HealthSnap

Case Study:

Capital Cardiology Associates

Capital Cardiology ASSOCIATES

How Capital Cardiology Associates improved hypertension control, reduced alert burden, and scaled proactive care delivery with integrated Remote Patient Monitoring (RPM) and Principal Care Management (PCM).

HITRUST

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About Capital Cardiology Associates

Capital Cardiology Associates is one of the largest private cardiology groups in the Capital Region of New York State, with **over 35 board-certified cardiologists, 25+ advanced practitioners,** and more than **180,000 annual patient visits** across inpatient and outpatient settings.

Their mission: to deliver comprehensive cardiovascular care while empowering patients to take control of their chronic conditions.

Challenge: Bridging the Gap Between Visits

Like many cardiology practices, Capital Cardiology Associates recognized a persistent challenge: what happens between patient visits often determines outcomes, yet clinicians had little visibility into that window.

Patients with **hypertension, heart failure, coronary disease, or atrial fibrillation** needed ongoing support, but traditional follow-up models couldn't deliver continuous care. The team sought a partner who could extend their clinical reach, streamline operations, and deliver measurable results all while maintaining their high standard of patient care.

"Every provider recognizes that there are these gaps between visits where we are blind to what's going on with the patients. PCM and RPM help bridge that gap."

Dr. Lance Sullenberger

CEO & Cardiologist, Capital Cardiology Associates

Solution: A Scalable Partnership with HealthSnap

Capital Cardiology selected **HealthSnap's integrated Remote Patient Monitoring (RPM)** and **Principal Care Management (PCM) platform** to provide proactive, data-driven support between visits.

HealthSnap's model enabled Capital Cardiology Associates to scale quickly by handling:

- Credentialed nursing staff to meet New York State requirements
- Device logistics, patient onboarding, and education
- 24/7 care navigation and triage
- Integrated communication with the practice's clinical team

This partnership freed Capital Cardiology Associates from HR, hiring, and credentialing burdens, allowing their clinicians to focus on higher-value patient care.

Care Navigator Impact: Extending the Care Team

A critical element of Capital Cardiology's success has been HealthSnap's team of dedicated Care Navigators—licensed, credentialed professionals who serve as the bridge between patients at home and the clinic's care team.

"With our partnership with HealthSnap, we have been able to operationalize our staff resources more efficiently. They provided us with the credentialed nursing staff we need here in New York State to be able to provide this service."

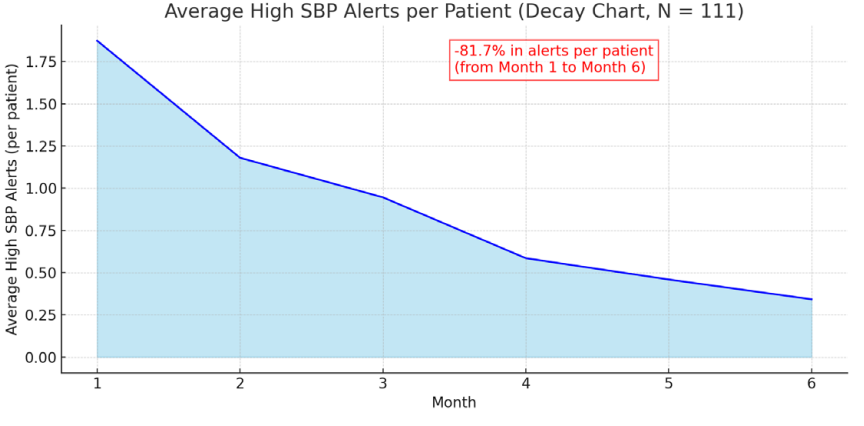
Patricia Dickson
Director of Operations, Capital Cardiology Associates

HealthSnap's team of **dedicated care navigators** has become a true extension of Capital Cardiology's care team—monitoring daily readings, identifying trends, and escalating cases to clinical staff only when needed.

This model allows Capital Cardiology to **expand capacity and maintain high-quality care** without increasing staff burden. The navigators provide the human connection patients need to stay engaged and on track, while freeing up clinic resources for the most complex cases.

"When the patients have a concern, they have a Care Navigator who knows them by name. They triage, find out what's going on, and work right alongside us." said Patricia Dickson, Director of Operations, Capital Cardiology Associates

By maintaining frequent touchpoints and tailoring coaching to each individual, navigators help patients understand their conditions, adhere to treatment plans, and stay motivated to make sustainable behavior changes.



Continuous engagement from HealthSnap's care navigators helped **reduce high blood pressure alerts by 81.7%,** giving clinicians visibility without added workload and patients the consistency they need to stay in control.

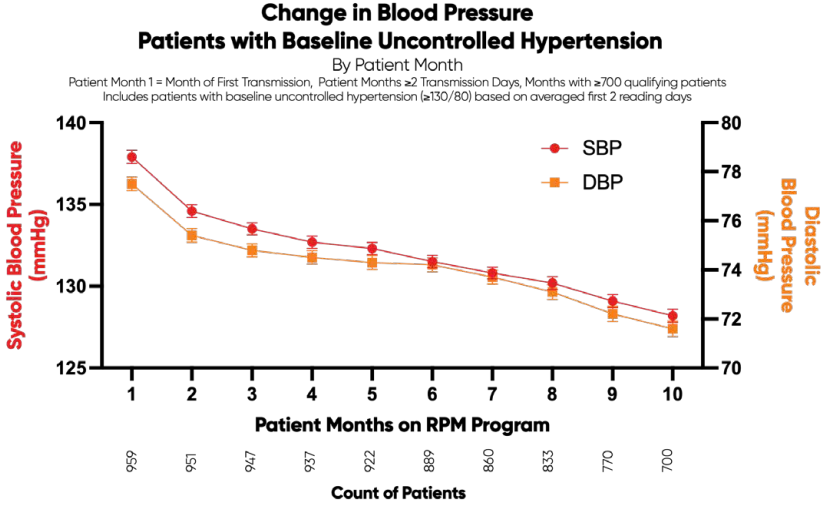
Clinical Outcomes: Turning Daily Data Into Sustainable Change

In cardiology today, **improving outcomes** must go hand in hand with **operational sustainability**. By integrating HealthSnap's Remote Patient Monitoring (RPM) and Principal Care Management (PCM) programs, Capital Cardiology Associates reimagined how continuous care can deliver both.

Through daily biometric insights, proactive patient engagement, and EHR-integrated communication, the practice improved hypertension control across all stages. Achieving measurable, lasting results **without increasing staff burden.**

Control of Hypertension

Capital Cardiology's integrated virtual care model drove consistent, measurable improvement across its full hypertension population. By pairing daily monitoring with ongoing navigator support, clinicians could intervene earlier and keep patients stable between visits.



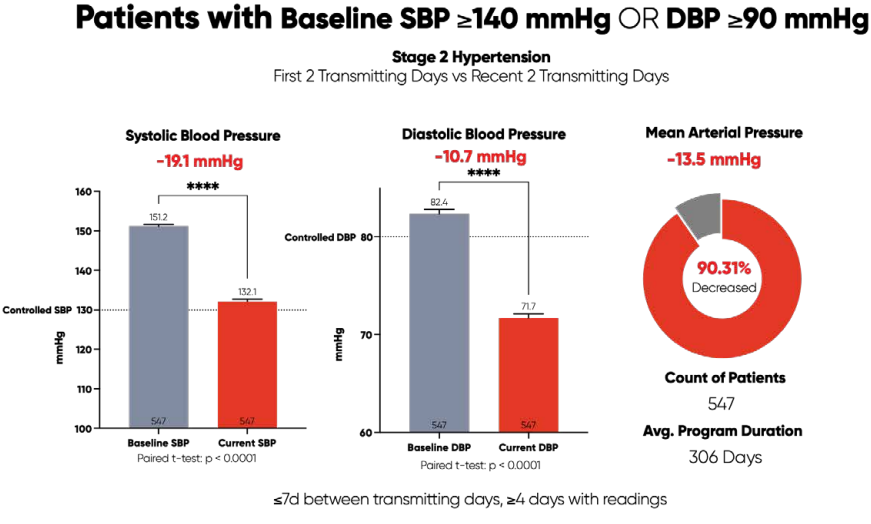
Among **996 patients** with uncontrolled hypertension at baseline:

- **80.3%** of patients improved BP control
- **−12.6** / **−7.8 mmHg** average reduction
- Continuous engagement sustained improvement over 10 months

These results show that proactive monitoring and navigator support improve outcomes at scale while reducing the need for reactive follow-up.

Stage 2 Hypertension Management

Patients with Stage 2 hypertension maintained lower, steadier blood pressure over time. This Illustrates how continuous engagement supports sustained control. The combination of patient education, navigator touchpoints, and real-time data insight enabled better adherence and earlier intervention.

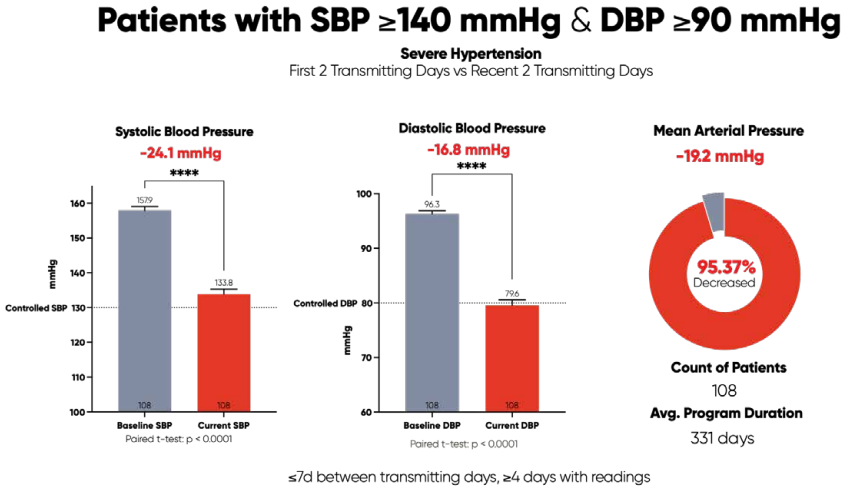


Among patients with baseline SBP ≥140 or DBP ≥90 mmHg:

- **90.3%** improved BP control
- **−19.1** / **−10.7 mmHg** average reduction
- **13.5 mmHg** reduction in mean arterial pressure

Improvement in Severe Hypertension

For the most clinically complex patients, sustained engagement through HealthSnap's RPM and PCM programs led to meaningful, lasting improvements. These results demonstrate how continuous virtual monitoring can help stabilize high-risk cardiovascular patients who need frequent follow-up.



Among patients with SBP ≥140 mmHg & DBP ≥90 mmHg at baseline:

- **95.3%** achieved meaningful improvement
- **−24.1** / **−16.8 mmHg** average reduction
- Significant reduction in mean arterial pressure (−19.2 mmHg)

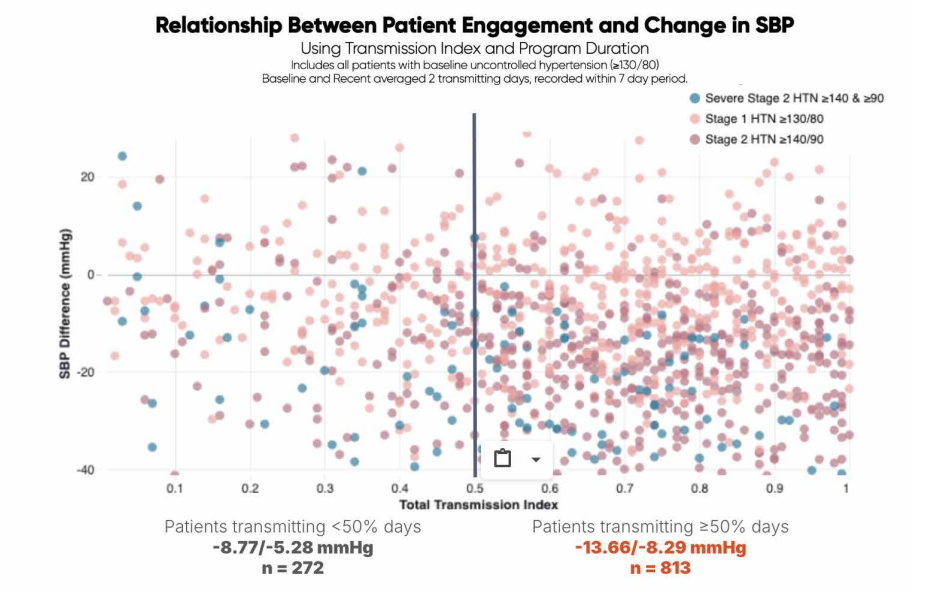
Impact of Patient Engagement on Outcomes

Sustained engagement proved to be a key driver of success. Patients who consistently transmitted data and stayed connected with HealthSnap's care team achieved significantly greater blood pressure reductions than those who engaged less frequently.

This reinforces an important insight for cardiology leaders: **outcomes depend as much on patient connection as clinical intervention.**

When comparing engagement levels among **1,085 hypertensive patients:**

- Patients who transmitted data on ≥50% of days achieved greater BP reduction **(–13.66 / –8.29 mmHg)**
- Patients transmitting <50% of days improved less **(–8.77 / –5.28 mmHg)**
- Continuous monitoring and navigator coaching reinforced long-term adherence and clinical success



Patient Perspective: From Monitoring to Peace of Mind

For patients, the value of this program goes far beyond improved blood pressure readings. Through consistent outreach and guidance from HealthSnap's care navigators, Capital Cardiology's patients felt supported, accountable, and empowered to take charge of their health.

"Before this, once a year you show up and, if your blood pressure's off the wall, they give you another pill. Now we have someone monitoring, a navigator who calls once a month. We go over the data and make a plan together. There's no negative talk — we talk about how to correct things." Patient, Capital Cardiology Associates

This perspective reflects the heart of Capital Cardiology's transformation: when patients feel connected and cared for, they stay engaged and outcomes follow.

Conclusion:

Through its partnership with HealthSnap, **Capital Cardiology Associates** has proven that scalable virtual care can deliver both clinical and operational value.By combining daily biometric monitoring, care navigator support, and integrated communication, the practice impr oved hypertension control across all patient segments while easing the workload on its clinical team.

This model exemplifies what's next for cardiology: **data-driven, patient-centered care that strengthens outcomes, streamlines operations, and sustains growth in a value-based world.**

"When I'm choosing a partner, I'm going to pick one that shares our vision for patient outcomes. With HealthSnap, we found a company that works as an extension of Capital Cardiology."

Patricia Dickson

Director of Operations, Capital Cardiology Associates

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