



REMOTE CONTROL

IN-HOME PATIENT CARE AND MONITORING SEEN AS MAJOR STEP FORWARD ON REAPING EFFICIENCIES FROM AN OVERWORKED SYSTEM

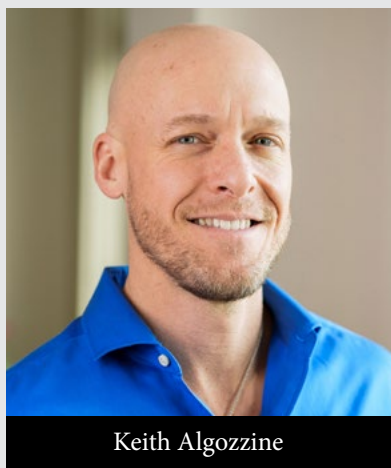
Greater acceptance and use of telehealth will continue to lighten the load of brick-and-mortar office visits and seed deeper operational efficiencies into a system that's rife with fraud, waste and abuse. However, there are built-in limitations, which are giving way to more of a hybrid approach post-pandemic. The next wave in virtual visits is expected in the form of remote patient care and monitoring.

Written By Bruce Shutan

A need for more meaningful house calls comes amid the convergence of what one industry analyst described as “a growing senior population, explosive Medicare spending and the sickest generation in the history of the U.S.” Fawad Butt, executive in residence at Canvas Ventures who advises startups in the healthcare, data and analytics space, believes the use of technology represents a profound change in that it can address more complex and costly conditions than basic telemedicine appointments.

But that model is just one aspect of a changing health care ecosystem that also includes remote patient treatment options. As technology continues to advance, opportunities to deliver care efficiencies and improve clinical outcomes will swell for self-insured health plans.

The chief motivator in pursuing more meaningful virtual visits is securing cost-effective solutions built around high-quality care, observes Lois Irwin, president of EZaccessMD. This emerging model allows patients to be seen and treated at their preferred location, which she says is increasingly in the home.



Keith Algozzine

Remote patient care and monitoring has evolved in recent years from addressing simple or minor medical problems for relatively healthy people to a second phase that the pandemic pushed to a peak, according to Keith Algozzine, co-founder and CEO of UCM Digital Health. COVID-19, of course, turned telehealth into the default option for most non-emergency care because hospitals and doctor's offices were overrun with infected patients.

But it also triggered a mental health and substance abuse crisis that necessitated its expansion into the psychotherapy arena where he saw a disconnect between mind-body treatment. Algozzine notes that siloed mental health providers will treat anxiety indefinitely even when it could be traced to, say, thyroid disease that went undetected and undiagnosed.

“Until you’ve actually treated their medical problem, you’re never going to solve it,” he cautions.

Another strong consideration in the evolution of virtual care is recent government policies supported by SIIA that allow health savings accounts to be used for telehealth, making it easier for patients to access treatment and monitoring remotely.

“It has made a measurable difference,” says Hunter Sinclair, VP of solution strategy at Teladoc Health, “expanding access and enabling better health outcomes. COVID-19 has shifted the expectations for



Hunter Sinclair

U.S. workers who now look to employers to provide a broad suite of virtual care services. Employers have responded in turn and dramatically expanded the scope and scale of services to support employees with chronic condition management, mental health and whole-person primary care.”

As many as 96% of employers surveyed by the Employee Benefit Research Institute adopted pre-deductible coverage for telehealth services under the CARES Act, while 76% would like to make this provision permanent.

One development that could slow growth, however, is movement toward payment parity that matches telehealth rates to in-person care. Sinclair is aware of specialized telehealth groups that actually charge more than standard in-person fee schedules and believes that trend will continue. Still, there's no denying that technology will continue to buttress in-home options.

EARLY ADOPTERS

While remote patient care and monitoring has gained traction in recent years, the concept took root more than a century ago. Irwin says legislation allowing Medicare to reimburse homebound patients for portable X-ray services performed in the home dates back to 1969.

Kim Darling, president of sales for Recuro Health, recalls attending a telemedicine meeting 20 years ago that featured a demo of Costa Rican clinic using TytoCare technology that projected data and imaging to the provider.

The emphasis today is on smartphones, tablets and wearables that can perform a plethora of health measurements, she observes, adding that virtual care automation and artificial intelligence will become more dominant in the face of continued shortages of doctors, nurses and pharmacy staffers.

Kaiser Permanente and the U.S. Department of Veterans Affairs were among the early adopters of remote patient monitoring, Sinclair notes. A significant drop in the cost of cellular technology means more Americans increasingly are going to be using more wearable solutions.

“We moved all of our solutions from Bluetooth to cellular so that as soon as someone wants to join remote patient monitoring, they raise their hand and then a device gets shipped to their house,” he says.



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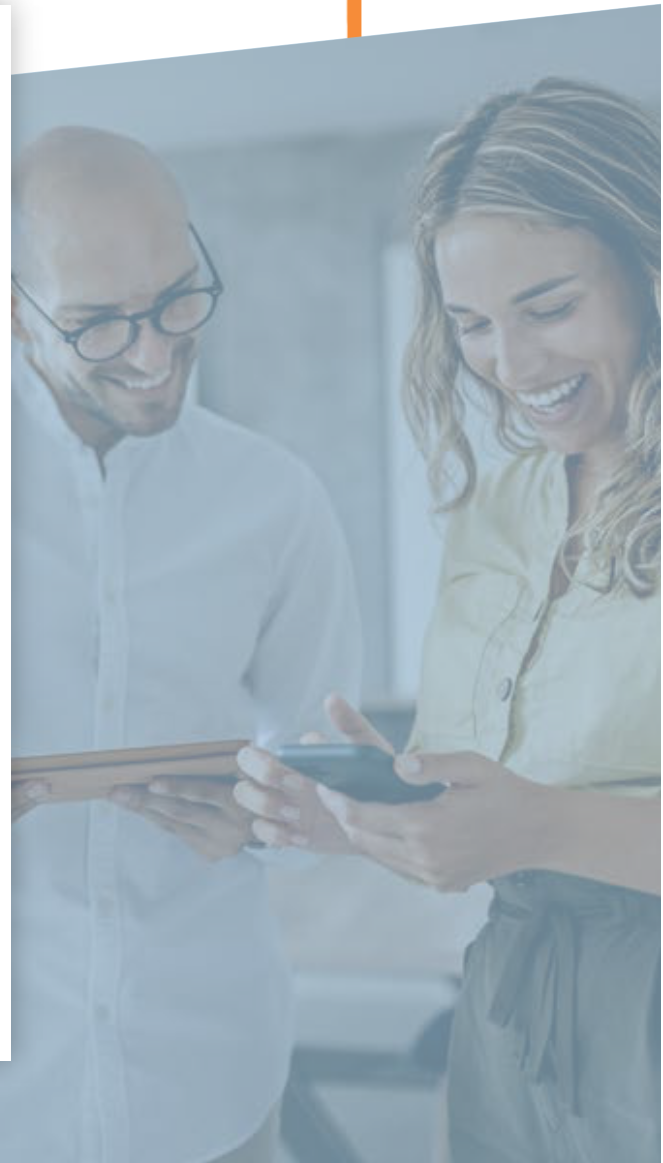
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“As they use the blood pressure cuff the first time or step on the scale, all of that information directly go to us. And then we’re able to use our data science to give real-time feedback to members.”

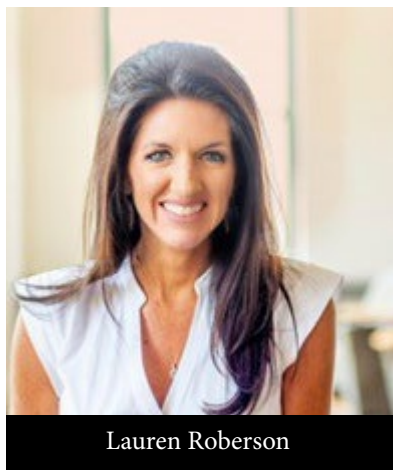
CRITICAL INSIGHT

The ability to take critical patient information and turn it into insight has scaled dramatically, Sinclair says. If somebody has a stubbornly high A1C or blood pressure, Teladoc suggests they speak with a physician to help understand what’s going on and improve those numbers. Steps may include sending a lab test to the patient’s home or using a continuous glucose monitor and examine the data to see what’s happening in between glucose checks.

Diabetes is fertile ground for remote patient monitoring. The trouble with treating this condition based on a reading at the point of care is that it’s hard to know what triggered blood sugar spikes or drops if, say, the patient’s medication hadn’t worked over several months and needs to be adjusted, explains Lauren Roberson, head of nurse advocacy for Connect Healthcare Collaboration. She says it’s also difficult to secure commitments to keeping a daily food journal.

But remote monitoring devices not only alert providers to what’s going on, she says they also let patients monitor their blood sugar in real time to help better associate their levels with what they just ate.

The onus is no longer on patients who then become more a part of a process wherein they can actually objectively review the decisions that they’re making and the impact on their blood-sugar levels, Roberson notes.



The use of technology has evolved in meaningful ways. “We would go to the patient’s bedside, bring the film back to the office and develop that into an X-ray,” Irwin recalls. “We would drive those films over to the hospital where the radiologist would read them and issue a report. Now all of that is done digitally.”



Irwin and her husband were inspired to start their company after providing mobile X-rays to the University of Rochester Medical Center, which received a Centers for Medicare & Medicaid Services grant in 2009 to study the impact of telemedicine on elderly populations.

As part of that effort, trained technologists were dispatched to a patient’s bedside with a suitcase full of equipment to perform physical exams, lab tests, and order bedside X-rays and ultrasounds as needed. The experience stuck with them.

At the end of five years, there was a 34% reduction in ER transfers from facilities when intensive telemedicine plus a bedside exam was made available to patients. They later realized this model also could greatly benefit 180 million Americans under age 65 who receive employer-provided health insurance coverage.

Digital technology is empowering the industry to better drive patient engagement, says Mary O'Connor, M.D., co-founder the chief medical officer of Vori Health. She cites motion-tracking home exercise with the camera on a smartphone, laptop or desktop computer replacing the need for strap-on sensors as one such example for treating musculoskeletal conditions.

“Our physical therapists perform a virtual visit with the patient and prescribe a home exercise program on our platform,” she explains. “They receive verbal feedback on whether they are doing the exercises properly

because the camera can track and compute their movement, and the program captures the number of repetitions performed by the patient.”

IMPORTANCE OF ACCESS AND CARE

Remote patient monitoring, while no doubt a powerful tool, has its limitations. “Other than installing the equipment, nobody’s coming to the home to deliver care,” Irwin explains. The key is early intervention, whose savings she says you don’t necessarily see on the ledger.

“The sooner any patient is able to talk with a physician and be diagnosed and get on a treatment plan,” she adds, “the better it is for that course of illness.”



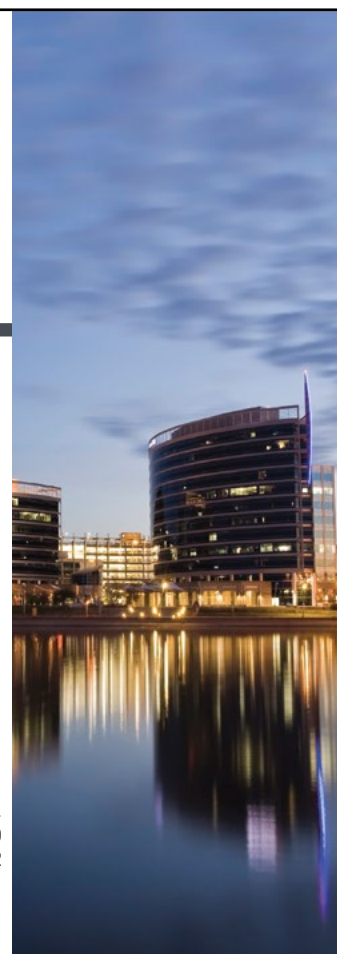
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Before embracing any technological advances with unbridled enthusiasm, some industry observers caution that a deeper perspective is needed to understand where improvements need to be made.

“Patients don’t need technology, they need care,”

Algozzine says. “They don’t want to feel any tech. They just want it to be convenient. They want it to be as inexpensive as possible. They want it to be as high-quality and personal as possible.” In a nutshell: expanded and affordable access.

An overarching goal with remote patient care and monitoring is to help recast a system that Algozzine describes as “singular point solution driven” and mired in siloed care. Before attempting to remotely measure blood pressure, glucose levels and any other key metrics, he says patients need to know they can connect 24/7 with a team of health care professionals, ask questions and determine whether or not they’re having a medical emergency.

Opening patient homes to care and monitoring could have a significant impact on specialty care. “I have the best coverage any American could have,” Darling admits, “but it takes me five months to see a cardiologist and six months to see a dermatologist where I live in Orange County California. So if it’s happening here you can only imagine what it’s like in more remote places to find pathways for people to get their care.”

RETURN ON INVESTMENT

Darling says there are a plethora of studies suggesting in-home care is better in many instances, noting how hospitals are not only





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costly but also a dangerous environment prone to infections and medical errors with inadequate levels of personnel.

Citing a 2022 Commonwealth Fund study, she notes that the U.S. has some of the poorest outcomes relative to other nations. They include the lowest rate of practicing physicians and hospital beds per 1,000 population, highest maternal and infant mortality, highest death rates for avoidable or treatable conditions, lowest life expectancy at birth and highest rate of people with multiple chronic conditions in the world. All of these alarming statistics suggest a need to vastly improve clinical outcomes.

Technology obviously can help reduce the amount of care delivered in costly settings by funneling it to the home.

“When you go to the ER, you are automatically charged a facility fee of \$500 to \$1,000 or more before you’re even seen by a doctor,” Irwin notes.


“And then you’re charged for a consult with the doctor and testing that’s needed,”

which often results in overutilization and much higher medical bills.

The return on investment for remote patient care and monitoring can be substantial. Using in-person urgent care as an example, Irwin notes how the collateral damage quickly adds up when an employee typically would miss four hours of work, depending on wait times.

With the average hourly wage just north of \$30 in the U.S., according to the Bureau of Labor Statistics, any missed work time will hit those households hard. But she says there’s also a steep cost to organizations that might have to pay another employee overtime to fill in for someone who’s absent or hire a temp, plus supervisory time.

If a virtual care visit averages \$45 relative to a brick-and-mortar doctor visit that ranges from \$80 to \$125, depending on an individual’s Zip code, Darling says those savings will add up over time. “The math is the same for urgent care and the ER,” she adds.



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One caveat associated with remote patient monitoring is information overload. “If I’m watching my blood pressure 24/7, am I constantly anxious as a patient because now I’m worried?” Algozzine wonders. “That could make me run to the ER more often, potentially because I’m panicked over my blood pressure.”

Noting there’s no one-size-fits-all to offering home care and monitoring, he says the needs of a healthy 20-year-old needs will be wildly different from a 78-year-old female on 10 medications with diabetes, COPD, congestive heart failure and early-onset dementia.

“You have to start looking at data and breaking it down based on segments,”

he explains. While all patients just need their smartphone and access to care, for example, he says only people with hypertension and high blood pressure will need blood pressure cuffs and heart rate monitors. Offering that technology beyond this segment “would be a tremendous waste of resources, money and a valuable clinician’s time,” he adds.

The future of medicine needs to be whole-person care, Algozzine opines.

“You have to be able to triage them, then you’d be able to actually provide both the acute care and longitudinal care in a team-based approach,”

he says. “The person treating the anxiety also knows about the thyroid and will check that. And the person who is monitoring blood pressure and glucose is also able to solve your problem in an instant if you have an emergency, then hold the patient’s hand when that one singular group can’t solve every problem through care coordination and navigation.”

“There’s a reason why ERs, hospitals, long-term care and acute-care facilities are so expensive,” he says. “It’s because they’re designed to save lives. So, when you come to them with something that doesn’t need lifesaving care, you end up essentially paying for the price of readiness and stressing the system.” ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 30 years.