Lightbeam Health Solutions

Transforming Community Health: El Centro de Corazón's Innovative Approach to Reducing Health Disparities and Improving Outcomes

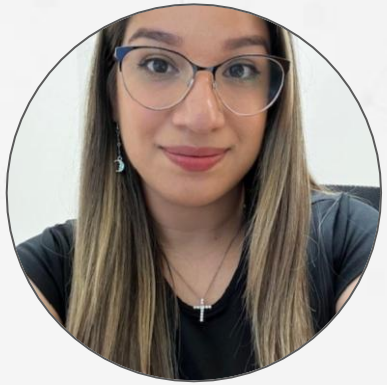
April 9th, 2025

VBCExhibitHall.com

Educational Webinar Series

Presenters

Laura Thomas, RN, MSN, Director of Clinical Quality, El Centro de Corazón



Griselda Noyola, Quality Assurance Specialist, El Centro de Corazón

Andy Dé, CMO, Lightbeam Health Solutions

Presentation Overview

Learning Objectives:

- Discover how El Centro de Corazón integrated remote patient monitoring and care management strategies to enhance proactive patient engagement.
- Evaluate El Centro de Corazón's outcomes, including substantial reductions in blood pressure and increased communication with patients.
- Examine best practices for implementing technology to reduce health disparities in underserved communities.
- Explore how El Centro de Corazón's success in hypertension management can be replicated in other communities

2025 Industry Trends & Challenges

Industry-wide & FQHC Challenges

Industry-wide shift to payment based on quality (VBC), not quantity of care (e.g., UDS)

Financial constraints, limited reimbursement rates

Workforce shortages amidst high patient volume

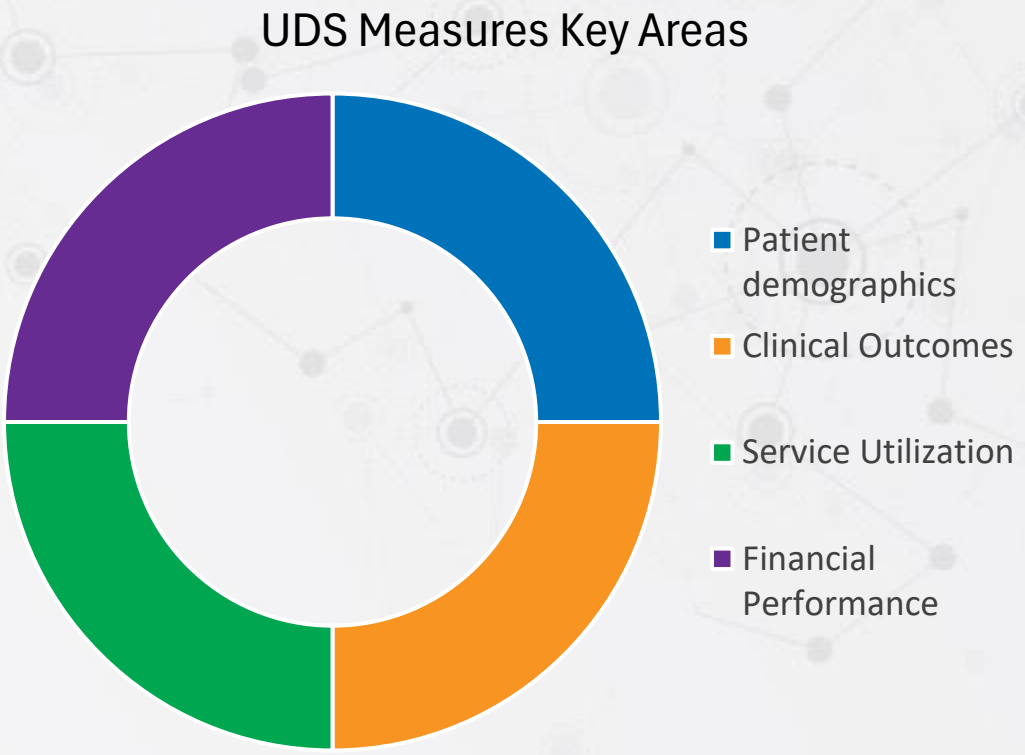
Access barriers for urban and rural areas

Technology integration for successful adoption and scale

Measures Determine Reimbursement

UDS Reports 30+ Metrics Across 4 Areas

- Patient demographics:
- Clinical outcomes:
  - Chronic disease management (HbA1c control for diabetes, blood pressure control)
- Service utilization:
  - Staff productivity ratios
- Financial performance:
  - Cost per patient



UDS Measures Directly Determine Reimbursement

- Federal grant eligibility
- Medicaid reimbursement
- Penalty avoidance

Partnership & Solution

About El Centro de Corazón

- Houston, TX, 4th largest city in the US
- One of the most diverse cities in the US

About El Centro de Corazón: FQHC

- Total patients: 12,820
- 95.4% patients are Hispanic, Latino, Spanish Origin
- 79.9% patients speak language other than English
- 56% of patients uninsured
- Three centers, just east of downtown (very central)

Eastwood **Magnolia** **Dunn**

Goals of Partnership

Deploy Lightbeam's Deviceless RPM solution, CareSignal® to Achieve:

1. Increase number of patients with controlled hypertension
2. Improve care management for patients through higher engagement rates
3. Improve communication with patients enrolled

About Deviceless Remote Patient Monitoring

Lightbeam Health Solutions

Transform care management from manual outbound outreach to automated inbound insights with 30+ chronic and behavioral health condition-specific programs from Lightbeam's Deviceless RPM™

- **No new devices required**
  No apps, downloads, or passwords
- **Accessible for all patients**
  Promote and elevate health equity
- **Clinically-Validated**
  13+ Peer Reviewed Publications
- **Engagement powered by AI**
  Predict and prevent drop-off

RPM Program: Hypertension

Inclusion Criteria: SBP > 120 or DBP > 90

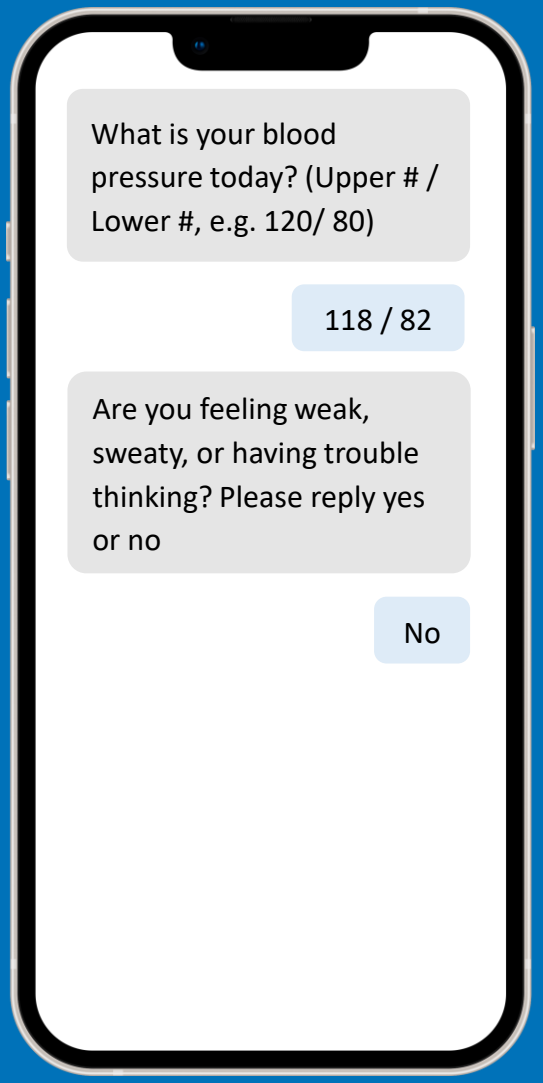
Alert Notifications:

- Hypotensive & Hypertensive crises with symptoms
- KCCQ Quality of Life

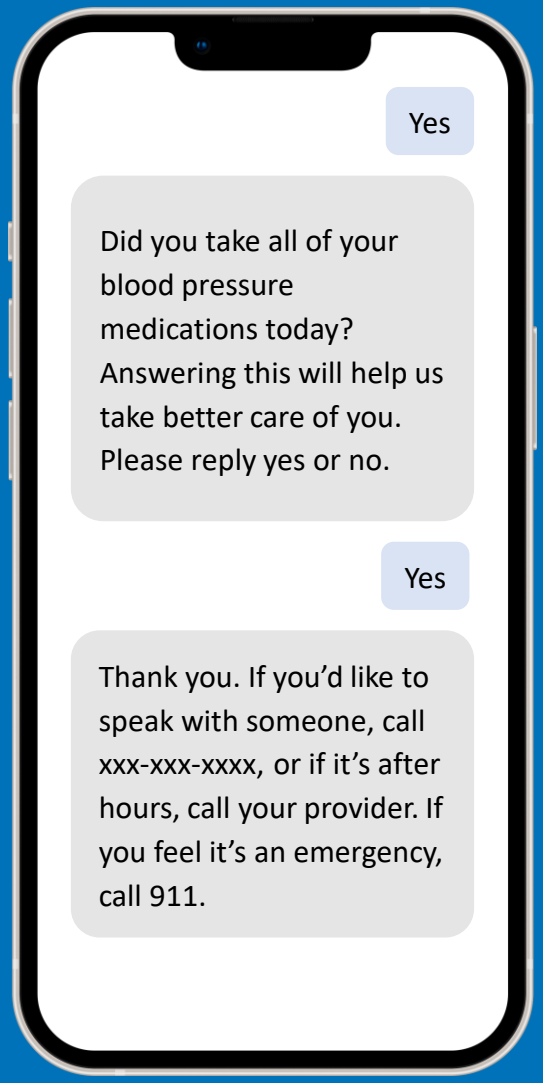
Default Alert Thresholds:

- Systolic < 90 or > = 180
- Diastolic < 60 or > = 110
- Risk Classification: Warning

Hypertension:
No Alert



Hypertension:
Alert Triggered



Alert Triggered

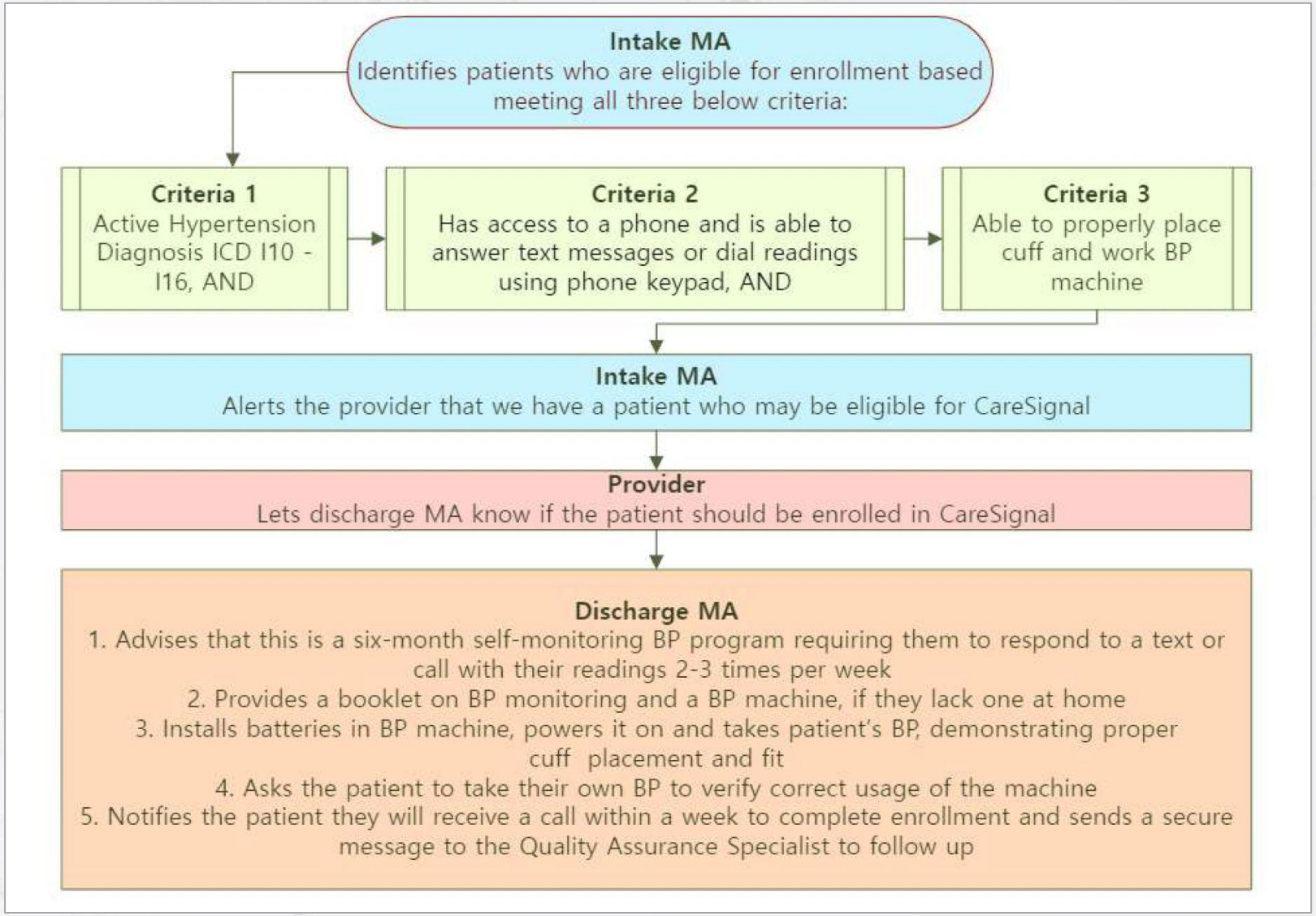
Polling Question

Implementation

Enrollment to Graduation Plan

Enrolled patients with this condition:

- Hypertension diagnosis:
  - sBP > 120 or dBP >90
- Providers reviewed ranges- newly diagnosed and existing- having harder time getting controlled



Patient Enrollment

Phase 1

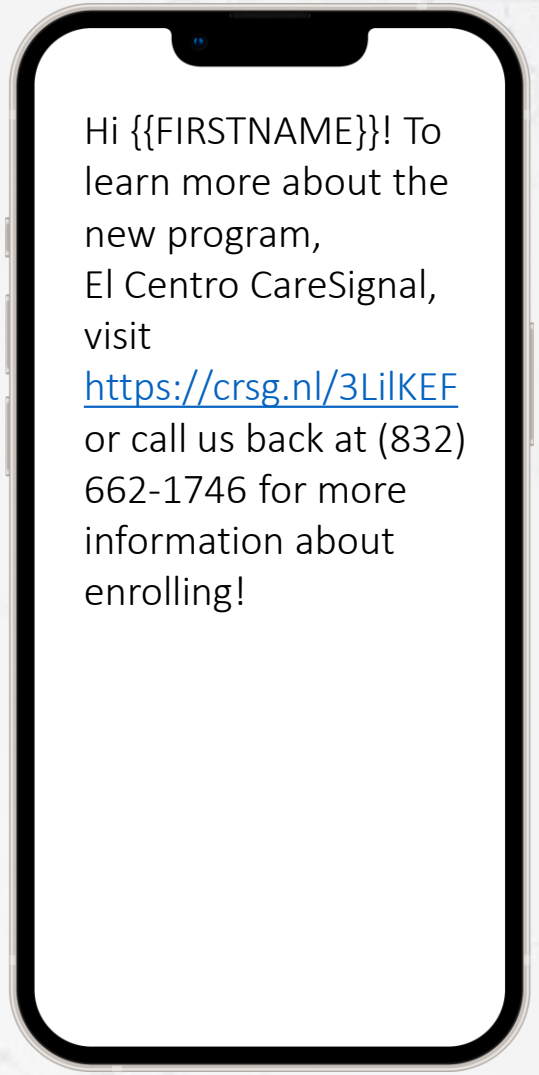
1. Started with vendor-led white-labeled enrollment until capacity reached
2. Tailored to increase awareness, confidence, and trust
3. Information sent to patient.. El Centro provided a bp cuff and taught them how to use. Provided by American Heart Association
4. Once enrollment full, offered in clinic once folks dropped out. (MA referral and Provider referral based)

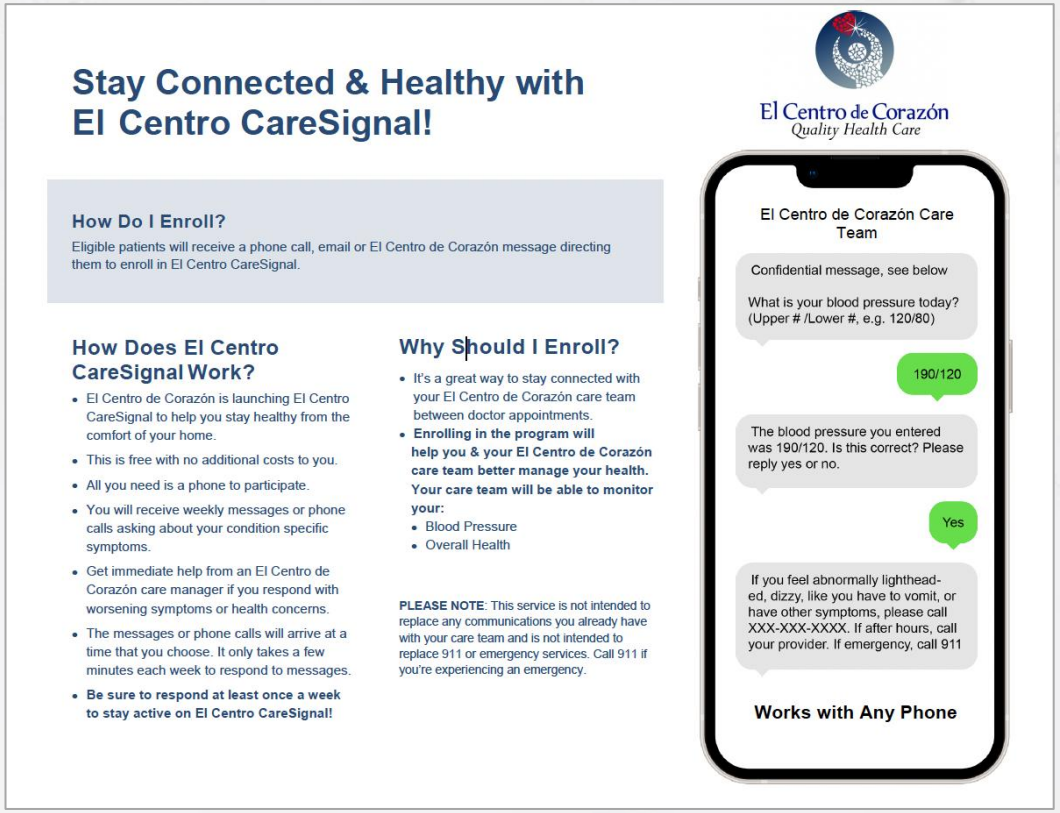
Phase 2

1. Once enrollment capacity reached, moved to a one in, one out offering.
2. Graduate patients who are controlled at 6 months.

Patient Enrollment- Text Flyer

- Link for additional information sent via text to reduce excess questions
- Patient flyer shown when link is clicked





Timeline: Multiple Hypertension Initiatives

BP Initiative #1:
Diet & Exercise

- Low engagement

BP Initiative #2:
RPM Bluetooth BP Monitors, IPhone & 1 yr data plan & MyChart

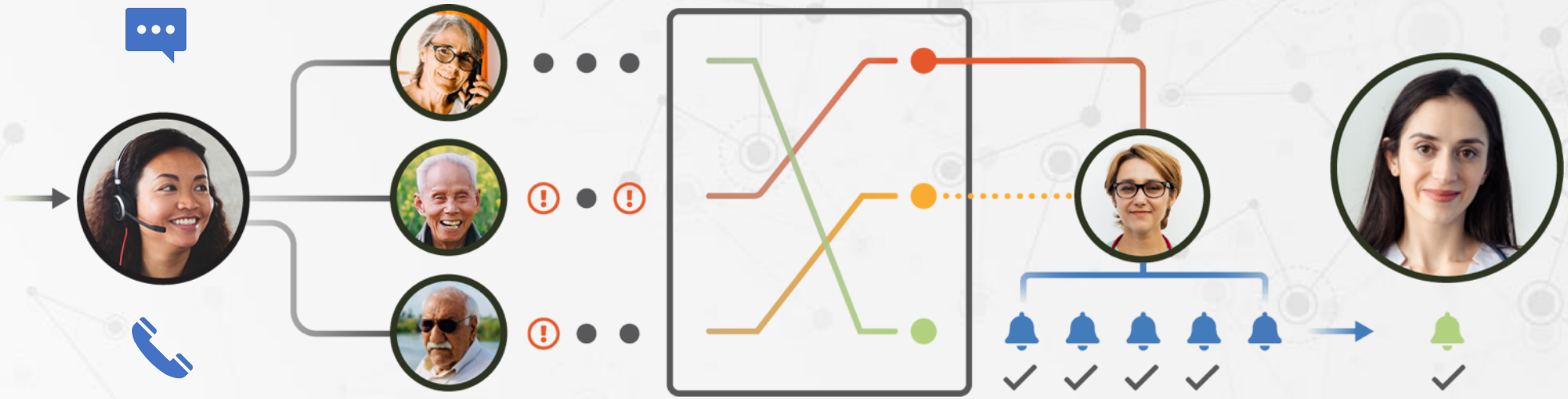
- N=5

BP Initiative #3:
Deviceless RPM (current)

- N=237

Offered patients RPM package or DRPM and majority chose DRPM

El Centro & CareSignal's Workflow



CareSignal
Enrolls eligible patients via text, email, mailers, and direct phone calls

El Centro's Patients
Answer automated SMS and phone call prompts, sending in clinically-relevant data

CareSignal
Categorizes at-risk patients and triggers alerts in real-time

El Centro's Care Team
Care Managers monitor dashboard and follow SOPs, outreaching to patients and documenting actions

El Centro's Providers
receive escalations, only as needed dependent on severity

Utilization

Executive Summary

Lightbeam Health Solutions

Utilization

26,073
Automated Text Messages

3,342
Automated Phone Calls

143
Proactive Alerts Raised

1
Program In Use

71
Engaged Between 2/12/25-3/14/25

237
Patients Enrolled

Highlights

55% of HTN Rising Rsk pts improved

Improved to Low-Risk Category (n=44)

21.13 mmHg sBP & 6.46 mmHg dBP drop

For baseline patients >160 mmHg sBP (n=8)

7.72 Score on Improved Communication

CareSignal Benchmark >6

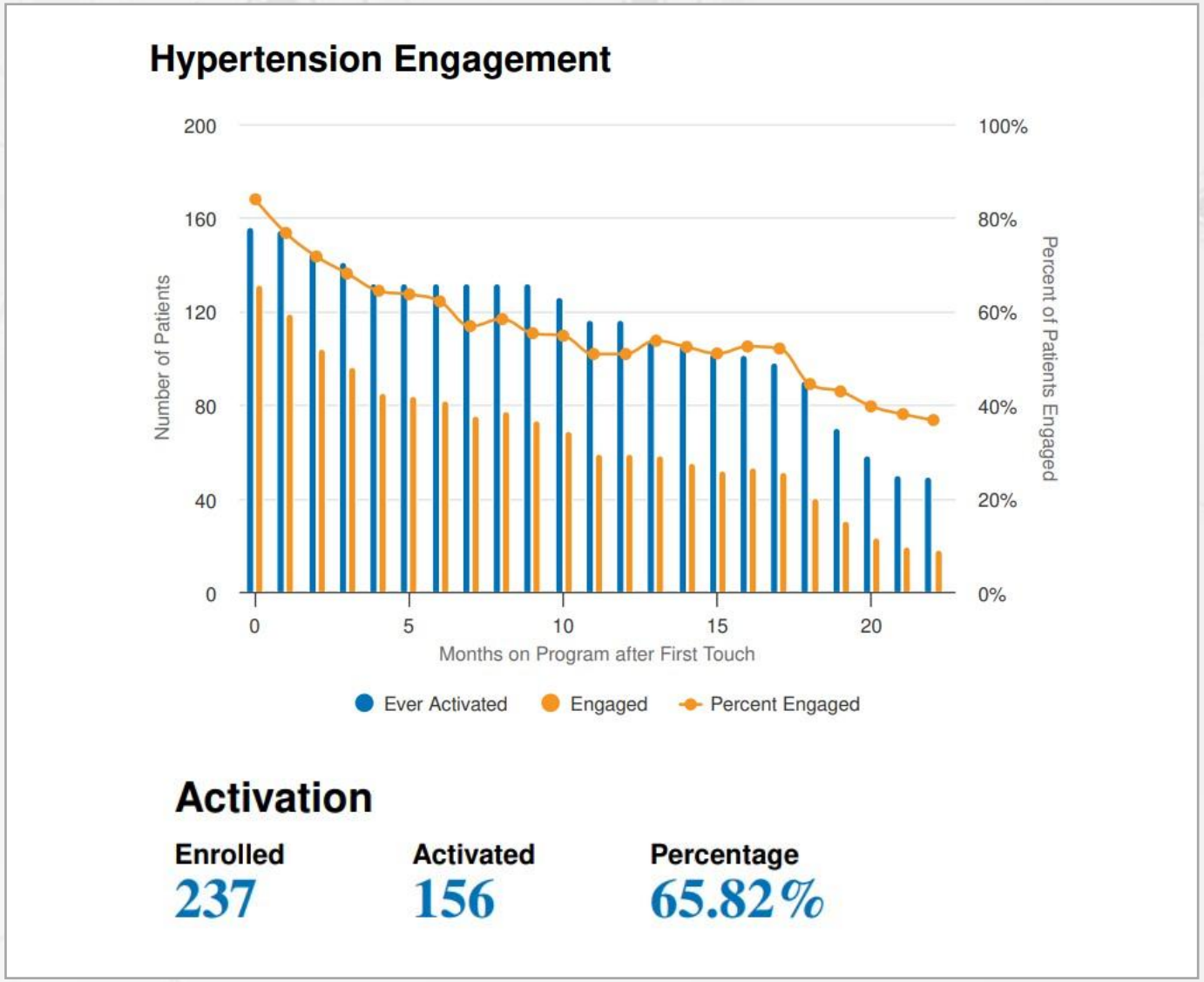
HTN Outcomes

Hypertension Activation & Engagement

Key Insights:

- 65.8% Activation Rate
- ~38% engaged at 23 months

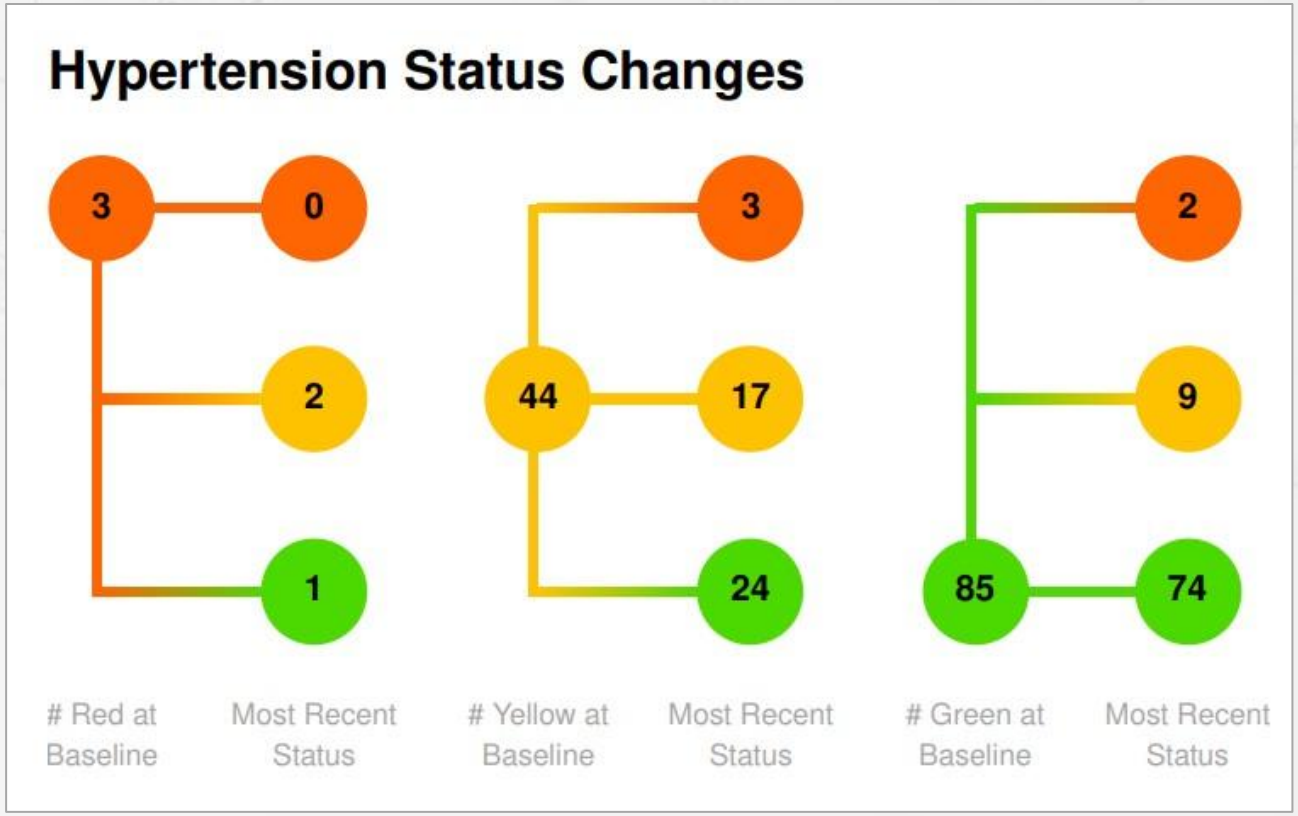
  (CS Benchmark= 41.6% at 16 mo)



Hypertension Outcomes

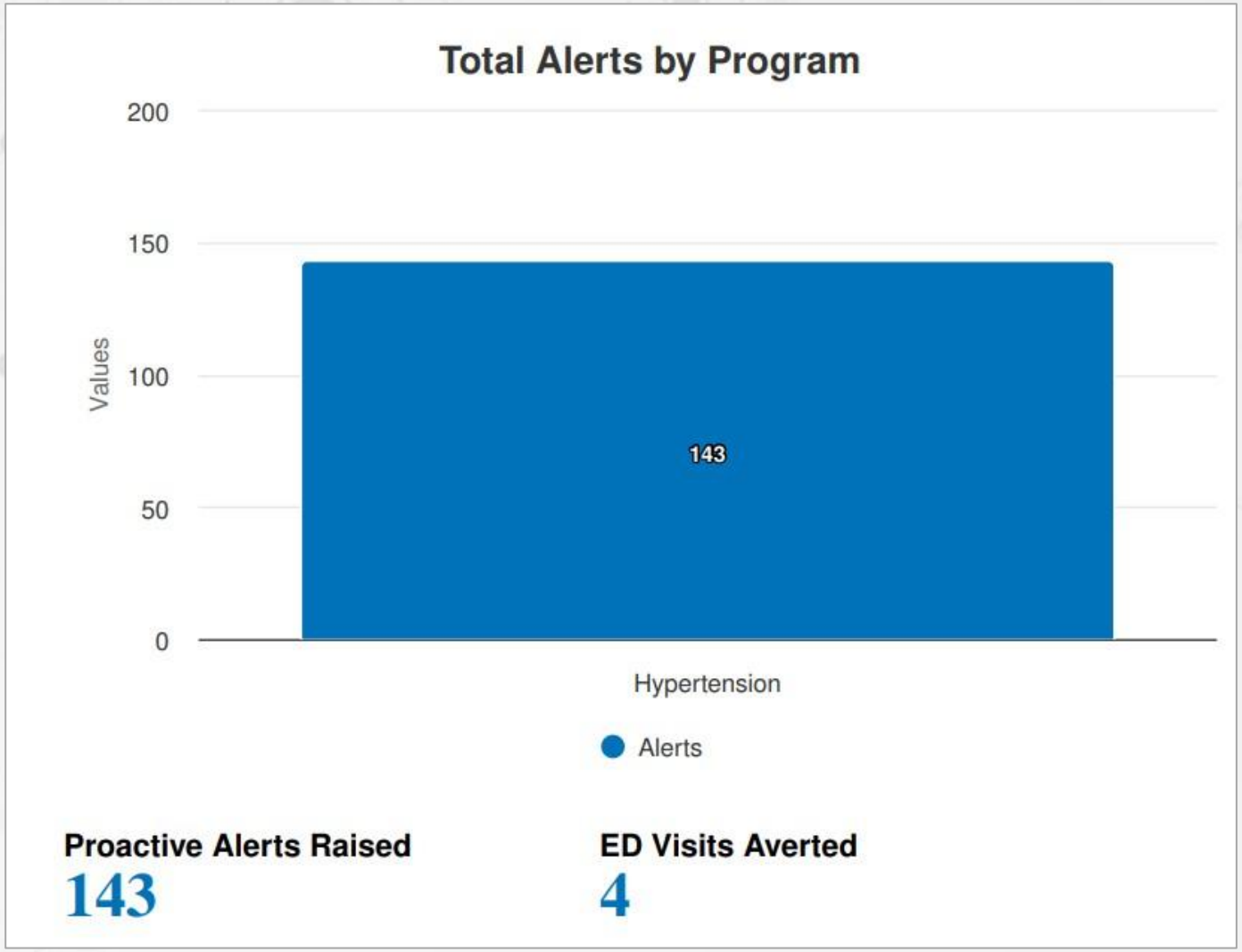
Key Insights:

- 100% High Risk Improved (n=3)
- 55% of Rising Risk Improved & 39% of Rising Risk maintained (n=44)
- 87% of Low Risk maintained (n=85)



Alert Breakdown

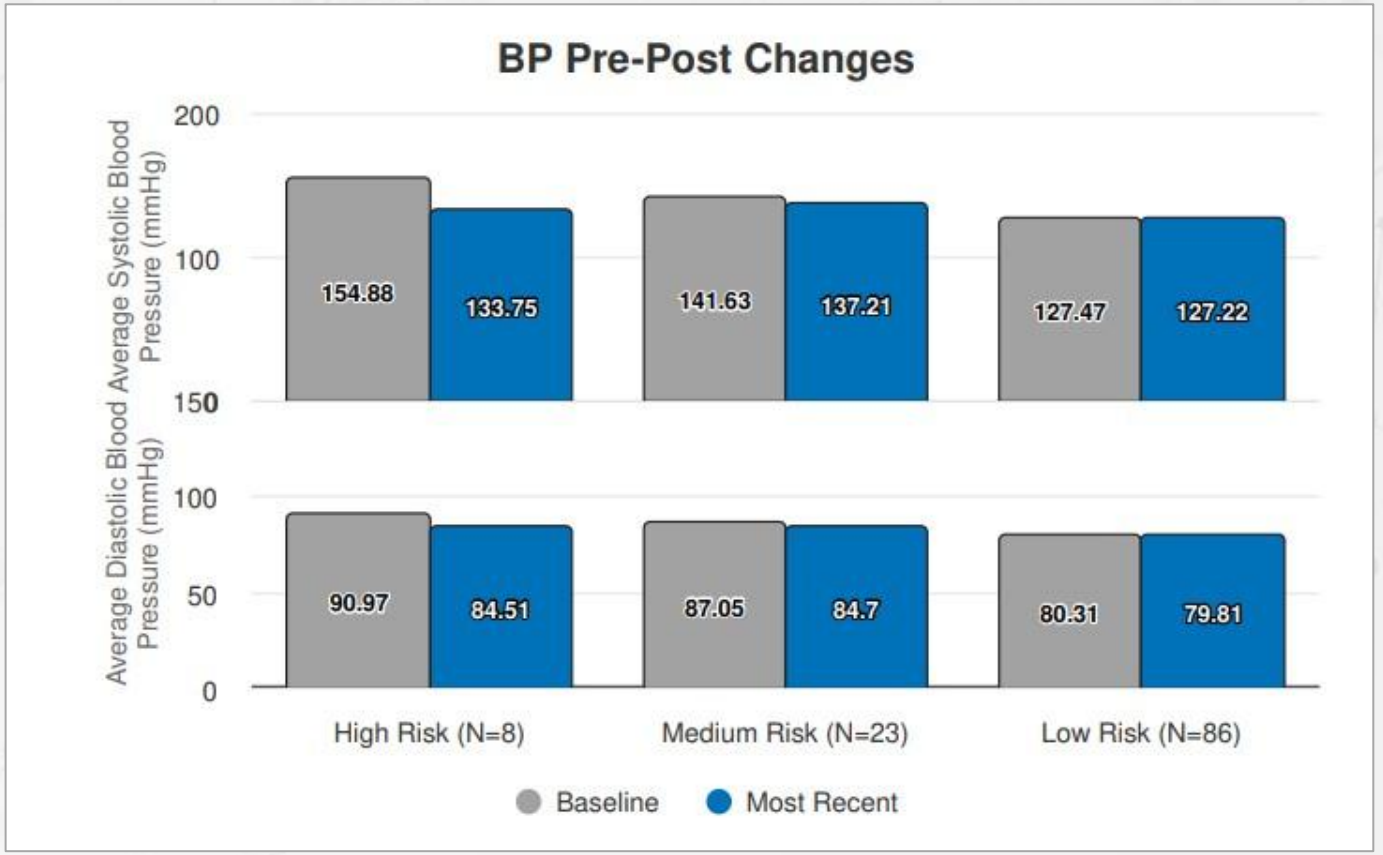
- **143** Hypertension Alerts triggered



Hypertension Outcomes

Key Insights:

- 21.13 mmHg drop in sBP & 6.46 mmHg drop in dBP for baseline patients >160 mmHg sBP (n=8)
- 8.73 mmHg weighted avg drop in sBP & 3.41 mmHg weighted avg drop in dBP for baseline patients >140 mmHg sBP (n=31)



UDS Impact

- Payers- evaluation
- CMS- recognition, future opportunities
- Every FQHC in the nation is rated
- Impact of Accurate Data:
  - BP measurement accuracy so confidence in high BP measures meant patient outreach/follow-up would occur.

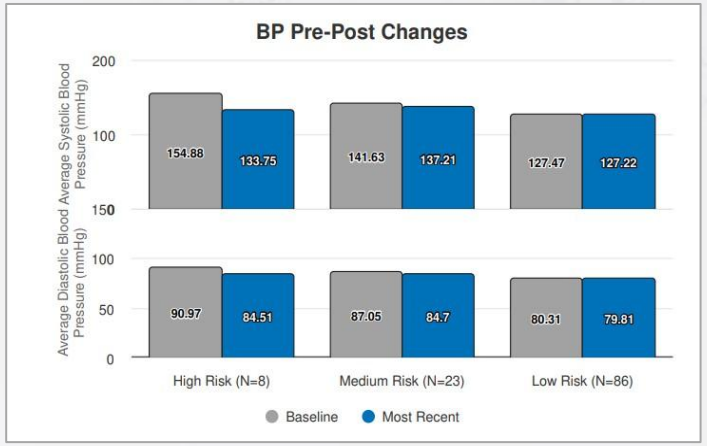
UDS Hypertension Baseline	Goal	Achieved
53%	60%	63%

Provider Experience

Provider Experience

- Before: Patients given physical BP logs but didn't use/didn't bring to in office visit

- After: Providers and MAs were able to pull up longitudinal BP data

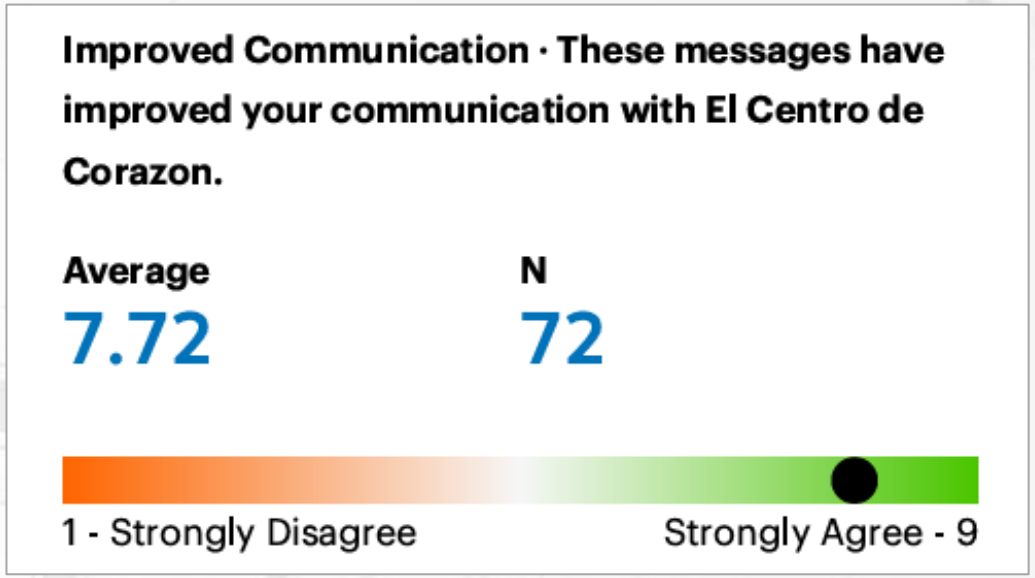


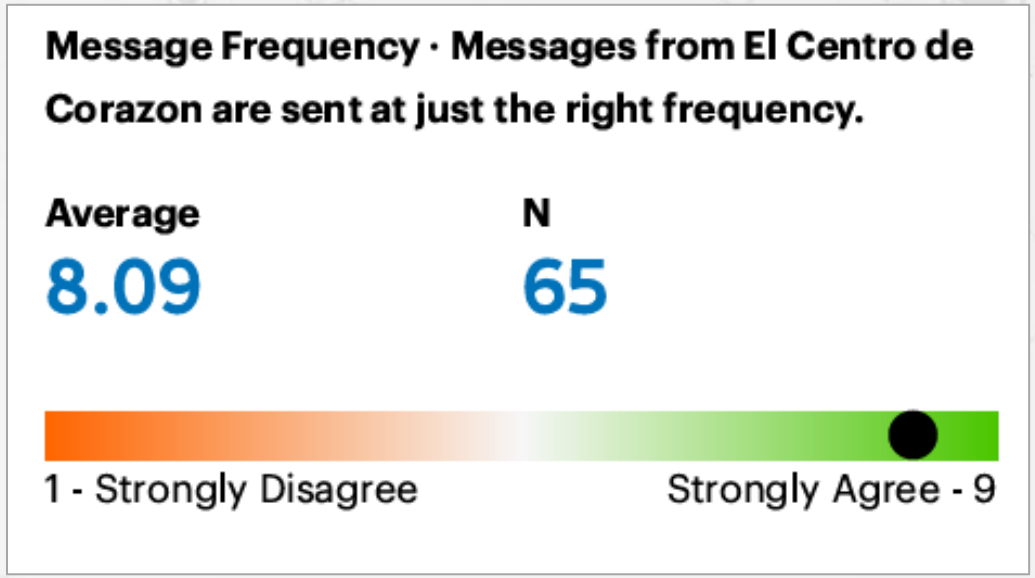
Patient Experience

Patient Satisfaction Surveys

Key Insights:

- **7.72** – Improved communication
- **8.09** – Message frequency

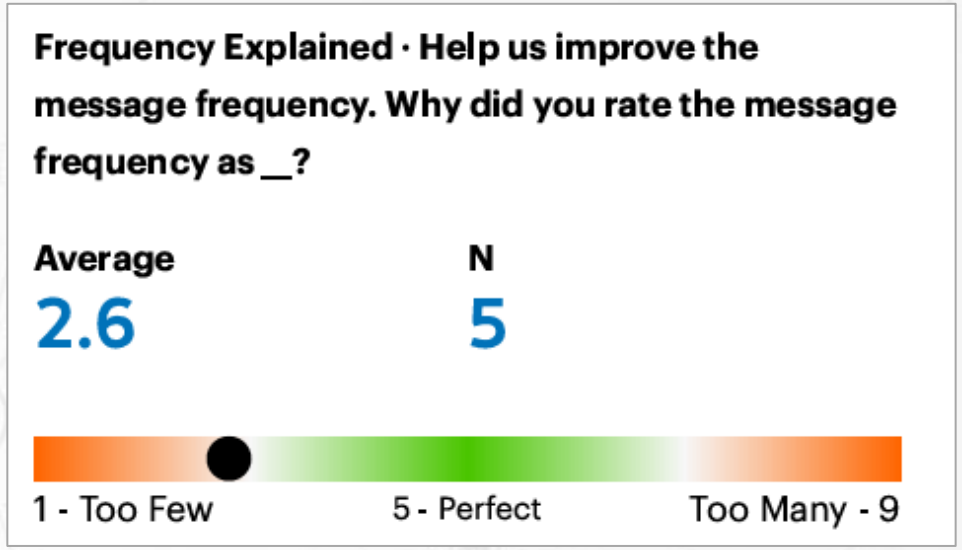


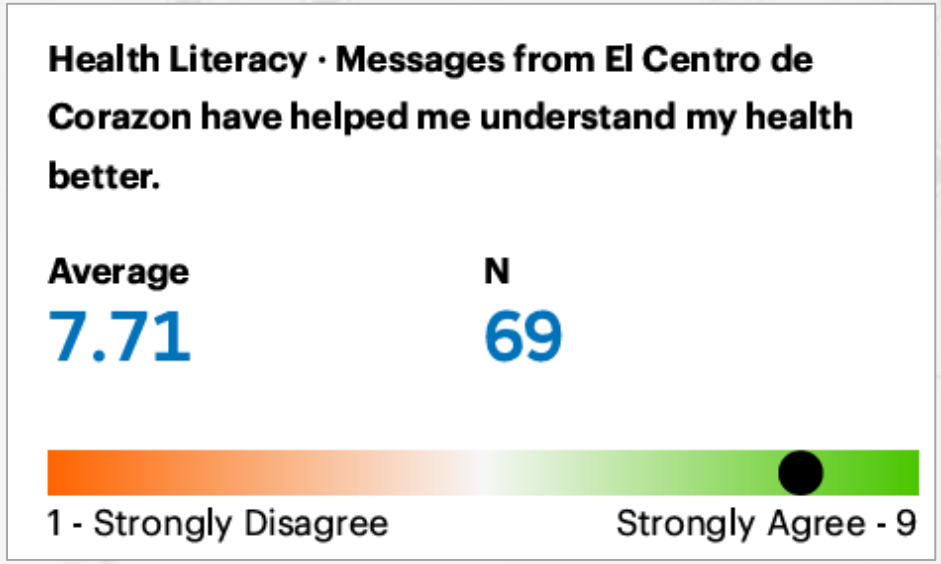


Patient Satisfaction Surveys

Key Insights:

- **2.6** – Frequency explained
- **7.71** – Health Literacy





Patient Feedback

"Thank you for taking the time to text the patient. This helps to keep track of appointments."

"I would not change anything. I like that we can take care of our health through text for those of us who have a busy schedule."

Patient Story:

During a family practice visit, a staff member provided education to a patient on taking her blood pressure at home and participating in our remote self-monitoring program. The patient was very grateful for the time spent and shared that no other provider had ever helped her understand how to manage her blood pressure at home. She stated she felt truly cared for and empowered by El Centro.

-Medical Assistant

Best Practices

- Understand patient technology needs/accessibility
- Patient education and support to drive support and data accuracy
- Invest in provider buy-in strategies
- Having a plan post-enrollment in writing (graduating patients)
- Aligning quality initiatives with UDS measures
- Evaluate success (ROI) to justify program sustainability

Q&A

For More Information Scan the QR Code *or visit Lightbeamhealth.com*

Or reach out directly at:
info@lightbeamhealth.com

Stop by our VBCExhibitHall.com Virtual Booth

[Visit the Lightbeam exhibit booth]

Contact Us

Info@lightbeamhealth.com gschmitt@TheExhibitHalls.com