Improving Access to Care by Meeting
Pediatric Patients and Their Caregivers
Where They Are through Remote Patient
Monitoring

Kylee Denker, MSN, RN, CPN Haley Edwards, MSN, RN, CPN



Remote Patient Monitoring

1 Current State (10)

2 Program Development (20)

3 Equity and Quality Improvement (10)

4 Breakout (15)

5 Q & A (5)

Remote Patient Monitoring (RPM)



- Form of telemedicine
- Submission of relevant health generated data
- Uses digital health technologies

What is NOT RPM?



- Telemedicine visit
- Home health visit
- HIPAA-compliant messaging between provider and patient <u>without</u> health generated data

Background Cincinnati Children's 2016 2018 • Pilots with 3 populations Transition to centralized nursing team Multiple platforms used • 4 RNs Staffing within division • FTE 50% bedside & 50% RPM 2017 2024 One platform selected • 24 live programs • 10 RNs Staffing resided within division • 100% FTE RPM

Staffing



- 1:80 nurse/patient ratio
- Centralized RN staffing model
 - RNs responsible for all patients
- Hybrid remote/in-person work
 - Patient management remote
 - Patient enrollments, education in-person

Staffing

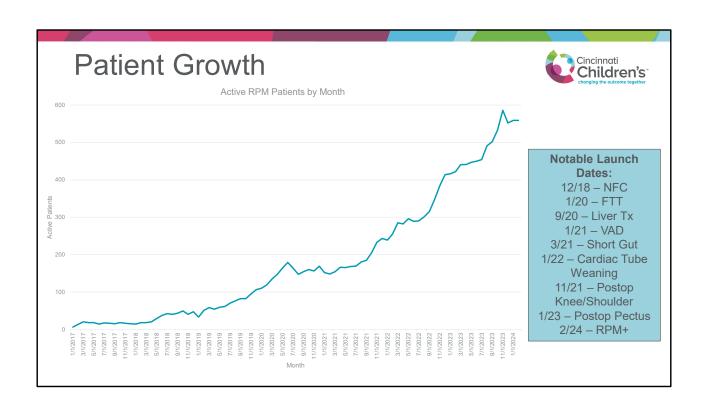


- RN leads for each division
 - Point person between division and RPM team
 - Consistent RNs for communication with patients
 - Lead for improvements to program

Current Programs



Division	Programs Offered
Cardiology	ACHD High Risk for Heart Failure, Cardiomyopathy, Cardiac Tube Weaning, Heart Tx, VAD
Complex Care	Failure to Thrive, RPM+ Feeding Intolerance
Endocrinology	Type 1 Diabetes Post DKA
Genetics	Cleft Infants
Gen Peds, Foster Care Clinic, Community Pediatrics	Asthma, Failure to Thrive
Gastroenterology	Advanced Nutrition TPN, Failure to Thrive, Interdisciplinary Feeding Team, Short Gut Non-TPN, Short Gut TPN Dependent
Neonatology	Feeding Tube Dependent, Concern for Inadequate Weight Gain, High Calorie Formula Dependent, Oxygen Dependent
Nephrology	Peritoneal Dialysis
Neurology	Ketogenic Diet Initiation
Pain	Post Op Knee/Shoulder Repair with Nerve Catheter, PostOp Pectus Excavatum Repair
Pulmonology	Cystic Fibrosis
Transplant	Liver Transplant



Divisional Partnership

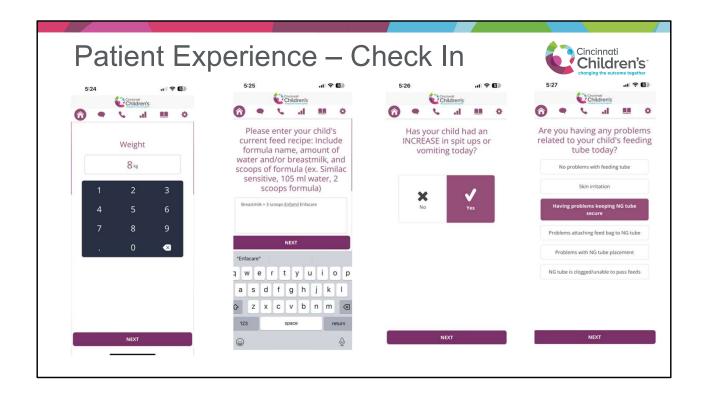


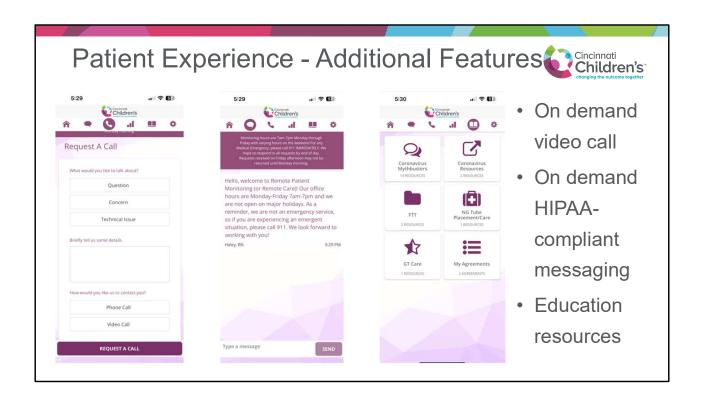
- Close partnership with interdisciplinary team members
 - o Clinic and Bedside RN's
 - Registered Dietitians
 - Managing Providers
 - Social Workers
 - Care Managers

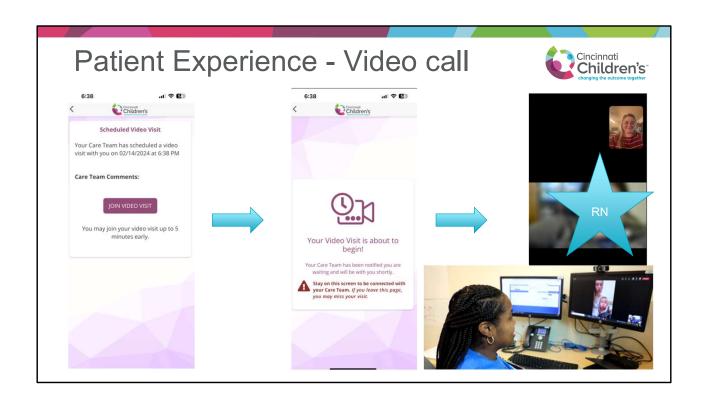
Patient Experience

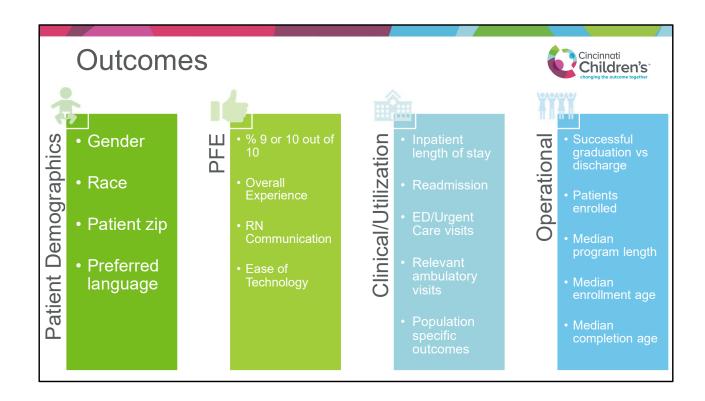


- · Login on pre-determined check-in day and time
- Completes pathway
 - Pathway:
 - Includes vital signs and questionnaires
 - Unique to population & diagnosis
 - Customizable to patient (i.e., breastfeeding, feeding tube)









New Program Development

Nursing, Population, Managing Team, Risk, Project Build, Patient Experience





Nursing





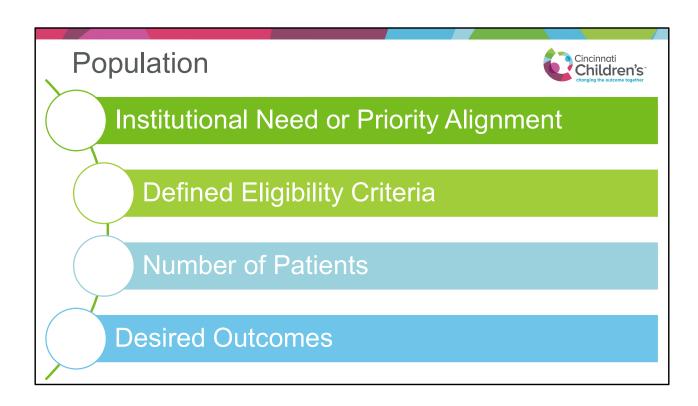
- Licensing
 - Required to be licensed in the statethe patient is located
- Education
 - Population specific assessments, interventions, and education

Nursing Example (NICU NG)





- Licensing
 - Ohio, Kentucky, Indiana, West Virginia
- Education
 - NG placement
 - Bowel management
 - Feed tolerance/management



Population Example (NICU NG) Institutional Need or Priority Alignment • Wildly Important Goal – Access! • Improve access to high acuity inpatient beds by reducing length of stay Defined Eligibility Criteria • Admitted to NICU • Managed output • NG tube dependent Number of Patients • Test of Change Phase 1: 5 patients • Test of Change Phase 2: 50 patients • Test of Change Phase 3: All eligible patients • Test of Change Phase 3: All eligible patients • Test of Change Phase 3: All eligible patients • Reduce length of NG tube dependence • Reduce length of NG tube dependence • Improve time to goal weight gain (g/d)

Managing Team





Responsibilities:

- Pathway and response plan collaboration
- Quality improvement lead
- Messaging to remaining divisional team

Managing Team Example (NICU NG Children's Choligo the outcome together



- Provider: NICU Follow Up Clinic Medical Director
- NICU Follow Up Clinic RN
- NICU Follow Up Clinic RD
- Inpatient Care Managers

Project Build

Cincinnati Children's

- Pathways
 - Frequency
 - Vital sign data/equipment
 - Qualitative questions to support assessment
- Education resources
- EHR build

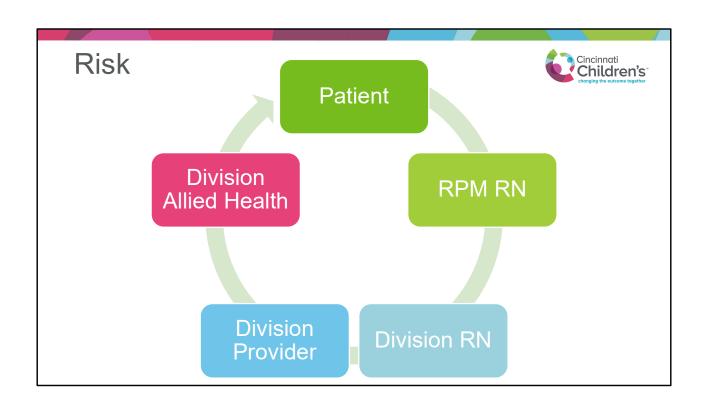


Project Build (NICU NG)

Cincinnati
Children's
changing the outcome together

- Pathways
 - Weekly
 - Weight infant scale
 - Feeding tolerance, issues with NG, PO
- Education resources
 - How to place NG, NG care
- EHR build
 - Weight gain flowsheet, growth curve





Patient - Completes check in weekly - Reports current patient weight Patient - Communicates feeding plan updates to patient - Updates RPM RN of goals - Receives escalation from RPM - Collaborates with RPM + NICU RD for updated plan - Receives provider in office or sends to back up

Patient Journey • Location • Enrollment • Check in requirements • RPM resources – HIPAA compliant messaging, on-demand video calls • Graduation • Graduation criteria • Clinical goal measurement and updates

Patient Journey (NICU NG) Inpatient NICU prior to discharge Teach & validate scale Run through questionnaire * Weekly check in Messaging with RN + RD Tideo call for feeding tube assessment + education * Weight gain at goal (g/d) x8 weeks Full PO feeds

Equity and Quality Improvement

Eligible Enrollments, Adherence, Dashboard

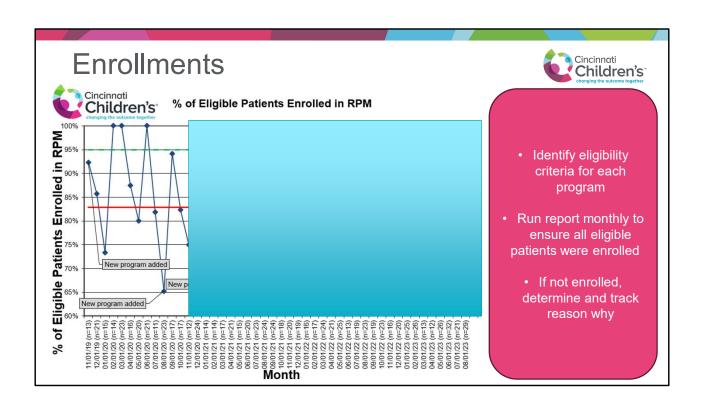


Equity and Quality Improvement



- Lens on equity and improving experience
- Formal QI group formed
 - RPM clinical manager
 - HM provider
 - Data analyst
 - QI analyst
 - Project manager
 - Population leads
 - CAREGIVERS!





Enrollments – Top Failures



Language Other than English

Application restraints

Preconceived non-adherence

Not offered RPM due to being non-adherent with other care

Eligibility missed by care team

- Rotating providers
- Lack of standard provider education

Caregiver declined

Enrollments - Actions

Cincinnati Children's changing the outcome together

Language Other than English

- Working with internal Language Access Services to find solution to message translation
- Working with vendor to ensure seamless pathway translation and app experience

Preconceived nonadherence

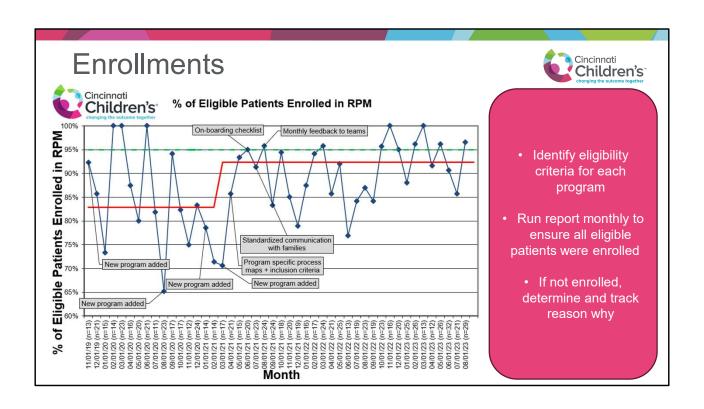
- Partnered with providers to show outcomes on adherence, benefits of program, etc.
- Emphasized need to offer to all eligible patients for equity to all care team members

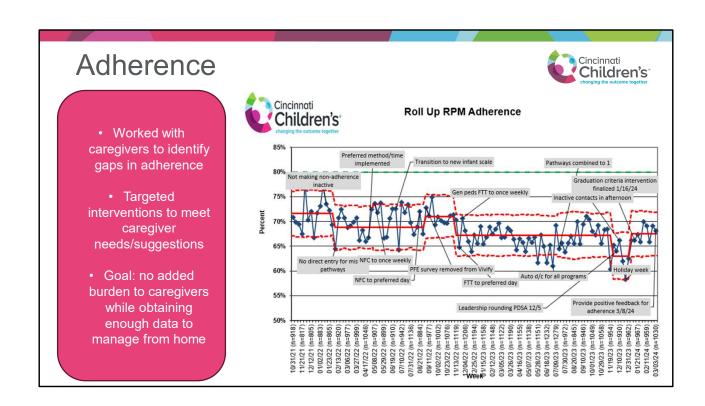
Eligibility missed by care team

- Defined eligibility criteria for all programs
- Created handouts for care team members that outlined eligibility
- Care team members added to discharge checklist, note smartphrases, order sets, and WOWs

Caregiver decline

- Created handout for caregivers highlighting benefits
- Care teams introduce RPM before RPM RN meets with family

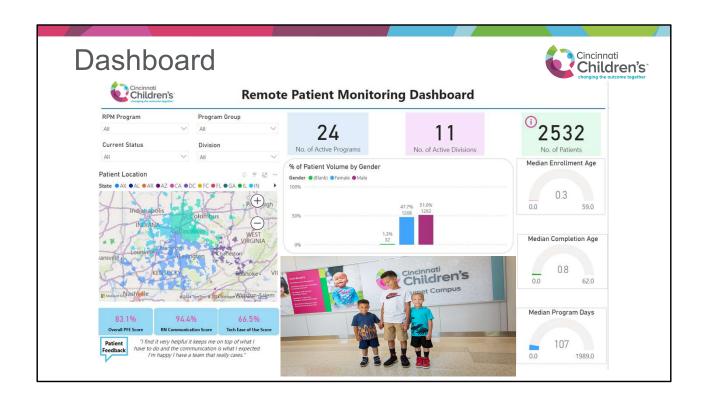




Adherence - Actions



- Implemented easier to use infant scales
- Optimized required check-in frequency
- Preferred day and time of check-in
- · Preferred contact method
- Virtual leadership rounding
- Encouraging message after pathway completion



Patient story



- 2-month-old presented to ED from West Virginia
- Birth weight 1.65 kg in ED, weight 1.45 kg
- Diagnosed with FTT
- Managed by outpatient craniofacial center; enrolled in RPM

Patient Story



- RPM weights collected weekly
 - Continued to fall farther off curve post discharge
- RPM identified mixing formula with mason jar
- Provided family with blender bottle for proper mixing
- Weight increased to 5th percentile



Breakout session

Create your own RPM Program!



Consider your patient population:

- Age considerations
- Patient diagnosis
- Risk factors (ex. Social)
- Common concerns
- Equipment needs
- Nursing triage/response to common concerns

Now time to create your own questions and response plan!

- Create 4 unique questions pertinent to assessing your patient needs/concerns
- Create a nursing triage/response plan for each question and response

Example



Have you been able to follow the recommended feeding plan?

- Yes continue to pathway
- No additional cause questions asked

Response/Triage

- RPM RN contact caregiver to triage and resolve concerns
- Route to appropriate EHR pool, provider, and SW with appropriate level of follow up
- Call clinic with immediate concerns

