Remote Monitoring:

First Remote Patient Monitoring Program in the Nation

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Presenter Disclosures

Mike Bruce

The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

- Owner and executive officer of InScope Health, a for-profit commercial entity
- Pending industry-sponsored grant to co-deploy an RPM pilot in Tennessee

A True Story … With a Happy Ending!

RCCHC Community

Health Disparities

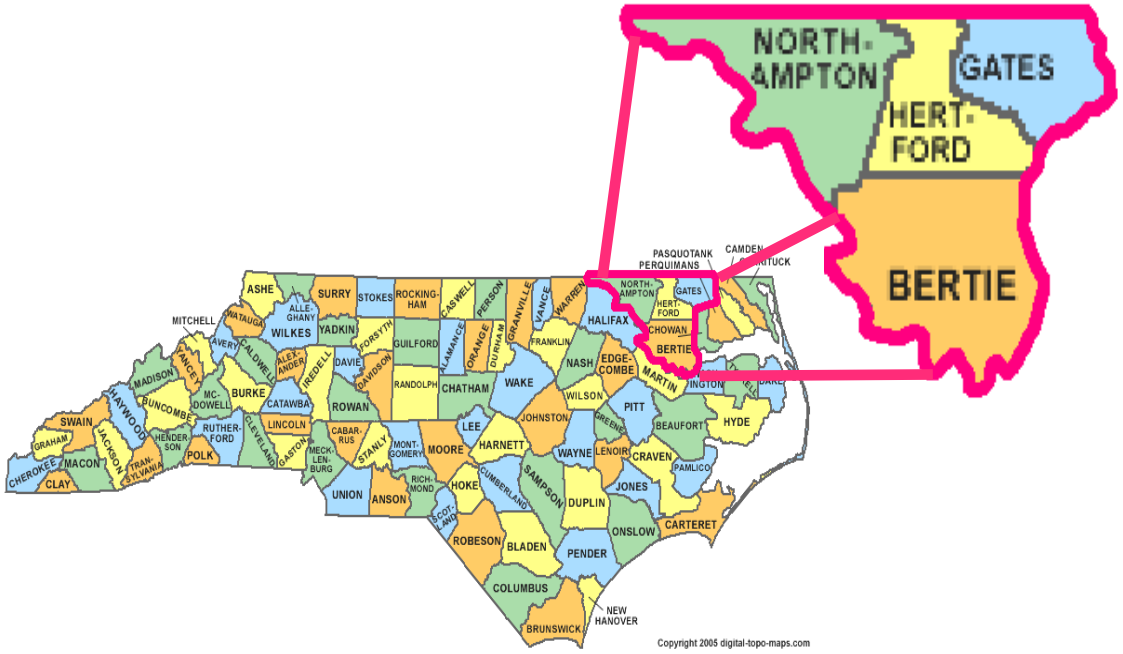
- Cardiovascular Disease
- Diabetes Mellitus
- Hypertension

Barriers to Care

- Transportation
- Economic Status
- Low health literacy

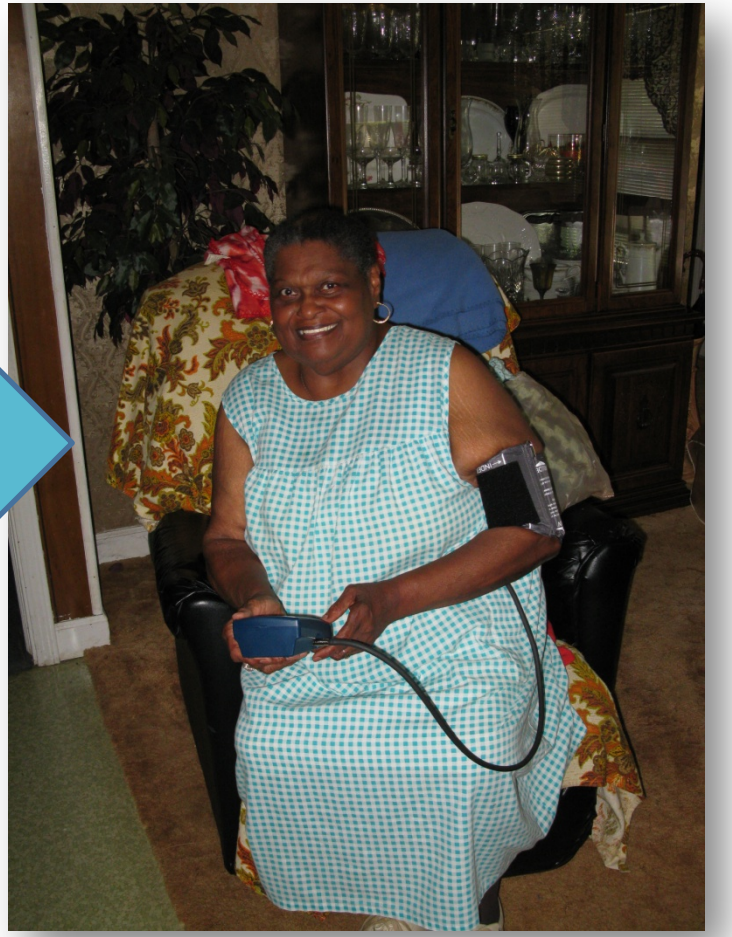
Population

- 21% uninsured
- Median income - $23,500
- 70% African American



Ahoskie Comprehensive Care

Enhancing the Provider-Patient Connection



Chronic Care Management Network

Improve health and enhance care by interconnecting stakeholders to increase accountability and change patient behaviors

Devices measure health data

Glucose Monitor

Blood Pressure Monitor

Weight Scale

Health data is securely transferred

Health trends are displayed on a user-friendly dashboard

Patients and family learn from seeing health trends

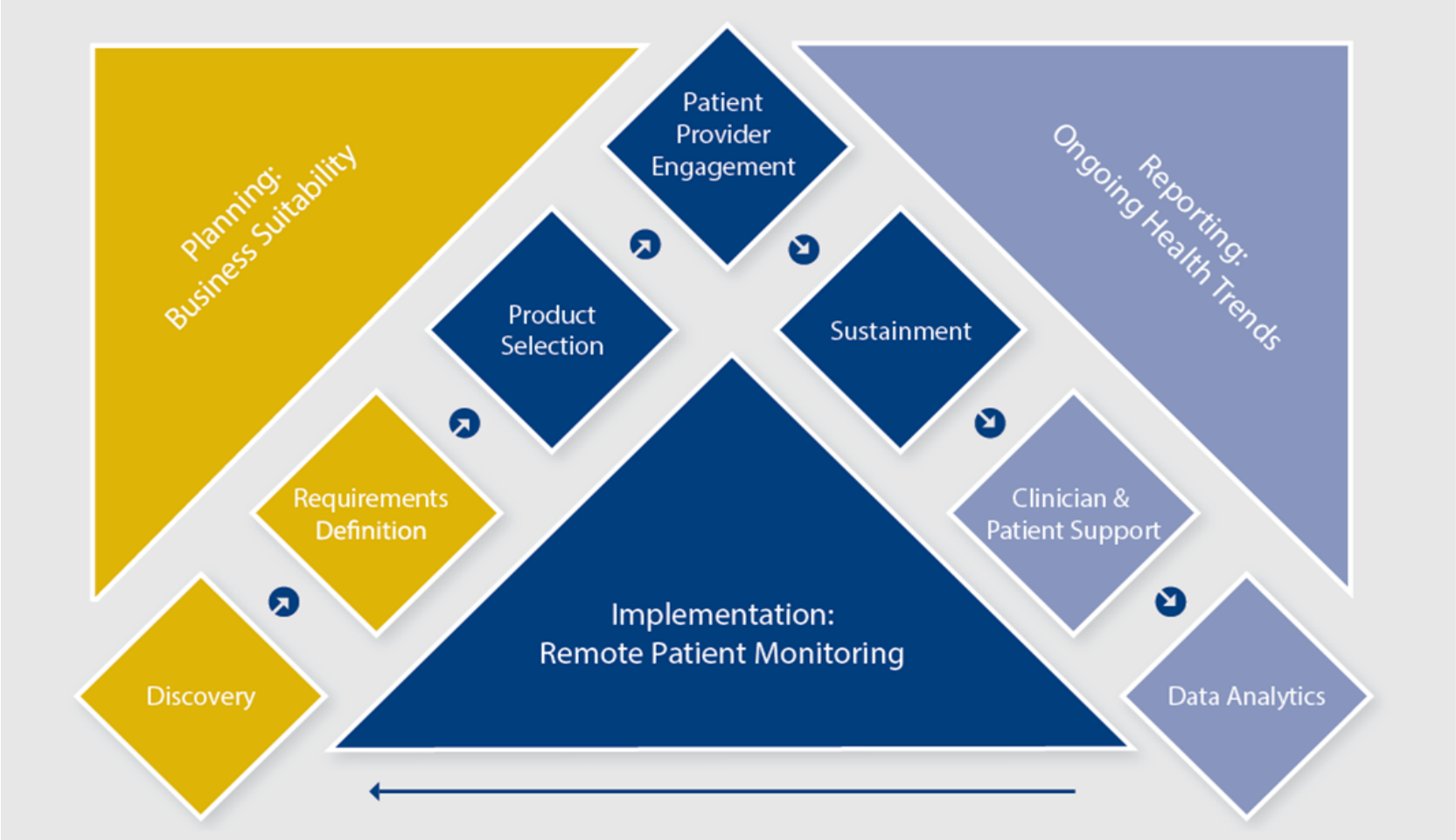
Nurses monitor health data and trends

Alerts are escalated to primary care provider

Patient behavior is modified through teachable moments

Enhances care. Changes behaviors. Lowers costs.

The Methodology



What Was Measured

Patient

- Satisfaction
- Patient Activation Measures Survey (PAM)
- Compliance
- Personal Cost

Clinical Indicators

- HgA1c
- LDL
- BP, Pulse
- Weight
- Blood glucose
- Oxygen saturation

Health Services Use:

- # PCP visits
- Hospital Bed Days
- Emergency Room visits
- Contact by monitoring Nurse

Medical Costs

- PCP visits costs
- Hospitalization costs
- ER visit costs

Patient Engagement

Overcoming the common barriers to gaining participation

Mutual Selection Process

- More than 1 hospital visit in last 6 months
- High utilization of ED, Ambulatory, Clinical Services
- At least 1 chronic disease which can be monitored by RPM

Comprehensive Patient Discovery

- Capturing demographic and psychographic assessment tool
- Gathering discrete environmental and social observations

Relationship-Centric Approach

- Up to 94% compliance in RPM Participants
- Trusted, accountable relationship between Nurse, Patient, and PCP

Physician Engagement

Enhancing a provider's ability to care for their patients

Improved Quality of Care

- Fine-tuned medication adjustment
- Healthcare data captured on a daily basis
- Secure access to timely data

"Provides good feedback to the patient on their day-to-day activities."

Dr. Colin Jones
RPM Physician

Improved Outcomes

- Decreased Emergency Department visits and Hospital bed days
- Improved BMI, A1C, weight, and BP

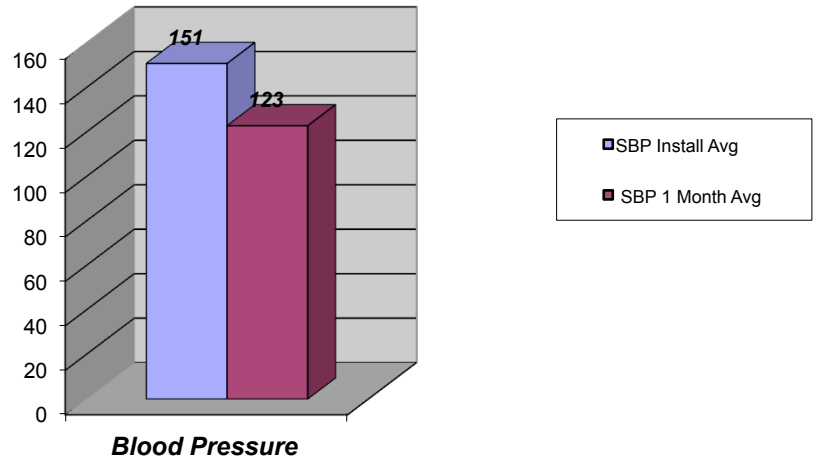
Relationship-Centric Approach

"Patients feel it's a tangible connection to their provider."

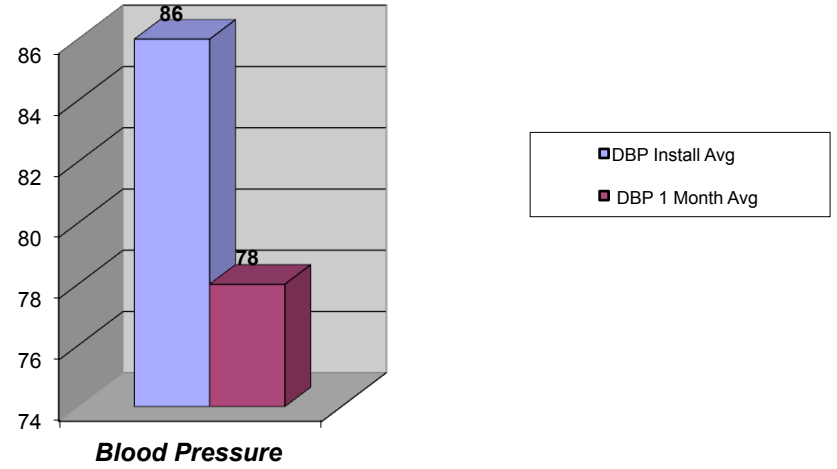
Dr. Hilary Canipe
RPM Physician

Clinical Results

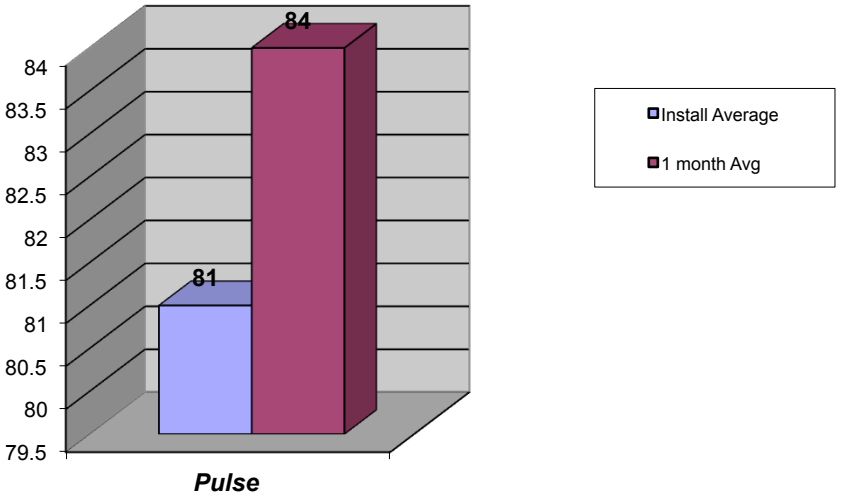
Average Systolic 18.543 % decrease



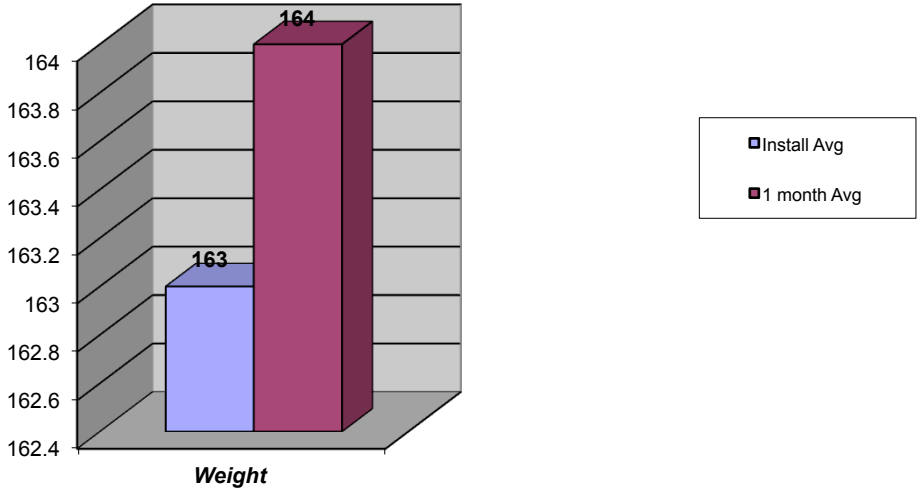
Average Diastolic 9.302 % decrease



Average Pulse 3.704% increase



Average Weight 0.613% increase



Economic Results

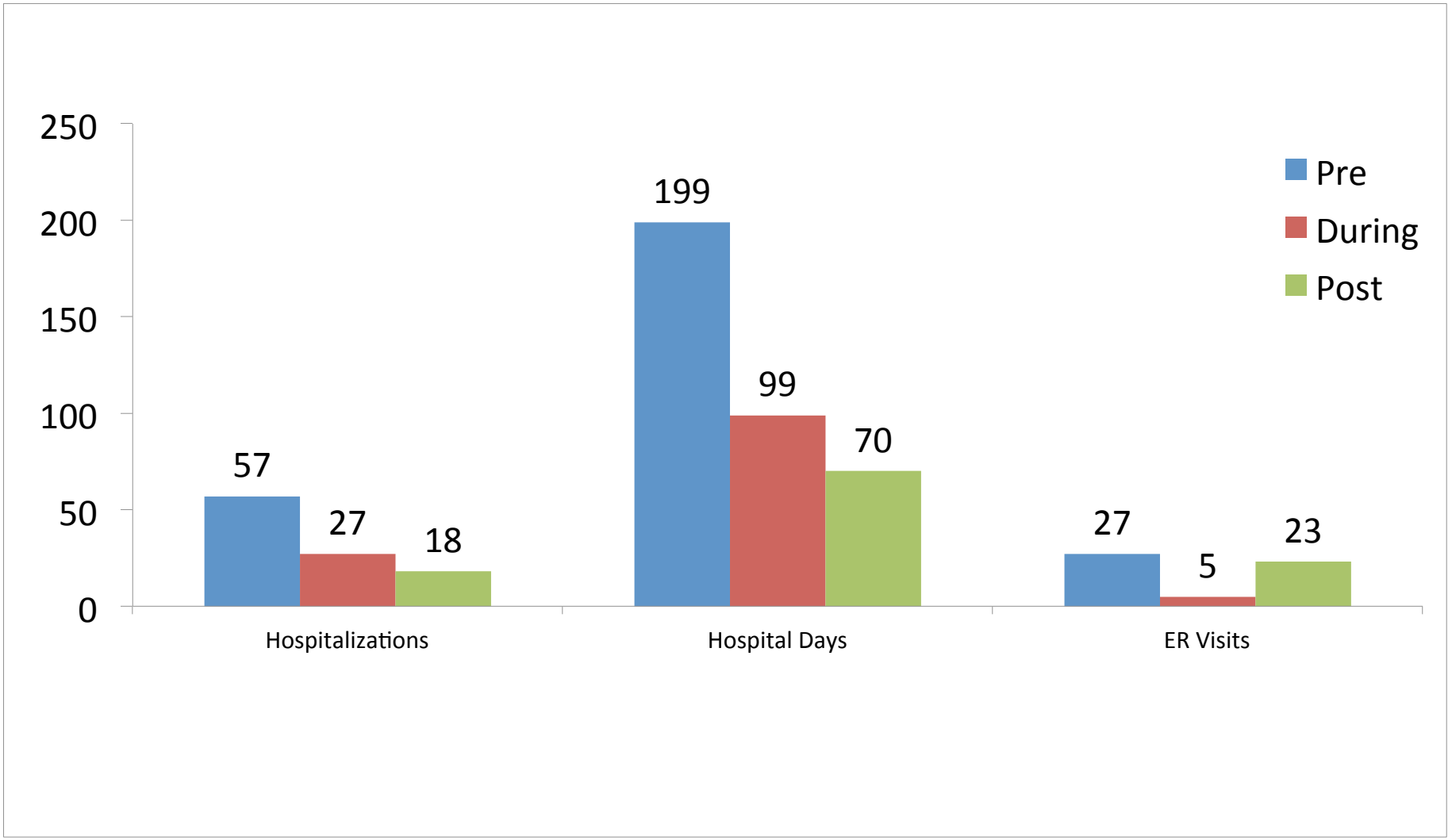
RPM cost containment validated by Wake Forest School of Medicine

64 Participants	Pre RPM 6 Months Prior to RPM	During RPM 6 Months During RPM	Post RPM Proven Long-term Results Over 3 Years
Hospital Bed Days	199	99	83% Reduction
ED Visits	27	5	79% Reduction
Hospital and ED Charges	$1.34M	$382K	87% Decrease

- Total Hospital and ED Charges for 24 months after RPM was $483,024. The cost of caring for these patients had significantly decreased

The RCCHC study demonstrates that Remote Patient Monitoring influences patient behavior which leads to persistent health benefits and cost containment

Hospitalizations, Hospital Days and Emergency Room Visits by Telehealth Status, All Participants (N=64)



Valuable Outcomes

PATIENT

Fewer ED/Offices visits

Fewer hospital re-admissions

Improves overall health and quality of life

Improves provider relationship

Reduces out-of-pocket expenses

Increases accountability and healthcare IQ

Ease of use

PROVIDER

Real time access to patient health data

Better view into patient's lifestyle

Supports meaningful use

Lower healthcare cost

Improves treatment plans and outcomes

Supports Patient Center Medical Home and NCQA accreditation

How can RCCHC's Mission be expanded?

Leveraging best practices of public-private partnerships (PPP)

- Linking credibility and capability to scale proven model – build upon our proven Community Health Programs
- HRSA 2013 grant awarded for the Central Oregon Telehealth Network (COTN)
  - Replicate RCCHC's program enabling primary care medical home teams to rapidly enhance the efficacy of its Patient-Centered Medical Home (PCMH)
  - Use clinical protocols via short-term remote patient monitoring interventions initially working with Mosaic Medical CHC.
  - The partnership of RCCHC, OCHIN and InScope will collectively support COTN in achieving their goals.

Delivering care via a "neutral" business and technical platform

- Vendor independence ensures right fit and best-of-breed solutions

Developing broad partnerships to cover diverse delivery needs

- Successful rural, suburban, and urban deployments require reach across FQHCs, HINs, Payers, product vendors, and data stores

InScopeHealth

Better Care Through Innovative Relationships.

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