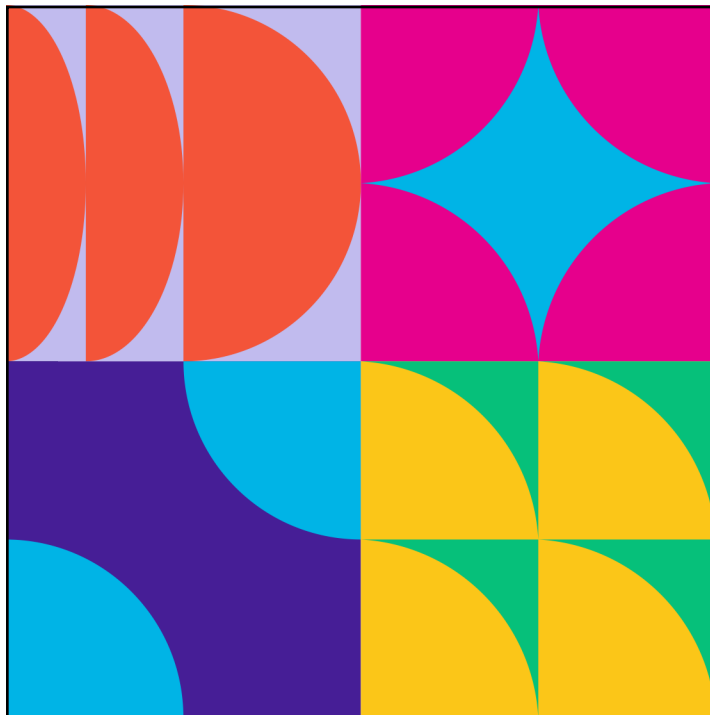




Care Beyond the Counter: Remote Monitoring and Telehealth Services

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Description

Remote care services — including remote therapeutic monitoring (RTM), remote patient monitoring (RPM), and other virtual care models — are rapidly expanding how pharmacies support patients between visits. Find out how virtual touchpoints and remote care services can strengthen adherence, engagement, and chronic care management. Get equipped with the skills to design a remote care service using workflows, documentation, and reimbursement strategies aligned with your pharmacy's staffing model and care priorities.

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Meet the Faculty



Amina Abubakar, PharmD

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Amina Abubakar

Amina Abubakar, PharmD, HIV Pharmacist (AAHIVP) is owner of Avant Pharmacy & Wellness Center in Charlotte, North Carolina, and founder of the Avant Institute, which trains pharmacies nationwide to implement sustainable clinical services through physician collaboration. She earned her PharmD from the Philadelphia College of Pharmacy (University of the Sciences).

An internationally recognized clinical pharmacist and Certified HIV Specialty Pharmacist, Amina serves as a preceptor for pharmacy students and residents and is a national leader in pharmacist-led care and pharmacogenomics. She was named the **2020 NCPA Independent Pharmacist of the Year** and received the **North Carolina Bowl of Hygeia Award** for outstanding community service. She has also advised the White House Office of Science and Technology Policy and the FDA on the role of pharmacists in pharmacogenomics.

Disclosures

- Amina Abubakar has no relevant financial relationships with ineligible companies to disclose.
- Amina Abubakar discloses that AI tools were utilized to generate content included in this presentation.

Funding for this course was provided by Cencora.

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Learning Objectives

Upon completion of this activity, learners should be able to:

- Differentiate remote physiological monitoring, remote therapeutic monitoring, and telehealth services in pharmacy practice.
- Identify operational, documentation, billing, and patient selection requirements for implementing remote care services.
- Examine patient engagement and monitoring strategies, including how patient-generated data supports care decisions and escalation.
- Apply workflow approaches that integrate remote care services into daily operations while meeting documentation, billing, and compliance requirements.
- Outline key steps to support a remote care workflow aligned with pharmacy staffing resources, documentation, and quality requirements.

The Case for Remote Care

Why virtual touchpoints matter for chronic disease management

What Is Remote Care?

Remote Patient Monitoring (RPM)

Collection and review of physiologic data, such as blood pressure, blood glucose, weight, heart rate, and oxygen saturation (SpO2), from connected devices in the patient's home.

Interchangeable with Remote Physiologic Monitoring – terminology dependent on CMS guidelines vs. formal CPT descriptor

Remote Therapeutic Monitoring (RTM)

Monitoring of non-physiologic data, such as medication adherence, response to therapy, respiratory function, musculoskeletal status, and patient-reported outcomes.

Goal is to track personal response vs. physiologic outcomes

Telehealth and Chronic Care Management (CCM)

Live audio or video visits and care coordination services that often pair with RPM and RTM to deliver a complete virtual care experience.

Remote Care and Chronic Disease

By the numbers

6 in 10 U.S. adults live with at least one chronic disease.

4 in 10 U.S. adults live with two or more chronic conditions.

Patients spend more than 8,700 hours each year managing their health outside of the clinic.

90% of U.S. healthcare spending is attributable to chronic and mental health conditions.

90% of Americans live within 5 miles of a community pharmacy.

Pharmacists are consistently rated among the most accessible health professionals.

Where pharmacy fits

Hypertension and heart failure

Type 2 diabetes and prediabetes

Asthma and chronic obstructive pulmonary disease (COPD)

Behavioral health and depression

Musculoskeletal pain and rehab

Weight management and obesity care

Anticoagulation monitoring

Centers for Disease Control and Prevention. *About Chronic Diseases; Health and Economic Costs of Chronic Conditions*. Bodenheimer T, Lorig K, Holman H, Grumbach K. *JAMA*. 2002;288(19):2469-2475.
National Association of Chain Drug Stores. *NACDS Facts and Figures*.

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Building Your Remote Care Service

Operations, documentation, reimbursement, engagement, and workflow

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Operational Requirements

People

Trained pharmacists and technicians
Collaborative practice agreement or partnering prescriber
Defined roles by state scope of practice
Clear escalation lines

Process

Eligible patient identification
Documented patient consent
Enrollment and onboarding standard operating procedures (SOPs)
Defined clinical alert thresholds
Monthly billing cycle review

Technology

FDA-listed connected devices
Cellular or app-based data capture
Vendor platform with patient and clinical dashboards
Secure messaging and video capability
Documentation that supports billing

Patient Case: Which Service Fits Best?

Patient Details

Patient: Mary Thompson
Age: 72 years
Insurance: Medicare Fee-for-Service
Medical History
Type 2 diabetes mellitus
Hypertension
Heart failure with preserved ejection fraction (HFpEF)
COPD
Osteoarthritis of both knees
Hyperlipidemia

Current Medications

Metformin 1,000 mg twice daily
Empagliflozin 10 mg daily
Lisinopril 20 mg daily
Furosemide 40 mg daily
Atorvastatin 40 mg daily
Tiotropium inhaler daily
Albuterol inhaler as needed
Acetaminophen as needed for knee pain

Recent Clinical History

Hospitalized 6 weeks ago for heart failure exacerbation.
Reports increasing shortness of breath with exertion over the past month; uses rescue inhaler 3-4 times daily.
Has gained 5 lbs over the last 10 days.
Admits she forgets to weigh herself consistently and use maintenance inhaler.
BP in clinic today: 154/88 mmHg.
Knee pain limits activity and participation in physical therapy exercises.
Missed her last primary care follow-up appointment due to transportation issues.
Lives alone and reports difficulty managing multiple chronic conditions.

What do you think?

1. Is this patient a candidate for Chronic Care Management (CCM)?
2. Is this patient a candidate for Remote Patient Monitoring (RPM)?
3. Is this patient a candidate for Remote Therapeutic Monitoring (RTM)?
4. If multiple programs are appropriate, which should be prioritized and why?
5. What outcomes would you expect to improve with each intervention?

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Patient Case: Which Service Fits Best?

CCM Candidate? → Yes

Has **two or more chronic conditions** expected to last at least 12 months.

Conditions place her at significant risk for hospitalization, exacerbation, and functional decline.

Would benefit from medication reconciliation, care coordination, appointment scheduling, and longitudinal management.

RPM Candidate? → Yes

Heart failure and hypertension are excellent use cases for physiologic monitoring.

Potential monitoring parameters:

- Daily weight
- Blood pressure
- Pulse
- Oxygen saturation

RTM Candidate? → Yes

COPD inhaler adherence and symptom monitoring align well with RTM respiratory codes. Osteoarthritis and physical therapy adherence could support musculoskeletal RTM.

Appropriate non-physiologic data:

- Medication adherence
- Symptom burden
- Therapy response
- Functional status
- Exercise compliance

Something to Consider

The best answer is often **not choosing one program over another**, but rather matching the intervention to the patient's needs:

- **CCM** addresses the complexity of managing multiple chronic diseases and coordinating care.
- **RPM** captures physiologic changes that may identify decompensation early.
- **RTM** helps assess adherence and response to therapeutic interventions.

Documentation and Reimbursement

Medicare CPT codes

RPM

- 99453: setup and education
- 99445: device supply/readings, 2-15 days in 30
- 99454: device supply/readings, 16+ days in 30
- 99457: first 20 minutes of management
- 99458: each additional 20 minutes
- 99470: 10-19 minutes of management

RTM

- 98975: setup and education
- 98976 to 98978: device supply
- 98979: first 10-19 minutes of management
- 98980: first 20 minutes of management
- 98981: each additional 20 minutes

Centers for Medicare & Medicaid Services. Remote Patient Monitoring. Telehealth HHS.gov. Billing for Remote Patient Monitoring.

Document or don't bill

Patient consent: captured before enrollment, refreshed annually

Device readings: auto-captured plus any manual entries

Time logs: minutes of monitoring; requires interactive communication per calendar month

Clinical decisions: alerts reviewed, actions taken, outcomes

Supervising qualified health care professional (QHCP): incident-to or collaborative practice as required

Engagement drivers

Right fit: uncontrolled, newly diagnosed, or high risk

Clear expectations: set at enrollment, reinforce often

Multi-channel: text, phone, video, secure message

Personalized: health literacy and social determinants of health (SDOH)-aware

Visible progress: share trends and small wins

Early re-engagement: act before silence leads to drop-off

Patient Engagement Strategies

Move from enrolled to engaged

Target the right patient at the right time, prioritizing newly diagnosed or poorly managed chronic conditions

Set clear expectations at enrollment: what data is reviewed, how often, and how the patient will be contacted

Use multiple touchpoint channels, including text, phone, video, and secure messaging

Personalize coaching for health literacy, language, and social drivers of health

Involve family or caregivers when appropriate

Share trended data visually so patients can see their progress

Re-engage non-responders early before they disenroll

Workflow Integration

Practice at the top of your role

Technicians lead enrollment, device shipment, routine outreach, and basic monitoring

Pharmacists own clinical alerts, medication adjustments, and billing-eligible interactions

Build the day around it

Block a daily review window scaled to caseload (about 30 minutes per 50 enrolled patients)

Define and document clinical alert thresholds and escalation pathways

Align review cycles to the monthly billing calendar

Protect the team

Cap caseload per pharmacist and rotate roles to prevent burnout

A day in the workflow

Morning: technician runs enrollment list, ships new devices

Midday: pharmacist triages overnight alerts, makes adjustments

Afternoon: technician completes outreach calls, logs interactions

Weekly: team huddle on caseload, no-data patients, escalations

Monthly: billing review and outcome metrics

Implementation Roadmap

Seven steps to launch and scale

1. Assess fit: patient population, payer mix, staffing capacity
2. Choose a platform and FDA-listed devices
3. Secure a collaborative practice agreement or prescriber partner
4. Build SOPs, consent forms, and escalation protocols
5. Train the team and pilot with 5 to 10 patients
6. Measure clinical outcomes, billing, and patient experience
7. Scale gradually with caseload and staffing checkpoints

What to measure

Clinical: A1C, BP control, adherence, emergency department visits

Financial: billable interactions, revenue per patient, cost to serve

Operational: enrollment rate, time per review, alert response time

Experience: patient and team satisfaction, disenrollment reasons

A Patient Case

Patient Profile:

Mr. James Wilson is a 78-year-old Medicare beneficiary referred for hypertension management after persistently elevated home blood pressure readings despite treatment with multiple antihypertensive medications. He is followed by nephrology and primary care.

A Patient Case: Mr. JW

Past Medical History

Hypertension
Type 2 diabetes mellitus
Hyperlipidemia
Chronic kidney disease stage V
Heart failure with volume overload history
Hypothyroidism
Mild cognitive impairment/dementia
Chronic pain
Depression

Current Medication List

Aspirin 81 mg daily
Atorvastatin 10 mg daily
Carvedilol 12.5 mg twice daily
Clonidine 0.1 mg patch weekly
Furosemide 40 mg daily
Hydralazine 100 mg three times daily
Nateglinide 120 mg three times daily
Linagliptin 5 mg daily
Insulin degludec 40 units daily
Levothyroxine 112 mcg daily
Donepezil 10 mg daily
Memantine 5 mg twice daily
Duloxetine 60 mg daily
Tramadol 50 mg twice daily

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A Patient Case: Mr. JW

RPM Data from Home Readings

Date	BP/HR	Date	BP/HR
7/4	136/79 (62)	6/25	173/99 (58)
7/3	153/88 (60)	6/24	172/94 (63)
7/3	166/121 (69)	6/23	168/98 (61)
7/2	155/90 (66)	6/22	161/94 (65)
7/1	153/85 (62)	6/21	152/92 (64)
6/30	155/93 (59)	6/20	146/80 (60)
6/29	148/84 (59)	6/19	142/79 (68)
6/28	151/92 (59)	6/18	156/89 (63)
6/27	141/84 (64)	6/17	131/78 (69)
6/26	149/88 (66)	6/16	112/77 (84)

RPM BP Summary (Last 20 Readings)

Average BP: 151/90 mmHg
Average HR: 64 bpm
Range: 112/77 to 173/99 mmHg
Highest Severe Reading: 166/121 mmHg
Readings >140/90: 15 of 20 (75%)
Readings >160 systolic: 5 of 20 (25%)
Heart Rate Range: 58–84 bpm
BP regimen: Carvedilol 12.5 mg twice daily, clonidine 0.1 mg patch weekly*, furosemide 40 mg daily, hydralazine 100 mg three times daily

**added 6/18 by primary care physician (PCP) due to elevated readings in office and at home previously*

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What would you do next?

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A Patient Case: Mr. JW

What to do next for RPM?

- Assess medications
 - Nephrology stopped lisinopril due to acute kidney injury (AKI) previously
 - On 6/18, nephrology added doxazosin 2 mg nightly, but daughter was afraid of hypotension as expressed at PCP visit, so only clonidine patch was started
 - Follow up in 2 weeks to assess BP with medication changes
- Monitoring practices
 - Call patient/caregiver and review adherence, external causes for elevated readings, symptoms, technique, and patient concerns
 - Determine provider protocol for when to escalate to PCP and patient-specific goal – earlier appointment, re-check, refer to ED, medication adjustment

A Patient Case: Mr. JW

What to do next for CCM?

- Assess medications
 - Adherence
 - Adverse drug reactions (ADRs)
 - Renal dosing
- Disease state review
 - Control
 - Labs
 - Screenings
 - Education for patient on lifestyle

Key Takeaways

RPM, RTM, and CCM are different tools for different patient needs and clinical goals.

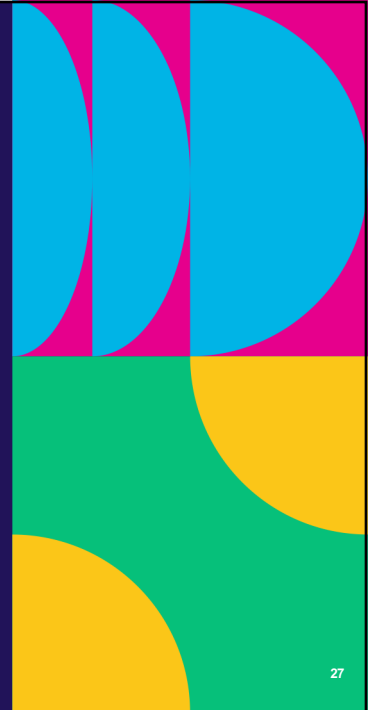
Successful remote care takes more than technology – it requires the right patients, documentation, billing, staffing, and compliance.

Patient-generated data supports earlier intervention and helps prevent avoidable complications and hospital use.

Strong workflows make remote care sustainable by aligning services with pharmacy resources and daily operations.

The right patient, the right service, and the right workflow transform remote monitoring from a technology solution into a scalable model of care delivery.

What is one next step
you will apply in your
practice as a result of
this session?



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Questions?