Remote Patient Monitoring: AdventHealth's SARS-CoV-2 Response and Outcomes

Welcome!

- All lines are muted, so please ask your questions in Q&A.
- For technical issues, chat with the Technical Support panelist.
- Please actively participate in polling questions that will appear on the lower right-hand side of your screen.

We will get started shortly!

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Remote Patient Monitoring: AdventHealth's SARS-CoV-2 Response and Outcomes

Event Hosts:
Melody Brown, MSM
Neil Finkler, MD, FACOG, FACS

December 14, 2021

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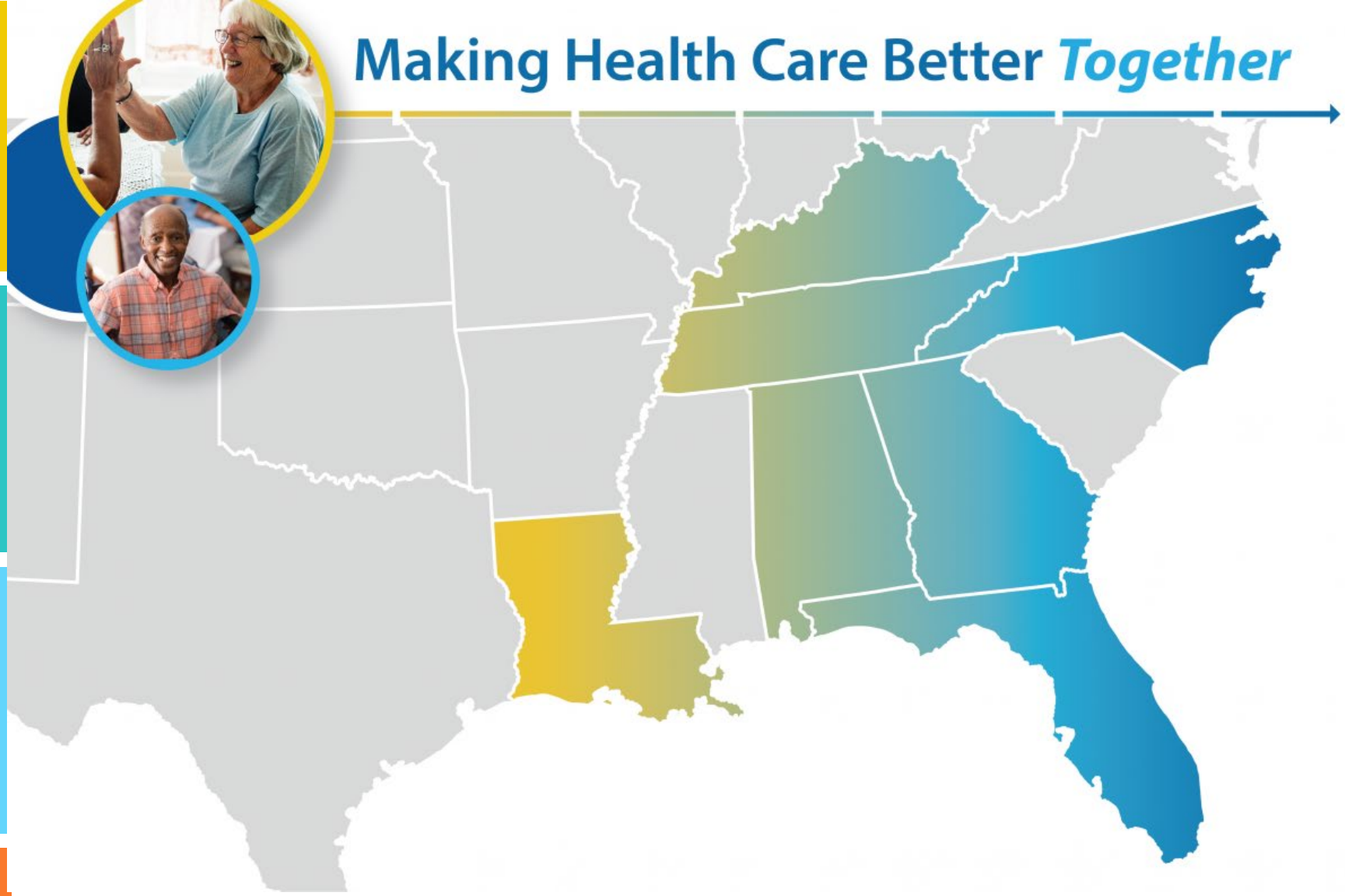

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Melody Brown, MSM

AIM MANAGER, PATIENT SAFETY

Melody's healthcare career started as a Medical Technologist over 40 years ago. She later moved on to Infection Control, Quality Management, and JCAHO Coordination in a rural hospital setting. Melody has had varied roles at Alliant Health Solutions working on the CMS contract for the Quality Innovation Network – Quality Improvement Organization (QIN – QIO) for Alabama, Florida, Georgia, Kentucky, Louisiana, North Carolina, and Tennessee. Coaching hospitals and nursing homes on all facets of healthcare quality improvement has been her focus as the Manager for Patient Safety most recently supporting the nursing home reporting to the CDC NHSN database for CDI and Decreasing Adverse Drug Events (ADE) in all settings.

Melody enjoys spending time with family, including her two grandchildren, camping, gardening and shopping.

"I did then what I knew how to do. Now that I know better, I do better."
~ Maya Angelou

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Neil Finkler, MD, FACOG, FACS

CHIEF CLINICAL OFFICER ADVENTHEALTH CENTRAL FLORIDA DIVISION

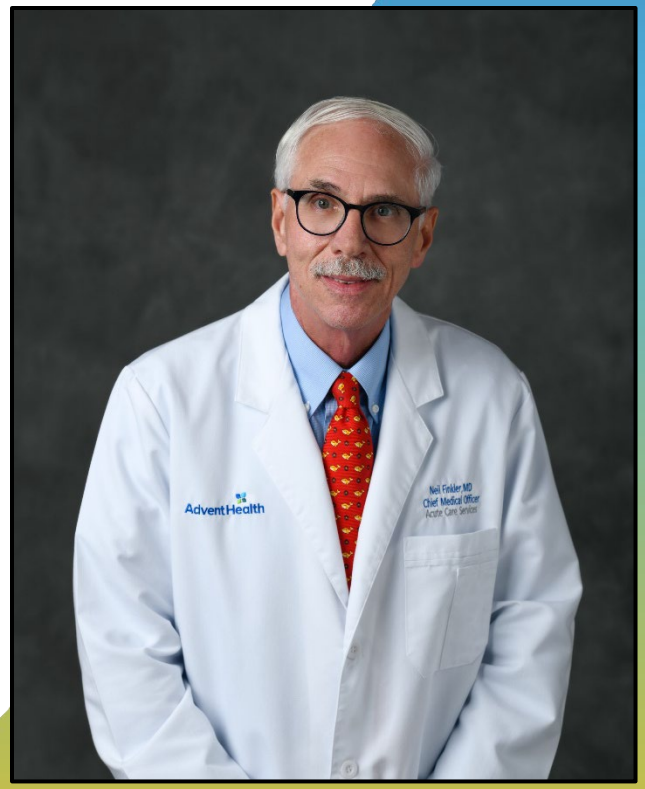
Dr. Finkler currently serves as the chief clinical officer for the entire AdventHealth Central Florida Division and leads the entire continuum of clinical care across the seven-county region that includes nearly 6,000 physicians and advance practice providers.

His almost 30 years of service at AdventHealth speaks to his commitment to patients. Nearly three decades ago, he founded our gynecologic oncology program and fellowship program and brought national prominence to this discipline, which continues to this day.

Finkler is board certified in both obstetrics oncology and gynecologic oncology, has served in multiple leadership and teaching positions at AdventHealth, Boston University School of Medicine, Harvard Medical School, and the University of Central Florida College of Medicine, and held the title of principal investigator for all GYN Oncology Group clinical trials, a National Cancer Institute cooperative group.

He completed his medical training at the Mount Sinai School of Medicine in New York (now renamed as Icahn School of Medicine at Mount Sinai) and conducted his OB-GYN residency and fellowship in gynecologic oncology at Brigham and Women's Hospital at Harvard Medical School.

Finkler is a Fellow of The American College of Obstetricians and Gynecologists (FACOG) and a Fellow of the American College of Surgeons (FACS). He is also the recipient of the American Society of Clinical Oncology (ASCO) Clinical Trial Participation Award; the Boston University Medical Center's prestigious C. Thomas Griffiths Memorial Lifetime Achievement Award and he is a highly published author and well-regarded speaker both nationally and internationally.



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Objectives

Learn Today:

- Define what remote patient monitoring is and how it is used.
- Identify benefits for both patients and health care systems of using remote patient monitoring.

Use Tomorrow:

- Identify ways to utilize remote patient monitoring in your facility.

Remote Patient Monitoring

AdventHealth SARS-CoV-2 Response and Outcomes

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Question: Have you used remote patient monitoring in your facility/practice?

A. No

B. Yes, we've been using since before the COVID pandemic

C. Yes, we started using during the COVID pandemic

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Remote Patient Monitoring (RPM)

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Unpredictability of COVID-19

- Changing recommendations from the CDC
- Community / team member fears
- Delays with COVID testing

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Clinical Criteria

COVID + Low to moderate risk

Pulse Ox > 93% RA

Pulse Ox > 92% on oxygen

Respiratory rate <30

Age 65+ with comorbid condition

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Process for Connected Care

1

ED Visit/Diagnosis

COVID + Diagnosis

2

Referral by Clinical Team

Nursing Team

3

Enrollment

Enrollment to Remote Patient Monitoring through Vivify

4

Home Physician Referral & Remote Patient Monitoring

Connected Care

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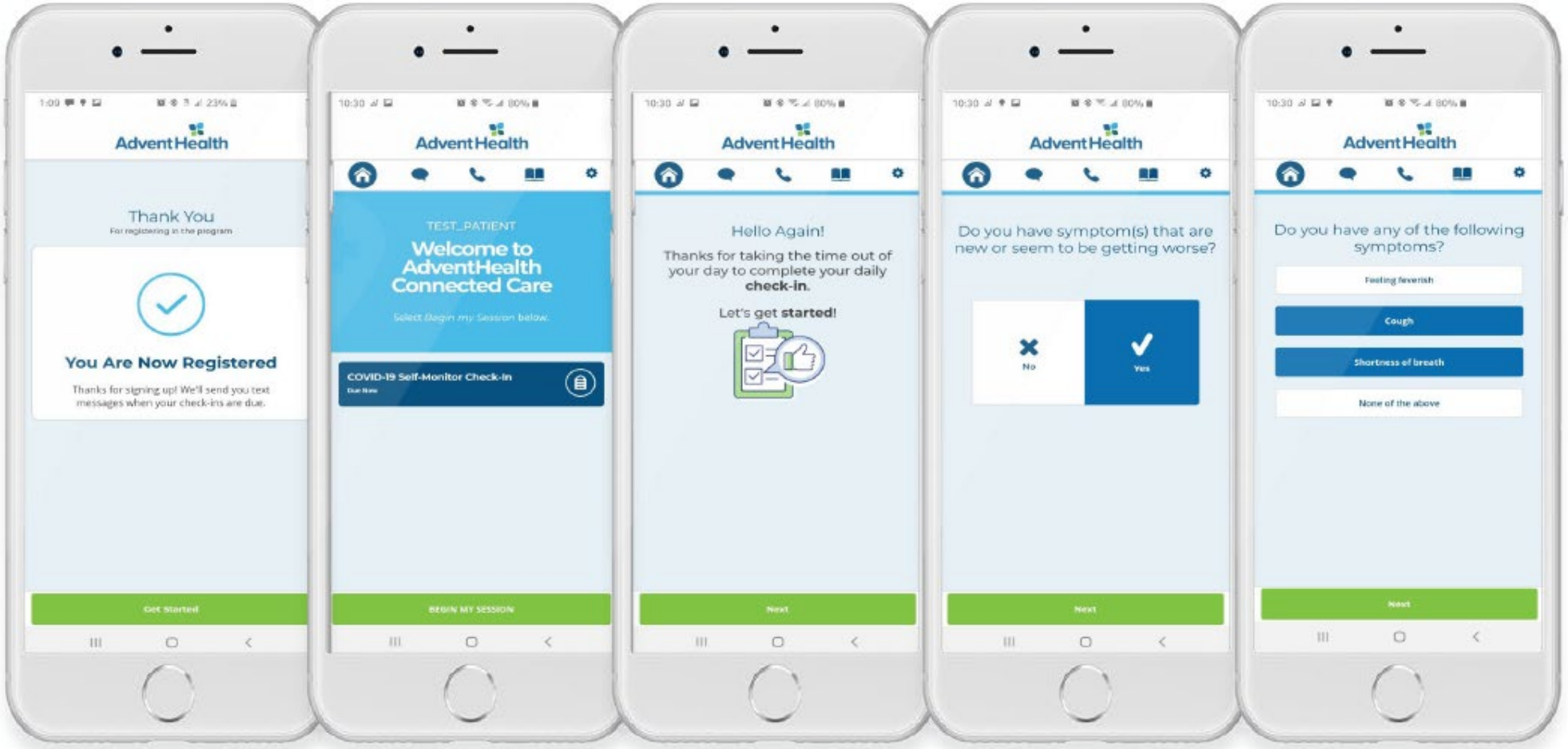
Remote Patient Monitoring | Consumer View



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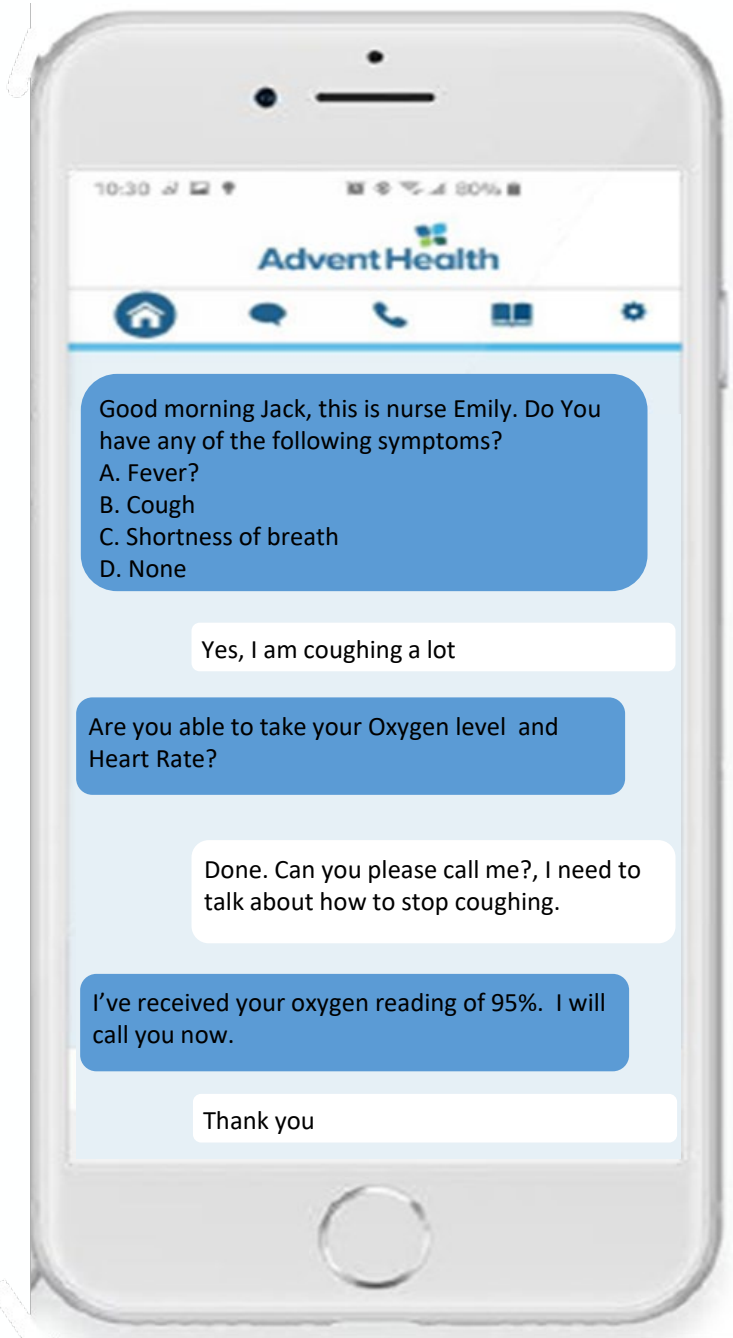
Pathway Questions

Daily check-in at 0900 and 1700

RPM nurse available 24/7

Patient can request a phone call or text message nursing team

CDC education material available on app for patient reference



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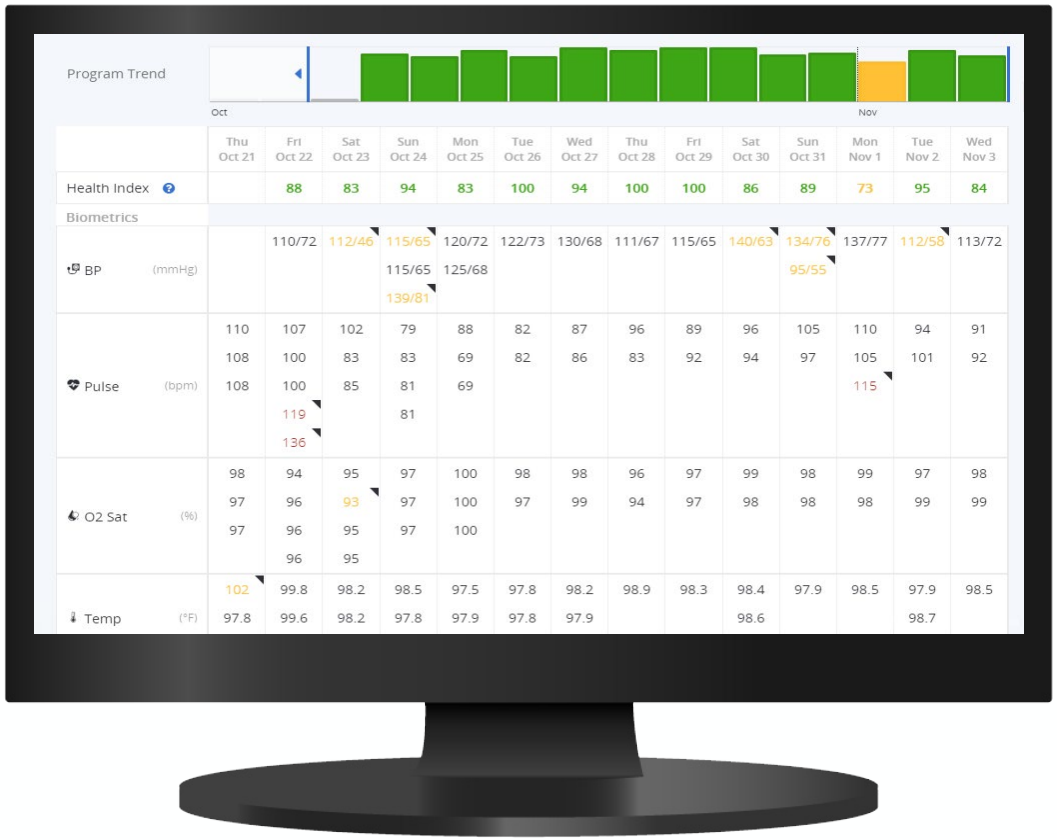
Remote Patient Monitoring | Nurse View



	Thu Oct 21	Fri Oct 22	Sat Oct 23	Sun Oct 24	Mon Oct 25	Tue Oct 26	Wed Oct 27	Thu Oct 28	Fri Oct 29	Sat Oct 30	Sun Oct 31	Mon Nov 1	Tue Nov 2	Wed Nov 3
Health Index		88	83	94	83	100	94	100	100	86	89	73	95	84
Biometrics														
BP (mmHg)		110/72	112/46	115/65 115/65 139/81	120/72 125/68	122/73	130/68	111/67	115/65	140/63	134/76 95/55	137/77	112/58	113/72
Pulse (bpm)	110 108 108	107 100 100 119 136	102 83 85	79 83 81 81	88 69 69	82 82	87 86	96 83	89 92	96 94	105 97	110 105 115	94 101	91 92
O2 Sat (%)	98 97 97	94 96 96 96	95 93 95 95	97 97 97	100 100 100	98 97	98 99	96 94	97 97	99 98	98 98	99 98	97 99	98 99
Temp (°F)	102 97.8	99.8 99.6	98.2 98.2	98.5 97.8	97.5 97.9	97.8 97.8	98.2 97.9	98.9	98.3	98.4 98.6	97.9	98.5	97.9 98.7	98.5

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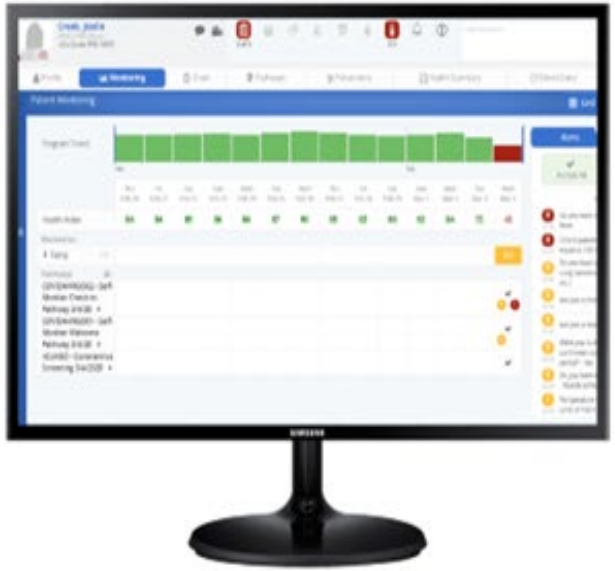
RPM Nursing Team (24/7)



RPM Escalation Process

Response to patient alerts:

- Re-assess patient's vital signs and symptoms
- Notify Home Health nurse to report changes in condition
- Contact Home Physician Group, PCP or ER, then following escalation plan

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Expenses

License fee

Home Monitoring kit

Staff 1:75 ratio, Work remotely

Laptop & Headset

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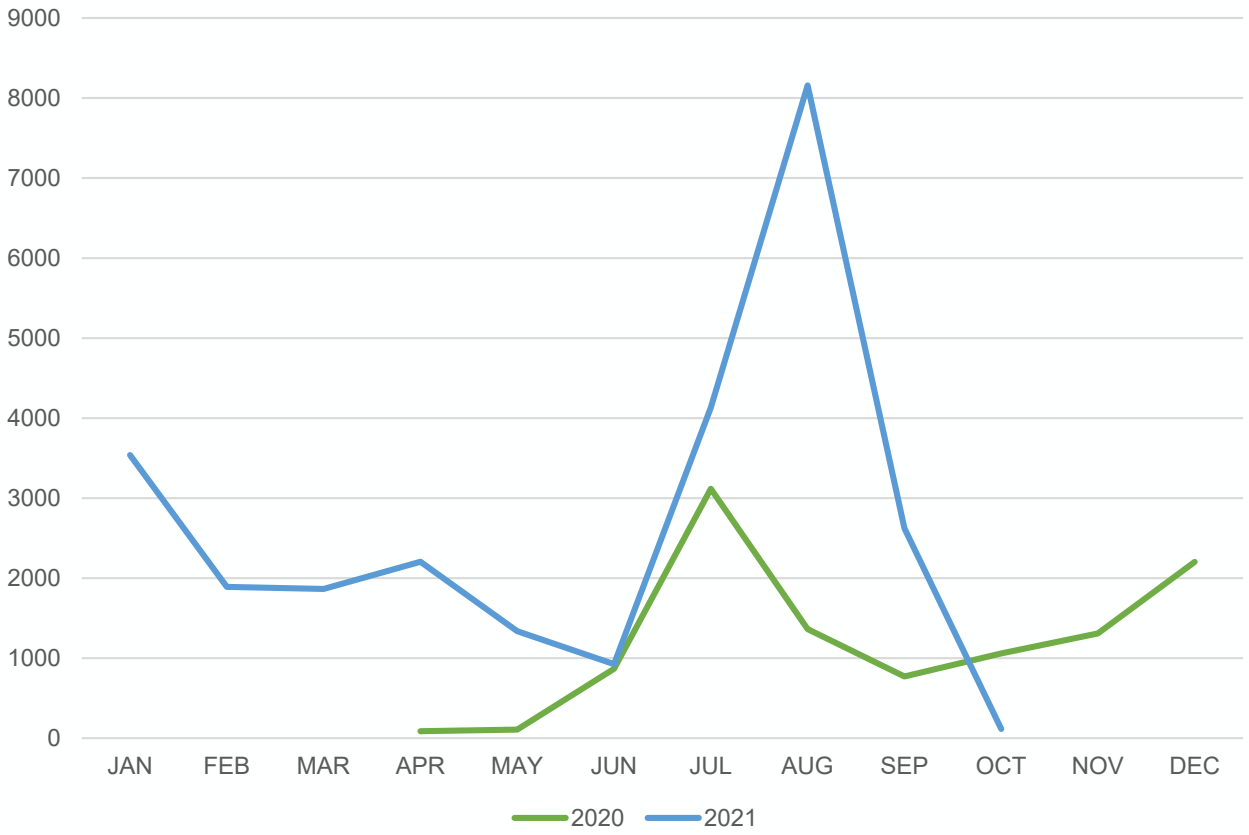
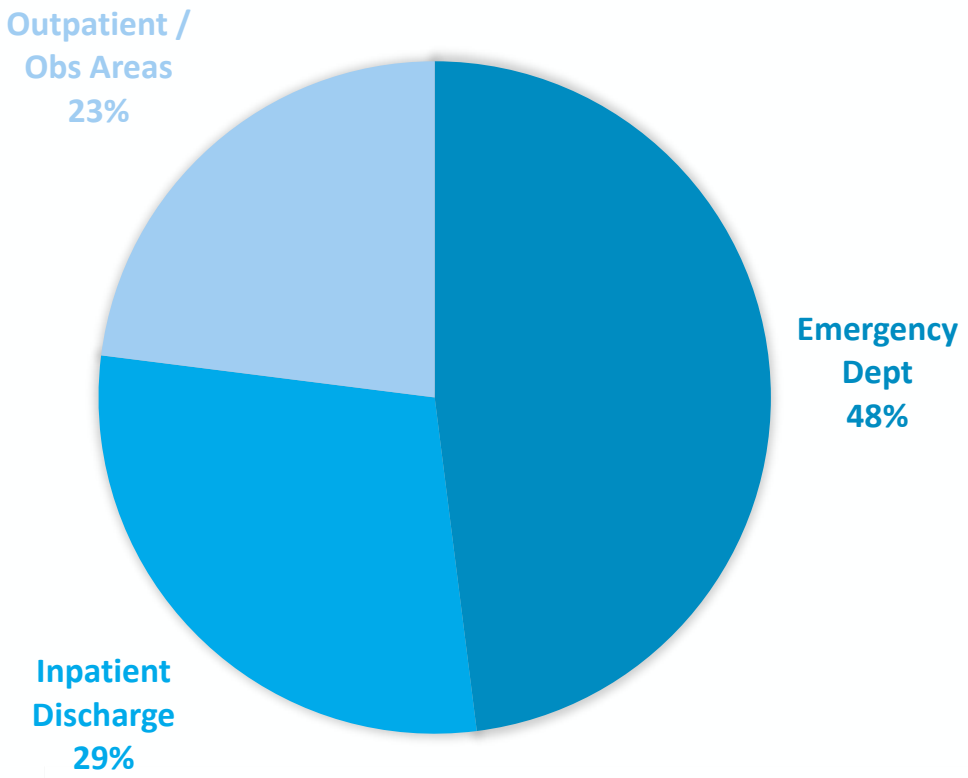
Monthly Volume by Year

Year Over Year Volume



Referral Source



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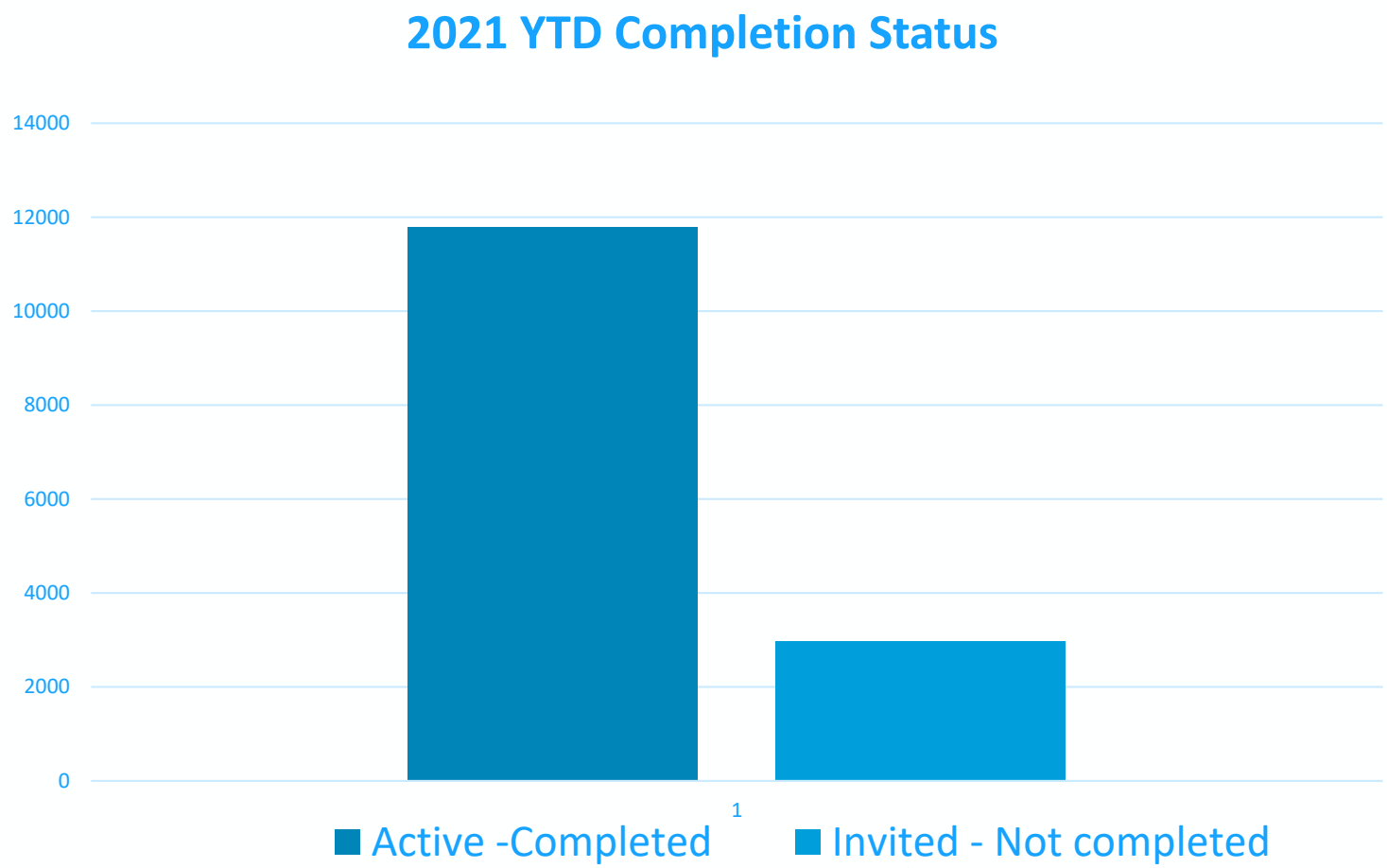
2021 YTD Completion Rates



Outcomes: Revisit Rates

Completed RPM

ED

Completed Program	30-day Revisit Rate
20.365	7.18%

Inpatient

	30-day Readmit Rate
Completed Program	4.2%

RPM Not Completed

ED

NOT Completed Program	30-day Revisit Rate
4,201	11.85%

Inpatient

	30-day Readmit Rate
NOT Completed Program	10.95%

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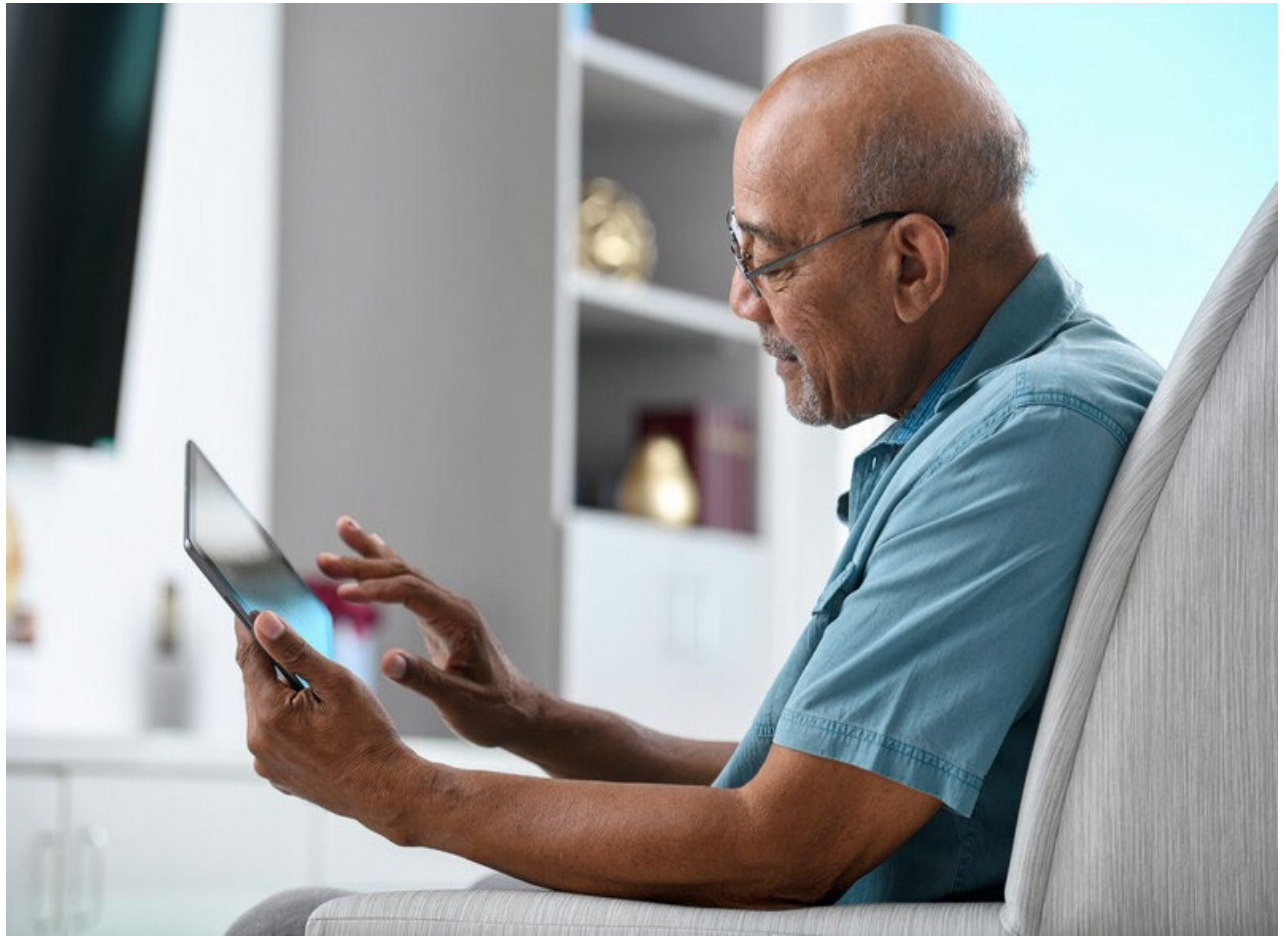
Consumer Feedback



“The monitoring team cared for me as a whole person.”

“Remote health monitoring service was really great. I felt support by the staff and was less anxious about my conditions”

“The app was reliable and easy to use”

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Virtual Care Monitoring Future State

Virtual Nursing Care - IP

Chronic Care Management

Telehealth

Dispatch Health

Transition Clinics

Community Care

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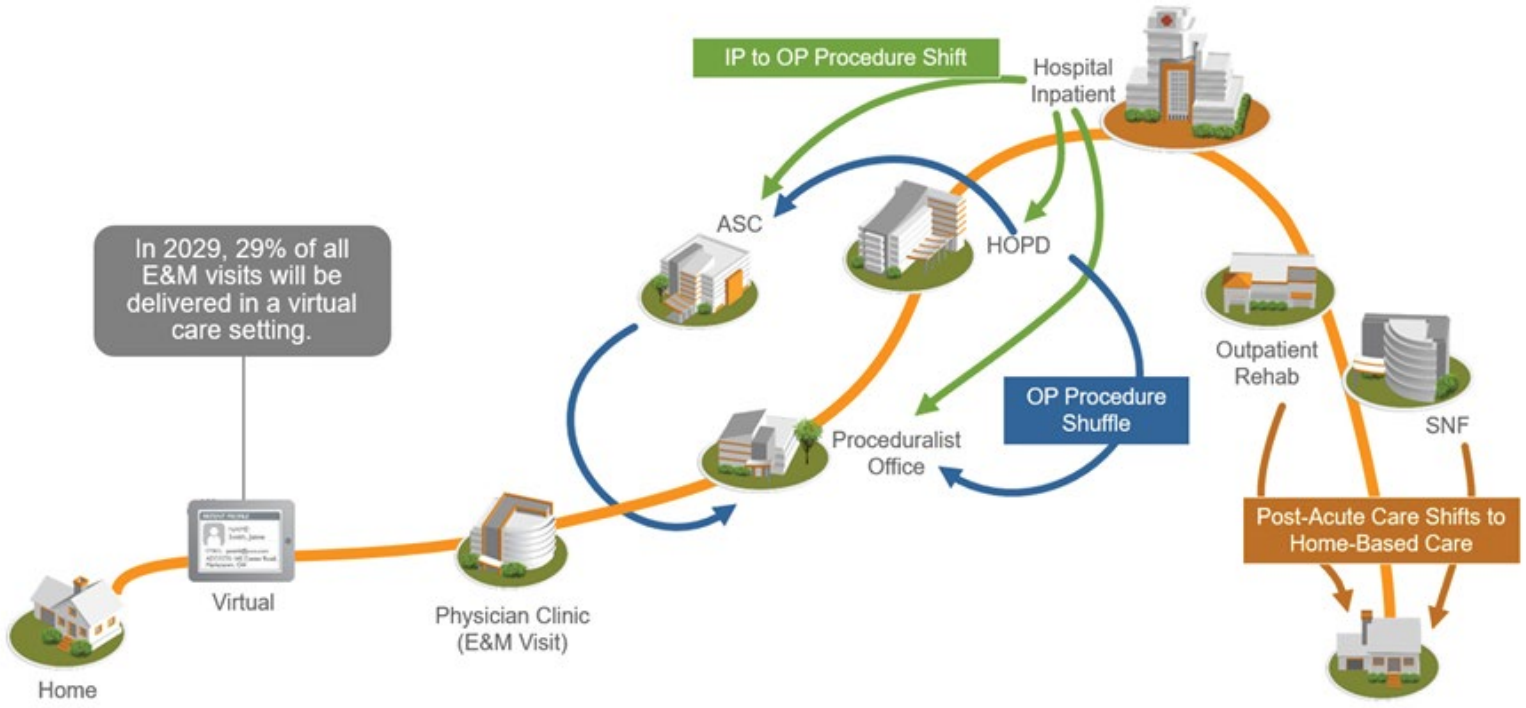
RPM and the Future: Virtual Care

Site of Care Shifts and Innovation Fuel Growth Trends Across Sites



Note: Analysis excludes 0–17 age group. ASC = ambulatory surgery center; E&M = evaluation and management; HOPD = hospital outpatient department; SNF = skilled nursing facility. **Sources:** Impact of Change®, 2021; Proprietary Sg2 All-Payer Claims Data Set, 2018; The following 2018 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2021; Sg2 Analysis, 2021.

E&M visits shifts to virtual care

Procedural IP shift to OP

Post-Acute care shift to Home Base

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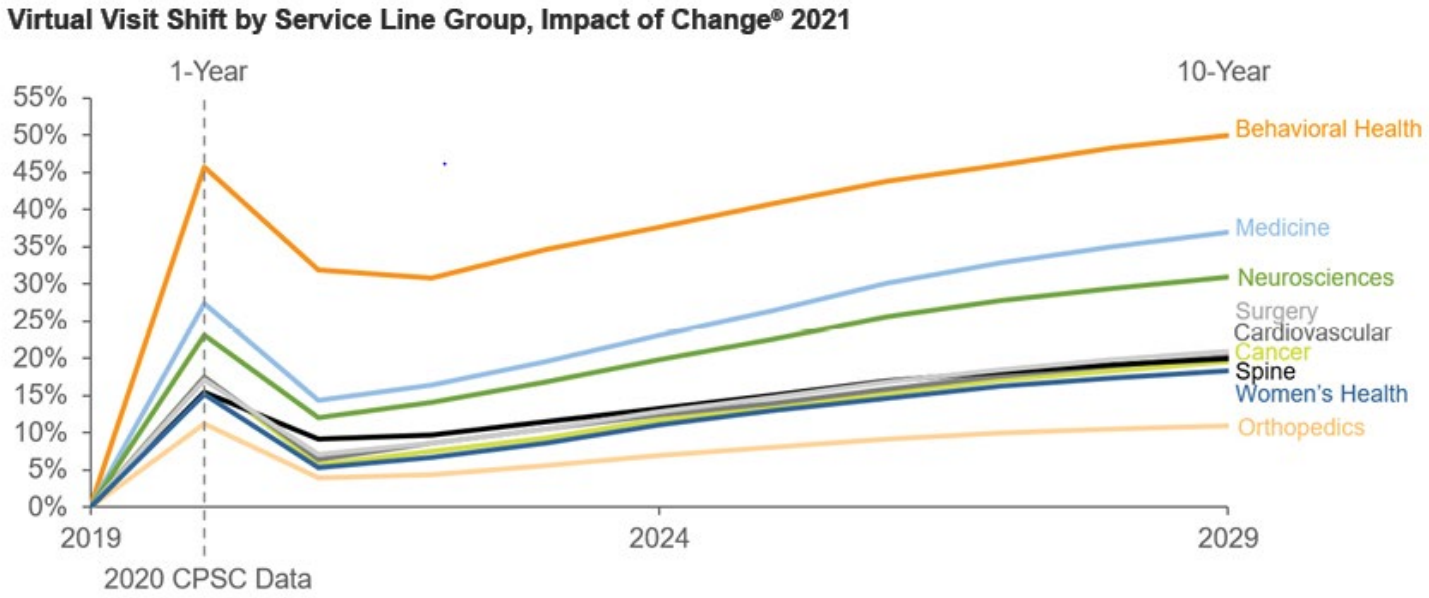
Virtual Visit Predictions – SG2



Behavioral health and Neurology specialties experience a high proportion of virtual visits through 2020 and into 2021.

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Virtual Nursing Care

- Operationalizes technology
- Promotes continuity of care
- Optimizes clinical decision-making
- Improves patient safety
- Retains skilled workforce

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Summary

RPM provided Emergency Rooms with a tool to avoid admission and safely discharge to home (COVID +, low-med risk)

Opportunity to increase patient engagement and participation with platform is face-to-face in the ER or IP.

RPM reduced revisits and readmissions for patients who actively participated and completed the monitoring program. Sets the stage for virtual services across the continuum of care

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feel whole™

Extending the Healing Ministry of Christ

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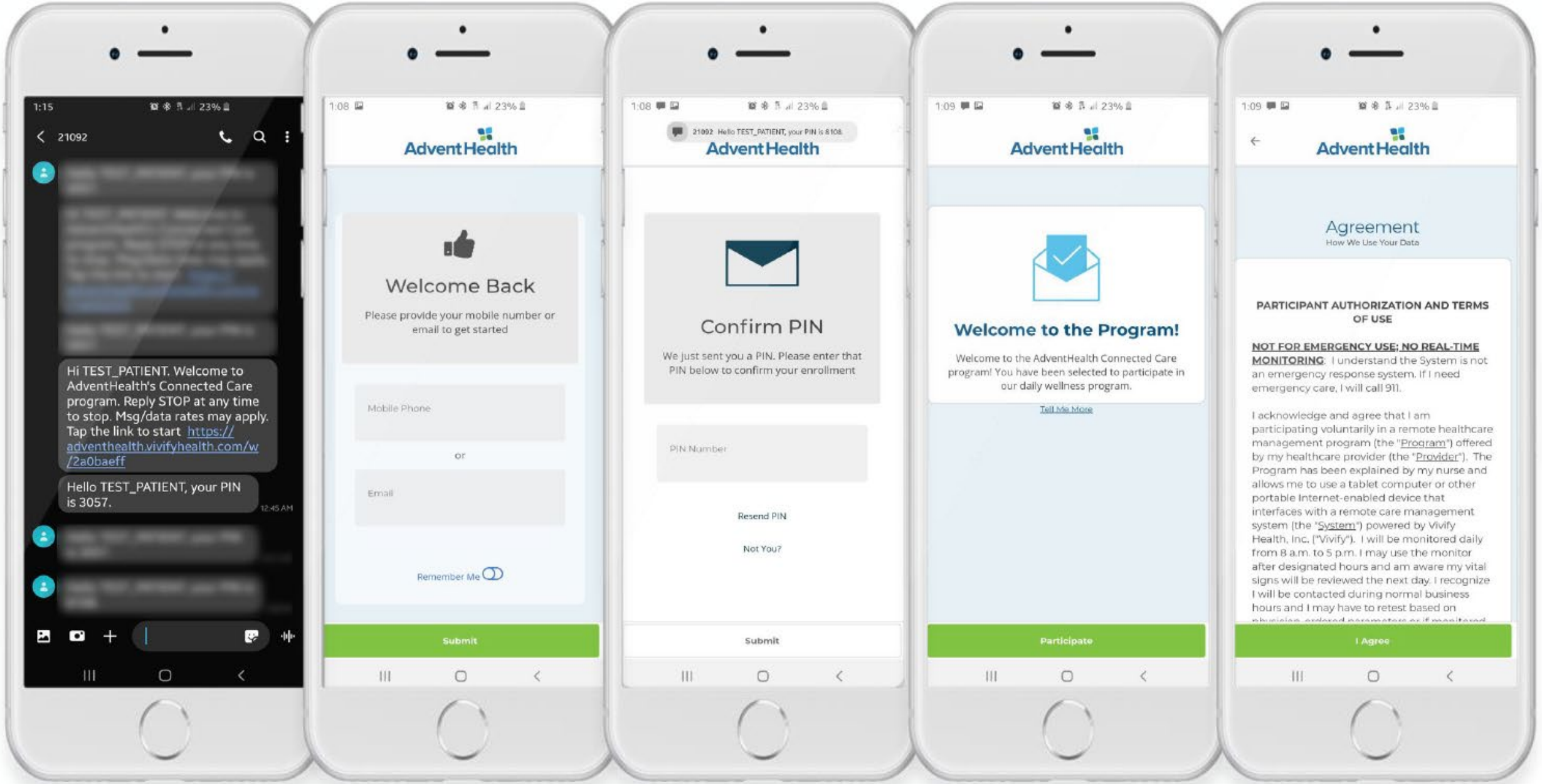
1. Patient enrolled in program. Welcome text with link sent to download the app

2. Welcome screen, enter Cell number or email to log in

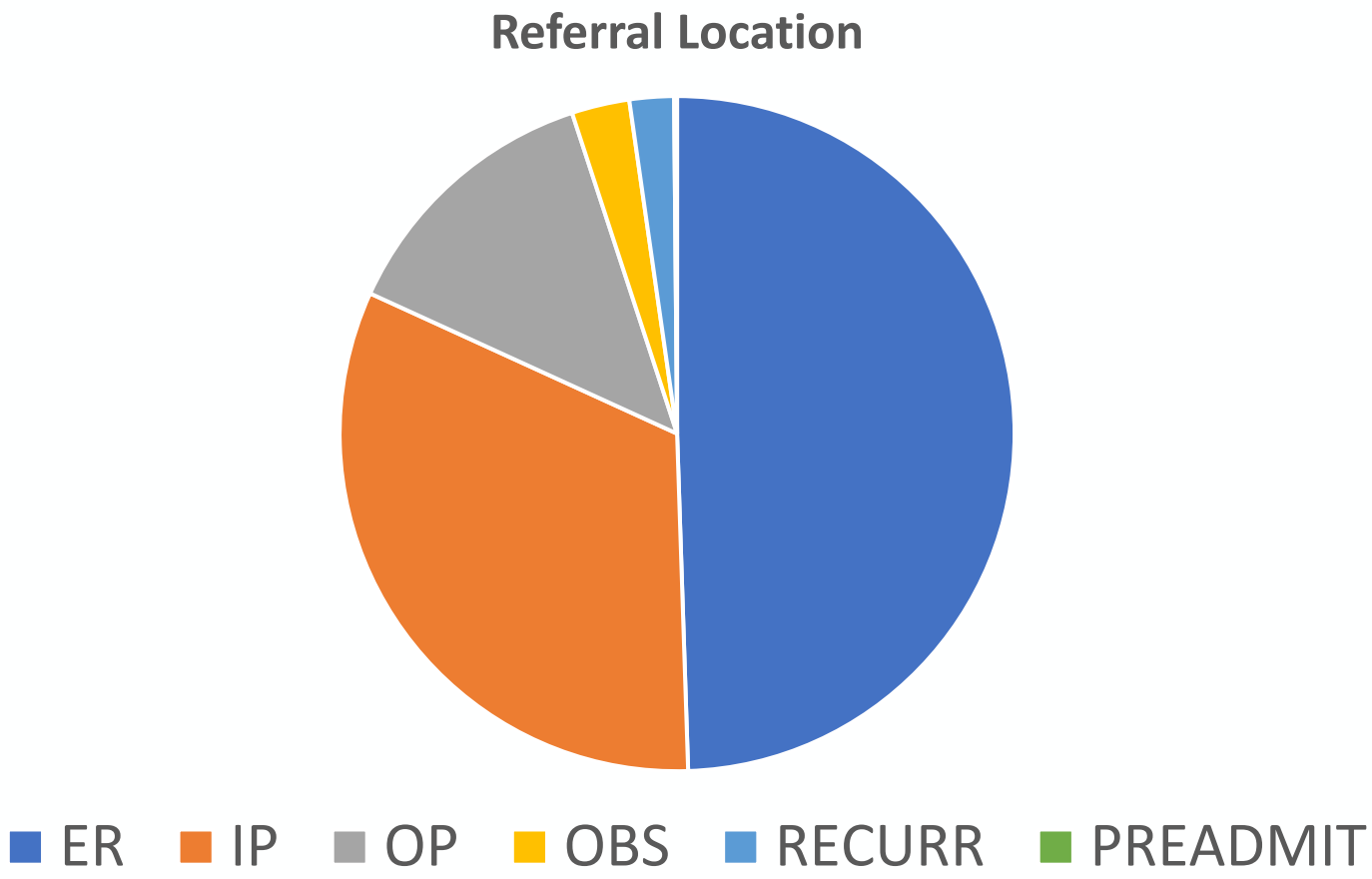
3. Pin sent to device or email. (Example text in step 1)

4. Program participation welcome screen

5. End user License Agreement



YTD Referral Source



82% of RPM referrals from ER and IP discharges

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Pathway Questions

Daily check-in at 0900 and 1700

RPM nurse available 24/7

Patient can request a phone call or text message nursing team

CDC education material available on app for patient reference

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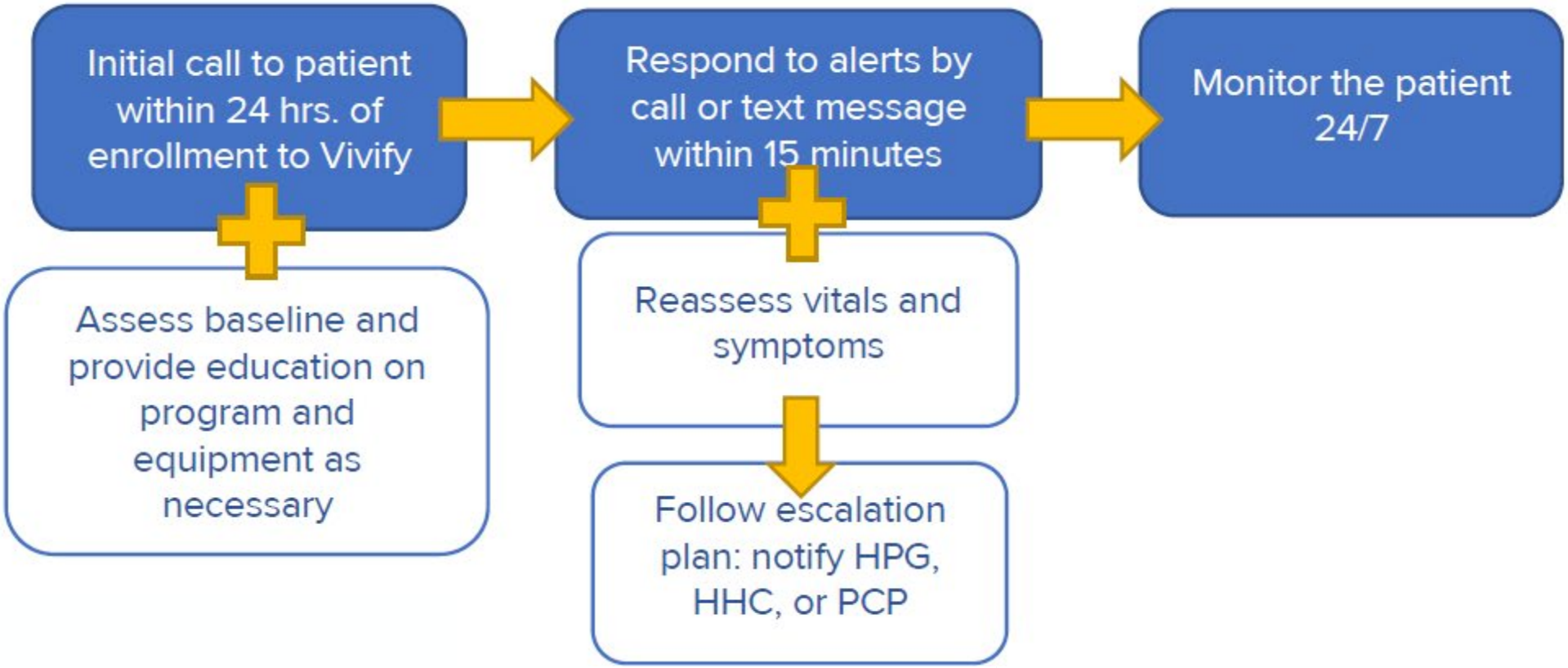
Escalation Plan

Remote Monitoring Nurse



ED Referrals?

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Clinical Criteria

- COV+ Low & Intermediate Risk
- Pulse Ox ≥ 93% RA
- Pulse Ox ≥92 on O2
- Respiratory Rate < 30
- Ages 65+ with Comorbidities

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Covid Remote Monitoring

Criteria

- Covid + Intermediate and low risk patients
- Pulse Ox ≥ 93% RA
- Pulse Ox ≥92 on O2
- Respiratory Rate < 30
- Ages 65+ or with Comorbid conditions

Order Bundle

- TOC Visit with Home Physician's Group
- Remote monitoring order
  - MD order and pt link to app
- Monitoring kit given to patient prior to discharge

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Consumer Feedback

"The monitoring team cared for me as a whole person."

"Remote health monitoring service was really great. It made me feel that I was never sick, with proper feedback from nurses everyday."

"I felt less anxious, more supported, and connected to healthcare provider during the program"

"The app was reliable and easy to use"

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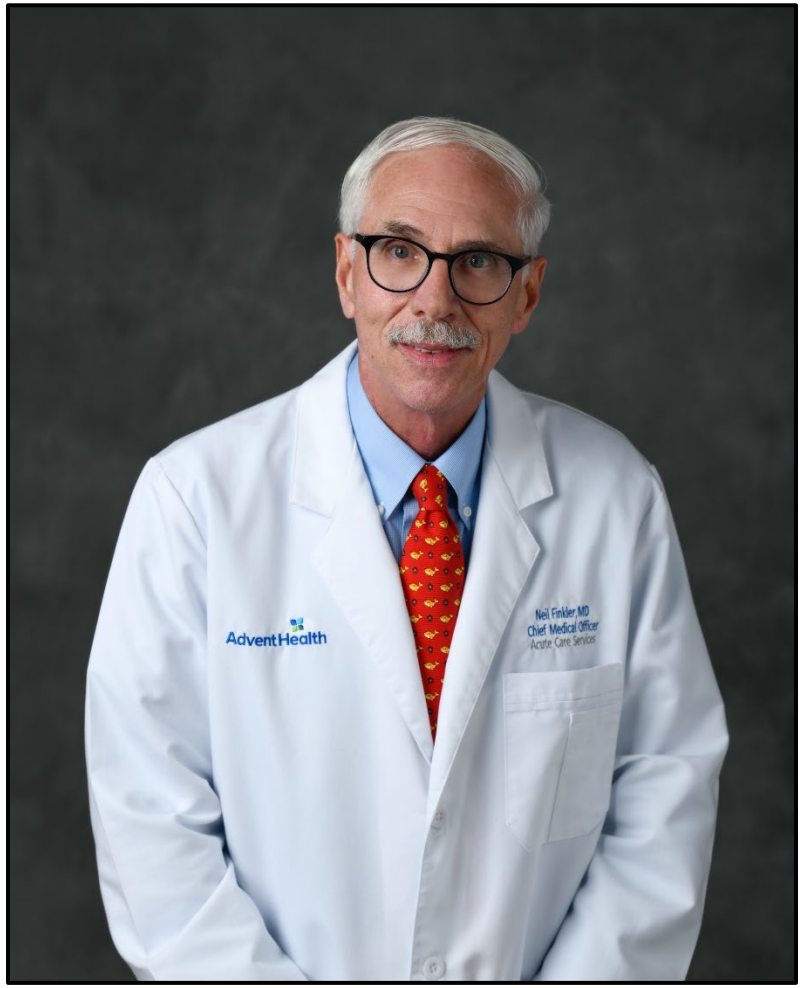

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Objectives Check In!

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- Define what remote patient monitoring is and how it is used.
- Identify benefits for both patients and health care systems of using remote patient monitoring.

Use Tomorrow:

- Identify ways to utilize remote patient monitoring in your facility.

How will this change what you do? Please tell us in the poll.

Closing Survey

Help Us Help You!

- Please turn your attention to the poll that has appeared in the lower right-hand side of your screen.
- Completion of this survey will help us ensure our topics cater to your needs.

CMS 12th SOW Goals

Behavioral Health Outcomes & Opioid Misuse

- ✓ Promote opioid best practices
- ✓ Decrease high dose opioid prescribing and opioid adverse events in all settings
- ✓ Increase access to behavioral health services

Patient Safety

- ✓ Reduce risky medication combinations
- ✓ Reduce adverse drug events
- ✓ Reduce C. diff in all settings

Chronic Disease Self-Management

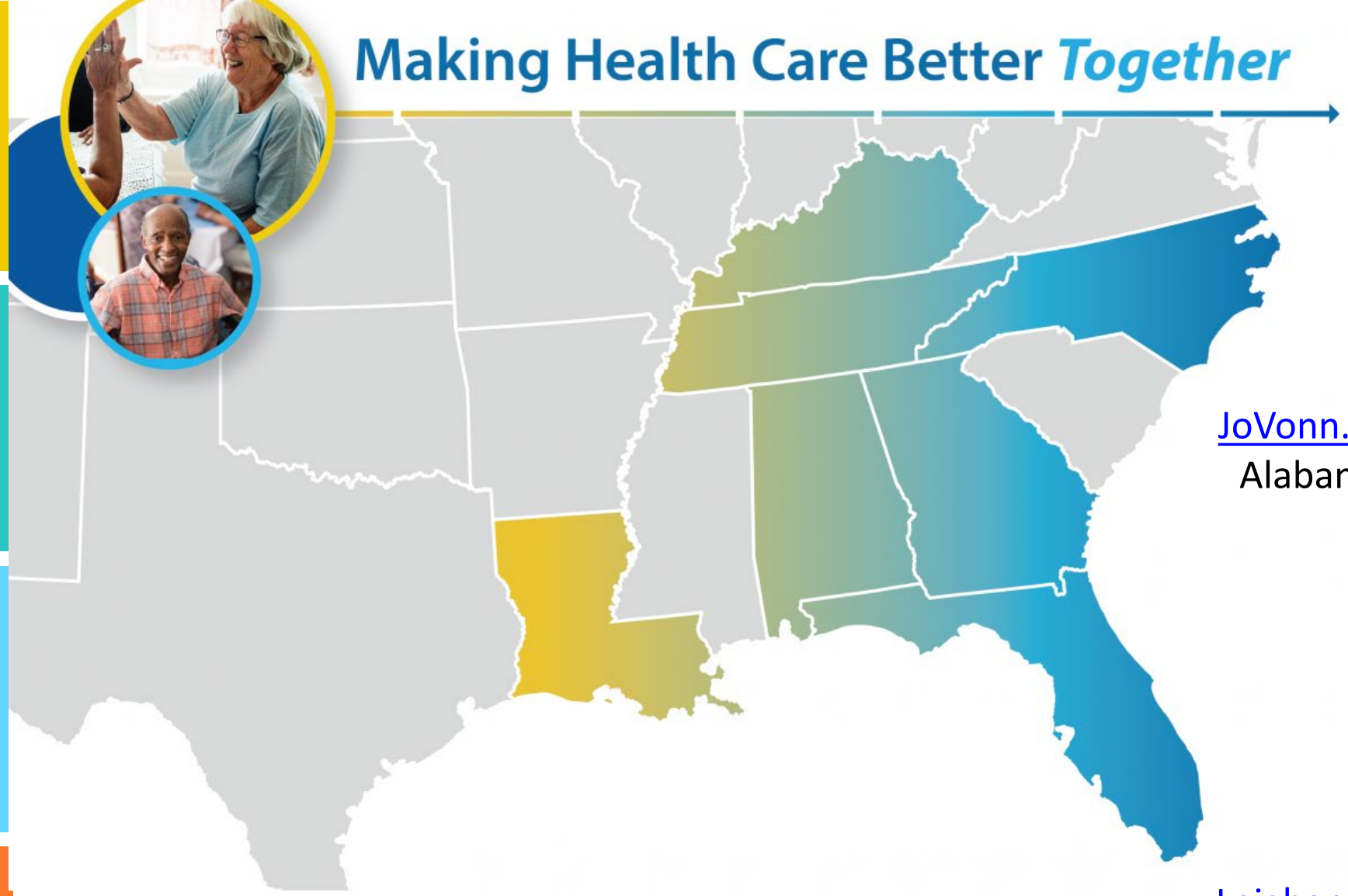
- ✓ Increase performance on ABCS clinical quality measures (i.e., aspirin use, blood pressure control, cholesterol management, cardiac rehab)
- ✓ Identify patients at high-risk for developing kidney disease & improve outcomes
- ✓ Identify patients at high risk for diabetes-related complications & improve outcomes

Quality of Care Transitions

- ✓ Convene community coalitions
- ✓ Identify and promote optical care for super utilizers
- ✓ Reduce community-based adverse drug events

Nursing Home Quality

- ✓ Improve the mean total quality score
- ✓ Develop national baselines for health care related infections in nursing homes
- ✓ Reduce emergency department visits and readmissions of short stay residents



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Happy Holidays!

We look forward to seeing you all in 2022!

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