

Federally Qualified Health Center's Remote Patient Monitoring Tool Kit

ADMINISTRATION

Develop detailed business plan to include:

- **Goals and Objectives**
 - Demonstrate value for the organization, your mission and culture...whatever that "value" is.
 - Financial ROI
 - Patient engagement
 - Patient clinical improvements
 - Increase access to care for vulnerable patients
 - Identify benchmarks and strategies that match stakeholder's goals and the goals of the organization.
- **Project Planning and Management**
 - Clearly define the roles of the Executive Team, Providers and Clinical staff.
 - Clearly define timing of internal meetings, data reports and documentation of meetings.
 - Include EHR integration and partnership activities in the program charter, if there isn't an interface in place.
 - Adjust the project schedule and deliverables to account for equipment vendor upgrades and EHR updates.
 - Produce a formal internal report every 6 months to document challenges, work completed, and recommendations for follow-up work.
- **Memorandums of Understanding**
 - Contractual Documents should be in place to address equipment vendor upgrades, EHR upgrades, and any supporting activities to ensure fulfillment of requirements.
- **Letters of Agreement**
 - Utilize Letter of Agreements to address roles and responsibilities for each organization.
- **Business Associate Agreements**
 - Establish Business Associate Agreements with all partnering organizations to ensure HRSA business practices are followed and to assure all organizations follow HIPAA guidelines and review guidelines annually to ensure contractual obligations and security are maintained.
- **Determine Patient Population(s)**
 - Hypertension
 - CVD
 - Diabetes
 - CHF
 - COPD
 - Chronic conditions

- Educate providers on the available equipment to determine all necessary data is captured and monitored.
- Educate/support providers to identify patients.
- **Determine proper resources needed including RPM equipment, educational plan and materials, and marketing plan.**
- **Develop Patient Consent/Authorization Form and submit to Legal for review.**
- **Develop Patient Inclusion and Exclusion Criteria**

Inclusion criteria:

Patients prioritized for enrollment into RPM include:

- Diagnosed with or at risk for chronic disease.
- High utilization of emergency rooms.
- Frequent hospitalizations.
- Prevalence of health disparities that limit access to regular medical care.
- Agree to terms of participation as outlined in RPM consent form.
- Follow instructions for collecting bio-metric data.
- Agree to communicate with RPM care team.
- Demonstrate the ability to use the equipment to ensure accuracy of readings.
- Have adequate mechanism for the transmission of data (POTS line, internet, cellular, smart phone).
- Have electrical outlet to plug in cell pod.

Exclusion Criteria:

- Unable to use devices correctly.
- Uncooperative/unwilling to take readings as instructed.

Develop Referral, Enrollment and Installation Workflows

- Make the referral process as easy as possible for the providers.
 - Identify person(s) who will identify and refer patients.
 - Determine the process for patient referral (electronically, phone, fax).
 - Determine who will educate the patient and obtain consent.
 - Determine who will install the devices.
 - Determine the timeframe for installing devices (within 2 days of receiving the referral).
 - **Develop Alert Escalation Workflow- RN Guide to Monitoring RPM Alerts**
- The purpose of RPM is to monitor trended data over time to aid the provider and determine the most appropriate plan of care and to also help the patient learn self-management skills. It's important to look at multiple readings over multiple days to analyze trends.

The RN shall:

- Set system parameters for all bio-metric device high and low alerts.
- Monitor data during normal business hours.
- Respond to alerts in real time.
- Review abnormal data alerts within 2 hours of the alert.

- Call the patient and conduct a nursing assessment, provide education and alert provider of changes in a patient's condition, if medical intervention is needed.
- Be aware that factors can influence the accuracy of readings:
 - Improper blood pressure taking technique
 - Stress
 - Exercise
 - Smoking
 - Time of medication administration
 - Cold fingers
- Document follow up on patient call encounter and update biweekly summary reports for providers.
- Create a balance between the frequency of nurse calls to the patient and focus on trended data over time.
- **Patient Education**
 - All patients with no alerts should be contacted a minimum of once every two weeks to provide patient education.
- **Documentation**
 - Document the review of the alert and any intervention/education provided.
 - If nursing judgment dictates that the patient does not need to be called, document that the alert was reviewed and rationale for no action as compared to patient's plan of care.
- **Develop De-Installation Workflow**
 - **Determine discharge criteria**
 - Determine the length of monitoring based on stability of readings, patient compliance, and availability of resources.
 - Provider determines patient is stable for graduation.
 - Provider no longer needs to receive data to review.
 - RN shall recommend to PCP if RPM is needed or if patient is ready for graduation/discharge.
 - Specific length of monitoring guidelines or specific discharge criteria can be set by medical directors and followed by RNs in case of limited resources.
 - Patient Non-adherent to the program.
 - Patient requests to stop the program.
 - **Determine discharge process**
 - Quick return process for the equipment will help prevent equipment loss.
 - RN calls patient to inform of graduation/discharge and discusses recommendations for follow up.
 - Determine how the devices will be collected (in-home vs shipping).

- Develop an incentive program for patients upon discharge (gift cards for healthy foods, copy of their trended data showing progress in achieving goals)
- **Redeveloping workflows is ongoing and fluid.**
- **Develop Evaluation Plan**
 - Identify the data to be captured:
 - Patient name
 - Diagnosis
 - Bio-metric devices per patient
 - Hospital costs
 - ED costs
 - Clinic revenues
 - Equipment inventory
 - Determine frequency of data collection.
 - Identify benchmarks & targets.
 - Create evaluations for patient satisfaction and provider satisfaction.
 - Recommend reviewing data monthly to define success and adjust as needed.
 - Analyze financial outcomes every 6 months.
 - Review the Evaluation plan and make adjustments. realign resources and determine if goals/work plan need to be adjusted at least on an annual basis.

Analyze and Create Return on Investment /Sustainability Plan

Sustainability is the most critical program goal to meet.

- Review internal strategic business plans and determine how the RPM solution can support the organizations goals.
- Determine how RPM can assist you in accomplishing your clinical goals, admissions/ readmission goals, and billing and coding goals.
- Define the organizations benchmarks for success
- Work with the Financial Department to determine patient populations where there is no profit or very little profit margin before the RPM program starts.
 - Define the Return on Investment.
 - Collect financial data on all patients (30 days prior to RM, the first 30 days during RPM) hospitalizations, ED visits, Bed Days.
 - Identify additional funding sources
- Explore partnerships with managed care organizations to provide funding to decrease hospitalizations and ED usage.
- Determine the need to implement CMS's Chronic Care Management Program to generate revenue to sustain the RPM program.
- Identify payment models and determine how to fund RPM to be a long-term solution for your organization.
- Maintain an average of 75 active patients to make the program effective and a strategic part of delivering care to your patients. Seventy-five patients provide the program continuity and the ability to get stakeholders supportive of the

program. Smaller pilots can work but may not achieve the goals for the strategic business plan with less patients.

EHR Integration

- Partnering early with EHR vendor is critical – especially if moving toward an interface build.
- Prepare to spend a lot of time planning and re-planning when interfacing RPM vendor software with the EHR.
- Identify a Key Stakeholder to participate in the EHR network to keep costs down.
- Clearly define how the RPM program works.
- Need to have all alerts flow into a single encounter that remains open for a specified monitoring period so all documentation is in one place.
- Create a Remote Patient Monitoring Encounter that allows alerts to flow and be charted in one place, can be routed to the PCP when intervention is needed and place an order to any care team member.
- Highly recommend on-site support when the EHR integration “goes live”.
- Create smart phrases for PCPs to respond to a RPM encounter.

Staffing

- Design the RPM Conceptual Model prior to determining your staffing requirements.
- Existing nursing staff or outsourced staff can provide RPM services.
- Cross train multiple staff.
- Train all new staff.
- Determine the skill sets needed and training aligned for each clinical role:
 - Good understanding of RN care coordination and triage
 - Ability to work within multiple care team
 - Flexibility in managing and supporting different care teams
 - Can work independently
 - Strong computer skills
- Patient volume is critical to determine resources needed to support the program.
- A limited RN workforce can challenge an organizations ability to hire and maintain the program without RN’s being assigned in a FTE capacity.
- A RPM program can be too small to isolate RPM from the rest of the organizational programs.
- Management continuity is essential to support resource allocations including personnel, equipment, and decision-making to ensure the program has enough support and oversight.
- Clinical Champion is needed to support this program, not the CEO.
- Work with smart, committed people. People who aren’t afraid to ask hard questions, work in a collaborative way to achieve success, and willing to do whatever it takes to make lasting relationships.
- Staffing changes during the program will be a hindrance to the program.
- 1 RN and 1 on-call RN for every 75 patents.

- 1 administrative assistant.
- 1 MA responsible for device management, installations and de-installations

Training

- Power point training session with Providers, clinical staff, and key stakeholders to explain the program and clinical workflows.
- Create a reference guide as follow-up education.
- Have a physical presence at all sites.
- Train the direct RPM team on:
 - Remote patient monitoring
 - Clinical Workflows
 - Hardware
 - Software
 - Soft-skills needed to work with patients through RPM and phone call outreach
- Additional training needs to occur when other team members join the team.

Communication

Internal Communication

- Develop a clear defined internal and external communication plan.
- Clearly communicate the goals of the program to all internal and external stakeholders.
- Participate in weekly calls, initially, for all partners to start up quickly and address challenges quickly and decisively.
- Partner commitment to participate in calls consistently is critical.
- RPM RNs communicate regularly with the nurses in the clinic via instant message, email or phone.
- After the initial few months of the program, calls can occur every other week and continue for the duration of the RPM Program.
- All partners need to be available through email and phone outside of the standing meetings.
- Stay actively engaged with the FQHC's CEO frequently to ensure success.
- Keep clear lines of communication with RNs from clinics to be sure that the patient isn't getting mixed messages.

External Communication

- Engage a payer or other organization early in the program if you desire to expand RPM.
- Identify partners with similarities to make collaboration successful, for example the same EMR or similar workflows.
- Present at Conferences, Regional Hospitals, Payors.
- Publish outcomes.

Provider Communication:

- Providers need to clearly understand the Inclusion Criteria and how to make a referral.
- An order for Remote Monitoring is not required but can be obtained.
- Determine the frequency that providers will receive patient data reports (we recommend every two weeks).

- Determine how much trending data the providers prefer.
- Determine where providers want the results/reports.
- An interface between the RPM device vendor and EHR helps with communication between the RPM program and the providers.
- Providers will receive biweekly summary reports, including subjective and objective Information gathered during the monitoring period to see the patient's trends over a period of two weeks, to obtain reading averages and review the patient's plan of care.
- Provide trending reports to the provider prior to the clinic visit to allow for more efficient visits and more engaged patients.
- RN will make recommendations for the patient to continue monitoring, to be graduated from the program or other recommendations.

Patient communication

- Frequent virtual outreach with the patients is critical for them to continually learn about their disease management/decision-making.
- RN will meet with RPM patients in their home to enroll the patient, install devices and assure devices are working properly.
- Identify barriers to a patient taking readings or to the successful transmission of RPM data.
- Review patient medications.
- The RN enrollment visit may also be conducted at a clinic office visit if the patient is not agreeable to a home visit, if RPM staffing time is limited, or if concerns over staff safety at a home visit.
- Enrolling a patient into RPM requires assessment and education within the RN Scope of Practice to make sure a patient takes accurate readings and that patients understand the readings and monitoring parameters.

The RN scope is necessary for in—home installation and patient education:

- Proper technique for using the peripheral devices (BP, Pulse, Weight, O2 Saturation, Glucose Level).
- Assess patient's educational needs and health literacy level.
- Review patient medications and problem list.
- Assess and triage patient symptoms or concerns.
- Triage abnormal readings taken while demonstrating use of equipment.
- Instruct patients what to do if they feel symptomatic or are concerned about a reading.
- Set patient goals and establish care coordination.
- Emphasize patient to follow up with PCP.

RN Visit Checklist

A RN Checklist will guide nurses in installing and training patients on RPM. The checklist is as follows:

1. Explain RPM and the purpose of the program.
2. Review patient medications, diagnoses and purpose for monitoring/monitoring instructions from PCP.
3. Explain hours of monitoring and what to do when experiencing symptoms or concerned about a reading.
4. Emphasize the on-call provider number for symptoms after hours.
5. Be clear that the patient is responsible for following up if concerned or symptomatic, as RPM is not a 24-hour triage service.
6. RPM helps a patient manage their care.
7. Determine availability for regularly standard phone calls.
8. Make sure patient has correct device.
Cross check the serial numbers on the Inventory Form with the serial number on the back of the blood pressure monitor, scale, enabler or SpO2 monitor.
9. Demonstrate how to use device(s), utilizing teach back method.
10. Discuss tips for taking a good home reading.
11. Assess potential barriers for patient success.
12. Assess the need for education and provide initial education on diagnosis and management and utilize additional educational handouts.
13. Develop patient's plan of care.
14. Have patient sign program consent and equipment inventory form.

OUTCOMES

Measures for success of a RPM program include:

- Provider satisfaction
- Patient satisfaction
- Population health clinical outcomes
- Individual clinical outcomes
- Meeting the program budget
- ROI

Patient Outcomes

- Enhanced bio-metric outcomes for:
 - Blood Pressure
 - Pulse
 - Weight
 - Oxygen Saturation Levels
 - Glucose Readings
- Subjective patient stories:
 - Positive patient stories/results and incredible outcomes.

- Increase quality patient interactions.
- Improved accountability, which results in sizable shifts in the patient's willingness to make changes and follow recommendations.
- Patient evolves from being very defensive and skeptical of his care team to being grateful and receptive.

Outcomes for Providers

- Useful actionable data.
- Enhanced patient engagement.
- Patients who haven't gotten engaged are now actively engaged.
- See value of using RPM to enhance/obtain patient engagement.
- Clinic visits are more efficient and effective.
- See real-time information that they can rely on to make clinical decisions, make a medication adjustment and watch the trends immediately with impact and further refine based on the biometric data.

Positive Program Outcomes: that define success:

- An interface between your EHR and Remote Monitoring vendor.
- Committed, invested leader.
- Proactive modeling through RPM improves patient's health and prevents patients from spiraling out of control.
- Cultural adaption to RPM program.
- Formalized compliance oversight.
- High referral rates.
- Proactive care by providing education and therapeutic nurse-patient relationship.

DEVICES

It is best to start a RPM program with new equipment to ensure it is warranted and working properly.

Device Management

- Receive devices.
- Inventory, tag and store devices.
- Pull devices for installation.
- Clean and refurbish devices after de-installation.
- Utilize device vendors inventory management tools.
- Keep devices in a central location.