

PAUL B. SIMMS

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January 26, 2016

The Honorable Orrin G. Hatch, Chairman
Committee on Finance for the U.S. Senate and
Chairman, Bipartisan Chronic Care Working Group
United States Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510
Chronic_care@finance.senate.gov

Dear Mr. Hatch,

This letter is sent to respond to the invitation from the Bipartisan Chronic Care Working Group (December 2015) to assist in guiding policies, program and guidelines for the evolution of telemedicine into the Medicare system. Our goal is to share some insights and make several suggestions as a result of our design and development experience, in crafting telemedicine-related systems of care and in-home diagnostic development efforts.

Our goal is to assist patients take greater responsibility over their own health and reconfigure a more effective partnership with primary care, specialists and community providers, each with a separate power that when integrated, would become powerful. Wrapped within this vision is guidance – coaching the American people through persuasive technologies on HOW to reshape our values and mores around prevention and health promotion, and WHEN to affirm primary prevention as a viable policy for us all to embrace.

System Reconfiguration

Dr. Chatterjee and Mr. Simms believe that safety net physicians should be reimbursed an additional fee to employ and coordinate the support services necessary to maintain a complex ambulatory care patient within a community setting for high need patients. In the 1970's and 1980's, many primary care physician's offices were supported by a registered nurse, who helped manage complex cases and explained the appropriate courses of action to take to prevent and/or better manage a particular health condition. This nurse would also serve as a coordinator of ancillary support systems - linking medical, emotional, psychological and spiritual needs of patients. These systems included home health coordination, mental health services, alcohol and drug detoxification services, support for transportation and housing.

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In the triaging that has occurred over the past three decades, free clinics have evolved to become Federally Qualified Health Centers (FQHC) where many of these multi-disciplinary support services now exist. Ancillary employee support has dwindled in private practice offices because these providers can only care for the most routine of these patients. Community Health Workers (CHW) have emerged in these institutions, along with the adoption of the Affordable Care Act. The Centers for Medicaid and Medicare Innovation has financed a number of innovative pilot projects that have energized CHW's effectiveness, particularly regarding the adoption of physician-inspired protocols and treatment plans for improved care management.

We propose that the Chronic Care Working Group analyze the evaluation reports from the Innovation projects funded over the past six years. This analysis should be targeted at identifying which telehealth initiatives should be approved as a usual benefit, rather than as an alternative mode of service delivery or supplemental service.

The phrase "High Tech – High Touch" illuminates the balance of tech-human interaction as the country's health systems rush toward digital APP solutions and which pays much less attention to the human follow-through process that shapes habits.

The National Academy of Sciences, Institute of Medicine has determined that over 90 million Americans are not health literate (2004). As the country evolves towards a digital and robotic frame of reference, the needs of low-income and uninsured patients must be met. These patients generally use emergency rooms more frequently because in the past, the ER was their sole source. With Obamacare, an alternative exists which has tilted towards health access without a shroud of degraded poverty as a pillow. By producing screening systems which make mammograms available, and counseling systems which remove the stigma of cancer or mental health, consumers will more effectively embrace preventive care services.

Our own efforts to translate care management information into Spanish for diabetic patients and their families being treated at a rural hospital, demonstrated the importance of remote-learning of complex information to patients sharing common health problems. This type of training begins with the premise that poverty is not the plank on which the employee in the health enterprise sits and where the judgment rests. Being a CHW means that it's OK for these poor patients to ask and obtain access to our physicians. The frame of community values is clear – if I have, we have. Classic values which dominate a significant portion of the health structure in this country have evolved from the Elizabethan Poor Laws –guidance that originated over 300 years ago and which articulated that patients were poor because they had sinned. This sinning was acceptable, only if it was temporary. Community residents frowned on laziness.

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One area of concern relates to the provision of mental health providers to support adults who have lost their children. These treatment plans should be acknowledged for their mental health status and should receive no less than six (6) visits during any year. We also believe that there should be treatment plans and that the treatment plans should include application of a. individual counseling; b. Group Therapy Sessions; and c. Focus Group Interactions.

Members of the Working Group believe that telehealth traditionally improves access to services. For neurology care (related to stroke assessment) this finding is particularly true. Telehealth has the potential to prevent long-term hospitalizations – because patients can more quickly access a neurological assessment and learn to directly benefit from the administration of TPA.

There are regional differences in the availability of telemedicine resources. In San Diego County, there are six regional stroke centers. In the Inland Empire (San Bernardino and Riverside County), there was no regional center. Loma Linda University provided the structure with over stroke support for all residents, but had not yet solved the geographic access and coverage issues necessary to cover 15-20% of the geography of California. Incentives should be provided to the academic health science center which partners with one or more health plans to finance telerehab stroke centers. Regional planning should identify and prioritize those communities where designating a stroke center will make a difference in diminished costs and longer life-span. These target communities will host millions of residents and no credentialed stroke center.

Background of Authors

Dr. Samir Chatterjee is an internationally recognized scholar and a pioneer in the use of persuasive messaging for healthcare and a visionary in Telemedicine. He is also a conceptual leader in the science of design. He is **Professor & Fletcher Jones Chair of Technology & Design** at Claremont Graduate University and has co-authored 1 book, over 115 peer-reviewed scientific journal and conference articles. He cofounded Voice Core, a VoIP startup in 2001. Dr. Chatterjee's research has been extensively funded by NSF, NIH and numerous private corporations. In 2015, he was awarded the Lifetime Achievement for his contributions to Design Science by Association for Information Systems community. Dr. Chatterjee has also been developing a healthcare technology company that has successfully delivered patented life-extending innovations to pilot stage. His corporation, DCL Health, has developed smartphone and sensor-based, in-home remote wireless monitoring technologies to assist chronic older adult patients with a primary focus in Type-2 diabetes and congestive heart-failure (CHF). The system is based on a device agnostic, wireless platform with pioneering algorithms that intelligently adjust to the patient's medical profile.

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Enormous demand for our product will be driven by the cost of hospital readmissions. Approximately 18 percent of Medicare patients who had been hospitalized last year were readmitted within one month. This amounts to nearly 2 million patients per year, costing Medicare \$26 billion. Officials estimate that \$17 billion comes from potentially avoidable readmissions. Further, Medicare is fining 2,610 hospitals (a record number) this year for patients returning within 30 days of release. The fines will amount for \$428 million (2014 Kaiser Health News). By promoting telehealth systems that connect patients to providers through in home remote wireless monitoring systems, patients will find confidence in their own awareness of their health status. When coached with a Community Health Worker and when needed access to specialist care emerges, optimal health will be pursued. Through this portal, conflicts of interest around medication management will be diminished and a greater balance will arise between patients and their own healing powers.

Paul B. Simms served as Deputy Health Director for the County of San Diego from 1980-96. For several years, (1996-99), he was Administrative Dean at the College of Allied Health at the Charles R. Drew University of Medicine and Science in Compton, CA. He also served as the Director of the Telehealth Initiative at Loma Linda University Academic Health Sciences Center from 2005 – 2009). Simms efforts focused on four program priorities in telemedicine: **tele ophthalmology** (for the examination and treatment of diabetes), **tele dermatology** (for the study of cancerous tissues and skin cells), **tele psychiatry** (with a primary interest in “5150” patients) and the **implementation of a tele stroke center**.

We trust you find these comments worthy of note. We can expand and refine them, should you care to pursue any aspect of this discussion. We value the opportunity to share our insights and we look forward to a reasoned solution to these complex problems.

Be well.

Sincerely,

Paul B. Simms

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