Honeywell | Connected Care

Redefining the Patient Care Model: Using Telehealth to Address Chronic Disease Care in Medicaid Populations

"Remote patient monitoring (RPM) provides our members with regular access to healthcare, which in turn empowers them to be more proactive and diligent in the management of their own health. And as healthcare providers, it gives us the ability to help achieve greater collective goals, such as the reduction of healthcare costs in our state."

- Mark Fuleihan, Vice President, Physicians Preferred Monitoring

Case Study

Physicians Preferred Monitoring (PPM) in Florence, SC, currently uses Honeywell's LifeStream Management Suite and Genesis DM remote patient monitoring (RPM) devices to successfully provide individual health and wellness care for high-risk chronic disease members in underserved and rural areas of the southeastern United States. Over the years they have operated, they have had high rates of success especially among Medicaid participants.

As a hospital readmission "frequent flier" for years, Medicaid-beneficent Patricia* was finally referred to Physicians Preferred Monitoring (PPM) – a health and wellness organization – following her discharge.

Through the staff at PPM, a Honeywell Genesis DM RPM device was installed in her home, providing daily medical oversight through the organization's telehealth nurses who monitored her vital signs every day.

That was five years ago, and Patricia's overall health has since improved dramatically under the care of PPM's nursing staff and the local primary care physician Patricia sees for any health issues that arise.

Recently, Patricia picked up the phone to call PPM – not because she had a health question, but simply to thank the nurses. Through tears, she explained she felt her remote patient monitor was quite literally her lifeline – her connection to the rest of the world, which in the absence of family was all she had.

According to PPM, stories like Patricia's are far from uncommon, and the organization boasts multiple healthcare-industry successes among its members – from saving state government organizations such as Medicaid thousands of dollars per member per year through reduced hospital readmissions, to improved health outcomes, to high member satisfaction rates.

And all this is achieved on a daily basis at PPM, despite overwhelming odds stacked against success – such as the fact that nearly 99 percent of the organization's Medicaid members live in rural parts of the state (South Carolina) while struggling with the daily challenges of being in the lowest socioeconomic groups.

The success PPM has had with its members is decidedly in a class by itself. On a national level, Medicaid enrollees are plagued by some of the healthcare industry's most troubling statistics, including the following:

- More than 60 percent of adult Medicaid enrollees have a chronic or disabling condition;
- A mere four percent of Medicaid enrollees absorb **more than half** of all Medicaid funding; and
- States are projected to have a combined deficit of $125 billion in fiscal year 2012, and expected to spend $195 billion in Medicaid, **a 48 percent increase** over 2010 budgets.[i]

At PPM, those statistics are significant drivers for the business strategy and how they provide care, which is designed to reduce costs and improve quality of care. Their formula for success hinges on one quintessential ingredient: they want their members to know they care about them. That business objective is achieved through consistent member contact with clinical oversight and coordination of care and contact with their clinicians, and RPM communication and oversight.

"Many of our members previously have had fragmented care and limited teaching on their disease(s). In addition, many members require coordination on improving their living conditions," said Mark Fuleihan, Vice President, PPM. "Our team at PPM helps to coordinate care psychosocially as well as clinically through our remote patient monitoring program through collaboration with case managers and primary care physicians."

And while many healthcare providers utilize telehealth equipment and services following a hospital discharge for the industry-standard 90 days, PPM has many members who have been using the monitors for years, as in the case of Patricia.

"When people are dealing with chronic diseases such as diabetes or congestive heart failure (CHF), we find that long-term monitoring is the key to steady improvement in overall health," said Mr. Fuleihan. "The consistent communication provides regular access to healthcare that so many people in lower socio-economic brackets lack, which in turn incentivizes and empowers them to be more proactive in the management of their health.

And as healthcare providers, it gives us the ability to help achieve collective goals, such as the reduction of healthcare costs in our state."

PPM's achievements in reducing healthcare costs and improving care outcomes are well-documented, and in fact one of their principal physicians – Dr. Kris Crawford – presented a study done in 2010 at the Society of Chest Pain Centers National Meeting illustrating how RPM could be used in the management of high-risk Medicaid CHF and comorbid patients.

The results of the study demonstrated that patients can be cost-effectively managed from home with a well-designed RPM program, and will likely also demonstrate improved levels of self-management, reduced length of stay when hospitalized, and reduced ER and medication costs.

PPM's formula for success is underpinned by significant industry data as well, as indicated by the research paper distributed by the Cameron Institute titled The Effectiveness of Disease Management Programs in the Medicaid Population, which found that inperson care management, self-management, and monitoring were significant variables for high-risk patients in terms of achieving overall patient improvement goals and cost savings.

The paper cited the following findings from independent studies offering return on investment (ROI) and patient health results from an approach similar to PPM's for chronic disease management:

- A recent study published in Health Affairs demonstrated that diabetes disease management programs resulted in 30% fewer hospital admissions in the intervention group.[ii]
- A study of a Vermontiii pilot program for chronic disease patients found that while group participants were seen more frequently by health care teams, hospital admissions and ER visits were lower. In addition, inpatient hospitalizations decreased 21%, and ER use decreased 31%.
- A study of chronic disease selfmanagement in Californiaiv observed reduced disability, fatigue and distress which resulted in fewer outpatient visits across populations with diverse chronic diseases.

The research compiled by the Cameron Institute concludes that patient care programs involving in-person care, patient self-management, and remote patient monitoring "improved the management of chronic disease in the Medicaid population, both in terms of improving health outcomes and saving money."

But to PPM physicians and executives, the biggest successes are told through phone calls like the one they received from Patricia: the remote patient monitors are their lifelines, and the nurses and physicians are their connection point to the world.

**Member name changed to protect privacy.*

Physicians Preferred Monitoring is an individual health and wellness management company focused on the recently hospitalized and high-risk chronic disease patient. Their clinical team serves members in underserved and rural areas of the southeastern United States, a region with unique challenges for managing chronic health conditions. They are working to make medical systems responsive, proactive, and holistic in the delivery of high quality healthcare. PPM is a physician led company and as such is committed to noninterference in its clients' existing physician-patient relationships.

[i] *Cameron Institute, The Effectiveness of Disease Management Programs in the Medicaid Population, 2012*

[ii] *Villagra, Victor G. and Tamim Ahmed, Effectiveness of a Disease Management Program for Patients with Diabetes, Health Affairs, 23, no. 4 2004 255266 http://content.health affairs.org/content/23/4/255.full.html.*

[iii] *BielaszkaDuVernay, Christina, Vermont's Blueprint for Medical Homes, Community Health Teams, and Better Health at a Lower Cost Health Affairs, Vol. 30 No. 3 March 2011 383386.*

[iv] *Lorig, Kate R. et al., Chronic Disease Self-Management Program: 2Year Health Status and Health Care Utilization Outcomes, Medical Care, Vol. 39 No. 11, June 2001 12171223.*

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