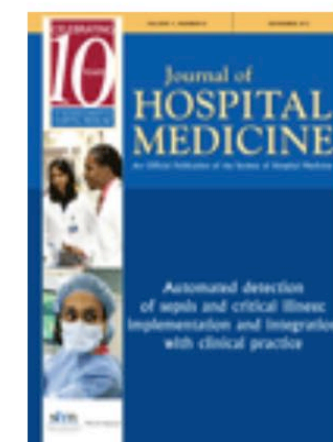


# Advance Alert Monitor Variables

Designed to predict an ICU transfer or unexpected death in the next 12 hours

Laboratory	Vital signs	Patient & hospital factors	Composite indices
Anion gap	Diastolic BP	Age	<b>LAPS2</b> – acute severity of illness
Bicarbonate	Systolic BP	Gender	
Glucose	Heart rate	Care directive	<b>COPS2</b> – chronic comorbidity score
Hematocrit	Oxygen saturation	Length of stay	
Lactate	Respiratory rate	Season	
Blood urea nitrogen	Temperature	Time of day	
Creatinine	Shock index	Admission type	
Sodium	Neurologic status	Hospital facility	
Troponin			
WBC count			

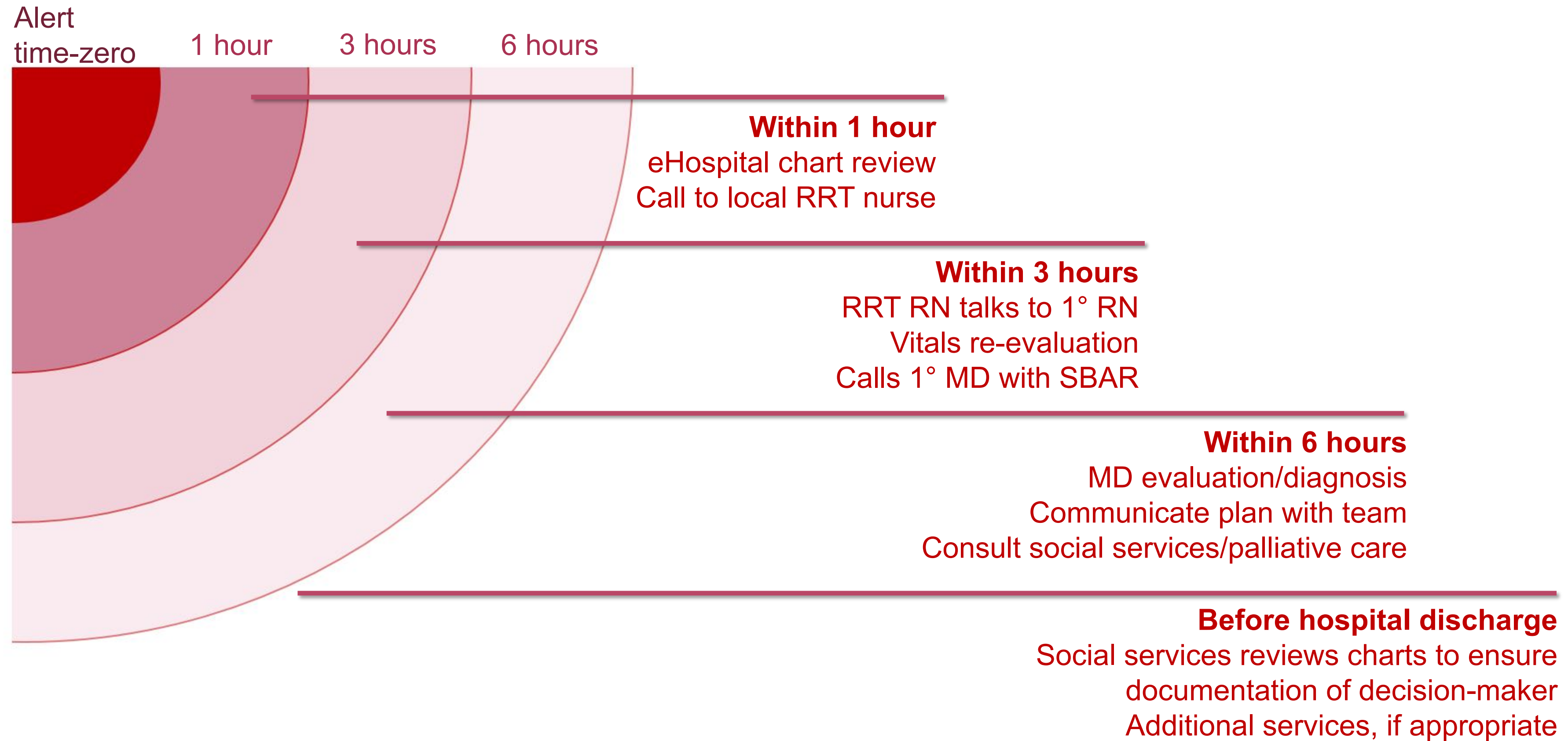
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DIVISION OF RESEARCH



Journal of Hospital Medicine 2017

# Designing integrated clinical response pathways

Establishing standardized processes and timelines for alert response



# Improving AAM patient-provider communication

Helping patients understand how our tools are designed to enhance clinical practice



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## Interim results of AAM Beta Pilots

Deployment based on 1<sup>st</sup>/2<sup>nd</sup> generation EMR-external solution

Matched groups	Alerted Patients in AAM Live Hospitals ( <i>n</i> = 3,097)	Matched Patients in non-AAM Hospitals ( <i>n</i> = 3,097)
Inpatient mortality	8.8%	10.8%
30-day mortality	14.2%	16.4%
Decision-maker documented <sup>1</sup>	76 – 95%	40 – 47%

<sup>1</sup>Data from first 3 medical centers on 2<sup>nd</sup> generation platform between 2016 to 2018



## Roger's Hospital Course – today with AAM

- 6 hours after admission:
  - AAM system alerts
  - RRT RN, bedside RN, and covering MD evaluate Roger
  - Document their assessment with criteria for escalation
- 7 AM the next morning:
  - Oncoming RRT RN conducts proactive AAM follow-up rounds
  - Roger is still confused, with worsened breathing
  - RN requests an arterial blood gas – Roger found to be retaining CO<sub>2</sub>
- 8 AM:
  - Based on the AAM score and her assessment, RRT RN calls the ICU team
  - They agree that Roger would benefit from ICU admission



## Roger's Hospital Course: towards recovery

- In the ICU that day:
  - Roger was sedated, given antibiotics, and placed on BiPAP overnight
- By the next AM:
  - Roger was off BiPAP and sitting with family
  - Imaging showed a psoas abscess
  - IR drained the abscess
- Two days later:
  - Roger recovered and went home



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## A RRT RN's experience of AAM

Thu-Thuy Bui, KP Santa Clara Medical Center

Nurses and doctors are sometimes too busy to keep track of small changes in patients and AAM can pick these up before an RRT...

I want to be able to see the AAM scores directly so we can improve our own screening practice...

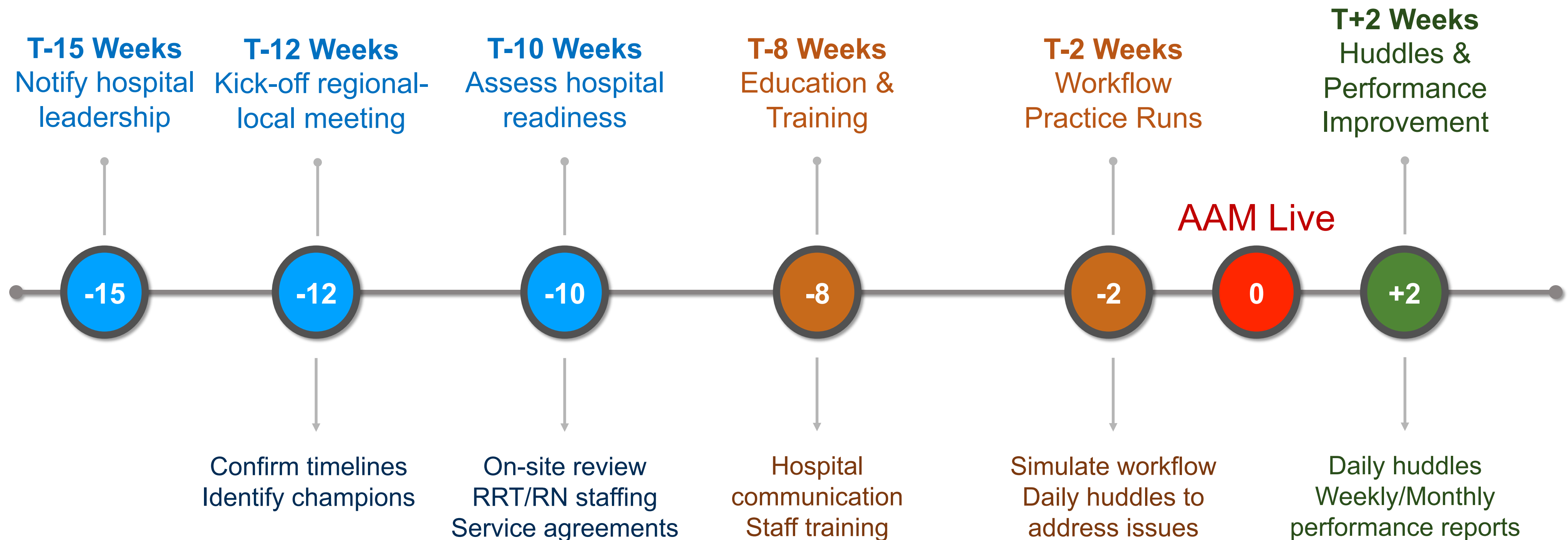
In my experience, about 20% of alerts turn out to be real...

I have so many stories like this of AAM working, where the score helps us to get to patients earlier...



# AAM Regional Spread Approach

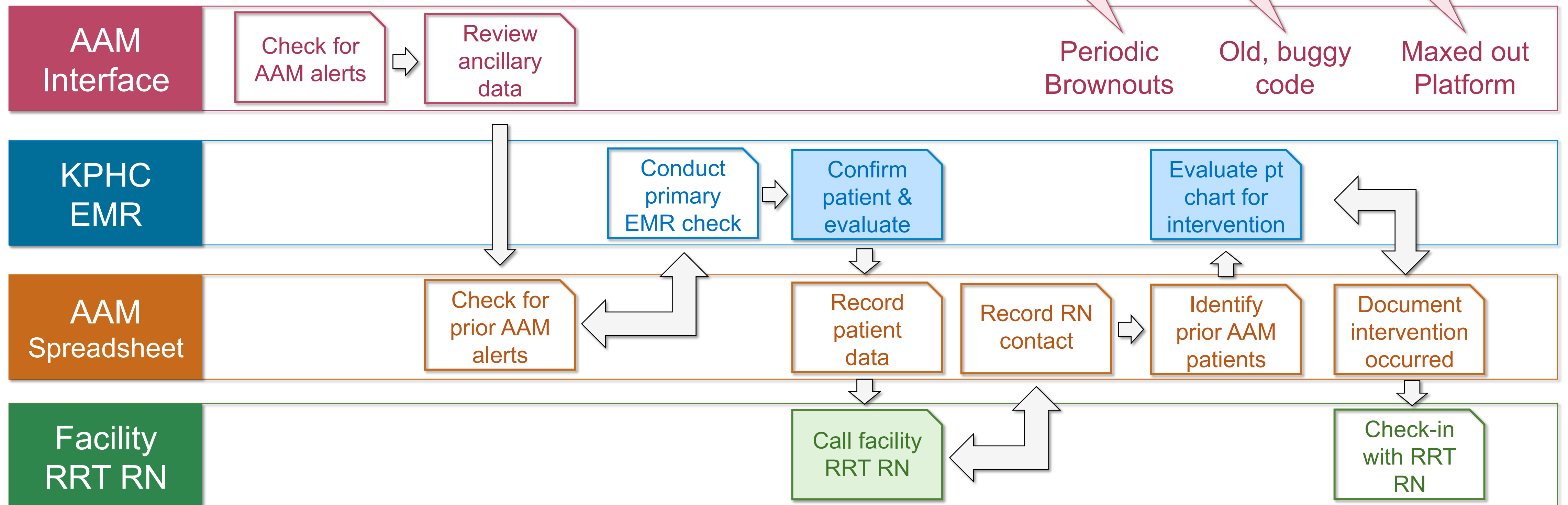
Timelines to prepare local facilities for AAM 'go-live'





# The quest for workflow integration

eHospital staff currently have a highly disrupted workflow



# LAPS2, COPS2, and AAM scores

KPNC-wide real-time risk scoring in production

Score	Metric	C-statistic (Live)	KPHC stored values per day
<b>LAPS2</b>	Acute severity of illness	0.84	~64,000
<b>COPS2</b>	Chronic comorbid disease burden	0.73	~400
<b>AAM</b>	Risk of ICU transfer or unexpected death among inpatients	0.76 <i>(low outcome rate)</i>	~45,000



## Challenges in model validation

Validation step	Example
Translating curated model parameters to real-time data	Lactate values
Simple transcription errors	SBP rules
Limitations to Epic properties	Ratios (shock index) Neuro scores
Timestamp data differences	All subscore values
Lack of decimal places in risk score output	AAM score alert threshold

## Key Takeaways

- The promise of real-time predictive models is exciting
- Explicit conversations between Data and Delivery Science are needed
- Governance is needed to improve all aspects of model value
- The Epic platform offers advantages for integrated model deployment
- However, there are challenges in the platform



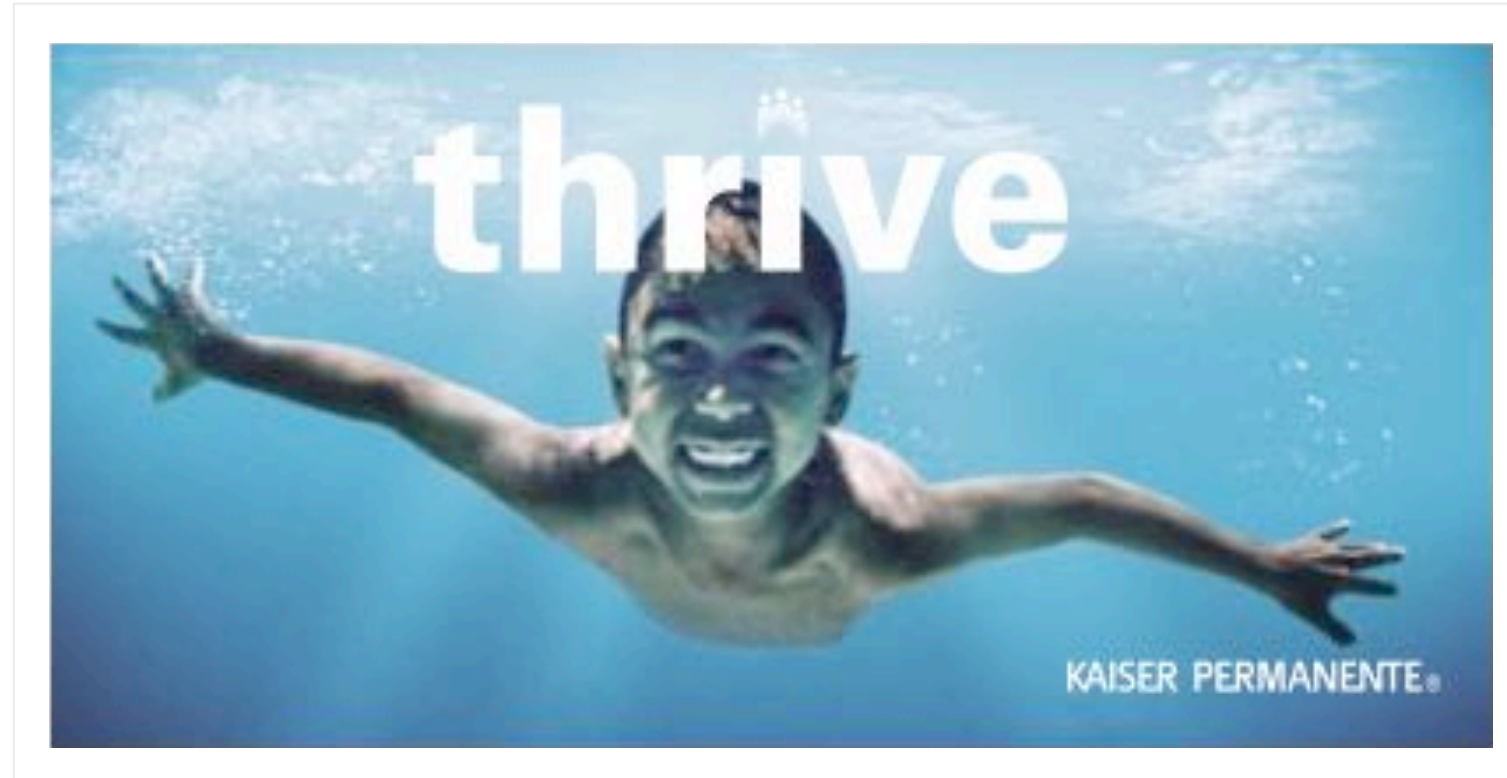
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