Heart of Innovation: How RPM is Eliminating Readmissions in Cardiology

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Session Agenda

1. Welcome & Speaker Intros
2. Leveraging RPM in Cardiology
3. CommonSpirit Health and South Denver Cardiology's RPM Program
4. Lessons Learned & Success Stories
5. Looking Ahead: Challenges & Opportunities for RPM
6. Open Q&A

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RPM Use Cases in Cardiology

Remote patient monitoring is an effective tool for reducing readmissions in patients with cardiac conditions.

Congestive Heart Failure (CHF)

Hypertension

Atrial Fibrillation (AFiB)

Cardiac Surgery

30-day readmissions **decreased by 53%** for heart failure patients

Penn Medicine

0% readmission rate for CHF patients

MaineGeneral Health

71% decrease in readmissions among CHF patients

Hackensack Meridian *Health*

70% of patients controlled Hypertension within four weeks

MaineHealth
Accountable Care Organization

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Current State of Cardiac Healthcare

Current State:

- ✓ According to the Centers for Medicare and Medicaid Services, Congestive Heart Failure (CHF) contributes to nearly **23% of 30-day hospital readmission rates**. To compare, the America Heart Association (AHA) research shows a **30% readmission rate for 90-days**. CHF has also been found to be the **most common cause of hospital readmission**.
- ✓ The CDC estimates that **12.1 million people** in the United States will have AFib in 2030. Only **33% of AFib patients believe they have a serious condition**, and less than half think they're at increased risk of stroke, heart-related hospitalizations, or death
- ✓ Hypertension affects nearly **50% of adults in the U.S.** Hospital readmissions are also more common among older hypertension patients over the age of 65

Did you know:

- ✓ In a recent report, the AHA describes how consistent blood pressure tracking and communication with a healthcare provider can improve patient health and decrease the rate of acute events and associated hospitalizations*
- ✓ The AHA supports initiatives that increase access to and incentivize the appropriate design and use of evidence-based remote patient monitoring technologies*

References: *remote-patient-monitoring-guidance-2019.pdf (heart.org)

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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 utilizing Registered Nurses available with up to 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 Health and South Denver Cardiology's RPM Program

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About the Organization

CommonSpirit Health is a non-profit, Catholic health system dedicated to advancing health for all people. With approximately 175,000 employees and 25,000 physicians and advanced practice clinicians, CommonSpirit operates 140 hospitals and more than 2,200 care centers serving sites across 24 states.

South Denver Cardiology (SDC) was established in 1973 to provide the highest level of cardiac care to the South Metro region. Now with 30 Cardiologists and 22 Nurse Practitioners on staff, SDC provides a full range of cardiac services, including our Transitional Heart Failure Clinic which has been open since 2016. Dr. Ira Dauber is the director of the clinic, and we meet with the other providers once a week in Grand Rounds to discuss difficult cases, but the daily operations of the clinic are run by the Nurse Practitioners and a team of highly specialized Heart Failure nurses.

RPM Program Overview

Highlights:

- 1+ year on RPM with HRS
- 0% readmission rate from August to December 2023
- Steady increase of patient enrollment for all of 2023
- Patient satisfaction feedback achieved and maintained at >80%

Operational Goals:

- Leverage kit reprocessing for improved logistics
- Connect with clinical and billing resources to optimize integral processes

Clinical Prioritization Goals:

- Reduction of hospital readmissions
- Supporting staffing workload
- Building a selective patient criteria/exclusion
- Having adequate resources available to manage patient adherence barriers
- Clinical support for patient care pathways

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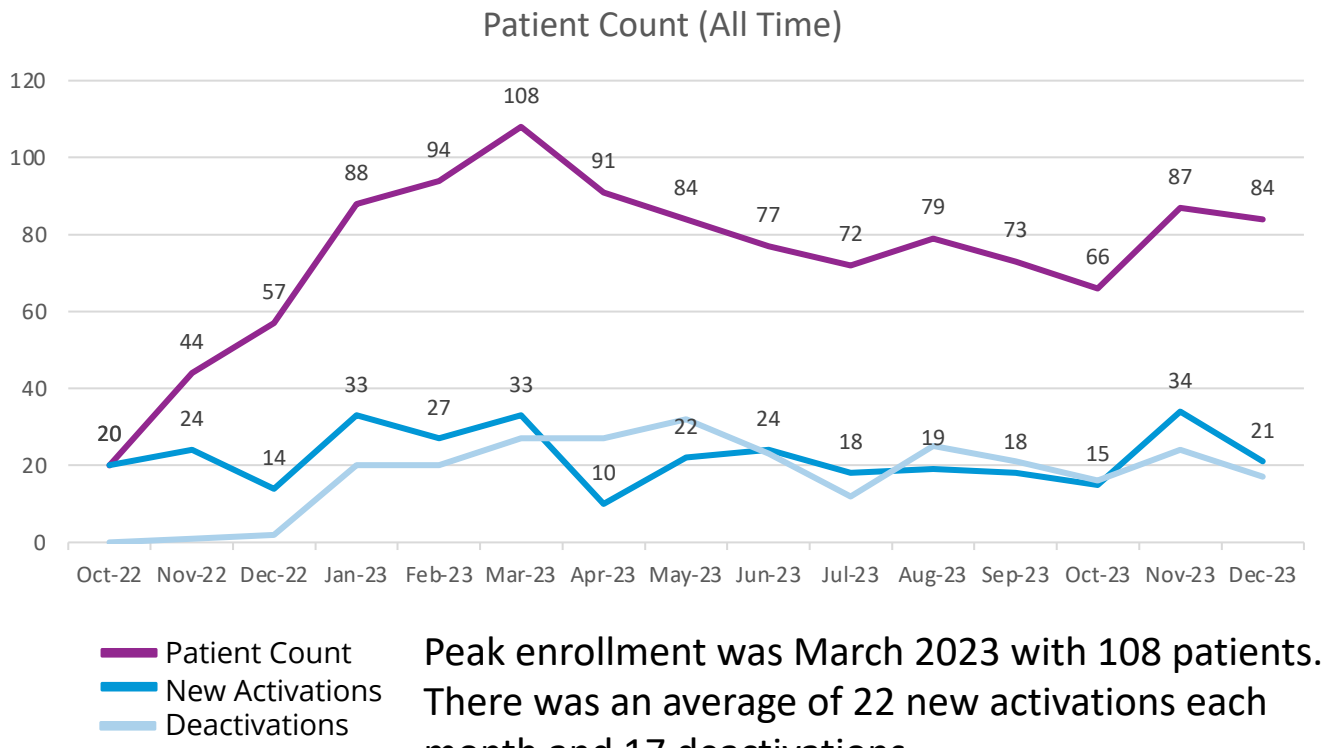
Program Statistics

The RPM program operated from Oct 2022 to Dec 2023. From August 2023 to December 2023 there was an average of 77 patients on RPM each month and 0 readmissions. The program received an overall 91% patient satisfaction rating.

	Totals/Averages*
Patient Count (Monthly Avg)	80
New Activations	332
Deactivations	267
Patients Admitted to Hospital	10
Rehospitalization Rate (90 days)	3.01%

Adherence Rates	HRS Avg	Our Avg	Difference
Blood Pressure	64.20%	75.88%	**11.68%**
Pulse Ox	65.94%	75.15%	**9.21%**
Weight	66.24%	78.04%	**11.80%**
Survey	50.19%	67.58%	**17.39%**

*Data collected Oct 2022-Dec 2023



Peak enrollment was March 2023 with 108 patients. There was an average of 22 new activations each month and 17 deactivations.

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Lessons Learned and Success Stories

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Patient Success Story: Saving Lives with RPM

"The following are the data from the last year of my **miraculous and unimaginable recovery from total catastrophic heart failure**. I was never supposed to leave the hospital; unless for home hospice care. But there has been a good good Lord and amazing team of human beings along with myself that have defeated every expectation and every statistic.

To the South Denver Cardiology Associates Transitional Heart Failure clinic, I can't be expressive enough about how amazing and essential you have been to my recovery! I shouldn't be alive and getting better. It was such a pleasure to have a team of **attentive, personable, positive yet realistic, interconnected specialist team** of special individuals.

Together we have made miracles happen!"

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Patient Success Story: Clinical Perspective

Triggering Event: After being discharged from the hospital status post an acute Congestive Heart Failure event, this patient was determined as a candidate for the RPM program. This patient's Ejection Fraction (EF) and inpatient BNP were well outside of the normal range. The EF was reading at 5-10% at discharge. This patient was introduced to the program, gave consent and was given HRS for home monitoring.

RPM begins: This patient upon admission to RPM was taking their vital signs daily with a connection to the clinical team. The patient was found upon admission to be tachycardic with a low Blood Pressure. Due to the daily readings being outside of the normal range the patient was prescribed Midodrine. The patient continued to have issues with fluid overload during these couple of weeks in January and was ultimately readmitted to the hospital-being one of two patients that month to be readmitted.

Showing improvement: Upon return from this rehospitalization in February, the patient was taking their blood pressures multiple times a day as prescribed, to address the continued incidence of low blood pressure. In March there were signs of improvement. The patient started to turn a corner and began to respond to treatment as evidenced by improved heart rate and blood pressure. With daily vitals to include daily weights, the team was able to get the patients weight down by 38 lbs. The patient's repeat Echo showed an improvement in EF at 15%.

RPM ends: By the end of April 2023 this patient had rebounded to baseline. The vital signs and weight had stabilized, with no incident of readmission to the hospital. With this the patient was discharged from the RPM program with goals met.

Patient recovery: By July 2023, the clinical team had the patient meeting all four pillars. A repeat Echo and EF showed 30-35%. By October 2023, the patient was stable on all medications and their last ECHO showed a recovered EF of 50-55%.

There is a lot that goes into a Heart Failure patient, but home monitoring in the first 90 days when they are not stable, really helps us get them started on their recovery.

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Clinical Feedback

There is one full-time employee focused on RPM, but full team is engaged with the process.

Feedback from the Clinical team has been positive.

"Going into a visit knowing the vital sign trend is important to their care."

"We have been able to prevent worsening outcomes by being proactive in between visits."

"Patients have expressed to us how much they like the home monitoring because they know we are keeping an eye on them."

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Lessons Learned

- ✓ Refining the patient inclusion/exclusion criteria
- ✓ Optimizing clinical workflows
- ✓ Identifying additional platform tools to support patient interaction
- ✓ Working closely with HRS resources for continuous support
- ✓ Training
- ✓ Billing/reimbursement

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Looking Ahead: Challenges and Opportunities

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Challenges & Opportunities for RPM

- ✓ Medicare, Medicaid, Private Insurance
- ✓ Legislative challenges in Colorado and Nationally
- ✓ Provider engagement on RPM
- ✓ Value based care vs fee for service
- ✓ Nursing time and reimbursement
- ✓ IT integration into Electronic Medical Record

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Questions?

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