Digital Health for Chronic Disease: Designing a Multi-Modality Care Pathway

Executive Quick Start Guide

CALIFORNIA TELEHEALTH RESOURCE CENTER

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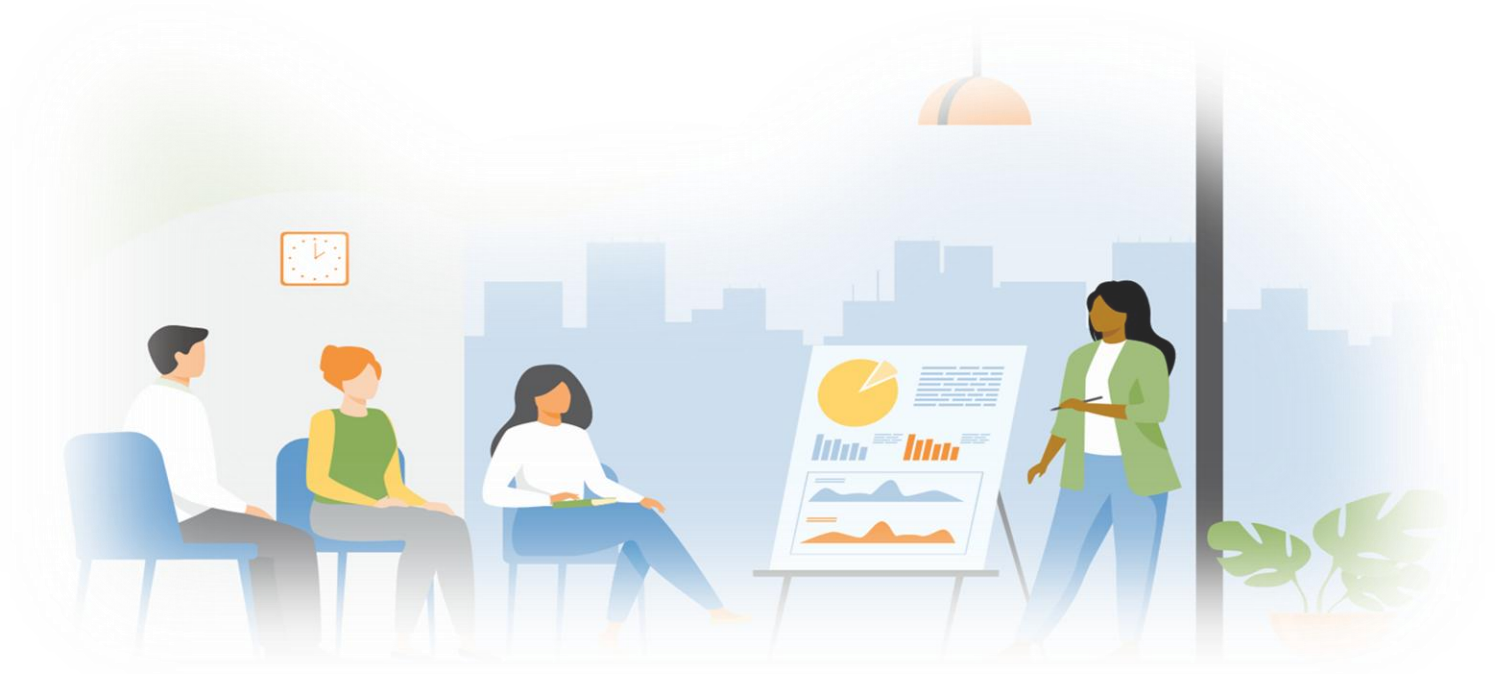
ABOUT CTRC

The California Telehealth Resource Center (CTRC) offers no-cost, unbiased training, educational resources, and technical assistance to help California providers and patients get the most from telehealth. As the federally designated telehealth resource center for the region, we offer unbiased tools and services based upon proven telehealth practices. We create lasting change and improvement by focusing on implementation, sustainability, reimbursement and policy, integration, workflows, and patient/provider adoption.

As part of the National Consortium of Telehealth Resource Centers and the OCHIN family of companies, CTRC assists thousands of providers and patients annually. We have extensive experience supporting the healthcare safety net, rural and urban providers, and patients and families throughout California who would otherwise be unable to access quality healthcare due to geographic isolation, language/cultural barriers, lack of insurance, disability, homelessness, and more.



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Digital Health for Chronic Disease: Designing a Multi-Modality Care Pathway

Chronic disease care is one of the best areas for digital health to make a real impact when the right tools are used for the right purpose. This guide focuses on building an integrated care pathway that combines in-person care, live telehealth visits, eConsults, remote patient and therapeutic monitoring (RPM/RTM), and, when appropriate, AI-enabled tools. The goal is to improve outcomes, reduce burden on patients and care teams, and support access and patient choice.

What problem or need are you addressing?

Chronic disease outcomes often suffer because follow-up is difficult, patients face transportation and access barriers, and care teams lack timely clinical data between visits. A well-designed multi-modality care pathway can improve continuity, support earlier intervention, and reduce avoidable emergency department visits and hospitalization.

30 / 60 / 90-Day Action Plan

Start small, build intentionally

- Select one chronic disease focus, such as hypertension, diabetes, congestive heart failure, or COPD.
- Map all patient touchpoints across a six-month period, including visits, check-ins, monitoring, and escalation points.
- Decide what should happen in person versus via telehealth, monitoring, messaging, or eConsult. Avoid defaulting every interaction to a video visit.
- Build a patient onboarding and support model, such as a digital navigator or community health worker, to help with devices, education,
- Align care modalities with current reimbursement and staffing capacity.
- Review outcomes monthly and adjust workflows as needed.

Evidence Snapshot

- CMS and AMA resources show that telehealth and RPM are most effective when they are paired with clear workflows and defined care team roles.
- DHCS telehealth policy allows flexibility in modality use under Medi-Cal when services are clinically appropriate and properly documented.
- Studies consistently show that combining monitoring and follow-up between visits can improve chronic disease control and patient engagement.

Safety & Regulatory Musts

- Obtain and document patient consent using approved language.
- Apply HIPAA, privacy, and cybersecurity safeguards across all modalities, including messaging and monitoring platforms.
- Ensure accessibility across every modality. This includes interpreter services, disability accommodations, and alternative formats as needed.

Payment & Sustainability: Verify Early

- Telehealth visits, RPM/RTM, and eConsults are billed differently. Set up clear, modality-specific billing workflows.
- For Medicare patients, monitor 2026 policy changes, including site-of-service rules that take effect after January 30, 2026, as outlined in CMS telehealth guidance.
- For Medi-Cal, confirm modifiers, documentation requirements, and coverage rules.

Liability & Audit Readiness

- Standardize escalation and follow-up rules across all modalities. Clearly document who contacts the patient, when contact occurs, and where it is recorded in the medical record.
- Review vendor contracts to ensure they address device accuracy, data reliability, and clear boundaries around clinical responsibility.
- Maintain consistent documentation across modalities to support audits and quality reviews.

Key Success Metrics

Clinical outcomes	• Blood pressure control • A1c levels • CHF admissions • COPD exacerbations
Access and Engagement	• Follow-up completion rates • Time to specialist input through eConsults • Monitoring enrollment and adherence
Accessibility	• Modality use by language preference and disability status • Broadband or device barriers • No-show and dropout rates
Financial Performance	• Denials by modality • Net revenue by service type • Cost avoidance from reduced utilization

CTRC Calls to Action

- Use CTRC's Equipment Selection Guide to align devices with care pathways
- Apply CTRC's RPM vendor toolkit and evaluation checklists
- Use the CTRC RPM Toolkit to design workflows, escalation protocols, and documentation processes

Trusted Resources

- AMA Remote Patient Monitoring Playbook | AMA
- Centers for Medicare & Medicaid Services. (2024). *Telehealth services and remote patient monitoring.*
- CMS MLN: Telehealth & RPM (PDF): MLN901705 -Telehealth & Remote Patient Monitoring
- ONC/ASTP Security Risk Assessment Tool: Security Risk Assessment Tool - ASTP - Assistant Secretary for Technology Policy
- HHS Telehealth and RPM: Preparing patients for remote patient monitoring | Telehealth.HHS.gov
- HHS RPM Research: Telehealth Research Recap: Remote Patient Monitoring

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