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Remote Patient Management to Improve Outcomes, Reduce Healthcare Utilization, and Increase Practice Capacity: A Demonstration Project in Georgia



Remote Patient Management to Improve Outcomes, Reduce Healthcare Utilization, and Increase Practice Capacity: A Demonstration Project in Georgia

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Disclosures



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Mindy Ditch and Ann Holder are employees of the Marani Health organization. They were not involved in producing the presentation content.



None of the Authors have other financial disclosures to report.



No off-label usage will be discussed.

THE PROBLEM

Challenges creating a *maternity crisis*

Lack of Access & Fragmented Care:

- 35% of counties lack birthing facilities or OB/GYNs¹
- 2.3 million women live in maternity deserts¹

High Chronic Disease Burden:

- Chronic conditions drive prenatal costs much higher than routine pregnancies.

Antiquated Technology:

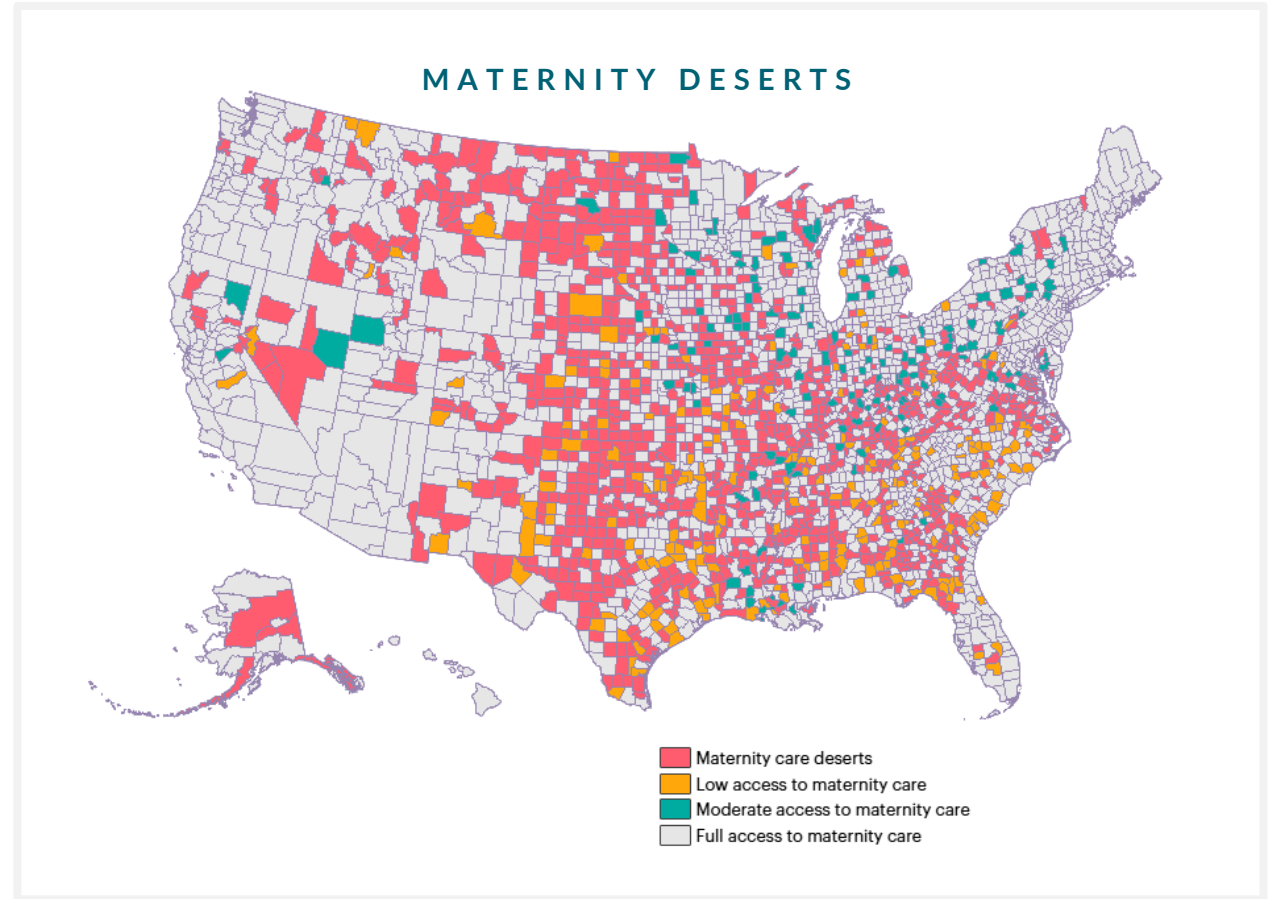
- Monitoring technology from the 1960's still in use

Health Inequities and Racial Disparities:

- Unequal access and treatment drive both higher costs and poorer outcomes in affected populations

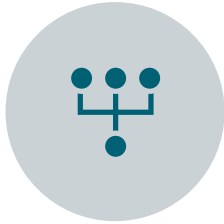
High Costs for Patients & Payers:

- Avoidable costs for maternal care, place financial strain on insurers, government programs, and patients alike.

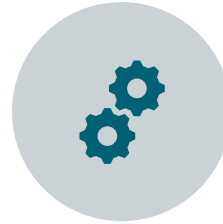


Accessible prenatal and
postpartum care *for all*





Alleviating strain in an already maxed-out system



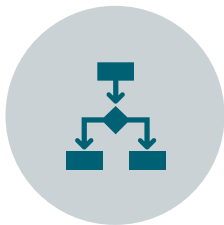
Baseline MCG operations show clear capacity strain:



4,861 OB ED encounters in a year for 1,324 deliveries (~3.7 ED visits per delivery)



ED diversions rising from 3% to 30%,



a clinic no-show rate of 10–13%.



The demonstration project is explicitly structured to **free up clinic space and staff time,**

Patient Care Obstacles

- Limited providers and Clinic availability
- Maternity Deserts and Travel Barriers
- Resource challenges
- Lack of patient engagement
- Limited data for clinical management



Wellstar Catalyst Demonstration Project | Obstacles

- Limited Access
- Disconnected episodes of care
 - Clinic
 - OB triage
 - Subspecialty care
 - Hospital follow-up
- Tracking disease management
 - Messaging
 - Blood pressure and weight
 - Diet and glucose monitoring
 - Social Determinants of Health
 - Opportunity to address therapy and early identification of disease progression



Marani: Digital health interface



Improve Outcomes

Get more patients to delivery without unnecessary hospitalizations / ER visits and preventable complications



Patient Experience

Innovative offering for patients looking for differentiated and convenient care



Inclusive

Providing remote access to care for all patients



Mitigate Risk

Increase efficiency and profitability using data and AI to monitor, intervene, and treat patients

Marani: *Connecting the Care Experience*

The maternal health ecosystem is complex and often disconnected.



Improve patient access to care in a resource-limited setting

- Targeting high-risk, hard-to-reach population
- **Eligibility**
- The program specifically enrolls pregnant patients with ≥ 2 chronic conditions or documented barriers to accessing OB care, i.e., those most likely to fall through the cracks in a constrained system.



Purpose-built for *Every Pregnancy*

Customized to meet the needs for each pregnancy and every care team

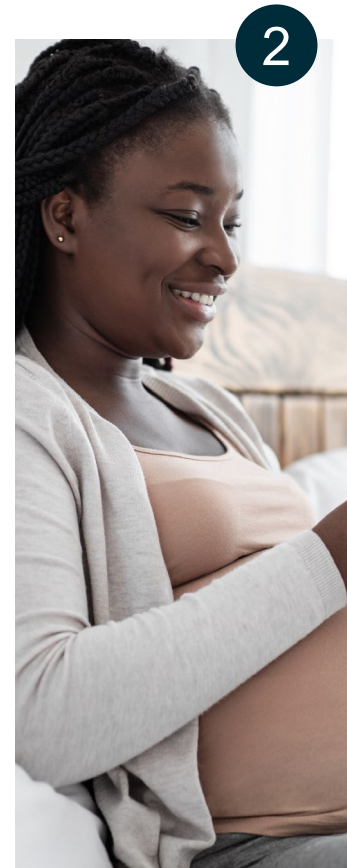


LOW-RISK

- Fewer in-person appointments
- Enhanced patient engagement
- Closer monitoring to catch rising clinical, mental and social health risks

GOALS

- *Reduction in antenatal ER visits*
- *Improved HEDIS Scores*



HIGH-RISK

- More frequent touch-points to drive improved patient compliance
- Personalized care plans
- Higher frequency of monitoring clinical, mental and social health measures
- Closer management of patients with gestational hypertension, gestational diabetes and preexisting conditions

GOALS

- *Reduction in NICU LOS*
- *Reduction in ER visits*
- *Improved HEDIS Scores*

Top pregnancy *complications driving outcomes*

GESTATIONAL HYPERTENSION

8% of all pregnancies



GESTATIONAL DIABETES

10% of all pregnancies



MENTAL HEALTH

20% of all pregnancies



100% Can Be Monitored & Managed Remotely

Evidence-Based Care Protocols

<i>Observation</i>	<i>Prenatal</i>	<i>Postpartum</i>	<i>Risk Levels</i>	<i>Links to Evidence & Guidelines</i>
Blood Pressure/Heart Rate	Yes	Yes	<ul style="list-style-type: none"> • Low Risk • Rising Risk • High Risk 	<ul style="list-style-type: none"> • AHA • AMA • CDC • CMS • NCQA/HEDIS • USPSTF, USPSTF 2 • Evidence-based RPM programs
Weight	Yes	Yes	<ul style="list-style-type: none"> • All patients 	<ul style="list-style-type: none"> • ACOG • CDC • USPSTF • Evidence-based RPM programs
Blood Glucose	Yes	Yes	<ul style="list-style-type: none"> • All patients with diabetes 	<ul style="list-style-type: none"> • ACOG • ADA • CDC • Evidence-based RPM programs
Mental Health	Yes	Yes	<ul style="list-style-type: none"> • All patients • High Risk 	<ul style="list-style-type: none"> • ACOG • CDC • NCQA/HEDIS, NCQA/HEDIS 2 • USPSTF • Evidence-based RPM programs
Social Determinants of Health	Yes	Yes	<ul style="list-style-type: none"> • All patients 	<ul style="list-style-type: none"> • AMA • ACOG • CDC • Evidence-based RPM programs

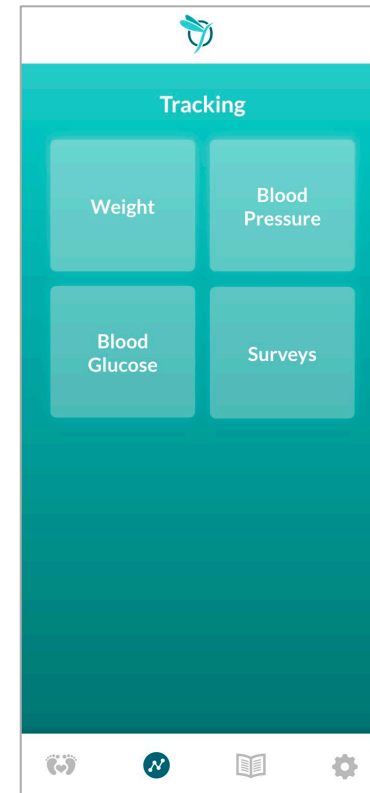
Care protocols are designed to be utilized from pregnancy confirmation to 52 weeks postpartum

THE SOLUTION

2 Connected Devices

Easily take measurements, store, and share health history data with care teams

- Devices include blood pressure, weight scale, and glucose monitor
- Connects to cellular service and linked to the consumer's MyOther App account, making it easy to collect readings and automatically store
- Trending of tracked vitals for members to gain valuable insights on their health and share with care teams










Portal Features | Patient Enrollment




All patients **My patients** Custom list

Records for search: 7 Search for patients

New Patient

Patient	Pre-e
 Johnston, Priscilla 01/05/2000 24 years	Asth Diab
 Grose, Terry 02/04/2001 22 years	
 December, Sharon 07/13/2006 17 years	Auto Eclar
 Garafolo, Jeneane 01/04/2000 24 years	
 Canholder, Susan 11/09/1995 28 years	
 Thornbush, Eliza 01/01/2000 24 years	
 Hughes, Alyssa 01/01/2000 24 years	

New patient



Name: **Thompson, Jenna**
DOB: **04/19/1998** | 25 years

EHR: _____
Platform ID: **(generated)**

Organization *
Mcare Demo

Identification

Demographic Details

Communication

Address

Program / Protocol

Devices

Prenatal Care Program
The M-care program for managing prenatal care. [more details](#)





























Prenatal Protocols

Blood Glucose Monitoring - Gestational Diabetes
Blood Glucose Monitoring - Gestational Diabetes [more details](#)

Blood Glucose Monitoring - Type 1/2 Diabetes
Blood Glucose Monitoring - Type 1/2 Diabetes [more details](#)

Blood Pressure Monitoring - Chronic HTN
Blood Pressure Monitoring - Chronic HTN

Cancel **Previous** **Next** **Save**

Care Team
TA BA    
BA TA    
BA TA    
BA TA    
BA TA    
TA    
TA    

Blood Pressure Monitoring - Chronic HTN
Mental Health Screening - Edinburgh Survey
Social Determinants of Health Screening - PRAPARE Survey
Weight Monitoring

BP HR
WT EPDS
BG SDOH

Active - Prenatal
28 weeks 6 days

Take Blood Pressure
01/31/2024 01:00

Portal Features | Patient Enrollment




All patients My patients Custom list

Records for search: 7 Search for patients New Patient

Patient	Pre-e
Johnston, Priscilla 01/05/2000 24 years	Asth Diab
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New patient



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EHR: Platform ID: (generated)

Organization *
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Demographic Details

Communication

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Program / Protocol

Devices

Ship Devices

- None
- [Pylo] Blood Pressure Monitor | 802-LTE (22 - 42 cm)
- [Pylo] Blood Pressure Monitor | 802-LTE, XL Cuff (22 - 45 cm)
- [Pylo] Glucometer | GM291
- [Pylo] Weight Scale | 300-LTE

Cancel **Previous** **Next** **Save**

Care Team
TA BA
BA TA
BA TA
BA TA
BA TA
TA
TA

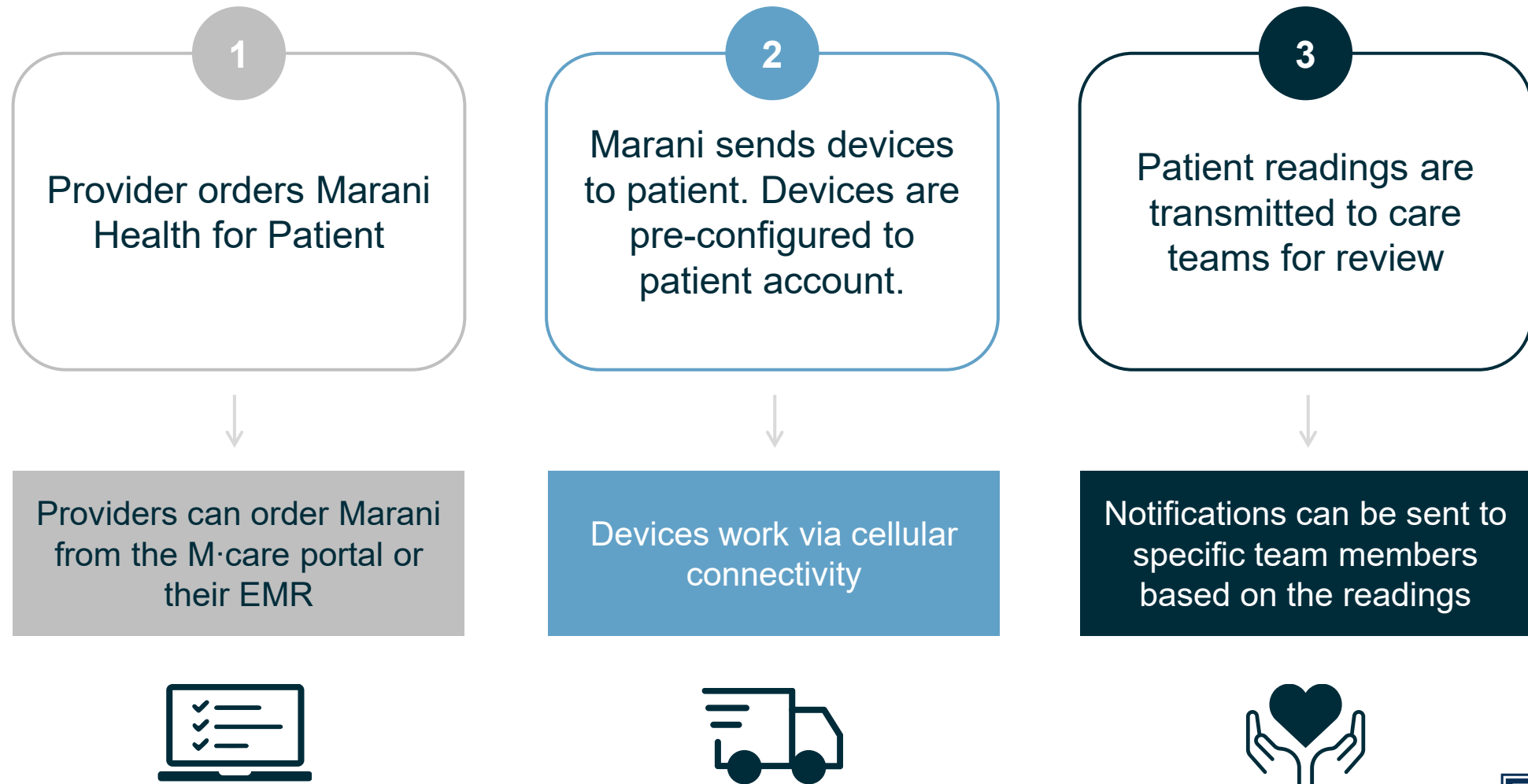
Blood Pressure Monitoring - Chronic HTN
Mental Health Screening - Edinburgh Survey
Social Determinants of Health Screening - PRAPARE Survey
Weight Monitoring

BP HR
WT EPDS
BG SDOH

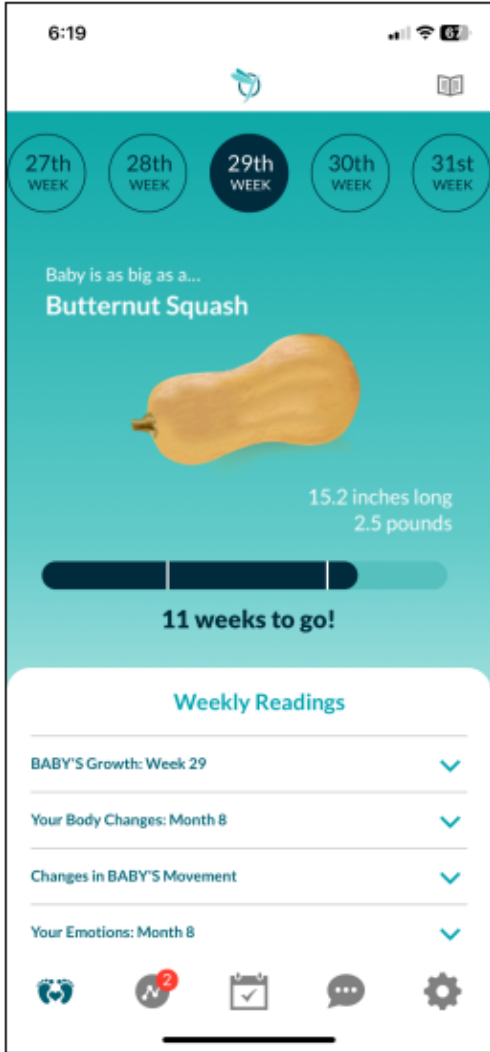
Active - Prenatal
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Take Blood Pressure
01/31/2024 01:00

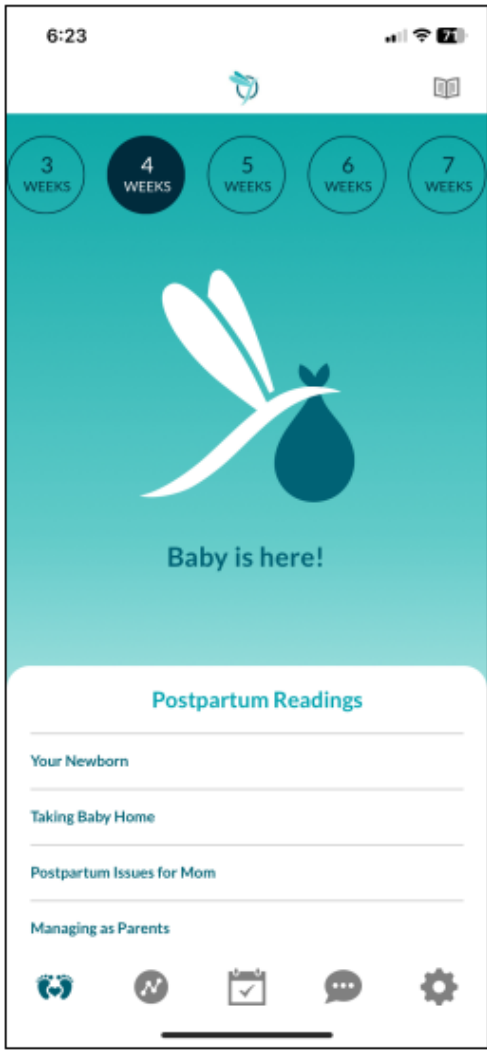
Deploying the Product *in Clinic*



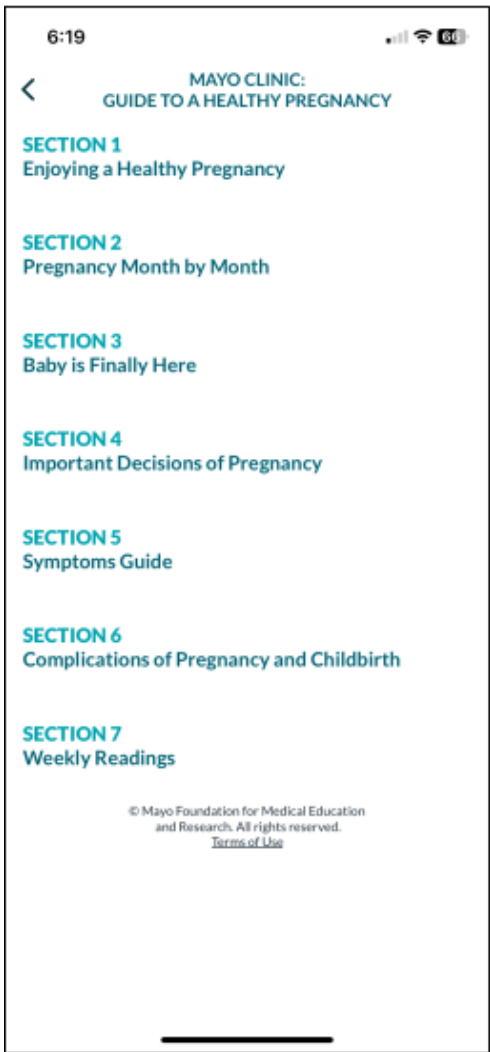
Mobile Features | Patient Education



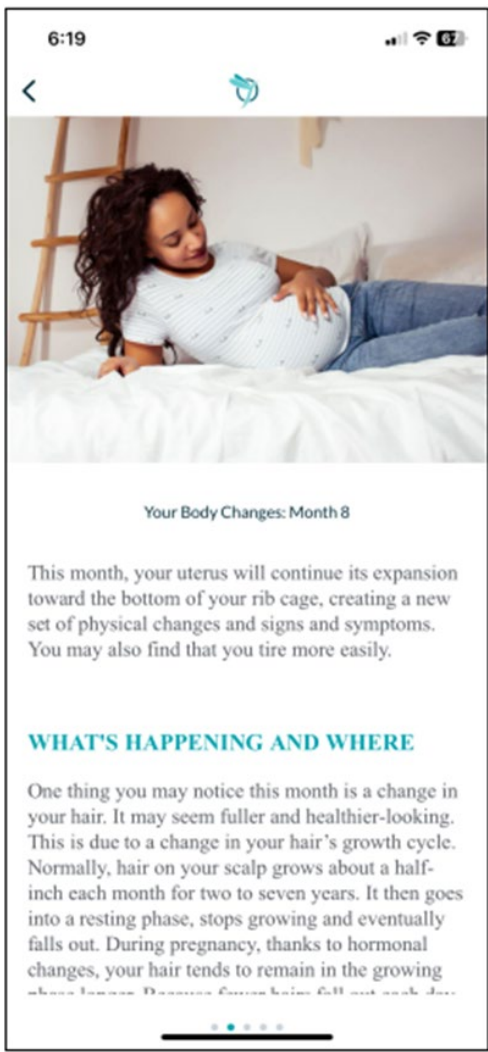
Education Content by Gestational Age



Postpartum Educational Content

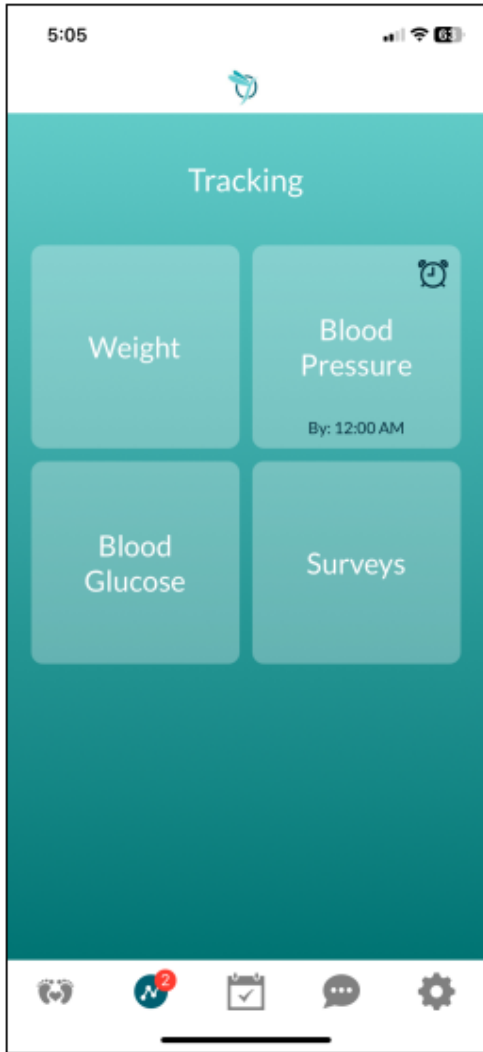


Mayo Clinic: Guide to a Healthy Pregnancy

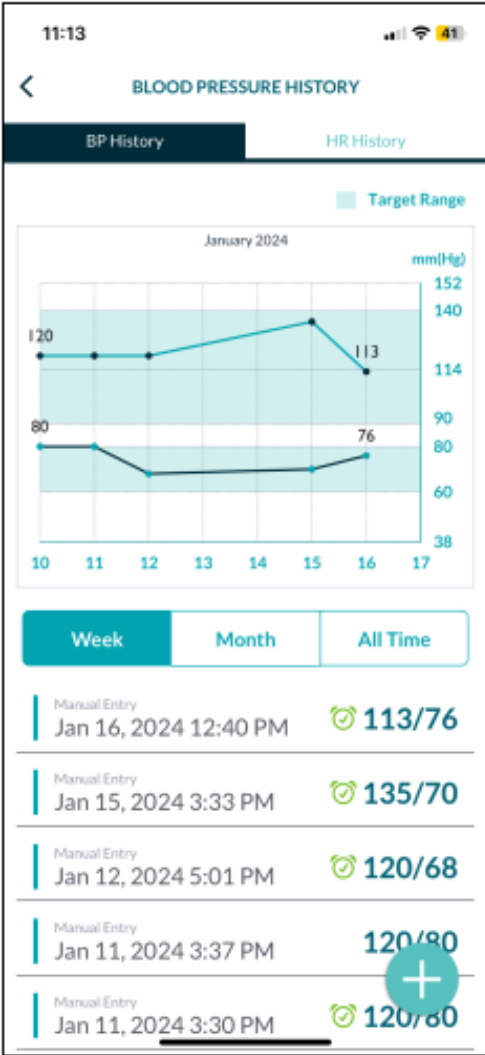


In-App Reader

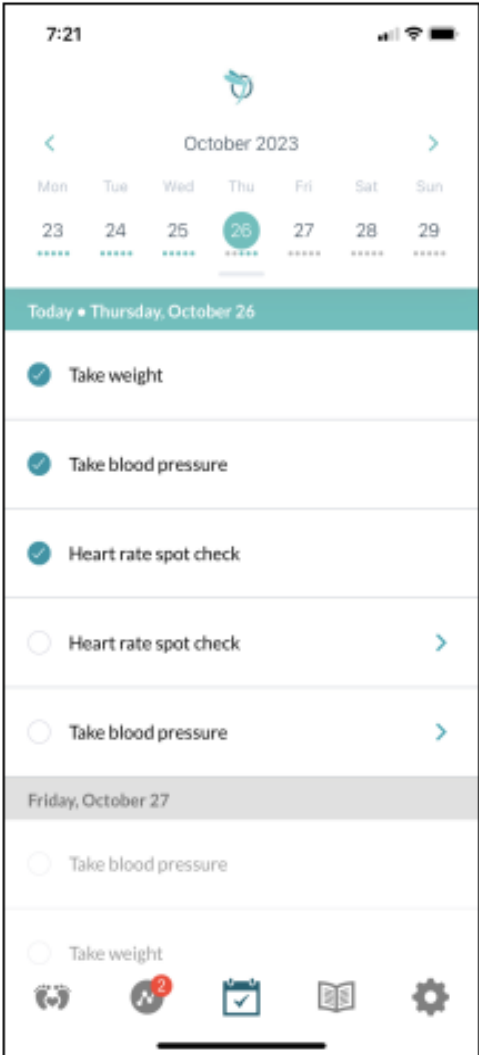
Mobile Features | Observations



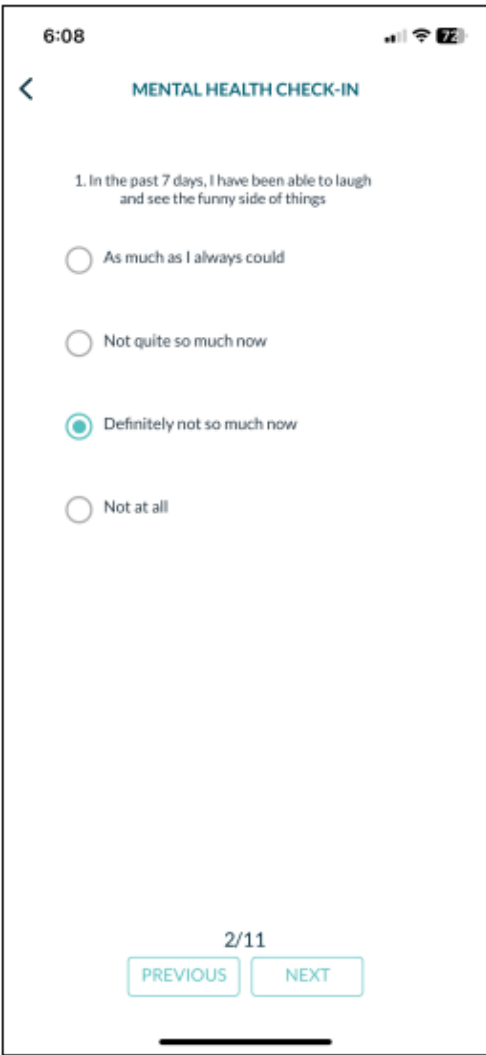
In-App Task Support



Reading History

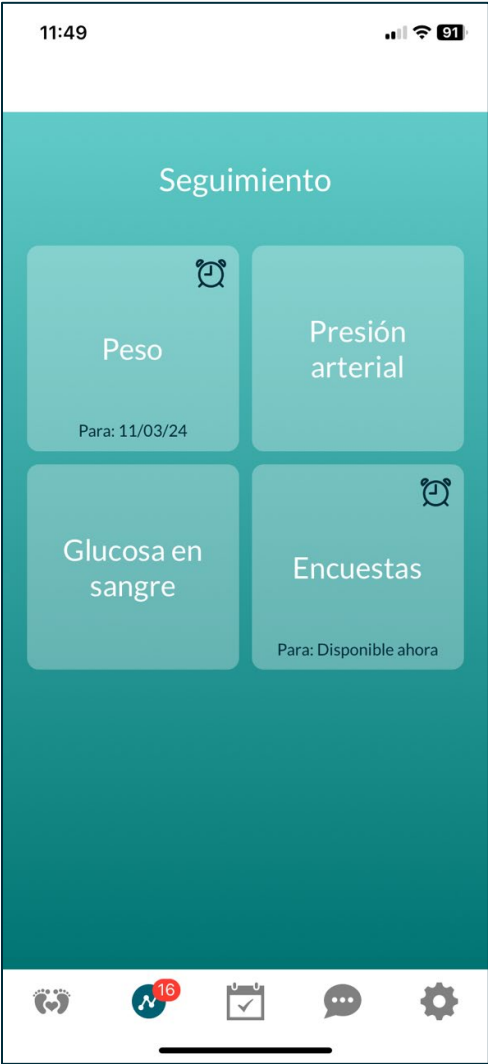


Care Plan Calendar

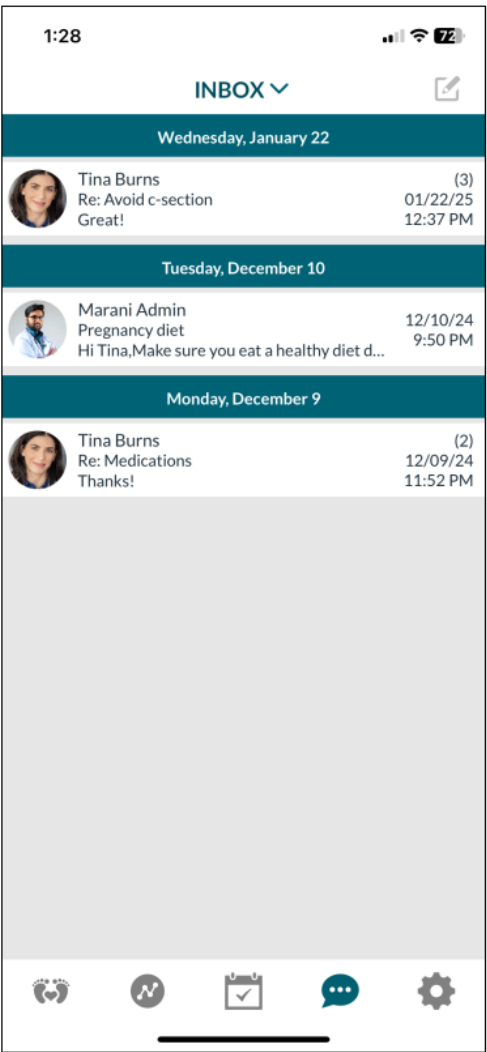


In-App Surveys

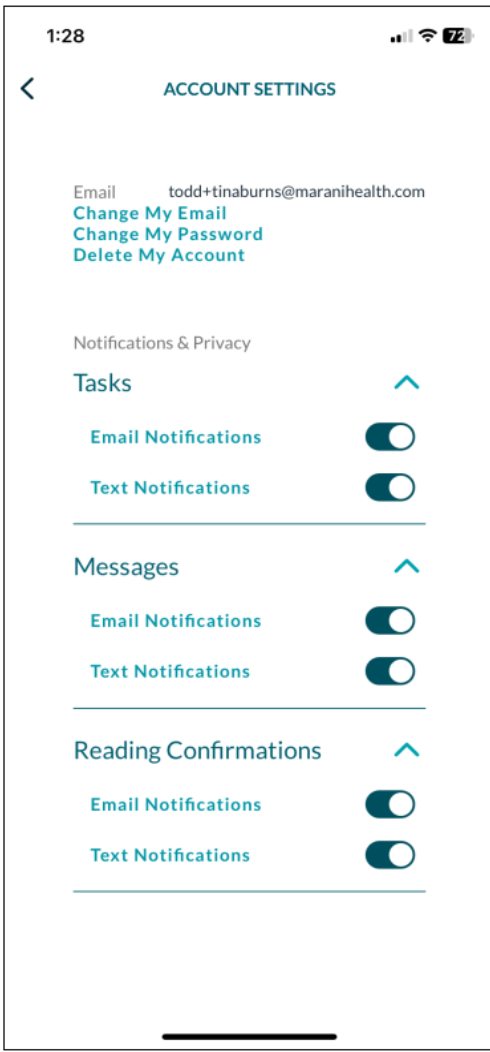
Mobile Features | Language Translation, Messaging & Notifications



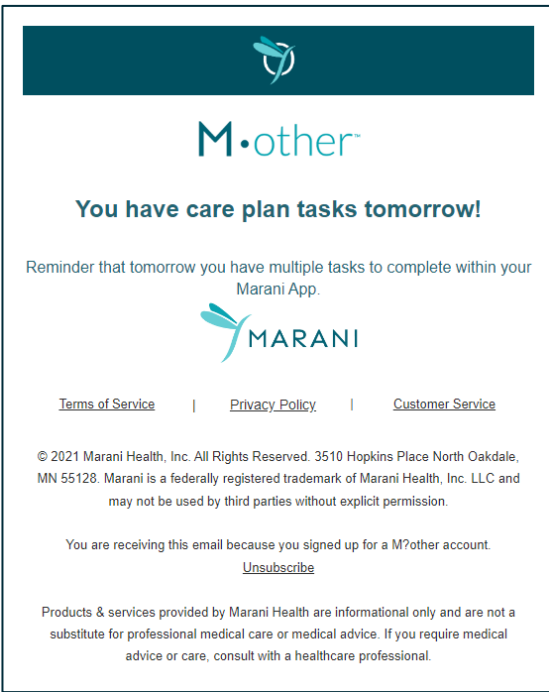
Language Translation



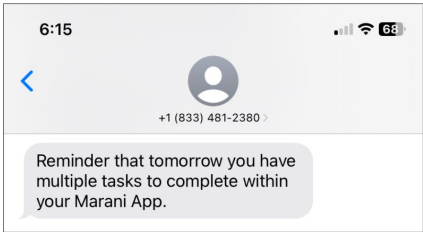
In-App Messenger



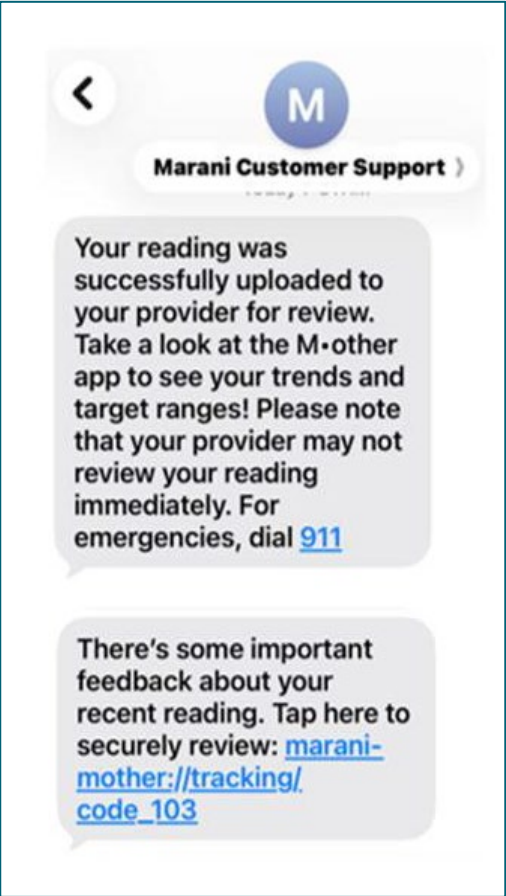
Communication Preferences



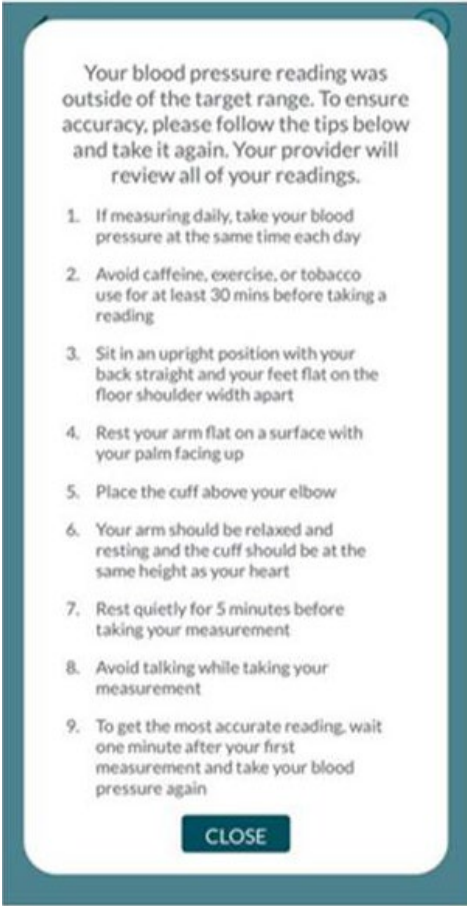
SMS & Email Management



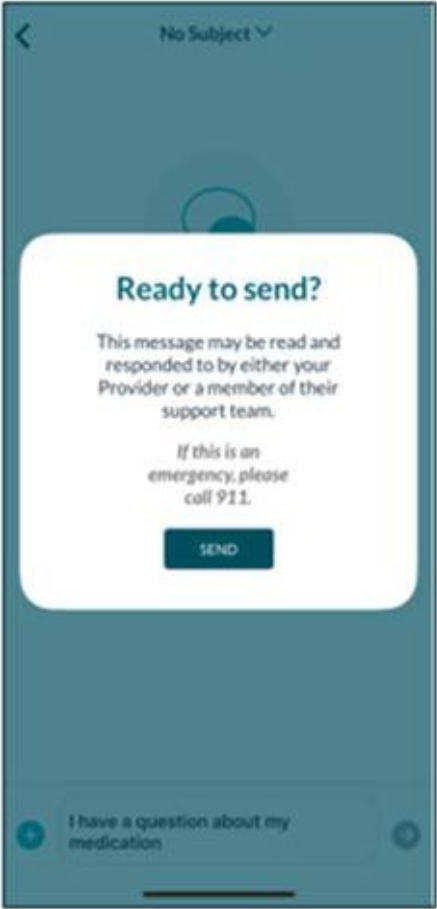
Mobile Features | *Outside Business Hours Notifications*



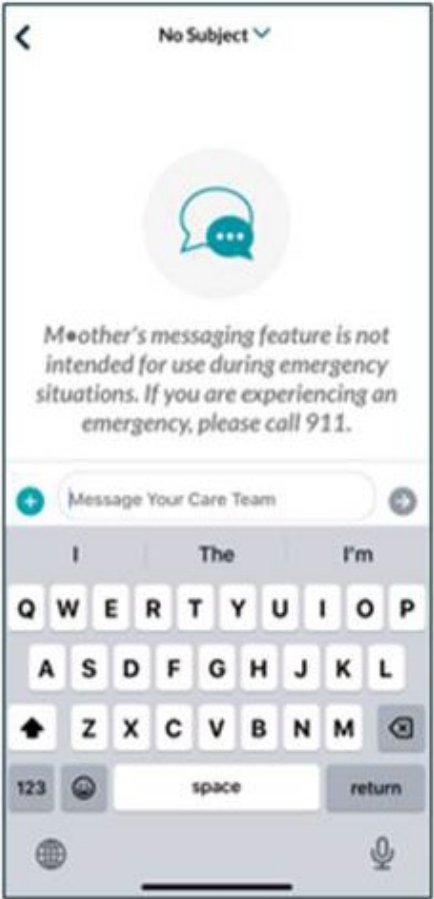
Reading Confirmation



Retake Instructions



Messaging



Not for Emergencies

How it works

1

Assess Risk & Assign Protocol



Risks Assessed & Personalized Care Plans Assigned

Patient is assigned an evidence-based care protocol

2

Patients Monitor

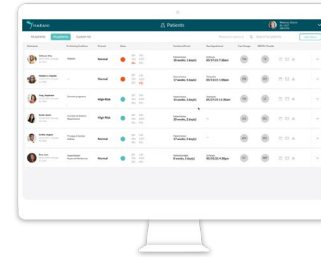


Patient Readings are Collected Remotely

Patient uses app and cellularly powered devices to register readings (BP, weight, glucose, mental health, & SDoH)

3

Providers Manage



Providers Monitor & Act on Patient's Needs

Patients are prioritized for providers based on their readings and utilization patterns.

4

Providers Collaborate



Care Teams

Care teams coordinate and collaborate in the M•care platform. May initiate contact (text, video, phone) with patient to triage issues/concerns & notify primary care.







































Provider Experience




Portal Features | Patient Dashboard

All patients My patients Custom list Prioritize: Patients with alerts first Records for search: 14 | Search for patients

Patient	Conditions	Protocol	Status	Patient Stage	Care Team
 Bowles, Tina DOB: 02/19/1997	2	Social Determinants of Health Screening - PRAPARE S... +1 more	● BP BG EPDS WT HR SDOH	 42 weeks 6 days	 📅 📧 ✍️ 1
 Buss, Genie DOB: 01/10/2000		Blood Pressure Monitoring - Normotensive +3 more	● BP BG EPDS WT HR SDOH	 15 weeks 6 days	 📅 📧 ✍️
 English, Regina DOB: 01/01/2000	2	Social Determinants of Health Screening - PRAPARE S... +3 more	● BP BG EPDS WT HR SDOH	 37 weeks	 📅 📧 ✍️ 2
 Dreyfus, Julia DOB: 01/01/2000	2	Mental Health Screening - 52 Weeks +1 more	● BP BG EPDS WT HR SDOH	 41 weeks 2 days	 📅 📧 ✍️ +1
 Jones, Paulina DOB: 02/01/1998		Blood Pressure Monitoring - Chronic HTN +2 more	● BP BG EPDS WT HR SDOH	 15 weeks 6 days	 📅 📧 ✍️
 Lungen, Brenda DOB: 02/13/1985		Blood Pressure Monitoring - Normotensive +3 more	● BP BG EPDS WT HR SDOH	 45 weeks 6 days	 📅 📧 ✍️
 McSorley, Belinda DOB: 01/01/2000 ID: 123456789		Social Determinants of Health Screening - PRAPARE S... +3 more	● BP BG EPDS WT HR SDOH	 29 weeks 6 days	 📅 📧 ✍️
 Messatesta, Belinda DOB: 01/01/2000		Weight Monitoring	● BP BG EPDS WT HR SDOH	 16 weeks	 📅 📧 ✍️
 Greenberg, Johanna DOB: 01/01/2000		Mental Health Screening - Edinburgh Survey +1 more	● BP BG EPDS WT HR SDOH	 51 weeks 5 days	 📅 📧 ✍️
 Ingrid, Lauren DOB: 02/19/1987	1	Social Determinants of Health Screening - PRAPARE S... +3 more	● BP BG EPDS WT HR SDOH	 42 weeks 6 days	 📅 📧 ✍️
 Knowles, Erica DOB: 12/12/1999		Social Determinants of Health Screening - PRAPARE S... +2 more	● BP BG EPDS WT HR SDOH	 38 weeks	 📅 📧 ✍️
 Messtest, Beth DOB: 01/01/2000		Mental Health Screening - Edinburgh Survey +1 more	● BP BG EPDS WT HR SDOH	 16 weeks	 📅 📧 ✍️

Portal Features | Observations


Johnston, Priscilla
01/05/2000 | 24 years

Patient cell number (845) 850-2565

Patient home email new+signup@marani.com

Due Date 04/17/2024

Gestational Age 31 weeks 2 days

Preferred Language English

[Edit profile](#)

Messages	Health Records	Programs	Care Protocols	Calendar	Team	Documents
Pre-existing Conditions	Vital observations	Device data	Configuration			
Observation	value	Recorded	Note			
EDPS Survey	13	View submission / Open form	02/14/24 6:29 PM	Fairly high possibility of depression - Monitor, support and offer educa...		
Suicidality risk assessment	3		02/14/24 6:29 PM	Warning - positive suicidality risk - Immediate discussion required. Ref...		
SDOH Survey	Completed	Open form	02/14/24 6:29 PM	Available to review		
Blood Pressure	114/65 mmHg		02/14/24 6:27 PM			
Check heart rate	68 bpm		02/14/24 6:27 PM			
Blood Pressure	120/70 mmHg		02/13/24 1:08 PM			
Blood Pressure	141/85 mmHg		02/13/24 1:05 PM			
Blood Pressure	120/70 mmHg		02/13/24 1:04 PM			
SDOH Survey	Completed	Open form	02/13/24 1:03 PM	Available to review		
EDPS Survey	21	View submission / Open form	02/13/24 1:01 PM	Probable depression - Diagnostic assessment and treatment by PCP a...		
Suicidality risk assessment	3		02/13/24 1:01 PM	Warning - positive suicidality risk - Immediate discussion required. Ref...		
Blood Glucose (Non-Fasting)	115 mg/dl		02/13/24 12:59 PM			

Portal Features | Charts & Trends



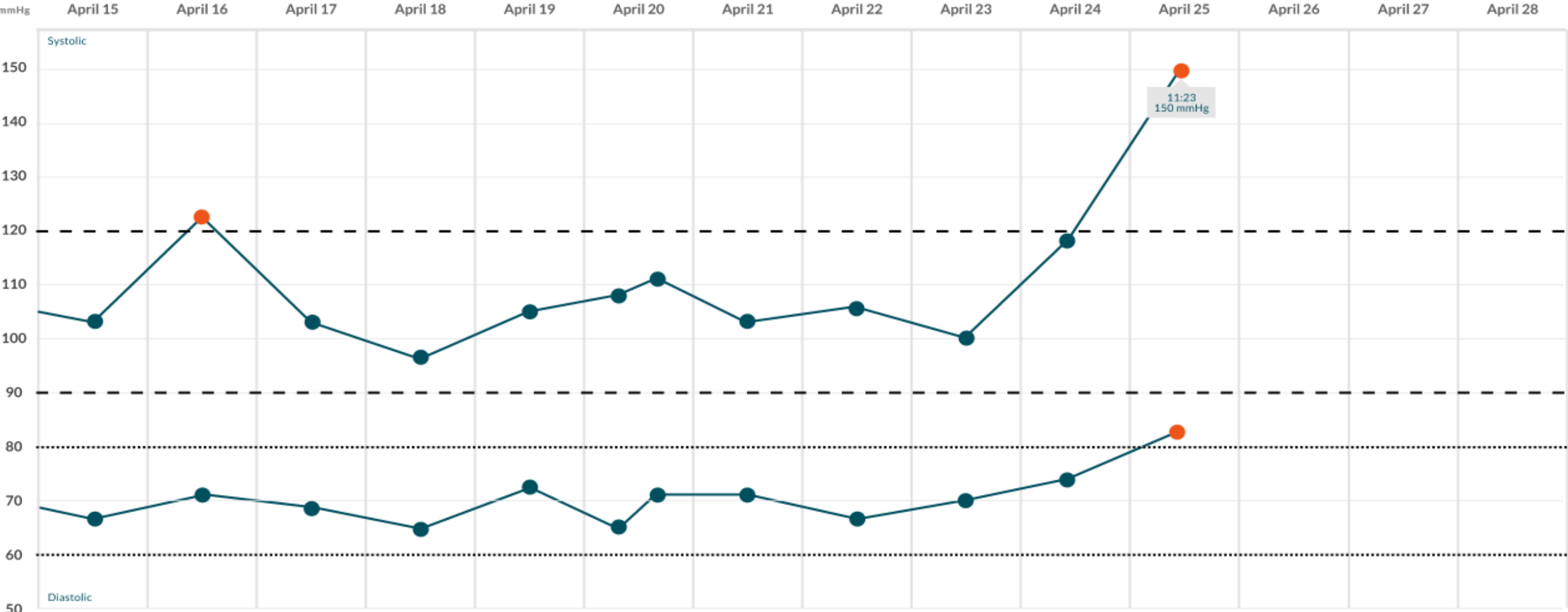
Patients

AP Admin Provider Administrator

Johnston, Priscilla | Gestational Age: 31 weeks 2 days | Pre-Existing Conditions: YES

- REVIEW
- WEIGHT
- BLOOD GLUCOSE
- BLOOD PRESSURE**
- MATERNAL HR
- MENTAL HEALTH

- WEEK
- 2 WEEK**
- MONTH
- LIST



Care Coordination Features | Escalation Pathway

MARANI Patients Admin Provider Administrator

Johnston, Priscilla 01/05/2000 | 24 years

Messages Health Records Documents

Pre-existing Conditions Vital observations Dev

Observation Type Severely Low

Maternal HR	50
Weight	Prima
BP - Systolic	80
BP - Diastolic	50
Blood Glucose - Fasting	60
Blood Glucose - Non-fasting	60

Set BP - Systolic Values

Severely Low

Severely Low 80 mmHg Notify Team

Lower Limit of Normal

Lower Limit Normal 90 mmHg Notify Team

Normal Range

Notify Team

Upper Limit of Normal

Upper Limit Normal 140 mmHg Notify Team

Severely High

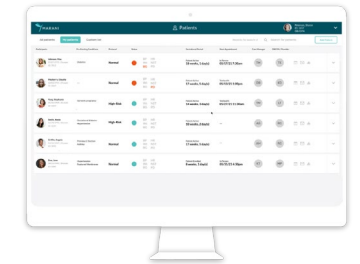
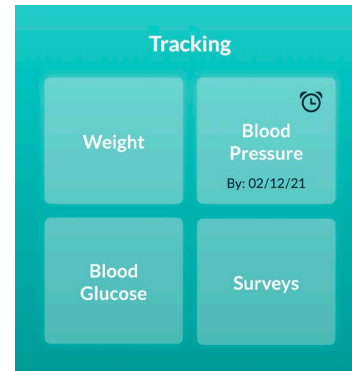
Severely High 150 mmHg

No Alert
Primary Contact
Team

Save

Upper Limit Normal	Notify	Severely High	Notify
100	Team	120	Team
60	Primary Contact		Primary Contact
140	Team	150	Team
80	Team	100	Team
95	Team	110	Team
180	Team	200	Team

The Patient Journey



ENROLL

Monitoring session days/times prescribed by Care Team

ONBOARD

Patient downloads Marani App, receives devices

ENGAGE

In-app notifications for prescribed tasks, along with nudges on educational content

DATA

Patient data sent to the Marani App and Provider Portal

CARE MGMT

Patient data reviewed, alerts prioritized, and care adjusted accordingly by the Care Team

MCG Experience



Enhanced Patient–Provider Communication Without Increasing Hospitalizations

- High-risk, underserved focus
- Continuous oversight across pregnancy
- Bridging geography and capacity limits

Patients enrolled: *71 patients*



Patient Demographics & Risk Factors

Patient Heat Map



Avg. Preexisting Conditions/Patient

3.23

Patients of Advanced Maternal Age

13

Education Level: Less Than College Degree or Unspecified

64

Race: Non-White or Unspecified

49

Relationship Status: Unmarried or Unspecified

55

Employment Status: Full Time Work

13

Patient Distribution

Task Resolution by Type



Registered Obs

63

Activated App

60

89.55%

Pending Activation

0

0%

Failed Activation

7

10.45%

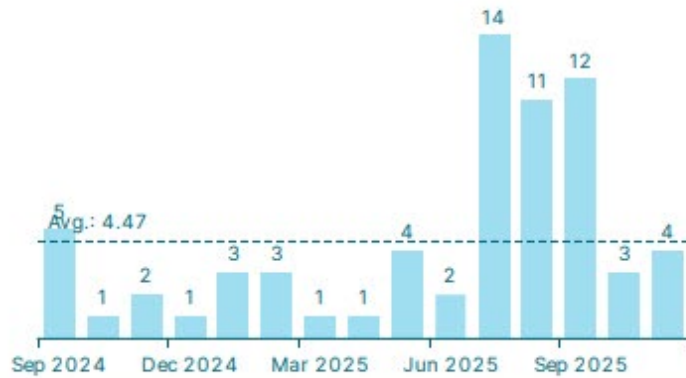
Wellstar Health System: Weekly Dashboard

Enrollment & Active Patient Panel Size

Patients Enrolled in Last 7 Days

0

Enrollments by Month



Total Invited

67

Active Patients

19

Prenatal

19

Postpartum

0

Patient Engagement, Adherence, & Retention

% Patients Engaged by Week

150%

100%

144.44%

115.38% 114.29%

Quality Management

% BP in Control

74%

Count of Total BPs 2,077 1,534

% V Low BP

0.29%

% Low BP

8%

% High BP

13%

% V High BP

4%

% Screened SDoH

22.39%

% MH Any Phase

31%

% + MH

32.14%

% PR MH

30%

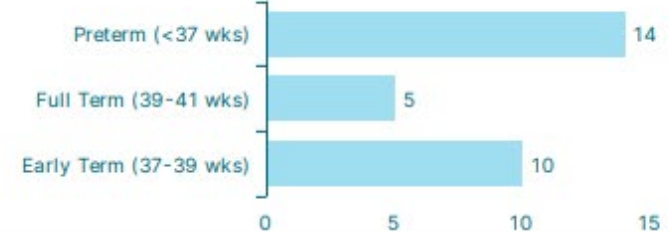
% PPD MH

3.45%

Total Births

29

Gestational Age at Birth



Patient Demographics & Risk Factors

Clinical Impact



Baseline MCG data show 4,861 OB ED visits for 1,324 deliveries in a year (~3.7 ED visits per delivery), in a system already experiencing ED diversions.

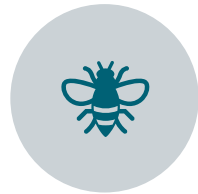


In contrast, the Marani cohort—despite being higher risk by design—shows a **decrease in ED contacts per patient**. That suggests the program is successfully **resolving many issues remotely and filtering only the truly necessary cases to ED**

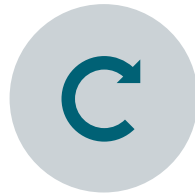


RPM allows timely escalation when required, while still reducing overall acute care use.

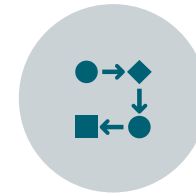
Enhance communication between patients and providers without raising hospitalizations



**High-touch,
asynchronous
communication**



“All patients’ task activity” shows
scheduled task-related touchpoints,
not just episodic phone calls.



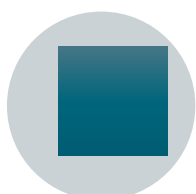
automatic data capture (BP, glucose,
weight, mental health screens) and
feedback loops to the care team.



**Ongoing clinical
oversight instead of
delayed recall**



escalate care promptly,
collaborate with patients more
effectively...
reducing data loss due to inaccurate
recall.”



Financial Impact





Potential Benefits

Remote titration of medications for gestational hypertension and gestational diabetes **may reduce the frequency of in-person clinic visits** and potentially prevent hospital admissions, not increase them.

MCG is using RPM to **increase frequency and quality of contact** (via tasks & real-time RPM data) while early analyses show no rise in hospitalizations and likely prevention of some

Improved management of gestational diabetes is projected to yield a 16% reduction in costs. C-section and NICU use are key levers for improving maternal–infant outcomes.

Summary



High-touch communication model



Structured task workflows and RPM dashboards support regular review of vitals and symptoms, prompting timely outreach and education without requiring in-person visits.



Real-time clinical visibility and data capture



Daily or weekly customized data capture (blood pressure, weight, glucose, mental health screening) reduces dependence on patient recall and enables earlier intervention and medication titration.



Hospitalization signal

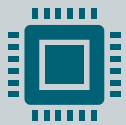


Preliminary findings show that remote titration for gestational hypertension and diabetes can replace some in-person visits and may prevent avoidable admissions, rather than shifting the burden from clinic to hospital.

Reimbursement



Georgia CPT schedules show that for each patient, the program can bill (per month, where criteria are met):



RPM codes: 99453 (\$15.02, setup), 99454 (\$51.55, device supply/data transmission), 99457 (\$41.29, first 20 min of interactive RPM management), 99458 (\$33.78, each additional 20 min, up to 2x).



Chronic Care Management (e.g., 99490 \$36.31, 99439 \$31.76), Principal Care Management, and a behavioral health screener 96127 (\$4.55, up to 1.5× per month).

Summary

Access has been expanded for high-risk, hard-to-reach pregnant patients through months-long remote monitoring and device-enabled home data capture.

Communication between patients and providers is more frequent and data-rich (tasks + real-time vitals) without evidence of increased hospitalizations.

Outcomes are trending positive in hypertension, diabetes, and postpartum mental health, aligned with targeting major drivers of maternal and neonatal morbidity.

ED and hospital utilization appear reduced or more appropriate, with far fewer ED visits per enrolled patient than historical norms despite a higher-risk cohort.

Financially, the combination of Georgia RPM/CCM reimbursement, modest per-member Marani costs, and modeled savings from avoided NICU, C-sections, ED visits, and hospitalizations supports both reimbursement feasibility and better use of clinic space and capacity.

OUR SOLUTION:

A *comprehensive* solution to complement traditional care

1

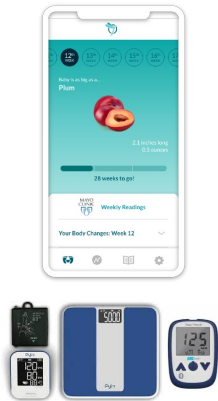
other's
Metric



Risk
Assessment

2

M•other™



Native App
& Connected Devices

3

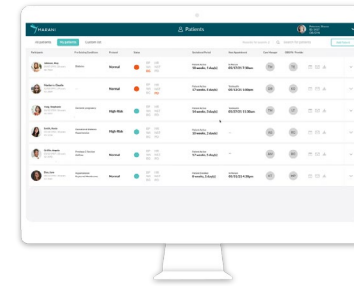
M•wrap™



Smart
Wearable

4

M•care™



Care
Platform

5

Telehealth



24/7 Physician Coverage,
Nurse Navigation & Lactation
Consulting



Reduced Unnecessary ED Visits and Hospital Admissions



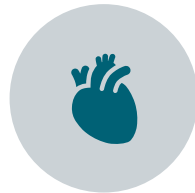
Lower ED utilization per high-risk patient



Within the monitored cohort, only a minority of patients use the OB ED, and ED visits per enrolled patient are substantially lower than historical ED visits per delivery—despite the cohort being higher risk.



Appropriate escalation patterns



ED presentations from enrolled patients (e.g., elevated blood pressure, decreased fetal movement, contractions, shortness of breath, bleeding, PPRM, trauma) are largely conditions where ED/hospital evaluation is clinically appropriate.



Shift of low-acuity issues to remote care



Minor concerns and early warning signs are increasingly handled through RPM-guided outreach, remote education, and medication adjustment instead of default ED use.



Net effect: ED and hospital use appears to both reduced in volume and improved in appropriateness.