



The Healthcare Delivery Revolution: Leveraging Remote Care Management for Practice & Patient Success



The healthcare industry is long overdue for a care delivery revolution. From headlines such as “live free and die” to stark reports underscoring the two-year decline in the average American life expectancy, healthcare as it has traditionally been delivered is no longer working as it should.

Indeed, chronic diseases afflict an estimated **133 million Americans**, roughly equivalent to 40% of the entire population. According to the CDC, **90% of the nation’s more than four trillion dollar health care expenditure** is spent on individuals with chronic and mental health conditions. As the American population continues to age, and the incidence of these persistent conditions grows, chronic condition management will evolve into an unbearable clinical and financial burden for the nation as a whole. With Americans sicker than ever before, an entirely new approach to care is needed. While office visits

will always remain integral for maintaining physician-patient relationships and conducting in-depth annual evaluations, they can no longer remain a status quo as the only care touchpoint, especially for the chronically ill. Rather, technology that facilitates ongoing remote care management will empower a new paradigm of care, one that routinely monitors and manages patients with chronic conditions—to help dramatically improve both individual level health outcomes and, on a macro level, the quality of care nationwide.



By outlining the five steps to remote care program success, this paper explores how adaptive solutions can liberate healthcare from its traditional confines. Ideally, these technologies will offer a dual-enrollment program that offers both remote patient monitoring (RPM) and chronic care management (CCM) to seamlessly support whole-person care. Not only will this help equip practices with the technology needed, but it will also offer the services required to provide proactive care exactly when needed and escalate care for those patients who need it most.

Step 1: Don't Rock the Boat — Ensure the Program Complements Your Existing Workflows

The impact of poor clinical workflows extends far beyond a practice's walls. The stress, documentation burden, and burnout caused by inefficient workflows **has been highly documented**. Indeed, one pilot conducted at an academic medical center in San Francisco found that efficiently designed, streamlined workflows can result in a **45% reduction in physician burnout**. With so much at stake, it's no wonder why physicians are hesitant to disrupt their carefully calibrated workflows when considering remote care management programs.

With new remote care platforms, however, preserving workflow integrity—and streamlining operations—is easier than ever. The most effective remote patient monitoring and chronic care management solutions serve as an extension of your organization's footprint and mirror your current workflows. Rather than requiring time-consuming implementations that restrict capabilities and limit patient care, these ideal partners seamlessly leverage your practice's established processes to extend capacity and impact far beyond the office walls.

When assessing remote care management partners, it's critical to prioritize workflow fit. Find a partner that is capable and flexible enough to easily integrate with and adapt to both your EHR and your unique needs. Remember that the more experienced a

remote care management partner is, the more likely it is that they have encountered a practice like yours in the past, and therefore, the easier it will be for them to quickly adapt to your workflows. Ask directly about their experience working with a practice like yours and ask the partner to share examples of how they've adapted their approach to meet a practice's specific workflow needs.

Fact or Fiction?

Debunking Remote Care's Most Common Myths

-  **FICTION:** The implementation process is a foreboding investment of resources, and remote care management requires time-consuming configurations and workflows.
-  **FACT:** The right partner can integrate with every EHR and seamlessly adopt any practice's existing workflows.
-  **FICTION:** Patients are too old or too unwilling to learn new tech, or are unlikely to regularly use remote monitoring devices.
-  **FACT:** Enrollment and adoption among patients — especially those enrolled via a partner's outreach and onboarding services — is consistently high (nearly one-third of eligible populations enroll).
-  **FICTION:** RPM will place an additional burden on my clinicians with new workflows, and require them to learn new systems and technology.
-  **FACT:** The best RPM programs are fully managed by a trusted partner who actively triages all incoming patient alerts, escalating only the critical cases to physicians. Workflows are streamlined, and technology is invisible to clinicians working seamlessly in their EHR.
-  **FICTION:** Remote care management will require a large investment, and won't provide a clear ROI.
-  **FACT:** Effective programs provide additional, steady, recurring revenue for practices and health systems. Dual program enrollment also fulfills the requirements for multiple, reimbursable codes.



Step 2: Gain Momentum by Prioritizing Patient Onboarding & Adoption

The next step is to ensure eligible patients receive a straightforward onboarding experience. While at a glance this stage may seem easy, it is deceptively nuanced. Pitfalls abound: from lack of clarity in communicating the program overview, value, and benefits to incomplete enrollment requirements and initial care plan outlines. Unclear directives and unfinished tasks at this stage can result in low patient adoption, lack of care plan adherence, and eventual program abandonment. Partnering for the support of a thorough and thoughtful patient onboarding experience is critical for the long-term success of any remote care program.

With myriad factors at play, and the program's success hanging in the balance, hitting the right note with onboarding is key. Ideally, best practice onboarding includes two phases that run in tandem: in-office enrollment or program awareness during the visit, and telephonic enrollment follow-up afterward, where a trusted partner connects with patients to reiterate value, obtain consent, and share logistics. In-office discussion is a critical foundation for program success, as it demonstrates the trusted provider and practice staffs' buy-in and adoption, which builds legitimacy and sets the stage for successful program enrollment over the phone.

Organizations seeking guidance should identify an experienced remote care management partner that can offer a polished experience, refined from years of experience identifying, onboarding, and engaging new patients. These partners can seamlessly engage with your EHR to readily flag new patients who qualify, identify all relevant chronic care medical history and risk factors, and leverage the best way to reach out to an individual, through an introductory text, email, or a friendly phone call.

Boost enrollment rates with an experienced partner:

CoachCares's fully managed patient enrollment program saves practices valuable time and bandwidth, but also drives unparalleled success. The enrollment rate averages approximately 30% when MDR conducts telephonic enrollment on a practice partner's behalf.





Better Together: Dual-Enrollment RPM & CCM Programs Yield Double the Impact

Versatile remote care programs that pair robust remote patient monitoring (RPM) with chronic care management (CCM) go the extra mile in providing whole-person care. When leveraged together, these two solutions produce additional operational efficiencies and, through two distinct fee-for-service codes, increase revenue opportunities at scale.

- **HIGHER ROI:** Dual-program telephone services require an equivalent time allotment as single-program enrollment, thereby streamlining workloads while fulfilling requirements for multiple billable codes.
- **MORE CLINICAL IMPACT:** Most eligible patients qualify for both programs, meaning a more comprehensive solution to impact health and increase engagement.
- **BOOST ADOPTION:** Standardized RPM monitoring enhances the effectiveness of CCM for chronic patients, ensuring accurate and consistent vitals.
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- **ENHANCED VISIBILITY:** Together, RPM & CCM help automate the capture of relevant billing codes for services likely already being performed by your practice.
- **SPEED-TO-VALUE:** Dual-enrollment fast-tracks implementation programs, helping them ramp up and mature more quickly than single RPM or CCM programs.

Step 3: Foster Long-Term Engagement with Care Planning

In this next phase, the true promise of remote care begins to materialize: Extending access to high-quality care and empowering patients to take an active role in their own health journeys. There are three key ingredients to success here: Establishing baselines, creating personalized care plans, and providing ongoing medical supervision. These elements help ensure fluidity of care plans, that care provided can evolve intentionally as patient needs change, and that care managers have access to a task-based platform that allows them to customize activities, assessments, and screenings.

As an extension of your practice, your remote care partner should be able to leverage the secure EHR integration to extract diagnoses, identify metrics and health goals, establish a care plan with recurring touchpoints to support adherence, ensure vitals collection, and maintain progress. These highly patient-centric care plans should be initially created based on a set of criteria, including medical history, gaps in care, predictive risk scores, and physician-established goals. Over time, as the program collects data and interacts with your patients, new information should help refine the recommendations. This should include data related to completed tasks, level of engagement and social and emotional cues, logged vitals, medication changes, personal goals, and changing risk factors.

Extending access to trusted forms of care is a core promise of remote care—and an essential one. In a recent poll that surveyed patient sentiment on the U.S. healthcare system, nearly eight in ten Americans reported feeling at least moderately concerned about their ability to access quality care when they need it most.



This level of personalized support makes it easy to fine-tune patient recommendations, offer regular health tips and support, and follow-up with patients to ensure they are continuing to log vitals and follow their care plans. It helps create lasting engagement with patients, as they're now empowered daily to be active participants within their own health journey.

While it may be remote, it is highly personalized. To ensure your remote care program can build comprehensive and engaging care plans around each patient, look for these capabilities:

- Ability to create interdisciplinary and evolving patient-centric care plans
- Capacity to support customized patient assessments for risk, baseline, SDOH, and more
- Ability to maintain care task management queues
- Robust patient outreach tools, including communication preferences
- Ability to ingest and combine health plan, physician, and personal goal setting

Step 4: Champion Better Outcomes through Health Coaches

To help extend the reach and impact of these remote care programs, the highest quality remote care partners layer in health coaching next. These advocates, educators, and influencers promote goals, inspire adherence, and as a result, help improve outcomes.

As it turns out, the impact of health coaches extends far beyond the intangible emotional and motivational benefits. A recent **study** showed that health coaches resulted in notable improvements across key indicators, such as systolic and diastolic blood pressure, total cholesterol, fasting glucose, body weight, and body mass index.

As the healthcare delivery landscape continues to shift, a new emphasis on preventative care and whole person health is rapidly emerging.

But when patients are asked to schedule check-ups only once or a handful of times a year, it is difficult—nearly impossible—for physicians to keep tabs on their vital baselines, condition management adherence, routines and personal habits, and overall health. With limited visibility, physicians sometimes struggle to build relationships that prioritize whole person health.

Not so with a dedicated remote patient monitoring and chronic care management program augmented with health coaches. These clinically informed partners work directly with patients to identify and align on personalized health goals that build healthier habits. With ongoing support, recurring touch bases, ready availability for patient questions, personal health tracking, and integration with secure, connected devices that transmit vitals, record exercise sessions and nutrition habits, health coaches help extend the impact of remote care by maintaining participation and collecting the information that helps build optimal health for the long-term.



Unique Healthcare Organizations Need an Experienced Partner with Program Adaptability

For rural health clinics, community health centers, federally qualified health centers and even critical access hospitals, population health program qualifications, care reimbursements, and billable codes are regularly shifting. For teams with limited bandwidth, adjusting practice operations to keep a breast of regulatory changes and maximize reimbursements for financial success is a challenge. When selecting a remote care partner, these organizations should seek solutions with unique experience related to these challenges. The partner should also offer proforma goal sharing, the flexibility to adapt the practice's goals as their own, and knowledge regarding how to navigate regulatory challenges and pursue the dual-enrollment reimbursement streams that best support clinical and financial success.

- **EXTEND CARE MANAGEMENT PROGRAM CAPABILITY:** With CCM capabilities, remote care partners can help FQHCs and CHCs extend their preventative care services on a larger scale, reaching more individuals, while saving time and money.
- **LEVERAGE REIMBURSEMENT KNOW-HOW:** As a cohesive program that supports preventative care delivery for hard-to-reach populations, RPM + CCM can fulfill CMS' Care Management reimbursement model. An audit-tested, experienced partner can unlock diversified revenue streams, mitigate risk, and extend a complete care management program to their dispersed, chronically ill patient population.
- **ENSURE COMPLIANCE THROUGH CHANGE:** Unique healthcare organizations with special financial concerns need experienced partners who can help them stay atop of compliance changes for billing. For instance, as CMS does not recognize RPM claims, to document care provided, these services

must be baked into Care Management codes. Seasoned partners help guarantee compliance throughout program management, ensuring that grant money used for devices is being responsibly spent, help document inventory management, and monitor overall clinical performance to maintain federal funding.

Step 5: Unlock ROI with a Dual RPM and CCM Program

Lastly, as patient outcomes begin to improve, so too will practices' financial outlooks. As noted, the most opportunity to optimize reimbursement lies in dual-pronged RPM and CCM programs. With a combined approach, healthcare organizations can experience a mirrored dual value story: improved outcomes and enhanced reimbursements.

On average, physician groups, FQHCs, RHCs, and other organizations who leverage these programs realize a higher ROI of their initial investment. The best remote care management partners will ensure goals are aligned to support clear progress, expectations, and shared success. From reducing the amount of chronic care management emergencies and improving weight, blood pressure, cholesterol and other markers, the programs can also unlock access to new revenue streams to augment your practice's finances related to traditional patient visits.

The most robust remote care partners are well-versed in the rules, regulations, and reimbursement qualifications for organizations of all shapes and sizes, and can help design specific strategies that yield the greatest financial impact. For many, comprehensive RPM and CCM programs ensure that practices are able to earn revenue for services that, in most cases, they have already been providing. For others, these partners are able to significantly streamline billing and claims cycles by fully managing coding across the various insurers, covered costs, patient copays, and fluctuating deductibles.



Join in the Patient Care Revolution

As the healthcare industry approaches this critical inflection point, the imperative is clear: a revolution in care delivery cannot wait. Proven, adaptable, and comprehensive remote care management solutions that emphasize healthier habits, establish routine check-ins, and activate individuals as participants within their own care journeys will lead the way.

As remote care continues to transform the paradigm of care in America today, ensure your organization is ready to meet the industry's new expectations. These programs are fully invested in patient success and promote better outcomes for longer, healthier, more active lives. Similarly, fully managed vitals and patient monitoring support ensure that your care teams are alerted only when intervention is medically necessary, so that the impossible is achieved: practices can extend preventative care, while limited clinical bandwidth is preserved. With fully integrated remote care management workflows, physician groups, independent practices, FQHCs, RHCs, and other healthcare stakeholders can transform their workflows, patient and provider experiences, and access a future that is a whole lot healthier — for practitioners, patients, and practice operations alike.

CoachCare delivers the solutions and platforms to practices that want to improve operational efficiencies and increase revenue opportunities at scale. CoachCare's Care Management platform RevUp is a service-model software that integrates with EHRs to support the management of remote patients for practices and health systems with their own dedicated care teams. CoachCare further supports virtual care initiatives with RevUp programs, which cover patient services that include care managers, clinicians, and communication provided by RevUp.

Interested in learning how RevUp can help your practice? **Contact us here.**