CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Advancing Team Based Telehealth in RI Webinar Series:

Remote Patient Monitoring – options and strategies for RI primary care practices“

Care Transformation Collaborative of R.I.

APRIL 27,2021

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 & understanding of patients, funding & resources

Patients' who had a telehealth visit suggestions for improvement: 24% would like to have RPM, 32% would like condition specific telehealth appointments

"…vitals so that I can do physicals over the phone too."

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Organizations

NORTHEAST TELEHEALTH RESOURCE CENTER
A program of MCD Public Health

- UnitedHealthcare - Vivify Health
- Blue Cross Blue Shield of RI - AMC Health
- RI Primary Care Physician Corporation
- Providence Community Health Center - Health Recovery Solutions
- Northeast Telehealth Resource Center (NETRC)

UnitedHealthcare®

Blue Cross Blue Shield of Rhode Island

RHODE ISLAND PHYSICIANS CORPORATION PRIMARY CARE

PCHC PROVIDENCE COMMUNITY HEALTH CENTERS

Presenters

United Healthcare	
Stephanie de Abreu, MPA	Manager, State Regulatory Affordability Programs, UHC
Sandy M. Curtis RN, BSN	Sr. Clinical Transformation Consultant, UHC
Edward Yoon MD, MBA	Medicare Chief Medical Officer NE Region, UHC
David Lucas	Chief Strategy Officer, Vivify Health
Robin Hill, BSN	Chief Clinical Officer, VP of Clinical Solutions, Vivify Health
Guy Henggeler	Optum
Blue Cross Blue Shield of RI	
Reena Jariwala, RN, CCM, MSHM	Manager Case Management, BCBSRI
Rena Sheehan	Managing Director Clinical Integration, BCBSRI
Johanna Georgilas, BSN, MBA,	EVP Operations and Chief Clinical Officer, AMC Health
Rhode Island Primary Care Physicians Company	
Darlene Dorocz, RN	Director of Nursing, RIPCPC
Providence Community Health Centers	
Amy Perry, BSN, MBA	Director of Case Management, Providence Community Health Centers
Jonathan Kijne	Client Success Manager, Health Recovery Solutions
Rich Curry	VP of Business Development, Health Recovery Solutions
Northeast Telehealth Resource Center	
Andrew P. Solomon, MPH	Senior Program Manager, Northeast Telehealth Resource Center

Northeast Telehealth Resource Center

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 or Andrew have any financial interest, arrangement, or affiliation with any organizations related to commercial products or services discussed in this webinar.

www.NETRC.org

Remote Patient Monitoring (RPM)

NORTHEAST TELEHEALTH RESOURCE CENTER
A program of MCD Public Health

Drivers

- Payment Reform
- Population Health
- Readmission Penalties
- COVID-19 Safety, etc.
- Consumer Demand
- Provider Shortages
- Competitive Forces
- Reimbursement

Barriers

- Access/Cost for Technology/Broadband
- Digital Literacy/Training
- Limited Privacy and Security Concerns
- Resistance to Change
- Legal/Regulatory Questions
- Licensure
- Practice ability to use RPM across patient panel/consistent approach among payers

Vivify Health / Optum / United Healthcare

Vivify Pathways

A Single End-to-End Platform

Home™
Fully Managed Kits

Go™
Bring Your Own
Devices (BYOD)

Portal™
Cloud-Based
RPM Management

Api™
BUILD Best-of-Breed
Apps + Devices

Voice™
Interactive
Voice Response

Vivify Pathways Home™

Often "Apps" Are Not Simple Enough for Complex or Elderly Patients. +Home is a Turnkey Solution Designed Specifically for That Population, Enabling Patients of Any Age and Technical Ability to Accomplish Remote Care With Ease:

- **Cellular Built-In** – integrated high-speed 4G connectivity
- **Biometric Devices** – integrated selected wireless devices
- **Virtual Visits** – care escalation, to any provider, anywhere
- **Customizable Pathways** – any condition and any language
- **Educational Videos** – any video, with hundreds built-in
- **Medication Reminders** – to the medication detail level
- **Health Tips** – rich media content, shaping patient behaviors
- **Text-to-Speech** – speaking all text content for simplicity
- **Remotely Managed** – remote control support and GPS tracking
- **Logistics Services** – integrated back-end logistics services

Vivify Pathways Home™

Wireless Medical Device Options

Weight

Blood Pressure

PulseOx

Blood Glucose (optional)

Vivify Pathways Home™

Integrated Logistics / Asset Management

PATIENT ONBOARDING

Vivify Logistics Ships Kit

Vivify Logistics Assisted Install

In-Home Kit Delivery & Install

DAILY SELF-CARE

Installation Options:
TECHNICIAN

SELF

PHONE-ASSISTED

- Integrated Clinical and Logistics Workflow
- Easy-On Setup
- Intuitive Experience
- Pre-Connected and Configured

Scheduled Kit Pickup

Kit Testing & Recycling

Kit Inventory Management

Vivify Pathways Home™

Fully Managed Kit

Vivify Pathways Home™

Easy Unpacking and Setup

Getting started for patients is as easy as a few simple steps. Complete with guided animated videos to make it fun.

To get started, follow the simple steps below.

Unpack Kit 1
Unpack all of the kit contents in a convenient location near a power outlet.

Plug In Tablet 2
Plug in the tablet. Place the tablet on the included stand.

Turn On Tablet 3
Turn on the tablet by pressing and holding the power button for *3 seconds*.

Watch Video 4
After the tablet turns on, watch a brief video that will teach you the basics of using the kit, review the patient consent, and then enter your birth year for your PIN code.

Store Box 5
Put all of the packing material back into the kit box, and store it in a safe place.

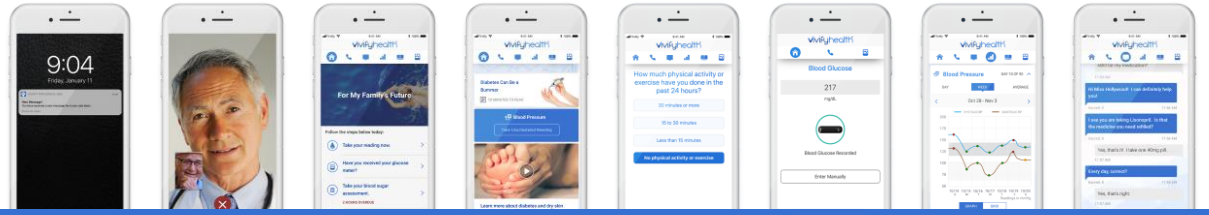
Wait for Call 6
Your remote monitoring team will call you within the next couple of days, to introduce themselves.

If you have any questions in the meantime, you can request a call by clicking the Phone icon button on the tablet. When you have a moment, review the enclosed Health Kit User Guide for more information.

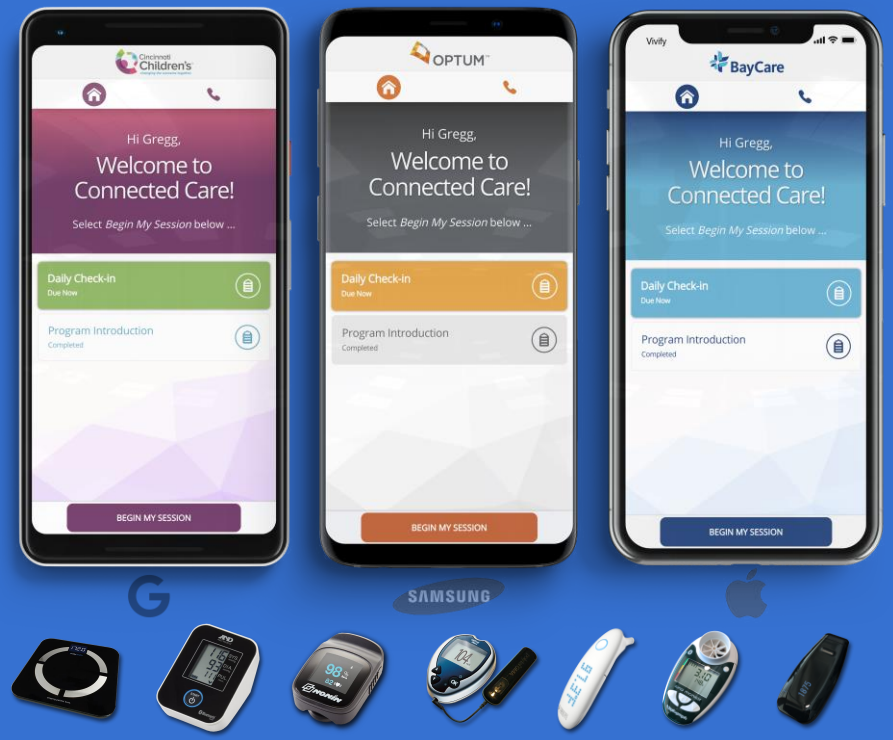
Read This First

Vivify Pathways™

Vivify Pathways Go™



Designed for Patients to Use Their Own Mobile or Desktop Devices (BYOD) to Easily Navigate Through Care Pathways, Biometric Measurements, and Appropriate Educational Content. Scaling Remote Care for Population Health:



(Medical Devices Optional)

- **Highly Scalable** – population health tools for broad deployment
- **Any Device** – designed for any device, without an app download
- **Push Notifications** – reminders without the app
- **No Download** – "responsive web" feels like an app, on any screen
- **Customizable Workflows** – not bound by an app
- **Customizable Pathways** – any condition and any language
- **Educational Videos** – any video, with hundreds built-in
- **Medication Reminders** – to the medication detail level
- **Health Tips** – rich media content of any kind
- **Virtual Visits** – requires a one-time app download

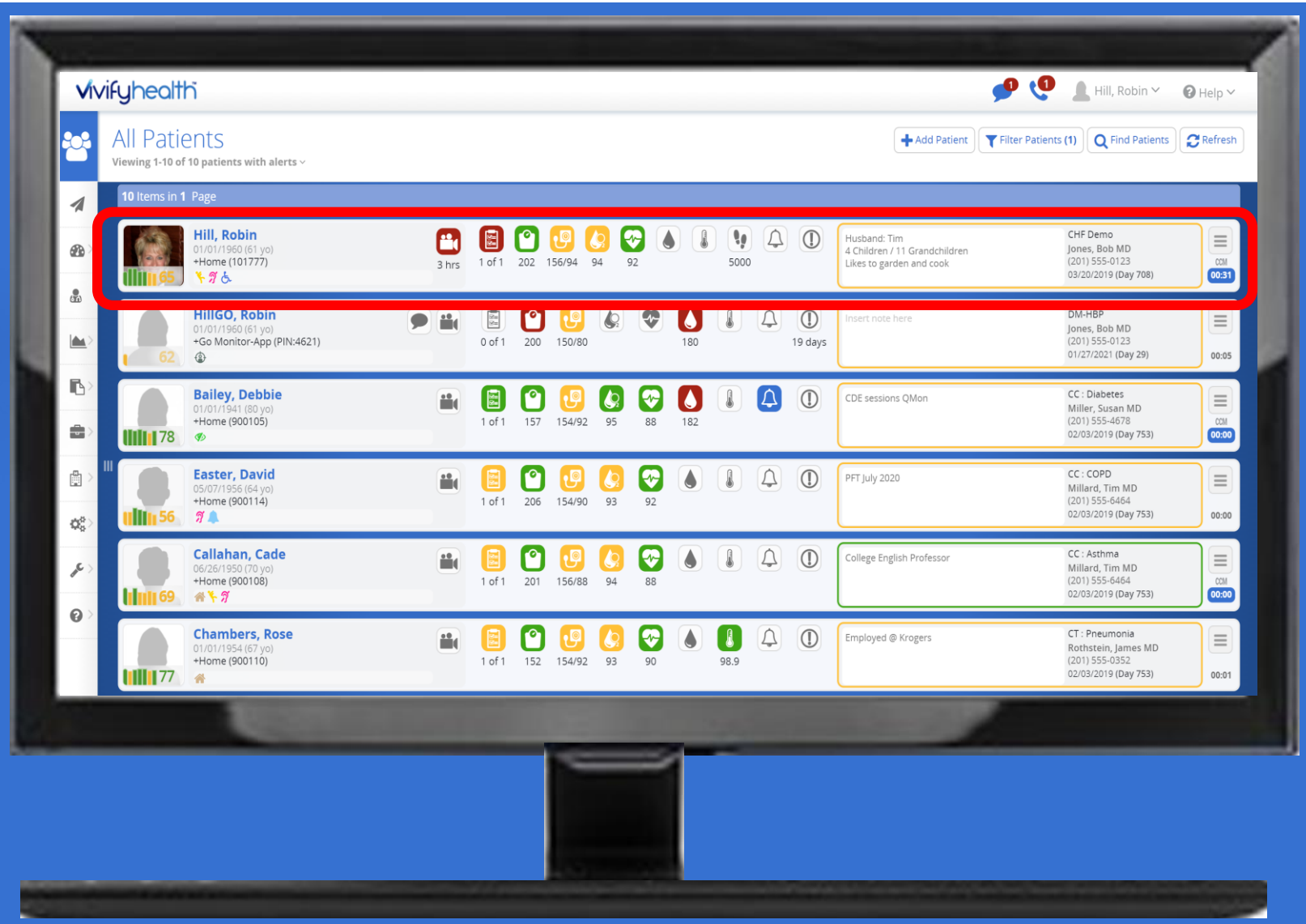
Vivify Pathways Voice™

When Advanced Technology is Not Necessary, +Voice is Designed to Scale To The Rest Of Your Population, with a Simple and Pleasant Automated Interactive Voice Experience, Assuring Compliance with Care Pathways Through Any Phone:

- **Any Voice Device** – engage patients with no technology
- **Speech Recognition** – speech or numeric responses
- **Customizable Pathways** – any condition and any language
- **Vital Measurements** – intelligent vital measurement gathering
- **Medication Reminders** – to the medication detail level
- **Call In or Out** - patients can also call in at their convenience
- **Call Backs** – automated call-back capabilities
- **Voicemail Recognition** - intelligent avoidance of voicemail
- **Brand Awareness** – reminding your consumers that you care
- **Care Continuation** – a solution to assure long-term compliance

Pathways Portal

- Role-Based Access and Views
- Patients Prioritized by Health Score
- Filters by Category of Care
- Unlimited Care Plan Customization
- Unlimited Care Plans per Patient
- Biometric Device Management
- Patient-Specific Alert Thresholds
- Integration with EMR Workflows



Patient Health Summary Report (Physician View)

Health Summary

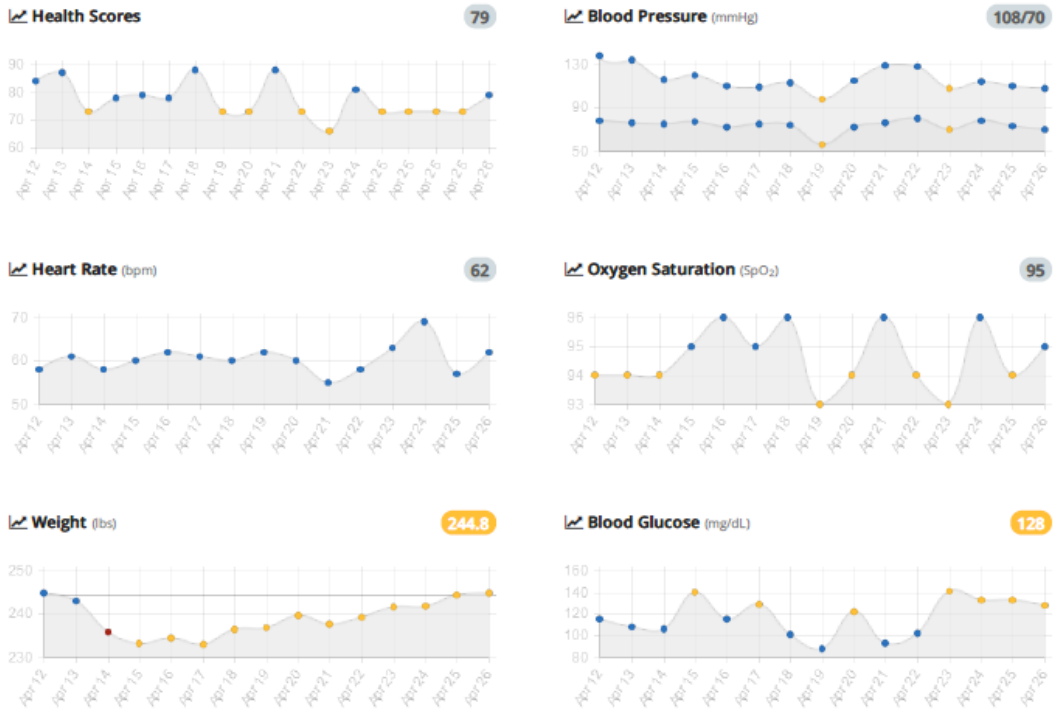
Vivify Health - Test HL7
General Hospital - Test Header

Stanley, Charles (76 years old) ☆
178 | 01/01/1940 | Black or African American | Male
Complex Chronic | DM/HTN/CHF | (972) 333-1212 | vivifypatient@yahoo.com

Medium Risk
Bob Jones, MD
Family Medical Center of Plano, Vivify General

Last Health Score
79

Metrics



Flowsheet

Date	Time	Health Score	Blood Pressure (mmHg)	Heart Rate (bpm)	Oxygen Saturation (SpO_2)	Weight (lbs)	Blood Glucose (mg/dL)	Temperature (°C/°F)
04/26/2016	07:30	79	108/70	62	95	244.8	128	
04/25/2016	08:44	73	110/73	57	94	244.4	133	
04/24/2016	08:48	81	114/78	69	96	241.8	133	
04/23/2016	09:34	66	108/70	63	93	241.6	141	
04/22/2016	09:58	73	128/80	58	94	239.2	102	
04/21/2016	09:31	88	129/76	55	96	237.6	93	
04/20/2016	09:40	73	115/72	60	94	239.6	122	
04/19/2016	09:29	73	98/56	62	93	236.8	88	

Responses

Date	Time	Question	Answer
04/26/2016	09:55	How would you rate your appetite since yesterday?	Good
	09:55	Overall, how have you been feeling since yesterday?	I feel about the same
	09:55	How much physical activity (exercising) have you done since yesterday?	Less than 15 minutes
	09:55	Have you had any of the following symptoms within the past 24 hours?	None of the above symptoms
	09:55	While at rest, how was your breathing yesterday?	A little short of breath
	09:55	Did you sleep in a chair or propped up on extra pillows last night?	No
	09:55	Did you wake up with shortness of breath last night?	No
	09:55	Did you notice an increase in swelling in your feet, ankles or hands yesterday?	No

Vivify Pathways Portal™

Evidence-Based Care Pathways

Any Clinical Condition

- Over 90 built-in care plans
- Proven outcomes with IRB studies

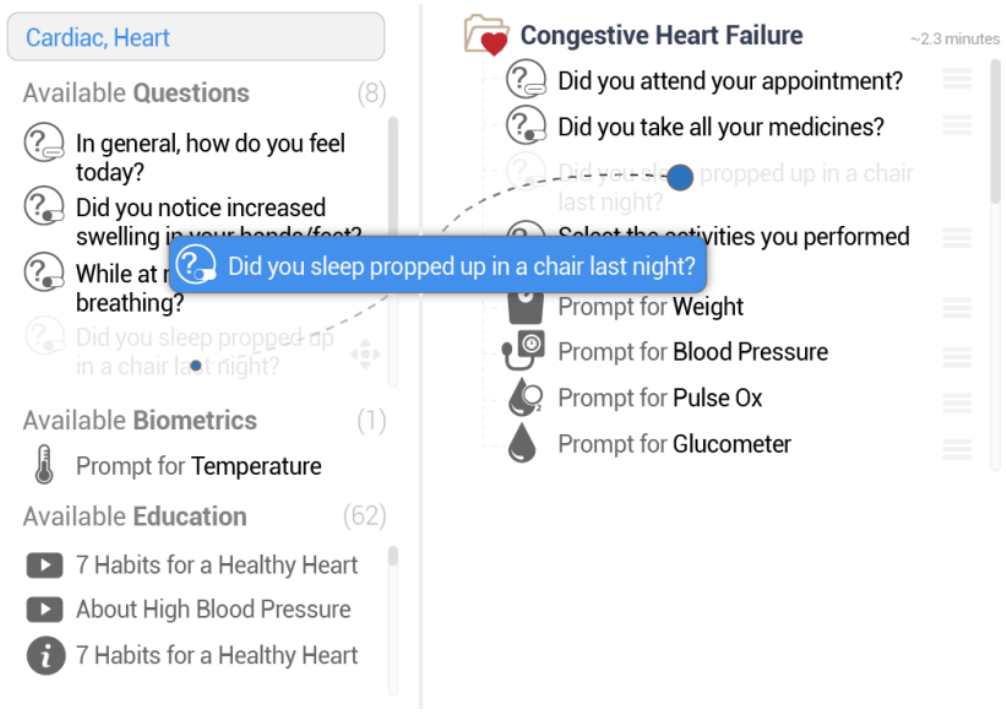
Evidence-Based Clinical Care Plans

- Incorporating evidence-based guidelines, including our partnership with American Heart Association
- Applying national best-practices

Unlimited Customization

- Drag-and-drop patient assignment
- Add your own care plans and videos
- Great for clinical trials, research studies, pre/post-surgical, patient surveys, etc.

American Heart Association.



Blue Cross Blue Shield RI

AMC Health Program Overview

CARE MANAGEMENT DEPARTMENT

Blue Cross Blue Shield of Rhode Island

Agenda

01 AMC Health Program Overview

02 Clinical Services

03 Enrollment and Engagement

04 Equipment Provided

05 Member Example

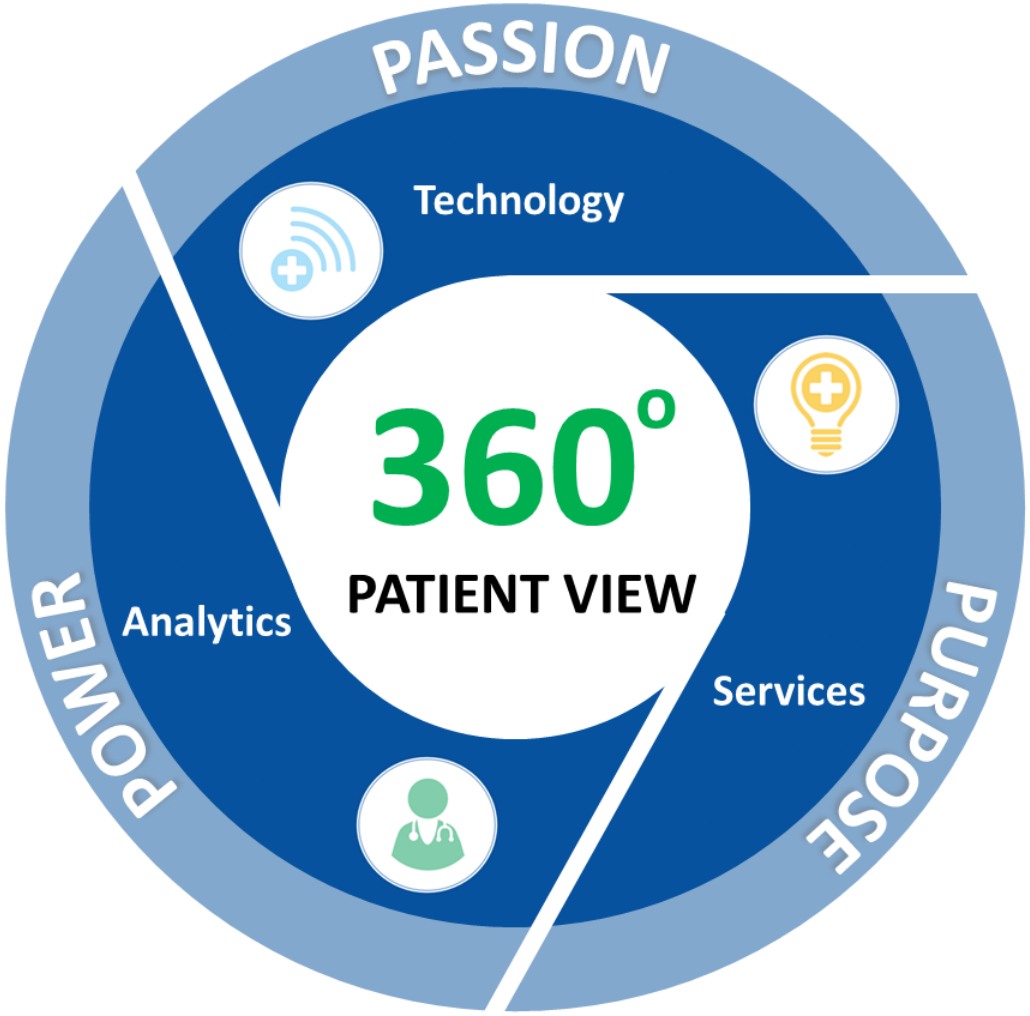
06 CareConsole®

AMC HEALTH

The **leading health-tech software company** that provides telehealth/RPM care for payers, providers, and government entities

AMC HEALTH MISSION

Give everyone with chronic conditions the **power to live healthier, more independent,** lives in the comfort of their own home.



Customized and Comprehensive Solutions

Focused, polychronic solutions to…

manage participants holistically

Data Collection Typologies

DATA INPUTS

ANALYTICS

PLATFORM

Customer Data

Cerner Epic McKESSON VistA homecare homebase

Patient History from Claims & PBM Datasets

Real-Time Patient Data from the Home

Biometric Data via 3rd-Party Monitors

Symptom Data from Automated Surveys

Medication Compliance Data via 3rd-Party Smart Dispensers

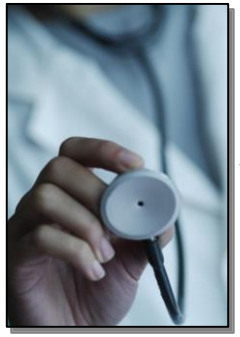
Telepresence Data

Data from 3rd -Party Service Providers (e.g. PERS)

AMC FDA Class II Data Integration Platform

Data is Collected, Engineered, Analyzed, and Presented as Actionable Information

Patient's Physician or Physician Extender



CARECONSOLE®

Remote Nurse or Care Manager

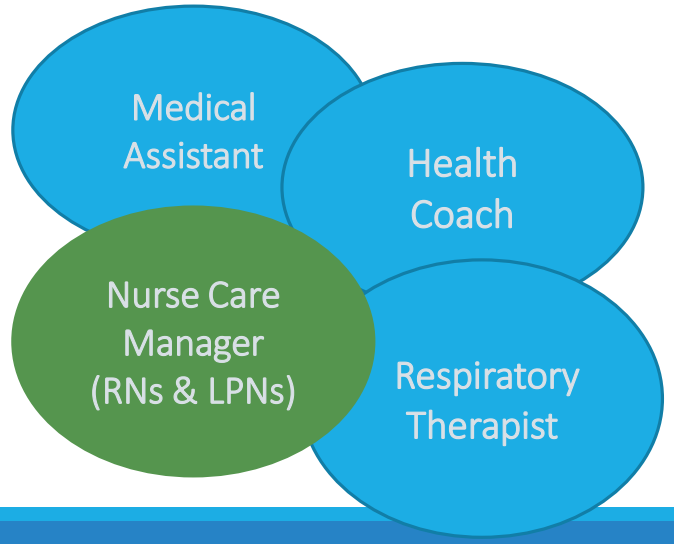
Patient Remote Care Management Application

With Embedded Clinical Decision Support Tools and All the Administrative Functionality Required to Manage *any* Virtual Care Program at Scale

Clinical Services Provided by a Multi-Disciplinary Care Team

- Nutrition counseling
- Pre- and Post- Physician visit
- Post-Hospitalization
- Gaps in Care
- Social Work referrals
- Care referrals (i.e. annual flu)

- Program orientation
- Health goals
- Med reconciliation
- Fall Risk
- Pain Management



- Assessment
- Education
- Adherence
- Pain Management

Enrollment and Engagement Process

Pre-enrollment communications sent to the member

Professional AMC Health enrollment staff provide outreach to each Member

Communications coordinated with the hospital staff and physicians as designed

- ✓ Explanation of Program
- ✓ Demographic Confirmation
- ✓ Verbal Consent
- ✓ Readiness to Participate
- ✓ Functional Capability
- ✓ Device Specific Discussion
- ✓ Supportive Caregiver, Alternate Contacts

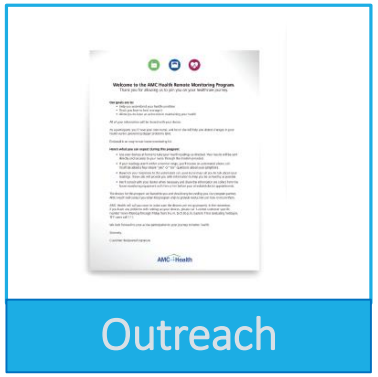
Set-up and Member Training Designed for Simplicity

Device Kit

Device kit (pre-paired with modem/tablet) assembled based on monitored conditions

Set-up

Set-up only requires the member to plug in the modem or turn on the tablet



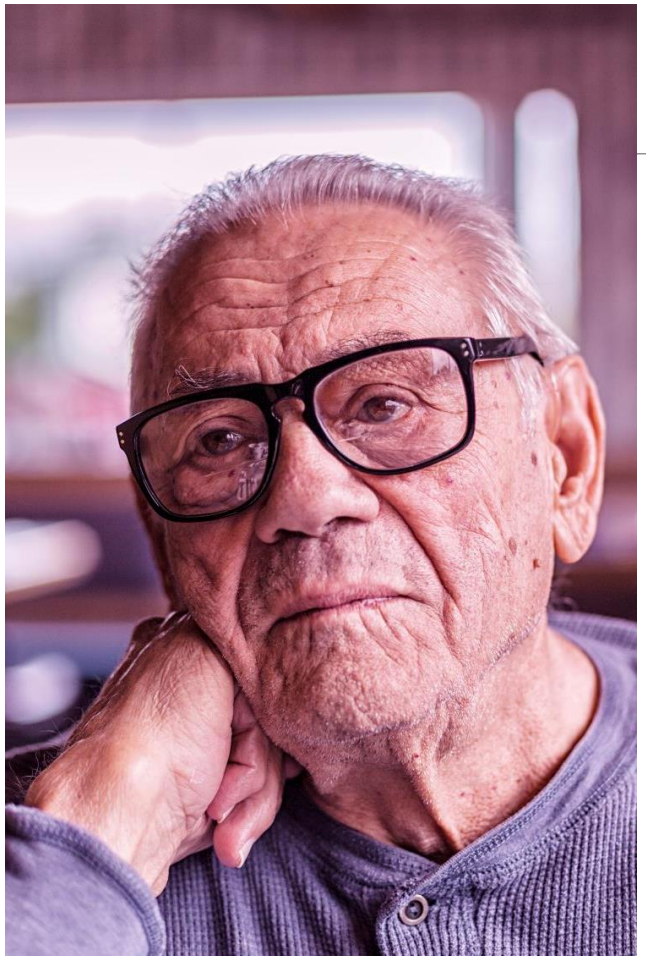
Outreach

We contact the member within 1 business day after arrival or even upon discharge

Technical/User Support

Ongoing technical and user support from kit arrival thru retrieval at graduation/ disenrollment for every enrollee regardless of level of service

Meet Sergey, Age 81, Medicare Advantage Member



CONDITIONS:
(Multiple Conditions)

- Heart Failure
- Hx of Myocardial Infarction
- CAD
- Hypertension

EXPERIENCE:
(BEFORE AMC Health)

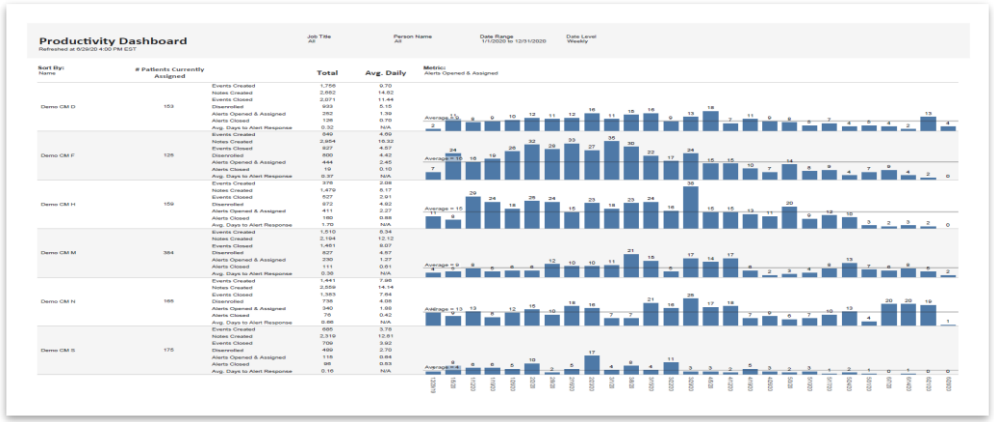
- Hospitalized for exacerbation of his heart failure twice in the last year

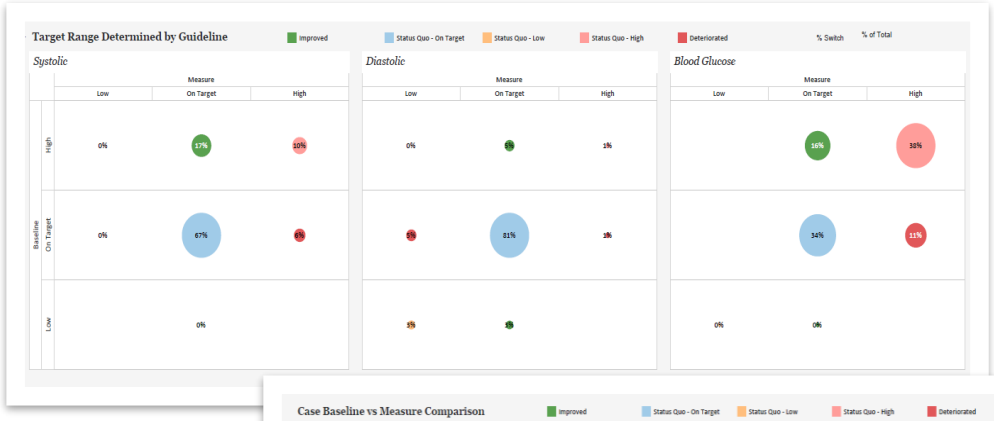
OUTCOME: (WITH AMC Health)

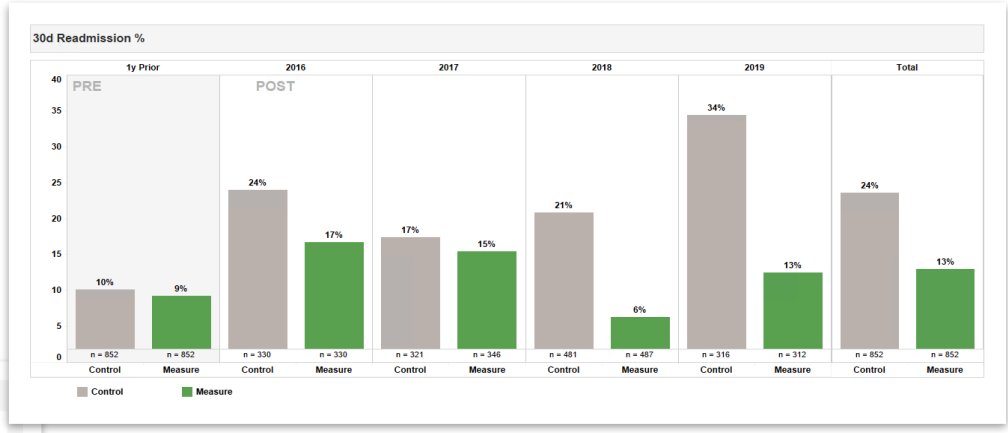
Sergey was enrolled with AMC Health and received a scale and BP monitor and assigned a Tele-Care Management Nurse. Sergey and his healthcare team remain connected through the sharing of his biometrics and timely outreach when he is showing signs or symptoms of exacerbation. Sergey receives clinical education and support as well for management of his conditions. Sergey reached his goals, including:

- ✓ **Weights within target range w/management of weight ↑ and/or S/S of exacerbation** (162)
- ✓ **Target BP average less than 130 mm HG systolic**
- ✓ **No** ER or Readmissions (60 Days Post Discharge)

CareConsole Analytics







Patient and Practice Experiences

- RIPCPC – Nurse Care Manager experience with patients in each program
- Coordination with Primary Care

RHODE ISLAND PHYSICIANS CORPORATION PRIMARY CARE

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

Remote Patient Monitoring

PCHC has two programs supported by technology from Health Recovery Solutions

- Biometric screening with symptom survey for patients with CHF and/or COPD.
- Symptom survey for patients engaged with the behavioral health case manager.

Why we chose these conditions to target

In Rhode Island (RI), residents with CHF are 13 times more likely to have an inpatient hospitalization (about 3 admits per year) and COPD patients are 7.5 times more likely to be admitted (about 2 admits per year). https://health.ri.gov/data/chronicconditions/

Of the top 10% considered high cost from a cohort of 21 million, a study by Milliman found that 57% of this group had a mental health or substance abuse diagnosis. The 57% was shown to contribute to 44% of all health care spending. https://www.ajmc.com/view/examining-the-impact-of-behavioral-health-costs-on-overall-health-care-spending

CHF and/or COPD

For the CHF and COPD program patients are provided with

- Tablet connected to cell towers- patients do not need internet to utilize this tool
- Bluetooth enabled blood pressure cuff
- Bluetooth enabled O2 sat monitor
- Bluetooth enabled scale

Equipment is shipped to the patient's home and they are assisted to set it up remotely

Patients are asked to monitor their vital signs and complete the symptom survey daily

High alerts are monitored and responded to daily Monday-Friday by a Nurse Case Manager

On a weekly basis all vital signs are reviewed for trends or patterns and uploaded into EHR

Behavioral Health

For our behavioral health program patients use their mobile device or a tablet to access the HRS app. Patients need access to a cellular data plan or internet access.

Patients choose 2-3 questions out of a menu of questions and are asked to complete the symptom survey daily.

Example questions:

- ✓Do you feel your health was worse than usual yesterday?
- ✓Did you do less than what you wanted to because of your health yesterday?
- ✓Did your health make it hard to do social activities yesterday?
- ✓Did you feel more down or sad yesterday?
- ✓Did you feel little interest or pleasure doing things you normally enjoy yesterday?
- ✓Did you sleep more or less than usual last night?

If a patient answers yes to any questions, it triggers review and follow-up by the behavioral health case manager.

Benefits

By preventing at least **one hospital day or about 2 ERs**, it **will** pay for the cost of the equipment with assumption that a hospital stay is about $1600/day and an ER visit is about $800/visit.

Example of potential inpatient avoidance: Patient with CHF, weight up 5 lbs in 24 hours on a Friday. NCM was able to call the patient who already had a sliding scale for her diuretics. Patient was not going to take the additional medication, with education and encouragement the patient agreed to take her medication. No ER or inpatient stay noted after that event.

Example of potential for ER avoidance: Patient with CHF, blood pressures running 150-160/ 100-110. We were able to work with the cardiologist through medication adjustments to watch and assess effectiveness of medication changes. Medication adherence education and support conducted. Additionally, education was provided to patient regarding non-pharmaceutical control of blood pressure. Care coordination of appointments to cardiologist was provided in addition to transportation and interpreter assist. Routine communication with cardiologist by NCM to follow blood pressure readings.

Future Initiatives

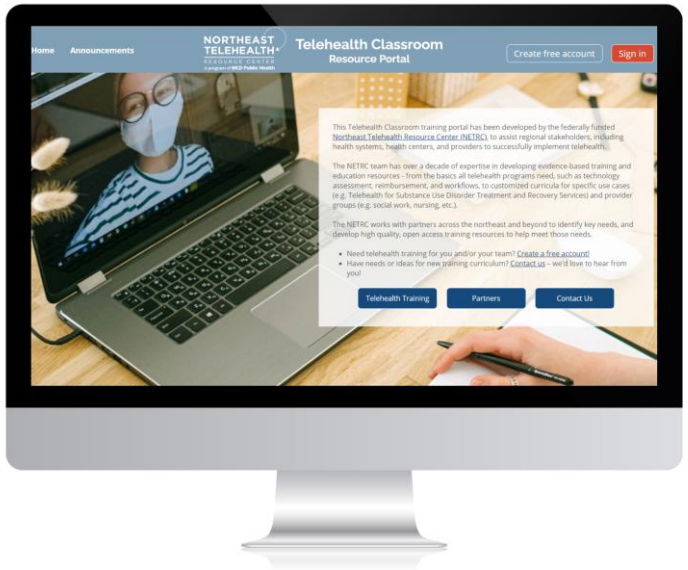
High blood pressure and diabetes are the most common conditions, affecting roughly 165,000 and 83,000 insured Rhode Islanders respectively (or about 17% and 9% of the entire Rhode Island population). High blood pressure and diabetes are two of the most common and most expensive chronic conditions in RI. https://health.ri.gov/data/chronicconditions/

PCHC Pharmacist is in discussions with HRS to implement a mobile app program for patients living with uncontrolled diabetes with recent medication changes. This would include glucose recording and symptom survey.

Funding for a program to monitor blood pressure through the HRS mobile app is being explored. The thought is to monitor patients with newly diagnosed high blood pressure or patients adjusting to medication changes for blood pressure control as a short-term intervention. This would be in conjunction with nurse case management support for education and monitoring.

Resources

www.NETRC.org



www.TelehealthClassroom.org

Evaluation and Upcoming Webinar

Webinar Eval

Please fill out our webinar evaluation using the QR code or at this link: https://www.surveymonkey.com/r/CTC-RIRPMWebinar

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

Next webinar: **May 25, 2021 – "Special Considerations for Pediatric Telehealth." Register here:** https://us02web.zoom.us/webinar/register/WN__E3Joia_QICdldf0BHD0oA

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!

Presenter Contact information

- Stephanie de Abreu, UnitedHealthcare: Stephanie_deabreu@uhc.com
- Reena Jariwala, BCBSRI: Reena.Jariwala@bcbsri.org
- Darlene Dorocz, RIPCPC: ddorocz@ripcpc.com
- Amy Perry, PCHC: aperry@providencechc.org
- Andrew Solomon, NETRC: asolomon@mcdph.org
- Rich Curry, HRS: rcurry@healthrecoverysolutions.com

ADVANCING INTEGRATED HEALTHCARE

Appendix

Vivify Health / Optum / United Healthcare

A reminder for how RPM's impact can be so profound…..as reported March 2021 by an Optum Case Manager whose patient was participating in the Vivify RPM program:

Good morning! I hope your day is going well so far. I have an awesome success story to share that I've entered onto the spreadsheet:

Member is in our program for CAD. He reports he had started having some angina and shortness of breath. He states he wasn't going to do anything about it. ***Then he remembered the education provided on the tablet regarding signs and symptoms of a heart attack****. Member called his physician who had him come in right away for a cardiac cath. Found to have a blockage in his heart that they were able to clear. Member states he's so thankful for RN and the tablet provided.* ***He reports the program saved his life. Member's physician said it saved his life as well, due to the early intervention.***

Our program is making a difference. Wishing you a wonderful day.

Vivify Health / Optum / United Healthcare

Vivify Health:
Outcomes
Sampling

62% Reduced 30-Day Readmissions @ Trinity Health	**81%** Rate of Acceptance of COVID-19 Screening Tool with HCA Employees	**66%** Reduced IP Admits @ C&S Wisconsin (Medicaid)
41,000 Patients Served b/n mid-2017 and Dec 2020 @ Trinity Health	**41%** Reduction in Hospital Admission Costs @ WellMed	**56%** Reduced PMPM Medical Expense @ C&S Wisconsin (Medicaid)
135,000 Video Visits Completed @ Trinity Health	**33K** Member Participation @ UHC M&R in First Year Post-Acquisition of Vivify (Medicare Advantage)	**74%** Reduced 90-Day Readmissions @ UPMC
44% Reduced 30-Day Readmissions @ Ascension	**3.1** ROI vs. Heart Failure Control Group @ Ascension	Consistent **90+%** of Patient/Member Satisfaction and Daily Compliance