In-house emergency med tech keeps the doctor away

A telephone call out of the blue has helped 202-bed Central Island Healthcare slash its rehospitalization rate, capture about $150,000 in bonus government payments and earn a No. 1 rating among the nation's 15,000 certified skilled nursing facilities. The secret ingredient for this metro New York provider? Embedded paramedics who connect with off-site, contracted physicians via telemedicine. *McKnight's* Editor James M. Berklan spoke with CIH Executive Michael Ostreicher about the startling results.

Q: So, you're reportedly number one in the nation and you're growing the bottom line. Safe to assume you're a popular guy?

A: I'm getting calls all the time from other nursing home operators. They want to know is it worth the bucks, worth the risk. Being first at anything is scary, but it's been phenomenal.

Q: How does it work?

A: When a resident experiences an acute change of condition, we activate Call9. Their specialist goes to the bedside with a suite of diagnostic equipment. This allows our staff to continue to care for chronic conditions.

With the exception of stroke and heart attack, they're treating everything in-house: Hypertension, fevers, chest pain, COPD, altered mental status, hyper lymphedema, pneumonia, chronic Afib, and anxiety disorders. If a nurse calls a doctor who's not in house, the physician doesn't want liability if they're not seeing the patient. So they'll commonly send the patient to the hospital and drop by in the morning.

Now, the EMT calls from the patient's room, engages in telemedicine and converses with the [contracted] emergency room doctor, who recommends X, Y and Z and says we can treat this in-house. The attending doctor can follow up in-person in the morning.

The EMT then calls the local doctor to inform him or her and are finding their answer is most commonly, "I'm comfortable with this intervention." There are M.D.s in-house every day,

Photos: Chris Taggart Photography

but none are working a full shift here. Everyone does rounds on their own patients, and then they are off to the office.

Q: What's been your investment in the set-up?

A: We supply office space for a person called a "clinical care specialist" — an EMT. They supply the specialist and equipment, like a treatment cart and a laptop for the EMT. They supply coverage 24/7 and participate in facility meetings. It's like having a new member on the management staff.

The benefits are patients getting a higher level of clinical care and fewer rehospitalizations, which is the whole point of them being here.

Q: What was your biggest challenge initially?

A: Getting our physicians to buy into this because they normally don't want an outside set of hands getting involved.

But then they realized if they're not in the building, they know that an EMT together with an emergency department physician via telemedicine is in that patient's room bedside, doing diagnostics and treatment.

After interviewing, diagnosing and starting treatment, they call the attending physician and share what the diagnosis is and what they've started treatment on. If the attending physician disagrees with anything that's done, they call the nurses' station. Luckily, that just about never happens.

Q: How good are the results?

A: We measure in six-month blocks and since we started in the summer of 2016, every block has seen discharges to hospital decrease by 40 to 50 percent.

"Fifty percent of the hospitalizations stopped. It obviously affects occupancy and greatly affects the bottom line."

Q: How did you get started ?

A: In 2016, hospitals were starting to get penalized for readmissions. Nursing homes were next. I'm looking at the patients coming in and seeing these are truly hospital patients, severely and clinically compromised, coming to us unstable.

I'm saying to myself, if we don't figure out a way to take care of these in-house, a hospital just won't send them to us. They'll just bypass us. So I'm going nuts trying to figure out this problem.

Out of absolutely nowhere, I got a blind email from Dr. Tim Peck, saying he's developing a telemedicine company [Call9]. I nearly collapsed at my desk reading that email.

I was thinking, 'Holy cow! This is the solution I was looking for!' Unbeknownst to me, he had contacted 2,000 other nursing homes earlier and no one else responded because it was too much of an unknown.

I told Tim I love taking chances and being innovative, but I needed one promise. We're not dealing with cargo or merchandise here, we're dealing with human lives, so I told him I needed a promise that he would live in Central Island until this thing works. He set up a foldable cot in my conference room and slept there for three months straight, literally living in my facility.

I can tell you straight out that for the first six months, I wasn't sleeping. I was terrified, thinking of all the things that could go wrong. I was absolutely worried: What if the technician makes the wrong decision?

It was also the fear of what if this bluetooth-enabled sonagram or EKG is giving the wrong reading to this faraway physician talking to us through FaceTime making the wrong diagnosis. There was so much that could have gone wrong.

Q: How has this paid off?

A: Initially, the great benefit was sending fewer patients out. But I look at it as patients who wouldn't have gone out are as valuable to you as a new admission on your census. Fifty percent of the hospitalizations stopped. It obviously affects occupancy and greatly affects the bottom line.

More recently, the first of the value-based purchasing performance scores came out and, based on 2017, our program ranked No. 1 among 15,000 eligible SNFs. I reached out to CMS to ask how many scored number one and they didn't answer. But I can tell you one of my sister facilities that doesn't do this scored in the area of 10,000.

It will, therefore, trigger a 2% increase of the Medicare rate for fiscal 2019. That's about $150,000, which would more than pay the subscription fee for Call9.

Q: What other positives have you noticed?

A: On top of all the financial benefits, the patient's family has a sense of security. This is major — an extra layer of protection is there, keeping an eye on Mom or Dad. There's a doctor or EMT onsite 24/7. They can't possibly send them to a place that does more.

More than anything else, patients are getting a very high level of care, which is obviously the reason we're doing this in the first place. We are caregivers at the end of the day, though businessmen as well.

Q: Any peer advice?

A: I would advise other providers to look into telemedicine. The current paradigm of nursing home care is not sustainable without it. ■