Community Wellness

Benefits of RPM+ for *hospitals and health systems*

The most important things for a hospital to consider when choosing a remote patient monitoring partner are enterprise application integration, patient engagement, local care manager deployment, and business intelligence. Unlike other RPM platforms, RPM+ is a full outsourced service that supports patients as an integrated part of the provider's care management team.

Create Capacity

Community Wellness is committed to integrating with the hospital and will staff resources in your community to deliver on these important initiatives.

- Move lower acuity patients to home
- Increase Case Mix
- Provide opportunities to increase surgical share
- Decrease losses on observation stays and low-acuity DRGs

Value-Based Program Support

Through the care management program deployed by Community Wellness, additional post-acute and ongoing patient management can provide the necessary infrastructure needed to be successful in the Bundled Payments and ACO Medicare Shared Savings Program.

Improve Patient Engagement

Community Wellness care managers reinforce communication post-discharge on the hospital's behalf and review discharge instructions with patients.

HCAHPS Measure	RPM+ Impact
Communication with nurses (composite measure)	**RPM+ will support improvement in communications**
Communication with doctors (composite measure)	
Communication about medicinces (composite measure)	
Responsiveness of hospital staff (composite measure)	
Discharge information (composite measure)	
Patients understood their care when they left the hospital (composite measure)	

- Create additional capacity
- Increase in short-stay discharges to home
- Lower length of stay
- Reduce hospital readmissions
- Reduce emergency visits for value-based programs
- Reduce necessary ACO and value-based infrastructure costs through care management provided by RPM+
- Create a new service line that provides a financial return to the provider

"RPM solutions have reduced hospital readmissions rates by 50% with over 80% of patients satisfied." *– (PR Newswire 2019)*

Effects of Telemonitoring on Glycemic Control and Healthcare Costs on Type 2 DM

- **10.5% reduction** in six months for RPM
- **$881 fewer** healthcare costs for RPM
- **0% change** in control group
- **$3,781** Intervention Group vs. $4,662 Control Group

Source: pubmed.ncbi.nlm.nih.gov/28814128

Transitions of Care

- Qualified healthcare professional for virtual face-to-face visit (physician, NP, PA with applicable state license)
- Contact the beneficiary or caregiver within 2 business days following discharge
- Conduct follow-up visit within 7 or 14 days of discharge, depending on complexity of medical decision-making
- Provide medication reconciliation and management and support medication adherence
- Obtain and review discharge information
- Review the need for diagnostic tests/treatments and facilitate scheduling them
- Educate the patient and family member/caregiver
- Assist in scheduling visits with PCP, specialists, and community services
- Provide dated documentation of the above services