BLUESTAR TELEHEALTH

13 Mistakes Made in RPM Programs

By Robert Wray and Michael Rolli MD

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Introduction

Over the past several years we've had the opportunity and the misfortune to observe mistakes in dozens of Remote Patient Monitoring (RPM) programs. Some we made, and some we watched others make. Under the assumption that it's always best to learn from the mistakes of others, here's a list of some of the mistakes we've seen. **They're not listed in any particular order.**

01.

Going **Too Slow**

We've seen some organizations take a couple years to build a program to contain a couple dozen patients. That snail-like pace loses any sense of excitement or momentum. But the time it finally gets going, the staff has forgotten that it exists. There's no reason a program can't go from concept to a hundred patients in a few months. Crawl-Walk-Run is good, but don't take years to get to the Run part.

02.

Going **Too Fast**

At the other extreme, we've found that adding patients too quickly at the beginning can result in problems not originally anticipated. It's best to get the program going, add patients in reasonable amounts, and fix the resultant snafus and process issues before stepping on the accelerator to add patients more quickly. We recommend running with a couple dozen patients for 60-90 days, and then stepping up the pace. Crawl-Walk-Run is good, but don't start Running until you've mastered the prior steps.

03.

Letting the **IT Tail Wag the Dog**

We've seen organizations that immediately assumed that an RPM program would start with six to twelve months of IT integration. We've seen IT departments effectively shut down programs that clinicians wanted and patients needed. There are ways to get programs started without a full-blown IT integration, which can come later. Why waste a year prepping IT for a pilot that might last only 90 days?

04.

Integrating IT
Too Much Too Early

At some point, it might be worthwhile to have RPM data pumped directly into the Electronic Medical Record (EMR). But what data, and how, and when? If a patient measures her BP 100 times a month, do you really want that many lines of data in the vitals page of the EMR? The best way, we believe, is to start the program without IT integration, and then figure out what data is desired, and at what frequencies, and in what form. Then, and only then, should it be hard-wired through an EMR integration. (There's a story about the college campus built with no sidewalks. They let people walk around on the grass for a year or two, until pathways were worn. Only then did they pave sidewalks to replace the paths, and they built sidewalks the way people wanted to walk.)

05.

Managing **Inventory In-House**

If a provider is giving away free items that need no tracking (my dentist always gives me a little goodie bag of toothbrushes etc), then it's easy. But if you are issuing expensive equipment that needs internet connections, software tracking, and eventual return, it's a different story. It's possible that it might exist somewhere, but so far we've never found a provider that is good at, or likes to, manage patient hardware inventory. It ends up stacked in closets, or piled behind counters. No one can keep track of which patients received which pieces of equipment, or which patients have returned their equipment, or, if they did, where they returned it. Best practice is for the provider to stick with what they do best (providing care), and let somebody else do the equipment kitting and shipping and tracking and returning and refurbishment. Or, if you're big enough, establish your own in-house equipment inventory processing center.

06.

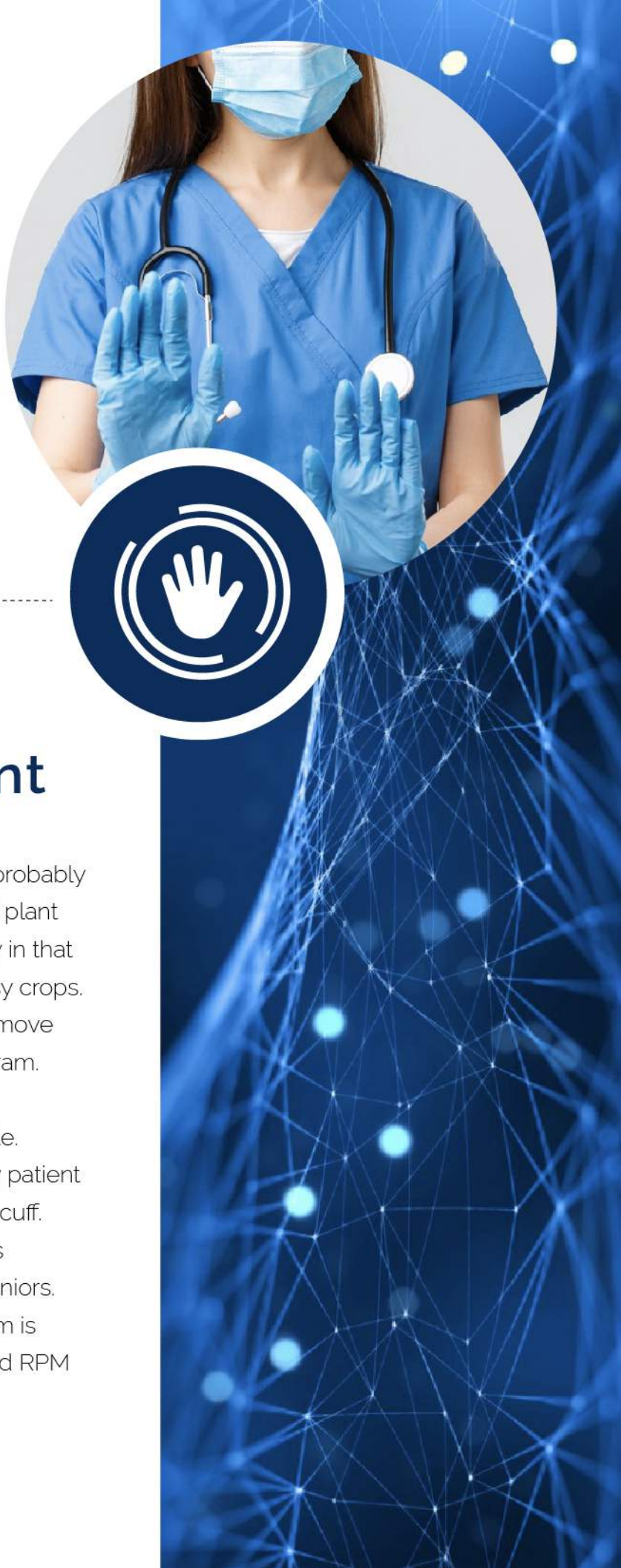
Not Worrying about **Revenue Cycle Management (RCM)**

Any fee-for-service provider has some RCM shop, either in-house or external, which is accustomed to getting reimbursement for the services typically delivered by that provider. However, starting an RPM program adds a new list of CPT codes and requirements, which will initially be unknown and confusing to most RCM groups. The RPM CPT codes are new, and are constantly changing. We've found that providers that just assume RPM reimbursement will be smooth and easy are usually disappointed. With some of our clients, RPM reimbursement has been the hardest part of the entire program.

07.

Lack of Sufficient **Internal Communications**

Most providers are busy organizations with many constituencies. An RPM program can be launched by one group within the organization, and inadvertently sabotaged by others within the organization that didn't get briefed, or who forgot they were briefed, or who don't believe in the concept. At the request of client providers, we have enrolled patients who subsequently disenrolled when their doctor at the same provider told them the program was probably a scam. A successful RPM program requires solid and continuous communication within the entire provider organization—it can't be hatched and executed in a silo.



08.

Trying To Do **Everything Up Front**

When planting one's first vegetable garden, it's probably not a good idea to plow the entire backyard and plant 20 different kinds of seeds. Better to start simply in that first growing season—a small plot with 2 or 3 easy crops. Then, when you've mastered zucchini, you can move on to watermelon. The same with an RPM program. It's best to start with a single population—say, geriatrics—and with a single chronic disease state. Hypertension is the most simple, because every patient understands and can manage a blood pressure cuff. Additionally, hypertension is the most ubiquitous chronic disease state, affecting over half of all seniors. Then, when the hypertension for seniors program is running smoothly, you can take on more involved RPM solutions for diabetes and CHF and COPD.

09.

Failing to Prove **Clinical Efficacy**

Remote Patient Monitoring exists to improve patient outcomes. We have found that many programs are launched and operated without taking the time and effort to measure those outcomes. Such measures are required to convince clinicians that it's worth their time, to convince patients that it's worth their time and co-pay, and to convince provider administrators that it's worth their time and investment. The data is (hopefully) resident in whatever RPM software is being used—the trick is to get the data, analyze it, and show (if possible) that the program is having the desired effect. This is particularly important in a value-based world, in which the entity paying for the program will insist on clinical and financial info to prove that the bang is worth the buck.

10.

Failure to Pick **the Right Tech**

Tech, in this use, is the right combination of software and hardware. The optimum tech for geriatric hypertension is probably not the optimum tech for maternal monitoring. Some tech is cheap, but then the provider staff spends all their time doing tech assist (downloading apps, pairing devices, etc) to help patients implement the cheap tech. Some tech is cool but expensive overkill—no sense buying streaming video capability if it won't be used. We believe that tech should be custom-selected based on the disease state being managed, and on the population being managed. Unfortunately, there is no one-size-fits-all solution; there is no one silver bullet.

11.

Underestimating the **Monitoring Workload**

RPM requires labor to implement. Labor to do the up-front activation and training of the patient. Labor to manage the system hardware and software. Labor to monitor the results and achieve the time investments required to get reimbursement. This takes staff time, and the average medical staff is busy enough with their day job—they can't be expected to just absorb new requirements. We recommend one full-time qualified healthcare professional for every 200 patients, if you want to achieve the timed requirements for RPM CPT codes 99457 and 99458. We've found that providers who just assume that their existing patient services team, or care coordination team, can handle RPM requirements have been, well, disappointed. Monitoring can be in-house or outsourced—but in either case, it must be properly staffed.

12.

Poor
Selection of Patients

The key to RPM is patient engagement, and the key to patient engagement is the proper selection of patients for enrollment. We've seen some providers throw RPM kits at anyone who walked in the door, which resulted in horrific patient attrition (and a pile of returned kits jumbled in a closet by the door.) The ideal patient (a) understands the benefits to be gained from the program, (b) is motivated to do something to improve her health, and (c) can afford the co-pay, if any, required to be in the program. Understanding, motivation, and financial capability—if any of those three legs are missing, the patient won't remain in the program for long.

13.

Understanding the
Reimbursement Environment

Like many of the new in-home reimbursable CPT codes (RPM, CCM, RTM, PCM, etc, etc), RPM is relatively new, and reimbursement is not uniform or ubiquitous. It is reimbursed nationally by Medicare. It is reimbursed in some states by Medicaid, but typically at different rates, and with different requirements, than Medicare. Private insurers are coming around slowly, but they're all over the block, and the specifics for any given private insurer are nearly impossible to know without being in network. Some providers have started programs with the expectation of reimbursement, and have then been sorely disappointed when their local Medicare Advantage program or the town's leading private insurer didn't reimburse in the amounts expected. Moral: don't start the program until you know every detail of the local reimbursement market. Or, start the program only with Medicare recipients, since those details are proven and easily available.

14.

EXTRA BONUS MISTAKE

Failure to Act

Despite the 13 mistakes we've seen as listed above, RPM is doable. It's good for patients, and it's good for the provider, and it's good for the healthcare system as a whole. It's part of two national and ongoing tidal waves in healthcare. The first is the continual move in the location of care from the monolithic hospital to the specialty center to the walk-in-clinic to the drugstore to the home. Patients like care in the home, when appropriate. The second wave is the move toward reimbursement of preventative care. Twenty years ago, we wouldn't pay a penny to help a patient avoid a stroke, but we'd pay a zillion dollars to help her after it happened. Now, the system is willing to pay about $1000 a year to employ RPM to help her avoid the stroke in the first place. Both waves are good, and both are enduring. Providers considering RPM should not be thinking if RPM—they should be thinking when, and how. The biggest mistake we've seen is when a provider decides that they can't support an RPM program, or that their patients don't need it. That's head-in-sand behavior—it's akin to the folks that originally fought electronic medical records as too hard. RPM and other low-acuity in-home program are here to stay. RPM is doable—organizations large and small are successfully implementing it every day. For the sake of your patients, and your organization, don't fail to act.

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