University of Mississippi Medical Center
Improving Patient Outcomes Through Sustainable Remote Monitoring

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American Heart Association® Center for Telehealth™

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SMART Goal

Achieve a **25% increase** in referrals to the RPM clinic and improve program enrollment and retention through monthly reporting and data-driven interventions to strengthen program sustainability.

Drivers

1. Increase referrals
2. Increase enrollment
3. Increase retention

Methods

Increase Referrals:

✓ Provider education and outreach
✓ Provider feedback survey
✓ Resident orientation sessions
✓ Quarterly department-level reports

Increase Enrollment:

✓ Provider education on payer coverage
✓ Maximized patient contact attempts (alternate numbers, varied times)
✓ AVS and educational materials with program information

Increase Retention:

✓ Patient readiness assessment
✓ Clear expectations and goals set at onboarding
✓ Reinforcement of adherence at follow-up
✓ Technical support: direct vendor communication

Ongoing Work:

✓ Expanded patient-facing promotional materials
✓ BPA criteria modifications to optimize referral capture
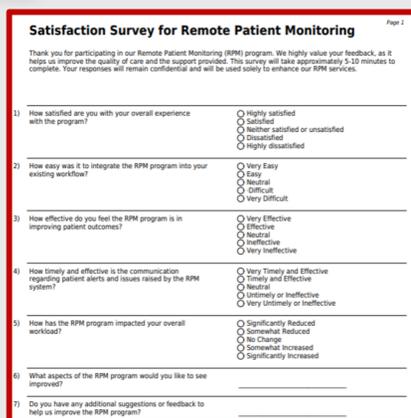
| Department of Cardiology – RPM Q1 Summary	
Number of referring providers	8
Number of new referrals	24
Number of patients enrolled	29
Number of patients discharged	5
Average SBP at first review (n=16)	157.8 mmHg
Average SBP at most recent review (n=16)	141.2 mmHg
Change in SBP	-16.6 mmHg
Average DBP at first review (n=16)	82.5 mmHg
Average DBP at most recent review (n=16)	74.3 mmHg
Change in DBP	-8.2 mmHg
% of completed monthly reviews	90%
% compliance (submitting daily measurements)	61%
Average days of enrollment	140.6 days
Number of medication changes (since enrollment)	28
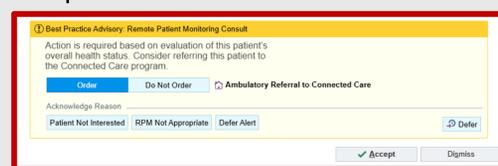
Results

Following QI interventions, referrals increased **24%** from Q1 to Q2 and enrollment rose from **47%** to **50%.** Patient compliance remained high. Blood pressure control improved **56%** to **72%** and more patients with diabetes met HbA1c goals (**45%** to **48%**). Early data suggest the enhanced RPM workflow supports program sustainability and improved chronic disease management, with ongoing evaluation through Q4.

Discharge Reasons — Quarter 1 / Quarter 2
Completed / Requested Discharge / Noncompliance
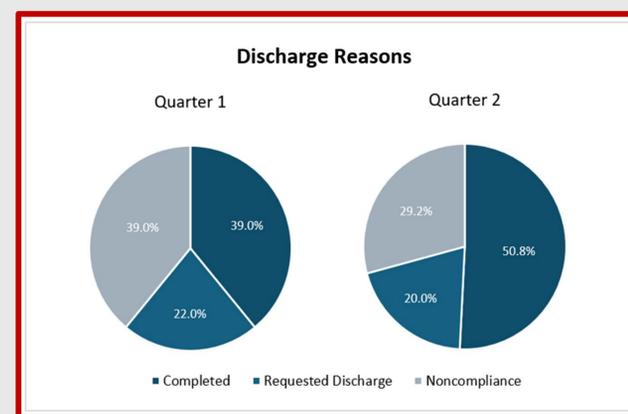
Between Q1 and Q2, RPM program completion rates rose from **39.0%** to **50.8%**, while discharges for noncompliance declined from **39.0%** to **29.2%**.

Referrals increased from 86 patients in Q1 to **107** in Q2, and enrollments rose from **40** to **54**. The proportion of successful enrollments improved from **46.5%** to **50.1%**.

Number of Referrals and Enrollments — Quarter 1 / Quarter 2
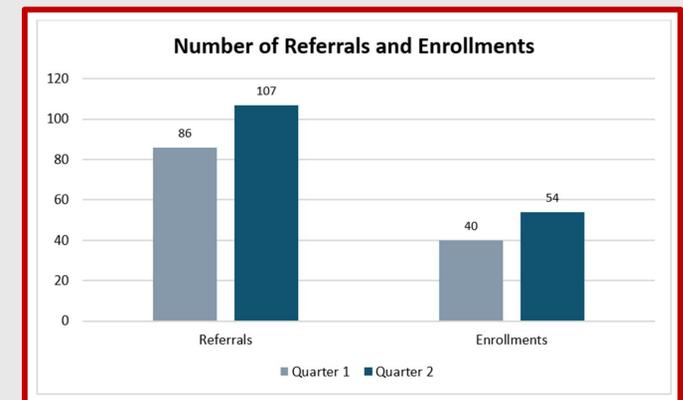
Conclusions

Targeted interventions in the pharmacist and nurse-led RPM program **increased referrals, enrollment, and engagement**. Q1 and Q2 data show promising improvements in clinical outcomes, while ongoing tracking through Q3 and Q4 will assess durability. Continued implementation of workflow enhancements and reporting will reinforce program sustainability.

Lessons Learned

✓ Capturing referrals and engaging patients required ongoing workflow adjustments.
✓ Flexible communication and clear expectations supported enrollment and retention.
✓ Regular reporting and feedback reinforced accountability and sustainability.