When Will Grasp Catch Up with Reach? Older People Are Missing the Benefits of Remote Patient Monitoring for Chronic Illness
Jessie Gruman | December 7, 2011

Jessie C. Gruman, PhD is president and founder of the non-profit organization Center for Advancing Health. Her experiences as a patient ' having been diagnosed with five life threatening illnesses ' informs her perspective as an author, advocate, and lead contributor to the Prepared Patient Forum blog. Her most recent book, AfterShock, helps patients navigate their way through the health care system following a serious or life-threatening diagnosis. You can follow her on Twitter at @JessieGruman.

Did you know that every nursing home resident in the U.S. must be asked every quarter whether she wants to go home, regardless of her health or mental status? And if she says yes, there is a local agency that must spring into action to make that happen.

This is the result of a 2010 Center for Medicaid/Medicare Services regulation aimed at helping keep older people in their (less expensive) homes rather than institutional settings. A New York Times article notes that the nursing home exodus, while modest to date, is building. This means the number of people with serious chronic conditions like congestive heart failure, diabetes and chronic obstructive pulmonary disease who draw heavily on community-based primary care services will grow. These returnees are joining their peers and the blossoming crowd of us Baby Boomers who intend to resist living in nursing homes with as much spirit as our parents did, while the consequences of our plump and sedentary lifestyles arrange themselves into a constellation of diabetes, congestive heart failure and COPD similar to the one that plagues our elders.

Much has been written about the overwhelming demand that caring for our collective chronic conditions will place on the primary care clinicians in our communities in the coming days. And many of the provisions of health care reform anticipate those demands: Accountable Care Organizations, Electronic Health Records, Patient-Centered Medical Homes. As each of these innovations staggers haltingly forward, the developers of patient-facing self-care technologies yap and nip' at patient's, health providers' and payers' heels, claiming the
effectiveness of devices and apps that could easily today help older people with serious chronic conditions care for themselves and lower the cost of care.

We have the Veteran’s Health Administration (VHA) to look to for the feasibility of those claims. The VHA has been using telehealth to support self care for veterans with serious chronic conditions since the late ’70s. In a 2010 interview, physician Adam Darkins, Chief Consultant for Care Coordination Services at the U.S. Department of Veterans Affairs, said: 'Much of the technology capability that is needed to support older adults in improving their health is already available; the pressing issue is how to increase the adoption and usage of these technologies.'

The VHA currently supports more than 46,000 vets using simple phone-based technologies like the Health Buddy, a device that lives near your phone into which you enter your blood sugar, weight, or blood pressure with the understanding that your nurse and doctor are looking for changes that signal trouble and will call to discuss them if they see any. And the agency will vastly expand the scope of its investment in remote patient monitoring approaches in the coming years.

But remote patient monitoring for chronic illness self care that is integrated into non-veteran primary care hasn't really caught on. Group and staff-model health plans such as Kaiser Permanente and Group Health Cooperative and other closed systems have piloted such programs with promising results but they have yet to take those pilots to scale. And while home health agencies have also experimented (and occasionally implemented) programs for two-way video conversations, for example, adoption has been modest.

Despite the VHA's confident move into using remote patient monitoring technology to help veterans care for a host of chronic conditions beyond COPD, CHF and diabetes'despite the large number of pilot studies' demonstrating that well-defined remote patient monitoring programs integrated into primary care produce better outcomes and save money'(and most importantly, from my perspective) despite the reports that participants in the trials and veterans say those technologies help them take better care of themselves, most older people with serious chronic conditions don't have the option of receiving this kind of support to care for themselves.

Why? Molly Coye' and her colleagues in a 2009 Health Affairs article ticked off the barriers:

- 'The principal barriers to innovation in chronic care (are) the effects of benefit design and reimbursement mechanisms;
- 'Most providers and delivery systems have little experience with remote clinical technologies. They are poorly prepared to evaluate the technologies or to make decisions about their acquisition or deployment'
- 'The financial models and assumptions needed to calculate costs and return on investment do not exist.
- 'Although most remote patient monitoring products on the market today have a functional interface with one or more electronic medical records (EMRs), installation and maintenance are an additional burden on delivery systems' information technology (IT) staff.'
These barriers are almost as insurmountable today.

OK. Maybe the solution is for individuals to seek out and contract with providers of such services on their own. After all, free-standing services such as Life Call (of 'I've fallen and I can't get up' fame) and other personal emergency response systems have long been popular among older people (and their children). There are undoubtedly some people' for whom corresponding free-standing devices and programs to help them monitor their symptoms are both affordable and preferable. It's likely, however, that their price, requirements for technical competence and enthusiasm for self-monitoring exceed those of most chronically ill older people.

Further, there is reason to believe that part of the effectiveness of the VHA approach and most other pilot programs is related to the technology's close connection to the individual's primary care clinicians. Brown geriatrician Richard Besdine told me: 'It's important to remember that the quality of the communicators, especially on the professional end, matters. Remote patient monitoring is only as good as what is on the other end.' David Lindeman, director of the Center for Technology and Aging' agrees: 'The barrier is not the hardware. It's the current system and the lack of care management programs. Individuals and family members can find a device or monitoring technology but there isn't a connection with the provider. And without a formal link to the primary care clinician or practice, the benefit is slim.'

Jeremy Rich, MD, who directed a pilot of a telephone-based monitoring system for older people with COPD in the staff-model HealthCare Partners Medical Group, told me about an older patient who desperately wanted to remain in his home to care for his two giant Macaws. The man said that not only did the monitoring give him confidence that he was doing OK and offer reassurance that his familiar medical team was looking out for him, but that he tried to do a little better because he knew they were watching.

Psychologist Richard Birkel of NCOA' (formerly of the Carter Center) has considerable experience implementing patient and caregiver support programs that include technology. He talked about hearing from patients in a short-term post-surgical care program that they didn't want to give up the monitoring once the program ended. 'They loved the relationship with the team and the certainty of having back-up if something were to go wrong.'

By no means is every older person with a serious chronic condition amenable to remote monitoring and support. Many are just fine on their own. Some of them have declines in vision, hearing, cognition and manual dexterity that make it difficult to make use of the technology. Some would rather meet their clinician face-to-face in their home or make the trip every couple weeks to see her at her office. But the desire to remain independent and at home is powerful for many, and knowledge that there are effective, affordable technologies that may help people do so safely has the potential to elicit robust demand ' and willingness ' to engage more fully in their care.

It is frustrating to wait for professionals to carefully renegotiate their roles and learn to work as a team, use the new electronic health record (EHR) and adjust to new lines of authority and accountability. It's excruciating to watch the majestic consolidation of practices and hospitals
into Accountable Care Organizations that will eventually use payment models that can support remote patient monitoring. It's exasperating to observe the fits and starts and resistance to implementation of EHRs. How long will it take for the 'back end' of the clinical enterprise to be configured so our clinicians can work with us and our parents and our neighbors to help us care for ourselves using these new technologies?

While I understand the tremendous effort these changes require, it breaks my heart a little to think of all of those whose independence and lives at home could be supported with the technology that exists today.

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