



FROM EVIDENCE TO ADOPTION: A FRAMEWORK AND GO-TO- MARKET STRATEGY FOR REMOTE PATIENT MONITORING IN INDIAN CARDIAC POST-DISCHARGE CARE

Smridhi Gupta

MBA Healthcare Analytics

Under the Supervision and Guidance of

Dr. Ritu Vashistha

RESEARCH QUESTION

What are the key barriers & adoption factors influencing the scalable implementation of Remote Patient Monitoring (RPM) for post-discharge cardiac care in India, and the Go-to-Market (GTM) strategy that can best support its successful adoption?

RESEARCH OBJECTIVES

Understand the burden of cardiovascular disease in India

Identify the key barriers affecting the adoption of Remote Patient Monitoring (RPM) in cardiac care

Recommend a Go-to-Market (GTM) strategy for adopting and scaling Remote Patient Monitoring (RPM) in India

RESEARCH METHODOLOGY

Qualitative secondary research using existing studies, reports, policy documents, and industry publications on Remote Patient Monitoring (RPM).

- *RPM's challenge in India is not lack of evidence, but the interaction of **trust, feasibility, cost, and scalability** across patients, providers, and healthcare systems.*
- *A **qualitative secondary research design** enabled the systematic synthesis of existing evidence to uncover these contextual adoption barriers and develop a practical go-to-market strategy.*

*Information gathered from **academic databases, healthcare policies, industry reports, and international RPM studies.***

- Conducted **data analysis of the GBD 2023 dataset** to assess the cardiovascular disease burden in India.
- Performed **literature review and content analysis** to identify barriers and adoption factors affecting RPM implementation.
- Compared different **RPM deployment models** in the Indian healthcare context.
- Findings were synthesized to develop a **Go-to-Market (GTM) strategy** for scalable RPM adoption in post-discharge cardiac care.

INTRODUCTION

Healthcare is shifting from *episodic treatment to continuous care*, particularly for chronic conditions that require ongoing monitoring and timely intervention. In India, this transition is challenged by a high chronic disease burden and limited healthcare infrastructure, creating critical gaps in post-discharge patient management.

- **Remote Patient Monitoring (RPM) can bridge post-discharge care gaps** by enabling continuous tracking of vital signs and early detection of patient deterioration.
- Despite proven effectiveness and available technology, RPM adoption in Indian cardiac care remains limited, prompting an investigation into the clinical, economic, and organizational barriers to its diffusion.

Longitudinal, Cardiovascular Disease Burden in India

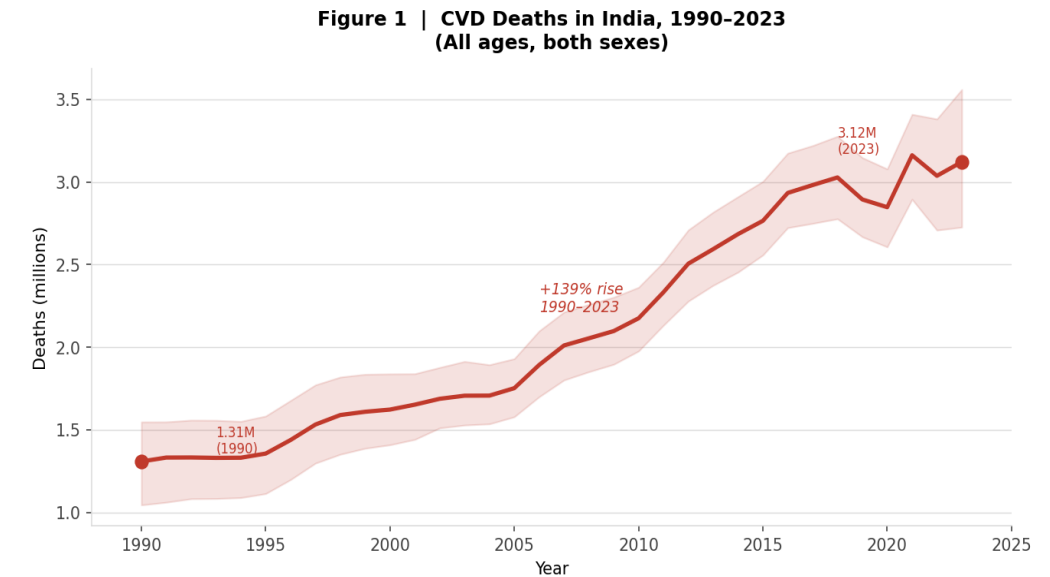
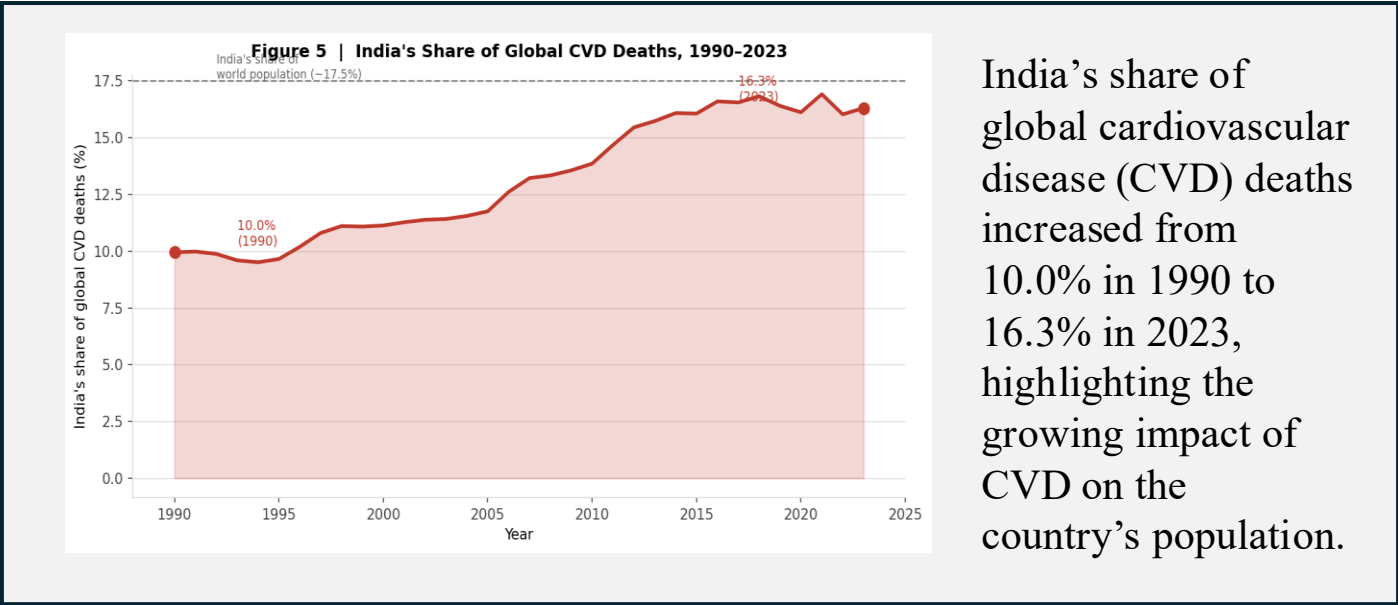
CVD deaths increased from 1.31 million to 3.12 million

138.7% rise over three decades

Annual new CVD cases grew from 3.16 million to 7.83 million

148% increase in incidence.

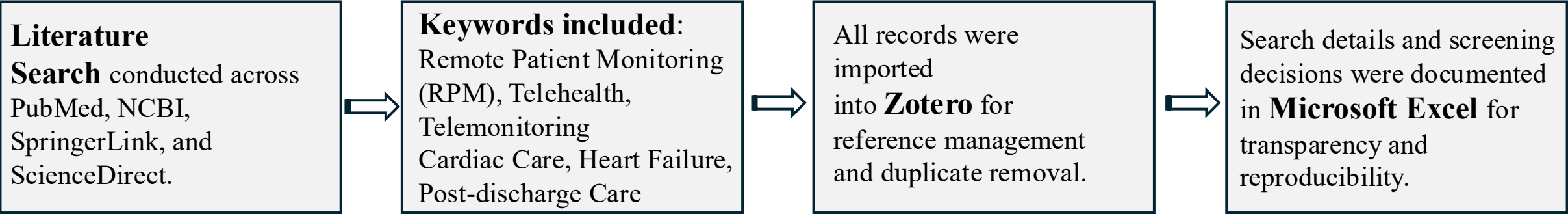
The data indicates a *persistent and worsening cardiovascular health crisis*. Rising mortality and incidence rates highlight the urgent need for *continuous disease management and post-discharge monitoring solutions*.



DETAILED METHODOLOGY

1 SYSTEMATIC LITERATURE REVIEW PROCESS

Objective: Identify and analyze evidence on RPM adoption in post-discharge cardiac care.



Study Selection & Evidence Synthesis

- A structured screening process involving **duplicate removal**, **title/abstract review**, and **full-text assessment** was used to identify the most relevant studies.
- A total of **28 studies** were analyzed, with findings coded and synthesized to identify RPM adoption barriers and develop the proposed GTM strategy.

Finding 1: Significant Gaps Exist in Post-Discharge Cardiac Care

Studies consistently reported limited follow-up, inadequate patient education, poor symptom reporting, and medication non-adherence after discharge.

Finding 2: System-Level Challenges Restrict Scale

Lack of reimbursement mechanisms, fragmented health information systems, and limited post-discharge care infrastructure were identified as key obstacles to large-scale RPM deployment.

Finding 3: Provider-Level Barriers Limit Adoption

Physician workload, alert fatigue, and lack of integration into existing clinical workflows were identified as major barriers to RPM implementation.

Finding 4: RPM Can Address Critical Post-Discharge Failure Points

The literature indicates that RPM can support early detection of deterioration, improve medication adherence, and enable continuous patient monitoring outside the hospital setting.

2 CONTENT ANALYSIS OF REGULATORY & POLICY DOCUMENTS

*Reviewed key regulatory frameworks including **Telemedicine Practice Guidelines** and **Medical Device Rules**.*

*Analyzed each policy to understand its impact on **RPM adoption**,*

- Assess whether existing policies support or restrict RPM implementation.
- Identify regulatory requirements related to telemedicine, medical devices, data privacy, and digital health.
- Understand areas of uncertainty, such as clinical liability and continuous remote monitoring.

Key Findings from the analysis

India's regulatory environment is broadly supportive of digital health and remote care, with policies such as the Telemedicine Practice Guidelines and ABDM providing a foundation for RPM adoption.

Data privacy and patient consent have become increasingly important considerations, with the DPDP Act strengthening requirements for the collection, storage, and use of patient health data.

Regulatory ambiguity remains around continuous remote monitoring and clinical liability, creating uncertainty for hospitals and technology providers.

Medical device regulations provide a framework for RPM devices, but compliance requirements may increase implementation complexity and costs.

The policy ecosystem enables RPM deployment but does not yet provide dedicated reimbursement mechanisms, limiting large-scale adoption.

3

COMPARATIVE ANALYSIS

Purpose: To evaluate different RPM adoption options using a consistent set of criteria and identify the most viable approach for the Indian market.

Areas Compared

Deployment Models: Hospital-led, Physician-led, Insurer-led, and Direct-to-Consumer RPM.



Approach

- Each option was assessed qualitatively against the **four criteria**.
- Findings were supported by evidence from the literature review and policy analysis.
- Comparative assessment was used to identify the most effective GTM configuration for RPM adoption in India.

Key Findings	Deployment Model	Clinical Value	Cost to Patient	Scalability	Key Consideration
	Hospital-Led RPM	High	Medium	Medium	Integrated into the hospital discharge process, enabling continuous monitoring and timely clinical intervention, but requires investment in staff and workflows.
	Physician-Led RPM	Medium-High	Medium-High	Low	Benefits from strong physician-patient trust, but adoption is limited because expansion depends on individual physician participation.
	Insurer-Led RPM	Medium	Low	High	Makes RPM more affordable and can reach a large patient base, but depends on insurers incorporating RPM.
	Direct-to-Consumer RPM	Low	High	High	Can be deployed rapidly without institutional involvement, but limited physician oversight and high out-of-pocket costs may reduce adoption and engagement.

METHODOLOGY>EVIDENCE>FINDINGS

Three methods, one converging conclusion

A qualitative secondary design built on three complementary methods. Each interrogates the evidence from a different angle, and all three point to the same answer.

Method 01

Systematic Literature Review

200+ records screened in a transparent PRISMA-style flow, de-duplicated and filtered to a final auditable set.

28 studies synthesised from 412 screened

Method 02

Regulatory Content Analysis

Each primary instrument read directly against a fixed set of questions on permission, silence and deployment risk.

4 core instruments analysed directly

Method 03

Structured Comparative Analysis

Every model, segment, channel and pricing option graded on four defined criteria, with each judgement justified.

4 criteria: feasibility, scale, cost, trust

WHAT IT ESTABLISHED

Clinical efficacy is proven worldwide, yet failure recurs at integration, financing and trust never at the device.

Regulation does not differ across models; it conditions feasibility and trust, so it is a backdrop, not a fifth criterion.

Choices are coupled, not separate; feasibility and scale trade off; and trust acts as a gate on every option.

All three methods locate the barrier in adoption, trust, feasibility, cost and scalability not in technology or clinical evidence.

THE STRATEGIC LOGIC: WHY A SEQUENCED BEACHHEAD BEATS A ONE-SIZE-FITS-ALL ROLLOUT

*The analysis converges on one conclusion: **no single configuration of segment, channel, and price point can serve all of India's post-discharge cardiac population at once.** The most RPM-ready segment, insured Tier 1 patients, is numerically small, while the segment that matters most for India's cardiovascular burden, the uninsured and government-hospital population, is the least institutionally ready.*

The strategy is therefore explicitly sequential rather than universal. Segment A is the entry point, not the final answer, chosen because succeeding there generates the clinical evidence, operational template, and institutional trust required to make the next, larger segment feasible. The currency carried forward from one phase to the next is credibility, with physicians, administrators, insurers, and policymakers.

Four findings run through every recommendation:

- **Coupling:** segment, channel, and pricing must be chosen as one reinforcing bundle.
- The product must address **multiple post-discharge failure modes** within a workflow a time-constrained clinical team can execute.
- Low-**trust** options underperform regardless of their cost or scalability standing.
- **Stakeholder misalignment:** influence and interest are mismatched across actors, so demand from high-interest actors must be routed through high-influence actors' endorsement.

Sequencing:

Segment A (insured Tier 1) first, to build evidence in a forgiving environment;

Segment C (Tier 2 mixed-pay heart failure) second;

Segment D (government teaching hospitals) third, once a financing mechanism closes the feasibility gap.

Segment B (uninsured, same hospitals) is solved through pricing, not waiting.

THE GO-TO-MARKET

Playbook

Seven moves that compound.
Enter narrow, prove the
model, and let measured
results open the door to each
next phase.

*Anchor on trusted champions,
price for access, scale on proof.*

1 ENTRY SEGMENT

Begin with insured patients at one Tier 1 private hospital chain.

2 ENTRY MECHANISM

Run a focused six-month pilot in one or two cardiology departments, 50 to 100 patients.

3 CHANNEL

Go direct-to-hospital, nesting one or two named, resourced physician champions per department.

4 PRICING

Launch with a hybrid co-pay, then migrate to insurer-funded coverage as the insurer track matures.

5 PRODUCT FRAMING

Position as a platform: counselling reinforcement, caregiver-inclusive alerts, adherence tracking.

6 PROOF TO CAPTURE

Measure readmission rates against a comparison group, plus physician workflow ease and usability.

7 SCALE-UP

Expand in clear phases, gated by results achieved rather than time elapsed.

From Evidence to Adoption: The Argument in One View

THE NEED

A Worsening CVD Crisis

India's CVD deaths rose 139% in three decades to 3.12 million a year, and its share of global CVD deaths climbed to 16.3%. The greatest risk concentrates in the weeks after discharge, where follow-up care is weakest.

THE EVIDENCE

Three Converging Methods

A systematic review of 28 studies, direct analysis of four regulatory instruments, and a structured comparative assessment all point to the same conclusion: clinical efficacy is proven; failure recurs at integration, financing and trust.

THE DIAGNOSIS

Barriers Beyond Technology

Adoption is constrained by physician bandwidth, absent reimbursement, fragmented systems and the need to earn trust. These factors are coupled, and trust acts as a gate on every option regardless of cost or scale.

THE STRATEGY

A Sequenced GTM

Enter through insured Tier 1 patients via a focused pilot, anchored in physician champions and a hybrid co-pay, framed as a platform across the recovery journey, and scaled in phases gated by measured results.

RPM's challenge in India is not a shortage of evidence or technology, but the interaction of trust, feasibility, cost and scalability across patients, providers and systems. The dissertation converts that diagnosis into a coupled, sequenced go-to-market strategy that enters narrow, proves the model, and scales on measured results.



Thank you