provision of mental health consultations within primary care practices/medical homes. The convened group should decide on action steps needed to replicate these successful models and best practices in either a pilot program or on a larger scale.

At a minimum, who needs to be at the table? Primary Care Providers, Mental – Behavioral Health Providers (includes substance abuse), Patients/Consumers, Medical Society, Division of Public Health - Maternal and Child Health, All Payers
D. Fragmentation/Gaps in Service (Caregiver and Patient In-Home Support): The ability to provide caregiver and patient support in the home setting was identified as one of the most important barriers to overcome to allow all residents to have more equitable access to affordable world-class, patient centered behavioral health, specialty care and chronic disease management services throughout the state. The following recommended action items are related to caregiver and patient in-home support:

D.1. Enable delivery of health services through telehealth in the home – including evaluation, treatment, follow-up, care coordination and education and support.

**Immediate Next Step:** Delaware Telehealth Coalition to identify successful models and best practices related to home telehealth.

D.2. Develop more favorable policies regarding reimbursement for home based services in order to support D.1. This includes reimbursement for home health services, remote patient monitoring, and using the home as the originating site of care.

**Immediate Next Step:** Delaware Telehealth Coalition to convene policy makers and appropriate others to share identified successful models and best practices related to home telehealth. Convened group should assess current practices and identify obstacles to implementation of successful models and best practices related to home telehealth.

**At a minimum, who needs to be at the table?** Payers (i.e., CMS/Medicare, Medicaid, private), state agencies, advocates, community support network, providers, patients, families, policymakers, legislators, technology experts

E. Workforce (Lack of Providers/Specialists/Interdisciplinary Teams): The ability to make increase the availability of providers, specialists and interdisciplinary teams was identified as one of the most important barriers to overcome to allow all residents to have more equitable access to affordable world-class, patient centered behavioral health, specialty care and chronic disease management services throughout the state. The following recommended action items are related to increasing the availability of providers, specialists and interdisciplinary teams:

E.1. Emulate or adopt Project ECHO. Programs like Project ECHO allow providers to share challenging cases with specialists thereby building capacity to safely and effectively treat chronic, common and complex conditions in rural and underserved areas. Collaboration between primary care providers and specialists enables patients to receive state-of-the-art healthcare from the professionals they know and trust in their own communities. For providers, the model brings added depth and technical competencies and reduces professional isolation. With continued involvement, providers become highly skilled in the treatment of these chronic and complex diseases, thus creating a center of excellence in their community. (Note: This action step is already in progress in Delaware.)

E.2. Inventory existing resources and create a database/statewide directory of specialists who can provide telehealth

E.3. Find other organizations that have the capacity to provide services through telehealth.

**Immediate Next Step:** Delaware Telehealth Coalition to work with the MATRC to identify what information is already available for the last two recommended action steps.
Followed By: Delaware Telehealth Coalition to reach out to: national certification/licensure boards, medical schools, 211/United Way, hospitals, health provider professional associations, University of Delaware Center for Applied Demography & Survey Research and University of Delaware Health Sciences Alliance.

F. Workforce (Provider Buy-In and Training). The ability to increase provider buy-in for telehealth through access to training was identified as one of the most important barriers to overcome to allow all residents to have more equitable access to affordable world-class, patient centered behavioral health, specialty care and chronic disease management services throughout the state. The following recommended action item is related to provider buy-in and training:

F.1. Research existing telehealth curricula and encourage adoption of such curricula in health professions education programs throughout Delaware.

Immediate Next Step: Delaware Telehealth Coalition to work with the MATRC to identify existing training curricula/programs

Followed By: Delaware Telehealth Coalition to meet with administrators of training and educational programs including the P-20 Council, an inclusive organization designed to align Delaware's education efforts of publicly-funded programs across all grade levels through higher education, to discuss health professions education programs and next steps to integrate telehealth into these education/technical training programs.

Next Steps

The DHSS will be partnering with the DTC to provide leadership for plan implementation. In order to support the vision driving this Strategic Action Plan, Delawareans must collaborate to implement the recommendations found in this document.
## Appendix A: Delaware Telehealth Roundtable Planning Team

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katherine Collison</td>
<td>Public Health Treatment Program Administrator</td>
<td>DHSS – Division of Public Health</td>
</tr>
<tr>
<td>Gerard Gallucci</td>
<td>Medical Director</td>
<td>DHSS</td>
</tr>
<tr>
<td>William Love</td>
<td>Director</td>
<td>DHSS - Division of Services for Aging and Adults with Physical Disabilities</td>
</tr>
<tr>
<td>J. Kevin Massey</td>
<td>Public Health Treatment Program Administrator</td>
<td>DHSS - Division of Public Health</td>
</tr>
<tr>
<td>Carolyn Morris</td>
<td>Planner IV</td>
<td>DHSS - Division of Services for Aging and Adults with Physical Disabilities</td>
</tr>
<tr>
<td>Brian Olson</td>
<td>CEO</td>
<td>La Red Health Center</td>
</tr>
<tr>
<td>Ingrid Pretzer-Aboff</td>
<td>Associate Professor</td>
<td>University of Delaware</td>
</tr>
<tr>
<td>Lisa Schieffert</td>
<td>Director, Health Policy</td>
<td>Delaware Healthcare Association</td>
</tr>
<tr>
<td>Betsy Wheeler</td>
<td>President</td>
<td>Wheeler &amp; Associates Management Services</td>
</tr>
<tr>
<td>Kathy Wibberly</td>
<td>Director, Mid-Atlantic Telehealth Resource Center</td>
<td>UVA Center for Telehealth</td>
</tr>
</tbody>
</table>
Appendix B: Delaware Telehealth Coalition Members

April 2014

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Olivia_Hayden@carper.senate.gov

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(302) 379-0470 (cell)
apretty@udel.edu
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Deputy Director
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(302) 698-9227
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Abi Rao
Account Manager
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Dover, NJ 07801
(856) 334-1431
(716) 465-0359
arao@vsgi.com
**Appendix C: Delaware Needs Assessments**


3. Beebe Medical Center Community Health Needs Assessment ([BBMC 2013.pdf](#))

4. Community and Choice: Housing Needs for People with Disabilities in Delaware. Delaware Housing Coalition and Housing Sub-Committee of the Governor’s Commission on Community Based Alternatives for People with Disabilities. April 2012. ([Housing Needs April 2012.pdf](#))

5. Community Health Needs Assessment Final Summary Report – Christiana Hospital and Wilmington Hospital. ([Christiana Care CHNA Final Summary Report.pdf](#))


7. Delaware Health and Social Services. Update: Delaware’s Settlement Agreement with USDOJ. ([DOJ settlementupdatejointhealth051513.ppt](#))

8. Delaware Health and Social Services Division of Public Health: Community Themes and Strengths Assessment (CTSA). ([CTSA Final 4-25-13.pdf](#))

9. Delaware Health and Social Services Division of Public Health: State of Delaware Community Health Status Assessment. ([CHSA_Final 4-25-13.pdf](#))


20. Draft Delaware State Plan to Address Alzheimer’s Disease, 7.11.13. (Draft Delaware State Plan to Address Alzheimer's Disease Goals 7-11-13.docx)


23. Examination of Healthcare Cost and Utilization Drivers within the Delaware Medicaid Population, January 31, 2013. (DE Medicaid Cost and Utilization Overview (Final Results) (v 6).pptx)

24. Exemplar Interventions or Potential Opportunities. University of Delaware College of Health Sciences. (medicaid_presentation_V4.pptx)


Appendix D: Delaware Telehealth Roundtable Agenda

Delaware Telehealth Roundtable
Wednesday, December 4, 2013 from 8:30 AM to 4:00 PM
Delaware Technical and Community College
Charles L. Terry Jr. Campus Conference Center, Dover, DE

8:30 AM Registration and Continental Breakfast

9:00 AM Welcome and Introductions (Secretary Landgraf)

9:10 AM Overview of Objectives for Roundtable (Kathy Wibberly)

9:15 AM Why Telehealth? (Karen Rheuban)

9:45 AM Telehealth Demonstration (Kathy Wibberly and Mark Fletcher)

10:15 AM The Vision Before Us (Bill Love)

10:30 AM Break

10:45 AM Defining the Problem (Barriers and Challenges)

- What prevents all residents from having equitable access to affordable, world-class, patient-centered healthcare throughout the state right now?
- What prevents telehealth from being fully integrated into Delaware’s healthcare system?

12:15 PM Lunch

12:45 PM Envisioning Telehealth Enabled Solutions (Goals and Objectives)

- How can telehealth play a role in addressing the identified barriers and challenges?

2:00 PM Prioritizing Goals and Objectives

2:30 PM Break

2:45 PM Identifying Strategies and Action Steps

3:45 PM Wrap Up and Next Steps
# Appendix E: Delaware Telehealth Roundtable Attendees

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<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Helen Arthur</td>
<td>Director of Planning &amp; Policy</td>
<td>Delaware Health Care Commission</td>
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<tr>
<td>Gregory Busch</td>
<td>Chief Medical Officer</td>
<td>United Healthcare</td>
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<tr>
<td>Susan Campbell</td>
<td>Assistant Part C Coordinator</td>
<td>DHSS/DMS/Birth to 3</td>
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<tr>
<td>Carol Cave</td>
<td>Senior Coordinator</td>
<td>Multiple Sclerosis Society Delaware Chapter</td>
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<tr>
<td>Judy Chaconas</td>
<td>Director, Office of Health Planning and Resources</td>
<td>Delaware Division of Public Health</td>
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<tr>
<td>Cassandra Codes Johnson</td>
<td>Community Health</td>
<td>DHSS/DPH</td>
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<td>Katherine Collison</td>
<td>Public Health Administrator</td>
<td>DHSS/DPH</td>
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<tr>
<td>Susan Cycyk</td>
<td>Division Director</td>
<td>DSCYF/DPBHS</td>
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<td>Steven Dettwyler</td>
<td>Director, Community Mental Health and Addiction Services</td>
<td>DSAMH</td>
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<tr>
<td>Chris Devaney</td>
<td>Chief Operating Officer</td>
<td>Connections Community Support Programs, Inc.</td>
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<tr>
<td>Harvey Doppelt</td>
<td>Director, Specialized Services</td>
<td>Division of Prevention and Behavioral Health Services</td>
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<tr>
<td>Barry Fabius</td>
<td>Medical Director</td>
<td>United Healthcare</td>
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<td>Jill Fredel</td>
<td>Director of Communications</td>
<td>DHSS</td>
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<td>Jane Gallivan</td>
<td>Director</td>
<td>Division of Developmental Disability Services</td>
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<td>Gerard Gallucci</td>
<td>Medical Director</td>
<td>State of Delaware – DHSS</td>
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<td>Eric Gibson</td>
<td>Physician</td>
<td>Nemours</td>
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<td>Bernie Glavin</td>
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<td>Resources for Human Development</td>
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<td>Rosanne Griff-Cabelli</td>
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<td>Division of Management Services/DHSS</td>
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<td>William Hickox</td>
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<td>Department of Technology &amp; Information</td>
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<tr>
<td>Kyle Hodges</td>
<td>Director</td>
<td>State Council for Persons with Disabilities</td>
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<td>Gloria James</td>
<td>Bureau Chief</td>
<td>Public Health</td>
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<td>Kevin Kelley</td>
<td>Director</td>
<td>DHSS/DMS</td>
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<tr>
<td>Dan Khebzou</td>
<td>Account Executive</td>
<td>Insight Telepsychiatry, LLC</td>
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<tr>
<td>Rita Landgraf</td>
<td>DHSS Cabinet Secretary</td>
<td>State of Delaware</td>
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<tr>
<td>Paul Lakeman</td>
<td>Senior VP, Government Relations</td>
<td>Bay Health</td>
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<tr>
<td>Jan Lee</td>
<td>CEO</td>
<td>DHIN</td>
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<tr>
<td>Betty Leebel</td>
<td></td>
<td>Parkinson’s Education and Support Group of Sussex Co</td>
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<tr>
<td>Dennis Leebel</td>
<td>Leader</td>
<td>Parkinson’s Education and Support Group of Sussex Co.</td>
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<tr>
<td>Glenn LeFevre</td>
<td>Executive Director</td>
<td>Gateway Foundation</td>
</tr>
<tr>
<td>Name</td>
<td>Title/Role</td>
<td>Organization/Department</td>
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<tr>
<td>William Love</td>
<td>Director</td>
<td>Division of Services for Aging and Adults with Physical Disabilities</td>
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<tr>
<td>Stan Lynch</td>
<td>CMO</td>
<td>DPCI</td>
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<tr>
<td>Gayle MacAfee</td>
<td>Executive Director</td>
<td>Division of Professional Regulation</td>
</tr>
<tr>
<td>Patricia Maichle</td>
<td>Director</td>
<td>Developmental Disabilities Council</td>
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<tr>
<td>Jeanne Mahoney</td>
<td>Telehealth Coordinator</td>
<td>Department of Veterans Affairs Medical Center – Wilmington</td>
</tr>
<tr>
<td>Kay Malone</td>
<td>COO</td>
<td>La Red Health Center</td>
</tr>
<tr>
<td>Sarah Marshall</td>
<td>Managed Care System Administrator</td>
<td>DSCYF</td>
</tr>
<tr>
<td>J. Kevin Massey</td>
<td>Public Health Administrator</td>
<td>Delaware, Division of Public Health</td>
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<tr>
<td>John McKenna</td>
<td>CEO</td>
<td>Rockford Center</td>
</tr>
<tr>
<td>Dave Michalik</td>
<td>Chief of Policy &amp; Planning</td>
<td>Division of Medicaid &amp; Medical Assistance</td>
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<tr>
<td>Carolyn Morris</td>
<td>Planner IV</td>
<td>DHSS/DSAAPD</td>
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<tr>
<td>Brian Olson</td>
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<td>La Red Health Center</td>
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<tr>
<td>David Parcher</td>
<td>CEO</td>
<td>KSACS</td>
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<tr>
<td>Cynthia Powell</td>
<td>Executive Secretary</td>
<td>DHSS/DSAAPD</td>
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<tr>
<td>Ingrid Pretzer-Aboff</td>
<td>Associate Professor</td>
<td>University of Delaware</td>
</tr>
<tr>
<td>Karen Rheuban</td>
<td>Professor</td>
<td>UVA</td>
</tr>
<tr>
<td>Albert Rizzo</td>
<td>Medical Director of eCare</td>
<td>Christiana Care Health System</td>
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<tr>
<td>Jill Rogers</td>
<td>Executive Director</td>
<td>Delaware Health Care Commission</td>
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<tr>
<td>Lisa Schieffert</td>
<td>Director, Health Policy</td>
<td>Delaware Healthcare Association</td>
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<tr>
<td>John Schmitt</td>
<td>Director</td>
<td>Delaware Hospital f/t Chronically Ill</td>
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<tr>
<td>Dyanne Simpson</td>
<td>Medical Director</td>
<td>DSAMH</td>
</tr>
<tr>
<td>Eileen Sparling</td>
<td>Project Director</td>
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</tr>
<tr>
<td>Kathy Wibberly</td>
<td>Director, Mid-Atlantic Telehealth Resource Center</td>
<td>UVA Center for Telehealth</td>
</tr>
<tr>
<td>Cheri Will</td>
<td>SA/DV Coordinator</td>
<td>Beebe Hospital</td>
</tr>
<tr>
<td>Glyne Williams</td>
<td>Social Service Chief Administrator</td>
<td>Division of Medicaid &amp; Medical Assistance</td>
</tr>
<tr>
<td>Virginia Yelland</td>
<td>Operations Manager for Ambulatory Care</td>
<td>Department of Veterans Affairs Medical Center, Wilmington, DE</td>
</tr>
<tr>
<td>Dory Zatuchni</td>
<td>CEO</td>
<td>Jewish Family Services of Delaware</td>
</tr>
</tbody>
</table>
Appendix F: Delaware Telehealth Roundtable Evaluation Summary

Attendance
- Number of Invitees: 85
- Number Registered: 59
- Number Signed In: 55 (a few may did not sign in)

Event Logistics

How satisfied were you with:

Registration Process: (n=22)

<table>
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<tr>
<td>Very Satisfied</td>
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<td>68.1%</td>
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<tr>
<td>Satisfied</td>
<td>6</td>
<td>27.2%</td>
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<tr>
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Location (Dover): (n=22)

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<tr>
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<td>4.5%</td>
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Venue (Del Tech): (n=22)

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<tbody>
<tr>
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<tr>
<td>Satisfied</td>
<td>7</td>
<td>31.8%</td>
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<tr>
<td>Very Dissatisfied</td>
<td>0</td>
<td>0.0%</td>
</tr>
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</table>
Meeting Room: (n=22)

- Very Satisfied: 10 (45.4%)
- Satisfied: 9 (40.9%)
- Neither Satisfied nor Dissatisfied: 3 (13.6%)
- Dissatisfied: 0 (0.0%)
- Very Dissatisfied: 0 (0.0%)

Quality of Food: (n=21)

- Very Satisfied: 9 (42.8%)
- Satisfied: 11 (52.3%)
- Neither Satisfied nor Dissatisfied: 1 (4.7%)
- Dissatisfied: 0 (0.0%)
- Very Dissatisfied: 0 (0.0%)

Opportunities for Networking: (n=22)

- Very Satisfied: 18 (81.8%)
- Satisfied: 3 (13.6%)
- Neither Satisfied nor Dissatisfied: 0 (0.0%)
- Dissatisfied: 1 (4.5%)
- Very Dissatisfied: 0 (0.0%)

Event Logistics Related Comments:

| Lessons Learned                                                                 |
|                                                                               |
| **Pay More Attention to Dietary Needs**                                     |
| I’m not sure if I was asked about food choices during registration. If I was, I would have indicated a vegetarian preference. Either way, there were no veggie sandwiches available. Fortunately, the pasta salad was available. |
| **Adjust Room Temperature**                                                  |
| Room was cold.                                                               |
| **Provide More Detailed Directions**                                        |
| Some confusion as to which building the meeting was in. The specific building was not apparent on the announcement. |
| **Room Format**                                                             |
| Room set up was not really conducive for the type of brainstorming work that took place. |
| **Include A Participant List**                                              |
| Include list of participants--- would increase networking possibilities      |
Event Format

How satisfied were you with the Roundtable format in accomplishing its intended purpose:

**Overall Agenda: (n=21)**

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<tr>
<th>Satisfaction Level</th>
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<tr>
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**Presentation (Karen Rheuban): (n=22)**

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**Moderator (Kathy Wibberly): (n=22)**

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<tr>
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<td>18.1%</td>
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<tr>
<td>Neither Satisfied nor Dissatisfied</td>
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<td>4.5%</td>
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<tr>
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**Length of Event: (n=22)**

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<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

**Composition of Attendees: (n=22)**

<table>
<thead>
<tr>
<th>Satisfaction Level</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Satisfied</td>
<td>9</td>
<td>40.9%</td>
</tr>
<tr>
<td>Satisfied</td>
<td>10</td>
<td>45.4%</td>
</tr>
<tr>
<td>Neither Satisfied nor Dissatisfied</td>
<td>2</td>
<td>9.0%</td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>1</td>
<td>4.5%</td>
</tr>
<tr>
<td>Very Dissatisfied</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
## Event Format Related Comments:

<table>
<thead>
<tr>
<th>Kudos</th>
<th>Lessons Learned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kathy is a very impressive one-woman show. Knowledgeable about many</td>
<td>Shorten Length of Event...</td>
</tr>
<tr>
<td>aspects of telehealth, good facilitator</td>
<td>• Thought the event might have been accomplished in a half-day.</td>
</tr>
<tr>
<td>and calm and collected.</td>
<td>• A full day is just too long. Although I stayed until the end, we lost quite a</td>
</tr>
<tr>
<td>Kathy and Karen were excellent. Kathy your use data gathering</td>
<td>number of people in the afternoon</td>
</tr>
<tr>
<td>techniques from problem identification, solving, etc...superb!</td>
<td>• Had good participation but number of attendees left early</td>
</tr>
<tr>
<td>Great presenters.</td>
<td>• Could have been done in an half day</td>
</tr>
<tr>
<td></td>
<td>• Cut by about an hour</td>
</tr>
<tr>
<td></td>
<td>• A few suggestions on how:</td>
</tr>
<tr>
<td></td>
<td>o shorten the flow of the agenda to shorten the event by 60 - 90 minutes</td>
</tr>
<tr>
<td></td>
<td>that may have help keep more participants there to the end</td>
</tr>
<tr>
<td></td>
<td>o The process of reading everyone’s comments was very time consuming.</td>
</tr>
<tr>
<td></td>
<td>o Distribution of some materials before the conference? For example, a</td>
</tr>
<tr>
<td></td>
<td>YOUTUBE telehealth demonstration and a survey - of what are the barriers,</td>
</tr>
<tr>
<td></td>
<td>how can it improve care, etc.? Do some of the work that was conducted</td>
</tr>
<tr>
<td></td>
<td>at the conference ahead of time</td>
</tr>
<tr>
<td></td>
<td>o Have participants stand for most of the discussion around the topics for</td>
</tr>
<tr>
<td></td>
<td>which we used flip charts. Move the flip charts rather than the people, it</td>
</tr>
<tr>
<td></td>
<td>reduces the time.</td>
</tr>
<tr>
<td></td>
<td>Or not?</td>
</tr>
<tr>
<td></td>
<td>• Seemed like we tried to do too much in too short of a timeframe.</td>
</tr>
<tr>
<td></td>
<td>Need More Diversity of Stakeholders...</td>
</tr>
<tr>
<td></td>
<td>• Needed more diverse representation...invite more stakeholders</td>
</tr>
<tr>
<td></td>
<td>• Mostly state employees talking to each other</td>
</tr>
<tr>
<td>Or not...</td>
<td>Change the Format of or Eliminate First Brainstorming Exercise</td>
</tr>
<tr>
<td></td>
<td>• The mix of stakeholders was really well done.</td>
</tr>
<tr>
<td></td>
<td>Morning exercise moving around could have been shortened.</td>
</tr>
<tr>
<td></td>
<td>Introduce all participants beforehand.</td>
</tr>
<tr>
<td></td>
<td>The first exercise where groups moved from table to table was not productive.</td>
</tr>
</tbody>
</table>
getting started on a meaty discussion when time was called for us to move on. I know our group lost interest at that point. Also felt a little disorganized at times.

- I liked the time we had to brainstorm challenges/barriers, but it was too long. They were very similar for all of the topics, so by the time we got to the 2nd and 3rd groups there wasn’t much more to say. This could have been shortened.
- Disappointed with having attendees brainstorm on the barriers for Telehealth for four different scenarios, then rotating to continue to build on the comments from the previous group…eliminate the attendee brainstorming session.

Test the Technology On Site

- Minor disappointment in the delays caused by technology issues
- Disappointed that the demo didn’t work

Overall Evaluation

Overall, how well did this Roundtable meet your expectations? (n = 21)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Significantly Exceeded</td>
<td>2</td>
</tr>
<tr>
<td>Exceeded</td>
<td>6</td>
</tr>
<tr>
<td>Met</td>
<td>11</td>
</tr>
<tr>
<td>Below</td>
<td>2</td>
</tr>
<tr>
<td>Significantly Below</td>
<td>0</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td></td>
</tr>
<tr>
<td>9.5%</td>
<td></td>
</tr>
<tr>
<td>28.5%</td>
<td></td>
</tr>
<tr>
<td>52.3%</td>
<td></td>
</tr>
<tr>
<td>9.5%</td>
<td></td>
</tr>
<tr>
<td>0.0%</td>
<td></td>
</tr>
</tbody>
</table>

What would you say was the most important benefit(s) you received from attending this Roundtable?

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better understanding of the potential for telehealth, future of telehealth, what is already occurring in the area of telehealth, success with telehealth</td>
<td>6</td>
</tr>
<tr>
<td>Networking/relationships developed</td>
<td>6</td>
</tr>
<tr>
<td>Engaging stakeholders in support of telehealth in a very organized manner/consensus building</td>
<td>2</td>
</tr>
<tr>
<td>Opportunity to contribute to the development of a state plan on telehealth</td>
<td>2</td>
</tr>
<tr>
<td>Opportunity to hear multiple perspectives/mix of stakeholders</td>
<td>2</td>
</tr>
<tr>
<td>Discovering good resources</td>
<td>1</td>
</tr>
</tbody>
</table>
General Comments:

- Very productive meeting. Well organized
- The roundtable provided an excellent overview.
- This was the best round table I have attended.
- This was good. I would like to see the same venue 6 months from now.
- It seemed anti-climactic in that I expected 3 or 4 drafts of the direction DE should consider at the end of the day. However, I realized this is the beginning of the process to final goals for the State and what seemed scattered will be clear in the end.
- Boil down priority steps to manageable number.
- Now that we have a start, participants in the future will have more targeted discussion with which they will work.
- It appeared to be cobbled together quickly. It needs time to plan and develop an agenda with speakers to support that agenda.
- Would like more opportunities to learn what others are doing in Delaware.
- I would have liked some more “in the weeds” discussion about how to actually implement tele-health, though I realize that it was likely more appropriate to do that at a different time.

Future

If we were able to make available individual demonstrations where you could actually experience being the “driver” of the telemedicine consult, would you be interested in doing this? (n=21)

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, let’s do it</td>
<td>9</td>
<td>42.8%</td>
</tr>
<tr>
<td>Maybe</td>
<td>10</td>
<td>47.6%</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

What is/are the best way(s) to keep you informed about future MATRC events, activities and resources? (n=21)

<table>
<thead>
<tr>
<th>Method</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email</td>
<td>21</td>
<td>77.7%</td>
</tr>
<tr>
<td>Website</td>
<td>4</td>
<td>14.8%</td>
</tr>
<tr>
<td>Twitter</td>
<td>1</td>
<td>3.7%</td>
</tr>
<tr>
<td>Facebook</td>
<td>1</td>
<td>3.7%</td>
</tr>
<tr>
<td>LinkedIn</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>RSS Feed</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
Appendix G: Glossary of Terms

For the purposes of this strategic action plan, the following definitions and terms are provided for reference:

**Action plan:**
An implementation strategy required to carry out strategies and meet objectives (Swayne, Duncan & Ginter, 2008).

**Benchmarking:**
A measurement of the quality of an organization's policies, products, programs, strategies, etc., and their comparison with standard measurements, or similar measurements of its peers. The objectives of benchmarking are (1) to determine what and where improvements are called for, (2) to analyze how other organizations achieve their high performance levels, and (3) to use this information to improve performance (What is benchmarking, n.d.).

**Credentialing:**
Examination and review of the credentials of individuals meeting a set of educational or occupational criteria and therefore being licensed in their field. Strict credentialing is required by both hospital and managed care accreditation bodies. The process is conducted periodically because of the responsibility of the organization for any claims of malpractice by its staff (credentialing, n.d.).

Also, Medspeak: the process of reviewing a health professional's credentials, training, experience, or demonstrated ability, practice history and medical certification or license to determine if clinical privileges to practice in a particular place are to be granted. A much less frequent use of the term applies to closed panels and medical groups and refers to examination of the credentials of a physician or other health care provider to determine whether that provider should be entitled to clinical privileges at a hospital or managed care organization (credentialing, n.d.).

**Electronic Health Record (EHR):**
A systematic collection of electronic health information about individual patients or populations that is recorded in digital format and capable of being shared across health care settings via network-connected enterprise-wide information systems and other information networks or exchanges. EHRs generally include patient demographics, medical history, medication, allergies, immunization status, laboratory test results, radiology and other medical images, vital signs, characteristics such as age and weight, and billing information (Telemedicine nomenclature, n.d.).

**Electronic Medical Record (EMR):**
A computerized medical record generated in an organization that delivers health care, such as a hospital or physician's office. EMRs are often part of a local stand-alone health information system that allow storage, retrieval and modification of records (Telemedicine nomenclature, n.d.).

**HIPAA:**
Acronym for Health Information Portability and Accountability Act. The HIPAA Privacy Rule protects the privacy of individually identifiable health information, the HIPAA Security Rule sets national standards for the security of electronic protected health information, and the confidentiality provisions of the
Patient Safety Rule protect identifiable information being used to analyze patient safety events and improve patient safety (Health information privacy, n.d.).

**Home Health Care and Remote Monitoring Systems:**

Care provided to individuals and families in their place of residence for promoting, maintaining, or restoring health or for minimizing the effects of disability and illness, including terminal illness. In the Medicare Current Beneficiary Survey and Medicare claims and enrollment data, home health care refers to home visits by professionals including nurses, physicians, social workers, therapists, and home health aides. Use of remote monitoring and interactive devices allows the patient to send in vital signs on a regular basis to a provider without the need for travel (Telemedicine nomenclature, n.d.).

**Interdisciplinary:**

An interdisciplinary team consists of practitioners from different professions who share a common patient population and common patient care goals and have responsibility for complementary tasks. The team is actively interdependent, with an established means of ongoing communication among team members and with patients and families to ensure that various aspects of patients’ health care needs are integrated and addressed (Module 4 | Interdisciplinary teamwork in health care, n.d.).

This interdisciplinary team approach is in contrast to the following approaches: (1) the disciplinary or independent medical management approach, in which a practitioner works autonomously with limited input from other practitioners; (2) the multidisciplinary care approach, which involves various health care professionals working independently—not collaboratively—and in parallel, each responsible for a different patient care need, and (3) the consultative approach, in which one practitioner retains central responsibility and consults with others as needed (Grant et al., 1995; Stritter, 1993).

**Interoperability:**

The ability of two or more systems (computers, communication devices, networks, software, and other information technology components) to interact with one another i.e., (communicate, exchange data and use the information that has been exchanged) according to a prescribed method in order to achieve predictable results. (Telemedicine nomenclature, n.d.; What is interoperability, n.d.).

**Medical home or Patient-Centered Medical Home (PCMH):**

The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system, and is a philosophy of health care delivery that encourages providers and care teams to meet patients where they are, from the most simple to the most complex conditions. It is a place where patients are treated with respect, dignity, and compassion, and enable strong and trusting relationships with providers and staff. Above all, the medical home is not a final destination instead, it is a model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient’s needs (Defining the Medical Home, n.d.).

**Memorandum of Understanding (MOU):**

A document that expresses mutual accord on an issue between two or more parties. Memoranda of understanding are generally recognized as binding, even if no legal claim could be based on the rights and obligations laid down in them (What is memorandum of understanding, n.d.).
Mission:

The mission or goal of an organization provides a general direction regarding quality of health and costs that reflects the overall organizational internal environment. The mission defines what an organization can do (Rivers & Glover, 2010).

The mission is a statement of distinctiveness; not and expression of hope but, rather, an attempt to capture the essence of the organizational purpose and commit it to writing. A mission is more concrete than a vision. The mission is the what, while a vision is the why (Swayne, Duncan & Ginter, 2008, pp. 161-162; Vision statement, mission statement and core values, n.d.).

Mission statement:

A mission statement specifies an organization’s purpose or “reason for being.” The mission should capture the essence of who the center is, what the center does, and for whom. The mission should guide each day’s activities and decisions. It is the primary standard against which the organization’s plans and programs should be evaluated. The mission statements use simple and concise terminology, speak loudly and clearly, and generate enthusiasm for the organization. The mission is the core, it is the purpose of the organization. Mission and vision statements create the foundation for action planning and a basis for accountability with the community (Vision statement, mission statement and core values, n.d.).

Originating Site:

Location of the patient and/or the patient’s physician at the time the service being furnished via a telecommunications system occurs. Other common names for this term include spoke site, patient site, remote site, and rural site (Telemedicine nomenclature, n.d.).

Patient-centered medicine/care:

As a form of practice, it seeks to focus medical attention on the individual patient’s needs and concerns, rather than the doctor’s. Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions (Bardes, 2012; Institute of Medicine, 2001).

Silo:

A system, process, department, etc. that operates in isolation from others (Definition of silo in English, n.d.).

Standard:

A statement established by consensus or authority that provides a benchmark for measuring quality and that is aimed at achieving optimal results (Telemedicine nomenclature, n.d.).

Store and forward:

This type of telehealth encounter or consult uses still digital images of patient data for rendering a medical opinion or diagnosis. Common services include radiology, pathology, dermatology, ophthalmology, and wound care. Store and forward includes the asynchronous transmission of clinical data from one site to another (Telemedicine nomenclature, n.d.).
**Strategic planning:**

Strategic planning is the process used by community groups, government departments, organizations, businesses and others to develop a blueprint for action and change within their community, department, organization or business. Regardless of the type of organization, a strategic plan must be based on a realistic assessment of resources, include all stakeholders, include ways to evaluate the plan’s success, and lead to long-term commitment (Strategic planning facilitator guide, n.d.).

**Telehealth:**

Telehealth: The use of electronic information and telecommunications technologies to support distance clinical health care, patient and professional health-related education, public health and health administration (What is telehealth, 2013).

**Telemedicine:**

Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient’s clinical health status (What is telemedicine, 2012).

**Videoconferencing:**

Real-time (synchronous) transmission of digital video images between multiple locations (Telemedicine nomenclature, n.d.).

**Vision:**

The vision creates a mental image of what leaders want the organization to achieve when it is accomplishing its purpose or mission. It is the organization’s hope for the future (Swayne, Duncan & Ginter, 2008, p. 161).

**Vision statement:**

Why do we pursue the mission every day? We pursue it to see the vision someday becomes reality. The vision of an organization is the *dream*, the type of statement that answers the questions “where are we going” and “what can we achieve?” It is a concise word picture of what the organization strives to be, and should always be the roadmap that drives, inspires, and motivates those affiliated with the organization. This is the *real purpose* for going to work every day...how the world will be different because of the organization. Mission and vision statements create the foundation for action planning and a basis for accountability with the community (Vision statement, mission statement and core values, n.d.)?
Appendix H: References

References


