AHA Board Task Force Report

Ensuring Access to Health Care

Virtual Care/Telehealth

April 27, 2017

AMERICAN HOSPITAL ASSOCIATION
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FOUNDED 1898

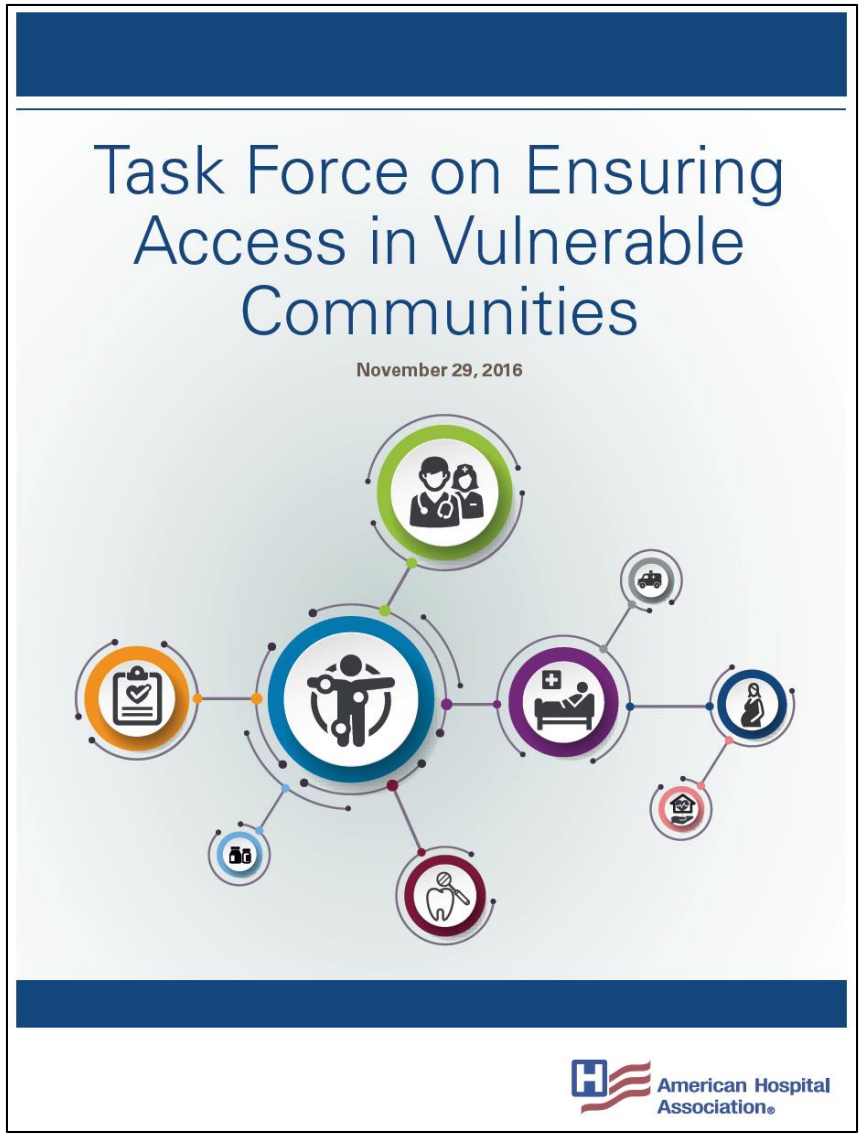
AHA Board Task Force Report

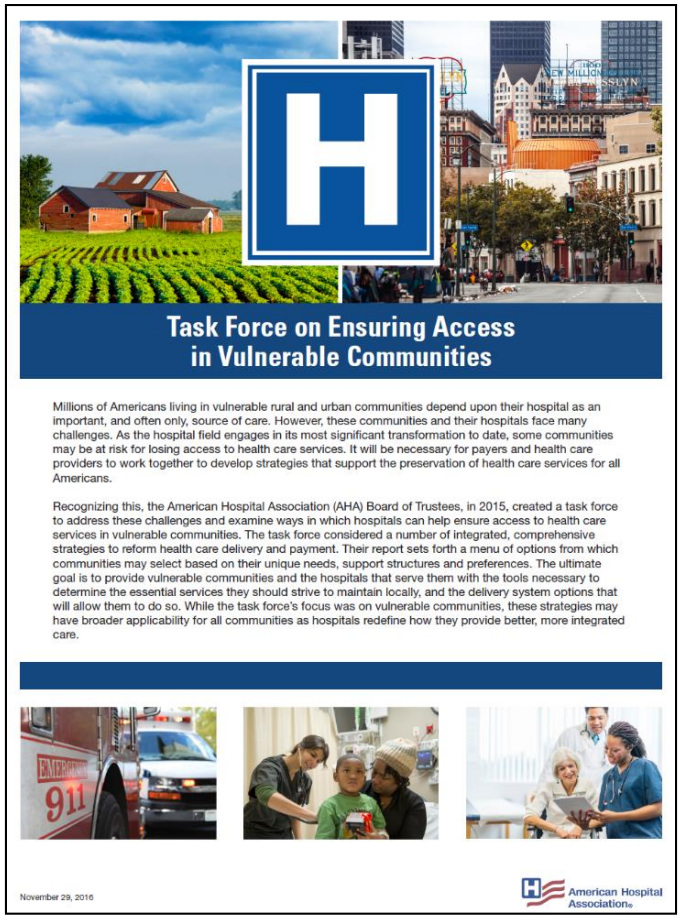
An Executive Leadership Series for Urban & Rural Safety-net Hospitals

Priya Bathija, American Hospital Association, Washington, DC

Bryan Slaba, Wagner Community Memorial Hospital, South Dakota

Janice Favorite, Dignity Health Telemedicine Network, Sacramento





To learn more about the work of this AHA Task Force, please visit www.aha.org/ensuringaccess

AHA Board Task Force Report

Table 1

Emerging Strategy

	Essential Health Care Service								
	Primary care	Psychiatric and substance use treatment services	ED and observation care	Prenatal care	Transportation	Diagnostic services	Home care	Dentistry services	Robust referral structure
Addressing the Social Determinants of Health					x				x
Global Budget Payments	x	x	x	x	x	x	x		x
Inpatient/Outpatient Transformation Strategy	x	x	x	x		x			x
Emergency Medical Center	x		x		x	x			x
Urgent Care Center	x					x			x
Virtual Care Strategies	x	x	x						x
Frontier Health System	x	x	x	x	x	x	x		x
Rural Hospital-Health Clinic Strategy	x	x	x	x		x		x	x
Indian Health Services Strategies	x	x	x	x	x	x	x		x

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Virtual Care Strategies

Virtual care strategies may be used to maintain or supplement access to health care services. These strategies could offer benefits such as immediate, 24/7 access to physicians and other health care providers, the ability to perform high-tech monitoring and less expensive and more convenient care options for patients.

American Hospital Association

Case Examples

Bryan Slaba, CEO, Wagner Community Memorial Hospital, Wagner, South Dakota

Janice Favorite, Senior Director, Strategy & Business Development Dignity Health Telemedicine Network, Sacramento

Dignity Health™
Telemedicine Network

American Hospital Association
Ensuring Access in Vulnerable Communities
Webinar: April 27, 2017

Bryan Slaba, MHA, FACHE
Chief Executive Officer
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Demographics and Stats

Wagner, SD

- **Population – 1,573 (Rural/Frontier)**
- **Service Area – 3,800**
- **AMI - $36,371, Nationally - $56,516**
- **Living in poverty – 30.4%, Nationally – 14.5%**
- **Below 50% of poverty – 28.6%, Nationally 6.1%**
- **Closest PPS – 50 miles**
- **Closest tertiary hospital – 120 miles**

Wagner Community Memorial Hospital

Avera

Stats

Wagner Community Memorial Hospital – Avera

- Affiliation: “Management Agreement” with Avera Health
  - Financial risk is with local association
- ADC – 1 Acute, 1 Swingbed, 1 OBS
- ED visits – 2,000
  - 1.25 visits per Wagner resident
  - 0.52 visits per service area resident
- 85% Governmental Payor Mix
  - 45% Medicare
  - 22% Medicaid
  - 13% Indian Health Services
  - 5% Other – VA, TriCare, etc…

Wagner Community Memorial Hospital

Avera

eServices

- Contracted through Avera eCare
- Hub 120 miles away
- Services Contracted:
  - eEmergency
  - eICU
  - eHospitalist (coming soon)
  - ePharmacy
  - eConsult (ID and coming soon Psychiatry)
  - Radiology Reading

Wagner Community Memorial Hospital

Avera

Financial Impact

- Introduced APP's as primary and eEmergency as sole physician back-up in 2014
- 40% of ER on call covered by APPs in FY16, estimated to be 60% by FY18
- Reduced FY16 direct ER expenses by 25% from FY14
- Reduced FY16 direct ER expenses to FY12 levels

Wagner Community Memorial Hospital

Avera

Quality Impact

- **Inpatient:**
  - **Patient Advocacy** (likelihood to recommend)
    - 46th percentile – June 2014
    - 96th percentile – April 2017
  - **Overall Rating of the Hospital**
    - 22nd percentile - June 2014
    - 83rd percentile - April 2017
- **Emergency Department**
  - **Patient Advocacy** (likelihood to recommend)
    - 60th percentile – June 2014
    - 92nd percentile – April 2017
  - **Overall Rating of the ED**
    - 71st percentile - June 2014
    - 89th percentile - April 2017
- **No adverse incidences**

Wagner Community Memorial Hospital
Avera

Take Away's

- Supplement not Substitute, telemedicine is a tool
- "Essential" services not "Want/Wish" lists
- Status Quo no longer: If we don't lead the way to new delivery and payment models we will be force to accept the hand dealt us and stating "your going to close down hospitals" is "crying wolf" and no longer effective!!!!

Wagner Community Memorial Hospital

Avera

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Ensuring Patient Access to Care and Supporting Hospitals in Providing Care

Dignity Health
Telemedicine Network

Janice Favorite, Senior Director
janice.favorite@dignityhealth.org

Mark Twain

Outpatient Clinic

Dignity Health.
Telemedicine Network

Dignity Health Telemedicine Network (DHTN)
Program Goal

Provide timely access to high quality specialized healthcare services that are not readily available

"LEAD WITH SERVICE…
DELIVER ON QUALITY"

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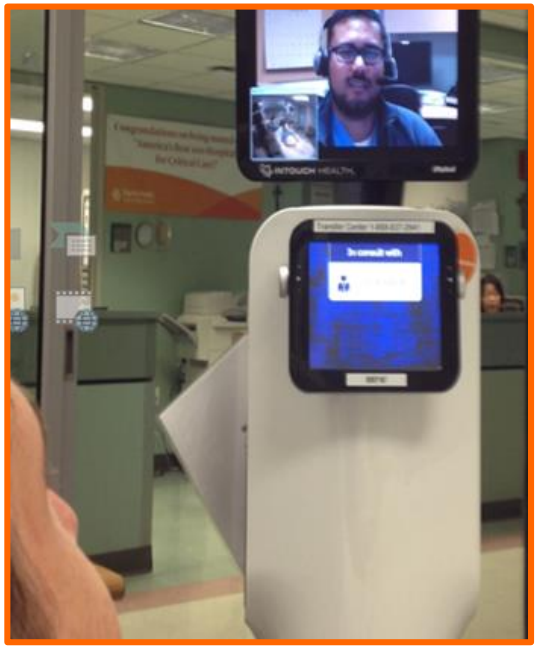
Telemedicine Network

Dignity Health Telemedicine Network (DHTN)

History

- ✓ The Mercy Telehealth Network Founded - 2008
- ✓ Recognized as the Dignity Health Telemedicine Network (DHTN) - 2014
- ✓ Approved to manage telehealth activities for Dignity Health and DHMF - 2016
- ✓ Fun Facts as of CY2016
  - 82 end points (robots)
  - 60 specialists
  - 12 Live services
  - 43 partner sites

➢ 30,000 patient encounters in CY 2016

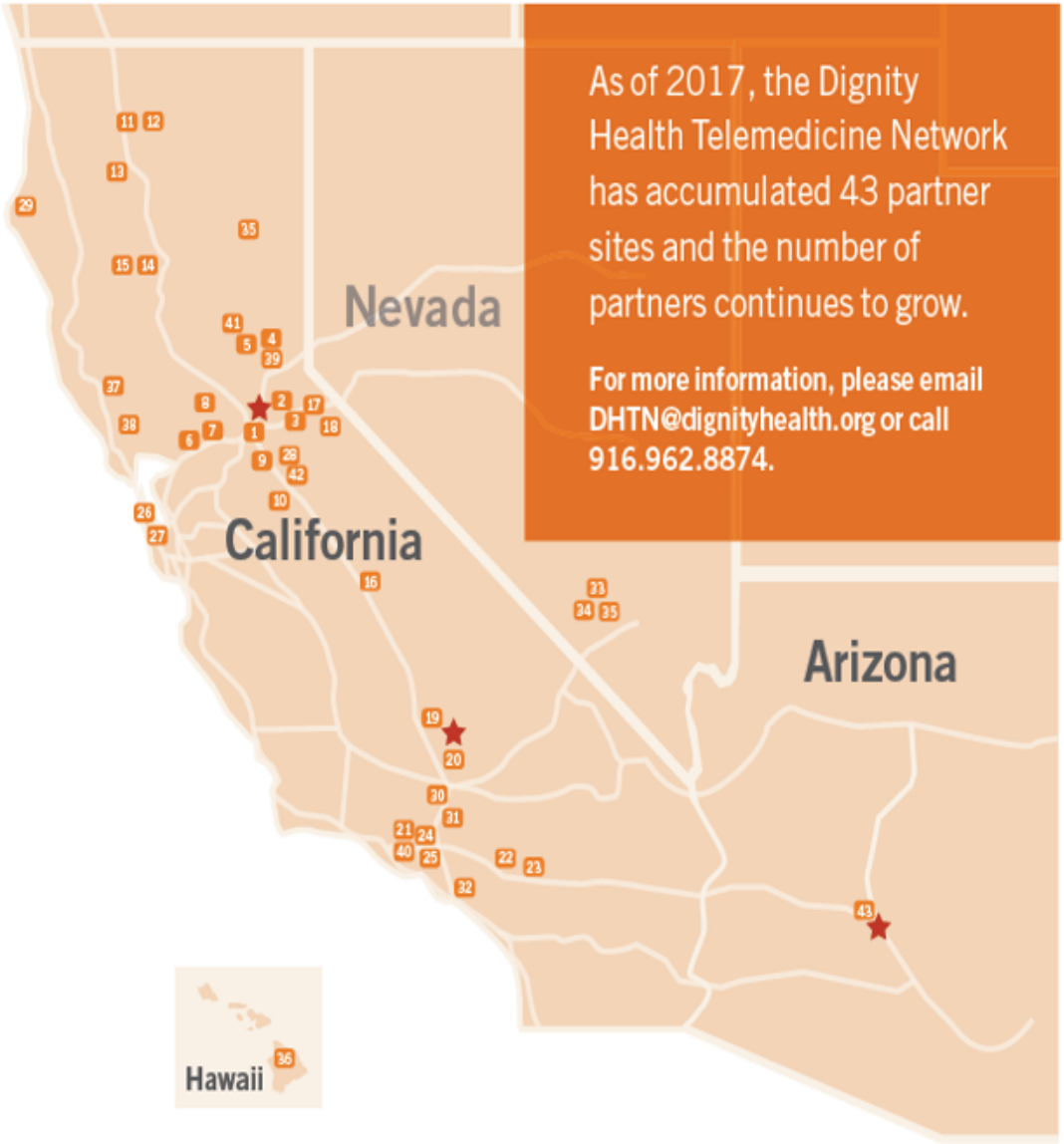


Dignity Health
Telemedicine Network

Telemedicine Network

1. Mercy General Hospital
2. Mercy San Juan Medical Center
3. Mercy Hospital of Folsom
4. Sierra Nevada Memorial Hospital
5. Sierra Nevada Medical Foundation
6. NorthBay Medical Center
7. NorthBay VacaValley Hospital
8. Woodland Healthcare
9. Methodist Hospital of Sacramento
10. St. Joseph's Medical Center
11. Mercy Medical Center—Mt. Shasta
12. Mercy Medical Center—Mt. Shasta Clinics
13. Mercy Medical Center—Redding
14. St. Elizabeth Community Hospital
15. Red Bluff Care Center
16. Mercy Medical Center Merced
17. Mark Twain Medical Center
18. Mark Twain Medical Center Clinics
19. Bakersfield Memorial Hospital
20. Kern Valley Healthcare District
21. California Hospital Medical Center
22. St. Bernardine Medical Center
23. Community Hospital of San Bernardino
24. St. John's Regional Medical Center
25. St. John's Pleasant Valley Hospital
26. St. Francis Memorial Hospital
27. Sequoia Hospital
28. Oak Valley Hospital
29. St. Joseph Hospital Eureka
30. Mercy Downtown Hospital
31. Mercy Southwest Hospital
32. St. Mary Medical Center
33. St. Rose Dominican Hospital—Rose de Lima
34. St. Rose Dominican Hospital—Siena
35. St. Rose Dominican Hospital—San Martin
36. Kona Community Hospital
37. Santa Rosa Memorial Hospital
38. Petaluma Valley Hospital
39. Lady of Lourdes Life Center, Auburn
40. Northridge Hospital Medical Center
41. Rideout Memorial Hospital
42. Bruceville Terrace Skilled Nursing
43. St. Joseph's Westgate Medical Center

★ Dignity Health Telemedicine Network Hubs



As of 2017, the Dignity Health Telemedicine Network has accumulated 43 partner sites and the number of partners continues to grow.

For more information, please email DHTN@dignityhealth.org or call 916.962.8874.

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Dignity Health Telemedicine Network (DHTN)
Available Services

ACUTE

- Stroke/Neurology
- Behavioral Health
- Critical Care/ICU
- EEG
- Nephrology
- Newborn Care
- Pediatrics
- PFT

AMBULATORY & POST-ACUTE

- Behavioral Health
- Cardiology
- Endocrinology
- Geriatrics
- Multiple Sclerosis
- Neurology
- Oncology
- Pulmonology
- Thoracic Surgery

POPULATION HEALTH/ HOME (launching)

- Asthma
- CHF
- COPD
- Diabetes
- Low Acuity Video Visits

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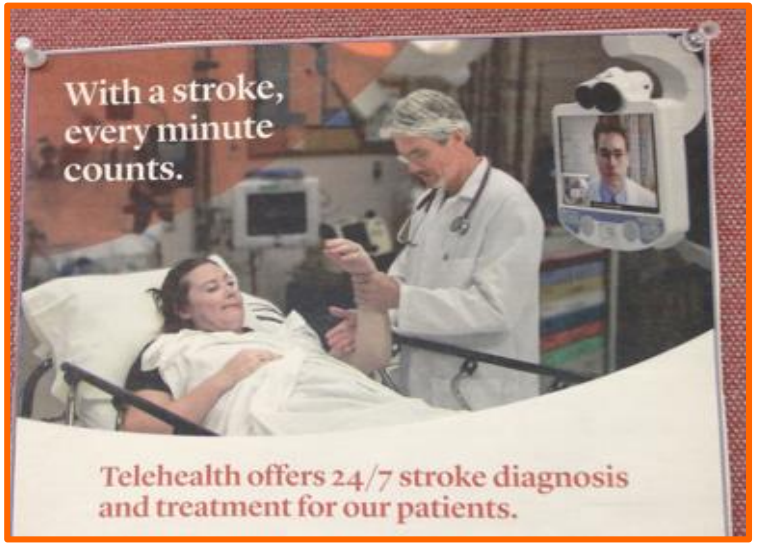
Telemedicine Network

TeleStroke
TeleNeurology



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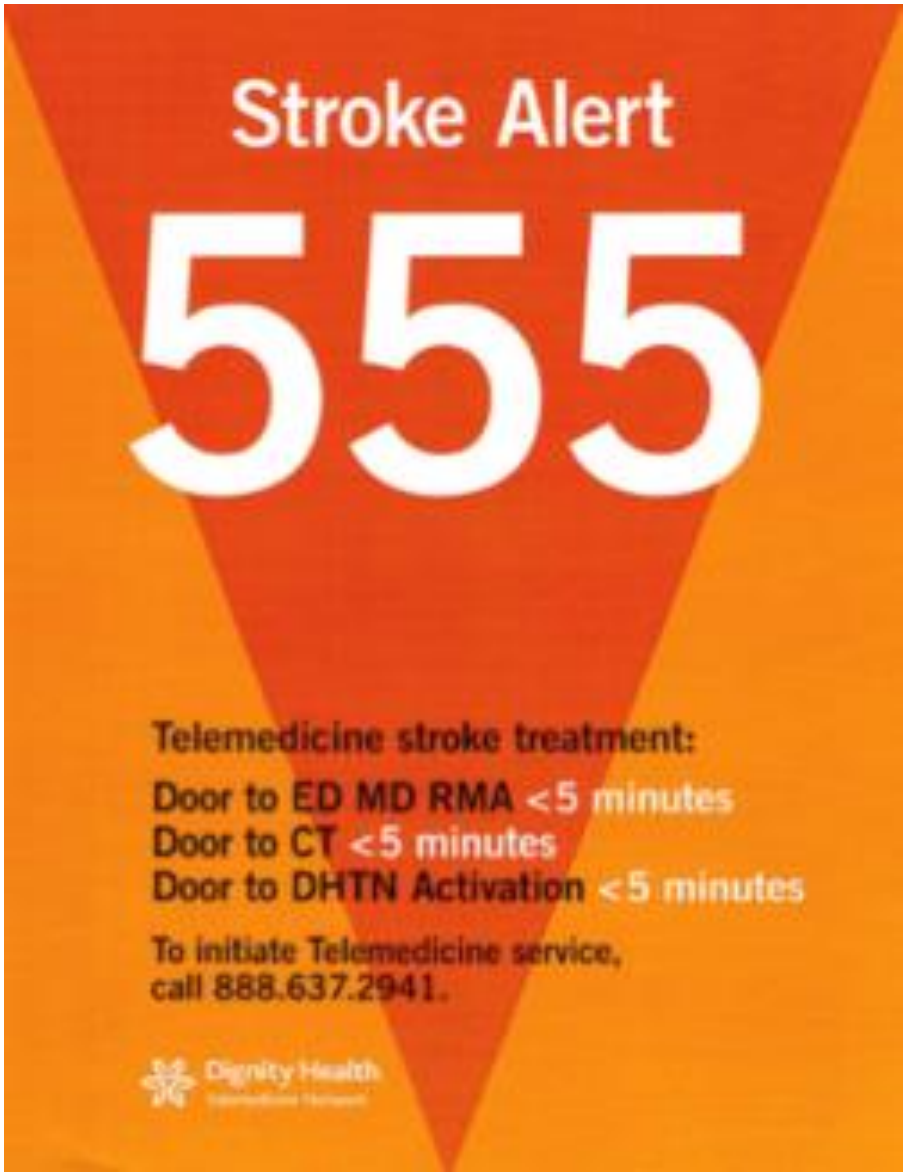
Why TeleStroke?

> “Telestroke networks should be deployed wherever a lack of **readily available stroke expertise** prevents patients in a given community from accessing a primary stroke center (or center of equivalent capability) **within a reasonable distance or travel time** to permit eligibility for intravenous thrombolytic therapy.”
>
> —ASA recommendations for the implementation of telemedicine within stroke systems of care, 2009

TELESTROKE PROCESS



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Dignity Health Stroke Timeline Report

Patient Name: _____ Hospital:

MRN: _____ Onset Time:

Date of Birth: _____ Age: _____

0 min	≤10 min	≤15 min	≤25 min	≤45 min	≤45 min	60 min	≤60 min
Suspected stroke patient arrives at ED	Initiate ED Rapid Medical Assessment (RMA) including patient history, last known well/time of symptom onset, NIHSS and order CT and lab work	Notify Stroke Team (including neurologic expertise)	Initiate CT scan	Interpret CT scan and labs; review patient eligibility for Activase	Activase (tPA) recommended	Review patient eligibility for Endovascular Reperfusion Therapy (Intraarterial Thrombolysis)	Give Activase bolus and initiate infusion in eligible patients
Goal Time:							
Feb 13 2016 11:26 PST	Feb 13 2016 11:36 PST	Feb 13 2016 11:41 PST	Feb 13 2016 11:51 PST	Feb 13 2016 12:11 PST	Feb 13 2016 12:11 PST	Feb 13 2016 12:26 PST	Feb 13 2016 12:26 PST
Actual Time:							
Feb 13 2016 11:26 PST	Feb 13 2016 11:30 PST	Feb 13 2016 11:31 PST	Feb 13 2016 11:45 PST	Feb 13 2016 11:53 PST	Feb 13 2016 11:45 PST	Feb 13 2016 11:40 PST	Feb 13 2016 12:01 PST
Difference:							
0 min	-6 min	-10 min	-6 min	-18 min	-26 min	-46 min	-25 min
Comments:							

PARTNER SITE WORKFLOW CHECKLIST

Telestroke Steps:

- ❑ Patient is identified with stroke like symptoms; *determine **last known well time***
- ❑ Rapid medical assessment (RMA) by Partner Site Physician
  - Target < 5 minutes; Door (ED) to RMA
- ❑ Call Internal stroke alert
- ❑ Call **Dignity Health Transfer Center (DHTC): 1-888-637-2941**
  - Target < 5 min; Door (ED) to call
- ❑ Patient taken *straight* to CT ***on EMS gurney*** (ED Admit)
- ❑ Place robot at the foot of the bed when patient returns from CT
  - Door (ED) to CT < 5 minutes
- ❑ Make sure patient is verbally consented for telemedicine
- ❑ Be prepared to assist with the NIHSS stroke scale
  - *Concentrate on: Visual field testing, extinction, and neglect*
- ❑ Be thinking about tPA preparation
- ❑ Once tPA is recommended; administration of bolus
  - Target <10 minutes; after receiving the recommendation
    - Monitor for improvement
    - RN communicates with Partner Site MD if patient is not improving within 15 minutes
- ❑ Screen for Endovascular Reperfusion Therapy for stroke patients
  - If appropriate, arrange for rapid transfer for possible intervention

Things to Remember:

- ❑ Partner Site RN or Physician ***must*** stay with the robot
  - Do not leave the robot unattended once a telestroke consult is requested
- ❑ Partner Site Physician ***must*** write the order for tPA
- ❑ Partner Site RN's ***do not*** take verbal orders from Teleneurologist
- ❑ Robot ***must*** be returned its docking area and plugged in when not in use

STROKE ALERT -WHEN TO CALL

- New or Acute Change in Mental Status or LOC
- Sudden Unilateral Weakness or Numbness of the Face, Arm or Leg
- Sudden Trouble Speaking, Understanding or Slurred Speech
- Sudden Trouble Seeing in One or Both Eyes
- Sudden Confusion, Agitation or Delirium
- New Onset Seizure Activity
- Sudden Severe Headache with no Know Cause
- Sudden Onset Blown Pupil
- Sudden Onset Nausea, Dizziness, Nausea, Vomiting with or without Gait Instability

Discussion

Questions and Comments

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Save the Date!

June 20	Social Determinants of Health
September 21	Hospital/Health Clinic Partnerships
October 12	Emergency Medical and Urgent Care Centers

Contact Information

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