INTEGRATING TELEMONITORING INTO THE CARE OF THE HEART FAILURE PATIENT TO REDUCE HOSPITAL READMISSIONS

Objectives

- Describe strategies to improve care of the patients with heart failure through
  - Improved clinician knowledge
  - Telemonitoring
  - Diuretic titration protocol
Advanced Home Care

- Not-for-profit home health agency that combines all home care services under one roof, to include the following:
  - Home Health Services
  - Home Medical Equipment (HME)
  - Infusion Services
  - Respiratory Services
  - Nutrition Services

Advanced Home Care

- Over 30 branches in NC, SC, VA, TN and GA
- 14 offer Home Health Services
  - North Carolina
  - Virginia
  - Tennessee
- Partner closely with our owner health systems to reduce hospital readmissions
Hospitals Challenged

- Among patients with Medicare in 2012, 23.3 percent of hospital admissions due to heart failure resulted in readmission of the patient within 30 days.

- Hospitals are now paying penalties for Heart Failure, Pneumonia and Acute Myocardial Infarction.

![Graph: Causes of Hospital Readmission for HF]
Telemonitoring

- Tool to reduce hospital readmissions
- Identify early changes in a patient’s condition

Barriers to Success

- “I did not know my patient had telemonitoring!”
- “What’s in it for me?”
- “What do I do with the information?”
- “It’s somebody else’s responsibility.”
Care of the Cardiac Patient

Course Objectives

- Verbalize components of a cardiac assessment
- Establish patient’s baseline disposition
- Evaluate and intervene for changes from baseline
- Identify barriers to making change
- Implement available nursing interventions
- Use health coaching to teach self-management skills
- Use SBAR to improve communication to the physician
## Physical Assessment

- **General appearance**
- **Weight**
  - Does the patient have a scale?
  - Is the patient weighing daily?
  - Is the patient keeping a written log of his/her weights?
  - Does the patient know how to interpret the weights?

## Pull out the stethoscope!

- **Blood pressure**
  - Take BP in both arms at SOC
  - Check BP in arm with the **highest reading** during future visits
    - So what?
- **Measure orthostatic blood pressure**
- **Lung sounds**
- **Respirations**
Listen

☐ Heart sounds
  ☐ Never listen through clothing
  ☐ Listen for S1, S2
  ☐ Is there an S3?
  ☐ IS THERE A CHANGE?

☐ Lung sounds

☐ Apical pulse

Touch Time

• Check peripheral pulses
  • If cannot feel pedal pulse, check posterior tibial pulse

• Radial pulse
• Pulse deficit
  So what?
Measure!

- Edema

Best Practice Standard of Care!

Establish the Patient’s Baseline

- Review referral
  - What was the patient’s condition at discharge?
- Perform comprehensive cardiac assessment
- Establish baseline weight of the patient
- Establish vital sign history
- Identify patient’s normal disposition
- Medication reconciliation!!!
Change from Baseline!!!

- Ongoing cardiac assessments and comparison to baseline

Weight & Zone Management

### My Goal Weight

<table>
<thead>
<tr>
<th>Green Zone</th>
<th>Yellow Zone</th>
<th>Red Zone</th>
<th>Emergent Alert</th>
</tr>
</thead>
<tbody>
<tr>
<td>- No extra fluid retention</td>
<td>- Sodium intake less than 3000 mg per day</td>
<td>- Sodium intake greater than 5000 mg per day</td>
<td>- Sodium intake greater than 7000 mg per day</td>
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<tr>
<td>- Baseline weight</td>
<td>- Baseline weight</td>
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### Daily Weight and Zone Chart

<table>
<thead>
<tr>
<th>Day</th>
<th>Green Zone</th>
<th>Yellow Zone</th>
<th>Red Zone</th>
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<tbody>
<tr>
<td>Monday</td>
<td>155 lbs</td>
<td>160 lbs</td>
<td>165 lbs</td>
<td>170 lbs</td>
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<tr>
<td>Tuesday</td>
<td>156 lbs</td>
<td>161 lbs</td>
<td>166 lbs</td>
<td>171 lbs</td>
</tr>
<tr>
<td>Wednesday</td>
<td>157 lbs</td>
<td>162 lbs</td>
<td>167 lbs</td>
<td>172 lbs</td>
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<tr>
<td>Thursday</td>
<td>158 lbs</td>
<td>163 lbs</td>
<td>168 lbs</td>
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<tr>
<td>Friday</td>
<td>159 lbs</td>
<td>164 lbs</td>
<td>169 lbs</td>
<td>174 lbs</td>
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<tr>
<td>Saturday</td>
<td>160 lbs</td>
<td>165 lbs</td>
<td>170 lbs</td>
<td>175 lbs</td>
</tr>
<tr>
<td>Sunday</td>
<td>161 lbs</td>
<td>166 lbs</td>
<td>171 lbs</td>
<td>176 lbs</td>
</tr>
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</table>

### What zone are you in today?

- Green Zone: This is good
- Yellow Zone: This is worrisome
- Red Zone: This is dangerous

Note: Consult with your healthcare provider if you are in the Red Zone or have any concerns.
Telemonitoring

- Identifies change from baseline
- Provides trended data
- Data received daily allowing **for early intervention** when changes are noted
- Facilitates VS trend communication to MD

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**Telemonitoring Trends**

<table>
<thead>
<tr>
<th>Date</th>
<th>Weight [lb]</th>
<th>Sys / Dia (Mean) Pulse</th>
<th>SpO2</th>
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<td>05/02/2014</td>
<td>180</td>
<td>94 / 48 ( 72) 60</td>
<td>96</td>
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Other Interventions

- Interdisciplinary approach
- Maintaining follow-up appointments
- Other Service Providers
  - Mobile X-ray
  - Laboratories
- Diuretic titration orders/IV Lasix

IV Lasix Protocol

- Varied degree of acceptance by physicians from:
  - Standardized in hospital discharge orders
  - Refuse to use
  - Somewhere in the middle
**IV Lasix Orders**

For use with CHF patient exhibiting signs of acute decompensation:

- Presence of crackles
- Peripheral edema
- Abdominal distention
- Increased dyspnea
  - Orthopnea and/or
- Rapid weight gain (3 or more pounds in 24 hours or 5 or more pounds in one week)

**Benefits**

- Allows for quick response by Home Health Nurse during a CHF exacerbation
- Prevents hospital readmissions for CHF exacerbation
- Decreases health care costs
- Allows patient to stay in home
Features

- Nurse administers IV Lasix as ordered
- Nurse administers Potassium Chloride
- Nurse stays with patient for one hour to ensure symptoms have improved
- Nurse returns next day to draw panel of labs. (Results are faxed to attending physician.)

IV Lasix Order Template

- Modifiable:
  - Lasix dose
  - Lasix route
  - Potassium dose
  - Labs on day 2
Diuretic Titration Protocol

Under development

CHF Patient Self Management

- If patient gains 3-5 pounds
  - 1 dose extra prescribed
    - Lasix Diuretic
  - Reassess next day
- If improved, resume current prescribed diuretic dose
- If same, one more day of extra dose diuretic
- If worse, 2 days of double prescribed diuretic

F/U Labs by SN after intervention
(lytes, bun, creatinine, bnp)
**CHF Nurse Protocol – CHF Exacerbation**

- If patient gains 5-7 pounds
  - 2 days double dosing prescribed diuretic
    - If improved, back to current regimen
    - Labs
    - No change or worse
      - Not symptomatic, Metolazone 2.5 mg x 2 days
      - Highly symptomatic, AHC IV Lasix protocol
    - After each intervention, SN to check labs (lytes, bun, creatinine, bnp)

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**CHF Patient Nurse Protocol-CHF Exacerbation**

- If patient gained 7+ pounds
  - Symptomatic
    - NO
      - Labs
      - 3 days double dose of prescribed diuretic
    - YES
      - IV Lasix protocol

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Putting It All Together to Reduce Hospital Readmissions

- Changes in patient’s baseline
  - Cardiac assessment parameters
  - Telemonitoring trends
- Early intervention with acute decompensation
- Ongoing use of telemonitoring to evaluate
  - Adherence to medication regimen
  - Medication effectiveness
  - Patient self-management skills

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patriciabeardrn@gmail.com
Expanding the Scope of Telemonitor in the Home Care Setting

Objectives

- Discuss the fundamental and organizational processes in place at Atlanticare Home Health Telemonitor Program in Collaboration with the Atlanticare Heart Failure Resource Center.

- Define system pilot strategy and parameters for non-homebound tele health monitoring.

- Discuss the responsibilities and role of the nurse Telemonitor coordinator in the Program

- Identify some common technological and logistical issues which may occur with set up and use of Telemonitoring on the non traditional homecare patient.
ATLANTIC COUNTY, NJ

AtlantiCare is an integrated system of services designed to help people achieve optimal health. It includes AtlantiCare Regional Medical Center, AtlantiCare Health Engagement, the AtlantiCare Foundation, and AtlantiCare Health Services. Its more than 5,221 employees and more than 700 physicians serve the community in nearly 70 locations. A 2009 Malcolm Baldrige Award winner, AtlantiCare was also included in Modern Healthcare’s Best Places to Work in Healthcare in 2010. ARMC became the 105th hospital in the nation to attain status as a Magnet™ designated hospital in March of 2004 and was re-designated a Magnet™ hospital in 2008 and 2013.

SERVICES AND PROGRAMS

- AtlantiCare is an integrated system of services designed to help people achieve optimal health. It includes:
  - AtlantiCare Regional Medical Center
  - AtlantiCare Health Engagement
  - The AtlantiCare Foundation
  - AtlantiCare Health Services, which manages many of AtlantiCare’s healthcare service offerings including:
    - Family Medicine and Internal Medicine
    - Urgent Care Centers
    - Pavilion OB/GYN
    - Neurology Associates
    - Vascular and General Surgery program
  - AtlantiCare Regional Medical Center (ARMC) is a 567-bed teaching hospital with campuses in Atlantic City and Pomona. ARMC also provides emergency services at its Satellite Emergency Department in the AtlantiCare Health Park Hammonton Campus.
  - ARMC is home to many specialized healthcare services, including:
    - ARMC’s Wound Healing Centers
    - AtlantiCare Cancer Care Institute, a Fox Chase Cancer Center Partner
    - The AtlantiCare Neurosciences Institute
    - AtlantiCare Women’s & Children’s Services
    - The Center for Surgical Weight Loss & Wellness
    - Harrah’s Regional Trauma Center
    - The Heart Institute – the Region’s only full-service cardiac surgery program
    - The Joint Institute
    - The Roger B. Hansen Center for Childbirth, which includes the region’s only Neonatal Intensive Care Unit
Number of monitors installed per month

Patient's with Primary or Secondary Diagnosis of Heart Failure
### 2011

<table>
<thead>
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<th>Month</th>
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<th>Patients with Primary or Secondary diagnosis of Heart Failure</th>
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### 2012

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<th>Month</th>
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<tr>
<td>June</td>
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</table>
NJ Readmissions

- NJ is ranked first in the US with the highest average readmission rate
- 62 of the 64 NJ hospitals are facing readmission penalties
- $14,000 average cost per Medicare CHF readmission
- Average CHF Patient has a 25% chance of being readmitted in 30 days.

AtlantiCare Regional Medical Center - City Div

CHF Readmission %: 26.6%
AMI Readmission %: 22.2%
PNM Readmission %: 21.2%

Readmission % (red line represents national average)
Readmissions above the acceptable rate will cost AtlantiCare $896K over the next three years.

Drivers of Readmissions

- Real-time data on the patient post-discharge
- A way to identify which patients are at an increased risk of readmission
- An effective method to intervene when patient is relapsing
- Platform to leverage caregivers & family member in formal discharge process
- An empowering way to change patient behavior
HOSPITAL READMISSION RATES FOR ATLANTICARE HOMECARE PATIENTS ON TELEMONITORING

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<th>Year</th>
<th>Quarter</th>
<th>Actual Rate</th>
<th>Adjusted Rate</th>
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<td>3.1%</td>
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<td></td>
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Atlanticare Heart Institute Quality Scorecard

<table>
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<tr>
<th>Heart Failure</th>
<th>Benchmark</th>
<th>1st Q 2013</th>
<th>2nd Q 2013</th>
<th>3rd Q 2013</th>
<th>4th Q 2013</th>
<th>1st Q 2014</th>
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<tbody>
<tr>
<td>HF Appropriate Care Score</td>
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<tr>
<td>Mortality Rate</td>
<td>&lt;1.0</td>
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<td>0.91</td>
<td>0.79</td>
<td>1.47</td>
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<td>&lt;1.0</td>
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<tr>
<td>Readmit 30 day (any dx)</td>
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<td>0.83</td>
<td>1.1</td>
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<tr>
<td>Complications</td>
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<td>0.63</td>
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<td>0.94</td>
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<tr>
<td>Total Cases</td>
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<td>195</td>
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HEART FAILURE CLINIC
Progression of referrals from Heart Failure Resource Center

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<tr>
<td>JUNE 2014</td>
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PARAMETERS FOR HEART FAILURE RESOURCE CENTER REFERRAL

- Diagnosis of Heart Failure with a recent hospitalization
- History of readmissions to the hospital
- Clinically unstable
- History of non-compliance with traditional follow up
- Patient agreement to perform monitoring daily for a minimum of 30 days.
GOALS OF THE PROGRAM

TRIPLE AIM
- Better cost
- Better outcomes
- Better health

DOWNSTREAM COST SAVINGS
Value to hospital, accountable care mandates, patient overall improvement in their health literacy

GAINING ACCEPTANCE
= increased referrals

- Referrals are generated from those who have accepted the telemonitor program.
How is the product promoted?

- Educate patients
- Educate staff
- Educate physicians & office staff
- Information in admission packet
- Information at Health Fairs
- Keep data
- Celebrate success

Promotion of our product is an ongoing process

Why does ACHC have acceptance of this program?

- Positive patient experiences increases security with product
- Patients learn better at home than in an office or hospital, improving their quality of life
- Physicians are recognizing telemonitoring & educating at home is more cost effective than hospital visit
- Nurses recognize the ease of use, improvement of patient outcomes and the value of collaboration with coordinator
How is the telemonitor program accepted?

- From positive customer experiences
- QI data that shows the decrease in Emergency Room visits and Hospital admissions —(shows cost savings, outcome improvements)
- Successful Staff experiences from telemonitor usage

Who needs to accept program?

- Patients
- Hospital liaisons
- Physicians
- Physician office staff
- Families/care-givers
- Employees
What type of patient/diagnosis do we target for a monitor?

- Hypertension
- Congestive HF
- Pulmonary
- Syncope
- Dizziness
- Primary cardiac but Other diagnosis depends on the nursing clinical decision

BENEFITS OF THE PROGRAM

- Phone triage can replace a skilled visit
- Reduce hospital emergency room visits
- Reduce hospital admissions
- Improve communication with Physician
- Improve patient outcomes
- Improve customer satisfaction
- Improve patient/CG health literacy
- Install is a skilled visit the nurse follows the POC
AtlantiCare Homecare Department-Employees and Staffing

- One full time RN coordinator-based on our current number of monitors

- Part time LPN- skilled visits knowledge of homecare, familiar trending, data collection

- PRN- CHHA—for monitor pick up & maintenance of equipment
- Coordinator is critical to a successful program
- They manage the day to operation and delivery of information
- Key promote and advertise your product

- Computer proficiency
- Clinically strong
- Maintain and collect data
- Excel savvy-for data collection
- Ability to triage, educate and communicate
- Know how the current health care system flows-
  Health care awareness across the continuum
- Homecare experienced
- Critical thinking ability
Confident and experienced to triage over the phone
Ability to negotiate between patient/family goals and MD/nurse goals
Self motivator and strong initiative
Generate reports to find possible referrals
Assess admissions & re-certification from homecare, assess hospital admissions for patients that would benefit from a monitor

Monitor Czar

- Where are at all times
- How they operate
- Clean or dirty
- Broken
- Set-up in home
- Functional ability of workstation
- Track of returns
- Data collection
Nursing at work in telemonitoring

**Critical thinking**
- Identify & Define problem
- Formulate solutions, compare and contrast
- Decide on solution utilizing evidence based information
- Evaluate outcome

**Nursing process**
- Assess
- Plan
- Implement
- Evaluate outcome
Its simple, maybe, maybe not
Challenges with non Homecare clients

- Not homebound
- Employed and working various shifts
- Medication compliance especially Lasix
- Attachment to devices
- I’m not chronically ill mentality

Equipment

- Monitor
- Phones
- Outlet
- Splitter
- Extra-long phone cords
- Faxes & computers
- Wireless stations
Other tech related stuff

- Electric
- Transportation equipment
- Storage tech equipment
- Clean area for tech equipment
- Dirty area for tech equipment

QUESTIONS

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