CASE STUDY: REMOTE MONITORING FOR CONDITION MANANGEMENT

CHALLENGE: A nationally renowned Integrated Delivery Network (IDN) faced a challenge: they were unable to scale their remote patient monitoring technology (RPM), and therefore their RPM program, to meet the diverse and complex needs of a growing population of people with chronic conditions. Past RPM programs lived outside the electronic health record (EHR) in onerous, web-based dashboards because integrating data into existing workflows came with exorbitant costs. Programs did not provide the level of flexibility or customization needed to accommodate the clinician managing type 2 diabetes in the Midwest and the high-risk patient with hypertension on the West Coast.

SOLUTION: The IDN partnered with Validic® to implement a cost-effective approach to RPM that met the needs of varied stakeholders. Validic's Impact solution integrates directly into the EHR. Impact makes personal health data accessible to thousands of clinicians via a single platform deployed across regions and Epic instances. Impact's analytics engine elevates critical data so care teams can quickly assess information and act accordingly. Visualizations make biometric and lifestyle data simple to understand and easy to trend.

OUTCOME: The organization has experienced strong enrollment and utilization from physicians and patients. Patients in the diabetes program averaged nearly a one point reduction in A1C within the first 65 days. Calls between care teams and patients went from an average of 15 minutes to 5.5 minutes – a 63% decrease. After three months, 70% of the patients who enrolled and began sharing data were still submitting readings at least twice per day.

.9 PT Average A1C reduction in 65 days

63% Average reduction in patient-clinician call times

70% The percent of enrolled patients still active after 3 months

THE VALIDIC IMPACT PATIENT EXPERIENCE

1. Care managers identify which patients are a good fit for the program, focusing on patients struggling to manage their condition, with declining health, or at risk for co-morbidities.

2. Patients are invited to join the program via remote or in-person enrollment. They receive an invitation by email with a link to enroll and instructions to walk them through the process.

3. Patients click the link in the email, where they confirm their identity, read consent and education about the program, and agree to participate. IT support is provided when needed.

4. From enrollment, patients are taken through a consent process to authorize their device to share data with the program and provider. Once the device is synced, data flows freely into the RPM program.

BEST PRACTICES IN RPM IMPLEMENTATION

1. **Integrate programs into the clinical workflow.** Data is integrated into the EHR's flowsheets and patient charts. Critical exception data is elevated to a clinician dashboard via automated triggers, sending notifications directly to the physician inBaskets, email or SMS messaging service. By integrating the data with visualizations to easily identify trends or exception values, clinician call times have reduced by 10 minutes.
2. **Provide IT support for participating patients and clinicians.** Patients and care teams have access to a toll-free number in which they can connect with a support team. Rather than having clinicians provide technology support, dedicated support personnel address patients' technical challenges, walk patients through enrollment, and manage device syncing. The support team also makes calls to patients who have been invited, but not yet enrolled, to bolster engagement.
3. **Allow for flexibility to meet program and individual needs.** Programs allow physicians to adjust clinical goals on both the population and individual level for deeper personalization. With this flexibility, health systems can support programs for blood glucose monitoring, blood pressure monitoring, and other chronic conditions – for both rising-risk and high risk populations – using a single, integrated solution. Providers and patients alike report these programs help care teams provide better assessments, connections, and treatments.

PROVIDERS SAY...

29

NPS SCORE, 152 RESPONDENTS

- 92% felt they provided better clinical care
- 88% of providers said the technology and program saved time

PATIENTS SAY...

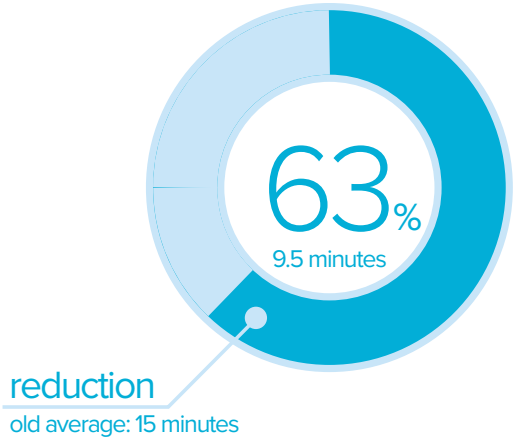
54

NPS SCORE, 540 RESPONDENTS

- 58% of patients felt more accountable
- 75% said care team provided 'better care'
- More than half saw health improvements

**Note: NPS Scores are on a scale from -100 to 100. For example, Tesla has an NPS score of 37, while Time Warner has a score of -5.*

Patient - clinician call times reduced from 15 minutes to 5.5 minutes



Total connected users increasing by 400 patients per week