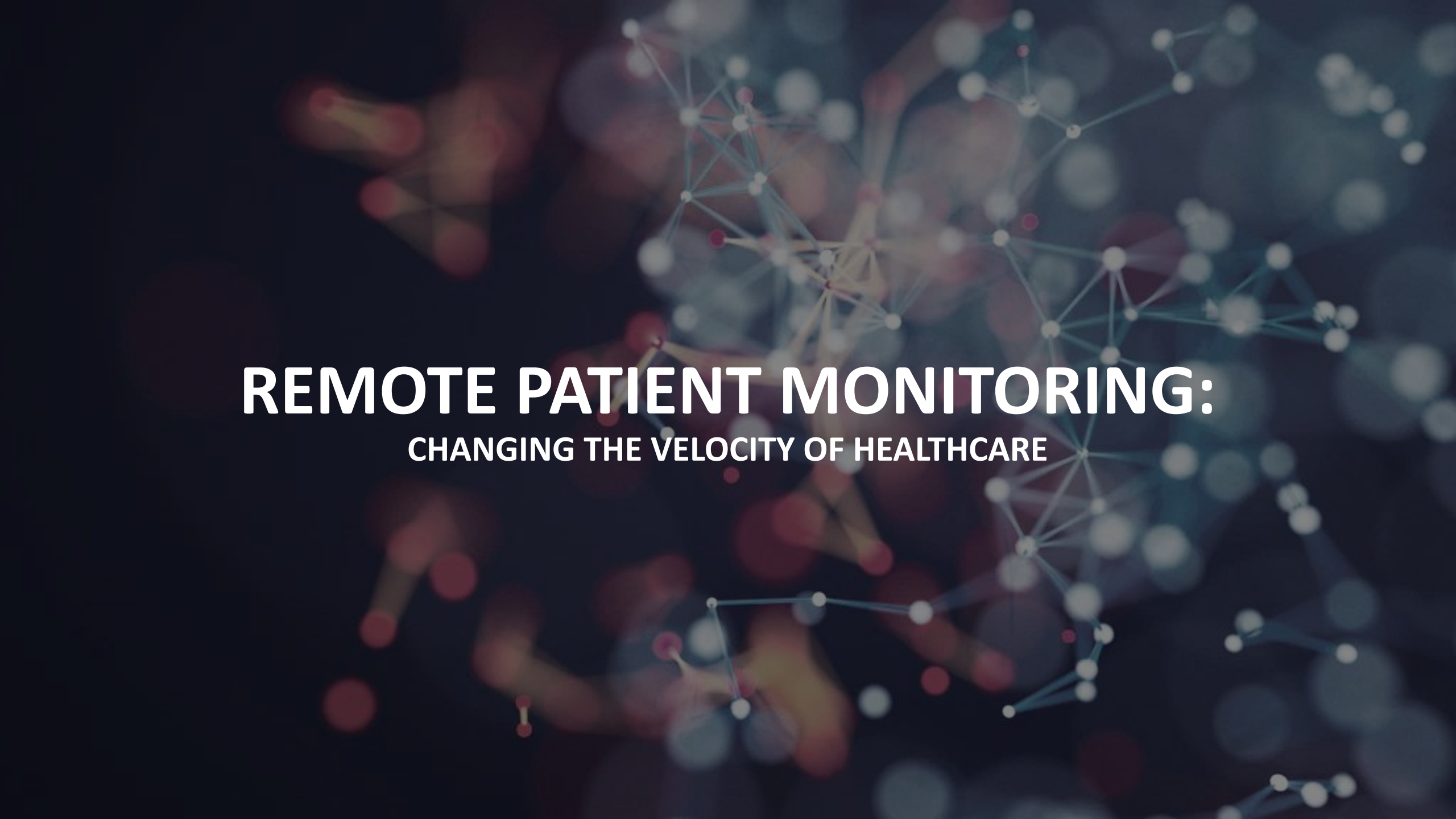


REMOTE PATIENT MONITORING:

CHANGING THE VELOCITY OF HEALTHCARE

DISCLOSURES

I do not have any affiliation with the resources used in this presentation. I do not have a financial relationship with or interest in a commercial entity.



AGENDA

- DEMOGRAPHICS & COLLABORATIVE COMMUNITY PARTNERSHIPS
- TELEHEALTH IN RURAL ND
- PATIENT ENGAGEMENT
- REMOTE PATIENT MONITORING
- DO’S AND DON’TS

COAL COUNTRY COMMUNITY HEALTH CENTER

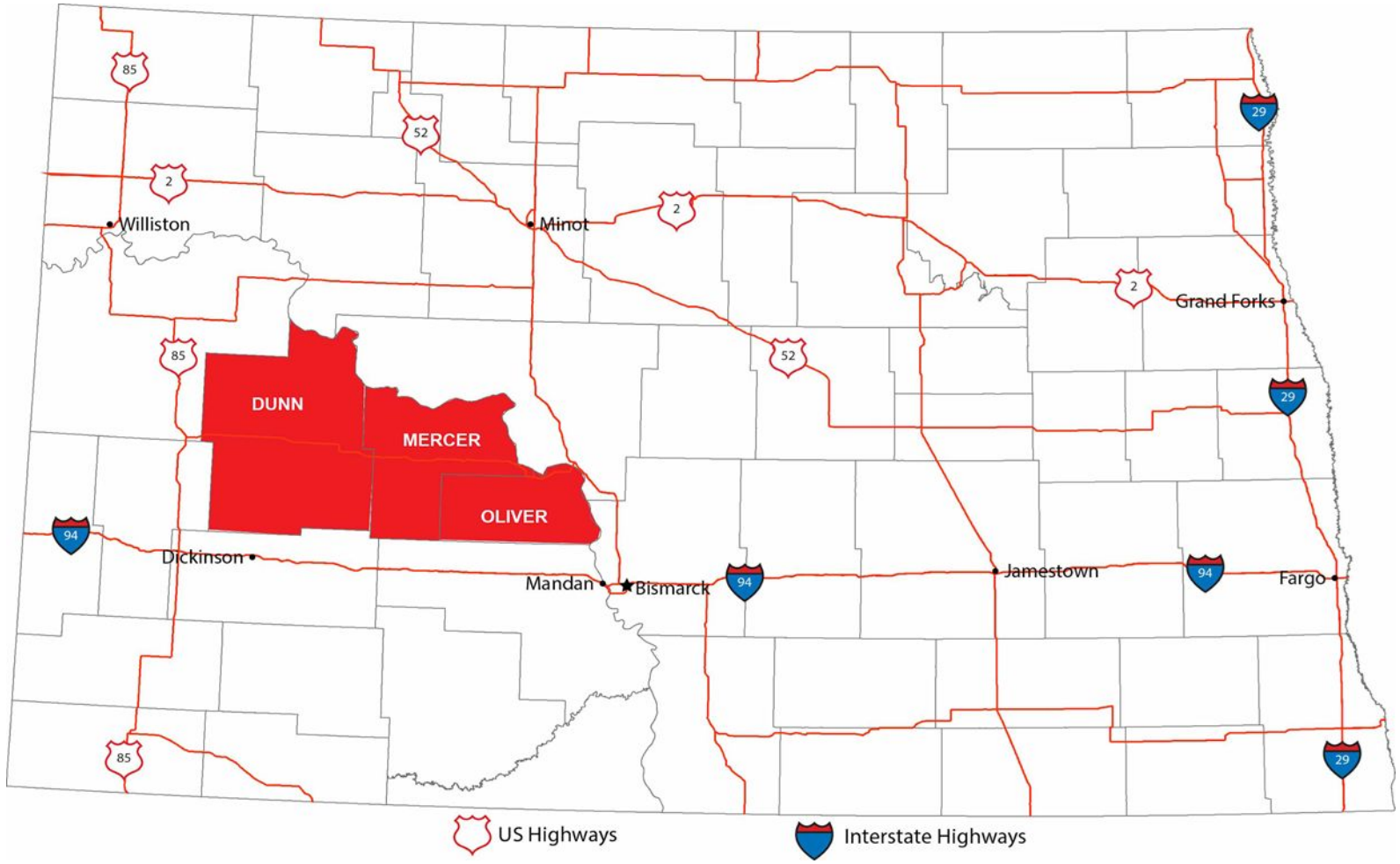
- Became a Federally Qualified Health Center on December 1st, 2003.
- Over 110 employees
- 4 health centers
- School-based clinics



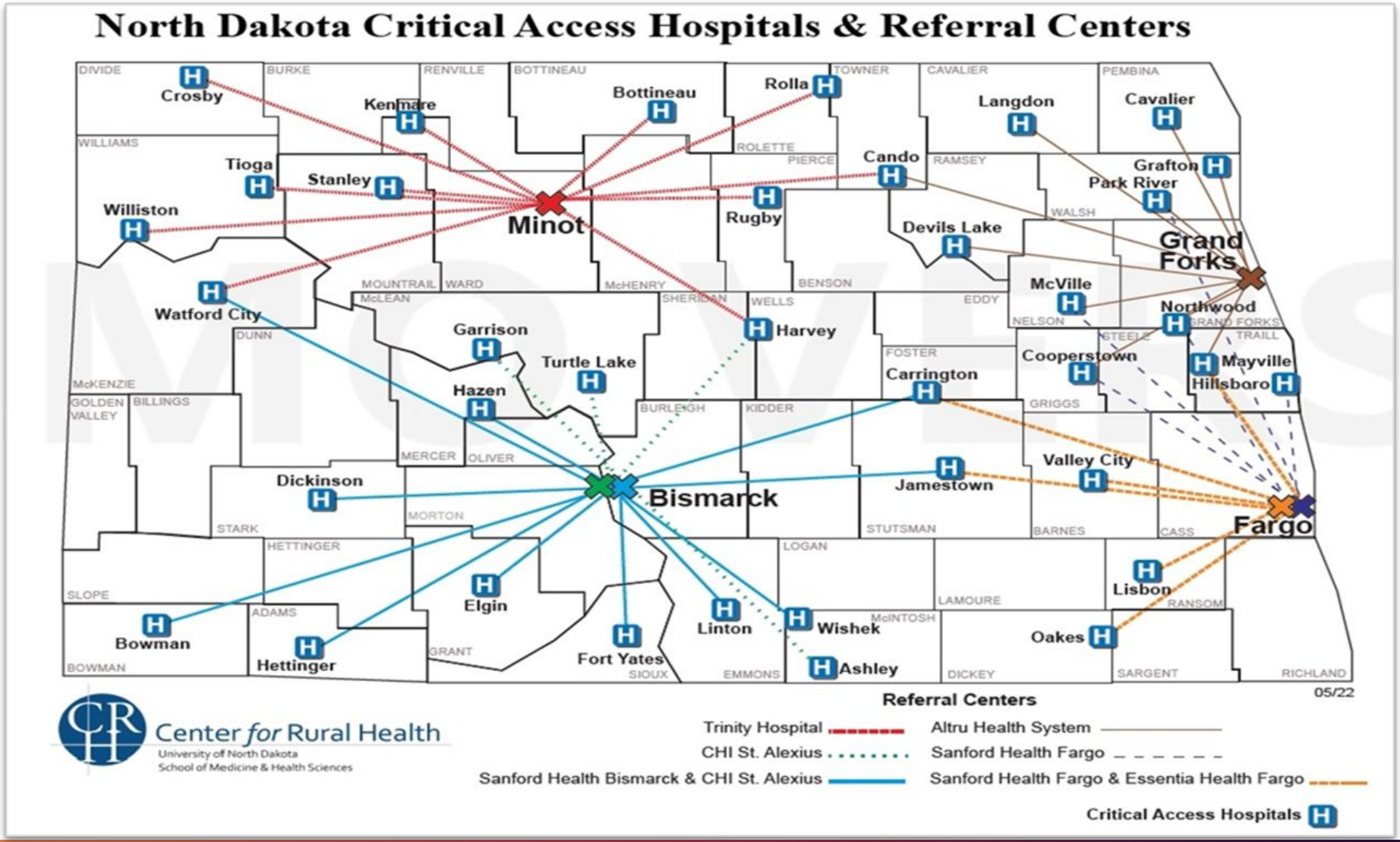
COMMUNITY HEALTH CENTER (CHC) LOCATIONS



COAL COUNTRY COMMUNITY HEALTH CENTER SERVICE AREA



CRITICAL ACCESS HOSPITALS & REFERRAL CENTERS



COLLABORATIVE COMMUNITY PARTNERSHIPS

Coal Country Community Health Center-FQHC

9,188 unique patients in 2023

4,500 square miles of rural/frontier service area



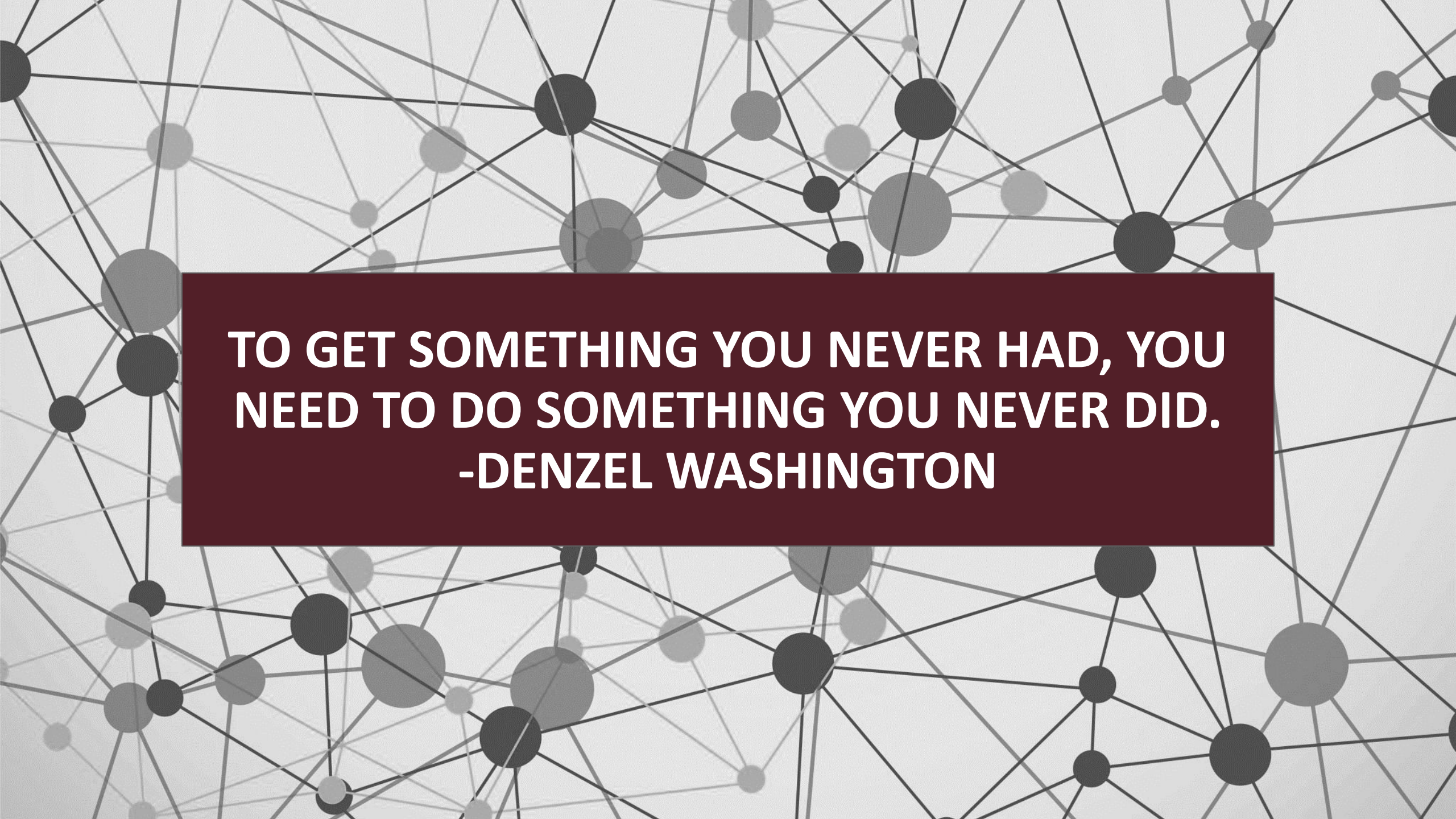
Sakakawea Medical Center
Critical Access Hospital



Knife River Care Center
Long-Term Care

Western Plains PUBLIC HEALTH

Western Plains Public Health Unit


TO GET SOMETHING YOU NEVER HAD, YOU NEED TO DO SOMETHING YOU NEVER DID.
-DENZEL WASHINGTON

PATIENT ENGAGEMENT



PROVIDE CONTINUOUS EDUCATION



OPEN LINE OF COMMUNICATION



FREQUENT FOLLOW UP

PRIMARY GOALS

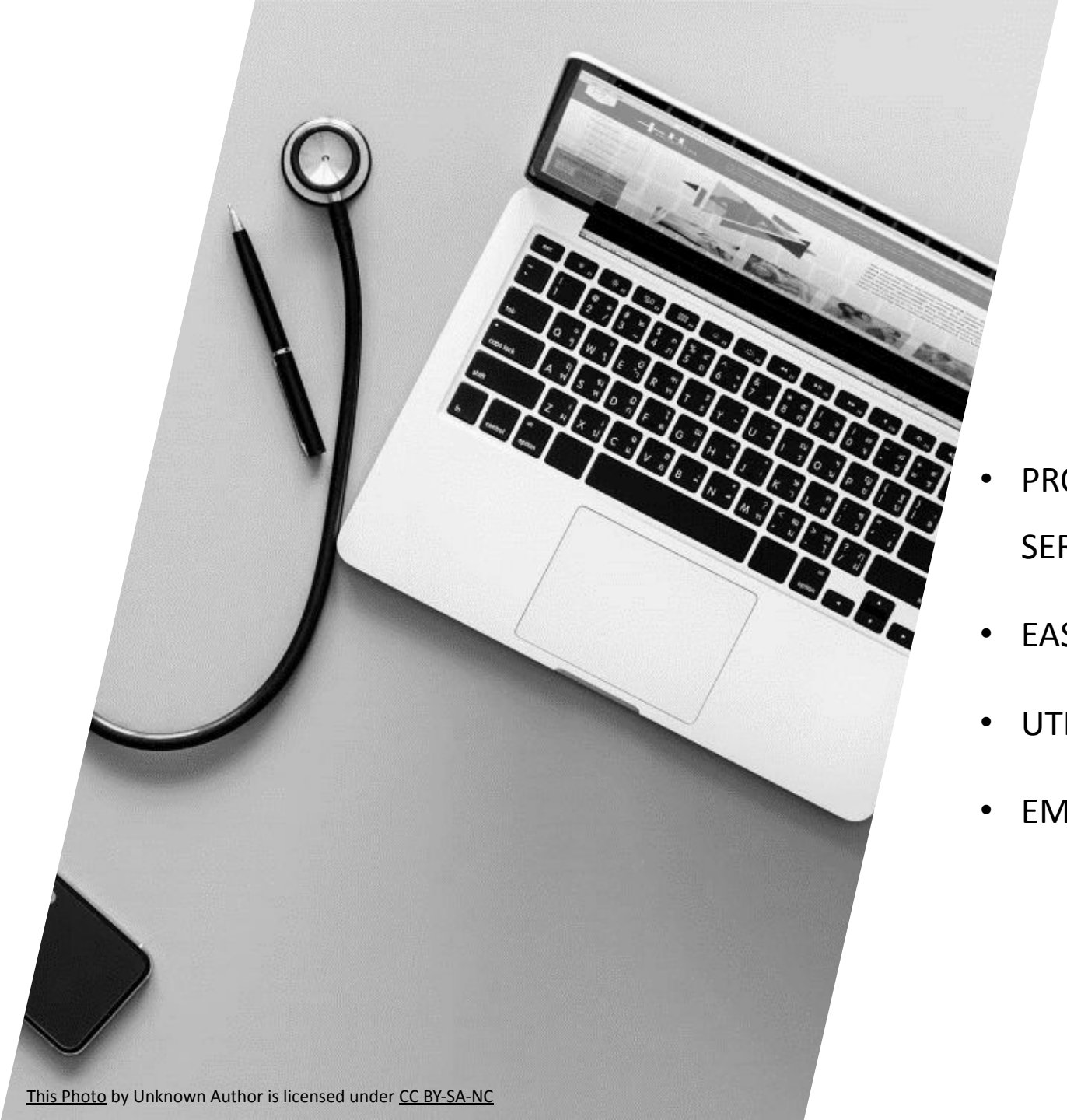
- Controlled hypertension <140/90
- Decrease cost of care for Medicare high-cost utilizers
- Decrease ER visits and admissions related to chronic disease

HOW TO GET STARTED

TELEHEALTH IN RURAL ND



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WISH LIST

- PROVIDE PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES IN THE HOME
- EASY FOR PATIENTS TO USE
- UTILIZE ASYNCHRONOUS TECHNOLOGY
- EMR INTEGRATION

INTERNAL REVIEW



WHERE DO I START?



zoom

tytocare™

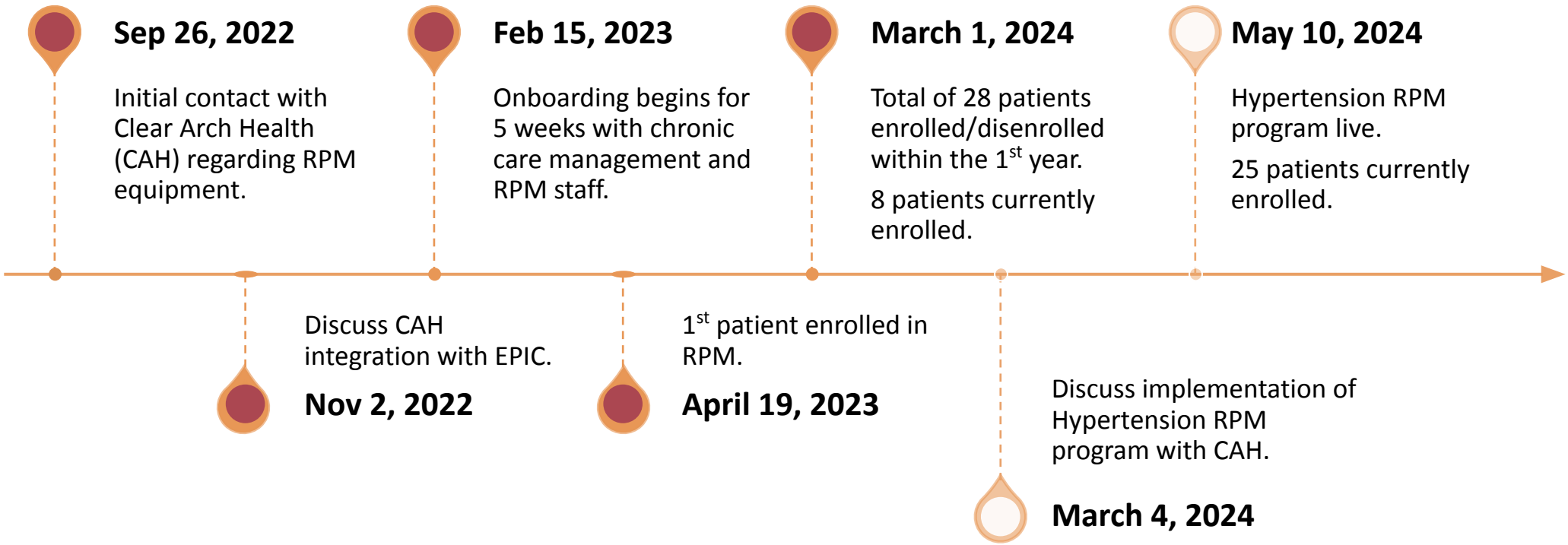
ClearArch Health

HRS Health Recovery Solutions

REMOTE PATIENT MONITORING

FULL SPEED AHEAD

TIMELINE FOR RPM IMPLEMENTATION



Standing Orders for Vital Signs

Vital Sign	Low Parameter	High Parameter	Monitor vitals:
Blood Pressure	Systolic: 90 Diastolic: 40	Systolic: 140 Diastolic: 90	☐ Take vitals daily
Heart Rate	60 bpm	100 bpm	☐ Take vitals twice daily
SPO2	88%		
Weight-from baseline weight	Increase in 2 pounds	Increase in 5 pounds	

Provider Orders for Vital Signs

Vital Sign	Low Parameter	High Parameter	Monitor vitals:
Blood Pressure	Systolic: _____ Diastolic: _____	Systolic: _____ Diastolic: _____	☐ Take vitals daily
Heart Rate	_____bpm	_____ bpm	☐ Take vitals twice daily
SPO2	_____%		
Weight-from baseline weight	Increase in _____pounds	Increase in _____pounds	

☐ I agree with the Standing Orders for Vital Sign parameters for the above patient for remote patient monitoring.

☐ I do not agree with the Standing Orders for Vital Sign parameters. I have indicated the parameters for this patient in the Provider Orders for Vital Signs section.

_____ ____/____/_____

Provider Signature **Date**

_____

Printed Provider

Chronic Care Management RPM Program Guidelines

Inclusion Criteria for Hypertension RPM (All must be true for enrollment):

- ☐ Patient has a current diagnosis of Hypertension, CHF, COPD, or Diabetes.
- ☐ Patient has Medicare for insurance.
- ☐ Patient is enrolled in the CCM program.
- ☐ Patient is not currently hospitalized.

Patient must:

- ☐ Give verbal consent to be enrolled in the Chronic Care Management RPM program.
- ☐ Understand this is a billable service and may be charged if they have a co-insurance.
- ☐ Take vital signs daily or twice daily per provider order.
- ☐ Follow up with the provider in 1 month from RPM enrollment.
  - Date of appointment: ____/____/_____
- ☐ Follow up with the provider in 4 months from RPM enrollment.
  - Date of appointment: ____/____/_____
- ☐ Return **ALL** remote patient monitoring equipment back to CCCHC at time of dis-enrollment.
  - If equipment is damaged or lost, the patient may be responsible for the cost of equipment.

Program Specifications:

- ☐ Patient will be shown how to use the RPM equipment while in the office or by CCM staff.
- ☐ Once the patient is enrolled in the program, the nurse will request an RPM kit to be mailed to the Home Health and Hospice building in the LifeStream Clear Arch Health platform.
- ☐ The patient will be disenrolled from the Chronic Care Management RPM program if they use the equipment less than 16 out of 30 days a month.
- ☐ Disenrollment by CCM staff must take place during the 3rd week of the month to avoid additional charges.

Documentation:

- ☐ If the patient's BP is out of range more than 4 consecutive days, the nurse will contact the PCP for direction on updating the plan of care and make any necessary medication changes.
- ☐ The nurse will validate vital signs and use the timer in the LifeStream Clear Arch Health platform that will sync into EPIC under the Synopsis-Remote Monitoring Vitals tab.
- ☐ Patient must have data for RPM 16 out 30 days to bill for RPM services.
- ☐ Staff must document 20 minutes of care management time per month in a patient outreach encounter to bill for RPM services.

Classic Model-HTN Program





Touch Tablet Model-CCM Program



Clear Arch Touch Tablet



Blood Pressure Monitor and Cuff



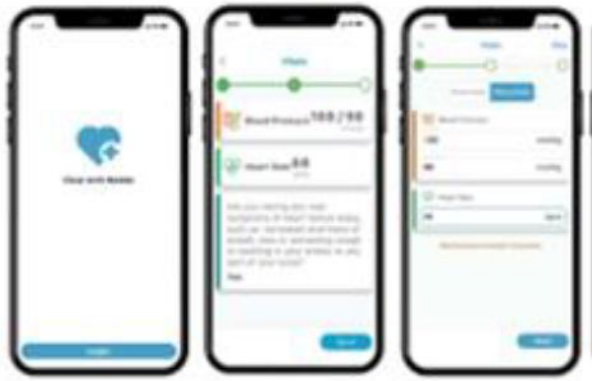
Pusle Oximeter



Standard Weight Scale

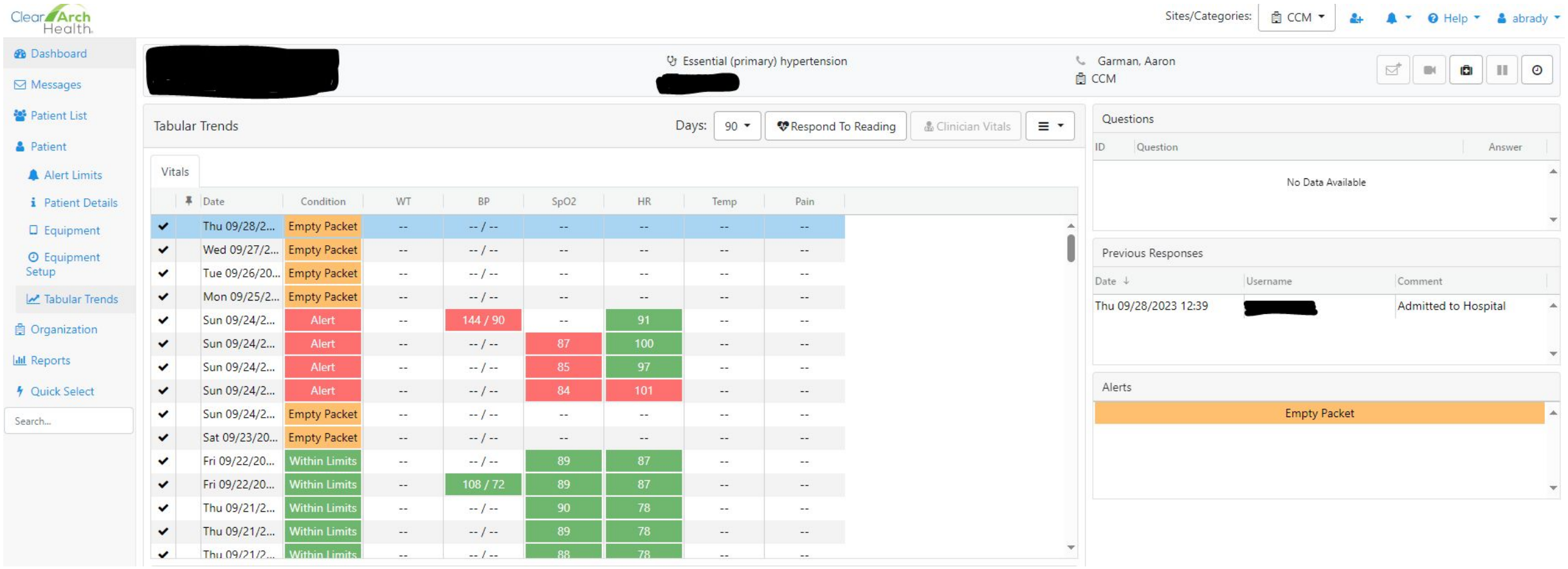
Bariatric Scale Available

Mobile App Option

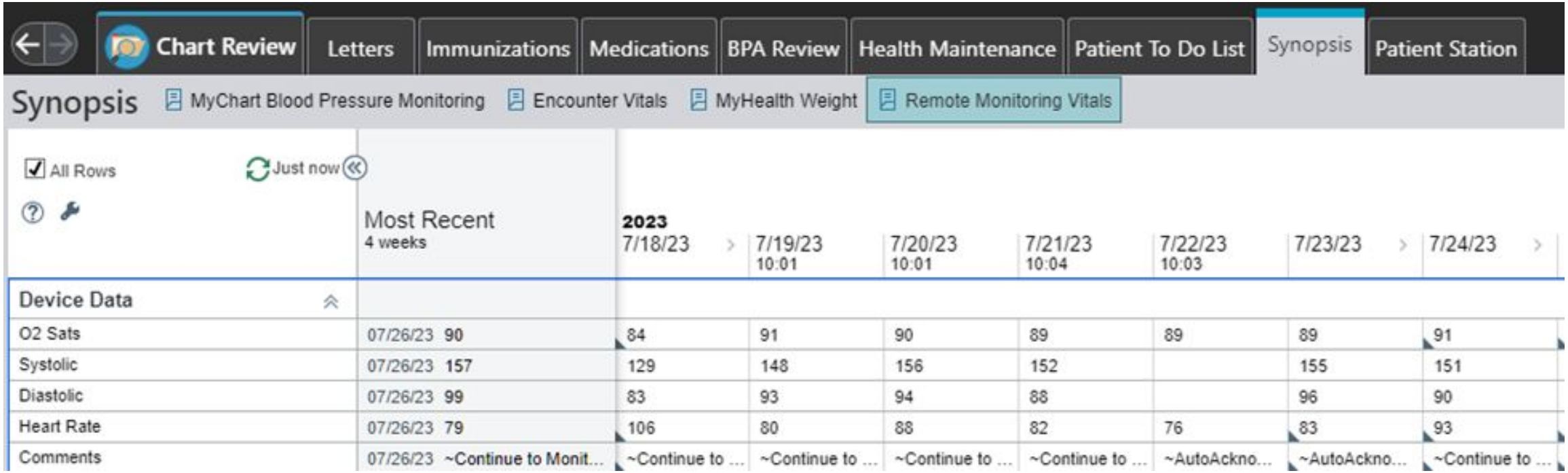




LIFESTREAM DASHBOARD



DATA VALIDATION



DO'S & DON'TS

DO

- Research different telehealth and RPM vendors
- Utilize asynchronous technology
- Have a realistic implementation timeline
- Find a motivated team to promote the program
- Get staff buy in
- Market your services
- Educate patients about the benefits of telehealth and RPM

DON'T

- Assume patients and staff know what RPM is
- Assume everyone wants to implement a new program
- Assume patients will utilize your RPM and telehealth services because you are their PCP
- Assume self reported data is accurate data

THANK YOU!

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