UnityPoint Health

Making Virtual Care Accessible & Scalable

Market Trends & Case Study Review

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Today's Agenda

- **Assess the Virtual Care Market**
  - What macro trends, including incentives and regulatory shifts, are imminent?
  - How do population health, telehealth, and remote monitoring align?
  - Where does the patient fit?

- **Define a New Remote Monitoring Category**

- **Examine the UnityPoint Health Case Study**
  - Focus on scalability
  - Feedback from clinical and support staff
  - Quantitative outcomes & lessons learned

UnityPoint Health

INNOVATION

UPH Innovation **connects clinical and operational leaders** throughout the health system with industry entrepreneurs to **test and scale solutions** that lower healthcare costs, improve the quality of care and **positively impact** population health initiatives.

Where Challenge Meets Opportunity

Healthcare Challenges

- Chronic Disease
- Pay For Outcomes
- Consumerism
- Geo-Agnostic Care

Healthcare Opportunities

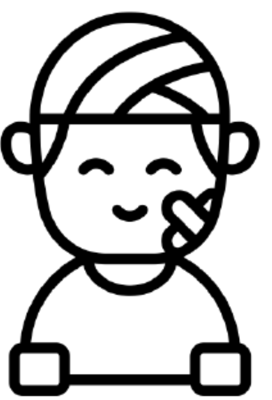
- Shared Decision Making
- Personalized Medicine
- Price Transparency
- Digital Front Door
- Digital Care
- Value-Based Care
- Virtual Care
- Remote Patient Monitoring

Our goal is to revolutionize care delivery and experience

Trend 1: Expanded Risk Arrives for Medicare

More risk opportunity for FFS

Expansion to MCOs & more



Beneficiary empowerment

Reduced provider burden

Trend 2: Refined RPM Requirements from CMS

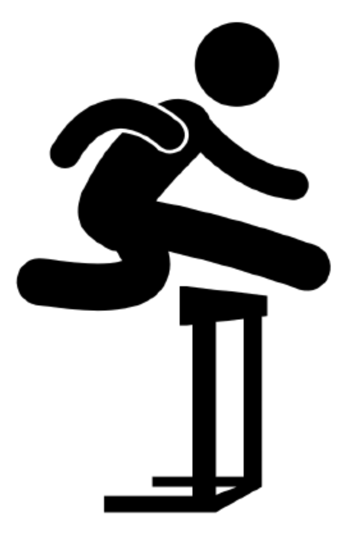
There must be a patient-physician relationship for RPM, post-COVID

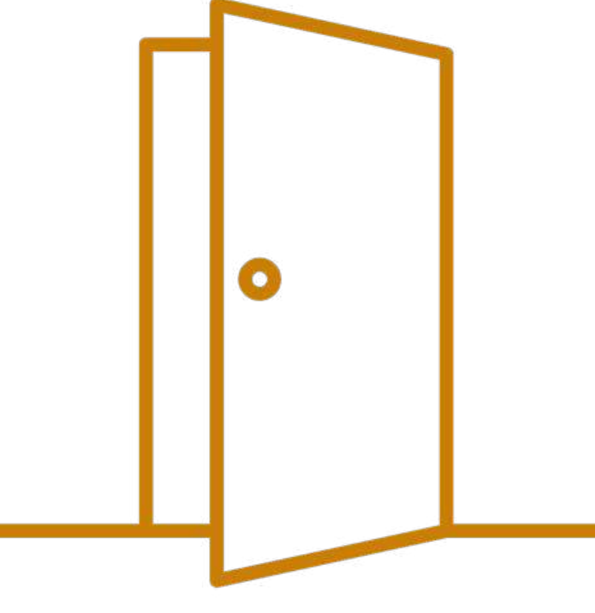
Only explicit physiological monitoring with FDA devices permitted

Only E&M-eligible physicians and NPPs; ≥16 days/month of data

CareSignal™

Trend 3: A Digital Front Door… for Some Patients





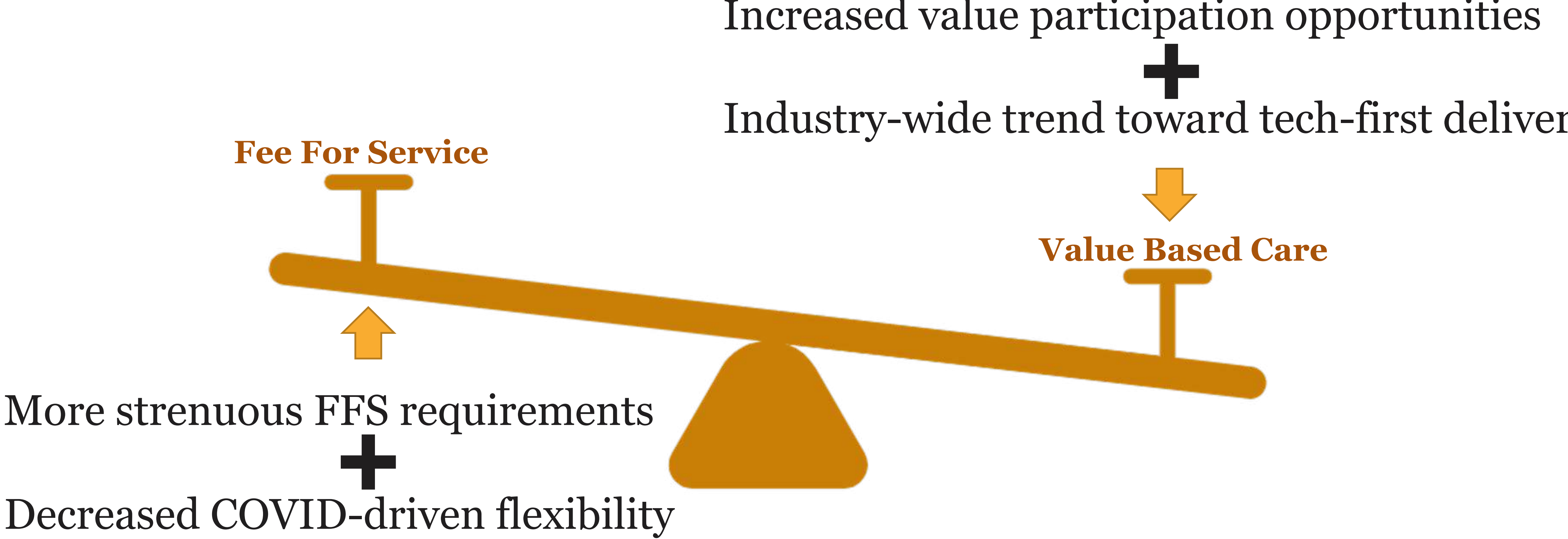
Resource awareness and sufficient health literacy

Necessary **technology familiarity** and accessibility

Positive first experience with functional, accessible product

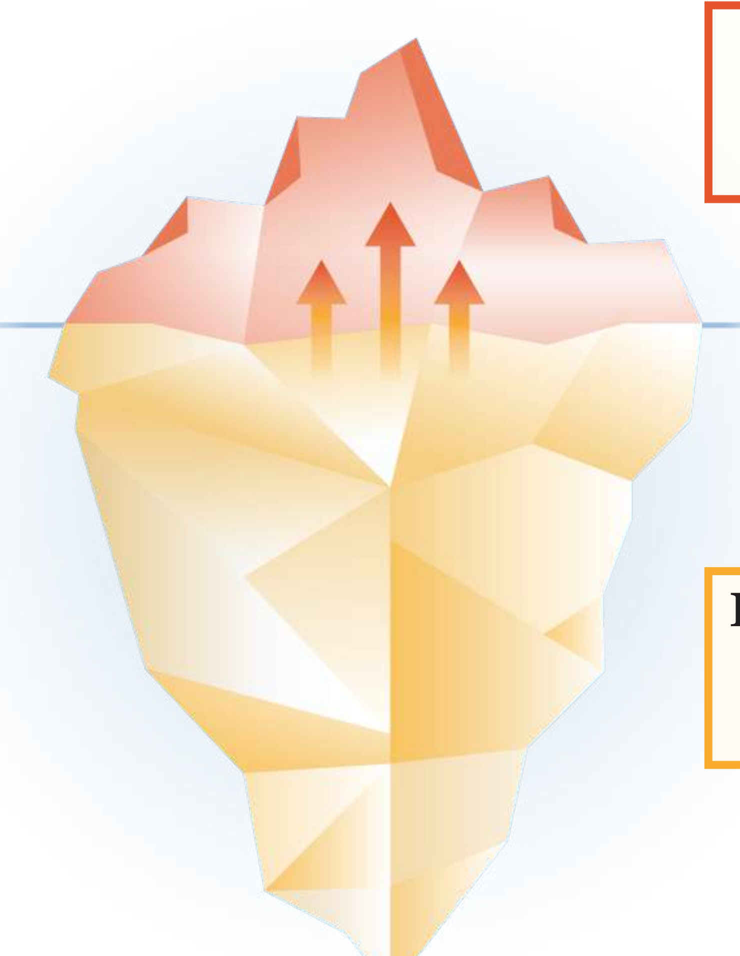
Sufficient back-end resourcing, following DFD interaction

Overarching Theme: Remote Monitoring for VBC



Rising-Risk Management is Vital to ROI in VBC

Each year, 1 in 5 of rising-risk patients become expensive, high-risk patients



High-Risk: 5% of population

Rising-Risk: 20% of population

"Our findings may also reflect fundamental challenges with the strategy of targeting superutilizers: ***many [members] whose medical costs are high today will not be as high in the future.****" – Hotspotting Study*

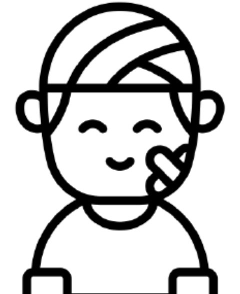
(A. Finkelstein et al., 2020)

How Does Virtual Care Arrive at a Patient?

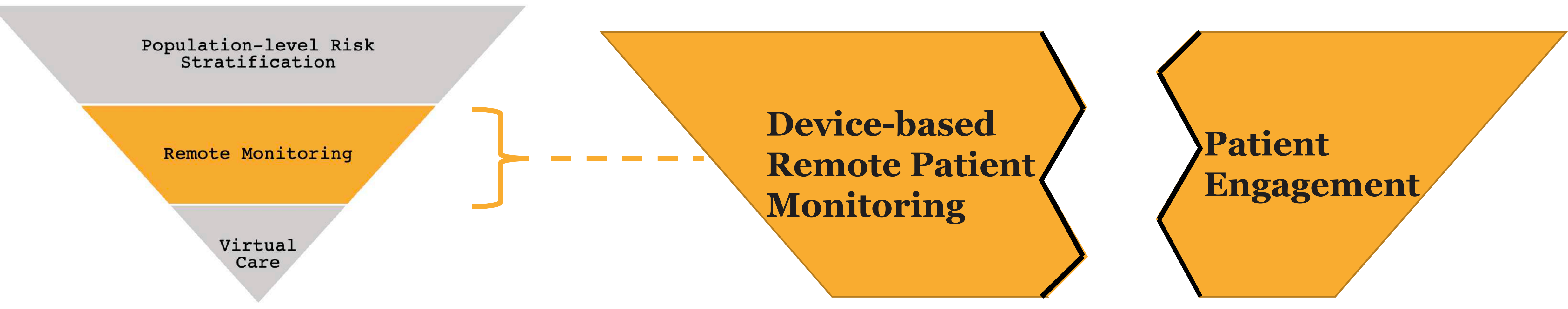
Population-level Risk Stratification

Remote Monitoring

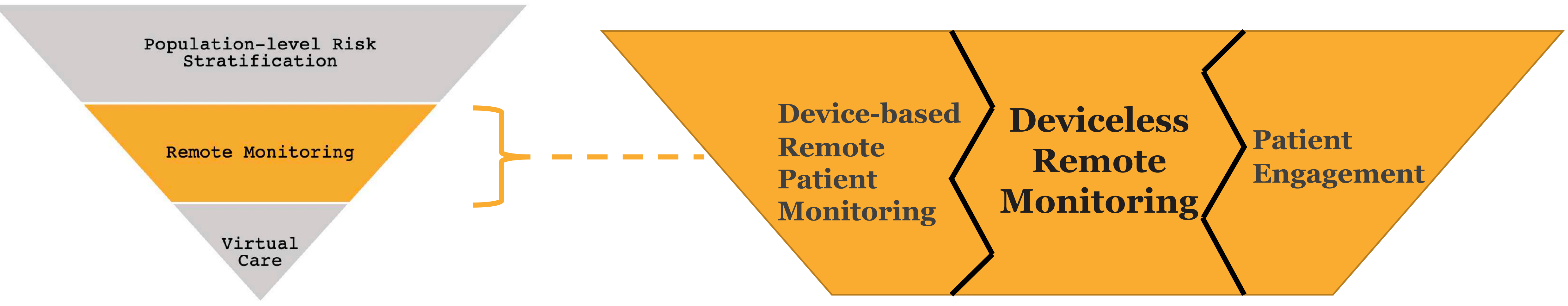
Virtual Care



Where does Remote Monitoring Fit?

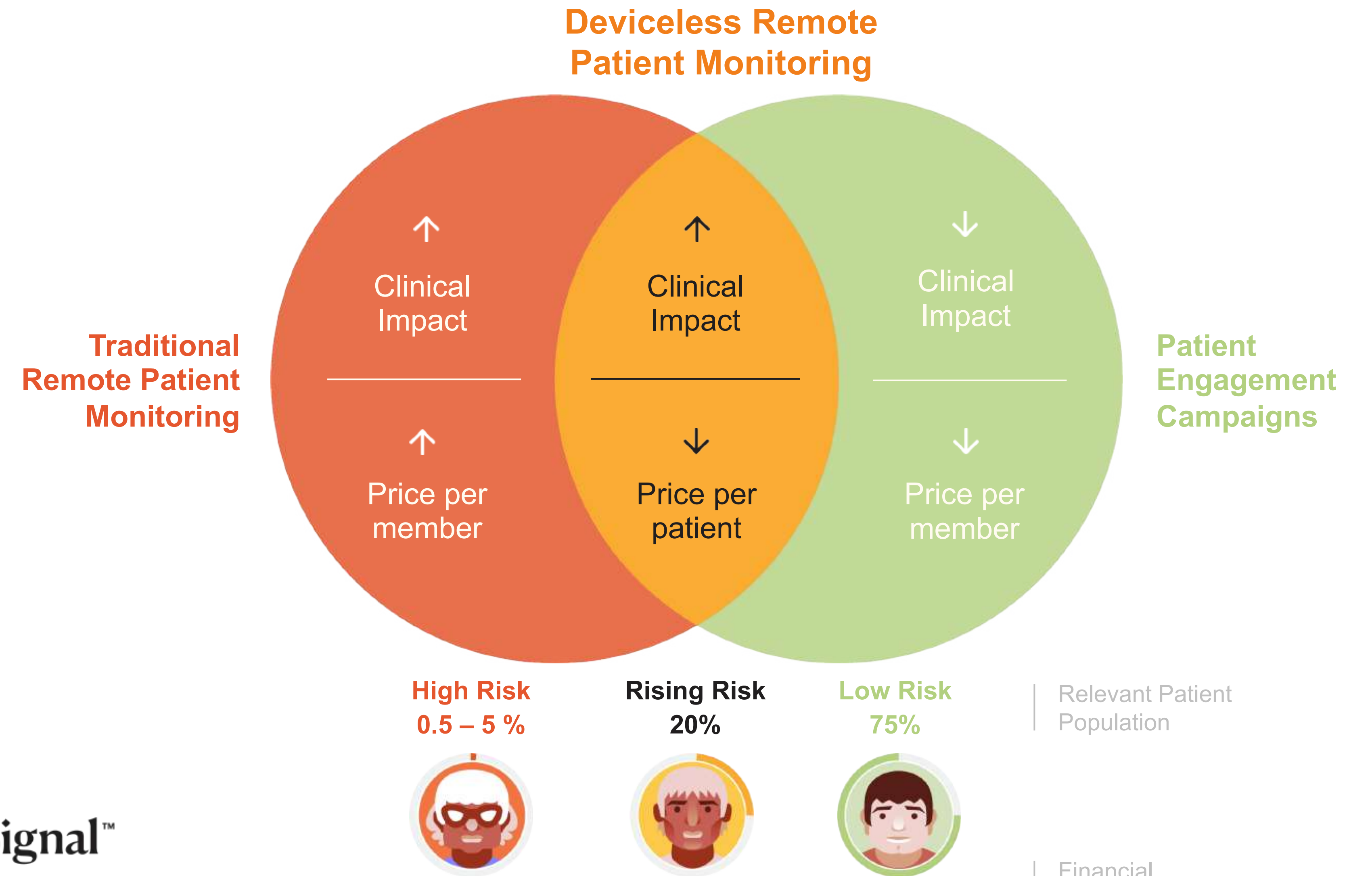


How Can Remote Monitoring Serve Rising-Risk?



Deviceless Remote Monitoring

Evidence-Based Quality. Sustainable Price. Higher ROI.



CareSignal™

Deviceless Remote Monitoring
Accessible, Scalable, Clinically Actionable

CareSignal works for **any** member

Via smartphone, pay-as-you-go phone, landline, or concerned caregiver's phone

PHILIPS
YOUR CARE TEAM
18669768910
OK BACK

INBOX-OPEN
From: Your Care Team
How are you feeling now? Please rate from 0 (very bad) to 10 (very good)
CB: 1-866-976-8910
Received
Jan 27, 2020
REPLY Options

MetroPCS 3G 9:41 AM 75%
Messages Your Care Team Details
What is your weight today? Please enter in lbs (e.g. 180)
197
How has your breathing or swelling in your legs felt compared to normal? Reply 1 if better, 2 if worse, 3 if the same.
3
Is your breathing while lying down better, worse, or the same compared to normal? Reply 1 if better, 2 if worse, 3 if the same.
Text Message Send

Accessibility Is King
Technology, Process, & Member Experience

Description	Principle	Principle	Description
Messages written at 4th - 6th grade reading level	Health Literacy	Free-to-End-User	CareSignal incurs cost of SMS texts and calls
Dynamic messaging adjusts to each member	Minimize Member Fatigue	Familiar Technology	Members use their own phones

Proven Clinical Outcomes & ROI

62% decrease
in hospitalizations
for patients with COPD

28% drop in PHQ-9
for patients with
depression

1.15% drop in HbA1c
over 4 months

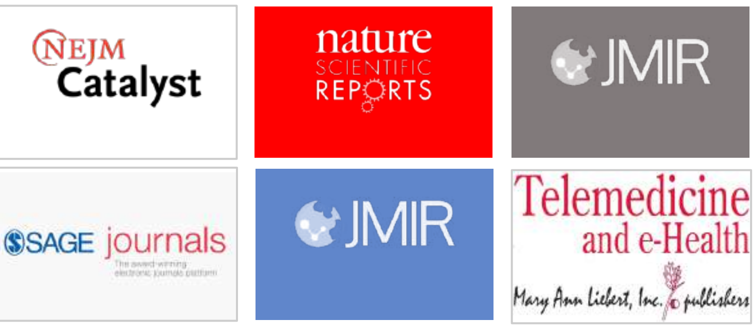
>2.1x increase in
follow-up appointment
adherence

50% improvement in blood pressure control over 12 weeks

58% decrease in CHF
ED visits

12 Publications

in Peer-Reviewed Medical Journals



(see all articles)

6 Case Studies

proving ROI through claims analysis
(read case studies)

7 Partner Webinars

describing clinical, operational, and financial ROI as a result of CareSignal
(watch webinars)

CareSignal Program Portfolio

30+ Condition-Specific Programs Available

Chronic Condition Management

- Diabetes
- Hypertension
- Heart Failure
- COPD
- Asthma
- Dialysis

Behavioral Health

- Depression
- Anxiety
- Substance Use
- Opioid Management
- Mood
- Caregiver support
- Social Determinants of Health

Maternal Health

- Breastfeeding
- Postpartum depression

Discharge Support

- Appointment Reminder
- Post Discharge
- Referral
- Surgery
- Pneumonia
- Vital Signs

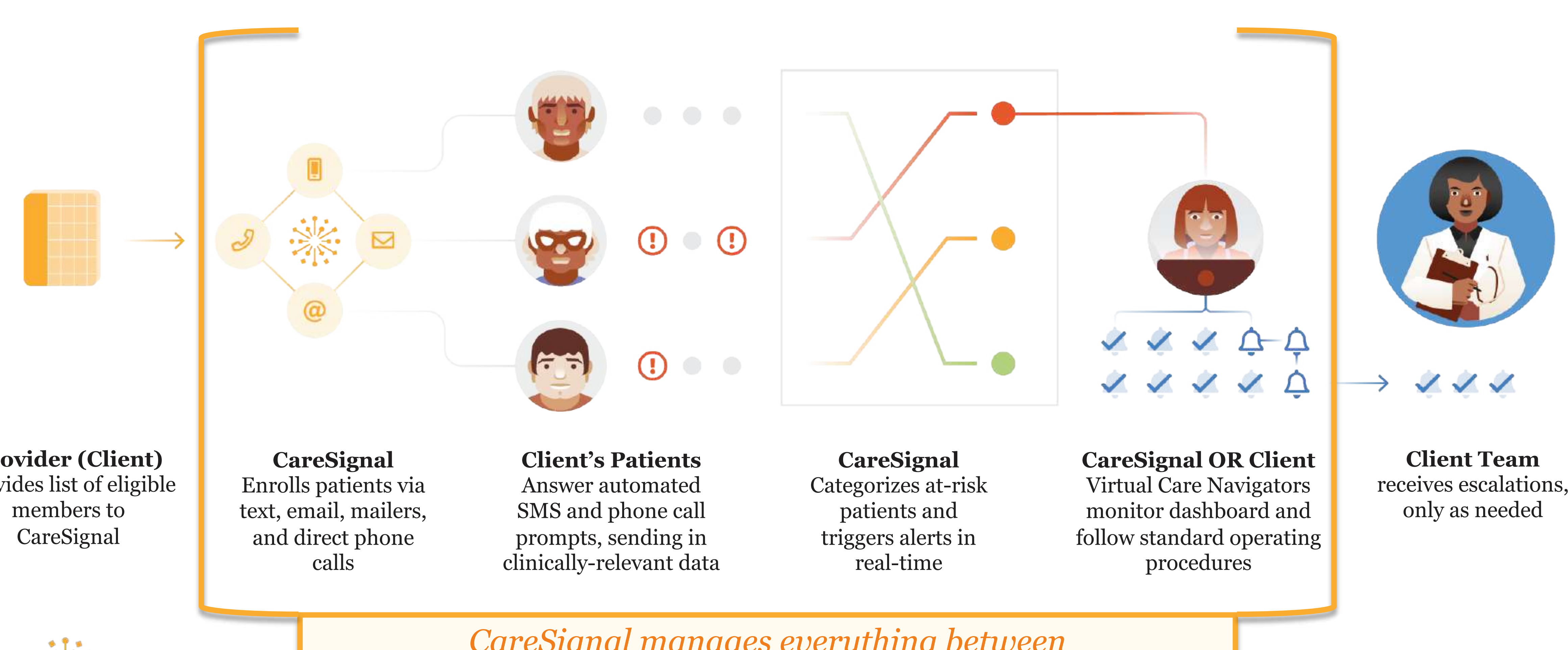
Screening Reminders

- Colorectal cancer
- Breast cancer
- Cervical cancer
- Diabetes ophthalmology
- Chlamydia screening
- Lead screening

Complementary Support

- COVID Suite
- Influenza
- Fall Risk
- Wellness
- Medication Tracking
- Medication Adherence
- Medication Companion

CareSignal Patient Journey
End-to-End Solution to Simplify Proactive Care



CareSignal manages everything between list generation & proactive notification

CareSignal™

UnityPoint Health Case Study

Project Implementation Timeline

April 14
Project kick-off

April 17
Identified Quad Cities region identified as initial pilot site 3 days after project start

April 27
Workflow and design complete; Quad Cities **began enrolling patients 10 days after being identified as pilot site**

May 4
178 unique patients **enrolled in** the **first week**

May 6
Expanded workflows into two additional regions

May 11
356 unique patients **enrolled in the first two weeks**

May 12
Expanded workflows into one additional region

May 21
Expanded to +1 region, bringing total to **5 regions in less than 30 days**

May 26
Resumed conversation regarding transitioning project to chronic condition management

May 27
742 unique patients enrolled **in the first 30 days**

UnityPoint Health Case Study

Results

<1% of patients required a referral to home health

<8% of patients needed a telemedicine visit while under remote monitoring

87% of patients were discharged to self-care upon conclusion of remote monitoring

Our home follow-up program gives providers the opportunity to keep tabs on a large group of patients and be reassured that they will know as soon as a patient isn't doing well and needs more attention.

–Megan, Physician

Home monitoring has helped reduce patient anxiety and calm their fears. Patients are appreciative we are following up on them.

–Crystal, CMA

UnityPoint Health Case Study

Project Approach and Keys to Success

Strategic Relationship

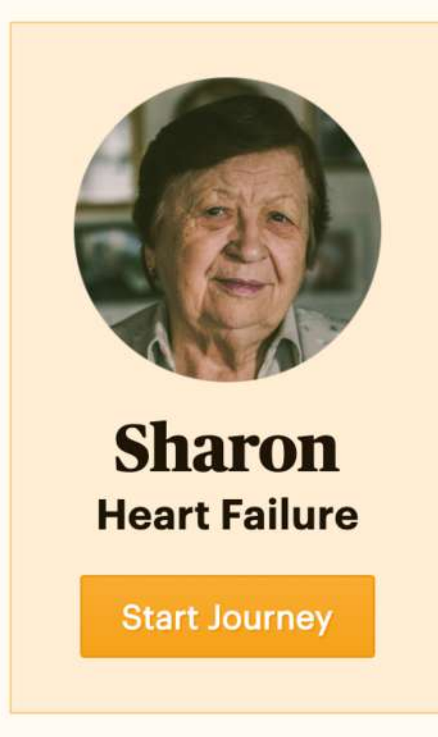
Acuity-based Monitoring

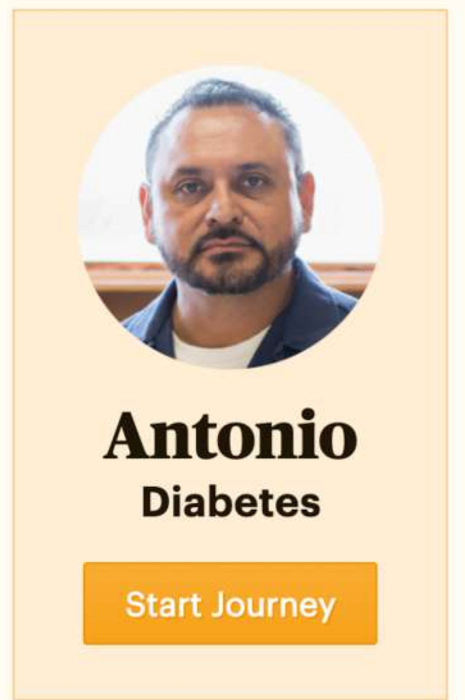
4047 Staff Users

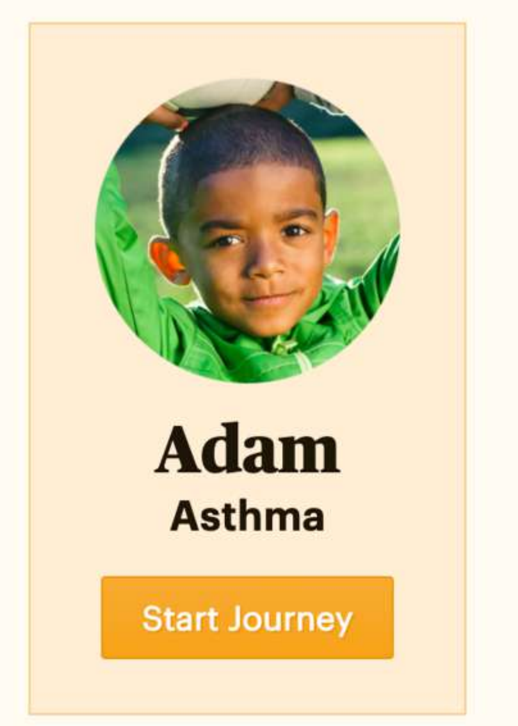
16,147 patient sessions

4% “alert” rate, resulting in >640 timely interventions during early COVID-19 triage

Visit try.caresignal.health





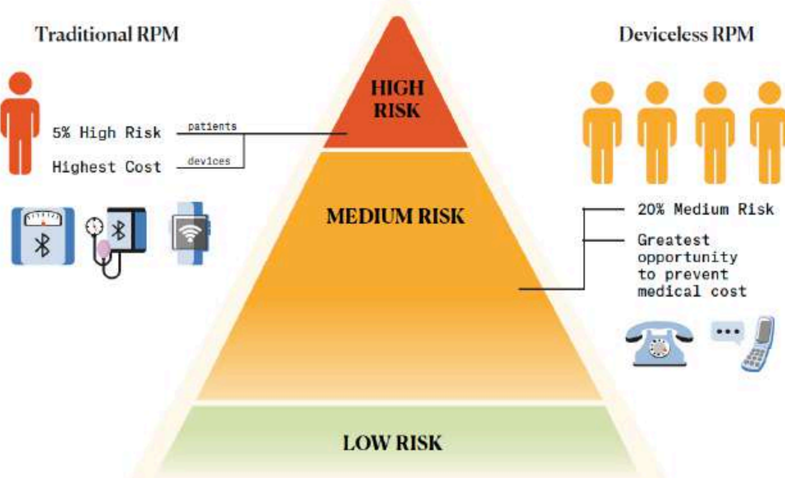


Thank You!

Large Medicare Advantage Physician Group (Fully Capitated)

Case Study

Deviceless Remote Patient Monitoring Scales to Rising-Risk Patients at a Fraction of the Cost of Device-Based RPM



"Now we've been able to wrap our hands around a whole group of people who otherwise might not have gotten all those touches that they received with the platform. We've been able to scale the outreach dramatically without an increase in staff, and that's really important. High-risk care management is inherently a reactive model. By extending care management into the rising-risk patients, we are becoming more proactive. Now we can say, 'Hey, there might be a problem developing. Let's reach out to the patient instead of waiting until he goes to the ED.' It's helped us manage rising-risk patients who might not have perceived a need for a care management team before."

– Carla Beckerle
Vice President of Clinical Programs at Esse Health

Reaching 15x More Medicare Advantage Patients

1 RN care manager sustainably grew caseload **100**

1,500 high-and rising-risk patients while maintaining high satisfaction.

= 100 patients

Reducing Emergency Room Visits by Nearly Half

Each of the alerts was an opportunity for proactive outreach to the patients who needed it most. This improved patients' clinical outcomes and reduced ED visits for patients with chronic conditions.

Diabetes
0.51% absolute reduction in A1C (n=111)

Heart Failure
46% reduction in congestive heart failure ED visits (n=1,018)

COPD
31% reduction in COPD ED visits (n=214)

Hypertension
-14.75 mmHg Average change in sBP
-7.55 mmHg Average change in dBP

Esse Lowered PMPM Costs by More Than $120, Sustained for 18 Months

Improved clinical outcomes led to over three million dollars in savings.

All Claims Analysis: Financial Savings (p = 0.017)

$3.6M total savings

8x ROI

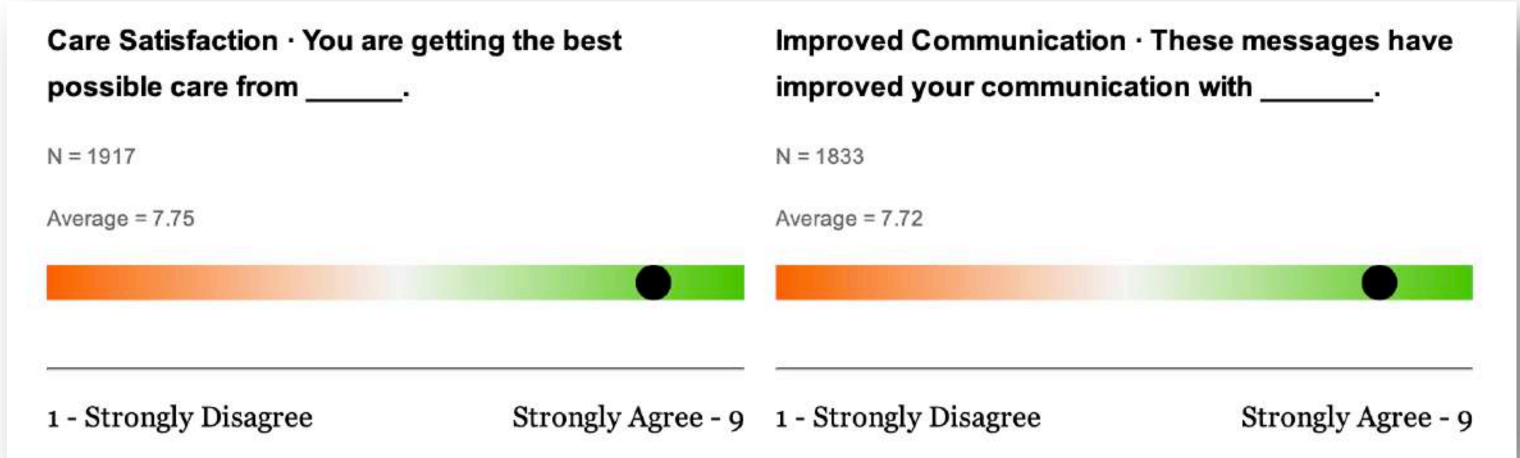
$124 savings PMPM

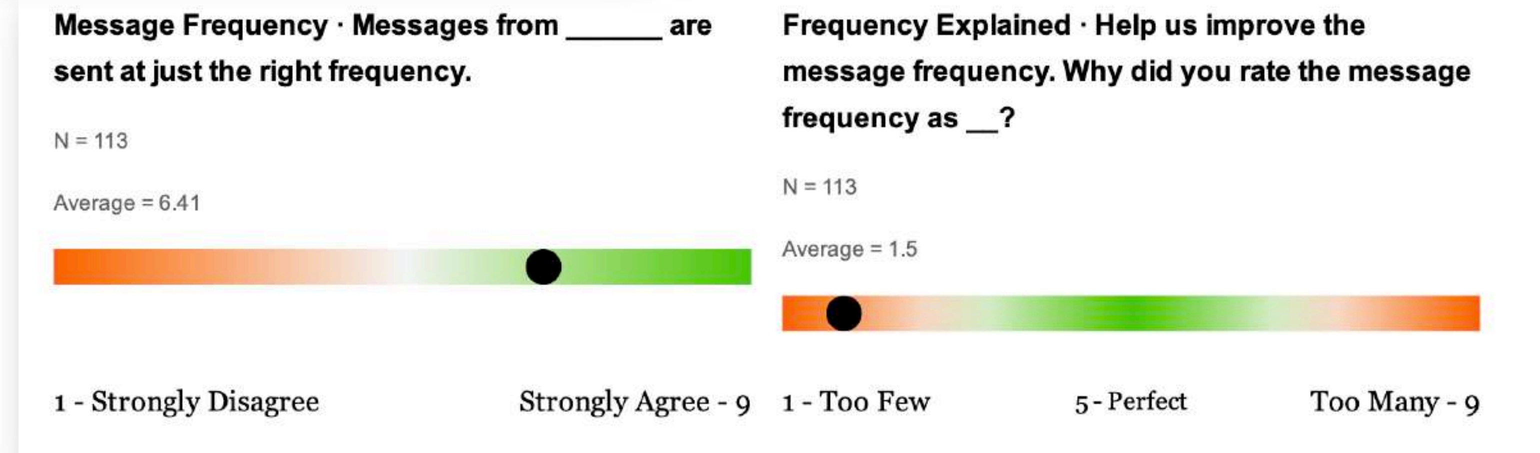
11% reduction in total paid medical claim costs

Paid claims per patient per day: Pre-CareSignal $35.46; Post-CareSignal $31.31 (axis $0–$40)

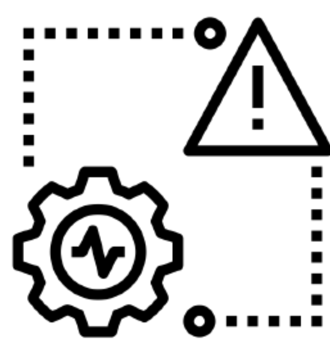
Presented outcomes at 2020 ATA & Abstract Published in Telemedicine and e-Health

Large IDN Supporting Medicare Advantage Population



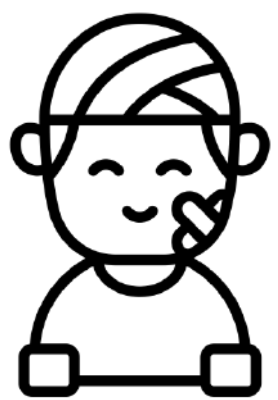


CMS Trend 1: Expand Risk to Medicare via DCEs



More risk opportunity for FFS

Expansion to MCOs & more



Beneficiary empowerment

Reduced provider burden

Case Study

Traditional Care Manager, RN· 30 High-Risk Patients

Hub and Spoke, MA · 300 Rising-Risk Patients

"CareSignal has created a technology that is simple to implement and produces a quick and sustainable impact on patient care. CareSignal allows Mercy to expand our ability to support patients with chronic conditions using a technology-first approach that allows nurse care managers to intervene when patients most need help.

Without this technology, nurses spent considerable time reaching out to patients in non-value-added activities that limited their ability to respond to patients at the right time. Now with smart technology, we can systematically reach out and connect with more patients on a routine basis and utilize our nurses to intervene when patients are beginning to have worsening symptoms.

This leads to a better patient experience, more targeted care management intervention, improved medication adherence, reduction in avoidable emergency department visits, and improved care manager and provider satisfaction."

- Mary Laubinger
Vice President, Population Health Navigation

Heart Failure

POPULATION
Employees diagnosed with CHF and a history of CHF-related ED visits prior to starting the intervention

CLINICAL OUTCOME
59%
reduction in CHF ED visits

HIGH LONGITUDINAL PATIENT ENGAGEMENT
57%
of patients were engaged at three months

33%
of patients were engaged at six months

FINANCIAL OUTCOME
-$848.20
per member per month

COPD

POPULATION
Employees diagnosed with COPD and a history of COPD-related ED visits prior to starting the intervention

CLINICAL OUTCOME
30%
reduction in COPD ED visits

HIGH LONGITUDINAL PATIENT ENGAGEMENT
54%
of patients were engaged at three months

39%
of patients were engaged at six months

FINANCIAL OUTCOME
-$193.85
per member per month

Diabetes

POPULATION
Employees diagnosed with diabetes

CLINICAL OUTCOME
2.03%
average reduction in HbA1C[1]

HIGH LONGITUDINAL PATIENT ENGAGEMENT[2]
89%
of patients were engaged at three months

78%
of patients were engaged at six months

FINANCIAL OUTCOME
-$200.71
per member per month

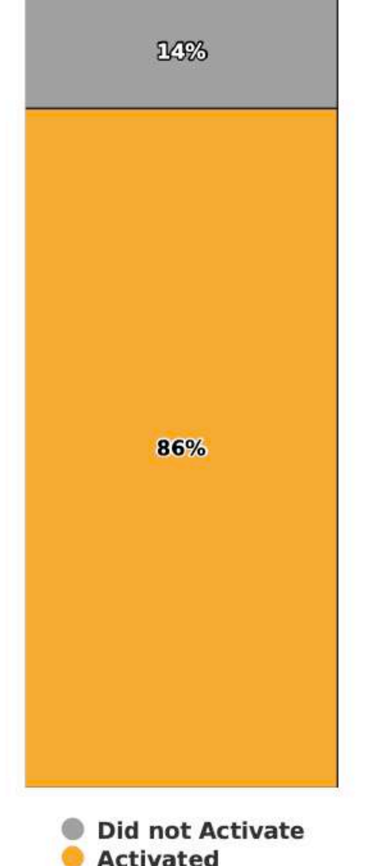
Mercy presented outcomes at 2020 AMGA Conference

Additional Outcomes

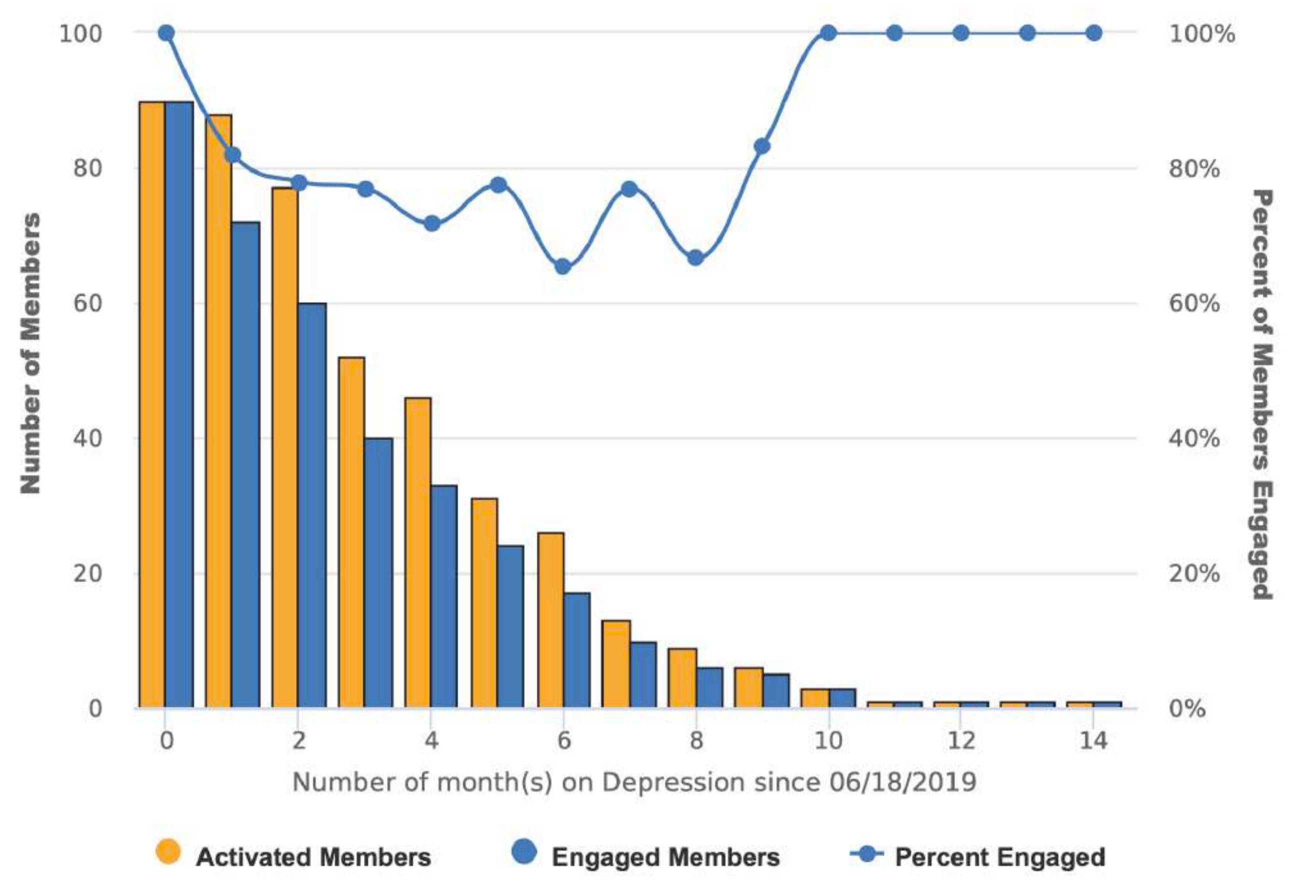
60% of Members with Depression Remain Engaged at Six Months

57% Reduced PHQ-9

Activation



Engagement



Case Study

Formerly WEA Trust

WEA trust | CareSignal

Introducing convenient, accessible symptom tracking for chronic *and* behavioral health conditions.

WEA Trust has partnered with CareSignal to increase member engagement and disease self-management. CareSignal's convenient text messages help members report symptoms and connect with WEA Trust Care Management. If members' symptoms worsen, Care Managers are alerted and proactively outreach to the member. Members in the program report feeling empowered, accountable, and cared for because of this proactive care.

Sample PHQ-9 Messages For Depression
Scale: 0 = not at all, 3 = almost daily

How often have you felt tired or had little energy? Rate 0 to 3.

3

How often have you had trouble concentrating? Rate 0 to 3.

3

Our Care Managers get alerts if members report a PHQ-9 score > 15, low mood, or thoughts of self-harm. Read Member Story »

Why invest in proactive care for chronic *and* behavioral health?

"During the turmoil and isolation of COVID, members need additional support. By taking action today and reaching out to members to ask about their symptoms we can help them feel in control of their health and know they matter. If we identify worsening symptoms early, we can maintain optimal control of chronic and behavioral conditions and prevent avoidable, costly hospitalizations. It is key to preemptively reach out to members in order to identify symptoms and notify Care Management to intervene promptly."

Dr. Bartholow Chief Medical Officer, WEA Trust

Did you know? U.S. adults are **3.6x more likely** to have depression if they have a chronic condition. And, that there has been a **3x increase** in reports of depression in U.S. adults during the COVID pandemic.

WEA Trust and CareSignal engage members and improve outcomes

Industry-Leading Engagement	Depression	Hypertension	COPD
75%	2 in 3	10.52 mmHg	100%
of members engage with and respond to CareSignal for at least 6 months	members reported improved mental health	average drop in sBP for members with baseline 140-160 mmHg sBP	of respondents reported improved communication with WEA Trust

Why does long-term engagement matter?

Engagement leads to better health and research shows that members in good health are more likely to deliver optimal performance in the workplace.

High Engagement → Improved Health → Optimal Performance

"Members appreciate and enjoy using thoughtfully-designed programs such as CareSignal because it fits into their busy lives."

Melanie Schoenemann
Director, Sales and Customer Retention, WEA Trust

Member Story: The power of proactive monitoring

"Because the program is so easy to get members on, we can begin helping them right away. On the first day that a new member began receiving Depression monitoring, she was able to let us know she was struggling by reporting her symptoms. That same day, our team was able to connect her to our Behavioral Health Specialist who talked with her to give her the resources she needed."

Kelli Outhouse, RN Medical Services Coordinator, WEA Trust

...t member wasn't the only one who needed support. ...re are stats from other members on the program:

1 in 4 members reported thoughts of self-harm

10% connected to a crisis hotline

...hat members say about the program:

"...e being checked in with every day. It makes me feel safe."

"...hey let me freely state how I am feeling on that ...rticular day and if I feel bad someone will talk to me."

"...uick and easy to answer, a good way to check ...without hassle."

Did you know? Deviceless remote health monitoring allows members to answer at their convenience—even on the job.

...estimonials

"...key advantage of the WEA Trust is that they ...nderstand the needs of the members and the culture ...f our employees better than any other insurer. In trying ...o develop a strategic plan to offer excellent benefits but ...lso hold the line on costs, I believe WEA is an ideal partner ...o help design a strategy that will be effective in ensuring ...igh levels of employee engagement."

...hn Stellmacher
...FO, School District of Hartford Jt. #1

"CareSignal enables us to interact with our members remotely and intelligently. With the CareSignal dashboard, we know which members are managing their health well and who is struggling. Our Care Managers reach out promptly to those members in need, allowing us to improve health outcomes and efficiently use the expertise of our clinicians."

Jeff Carter
Manager of Utilization Review, WEA Trust

We Transform 'Benefit' into 'Beneficial'

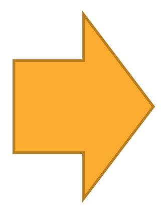
Many members are unaware of all of their benefits. At WEA Trust, we take every opportunity to help members connect to beneficial company resources. We work with CareSignal to get the word out: from phone call outreach to members to inform them about the program to multi-channel, condition-specific awareness campaigns for member self-enrollment options.

Learn More: Proactive Symptom Monitoring

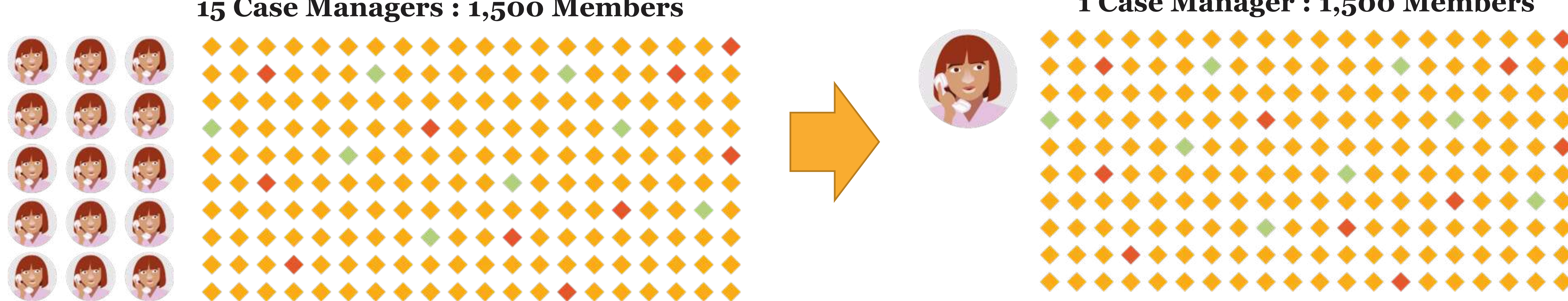
Your Care Management Team at WEA Trust

Automated, engaging, and scalable programs *are required to reach the tipping point for proactive care*

Manual outbound outreach limits case management impact and efficiency

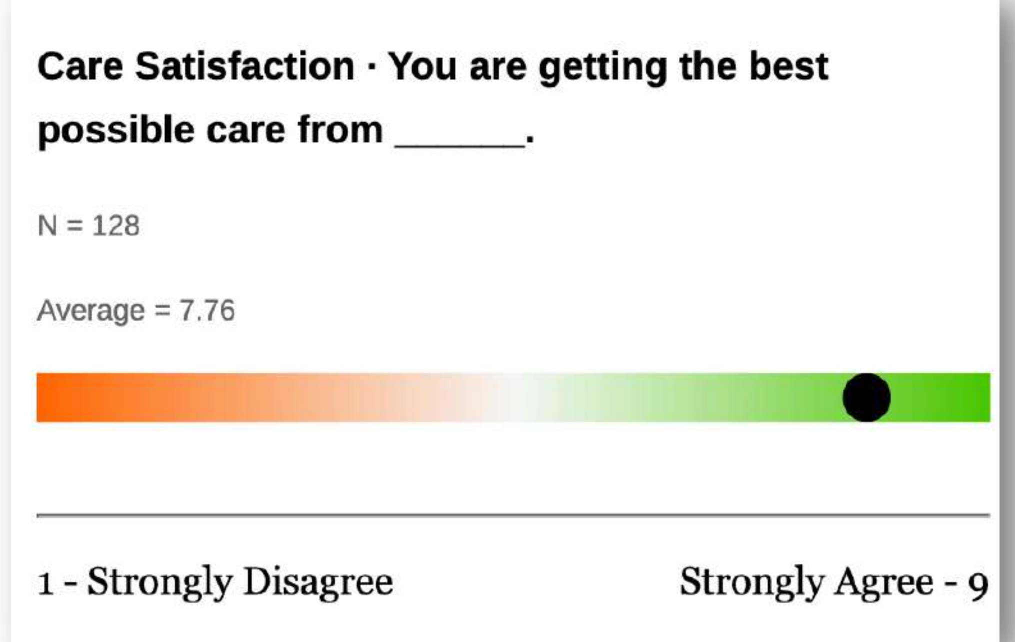


Automated inbound insights allow case management to focus on the right members



Large Payer-Provider Joint Venture

Improve Satisfaction & Outcomes Simultaneously



Improved Communication · These messages have improved your communication with ______.

N = 124

Average = 7.69

1 - Strongly Disagree

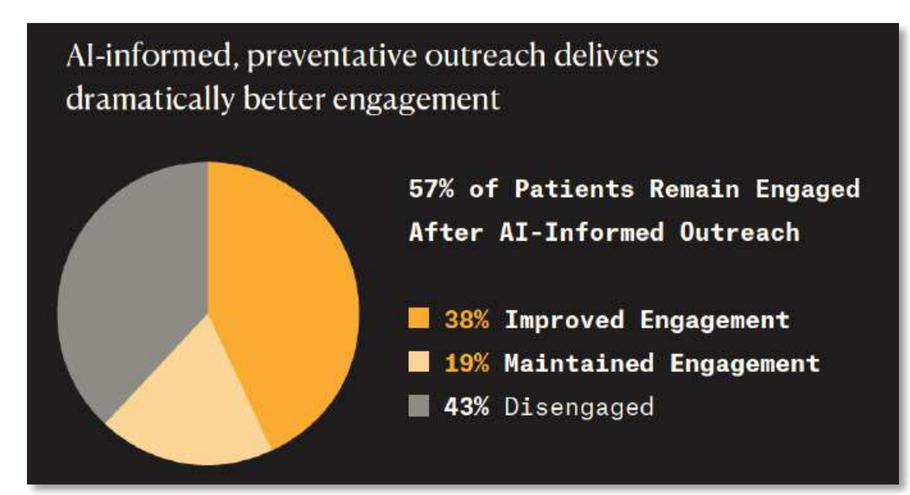
Strongly Agree - 9

CareSignal.AI
Predict & Proactively Prevent Engagement Dropoff

>50% 12-month retention

7,280,273+
Patient/Member days of data and metadata

16.62+
Lifetimes of care manager interactions

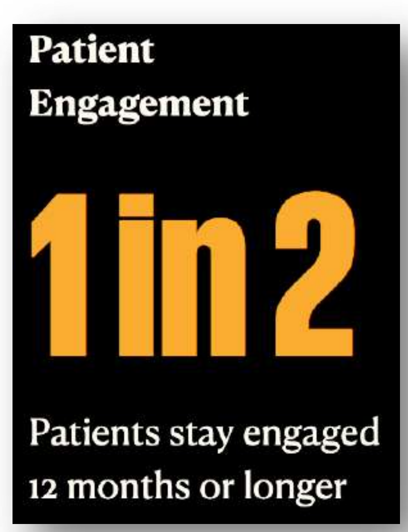


Without CareSignal AI
1 in 2 patients stay engaged with CareSignal over a 12-month period

With CareSignal AI
57% more patients may remain engaged over the same 12-month period

CareSignal Delivers Long-term Engagement

6x-12x Better Engagement & Retention Duration



Text Message vs. Phone Call Engagement Over Time

Average Health App
CareSignal Text Messages
CareSignal Phone Calls

Engagement Rate

1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0

Year 1
Year 2
Year 3

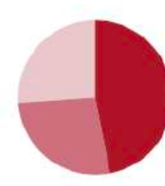
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36

Normalized Month

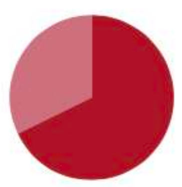
Case Study

"I like knowing that I have support when I feel my lowest. I love this service! It helps me keep track of my moods and to better communicate between my doctor and me."

"This [program] has helped me remember to think about what I do to stay healthy and keep working and going."



Generation
47% GenX
27% Baby Boomers
26% Other



Job Type
68% Manufacturing
32% Administration

Medication Adherence
>10% increase in self-reported adherence, from 70% to >80%. Refill data (MPR) averaged 86.5%.

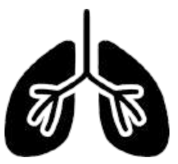
Diabetes
13.7% average reduction in blood sugar in 19 weeks.

Hypertension
50% improvement in blood pressure control over 4 months.

Depression
28% average reduction in PHQ-9 scores in 11 months.

Chronic Condition Programs

Diabetes
Monitors blood glucose levels and supply accessibility



COPD
Tracks breathing to prevent worsening symptoms

Heart Failure
Monitors heart health through tracking breathing, edema and weight

Hypertension
Tracks blood pressure and hypo- and hypertensive symptomology

Asthma
Monitors breathing with/without peak flow meter and tracks inhaler utilization

Dialysis
Monitors symptoms and tracks appointment/treatment adherence

Epilepsy
Tracks seizure frequency

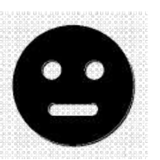
Behavioral Health & Sub Use Programs

Depression
Tracks mood and depressive symptoms via PHQ-9.

Substance Use
Monitors likelihood of relapse for patients in remission.

Opioid Management
Monitors pain level via PDI survey and tracks med consumption.

Caregiver Support
Monitors risk of caregiver burnout using IDT questionnaire.



Mood
Tracks general mood to help providers titrate medications.

Basic Needs/SDoH
Tracks patients' maintenance of basic needs.

GAD-7 (Anxiety)
Monitors anxiety symptoms using the GAD-7 scale.

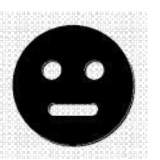
Behavioral Health & Sub Use Programs

Depression
Tracks mood and depressive symptoms via PHQ-9.

Substance Use
Monitors likelihood of relapse for patients in remission.

Opioid Management
Monitors pain level via PDI survey and tracks med consumption.

Caregiver Support
Monitors risk of caregiver burnout using IDT questionnaire.



Mood
Tracks general mood to help providers titrate medications.

Basic Needs/SDoH
Tracks patients' maintenance of basic needs.

GAD-7 (Anxiety)
Monitors anxiety symptoms using the GAD-7 scale.

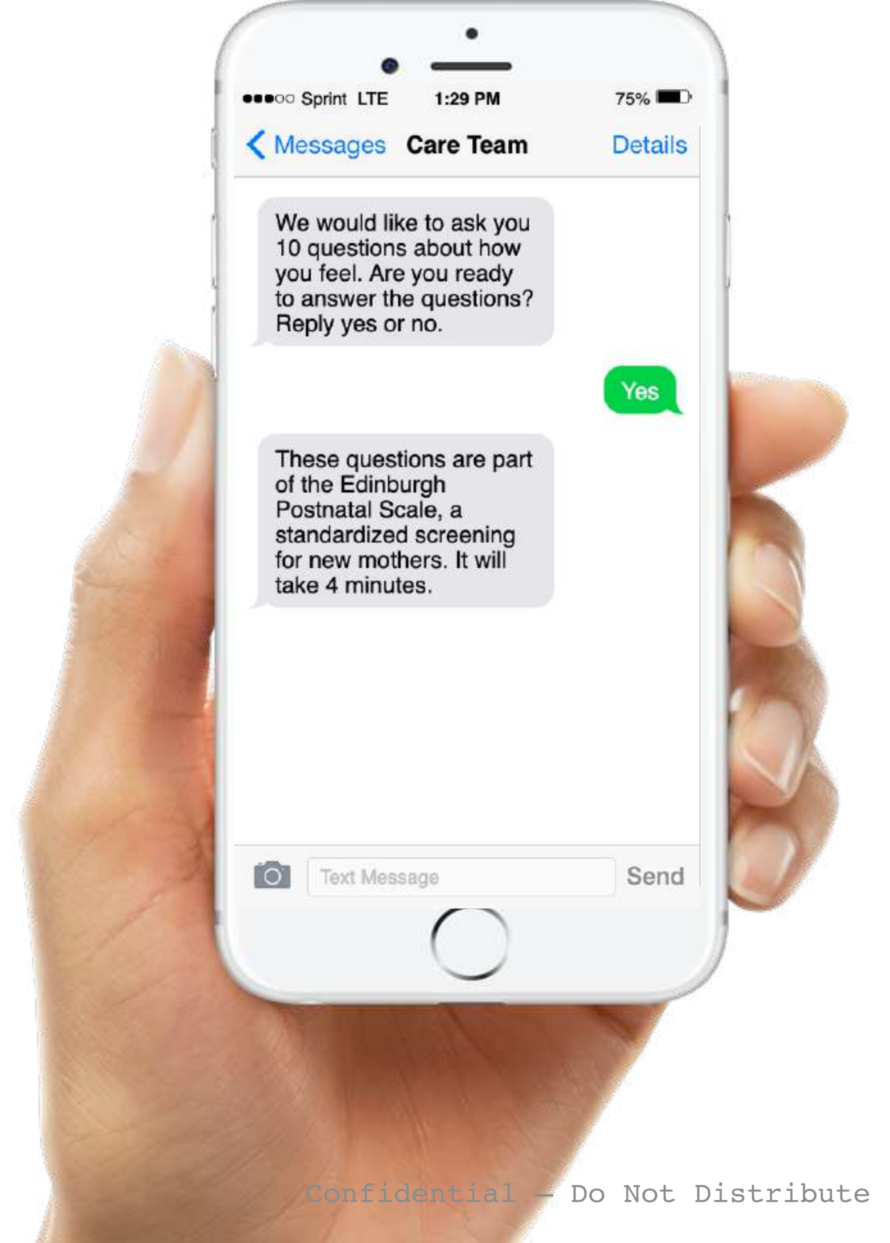
Home

Maternity Programs

Post Partum Depression
Series of 10 questions based on the Edinburgh Postnatal Depression Scale.

Breastmilk
Tracks breastmilk production and provides breastfeeding/pumping reminders.

Breastfeeding
Tracks breastfeeding habits and provides feedback and education.



Complementary Support Programs

Fall Risk
Monitors patient's fall risk.

Wellness
Reinforces healthy diet and exercise habits.

Medication Tracking
Provides reminders and tracks reasons for missing medications.

Medication Adherence
Tracks reasons for missing prescription refills.

Medication Companion
Tracks reasons for missing medications and prescription refills.

Vital Signs
Collects temperature, blood pressure, heart and additional vitals.

Formerly WEA Trust

Case Study

Industry-Leading Engagement

75%

of members engage with and respond to CareSignal for at least 6 months

Depression

2 in 3

members reported improved mental health

Hypertension

10.52 mmHg

average drop in sBP for members with baseline 140-160 mmHg sBP

COPD

100%

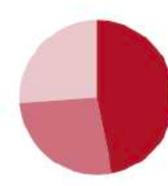
of respondents reported improved communication with WEA Trust

"**A key advantage of the WEA Trust is that they understand the needs of the members and the culture of our employees better than any other insurer.** In trying to develop a strategic plan to offer excellent benefits but also hold the line on costs, I believe WEA is an ideal partner to help design a strategy that will be effective in ensuring high levels of employee engagement."

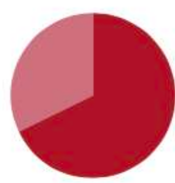
John Stellmacher
CFO, School District of Hartford Jt. #1

Case Study

"I like knowing that I have support when I feel my lowest. I love this service! It helps me keep track of my moods and to better communicate between my doctor and me."



Generation
47% GenX
27% Baby Boomers
26% Other



Job Type
68% Manufacturing
32% Administration

Medication Adherence
>10% increase in self-reported adherence, from 70% to >80%. Refill data (MPR) averaged 86.5%.

Diabetes
13.7% average reduction in blood sugar in 19 weeks.

Hypertension
50% improvement in blood pressure control over 4 months.

Depression
28% average reduction in PHQ-9 scores in 11 months.

"This [program] has helped me remember to think about what I do to stay healthy and keep working and going."

Remote Monitoring: Detailed Comparison

	Classic Remote Patient Monitoring	Deviceless Remote Patient Monitoring™	Patient Engagement Campaigns
Patient Population	✖ High-Risk	✔ Rising-Risk	● Low-Risk
Clinical Impact	✔ High	✔ High	✖ Low
Price Per Patient	✖ High	✔ Low	✔ Low
Financial Opportunity	✖ Low	✔ High	✖ Low
Legend: Impact on ROI	✔ = Good	● = Neutral	✖ = Bad

Remote Monitoring: Detailed Comparison

Classic RPM	Deviceless RPM™	Patient Engagement
• $100 Per Active Patient Per Month • Only feasible when billed • Requires patient implementation and training • Clinicians become tech support for patients • Appropriate for highest-morbidity populations	• Clinically actionable insights, keeping team top-of-license • Ready to scale immediately, with no patient-facing implementation or training • Proven ROI for patients, including > 20 chronic & behavioral conditions	• ≤$1 Per Active Patient Per Month • Highly automated, limited clinical value • Best used for relationship management and transactional interactions • Often customizable platforms with no content, clinical logic, SOPs or evidence of efficacy

Large Payer-Provider Joint Venture

Message Frequency

Frequency Explained · Help us improve the message frequency. Why did you rate the message frequency as __?

Average = 1.86

1 - Too Few   5 - Perfect   Too Many - 9

Message Frequency · Messages from ______ are sent at just the right frequency.

Average = 4.93

1 - Strongly Disagree   Strongly Agree - 9

CareSignal Operational Excellence
Proven Enrollment, Engagement, Outcomes, and Scale

Enrollment

1 in 4
Eligible patients enroll

Engagement

1 in 2
Patients stay engaged for >12 months

Scale

1,500+
Patients managed per care manager

10+ Publications
in Peer-Reviewed Medical Journals

62% decrease
in hospitalizations
for patients with COPD

28% drop in PHQ-9
for patients with
depression

1.15% drop in HbA1c
over 4 months

>2.1x increase in
follow-up appointment
adherence

50% improvement in blood pressure control over 12 weeks

46% decrease in CHF
ED visits

Partnership Testimonials

Patients

*"The easy way to report the information without having to login in a computer. I get so busy at work I tend to forget to do it. **This way is so easy.**"*

*"I feel safe because **I feel that my doctor is next to me even thou I am 2 hrs away from him**. Different city."*

*"It reminds me to test my sugars and to take my insulin. Helps keep me accountable. When my sugars spiked an actual person called to give me support. **This may have saved my life**."*

"Mostly **I like keeping in contact with the Healthcare team without leaving home. I feel that I am protecting my health better by remaining in and not taking chances with the public**. I appreciate that my health concerns are being addressed in the safest way possible."

Executives & Clinicians

*"The entire team was wonderful. **The most organized roll out of a project with an outside company** I have been involved with. Refreshing!"*

Chief Informatics Officer, Physician Group

*"It's a **great benefit to have a program that will assist patients**, especially patients who may not have family or friends who can check up on them on a regular basis".*

Care Manager, ACO

*"Epharmix has **improved the ability for our providers and care management staff to connect with our chronic disease patients**. It should help our patients achieve and maintain their treatment goals and allow us to identify patients needing an acute intervention to prevent ER and hospital visits."*

Medical Director, Top 5 Large Health System

*"**We had never had such a positive and supportive implementation partnership in such a short turnaround**. Everyone was respectful yet accountable and ensured success at every phase. Bravo!"*

Chief Clinical Officer, BH Network

Enrollment Performance

Physician Group Case Study

3,182

COPD & CHF

1,260
(40%)

Timeline: less than 4 months

Recent Campaigns

	COPD 8,468 calls	CHF 8,216 calls
Outbound calls		
Success	91%	92%
Pick-up	50%	50%
Connection	87%	83%
Decision	71%	70%
Accept	71%	69%
Total per call conversion	19.6%	18.6%
Avg calls per patient ~2.1		

CareSignal™

Beyond Technology: Supportive Services to Ensure Success

"The entire team was wonderful. ***The most organized roll out of a project with an outside company*** *I have been involved with. Refreshing!"*

Chief Informatics Officer, Physician Group

*"****We had never had such a positive and supportive implementation partnership in such a short turnaround****. Everyone was respectful yet accountable and ensured success at every phase. Bravo!"*

Chief Clinical Officer, BH Network

Patient Services

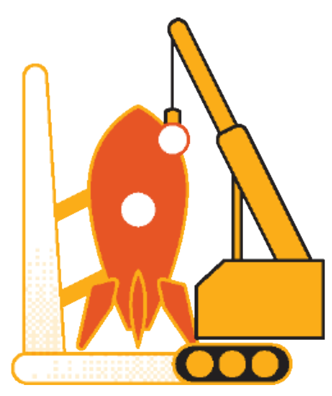
Partner Services

- Enrollment Services
- Reengagement Services
- Virtual Care Navigation
- Broadcast Campaigns
- Project Management
- Account Management
- Enhanced Reporting
- EHR & API Integration

Going Beyond Technology: Partnership Support

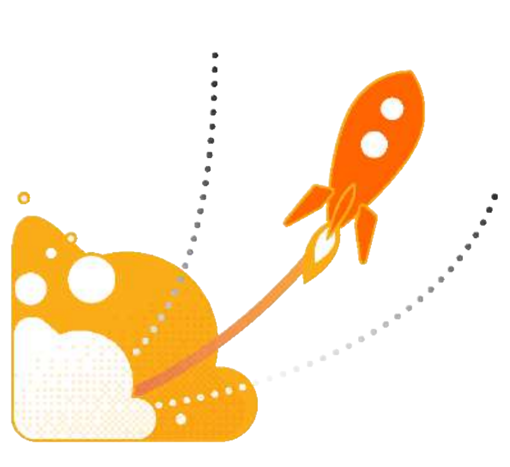
Kick-off

- Meet CareSignal team!
- Establish program goals
- Review project plan



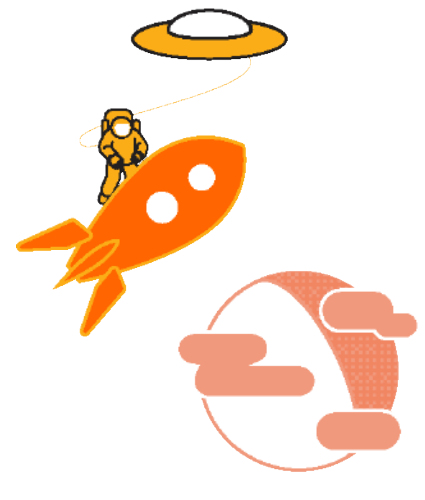
Onboarding

- Enrollment
- Operational workflows
- Clinical SOP's
- Training & Education



Ramp-up

- Patient Engagement Specialist increasing enrollment to target
- Check-ins every two weeks to streamline workflows



Ongoing Support

- Monthly utilization reviews
- Quarterly outcome reviews
- Accessible technical support
- Claims reporting available

Virtual Care Navigation

Flexible Extension of Care Management Resources

	Care Coordination	Health Coaching	Behavioral Health	Maternal Health
Programs	1. CHF 2. Diabetes 3. Asthma 4. COPD 5. HTN 6. Post-Discharge	1. Diabetes 2. Asthma 3. Wellness 4. HTN 5. Med Adherence	1. Depression 2. Anxiety 3. SubstanceUse	1. Breastfeeding 2. Post-Partum Depression
Monitoring	• MA • RN / LPN	• Diet & Nutrition • Exercise & Weight • Tobacco Cessation • Home Equipment Needs • Medication Needs	• Low Mood • Suicidal Ideation • PHQ-9 & GAD-7 Surveys • Recent SubstanceUse • Increased Triggers to Use	• Loss of Pregnancy • Transition from Breastmilk to Formula • Breastfeeding Complications • EPDS Survey Score • Indication of Self-Harm
Licensure	• MA • RN / LPN	• RN / LPN • CDCES	• LCSW	• Lactation Consultant • LCSW