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Remote Patient Monitoring at NEVHC

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Northeast Valley Health Corporation (NEVHC)

- PCMH & Joint Commission Accredited FQHC
- Los Angeles County (SPA 2)
- 17 licensed clinic sites
- 80,000+ patients
- 93% <200% of FPL
- 51% ages 0-17; 49% 18 & up
- 19% uninsured

COVID-19 Impact on HTN Control Rate

- Prior to the COVID-19 Pandemic, blood pressure readings were taken during all medical visits. As we quickly pivoted to telephone and telehealth (video) visits during the pandemic, blood pressures were not being taken nor documented in the electronic health record.
- Due to missing blood pressure readings, our hypertension control rate decreased from 70.8% in December 2019 to 40.6% in March 2021.
- As of July 2021, there were 3,578 patients without a blood pressure documented in their EHR in the last 12 months.

Unconnected BP Monitors

- In an effort to increase our hypertension control rate:

Health Education Department provided unconnected blood pressure monitors to patients with HTN

Care Teams were able to collect and document the patient's home blood pressure readings

Challenges to Unconnected BP Monitors

- Accuracy of BP reading due to self-reporting
- Home BP readings not being documented in the vitals sign template in the EHR
- Patient digital literacy
- Patient engagement/lost to follow up

RPM Pilot for HTN

- NEVHC partnered with Rimidi to pilot a 50-patient cohort to improve our hypertension control rate.
  - 100% FTE RPM Coordinator
  - Identified patients with hypertension not in control & created a workflow for providers to refer patients to the RPM-HTN pilot
  - Created a script to enroll patients
  - Provided patients with cellular connected BP monitors
  - Monitor RPM (Rimidi) platform for high/low blood pressures
  - Provide HTN education to patients

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HTN RPM Follow Up Workflow

Patients Not In Control (BP >130/80)
HE managing the referral schedules 1:1 or group
HTN Education
HE Rimidi daily
Pt instructed to check BP daily
HE and Pt have monthly counseling sessions for routine *HTN education and HE uploads BP log and tasks provider

Missing BP Alert every 3 days → **Send Reminder Text Reset Alert 1 Day**

If every BP reading is <130/80 (minimum of 3 readings a week) ↓

Patients In Control (BP <130/80)
HE checks Rimidi once a week
Pt instructed to check BP once a week
HE and Pt have monthly counseling sessions for routine *HTN education

Missing BP Alert every 10 days → **Send Reminder Text Reset Alert 3 Days**

If every weekly BP reading is <130/80 (minimum of 4 weekly readings) ↓

Patients Consistently In Control (BP <130/80)
HE checks Rimidi once a month
Pt instructed to check BP once a month

Missing BP Alert every 6 weeks → **Send Reminder Text Reset Alert 3 Days**

← **6 consecutive months of in control, patient "graduates"**

BP >130/80 OR <60/40 → back to Patients Not In Control

High BP Alert = BP >160/100
Low BP Alert = BP <60/40
HE follows up with patient for BP rx adherence, uploads BP log to EHR, and sends PTA to provider informing them of rx adherence and directing them to BP log.
HE clears High/Low BP Alert in Rimidi
Workflow returns to "Patient not in control" category.

*HTN education includes nutrition education, BP log review, BP medication adherence.

If BP is ≥180/110 patient must be connected to RN for triage.

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RPM HTN Data

% of Patients with HTN and Blood Pressure <140/90

	Mar.21 n=50	Apr.21 n=50	May.21 n=50	Jun.21 n=50	Jul.21 n=50	Aug.21 n=50	Sept.21 n=48	Oct.21 n=47	Nov. n=46	Dec. n=46
Rimidi HTN Control	38.0%	41.7%	43.1%	48.0%	68.8%	70.0%	66.7%	65.9%	65%	70%
NEVHC HTN	40.6%	42.0%	44.0%	44.6%	46.8%	48.5%	57.0%	51.04%	51.97%	53.03%
Pts. with unconnected BP Monitor	46.7%	47.8%	49.1%	50.0%	50.0%	51.7%	58.0%	58.5%	58.3%	62.4%

Median: **56.6%**

Y-axis: 20.0% – 100.0%

Pending NEVHC HTN DATA

Successes & Challenges to RPM

Success

- Increase in HTN control rate
- Clinical decision making tool
- Cellular connectivity (easy set up)
- Ability to access RPM platform through EHR
- Access to real time data
- Automated & customizable high/low and missing BP alerts
- Text message feature

Challenges

- Patient utilization/engagement
- Sharing of devices
- RPM Coordinator bandwidth to monitor high risk patients
- Cost
- Full EHR integration

Solutions

- Revised enrollment script to include patient engagement expectations
- Developed a device agreement form
- Identified other staff that can assist with monitoring and education (i.e. Health Educators, FM Care Coordinators)
- Developed RPM-HTN Graduation Workflow
- Grant opportunities to fund efforts
- Explore RPM reimbursement for FQHCs
- New feature to push vital signs log to EHR

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RPM Expansion

HRSA-ARPA

- Renewal of 50 BP monitors from pilot
- Expanding to 100 additional BP monitors
- Piloting 50 glucometers

HRSA-OVC

- 600 glucometers
- 375 BP monitors
- Piloting 25 weight scales for patients with CHF
- Screening for SDoH and Digital Literacy
- Patient Navigation services to community resources and internal resources
- Providing telehealth support to clinical team and patients
- Hiring Staff:
  - 3 FT Health Educators
  - 3 FT Community Health Workers