Increasing Access to Services Provided through Indian Health Services Subcommittee

Meeting Notes 11/04/2015

Attendees: Jerilyn Church, Kim Malsam-Rysdon, Lynne Valenti, Kathaleen Bad Moccasin, Brenda Tidball-Zeltinger, Tim Trithart, Justin Taylor, Bryan Slaba, Rachael Sherard, Monica Huber, Angelia Svihovec, Sonia Weston, Richard Huff, Charlene Red Thunder, Mike Diedrich, Terry Dosch, Evelyn Espinoza, Sonny Colombe, Gilbert Johnson, Sara DeCoteau

Welcome and Introductions

Stephanie Denning, Health Management Associates, welcomed the sub-committee members and provided a high level overview of the last meeting, highlighted the discussion topics to expand Access through the use of Tele-Health services, the addition of both OB-GYN, and General Surgery at IHS facilities. There was also an update on the IHS contracting discussion from the 10/21 meeting. Rachel Sherard from Avera acknowledged and thanked Richard Huff for his collaboration on the Tele-Health topic since the last Access subcommittee meeting.

Kim Malsam-Rysdon thanked the subcommittee members that submitted proposals on ways to increase access to services to IHS facilities. At the October 21 meeting the subcommittee recommended focusing on tele-health and OB/GYN care proposals. Avera, Sanford, and Regional Health submitted proposals in these areas and will share more detail about those areas. Jerilyn Church also asked JoEllen Koerner from CareSpan to discuss CareSpan's technology that supports tele-health services.

Telehealth:

Rachel Sherard with Avera shared information regarding the E-Emergency proposal which supports the ability to connect IHS Service Unit Emergency Departments to E-Emergency through telehealth technology. E-Emergency provides 24-hour access to a dedicated team of Emergency Department Board-Certified physicians and ED/Critical Care Nurses. Medical professionals connect to subscribing locations within 30 seconds of the request via high definition, two-way video. Through the tele-health technology, the E-Emergency team can collaborate with the IHS clinical team at the patient's bedside providing support to the IHS Care team to facilitate a plan of care, link to consults, expedite decisions to transfer the patient or keep local, and assist with transfers when needed, including the coordination for air or ground ambulance, and arrangement of transfer with receiving provider and facility. E-Emergency provides complex ER cases with immediate medical expertise and directions. E-Emergency has implemented services over 100 locations in 8 states. Implementing facilities need to have a strong medical team within the IHS provider sites to support use of E-Emergency.

The E-Emergency implementation plan includes readiness assessment, including review of technical needs, workforce readiness, technical and workforce orientation, an ongoing education plan, regularly scheduled team update calls and onsite visits, regular clinical performance and service utilization reporting, as well as support in the development of performance improvement planning. Engagement strategies include tested change management tactics, clinical protocols, monthly education, and participation in quality improvement projects that support ongoing appropriate utilization.

The key outcomes experienced by sites implementing this telemedicine service include:

- Better quality care; greater adherence to evidence based care
- Faster care in a setting where every minute counts
- Better patient outcomes; fewer unnecessary transfers or delays
- Lower costs, related to unnecessary transfers and ER staffing

Lessons Learned:
Transportation is a barrier for families, with E-Emergency care families can be part of the care plan when transfers are eliminated. The reduction in transfers has been significant. The program is starting to use Advanced care practitioners, rather than physicians. You can have right personnel at a lower cost. Direct care implications without loss of quality

The contracting process through IHS takes a long time, at least 6-9 months. Credentialing processes vary, and IHS hopes to have a single credentialing process for all IHS facilities. Ron Cornelius indicated IHS is working on a single credentialing process. Once IHS providers become familiar and comfortable with determining when they need E-Emergency assistance this will impact utilization. Local clinical directors and CEOs need to be on board to ensure telehealth is used. Brian Slaba noted that some sites have invested in additional staff to get providers to use telehealth. Brian said there was lots of initial resistance but through these efforts utilization of the system continues to increase.

Richard Huff indicated that he is having conversations with his chief contracting officer regarding prioritizing IHS sites and identifying contracting and equipment needs, etc. Pine Ridge, Eagle Butte, and Rosebud are the next sites to be evaluated. Telehealth has become a high priority because there are not enough specialists throughout the region. IHS feels that telehealth is the answer to increasing the level of care that IHS facilities can provide.

A question was asked as to how fast a facility can get up and running. Rachel outlined that all facilities will need to install a T1 line and determine what their capacity is. Monica Huber reiterated you need good connections to get good outcomes. IHS has added IT to their contracting line. Local buy-in and IT capacity and assessment, are needed to determine where this is more feasible and where there are fewer barriers. Ron Cornelius said that IHS is ready to go and needs to get moving internally. Rachel mentioned that once you have the volume, the contracting facility may need to increase staff. Monica and Rachel also noted that e-Emergency and tele-health needs to be aligned with medical records for efficiency and to have a direct improvement in patient care and outcomes.

Next steps for IHS include a readiness assessment from each sites CEOs. IHS will provide details of a tele-health implementation plan at the December 3rd meeting. Ron noted that equipment costs are much less than anticipated, and the administrative costs are also significantly less than expected however, transmission costs are unknown at this point.

<u>Prenatal and OBGYN</u>

Rachel Sherard shared information on the Centering prenatal program. This program has been implemented at South Dakota Urban Indian Health in Sioux Fall and incorporates culturally appropriate care. Nine ladies participated in the program in Sioux Falls. The program offers a peer support

approach addressing both the spiritual and medical component of pregnancy and birth. The outcome resulted in the delivery of 9 full-term, full-weight babies. March of Dimes was interested in partnering in the model and helping to pay some of the costs. In conjunction with prenatal appointments and group meetings, groups had beading classes where moms made handmade moccasins for babies. This created a good bonding experience with fellow program participants. Resources are necessary to support the program however the positive birth outcomes result in avoiding higher cost care and can actually reduce costs.

The Sioux Falls program built in rewards for enrollees that kept all of their appointments. Programs should look for a grant and other funding options for a reward program. There are good collaboration opportunities for the centering program.
Outcomes include:

- Reduces the risk of premature births by 33%,
- Reduces the cost per patient by $2K,
- Elimination of each pre-term birth saves an estimated $53K

IHS asked if the program could be replicated in other geographic locations. The centering model participants all have roughly the same expected delivery date. Navajo Nation has made adaptions based on geographic considerations.

The group suggested that we invite Donna Keeler to present the model at the next meeting. Bernie Long (Ft. Thompson IHS) expressed this as a need in his community and also noted collaboration with Healthy Start programs (HSP) on the reservations will be important.

Mike Diedrich noted that Regional Health had suggested embedding certain family practice and other physicians within IHS facilities and continues to work on that proposal. This could be another way to support OB/GYN care.

<u>E-Consult:</u>
Another tele-health strategy proposed by Avera includes connecting specialists to IHS patients through use of consult services in IHS Service Unit facilities. E-Consult supports care delivery between primary care clinics that lack primary and specialty care providers on staff and can address specialty needs in areas with provider shortages. E-consultation has grown to serve over 10,000 patient consults a year. E-consult provides both Physical Support by assisting family and primary care practitioners to provide consultative care to their patients within their local communities, and Educational Support, through access to resource information, best practice protocols and video access to grand rounds and educational events.

E-Consult is a non-urgent, scheduled visit model that connects specialty care for patients in local rural clinic/hospital. Consult serves both outpatient and inpatients populations, averages an estimated 1,000 video encounters per month. Similar to E-Emergency, consult also utilizes a two-way high definition video, along with a telephonic stethoscope, a high definition exam cam, and an otoscope. Infectious Diseases and Oncology are two of the most common services provided via E-Consult in Avera facilities.

Sanford and Avera met last week to discuss this approach further. E-Consult can be readily turned on based on the specialty needed. Start-up is easier because the provider does not have to be onsite. IHS needs to look at the population that typically transfer or are referred out and what they pay for to determine what the needs are for e-consults. IHS may not know the specifics of denials because they are

lower on the referral priority list.

Jerilyn suggested performing a survey in IHS/Tribal Health facilities to include items that get denied due to lack of funding. Some services unit referrals show zero as they could not be referred and she will work that aspect into the survey.

The group discussed if telehealth could be used to facilitate surgeries that can't be preformed at IHS. Facility and equipment issues would create concerns for surgical consults. Addressing the safety and quality piece requires working with a familiar team and equipment. A question was asked if IHS should be considering pre-operation consults for patients that will be referred out. Monica Huber stated that if labs and diagnostics are readily available, specialists may consider participation.

CareSpan:
Joellen Koerner presented another tele-health tool and provided an overview of CareSpan's Primary Care E-Health system. The CareSpan Primary Care E-Health system is a cloud based solution. It uses bio-sensors that can be connected to the patient and the computer to measure vital signs, use of EKG, etc. Carepoint is CareSpan's point of the access system that can be set up anywhere where there is an internet connection. The goal is to help providers to get services to their patients. The system can be set-up in a clinic where the patient is present allowing the provider to review patient data and direct care from a remote location, i.e., the provider does not have to be in the clinic in-person to review results and provide care. They are working with Alaska and also on a reservation in Arizona. The necessary bio sensors cost less than $2K for everything; there is a subscriber fee that covers access and medical record costs. The cost to use the system is about $15 per member per month (PMPM).

IHS questioned where the medical record will be stored, security issues. Joellen said that the data can be pushed to the facility's EMR. Joellen said that Avera is considering a contract with Primary Care E-System. Joellen confirmed the Primary Care e-Health system always use an existing provider. Unlike e-emergency and e-consult, CareSpan system does not have a network of clinicians to access via this technology.

Next Steps

- Ron Cornelius will provide an IHS E-Emergency implementation update at the meeting on 12/3.
- Jerilyn Church will work with IHS to identify what specialties are needed via telehealth.
- Next meeting will focus on prenatal care.
- DSS will provide more information on the Medicaid global pregnancy benefit.
- Ron will assess IHS clinical capacity within clinics to provide pre-natal care.

Next Meeting

Wednesday, November 18, 3:15 – 5:15 p.m., Ramkota, Gallery B