





✔ Value Proposition

✔ Reduce Unnecessary Hospitalizations, ER, Home Visits

- ✔ Remote Data Collection / Near Real-time Feedback

✔ Minimize Costs and Maximize Resources

- ✔ Ability to Serve More Patients / Increase Staff Efficiency / Lower Re-admissions

✔ Help Reduce Advancement to More Severe Disease States

- ✔ Proactive vs. Reactive / Watch Trends / Stay Ahead of Disease

✔ Lower Cost to Deploy & Maintain

- ✔ End to end remote health monitoring solution for long term sustainable chronic condition management
- ✔ Smart, automated, wireless devices that are familiar to users and fit lifestyle
- ✔ Simple, affordable and flexible connected tools through an end-to-end service offering
- ✔ Flexible, intelligent web-based communications platform that fit any operational setting

✔ Easy to Use

- ✔ Out of the box setup for consumer and auto transmission
- ✔ Multiple options for care provider reporting and interaction

✔ Scalable with Mass Market Appeal

- ✔ Auto-pairing, auto-time setup, remote battery indicator
- ✔ Group enrollment, affordable, flexible (The comprehensive mTelehealth home health monitoring kits for CHF, COPD, Diabetic, and Hypertensive patients cost between \$2.97 and \$3.50 USD per day)

✔ Ability to Provide Full Patient Virtual Care Exam

- ✔ Platform provides medical devices which collect basic vitals (i.e. - weight, blood pressure, pulse, oxygen level, and glucose level) as well as advanced "in office/clinic" exam patient data (i.e. - images of the ears, skin, throat, and tonsils, plus heart, lung, and abdominal sounds)

Telehealth and Remote Patient Monitoring (RPM) - Provider Case Studies – Vidant Health System

- ✔ Vidant Health System, a nine-hospital, 70+-clinic network serving some 29 counties and 1.4 million people, reported a whopping **67 percent reduction in hospitalizations** and a **68 percent reduction in hospital bed days**.
- ✔ The study is further proof that health providers are seeing measured success in connecting recently discharged patients and those with chronic conditions to home-based care programs that make use of monitoring devices and a communications link to care providers.
- ✔ Hospital administrators proposed the post-hospital discharge program to target patients with cardiovascular disease and pulmonary disease, who are generally part of a health network's high-risk, high-cost population. The project was designed to measure patient communication and access to care after discharge, as well as readmissions and days spent in the hospital as a result (bed days).