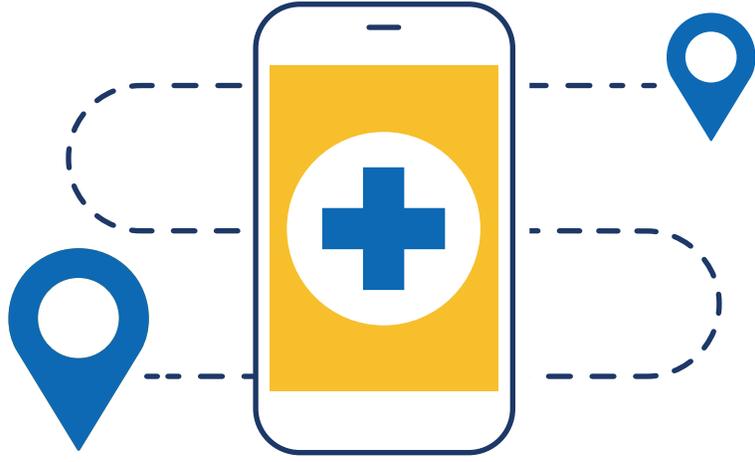




UNLOCKING THE POTENTIAL OF RPM

Keys to Building a Successful Remote Patient Monitoring Program

Seven building blocks that deliver the best results while saving
time, money, and effort.



THE VIVID SUMMARY

“Organizational readiness is key for any RPM program and is established by high-level engagement from executive leadership, the HIS team, and clinical stakeholders to help drive processes and workflows and achieve strong patient outcomes and financial goals. Choosing the right vendor is paramount to your success.”

- **Kim Johnson, DNP, Director of Clinical Consultants, Vivify Health** (part of Optum)



For the past 15 years, virtual health has been heralded as the next disruptor, a game-changer in connected care delivery. The COVID-19 pandemic demonstrated its clinical and cost-effectiveness, pushing against structural barriers that had previously slowed health system investments in integrated virtual health applications.



Regulatory changes and federal benefits have further encouraged hospitals and health systems to adapt and expand to a new care delivery model. In doing so, healthcare organizations quickly realized that deploying a Remote Patient Monitoring (RPM) platform can boost organizational efficiency, ensure compliance, reduce unnecessary ED visits, and improve care quality.

For the best RPM outcomes, however, healthcare organizations must do more than purchase technology. They need to plan out their RPM solution to ensure that they achieve all the quality benefits and receive their due reimbursement. Selecting the right vendor is critical to the organization's success. It is more than a vendor/client relationship—it is a partnership that can grow with the organization, continually helping it refine processes and best practices to meet strategic goals.



This white paper will provide you with all the relevant information and key insights on the best RPM practices that every provider or health system must consider when launching (or re-launching) an RPM program.





The RPM Revolution

While they are often viewed as recent developments, RPM and telehealth technology have been used in healthcare in one form or another [for decades](#). Some of the first documented uses as we think of them occurred in the early 1960s. Back then [Veterans Administration \(VA\) physicians](#) used television sets to communicate with patients in a rudimentary form of telehealth and the National Aeronautical and Space Administration (NASA) [used an early form of RPM](#) to monitor the health of astronauts in space.

Still, despite these successful use cases, as well as the widespread availability of broadband Internet and tremendous advances in medical monitoring technology, telehealth and RPM remained grossly underutilized for the next half-century. There are several reasons for this lack of interest.

One of the most important reasons is that there was very little interest in the technology or buy-in from healthcare providers. They had been immersed since medical school in a culture that valued one-to-one, face-to-face encounters and saw little reason to deviate from this approach. That model also viewed episodes of care, especially in a hospital setting, as individual encounters rather than stops along a continuum of care.

Another critical factor was that there was almost no financial incentive due to the fee-for-service (FFS) reimbursement model almost universally used by the Centers for Medicare and Medicaid Services (CMS) and commercial health plans. FFS rewards providers for delivering more care, whether in the office, the hospital, the emergency department (ED) or other care sites. The promise of RPM in particular to reduce the number of unplanned hospital admissions or ED visits required was antithetical to providers' financial interests. Even when CMS took the lead in creating incentive programs and 30- and 90-day penalties for unplanned readmissions and ED visits, the aggregate difference was insufficient to move the needle on telehealth and RPM.

Adding to the financial disincentive was the reality that CMS and commercial health plans had minimal mechanisms in place to pay for the delivery of telehealth or RPM. Providers that implemented these solutions paid for much of them out of their own already narrow margins.

Even if they wanted to implement telehealth and RPM, there were other obstacles –not the least of which was a lack of Bluetooth-enabled, FDA-approved devices to send home with patients. Additionally, the all-important content that informs and educates patients about lifestyle changes to help them avoid readmissions and ED visits was neither dynamic nor engaging, significantly limiting its use in an RPM program.

Then came the COVID-19 global pandemic. Almost overnight, every available bed in the hospital, especially in the intensive care unit (ICU) at many hospitals, was needed for COVID-19 patients. Hospitals went on lockdown, and in an effort to limit the exposure of patients and frontline healthcare workers, patients were encouraged not to come to the ED unless the need was urgent. Most hospitals stopped performing so-called elective surgeries, and even physician offices were limiting patient hours and implementing new safety protocols that severely reduced the number of patients who could be seen in a day.

That does not mean patients stopped needing care for conditions other than COVID-19, particularly chronic conditions such as CHF, COPD, and diabetes. It just meant they could no longer easily go to the physician's office, ED, or hospital to receive it.

Faced with an untenable situation, healthcare organizations in all care settings began looking into and experimenting with telehealth and RPM.

For some, that meant implementing formal programs. Others adopted whatever tools could be enabled quickly, such as Zoom calls to replace face-to-face meetings to help them maintain contact with patients with ongoing needs.

In many cases, there was not much planning involved. Desperate times call for desperate measures, and these were unquestionably desperate times. These organizations, however, did the best they could, aided by CMS and commercial health plans that recognized the need and [changed their reimbursement rules](#) to encompass more telehealth and RPM services. In fact, CMS has made it highly favorable in the [2021 physician fee schedule](#).

The result was that telehealth and RPM now had a big, important stage on which to prove themselves, and they did so admirably. Providers and health plans saw the value, and providers, in particular, recognized that they could successfully work with as many patients (or more) than they did before without requiring an in-person visit while maintaining the same level of quality. As a result, even as the COVID-19-related surge abated, and offices and bed space opened, many healthcare organizations have continued to pursue and even expand the programs they launched during the pandemic.

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At the same time, many now also better understand that while telehealth and RPM are often lumped together as a single category, they are two different types of solutions.

The RPM Realization

Telehealth, in the strict definition of the word, is a one-to-one solution. It is essentially an office visit without either party leaving their location. The physician and patient meet synchronously with voice or voice+video calls. These calls are mostly for scheduled check-ins or acute issues.

Remote Patient Monitoring, on the other hand, is a one-to-many technology, i.e., one clinician can monitor the health of multiple patients at the same time. This monitoring can occur continuously, through daily snapshots, or through some other frequency. It is completely asynchronous; while data uploads and engagement strategies may be scheduled regularly, they occur independently of the provider's activities.

In 2021, RPM is primarily used to manage chronic conditions. It can be and is used, however, in many other situations, such as pre- and post-surgeries, high-risk pregnancies in women with gestational hypertension and gestational DM, behavioral health programs, weight management programs, and medication management programs.

One of the attractions of RPM is its ability to manage large populations utilizing exception management. While data is collected from all patients within a population, the technology parses it and enables the sickest to bubble to the top. When RPM patients cross a pre-determined threshold, an alert generates automatically and sends to a clinician for evaluation and possible remediation.

While they have different functions, both telehealth and RPM are valuable components of an overall digital health strategy. As such, they are often used together to drive better health outcomes for hospitals and health systems, primary and specialty care provider offices, Hospital at Home® programs, accountable care organizations (ACOs), home health agencies, hospice, and other care organizations.

Best results are attained, however, when telehealth and RPM are optimized. Herein lies the challenge for many healthcare organizations that jumped into them during the pandemic.

While data is collected from all patients within a population, the technology parses it and enables the sickest to bubble to the top.



The Critical Importance of Executive Sponsorship

Before beginning any program of this magnitude, best practices and more than 10 years of experience dictate the need to secure engaged executive sponsorship. Anyone who has ever been involved in making a fundamental change in operations at an organization, especially a healthcare organization, can attest to this requirement.

Change often comes with great difficulty, and resistance to new ideas or methodologies can come from many quarters. A review of the [history of EHRs](#) demonstrates what can happen when technology is forced into an organization without sufficient executive sponsorship or consideration for how it will affect existing protocols and workflows.

A strong, engaged executive sponsor can encourage, promote, and (where needed) cajole and apply pressure to ensure solutions are adopted and followed. Part taskmaster and part cheerleader, they send a message that the organization is serious about implementing the solution and seeing it used.

A physician sponsor can help shortcut the adoption among physicians by speaking peer-to-peer. This type of sponsor also understands the challenges and can be invaluable during the planning process to ensure minimal disruptions to current workflows.

The bottom line is that organizations must enlist an executive sponsor from the beginning if an RPM program is to achieve widespread adoption and use. With interoperability being critical to the success of any program, HIS executive leadership must be engaged as well.

The RPM Re-Set

Providers who adopted RPM programs in 2020 generally fell into two categories. Some seized on the opportunity to roll out a full program, while others only implemented trial programs to determine if the solution would hold value for them.

Now that the crisis has mostly passed, organizations in both camps realize that their solutions may not be all they can be. Perhaps they did not understand at the time what launching an RPM and telehealth solution would entail, or they did not fully comprehend what types of people, processes, and products/technology they would need to ensure an effective program.

The current state gives them an opportunity to perform a re-set. To do that, however, they recognize they must do more than purchase technology. What they are looking for today is guidance on how to do it better and how to plan out their RPM solution to ensure they are achieving all the quality benefits they desire and receiving all the reimbursement they are due. Selecting the right vendor who can grow into a true partner, helping develop best practices and strategic direction, is critical to your success.

That is the purpose of this white paper. In the following pages, we will describe the building blocks to consider when launching (or relaunching) an RPM program that achieves the healthcare organization's stated goals.

Selecting the right vendor who can grow into a true partner, helping develop best practices and strategic direction, is critical to your success.



The RPM Foundation

The following building blocks of an RPM program are presented in starting order. While some may occur concurrently, following these steps in this manner is key to achieving the greatest level of success with the least amount of wasted time, money, and effort.

Building Block #1: Know what you are trying to achieve

Before jumping into the technology, it is important for healthcare organizations to understand what problems they are trying to solve—and what metrics will indicate success.

Do they want to:

- Improve patient health related to specific conditions?
- Reduce preventable hospital readmissions and ED visits?
- Reduce predicted days in the hospital for a specific population?
- Reduce unscheduled nurse visits for a home health agency?
- Reduce the cost of care, either overall or for specific populations?
- Improve quality scores (HCAHPS/STAR)?
- Improve patient satisfaction with their healthcare experience?
- Improve clinical satisfaction and avoid nurse and physician burnout?

The issues addressed should be related to the healthcare organization's larger goals and mission. Without this information, the organization and the program's participants will not know where they are going or why they are doing what they are doing. This is a recipe for failure.

When determining these goals, it is also important to keep organizational limitations in mind. For example, if care management is required and the organization does not have care coordinators or does not have as many as required for this instance, the RPM program is likely to fail.

Infrastructure can also be a limitation, so it is important to ensure that the current systems are prepared to handle the sudden tsunami of data the RPM program will unleash. This evaluation is not limited to hardware and software, incidentally. The organization must have IT stakeholders engaged in the RPM program and have systems that enable data from the RPM solution to be easily integrated into other systems. The people portion of the infrastructure also must be constructed in a way that enables care coordinators (i.e., nurses) to work at the top of their licenses while serving multiple patients.

When considering the purpose behind an RPM program, the internal champions must recognize that a single implementation will not solve every issue. Instead, they should focus on areas of specific need, establish metrics, and use reporting and dashboards to ensure the organization is improving the areas originally set forth in the goals.

Building Block #2: Use a multi-tenant portal to select the right location(s)

Many healthcare organizations interested in RPM, especially in these M&A-driven times, have multiple locations. While it may be tempting to address every member of a population (such as patients with diabetes) at one time, best practices and more than 10 years of experience show it is best to start small and then build out the program from there.

The initial RPM program might be limited to a single physical location, or a particular specialty/department, or some other designation. When deciding, stakeholders should look for a location or group within the organization known for willingness to change, active participation, and openness to new solutions.

When evaluating the data and running simulations, decision-makers should also look for a location where even a small improvement can have a measurably significant impact that supports organizational goals. Getting permission and funding for a larger implementation is easier when the first attempt offers results that satisfy the Board.

Then there is the question of which patients within a population should first be engaged.

Building Block #3: Select the right populations

It is important to recognize that RPM is not the be-all and end-all solution for everyone with any condition. While it can make a significant difference for some populations, or some subset within a population, it may make little difference for others.

To ensure initial success, decision-makers will want to use their own and historical data to determine which populations will have the greatest impact on achieving the organization's goals, and then focus first on them. For example, if lowering preventable readmissions is an organizational goal, stakeholders should use analytics to find the populations with the highest risk of readmission.

Determine which population(s) will have the greatest impact on achieving the organization's goals, and then focus first on them.

Fortunately, many EHRs have embedded risk-scoring tools for this purpose. Other data that can determine risk include claims data in hospitals and Strategic Healthcare Programs (SHP) for claims data in home health agencies.

The key is to look for populations in which the RPM program can achieve quick, meaningful wins to help promote the program and "sell" it to others within the organization. Organizations should make sure they do it right from the start.



Case Study: Deaconess Re-Starts RPM Program by Re-evaluating Participants

Deaconess Health System, an Evansville, Indiana-based organization that includes 11 hospitals with 900+ beds, 96 locations, its own ACO, and a large 538-provider multispecialty group serving patients in 26 mostly rural counties in Southwestern Indiana, Southeastern Illinois, and Western Kentucky, was an early adopter of RPM. The health system launched its first RPM program in 2010, but by 2018 the legacy program rarely was used because it had not produced the expected results.

Yet, Chief Transformation Officer Amanda Bohleber, MD, and Telehealth Clinical Manager, Allison Flowers, RN, believed the problem was not with RPM itself but rather in the program's design. Instead of carefully determining whether the patients enrolling could be helped by RPM, Deaconess had previously enrolled everyone with conditions such as CHF and COPD.

Using Epic's risk scoring tools, Dr. Bohleber and Flowers revamped the program only to include those with risk scores above 20% and replaced the legacy RPM system with the Vivify +Home solution. Within the first year after the go-live, the 30-day readmission rate for the RPM population was cut in half from 14% to 6.93%.

In addition, the RPM program has resulted in \$500,000 in avoided readmission penalties and a total cost of care savings of \$6.5 million.

When the pandemic struck, Deaconess added Vivify +Go to help monitor patients suspected of having COVID-19 but not considered sick enough to admit to the hospital. The Vivify +Go platform allows the patient to use their own smart phone (iOS/Android) to self-monitor, utilizing Bluetooth devices to capture vital signs. Additionally, providers can easily push important videos and other resources to their patients. This quick pivot kept hospital beds available for those who truly needed them while keeping those who did not have the virus from potentially being exposed to it through a hospital stay.

Building Block #4: Match the available technology to the patients who will use it

The next step is selecting the appropriate technology that the patients will use. Once the target population is chosen, it is time to look deeper into who makes up that population.

Start by identifying the at-risk, rising risk, and high-risk patients within that population. Then develop general profiles or personas for those patients. Areas to consider include:

- Age
- General health (outside of the condition putting them in the RPM program)
- Conditions creating the need for participation in RPM (including co-morbidities)
- Comfort with technology
- Mobility (i.e., likelihood/frequency of leaving the patient's primary home location)

Once these characteristics are understood, the organization can select which technology options, i.e., a self-contained turnkey kit with 4G enabled, or a mobile alternative that allows the patient to use their own smartphone, best fit the populations they are targeting.

Self-Contained Kits

Self-contained kits with tablets are generally best for populations that primarily stay in one location, such as aging populations that are confined to their homes or will be in a long-term care facility for the duration of the RPM program. They are also suitable for those with multiple co-morbidities since everything needed will be included in the kit.

Well-designed health kits for aging populations will have larger buttons to work around problems with vision or trembling hands. They will also include the ability to hear the program content and see it to improve comprehension of the materials, which is critical to driving behavioral changes.

Since these populations are often not very tech-savvy, a well-designed health kit will have the ability to walk patients through the data-reporting process each day.

Mobile technologies

This option is generally the preferred choice of patients who have their own iOS or Android smartphones and are comfortable using apps on those devices. These patients will also tend to be away from home more often, so they need to upload data from wherever they happen to be at the moment.

They often will prefer to use their own FDA-approved, Bluetooth-enabled monitoring devices, particularly if they plan to continue measuring their health once they have matriculated out of the formal RPM program. Additionally, candidates for a mobile option generally have full possession of their mental faculties and at minimum, enough physical strength and dexterity to operate their own devices.

Because the patients are supplying their own devices (smartphones), a mobile RPM can scale rapidly to address larger populations. In fact, during the COVID-19 pandemic, mobile RPM programs were often used to monitor patients diagnosed with the virus but whose symptoms were not virulent enough to warrant admitting them to the hospital. This type of rapid reaction and scaling makes mobile RPM an important addition to future pandemic playbooks.

Not mutually exclusive

At this juncture, it is important to note that the decision to use self-contained health kits or mobile technologies does not have to be either/or. Providers can use a combination of both if their target population has mixed needs. Another strategy is to use self-contained health kits for patients who start out needing a lot of care but then can be stepped down to a mobile device as their conditions improve. The reverse can also occur.

Because the patients are supplying their own devices (smartphones), a mobile RPM can scale up rapidly to address larger populations.



The critical factor is that the solution selected must have the flexibility and scalability to incorporate both options in a single, comprehensive instance.

Building Block #5: Establish the logistics for self-contained kits

Working with self-contained health kits does add other elements to consider: the logistics of getting those kits to and from patients along with the work required to connect those kits to the clinicians who will be monitoring them.

Often this burden falls on already overworked nurses. While that approach may suffice in an RPM program where there are only a dozen or so kits to manage, it severely limits the ability of the organization to quickly scale the program as it proves successful.

A better approach is to assign a single kit logistics administrator and then have that person work with a vendor with an end-to-end logistics model built into their platform. Following this path shifts the burden of getting kits to and from patient homes (and setting them up) from the organization's nurses to professionals at the vendor organization who focus on these operations all day, every day.

There are several advantages to this approach, not the least of which is freeing nurses and other clinicians to work at the top of their licenses while managing hundreds of patients at a time. Another is that with the vendor managing the inventory, there is no need to find a secure area to store kits until they are deployed.

An experienced vendor logistics program will ship kits directly to patients, usually the same day or within two business days of order to ensure monitoring begins immediately. Another important feature to consider is making sure the vendor has the logistics services built-in to their platform, so the care team is only working out of one portal. When the patient completes the RPM program, the vendor will also pick up the kits and clean and sanitize all components before returning them to inventory.

Of particular value to larger RPM programs is the vendor's ability to produce instant reports showing the status of every kit in the program. These reports help ensure providers always have the right level of kit availability for their current needs.

They also enable healthcare organizations to examine patterns of use and look for opportunities to expand the program, which will be covered more extensively under Building Block #7.

The bottom line here is that the amount of work required to manage the logistics of an RPM program that services more than a handful of patients can overwhelm the best of intentions. When vetting RPM vendor options, healthcare organizations should examine this aspect thoroughly to ensure the vendor's logistics management mechanisms are yielding high levels of patient satisfaction.

Building Block #6: Integration with EHRs

One of the most common barriers to provider adoption of digital health technology, as evidenced by this [2019 study](#) of existing literature on the topic, is a [lack of integration with clinical workflows](#). As a result, one of the keys to success for any RPM program is that it should be easy for physicians to order within their normal workflows. Since the EHR is the digital heart of healthcare today, tightly integrating the RPM program with the EHR ensures it is always available as an option and easy to execute.

This same tight integration also applies to the data coming back from the patient. While nurses will likely use the RPM technology's software to monitor the data of hundreds of patients at a time and the software's ability to identify and prioritize any patients in need of an intervention, the data should not stop there. It should also easily flow into the EHR, so it is available to clinicians when they are in direct contact with patients, either in-person or through a telehealth encounter.

The result is that clinicians who work with patients in an RPM program daily will be able to move easily back and forth between that application and the EHR as needed while continuing to work within their normal workflows.

While this is important for clinical effectiveness, experience shows that this capability is also critical for driving adoption among clinicians, especially among physicians.



Building Block #7: Extensive, ongoing training and documentation

During the sales process, most technology vendors will tout the extensive training they provide as a reason to purchase their solution. Yet, for many vendors, training is a one-time event that occurs shortly before go-live. For a complex solution such as RPM, which has many moving parts, this limited exposure may be enough to get the program operational. But it will not place it on the fast track to maximize results.

When considering which vendor to select, providers should look for RPM solutions that offer continuous training options in a variety of formats, including live training, online self-study, refresher training, and upgrade training. The training itself should incorporate all [six perceptual modalities of learning](#): visual, aural, print, tactile, interactive and kinesthetic to ensure the staff members who will be using the RPM solution learn in the way best suited to them and will engage them most effectively.

One of the most critical contributions a vendor can make to the overall success of the training program is to assign a clinical consultant to manage the needs of the customer. This is normally a nurse who understands the nuances of the RPM solution and the environment in which it will be used. The clinical consultant will interact with the organization in a variety of ways.

A clinical consultant will be engaged early on, even during the sales process. This person regularly meets with the clinical stakeholders to help get the clinical team operationally ready for a successful implementation. The clinical consultant will be onsite during go-live and for a week or more. This is a critical point in the introduction of any technology-driven program because a stumble or delay here can set the program back years in the eyes of the stakeholders. While COVID-19 restrictions on who could enter the hospital necessitated a move to online support, it is expected that clinical consultants will return to in-person support during go-lives as soon as it is safe to do so.

The training delivered by clinical consultants should not end with the go-live, however. Inevitably, some clinicians will not be able to participate in the initial training sessions, so clinical consultants will be responsible for ensuring they are brought up to speed, either through group or one-to-one sessions.

“We had a clinical consultant from Vivify here onsite prior to the go-live to oversee the implementation and deliver training to our staff. She was here for two or three days, and after she left, she checked in frequently to ensure everything was going well. She was very connected to the process and continued to help us build out the program as we expanded it.”



Allison Flowers, RN
Telehealth Clinical Manager
at Deaconess Health

Additionally, healthcare is a dynamic environment with personnel constantly in motion. Nurses change jobs, or departments, or roles all the time, which means new team members will need to be trained as they come on board. Rather than burdening their peers or supervisors with this task, the clinical consultant can quickly ensure they are fluent in the solution.

By delivering this continuous training, the healthcare organization can ensure that no matter who monitors the patients, they will achieve high-quality outcomes in line with program goals.

Once the RPM program is operational, clinical consultants (under normal circumstances) will return to the site for meetings with clinical stakeholders to share data, executive summaries and insights about the current program, and help plan for future expansion. The clinical consultant will also return regularly to deliver training on new features and functionality, share updates and best practices assembled from other providers, and gather input about how the RPM program works so any needed improvements can be developed and incorporated.

The clinical consultant will be instrumental when new pathways need to be developed or current content needs to be updated or edited. Having an assigned clinical consultant who can deliver new pathways will enable the healthcare organization to react quickly to changing needs (such as the sudden onset of a global pandemic) without the delays that are normally experienced when involving a developer.

Another function of the clinical consultant is to review the entire RPM program to ensure it is operationally sound and running smoothly. For example, the clinical consultant will look at the utilization data within the current deployments to determine where improvements can be made and ensure self-contained kits are not sitting on the shelf, rather than helping patients—which is particularly critical when the inventory is not readily visible to clinicians because it is being managed off-site. The ability to readily see this data on a logistics usage report is extremely useful.

If all patients who fit the criteria for the RPM program are being serviced properly and there is still inventory available, the clinical consultant will look for and suggest opportunities to use that inventory to roll out new programs. Some options include:

- Home health
- Hospice and palliative care
- Hospital at Home
- Pre- and post-operative surgeries
- High-risk pregnancies (gestational hypertension and DM)
- Behavioral health programs

As part of the data analysis, the clinical consultant will also look for patients who have been sitting at the same status too long and bring it to the attention of clinicians to take appropriate action.

One additional responsibility the clinical consultant can take on is ensuring all the care the organization is delivering through the RPM program is being properly documented. As mentioned previously, CMS and commercial health plans only recently started paying for telehealth and RPM implementation and ongoing care delivery. As a result, staff members may not understand the correct CPT codes to use for the various care delivery mechanisms, which can lead to denials and delays in reimbursement.

Adding to the complexity, the codes and rules are in constant flux. What may have been correct and appropriate three months ago may no longer be so. Since reimbursement is tied directly to proper coding, it is crucial for clinicians and coders to get it right from the start.

A clinical consultant will help train the entire staff on how and when to capture the right data points to ensure the healthcare provider receives all the reimbursement it is due for the care being delivered while avoiding mistakes and over-billing that can sour relationships between health plans and providers and severely impact cash flow.

It's imperative that the vendor you are partnering with implements an annual Net Promoter Score. This helps the RPM vendor to continually meet or exceed your needs and goals. Ideally, the RPM vendor's strategic account manager will also conduct customer satisfaction surveys with your executive leadership team.



The RPM Resolution

Telehealth and RPM have the potential to positively impact the quality of care and patient satisfaction with that care while reducing its cost. It is, in many ways, one of the most important gateways to achieving true value-based care.

The COVID-19 pandemic demonstrated RPM's clinical and cost-effectiveness in ways that otherwise might have taken many years and made believers out of many of the skeptics. It also showed that telehealth and RPM should not be viewed as outliers or "nice to have" additions but rather should be incorporated as core elements of providers' overall care programs.

While these are all positives, this surge in acceptance can lead healthcare organizations to rush into telehealth and RPM without the proper motivation and preparation. By following the seven building blocks outlined here, healthcare organizations of all sizes throughout the U.S. can begin to incorporate or expand their telehealth and RPM programs in a way that will lead to early successes and a sustainable approach for the long haul.

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