2020 NRTRC TAO VIRTUAL CONFERENCE

Northwest Regional Telehealth Resource Center and the Telehealth Alliance of Oregon

Welcome You

Bronze Sponsors:

zoom WGU poly

Exhibitors:

amwell SimpleVisit Telehealth Made Simple.

Non-profit:

Pacific Northwest University of Health Sciences

University of Utah Health Clinical Neuroscience

VIRTUAL SESSION INSTRUCTIONS

- Audio and video are muted for all participants
- Use the Q&A feature to ask questions
- Moderator will read questions to the speaker
- Presentation slides are posted at https://nrtrc.org/sessions. Recordings will be posted after the conference.

Remote Patient Monitoring Workshop

- Moderator: Matt McCullough
- Presenter:
  - Bonnie Britton, Board Advisor and Consultant for the Mid Atlantic Telehealth Resource Center (MATRC) and Executive Director, Reconnect 4 Health

Expert Care. Proven Solutions.

NRTRC TAO Virtual Remote Patient Monitoring

Bonnie Britton *MSN, RN, ATA Fellow*

CO-FOUNDER & EXECUTIVE DIRECTOR

Reconnect4Health.com

Presentation Goals

At the end of the session, participants will be able to:

- **Discuss use cases for Remote Patient Monitoring (RPM)**
- **Identify RPM Conceptual Models**
- **Explore RPM technologies**
- **Articulate CMS's RPM Reimbursement**

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Remote Patient Monitoring

Patients collect bio-metric data remotely & data is electronically transmitted for review.

Patient bio-metric data includes:

- **Weight**
- **Blood Pressure**
- **Heart Rate**
- **Pulse Oximetry**
- **Glucometer**

Patients with chronic condition(s).

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Critical Components Of RPM

Identify Use Cases

Develop Conceptual Model

Develop Clinical Workflows

ROI/Scalability

Technology

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RPM Use Case Goals

Hospital & Health Systems

- Reduce < 30-day hospital readmissions
- Reduce ED usage
- Lower health care costs
- Decompress hospitals during Pandemic

Home Health

- Reduce < 30-day hospital readmissions
- Increase revenue by including RPM in annual cost report

Nursing Homes

- Reduce < 30-day hospital readmissions
- Reduce ambulance transfers

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RPM Use Case Goals

PCP Clinics

- Increase CMS reimbursement
- Increase in MACRA and MIPS scores
- Decrease in clinic visits during the pandemic

Health Plans

- Lower expenditures

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RPM Patient Populations

- Cardiovascular Disease
  - HTN
  - HF
  - Post CABG
  - MI
- Pulmonary Disease
  - COPD
  - Asthma
  - Pneumonia
- Kidney Disease
- Diabetes
- COVID-19

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RPM Patient Locations

Home

Nursing Home

Assisted Living Facility

Group Homes

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Inclusion & Exclusion Criteria

Inclusion Criteria

Recommend opt out approach

All patients will receive unless they are excluded

Exclusion Criteria:

Unable to transmit data

Unable to learn how to use devices

Unwilling &/or unable to communicate with HC Team

Unsafe environment

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Develop Conceptual Model

Device management

- Inventory
- Storage
- Pulling devices
- Refurbishing devices

Installation Options

- In home installation, training, and competency validation
- In clinic or in-hospital training
- Outsource to 3rd party

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Develop Conceptual Model

RPM Monitoring

Insource

Outsource

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RPM Conceptual Model Examples

Health System Examples

1

- Insource device management & installation
- Outsource RPM Clinical Services

2

- Insource device management & installation
- Insource RPM Clinical Services

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Patient Identification, Enrollment, & Referral Workflow

Who is the best person(s) to identify patients?

Who is the best person to meet/call the patient and explain the program and obtain verbal consent?

Who is the best person to refer the patient?

Who is the best person to enter patient information into RPM software?

Who is the best person to identify devices needed?

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Patient Installation & Education Workflow

Patient Installation & Education Workflow

Obtain written authorization

Provide educational sheet on proper data collection technique

Demonstrate how to use devices

Patient collects 2 sets of readings per device

Patient signs Competency Validation Form

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Alert Review, Assessment, & Education Workflow

Monitor bio-metric data M-F

Respond to alerts:

With-in 4 hours or next business day

Call patients with alerts

Validate accuracy of alerts

If alert is not accurate:

Instruct patient on device technique

Instruct patient to recheck readings

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Alert Review, Assessment, & Education Workflow

When alerts are valid, a RN will:

Conduct a nursing assessment

Utilize "See Feel Change" Methodology to create long-term behavior change

Provide patient education:

- Nutrition
- Medications
- Activity
- Symptom Management

Escalate useful actionable data

Document each encounter

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Devices

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Weight Scale

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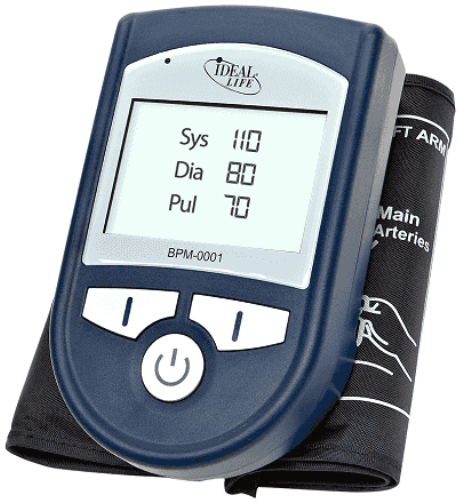
BP & HR Monitor



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Glucose Meter

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Pulse Oximeter

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RPM Medicare CPT Code 99453

Remote monitoring of physiologic parameters:

Initial set up

Patient education on equipment use

Can be billed after 16 days of monitoring

Average Reimbursement: $21

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RPM Medicare CPT Code 99454

Remote monitoring of physiologic parameters:

Device supply with daily readings or programmed alerts transmission, each 30 days.

Can be billed after 16 days of data collection and transmission.

Average Reimbursement: $ 69 PPPM

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RPM Medicare CPT Code 99457

Remote physiologic monitoring treatment management services:

20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month

Average Reimbursement: $ 54 PPPM

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RPM Medicare CPT Code 99458

Remote physiologic monitoring treatment management services:

Additional 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month

Reimbursement: $ 54 PPPM

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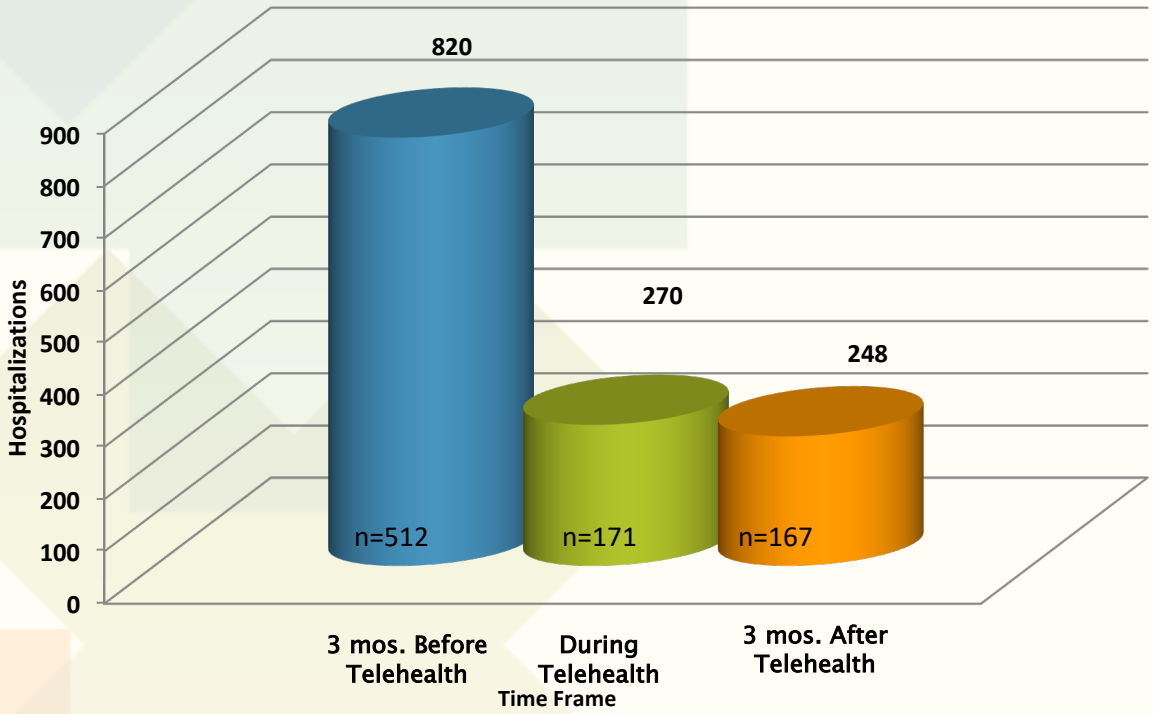
Year 1
Vidant Health Hospital Admissions
Total Telehealth Patients = 683



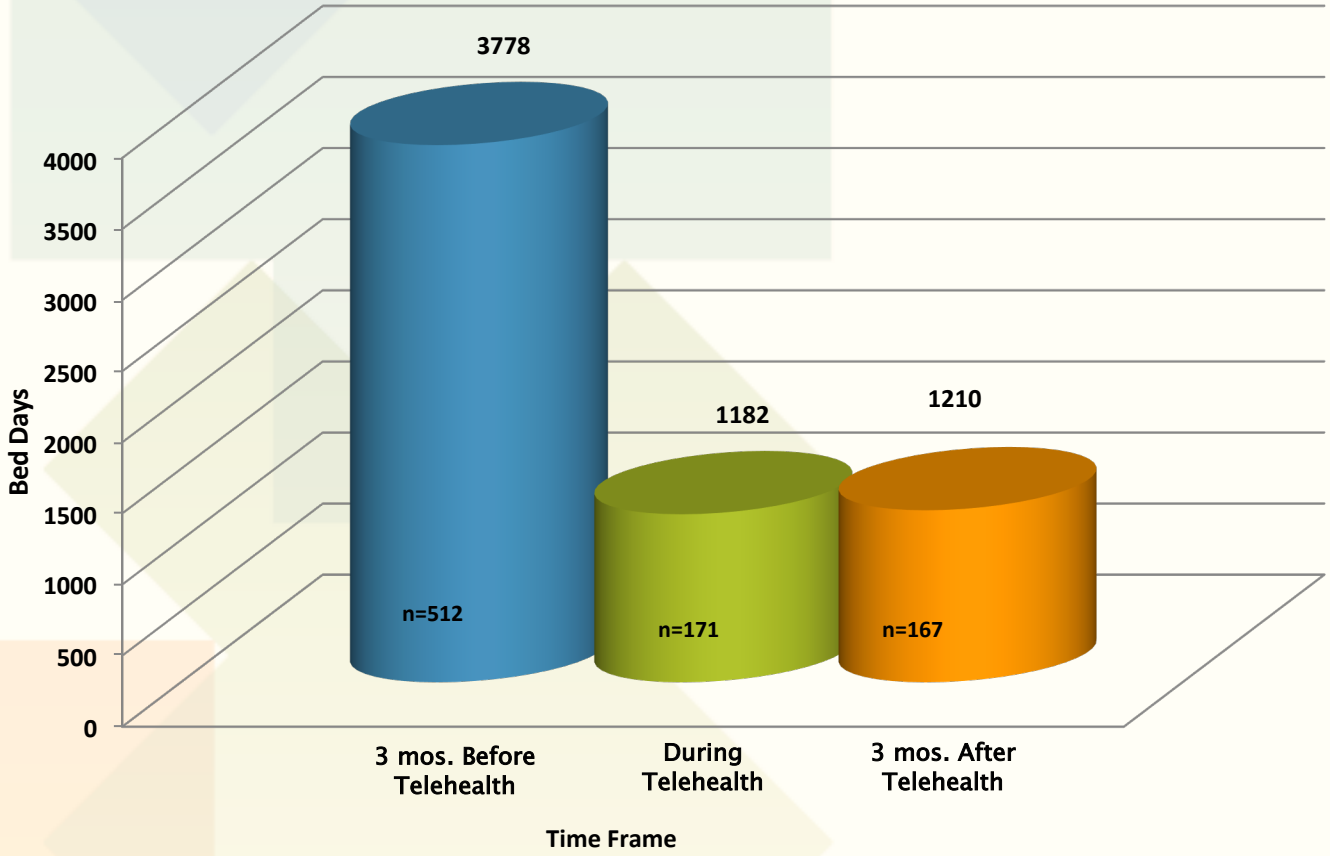
Hospitalizations decreased by 67% during Telehealth

Discharged Patients from February 1, 2012 - January 31, 2013

Some patients were counted in multiple time frames.

Year 1
Vidant Health Hospital Bed Days

Total Telehealth Patients = 683

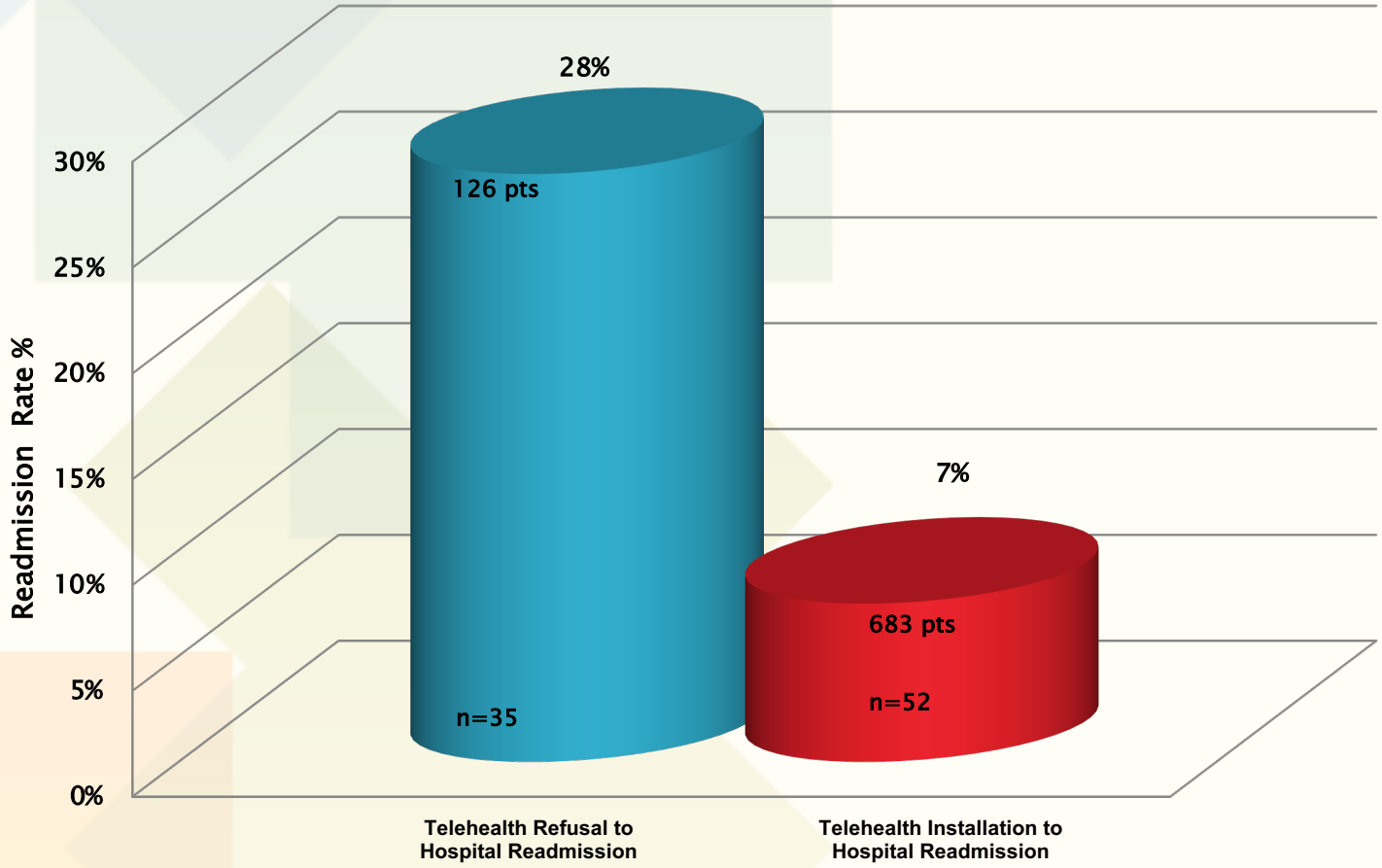


Bed days decreased by 68% during Telehealth.

Discharged Patients from February 1, 2012 - January 31, 2013

Some patients were counted in multiple time frames.

Vidant Health's < 30 DAY Heart Failure READMISSION RATES



Discharged Patients from February 1, 2012 - January 31, 2013

Rural Health System Outcomes

Patients who participated in RPM experienced:

- Decreased IP cost during the 1st 30-days on RPM compared to 30 days prior to RPM
  - Org. #1- **80%** reduction in < 30 day IP readmission costs
  - Org. #2- **61%** reduction in < 30 day IP readmission costs
  - Org. #3- **78%** reduction in < 30 day IP readmission costs

- **Total IP Cost reduction $253,268**
- **76% reduction in costs during RPM compared to before RPM**

Patient who refused RPM experienced:

- **0 – 57% reduction in < 30-day IP readmissions**
- **32% reduction in costs 30 days after refusal compared to prior**
- **Financial losses $15,617**

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Questions

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Contact Information

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