

BUSINESS TRACK

Care Without Walls: Strengthening Patient Connections through RPM



Introduction by:
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SEPTEMBER 2
10:30AM-11:15AM



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13TH ANNUAL TELEHEALTH SUMMIT OF SOUTH CAROLINA

Care Without Walls



Strengthening Patient Connections through RPM

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The Power of Connection
August 31, September 1, and September 2, 2026



Objectives



Why care beyond the walls matters in rural South Carolina



How our RPM program runs — enrollment to graduation



How RPM strengthens the patient–care team connection



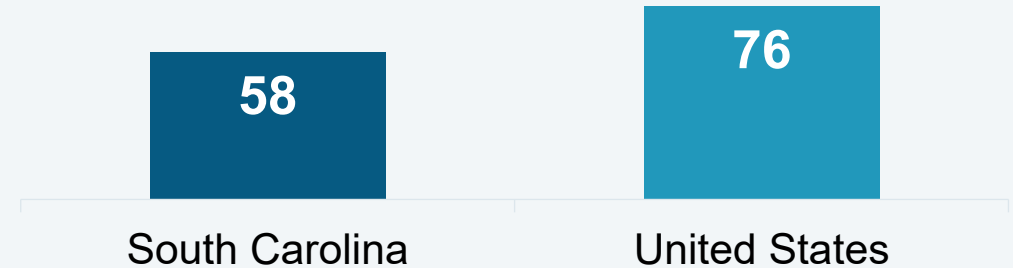
What a year of data — and three patients — taught us

The Math Doesn't Work

60%

of South Carolina adults live with at least one chronic condition

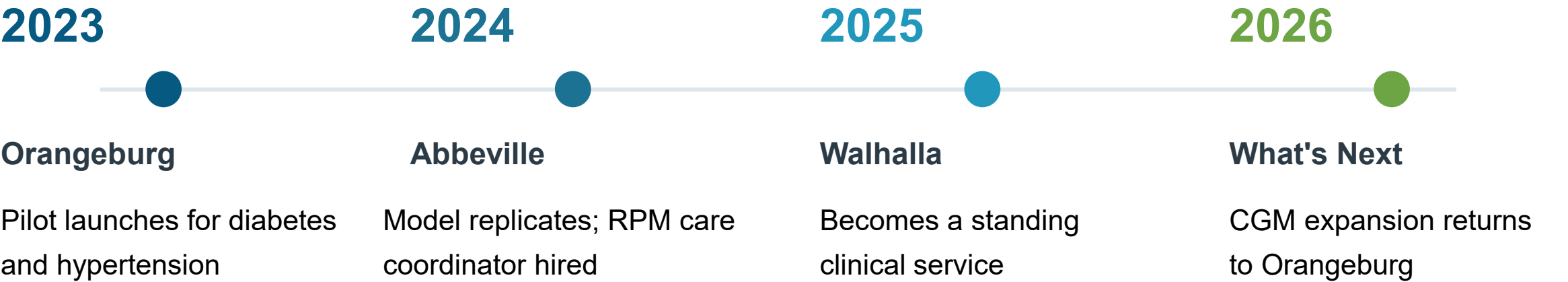
PRIMARY CARE PHYSICIANS PER 100,000



Not enough visits to manage chronic disease well. For us, RPM is an access strategy — not a technology project.

Much of our service area sits in a federally designated health professional shortage area.

From Pilot to Program



Three areas, one model — standardized workflow, same devices, same protocol.

Our Workflow, Start to Finish



STEP 1 Identify & Refer

CRH provider or outside PCP



STEP 2 Enrollment Visit

A standalone hour with the nurse



STEP 3 Home Monitoring

Daily readings, cellular devices



STEP 4 Daily Nurse Review

The dashboard, every single day



STEP 5 Triage & Escalate

Verify first, then bring a pattern



STEP 6 Graduation

3 stable months — the seat opens

Billing tracks the workflow, not the other way around.

The RPM Nurse Is The Connective Tissue



THE RPM NURSE

Every day

- Onboards and trains the patient and family
- Reviews the dashboard daily
- Calls to verify before anything escalates
- Re-engages patients who stop transmitting
- Documents the time that supports billing



THE PROVIDER

At the decision point

- Refers and confirms eligibility
- Decides — titrate, stop, or hold
- Signs off on documentation



The provider doesn't get 30 days of numbers. They get one nurse who already checked the cuff, called the patient, and can say what changed.

HOW WE DO IT

The RPM Nurse's Day

 Morning dashboard review

 Verification calls

 Re-engagement outreach

 Check-in calls

 Time documentation

The verification call is the step most programs skip — and it's the one that makes the data trustworthy.

HOW WE DO IT

Escalation: Who Does What



**NURSE
HANDLES IT**



**NURSE
ESCALATES**



**PROVIDER
DECIDES**

Most of what RPM generates never reaches the provider. That's the design, not a gap.

What It Takes to Run It



197

patients enrolled
since 2023



1.25 FTE

two RNs, shared
across three sites



~90

active patients
per FTE



~60 / mo

transmitting enough
to meet billing thresholds

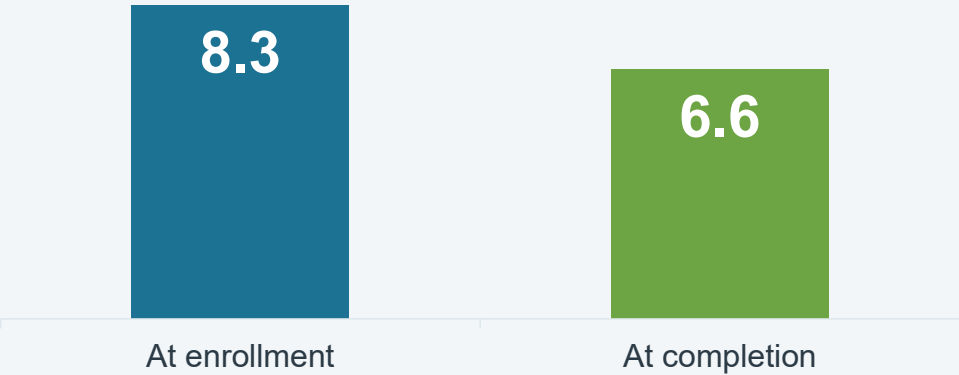


New for 2026: a CMS threshold for fewer than 16 days of transmission — which should capture the enrollees we could not bill for before.

Monthly average across 2024–2025. Panels are complex — diabetes and hypertension, often both.

What the Data Shows

AVERAGE HEMOGLOBIN A1C



76 → 31

participants with uncontrolled diabetes
(A1c above 8%)

20 of 35

patients who started above 10%
finished below 7%

-8 mmHg

average systolic drop · 13 → 17 at
guideline BP control



Every one of these numbers came out of a phone call the patient wasn't expecting.

REAL PATIENTS, REAL IMPACT

**The best evidence for RPM isn't in the numbers.
It's in the calls the numbers triggered.**



All three examples are de-identified.

The Nurse Who Noticed a Slow Drift



PATIENT PROFILE

73-year-old woman

Hypertension, OSA,
prediabetes, hyperlipidemia,
bradycardia

On diltiazem (Cardizem)

Enrolled for hypertension
monitoring

1 WHAT THE NURSE SAW

A drift, not an alarm. Systolic stepping down for weeks, heart rate at the low end of her baseline.

2 WHAT SHE DID FIRST

Called. Checked cuff placement, medication timing, and symptoms. The readings were real — not user error.

3 WHEN THE PROVIDER CAME IN

A verified multi-week trend, same day — not an alert. Diltiazem was safely discontinued.



One decision, from one summary. No extra visit just to gather the data.

The Phone Call That Found the Pill Bottles



PATIENT PROFILE

83-year-old woman

History of dementia

Husband is her caregiver
at home

Enrolled for hypertension
monitoring

1

WHAT THE NURSE SAW

Enrolled for high blood pressure — but the readings started running the other way. A hypotension pattern, over weeks.

2

WHAT SHE DID FIRST

Called the home. Walked the husband through the morning medications, bottle by bottle. It didn't match the chart.

3

WHEN THE PROVIDER CAME IN

Both came in with every bottle from home. Wrong bottles, split tablets, and a discontinued BP medication still in daily use.



A medication reconciliation in the chart would have looked fine. The call is what surfaced it.

The Patient Who Said No to Medication



PATIENT PROFILE

Woman in her early 50s

Newly diagnosed diabetes,

A1c of **10**

Preferred not to start
medication

Enrolled in continuous
glucose monitoring

1 WHERE MOST PROGRAMS STOP

A new diagnosis, an A1c of 10, and a patient who declines medication. Usually the end of the conversation.

2 WHAT THE NURSE AND DIETITIAN DID

CGM made cause and effect visible — she could see what a specific meal did to her own numbers, in real time.

3 WHERE THE PROVIDER CAME IN

Informed throughout, but never needed to intervene. A1c fell from 10 to 6.3 in three months — diet and exercise alone.



We didn't override her choice. We gave her the data to make it work.

Does It Pay for Itself?

~\$1,000

cost per patient per year — devices and nurse time

~\$1,550

potential annual reimbursement at full billing

\$150K in claims

\$50K reimbursed · \$35K pending

~45% written off
TOP WRITE-OFF REASONS

Contractual · Medical Necessity · Timely Filing

TOP PAYERS, IN ORDER:

United · Medicare · Healthy Blue · Humana ·
Ambetter · Aetna · BCBS (out of state)

What Changed at CMS in 2026

- Effective Jan 1, 2026: lower thresholds added alongside the existing ones — as few as 2–15 days of data in 30, and 10 minutes of monthly management.
- The original 16-day / 20-minute options remain. More room to bill for shorter periods and lower-acuity patients.
- HHS OIG (Aug 2025) flagged patterns to watch — RPM billed heavily to brand-new patients, or multiple devices per patient per month.

WHAT IT MEANS FOR US

~60 / mo

is what we average clearing the old 16-day threshold

The new code should capture engaged patients we could not bill for before.

Technology, Devices & What's Next



PLATFORM

Carium, through our partnership with Palmetto Care Connections



DEVICES

Cellular Tenovi — BP cuff, glucometer, scale, pulse ox; CGM for diabetes



CONNECTIVITY

Multi-carrier cellular. Deliberately no dependence on home broadband.

WHY CELLULAR MATTERED

Tablets on cellular still left gaps at Abbeville. We moved to an all-in-one device that picks up multiple carriers.

The device that asks nothing of the home internet is the one that gets used.



What's next for us: CGM returns to Orangeburg via BCBS Diabetes Free SC

What We'd Tell You Before You Start



Rural connectivity

All-in-one cellular devices, multi-carrier. Nothing depends on home internet.



Enrollment takes an hour

Its own appointment — not the last four minutes of a sick visit.



Engagement needs structure

Early follow-up calls, and clear graduation criteria so it has an end point.



Reimbursement is complicated

Revenue cycle at the table on day one — not after the first denial.

None of these were technology problems.

KEY TAKEAWAYS

What to Take Back With You

- 1 Nobody was worried about these patients.**
All three were stable on paper. The signal was a trend, not a crisis.
- 2 RPM catches what a routine visit can't.**
Trends, drifts, and what's actually happening in the kitchen at 7am.
- 3 The nurse is the program.**
An alert is a number. She is the one who called and worked out what it meant.
- 4 It replicates.**
Three areas of the state, one model.



Proactive monitoring surfaces the problem. A human being solves it.



Questions?

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