PALMETTO CARE CONNECTIONS™

technology. broadband. telehealth.

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Palmetto Care Connections

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How?

- FCC Connected Care Pilot Grant
  - $7.2 Million
  - Primarily for connecting patients to care
  - Supports ongoing costs
- FCC COVID Telehealth Grant
  - $785,000
  - Primarily meant to build out Phase 2 of platform
- USDA Emergency Telehealth Grant
  - $282,000
  - Primarily built out Phase 1 of Platform

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WELL + SC CONNECT

Why/Benefits

- Built for Rural
  - Ideal for low Bandwidth Situations
  - Little to No configuration for providers or patient
  - All hosted requiring No IT support
- Highly Customizable
  - Create your own dashboards
  - Patient data tracking to meet your needs individually
- Built by Providers
  - Received input from several rural healthcare providers
  - Used feedback over years of in the field conversations
- One single pane of glass
  - Remote Patient Monitoring
  - Synchronous Video
  - Asynchronous Communication through patient individual or Group Messaging
  - Care Plans with patient reminders (Build your own or choose a template to get you started)
  - Appless Calling to any device and/or SIP end point
- No Cost Solution
  - Grant funded
  - Unlimited Providers
  - Unlimited Patients
  - Unlimited Encounters
- Independently Owned and Operated
  - Owned and Operated by Palmetto Care Connections
  - Segregated by provider groups for patient and provider privacy
  - No Data Shared with any other entity or outside source

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Telehealth Hardware

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Questions

CLEMSON RURAL HEALTH

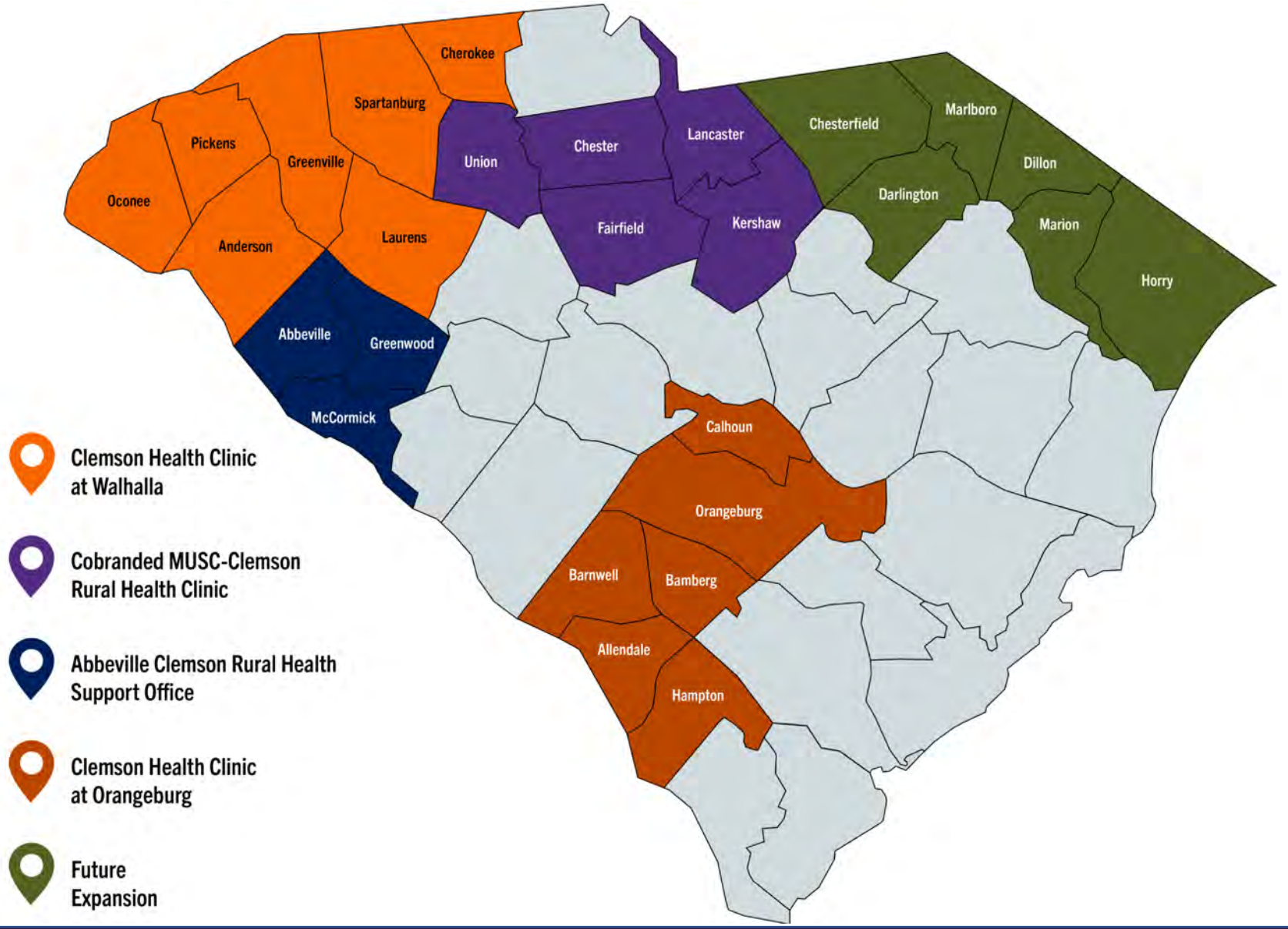
An academic unit of the College of Behavioral, Social and Health Sciences.

Reimagining Rural Health

Caitlin Kickham, MS, APRN, FNP-C, Associate Director for Clinical Operations

Ron Gimbel, PhD, Professor and Director, Clemson Rural Health

Our vision is to transform health outcomes in rural and underserved South Carolina.



CLEMSON RURAL HEALTH


Reduce Premature Deaths
↓
Reduce Preventable Hospitalization
↓
Improve Overall Quality of Life
↑

Our Mission

Filling Health Care Gaps through Innovation

- Providing comprehensive care in high need communities
- Building strategic partnerships throughout the state
  - Two absolutes
- Educating the future rural health workforce
- Conducting and facilitating research

Partnership with Palmetto Cares Connections

- Since the COVID-19 pandemic, CRH has worked with PCC to provide telehealth access in rural communities.
  - Telehealth Carts
  - Remote Patient Monitoring

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Telehealth Carts

- Strategy:
  - Kick Off Event
  - Deploy mobile health units on reoccurring basis to sites where telehealth carts are installed
  - Utilize telehealth carts and telepresenter (PCC) for follow up visits in between mobile health unit visits
- Current Locations:
  - Generations Unlimited (Barnwell, SC)
  - Good Hope AME (Cope, SC)
  - Bamberg Office on Aging (Bamberg, SC)
  - Bamberg Villas (Bamberg, SC)

Remote Patient Monitoring

- Implementation
  - Hire RPM Care Coordinator
  - Select devices, platform, conditions to be monitored
  - Develop protocols and set thresholds
  - Set up EHR documentation templates

Remote Patient Monitoring

- Process
  - Patient is referred to RPM Care Coordinator for enrollment
    - Internal referrals from CRH provider
    - External referrals from community providers
  - Patient completes enrollment with RPM Care Coordinator (45 mins)
  - RPM Care Coordinator works with patient throughout the month
    - Reviews data, messages patient, notifies providers of alert values
  - RPM Care Coordinator completes telehealth check in with patient monthly and documents in EHR
    - Submits for billing when thresholds are met
    - Sends report to PCP

Case Study #1

- 62 y.o. female with history of Type II DM and obesity
- Established care in August 2023, enrolled in RPM August 2023
  - Blood pressure monitor, scale, glucometer
  - Glucometer disconnected – troubleshooting appointments x 5
- **A1C 10.8% at enrollment**

Case Study #1

- Referred to VeggieRX – 3 pick ups to date
  - Participated in 2 sessions of cooking demonstration
- Referred to DSMES – completed 4 sessions to date
- Maintains relationship with PCP for medical management: CRH provider working collaboratively to adjust DM medications for decreasing A1C
  - PCP provided samples of Trulicity, patient ran out and PCP said it was not covered by insurance; CRH provider worked with insurance company for prior authorization (approved) and continued Trulicity after discussion with PCP

Case Study #1

- **Repeat A1C: Incomplete (to be completed in December)**
- Month 1 RPM: Devices disconnected; brought in for troubleshooting
- Month 2 RPM: ALMOST enough submitted days for billing (14)
- Month 3 RPM: Enough data for billing!
  - Continued elevation in fasting blood sugars this month, this is when CRH provider worked with PCP to adjust medications

Case Study #2

- 74 y.o. female with history of type II DM, hypertension, hyperlipidemia, arthritis and obesity
- “Doctor Shopping” and polypharmacy
- Established care in June 2023, enrolled in RPM August 2023
  - Blood pressure monitor, scale, glucometer
  - Glucometer disconnected – troubleshooting appointments x 5
- **A1C 13% at enrollment**

Case Study #2

- Referred to dietitian – completed 2 sessions
- Referred to VeggieRX – completed program (12 boxes)
- Medication management (DM, HTN, hyperlipidemia)
  - BS continued to be elevated 300s-400s
- Medication management (increased insulin TID)
  - BS continued to be elevated (300s-400s)
- Patient returned to clinic for teaching – “does not like needles”
  - Patient not using insulin correctly / requests oral medication
  - Changed insulin to long acting BID

Case Study #2

- Month 1 RPM: not enough submitted days for billing (8); brought in for teaching, resync glucometer
- Month 2 RPM: Enough data for billing (BP, pulse, weight)! Glucometer still not syncing, brought in for teaching
- Month 3 RPM:Enough data for billing (BP, pulse, weight)! Glucometer still not syncing, brought in for teaching
  - BS uncontrolled – provided CGM, medication adjusted
  - Patient used Freestyle libre for only a few days – did not like the alarm going off and took it off
- Month 4 RPM: Patient frustrated with glucometer not syncing

Case Study #2

- **Repeat A1C: STILL 13%**
- Patient frustrated because glucometer still not syncing after 4 months in RPM platform with multiple troubleshooting visits (and new devices provided). Also frustrated blood sugar continues to be elevated but refuses additional medical management from provider.
- **Quits RPM program and states she will find a new doctor.**

Case Study #3

- 62 y.o. female with history of Type II DM, chronic kidney disease, hypertension, hyperlipidemia, obesity, and cognitive impairment
- Established care in March 2023, enrolled in RPM March 2023
  - Blood pressure monitor, scale, glucometer
  - Glucometer disconnected – troubleshooting appointments x 5
- **A1C 10% at enrollment**

Case Study #3

- Referred to dietitian – completed 3 sessions
- Referred to VeggieRX – completed program (12 boxes)
- Referred to DSMES – completed 6 sessions
- Maintains relationship with PCP for medical management

Case Study #3

- **Repeat A1C: 6.8%**
- Month 1-4 RPM: not enough submitted days for billing; brought in for teaching
- Month 5 RPM: ALMOST enough submitted days for billing (14)
- Month 6 RPM: No uploads – devices disconnected; brought in for troubleshooting
- Month 7 RPM: Enough data for billing!
- Month 8 RPM: Enough data for billing!

Wins

41 enrollees actively participating!
Including enrollees with cognitive impairment!

"I truly believe this program will make a big difference in getting my health on track. This program provides me somewhat of an accountability of my actions and guidance in healthy choices. I'm so excited to be apart of this."

"I am excited to be in this program. Now it is time for me."

"I was happy to have the good care and caring people that care about me."

Lessons Learned

- Successful RPM Program needs dedicated RPM Care Coordinator
- Device troubleshooting takes time