Advancing Health Equity within Hypertensive & Postpartum Patient Populations Using RPM

How Evara Health improves health equity among hypertensive and postpartum patient populations using RPM

Presented by:
Howard Rubin, Chief Information Officer, Evara Health
Marie Menendez, Telehealth Specialist, Evara Health
Florence Kariuki RN MHA, Chief Clinical & DEI Officer, Health Recovery Solutions

VISION to VIRTUAL
Transforming care delivery

Howard Rubin

Chief Information Officer
Evara Health

Marie Menendez

Telehealth Specialist
Evara Health

Florence Kariuki RN MHA FHELA

Chief Clinical & DEI Officer
Health Recovery Solutions

VISION to VIRTUAL
Transforming care delivery

Session Agenda

1. Welcome & Speaker Intros
2. The Importance of Health Equity in Addressing Health Disparities
3. CMS Framework and New Joint Commission Standards for Health Equity
4. Evara Health's Approach to Improving Health Equity & Overcoming Barriers
5. RPM Hypertensive & Postpartum Patients
6. Open Q&A

VISION to VIRTUAL
Transforming care delivery

Health Inequity in the U.S.

Racially-Diverse Populations (KFF Analysis of 2021 Health Data):

- **Chronic Disease Burden:** AIAN, NHOPI, and Black people were **more than twice as likely as White people to die from diabetes**, and Black people were more likely than White people to die from heart disease

- **Poor Access:** Hispanic (18%), AIAN (15%), NHOPI (14%), and Black (14%) adults were more likely than White adults (9%) to **report not seeing a doctor in the past 12 months because of cost**

- **Maternal Health:** Black and AIAN women had the **highest rates of pregnancy-related mortality.** Black infants were more than two times and AIAN infants were nearly twice as likely to die as White infants

- **Growing Population:** In 2021, **42% of the total population** in the United States were people of color, projected to reach over 50% by 2050

Rural Populations (CDC):

- 46 million+ people live in rural areas (15% of the total population)
- More likely to die from heart disease, cancer, and stroke
- Deaths from unintentional injury are 50% higher

Barriers to Access

- Transportation
- Out-of-Pocket Costs
- Language
- Health Literacy

References: https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity; https://www.cdc.gov/ruralhealth/about.html

VISION to VIRTUAL
Transforming care delivery

CMS Framework for Health Equity

CMS defines **health equity** as: the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other circumstances.

CMS Framework for Health Equity (2022-2032)

- An integrated, action-oriented approach to advance health equity among communities who have been historically underserved or disadvantaged
- Update to the 2015 Medicare-focused CMS Equity Plan for Improving Quality in Medicare

Five Priority Areas:

1. **Expand the Collection, Reporting, and Analysis of Standardized Data**
2. Assess Causes of Disparities Within CMS Programs and **Address Inequities in Policies and Operations to Close Gaps**
3. **Build Capacity** of Healthcare Organizations and the Workforce **to Reduce Health and Healthcare Disparities**
4. **Advance Language Access, Health Literacy,** and the Provision of **Culturally Tailored Services**
5. **Increase All Forms of Accessibility** to Healthcare Services and Coverage

The latest CMS report, **The Path Forward: Improving Data to Advance Health Equity Solutions (PDF),** outlines the current state of health equity data collection, details progress to date in improving data collection, and defines future actions to continue to improve health equity data.

References: https://www.cms.gov/blog/establishing-framework-health-equity-cms; https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework;

VISION to VIRTUAL
Transforming care delivery

CMS States Advancing All-Payer Health Equity Approaches and Development Model (AHEAD Model)

This new, voluntary model from CMS is designed to help states redesign healthcare delivery to improve the total population health of a participating state or region by improving the quality and efficacy of care delivery, reducing health disparities, and improving health outcomes.

Key Features of the AHEAD Model

- **Primary Care:** Focus resources and investment on primary care services, giving primary care practices the ability to improve care management and better address chronic disease, behavioral health, and other conditions
- **Financial Incentives:** Provide hospitals with a prospective payment stream via hospital global budgets, while including incentives to improve beneficiaries' population health and equity outcomes
- **Care Coordination:** Address healthcare disparities through stronger coordination across healthcare providers, payers, and community organizations in participating states or regions
- **Community Resources:** Address the needs of individuals with Medicare and/or Medicaid by increased screening and referrals to community resources like housing and transportation

References: https://www.cms.gov/newsroom/press-releases/cms-announces-transformative-model-give-states-incentives-and-flexibilities-redesign-health-care

VISION to VIRTUAL
Transforming care delivery

Joint Commission Standards

Effective January 1, 2023, **new and revised requirements to reduce health care disparities** apply to organizations in the Joint Commission-accredited ambulatory health care, behavioral health care and human services, critical access hospital, and hospital programs.

6 Elements of Performance (EPs) for Healthcare Organizations:

1. **Designate an individual(s) to lead activities** to reduce health care disparities
2. **Assess the patient's health-related social needs** and provide information about community resources and support services
3. **Identify health care disparities** in the patient population by stratifying quality and safety data using sociodemographic characteristics
4. **Develop a written action plan** that describes how to address at least one of the health care disparities identified in the patient population
5. **Take action** when the goal(s) in the action plan are not achieved or sustained
6. At least annually, inform key stakeholders (leaders, licensed practitioners, and staff) about progress to reduce identified health care disparities

References: https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_disparities_july2022-6-20-2022.pdf

VISION to VIRTUAL
Transforming care delivery

How RPM addresses SDOH barriers to enable advances in Health Equity

Remote Patient Monitoring (RPM) reduces or eliminates barriers and improves access to care by equipping patients with technology and training to track their health status and easily share data with healthcare providers. RPM facilitates two-way communication for patients and providers to support ongoing care, enabling patients to receive the right care at the right time.

- **Address Transportation Barriers-** Ability to conduct virtual visits, capture biometrics and transmit patient's clinical data via Bluetooth or Cellular connection creates opportunities to supplement in-person doctor visits and reduce transportation dependencies.

- **Improve Clinical-Outcomes-** Collection of physiologic and non-physiologic data in between office visits gives visibility and ability to adjust medication or intervene timely to improve clinical outcomes.

- **Enable Health & Digital Literacy**- All condition-specific patient educational content within the HRS tablet is created at the 2nd Grade Level with a focus on simplified medical jargon.

- **Overcome Language Barriers**- Support for multiple languages on the HRS tablet interface overcomes the language barrier that impacts patients with Limited English Proficiency (LEP) - HRS currently supports 16 languages

- **Enable RPM 'Techquity'**- HRS tablets do not depend on patients having their own Wi-Fi networks but rather come readily enabled with cellular Sim Cards used by First Responders in rural settings. This ensures that patients are not marginalized due to lack of connectivity.

- **Collecting SDOH Data –** Available Pre-Set to help you collect pertinent data

VISION to VIRTUAL
Transforming care delivery

HRS Services that Support Health Equity

Patient-centric solutions to meet the needs of every patient

PatientConnect RPM

- ✓ FirstNet First Responder Cellular Network Access
- ✓ Condition-Specific Videos, PDFs, Quizzes
- ✓ 2nd-Grade Reading Level
- ✓ 16 Languages Supported
- ✓ Out-of-the-Box Ready (no Wi-Fi or complicated set-up)
- ✓ Automatically-Transmitted Vitals (no hitting "send")
- ✓ 24/7 Technical Support

HRS Logistics

- ✓ Equipment delivery direct to patient home
- ✓ Remote patient onboarding
- ✓ Remote patient offboarding and returns coordination
- ✓ Storage of equipment, cleaning, sanitizing and provisioning

VISION to VIRTUAL
Transforming care delivery

Evara Health: Improving Health Equity through RPM

VISION to VIRTUAL
Transforming care delivery

Evara Health 2022 in Numbers

- 3 Medical Food Rx Locations
- 11 Service Lines
- 29 Grant Funding Sources/Projects
- 61,000 Individual Patients
- Service Delivery Modalities 3
- Clinical Locations 16
- Employees 434
- Economic Impact $119.6M

Evara Health Providing Access 2022

PROVIDING QUALITY HEALTHCARE FOR ALL.

About Our Patients…

61%
of patients racial and/or ethnic minorities

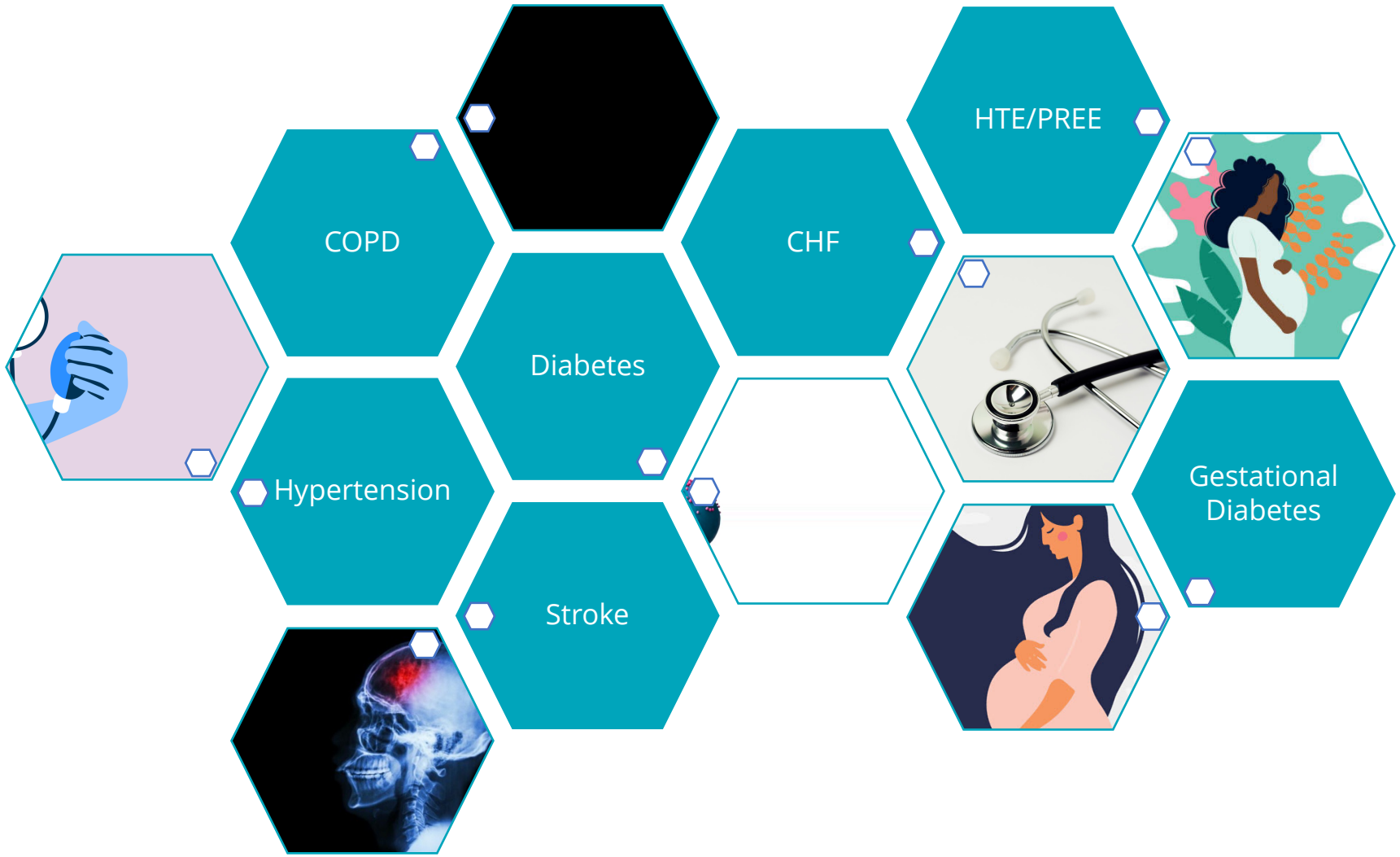
94%
of patients below 200% FPL

80%
of patients below 100% FPL

46%
of patients on Medicaid / CHIP

25%
of patients uninsured

Our Approach



VISION to VIRTUAL
Transforming care delivery

Goals

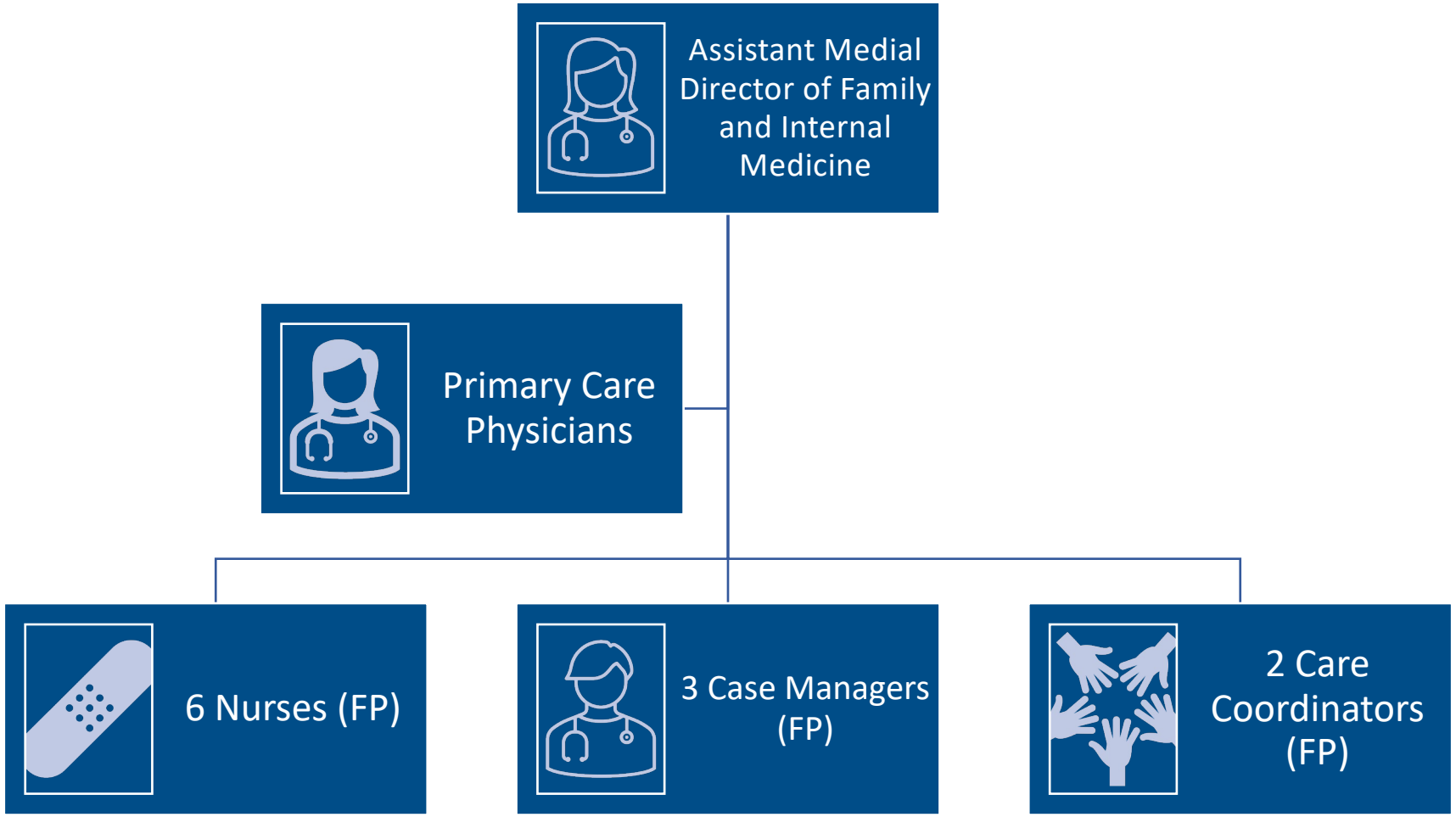
Be Flexible

- Implement the use of remote patient monitoring devices to help improve management and outcomes of chronic diseases like Diabetes (DM), Hypertension (HTN), Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD) for more than 300 patients
- Empower patients to better manage health disorders
- Decrease unnecessary hospital readmission
- Improve health care equity

VISION to VIRTUAL
Transforming care delivery

Our Teams

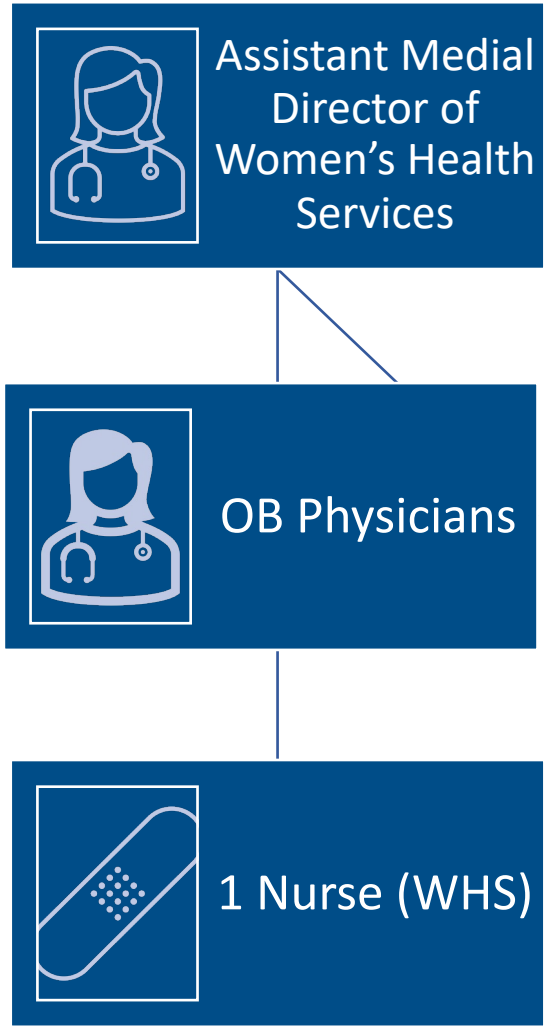
Value Based Services for Family Practice



VISION to VIRTUAL
Transforming care delivery

Our Team

Women's Health Services



VISION to VIRTUAL
Transforming care delivery

Clinical Workflow

- Internal provider referral
- EHR reporting of exiting patients with chronic conditions
- Recent hospital discharge
- Monthly compliant and non-compliant reports from our payers
- CCMS referrals

- Provided during MHH or office visit
- In-person training on telehealth devices

- Nurse monitors
- Check-in performed on non-compliant patients
- Encourages patients and caregiver participation

VISION to VIRTUAL
Transforming care delivery

Clinical Criteria for Internal Referral to RPM

We ask our providers to consider the following when referring a patient into the program

Family Medicine

- Any new life altering diagnosis
  - Recent MI, recent stroke, new dx of diabetes
- Elevated A1C
- BP greater than 140/90
- Poorly compliant
- Poorly controlled
- Recent hospitalizations
- Stroke
- COPD
- Hypertension
- Diabetes
- CHF

Women's Health

- BP greater than 140/90
- Hypertension - gestational or chronic
- Preeclampsia
- Gestational Diabetes
- Post Op C-section
- Postpartum

VISION to VIRTUAL
Transforming care delivery

Patient Feedback

Patients feel assured and less anxious or fearful knowing a nurse is monitoring their daily vitals

"Knowing that a nurse is reviewing my results each day makes me feel safer and has made a big difference."

"I appreciate knowing that you're monitoring my vitals and reaching out when something is off."

Patients and their caregivers appreciate the real-time information and personalized education they now receive about their health

"I did not know how much drinking 1 cup of juice affected my blood sugar before using this machine"

"I knew smoking was bad for my blood pressure, but I didn't understand how big of change it made"

"Checking my blood sugar more often has encourage me to walk more after meals"

VISION to VIRTUAL
Transforming care delivery

Enrollment by Chronic Condition

Remote Patient Monitoring
as of August 31, 2023

32 - DM + HTN + Other
22 - DM + HTN
24 - HTN + Other
1 - DM + Other
39 - HTN
6 - DM
1 - Other

Total Patients Enrolled - 125

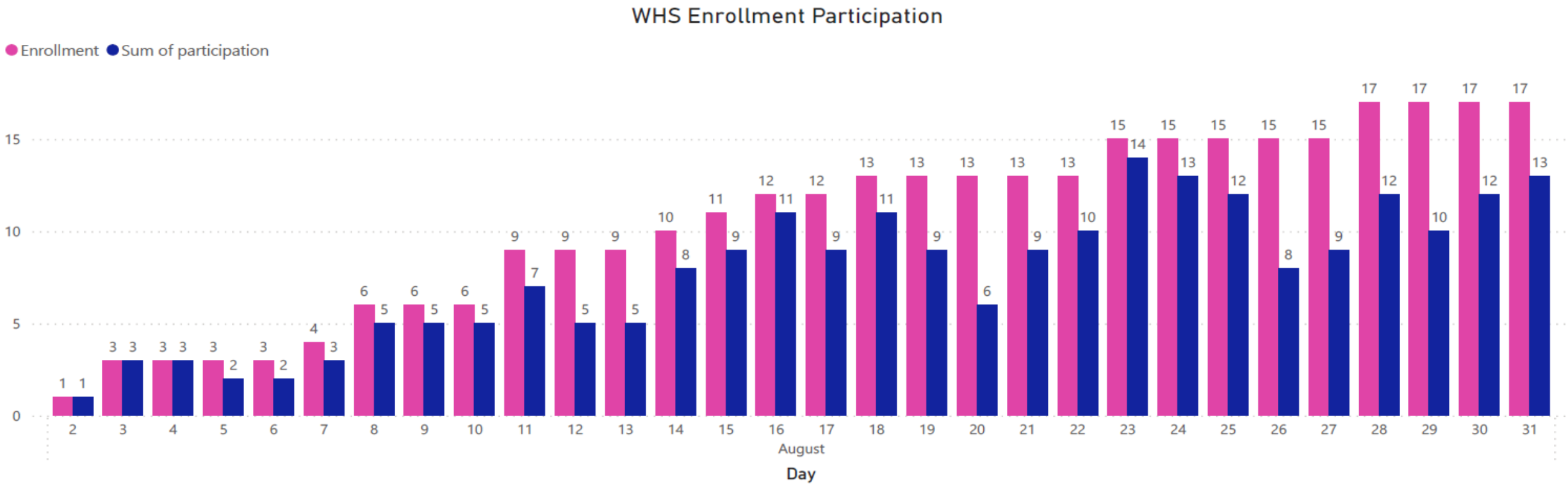
Status	22-YTD	23-Jan	23-Feb	23-Mar	23-Apr	23-May	23-Jun	23-Jul	23-Aug	Total
Enrolled	95	11	6	7	10	5	9	15	29	187
Deactivated	46	5	2	0	4	0	3	1	1	62
Paused	0	0	0	0	0	0	0	0	0	0
Total (Active)	49	55	59	66	72	77	83	97	125	

VISION to VIRTUAL
Transforming care delivery

WHS Enrollment Participation

evara HEALTH
CARE THAT EMPOWERS

Remote Patient Monitoring
as of August 31, 2023

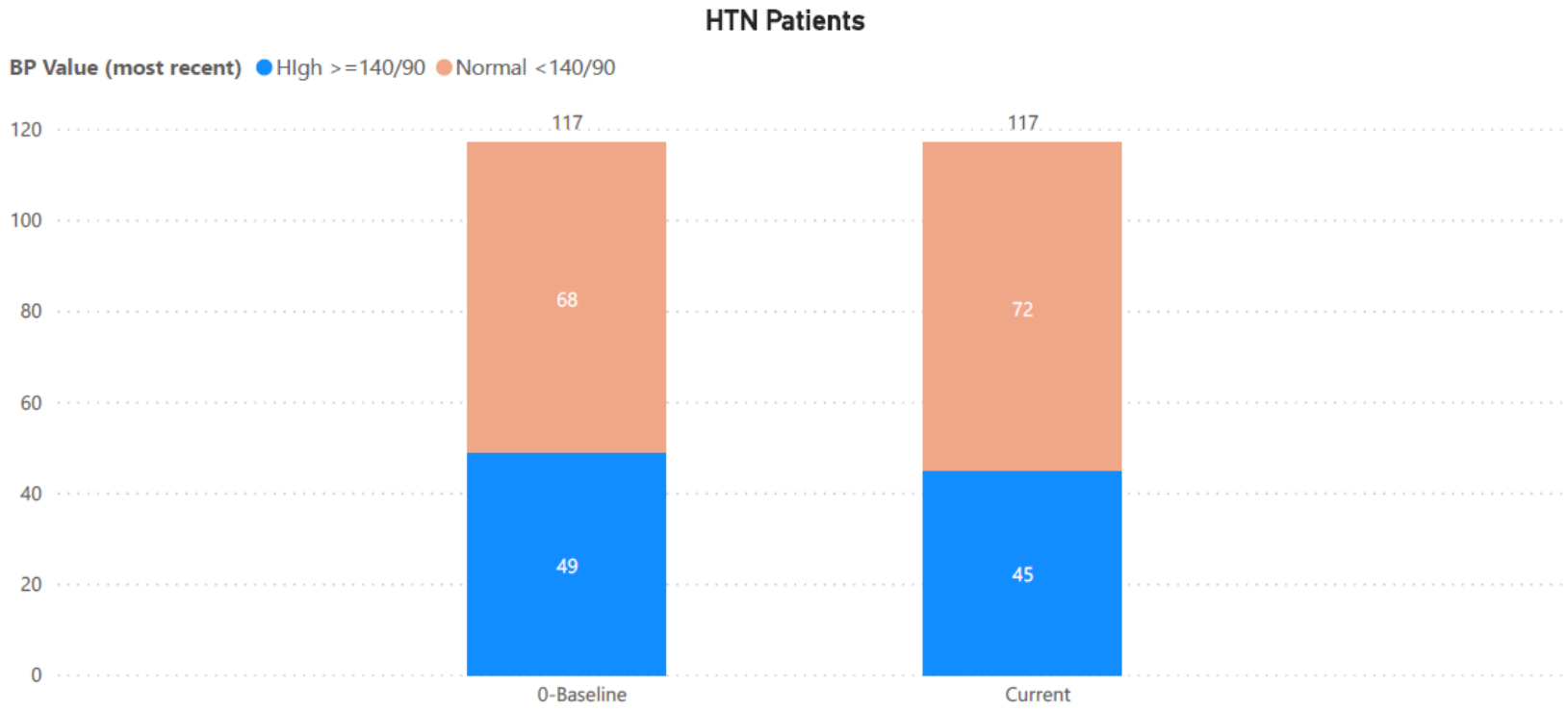


VISION to VIRTUAL
Transforming care delivery

Hypertension Enrollment

evara HEALTH
CARE THAT EMPOWERS

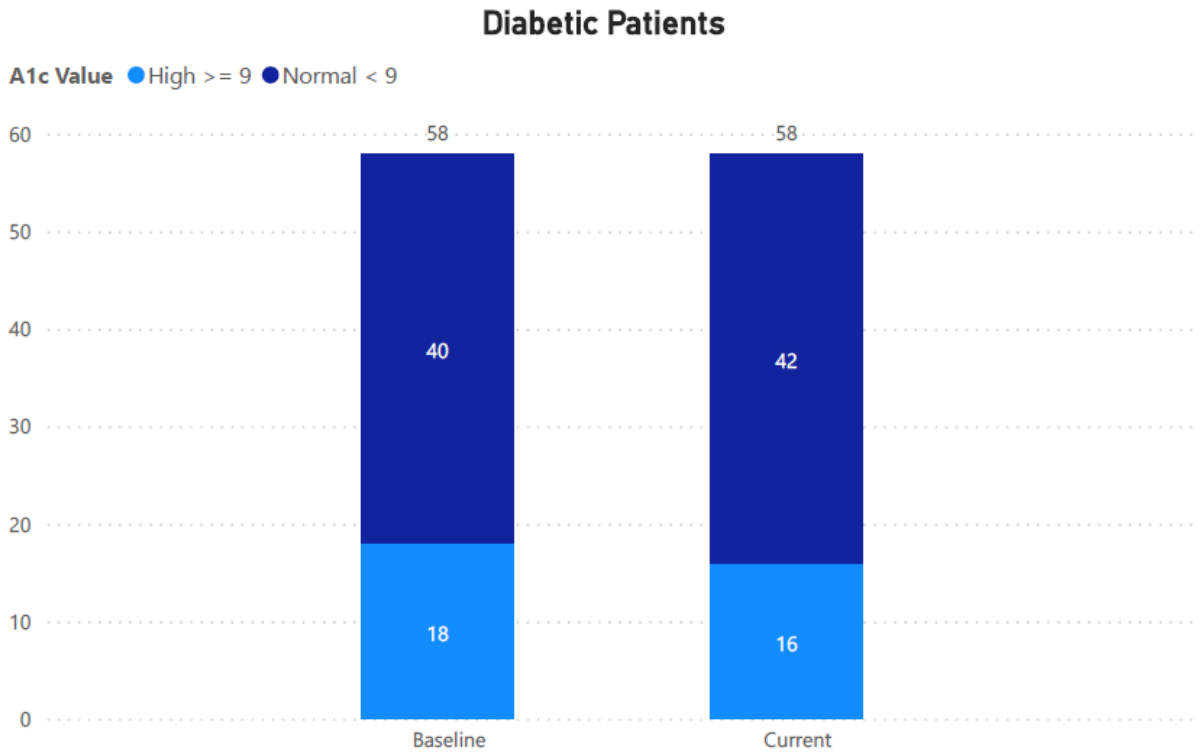
Remote Patient Monitoring
as of August 31, 2023



VISION to VIRTUAL
Transforming care delivery

Diabetes Enrollment

Remote Patient Monitoring
as of August 30, 2023



*3 new WHS patients with no A1c yet

Evara Health: Overcoming Challenges

VISION to VIRTUAL
Transforming care delivery

Challenges to Program Launch

Identifying Patients that are Good Candidates for RPM

1. We initially pulled a list of all our ACO patients with multiple chronic conditions (Diabetes, Hypertension, COPD, or CHF) and outreached them. We recently reduced the requirement down to just two of the four conditions to “qualify.”
2. Next, we pulled a list of patients in one of our larger Managed Medicaid plans also with multiple chronic conditions.
3. Recently we demonstrated the system to our Providers and are training them on how to identify patients and “refer” them to our VBS team to be contacted.

Distributing Equipment

- We initially had our Medical Home@Home team deliver and set up the system for our patients when they go out on MH@H calls. We have since expanded to two MHH teams.
- We also trained a group of Providers and Medical Assistants on setting up patients with either the Kit (with tablet and peripherals) or Mobile App with peripherals for patients who come into the clinic.
- We are in the process of setting up MHH team for WHS maternal services.

VISION to VIRTUAL
Transforming care delivery

Recommendations for Program Launch

Again….Be Flexible

- ✓ Develop clear criteria for which patients qualify or could most benefit from the program
- ✓ Develop a marketing/outreach plan and staffing, it will take a lot of calls to get your initial cohort of patients and make sure you have a good “script” for them to use when making the calls (only 10% of the patients on our list agreed to try the program)
- ✓ Develop a distribution and support plan…how will you get the equipment to the patient, will you assist in setup, who will answer questions
- ✓ Do your homework on reimbursements, since Medicare will pay for some RPM services, but most Medicaid plans will not currently (although that is changing) and it varies greatly for private insurance plans, and what about uninsured patients
- ✓ Develop a monitoring plan; who will monitor the portal, what times of day/days of the week will it be monitored, what events/alerts require action and what will that action be

VISION to VIRTUAL
Transforming care delivery

Questions?

VISION to VIRTUAL
Transforming care delivery