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
Task Force on Ensuring Access in Vulnerable Communities

November 29, 2016

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

### Table 1

<table>
<thead>
<tr>
<th>Emerging Strategy</th>
<th>Primary care</th>
<th>Psychiatric and substance use treatment services</th>
<th>ED and observation care</th>
<th>Prenatal care</th>
<th>Transportation</th>
<th>Diagnostic services</th>
<th>Home care</th>
<th>Dentistry services</th>
<th>Robust referral structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addressing the Social Determinants of Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Global Budget Payments</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient/Outpatient Transformation Strategy</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Medical Center</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Virtual Care Strategies</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frontier Health System</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural Hospital-Health Clinic Strategy</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indian Health Services Strategies</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

American Hospital Association
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.
Bryan Slaba, CEO, Wagner Community Memorial Hospital, Wagner, South Dakota

Janice Favorite, Senior Director, Strategy & Business Development, Dignity Health Telemedicine Network, Sacramento
American Hospital Association
Ensuring Access in Vulnerable Communities
Webinar: April 27, 2017

Bryan Slaba, MHA, FACHE
Chief Executive Officer
Bryan.Slabab@avera.org   605-384-7284 Direct
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
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…
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
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
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
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!!!!
Ensuring Patient Access to Care and Supporting Hospitals in Providing Care

Janice Favorite, Senior Director
janice.favorite@dignityhealth.org
Mark Twain
Outpatient Clinic
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”
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
Telemedicine Network

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.
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
TeleStroke
TeleNeurology

With a stroke, every minute counts.

Telehealth offers 24/7 stroke diagnosis and treatment for our patients.
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"
Stroke Alert

555

Telemedicine stroke treatment:
Door to ED MD RMA < 5 minutes
Door to CT < 5 minutes
Door to DHTN Activation < 5 minutes

To initiate Telemedicine service, call 888.637.2941.
# Dignity Health Stroke Timeline Report

**Patient Name:**
**MRN:**
**Date of Birth:**
**Hospital:**
**Onset Time:**
**Age:**

<table>
<thead>
<tr>
<th>Time</th>
<th>Task Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 min</td>
<td>Suspected stroke patient arrives at ED</td>
</tr>
<tr>
<td>≤10 min</td>
<td>Initiate ED Rapid Medical Assessment (RMA) including patient history, last known well/time of symptom onset, NIHSS and order CT and lab work</td>
</tr>
<tr>
<td>≤15 min</td>
<td>Notify Stroke Team (including neurologic expertise)</td>
</tr>
<tr>
<td>≤25 min</td>
<td>Initiate CT scan</td>
</tr>
<tr>
<td>≤45 min</td>
<td>Interpret CT scan and labs; review patient eligibility for Activase</td>
</tr>
<tr>
<td>≤45 min</td>
<td>Activase (tPA) recommended</td>
</tr>
<tr>
<td>60 min</td>
<td>Review patient eligibility for Endovascular Reperfusion Therapy (Intraarterial Thrombolysis)</td>
</tr>
<tr>
<td>≤60 min</td>
<td>Give Activase bolus and initiate infusion in eligible patients</td>
</tr>
</tbody>
</table>

**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:**
Telesstroke 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 telesstroke 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 Known Cause
• Sudden Onset Blown Pupil
• Sudden Onset Nausea, Dizziness, Nausea, Vomiting with or without Gait Instability
Discussion

Questions and Comments
Ensuring Access to Vulnerable Communities
An Executive Leadership Series for Urban and Rural Safety-net Hospitals

Save the Date!

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 20</td>
<td>Social Determinants of Health</td>
</tr>
<tr>
<td>September 21</td>
<td>Hospital/Health Clinic Partnerships</td>
</tr>
<tr>
<td>October 12</td>
<td>Emergency Medical and Urgent Care Centers</td>
</tr>
</tbody>
</table>
John Supplitt
Senior Director
AHA Constituency Sections
312-422-3306
jsupplitt@aha.org