Chronic Diseases Managed from the Comfort of Patients' Own Home

Chronic Disease Diagnosis Rates Increasing

The prevalence of chronic diseases is rapidly increasing in the United States. According to the CDC, more than 29M Americans have diabetes, and an additional 86M have prediabetes. Source: http://www.cdc.gov/features/diabetesfactsheet/. By 2025, the study estimates, 43% of women and 45% of men in the United States will be obese. Source: http://www.cnn.com/2016/04/01/health/global-obesity-study/. As obesity is a risk factor for many chronic conditions, including diabetes, hypertension, heart disease, and high cholesterol, this increase in obesity is concerning, expecting it directly relates to patients "obtaining" chronic disease or facing co-morbidities. The prevalence of these chronic conditions create a need to provide care with patients requiring ongoing chronic care support. This additional need is stressing a healthcare system already faced with a provider shortage, co-morbidities, and disparities between rural and urban healthcare, among other challenges. One part of the solution is the success found with Remote Patient Monitoring (RPM) for chronic conditions.

Remote Patient Monitoring Affordably Addresses Chronic Care Management

RPM allows providers insight into a patient's daily lives and habits, and gives patients an ability to learn, take ownership, and proactively take care of their chronic disease. Many forms of RPM exist. The time-proven workflows, Registered Nurse ongoing support and active program management with timely communication makes all of the difference between short term and longer term success. The focus is near term – avoid readmissions; and long-term – educate patients to seek the right level of care based on their situation. Administering RPM with a focus on better health, better healthcare, and lower costs results in a program that pays for itself many times over. ROI, though hard to calculate, is easy to achieve: If RPM even prevents a single ER visit or hospital bed day, the program pays for itself and then some.

RPM In Action:

Lincoln Hospital District #3, working alongside with Health VUE, formerly InScope Health, has successfully used RPM for the past year to improve the care and support of their patients, many with multiple chronic conditions, while positively impacting associated claims.

A patient uses non-disruptive telehealth devices to monitor their blood glucose, blood pressure, pulse ox, and weight daily from the comfort of their own home. The trends of this daily monitoring, without the patient having to call in the results enables clinicians to help patients own and manage their care like never before.

The patient's health IQ, the ability to make appropriate medical decisions, is as critical as bringing clinical outcomes within established parameters. Increasing a patient's knowledge assists with their long-term care for themselves and the caregivers such as family members around them.
Providers benefit from receiving patients' biometric data trends because it allows them to take a deeper look into the patients' daily living and manage each patient's ongoing care. In the past they were limited to just the office visits to see how a patient was responding to the treatment plans they prescribed.
LHD3 began with a focus on diabetes management, however many of their patients had co-morbidities which benefited from being monitored simultaneously. In one pilot group of patients' clinical outcomes the drop in their A1c's has been so dramatic, Lincoln decided to move forward with their plans and identify patients with other primary chronic diseases such as COPD and CVD.

Patient	A1C Prior to RPM	A1C During/Post RPM

A	8.0	6.3
B	7.6	7.0
C	11.9	9.6
D	7.6	7.0
E	8.2	6.4
F	8.8	6.9
G	9.8	6.6
H	>14	10.1
I	8.4	7.8

This ongoing, hands-on nurse coaching has tangible and intangible benefits. In a recent article in the Spokesman Review out of Spokane, WA, the results of Lincoln's Health@Home program encouraged participants to take ownership of their health and chronic disease, and encourage providers to expand the program's reach by identifying patients who can benefit from RPM to help manage diabetes, COPD, CVD, and asthma. Source: http://www.spokesman.com/stories/2015/dec/13/wired-for-heath-remote-diabetes-monitoring-keeps-p/

LHD3 partnered with Health VUE, formerly InScope Health, for their Health@Home program to achieve positive clinical and financial results. If your organization is struggling to find proven ways of combatting chronic disease, consider Remote Patient Monitoring. Health VUE uses a consultative approach to learn about each client's individual needs as they recommend how to help reduce hospital readmissions, improve health for patients with chronic diseases, and equip providers to make more informed decisions about patient care. For more information, please contact Rachel Mora at rmora@patriotvue.com or 702-498-6416.

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