

The impact of the HRS 2023 remote monitoring expert consensus statement on AP practice



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The 2023 HRS/EHRA/LAHRS/APHRS Expert Consensus Statement on Practical Management of the Remote Device Clinic¹ was presented at the Heart Rhythm Society's 2023 Annual Scientific Sessions and is now published. As co-chair of the writing committee and having worked with remote monitoring (RM) programs that have had no additional help for clinical staff, outsourced to merge manufacturers' websites into one, and outsourced all aspects of RM, it is my opinion that most impacted by these recommendations will be the allied professionals (APs). The added deluge of work associated with implantable loop recorder (ILR) transmissions has made this document even more significant to this group. This expert consensus document and the 2015 document² recognize RM as a standard of care for cardiac implantable electronic devices. This article discusses this document's features that support how APs can manage RM more effectively, enumerated below.

- (1) Multiple tasks³ are associated with processing RM transmissions. This document emphasizes a team-based approach, including administrative and nonclinical roles and responsibilities, in caring for patients on RM. It takes a village!
- (2) Because of the many RM tasks, it is recommended that each clinic develop a workflow design specific to their clinic needs. Currently, clinics have reported mandatory cross-coverage for other tasks. This document recommends assigning specific responsibilities to each RM team member with dedicated time to fulfill those responsibilities.
- (3) Three full-time-equivalent staff members are needed to efficiently cover 1000 RM patients. This includes clinical, nonclinical, and outsourcing personnel determined by the specific RM workflow design. This staff-to-patient ratio provides a tangible number for administrators to plan for an efficient RM clinic. Long time coming! With requests for more RM staff, hospital administrators have asked, "What are the rec-

ommendations?" This becomes an important recommendation for APs.

- (4) Continuous patient connectivity is the only way to operate an efficient RM clinic. Patients should be enrolled and connected to RM soon after implantation. Nonclinical personnel should contribute by assuring patients are connected and transmitting continuously.
- (5) Patient education is key to maintaining patient connectivity. Suggestions for when, where, and how to communicate with RM patients are presented. Patient education ideally starts before implant and is lifelong. Patient and clinic workflow needs are considered for developing appropriate educational tools.
- (6) Eliminating unactionable transmission alerts with more standard and customized alert programming is essential. Recommendations include programming parameters for yellow and red alerts for each type of cardiac device, definitions of high-priority alerts, and alert response timelines.
- (7) Clinical staff who read, interpret, and report RM transmissions should be appropriately educated and credentialed. Recommendations for education, certification, and participation in ongoing quality improvement programs are made to assure evidence-based practice. The guideline recommends that clinical practices and institutions offer credentialing reimbursements.
- (8) Reporting results to patients and their healthcare providers, and into electronic medical records, is part of the process for RM programs to maintain optimal patient care and should be accomplished by assuring confidentiality and privacy.
- (9) Manufacturers are an integral component of an RM clinic, especially with evolving technology. Industry contribution comprises staff training, patient connectivity strategies, and patient education. Future technology development should be bidirectional and involve all stakeholders, including patients.
- (10) There is a section on managing implantable loop recorder alert programming based on indication with standardization and customization of alert programming to minimize the deluge of nonactionable events.

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- (11) Alert-based⁴ scheduling may be considered for stable patients with few comorbidities when continuous connectivity is assured. Recommendations for shifting this paradigm are included.
- (12) Other considerations affecting APs include pediatrics, geographical reimbursement disparity, and outsourcing, all needing to be addressed. Future goals for RM with required research to support evidence-based practice are reviewed.

This is a summary of topics in this consensus statement. Consider reading the entire document. Keep your eye out for associated educational derivatives such as a recommendation pocket guide, staffing ratio calculator, key points for administrators, and patient educational materials.

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References

1. Ferrick AM, Raj SR, Deneke T, et al. 2023 HRS/EHRA/APHRS/LAHRs expert consensus statement on practical management of the remote device monitoring clinic [published online ahead of print May 19, 2023]. *Heart Rhythm*. doi:10.1016/j.hrthm.2023.03.1525
2. Slotwiner D, Varma N, Akar J, et al. HRS consensus statement on remote interrogation and monitoring for cardiovascular implantable electronic devices. *Heart Rhythm* 2015;12:e69–e100.
3. Seiler A, Biundo E, DiBacco M, et al. Clinic time required for remote and in-person management of patients with cardiac devices: time and motion workflow evaluation. *JMIR Cardio* 2021;5:e27720.
4. Chew D, Piccini J, Frazier-Mills CG, Michalski J, Varma N. Alert-driven vs scheduled remote monitoring of implantable cardiac defibrillators: a cost-consequence analysis from the TRUST trial. *Heart Rhythm* 2023;20:440–447.