Value-Based Care Integration: Using RPM Data to Succeed in Alternative Payment Models

June 18, 2026

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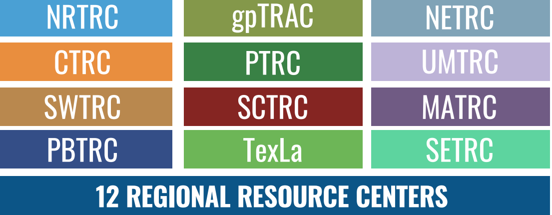

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Jason C. Goldwater, MA, MPA

Laurel Health Advisors, LLC

June 18, 2026

The Shift to Value-Based Care

From Volume to Value in Healthcare

Success Requires Continuous Patient Insight

RPM Enables Proactive, Data-Driven Care

The Role of Remote Patient Monitoring

Continuous Patient Data Outside the Clinic

Common RPM Dta Sources:

- **Blood pressure** monitors
- **Glucose** monitors
- **Pulse** oximeters
- **Weight scales**
- **Wearable** devices
- **Digital** symptom tracking

Continuous patient visibility enables **earlier intervention** and proactive care

Continuous Data That Drives Better Outcomes, Lower Costs, and Smarter Care

Value-Based Care Requires Providers to...

Prevent Complications

Manage Chronic Disease Effectively

Reduce Avoidable Utilization

Demonstrate Measurable Quality Improvement

RPM Enables:

Detect Risk Earlier

Enable **Proactive Intervention**

Improve Patient **Engagement**

Generate **Measurable Performance Data**

Support Long-Term **Care Improvements**

Better Outcomes

Lower Costs

Higher Patient Satisfaction

Stronger Quality Metrics

Key Value-Based Payment Models

Managing Financial Risk in Alternative Payment Models

RPM is Particularly Valuable in:

Accountable Care Organizations

Population Health Management & & *Shared Savings*

Bundled Payments

Episode-Based Care Management

Medicare Advantage

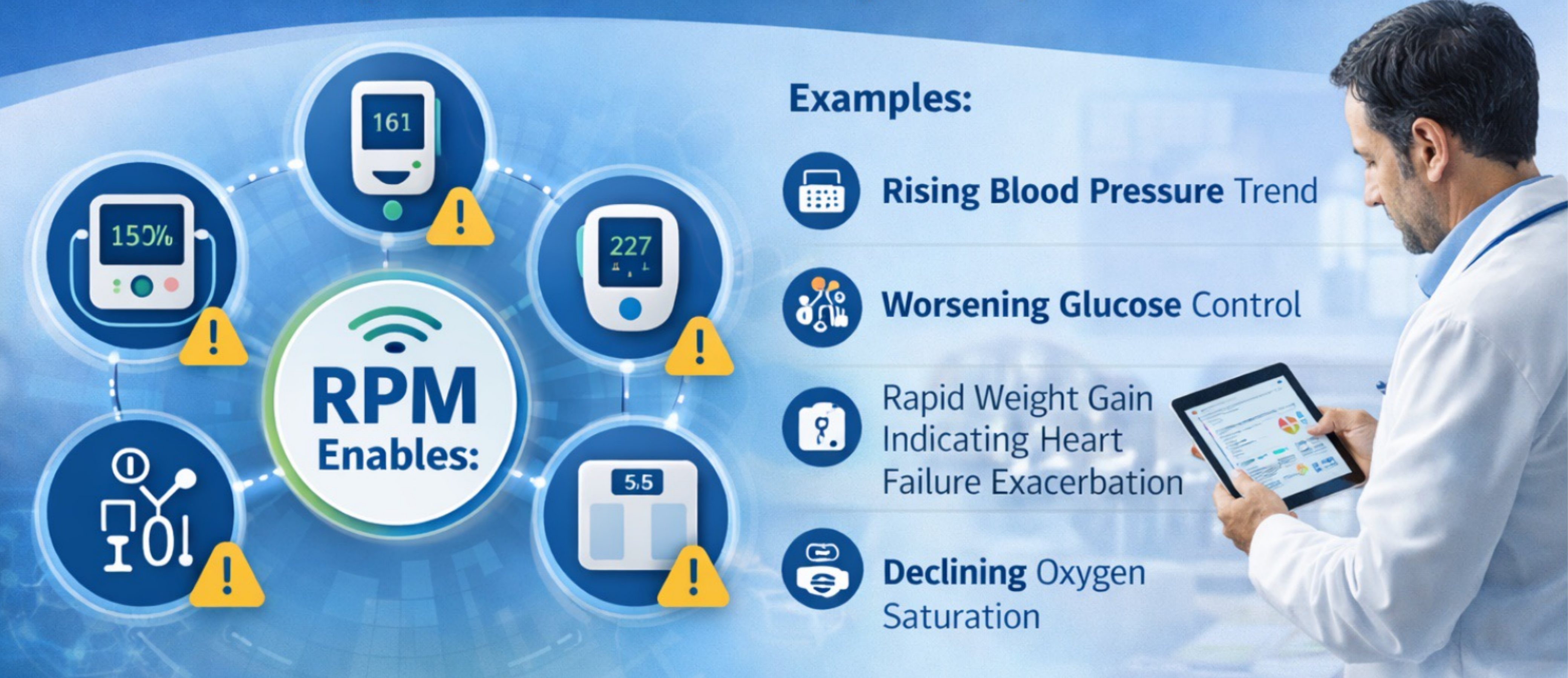
Value Programs

RPM *Enables:*

Commercial

Value-Based Contracts

RPM Provides the Data Infrastructure Necessary to Manage Financial Risk


Identifying High-Risk Patients Earlier
Using Remote Patient Monitoring for Early Risk Detection
161
150%
227
5.5
RPM
Enables:
Examples:
Rising Blood Pressure Trend
Worsening Glucose Control
Rapid Weight Gain
Indicating Heart
Failure Exacerbation
Declining Oxygen
Saturation
Early Detection Allows Medication Adjustments | Telehealth Consultations | Preventive

669
162
197
EMERGENCY
RPM
Enables:
5.5
Early Detection Allows Medication Adjustments | Telehealth Consulrations

RPM and Chronic Disease Management
Supporting Control of High-Cost Health Conditions
227
167
RPM
Enables:
Hypertension
Diabetes
Heart Failure
COPD
Post-Op
Recovery
→ Improved Clinical Stability
→ Improved Medication Adherence
→ Better Patient Self-Management

Improving Quality Measure Performance

Value-based care contracts depend heavily on quality measures.

- **Blood pressure** control (HEDIS)
- **Diabetes** A1c management
- **Heart failure** management
- **Readmission** rates
- Preventive care adherence

Continuous data allows **better documentation** of clinical improvement.

Documenting Care Coordination and Engagement

Value-based care requires proof of:

- Care management activities
- Patient engagement
- Coordination across providers

RPM supports documentation of:

- Clinical alerts and interventions
- Care team outreach
- Patient communication
- Monitoring compliance

These activities strengthen quality reporting and payer accountability.

Integrating RPM Into Population Health Platforms

RPM data becomes most valuable when integrated into population health tools.

- **Electronic** Health Records (EHRs)
- **Population** health dashboards
- **Risk** stratification systems
- Care management platforms

This enables data-driven clinical decision making.

Integration components include: ✓ **Electronic** Health Decirbboards

Building RPM Population Health Dashboards

RPM data becomes most valuable when integrated into population health tools.

- **Key dashboard** capabilities:
  - **Risk** segmentation
  - **Alert** prioritization
  - **Trend** analysis
  - **Outcome** monitoring

Effective dashboards combine:

- **RPM data with:**
- **Claims** data
- **Clinical** records
- **Social** determinants of health
- **Utilization** patterns

Key dashboard capabilities:

- **Risk** segmentation
- **Alert** prioritization
- **Trend** analysis
- **Outcome** monitoring

BLOOD PRESSURE
140 / 82
153 mg/dl
BLOOD
5 high risk
COMPLIANCE
78%
RPM VITAL SIONS
Algn risk
5
High Risk
55
5.2
Average Stay
27%
15 %
31%
UTILIZATION
DEMOGRAPHIA
20%
High risk
65%
Rising risk
13%
14%
READMISSION
5.2
DEMOGRAPHIC
75%
42%
SESS
30%

Using RPM Insights to **Drive Care Management**

RPM data should **trigger targeted care management** interventions.

Nurse outreach when thresholds exceeded

Medication titration protocols

Telehealth visits

Referral to specialty care

Behavioral coaching

This creates **proactive** rather than **reactive** care.

Aligning RPM With Care Management Workflows
RPM works best when integrated into existing workflows.
Automated alert generation
Clinical triage protocols
Care manager outreach
Provider escalation
Intervention documentation
RPM DATA
Workflow integration ensures RPM improves care rather than creating alert fatigue.

Demonstrating Value to Payer Partners

Payers want ovidence of:

Cost Reduction

Improved Outcomes

Better Chronic Disease Control

RPM provides measurable metrics such as.

Reduced Admissions

Reduced ED Visits

Improved **Quality Scores**

Improved **Medication** Adherence

Workflow integration ensures RPM improves care rather than creating.

Sharing RPM Data With Payers
Healthcare organizations can use RPM data to:
Support value-based contract performance reports
Demonstrate clinical improvements
Provide population health insights
Document intervention activities
140 / 82
134 / 100
RPM DATA
✓ Support value-based contract performance reports
✓ Demonstrate clinical improvements
✓ Provide population health insights
✓ Document intervention activities
Transparency builds stronger payer-provider partnerships.

Structuring Shared Savings Models with RPM

Organizations can incorporate RPM into value-based contracts through:

Shared Savings
Tied to utilization reduction

Quality Bonuses
Linked to chronic disease metrics

Care Management
Payments

Risk-Adjusted
Patient Monitoring Programs

Clinical Tool | Financial Strategy | Better Outcomes

Operational Considerations for RPM Implementation

Successful RPM programs require:

Technology Infrastructure

Device integration

EHR connectivity

Data analytics platforms

Operational Infrastructure

Care management staff

Clinical protocols

Data governance

RPM must be embedded within population health strategy.

Future Directions: AI and Predictive Analytics

The next generation of RPM will include:

AI-driven risk prediction

Predictive hospitalization models

Automated care pathway recommendations

AI

Automated care pathway recommendations.

RPM must be **ernbedded** within population health strategy.

Key Takeaways
Remote Patient Monitoring is becoming essential for success in value-based care.
140 / 82
166 / 78S
RPM
Identify high-risk patients earlier
Reduce avoidable hospital utilization
Improve quality metrics
Enhance care coordination
Organizations that successfully integrate RPM into population health management
will be best positioned to succeed in alternative payment models.

Thank You!

Laurel Health Advisors, LLC

301-529-4245

jgoldwater@lh-advisors.net

https://www.laurelhealthadvisors.net

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The NCTRC Webinar Series

Occurs 3rd Thursday of every month.

Hosting TRC: Pacific Basin Telehealth Resource Center (PBTRC)
Telehealth Topic: Trust as Infrastructure: The Human Foundation of Sustainable Telehealth Programs
Date: July 16, 2026
Times: 11 AM – 12 PM (PT)

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