

Emergency Care Innovation of the Year Award Submission Form

Was this innovation submitted to the Emergency Care Innovation of Year Award contest last year?

- Yes
 No

Innovation Title: The Tech-enabled Emergency & Acute Medicine at the Skilled Nursing Facility bedside (**TEAM SNF**) Model of Care

Hospital: Call9

Innovation Category:

- Safety and Quality
 Flow and Efficiency
 Care Coordination
 Patient Experience
 Cost-Consciousness

Hospital: Call9

Location: Remote [currently operating in skilled nursing facilities in New York]

Contact: Sylvan Waller, Call9's Chief Operating Officer and Chief Medical Officer

Innovation Summary:

Call9 provides Emergency Medicine without brick and mortar limitations. Call9 humanizes telemedicine by connecting on-site, emergency-trained first responders to remote physicians, delivering care to patients at their bedside in nursing homes and rehabs. The company's embedded care model approach is an alternative to 911 and subsequent hospitalizations and readmissions, lowering healthcare costs while improving care outcomes.

Category:

- Arrival
 Bed Placement
 Clinical Initial Evaluation
 Disposition Decision/Throughput
 Exit From the ED

Hospital Metrics:

- **Annual ED Volume:** 6,500 acute SNF activations
- **Hospital Beds:** 3,584 SNF beds presently; 6,000+ by EOY
- **Ownership:** Call9 Medical PC
- **Trauma Level:** none

- **Teaching Status:** Department of Emergency Medicine Affiliate Program in Telemedicine/Palliative Care at SUNY Health Science Center at Brooklyn (SUNY-HCSB)

Key Words:

Care Transitions, Communication, Consults, Continuity of care, Door-to-Doc, Follow-Up, Geriatric, Information Systems, Lean, Patient Satisfaction, Rapid Intake, Telemedicine

Tools Provided:

Integrated telemedicine technology platform, real-time ultrasound feed, acute activation workflow; quality dashboards; MD dashboards; ops dashboards; abstracts

Clinical Areas Affected:

ED, EMS, geriatric, inpatient units laboratory, nursing home, outpatient units

Staff Involved:

Administrators, case management, clerks, clinic registration, communications, consult services, ED palliative care team, ED staff, IT staff, nurses, nursing home administration, pharmacists, physicians, social workers/case managers, technicians

Innovation:

Approximately 1.3 million patients are transferred from a Skilled Nursing Facility (SNF) to a hospital Emergency Department every year, where care is both costly and often inconsistent with patients' wishes. According to the Centers for Medicare & Medicaid Services, two-thirds of these transfers from SNFs are avoidable, and 45% of hospitalizations from SNFs are unnecessary and can be prevented via treatment at the patient's bedside. A study conducted by the Agency for Healthcare Research Quality (AHRQ) demonstrated that more than \$41.3 billion is spent annually treating patients readmitted within 30 days of discharge.

To treat the acute medical needs of vulnerable patients in SNFs, Call9 has created a new model of providing person-centered care through a high-tech, high-touch and multidisciplinary care model that delivers integrated emergency, critical and palliative care to the patient rather than the other way around.

The Call9 model eliminates care siloes, treatment disruption, patient disorientation and frustration, and the exorbitant waste associated with traditional ED processes, including the back-and-forth transfers and hospital admissions for this high-risk population. It closes the gaps in care delivery by focusing on value-based care over volume-based care. Given the tremendous cost and low value of a volume-based approach to reimbursement for SNF patients, this paradigm change is a critical evolution in care for this population.

Call9's model also showcases the unique skill sets of Emergency Medicine physicians in that EM physicians' ability to do initial critical assessment and interventions is not limited to location.

This model allows patients outside of the four walls of the ED to benefit from these critical interventions.

Background:

Designing new approaches to acute unscheduled care that avoid subjecting patients to the risks of ED visits and admissions is critical for the well being of frail, older adults and the sustainability of our healthcare system. Call9 has created a tech-enabled, human-powered solution that delivers immediate emergency care to patients in skilled nursing facilities at the bedside, which reduces unnecessary ED visits, hospitalizations and subsequent readmissions in nearly 80% of patient encounters.

Call9 embeds emergency-trained first responders—generally an EMT, paramedic or ED tech—on-site, in nursing homes, 24 hours a day, 7 days a week, 365 days a year. When a patient has an emergency event, the nursing home nurse activates Call9’s on-site first responder, who goes to the patient’s bedside, taps Call9’s proprietary app and is immediately connected to one of Call9’s remote Emergency Medicine physicians or advanced practice providers (Physician Assistants or Nurse Practitioners) via our virtual care platform.

Via the first responder, Call9’s technology and a suite of diagnostics, physicians have access to a full-range of patient vitals/information—including point-of-care ultrasound, 12-lead EKGs, telemetry, pacing, vital signs, CPAP/BiPAP, heart and lung sounds via electronic stethoscope, urinalysis and on-site blood work in less than two minutes—all of which stream onto the laptop of the Call9 provider, who is running a remote Emergency Department and treating patients in different rooms and in different nursing homes. Subsequent rounding and patient monitoring for changes in condition ensures care coordination with the patient’s primary care physician.

Call9’s integrated, interdisciplinary approach includes a palliative care program that’s staffed by a team of board-certified palliative care physicians, nurses, social workers and other specialists, and works in partnership with the patient’s PCP to provide an extra layer of comfort and support for patients and their families. The team provides expert symptom management, extra time for communication about goals and treatment options and help navigating the health system.

Innovation Implementation:

Despite making up only 0.5% of the population, nursing home patients make up nearly 20% of ambulance transfers to the ED. This overutilization of EMS services by SNFs often results due to a few key reasons: 1) the average nurse-to-patient ratio in SNFs is 1:36, and nursing home nurses are often trained in chronic care instead of acute care, 2) advanced diagnostics are typically not readily available in the SNF, which impedes timely care, and 3) physicians aren’t present all that frequently, particularly nights, weekends and holidays.

Call9’s high-quality, patient-centered care delivery model puts emergency-trained decision makers on-site in the facility, replacing the traditional decision to transfer a sick SNF patient to the ED with a bedside “equivalent” acute care team. This team, embedded within the SNF and

activated (utilizing INTERACT® guidance to determine if immediate provider notification is required) when a patient appears to be having a medical emergency, can quickly and effectively provide flexible treatment plans tailored both to the patient's immediate clinical needs and long-term goals of care.

Because the Call9 acute care team is embedded in the SNF 24/7, the facility staff know that they can access a board-certified Emergency Medicine physician within minutes when the need arises. Call9's ability to perform on-site emergency care and assessment alleviates the burden on the facility primary care team, who often has training mainly in primary care and chronic care.

The on-site Call9 first responders are emergency-trained operators of Call9's on-site diagnostics, experts of proprietary telehealth cart technology and the extended hands of Call9's 100% remote physician team. Call9 Emergency Medicine physicians are credentialed as SNF attendings at each facility, enabling real-time access to the SNF EMR and patient medical history with the ability to prescribe medications.

The regular presence of the on-site first responder in the SNF enables Call9 to observe patients for one to two days following initial Call9 treatment to ensure clinical stability and foster a smooth continuum of care. This ability to monitor patients for changes in condition over time—particularly within 24 hours of an acute episode when patients are most vulnerable for hospitalization—is critical for patient safety in the care of complex, chronically ill older adults.

Call9 prioritizes shared decision making and regular communication with the patient, family, PCP and SNF clinical team during every patient encounter to ensure high-quality, patient-centered coordinated care. Call9 physicians provide updates to the patient's PCP and coordinates all acute care plans with the facility care team—including social workers, case managers, respiratory therapists, pharmacists, among others—in order to provide seamless care delivery that is consistent with the patient's goals of care. PCPs are notified of any significant change in status or unexpected decompensation, and care plans are shared with the facility primary care team and documented in the SNF medical record.

Timeline:

In the spring of 2015, Timothy C. Peck, MD, an Emergency Medicine attending and previous Chief Resident in the ED at Beth Israel Deaconess/Harvard, founded Call9 in Silicon Valley to provide an alternative to 911 for patients in nursing homes and rehabilitation centers, avoiding unnecessary emergency room visits, hospital admissions and subsequent readmissions. In May 2015, the first line of code for Call9's proprietary telemedicine platform was written.

In the summer of 2015, Call9 entered Y Combinator, the famed Silicon Valley startup accelerator that helps fledgling companies with big ideas work towards transforming industries. From that experience, Peck realized his vision would only be possible if he fully embedded himself in a nursing home in order to learn everything he could about the operations, care delivery, finance system and more.

In June 2015, a nursing home administrator from Plainview, NY, agreed to let Peck develop Call9 at his facility on the condition that he stay there 24/7 to ensure residents were receiving the best treatment. Call9 officially entered its first facility—Central Island Healthcare—in July 2015 and both saw—and saved—its first patient on July 15, 2015.

In September 2015, the clinical team expanded its operations to the full 24/7 service at Central Island. Three months later in December, Call9 entered its second facility: St. James Center for Health and Rehabilitation, also in New York.

The company then took the next 14 months to build out the model of care, establish payor relationships and create the technology that would make a telemedicine solution possible. In the fall of 2016, the executive, engineering and operations teams moved from Palo Alto to Brooklyn in order to be closer to where Call9's services were being delivered.

In late 2016, Call9 contracted a third-party economics firm to track its work and identify the company's savings to the insurance industry. The results of that study identified that Call9 saves insurance payors, collectively, \$8M a year in each 200-bed nursing home the company is in. Following that study Call9 was able to contract with Anthem, United, Emblem, Healthfirst and ArchCare, all within 2017.

Starting in the second quarter of 2017, Call9 began expanding its footprint in the New York market, extending its reach to seven New York counties. Call9 tripled the beds covered to 1,976 in 2017 and to 3,584 as of August 2018.

Results/Evaluation:

Call9's model of care has been shown to increase healthcare quality and delivery while reducing total cost of care by 50%+ (see attached External Literature Studies) by ensuring care is truly patient centered. Call9 goes to great lengths to ensure that we know patients' advance care wishes and act in accordance with these. The savings come in part from avoiding transport and ED costs of care; however, a tremendous portion of the savings come from avoiding unnecessary hospital admissions. In our current fragmented health care system, without Call9, once a frail older adult from a SNF arrives in the ED, the risk of admission is very high even when hospital admission could be avoided by offering care from clinicians who know the patient at the facility. Call9 allows the SNF to care for these complicated residents at the SNF. This level of care is particularly important with an acute change in patient condition and with an acute illness layered on complex chronic conditions.

Additionally, there was an approximate 30% decrease in the transfer rate to the ED (per 1,000 patient days) in the MA population after Call9's delivery model was implemented (see **Table 1** attached).

Cost/Benefit Analysis:

Call9's model of care has been implemented for SNFs and Medicare Advantage (MA) payors in the New York market to great success. **Table 2** (see attached) demonstrates how, as a result of these implementations, MA as well as Medicare and Medicaid have experienced significant savings.

In 2017, Call9 avoided approximately \$9.1 million in spend to Medicare, and in 2018, is projected to avoid \$21.8 million in Medicare spend. This savings, coupled with the MA successes, suggest an extraordinary opportunity for the Medicare FFS Program, as the model would provide a direct pathway for Emergency Medicine providers to shift from volume and fee-for-service to value-based care.

The savings are primarily a result of avoiding unnecessary hospital admissions. Given the average cost of a SNF resident hospital admission is \$15,735, Call9 is able to save tremendous amounts of money for the health care system by treating these residents at the SNF (which we are able to do 73% of the time we are activated for acute urgent or emergent medical situations) while still providing excellent, advanced care for all of our patients.

Savings data is also available for three of the abstracts referenced above and attached.

In the case of "Use of Noninvasive Positive Pressure Ventilation By An Advanced Emergency Telemedicine To Reduce Unnecessary Ambulance Transports And Emergency Department Visits from Skilled Nursing Facilities," over 859 encounters, 70% (CI 67-73) avoided transport to the ED. SNFs made \$944,882, and payors saved \$9,503,696.

In the case of "Advanced Emergency Telemedicine Service Reduces Unnecessary Emergency Medical Service Transports And Emergency Department Visits From Skilled Nursing Facilities," over a nine-month period, 654 patients were seen by the ETS since the inception of the program. 70.% (CI 66.6-73.8%) of patients avoided transport to the ED by EMS. SNFs made \$1,027,695, and payors saved \$10,336,663.

In the case of "Emergency Telemedicine Bundled with Embedded Staff Reduces Hospitalizations from Skilled Nursing Facilities," a before and after study design was used to examine the implementation of an ETS at a single 202-bed SNF from July 1, 2014, to June 20, 2017. Over the course of the study, a relative reduction in transfers of 38.3% (95% CI 25.6-48.8) occurred. SNFs made \$177,568, and payors saved \$1,785,993.

Advice and Lessons Learned:

Technology Is Part of a Solution – But Not All of It

In our current healthcare environment, many new healthcare companies are attempting to leverage technology alone to streamline care; however, many fail to incorporate a component of human interaction and judgement, which is essential for delivering high quality care. We have

learned that any truly innovative solution must be a collaborative effort that interweaves technology with an actual on-site presence. Call9's on-site first responders extend the SNF staff bandwidth and skill set via their experience in emergency situations and the clinical services they're able to provide, in addition to collecting intake forms to risk stratify patients and rounding on patients following acute events.

Call9's approach to embedded resources, combined with leveraging on site resources at SNFs (such as arranging for outpatient cat scans and blood transfusions), has helped to create such success. Call9 also enters into partnerships with participating SNFs and their medical staffs, allowing for increasing levels of engagement and collaboration that result in fewer unnecessary hospital transfers.

Call9 Clinicians Are Different than Traditional EM Clinicians

A gap exists between traditional inpatient medicine (ED and hospital) and traditional outpatient medicine (skilled nursing facility); caring for patients in this new territory requires a unique blend of various disciplines. Accordingly, there is an analogous gap between a well-trained Emergency Medicine provider and the ideal Call9 provider. It requires a different knowledge and skill set to care for patients in this new territory, compared with a brick and mortar ED.

We have learned that, in order to bridge this gap, we must select, train and onboard new physicians in a way that sets them up for success. To maintain our "cultural standards" and to help guide the manner in which Call9 providers make medical decisions, we have prioritized the following: focusing on professional growth and innovation on a personal level; offering continuing medical education with content specific for our practice environment; and establishing clinical guidelines that are specific to our practice environment. Call9 begins with experienced, caring board-certified Emergency Physicians and then trains them in a new modality of care, which is a departure from traditional telehealth applications (e.g. doc on a video chat).

All Call9 Clinicians Are Champions for Palliative Care

We learned early on that it was critical for all Call9 clinicians have the tools to identify high-risk patients in an acute setting, engage in basic conversations on goals of care and perform symptom management to ensure patients are comfortable. All Call9 clinicians receive extensive training in the practice of primary palliative care. Utilizing real-time assessment and risk stratification, they are able to recognize the need early on for end-of-life conversations; they are trained both to initiate these timely conversations with the patient and his or her care team, and to engage one of Call9's full-time palliative care physicians, eliminating the need to transfer to the patient to a different facility.

Call9 has identified MOLST and eMOLST as critical tools for palliative care discussions conducted via telemedicine, which is an integral part of Call9's care model. Proactively utilizing the eMOLST registry has allowed Call9 physicians to focus on supporting patients and families

as they navigate a complicated system while experiencing chronic illness and episodic acute conditions.

Sustainability:

The Call9 care delivery model in New York has achieved success in establishing a cultural mission of “do right by the patient and all else will fall into place,” which guides the manner in which employees in every division of the company approach problems and make decisions. As Call9 expands into new markets and goes into more states, maintaining this cultural identity and patient-first approach will be one of the most important drivers of sustainability and success.

In order to maintain the highest level of quality care, Call9 has also established a measurement framework to evaluate impact and promote continuous learning through ongoing monitoring. Call9 uses both existing metrics (e.g. CMS, Joint Commission, NQF) when applicable in addition to new metrics that have been piloted in existing programs to expand quality standards. The quality metrics include patient experience measures that are survey-based, measuring from the perspectives of the beneficiaries or their family caregivers rather than from clinicians and representing a robust and person-centered standard for quality measurement.



Advanced Emergency Telemedicine Service Reduces Unnecessary Emergency Medical Service Transports And Emergency Department Visits From Skilled Nursing Facilities.

National Association of EMS Physicians (NAEMSP) - August 2016

Jonathan Fisher; Timothy Peck; Katie Davis; XiaoSong Mu; Claritza Rios; Michael Hartman; Erika Green; Andrew Moczula; Dara Kass; Kevin Biese

Department of Emergency Medicine, Maricopa Medical Center, University of Arizona Phoenix College of Medicine; Call9; Call9; Call9; Call9; Call9; Call9; Call9; Department of Emergency Medicine, Beth Israel Deaconess Medical Center; Department of Emergency Medicine, New York University; Department of Emergency Medicine, University of North Carolina

In medical emergencies, there are limited alternatives to Emergency Medical Services (EMS) and Emergency Department (ED) visits in skilled nursing facilities (SNF) particularly during off hours. Literature suggests that many of these visits are unnecessary and avoidable.

Objective:

To demonstrate the feasibility of an Emergency Telemedicine Service (ETS) staffed by Emergency physicians and Emergency Medical Technicians (EMTs) in order to reduce the need for EMS and ED visits in SNFs.

Methods:

Emergency Providers delivered care at the bedside using a novel telemedicine platform. The staffs at two selected SNFs were trained to activate the ETS to evaluate patients in the same manner that SNF staff would call the patient's physician or EMS in other emergencies. Patients were evaluated and treated at their bedside by the ETS Physicians with the aid of the SNF staff and specially trained EMTs. Patient care included, but was not limited to, review of medical history and medications, modified physical exam, diagnostic testing and administration of certain medications. Key quality metrics including chief complaint, the ability to avoid transfer to the ED and patient outcomes were tracked during a 9 month pilot period. All patients were reviewed and monitored for delays in care, adverse events and medical errors. Descriptive statistics and confidence intervals were calculated.

Results:

654 patients were seen by the ETS since the inception of the program. 70.2% (CI 66.6-73.8%) of patients avoided transported to the ED by EMS. 29.1% (25.5-32.6%) of patients were transferred to the ED. Frequent presentations included shortness of breath (n=97) and altered mental status (n=70). These presentations avoided transfer 76.3%(67.7-84.9) and 58.6% (46.8-70.3), respectively. 85.0% (73.7-96.3) of patients who presented for abnormal vital signs (n=40) avoided transfer. There were no significant delays in care or serious adverse events resulting from medical error or not activating EMS.

Conclusion:

An advanced ETS safely and efficiently managed patients with emergent medical conditions in SNFs dramatically reducing EMS activations and ED visits. Further investigation needs to be done to understand the scope of practice, potential cost saving, and integration with EMS of an ETS in SNFs and other settings.

Chief Complaint	n	Avoided ED Transfer	Confidence Interval
Shortness of Breath	97	76.3%	(67.7% - 84.9%)
Altered Mental Status	70	58.6%	(46.8% - 70.3%)
Febrile	41	82.9%	(71.2% - 94.7%)
Abnormal Vital Signs	40	85.0%	(73.7% - 96.3%)
Cardiac	36	58.3%	(41.9% - 74.8%)
Fall	34	58.8%	(41.9% - 75.7%)
Emesis	25	72.0%	(54.0% - 90.0%)
Pain	24	66.7%	(47.4% - 85.9%)



Use of Noninvasive Positive Pressure Ventilation By An Advanced Emergency Telemedicine To Reduce Unnecessary Ambulance Transports And Emergency Department Visits from Skilled Nursing Facilities

Awarded by The Academy of Geriatric Emergency Medicine (AGEM) - April 2017

Background:

Dyspnea is a common complaint leading to activation of EMS and transport to the Emergency Department (ED) in the elderly residing at skilled nursing facilities (SNFs). Prehospital use of non-invasive positive pressure ventilation (NIPPV) has been shown to reduce mortality and hospital admission. We examined the impact of the use of NIPPV by an Emergency Telemedicine Service (ETS) at SNFs to reduce need for EMS and ED visits.

Methods:

Staffs at two SNFs were trained to activate an ETS to evaluate and treat patients who otherwise would be considered for transport to the ED. Encounters were performed with aid of SNF staff and emergency care technicians in the facility. Staff was trained to initiate NIPPV. Data was retrospectively collected from the electronic health record over a 10-month period. Chief complaints (CC) were categorized using the Coded Chief Complaints for Emergency Department Systems schema. The primary outcome was avoidance of EMS transport with secondary outcomes of reduction in respiratory rate (RR) and increase in oxygen saturation (SpO₂). All encounters were monitored for delay in care and adverse events. Descriptive statistics, confidence intervals and paired t-tests were calculated.

Results:

There were a total of 859 encounters, of these, 70% (CI 67-73) avoided transport to the ED. 16% (n=137) had a CC of "difficulty breathing", of which 19% (n=26) received NIPPV. 73% (n=19) of those treated with NIPPV avoided EMS transport. There was a mean reduction in RR of 6 breaths/min ($p < 0.001$) and increase in SpO₂ of 9% ($p < 0.001$) in those treated with NIPPV. No significant delays in care or serious adverse events resulting from medical error occurred.

Conclusion:

The use of an ETS led to a reduction in EMS transports from SNFs. NIPPV was safely implemented and managed via telemedicine physicians for patients with respiratory distress. Use of NIPPV significantly improved quantitative metrics (RR, SpO₂) and may help prevent need for EMS transport. Additional research is needed to fully understand the efficacy, scope and cost saving benefits of an ETS and the use of NIPPV at SNFs.



Emergency Telemedicine Bundled With Embedded Staff Reduces Hospitalizations From Skilled Nursing Facilities

Accepted for Society of Academic Emergency Medicine (SAEM) - May 2018

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Category:

Geriatrics

Abstract:

Background: When medical emergencies occur in skilled nursing facilities (SNF), there are limited alternatives to Emergency Medical Services (EMS) use, Emergency Department (ED) visits, and likely hospitalization. Research suggests that many of these visits may be unnecessary, avoidable, and harmful. An enhanced Emergency Telemedicine Service (ETS) staffed by remote emergency physicians bundled with embedded emergency technicians was implemented to allow for monitoring over time and patient reassessment. The objective was to examine the impact of the enhanced ETS bundle on the number of ED transfers and hospitalizations of SNF patients.

Methods:

A before and after study design was used to examine the implementation of an ETS at a single 202 bed SNF from July 1, 2014, to June 30, 2017. Data regarding the number of ED transfers and hospital admissions from the SNF were collected. There were three time periods: a pre-implementation phase during the first year, a one year washout and implementation period, and a post-implementation phase during the final year. All patients in the facility were included whether or not they were seen by the ETS during the relevant time periods. No patients were excluded. Absolute rates and rate of hospital transfers per 1,000 patient days in the SNF were calculated and compared using a Fisher's exact test and 95% confidence intervals.

Results:

A total of 467 SNF patients were transferred to the ED and admitted to the hospital over 133,219 patient days. During the pre-implementation period, 290 patients were transferred to the ED and admitted to the

hospital for evaluation. During the post-implementation period, 177 patients were transferred and admitted over the same length of time. The pre-implementation transfer rate was 4.33 transfers per 1000 patient days (95%CI 3.85-4.86), as compared to the post-implementation transfer rate of 2.67 transfers per 1000 patient days (95%CI 2.29-3.10) ($p < 0.001$). This represents a relative reduction in transfers of 38.3% (95%CI 25.6-48.8).

Conclusions:

Implementing an ETS resulted in decreased ED transfers and hospital admissions from a SNF. It is likely that patients in multiple SNFs would benefit from the broader dissemination of this model. Further studies need to examine the cost savings, quality improvement, and patient outcomes related to ETS implementation at multiple SNFs in various settings.

Submission ID: 425337



End of Life Discussions Using Emergency Telemedicine in Skilled Nursing Facilities

Accepted for Society of Academic Emergency Medicine (SAEM) - May 2018

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Category:

Palliative

Abstract:

Background: When patients in skilled nursing facilities (SNF) are nearing end-of-life there is a particular importance placed on establishing goals of care and ensuring that the patient's wishes are respected. This process is facilitated by working with the patient and their loved ones to create Medical Orders for Life-Sustaining Treatment (MOLST). Existing literature discusses the lack of planning in many cases leading to unwanted and unnecessary treatments and costs. Our objective was to specifically examine the feasibility of initiating end of life discussions and completing Medical Orders for Life-Sustaining Treatment (MOLST) with SNF patients through an Emergency Telemedicine Service (ETS).

Methods:

A retrospective chart review was used to examine palliative care consults performed via an ETS that provided services to two SNFs from January 1, 2016 to September 30, 2017. Data regarding the number of palliative care consults, MOLSTs and code statuses were abstracted. Code statuses were classified as full code status, do not resuscitate (DNR) status, do not intubate (DNI) status, do not hospitalize (DNH) status, limited intervention (LI) status, or comfort measures only (CMO) status. Percentages and confidence intervals were calculated. Patients with incomplete MOLST documentation or without ETS palliative care consultation were excluded. Follow up chart review looked for changes of code status.

Results:

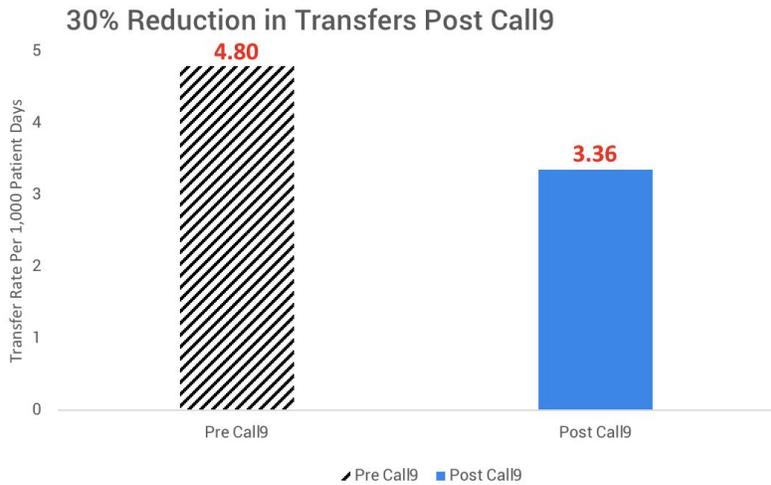
A total of 200 patient charts were identified. 11 charts were excluded because of a lack of a palliative care consult. 91. 5% (95%CI 86. 6-94. 8) of patients seen by the ETS had a documented MOLST. Of the 173 patients with completed MOLSTs: 2. 9% (95%CI 0. 4-5. 4) were classified as full code, 93. 6% (95%CI 88. 9-96. 8) were DNR, 90. 8% (95%CI 85. 4-94. 6) were DNI, 57. 8% (95%CI 50. 1-65. 3) were DNH, and 41. 6% (95%CI 34. 2-49. 3) were LI. A total of 48. 6% (95%CI 40. 9-56. 3) were CMO. 101 patients received follow up care from the ETS. 11 patients updated their MOLST status during follow up. The code status for all patients was respected during follow up encounters.

Conclusion:

Telemedicine provides a viable avenue for establishing, updating, and adhering to MOLST for an ETS charged with two separate SNFs. There is a promising role for such services in the future at all SNFs. Further studies need to examine the benefits and outcomes of End of Life discussions using telemedicine.

Submission ID: 425346

Table 1. Transfer Rates Before and After Call9 Implementation Per 1,000 Patient Days



Note: The post-Call9 transfer rate includes patients who were transferred to the ED without being seen by Call9 (e.g. SNF transferred the patient without activating the Call9 service).

Table 2. Call9 Annual Spend Avoidance for Medicare FFS, MA/Commercial and Medicaid in New York State

