



# Hospitals and Health Systems Ensuring Access in Their Communities

*A Compendium of Case Examples*



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# Introduction

In late 2016, AHA’s Task Force on Ensuring Access for Vulnerable Communities issued a report examining ways in which vulnerable rural and urban communities, and the hospitals that serve them, could safeguard access to health care services. The task force considered a number of integrated, comprehensive strategies to reform health care delivery and payment and its report sets forth a menu of nine emerging strategies from which communities may select based on their unique needs, support structures and preferences. While the task force’s focus was on vulnerable communities, these strategies have broader applicability for all communities as hospitals redefine how they provide better, more integrated care. The nine strategies considered by the task force are described on the next page.



Following the release of the report, AHA began developing resources and tools to help our members evaluate to the strategies included in the task force report. As a result, we have released a variety of webinars, educational opportunities, guides and toolkits to assist AHA members as they discuss and implement these strategies. For example, AHA has developed one-page guides on each of the emerging strategies. We also have released guides that help hospital leaders initiate dialogue on these topics with their governance boards and communities. *Hospitals and Health Systems Ensuring Access in Their Communities* guide is a compendium of case examples of AHA members from across the country employing these innovative strategies in their communities.

The AHA remains committed to ensuring access to critical health care services and we will continue developing new tools and resources. All of these resources are housed on our task force website, [www.aha.org/EnsuringAccess](http://www.aha.org/EnsuringAccess), which serves as an online catalogue of AHA resources on ensuring access in vulnerable communities.

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# Emerging Strategies to Ensure Access to Health Care Services

## Addressing the Social Determinants of Health

Social challenges often prevent individuals from accessing health care or achieving health goals. This strategy includes screening patients to identify unmet social needs; providing navigation services to assist patients in accessing community services; and encouraging alignment between clinical and community services to ensure they are available and responsive to patient needs.

## Global Budgets

Global budgets provide a fixed amount of reimbursement for a specified population over a designated period of time. They may be designed in a way that allows each provider to create a unique plan to meet mandated budgets, thereby allowing vulnerable communities autonomy and flexibility to create solutions that work best for them.

## Inpatient/Outpatient Transformation Strategy

This strategy involves a hospital reducing inpatient capacity to a level that closely reflects the needs of the community. The hospital would then enhance the outpatient and primary care services they offer.

## Emergency Medical Center (EMC)

The EMC allows existing facilities to meet a community's need for emergency and outpatient services, without having to provide inpatient acute care services. EMCs provide emergency services (24 hours a day, 365 days a year) and transportation services. They also would provide outpatient services and post-acute care services, depending on a community's needs.

## Urgent Care Center (UCC)

UCCs allow existing facilities to maintain an access point for urgent medical conditions that can be treated on an outpatient basis. They are able to assist patients with an illness or injury that does

not appear to be life-threatening, but requires care within 24 hours.

## 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.

## Frontier Health System

This strategy addresses challenges faced by frontier communities, including extreme geographic isolation and low population density. It provides a framework for coordinated health care as individuals move through primary and specialized segments of the medical system.

## Rural Hospital-Health Clinic Strategy

This strategy allows for integration between rural hospitals and various types of health centers in their communities (e.g., Federally Qualified Health Centers and Rural Health Clinics). These partnerships also could facilitate integration of primary, behavioral and oral health and allow for economies of scale between both organizations.

## Indian Health Services (IHS) Strategies

This strategy includes development of partnerships between IHS and non-IHS health care providers aimed at increasing access to health care services for Native American and Alaska Native Tribes and improving the quality of care available and promoting care coordination.

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To learn more about these strategies and explore case examples, please see the full report at [www.aha.org/ensuringaccess](http://www.aha.org/ensuringaccess).

# Social Determinants of Health

## *Chadron Community Hospital & Health Services – Chadron, NE* *Integrating Patient Care With Human Services*

### **Overview**

Weaving health, human and social services into the fabric of an integrated system of care is characteristic of many frontier hospitals. Non-medical, non-emergent needs, otherwise known as the social determinants of health, are often intricately tied to personal health and well-being. For decades, rural communities have pooled resources to improve population health, expand access and reduce per-capita costs by attending to these social determinants. Chadron Community Hospital and Health Services (CCH&HS) is an excellent example of this kind of resourcefulness.



Located in the northwest corner of the Nebraska panhandle, CCH&HS serves patients from rural areas in Nebraska, eastern Wyoming and southern South Dakota, including the Pine Ridge Native American reservation. Its nearest tertiary health care systems lie 100 miles to the north and 100 miles to the southwest. In addition to its role as a full-service critical access hospital (CAH), hospital leaders have cultivated diverse partners from across the region to provide a range of health care and social services to the citizens of the tri-state area.

CCH&HS offers medical and surgical care, obstetrics and newborn care, emergency care, rehabilitation services, dialysis, home health and hospice. Also available are a wide range of visiting specialists, who come to Chadron to see their patients, bringing specialty care closer to home. Licensed ground transport, two helicopter services and a fixed-wing airplane serve the hospital. However, CCH&HS is more than a health care provider. It also addresses the community health needs of the 15,000 residents of this vast region by attending to the social determinants of health.

Valuing the importance of shared assets, strategic collaborations were made among area providers and agencies to expand services and reduce costly duplication. Western Community Health Resources (WCHR) is an extension of CCH&HS with service to Chadron, Crawford and Gordon counties. WCHR received funding for the programs of Women Infant and Children, immunizations, family reproductive health, commodity supplemental food program, HIV testing and counseling, and maternal and child health.

### **Impact**

Additional collaborations led to re-opening the Closer to Home Soup Kitchen in downtown Chadron, the creation of a public dental health clinic and a partnership with the Circle of Light nonprofit to provide 100 percent of its proceeds to assist patients undergoing cancer treatment. Collectively, the hospital participates in three different food banks and partners with two community action agencies. Also, it is a member of the Nebraska Northwest Development Corporation to promote and assist economic development across the region.

Hospital leaders have chaired the Chadron Housing Authority (CHA), which administers management and oversight of 100 federally funded apartment units assisting low-income, elderly, and disabled individuals

to secure affordable housing. The CHA also oversees 85, Section-8 housing vouchers, helping low-income families obtain affordable housing.

The hospital works with the local college and primary school systems to provide various nursing services, in addition to developing an alcohol education program with area law enforcement agencies. In partnership with Chadron Medical Clinic, the health system supports the Chadron State College Clinic with immunizations, primary care and wellness and prevention services.

CCH&HS championed the Rural Nebraska Healthcare Network, a consortium of rural hospitals and clinics that has coordinated a health care broadband fiber-network care system for western Nebraska. The system spans 12 counties, connects 23 Nebraska hospitals, behavioral health providers and their associated clinics, and provides access to the National LambdaRail and Internet2 research networks. It has improved the diagnostic capabilities of the participating hospitals as telemedicine originating sites linked to Denver facilities.

True to its mission to promote a culture of health, the system has a successful employee wellness program with a more than 70 percent participation rate. The hospital's health risk assessment shows the wellness program has contributed to an almost 10 percent drop in the number of employees at risk for diabetes.

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## **Yale New Haven Health – New Haven, CT**

### *Home Ownership and Housing Security*

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#### **Overview**

“The Hill” is the southwestern-most neighborhood of New Haven, CT. The Hill neighborhood contains the majority of the buildings of Yale New Haven Hospital (YNHH) and Yale School of Medicine. The expansion of the medical campus area over the years is often a source of tension with the bordering residential areas, as it alters the neighboring landscape and inflates property values.

The residential areas of The Hill are mostly working-class and minority neighborhoods where crime and poverty remain concerns. It also is home to a number of YNHH employees.

A 2015 survey by the Community Alliance for Research & Engagement reveals challenges still exist for The Hill:

- 42% do not feel safe enough to go for walks in their neighborhood at night
- 25% of residents are unemployed, the highest among all of New Haven's low-income neighborhoods
- 22% own their homes
- 69% are low income, 43% at or below poverty

Vulnerable communities, even if quality health care is available, discover social challenges often prevent community members from accessing health care or achieving their health goals. Addressing these social determinants, such as food, housing or transportation, through enhanced clinical-community linkages aid community members' access to available health care services, which in turn, improve their health outcomes.

YNHH is one of several community partners that have joined efforts to address the social determinants of health effecting their community, specifically housing security. Here are two examples: Habitat for Humanity and Home Ownership Made Easy.

## Habitat for Humanity

In the mid-1980s, the city of New Haven had a growing problem of residential flight. Middle-income families were leaving the city, making the city appear run down and abandoned. After several fits and starts, *Habitat for Humanity of Greater New Haven* focused on developing single-family homes in resource-challenged areas of the city, specifically in the north section of The Hill in proximity to downtown and YNHH. YNHH established a relationship with Habitat in 2008 to increase the supply of affordable homes.

## Home Ownership Made Easy

In July 2006, by what was then New Alliance Bank (currently Key Bank), YNHH established the *Home Ownership Made Easy (HOME)* program for its employees. HOME offers first-time homebuyers up to \$10,000 in forgivable, five-year loans and other incentives when they purchase homes in New Haven. Employees who purchase homes in specific neighborhoods surrounding the YNHH community – Hill, Dwight, West River and City Point – are eligible for an additional mortgage subsidy of \$200 per month during the first two years of their home ownership. This subsidy can increase the total benefit by \$4,800.



Through the HOME program, YNHH and Key Bank provide extensive education and consulting to aid prospective homeowners (employees) in learning about the process of home purchase, home ownership responsibilities, housing rehabilitation and credit counseling.

## Impact

With support of hundreds of volunteers and thousands of hours, Habitat for Humanity has built nine homes in The Hill sponsored by the hospital. These efforts continue, now concentrating on Vernon Street near YNHH, building two more homes beginning February 2018. Additional homes are planned for the future. With the HOME program, more than 143 YNHH employees have purchased homes.

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## Inpatient/Outpatient Transformation Strategy

### Guadalupe County Hospital – Santa Rosa, NM

#### Building a Replacement Hospital

## Overview

Guadalupe County Hospital (GCH) was built in 1952 as a 31-bed general acute care hospital with maternal, medical and surgical services. However, over many years this county hospital faced challenges related

to finances, staffing and geographic isolation. Santa Rosa has a population of 2,848, and GCH has the only emergency department in a 173-mile stretch of Interstate 40 between Albuquerque and Tucumcari in the eastern half of the state. In 2011, GCH worked with the community to plan, finance, design and construct a replacement facility that better suited to the needs of the community. The new facility has only 10 inpatient beds, in addition to a primary care clinic, a retail pharmacy, a public health clinic and a dental facility next to the hospital.



## Impact

The hospital's redesigned, patient-centered services have resulted in improved quality measures, increased patient experience scores and a more stable financial picture.

## Community Engagement

The hospital relied on feedback from the community when developing plans for the replacement hospital.

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## Mount Sinai Health System – New York, NY

### Rebuilding a Hospital to Meet Patient Needs

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## Overview

In order to better meet the needs of patients, the hospital system started a four-year project replacing Mount Sinai Beth Israel Hospital, which is licensed for 799 beds, with a new health care network. The new facility will have significantly fewer inpatient beds – 220 – and will include a full-service emergency department and a network of greatly expanded primary, specialty, urgent, behavioral and outpatient surgery services.



## Impact

The shift in services from inpatient to outpatient is the result of changes in technology, as well as more demand for outpatient care and less demand for inpatient care. In recent years, only 400 of the beds were in use on a daily basis.

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## Carolinas HealthCare System Anson – Wadesboro, NC

### Improving Sustainability by Enhancing Outpatient Care

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## Overview

The hospital recognized it would have to transform its model of delivering care to remain viable. Carolinas designed a new facility that reduced inpatient capacity from 52 to 15 beds and allowed the hospital to offer enhanced outpatient and primary care services to the community. These services include a patient-centered medical home, increased emergency department (ED) capacity and increased behavioral health services.

## Impact

As a result of implementing patient flow and care coordination models in the new facility, the hospital improved outcomes; enhanced primary care, wellness and prevention; and screened patients to ensure they were treated in the most appropriate settings. ED visits have decreased and primary care volumes have increased. In addition, Carolinas has transitioned 2,631 patients into the new primary care/medical home model in the first year – which is significant, given the total population of the hospital’s service area is only 25,765.

## Community Engagement

The hospital sought input from the community, physicians and staff to ensure the design of the new facility would meet the patients’ needs.

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# Emergency Medical Center

## *Piedmont Mountainside Hospital Emergency Services – Ellijay, GA*

### *Converting Hospital to Freestanding Emergency Department*

## Overview

Atlanta-based SunLink Health closed North Georgia Medical Center (NGMC) in Ellijay in 2016 as a result of unstable finances, low patient volumes, a high public-payer mix and significant charity and indigent care. Piedmont Mountainside Hospital (PMH), some 20 miles away in Jasper, expanded its footprint of services in Ellijay by leasing the shuttered NGMC facility and converting it into the state’s first freestanding emergency department. The newly renovated facility opened in 2017 and houses a CT scanner, X-ray, ultrasound, pharmacy and lab. PMH hired 35 new employees to staff the emergency center.

## Impact

Rather than losing emergency services altogether, Gilmer County residents can access care 24 hours a day at the renovated facility. The freestanding center is an extension of the emergency services at PMH, providing access to physicians, nurses, lab technicians and radiology technicians. Patients receive care for heart attacks, strokes, minor trauma, blood testing and advanced imaging. The facility cares for about 30 patients a day; in the first six months, there were more than 5,000 emergency visits. PMH is working collaboratively with the local Gilmer County EMS/ambulance service to ensure patients are transported to the most appropriate facility.

## Community Engagement

Though many people traveled outside of Gilmer County for health care, they were upset at the prospect of losing the hospital and appreciate having access to services close to home. Because it was the first freestanding emergency department in the state, several local, county, state and federal agencies were engaged in approving the new facility.



## Future Goals

The forecast is for patient volume to continue to grow to almost 10,000 in 2018.

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## *Monmouth Medical Center & Monmouth Family Health Center – Long Branch, NJ Emergency Department Community Partnership Project*

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### Overview

Monmouth Medical Center (MMC) is a 527-bed community hospital affiliate of RWJBarnabas Health in east central New Jersey. It is a not-for-profit, regional tertiary care teaching hospital that provides a full spectrum of services, ranging from high-risk neonatology to geriatric care.

MMC's service area represents a population of nearly 1 million residents in Monmouth and portions of Ocean and Middlesex counties. With more than 21,000 inpatient admissions, 50,000 emergency department (ED) visits, 9,500 outpatient surgeries, 5,500 deliveries and 190,000 outpatient visits, MMC is one of the largest community teaching hospitals in New Jersey.

Monmouth Family Health Center (MFHC) is a federally qualified health center (FQHC) with a mission of providing economically disadvantaged individuals in Long Branch and surrounding communities high-quality, comprehensive, affordable, culturally sensitive and linguistically appropriate primary and preventive health care. MFHC also is pursuing recognition as a Patient Centered Medical Home through the National Committee for Quality Assurance.

MFHC provides health care services to more than 14,000 people each year, with more than 54,000 visits annually. The center provides services in pediatrics, adolescent and adult medicine, podiatry, HIV care, nutrition counseling, health education, social services, pre-natal and gynecological care and dental care. OB/GYN services are provided in the wellness center adjacent to MMC. In addition, MFHC patients have access to specialists through an affiliation with MMC Specialty Clinics.

When the MFHC was founded in 2004, it was sponsored by MMC and its classification was as an "FQHC Look-Alike," which means that all federal requirements were followed, but MFHC did not receive federal support to fund its operation. Rather, MMC heavily subsidized the early operation of the health center and some of the services were provided on the hospital campus.



In 2009, that all changed. Through the American Recovery and Reinvestment Act, MFHC obtained 330 funding for two years. In 2011, through the Affordable Care Act (ACA), the MFHC was permanently funded by the Health Resources and Services Administration. Since then, additional funding has been obtained to improve cervical cancer screenings and facilitate ACA outreach and enrollment activities. Through the Centers for Medicaid & Medicare Services (CMS), the MFHC and MMC received funding to establish an Emergency Diversion Program. This funding and collaboration resulted in a decrease in number of patients visiting the ED for non-emergent visits,

thus allowing the ED to improve the throughput of real emergency cases and reduce waiting time.

To address the issue of non-emergency cases turning up in the state's EDs, the "Community Partnership for ED Express Care and Case Management" initiative was developed as a demonstration project led by New Jersey Hospital Association's Health Research and Educational Trust, the state Department of Human Services and the New Jersey Primary Care Association. Implemented from September 2008 through April 2011, the project tested a model for providing alternate non-emergency services to patients who presented to the ED with non-urgent primary care needs.

MMC served as one of two pilot sites, in tandem with the MFHC. The model used an "express care process," in which patients who came to the ED with a non-emergency situation were assessed by a clinician and provided the appropriate services. The ED staff then took extra steps to refer patients for follow-up visits with their primary care providers. If the patient had no regular physician, MMC ED staff scheduled an appointment for the patient at MFHC. The ED staff also educated the patient on the appropriate site of care for various health needs and the importance of having a "medical home" for primary care needs.

In addition, case managers stationed at both the hospital ED and health center coordinated services and arranged transportation and support services. The site also identified repeat ED users, tracked compliance with follow-up care and assisted with referrals for specialty care. Through it all, the initiative stressed communication between the hospital and health center, supported by mutual electronic systems that could schedule appointments and coordinate care.

## **Impact**

Upon its conclusion, the demonstration revealed the following results:

- ED visits for primary care needs declined 22% at a time when overall ED visits increased by about 1%. Inappropriate utilization decreased 47% among Medicaid patients in particular.
- There was a 19% increase in patient volume at the community health centers, including a 30% increase for Medicaid patients.
- Reduced ED utilization for primary care helped improve patient flow throughout the ED, cutting patient turnaround time by an average of 15%.

## **Community Engagement**

MFHC is governed by an 11-member community board and, as in many relationships between an FQHC and a hospital, the boards of trustees remain independent. Nevertheless, MMC has representation on the board executive committee as well as on the MFHC finance and quality committees. This relationship fosters communication, as well as clinical and fiscal accountability between the two providers.

## **Future Goals**

MMC is working to revitalize the ED case management program and build upon its experience to strengthen the relationship with MFHC. Physician recruitment and retention is a continuous challenge as the collaborators work to increase access points for primary care and ultimately improve population health. MMC continues to lend administrative support to MFHC and is working to help the health center expand and grow.

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# University of Maryland Upper Chesapeake Medical Center – Havre de Grace, MD

## Ensuring Access to Emergency Services through Facility Redesign

### Overview

In January 2016, the University of Maryland Upper Chesapeake Health (UM UCH) announced that University of Maryland Harford Memorial Hospital (UM HMH) - one of its two hospitals - would close once the development of a modern medical campus is completed. The current hospital, located near the Susquehanna River in Harford County, is at the end of its useful life as a medical facility and has numerous infrastructure issues that do not align with changing health care needs. Renovation is not cost-effective, and the site of the hospital is landlocked, which limits expansion.



UM UCH leaders recognized major shifts in health care delivery, both nationally and in the state of Maryland. This changing health care environment gives rise to a new category of health care facilities that offer easy access to the most in-demand health services and resources with a broader range of services than what the traditional hospital offered in the past. Havre de Grace will be among the first communities in Maryland to welcome this new approach to care delivery while maintaining access to critical emergency services.

The project involves closing UM HMH in downtown Havre de Grace and opening a new freestanding medical facility and medical campus three miles away on a currently undeveloped property. This new property is more centrally located for the northeast Maryland region, just off Interstate 95/Route 155. The new campus is projected to open by 2020. UM UCH's new development will be called University of Maryland Upper Chesapeake Medical Center – Havre de Grace (UM UCMC – HdG). In addition to an emergency department (ED), services offered at the 190,000-square foot UM UCMC – HdG medical campus will include:

- observation beds for short-stay medical patients
- diagnostic imaging
- cardiology testing
- pharmacy
- laboratory
- rehabilitation therapies
- chemotherapy/infusion
- physician office space
- prevention/wellness services
- public education/conference space

The new Havre de Grace medical campus will include expanded emergency behavioral health services, currently offered at UM HMH and at Union Hospital in Elkton, about 25 miles away. In Harford County, there has been a 47 percent increase since 2008 in the number of ED visits related to drug and alcohol addiction. The new Havre de Grace medical campus will include a state-of-the-art facility offering behavioral health services for adults with mental illness and substance abuse issues, as well as seniors requiring hospitalization for behavioral health issues.

UM Upper Chesapeake Medical Center in Bel Air will provide the surgical capacity and higher acuity inpatient services presently found at UM HMH.

### Community Engagement

An opportunity exists to identify new uses for the old hospital site and adjacent properties that currently

house physician offices, with the goal of strengthening and enriching the community. UM UCH is committed to working with the city of Havre de Grace, Harford County and the state of Maryland on identifying productive new uses for the site. UM UCH hired a firm that provides expertise in community redevelopment to help them explore the best use for this property for the long term.

The new medical campus will emphasize wellness and fitness through partnerships with Maryland University of Integrative Health, University of Maryland School of Medicine's Department of Psychiatry, Healthy Harford and other community health-related programs and services. As part of an ongoing commitment to improve the population's health, UM UCH is reviewing options such as a walking/jogging/biking trail on the campus for use by patients, team members and the general community.

## Future Goals

UM UCH officials plan to invest more than \$160 million for its Vision 2020 planning. Those changes include emphasis on outpatient treatment rather than extended hospital stays and a greater focus on providing expanded mental health care services to the community. Programs such as Healthy Harford use both UM UCH resources, in addition to community resource providers to connect patients who make frequent ED visits with physician providers and social services in the area. For patients who are homebound, providing in-home care also is an important part of the overall health care delivery strategy.

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## Urgent Care Center

### *Our Lady of the Lake Regional Medical Center – Baton Rouge, LA*

*"Right Care, Right Place, Right Time"*

#### Overview

After a state-run safety-net hospital closed and an emergency department (ED) at another hospital shut down, Our Lady of the Lake Regional Medical Center (OLOL) opened two urgent care centers and expanded its graduate medical education offerings. After implementing the community campaign "Right Care, Right Place, Right Time" to educate the public about where to seek appropriate levels of care, the new urgent care centers were able to fill the gap for the non-emergency care needs. Both urgent care centers provide services for non-emergency conditions including ear or eye infection, fever, cuts that may need stitches, possible broken bones or simple fractures, severe sore throat, sprains and strains, and vomiting and diarrhea. The hospital that closed, Earl K. Long (EKL) Medical Center, served as home to several clinical training sites for the Louisiana State University School of Medicine. OLOL filled the gap by initiating local graduate medical education training, thus preserving access to care and medical training in the Baton Rouge community. To mitigate the decreased capacity from the hospital and ED closure, OLOL added 25 beds to address this need, including a mixture of regular emergency beds, fast-track beds for patients with non-emergent conditions, trauma bays and treatment beds for people with minor-to-moderate illness.

#### Impact

The new urgent care centers are proving to be a less expensive alternative to the ED. EKL treated about 30,000 patients per year in the ED; urgent care clinic visits in the first year (2012) totaled approximately that

amount and have grown to about 50,000 per year. By leveraging existing operations and providing care in less expensive settings, overall cost per patient day decreased from \$4,137 at EKL to \$1,690 at OLOL. Enhanced staffing models at the clinics also decreased wait times for new patient appointments from an average of eight months to less than 30 days and decreased wait times from prescriptions from two weeks to seven minutes. In addition, each year 260 individual medical residents and 300 medical students train at OLOL. Residency programs serve some 52,000 patients annually in 16 medical disciplines, making OLOL the fourth-largest teaching hospital in Louisiana. As the medical center increased program accreditation, resident satisfaction has increased and the programs continue to see successful match rates.

## Community Engagement

OLOL implemented a successful community outreach campaign, educating the public about the service closures and where to seek the most appropriate level of care in the future. Through forums at churches and town hall gatherings, residents learned about the new urgent care centers and when it's appropriate to seek care in a physician's office vs. an urgent care clinic vs. the ED.

## Future Goals

Continued growth is expected at the urgent care centers and clinics.

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## Virtual Care and Telehealth

### *Dignity Health's Mercy General Hospital (Sacramento) and Mercy San Juan Medical Center (Carmichael), CA*

#### *Dignity Health Telemedicine Network*

### Overview

The Dignity Health Telemedicine Network (DHTN) was launched to broaden the reach of its highly trained specialists' skills to smaller community hospitals. The primary goal of DHTN is to partner with physicians outside of the hospital walls to provide care that serves the best interests of patients and families, no matter where they are located.

DHTN combines expertly trained physicians and state-of-the-art technology to offer patients immediate access to 16 acute, post-acute, behavioral and wellness services. Available 24/7, the service connects patients and their attending physicians to hub specialists via two-way live video/audio feed and image sharing technology. DHTN features the only FDA-approved mobile unit equipped with a camera, microphone and monitor. This equipment is located at the partner hospitals. This robotic unit can move untethered, allowing the doctor to freely interact with the hospital staff, patients and family members in real time.

### Impact

In 2016, there were 30,000 patient encounters across various sites including 82 end points (robots), 60 specialists, 12 live services and 43 partner sites. For telepsychiatry, the hospital typically connects the patient to a psychiatrist through telehealth within 90 minutes from arrival at the emergency department (ED). In the

past year, DHTN has consulted on about 8,500 psychiatric patients with an average response to page time of six minutes and a physician notation of about 1.75 hours. For telestroke, the goal is to transport a patient from door to ED, door to CT, and door to DHTN activation, each step within five minutes. For a year, from 26 partner sites and based in Folsom, California, DHTN had over 6,700 consults, 412 patient transfers and 743 tPA recommendations. The average response time from physician consult notification/page to response of telestroke patients was 2:18 minutes. DHTN provided almost 4,400 TeleICU consults with an average physician response time of four minutes. One TeleICU partner site saw a significant decrease in severe sepsis and shock mortality, and ventilator days. TelePulmonology clinic also was implemented, to allow the critical care physicians to follow up with patients after discharge. This resulted in a significant decrease in the readmission rate for COPD patients. There also was a significant decrease in the number of critical care patients being transferred to other facilities.

## Community Engagement

DHTN is made possible by a gift from The Elliott Family Foundation, the philanthropic arm of Elliott Homes.

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## Rural Hospital-Health Clinic Integration

### *Lafayette Regional Health Center and Health Care Collaborative of Rural Missouri – Lexington, MO*

#### *Expanding Access Points for Primary, Dental and Behavioral Health*

### Overview

To better meet the community's need for primary care, dental care and behavioral health services in its rural area, Lafayette Regional Health Center (LRHC) partnered with LiveWell Community Health Center and the Health Care Collaborative of Rural Missouri (HCC) and its four federally qualified health centers (FQHCs) to provide care while conserving scarce resources.

LRHC is a 25-bed critical access hospital. It is a part of HCA Midwest Health, a network of hospitals in the greater Kansas City area. LRHC provides 24-hour emergency services, general and orthopedic surgery, imaging, cancer care and post-acute care, and operates clinics in Higginsville, Odessa and Lexington, Mo. Initially, HCC was an organization that largely coordinated services for low-income individuals. Over the past decade, it has grown to a point where its community-based programs include case management, counseling and assessment, health education, transportation, translation services, rural health professional recruitment, ACA Marketplace enrollment, Medicaid and Medicare enrollment, LiveWell Connectors, a student nursing program, health care advocacy initiatives and health information technology to link services.

In 2013, two of LRHC's clinics were struggling to maintain primary care and clinical services in and around Lexington. Ownership of two LRHC clinics in Waverly and Concordia was transferred to HCC. In 2015, HCC expanded in Carrollton and ultimately reopened a shuttered clinic in Buckner. Today, all four HCC clinics are FQHCs and operate under the brand of LiveWell. They offer dental, behavioral health, primary care and social support services. In addition, the LiveWell Community Health Centers have achieved Level III Patient

Centered Medical Home recognition under NCQA.

HCC and its LiveWell Clinics work with the LRHC emergency department (ED) to assist patients who frequently use the emergency room for primary care find a primary care doctor, dentist or behavioral health professional. Patients who have Medicaid are coached on the appropriate use of the hospital ED, and given a list of locations that accept Medicaid and instructions on how to contact the LiveWell Centers' after-hours answering service prior to utilizing the ED.

## Impact

The providers have expanded access, improved efficiency, enhanced the health of the population and maximized resource utilization by avoiding unnecessary duplication of services while directing patients toward the appropriate site of service.

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## Indian Health Services Strategies

### *Mackinac Straits Health System and Sault Tribe of Chippewa Indians – St. Ignace, MI*

#### *Partnering to Improve Population Health*

### Overview

The old Mackinac Straits Hospital is located in St. Ignace, MI, a town of about 2,500 residents and a county of 11,000. It was a small Hill-Burton facility built in the 1950s that struggled to meet its community's health needs. The hospital's board grappled with whether to shut it down or find a way to finance a new, larger and up-to-date facility.

Enter the Sault Tribe of Chippewa Indians (STCI), which has close ties to the health system, and was dissatisfied with its own overcrowded health clinic. The Tribe donated a 16-acre parcel of land valued at \$1.2 million for a new hospital, and entered into an innovative joint arrangement to include a tribal health and human services clinic inside the facility.

The new Straits Healthcare Village (SHV) includes the hospital offering comprehensive services that best respond to the community's needs, including a 48-bed skilled nursing facility. In addition, the Mackinac Straits Health System (MSHS) coordinated a visiting physician program within the hospital and in five satellite clinics throughout the county and surrounding area.

The Sault Tribal Health & Humans Services Center also is located in the SHV and offers outpatient medical, health promotion, behavioral health, dental and community health nursing among other services. The Traditional Medicine Program was the first tribal traditional medicine program in the United States integrated into a tribal health delivery system and has served as a model for traditional medicine programs offered by other tribes.

MSSH has engaged in several other strategic partnerships to find creative solutions to the health care access and delivery challenges facing the community and organization. In July 2015, Mackinac Straits and Munson Healthcare entered a regional affiliation agreement that gives them access to a broad range of Munson Healthcare system services.

Another partnership is a collaborative effort by the hospital, city, county and Beacon Specialized Living Services that resulted in St. Ignace Shores. This eight-bed facility is the first of its kind to integrate social detox with a mental health crisis unit under one roof.

## Impact

By engaging in strategic partnerships to find creative, collaborative solutions to health care access and delivery challenges, MSSH and STCI were able to increase the quantity and quality of services available to the community. The collective comprehensive services include inpatient, outpatient, behavioral health, and long-term care.



## Community Engagement

To address regional mental health/addiction needs, a Straits-sponsored community task force developed strategies to meet community needs. The partnership includes Hiawatha Behavioral Health, local law enforcement, hospital staff, community members and judicial leaders.

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## *Wagner Community Hospital-Avera – Wagner, SD* *Overcoming Barriers to Care for Native Populations*

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### Overview

Wagner is a frontier community of about 1,500 people located in Charles Mix County in south central South Dakota. It is adjacent to the Yankton Sioux Reservation and is 120 miles from the closest major tertiary hospital in Sioux Falls, SD. The median household income is well below the median for the state and the poverty level is higher.

Wagner Community Memorial Hospital-Avera (WCMH-A) is a 20-bed critical access hospital (CAH) in Wagner. In December 1947, the community founded the hospital, which opened in 1951 in an effort to establish permanent health care access to the Wagner area. The current facility opened in 1974. In 2002, Wagner Community Memorial Hospital partnered with Avera Health system in Sioux Falls, SD, and Avera Sacred Heart Hospital in Yankton, SD, to become a managed facility. WCMH-A provides over half of its services to Native Americans and members of the Yankton Sioux Tribe. This mix of diverse cultures, where health care practices and local politics play an intricate role, affects how health care is managed and delivered. The priority of WCMH-A is ensuring access to care while considering the population's formidable social determinants of health.

The hospital underwent extensive renovations from 2007 to 2012 with the addition of a new inpatient wing, emergency room, hospice room, intensive care room, ambulance bay, pharmacy, nurse's station, physical therapy area and a four-provider clinic. There were also improvements made to outpatient rooms and pre-



and post-op rooms. WCMH-A also offers many outpatient services including surgery, specialty clinics and eCare services.

WCMH-A serves a mix of more than 80 percent public pay, of which 13 percent is from the Indian Health Service. WCMH-A provides more than half of its services to Native Americans and members of the Yankton Sioux Tribe. To meet local health care needs and the needs of the Native Americans and members of the Yankton Sioux Tribe, the hospital adopted strategies related to telemedicine, population health, access to primary care, housing and economic development.



## Telemedicine

A challenge for WCMH-A is timely and efficient delivery of care. A lack of medical specialties and current diagnostic modalities impedes access. Inclement weather also may restrict access to care and compromise patient safety. Enter AVERA eCare. In 2009, through a grant from The Leona M. and Harry B. Helmsley Charitable Trust, Avera eCARE launched eCARE Emergency and eCARE Pharmacy for all of its rural hospitals. eEmergency provided staff an immediate resource through real-time audio/visual consultations with specialty care providers and nurses located at a central hub in Sioux Falls. The technology allows specialists to evaluate and assess the patient, review laboratory and imaging results, and make decisions or suggest interventions pertinent to the patient condition.

eEmergency proved to be an invaluable tool in managing critical cases for the Yankton Sioux Tribe and the larger community, caring for patients who may have been too challenging for an ordinary community hospital to handle. WCMH-A added eICU, now referred to as eHospitalist and eConsult. By partnering with Avera eCare, WCMH-A became one of the most technologically advanced CAHs in the state.

## Population Health

The 2013 WCMH-A Community Health Needs Assessment identified a significant need for an upgraded and expanded dialysis unit in the Wagner area. Patients who are not able to get into the current dialysis unit have the option to commute an hour or more to other dialysis units. The Yankton Sioux Tribe has above average rates of diabetes, obesity and other chronic conditions, increasing the need for dialysis care. In the summer of 2015, the Yankton Sioux Tribe Health Director reached out to the WCMH-A and established a new tribal-owned, Avera-managed dialysis unit.

The End Village Dialysis Center now offers services for the Yankton Sioux Tribe and the surrounding area. It has doubled the capacity of the previous program and serves more than 20 patients daily. Improved patient compliance and a higher quality of life are results of the ability to obtain dialysis locally.

## Access to Primary Care

The 2013 Community Health Needs Assessment identified a shortage of primary care providers for the Yankton Sioux Tribe and Wagner community, noting that 11 of the last 12 physicians left within four years of employment. Physician recruitment efforts in the past were minimally successful and expensive. WCMH-A embarked on an ambitious path to recruit hospital nurses to become certified nurse practitioners (NP-C). Impact: Five registered nurses immediately accepted the challenge. In 2014, the first was certified and started her practice with several to follow. The success of home-grown NP-Cs has improved emergency department (ED) coverage, as well. Access to Avera eEmergency and eHospitalist allows NP-Cs to achieve the full

potential of their license. WCMH-A is using advanced practice providers for 60 percent of ED call coverage, on the path to 80 percent. This has reduced direct ED costs by 25 percent. Inpatient satisfaction improved from the 33rd to the 99th percentile, and ED services improved from the 60th to the 93rd percentile while maintaining patient safety.

## **Housing and Economic Development**

In 2010, WMCH-A engaged in efforts to address a need for senior housing for the tribe and community. Leaders established Parkview Villa Inc. to rehabilitate a 31-unit elderly housing complex. The corporation received federal grants and guaranteed loans from the U.S. Department of Agriculture and the South Dakota Housing Development Authority.

Within two years, Parkview Villa occupancy grew from eight to 30. The organization re-established a seniors' meal program and its participation has grown and, on average, 40 of Wagner's most vulnerable seniors receive a nutritious meal each day. In 2015, Parkview Villa Inc. accepted the transfer of two more low-income elderly housing complexes, increasing the number of units under its management to 57, with an occupancy rate of more than 95 percent.

WMCH-A leaders also helped revive a dormant Wagner Area Growth (WAG) non-profit economic development corporation. WAG hired an economic development director and recruited a major variety store chain to locate in the community with a sales tax rebate through the city of Wagner. The greater selection and quality of products resulted in an estimated doubling of retail sales, increased jobs and better economic stability.

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## **Emergency Medical Center & Virtual Care Strategies**

### ***Copper Queen Community Hospital – Bisbee, AZ***

#### *Virtual Care Through Telemedicine/Establishing a Freestanding ED*

### **Overview**

Copper Queen Community Hospital (CQCH) is in a remote area of Arizona near the border with Mexico with a service area of approximately 2,500 square miles. The 14-bed acute care critical access hospital (CAH) is the largest non-government employer in Bisbee, serving more than 6,000 Bisbee residents and many of the county's 140,000 residents.

Reaching beyond the main campus, the hospital operates three rural health clinics. This network of coordinated care is vital for the aging population of Cochise County, where many residents face complex chronic health issues. In April 2017, CQCH extended its service area to include Douglas, AZ, which had closed its hospital and its 17,000 residents were desperate for access to emergency and other health care services.

### **Virtual Care through Telemedicine**

CQCH meets the needs of its community through collaboration and innovation, including electronic health records, home health services and telemedicine. Among the primary challenges of CQCH was how to provide

care for patients who needed specialists. The successful telemedicine program has improved the efficiency of patient care while increasing access to specialists.

CQCH has contracts to receive telemedicine with several tertiary care hospitals in Arizona. The programs and services include trauma and pediatrics (University of Arizona University Medical Center), behavioral health (Sonora Behavioral Health), neurology (Mayo Clinic), cardiology (Pima Heart Group), ER burn (Dignity Health St. Joseph's Maricopa), and endocrinology (Tucson Medical Center).

## **Creating a Freestanding ED**

In July 2015, the Cochise Regional Hospital in nearby Douglas, a 25-bed CAH closed its doors. For many residents of Douglas, the hospital was their most reliable source for emergency health care. CQCH, which is more than 20 miles away, is the next nearest emergency department (ED).

CQCH intervened immediately and within a month opened the Douglas Medical Complex Quick Care facility, which is the community's new staple in emergency health care. In addition, a specialty clinic was designed as part of the facility, as a time-share for visiting specialist doctors.

However, the Quick Care clinic was an interim step toward a more permanent solution to the health needs of Douglas. CQCH leaders with support from Tucson Medical Center, Med-Trans Lifeline and the Douglas Industrial Development Authority embarked on an effort to establish a freestanding, state-licensed ED.

In April 2017, the Douglas ED opened its doors to patients. In accordance with Arizona Department of Health Services guidelines, the facility will act as an extension of CQCH's existing ED and accept payment under Medicare and the Arizona state Medicaid program.

The ED provides a hospital-level of care, with physicians and nurses who have received training in stroke treatment, pediatrics and trauma. An ED physician at Bisbee supervises the nurse practitioners in Douglas, expanding capacity and extending the hours of operation.

## **Impact**

The state-of-the-art facility expands local emergency services with 24-hour registration, eight treatment and exam rooms, one critical care and trauma room, lab and radiology services and Computer Tomography equipment, among other attributes. In addition, the Douglas ED has access to all the telemedicine services available through CQCH in Bisbee including telepharmacy, licensed through the pharmacy at CQCH.

This facility is an important center of the Mayo Clinic Telestroke Program, based in Phoenix, which works to ensure that rural patients have access to quick and appropriate stroke care. Telestroke services are made possible by inTouch Health endpoints, which allow physicians from anywhere in the country to conduct full consultations with patients.

The ED is experiencing volumes above expectations at 1,400 visits per month. It also is equipped with a helipad to facilitate transfer of higher acuity patients to Tucson or Sierra Vista.

This facility has benefits beyond health care. It has lured back several health care employees and helped Douglas attract and retain new community members and new employers.

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