RemetricHealth

bringing healthcare home

A medical device, digital health, remote patient monitoring and chronic care management services company.

Philadelphia, PA

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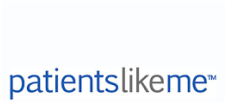
Markets and Customers

Providers | **Pharma/Research** | **Home Health** | **Advocacy / Patients**



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Our RPM Program

As Simple as 1, 2, 3...

1). CLINICALLY RELEVANT

Easy to use medical devices

Bluetooth-enabled remote patient monitoring devices collect biometric data in real-time.

2). EASY TO IMPLEMENT & USE

HIPAA-compliant data portal

Data remotely captured and electronically transmitted to the PMD Healthcare, HIPPA compliant, Wellness Management Services Portal.

3). POSITIVE ROI

Remote patient monitoring is now fully reimbursable.

Three new CPT Codes reimburse setup, device utilization and clinician monitoring at up to $165 per patient per month.

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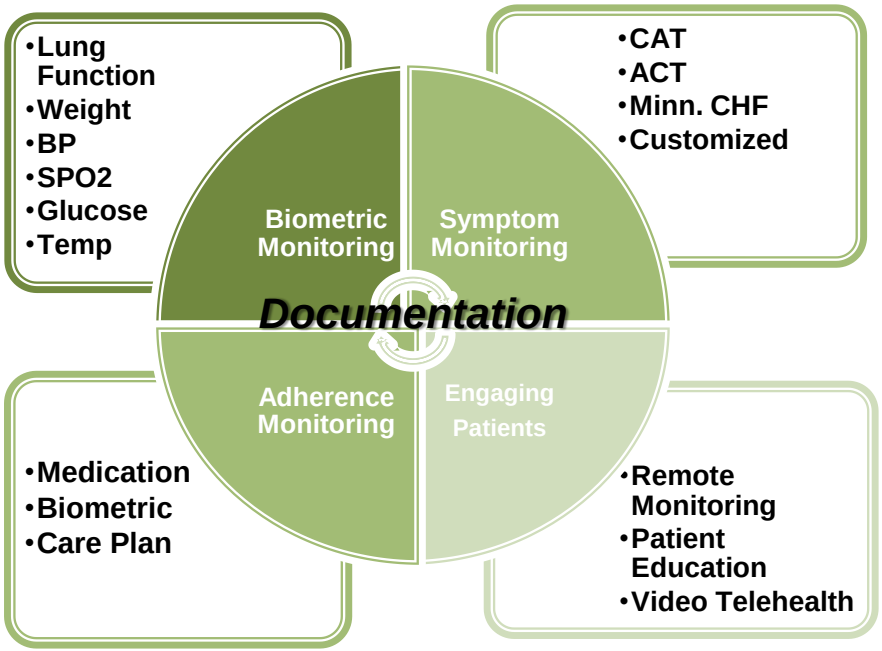
Our RPM Solution

What we Do

Provide Real- Time Data for Evidence Based Interventions
Enhances Patient Engagement and Medication Compliance
Improve Care Coordination
Reduce ER Visits, Hospital Admissions and Readmissions
Improve Patient Outcomes
Achieve Performance Measures
Financially Support Quality Care

How we do it



Connect, Engage, Monitor

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Connected Health + Remote Patient Monitoring				
Essentials BP	**Essentials Weight**	**Essential+**	**Advanced**	**Premier**
4G Tablet	4G Tablet	4G Tablet	4G Tablet	4G Tablet
Video / Audio Telehealth	Video/ Audio Telehealth	Video / Audio Telehealth	Video / Audio Telehealth	Video / Audio Telehealth
Blood Pressure Monitor	Weight Scale	Blood Pressure Monitor	Blood Pressure Monitor	Blood Pressure Monitor
		Weight Scale	Weight Scale	Weight Scale
			Pulse Oximeter	Pulse Oximeter
				Spirometer
All connected health offerings come with unlimited access to RemetricHealth's Wellness Management Services Portal inclusive of (Medication Adherence Program, Validated Symptom Tools, Customizable Assessment Tools, Electronic Care Plans, Patient Education Tools, Automated Documentation and Reporting.				

PMD Biometric Devices Offered

FDA Class 2 Certification · ISO · HIPAA COMPLIANT · HITRUST

Patient Friendly Use

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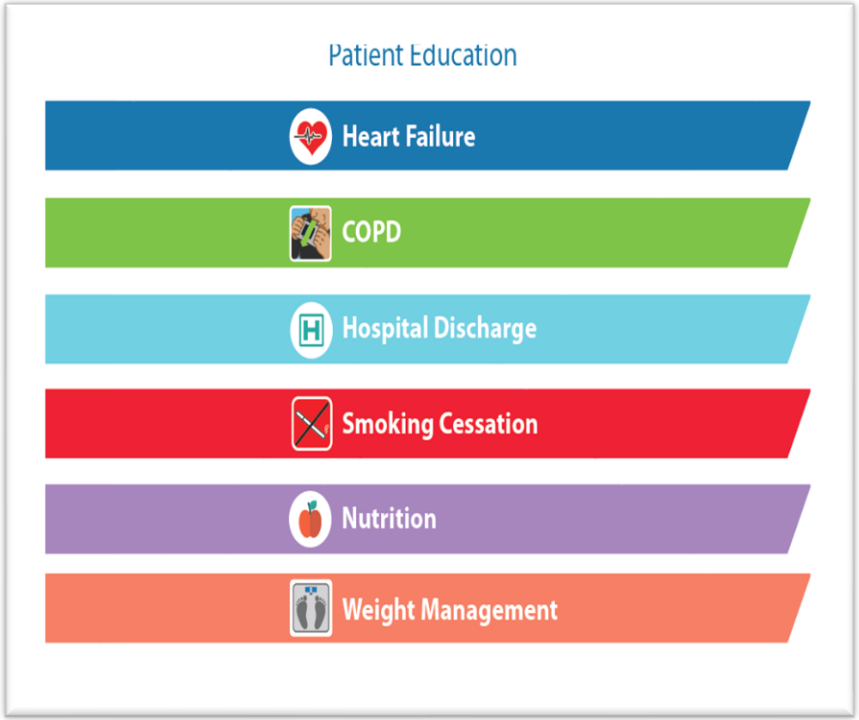

Simple to use all inclusive kits enable hassle free implementation of remote care with zero technology experience required:

- No device pairing required
- Included 4G connectivity (no WIFI or data plans required)
- Automated Medication Reminders via tablet, text, email
- Prompted Symptom Tools
- Touch and View Educational Materials

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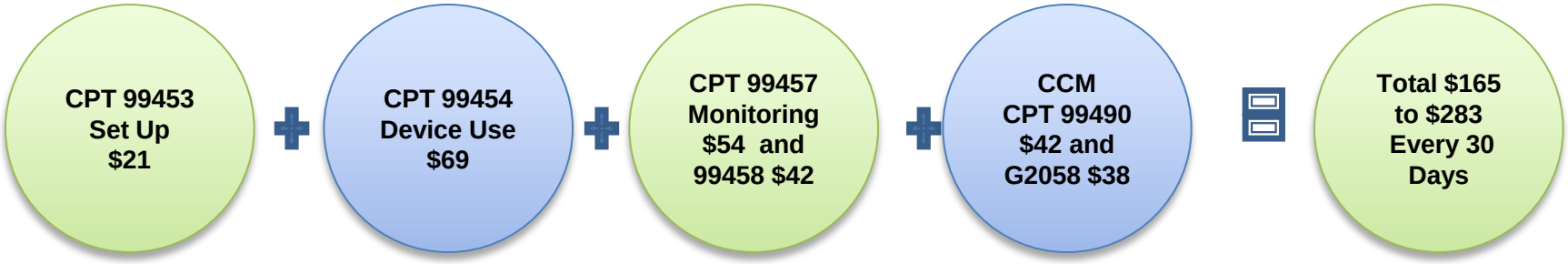
Fully Reimbursable with Positive ROI



CPT Code 99453 (Setup)
Remote monitoring of physiologic parameters, (eg, weight, blood pressure, respiratory flow rate. Initial set-up and patient training on use of equipment.

CPT Code 99454 (Equipment)
The provider supplies the patient with remote physiologic monitoring equipment and receives daily recordings and/or programmed alerts. Report this code for each 30 days of equipment supply and monitoring.

CPT Code 99457 / 99458 (Monitoring) /
Monitoring a patient's remote physiologic recordings and/or programmed alerts and interacts with the patient or caregiver to adjust treatment based on the recordings. CPT 99457 is for the first 20 minutes. CPT 99458 is for the second and third 20-minute increments.

CPT Code 99490 (CCM)
Chronic care management services, at least 20 minutes of clinical staff time a physician or non-physician practitioner (Physician Assistant [PA], Nurse Practitioner [NP], Clinical Nurse Specialist [CNS], Certified Nurse-Midwife [CNM]) and their clinical staff. G2048 is for the second and third 20-minute increments.

***Leveraging RemtricHealth's Remote Patient Monitoring Program can provide $1300+ per patient per year in net revenue.**

Recurring Revenue for Providers

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RPM Recurring Revenue		
CPT 99454 – Device Use		$69
CPT 99457 - Monitoring for the 1st 20 minutes	+	$54
CTP 99458 - Monitoring for the 2nd 20 minutes	+	$42
Total RPM Monthly Reimbursement	=	$165
RemetricHealth's RPM Program Monthly Fee	-	$45
Physician's Gross Margin/Patient per month	=	$120
Physician's Gross Margin/Patient per year	x12=	$1,440
One Time Device Acquisition Cost (Essentials +)	-	$95
Physician's Net Revenue per Patient		$1,345
Net Revenue on 100 patients		**$134,500**

Recurring Revenue for Providers including Staff Time

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RPM Recurring Revenue		
CPT 99454 – Device Use		$69
CPT 99457 - Monitoring for the 1st 20 minutes	+	$54
CTP 99458 - Monitoring for the 2nd 20 minutes	+	$42
Total RPM Monthly Reimbursement	=	$165
RemetricHealth's RPM Program Monthly Fee	-	$45
Provider's Staff Time (40 Mins @ $30 per hour)	-	$20
Physician's Gross Margin/Patient per month	=	$100
Physician's Gross Margin/Patient per year	x12=	$1,200
One Time Device Acquisition Cost (Essentials +)	-	$95
Physician's Net Revenue per Patient		$1,105
Net Revenue on 100 patients		**$110,500**

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Recurring Revenue for Providers with RemetricHealth's Clinical Services

RPM Recurring Revenue		
CPT 99454 – Device Use		$69
CPT 99457 - Monitoring for the 1st 20 minutes	+	$54
CTP 99458 - Monitoring for the 2nd 20 minutes	+	$42
Total RPM Monthly Reimbursement	=	$165
RemetricHealth's RPM Program Monthly Fee	-	$45
Clinical Service Fee ($30 per 20 mins)	-	$60
Physician's Gross Margin/Patient per month	=	$60
Physician's Gross Margin/Patient per year	x12=	$720
One Time Device Acquisition Cost (Essentials +)	-	$95
Physician's Net Revenue per Patient		$625
Net Revenue on 100 patients		**$62,500**

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We'll be here for you!

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Our Partners

EHR Integration Process

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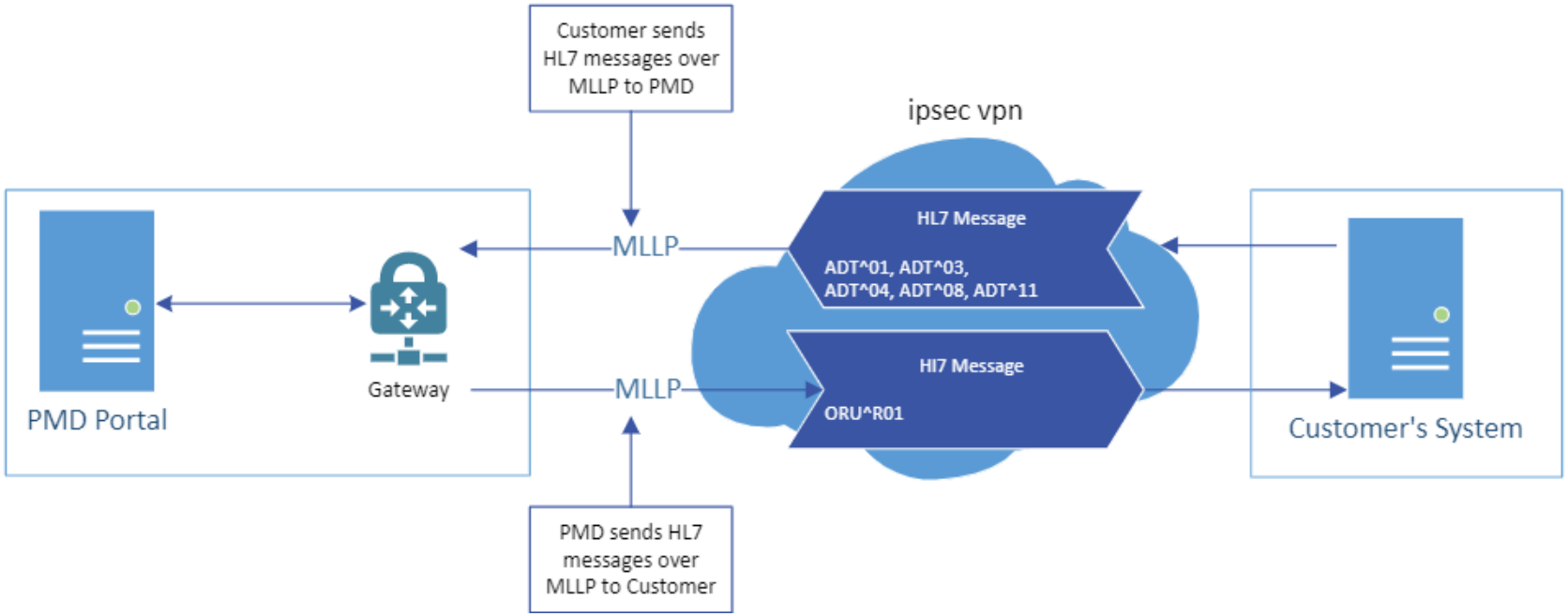
- Data is bidirectional
  - Customer sends patient messages for creating or updating a patient profile
  - RemetricHealth sends patient measurements to the customer's system
- Steps to integrate
  - Customer system should support HL7 v2.5 messages
  - Secure network connection (example IPSEC VPN) should be established between RemetricHealth and Customer
  - Setup Gateway on RemetricHealth's site with new Customer



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Get Started with Ease

IDENTIFY
Appropriate patient

- Recently hospitalized
- High risk for re-hospitalization or E.R visits
- Difficulties with transportation
- Lives in rural setting
- Lives alone

SELECT
Right Care Plan

- Customized care plans to fit the needs of each patient
- Select from validated symptom tools
- Define adherence goals and manage
- Customize patient learning plans

DEPLOY
Necessary Devices

- Select what's best for the individual patient based upon conditions
  - CHF
  - COPD
  - Diabetes
- Easy no hassle set up for patients
- Logistics management customized

ENGAGE
Stakeholders

- Wireless Bluetooth Devices send data effortlessly from patients home to Secure HIPPA compliant Web Portal
- Access data 24/7
- Downloadable data for printing, sharing
- EMR Integration for easy access to data

INTERVENE
Anytime/Any where

- Customize alerts and notifications
- Send notifications where and how you want them sent
- Simply manage large #'s of patients based upon standard or customized plans
- View only alerts/flags, trends

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Demonstrated Clinical Impact

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Osler Health Network 2019 RPM Case Study

BACKGROUND

As Value-Based Healthcare prevails, executives turn to RPM to help control costs, increase quality of care, and improve overall outcomes.

Osler Health Network is an Independent Practice Association and an Accountable Care Organization comprised of 22 Primary Care Offices in Northern New Jersey. Led by Rick Pullman, CIO of Osler Health, the Network turned to RemetricHealth's Remote Patient Monitoring Program to support their high-risk chronically ill patients.

METHODS

RPM Kits were provided to high-risk patients enabling real-time monitoring of biometrics, symptoms, and program adherence.

RemetricHealth's remote patient monitoring data was integrated directly into Osler Health's EHR system to improve patient health outcomes across its 22 practices

The system generated automatic notifications of potential acute events. A nurse triaged accordingly when warning notifications were received

RESULTS

Osler Health Network was able to cost-effectively manage the growing number of patients with chronic conditions.

Each month, the CMS reimbursements for utilizing RPM largely surpassed the cost of the RPM program, significantly increasing Osler Health's net revenue.

The continued expansion of RPM reimbursements allow providers to build a strong financial model for RPM services while delivering higher-quality care to more patients.

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Southeastern Home Health on RPM

REMOTE PATIENT
MONITORING CASE STUDY

Southeastern Home Health Agency

SUMMARY

Southeastern Home Health Agency is one of the largest providers of home care services in the U.S., serving over 10,000 patients. After switching from Phillips to PMD Healthcare's Remote Patient (RPM) Program, Southeastern Home Health rapidly tripled their RPM utilization to over 200 of their most complex patients with chronic conditions. The program has proven to reduce re-hospitalizations, increase the number of days kept out of the hospital, and improve the quality of life for patients.

"After deploying PMD Healthcare's Remote Patient Monitoring technology, Southeastern Home Health Agency was able to dramatically reduce readmissions to our most at risk patient population. PMD Healthcare successfully integrated their platform with our Electronic Medical Record System, streamlining our operations and increasing the efficiency of the technology. Our short and long-term plans are to continue to grow our use of PMD Healthcare's Remote Patient Monitoring."

-George Pinel, CEO

Original Research Feasibility and Acute Care Utilization Outcomes of a Post-Acute Transitional Tele-monitoring Program (COPD/HF)

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BACKGROUND

COPD and Heart Failure are chronic diseases that impart significant health and care costs on the patient and healthsystem.

METHODS

The intervention as a prospective 90 day transitional care program following an acute event that integrated a mobile health technology and home visits for patients with COPD and/or Heart Failure.

RESULTS

The 30 day readmission rates were reduced by 50% for both COPD and Heart Failure patients versus the control group.

The program was feasible and satisfactory to patients with daily adherence greater than 70%.

Patients sustained clinically meaningful improvements in their health status.

TELEMEDICINE and e-HEALTH SEPTEMBER 2015

ED and Readmission Rates

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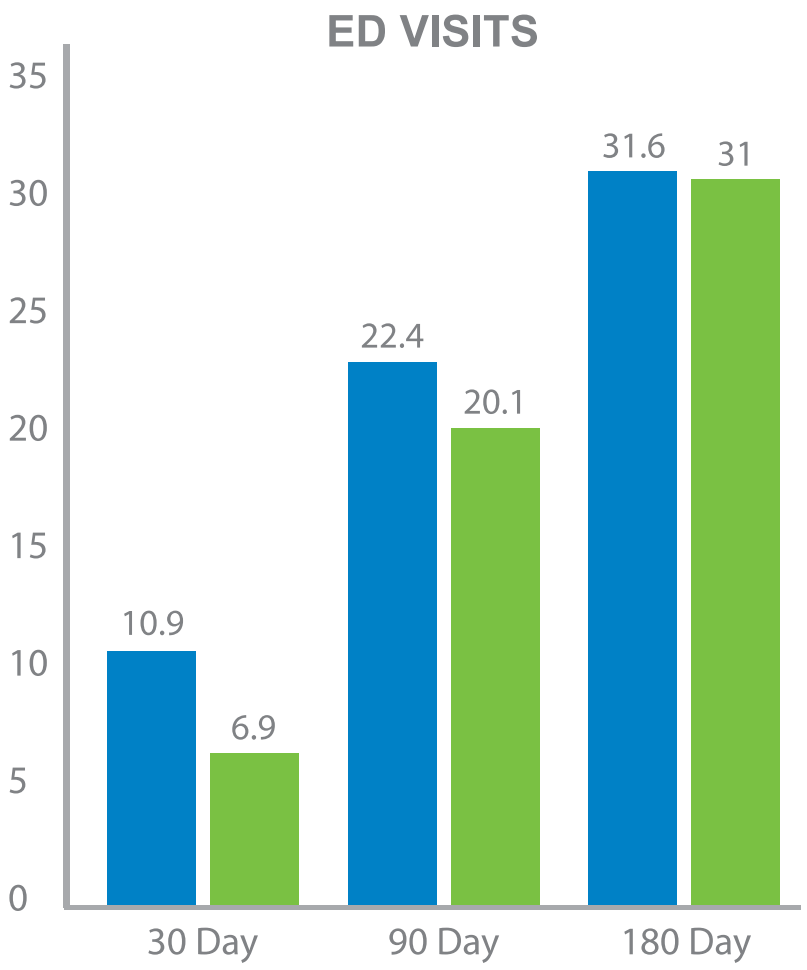

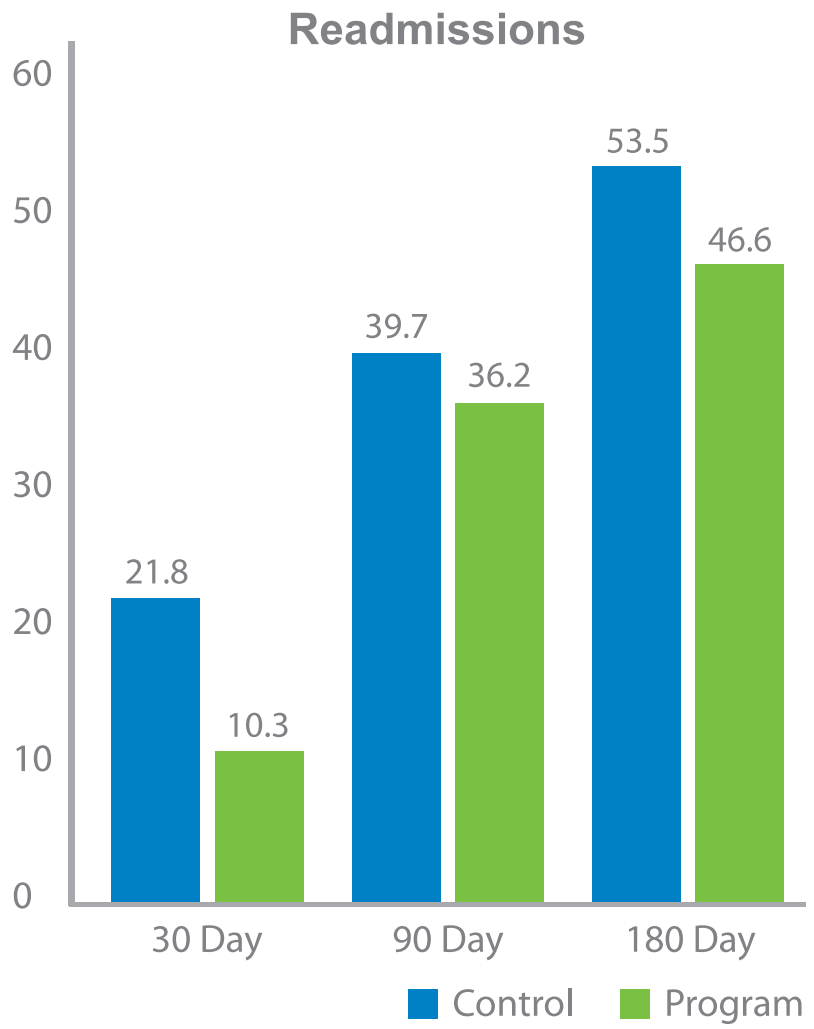

TELEMEDICINE and e-HEALTH SEPTEMBER 2015

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Seminal VA Study on RPM

RPM Trials—The Seminal VA Study

- At the end of 2008, the US VHA released its findings for its care coordination/home telehealth program, and the results were quite positive. In essence, this was the first study of this magnitude in the United States concerning remote telehealth services. The data analysis consisted of 17,025 patients. The data showed a 25.0% reduction in the number of bed days of care, a 19.0% reduction in the number of hospital admissions, and a mean satisfaction score rating of 86.0% after enrolment into the program.
- These results were a step toward confirming what the healthcare providers in an enterprise-wide environment have speculated for years with smaller studies, namely that home telehealth is an appropriate form of chronic care patient management. This data also shows that remote monitoring has cost-saving potential, particularly compared to existing alternative programs, although its overall healthcare system cost savings is still debated. One such example is the fact that while decreases in hospital bed days of care have been shown, increases in clinic visits are also common in remote monitoring systems, and can balance out the cost savings across the healthcare system.
- Nevertheless, these published findings by the VA are a big first step toward home telehealth adoption within the United States at a time when validations are strongly needed for market growth. This has resulted in a continued expansion for remote monitoring services by the VA and other public sources up until the forecast base year. More expansion is expected beyond that date.

Direct source:
http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2013/Jan/1657_Broderick telehealth_adoption_VHA_case_study.pdf

Source: Frost & Sullivan

VA 2.0

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More Recent VA Findings

Key Takeaway: In the United States, the largest adaptor of Telehealth services continues to be the VA.

- Based on 2012 data, the VA reports, "the VHA represents half of the 300,000 chronic disease remote monitoring patients in the US. It has awarded contracts for $1.4 billion to mHealth technology vendors for devices and services and has published the most comprehensive studies on the costs and benefits of deploying mHealth and remote patient monitoring across multiple chronic disease, geographies, and socio-demographics."
- The VA's telehealth and RPM grew from an initial program of 2,000 patients in 2003 to over 150,000 in 2012. Services are to largely men between the ages of 50 and 90 years, with specific disease programs addressing diabetes (48%); hypertension (40%); congestive heart failure (CHR) (25%); chronic obstructive pulmonary disease (COPD) (12%); and mental health (about 5%).

Significant findings include:

The annual cost to deploy these programs is $1,600 per patient per year, compared to over $13,000 for traditional home-based care and over $77,000 for nursing home care.

The key economic benefit occurs from the cost avoidance associated with telehealth and mHealth remote monitoring services that have led to 25% reduction in number of bed days of care and a 19% reduction in hospital admissions

Benefits vary by disease; for example, the reduction in hospitalization for mental health patients exceeds 40%, while those for CHF and hypertension range from 25% to 30% and diabetes and COPD average about 20%.

Source: US VHA[80f9]; Frost & Sullivan

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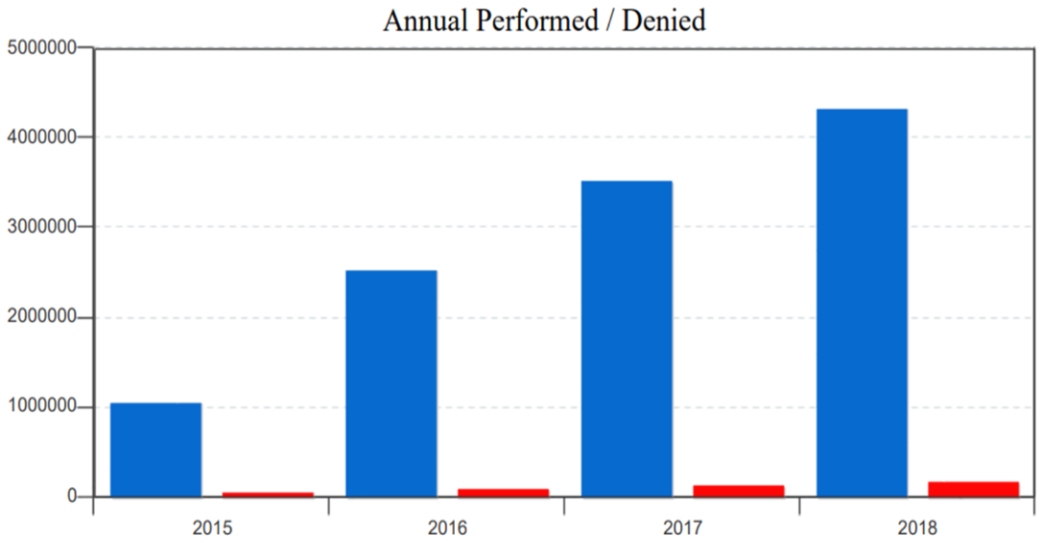
CPT 99490
2018 Medicare Claim and Payment

Medicare Part B Utilization Data for 99490*



Total National Services (all modifiers) Submitted 2018: 4,322,763
Total Services Denied 2018: 169,427 (3.9%)