PRIMARY CARE MODERNIZATION

Remote Patient Monitoring

CORE CAPABILITY

Remote patient monitoring uses connected digital devices and technology to move patient health information from one location, such as at a person's home, to a healthcare provider in another location for assessment and recommendations, usually at a different time. It is most helpful for patients with certain conditions including congestive heart failure, often called CHF.

DRAFT

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Have certain health conditions monitored from home by the primary care team without the need for transportation, child care and time off work
- Benefit from early detection of changes in their health conditions and timely adjustments to the care plan
- Be assured that their care team has information about how their conditions are responding to treatment
- Transition to home from the hospital with more help from primary care teams
- Avoid some emergency department visits and hospital stays through better management of health conditions

PRIMARY CARE TEAMS CAN...

- Better support patients with more complex needs between visits and after hospital stays for improved clinical outcomes
- Have real-time information about changes in condition and response to treatment in order to inform care plan adjustments
- Have the data necessary to inform patient coaching (e.g. medication compliance, lifestyle changes) without the need for an office visit
- Enable patients to avoid unnecessary emergency department visits and hospital admission

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Diane is a grandmother who takes care of her daughter's two children full time. She has congestive heart failure (CHF), but caring for the children, she doesn't have much time to go to the doctor's office.

Recently, she was having chest pain and shortness of breath and was admitted to the hospital for four days. After being discharged, a nurse care manager from her primary care practice made a home visit.

The nurse set her up with a remote patient monitoring system to check her weight, blood pressure and other vital signs daily. The nurse showed her how to use it and how it automatically sends information to her primary care team.

Diane's weight went up quickly, a sign she was retaining water and needed to change her medication. Her nurse saw the change in data and called to talk about adjustments to Diane's diet and medications.

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HOW

Care Team and Network Requirements

- Use evidence to develop protocols to determine which conditions, in addition to congestive heart failure (e.g., chronic obstructive pulmonary disorder) and which patients with those conditions will receive remote patient monitoring based on level of risk
- Establish systems and staff workflows for transmission of health data from the patient to the provider
- Establish systems to enable care team members to receive and monitor data
- Ensure patients or their caregivers have the necessary tools and instruction to participate in remote patient monitoring and transmit data through a secure platform
- Nurse care managers or other qualified team members monitor the data and consult with a primary care clinician about treatment plan
- Facilitate trainings for designated members of the care team with respect to use of technology and related clinical protocols work flows
- Process actionable, clinically-relevant data with trends identified for use in routine clinical practice
- Determine legal liability for response protocols

Health Information Technology Requirements

- Remote monitoring devices with mechanism to transmit data to healthcare provider
- Data transmission method incorporates data into EHR and clinical workflow
- Platform has ability to alert care team when data values exceed thresholds
- Data is received on platform compatible with practice's electronic health record (without a separate login)

MEASURING IMPACT

✓ Patient Experience
- Improved patient experience with respect to timely care, communication, coordination, provider support, care outside of office hours, and overall satisfaction with provider

★ Quality
- Improved chronic illness outcomes (e.g., diabetes control)
- Reduced preventable hospital admissions for ambulatory care sensitive conditions
- Reduced all-cause unplanned hospital readmissions

$ Cost
- Reduced emergency department visits and hospital admissions for ambulatory care sensitive conditions
- Lower out of pocket costs for patients able to avoid unnecessary services

⚷ Access
- Reduced wait time to address changes in condition and response to treatment
- Eliminates access barriers by allowing visits to be avoided (e.g., cost-share, transportation, childcare, time off work)

IMPROVING HEALTH EQUITY

Many patients with chronic conditions experience health disparities. These disparities may result from less engagement with care teams and social determinant barriers such as transportation, child care, or out of pocket costs. Remote patient monitoring can reduce chronic illness disparities in the following ways:

✓ **Offer ways for care teams to monitor patients** without requiring an office visit.

✓ **In conjunction with telemedicine and diverse care teams** it will improve engagement of under-served patients experiencing barriers to care and health disparities with respect to chronic illness outcomes.

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1. Health Resources and Services Administration (September 2017). Telemedicine and Telehealth. Retrieved from: https://www.healthit.gov/topic/health-it-initiatives/telemedicine-and-telehealth