

Federally Qualified Health Center's Remote Patient Monitoring Tool Kit ¹

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Disclaimer

CCALAC received some additional funding to help support health care providers and their patient populations navigate through telehealth services. As we spread remote patient monitoring (RPM) tools out to our membership we are limited in the types of devices and amounts for purchase. In July and August, CCALAC Clinical Services reached out to all organizations to describe this process in more detail. We also gathered your suggestions and needs. Through a group purchasing program with McKesson, we were able to get some RPM tools at the lowest cost. We understand that this will only be able to assist you getting started with low-tech RPM distribution to only a fraction of your populations, and in the midst of COVID-19, these tools will be given to patients and not returned. It will be up to each clinic to review the toolkit to determine how best each organization implements their RPM program and the appropriate use of the devices, and how you prioritize certain patient populations for RPM distribution. Each clinic will receive a maximum of 200-400 devices. These devices should be used with patients that can not receive devices from their payor or other free programs.

RPM (Remote Patient Monitoring) General overview

Many of us have worked with a patient who takes a biometric reading at home. Scales, blood pressure cuffs and glucometers are great tools that can be prescribed and obtained at low-cost to enable a patient to have an enhanced view into their wellbeing. Today we are trying to overcome the lack of visibility that a provider has into those readings. In a perfect world a patient has a plan that guides them on what to do in response to their readings and when to contact the office. Hopefully, they follow that plan and keep a log that they bring to their appointments. Today we want to implement better processes and better tools that allow us to:

- Monitor readings between visits
- Identify patients who are unmanaged sooner
- Collect more data in a way that allows us to better assess the patient's state and treatment plan

As we enter the RPM age we will need to be prepared to work with low tech while trying to transition to high tech capable devices as quickly as possible.

Low-tech devices are units that only obtain a local reading. Low tech devices do not have the ability to transmit data to medical professionals.

High-tech devices have two important capabilities:

- 1) The ability to transmit data:
 - a.** The most common are Bluetooth enabled devices that allow for transmission to a second device that connects the internet (i.e. smartphone, tablet, or hub). This enhances care in two ways; the ability for readings to be sent to the clinical team via a portal or EMR integration and the ability for patients to visualize their trends on their connected device.
 - b.** Some devices will connect directly to the internet via the patients WIFI connection. This provides an easier setup vs needing to pair the devices to an internet connected device. Not all patients have WIFI and only use a smart phone.
 - c.** Some patients do not have WIFI or a device that connects to the internet. To meet these patients needs there are devices that connect to the internet directly with an internal cellular antenna. These devices are typically the most expensive and have a small monthly charge from a cellular provider.
- 2) The ability to provide patients with automated feedback
 - a.** Some devices allow your clinical team to provide the patient with feedback on their reads. An example of the way an office uses this capability would be when a patient's reading is out of range, they are told to call your offices RPM champion.

RPM Program and Toolkit

Program

- We did a group purchase with McKesson.
- You will get a small number of these low-tech devices
 - BP machines
 - Glucometers and Strips
 - Pulse Oximeters
- We are looking into thermometers and scales and may be able to provide them later.
- The first step will be to identify those most in need of these tools, that do not have any other criteria to receive these tools through other programs or payors.

Toolkit

- You will use the toolkit to determine what will work for your individual clinic's programs and services.
- This toolkit will guide you through all key areas of consideration as you prepare to implement this program with your staff and patients.
- This toolkit will expand over time with an FAQ and content based on your feedback. Please click [here](#) if you have questions or feedback related to this toolkit. We encourage you to use think [link](#) to let us know anyway we can help!

Operations

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, agenda 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.
- How data from RPM devices will be collected, reported and tracked and by whom and determine the protocol if a patient is out of range. (I know this is mentioned in more detail later, but it may be good to include one point about it under this section too high-level part of PM)

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
- Other Chronic conditions

Educate providers on the available equipment to determine all necessary data is captured and monitored.

- Utilize your vendors online resources, implementation and support teams for education resources.

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.
- Establish communication path and frequency with patient (i.e. email, patient portal, schedule bi-weekly calls).
- 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).

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 an incentive program for patients upon enrollment (gift cards for healthy foods, copy of their trended data showing progress in achieving goals)

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 is important to look at multiple readings over multiple days to analyze trends.

The RN/MA/Health Educator 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.
- Patient leaves practice

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.
- For devices that are purchased by your organization (not reimbursed by the patient's payer or provided as a part of a no cost program) Determine how the devices will be collected (in-home, shipping or office).

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 and method 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 annually and adjust by realigning resources or augmenting goals.

Reassess all workflows on a regular basis to ensure they are efficient and follow the natural flow of your organization.

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 an 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 an FTE capacity.
- An 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 are not 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/MA/Health Educator 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 skillsets for RPM and phone call outreach
 - Additional training as new team members join the team

Communication

Internal Communication

- Develop a clearly 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 RN/MA/Health Educators 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 RN/MA/Health Educators from clinics to be sure that the patient is not 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/MA/Health Educator 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/MA/Health Educator 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.
- Identify device support person in your office. This person will be a device support specialist that can assist patient with basic support and escalate issue to the vendor as needed.
- Review patient medications.
- The RN/MA/Health Educator 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/MA/Health Educator Scope of Practice to make sure a patient takes accurate readings and that patients understand the readings and monitoring parameters. (Please see appendix for more information)

The RN/MA/Health Educator 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/MA/Health Educator Visit Checklist

This RN/MA/Health Checklist will guide nurses in installing and training patients on RPM. The checklist is as follows:

- Explain RPM and the purpose of the program.
- Review patient medications, diagnoses and purpose for monitoring/monitoring instructions from PCP.
- Explain hours of monitoring and what to do when experiencing symptoms or concerned about a reading.
- Emphasize the on-call provider number for symptoms after hours.
- Be clear that the patient is responsible for following up if concerned or symptomatic, as RPM is not a 24-hour triage service.
- RPM helps a patient manage their care.
- Determine availability for regularly standard phone calls.
- 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.
- Demonstrate how to use device(s), utilizing teach back method.
- Discuss tips for taking a good home reading.
- Assess potential barriers for patient success.
- Assess the need for education and provide initial education on diagnosis and management and utilize additional educational handouts.

- Develop patient's plan of care.
- Have patient sign program consent and equipment inventory form.
- Explain to clinic what to do if they need technical help (call RN/MA/Health Educator, call RPM vendor, or call your designated RPM device specialist)
- Explain to patients that this tool is for them to keep unless (note scenarios when it must be returned?)

Measures for success of an RPM program include:

- Provider satisfaction (see appendix for example)
- Patient satisfaction (see appendix for example)
- Population health clinical outcomes
- Individual clinical outcomes
- Meeting the program budget
- ROI
- Patient Outcomes:
 - Enhanced bio-metric outcomes for: Blood Pressure, Pulse, Weight etc.
 - 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 have not 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:

- Committed, invested leader.
- Clinical outcomes and quality improvement measures
- 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.
- When possible, an interface between your EHR and Remote Monitoring vendor.

Devices

It is best to start an RPM program with new equipment to ensure it is warrantied and working properly. It is important to always test a small batch of new devices with your team before ordering a large supply. If you can to a test with five patients before distributing them to all patients it will help you better assess your vendors and ensure a successful implementation.

It is important to note that these devices can sometimes be paid for by their payer.

Glucometers

The OneTouch Verio Flex is the most popular high-tech device covered by many payers. To ensure that patients do not run out of testing supplies, a best practice is to order supplies from a mail order pharmacy that delivers 90 day supplies on a reoccurring basis.

Here are some resources on this device and payer coverage:

<https://www.onetouch.com/products/glucose-meters/onetouch-verio-flex>

<https://professional.onetouch.com/insurance-access/medicare-diabetic-supplies>

<https://www.wellspan.org/media/2226833/Meter-Insurance-Coverage-1-9-20.pdf>

Blood Pressure Cuff

Medicare and many payers only pays for at-home blood pressure monitors if you are on renal dialysis in your home or if your doctor has recommended an Ambulatory Blood Pressure Monitor (ABPM).

<https://www.healthline.com/health/medicare/will-medicare-pay-for-a-blood-pressure-monitor#medicare-coverage-overview>

This resource can offer further information on reimbursement and the future of this practice:

https://millionhearts.hhs.gov/files/MH_SMBP.pdf

General Durable Medicare coverage info:

<https://www.medicare.gov/coverage/durable-medical-equipment-dme-coverage>

Device Management (Supply Chain)

- Receive devices.
- Inventory, tag and store devices.
- Pull devices for installation.
- In cases where devices need to be returned: Clean and refurbish devices after de-installation.
- Utilize device vendors inventory management tools.
- Keep devices in a central location.

Appendix

Resource One:	Consent Form Example
Resource Two:	RPM Reimbursement for clinical time
Resource Three:	Remote Patient Monitoring RPM Workflow
Resource Four:	RPM Device allocation examples
Resource Five:	MPB Guidance from AHA
Resource Six:	Additional Information for the RPM Toolkit
Resource Seven:	RPM L.A. Care Coverage Overview
Resource Eight:	Sample Patient Satisfaction Survey
Resource Nine:	Sample Provider Satisfaction Survey
Resource Ten:	AMA Quality Measure Updates (click here)
Resource Eleven:	Sample Blood Pressure Log (click here)
Resource Twelve:	RPM Data Collection Form (click here)
Resource Thirteen:	McKesson RPM Tool Details (click here)
Resource Fourteen:	HEDIS MY 2020 Telehealth Guidance (click here)
Resource Fifteen:	eClinicalWorks RPM Device Compatibility with Healow Hub (click here)
Resource Sixteen:	G0511 Billing Guidelines (click here)
Resource Seventeen:	Internal Launch Plan Example (click here)

Remote Patient Monitoring (RPM) Consent Form

I understand that:

- I am the only person who should be using the remote monitoring equipment as instructed. I will not use the device for reasons other than my own personal health monitoring. I understand that I can only participate in this program with one Medical Provider at a time.
- I will not tamper with the equipment. I understand that I am responsible for any fees associated with misuse of the equipment.
- I understand the devices are only designed for the RPM program.
- I acknowledge that I received Blood Pressure Monitor Serial # :

- The device is meant to collect Blood Pressure Readings and transfer those readings to an online website. It is **NOT AN EMERGENCY RESPONSE UNIT AND IS NOT MONITORED 24/7**. Call 911 for immediate medical emergencies.
- I am aware my BP daily readings will be transmitted from the monitor to a website located at www.myhealthconnected.net in a safe and secure manner. I can withdraw my consent to participate in this program, and revoke service at any time by returning the BP Monitor/Cuff device. _____ (name of healthcare professional) will securely and confidentially store my collected data, and record and store my readings into my Electronic Medical Record monthly.
- I will do my best to take my BP every day. I am aware that a Remote Patient Monitoring Qualified Health Professional will only view my readings every 30 days, and that this program is **NOT** a 24/7 Monitoring Service. I will be contacted every 30 days, by phone, to review and discuss my results and progress.

I, _____ have read and understood the information (Print your name) and consent to participate in the Remote Patient Monitoring program as stated above. I am aware that this consent is valid as long as I'm in possession of the RPM equipment/device.

Date: _____ (dd/mm/yyyy)

Signature of Patient or Authorized Person (Relationship of Authorized Person)

RPM Reimbursement

At FQHC, RHC and CHC Medical Organizations there currently is NOT a code for RPM.

RPM can be incorporated in the CCM code G0511 which has a reimbursement of about \$68 per patient per month.

Please refer to this CMS resources for billing, compliance and FAQ for CPT G0511:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf>

Remote Patient Monitoring RPM Workflow

Eligibility

1. High-risk patients, For example- DM, HTN, Heart Failure, A-fib, Stroke, Migraine, Chronic pain, COPD, Obesity, etc.
2. Dual Insurance Coverage - Ideal Patient
3. SMS and/or Email Access - Best case user
4. Identify patients with devices covered by payer or eligible for low/no cost program

Enrollment/Initial Set-up of Equipment

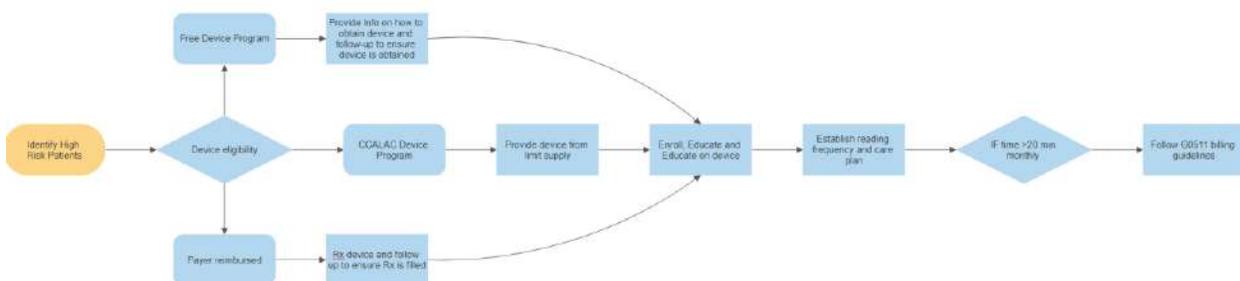
1. Enroll patients to RPM via Phone calls using the RPM Enrollment form
2. Invite patients to OH Patient App
3. Explain the RPM benefits and request the patients to enter the readings daily
4. Financial disclosures
5. Educate on how to use the device

Data Gathering

1. Gather readings daily or send notifications to the patients daily to check their vitals (Platform)
2. Track the readings in EMR

RPM Interpretation and Management guidance

1. Review the readings and make a note of high or low or out of normal range readings
2. Summarize all the readings and share with the Providers or Nurses at the practice
3. Call the patient and discuss any changes to the treatment protocols and provide guidance to the patient on medical and preventative care management
4. Total 20 minutes spent on reviewing, analyzing the data and discussing the treatment plan with the patients (20 min required for G0511 CPT Billing)



RPM Device allocation examples:

Conditions	Vitals
Essential Hypertension	Blood Pressure, heart rate
Heart Disease	Blood Pressure, heart rate
Atrial Fibrillation	Heart rate, Blood Pressure
Congestive Heart Failure	Weight, Pulse rate
Diabetes Mellitus	Blood Glucose
Emphysema	Pulse Oximetry
COPD	Pulse Oximetry
Obstructive Sleep Apnea	Pulse Oximetry, weight
Rheumatoid Arthritis	Pain Scale
Migraines	Pain Scale
Obesity	Weight
Cervical Spondylosis or stenosis	Pain Scale
Lumbar Spondylosis or stenosis	Pain Scale

SMPB Guidance from American Heart Association:

Step by step guide on AHA's best practices on how to implement SMBP at your clinic (Including loaner device logistics, selecting Cuff Size, Training Patients, Collecting Details and more)

<https://targetbp.org/patient-measured-bp/implementing/>

1. Frequency of patient reporting BP:

Because SMBP is a strategy to assess/confirm a hypertension diagnosis, our recommendation for the first 7 days of SMBP is for patients to document their BP readings, twice in the morning and twice in the evening. Then by averaging the measurements, you can make the correct diagnosis. After the initial 7-day data collection period, it will depend on the diagnosis of the patients to determine how often they should record their BP in the future. For example, if the patient is prescribed BP medication, it is recommended for patients to measure and record their BP daily.

2. How long should patient report BP:

The initial strict data collecting mentioned above for your SMBP program should be 1 week (7 days) in order properly assess and diagnose your patient BP condition. Following that, the data collecting does not need to be as strict depending on the diagnosis of the patient. You may want to recommend the patient to continue to measure and record their BP on a daily or weekly basis if the physician determines a follow-up is necessary. The data collection period is 1 week.

For more detail: <https://targetbp.org/patient-measured-bp/implementing/smbp-data-collection-review/>

Additional Information for the RPM Toolkit

In Disclaimer – It's important for clinics to initially determine where they are in using these tools for their patients. You can use these tools to pilot a program to help clinics determine and develop a process to roll this out and meet the needs of a small segment of your patient population.

(For Webinar) Add in the Q&A Log – where we can collect questions on Toolkit and Provide Responses in a FAQ – note that we will have some time to add in more information into the Toolkit (after webinar)

Attached:

- Sample Patient Data Collection Logs (RPM logs for internal use, an external BP log, and here is a [link](#) to some glucose monitoring logs. CareOptimize can choose which, if any, to include in the appendices.)
- Information from McKesson on Devices
- Reimbursement Information from LA Care and Health Net
- Data Collection Recommendations (UDS/HEDIS) Criteria (HEDIS accepts patient-reported BP, but UDS only accepts remote BP readings if they are digitally stored and the provider sees the reading during a video visit.)

Devices:

These devices are provided by McKesson via a group purchasing program with CCALAC. If you would like to inquire about more devices, reach out to your McKesson representative. If you do not have a McKesson Representative or you don't know who that rep is, you can contact Scott Bearden who is assisting with this program.

Scott Bearden

Account Manager
Cell: 714-688-6824
eFax: 866-381-2212
scott.bearden@mckesson.com

McKesson Medical-Surgical

16043 El Prado Rd.
Chino, CA 91708
mms.mckesson.com

Information from another Glucometer/Strips vendor that clinics already use:

Mike Dvorak

Territory Account Manager

Consumer Healthcare Division

ARKRAY USA

1-800-818-8877 EXT 2618
Cell 952 737-7284
dvorakm@arkrayusa.com
www.arkrayusa.com

RPM L.A. Care Coverage Overview

Glucometers – To process a request for L.A. Care members, all formulary **blood glucose monitors and test strips** require a prescription in order to be filled through the Pharmacy benefit for L.A. Care members. **Continuous Glucose Monitors (CGMs) and sensors** require a prescription and a prior authorization must be completed before it can be filled at the pharmacy. L.A. Care prior authorization available at - <http://www.lacare.org/providers/provider-resources/pharmacy-services/prior-authorizations>

Glucometers – A list of devices and compatible strips by line of business.

Line of Business(s)	Meter/Receiver	Test Strips/Sensors
MCLA/PASC/CMC	<p>Blood Glucose Monitor: Freestyle Freedom Lite Meter Freestyle Lite Freestyle InsuLinx Meter Precision Xtra Meter</p> <p>Continuous Glucose Monitor (MCLA/PASC Only): Freestyle Libre Receiver</p>	<p>Blood Glucose Monitor: Freestyle Test Strips Freestyle Lite Test Strips Freestyle InsuLinx Test Strips Precision Xtra Test Strips</p> <p>Continuous Glucose Monitor (MCLA/PASC Only): Freestyle Libre Sensors</p>
LACC	<p>Blood Glucose Monitor: Freestyle Freedom Lite Meter Freestyle Lite Freestyle InsuLinx Meter Precision Xtra Meter Accu-Chek Aviva Plus Meter Accu-Chek Guide Care Meter Accu-Chek Nano Meter</p> <p>Continuous Glucose Monitor: Freestyle Libre Receiver</p>	<p>Blood Glucose Monitor: Freestyle Test Strips Freestyle Lite Test Strips Freestyle InsuLinx Test Strips Precision Xtra Test Strips Accu-Chek Aviva Plus Test Strip Accu-Chek Guide Test Strip Accu-Chek Nano Smartview Test Strip Accu-Chek Test Strip</p> <p>Continuous Glucose Monitor: Freestyle Libre Receiver</p>

Blood Pressure Devices and Scales (*considered durable medical equipment*) – For shared risk contracts (majority of IPAs, including HCLA), available by submitting a prior

authorization to L.A. Care with information on the member’s condition - <http://www.lacare.org/providers/provider-resources/forms-manuals/prior-authorization-request-forms>. Providers must include HCPCs code A4670 for the blood pressure cuff machines and HCPC code E1639 for the scale.

Important Note: Clinics may want to request Western Drug on the PA form to ensure access to the specific model; otherwise, models will differ by vendor.

Western Drug confirmed they will provide the following items when requested:

- BP Monitor: Omron 3 Series – Upper Arm (or similar if unavailable)
- Scale: Health-O-Meter 800KL (or similar if unavailable)

Blood Pressure Devices – the following IPAs have shared risk contracts with L.A. Care for Medi-Cal and can use the above process; for other IPAs, the request should go to the IPA (not L.A. Care).

List of IPAs			
AltaMed Health Services Corporation	Community Family Care – Antelope Valley	Pioneer Provider Network, A Medical Group, Inc.	Seaside Health Plan
Angeles IPA	Crown City Medial Group	Pomona Valley Medical Group	South Atlantic Medical Group
Apple Care Medical Group, St. Francis, Inc.	El Proyecto Del Barrio, Inc.	Preferred IPA of California	Superior Choice Medical Group
Apple Care Medical Group, Inc. Select Region, Downey and Whittier	Exceptional Care Medical Group	Prospect Healthsource Medical Group, Inc.	Universal Care Medical Group
Axminster Medial Group	Family Care Specialists IPA, A Medical Group Inc.	Prospect Medical Group Los Angeles, Inc.	
Bella Vista IPA	Global Care IPA	Prospect Medical Group, Inc.	
Citrus Valley Physician Group	Health Care LA, IPA	Prospect Nuestra Familia	
Community Family Care	Healthcare Partners Medical Group	Prospect Professional Care Medical Group, Inc.	

Glucometers and testing strips

Our questions to L.A. Care subject matter experts and [responses](#).

1. Does L.A. Care have a limitation on the quantity of strips a patient is eligible for in a given month? [Yes, the limit is 50 strips/month.](#)
2. If so, do limits on access to strips vary by patient diagnosis/needs or based on provider requests/recommendations? [Yes, members with Diabetes Mellitus \(those on oral/injectable medications\) and members who are pregnant \(those on prenatal vitamins\) have no quantity limit. For pregnant patients who are not using prenatal vitamins, a prior authorization can be submitted to L.A. Care to review for medical necessity and other factors.](#)

Weight Scales

L.A. Care addressed this concern by outlining the process for submitting a PA for scales, HCPC code E1639 recommended for the scale and the model (Scale: Health-O-Meter 800KL *or similar if unavailable*) we can offer.

Our question to L.A. Care subject matter experts and [response](#).

1. Does L.A. Care have other recommendations we can share with clinics? [Not at the moment, but we are actively working on making guidance available in formal communications \(FAQ, summary sheets, etc.\) for providers to access.](#)

Reference Materials

CCALAC proposes that we consider ways to disseminate information on covered DME.

Our question to L.A. Care subject matter experts and [response](#).

RPM Health Net Coverage Overview

Here is a summary taken from the Medi-Cal provider manual and our own DME policies. This is the guidance we are giving for MedZed members and other high-risk members:

1. **Scales** are not a Medi-Cal benefit but may be considered appropriate for patients with certain conditions.

Recommended guidelines:

- To manage a medical condition in which frequent weight measurements are medically necessary, examples are (not an all-inclusive list):
- Stage C (current or prior symptoms) Heart Failure and recent (within one year) ER visits or IP admissions
- Renal Failure/Disease

Ordering: E1639-NU Scale

2. **Pulse Oximeters** are a Medi-Cal benefit only for patients using home ventilators but using them for high risk members as noted below would also be appropriate.

Recommended guidelines (CP.MP.107 DME):

- To monitor individuals on a home ventilator or with a tracheostomy
- To determine appropriate home oxygen requirements
- To wean an individual from home oxygen and to monitor an unstable respiratory condition

Not medically necessary when used for any of the following:

- Oximetry when used as a diagnostic procedure
- Monitoring of a stable respiratory condition
- Asthma management
- Other conditions not listed above

Ordering: E0445-NU Oximeter Noninvasive

3. **Blood Pressure Cuffs** are a Medi-Cal benefit and for any ICD-10-CM diagnosis code that justifies medical necessity.

Recommended guidelines:

- To manage a medical condition in which regular blood pressure measurements are medically necessary

Ordering: A4670-NU Automatic Blood Pressure Monitor

The arrangement for BP cuffs and weigh scales was arranged for high risk OB members. The pulse oximeters however were added to this provider contract to meet the MediCal benefit.

As in any DME item, even if there is no authorization requirement, the beneficiaries cannot go directly to the DME provider. The order must be given either by the physician or HN (UM or case management).

Patient Satisfaction Survey

Program questions

1. What is your overall level of satisfaction with this program?
 - a. Very Satisfied
 - b. Satisfied
 - c. Neutral
 - d. Unsatisfied
 - e. Very Unsatisfied
2. What is your overall satisfaction with your Care Coordinator?
 - a. Very Satisfied
 - b. Satisfied
 - c. Neutral
 - d. Unsatisfied
 - e. Very Unsatisfied
3. Do you feel you are more in control of your health?
 - a. Definitely
 - b. Probably
 - c. Not sure
 - d. Probably not
 - e. Definitely not
4. Do you feel better connected to your practice and your provider?
 - a. Definitely
 - b. Probably
 - c. Not sure
 - d. Probably not
 - e. Definitely not
5. Do you feel your health is benefiting from these monthly calls and closer attention on your readings?
 - a. If yes, how
 - b. If no, why?

Open-ended questions

6. What do you like most about the program?
7. Anything you wish your care coordinator would cover?

RPM Provider Satisfaction Survey

Please Select for Each: NA, 1 = completely disagree, 2 = somewhat disagree, 3 = neutral, 4= somewhat agree, 5 = completely agree

1. I am pleased with the service that has been delivered by our RPM program.
2. I believe that the RPM program is having a positive effect on my patients.
3. During the implementation process, the team clearly explained what was expected of the practice for the RPM program.
4. The care plans being delivered by the nursing teams have met or exceeded my expectations.
5. Signing up patients for the program has been easy to integrate into my current office workflow.
6. The RPM staff assigned to my patients has identified clinical issues that my patients have had and communicated them to myself/my staff in a time effective manner so that I can appropriately address them.
7. My staff has embraced the RPM program.