

**AnewCare Collaborative ACO** is excited to announce a **new Remote Patient Monitoring (RPM)** program for high opportunity ACO beneficiaries with a variety of chronic conditions including **diabetes**, **hypertension**, **CHF**, **and COPD**. RPM provides clinicians with the tools necessary to monitor patients' biometrics more closely and ensure high quality disease management after a health event such as a hospitalization or disease exacerbation.

## How it Works

Patients will be enrolled through three pathways: provider referral, care manager referral, or at discharge from a facility.

Once enrolled patients will receive **biometric devices** that monitor blood pressure, weight, heart rate, and blood oxygen levels as needed. This biometric data is automatically uploaded to and monitored by **AnewCare's Care**Management Team. Our Care Managers will communicate with patients and their providers and care teams (including additional partner organization's care management teams) to ensure appropriate disease management behaviors are followed and adverse events are caught prior to resulting in a hospital admission.



Our RPM program will alert clinicians to potential **changes in a patient's condition** and help teach appropriate **self-management practices**. Clinicians will receive real time communications only when necessary and can be confident that all biometric data are being closely followed by our Care Managers.





## Program Features and Patient Benefits



**Vital sign and symptom monitoring** to promote early intervention and insight into a patient's condition, prior to exacerbation



**Educational videos and teach-back quizzes** educate patients about their conditions and how to avoid exacerbations



Improve quality, reduce total cost of care by preventing costly hospitalizations and help patients recover at home



**Medication reminders** to help patients track their medication and stick to their care plan

