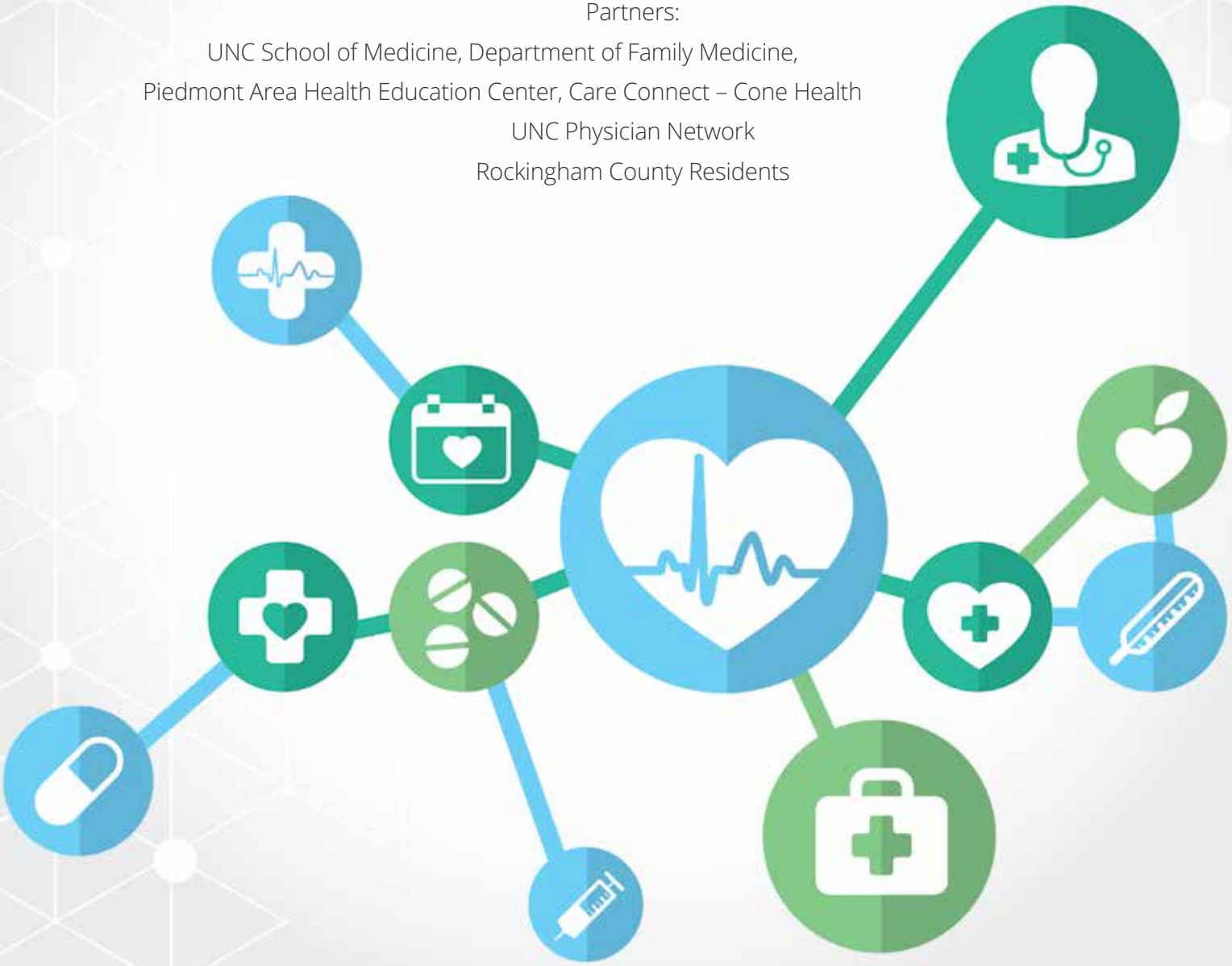
# Remote Monitoring in the Rock* "Practice Guide"

*Rockingham Primary Care Initiative

Funded by Blue Cross and Blue Shield of North Carolina

Partners:
UNC School of Medicine, Department of Family Medicine,
Piedmont Area Health Education Center, Care Connect – Cone Health
UNC Physician Network
Rockingham County Residents



PIEDMONT AHEC
PART OF NC AHEC

UNC SCHOOL OF MEDICINE Family Medicine

# What Is This Initiative?

## Purpose Statement:

To create a sustainable model of virtual care wellness visits and remote monitoring of chronic conditions among Medicare and Uninsured patients.

## Goals:

- To increase access to primary care and help close care gaps in preventative care.
- To improve patient outcomes through remote monitoring.
- To contribute to literature about virtual visits and remote monitoring.

## Objectives:

- To collaborate with 2-4 practices in Rockingham County to identify up to 200 patients to enroll in the pilot initiative.
- To support practices in developing their operational capability to offer remote patient monitoring.
- To collect community voices in the design of the program.
- To collect and report project data.
- To measure patient and staff satisfaction with the pilot.

# Contents

# Practice Participation

## How to participate?

The practice will review and sign a memorandum of understand (MOU) and shared data agreement, indicating their intent to join the initiative. All documents will be returned to the initiative program manager.

A general timeline for this initiative is displayed below.

**Months 1-2**
Clinic enrollments/ training

Staff baseline surveys

Community Advisory Board

**Months 3-12**
Patient enrollment/ training, clinic documentation of patient progress/ outcomes in EHR

**Month 13**
Clinic outcomes reporting to AHEC Coach

Staff remeasure surveys

**Months 14-18**
Data complied, outcome trends reported to clinics and stakeholders

Staff remeasure surveys

**Months 18-24**
Initiative process and outcomes are written for a professional journal, presentation, or society

## Initiative impact on your practice

Variables you may want to consider before joining this iniative include the following. The larger the word below indicates more resources that may need to be dedicated to that variable.


## Practice incentives

| |
|---|
| $50 per enrolled patient who completes the onboarding criteria. Onboarding criteria includes completing the patient consent, patient survey, and transmits first data points. |
| No cost remote monitoring equipment. This includes blood pressure devices and scales. |
| You will receive onsite or remote side-by-side AHEC practice coaching for training, workflow development, documentation, and data collection. |
| Your practice **may also** be able to collect increased revenue through the addition of insurance billing codes for remote patient monitoring. * See Page 8 for billing information. |

# Getting Started with Remote Patient Monitoring

What are characteristics of practices that will success with a remote monitoring program?


If this is your team, the first step is to sign a MOU (See Page 10) that allows us to share patient data in a HIPAA-compliant way.  Then we will help you identify candidates for the program.

# Notional Clinical Workflows

## The program starts with a health assessment or wellness exam.

The program for traditional practice enrolls Medicare patients at the time of the Annual Wellness Visit who have one or more chronic problems.

For safety net practices, we will enroll uninsured patients with health needs assessments that identify gaps in preventative care and health maintenance.

Enrollment can be accomplished through an on-site, home, or telehealth visit with a non-provider team member who is supervised by an APP, DO, MD in the practice.

The data and the devices are enablers. The real problem is the standard work we develop together to monitor and coach patients to make better choices.

These are the reimbursable "remote monitoring visits".

Your practice will receive a small payment to defer the cost of each enrollment.

Each patient that enrolls in the program will get a Bluetooth -connected scale and blood pressure cuff at no cost. They will be asked to download a free application that transmits data to your team via a portal.

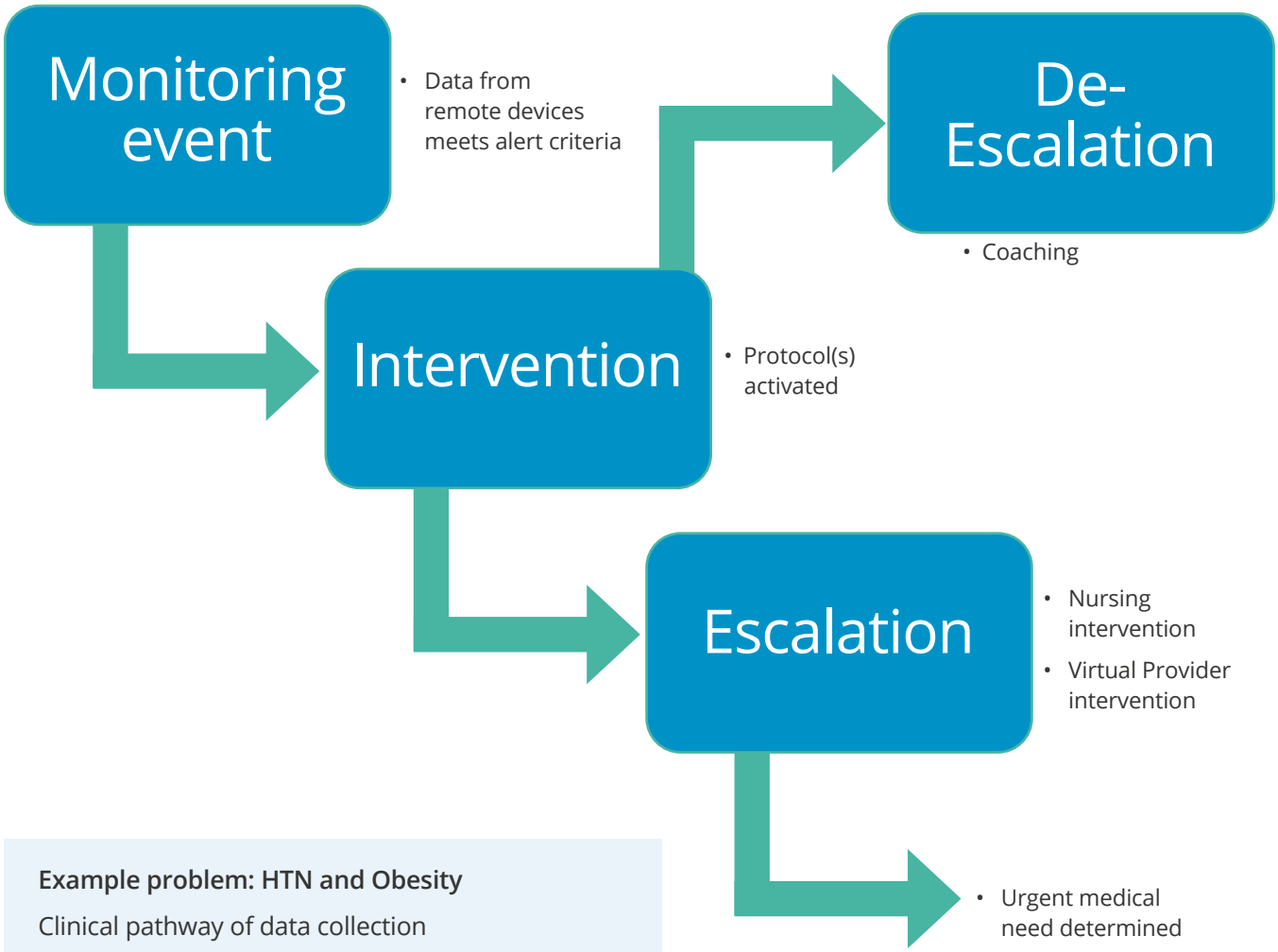
The program will work with your team to develop:

1. A process for onboarding patients
2. Standard work to review and report data
3. Coaching techniques & strategies for active patients
4. The use of telehealth to make patient contact convenient and desirable
5. Key performance indicators to measure success
6. Replacement program for lost or broken devices

We are looking for patients with obesity HTN, CHF or T2DM who are at low to moderate risk that you follow regularly.

- A care plan that requires action from the patient
- Patients with end stage conditions like ESRD are excluded
- One or more chronic medications
- The ability to consent to participate

# Remote Patient Monitoring Notional Clinical Pathways




**Example problem: HTN and Obesity**

Clinical pathway of data collection
- Daily weights
- Twice daily BP

Self-care protocols

Alerts: BP>x or ,Y (data analysis)

Critical alerts: Call your doctor if...
- Bothvalues and symptoms

Provider approved intervention pathways
- Confirmation of value
- Risk Assessment
- Health Coaching
- See, Feel, Change

Escalation and de-escalation rules
- Acute virtual provider
- Urgent FTF care
- Resume monitoring

# 7 Steps for Self-Monitoring Blood Pressure

## 1. Identify

**Identify** patients for SMBP

- Patients with an existing diagnosis of hypertension
- Patients with high blood pressure without a diagnosis of hypertension
- Patients suspected of having hypertension (labile or masked hypertension)

## 2. Confirm

**Confirm** device validations and cuff size

- Make sure patients have automated, validated devices with appropriately sized cuffs

## 3. Train

**Train** Patients

- Educate Patients on how to perform SMPB using an evidence-based protocol
- https://www.ama-assn.org/sites/ama-assn.org/files/2019-07/SMBP-Training-English.mp4
- https://www.ama-assn.org/sites/ama-assn.org/files/2019-07/SMBP-Training-Spanish.mp4

## 4. Perform

Have the patients **perform** SMBP

- Agree on a time of day for measurements
- To confirm a diagnosis, assess after a set period if BP is controlled

## 5. Average

**Average** all SMBP for a monitoring period (e.g., one week)

- Document and use the average systolic and diastolic BPs for clinical decision making. Use a minimum of 3 days.

## 6. Interpret

**Interpret** all results

## 7. Document

**Document** your plan and communicate it to patients

- Confirm your patient's agreement and understanding

*Please note this information is adapted from the CDC's Million Hearts Program* https://millionhearts.hhs.gov/

# Billing for Remote Patient Monitoring

| | |
|---|---|
| **99453** ***(Set up)*** | Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), plus initial set-up and patient education on use of equipment. (Initial set-up and patient education of monitoring equipment included; do not report 99453 for monitoring of less than 16 days.) ***CMS reimbursement approx. $20, NC Medicaid $15.71** |
| **99454** ***(Equipment & Monitoring)*** | Device(s) supply with daily recording(s) or programmed alerts transmission, each 30 days. (Initial collection, transmission, and report/summary services to the clinician managing the patient.) *** CMS reimbursement approx. $64, NC Medicaid $52.57** |
| **99457** ***(Interventions)*** | Remote physiologic monitoring treatment management services, clinical staff physician/ other qualified healthcare professional time in a calendar month, requiring interactive communication with the patient/caregiver during the month; first 20 minutes. *Reimbursement approx. **$54. Varies by payor, NC Medicaid $28.48** |
| **99458** | Each additional 20 minutes (List separately in addition to code for primary procedure.) |
| **99091** | Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring), digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/ regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days. |

## Remote Patient Monitoring Documentation

- Medical necessity for RPM must be noted in patient record (i.e. assigning the correct ICD-10-CM code (diagnosis)
- Must also receive advance patient consent for RPM
- Permission for the service from the patient and justification for RPM should be documented in the medical record.
- Per the April 30 COVID Interim Final Rule, CMS will allow RPM services to be reported to Medicare for periods of time of fewer than 16 days, but no less than two days, during the public health emergency (PHE).
- For monitoring of less than 16 days, but more than two days, payment for CPT codes 99453, 99454, 99091, 99457 and 99458 is limited to patients who have a suspected or confirmed diagnosis of COVID-19.
- The device used to capture a patient's physiologic data must meet the FDA definition of a medical device. For more information, see: https://www.fda.gov/medical-devices.
- To bill for RPM services, patients' physiologic data must be wirelessly synced where it can be evaluated. Transmission can be synchronous or asynchronous (i.e. data does not have to be transmitted in real time as long as it is automatically updated on an ongoing basis for the provider to review).
- Physicians, nurse practitioners, physician assistants and certified nurse midwives are eligible to bill for RPM and RPM treatment management services. FQHCs, FQHC Lookalikes and RHCs can bill under fee-for-service reimbursement for services provided by physicians, nurse practitioners, physician assistants or certified nurse midwives.
- If the services described by code 99453-99458 are provided on the same day the patient presents for an evaluation and management service to the same provider (whether by telehealth or in person), these services should be considered part of the E/M service and not billed under code 99453-99458.

## Resources

https://mtelehealth.com/cms-guidance-for-remote-patient-monitoring-rpm-during-covid-19-cpt-code-99453/

https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

https://medicaid.ncdhhs.gov/blog/2020/04/17/special-bulletin-covid-19-48-telehealth-clinical-policy-modifications-remote

https://files.nc.gov/ncdma/documents/files/1H_3.pdf

# Initiative Metrics and Outcomes

Some of the key indicators identified by innovative programs like this at Cleveland Clinic, University of Pittsburg Medical Center and The University of Mississippi include:

- ➡ Reduction in the use of emergency rooms
- ➡ Increased adherence with medications
- ➡ Improvement in clinical measurements
  - BMI
  - A1C
  - Mean BP
  - Dry weight
- ➡ Close gaps in care for:
  - Immunizations
  - Preventative screening

Over the course of the initiative, the practice will complete an agreement to develop and report out custom report measures. Your AHEC coach will support you in creating a practice-specific dashboard, and your clinic will have access to the dashboard data.

| Outcomes Measures | Baseline | 3-months | 6-months | 9-months | 12 months | 18 months |
|---|---|---|---|---|---|---|
| Patient knowledge on self-management survey | | | | | | |
| Patient satisfaction with participation in initiative survey | | | | | | |
| Staff Satisfaction | | X | X | X | | |
| **Clinical Measures** | **Baseline** | **3-months** | **6-months** | **9-months** | **12 months** | **18 months** |
| # of billed Medicare Annual | | | | | | |
| (G0402, G0438, G0439) | | | | | | |
| % of Diabetes Care Gaps Close | | | | | | |
| DM | | | | | | |
| DM | | | | | | |
| DM Eye Exam | | | | | | |
| DM Foot Exam | | | | | | |
| DM with A1c < 9 | | | | | | |
| % of Hypertension Care Gaps Closed | | | | | | |
| Blood pressure taken in office | | | | | | |
| % of blood pressure <130/80 | | | | | | |



# Academic Resources for Remote Patient Monitoring

- Welch Allyn Home(TM) Blood Presure Monitors and Scales Information

  https://www.welchallyn.com/content/dam/welchallyn/documents/upload-docs/Product-Literature/Brochure/MC13985_VerB_WA_Home_BP-scale-App_brochure_WR.pdf
- High blood pressure is the number one risk for heart attack, stroke and kidney disease, affecting nearly 1 in 2 American adults. https://www.welchallyn.com/en/microsites/welch-allyn-home.html
- AMA Digital Health Implementation PlayBook. https://www.ama-assn.org/amaone/ama-digital-healthimplementation-playbook
- HITEQ Remote Patient Monitoring Implementation Guide January 2021. https://hiteqcenter.org/Resources/Priority-Topics/Ending-the-HIV-Epidemic/safer-at-home-using-remote-patient-monitoring-for-patient-care
- Dr. John Jenkins, Remote Patient Monitoring (RPM) Clinical Pathways
- Dr. John Jenkins, CMS Rules for Remote Patient Monitoring (RPM) in the Clinical Setting

# Appendices
# Preparing the Care Team

## Why preparing the care team is important

*Successful implementation of an RPM solution is a team effort.*

Your team will serve on the front line, reviewing clinical data and engaging patients, so it is important for them to know their role and responsibilities within the implementation.

Proper staff preparation ensures:

- Staff understand the importance of the program and are motivated to participate.
- Staff understand their key responsibilities in achieving aligned success metrics.
- New procedures are understood, correctly followed, and documented.
- Data is collected, analyzed, and presented to physicians in a clinically relevant manner.
- Staff are prepared to impart the skills, knowledge, and mindset patients will need to be successful with the program.

## Goals to accomplish during preparing the staff

___ Talk with your vendor about available training support.

___ Identify staff leaders who can help develop, position, and socialize training materials.

___ Identify "superusers" who can act as ongoing trainers for other staff.

___ Develop (or source from your vendor) written and/or video training materials (scripts, guides, reference documents) that staff can use and refer back to.

___ Schedule large-group training session(s).

___ Plan for how and when training will be refreshed/reviewed.

___ Educate staff on the new workflow, clinical protocols, and operation of the RPM solution.

___ Train staff to educate patients.

___ Provide a process/opportunity for staff to provide ongoing feedback or ideas for improvement.

**Information modified from AMA Digital Implementation Playbook**

https://www.ama-assn.org/amaone/ama-digital-health-implementation-playbook

# Staff Survey

## Staff Remote Monitoring Survey

1= low 5 = high

### Blood Pressure Cuff

| | | | | | |
|---|---|---|---|---|---|
| The blood pressure cuff was easy to use. | 1 | 2 | 3 | 4 | 5 |
| The blood pressure cuff display was easy to read. | 1 | 2 | 3 | 4 | 5 |
| The blood pressure cuff is reliable and had few technical problems. | 1 | 2 | 3 | 4 | 5 |
| The blood pressure cuff gives me accurate test results. | 1 | 2 | 3 | 4 | 5 |

### Scale

| | | | | | |
|---|---|---|---|---|---|
| The scale was easy to use. | 1 | 2 | 3 | 4 | 5 |
| The scale display was easy to read. | 1 | 2 | 3 | 4 | 5 |
| The scale is reliable and had few technical problems. | 1 | 2 | 3 | 4 | 5 |
| The scale gives me accurate test results. | 1 | 2 | 3 | 4 | 5 |

### Communications/Interactions

| | | | | | |
|---|---|---|---|---|---|
| I had adequate time to train patients on home blood-pressure-monitoring equipment. | 1 | 2 | 3 | 4 | 5 |
| I had adequate time to train patients on home weight-monitoring equipment. | 1 | 2 | 3 | 4 | 5 |
| I had adequate time to train patients on how to share data. | 1 | 2 | 3 | 4 | 5 |
| I had adequate time to train patients on how to access the data. | 1 | 2 | 3 | 4 | 5 |
| I had adequate resources to train patients on equipment. | 1 | 2 | 3 | 4 | 5 |
| I had adequate time to respond to patients' questions about home monitoring program. | 1 | 2 | 3 | 4 | 5 |

### Program Evaluations

| | | | | | |
|---|---|---|---|---|---|
| I was adequately trained on the patient remote-monitoring program in my clinic. | 1 | 2 | 3 | 4 | 5 |
| I am satisfied with the home blood-pressure-monitoring program. | 1 | 2 | 3 | 4 | 5 |
| I am satisfied with the home weight-monitoring program. | 1 | 2 | 3 | 4 | 5 |
| I would recommend using home blood pressure to other patients. | 1 | 2 | 3 | 4 | 5 |
| I would recommend using home weight-monitoring to other patients. | 1 | 2 | 3 | 4 | 5 |
| The patient remote monitoring program added value to my patients' care. | 1 | 2 | 3 | 4 | 5 |
| I was able to bill insurance for my patient remote-monitoring program. | 1 | 2 | 3 | 4 | 5 |

*Source:* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5659856/

- No cost remote health devices
- Virtual visits for chronic conditions at no cost
- Help improve local telehealth

## Rockingham Primary Care Initiative presents

# Remote Monitoring in the Rock*

PATIENT ENROLLMENT INFORMATION

*Are you a Rockingham County resident who wants the convenience of at-home health monitoring as well as visiting your doctor from your computer or smartphone? Remote Care in the Rock is a no cost service available to eligible participants through your local primary care practice.*

## Am I eligible?

The program is open to Residents of **Rockingham County, N.C.**, who have **Medicare** or are uninsured and suffer from one or more chronic health conditions.

## What will I receive?

- Monitoring devices: Blood pressure cuff and scale at no cost to you
- Ongoing virtual visits: Continual support and virtual care wellness visits from local nurses and medical staff
- Participant survey(s): An opportunity to provide feedback about virtual visits and the use of remote monitoring devices

## How to I enroll?

Your primary care physician, nurse, and/or care team can assist you in enrolling in the **Remote Care in the Rock** program and answer any questions you may have. There is no fee for patients to participate in the program.

CareConnect
Linking Your Community and Health

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- Equipos médicos gratuitos para el control de la salud a distancia
- Visitas virtuales gratuitas para enfermedades crónicas
- Ayudar a mejorar la telesalud local

## La iniciativa de cuidados primarios de Rockingham presenta

# La telesalud en el condado de Rockingham*

INFORMACIÓN SOBRE LA INSCRIPCIÓN DE LOS PACIENTES

*¿Es usted un residente del condado de Rockingham que quiere la comodidad de un control de la salud desde su casa, así como visitar a su médico desde su computador o con un teléfono inteligente?*

*La telesalud en el condado de Rockingham es un servicio gratuito disponible para los participantes que reúnen los requisitos a través de su consultorio local de cuidados primarios.*

## ¿Tengo derecho a participar?

El programa está disponible a los residentes del condado de **Rockingham, N.C.**, que tienen Medicare o no tienen seguro médico y que padecen de una o más condiciones físicas crónicas.

## ¿Qué recibiré?

- Equipos de control gratuitos: una manga de presión arterial y una báscula
- Visitas virtuales continuas: apoyo continuo y visitas virtuales para el manejo de su bienestar y cuidado por parte de enfermeras y personal médico
- Encuesta(s) a los participantes: una oportunidad para dar su opinión sobre las visitas virtuales y el uso de los equipos para control de la salud a distancia

## ¿Cómo me inscribo?

Su médico de cabecera, enfermera y/o equipo de atención médica pueden ayudarle a inscribirse en el programa de Telesalud en el condado de Rockingham y responder a cualquier pregunta que usted pueda tener.

La participación de los pacientes en el programa es gratuita.

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Patrocinadores

UNC School of Medicine, Department of Family Medicine | Piedmont Area Health Education Center
Care Connect– Cone Health | UNC Physicians Network | Residentes del condado de Rockingham

# Remote Monitoring in the Rock

## Patient Readiness Questions

## English:

1. Have you previously joined a home monitoring program to help you control your blood pressure?

2. What, specifically, has stopped you in the past from reaching your goal of managing your blood pressure?

3. Using a scale of 1 to 10 (1 =“there’s no way” and 10 =“definitely will do”), would you be able to monitor your blood pressure for 7 out of 7 days?

**These documents are available upon request. These documents are available in Spanish.*

# Remote Monitoring in the Rock

## Remote Patient Monitoring (RPM) Consent Form

I understand that:

- I understand the devices are to be used only for the Remote Monitoring in the Rock program.
- I will do my best to use the equipment as instructed.
- I am the only person who should be using the remote monitoring equipment.
- I will not use the devices for reasons other than taking my own personal blood pressures (BP) and weights.
- I will not tamper with the equipment. I understand that I am responsible for any fees associated with misuse of the equipment.
- I acknowledge that I received blood pressure monitor Serial #_____
- The device is meant to collect BP 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 acknowledge that I have received electronic weight scale Serial #_____.
- I am aware my BP daily readings will be transmitted from the monitor to a website in a safe and secure manner.
- My consent to participate in Remote Care in the Rock will remain in place as long as I keep the equipment.
- I can withdraw my consent to participate in this program at any time by returning the BP Monitor/Cuff device.
- The Care Connect team will securely and confidentially store my collected data. Nursing notes about my BP and weight will be stored in my electronic medical record.
- I will do my best to take my BP two times a day, every day.
- I will do my best to measure my weight on the electronic scale every day.
- I am aware that a Remote Patient Monitoring Qualified Health Professional will only view my readings every 4 days, and that this program is NOT a 24/7 Monitoring Service.
- I will be contacted every 4 days, by phone, to review and discuss my results and progress.

I, _____ *(Print your name)*

*have read and understood the information and consent to participate in the Remote Patient Monitoring program as stated above.*

Date: _____ (dd/mm/yyyy)

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

**These documents are available upon request. These documents are available in Spanish.*

*Last updated: 5/27/2021*

# Patient Goal Setting

## Blood Pressure Remote Monitoring Goal Sheet

Name: Date: Daily at:

Measure your weight without any clothes. If is best to weigh after you have gone to the restroom and always before you eat or drink anything.

Measure BP twice at _____am and _____pm

Take two readings both in the am and pm 5 minutes apart.

Follow the AMA diagram.

Don't take extra readings unless you are having symptoms or are told to do so by your team.

When to call the office: _____

When to go to ER:

If you are having a medical emergency. Do not call your care team. Call 911. Read the hypertensive crisis sheet. If you experience any of the symptoms with elevated blood pressure, call 911.

Your Care Connect team will contact you _____ time(s) a week. If you have a question, please call your primary care provider for medication issues if you become ill.

Disclaimer: Remember, your Care Connect Case Manager's are available from 9 a.m. to 5 p.m. Monday - Friday. This program is not an emergency service. Your blood pressure is not monitored by clinical staff in real time. Any symptomatic high blood pressures should be evaluated at a clinic or emergency facility.

**These documents are available upon request. These documents are available in Spanish.*

# Patient Survey

## Remote Patient Monitoring Survey

| | 1= low | | | | 5 = high |
|---|---|---|---|---|---|
| **Blood Pressure Cuff** | | | | | |
| The blood pressure cuff was easy to use. | 1 | 2 | 3 | 4 | 5 |
| The blood pressure cuff display was easy to read. | 1 | 2 | 3 | 4 | 5 |
| The blood pressure cuff is reliable and had few technical problems. | 1 | 2 | 3 | 4 | 5 |
| The blood pressure cuff gives me accurate test results. | 1 | 2 | 3 | 4 | 5 |
| If technical programs occur, the staff are quick to respond and fix the problems. | 1 | 2 | 3 | 4 | 5 |
| The amount of time it takes to complete my daily home blood pressure is acceptable. | 1 | 2 | 3 | 4 | 5 |
| **Scale** | | | | | |
| The scale was easy to use. | 1 | 2 | 3 | 4 | 5 |
| The scale display was easy to read. | 1 | 2 | 3 | 4 | 5 |
| The scale is reliable and had few technical problems. | 1 | 2 | 3 | 4 | 5 |
| I received adequate training in using my home scale. | 1 | 2 | 3 | 4 | 5 |
| The scale gives me accurate test results. | 1 | 2 | 3 | 4 | 5 |
| If technical programs occur, the staff are quick to respond and fix the problems. | 1 | 2 | 3 | 4 | 5 |
| The amount of time it takes to complete my daily weight is acceptable. | 1 | 2 | 3 | 4 | 5 |
| **Communications/Interactions** | | | | | |
| The home monitoring staff are responsive to my questions and concerns. | 1 | 2 | 3 | 4 | 5 |
| My doctors are interested in reviewing my home blood-pressure and scale tests. | 1 | 2 | 3 | 4 | 5 |
| I am satisfied with amount of communication I received from the home monitoring staff. | 1 | 2 | 3 | 4 | 5 |
| I am satisfied with the quality of my interactions with the home monitroing staff. | 1 | 2 | 3 | 4 | 5 |
| **Program Evaluations** | | | | | |
| I am satisfied with the home blood-pressure-monitoring program. | 1 | 2 | 3 | 4 | 5 |
| I am satisfied with the home weight-monitoring program. | 1 | 2 | 3 | 4 | 5 |
| Doing home blood pressure makes me feel more secure in detecting problems with my blood pressure. | 1 | 2 | 3 | 4 | 5 |
| Doing home weight-monitoring makes me feel more secure in detecting problems with my weight. | 1 | 2 | 3 | 4 | 5 |
| Home blood presssure allows me to stay better connected to my healthcare providers. | 1 | 2 | 3 | 4 | 5 |
| Home weight-monitoring allows me to stay better connected to my healthcare providers. | 1 | 2 | 3 | 4 | 5 |
| I would recommend using home blood-pressure-monitoring to other patients. | 1 | 2 | 3 | 4 | 5 |
| I would recommend using home weight-monitoring to other patients. | 1 | 2 | 3 | 4 | 5 |

*Source:* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5659856/

# Remote Monitoring in the Rock

## Participation Guidelines

### What are the participation requirements?

A patient will be required to meet a goal of obtaining **12 blood pressure readings over a 7-day period for 6 months**. The participant will have an option of selecting any day of the week combination of their choice by FIRST selecting one (1) of the choices below.

### Choices/Selection of Days for BP Monitoring and Weight Check

(Participant should choose (one) 1 of the following:

1. Monitor BP for **3 days** with 1 weight check for each week
   *(Paired reading should be 2 times a day for 3 days =12 readings)*
2. Monitor BP for **4 days** with 1 weight check for each week
   *(Paired reading should be 2 times a day for 2 days AND 1 time a day for 2 days =12 readings*
3. Monitor BP for **6 days** with 1 weight check for each week
   *(Paired reading should be 1 time a day over 6 days =12 readings)*

### What is the length of time the participant needs to maintain BP monitoring and weight check requirements?

Participant should maintain target BP GOAL (135/85 OR 145/85) received during onboarding/ enrollment day by obtaining 12 readings/week for 3 months

If patient is STABLE (refer to definition) after 3 months, the participant could be allowed to obtain 1 paired blood pressure reading with 1 weight check over the next 3 months

### What is the timeline for non-compliance of participation?

| | |
|---|---|
| 1. Verbal Counseling | (After Week 2 of onboarding/enrollment day) |
| 2. Repeat verbal warning with 30-day probation | (After Week 4 of providing verbal counseling) |
| 3. Written notification to include next steps of discharge with lack of participation | (After Week 6 of continued non-compliance) |
| 4. Discharge from program | (Participant should return ALL equipment) |

### What are the Graduation requirements?

Graduation from the program is when the patient blood pressure is STABLE or in MAINTENANCE for 6-months. The participant will be able to keep all equipment and may OPT to stay in the program per discussion with the health coach.

### Will there be follow-up after graduation?

We recommend that there is a 6-week, 3-months, and 6-month post-graduation follow-up.

# Strategies in Supporting Patient Behavior Change

Working with patients on behavior change can present many challenges. Two popular strategies when working with patients include addressing the constructs in the **health belief model** and using **motivational interviewing** strategies.

The **HEALTH BELIEF MODEL** stipulates that a person's health-related behavior depends on the person's perception of four critical areas:

- the severity of a potential illness
- the person's susceptiblity to that illness
- the benefits of taking a preventative action
- barriers to taking the action *(Hickbaum 1958; Rosenstock 1960, 1966)*

The model also incorporates cues to action, (e.g. leaving a written reminder to oneself to walk) as important elements in eliciting or maintaining patterns of behavior *(Becker 1974)*. The construct of selfefficacy, or a person's confidence in his or her ability to successfully perform an action, has been added to the model *(Rosenstock 1990)*, perhaps allowing it to better account for habitual behaviors, such as a physically active lifestyle.

*Source:* https://www.cdc.gov/nccdphp/sgr/pdf/chap6.pdf

*__Provider tip__: When introducing new remote-monitoring equipment to a patient, be sure review the condition's severity, individual's susceptibility to the condition, and the benefits and possible barriers to measuring the patient's health at home.

**MOTIVATIONAL INTERVIEWING (MI)** is a specific way of speaking with a patient in order to activate their internal motivation for behavior change. The origins of MI are from addiction/counseling fields. Applications of MI have been effective in disease prevention and chronic disease management. MI communication principles include:

- Expressing empathy
- Developing discrepancy
- Rolling with resistance
- Avoiding argumentation
- Supporting self-efficacy

MI is intuitive, however it requires training and practice. Moving from a directive/educator communication style to a collaborative sytle can be difficult. One must cultivate the skillset to be a good listener, elicit change talk, and provide meaningful feedback.

*Provider tip:

1. Establish patient understanding about diagnosis, risks, and susceptibility.
2. Support patient autonomy by using agenda-setting, asking permission to give information/advice, and asking open-ended questions.
3. Engage the patient in change talk: the patient talking about reasons, need, benefits for change.
4. Set incremental goals to build self-efficacy.

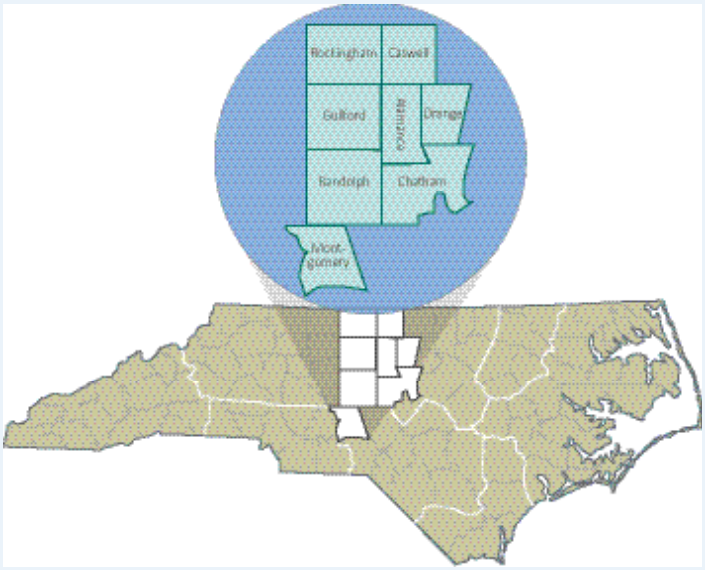
*Source:* https://www.cdc.gov/diabetes/ndep/pdfs/ndep_motivational_interviewing_webinar_slides.pdf

## The UNC School of Medicine, Department of Family Medicine

UNC Family Medicine provides patient-centered primary care, conducts groundbreaking research, and trains the best and the brightest young doctors. Top-ranked in primary care, the Department aims to support and improve the health of the communities it serves, with a special commitment to the underserved, mothers and children, the elderly and other populations at risk in a time of rapid changes in the organization of health care.

## Piedmont Area Health Education Center

The Piedmont AHEC has provided FREE on-going practice support for ambulatory care clinics since 2010. We have helped practices achieve Meaningful Use, HEDIS and NCQA's Patient Center Medical Home recognition. We are the NC resource for practice improvement and success.
For more information on how to apply for services with the Piedmont AHEC Practice Support Team, contact us at piedmontahec.org or call 336-832-8025, and ask to speak to a member of the practice support team.

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