Annual Telehealth Summit of South Carolina
13th
October 28-30, 2025

CONNECT. EMPOWER. INSPIRE.

## WEDNESDAY, OCTOBER 29 | 3:00 PM - 3:50 PM

# Remote Patient Monitoring: Enhancing Care Beyond the Walls

**Moderator**
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Palmetto Care Connections

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Clemson Rural Health

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Bamberg Family Practice

**Kamryn Williams, LPN**
Palmetto Care Connections

*Clinical Breakout Session*

PALMETTO CARE CONNECTIONS™

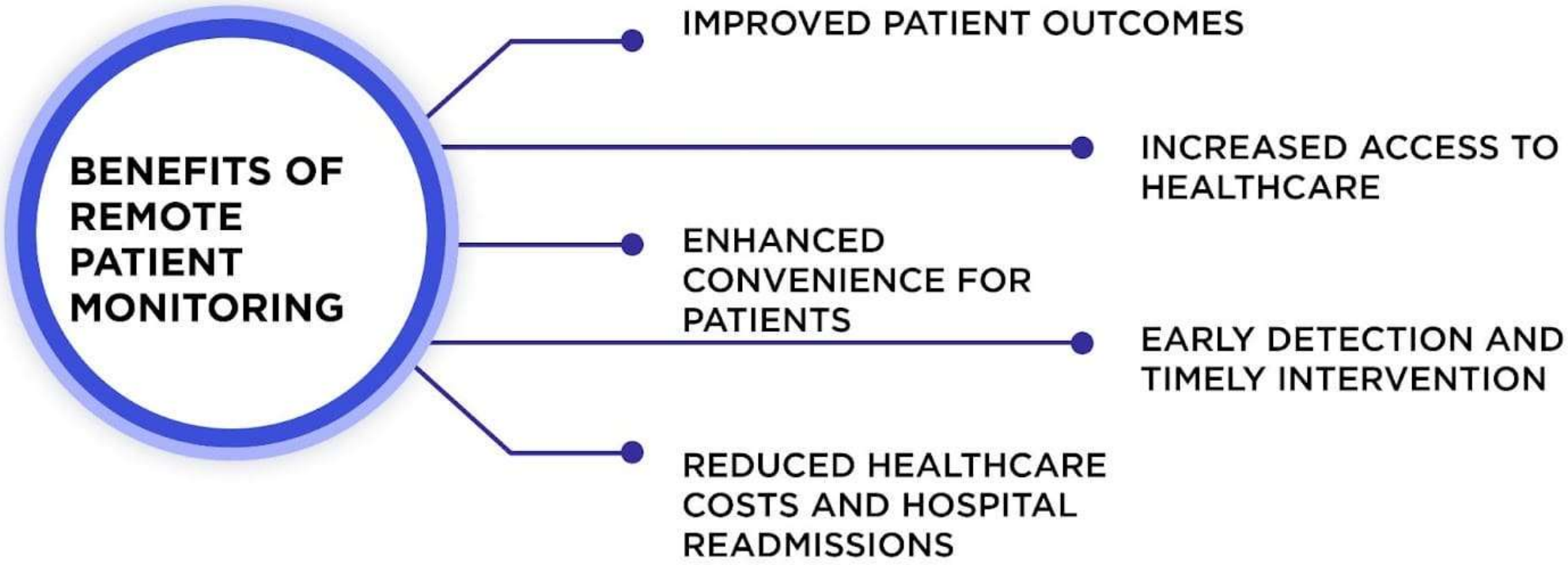
# Objectives

- Understand the importance of extending care outside traditional clinic settings.
- Learn how RPM supports patients at home and improves chronic disease outcomes.
- Review challenges, solutions, and lessons learned.
- See real-world patient impact and program outcomes.

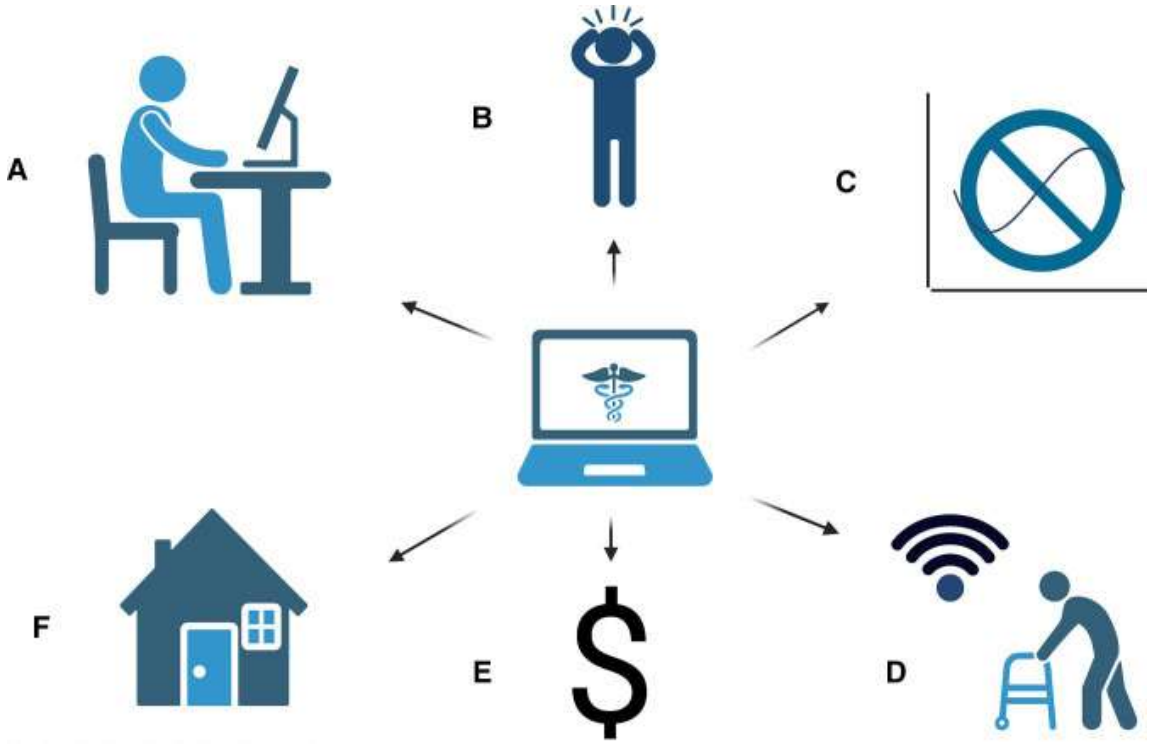
# What is Remote Patient Monitoring?

A healthcare delivery method that uses technology to collect and transmit patient health data from outside traditional clinical settings–such as a home or remote location–to healthcare providers in real-time or at scheduled intervals.

# RPM Benefits



# RPM Challenges and Considerations




- Data Accuracy & Reliability
- Patient Engagement & Compliance
- Data Overload & Workflow Integration
- Privacy & Data Security
- Connectivity & Technical Challenges
- Cost and Reimbursement
- Clinical Liability & Responsibility
- Interoperability
- Ethical &Equity Issues
- Regulatory & Compliance Barriers

# Why Care Beyond the Walls Matters

•Chronic disease is pervasive; continuous monitoring improves outcomes.
•RPM enables proactive intervention at home.
•Reduces avoidable ED visits and hospitalizations.
•States leading in RPM adoption: CA, FL, TX, NY, MI.
•Conditions with strong RPM evidence: hypertension, diabetes, heart failure, COPD.

| Number of RPM Patients by state (2023) | | |
|---|---|---|
| 1 | California | 172,530 |
| 2 | Florida | 171,294 |
| 3 | Texas | 169,445 |
| 4 | New York | 165,656 |
| 5 | Michigan | 107,789 |
| 9 | South Carolina | 58,563 |

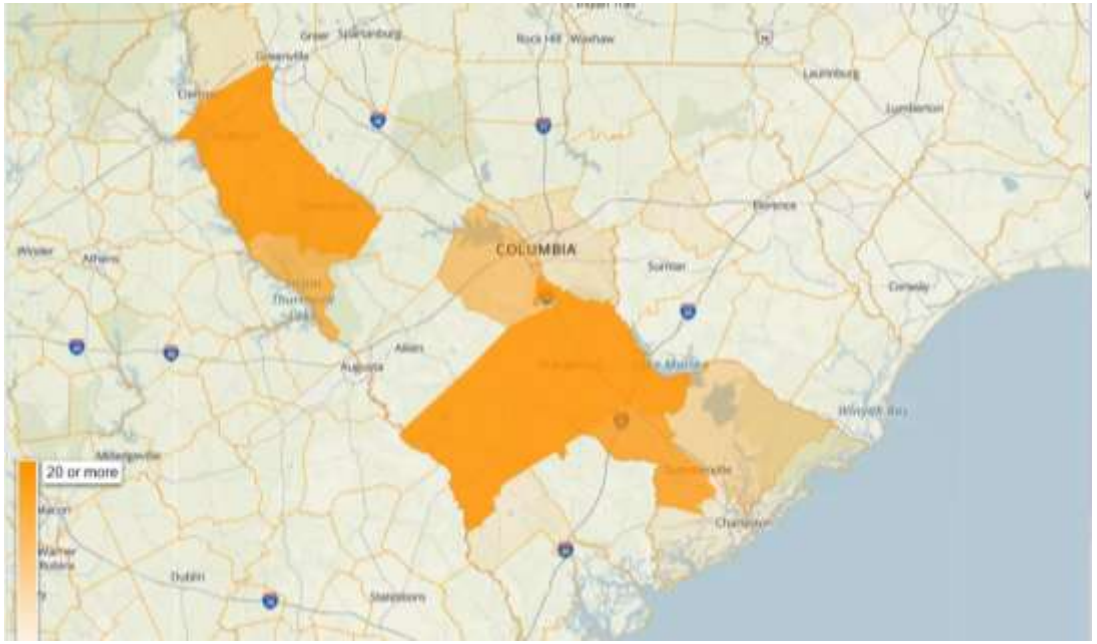
# South Carolina Snapshot

- Population: ~5.2M, median age 40.7, median income ~$66,800.
- Chronic disease burden: 60% of adults have ≥1 chronic condition.
- PCP density: ~58 per 100,000 vs US 86 per 100,000 → limited access.
- Rural areas & HPSAs → care gaps.

- Rural HPSAs + high chronic disease prevalence make RPM a practical way to extend primary care reach and reduce avoidable ED/clinic visits.

# CRH RPM Program Overview

- Locations: Orangeburg (established March 2023), Abbeville (new – November 2024)
- Grant funding
- Population served: chronic disease focus (diabetes, hypertension)
- Core components: devices, dashboards, patient education, care team monitoring.



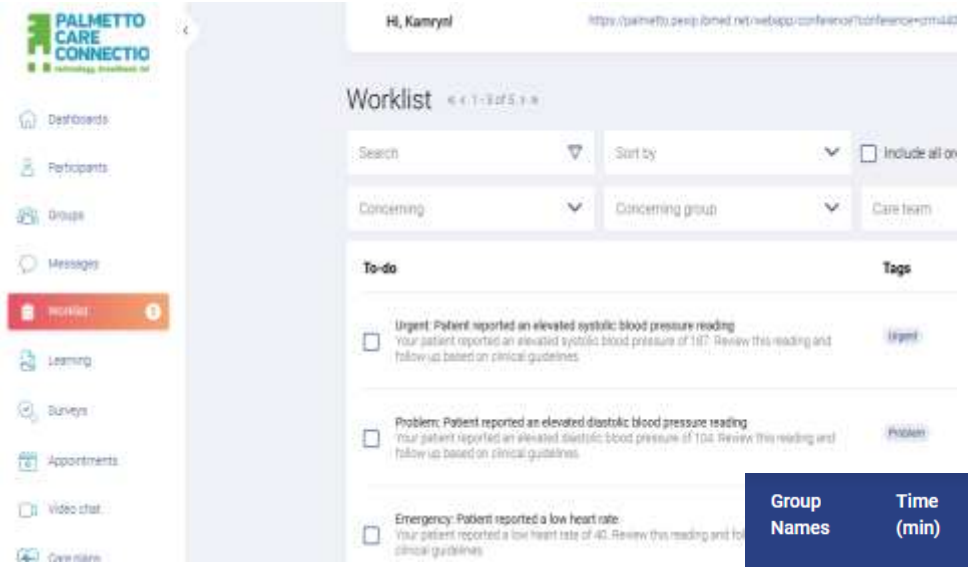
# Bamberg Family Practice Program Overview

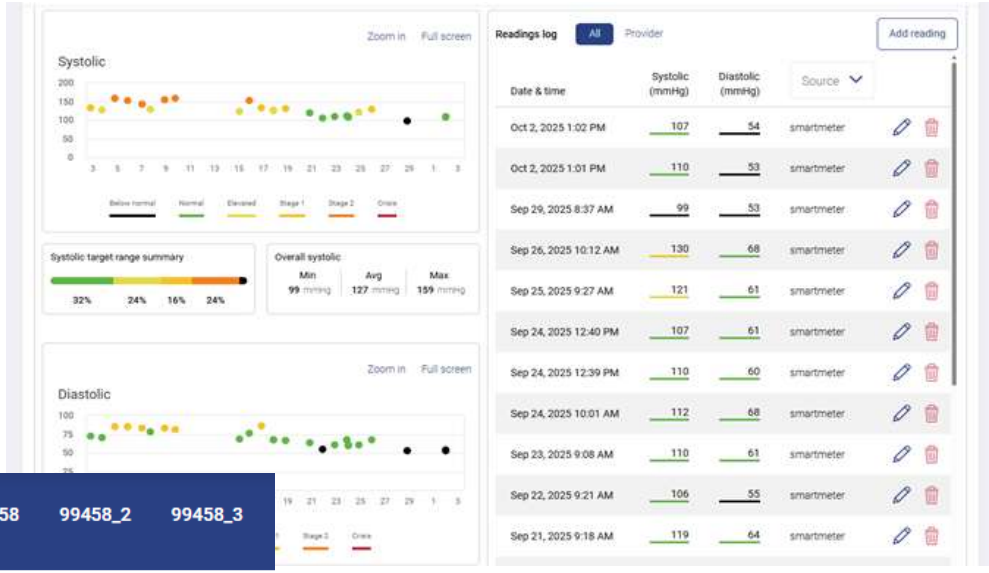
- Grant Funding
- July 2024- RPM Launch for Chronic Care Management Patients at BFP
- RPM Program was opened to patients outside of the CCM program who had 2 or more Chronic Health Conditions
- September 2025- 97 RPM referrals have been received.  55 patients are actively enrolled and monitoring

# Devices

Carium
A Healthmap Solutions Company

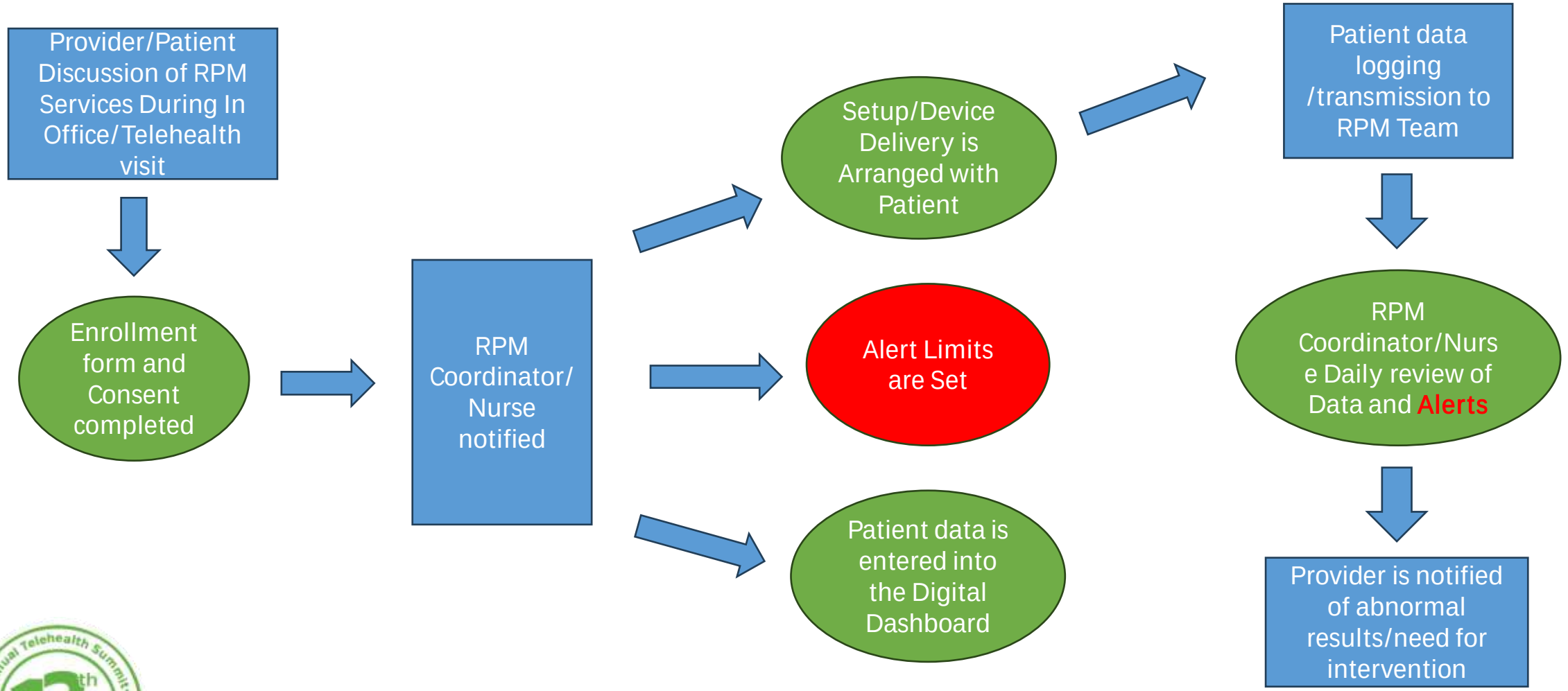
# Carium – Monitoring Platform




| Group Names | Time (min) | Time Rolled Over | Count | 99453 | 99454 | 99457 | 99458 | 99458_2 | 99458_3 |
|---|---|---|---|---|---|---|---|---|---|
| Bamberg Family Practice | 15 | 3 | 12 | N | N | N | N | N | N |
| Bamberg Family Practice | 42 | 9 | 8 | N | N | Y | Y | N | N |
| Bamberg Family Practice | 0 | 0 | 7 | N | N | N | N | N | N |
| Bamberg Family | 11 | 10 | 16 | N | Y | Y | N | N | N |

# How Does RPM in a Rural Clinic Work?



# BFP/PCC Nurse Coordinator and Provider Responsibilities

## Nurse Coordinator

- Enrollment and Eligibility
- Referral for RPM Services
- Clinical Oversight
- Medical Decision-Making
- Escalation & Follow-Up
- Billing & Compliance
- Provides Chronic Condition Education

## Provider

- Onboarding & Training Patients
- Daily Monitoring
- First-Line Triage
- Patient Engagement
- Escalating Issues
- Care Coordination
- Documentation

# Implementation Challenges and Lessons Learned

Broadband/telecom in rural homes

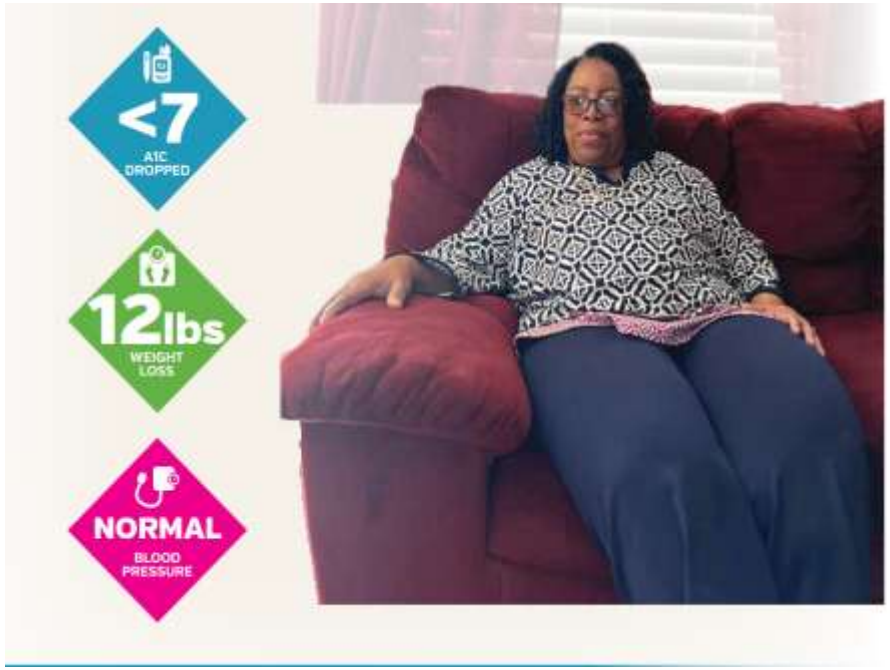
Workflow integration

Patient tech literacy

Reimbursement and coding

Staffing bandwidth

# BFP & PCC PATIENT SUCCESS STORIES



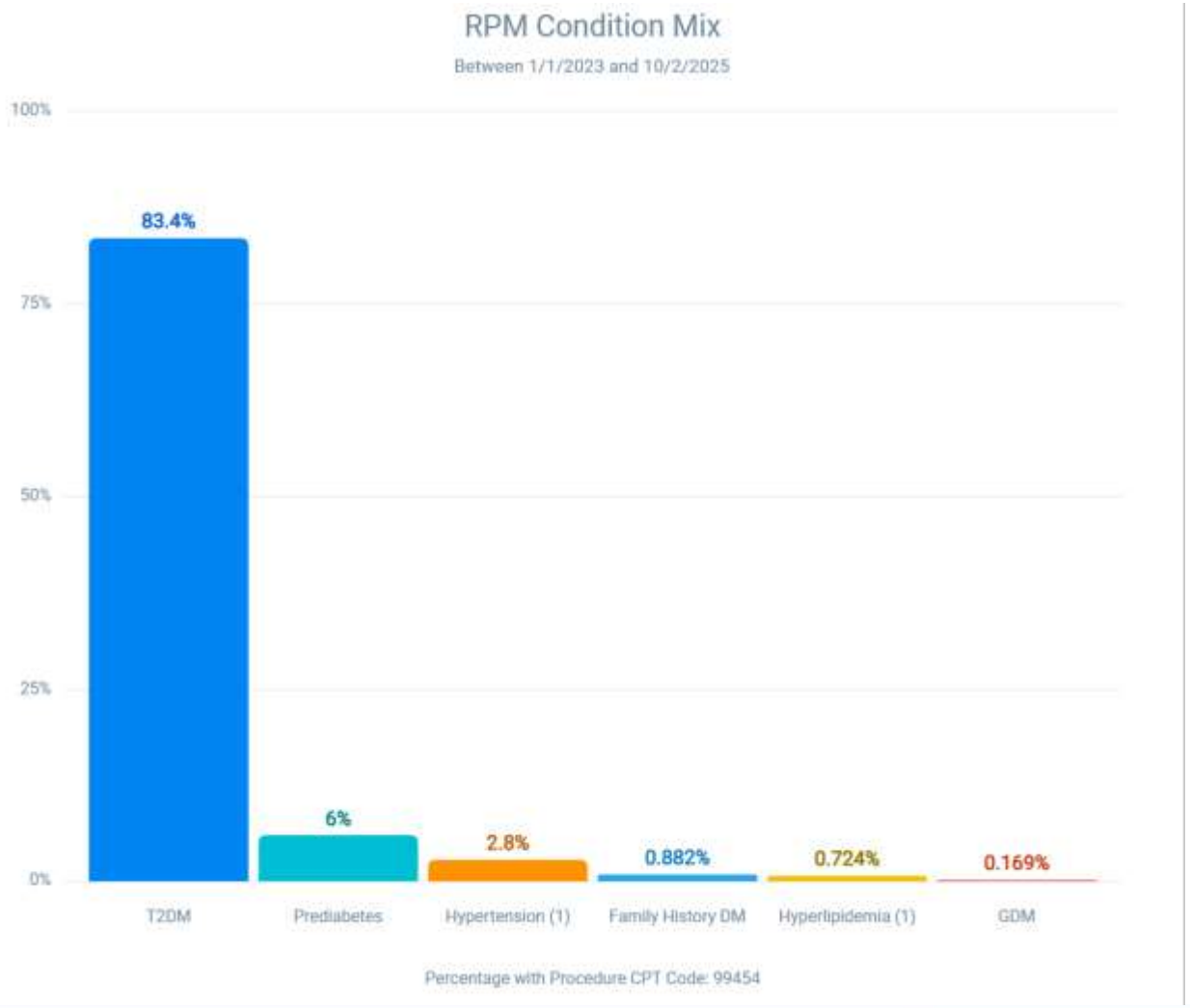

- 75-year-old Caucasian Male referred to cardiology and diagnosed with atrial fibrillation – started on anticoagulant therapy

# CRH PATIENT SUCCESS STORIES

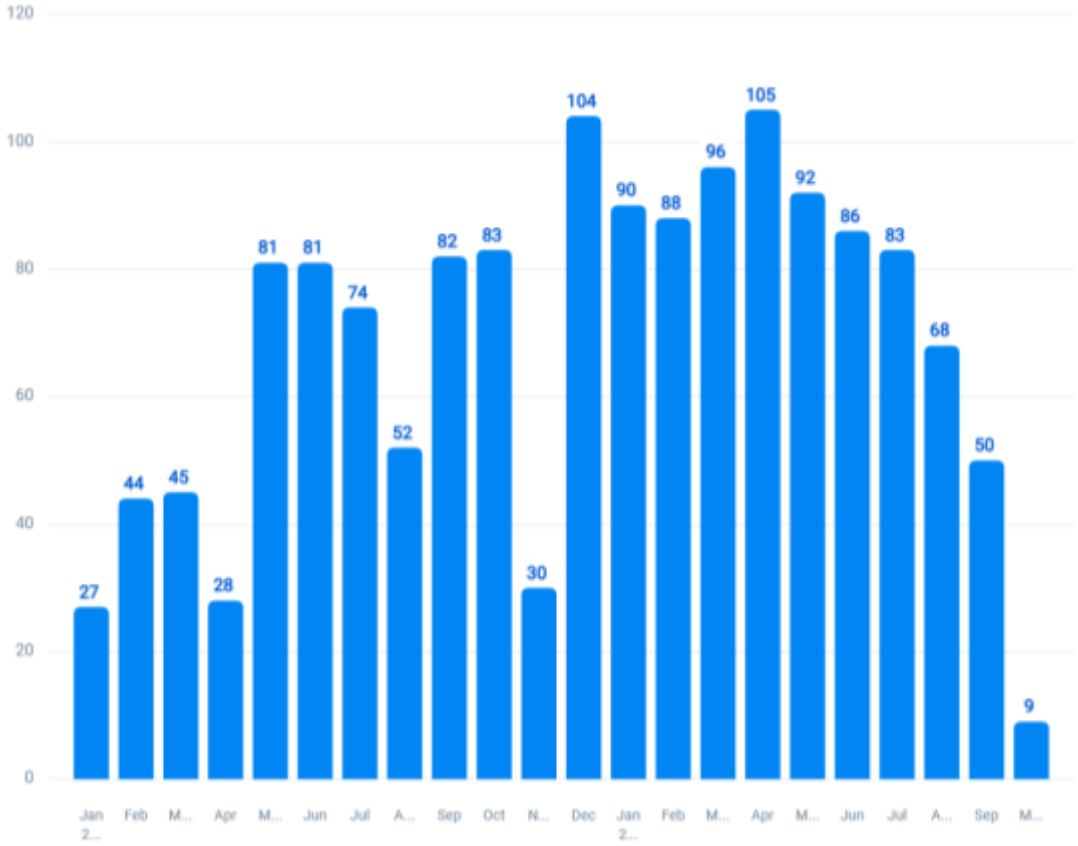
- Please see “recorded video” to watch success story

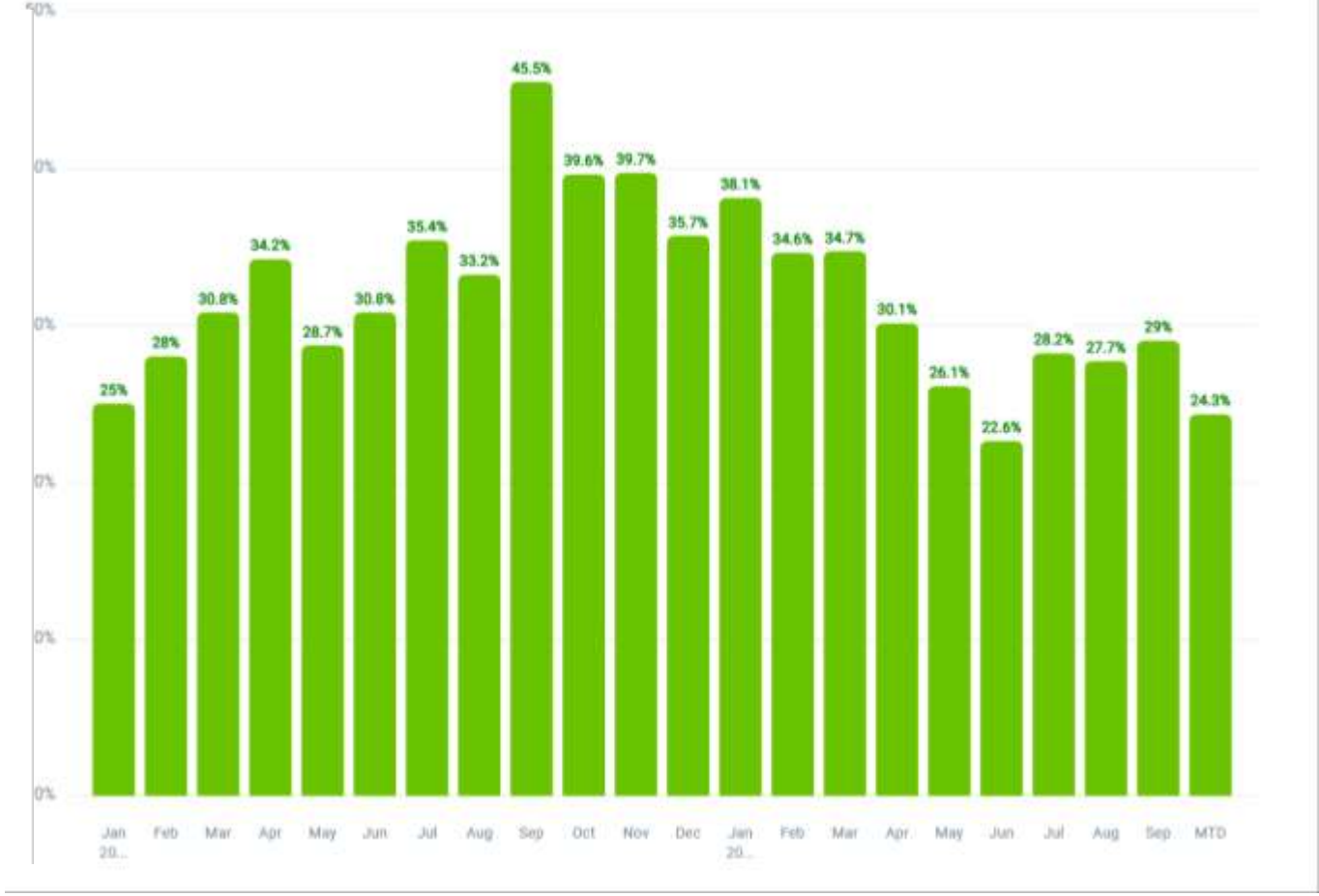
# CRH Current RPM Patient Stats

- All Time Enrolled patients: 267
- 67% with A1c < 8% after enrolling in RPM
- 82% with BP < 140/90 after enrolling in RPM
- Billing Eligible Patients: 54%



# CRH Monthly Engagement



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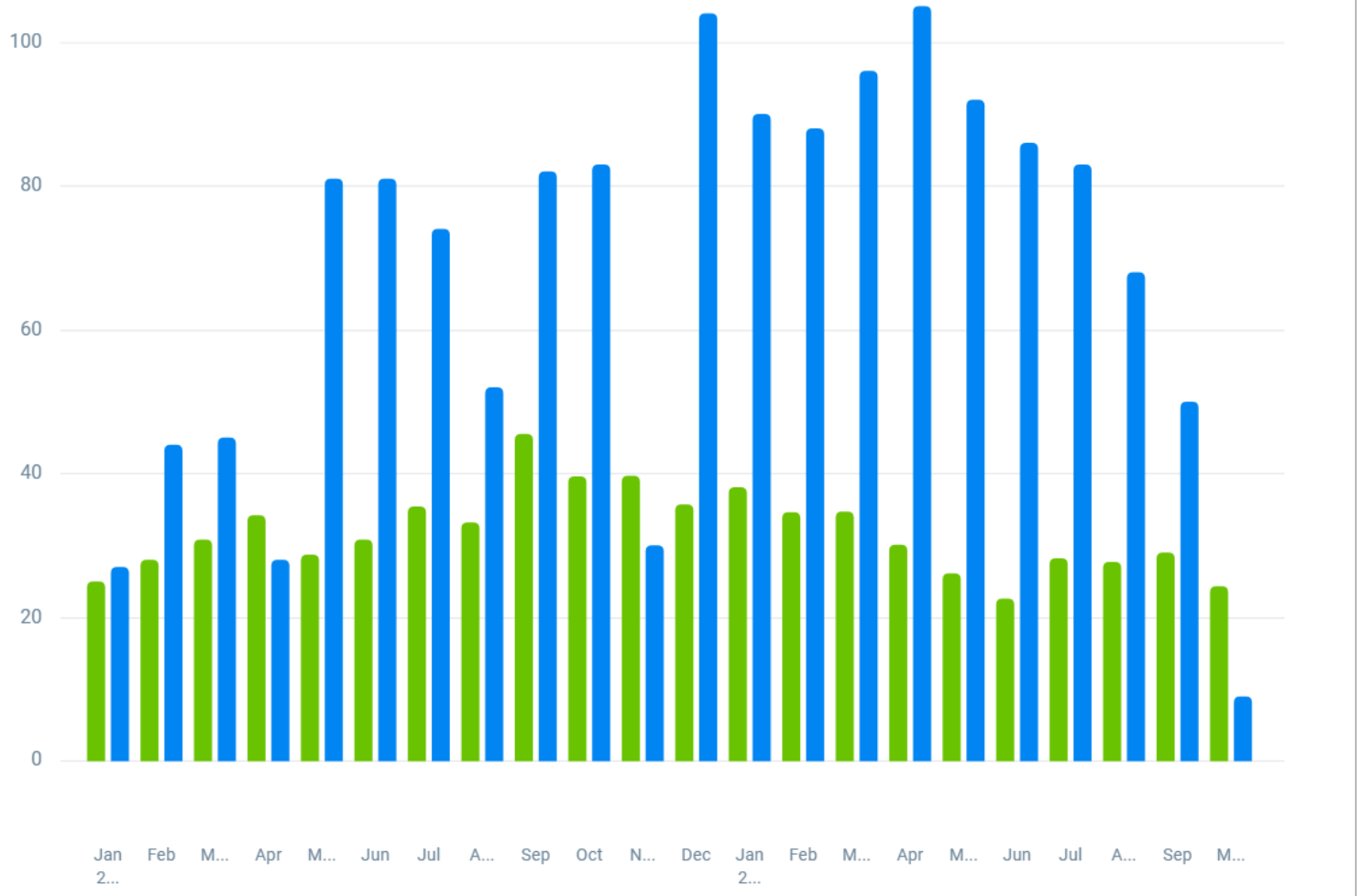
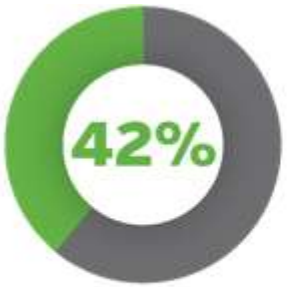
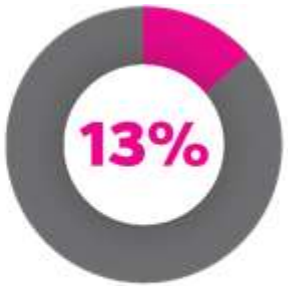


# BFP/PCC Current RPM Patient Stats


Improvement in Blood Pressure


Improvement in A1C




Maintained


Patients released from care after stability

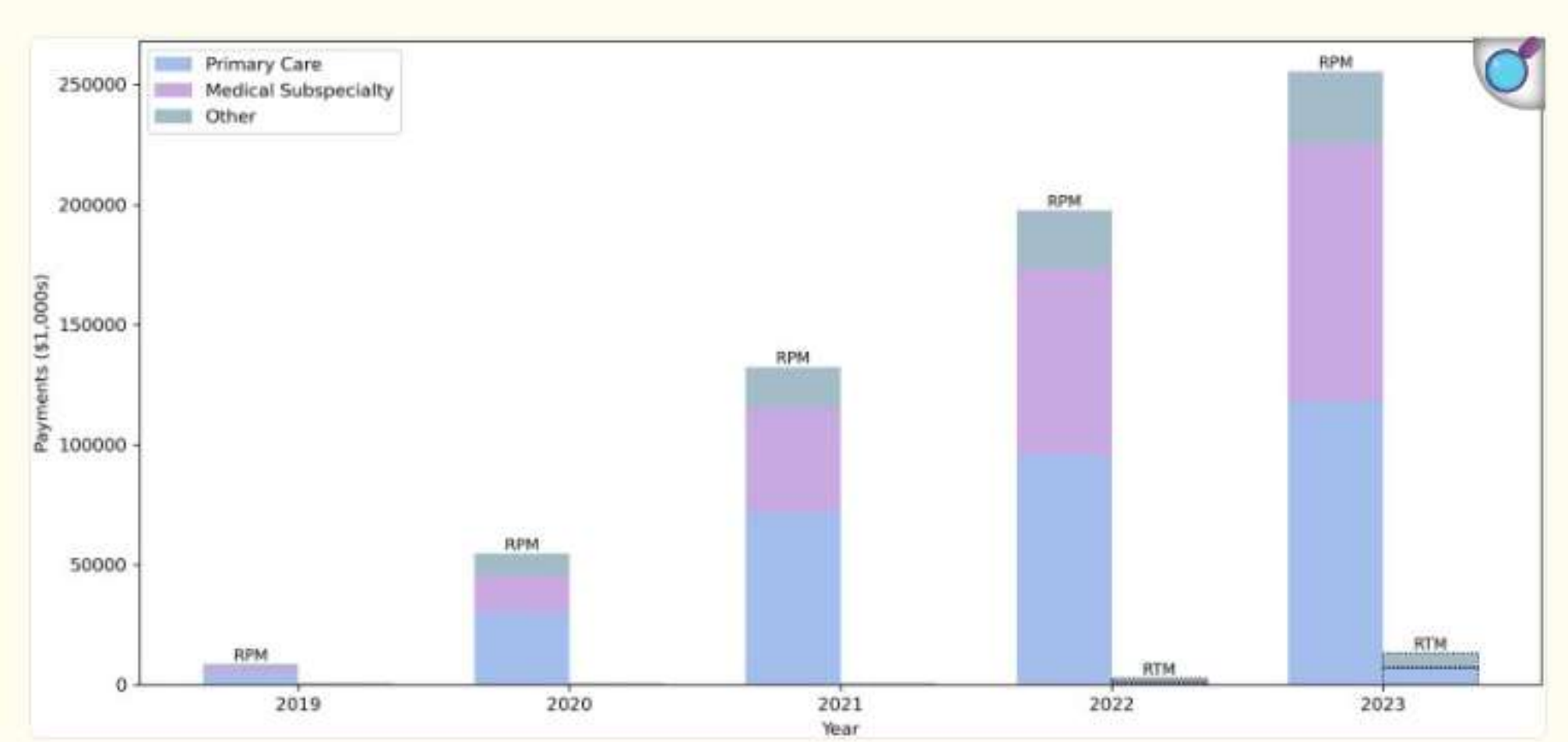

Patient Engagement & Compliance


Billing Eligible Patients

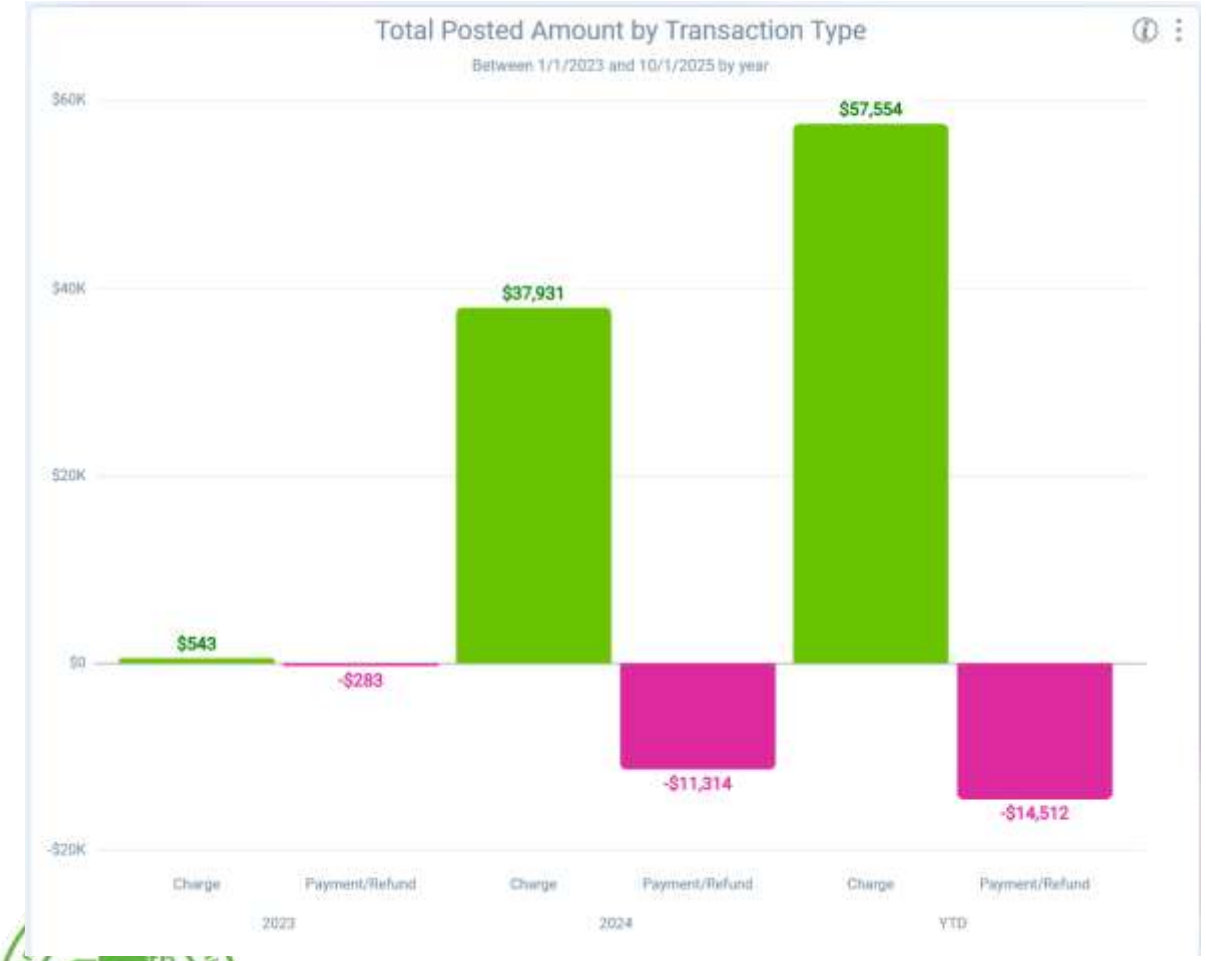
# Economic Impact

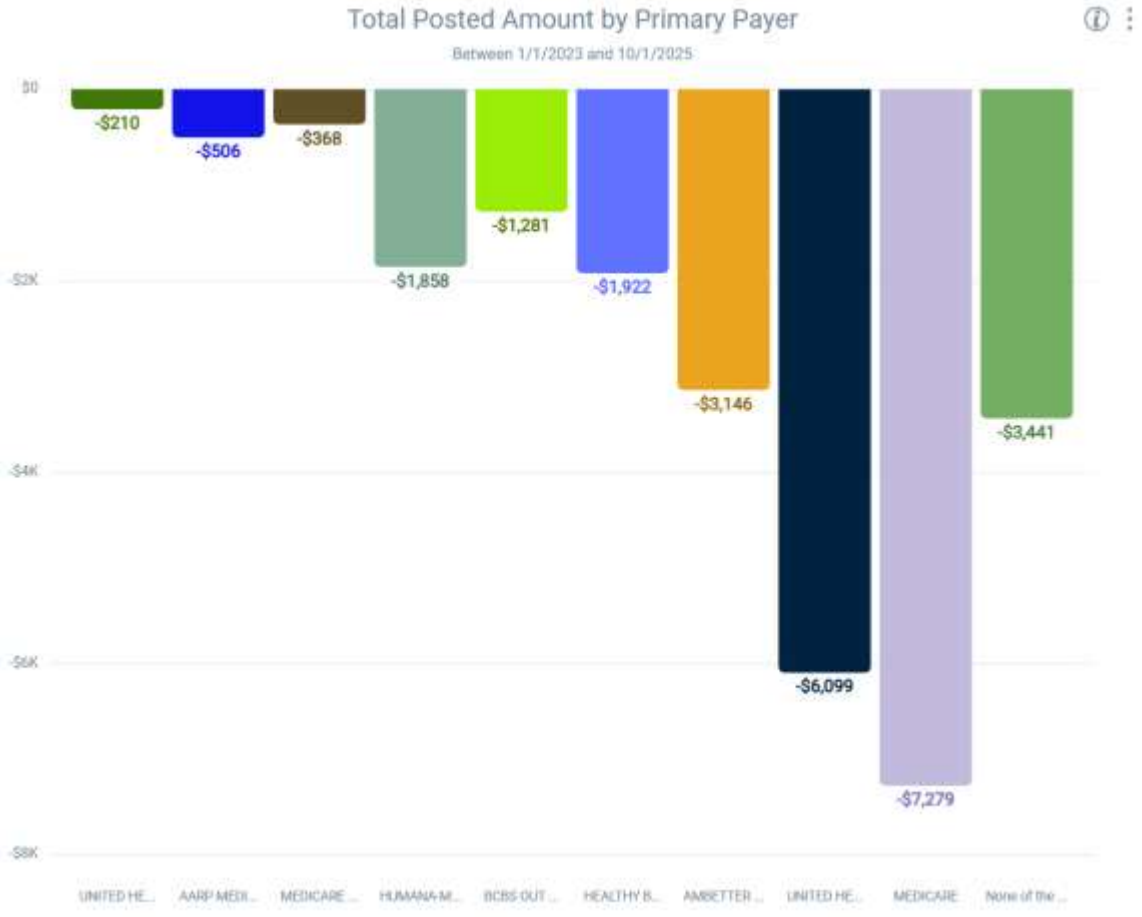
- “Meta-analyses and trials show RPM programs reduce hospitalizations by ~5–10% and lower ED visits at 3–6 months, producing cost savings primarily via avoided admissions.”
- Improved clinical metrics → downstream financial value. RPM improves BP control, glucose monitoring adherence, and early detection of deterioration – these outcomes help lower utilization and can improve performance on value-based contract metrics (readmissions, total cost of care, risk-adjusted utilization), which drives both shared-savings and payer incentive payments.

# Reimbursement Trends



# CRH Reimbursement Trends



# Understanding & Meeting CPT Code Requirements

## RPM Billing

### First Month

#### Initial Enrollment

99453: Initial patient setup and enrollment into RPM program. Averages $20.

$20

### Monthly

#### Base Monthly RPM

99454: Remote monitoring and management of device readings. Averages $43.

$43

20 min

#### Initial Care Management (20 min)

99457: 20 miutes of clinical staff time communication with patient or caregiver. Averages $48.

$91

+20 min

#### Additional Care Management (40 min)

99458: Additional 20 miutes of clinical staff time communicating with patient or caregiver. Averages $38.

$129

+20 min

#### Additional Care Management (60 min)

99458: Additional 20 miutes of clinical staff time communicating with patient or caregiver. Averages $38.

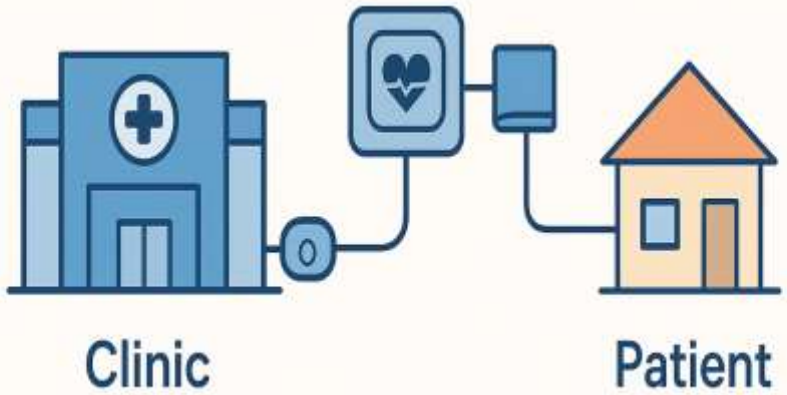
$167

# The Broader Vision

**Patient Satisfaction**

On Average 8 medicine changes per month based on 50 patients

Average of 6 Telehealth Visits monthly based on 50 Patients






# What to Consider when Implementing a RPM System?

| | | |
|---|---|---|
| Appropriate technology | HIPAA-compliant platforms | Integration with existing systems |
| Customization capabilities | Support and troubleshooting | Clinical workflow integration |
| Patient engagement | Legal and regulatory compliance | Cost and reimbursement |

# Billing and Reimbursement Barriers

- Complex and Evolving Reimbursement Policies
- Eligibility and Documentation Requirements
- Low or Inconsistent Reimbursement Rates
- Provider and Practice Barriers
- Technology and Data Integration Issues
- Patient Cost-Sharing and Engagement

# Key Takeaways

- Care doesn’t have to stop at the clinic door.
- RPM improves chronic disease outcomes in rural / underserved areas.
- Replicable model for other communities.

# Questions?