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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

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Rimidi

Rimidi is a web-based clinical management platform designed to support clinical decision making, quality improvement, workflow optimization, and patient engagement within existing EHR workflows through remote patient monitoring (RPM).

- Cellular connected devices
  - Glucometers
  - Blood pressure monitors
  - Weight scales
- Digital literacy
- EHR integration
- Ongoing technical assistance (TA) calls

rimidi

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RPM Pilot Program

In April of 2021, NEVHC piloted a 50-patient RPM cohort for hypertension management.

- Identified patients with uncontrolled hypertension (BP $\geq$ 140/90)
- Developed a patient recruitment script, enrollment workflow, and chronic disease management workflow
- Hired and trained a 1.0 FTE RPM Program Coordinator
- RPM hypertension dashboard reported monthly to leadership team

RIMIDI Hypertension Control 2021-2022

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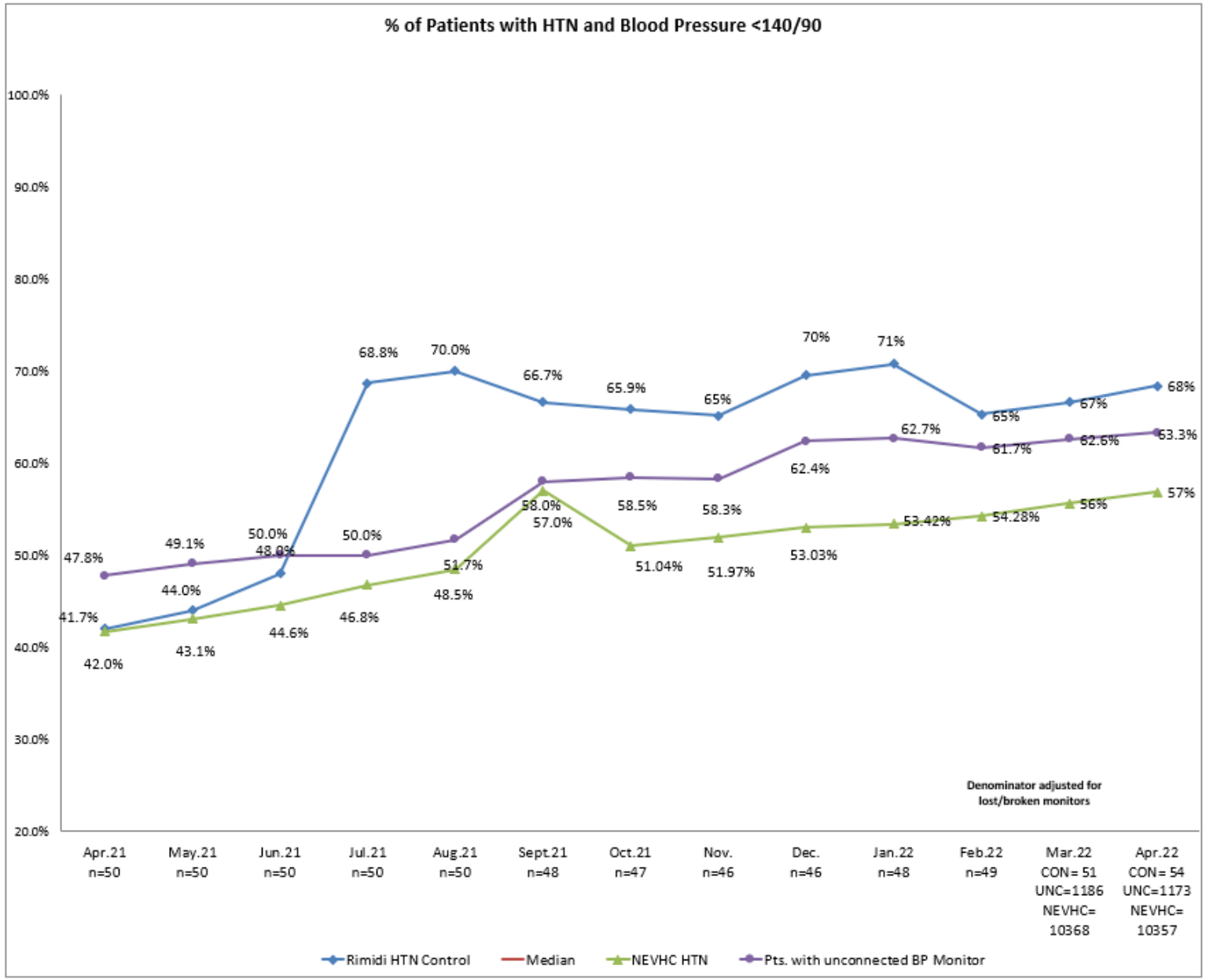

RPM Expansion

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- NEVHC was awarded the HRSA American Rescue Plan (ARP) grant and the HRSA Optimizing Virtual Care (OVC) grant, which allowed us to expand our RPM program.

- HRSA ARP
  - Continued managing the 50 pilot patients with hypertension
  - 50 glucometers for patients with diabetes
  - 100 additional blood pressure monitors for patients with hypertension

- HRSA OVC
  - 25 weight scales for patients with congestive heart failure
  - 375 additional blood pressure monitors for patients with hypertension
  - 600 additional glucometers for patients with diabetes

RPM – OVC Team

With the OVC award, we were able to hire a RPM team to assist with program activities, coordination, device distribution, and chronic disease management.

- Program Manager
  - Management of program activities and personnel
- 4 FTE Health Educators
  - Patient recruitment and enrollment
  - Device distribution
  - Chronic disease education
  - Monitoring of RPM platform for critically high or low readings
  - Coordination with PCP and care teams
- 3 FTE Community Health Workers
  - Patient recruitment
  - Social determinants of health (SDoH) screenings
  - Referrals to internal and community resources
  - Digital literacy screenings
  - Telehealth support

RPM – Workflow

Enroll high risk patients → CHWs assess patients for SDoH, digital literacy, and provide telehealth support → Health Educator appointment for device distribution and initial education (**CPT 99453** – RPM initial, device set-up and education) → Daily monitoring for high/low alerts and routine follow-up for uploading log to EMR, education, coordination with clinical care team, (**CPT 99454** – RPM daily recording)

Patients with hypertension are eligible to graduate from the program if there BP is kept <130/80 for six consecutive months

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OVC Device Distribution

RPM DEVICES	GOAL PER MONTH	AUGUST DISTRIBUTION	SEPTEMBER DISTRIBUTION	OCTOBER DISTRIBUTION	NOVEMBER DISTRIBUTION	DECEMBER DISTRIBUTION	JANUARY DISTRIBUTION	TOTAL DEVICES DISTRIBUTED
Blood Pressure Monitors	38	11	51	53	34	32	47	228
Glucometers	60	1	48	53	48	43	41	234
Weight Scales	3	-	-	-	-	1	3	4
TOTAL	**101**	**12**	**99**	**106**	**82**	**76**	**91**	**466**

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Lessons Learned

To maintain a successful program, it is important to:

- Maintain continuous engagement with various parties
  - Patients for engagement and improved health outcomes
  - Vendor for platform troubleshooting
  - Clinical leaders for clinical decision making and clinical workflow feedback
  - RPM team for workflow feedback
- Share monthly clinical dashboards with key stakeholders
- Explore sustainability strategies

Thank you!