Guide

Hypertension Virtual Care Management Best Practices Guide

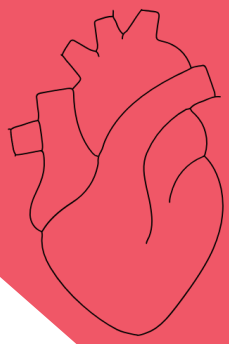
Treat the whole patient with remote patient monitoring and chronic care management powered by the right technology.

TIMEDOC HEALTH

INTRODUCTION

Hypertension

Effective virtual care management practices



Implementing a successful, compliant, outcomes-driven virtual care management program for hypertensive patient populations is not easy.

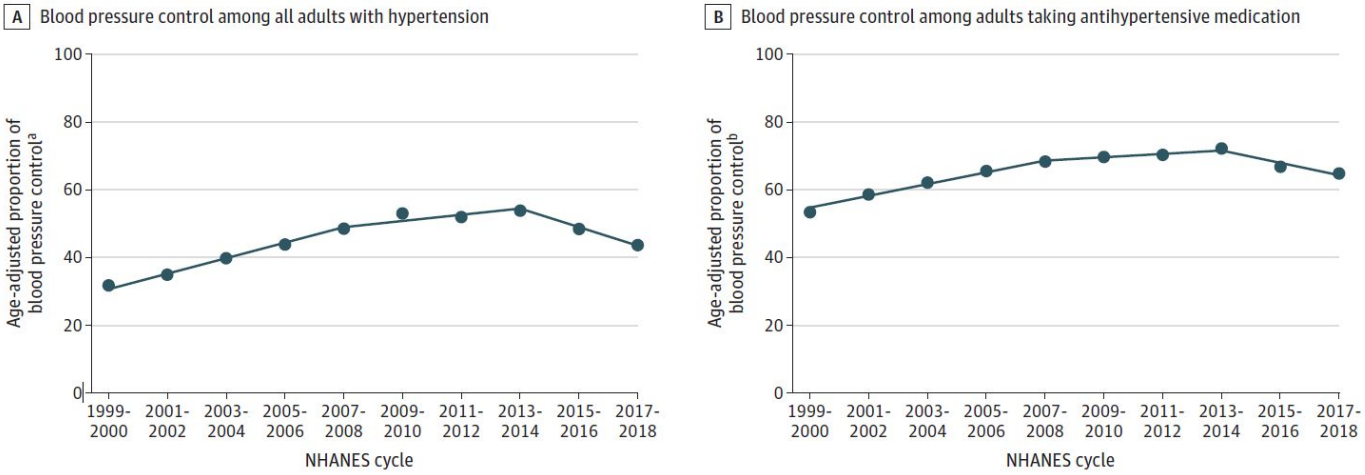
With so many options in the health technology and care management space, selecting the right partner can be confusing and time-consuming. There are so many factors to consider when looking to manage complex populations holistically, virtually, and at scale.

- Hypertension is among the most important modifiable risk factors for cardiovascular disease.
- Fewer than 50% of adults with hypertension have good control of their blood pressure.
- More than 50 million adults have inadequately-controlled hypertension.

While some providers have started to adopt remote patient monitoring as an answer to the hypertension puzzle, the overall effectiveness of remote patient monitoring (RPM) alone remains unproven.

A recent article from JAMA Internal Medicine looking at the cost-effectiveness of RPM found that the dominant primary diagnosis for general RPM services was hypertension (62.5%), though the authors noted that remote monitoring initiatives have mixed results for improving patient outcomes.

Figure. Age-Adjusted Estimated Proportion of Adults With Hypertension and Controlled Blood Pressure



Choose a partner that prioritizes outcomes with a platform that enables evidence-based hypertension management, so you can make effective clinical decisions at the right time.

Six Best Practices for Virtual Care Management of Hypertension:

1) Treat the Whole Patient with the Right Technology and Right Partner
2) Leverage Flexible Patient Programs
3) Identify an Internal RPM Champion
4) Extend your Practice into Patient Homes
5) Ensure Technology Empowers Evidence-Based Care at Scale
6) Prioritize Actionable Data Pushed to Your EHR

Holistic care for multi-chronic hypertensive patients can now be provided at scale with a combination of chronic care management (CCM) and remote patient monitoring (RPM).

When implemented successfully, virtual care management programs drive outcomes and revenue for your practice.

Want to skip to results before diving into the guide?

One client achieved 75%* greater BP control with TimeDoc Health virtual care management for hypertension.

REQUEST A MEETING

With any questions about implementing a virtual care management program for hypertension, please don't hesitate to contact us.

*according to TimeDoc internal data

1) Treat the Whole Patient with the Right Technology & Right Partner

Hypertension & Vulnerable Patient Populations

Virtual Care Management for hypertension is effective as a combination of chronic care management and remote patient monitoring and is ideal to treat and engage the whole patient, especially hypertensive patients.

Often, hypertension is not the only chronic condition your patients are dealing with daily. Many hypertensive patients, don't feel sick.

So getting them to stick with a remote physiological monitoring program long enough to impact outcomes can be nearly impossible without the right patient engagement strategy.

We've found that remote patient monitoring (RPM) alone isn't enough to complete the shift to patient-centered care. One challenge is adherence to RPM itself. Medicare guidelines require 16 readings per 30-day period.

Factoring engagement and follow-through is critical in program setup as many patients don't associate active symptoms with their vitals.

We have seen a 23% increase in RPM adherence with full virtual care management programs in which **care coordinators engage with patients** and remind them to continue home monitoring.

Meet Alan

During an office visit with his PCP, Dr. Paul Helmuth (TimeDoc's VP for Quality and Population Health), Alan's blood pressure was slightly elevated.

Alan is a retired school teacher
He has hypertension and diabetes
He struggles with medication adherence and smoking cessation

Alan doesn't check his blood pressure regularly with his home cuff, because he doesn't feel unwell, and doesn't see the need to check on his vitals. He believes that twice-per-year visits to his provider are enough monitoring.

Dr. Helmuth encouraged him to begin a remote monitoring program to help with management, noting to Alan that home blood pressure readings are more highly correlated with cardiovascular outcomes than in-office readings.

Dr. Helmuth noted "it will help me give you the best care to reduce your risk for stroke and heart attack if we start measuring your home blood pressure!" After enrollment, Alan started regularly working with his care coordinator who encourages him to monitor his BP regularly and keep taking his daily medications as prescribed.

Our team has observed that RPM combined with the human touch of care coordination encourages patient engagement within the program and enhances communication with the practice between office visits.

When care coordination is combined with the right technology, you can ensure relevant and actionable data is pushed directly to your EHR without interrupting your workflow.

MANAGING CHRONIC CARE SHOULDN'T BE A CHRONIC CHALLENGE

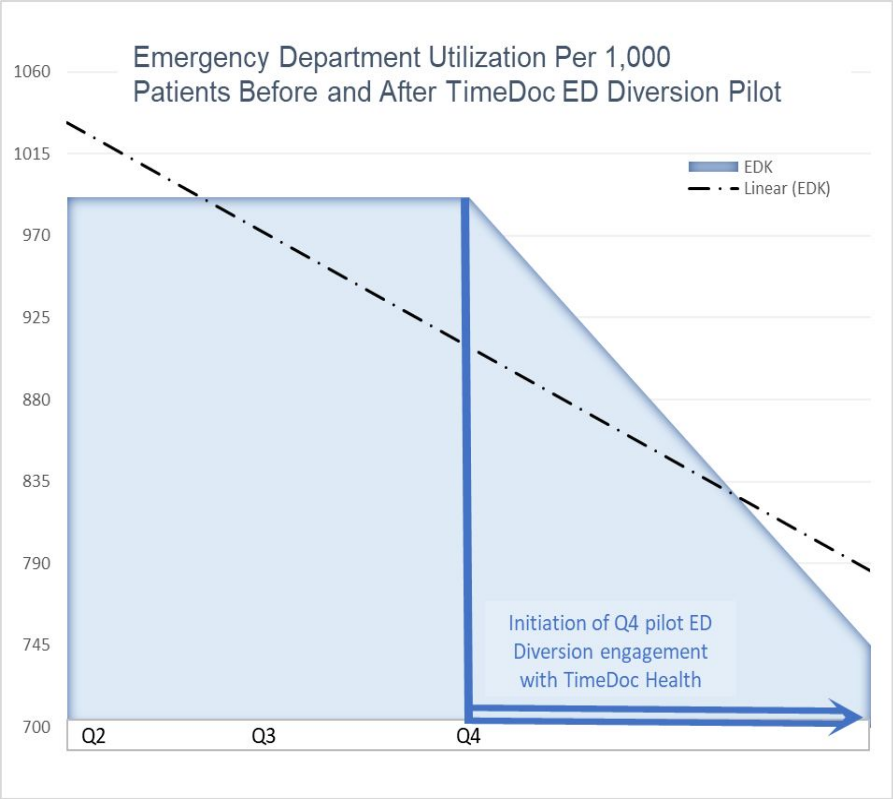
2) Deploy Care Management Programs with an Experienced, Strategic and Outcomes-driven Partner

TimeDoc Health partners with providers to create custom patient programs because you know your patients better than anyone else.

Inadequate or inefficient communication between patients and their care team is not only frustrating for patients and providers but can also be dangerous. **Remember Alan?**

The difference between care management and personalized care management *at scale* is huge.

One-size-fits-all programs tend not to fit most, so we partner with you to deploy programs based on the needs of your unique patient population and organizational goals.



TimeDoc Health helped reduce ED utilization by 25%* through an ED deferment pilot with a FQHC client.

If your practice is looking to implement pilot programs to support a subset of your patient population prior to an annual commitment, please don't hesitate to schedule a consultation.

Our clients have seen an average improvement of 14.6%* in BP control over 10 weeks. Some clients stand out as leaders with a 60%-80% improvement in control. **Those practices have incorporated our next recommendation into their workflow - to identify an internal "RPM champion".**

*according to TimeDoc internal data

3) Identify an Internal "RPM Champion"

We have observed the best clinical results and provider satisfaction with RPM among those practices that identify an "RPM champion" who manages their program, actively monitors patient data and makes certain that patients are contacted to arrange follow-up care.

One of our partners that adopted a virtual care management model for hypertension and identified an internal RPM champion went from having 26% of their patients in the target range to 47% at 10 weeks, which is a 78% improvement in control.*

Remote monitoring and centralized blood pressure management programs that combine technology and human services fit in most naturally as tools for success in value-based care reimbursement models.

The combination of continuous monitoring with patient engagement promotes important health outcomes including rates of admission and readmission, total medical expenses, and adherence to medical therapy.

Federally Qualified Health Centers and Rural Health Centers will see about $79/pppm in reimbursement for chronic care management while other fee-for-service organizations can see up to ~$160/pppm for programs combining remote patient monitoring and chronic care management.

Over 75%* improvement in BP control was achieved for a practice that identified an internal "RPM Champion" to *own* their hypertension RPM and CCM program success.

Why combine RPM and CCM?

CMS' financial analysis of CCM programs showed reduced ED visits and hospitalization rates among CCM beneficiaries.

The difference in the rate of growth of ED utilization and hospitalization between CCM beneficiaries and the comparison groups were -23 and -47 visits per 1,000 beneficiaries on average, respectively.

CCM alone has been proven to reduce costs by $74 per beneficiary, and RPM can increase this significantly. That's why we design programs to keep patients engaged and recommend that practices do too when looking to implement CCM and RPM programs on their own.

Increase Revenue

$79 pppm

Medicare has increased reimbursement for CCM to $79 per patient per month.

Reduce Costs

$74

CCM alone has been proven to reduce costs by $74 per beneficiary, RPM can increase this significantly.

*according to TimeDoc internal data

4) Extend the Reach of Your Practice into Patients' Homes

Engage a true strategic partner with a flexible model that allows you to choose your level of outsourced care coordination support.

With three different models, TimeDoc Health programs allow you to scale support up or down based on your organizational needs.

Tech-Only Deployment

With a software-only model, your practice takes the reins for care coordination, in addition to patient enrollment and education.

Time spent on qualifying activities will be tracked and managed through the software and can be easily submitted for reimbursement.

Co-Sourced Hybrid

With our flexible hybrid model, we take on a subset of your patient population for care coordination in addition to the software.

TimeDoc works closely with you to ensure the right patients are getting the support they need at the right time.

Fully Outsourced VCM

With a fully outsourced care coordination model, your practice can focus on moments that matter, knowing VCM is in the hands of a trusted partner.

We offer a fully turnkey virtual care management program inclusive of our platform and services that can be up and running in as little as 6 weeks.

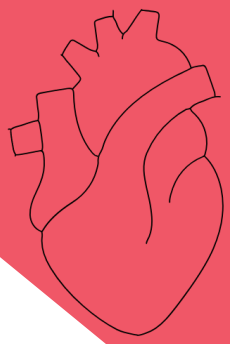
But how do each of these models impact program success for hypertension management?

Personalized care is finally managed at scale with the right people, process, and technology.

Outsourced care coordination for hypertension increases engagement with your practice as we perform services on your behalf. TimeDoc's platform enables holistic, data-driven clinical care so now there's time to reach, enroll and engage more patients than ever.

With 90% patient retention in TimeDoc health programs, we ensure that patients understand their benefits and the support they can expect from care coordination.

CMS also found that while ED visits and hospitalization rate of growth slowed for CCM beneficiaries, the rate of primary care visits increased.



Reduced Cost of Care is Core to Our Mission

While we've known these programs make an impact on outcomes and provide strong financial value to our clients, we also see immeasurable value in patient lives

We have the privilege of serving tens of thousands of enrolled patients and the honor of making a difference in their lives, with real multi-chronic hypertensive patient stories like this every day

Critical Alert Intervention

One of our care coordinators noticed a pattern of critical blood pressure levels before a new critically high BP alert.

The coordinator was unable to reach the patient following the alert and initiated a wellness checkup.

The patient was able to be seen at urgent care and their PCP a few days later and avoided going to the emergency department.

Medication Review

One patient in a hypertension program reported feeling confused about medication direction as she was seeing multiple providers.

Her dedicated care coordinator was able to ensure a medication reconciliation was performed, and in fact, a discrepancy was found and resolved.

The patient expressed gratitude for the program, feeling like there was truly someone looking out for her well-being in-between visits.

Smoking Cessation Support

One hypertensive patient informed their dedicated care coordinator of their desire to quit smoking.

The coordinator was able to engage the provider and follow up with the patient to ensure that smoking cessation products were sent to the patient's home.

Strikingly, among fee-for-service Medicare beneficiaries, people suffering from multiple chronic conditions account for 93% of total Medicare spend.

Our partnership approach to care coordination allows us to impact those outcomes that providers are looking to scale up. We take a pilot approach to ensure value for both organizations.

In general terms, costs relating to patients with uncoordinated care are 75% higher than those with joined-up medical service provision.

5) Ensure Technology Empowers Evidence-Based Care at Scale

Engage a true strategic partner with a flexible model that allows you to choose your level of outsourced care coordination support.

With three different models, TimeDoc Health programs allow you to scale support up or down based on your organizational needs.

Evidence-based hypertension management is baked into our platform

TimeDoc's software guides care coordinators in the evidence-based management of hypertension, including attention to:

- treatment adherence,
- barriers to care,
- health risk behaviors,
- and self-monitoring programs

Relevant data is directly pushed to your EHR so you can keep a pulse on patient care. If utilizing care coordination services, we follow your protocols and ensure that actionable data is provided without interruption to your workflow, so you can focus on moments that matter.

TimeDoc Health has the right technology, the right care coordinators, and the right process so you can:

1) **Keep It Simple** with an intuitive platform that gives you remote monitoring and chronic care management in one place, and that's easy for anyone on your staff to learn and use.
2) **Keep It Connected** with a system that integrates with your EHR, plus dedicated care coordinators who connect with your patients.
3) **Keep It Going** with a flexible, scalable model that gives you the option to use our care coordinators, yours, or a mix of the two.

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6) Prioritize a Partnership that Ensures Actionable Data is Pushed to Your EHR

Engage a true strategic partner with a flexible model that allows you to choose your level of outsourced care coordination support.

With three different models, TimeDoc Health programs allow you to scale support up or down based on your organizational needs.

With secure and compliant EHR integrations including:

- ***Allscripts***
- ***Athena***
- ***AthenaFlow***
- ***eClinicalWorks***
- ***Epic***
- ***NextGen***
- ***Nextgen Office***
- *AdvancedMD*
- *AllegianceMD*
- *Care360*
- *Centricity*
- *Centriq*
- *CGM*
- *ChartPath*
- *eMDs*
- *InSync*
- *Intergy*
- *Kareo*
- *Medent*
- *OneTouch*
- *PracticeFusion*
- *PracticePartner*
- *PrimeSuite*
- *Soapware*
- *SRSoft*
- *SuccessEHS*
- *Touchworks*
- *and more*

We partner with you to ensure you receive relevant data without interruption to your workflow.

One benefit of managing hypertension with remote patient monitoring and chronic care management is getting the data you need to inform clinical decisions at the right time.

We have clinical staff that utilizes reporting of physiological data from your patient population to provide patient lists to your practice that may indicate that it's the right time for medication titration for that patient subset. Talk about managing care at scale.

Successful outcomes driven by virtual care management for hypertensive populations are possible. Choose a SaaS partner that prioritizes a ***true partnership*** for program success and cares just as much as you do.

Ready to see how TimeDoc Health can work for your practice?

Request a session with the TimeDoc Health team to discuss how implementation of a virtual care management program could work for your patients, staff and practice.

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