Testimony of Stephen J. Brown
President and CEO, Health Hero Network
before
Senate Special Committee on Aging
Thursday, June 30, 2005

Mr. Chairman and Committee Members:

My name is Steve Brown, and I am the CEO of Health Hero Network, a technology company in Mountain View, California. We serve people struggling with chronic illness by developing technologies that enable caregivers to coach and monitor patients at home.

We have been working with care coordination programs of the Veterans Health Administration for five years. We are participants in two of the nine Medicare Health Support Programs recently awarded under the Medicare Modernization Act of 2003.

My view is that health care does not start when you are wheeled through the emergency room door. Health care does not start at the doctor's office.

Health care starts at home.

Health care starts at home with our own behavior: The little things we do for ourselves every day, and the things that we notice and can do something about while they are still small problems, rather than waiting until they become a crisis.

Most of today's Medicare beneficiaries already have one or more chronic diseases – particularly hypertension, lung disease, diabetes, heart failure, and depression. Today, the concept and practice of prevention in Medicare is really about ensuring that people with chronic illness develop fewer complications and live independent longer – and stay out of the emergency room and hospital, the health care system's most expensive settings.

From our work with patients at the VA, we have seen that when health care providers and patients with chronic illness work together and focus on daily management and prevention, they can have a huge impact on patients' quality of life while reducing the cost of their care.

I would like to show you an article from The Herald-Dispatch, a local newspaper of Huntington, West Virginia, from May 17, 2005. It is about a man named Wally Browning who served our country in Vietnam, and who now is being served by the VA and by Health Hero Network.

Every day, Wally's nurse at the VA remotely checks on how Wally is doing by automatically sending personalized text questions and messages to a device called Health Buddy installed in Wally's home. With simple pushbuttons, Wally answers questions that appear on the screen, telling his nurse how he is feeling and whether he has any new symptoms. Then Wally might connect his blood pressure cuff or weight scale and transmit the latest readings. The system also gives Wally feedback and coaches him to stick with his care program and make healthy choices.

The nurse at the VA opens a secure Internet page to track Wally and other patients. The page flags potential problems according to rules set by the VA and their standard practice guidelines.

The result is fewer emergencies, fewer stays in the hospital, and greater peace of mind for Wally – and tremendous cost savings for the VA. His nurses help him stay on track with his prevention-oriented chronic care program rather than letting him fall through the cracks. As Wally puts it, after he checks in with Health Buddy, he feels like he is "good for another day." [1]

[1] "Daily monitoring helps patients keep control," *The Herald Dispatch*, May 17, 2005

Why is this important for Wally? Because Wally has congestive heart failure, a chronic condition that can send him to the hospital if his heart gets out of balance and his lungs start to fill up with fluid. With careful management, however, Wally may be able to keep things under control and live independently at home much longer.

There are 5 million people with congestive heart failure, and it has become a leading cause of hospital admissions for Medicare. There are also millions of people with other high risk chronic conditions that should be managed at home rather than in the hospital, such as diabetes, hypertension, and heart disease, and respiratory disease.

In fact, you will find at least 20 million Americans like Wally, most of them seniors, who have multiple complex chronic diseases, and who are at risk of going to the hospital. But effective prevention is possible, through coaching and monitoring at home as evidenced by the numerous published studies of our simple Health Buddy system. The cost of these programs is minimal, especially compared to the savings from prevented ER visits and hospital admissions.

According to many experts and studies, chronic illnesses account for a majority of total US health care spending, which is now nearing $2 trillion per year. Why is our health care system in so much trouble, even though we spend nearly $2 trillion a year on it?

The federal government is the biggest payer for health care, and the only one big enough to change the practice of medicine. Yet for 40 years, the federal government through Medicare has primarily paid for episodic, face-to-face encounters with a doctor – usually in reaction to a crisis. Medicare has specifically excluded most care that is continuous and long-term, and with rare exceptions, anything outside the doctor's office or hospital.

But chronic illnesses aren't episodic. They are long term and they need to be managed every day. If you want to prevent hospitalizations, you need to coach people about preventive behavior and interact with them at home to spot problems early.

In short, you need to coach and monitor patients at home.

We know it is possible because we are doing it every day across the country for thousands patients cared for by the VA. According to the VA, hospital admissions for patients in the prevention-focused care coordination program were 63% lower than for a comparison group of similar patients with high-risk chronic conditions.[2]

Last year, we worked with the Information Technology Association of America to answer the question: “What if Medicare could achieve similar results with similar patients?” The result published by the ITAA said that if we could achieve, through coaching and monitoring patients at home, results in Medicare similar to those of the VA, we'd save over $30 billion a year.[3] That savings would grow as the huge swell of Baby Boomers hit retirement.

Most analysts agree that there are currently 6 million Medicare patients, most with severe chronic illness, and typically multiple severe and complex chronic conditions, who account for 75 percent of Medicare spending. Prevention-oriented, technology-based health coaching and monitoring of those patients at home will yield substantial improvements in quality of life while making a big dent in the costs of their care.

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[2] "Virtually Healthy: Chronic Disease Management in the Home," Disease Management, Volume 5, Number 2, 2002, pp. 85-94.

[3] "Chronic Care Improvement: How Medicare Transformation Can Save Lives, Save Money, and Stimulate an Emerging Technology Industry," Information Technology Association of America, May 2004.

As a result of your leadership and that of your colleagues, the Medicare Modernization Act of 2003 asks CMS to find ways to improve chronic care and mandates several large-scale pilots that could become permanent programs if successful. “Chronic Care Improvement” is defined in the Medicare Modernization Act as a service in which care coordinators coach and monitor patients at home and use monitoring technologies, decision support tools, and clinical information databases to ensure better results for patients, higher quality care, and best practices.

The recognition that people with chronic conditions require continuous care rather than episodic crisis management is a major step forward for Medicare.

Now the challenge is execution. How can prevention and chronic care be implemented to best reach the people who need it and to become embedded in our health care delivery system? How can we keep these new services accountable and ensure we are getting the results we hope for?

As I said earlier, we are participating in two of the nine Medicare Health Support Programs that the MMA authorized. We are also working with the American Medical Group Association and its large multi-specialty physician practices to replicate a consistent care management program that assists patients in taking more control of their chronic illnesses through coaching and monitoring, under the care of their primary physician.

Part of the wisdom of the Medicare Health Support Program and similar CMS initiatives is the recognition of the key role that information technologies can play in transforming the delivery of chronic care. Information technologies are a critical part of the success of this program, because they allow best practices to be repeated and scaled. Information technologies also enable data to be collected to ensure that services are accountable and that guidelines are followed.

Most importantly, information technologies can extend care into the home, helping patients improve their own lives and change their own behavior. Care providers can better support patients with the right care at the right time, before there's a crisis.

Health care—and prevention—starts at home. The right technology can help empower patients struggling with chronic conditions and connect them to better care.

In closing, I again want to thank the Committee for inviting me to testify today and commend you, Mr. Chairman, for holding this hearing. While the Medicare Modernization Act is now in its implementation phase, I believe that Congress must continue to support CMS in its effort to transform Medicare into a program that is focused on prevention and keeping people healthy. Technology and care management for coaching and monitoring at home can transform how Medicare serves patients and make a tremendous impact on the economics of the program.

I am happy to answer any questions you may have.