

Remote Patient Monitoring and Health Equity

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More than 40 ACCC members registered for the November 10 Tech Talk, “Applying a Health Equity Lens to Remote Patient Monitoring.” When asked to describe where their cancer

program was in its use of remote patient monitoring technology, the majority (61 percent) indicated that they currently do not use but are actively researching this technology. Twenty percent identified their program as “new users” of remote patient monitoring technology, with an additional 11 percent identifying themselves as “experienced users.”

This Tech Talk (the third in a series) was driven by the ACCC *Digital Tools in Cancer Care* education program, with three members of the project’s Advisory Committee serving as panelists.

Amanda Dean Martin, DNP, CNEP, ACNP-BC, RNFA, chief, Division of Advanced Practice and Clinical Integration at Banner MD Anderson Cancer Center, kicked off the talk with a brief history of remote patient monitoring and its transition from capturing only objective data like blood pressure to subjective data like the information being collected through ePROs. Dean Martin discussed the growing use of medical devices to capture these data and how oncology is using these technologies to successfully manage patients’ symptoms and monitor treatment compliance.

Cardinale B. Smith, MD, PhD, chief quality officer, Cancer Services, and vice president, Cancer Clinical Services at Mount Sinai Health System & Tisch Cancer Institute, shared how COVID-19 changed remote patient monitoring. “Telehealth and virtual care are here to stay,” she told Tech Talk participants. “We now have the opportunity to envision how we want this care to be delivered going forward.” For those looking to select a remote patient monitoring technology partner, Dr. Smith suggested

a focus on six key areas: 1) patient vitals you want to track; 2) access to video visits; 3) user web interface—the technology must be easy for clinical staff and patients to use; 4) connectivity, including solutions for patients without broadband access; 5) home set-up and orientation; and 6) tech support, as vendors must be available to troubleshoot with patients.

The use of tablets to perform remote patient monitoring “opens up the opportunity to collect ePROs and push out surveys to at-risk and underserved patients,” Dr. Smith suggested, concluding that “there is no roadmap for this type of care. Engaging patients is challenging, and it took us some time to develop the right patient education.” The other challenge is cost. While Mount Sinai Health System used a grant from the Federal Communications Commission to fund a pilot remote patient monitoring program aimed at improving care of Black and Latinx patients with cancer, questions regarding how to pay for this technology and bill for these services going forward remain.

Yet, “technology itself is not the number one cost. There are a lot of platforms available at different price points,” pointed out panelist Adam Dicker, MD, PhD, FASTRO, FASCO, senior vice president, Radiation Oncology at Thomas Jefferson University Hospitals, Bodine Center for Cancer Treatment. “Instead, figure out how to deploy your human capital because that is the costliest asset [in remote patient monitoring].”

At the start of the Tech Talk, I asked this question: Does technology help or hinder health equity?

“The healthcare community was prepared for the COVID-19 pandemic,” Dr. Dicker told participants. “Not all of our patients were prepared.”

It is clear then that there is still work to be done to ensure that all patients with cancer—regardless of race, ethnicity, and socio-economic status—benefit equitably from remote patient monitoring technology.

Listen to this Tech Talk in its entirety at: acc-cancer.org/techtalk3. 

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