Delta Region Community Health Systems Development (DRCHSD) Program

Telehealth Webinar Series: Remote Patient Monitoring

National Rural Health Resource Center

The Center's Purpose

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

DRCHSD Program Supported by FORHP and DRA

U.S. Department of Health & Human Services

HRSA

Federal Office of Rural Health Policy

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U65RH31261, Delta Region Health Systems Development, $10,000,000 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

ruralcenter.org

National Rural Health Resource Center

Diversity, Equity, Inclusion, & Anti-racism

Building a culture where difference is valued

The Center is committed to DEI and anti-racism. We create an environment that reflects the communities we live in and serve; a place where everyone feels accepted and empowered to be their full, authentic selves; and where everyone belongs.

We understand the impact of and seek to defeat racism and discrimination in ourselves, our workplace, and the world. This guides how we cultivate leaders, build our programs and resources, and deliver our technical assistance.

We are an organization that honors, celebrates, and respects all dimensions of diversity. These principles are central to our mission and to our impact.

Read more at ruralcenter.org/DEI

ruralcenter.org

National Rural Health Resource Center

Upcoming DRCHSD Webinars

- March 23
  Telehealth Webinar Series Session 2: Telehealth for Older Adults
- March 30
  National Health Services Corps Webinar
- April 5
  Federal Office of Rural Health Policy Webinar Part 1: Welcome to FORHP!
- April 12
  Federal Office of Rural Health Policy Webinar Part 2: Federal Grants 101

Telehealth Webinar Series: Remote Patient Monitoring

Vicki Brown

Pinckneyville Community Hospital

Cohort 2019

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Sparta Community Hospital

Cohort 2019

Pinckneyville Community Hospital

Remote Patient Monitoring

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Wellness Center Operations Manager

Pinckneyville Community Hospital

Disclaimer

This presentation is for informational purposes only and does not constitute medical, legal, regulatory compliance, or reimbursement advice nor is it intended to establish a standard of care. Please consult professionals in these areas if you have questions related to implementation in your organization. The views expressed in this presentation are those of the speaker and not necessarily those of Delta Region Community Health Systems Development.

Pinckneyville Community Hospital

Objectives

- Origin
- Determining the need
- Feasibility Study
- Workflow
- System Selection
- Vendor Onboarding
- Challenges/Barriers

Pinckneyville Community Hospital

How It All Began

- Grant funding
- Expansion of telemedicine services
- Current services that could be expanded upon

Pinckneyville Community Hospital

Determining the Need

- Hospital Metrics
  - Overall readmission rate
  - CHF readmission rate
  - Average LOS
  - Total CHF admissions
  - CHNA (Perry County Health Department, 2017)

Pinckneyville Community Hospital

RPM Feasibility Study

- Goals of the study
- Timeline
- Interviews
- SWOT analysis
- Recommendations
- GAP analysis
- Forecasted challenges

Pinckneyville Community Hospital

Workflow

Current

Future

Pinckneyville Community Hospital

Current Workflow: TCM

TCM staff attends daily IDT meeting

High risk patients are identified

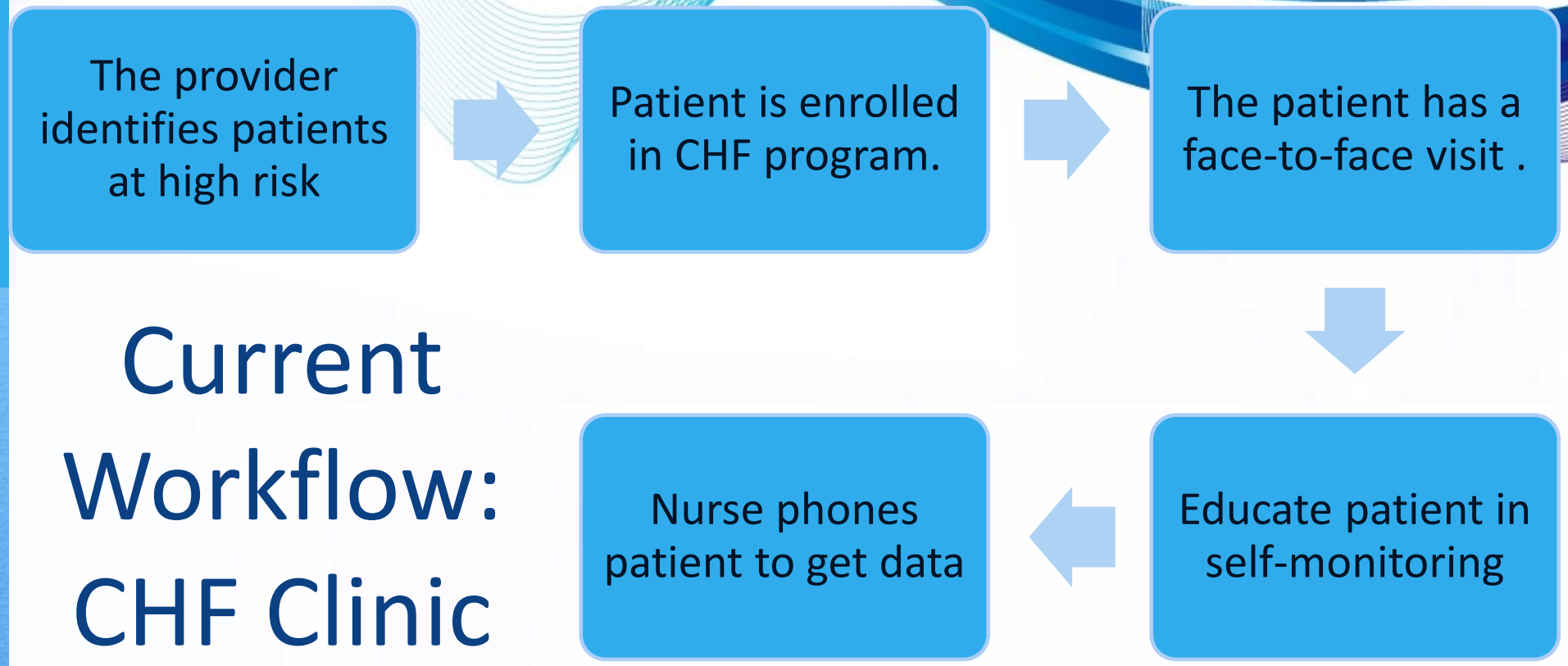
The hospitalist enters the order and documents necessity for TCM

Patient is informed regarding TCM enrollment and consent is procured

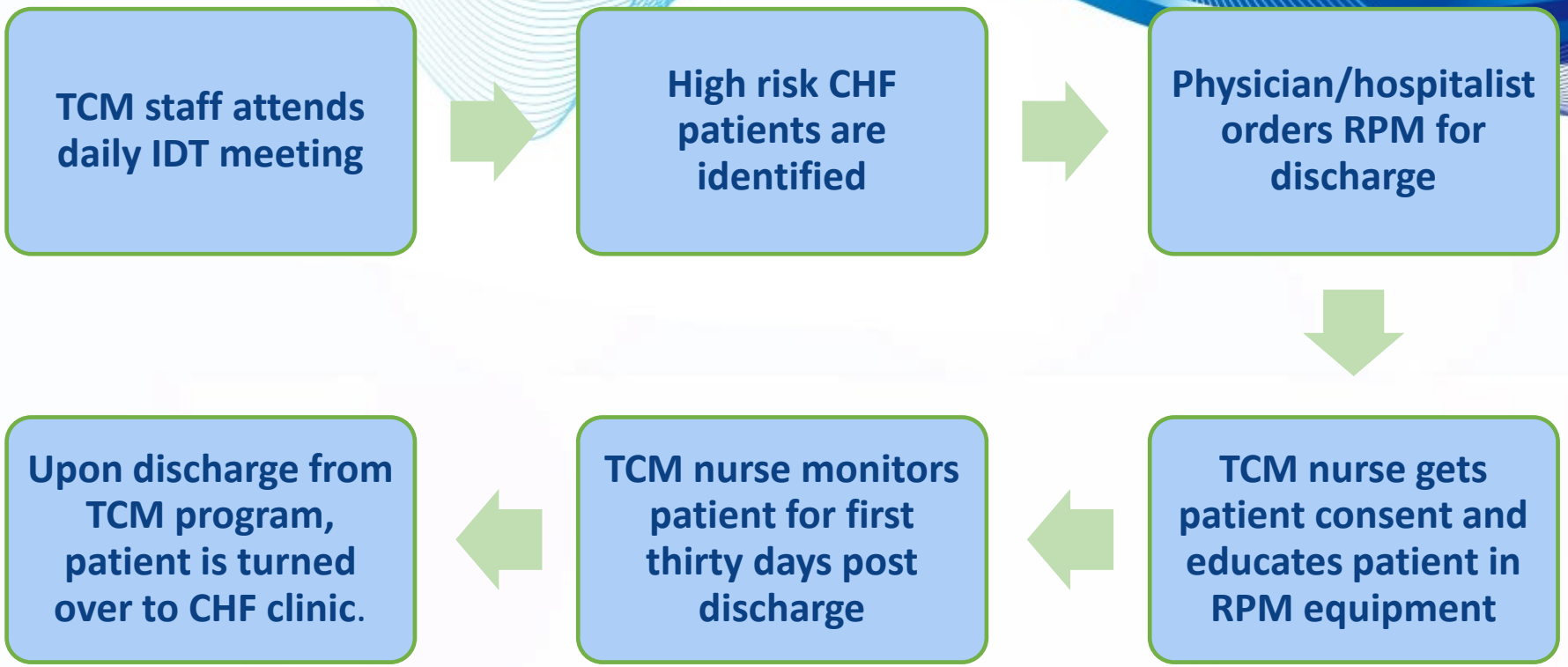
The non-clinical staff gains insurance approval for the TCM program.

Pinckneyville Community Hospital

Current Workflow: CHF Clinic

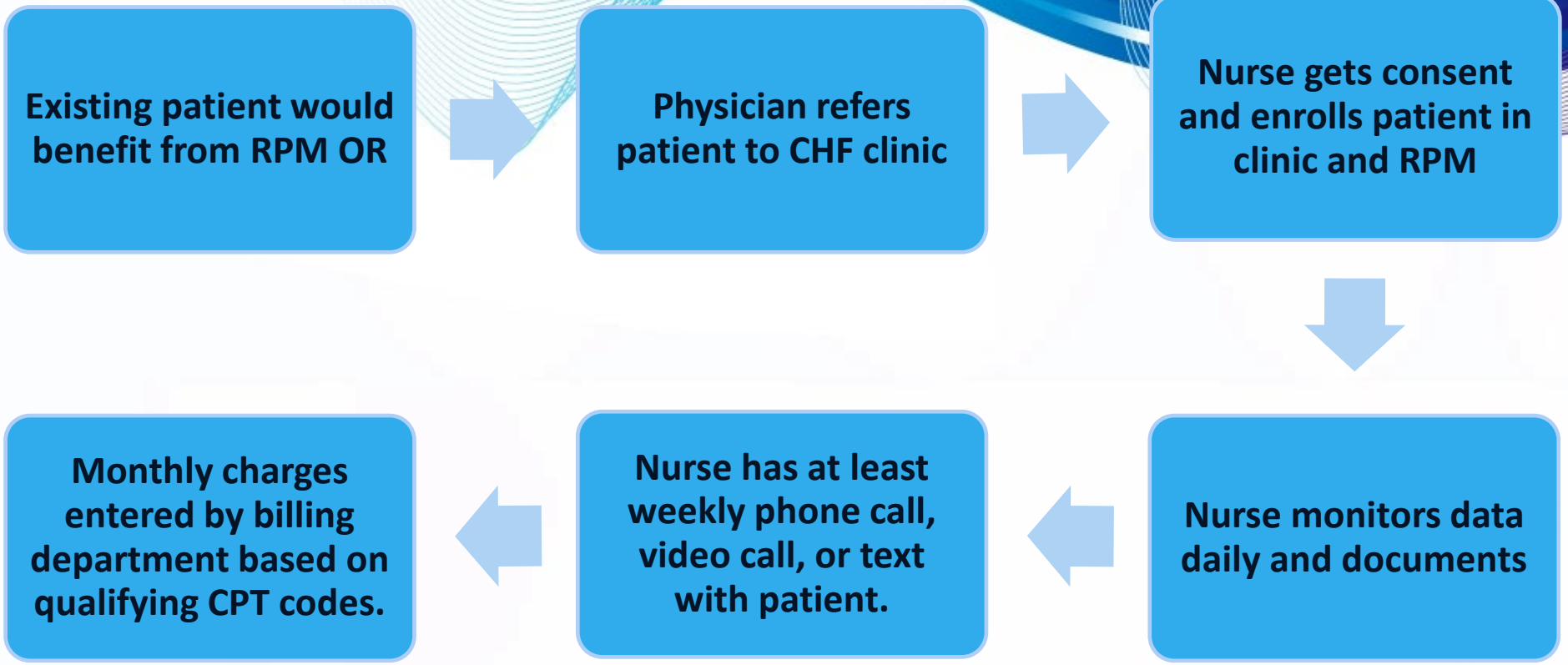


Pinckneyville Community Hospital



Future Workflow TCM

Pinckneyville Community Hospital



Future Workflow: CHF clinic

Pinckneyville Community Hospital

System Selection

- Consulting services
- Vendors A, B, and C
- Vendor selection and intent

Pinckneyville Community Hospital

Vendor Onboarding

- Timeline
- Workflow
- System setup
- User Training
- Go live

Pinckneyville Community Hospital

Challenges of Implementation

- Staff availability
- Buy-in
- Funding
- Regulations

Pinckneyville Community Hospital

Conclusion

Pinckneyville Community Hospital

Resources

Perry County Health Department. (2017). Perry County 2017 – 2020 IPLAN. Retrieved from https://perryhealth.net/wp-content/uploads/2014/07/iplan-1217.pdf.

Home Health Decreases Acute Care Hospitalizations Utilizing Telemedicine

At-Home Health Care

A Service of Sparta Community Hospital

At-Home Health Care

- A service of Sparta Community Hospital
- Not for profit
- Service area = 35 mile radius of Sparta, IL
- Ranked as a top performer in Home Health Compare
- Recognized by Fazzi as Top 20 for patient experience.

Our Outcomes Prior

- Acute Care Hospitalization Rate 17.4%
- Emergency Room Visit Rate at 23%
- Frequent calls on weekend regarding questions & problems

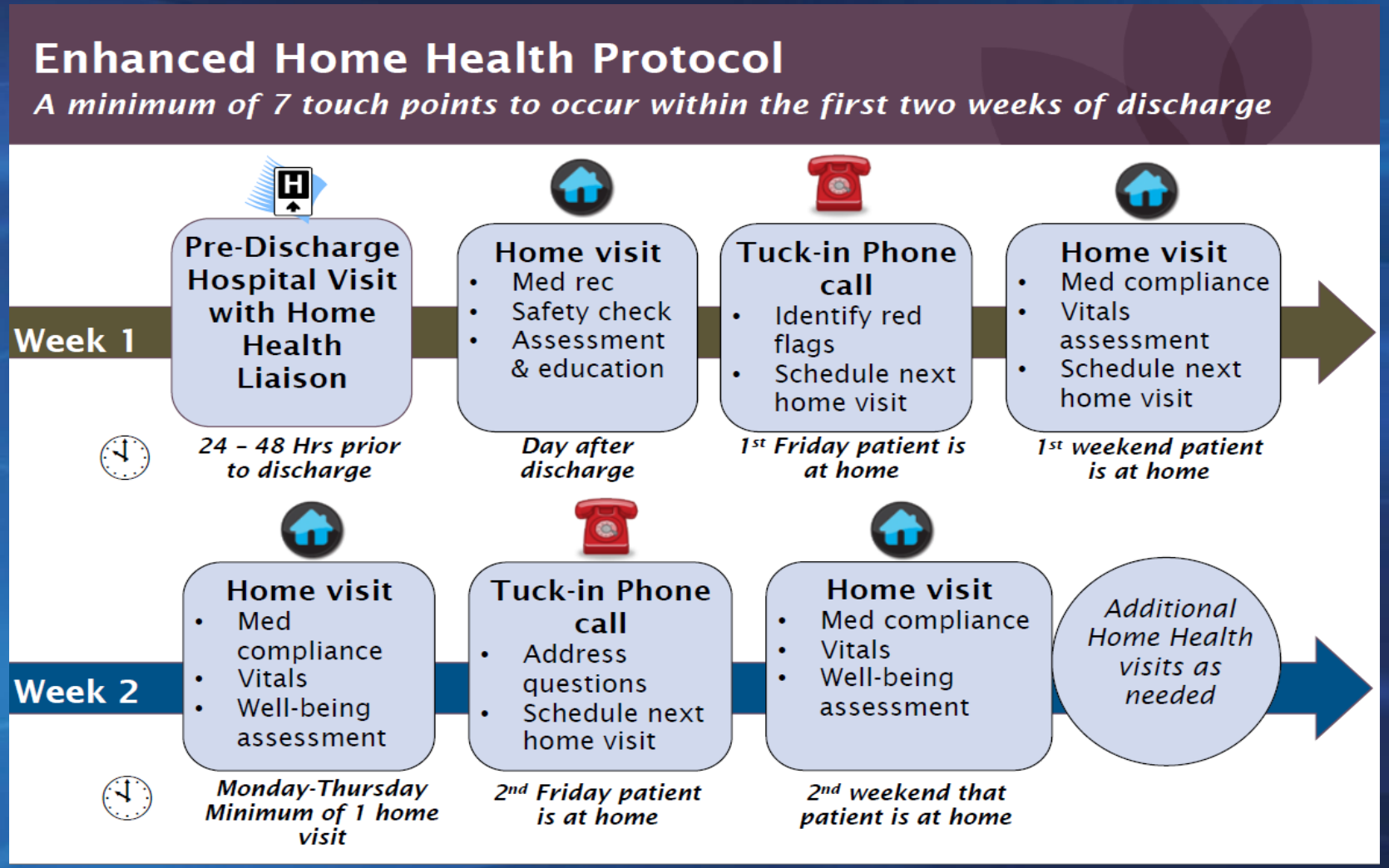
Our Approach

- Solutions from outside of the hospital environment to:
  - Optimize patient health and experience across the continuum
  - Build high performance win/win partnerships with providers and patients/families

Root Causes for Home Health Readmissions

- Patients & families often turn away Home Health agencies after hospital discharge
- Inconsistency in frequency of home visits post-discharge
- 45% of readmissions occurred on the weekend
- Patient/Family not communicating Red Flags to home health agency
- Patient/Family immediate response to problems is Emergency Room
- Medication management
- Physicians not responsive when agency has questions/concerns

Low Tech Solution



What are Tuck-In Phone Calls

- Call to the patient shortly after admission and weekly on Thursday or Friday
  - Do they have necessary supplies
  - Medications
  - Assess for Problems such as complaints of increased pain, wound issues, shortness of breath
  - Reminder: Nurse on call 24 hours a day 7 days a week. Call afterhours number for concerns.

Tuck-In Phone Calls

Is there anything that makes you feel more loved and safe than being tucked in to your bed at night?

Home health patients are always going to have some fears about the future. It's nice to know that we have the ability to provide comfort and peace of mind, especially before the weekend – a time often considered 'off the clock' in the healthcare world. But just like mothers will never ignore the needs of their children, At-Home Health Care is never off the clock when it comes to patients. Our patients will always be comforted by an extra touch, loving care, and a tuck-in is always welcomed. At At-Home Health Care, we want our patients to have that safe, comfortable feeling too. So we did something about it.

We have started something new that we are calling the 'Tuck-In' program. We are not physically tucking our patients in at night, but we are calling them before the weekend rolls around to make sure they have everything they need. Supplies? Check! Medications? Check! Any other concerns we need to be aware of? Being customer-focused is extremely important to us. Our patients are fragile and their comfort is our utmost concern. The 'Tuck-In' program is just one more way to stay connected to the individuals who depend on us for their care.

Contact Us Today And See How We Can Make A Difference In Your (Or Your Loved Ones) Life!

We Offer A Variety Of Services To Give Our Clients

- Skilled Nursing – Wound Care, Medication Management, IV Therapy, Catheter Maintenance, Education For Disease Management
- Home Health Aide
- Physical, Occupational & Speech Therapy
- Medical Social Worker

"At-Home Health Care... Creating Moments In Your Home... Our Hands And Hearts To Care For You."

At-Home Health Care

A Service Of Sparta Community Hospital

(618) 443-2390

Licensed & Medicare Certified

Then……

- Clinicians are assigned to the phone calls
  - All disciplines can do phone calls.
- Document phone calls as the clinician talks with the patient/caregivers
  - Protocol is a script to follow

Telehealth Solution – RPM

- Ability to monitor cardiopulmonary status
  - Blood Pressure
  - Pulse
  - Oxygen Saturation
  - Weight
  - Peak Flow
- Ability to monitor Diabetes
  - Blood Glucose

Who receives Telehealth?

- Diagnosis
  - COPD
  - CHF
  - CABG
  - DM
- History of Rehospitalizations

Managing Telehealth

- Consent/agreement with patient for remote monitoring
- Devices deployed by the second visit
- Patient/Family Education on use
- Care plan developed for parameters and frequency
- Each time patient takes a reading it appears in the EMR -- manage telehealth
- Alerts managed

Video Calls

- After hours calls
  - Wound concerns
  - IV concerns
- Physician notification of change in condition
  - Wounds
- Cure Companion – Telehealth kits
  - Allow for face to face with the PCP and peripherals for assessment while the nurse is present in the home.

Our Outcomes Now

- Acute Care Hospitalization – 13%
- Emergency Room Visit Rate –14%
- 0 calls for supplies afterhours and weekend
- HHCAHPS 5% increase in medication and safety question.
- Overall HHCAHPS Satisfaction

Reframing the relationship to build a partnership

Remember

Questions

Questions or Comments

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