Q&A

# Can Telehealth Improve Care for Patients with Chronic Illness?

**Randy Moore, MD**, MBA, is chairman and chief executive officer of American TeleCare, Inc. (ATI), a telehealth technology company. A diplomat of the American Board of Internal Medicine, he has held a variety of clinical, administrative, and teaching positions at the University of Minnesota Medical School. In this interview with Editor-in-Chief Richard L. Reece, MD, Moore shares his perspectives on the role of telehealth in meeting the challenges of managing chronic illnesses such as diabetes.

**Q** *Dr. Moore, you've written that the costs of chronic illnesses represent one of the biggest threats to health care reform. What do you mean?*

**A** Chronic illnesses account for about 75% of total U.S. health care expenditures. Looking ahead, the challenge of caring for people with chronic conditions looms large. By 2020, the number of Americans with one or more chronic disease will climb to about 157 million. That is when the shortage of physicians in the United States will reach 200,000 and when the shortage of registered nurses could top 340,000. In addition, the Medicare trust fund could be broke by then.

So we face the prospect of more and more patients with increasingly complex and intense care needs, a shortage of clinicians to care for them, and uncertain funding. If we do not get chronic care management right, we cannot make effective use of resources, and we cannot control costs. For health system reform to succeed, we need to do both of those things.

**Q** *Seventy-five percent is a huge share of health expenditures. How do we get some focus on the problem of chronic disease?*

**A** We need to zero in on those patients with the highest burden and complexity of disease and the highest level of risk. Think 5/55. The top 5% of patients with the highest clinical complexity—and often multiple chronic conditions—utilize 55% of all health care dollars. For this 5/55 group, the right care is routinely delivered too late, or not at all.

This is because health care in the United States has evolved to react to episodic, acute illness and injury. To care for the 5/55 population, we still rely on emergency rooms (ERs), inpatient services, and skilled nursing facilities. We rescue patients after exacerbations of chronic disease. We have not developed the capacity to leverage the expertise of physicians and establish high-value, patient-centered care to proactively manage patients with chronic disease and complex clinical problems.

Ambulatory care remains stubbornly episodic, discontinuous, and disjointed. By default, reactive acute care interventions are required and apply the most expensive expertise and resources to rescue patients after they have become gravely ill.

> **"A team that blocks an exacerbation of diabetes today is more effective than a team that must use all the resources of the ER and intensive care to rescue the patient from an advanced deterioration tomorrow."**
>
> Randy Moore, MD, American TeleCare Inc.

**Q** *So how do we ensure that patients with chronic disease receive the care that they need?*

**A** When patients with chronic disease and complex medical problems have office visits, they can get the routine care they need, and that's important. When their conditions deteriorate and they are admitted to a hospital, they generally have access to the essential expertise and get the care they need—despite the overcrowding seen in most ERs. What's missing? We need to keep 5/55 patients connected to the right clinical expertise in between office visits in order to avert the medical crises that land them first in the ER and then in the hospital.

**Q** *That's what you refer to as "consumer-centric care continuums."*

**A** Yes. When 5/55 patients get sustained access to the right care delivered with the right expertise and the right resources at the right time, chances are that outcomes will be good

*Continued on page 10*

*Continued from page 9*

and costs will be controlled. For that to happen consistently, patients must be at the center of high-value expert care teams that stay connected with them. Patient-centered care connections have to be supported by an ongoing flow of information to monitor patients, track the implementation of their care plans, educate patients and guide their self-care, and support timely clinical decision making.

**Q** *Is that where telehealth technology comes into play?*

**A** I have to give you a "yes, but" answer. The right technology is important and necessary, but it is not sufficient. It has to be used to implement new systems of patient-centered, connected care continuums. It must be used to establish and maintain ongoing monitoring of patients at home, timely detection of potential acute events, and prompt intervention by care teams with the requisite knowledge and skill to attain positive clinical, health status, and financial outcomes. We call this solution "advanced care management."

**Q** *What are the elements of this approach?*

**A** A complete solution set includes clinical and operational re-engineering, operations support, clinical management program portfolios, associated business and financial models, and enabling telehealth technology.

For example, for congestive heart failure (CHF) patients and others at high risk for readmissions, we're working with integrated health systems, their physicians and their home care divisions to build care teams, re-engineer clinical processes and operational workflow, introduce best practices, and implement telehealth systems that boost and extend clinical team efficiency and effectiveness. This enables the expertise that resides within these health systems to be delivered to patients wherever and whenever they need it, and they are achieving substantial reductions in readmission rates.

**Q** *How would the approach we're discussing apply to diabetes?*

**A** First of all, let's recognize that health systems and large group practices don't have the operational capacity, change management capabilities, or resources to do everything we could do for everyone. So shouldn't we focus first on where we can get the biggest clinical and financial results?

We have to segment the diabetes patient population. Start, for instance, by targeting those whose level of kidney disease puts them at highest risk for kidney failure. We identify the endocrinologists with proven expertise and competence in holding off kidney failure and dialysis: those specialists who understand the nuances of genetic factors and metabolic abnormalities that define Type II diabetes for specific patients. We undertake clinical and operational re-engineering, develop a clinical management program, and provide operations support—including telehealth—to connect the highest-risk patients with expert-led care teams capable of keeping them out of the hospital and delaying the necessity of dialysis for as long as possible.

The health system saves from $5,000 to $10,000 per patient for every month we can delay dialysis. And we give those patients that many more months living with a higher quality of life. With such savings, health systems can reinvest those savings to build up the capacity in primary care to focus on patients at lower risk levels.

**Q** *Do you mean rather than having a medical home for all patients with diabetes, are you envisioning sort of advanced medical homes for those at highest risk?*

**A** Yes. The National Coalition on Care Coordination refers to them in this way. It's the only way medical homes can achieve clinical results big enough to generate net savings.

**Q** *Can you provide another example of how your model might be used?*

**A** Sure. Let's consider transplant care. Transplant surgeons have extraordinary clinical expertise with strong teams built around them. Consider how we might leverage that expertise and extend the teams to provide more high-value, high-impact connected care: a complete pre-transplant care protocol

## CEO Offers Innovative Approach to Reimbursement

Randy Moore, MD, MBA, the chairman and CEO of American TeleCare, Inc. (ATI), has a surprising opinion about reimbursement for telehealth. He believes that to achieve the outcome-improving and cost-controlling benefits of telehealth, we should not pay for it as a stand-alone technology.

Long experience with introducing promising technologies into fee-for-service systems suggests to Moore that reimbursing physician practices that adopt telehealth technology will lead to predictable results. TeleCare pioneered the development and deployment of telehealth-supported solutions.

"If telehealth becomes another covered service to which all patients are entitled, patients will demand it, and we'll provide it, and bill for it. Costs will go up," says Moore. "If we use telehealth to just substitute $50 video visits for $100 office visits, a tsunami of demand will wash away potential cost savings."

Instead, Moore advocates pay-for-performance alternatives that center on patient outcomes. "Rather than paying for the process of providing telehealth as a convenience for all patients, we should pay for the results that it can help achieve with segmented high-risk patient populations for whom it will yield the highest value," he says.

—RLR

## Advanced Care Management Aligns With N3C Success Factors

In March, the New York Academy of Medicine and the National Coalition on Care Coordination (N3C) assessed the attributes of models of care that have the potential to decrease rates of hospitalization and improve outcomes for Medicare beneficiaries with chronic illnesses. In a report on the assessment, *The Promise of Care Coordination,* the authors identified six critical success factors that distinguish effective care models. The Advance Care Management (ACM) model developed by the medical technology company American TeleCare reflects these elements.

| N3C Critical Success Factors | ACM Key Attributes |
|---|---|
| Targeted care | Care is focused on those patient populations at highest risk |
| In-person contact | Continuing personal contact with caregivers via televisits supplements and complements home care and office visits |
| Timely information | Care includes ongoing monitoring of physiological data and patient-reported health status information |
| Close interaction between PCP and care coordinator | Care teams collaborate |
| Staffing skills and continuity | Care team expertise is matched to individual patient's needs; continuity of care is maintained in the care team |
| The services provided include patient assessment, care planning, monitoring, patient education, enabling self-care, medication compliance, and social support | Includes all required services |

*Source: American TeleCare Inc., Minneapolis, 2009*

that coordinates outpatient care. Telehealth-enabled interdisciplinary transplant teams provide ongoing clinical evaluation of people awaiting transplants, which is complementary to the care provided by their primary physicians; maintain their health status; and keep them ready for transplant. Then they provide a post-transplant program for when the patient returns home, to support the patient and the primary care physician. In this way we leverage the expertise of the transplant team and maintain a continuum of connected care, pre- and post-transplant. It makes sense to have an interdisciplinary care team that knows all about these patients to establish and maintain a continuum of connected care in support of primary care physicians.

**Q** *What's the real difference between this approach and those that have fallen short?*

**A** We are on the inside of the care process. We partner with health systems and their physicians to develop care teams and deliver a new level of advanced care management. In contrast to disease management, we're trying to bring expert, physician-led team care to patients when and where they need it. A team that blocks an exacerbation of diabetes today is much more effective and efficient than a team that must use all the resources of the ER and intensive care to rescue the patient from an advanced deterioration tomorrow.

**Q** *Payers and health plans have devised special programs to deal with high-cost illness. Why haven't these programs been effective?*

**A** The inherent problem is in the design of prevailing approaches to managing the 5/55 group. Programs like case management and disease management are applied as supplements to the care process in order to patch gaps in our disjointed health system. They are external and only minimally coordinated with physician practice. They aim to augment and affect the management of patient care from outside the care process itself.

They do not fundamentally change the basic way in which the direct care of 5/55 patients is organized and delivered. We have yet to get deep, lasting change to take root.

**Q** *What about the medical home concept? Medical homes are designed to change primary care physician practice for patients with chronic disease.*

**A** The critique of the concept of the medical home in the National Coalition on Care Coordination report seems right on target to me: the medical home is not targeted. The eligibility criteria in the Medicare medical home demonstration project are so broad that participating physician groups will get monthly fees for almost all their Medicare patients.

The concept spreads too few resources too thinly rather than concentrating on the segment of patients at highest risk. And even with the fees, it's unrealistic to expect primary care practices to have the time, capability, and resources to manage and coordinate the care of the most complex patients, especially those with the very highest levels of disease burden.■