Allina Health TeleHospitalist Service: The Evolution of Patient Care

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Allina Health

Disclosure Statement

- No financial disclosures to report

Agenda

- Allina TeleHospitalist service expansion
- Growth challenges
- Innovative solutions
- Impact to the organization

Pre-Allina TeleHospitalist Service



Difficulty with staffing



Needed a more cost-effective model

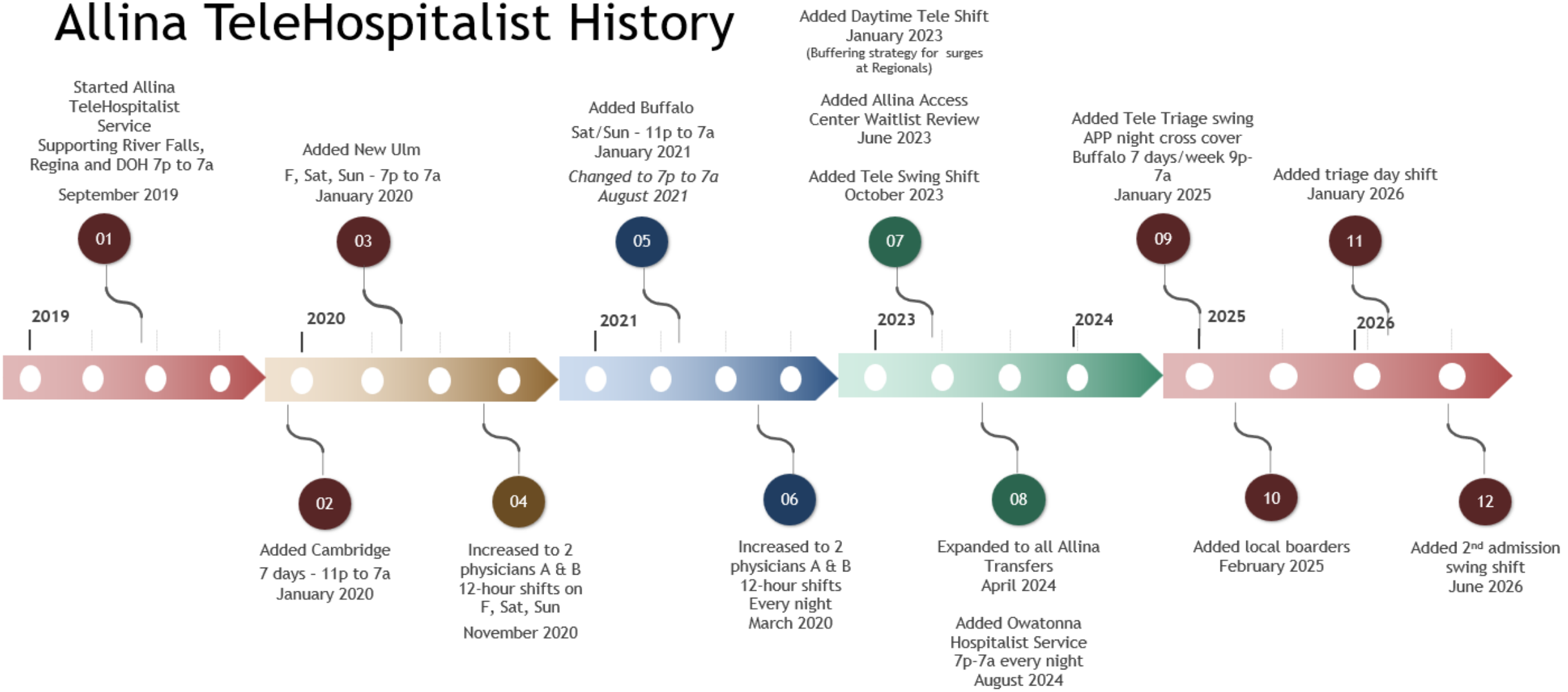


Contracted w/ Eagle Telemedicine

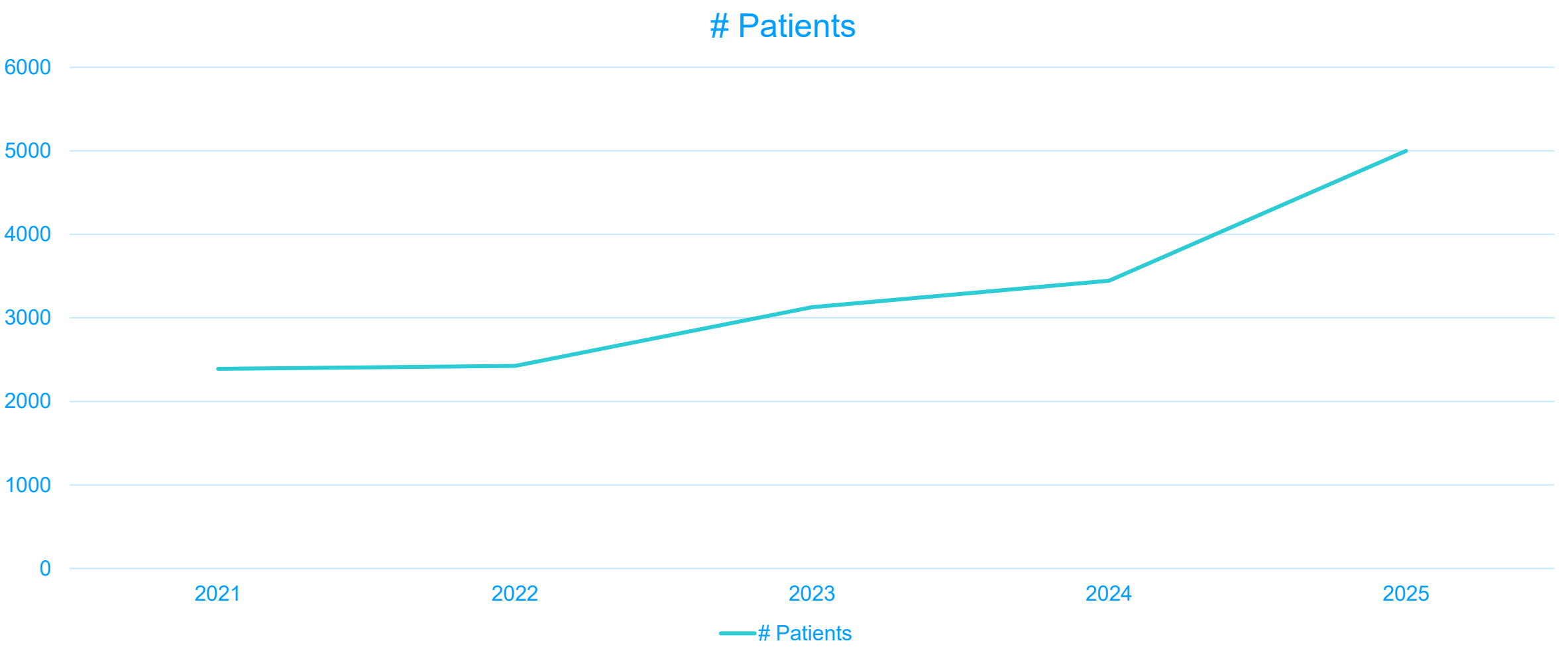
- Began December 2017
- Supported River Falls hospital
- Added Regina June 2018
- Added Faribault Oct 2018

Program Growth

Allina TeleHospitalist History



TeleHospitalist Admission Volumes



Growth in Subspecialty Service Availability

Ability to keep patients locally

Available services

- TeleNeurology
- TeleHeart
- TeleCritical Care
- TelePulmonology
- TeleInfectious Disease
- TelePsychiatry
- Mental Health Crisis Consultation
- TelePalliative Care
- TeleNephrology

Growth Challenges

- Process inefficiencies
- Nursing buy in
- Work exceeding capacity
- Technology concerns
- Rate of expansion
- Missing core PI components

Process Improvement Initiative – Delay in Access to Patients

- A3 project for quicker access to patients
- In-person multidisciplinary approach
- Process mapping
- Developed standardized workflow



Process Improvement Initiative – Delay in Access to Patients

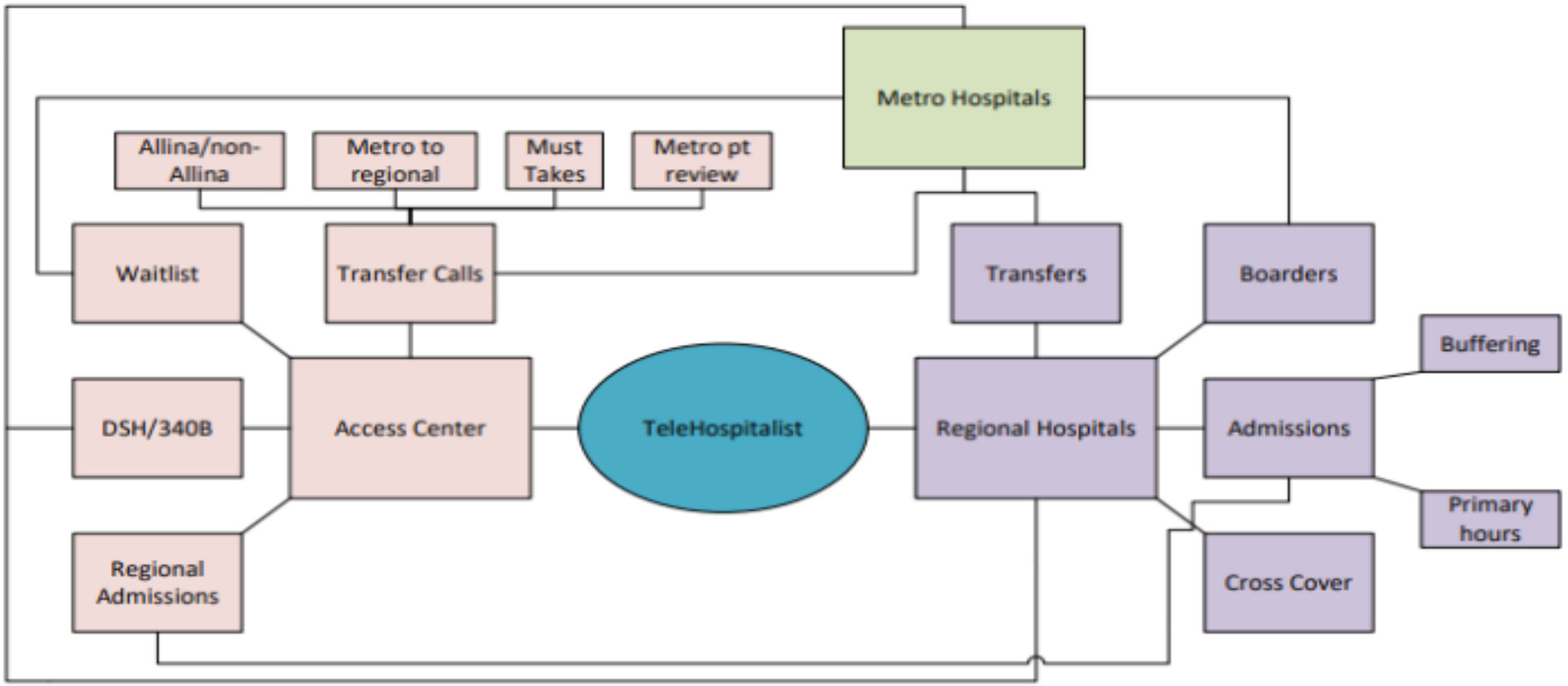
- Connection times assessed pre and post workflow implementation
- Significant reduction in the amount of time for providers to have access to patients

Study/Results

- Median connection time in minutes was assessed pre and post workflow implementation, each regional ED site reporting significant reduction in time it took for TeleHospitalists to connect with patient and determine the plan of care.
- One site reducing the wait time by ~60 minutes.
- This work not only enhanced operational efficiency but also supports a more reliable and equitable care experience for patients and care teams across regional sites.
- TeleHospitalist Assigned to Connection Time

	Average (mins)	Median (mins)
Pre PI Process	98	82
Post PI Process	51	36

TeleHospitalist Scope



Admitting Shift Responsibilities

Day shift

- Admission buffer
- ED boarders

Evening shift

- Admissions
- ED boarders

Night shift

- Admissions
- Cross cover

APP night shift

- Cross cover

Triage Shift Responsibilities

Day shift

- Triage waitlist
- Transfer calls
- Complex care coordination

Evening shift

- Triage waitlist
- Transfer calls
- Complex care coordination

Surge Capacity

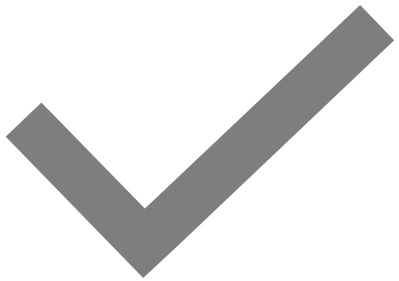
Increase provider capacity across system

4 surge status levels

Levers created for each hospital

TeleHospitalist assistance based on need

ED Boarding Patients



Complete admission process for local boarders



Consult system boarders

Triage Shift Initiatives



Act

Act as an “air traffic” controller for beds across the system



Increase

Increase lateral transfers to regionals



Drive

Drive goal of care conversations



Minimize

Minimize need for ED to ED transfers



Load level

Load level based on site capabilities

Triage Shift: Day 1

Outcomes

- **12** non-Allina patients remained at other health systems or were placed elsewhere when services were unavailable
- **4** patients stayed at their local Allina site
- **2** discharged home after subspecialty involvement
- **3** goals-of-care conversations for transfer appropriateness and expectations
- **3** complex cases flagged for additional review
- **2** redirected to regional sites instead of metro beds
- **8** Mercy patients transferred to United/ANW to offload their ED
- **4** “must-take” patients prioritized



Case Example – Clinical Context

84-year-old woman with severe hypertension and a two-year history of progressive speech impairment.

Neuroimaging showed a **left frontal lobe mass with midline shift**, concerning for **high-grade glioma**.

No acute neurologic deterioration; laboratory studies unremarkable.

Patient and husband initially requested **full code status** and **surgical intervention**.

Both had **limited decision-making capacity** for complex goals-of-care discussions; no engaged next of kin available.

Fragile social situation; husband also required admission for social reasons.

Case Example – What Could Have Gone Wrong

What Could Have Happened Under a Rigid / Protocol-Driven Approach

- Premature transfer for neurosurgical evaluation **before** full imaging review, radiology interpretation, and realistic surgical outcome clarification.
- Insufficient goals-of-care discussions involving both patient and spouse.

Potential Negative Outcomes

- **Non-beneficial surgery** with high risk of postoperative debility.
- **Separation of patient and spouse**, increasing distress and limiting shared decision-making.
- **Fragmented communication** across sites, delaying palliative involvement.

Case Example – What Went Right

Identified that the case was **not neurosurgical-urgent**, allowing time for full expert review.

Interdisciplinary communication clarified that surgery was unlikely to help, carried high disability risk, and the lesion was life-limiting—shifting the risk-benefit balance.

Decisions aligned with the patient's **medical, social, and cognitive context**, prioritizing keeping the couple together and supporting shared understanding.

Early anticipatory planning, including palliative availability and intentional handoffs, ensured continuity.

System-wide coordination across ED, hospital medicine, neurosurgery, and tele-admitting created a unified care plan and avoided conflicting recommendations.

Case Example – Outcome

Patient remained at local hospital with her husband

Care team had contextual information to guide goals-of-care discussions

More goal-concordant approach without exposing patient to unnecessary transfer or high-risk intervention

Case Example – Key Learning Points

Safety emerges from thoughtful adaptation, not just protocol adherence.

Deliberate pauses to obtain complete information can prevent downstream harm.

Keeping patients in their social context can be a safety strategy, not a delay in care.

Clear interdisciplinary communication reduces the risk of non-beneficial escalation.

Early palliative framing supports better decision-making even when patients initially request maximal intervention.

Impact to organization



7 REGIONAL HOSPITALS STAFFED W/ TELEHOSPITALIST SERVICE



8 REGIONAL HOSPITALS STAFFED W/ TELEHOSPITALIST APP CROSS COVER



TRIAGE PROVIDERS DIRECTING COMPLEX CARE COORDINATION

Impact to organization



MILLIONS IN SAVINGS
PER YEAR

- Downstream impact
- Provider retention
- Decreased burnout
- Decreased length of stay
- Staffing efficiency
- Expanding footprint

What's Next?

- Expand integration with Allina Access Center
- Expansion to sites outside of Allina Health

Questions?

Thank you!

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