Remote Patient Monitoring:
In rural independent hospitals

Tuesday, June 11, 2024

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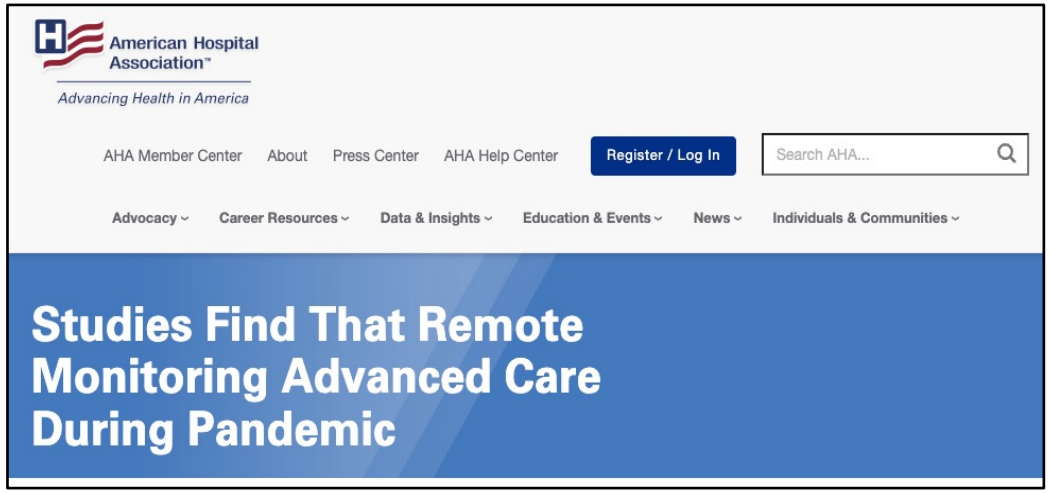
What is Remote Patient Monitoring? (RPM)

- A form of telehealth.
- Supports primary care team to assist patients in effectively managing their medical conditions. This is achieved by utilizing medical devices outside of conventional healthcare settings, such as in the comfort of their own home.
- Devices capture physiological biometric readings that are then electronically transmitted to a patient's care team in between office visits.
- Supports early identification and intervention for adverse clinical changes.
- Supports patient engagement and accountability as they learn lifestyle behaviors that impact their health.

Clinical evidence backing RPM use

- Evidence backing the clinical benefits of RPM has been available for 20+ years and the research database continues to grow.
- Use cases for RPM continue to evolve - although RPM has historically been thought of as a tool to help manage chronic conditions.
- In the more recent past, RPM has been deployed as an intervention for higher-acuity conditions as well as leveraged for patients' post-operatively or post medical admission.



Benefits of RPM

Reduced ED visits, inpatient admissions & readmissions

Increased access to care

Increased patient engagement & satisfaction

Higher quality care

Early detection & intervention

Cost avoidance for patients & healthcare organizations

RPM benefits amplified in rural settings

Accessibility

Real time data & care adjustments

Helps identify social drivers of health issues

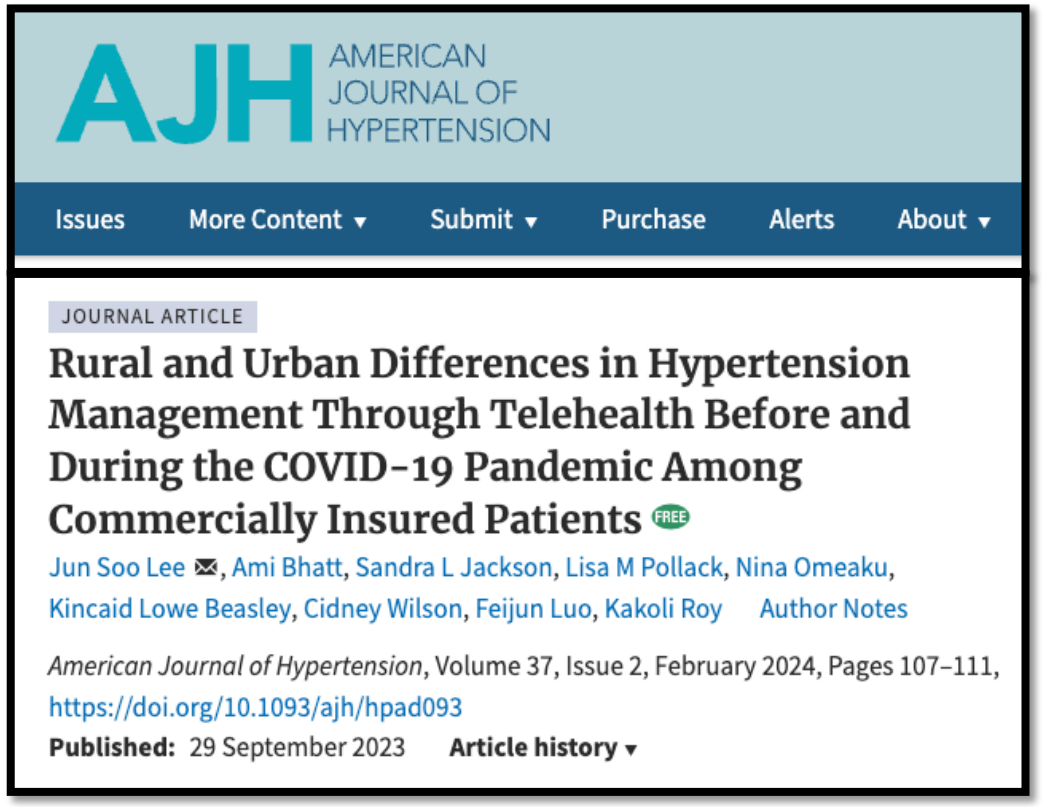
Peace of mind for patients & families

Reinforces positive lifestyle changes

Enables patients to get the right care, right place, right time

RPM potential barriers in rural settings

RPM barriers in rural settings



Source: https://academic.oup.com/ajh/article/37/2/107/7285933

Conclusions

Data show that rural residents were less likely to use telehealth for hypertension management. Understanding trends in hypertension-related telehealth utilization can highlight disparities in the sustained use of telehealth to advance accessible health care.

One less barrier for RPM in rural settings today!

- Although Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) could provide RPM services prior to 2024, it was not until January 1, 2024, that CMS granted RHCs and FQHCs the ability to bill CMS for RPM services.
- This has served as a true turning point for many rural providers as it has granted them greater flexibility in how they can go about implementing RPM for their patient population.
- With RPM identified as a tool to help providers meet important performance metrics underlying value-based care, this change in regulations was one long awaited by the greater rural healthcare community.

Industry trends

- RPM is not going anywhere, and innovation will continue.
- The more the industry shifts to value-based care, the greater the demand for RPM services will become.
- Use cases for RPM will continue to evolve, as will outcomes research.
- Expanding provider shortages can be partially addressed by digital engagement tools such as RPM.

Higi Care Everyday is backed by a clinical network that puts patients first

Built on the belief that nurturing human relationships and meeting patients in their community and at home leads to great quality and improved health outcomes

- Filling the gaps for patients
- Enhancing existing healthcare teams
- Enhancing coordination of care & navigation to resources
- Patient health & safety first

Clinician-Led

High touch clinical care power with remote monitoring devices for polychronic patients, with ongoing management and coaching. Technology enabled; relationship driven.

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Higi Care Everyday solution process overview

Identify
Referral or eligibility file

Connect
Educate patient & onboarding

Communicate
Regular updates & coordination of care

Patient Identification

Identification in conjunction with partner ● Outreach to set up appointments for onboarding

Enrollment & Initial Visit

Initial enrollment ● Telehealth provider visit ● Capture medical history, medications, PCP ● Determine unique needs ● Devices sent to home

Remote Monitoring (ongoing)

Monthly practitioner reviews ● Care team collaboration ● Regular physiological data capture and reporting

Higi & Partner Collaboration (ongoing)

Ongoing data to support interventions as needed ● Navigation to additional services or resources identified in the Playbook

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Higi Care Everyday as an extension of the patient's PCP

Higi's goal is to amplify and augment the fantastic work that primary care providers are already championing in their community. We are able to flex our Higi workflows to best meet the needs of our partner organizations, leveraging existing care management relationships where appropriate.

If a patient escalation is required, the patient's dedicated Higi RN CM contacts the patient to clinically validate the situation

If further intervention is warranted, the Higi CM sends an Escalation Report to the patient's appropriate PCP clinical contact*

Higi RN CM follows up with a phone call to the appropriate PCP clinical contact to ensure receipt of the Escalation Report & discuss further if desired by PCP

Higi RN CM works collaboratively with the PCP care team to support their recommendations

*Depending what is agreed upon, could be the patient's home organization's care manager or PCP; items such as these are addressed during program build/workflow development sessions

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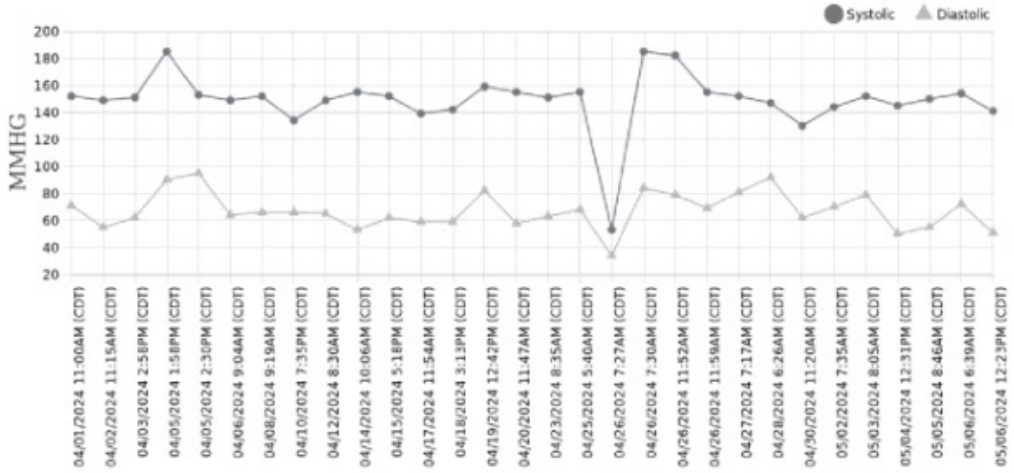
- Monthly patient-specific status reports provided to PCP and any specialty providers (as requested by the patient)



Notes:

- **04/26/2024:** S/O reviewed alert for elevated bp. Contacted patient, denies symptoms. / A/P repeat blood pressure when patient can get back home. No further action needed.
- **04/05/2024:** S/O reviewed alert for elevated bp. Contacted patient, denies symptoms. A/P repeat within normal range. No further action needed

- **04/04/2024:** Monthly Call Today, a monthly phone call was conducted with to review and update care plan. The call served as an opportunity to assess the patient's current health status, discuss any concerns or changes in their condition, and collaboratively update their care goals and interventions. Updates: is doing well. She currently is experiencing s/s of a UTI and dropping off a specimen to her PCP. She otherwise has no other medication changes. Her weight fluctuations are due to having a saturated depends on and often weights with them wet. Discussed making sure she is dry and if not then please remove before weighing in as this throws off the trending of the daily weight. Verbalized understanding. Discussed diet and exercise. Currently goes for walks around cul-de-sac with home health aide. Diet is okay as appetite is poor. *Reviewed and updated the care plan to align with the patient's evolving needs and preferences. *Discussed progress made towards previously established goals and identified new goals as appropriate. *Confirmed medication regimen and addressed any medication-related concerns. *Established a follow-up plan and scheduled the next appointment or phone call. The completion of the monthly phone call ensures that the patient receives comprehensive and coordinated care tailored to their individual needs. Patient verbalized understanding of the importance of each call. Verbalized understanding of when to seek attention from PCP vs. Care Manager and 911/ER.

Michigan Health Endowment Fund (MHEF) RPM Pilot

MICHIGAN HEALTH ENDOWMENT FUND

MEDIGAP GRANTS PORTAL ABOUT GRANTMAKING

Home » Announcing $15.2 Million in New Grant Awards

ANNOUNCING $15.2 MILLION IN NEW GRANT AWARDS

Nov 15, 2022 | **Healthy Aging, News**

Michigan communities are driving solutions to health challenges across the board. The Health Fund just awarded more than $15 million to 60 projects in Michigan, ranging from responses to dementia and elder abuse to support for maternal mental health and school food systems. From small, community-driven initiatives to systemic, statewide models, the selected organizations are pairing innovation with a vision of sustainability to lay the groundwork for lasting change.

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2022 SPECIAL PROJECTS & EMERGING IDEAS INITIATIVE GRANTS

Michigan Center for Rural Health

Enhancing RPM in Independent Rural Hospitals

To pilot a remote patient monitoring and chronic care management platform to improve access to care for older rural residents.

MHEF RPM Pilot

An 18-month pilot funded by the MHEF focused on serving seniors with Medicare Part B who have polychronic conditions or health complexities such that treating providers believe at-home monitoring would be necessary to improve or stabilize their health. (Scheduled to run through June 2024)

Goals:

- Increase access to care the pilot communities while simultaneously avoiding additional clinical burden
- Improve health outcomes for seniors
- Develop a rural health RPM playbook that outlines steps and associated best practices enabling the launch of RPM services in rural and/or remote areas

Overall pilot enrollment

70

# of patients enrolled in the pilot

48.7%

Conversion rate for eligible patients referred by PCP or home organization care manager

3.7%

Conversion rate for patients approached by RPM partner on behalf of home organization

Pilot outcomes | Improved medical management

Patient engagement

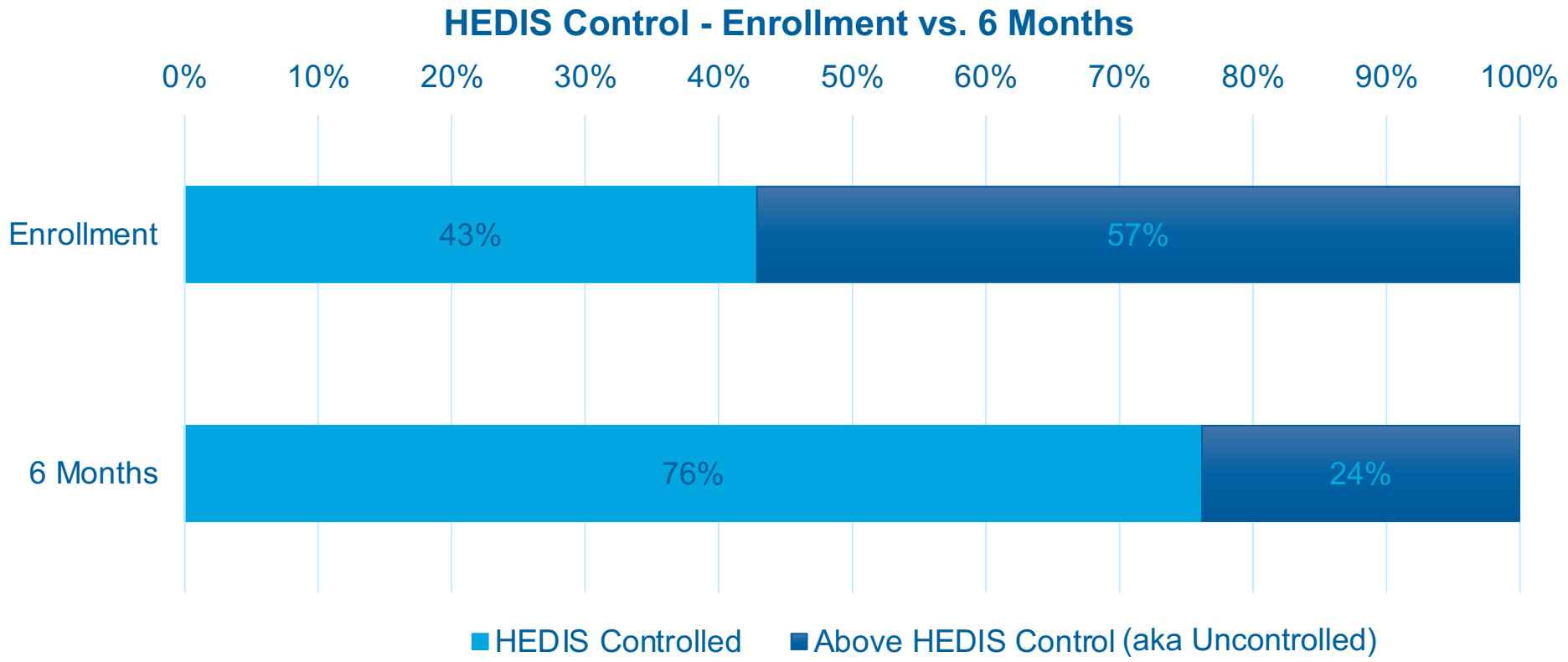
Medication adherence

Medication adjustment facilitation

Enhanced coordination of care

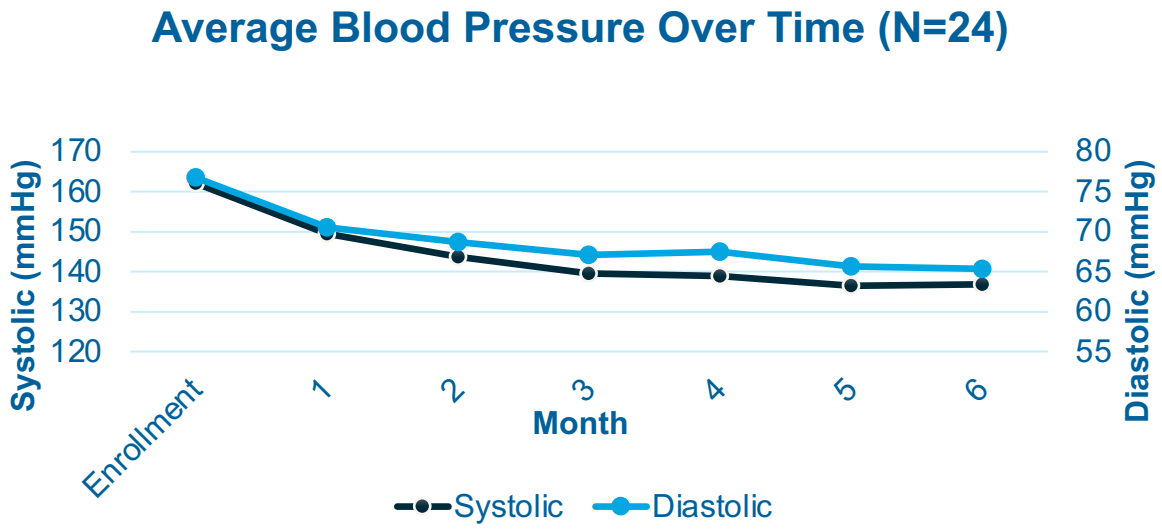
Pilot outcomes | Improved health outcomes

- 42 patients have 6 months of blood pressure readings
- Within our 6-month cohort, we saw a 78% increase in population under HEIDS control!



Pilot outcomes | 6-month blood pressure trends cont.

Patients initially uncontrolled

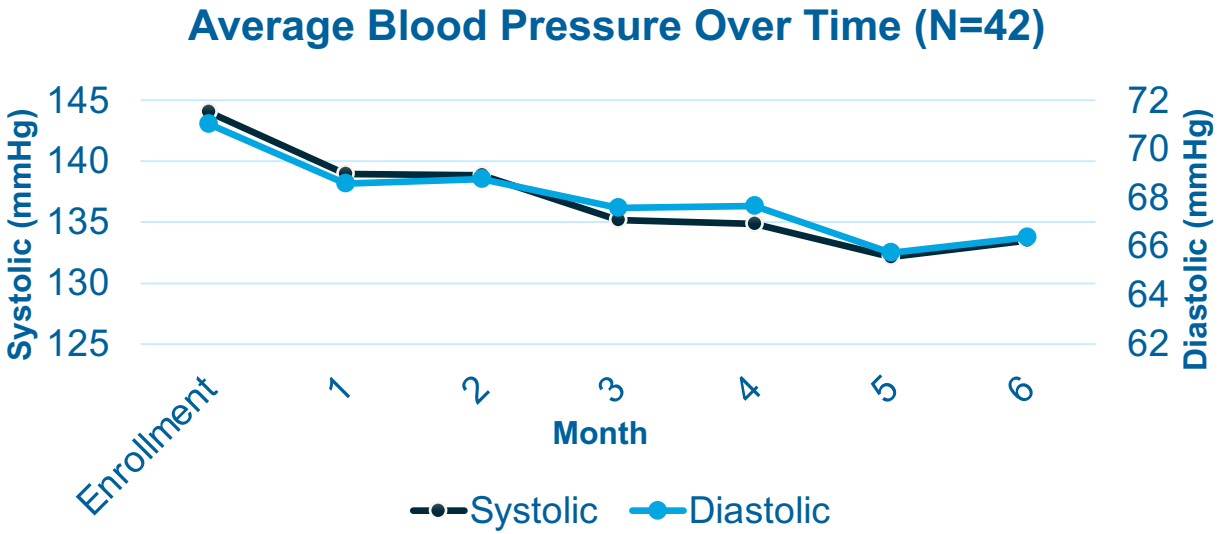


- N = 24 patients
- Average reduction in blood pressure:
  - Systolic: **25 mmHg**
  - Diastolic: **11 mmHg**
  - Mean Arterial Pressure: **16 mmHg**
- 5 mmHg drop in systolic blood pressure reduces risk of major cardiovascular event by 10%*

*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8102467/

Pilot outcomes | 6-month blood pressure trends cont.

Full 6-month patient cohort



- N = 42 patients
- Average reduction in blood pressure:
  - Systolic: **11 mmHg**
  - Diastolic: **5 mmHg**
  - Mean Arterial Pressure: **7 mmHg**
- 5 mmHg drop in systolic blood pressure reduces risk of major cardiovascular event by 10%*

*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8102467/

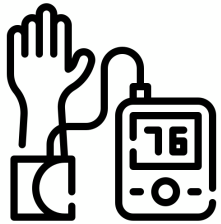
Pilot outcomes | Patient satisfaction

40

# of patients surveyed

9.18/10

Likelihood to recommend average score



9.30/10

Device ease of use average score

9.75/10

Initial telehealth appointment experience average score

9.70/10

Overall experience with Higi Care Manager average score

Pilot outcomes | Patient satisfaction cont.

"I would recommend this to anybody…I really would"
Referring to the RPM program

"I am really happy with [my dedicated care manager]. If I have a question, they are great about answering it."

"I am checking everything better now."
Patient has all three devices & takes readings daily; only took readings once a month prior to RPM enrollment

"I enjoy the whole process of [my care manager] telling me all the averages 'cause I am trying to get off the blood pressure medication and that's my goal. So, we're working towards that, so I appreciate her input and giving me tips along the way."

"[The program] makes me more accountable for some things because I know they will be registered and looked at. I think that helps me."

"I am definitely a 10. The whole experience has been helpful and great."

"I am more concerned about my blood sugar than I was before because I know it is being checked."
Patient has lost a few pounds and is able to see that her BP medication is working and regulating her BP which she is happy to have visibility into

"keeps me more aware of the situation."

"I am so glad my doctor hooked me up with it -- it has been very helpful. [My care manager] is so caring and considerate and helpful, informative. This experience has been very good for me. I didn't realize I was having blood pressure challenges because when I went to the doctor's my blood pressure would be ok but that was usually in the middle of the day a couple hours after medication. We found out that I did have a blood pressure challenge between medication doses, and now doctors are experimenting with different medications and doses and stuff like that. Blood pressure is a silent killer I guess, and it was silent with me, but it was too high a lot of the time."

"Makes me pay more attention to my blood pressure and everything -- that's for sure."

"It has gotten my sugars down – they are pretty much normal. I have lost about 15 pounds […] my blood pressure is doing good. It makes you think more about what you are doing."
"I think it is a great program. I was kind of skeptical at first, but it works."

"They let my doctor know what's going on"

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Partner hospital spotlight: Helen Newberry Joy Hospital & Healthcare Center

- Why did we almost say no?
- In the end why we happily said, YES!
- Keeping the patient at the center of everything we do.
- Extending the reach of our providers.
- Planning is key – have your team ready
- Seamless coordination of care is possible
- RPM is a great tool in a CAH toolbox if….
  - Organizational buy in
  - Put in the needed time to plan & implement

HNJH Chronic Care Management Team

Mandy Butkovich, LPN

Bonnie Davis, LPN

Andrea Marsh, LPN

Nicole Butkovich, LPN

Thank you to our partner hospitals!

Helen Newberry Joy Hospital & Healthcare Center

Allison Holbrook, BSN, RN
Population Health Manager

SCHOOLCRAFT MEMORIAL HOSPITAL

Tiger Marcotte, MHA, MSN, RN
Director Rural Health & Specialty Clinics

McKENZIE HEALTH SYSTEM
Experience Our Difference

Heather Baumeister, BSN, RN
Director of Healthcare Practices

Best practices

The importance of local organization's care managers from the start

Address telehealth intimidation

PCP verbal closing the loop with patients

Easy to use devices

Data integration

Leveraging underutilized services to bring the program to life

Where to go from here?

Our RPM in Rural Michigan Hospitals Playbook!

This guide will help health organizations, and especially practice teams, consider key issues that may impact the successful launch of an RPM program and promote thoughtful decisions that best fit the individual circumstances of each organization.


Questions?
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