**Remote Patient Monitoring: Is It Enough For Chronic Disease Management?**
**By Scott A. Bowers, CEO, Spiras Health**

Throughout my career in healthcare, I've been on a mission to help improve access and quality care for complex and underserved populations who need support the most—individuals who might otherwise fall through the cracks.

In March 2020, however, I understood first-hand the unique challenges of caring for someone with a complex chronic disease, when virtually overnight, I was thrust into the role of caregiver.

My father, who is in his early 80s and has chronic obstructive pulmonary disease (COPD), had several heart attacks and had to undergo emergency surgery. Unfortunately, there were complications from the surgery, and he had internal bleeding and lost both kidneys. As I sat in the ICU at his bedside holding his hand, and the sound of monitors beeped all around him, all I could think was, *life will never be the same*.

When he finally came home, I started to sort through his list of doctors and medications, and address his diet. The home health care agencies were brought in, but everyone was asking the same questions again and again and no one in the system was streamlining the communication. Fortunately, for him, I understood the ins and outs of care coordination and advocacy and he eventually resumed an independent life, yet I knew not everyone is so fortunate.

At the time, I was on the board of directors for Spiras Health, and I had a new understanding of chronic disease management and appreciation for the care that's required. When I was asked to take on the role of CEO in January, I couldn't imagine being anywhere else.

**The Complexities of Complex Chronic Disease Management**

In the U.S., stories like my father's are commonplace. According to a RAND study, in 2014, 150 million people in the U.S. were living with at least one chronic disease like COPD and congestive heart failure (CHF), while nearly 100 million had more than one.

Complex populations with chronic diseases are also high-cost drivers, accounting for $3.8 trillion in annual health care costs.

Most of the spend is due to *avoidable* emergency room visits, hospital admissions, and re-admissions. According to a 2020 study in the *Journal of General Internal Medicine*, based on 2014 data, the average potentially preventable spending for high-cost patients was $11,534. Every year, this avoidable spending will continue to climb.

Members with chronic diseases often have other comorbidities as well as social determinants of health (SDOH) at play. A 2019 study in the journal *JAMA Network Open* found that social and behavioral factors were strongly associated with the development of chronic disease.

Medicare Advantage plans, in particular, attract more members who need chronic disease management than fee-for-service Medicare. In fact, in 2020, 70% of Medicare-eligible seniors with five or more chronic conditions said they were more likely to choose a Medicare Advantage plan compared to those without chronic diseases, a report by Better Medicare Alliance found.

Some Medicare Advantage plans have turned to remote patient monitoring (RPM) to improve health outcomes, their quality metrics, and STAR ratings, and drive patient engagement, but RPM alone isn't enough to solve for the complexities of chronic diseases management.

**Remote Patient Monitoring Must Be Supported By a Clinical Care Team**

In recent years, there's been a lot of buzz about digital therapeutics, apps, and RPM.

In fact, 60% of healthcare c-suite and clinical leaders think RPM will be the new standard of care within the next two years, a recent report found. Plus, investments in RPM have nearly doubled between 2019 and 2020, from $417M to $941M.

RPM as a standalone solution, however, is not effective for chronic disease management because, like any technology, it's only as good as the rate of adoption and utilization.

One barrier is how older adults engage with digital solutions—if at all. In fact, a report by Older Adults Technology Services from AARP (OATS), found that 22M older adults lack wireline broadband access in their homes. For seniors who do have internet access, they may not understand how to use RPM or be motivated to use it.

Clinical support, therefore, is vital to a patient engagement strategy that uses RPM. In fact, a recent study in *JAMA Network Open* found that RPM is effective for chronic disease management but it must be paired with other engagement strategies like health coaching.

Plus, while RPM can gather a ton of data, the clinical care team must know what to do with that data. Whether they're in the home or providing care via telehealth, they must be able to use the data to inform the next steps of the patient's care plan. RPM in the absence of a specialty-trained clinical care team is like an air traffic control technology system without the air traffic controllers.

**Chronic Disease Management Programs Require a Comprehensive Solution**

For Medicare Advantage plans looking for a solution to reduce hospital admissions, drive patient engagement, and achieve optimal STAR ratings, they must target the highest cost drivers—member populations with complex chronic diseases including COPD and CHF.

While RPM technology can gather data and inform care, a comprehensive solution that combines in-person, home-based specialty care, telehealth, and a multi-modal approach is the only way to identify gaps, drive patient engagement, and ensure improved health outcomes.

A multimodal approach ensures that the clinical care team can "nudge" patients via their preferred method of contact, whether that be phone, video text, or an in-person visit. It also meets the needs of the patients wherever they are in their healthcare journeys—which can change at any time—and their level of engagement.

Initiating specialty care in the home, rather than virtually, allows providers to conduct a thorough assessment, identify risk scores, understand symptoms, develop a personalized care and treatment plan, and address the social determinants of health. Wrapping the in-home specialty visit with the latest digital supports can create a winning comprehensive solution. This holistic approach allows Medicare Advantage plans to achieve their clinical quality and patient satisfaction metrics, attract and retain members, and reduce the total cost of care. Most importantly, this approach allows patients like my father to spend more healthy days in their own homes enjoying a better quality of life.

To learn more about Spiras Health, contact us today.