RPM Resources & Sample Workflows

FQHC TELEHEALTH CONSORTIUM

Bridging the health equity divide

RPM Program Planning

- Determining the overarching goal(s) and priority population(s) is an important first step to planning your RPM program

- SMART (specific, measurable, achievable, relevant, and time-bound) objectives and measures should be developed to guide and evaluate program progress and success

- A project charter and work plan are great tools to define program scope, stakeholder responsibilities, and provide a roadmap for the program

Aims and Measures - Sample 1

Aims:

1. Expand our current RPM program to sites A and B with a goal of 350 patients enrolled in the program by EOY 2023
2. By December 2023, fill 90% our telehealth appointment slots

Process Measures:

- # of calls made for Telehealth visits
- # of calls to patients with HTN for SMBP enrollment
- # of telehealth appointments scheduled

Outcome Measures:

- # of telehealth appointments kept
- # of patients enrolled and set up for SMBP program
- # of patients in the SMBP cohort who had their blood pressure within range at the EOY

Aims and Measures - Sample 2

Aims:

1. Optimize patient utilization of telehealth and add at least one additional telehealth modality by the end of the grant period
2. Improve provider perception through education and care integration

Process Measures:

- Enroll 50 patients in the existing RPM BP Program
- Implement two staff surveys, one at the beginning and another at the end, to 20 staff to assess knowledge and optimization opportunities

Outcome Measures:

- Reduce blood pressure measures for RPM enrolled patients by X% overall
- Improve staff experience with telehealth by Y%

Care Team Designs

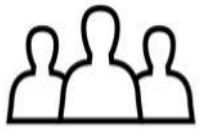
- It's important to align your RPM approach to your practice environment and staffing capacity
- Common responsibilities fall under these general roles: program manager, outreach coordinator & trainer, and clinical champion. Many of these roles can also be shared and modified based on the unique needs of your healthcare facility
- A successful RPM Care Team clearly defines the responsibilities of each member and ensures everyone is practicing at the top of their license

Clinical Pharmacist Led RPM Care Team

Sample roles and responsibilities for a clinical pharmacist (CP) led RPM program

Care Coordinator

- Outreaches identified patients for consents, patient education, and device management
- Triages readings
- Assists Clinical Pharmacist



Clinical Pharmacist

- Identifies patient through report or checks referral
- Conducts initial visit and follow-up
- Make medication adjustments (if on CPA*) and counsel patients on lifestyle modifications

Primary Care Provider

- Identifies suitable patient at point of visit and makes referral
- Resumes patient care once discharged from program

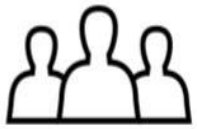
* Collaborative Practice Agreement (CPA): formal agreement that allows for shared supervision of patient whereby the CP can perform specific patient care functions

Registered Nurse Led RPM Care Team

Sample roles and responsibilities for a registered nurse (RN) led RPM program

Community Health Worker

- Checks referral and assigns to RN
- Onboards patient: consents, patient education, set up devices
- Assists RN with readings



Registered Nurse

- Reviews patient data (e.g., BP)
- Coordinates follow ups
- Triages readings and engages PCP as appropriate (abnormal readings X days in a row)

Primary Care Provider

- Identifies suitable patient at point of visit and makes referral
- Manages patient's care, including medication intervention

Practice level support functions

- ★ Admin: IT, interpreter services
- ★ Complex Care
- ★ Population Health
- ★ Quality

Visit Process Maps

- A critical piece to program success is developing, testing, and implementing effective RPM workflows
- Rapid cycle testing is encouraged to refine RPM workflows so they are aligned with your aims and can be adapted to changing practice environments
- Depending on the care team composition and where your program is situated, the responsibilities associated with each step of a workflow will vary

Chronic Disease Management Visit Workflow

Sample RPM workflow for treatment and follow up of chronic disease

1-2 Weeks | 1-3 Months | + 3 Months

Initial Visit

- ~1 hr in-person
- Confirm patient readiness/efficacy
- Explain program goals and expectations
- Set up and demo device, portal, and technique for self-monitoring
- Consent forms, educational handouts
- Schedule follow-up in 7-14 days

1st Follow-up Visit

- ~30 min virtual
- Patient gives feedback
- Review current medication and/or changes
- Review recordings
- Ongoing education
- Let Patient know "this information will go to your PCP for review"

Subsequent Visits

- ~15-30 min virtual
- Assess effectiveness of drug therapy
- 1/month or as indicated by provider/clinical needs
- Discuss Patient's goals and progress in the program
- Review, educate, accept feedback

Discharge/Last Visit

- ~30 min either in person or virtual
- Discuss reason: Patient is at goal, asks to unenroll, or lacks engagement/interest
- Form a plan to sustain treatment and stability
- Offer to schedule annual PCP visit

Patient engages in self-monitoring, updates logbook, and submits readings to portal

Home Diagnostic RPM Workflow

Sample RPM Workflow for diagnosing hypertension (HTN) and can be replicated for other chronic disease

Clinical Use Case

Diagnosing sustained HTN can be tricky since patients can be controlled at home and have white-coat readings in the clinic

The American College of Cardiology and American Heart Association (AHA) recommend using RPM to confirm newly diagnosed HTN by obtaining additional at-home readings[1]

Initial Visit

- Patient identified via provider referral, registry outreach, or HTN clinic
- ~30 hr in-person
- Communicate program goals, set up device, and educate on self -monitoring technique
- Schedule follow-up in 10 days

Follow-up Visit

- ~15-30 min virtual or in-person
- Review with patient their avg BP readings
- Communicate diagnostic decisions
- Document summary note to doctor
- If controlled, no further action

If Uncontrolled

- Enroll in HTN management program
- 3 month follow-up
- Patient continues to record readings
- Medication changes and lifestyle coaching
- Ongoing monitoring and evaluation

** AHA recommends 2-3 readings be taken per day, both in the morning and at night, over a period of one week for a total of ≥ 12 readings, and excluding first-day measurements from analyses [2]*

1. https://www.ahajournals.org/doi/full/10.1161/JAHA.118.008658
2. https://www.ahajournals.org/doi/full/10.1161/HYPERTENSIONAHA.107.189010

On final note…

This content was informed through a series of work groups with FQHCs in the Massachusetts FQHC Telehealth Consortium and their team-based endeavors to deliver equity-driven, patient-centered care.