Innovations in Nursing Telehealth
Part 2: Chronic Disease Management and Population Health

MATRC Annual Summit
April 12, 2016

Nursing Panelists

Tamara Broadnax, MSN, RN, NEA-BC, Telemedicine Director, VCU Medical Center, VCU Health

S. Craig Thomas, MSN, RN, ACNP, CHFN, Acute Care Nurse Practitioner, Division of Cardiovascular Medicine, University of Virginia Health System

Bonnie Britton, MSN, RN, ATAF, Owner/Manager, Reconnect4Health

Charlene McFeeley, MSN, NP-C, LNC, NLCP, SANE, CME, Co-Founder and Managing Partner, The River Practice

- How are Chronic Disease and Population Health Related?
- What Role do Nurses Play in Chronic Disease Management and Population Health?

The infusion of telehealth technology into health care and health care delivery has presented new opportunities for increasing patient access to care and decreasing costs, while improving desired care outcomes

Improve Health	Lower Cost	Better Care
• Decrease Mortality • Decrease Readmission • Improve Quality of Life • Better Disease Management • Improves Patient Outcomes • New Model of Clinical, Translational and Population Health Care (Care Delivery Disruption)	• Reduce Inpatient Readmissions • Decreased ED overcrowding and unnecessary visits • Reduced Labor Costs (cheaper and more cost efficient than home visits)	• Drives Continuous Relationship and follow up with the Care Teams • Increases Cooperation among Clinicians creating an environment of shared responsibility • Improve Patient Participation and Satisfaction • Increases Patient Access

VCU Health

Chronic Care Management

Nurse Practitioner driven program

Home visit by Nursing Aide

Technology with human touch

Telehealth

Heart Health@ Home (3H)

Heart Failure

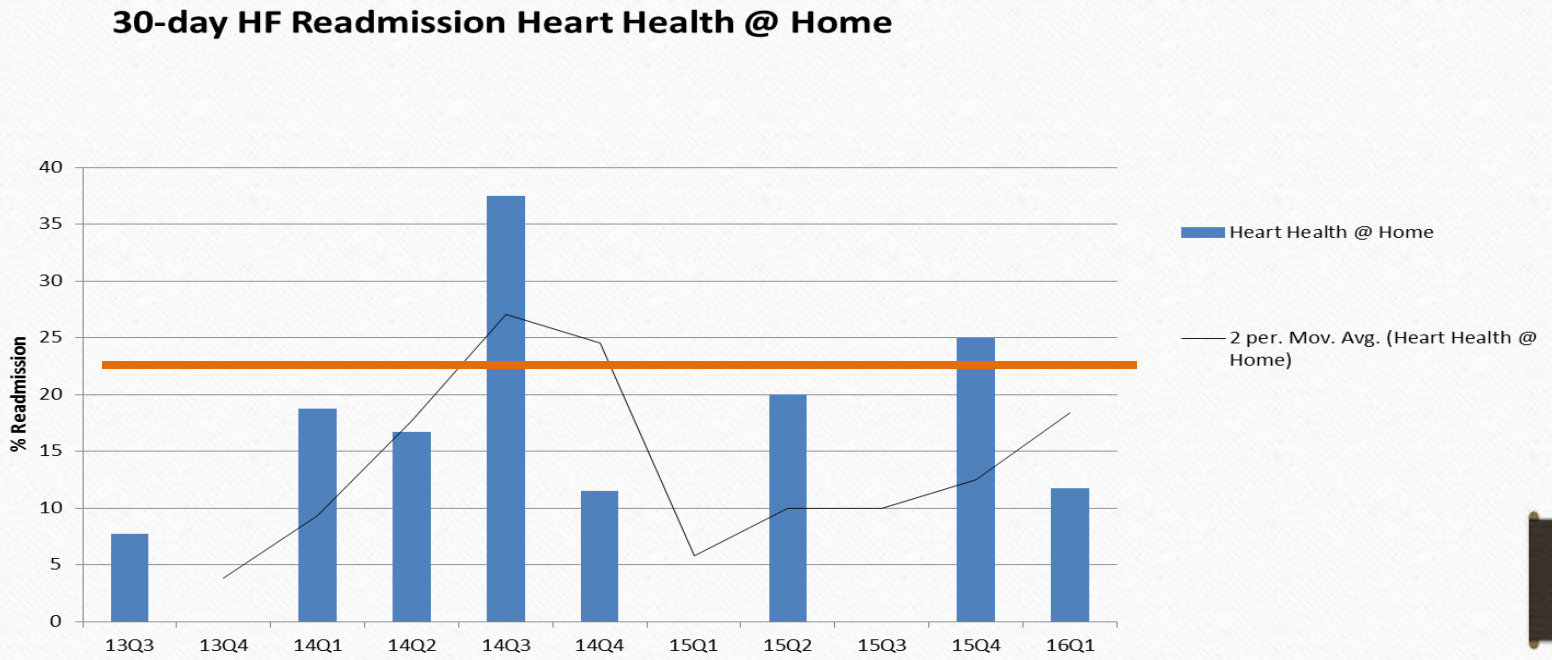
Patient-centered care

Transitional Care

Low cost healthcare extenders

Readmission Reduction

Outcomes



- Total Patients served through program: **179**
- Total visits over last 3 years: **4400+**
- Patients transitioned to Hospice care: **10**
- Total 30 day readmission rate since inception: **11.7%** compared to national HF 30-day readmission rate of **22%** (Data.Medicare.gov updated 8-Oct- 15)

Chronic Care Management, Remote Monitoring & Direct to Consumer Nursing Models of Care

Bonnie Britton, RN, MSN, ATA Fellow

MATRC Board Advisor & Consultant

Executive Director

Reconnect4Health

Nurse's evolving role in Health Care Reform

CMS's Chronic Care Management Services:

CPT Code 99490- reimburses $42.60 PMPM

Medicare patient with 2 or more chronic conditions

20 minutes of non-face to face care management

Remote Patient Monitoring:

Improves the patient experience of care

Improves the health of populations

Reduces the per capita cost of health care

- Reduced bed days by 68%
- Reduced <30 day readmissions by 21%
- Reduced hospital readmissions by 67-74%
- Reduced per capita cost by minimum of 50%

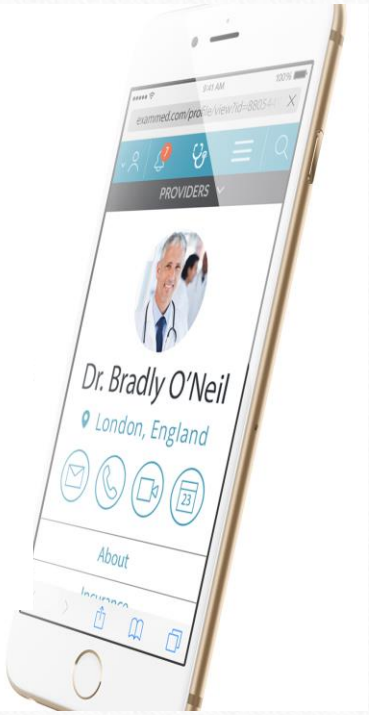
Lowers CMS < 30 day readmission penalties /lowers Health Plan costs

HIPAA secure video Direct to Consumer

Reconnect 4 Health

Nurse Practitioner Led Virtual Practice

The River Practice
Innovative Patient Care



Outcomes

Patient Data	% of patients
Felt chief complaint was emergent	280%
Sent to E.D. for evaluation	<0.002%
Medications prescribed	75%
Diagnostics prescribed	60%
Specialty referrals	10%
Mental health counseling referrals	10%

Conditions

Patient Condition	Outcomes of Subsets
Diabetes	58% with reduction of HgA1C
HTN	84% with improved BP
Acute Conditions	100% with 1-2 visits
Mental Health	81%
Population Health	80%
Skin surveillance – new diagnosis of cancer	100%

Questions?

Contact Information

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