HEALTH EVERYWHERE

September 21, 2012

Karen Rheuban
Planning Committee Chair
Keck Center
500 Fifth St. NW
Washington, DC 20001

Re: Workshop on the Role of Telehealth in an Evolving Health Care Environment

Dear Dr. Rheuban:

HealthEverywhere would like to thank the Institute of Medicine (IOM) for hosting the workshop, "The Role of Telehealth in an Evolving Health Care Environment" August 8th and 9th, 2012. The presentations and discussions effectively promoted the benefits telehealth and disseminated perspectives relevant when considering the needs of rural populations, including from academia, government, and industry. We look forward to further discussions on the subject, particularly related to remote patient monitoring (RPM) interventions.

HealthEverywhere is a collaboration of RPM policy and industry stakeholders dedicated to providing Medicare beneficiaries' broad access to RPM. HealthEverywhere members include Cardiocom, Inc., Philips Healthcare, and Robert Bosch Healthcare Systems, Inc. Collectively, our products provide care to approximately 50 percent of patients benefiting from RPM in the US.

Our goals are to improve health outcomes for patients and achieve lower costs for the healthcare system through the use of home-based RPM interventions. These interventions improve care management by providing a range of clinical and supporting information, and engender a more proactive role for patients in their prescribed treatment.[1] The interventions are also beneficial to physicians and other providers, who receive more regular and consistent updates from patients before an exacerbation of illness occurs. While RPM has already demonstrated it can reduce health care expenditures for some government entities and private insurers,[2,3] our efforts are focused on enhancing federal health care policies in order to provide Medicare beneficiaries with access to RPM through Medicare coverage and reimbursement.

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[1] Schofield, R. (2005). Early outcomes of a care coordination-enhanced telehome care program for elderly veterans with chronic heart failure. Telemed J E Health, 20-27.

[2] Baker, L. C. (2011). Integrated Telehealth and Care Management Program for Medicare Beneficiaries with Chronic Disease Linked to Savings. Health Affairs, 1689-1697.

[3] Klersy, C. (2011). Economic impact of remote patient monitoring: an integrated economic model derived from a meta-analysis of randomized controlled trials in heart failure. European Journal of Heart Failure, 450-459.

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Because the workshop discussions and presentations were insightful and educational, HealthEverywhere would like to see another workshop to discuss RPM interventions in particular, as we believe evidence increasingly indicates that such interventions have a significant beneficial impact for patients and providers.

HealthEverywhere defines RPM technology as a coordinated system that uses one or more home-based monitoring devices that automatically transmit vital sign data and responses to assessment questions. The data are collected via the RPM technology wirelessly or through a telecommunications connection to a server that complies with the Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules. RPM includes the review and interpretation of vital sign data by a health care professional as part of an established plan of care for a patient.

Because the IOM hosted the panel on behalf of HRSA, we understand the emphasis on rural access because that is a key population served by HRSA programs. However, Health Everywhere believes policies related to the use of telehealth interventions like RPM should take into consideration the potential health care benefits for specific groups patients regardless of where they live. Patients who would benefit from RPM should not be limited based on geographic considerations such as rural locations. If a Medicare beneficiary could substantially improve their health outcomes with RPM, they and their provider should be able to make that decision without being constrained by regulatory guidelines.

Bonnie Britton from Vidant Health, who spoke at the IOM workshop, provided a case study of the substantial clinical and administrative benefits of RPM technology for Vidant Health's rural populations. Vidant Health RPM program can translate across many geographic settings. For example, Vidant Health's success could partially be attributed through its protocol to use discharge planners as the medium for the provision of telehealth. This type of novel idea could be spread to non-rural settings if barriers to their implementation are eradicated.

There is currently a significant body of evidence to support the benefits of RPM for patients with congestive heart failure, diabetes, and chronic obstructive pulmonary disease (COPD). We believe the evidence demonstrating positive health outcomes, cost decreases, and resource use reduction are strong enough to begin moving forward with wide-spread adoption and use of RPM technologies, particularly for use with congestive heart failure care management (Please see "Attachment A: Evidence to Support the Use of RPM in Chronic Disease Management").

An IOM workshop is an ideal environment to discuss these issues and bring forward evidence to the substantial benefit these technologies could offer patients, while reaching a wide audience of stakeholders and providers. We would like to discuss this opportunity with you and will follow-up in the near future. In the meantime, if you have any questions please contact James Scott at 202.558.5272 or jscott@appliedpolicy.com.

HealthEverywhere would like to thank the IOM again for hosting its workshop on telehealth. We hope to attend and join future discussions on the subject and look forward to making a strong case for the adoption of RPM services.

Sincerely,

James G. Scott
HealthEverywhere

CC: Mary Wakefield, Administrator, Health Resources and Services Administration

Nina Antoniotti, Telehealth Director, Marshfield Clinic

Kamal Jethwanit, Corporate Manager – Research and Innovation, Center for Connected Health

Spero Manson, Distinguished Professor, University of Colorado, Denver

Thomas S. Nesbitt, Director – Center for Health and Technology, University of California, Davis

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ATTACHMENT A: EVIDENCE TO SUPPORT THE USE OF RPM FOR CHRONIC DISEASE MANAGEMENT

1.) Baker, L. C. (2011). Integrated Telehealth and Care Management Program for Medicare Beneficiaries with Chronic Disease Linked to Savings. Health Affairs, 1689-1697.

2.) Dang, S. e. (2006). Differential resource utilization benefits with Internet-based care coordination in elderly veterans with chronic diseases associated with high resource utilization. . Telemed J E Health, 14-23.

3.) Danksy, K. a. (2009). Managing heart failure patients after formal homecare. Telemed J E Health, 1-9.

4.) Department of Health. (2011). Whole System Demonstrator Programme. Crown.

5.) Inglis, S. (2011). Which components of heart failure programmes are effective? a systematic review and meta-analysis of the outcomes of structured telephone support or telemonitoring as the primary component of chronic heart failure management in 8323 patients. European Journal of Heart Failure, 1028-1040.

6.) Klersy, C. (2011). Economic impact of remote patient monitoring: an integrated economic model derived from a meta-analysis of randomized controlled trials in heart failure. European Journal of Heart Failure, 450-459.

7.) Polisena, J. e. (2009). Home telehealth for chronic disease management: A systematic review and an analysis of economic evaluations. Int J Tech Assess Health Care, 339-349.

8.) Schofield, R. (2005). Early outcomes of a care coordination-enhanced telehome care program for elderly veterans with chronic heart failure. Telemed J E Health, 20-27.

9.) Seto, E. (2008). Cost comparison between telemonitoring and usual care of heart failure: a systematic review. Telemed J E Health, 679-686.

10.) Sohn, S. P. (2012). Costs and Benefits of Personalized Healthcare for Patients with Chronic Heart Failure in the Care and Education Program "Telemedicine for the Heart". TELEMEDICINE and e-HEALTH, 198-204.

11.) Vaccaro J, e. a. (2001). Utilization reduction, cost savings, and return on investment for the PacifiCare Chronic Heart Failure Program, “Taking Charge of Your Heart Health”. Disease Management, 131-142.