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ADVANCING INTEGRATED HEALTHCARE

Advancing Team Based Telehealth in RI Webinar Series:

"Virtual Care & Patient Self-Monitoring Tools – strategies for RI adult primary care practices"

Care Transformation Collaborative of R.I.

JUNE 29, 2021

What we learned from Practice Assessment & Patient Surveys

UnitedHealthcare Telehealth Project:
47 Practices completed Practice Assessment; Over 900 Patient Surveys

Top 4 things to improve telehealth: Patient education, better workflows, improved internet in community, staff training

Top topics Webinar Series – Remote Patient Monitoring: 1. Selecting RPM Equipment, 2. Integration into EHR, 3. Coding, Billing and Reimbursement (Medicaid, Medicare, Commercial)

Top 4 visits types: Sick visits, medication management, COVID concerns and routine follow up for chronic conditions

Challenges to patients using RPM: Technological savvy of patients, patient understanding, funding and resources

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Patient Comments from the Telehealth Needs Assessment

Do you have any other comments about your telehealth visit?
Would you be willing to have a telehealth visit in the future?

[I wouldn't agree to another telehealth visit because I] can't have a Physical exam over the phone!

I would rather have phone/video visit due to having to take bus to office

I wish that my doctor could do video visits since they can see conditions that would require photos or visuals to see

I would like there to be some type of way to have the nurse come and do vitals

[I would like] basic temperature, ear nose and eye check, blood pressure measurement. Maybe somehow to complete physical. Only piece that was missing

Organizations/Presenters:

East Bay Community Action Program (EBCAP):

Sarah Reinstein, MPH, Quality Improvement Project Manager, EBCAP

Carol Falcone, RN, Nurse Care Manager, EBCAP

Healthcentric Advisors (HCA):

Lauren Capizzo, MBA, PCMH CCE, Director, Practice Transformation, HCA

Brenda Jenkins, RN, D.Ay., CDOE, CPEHR, PCMH CCE, Senior Program Administrator, HCA

Reid Plimpton, MPH, Project Manager, Northeast Telehealth Resource Center (NETRC)

NORTHEAST TELEHEALTH RESOURCE CENTER
A program of MCD Public Health

east bay community action program
THE BRIDGE to SELF-RELIANCE

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Northeast Telehealth Resource Center

MCD

MCD Public Health MCDI

MEDICAL CARE DEVELOPMENT, INC.

THE University of Vermont MEDICAL CENTER

NATIONAL CONSORTIUM OF TELEHEALTH RESOURCE CENTERS

NETRC is made possible by grants G22RH30352 and GA5RH37459 from the Federal Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.

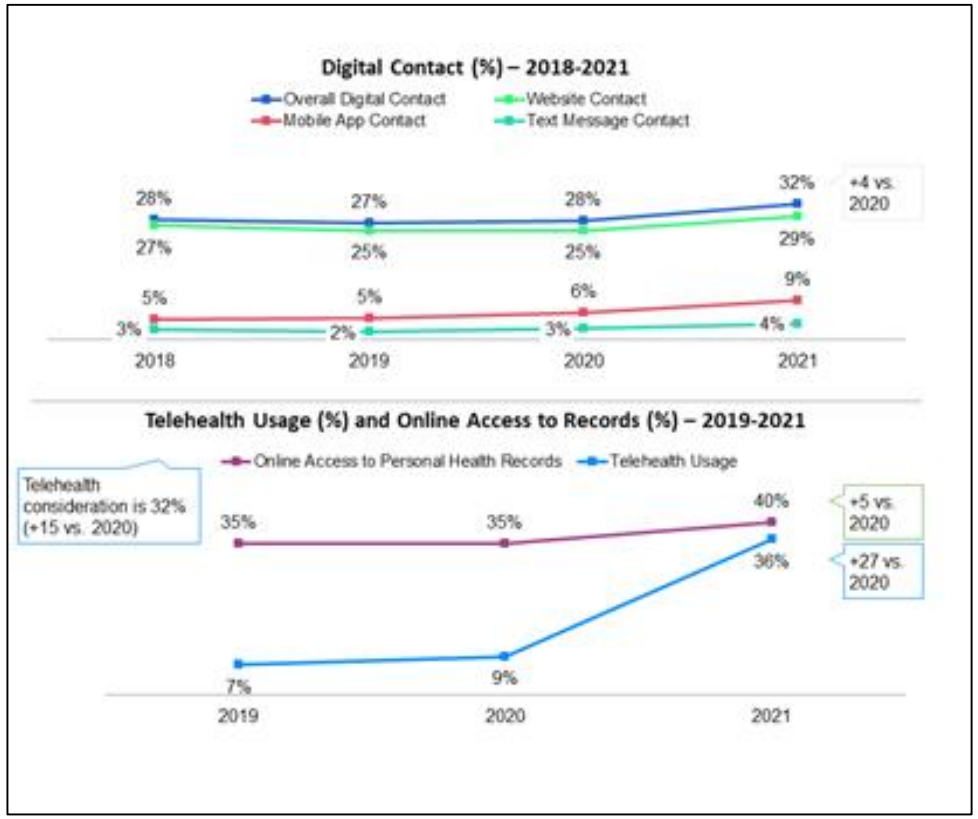
About Us:

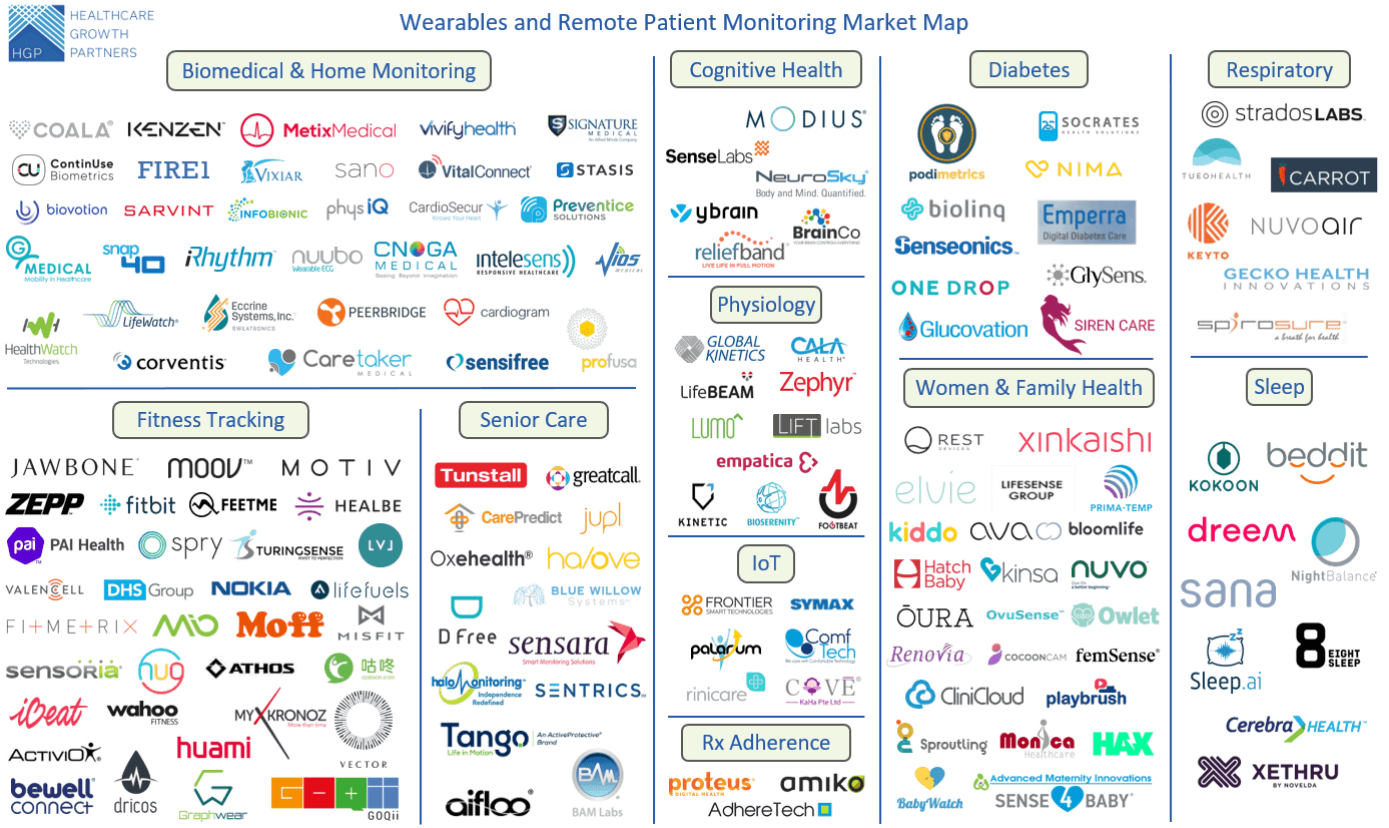
NETRC aims to increase access to quality health care services for rural and medically underserved populations through telehealth. We serve New England and New York, and are a proud member of the National Consortium of Telehealth Resource Centers.

Disclaimer:

- Any information provided by NETRC is for educational purposes only and should not be regarded as legal advice.
- Neither NETRC nor I (Reid) have any financial interest, arrangement, or affiliation with any organizations related to commercial products or services discussed in this webinar.

Brief Exploration of the Tech Market for Wearables and RPM Devices





EBCAP

Background:

September 2020: EBCAP applied for and was accepted to the National Association of Community Health Center (NACHC)'s "Leading Change: Transforming At-Home Care" pilot program.

- Goal: To improve patient health outcomes and care team communication through use of Remote Patient Monitoring (RPM) tools combined with Nurse Care Manager virtual visits
  - Care Kits contained BP monitor, HbA1c meter, digital scale, iFOB test, thermometer

- Method:
  - Use risk stratification to identify and enroll up to 20 patients:
    - ✓Current patient
    - ✓Age 50-75
    - ✓At least two chronic condition diagnoses, one of must which be diabetes
    - ✓Focus on care managed patients – utilized Nurse Care Manager (NCM) connections to recruit and enroll patients
  - Patients received At-Home Care Kits with patient education on how to use and record measurements
  - Monthly virtual visits to allow nurse to observe measurements and provide support and answer questions

Process

Planning

- NCMs provide Care Kits to patients at initial visit
- Patient education on program expectations, how to use RPM tools, and how to record measurements
- Collect baseline measurements (clinical data and Social Determinants of Health)

Month 1

- NCMs provide Care Kits to patients at initial visit
- Patient education on program expectations, how to use RPM tools, and how to record measurements
- Collect baseline measurements (clinical data and Social Determinants of Health)

Months 2-5

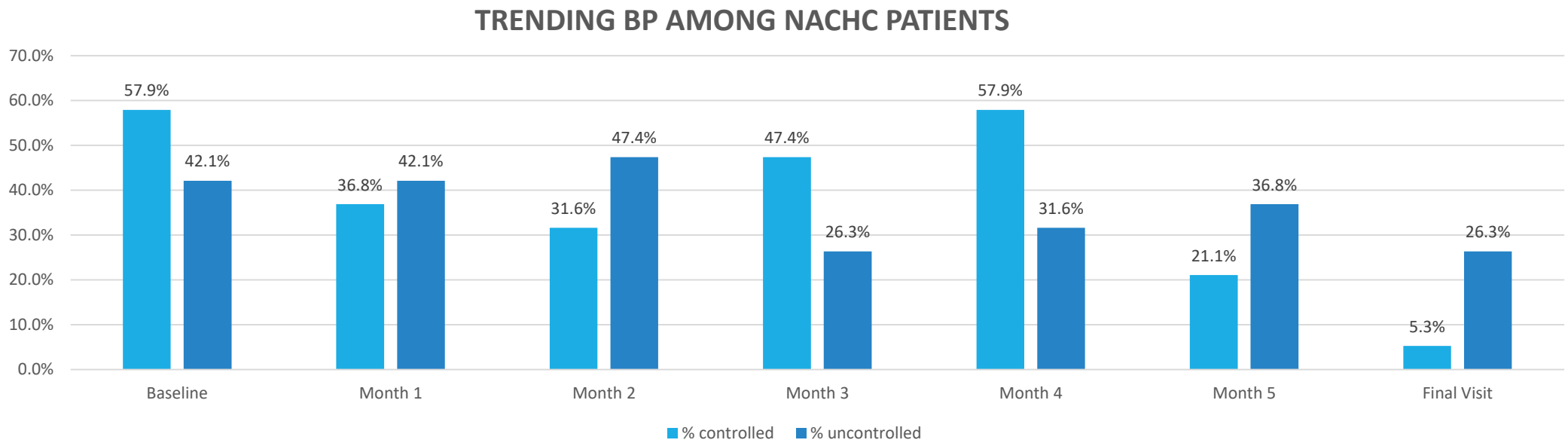
- NCMs conduct monthly virtual visits to observe measurements and provide support
- Monthly peer exchange meetings and internal staff huddles
- Monthly data submission to NACHC project team
- Incentives at halfway point (Month 3) – gift cards and groceries

Month 6

- Collect final measurements
- Final data submission to NACHC project team
- Incentives for program completion – gift cards

Findings

- 17 EBCAP patients completed the program.
- Most data collected did not reflect significant trends in either direction.
- Blood pressure showed the most promising results.



Findings (cont'd)

- The program allowed for increased communication with the patient and there were opportunities to intervene and prevent unnecessary ED visits.
- Providing a means for patients who are part of a vulnerable population to stay in communication with their team was especially important during a public health emergency such as the COVID-19 pandemic.
- Despite the lack of strong trending data, RPM tools combined with virtual visits are vital to improving patient outcomes and communication between the patient and their care team.
- We are optimistic that due to the education nurses provided to patients, along with the patients being able to keep these RPM tools, we will see some positive trends in these measures by the end of the year.

An Example of Patient Success

- 57-year-old female
  - History of diabetes, hypertension, COPD, atrial fibrillation, anxiety and depression, ETOH abuse
  - Known history of multiple hospitalizations related to diabetes control
- Baseline visit: 1/11/2021
  - HbA1c at baseline: **11.1%**
- Final visit: 6/18/2021
  - HbA1c at final visit: **5.0%**
- Patient has avoided ED use since entering the program in January 2021
- Support provided by NCM and participation in program has had psychosocial benefits as well

What worked?

- The nurses were in regular communication with patients between virtual visits to offer encouragement and answer questions
  - This was especially important during the beginning of the program, when participants were expected to take measurements more frequently.
- Offering incentives at the halfway and completion points
- Monthly internal huddles with care team
  - Opportunities to collaborate on strategies, share feedback, troubleshoot issues, and communicate updates from NACHC project staff
- Utilizing the care management team's established relationships with patient population

What didn’t work?

- Program expectations at beginning of program
  - Participants were expected to take BP readings up to four times daily for the first week of the program, along with weekly weight and temperature readings for the first month.
  - Some patients left the program because they felt it was overwhelming and could not continue under the program’s expectations.
- Telehealth issues
  - Limited number of telehealth licenses available for clinical staff – audio only
- Equipment issues
  - Limited blood pressure cuff size availability, which also limited program participation
  - A1c meter often gave inaccurate readings

Implications for Future Telehealth/RPM Programs

- Data collection expectations should be realistic, especially at the beginning of the program.
  - What can patients realistically commit to?
- Equipment should be as user friendly and inclusive as possible
  - Size XL blood pressure cuffs
  - RPM tools that require little effort from patient
    - E.g., cellular-enabled blood pressure monitor that automatically transmits readings to the care team and does not require patient to record measurements
- System improvements
  - Ensuring there are sufficient resources (e.g., telehealth platform licenses) available to clinical staff
  - Increased involvement from senior health leadership and patient's primary care provider

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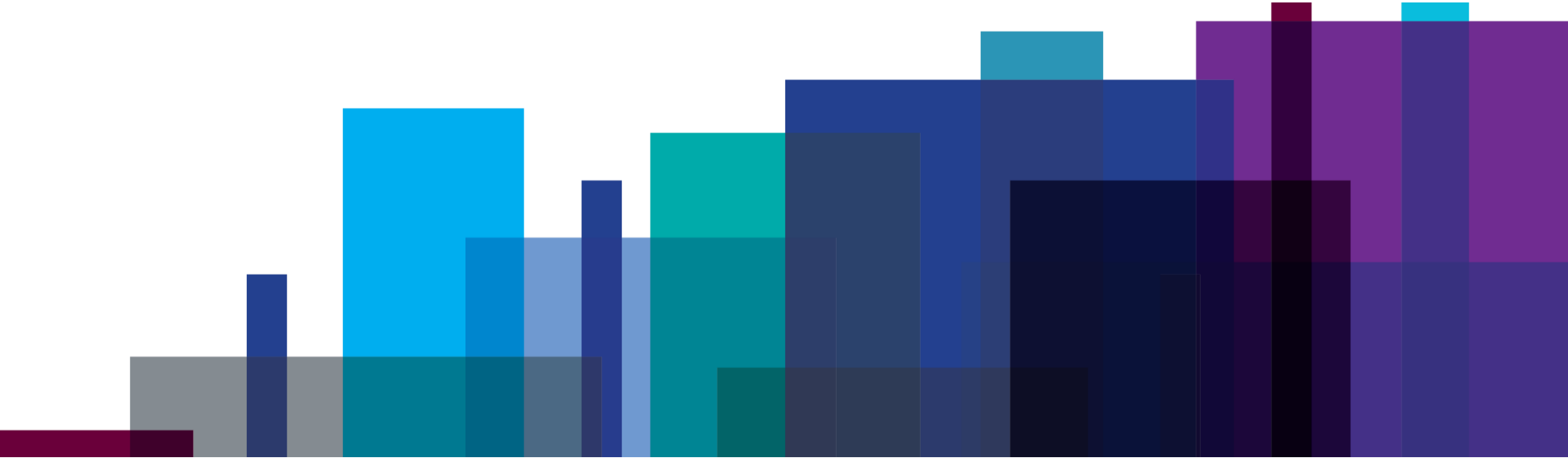
Remote Patient Monitoring

Digital Solutions for Health Care Today



Healthcentric Advisors' Solutions for RPM and Digital Health

Strategies for practices to engage high-risk patients for positive outcomes

Patient outcomes, feedback and case study data from RI practices and patients

New services and features to be offered soon

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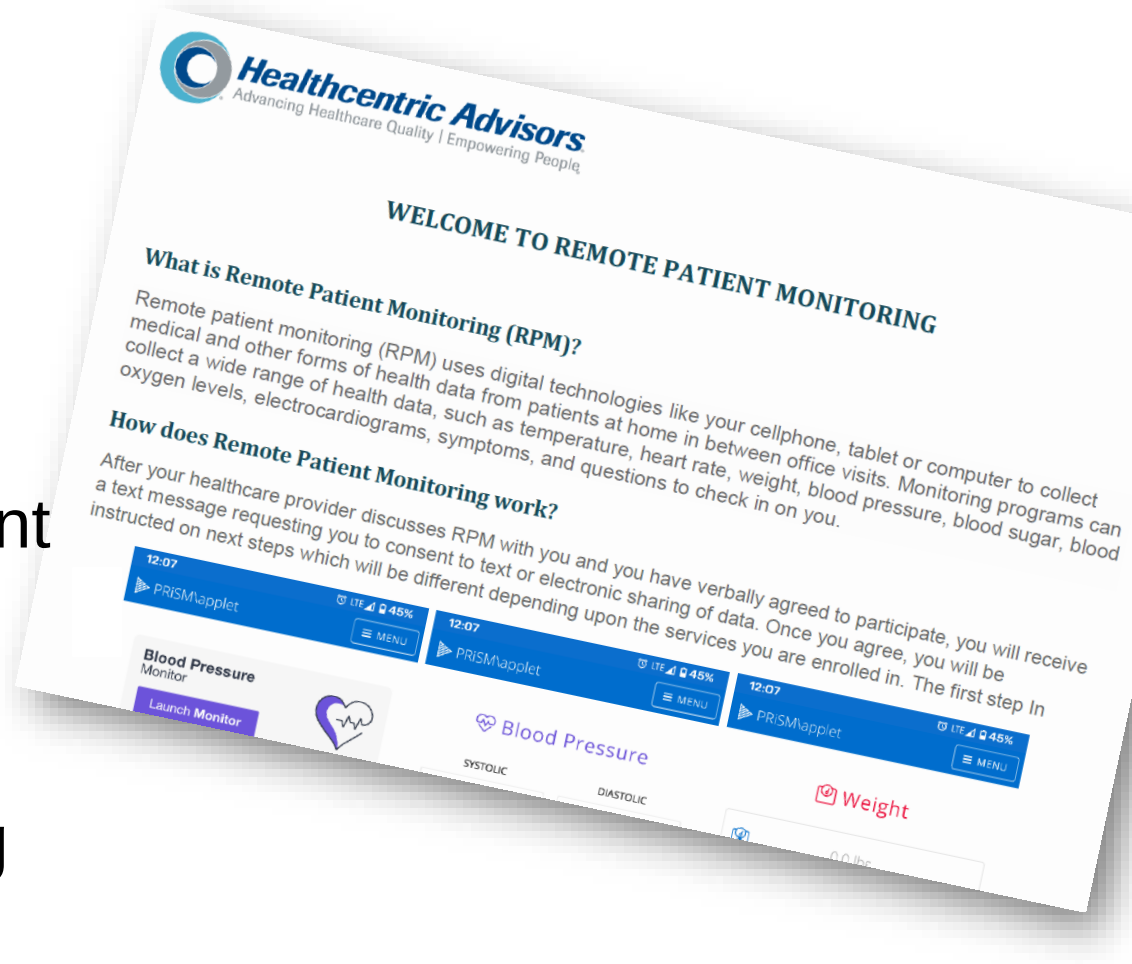
Strategies to Engage High Risk Patients for Positive Outcomes

Strategies to Engage High Risk Patients for Positive Outcomes: **Identify**

- Things to consider when identifying patients:
  1) Review your high risk list as a whole
  2) Start with those you're already monitoring, but not monitoring digitally
  3) Start with one high-risk condition
  4) Start with individuals with care giver support
  5) Start with one provider / care team

Strategies to Engage High Risk Patients for Positive Outcomes: **Initiate**

1) Ways to Initiate with patients:
   - Plant the Seed:
     - Conversations with patients regarding the benefits *before* enrollment
   - Supporting Education & Self-Management
     - What RPM is
     - What RPM is NOT
     - What to expect from their care team
2) Have RPM become part of the ongoing outreach and discussions w/ pts.

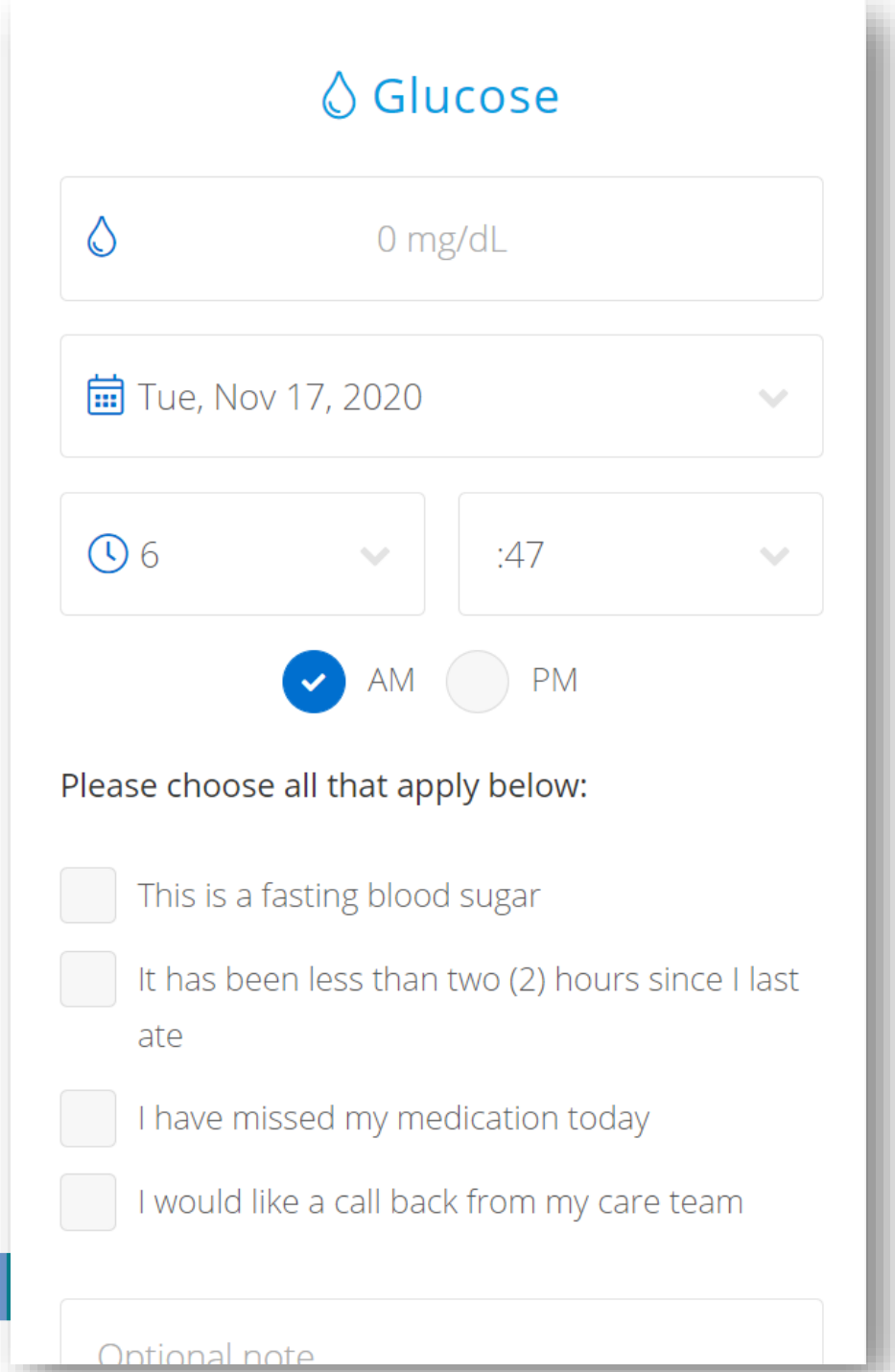


Strategies to Engage High Risk Patients for Positive Outcomes: **Integrate**

1) A new way of care delivery
2) Integrate into the care management model
   - Establish clinical champion(s)
   - Ensure full of awareness across the entire care team
   - Create workflows with clear paths to patient:
     - Outreach and Monitoring
     - Process for provider intervention and follow up as needed
2) Have RPM become part of ongoing discussions, patient self-management & goal setting

RPM needs to be easy for patients & families to integrate

1. Needs to be accessible to broadest # pts.
   - Works on smartphones, legacy flip phones, tablets, and computers
   - Uses only internet, not Wi-Fi
   - Translated into multiple languages
2. Allows patient to:
   - Leave a msg with their biometric data
   - Request a call from the care team



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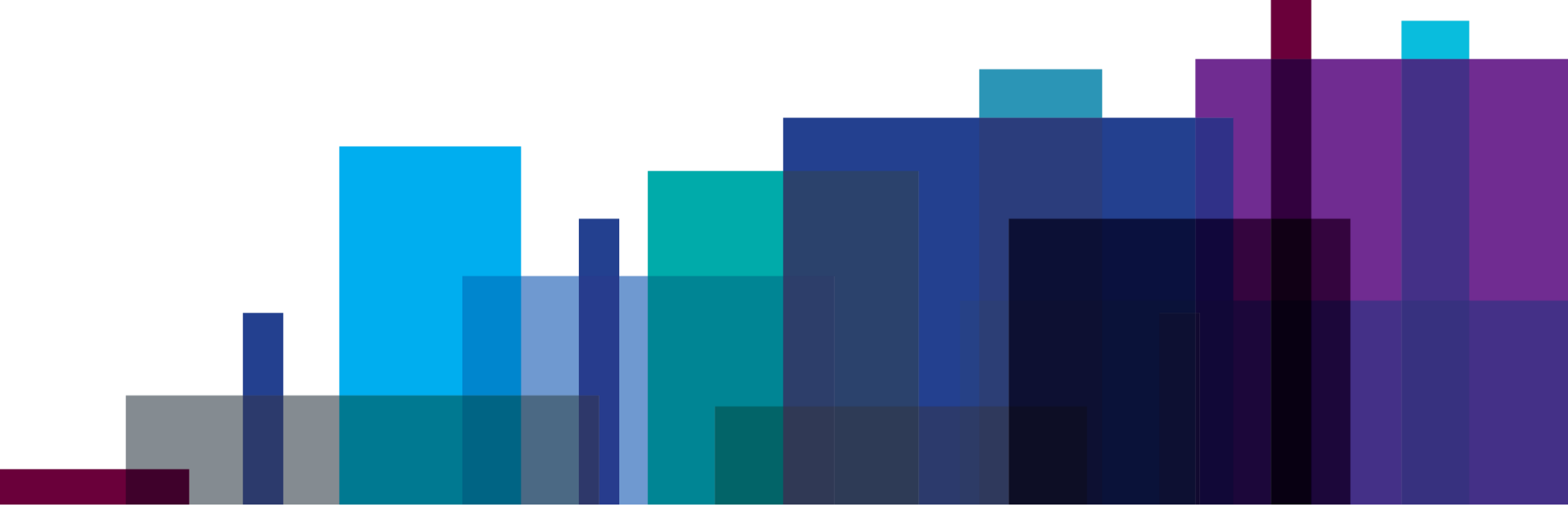

Data and examples from RI practices using PRiSM RPM technology

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Case Study - Diabetes

Data from RI practice using HCA PRiSM RPM technology

- Case Study of Patient with Diabetes- office visit
  - 61 yr old female w/10 yr hx of A1C>9%
  - Presents in office w/ A1C 14.7% (previous was 10.5%)
  - Isolated (COVID), depressed, stopped meds
  - Seen by PharmD & MD- oral DM meds & insulin restarted

Case Study - Diabetes

Data from RI practices using HCA PRiSM RPM technology

- Case Study of Patient with Diabetes- RPM enrolled
  - Data from RPM → wkly meds changes by practice
  - Pt states, RPM/texting service "felt like a lifeline"
  - Knowing care team is reviewing data → her motivation
  - **A1c 7.1% in 90 days!!!** Also improved kidney function, cholesterol, wt

"I'm honestly not sure that we/this patient would have had this level of success (especially during COVID-19) without the PRiSM RPM software"

***Kenny Correia**, PharmD/Board Certified Ambulatory Care Pharmacist*

RPM Project Lead, Anchor Medical

Case Study – Blood Pressure

Data from RI practice using HCA PRiSM RPM technology

- Data from **May 2021** on patients enrolled in **SMBP RPM**
  - Average BP of 133/77
  - On 3 medications to manage their hypertension
  - Only 1 patient currently on 5 antihypertensive agents
  - 75% of patients achieved goal BP (less than 130/80)
    Note: Data includes patients who were onboarded during the month of May.

***Kelley Doherty Sanzen**, Pharm.D., PAHM,CDOE, Clinical Pharmacy Specialist, Division of Kidney Disease and Hypertension, Clinical Assistant Professor Warren Alpert School of Medicine, Adjunct Clinical Associate Professor of Pharmacy Practice URI*

Case Study – Blood Pressure

Data from RI practices using HCA PRiSM RPM technology

- A nephrologist was recently able to make a rare diagnosis characterized by high blood pressure.
  - SBP at onboarding was 180-200
  - 4 drug regimen to which we added a 5th agent
  - Based on RPM data and labs-
    - Switched her medications again/ excellent response, so much so that she became hypotensive.
  - **She's now on a 2-drug regimen and well-controlled**

***Kelley Doherty Sanzen**, Pharm.D., PAHM,CDOE, Clinical Pharmacy Specialist, Division of Kidney Disease and Hypertension, Clinical Assistant Professor Warren Alpert School of Medicine, Adjunct Clinical Associate Professor of Pharmacy Practice URI*

Case Study – Blood Pressure

Data from RI practices using HCA PRiSM RPM technology

"In addition to the majority of our patients realizing better blood pressure control and/or achieving goal, **this platform has also helped individuals to make and sustain lifestyle changes.** One patient I was working with asked what else he could do besides medications to control his blood pressure. I provided education regarding the DASH diet, increasing physical activity, and advised him to set a goal of 10% weight loss of total body weight using a combination of healthy eating and increasing physical activity. **He has lost 43# since enrolling in the BP project and as a result we've been able to d/c meds, his kidney function has improved and his blood pressure is at goal."**

***Kelley Doherty Sanzen**, Pharm.D., PAHM,CDOE, Clinical Pharmacy Specialist, Division of Kidney Disease and Hypertension, Clinical Assistant Professor Warren Alpert School of Medicine, Adjunct Clinical Associate Professor of Pharmacy Practice URI*

Case Study – CHF
Data from RI practice using HCA PRiSM RPM technology

”One of our HF patients has been **very difficult to reach by phone** due to work schedule and general reluctance in the past. **He has a history of several admissions for HF in the past two years.** Since enrolling in PRiSM, we have made several short-term diuretic dose adjustments in response to his weight gain. Last week, he had a weight gain and he sent a message in the notes section of PRiSM to the effect of "don't worry, I took an extra torsemide, my weight is back down and I'm feeling better.” **A BIG win** for this **patient to engage with his care team**, the remote monitoring portal, and most importantly, to **empower this patient with a self-management tool**.”

– ***NCM CHF Program,*** Coastal Medical Team

Case Study – CHF
Data from RI practice using HCA PRiSM RPM technology

- Using [the PRiSM] INSIGHTS dashboard, I had realized a patient had gained weight via her weight entry in the portal on a Friday afternoon. With PRiSM, I was able to call her to verify her weight entry was correct, conferenced into the call our NCM to join in on the phone call and she helped call the diuretic in to pharmacy before the weekend. **What historically would have likely resulted in a weekend admission was avoided** by this key information before the weekend allowing for care team intervention.
  - ***Navigator,*** Coastal Medical Team

Decrease Utilization

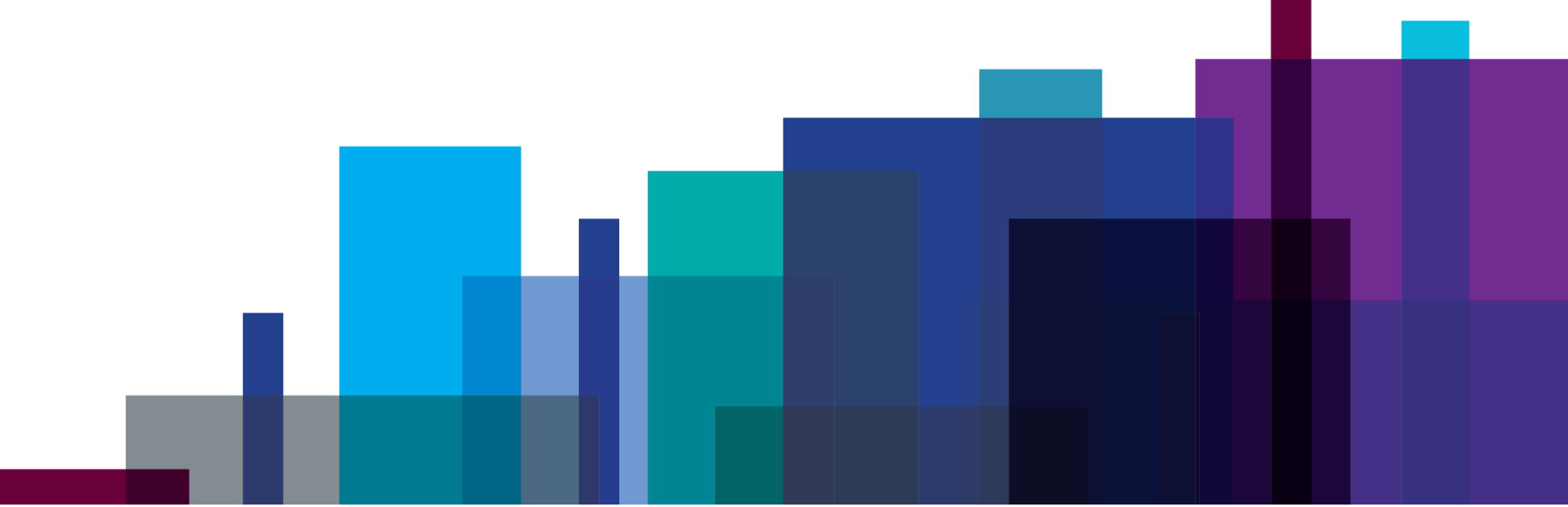
Survey Says….

Provider Feedback

- “Less phone calls, able to communicate with pts via text regarding their wt/pulse ox readings”
- “We can easily monitor many patients and outreach to only the patients that need or want it at the time they need or want it.”
- “PRiSM empowered patients to take control of their CHF and COPD diseases and connected the providers with patients faster than before.”
- “PRiSM allowed care to focus on patients that are experiencing a change in symptoms.”

Patient Feedback

- “I feel better knowing they are there monitoring me, supporting me, and ready to help.”
- “This is no doubt a program that will save lives or in my case, add years to my life.”
- “Happy to be in the program. My BP is under control. And I’ve never felt better.”
- “I appreciate how easy it is to use. No documentation is needed.”
- “Great remote monitoring!”



New services and features planned for PRiSM

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New Feature Enhancements and Services Planned

Features and Enhancements

- Voice API for landlines
- SDOH Screening Campaigns
- Transitions of Care and Utilization D/C Outreach
  - D/C Summaries and Dynamic Care Plan Updates
  - 2 Way Text communication b/w pt and care team
- Polypharmacy Management

New Specialty Services

- High Risk Maternal / Fetal Medicine
  - HTN Management
  - PPD Screening
- Pediatrics
  - Asthma Action Plans
  - Anxiety and Depression Screening

Questions?

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NETRC Resources

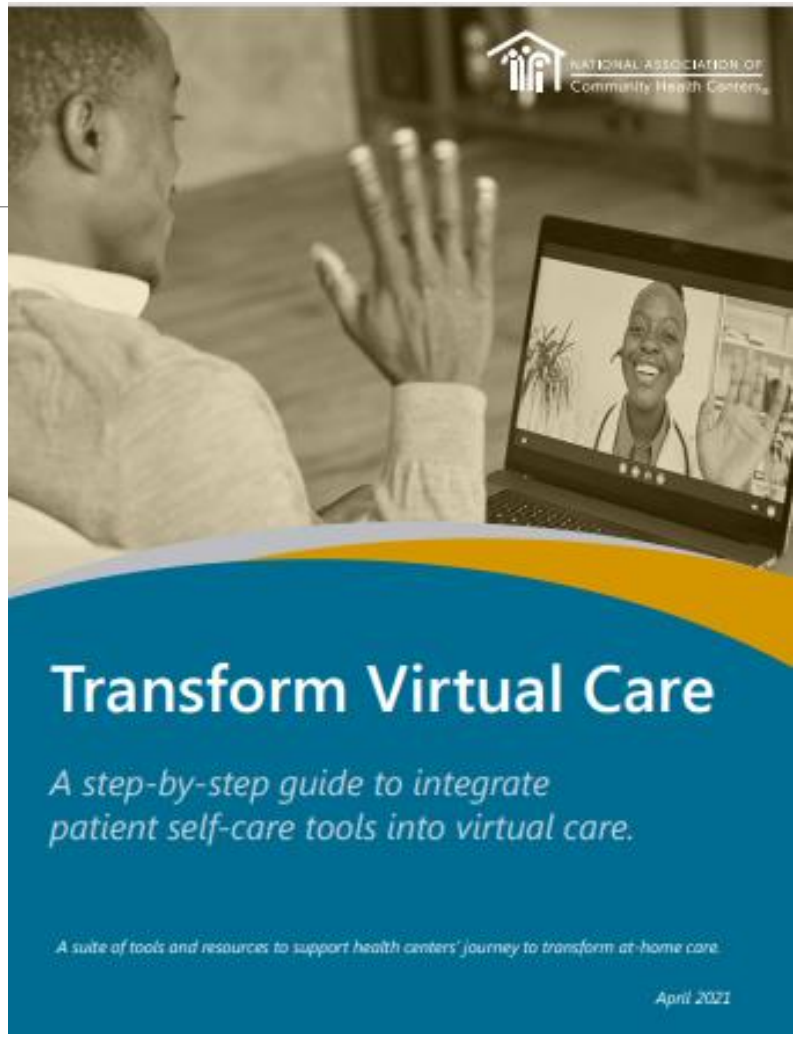
www.NETRC.org

[www.conference. NETRC.org](http://www.conference.NETRC.org)

www.TelehealthClassroom.org

NACHC Patient Care Toolkit

“Leading Change—Virtual Care & Patient Self-Monitoring Tools.”



https://www.nachc.org/wp-content/uploads/2021/04/Virtual-Care-Action-Guide_FINAL-04.20.21.pdf

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Evaluation and Recording

Webinar Evaluation

Please fill out our webinar evaluation using the QR code or at this link: https://forms.office.com/r/sVAytUQNX5

CTC-RI Telehealth Project Materials- The Recording of this session, and materials for all other sessions as a part of this project can be found here: https://www.ctc-ri.org/telehealth-project-overview

Questions: Sarah Summers, CTC-RI Program Coordinator, ssummers@ctc-ri.org

Thank you…

…UnitedHealthcare for generous funding!

…to our expert Panel!

Thank you for your participation!