Building a Sustainable RPM Program without Reimbursement

How CommonSpirit Health at Home built a sustainable, data-driven RPM program without reimbursement to improve patient outcomes

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Session Agenda

1. Welcome & Speaker Intros
2. Tips for Launching an RPM Program
3. CommonSpirit's RPM Program
4. Open Q&A

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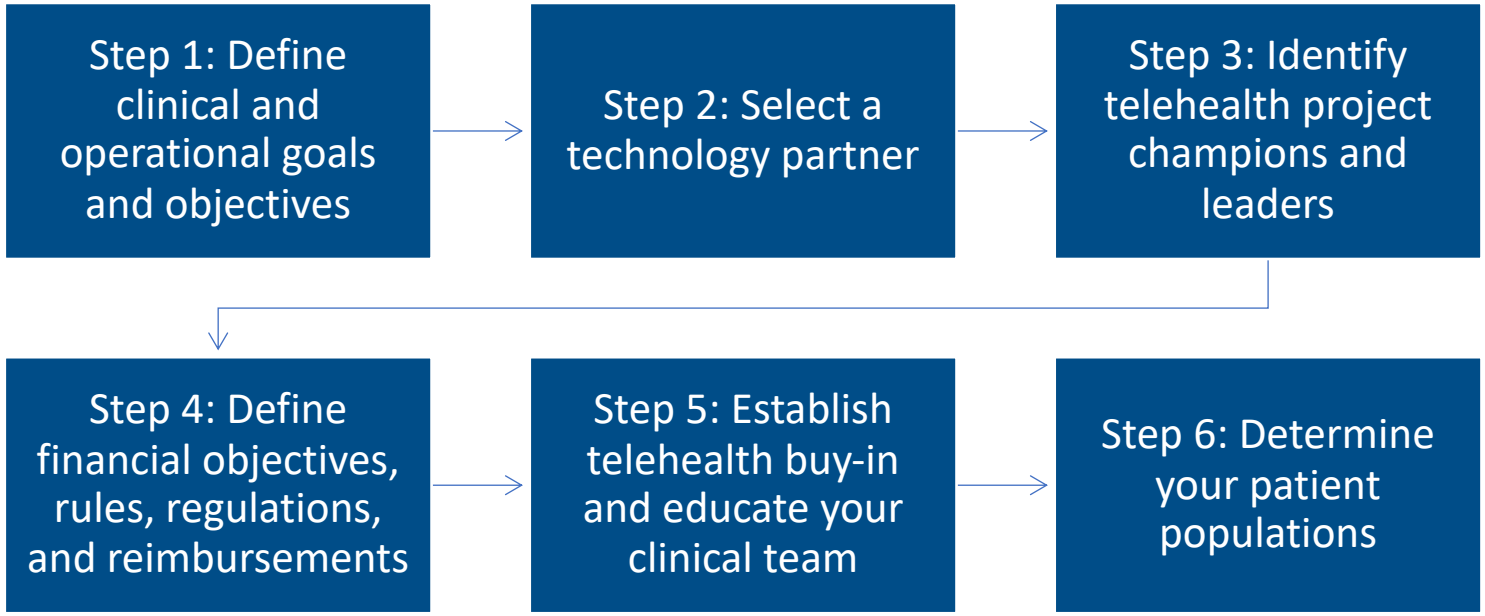
6 Steps to Launching an RPM Program

We've helped hundreds of organizations build sustainable RPM programs that drive results – and not everyone relied on reimbursement to fund/grow their program. Following this 6-step process will help you build a successful, sustainable RPM program.



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HRS Services to Help Your Program Succeed

Supporting you and your patients every step of the way

Logistics

- ✓ Equipment delivery direct to patient home
- ✓ Remote patient offboarding and returns coordination
- ✓ Storage of equipment, cleaning, sanitizing and provisioning

Virtual Installs

- ✓ Set up your patients for success with HRS-led remote training and onboarding
- ✓ Increase rates of patient adherences to your RPM program

Users of this service have increased patient adherence by 13%

Clinical Monitoring

- ✓ Remote clinical monitoring with 24/7 availability to supplement your clinical staff
- ✓ Service is available for all Acute and Post Acute RPM programs to include Hospital at Home

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CommonSpirit: Sustainable, Data-Driven RPM

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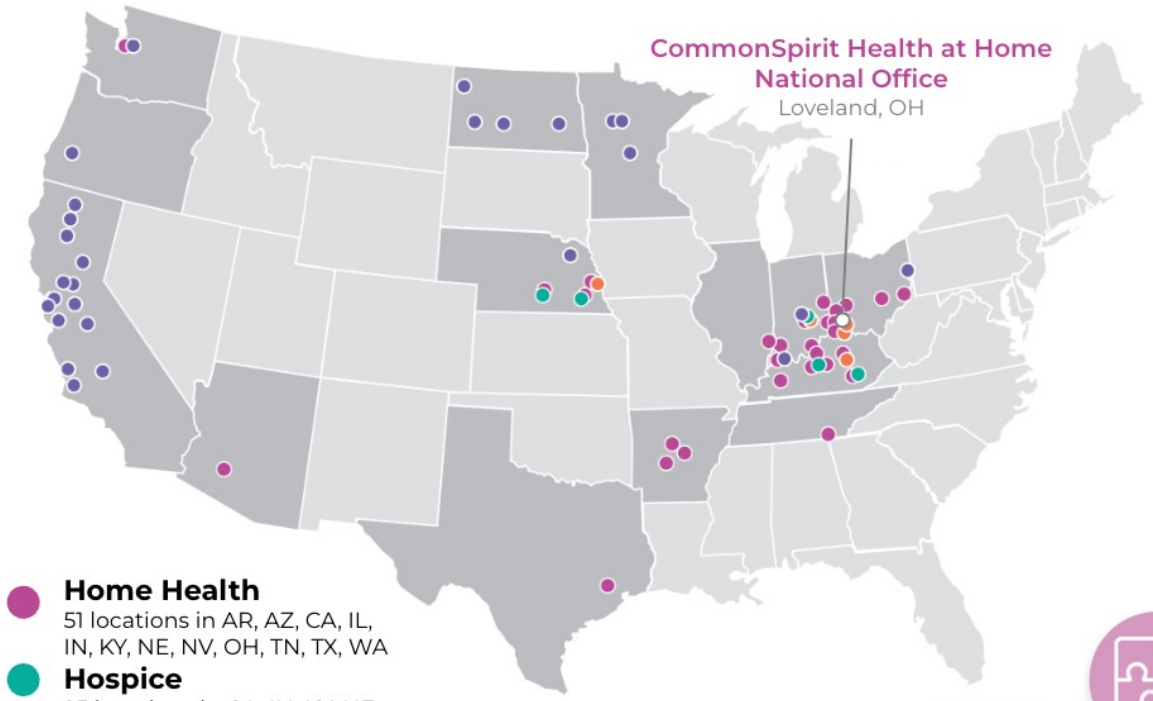
CommonSpirit Health at Home

Who We Are

CommonSpirit Health at Home is a full service health care organization that believes the best place for someone to get better, and faster, is in their own home. Our commitment is to deliver consistent enterprise value as a formidable home-based services partner by meeting each market's needs while achieving the highest clinical, operational and financial outcomes.

CommonSpirit Health at Home



- **Home Health**
  51 locations in AR, AZ, CA, IL, IN, KY, NE, NV, OH, TN, TX, WA
- **Hospice**
  25 locations in CA, IN, KY, NE
- **Home Infusion**
  5 locations in IN, KY, NE, OH
- **Mgmt. Service Agreements**
  42 MSAs in CA, IN, MN, ND, OH, WA

1,076 Clinical Employees Needed by FY29

- **601** Skilled Nurses
- **191** Physical Therapists
- **123** Occupational Therapists
- **58** Speech Therapists
- **47** Social Workers
- **53** Home Health Aides
- **3** Chaplains

24 Wholly Owned + **13** Joint Ventures + **44** MSAs = **81** Locations Nationwide

CommonSpirit's RPM Program

Remote Patient Monitoring (RPM) Program Pilot (2018)

- Seeking to change patient behavior to reduce rehospitalizations and ED visits
- Focused on highest risk for readmission, specifically congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) patients

RPM Program Expansion (2020)

- Supporting home health patients in 12 states across 40 locations during the Covid-19 pandemic
- Focused on highest-risk patients with multiple comorbidities, a history of medication and symptom mismanagement, and elevated risk for hospital readmission
- Conditions including CHF, COPD, hypertension, diabetes, post-surgical, pneumonia, oncology, and COVID-19, among others
- Between April 2020 and May 2021, CommonSpirit Health at Home's program monitored over 2,800 patients between the ages of 1 to 103
- 87% of RPM patients stated they would "definitely recommend" the program after participating
- RPM patients reported greater improvement than the global CommonSpirit Health at Home patient population across three criteria: ambulation, bathing, and pain management

RPM Program Goals:

- ✓ Reduce hospital readmissions and ED visits
- ✓ Increase clinical touch points through virtual visits
- ✓ Increase in patient satisfaction
- ✓ Enhance pain and medication management for chronic care patients

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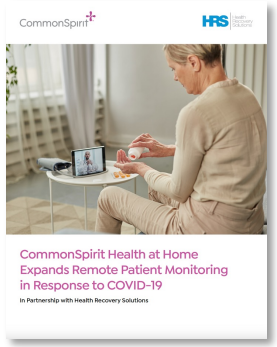
Key Strategies

CommonSpirit Health at Home worked backwards to calculate the potential value and ROI for their RPM program.

- **Objective:** decrease in-person visits per episode by 2.5 to offset costs/reach profitability
- **Objections:** expectation that patient outcomes would worsen with the shift to remote care/virtual visits, readmissions would increase, and patients wouldn't adhere to the program
- **Outcome:** readmissions decreased, patient adherence and satisfaction increased, field staff feel supported by the safety net provided by the telehealth nurse



CASE STUDY

CommonSpirit Health at Home Expands Remote Patient Monitoring in Response to COVID-19

Download the full case study.

Partnering with accountable care organizations (ACOs)

Deploying a skilled nursing facility (SNF) at home model

Leveraging remote patient monitoring interventions

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Partnering with ACOs

CommonSpirit Health at Home partners with Accountable Care Organizations (ACOs) across the country to ensure patients receive the necessary care at an affordable price

- As hospitalizations increased, CommonSpirit Health at Home partnered with an ACO to expand patient enrollment to manage a financially at-risk population
- The partnership enabled monitoring a broad range of patients, specifically COVID-19 patients not eligible to receive home health services
- Patients were identified by the ACO based on patients' risk level, oxygen (O2) saturation, and home caregiver support
- Monitored patients' vital signs and symptoms, provided educational materials, reviewed patient medications, and coordinated care with physicians
- Resulting in a **25% lower acute care hospitalization rate** among RPM patients

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Deploying a SNF at Home Model

- The pandemic accelerated deployment of the new SNF at Home model of care
- Program initially launched in communities across Omaha, Nebraska, targeting Medicare Shared Savings Program (MSSP) patients
- Program success was measured based on several key criteria:
  - number of patients referred
  - number of patients admitted to the ED
  - cost of care for value-based contracts
  - average length of stay
  - hospital readmissions rate
  - patient satisfaction scores
- **Reduce Hospital Length of Stay:** Stable, medium-acuity patients were diverted home following a brief hospital stay, freeing up hospital beds, staff, and resources
- **Prevent Contraction of COVID-19:** Allowed post-acute patients to receive facility-level care at home, reducing the risk of contracting COVID-19 while being treated in a hospital or in-patient facility
- **Care Provided in Preferred Setting:** Allowed for patients to be cared for at home in the least costly and most desired location for patients and caregivers

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Leveraging RPM Interventions

Symptom Management

- Disease-specific symptom surveys are provided through the RPM platform

Biometric Monitoring

- Patients receive a set of biometric monitoring devices to record their vital signs (blood pressure, weight, oxygen levels, etc.) each day
- All biometric data is shared in real time with the CommonSpirit team, allowing for immediate evaluation of patients' vitals and interventions if necessary

Medication Adherence

- Medication adherence is a key goal of the RPM program
- Patients receive medication reminders and are required to record their daily medication intake
- When patients do not indicate that their medication was taken, the CommonSpirit Health at Home team reaches out to them

HIPAA-compliant Virtual Visits

- Prioritized virtual visits, incorporating them into each patient's plan of care
- Augmenting in-home visits with virtual visits leads to the cost savings that supports the RPM program
- Virtual visits are also utilized to triage patients when risk alerts are received

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Lessons Learned

Your Program is Always Evolving:
- Payer and diagnosis agnostic, focused on patients highest-risk for readmission

Expand Patient Reach & Access to Care:
- Carefully consider and refine patient enrollment criteria to maximize program impact and access to care
- Leverage technology and telehealth solutions to overcome geographic and resource limitations

Create Strong Feedback Loops:
- Actively seek and incorporate feedback from field staff, telehealth nurses, and other stakeholders to optimize program effectiveness

Lead with Data:
- Set clear goals and metrics. Define KPIs and track program outcomes to demonstrate success and value
- Share data and results with stakeholders to advocate for program expansion and continued support

Evolving with the Healthcare Landscape:
- Virtual Command Center Model: Implement a virtual command center for centralized RPM program management and improved workflow efficiency
- Reimbursement: Strategize and adapt program structure to align with evolving reimbursement models for sustainable long-term viability

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Questions?

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