

# Expanding Access Through Remote Patient Monitoring: Strategies and Outcomes



## Presenter:

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**Wednesday, March 11, 2026**



**11:00 AM - 11:45 AM EST**

# Expanding Access Through Remote Patient Monitoring (RPM): Strategies and Outcomes

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# Objectives

- Define Remote Patient Monitoring (RPM).
- Describe how RPM improves outcomes in rural populations.
- Identify common implementation challenges.
- Discuss billing and reimbursement opportunities.
- Explore strategies to successfully implement RPM.

# Meet Mr. James...

- Lives 45 minutes away
- Multiple co-morbid conditions
- Last PCP visit – 6 months ago, poor medication adherence
- ED visit - stroke
- What if we could have seen the warning signs earlier?

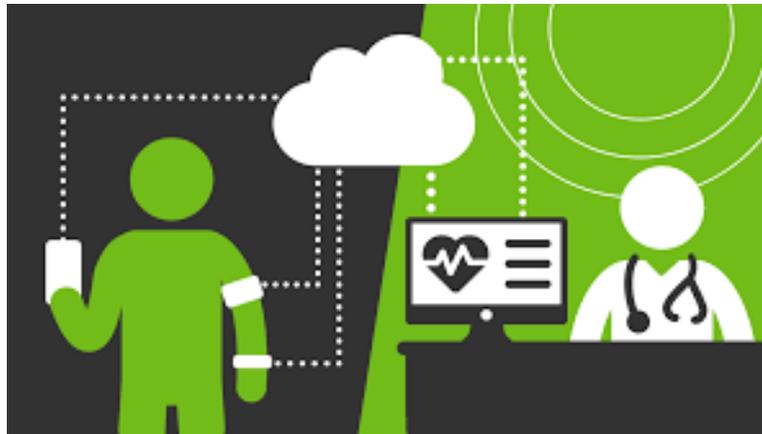


# How familiar are you with RPM?

- A. I currently use RPM in my practice.
- B. I am exploring RPM.
- C. I know a little about RPM.
- D. I am completely new to RPM.

# What is Remote Patient Monitoring?

a healthcare delivery method that uses technology to collect and transmit patient health data from outside traditional clinical settings; such as a home or remote location to healthcare providers in real-time or at scheduled intervals.

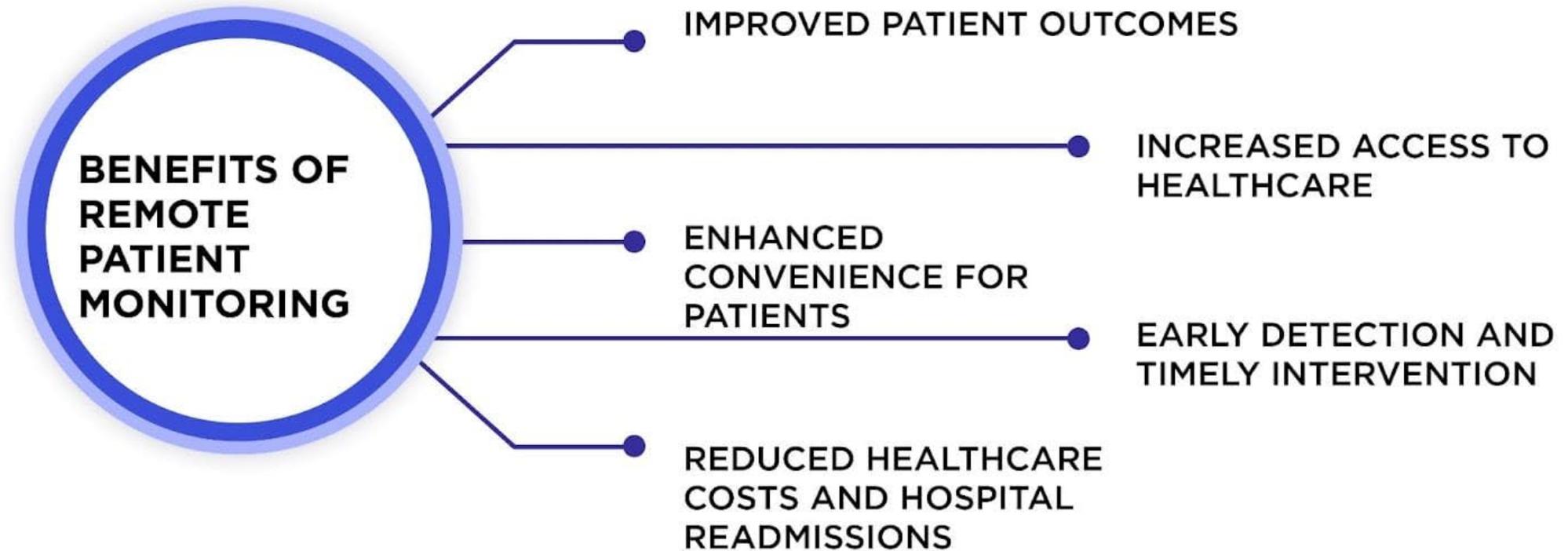


# Examples

- Blood pressure monitoring
- Glucose monitoring
- Pulse oximetry
- Weight monitoring



# RPM Benefits



**Type in the chat:  
What is one barrier your clinic faces in  
managing chronic disease in rural  
patients?**

# Why Expanding Access Matters

- Chronic disease is pervasive; continuous monitoring improves outcomes.
- RPM enables proactive intervention at home.
- Reduces avoidable ED visits and hospitalizations.
- States leading in RPM adoption: CA, FL, TX, NY, MI.
- Conditions with strong RPM evidence: hypertension, diabetes, heart failure, COPD.

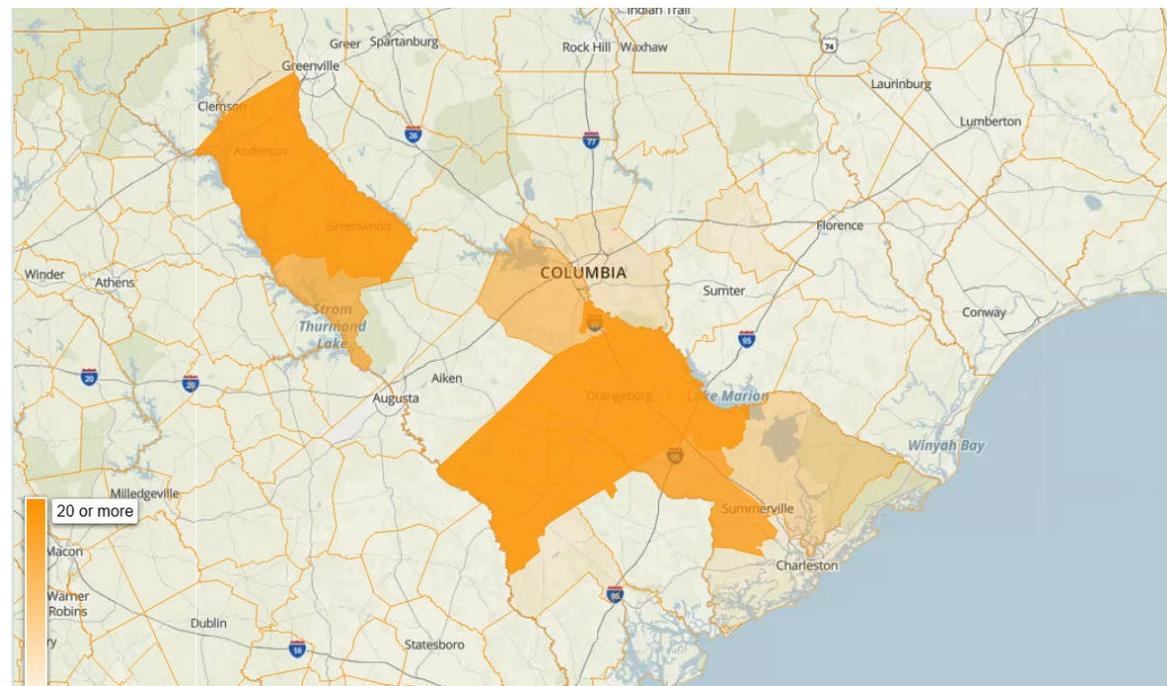
Number of RPM Patients by State (2023)		
1	California	172,530
2	Florida	171,294
3	Texas	169,445
4	New York	165,656
5	Michigan	107,789
9	South Carolina	58,563

# South Carolina Snapshot

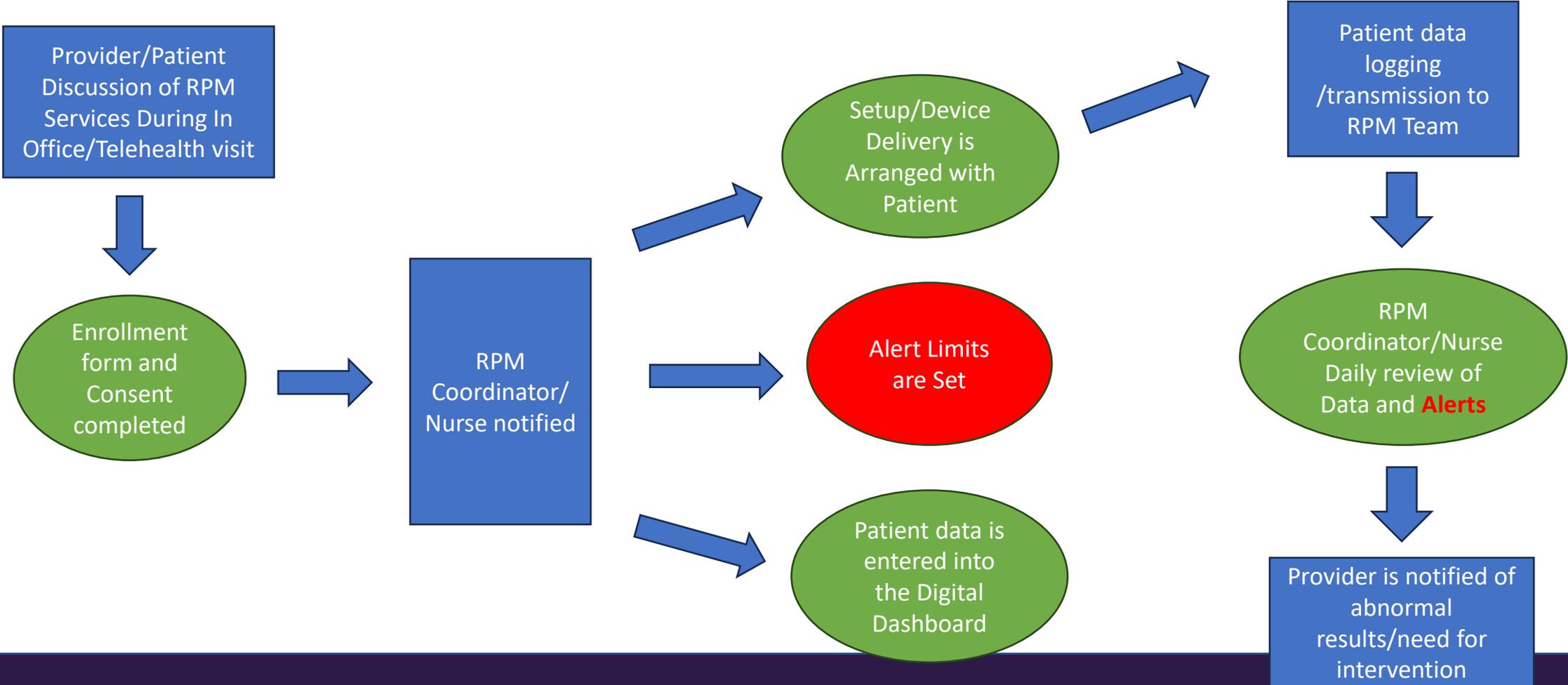
- Population: ~5.2M, median age 40.7, median income ~\$66,800.
- Chronic disease burden: 60% of adults have  $\geq 1$  chronic condition.
- PCP density: ~58 per 100,000 vs US 86 per 100,000 → limited access.
- Rural areas & HPSAs → care gaps.
- Rural HPSAs + high chronic disease prevalence make RPM a practical way to extend primary care reach and reduce avoidable ED/clinic visits.

# CRH RPM Program Overview

- Locations: Orangeburg (established March 2023), Abbeville (new – November 2024)
- Grant funding
- Population served: chronic disease focus (Diabetes, Hypertension)
- Core components: devices, dashboards, patient education, care team monitoring.
- Team members: HCP, RN, MA, and CHW



# CRH RPM Workflow



# Patient Outcomes



IMPROVED  
BLOOD  
PRESSURE  
CONTROL



IMPROVED A1C  
LEVELS



REDUCED  
HOSPITAL  
ADMISSIONS



IMPROVED  
MEDICATION  
ADHERENCE



EARLIER  
DETECTION OF  
PREVENTABLE  
COMPLICATIONS

# Program Outcomes



IMPROVED QUALITY  
METRICS



INCREASED PATIENT  
ENGAGEMENT



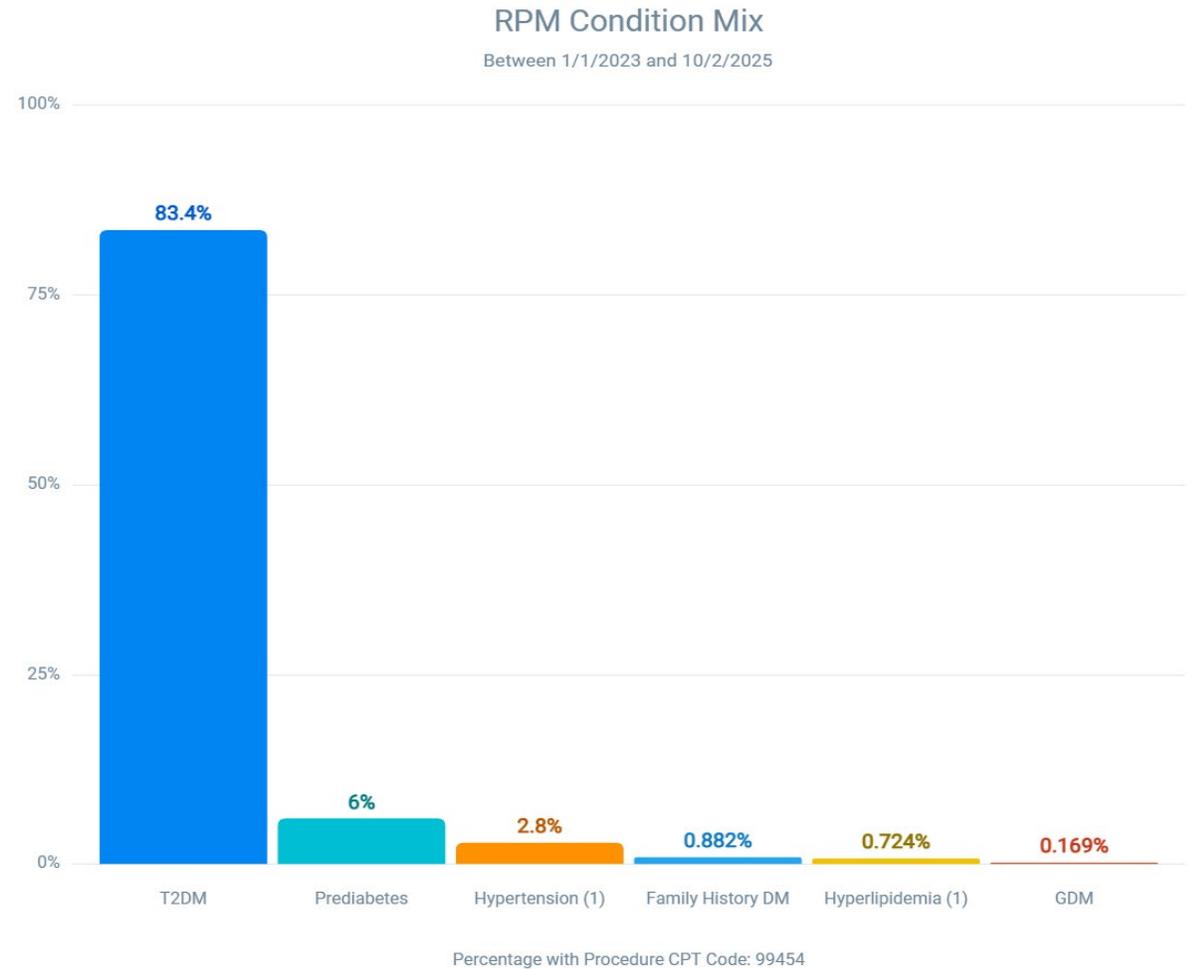
IMPROVED  
CHRONIC DISEASE  
MANAGEMENT



INCREASED  
REVENUE THROUGH  
REIMBURSEMENT

# CRH Current RPM Patient Stats

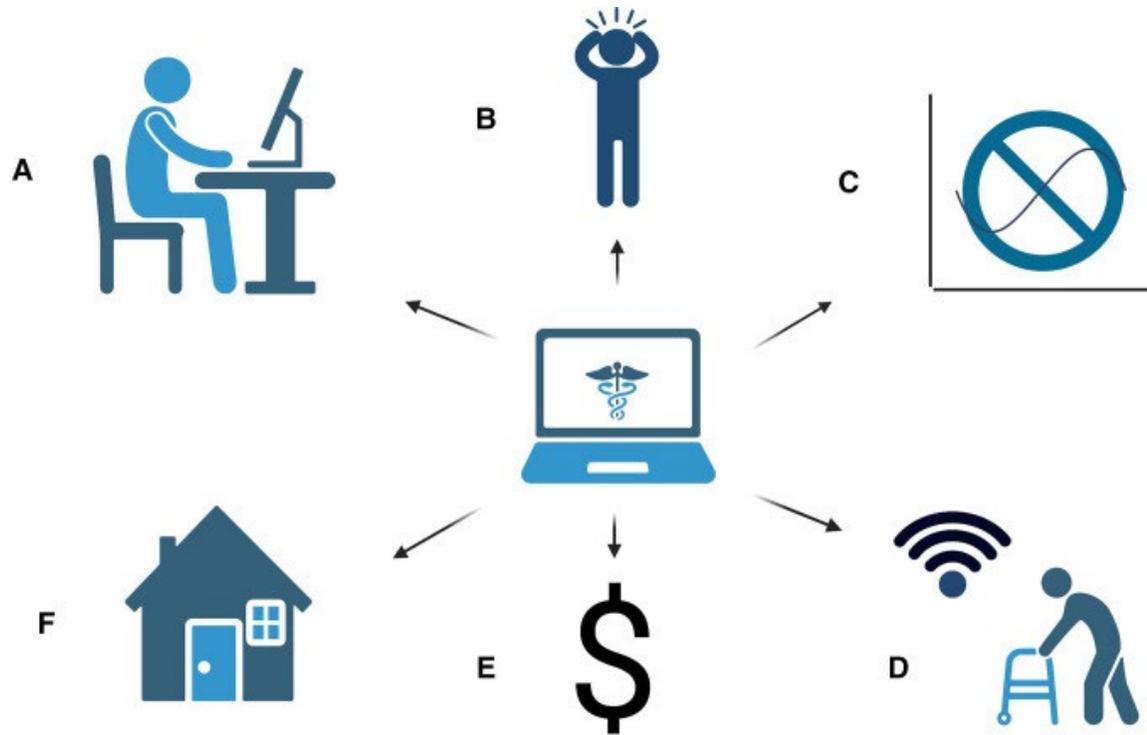
- All Time Enrolled patients: 267
- 67% with A1c < 8% after enrolling in RPM
- 82% with BP < 140/90 after enrolling in RPM
- Billing Eligible Patients: 54%



# What would be your biggest concern about implementing RPM?

- A. Staff workload
- B. Technology barriers
- C. Patient participation
- D. Reimbursement
- E. Data overload
- F. All the above

# RPM Challenges and Considerations



- Data Accuracy & Reliability
- Patient Engagement & Compliance
- Data Overload & Workflow Integration
- Privacy & Data Security
- Connectivity & Technical Challenges
- Cost and Reimbursement
- Clinical Liability & Responsibility
- Interoperability
- Ethical & Equity Issues
- Regulatory & Compliance Barriers

# Implementation Challenges and Lessons Learned



Broadband/telecom  
in rural homes



Workflow  
integration



Patient tech literacy



Reimbursement and  
coding



Staffing bandwidth

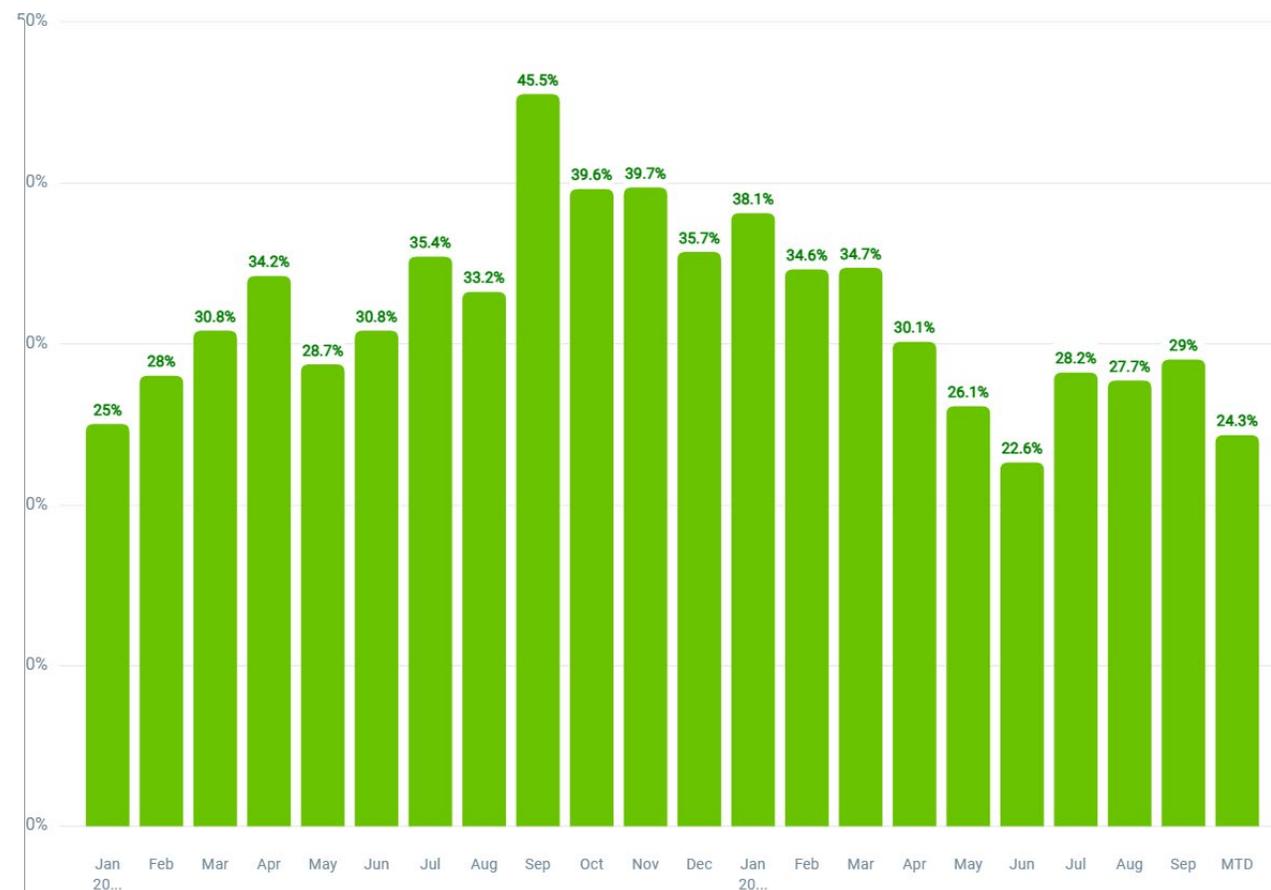
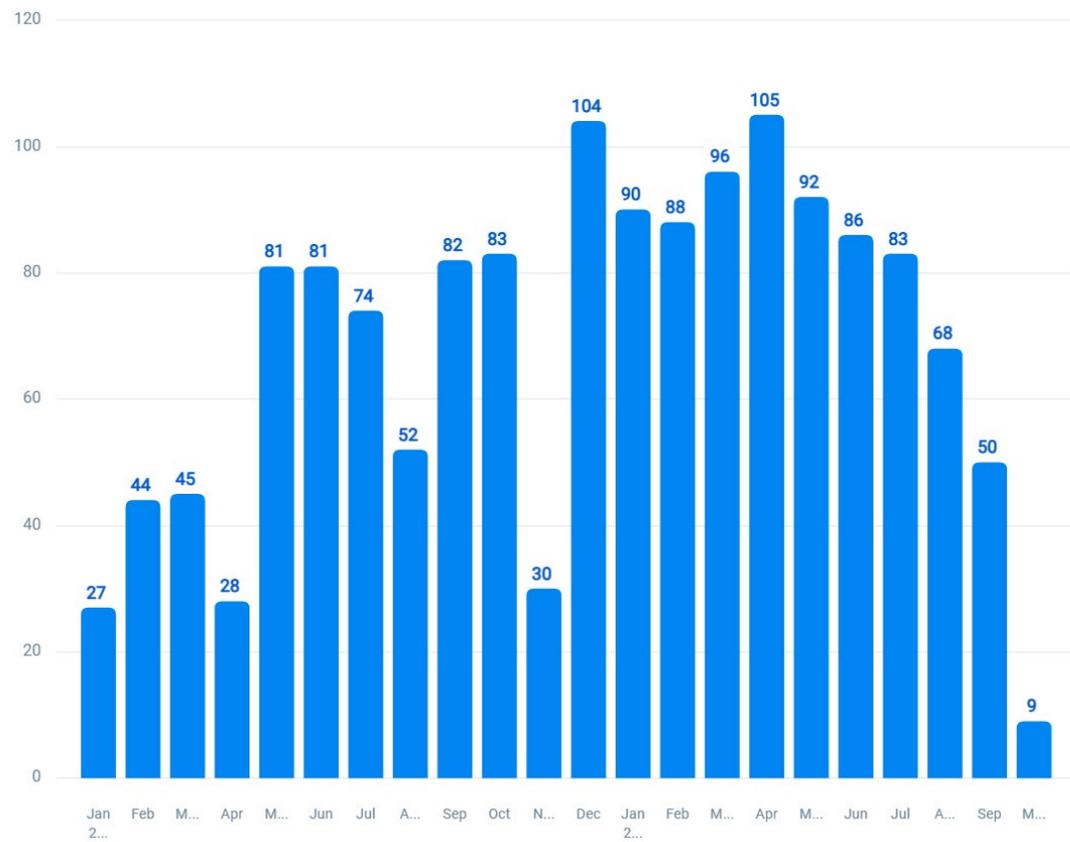
# Patient Engagement Strategies

- Simple device training (w/ reference handout and link to instructional video)
- Scheduled patient follow-ups
- Health coaching
- Motivational interviewing
- Incorporating family support

***Key insight:***

***Technology alone does not improve outcomes — engagement does!***

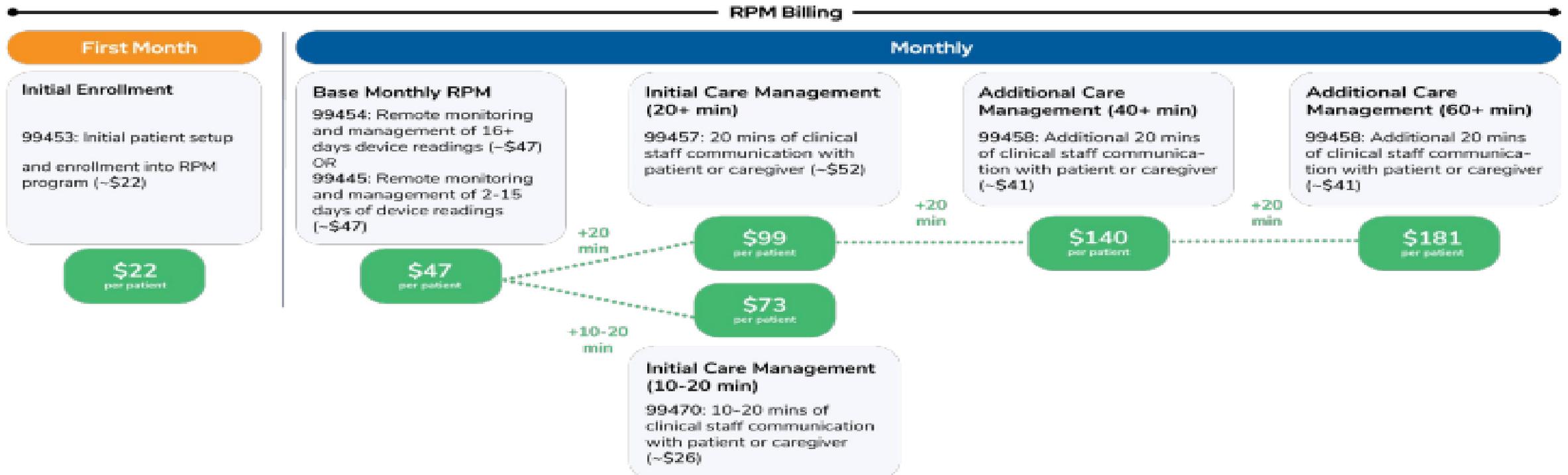
# CRH Monthly Engagement



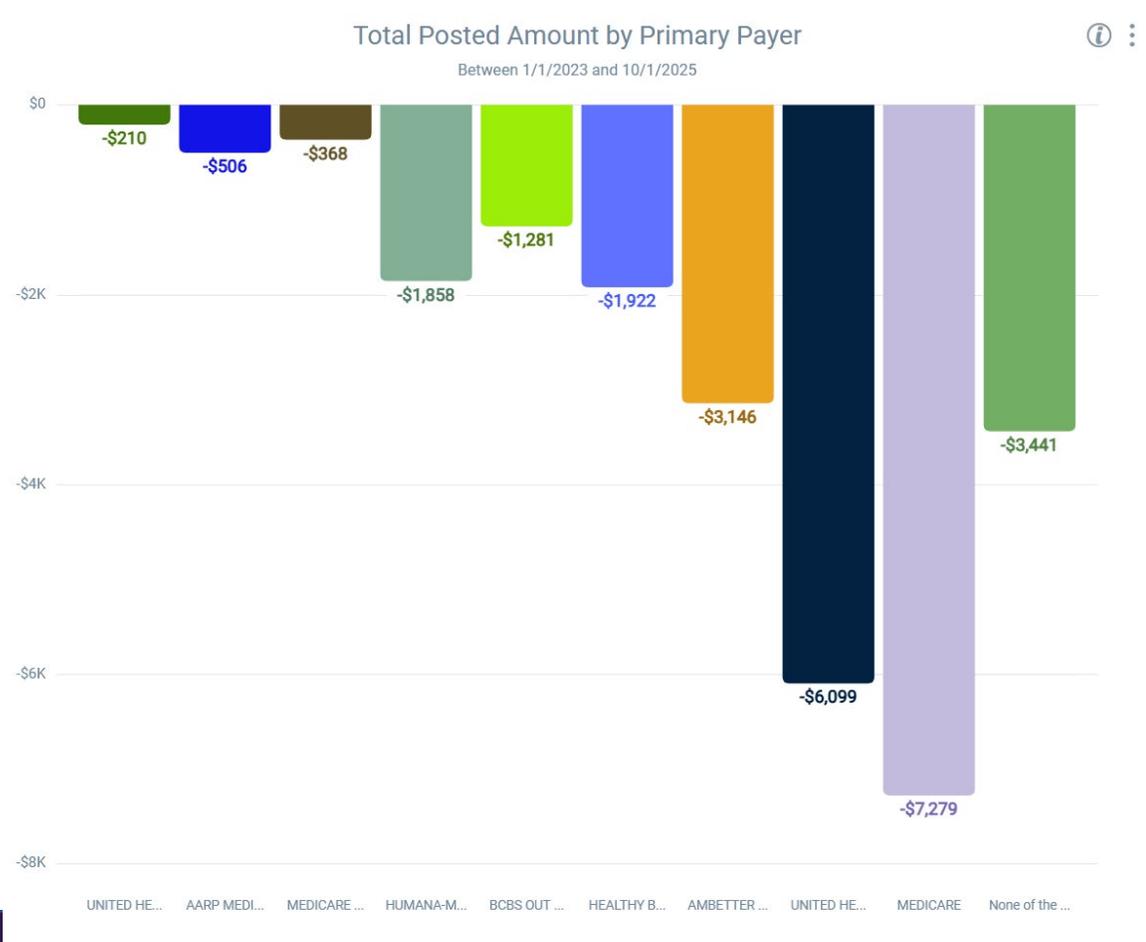
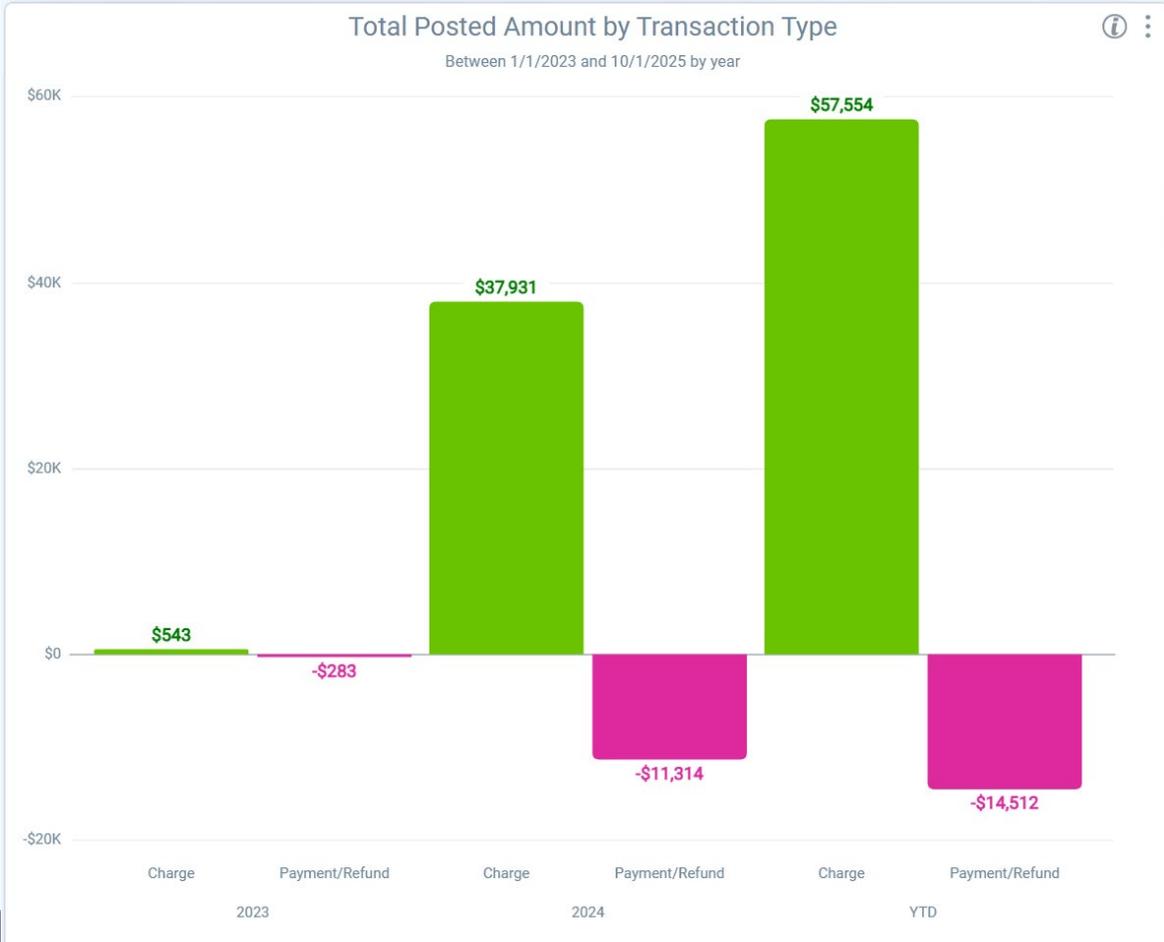
# Patient Story

- 59-year-old female, A1c in Nov 2024: 12.3%
- PCP referred to Endocrinology and to RPM
  - Endocrinology starts insulin (Kwik pen)
  - In January 2025, eA1c continues to hover at 12%
  - Monthly in person visits with RPM Care Coordinator – medication, nutrition, healthy coping teaching!
- After 6 months RPM, A1c: 6.5%

# Understanding & Meeting CPT Code Requirements



# CRH Reimbursement Trends



# Economic Impact

- “Meta-analyses and trials show RPM programs reduce hospitalizations by ~5–10% and lower ED visits at 3–6 months, producing cost savings primarily via avoided admissions.”
- **Improved clinical metrics → downstream financial value.** RPM improves BP control, glucose monitoring adherence, and early detection of deterioration — these outcomes help lower utilization and can improve performance on value-based contract metrics (readmissions, total cost of care, risk-adjusted utilization), which drives both shared-savings and payer incentive payments.

# Billing and Reimbursement Barriers

- Complex and Evolving Reimbursement Policies
- Eligibility and Documentation Requirements
- Low or Inconsistent Reimbursement Rates
- Provider and Practice Barriers
- Technology and Data Integration Issues
- Patient Cost-Sharing and Engagement

# What to Consider when Implementing a RPM System?

Appropriate  
technology

HIPAA-compliant  
platforms

Integration with  
existing systems

Customization  
capabilities

Support and  
troubleshooting

Clinical workflow  
integration

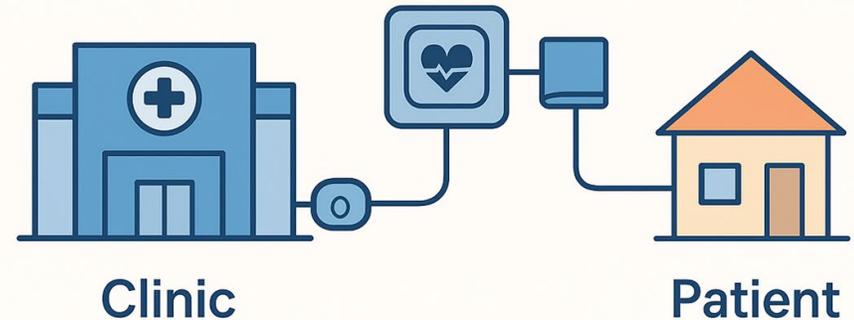
Patient engagement

Legal and regulatory  
compliance

Cost and  
reimbursement

# Key Takeaways

- Care doesn't have to stop at the clinic door.
- RPM improves chronic disease outcomes in rural / underserved areas.
- Replicable model for other communities.
- The goal is not more data, but:  
**Improved care, earlier care, and more connected care!**



# Do you plan to explore RPM implementation after this webinar?

- A. Yes
- B. Possibly
- C. I need more information
- D. Not at this time

# Questions?

## **Contact Information:**

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