News & Views

Citizen Advocacy Center

Fourth Quarter, 2016 – Health Care Public Policy Forum – Volume 28 Number 4

Announcement

CAC is pleased to announce that our 2017 Annual Meeting will be incorporated into CLEAR's Annual Educational Conference in Denver, Colorado on September 13, 2017 – September 16, 2017. One registration will entitle CAC Annual Meeting registrants to attend CLEAR-sponsored sessions of their choosing in addition to CAC's public member-oriented activities. Visit CAC's website at www.cacenter.org in early spring for more details.

PROCEEDINGS FROM CAC'S 2016 ANNUAL MEETING

Modernizing the Regulatory Framework for Telehealth

Portland, Oregon

September 17-18, 2016

Editorial Note: These proceedings are not a verbatim account but are faithful to the speakers' remarks. Readers may wish to consult the speakers' PowerPoint slides posted on CAC's website at: http://tinyurl.com/zuprgjw.

Opening Remarks

Becky LeBuhn, CAC Board Chair

CAC is extremely pleased to be holding our annual meeting in conjunction with CLEAR's annual conference and with CLEAR's co-sponsorship. We look forward to continuing and strengthening this association in the future. Earlier this year CAC

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and CLEAR jointly sponsored some webinars; we are talking about collaborating in other ways - on meetings, publications, trainings, and so on. And recognizing that it is asking a lot to expect people to attend back-to-back meetings, we look forward to integrating our agendas more fully beginning in 2017.

On behalf of CAC, I'd also like to thank other co-sponsors: The Oregon Health Licensing Office, and the Oregon Boards of Dentistry, Medicine, Nursing, Naturopathy, Pharmacy and Physical Therapy.

On to the topic of our meeting – Telehealth – Telemedicine – We will talk about technologies ranging from electronic communication and patient monitoring to remote clinical care delivery – from patient education to tele-ER and tele-intensive care.

The original program featured the report from the National Conference of State Legislatures entitled, *Telehealth Policy Trends and Considerations*. NCSL was unable to provide a speaker, but we consider the report so significant that we've put a copy of it in your packet.

The report is at http://tinyurl.com/zu56re3.

The NCSL report discusses policy considerations related to coverage and reimbursement, licensure, and safety and security. The report is addressed primarily to legislators, and poses questions they should ask as they consider telehealth-related legislation. Many of these same questions are relevant to regulators as they consider rules and policies to implement a legislative mandate or clarify what they consider acceptable practice by the practitioners they regulate.

In connection with licensure – the responsibility of most of you in this room – the NCSL report focuses primarily upon license portability and practice across state lines. But regulatory boards also play a role in defining what constitutes telehealth, determining which services can safely and effectively be delivered remotely, and specifying the nature of the relationship between provider and patient.

Given CAC's focus on public members and the public's stake in regulatory policy, we will hear a lot about consumer perspectives on telehealth. And, it seems to me there is a lot for patients and their families to like about telehealth:

- access to care, especially for those in rural areas and patients who need consultation with specialists who may only be available elsewhere in the country;
- convenience;
- quality and outcomes, which studies show are comparable to standard, in person care;
- more economical care;

Telehealth has a lot to offer from a public health perspective:

- A reduction in health discrepancies;
- A reduction in unnecessary hospitalizations;
- Shorter waiting times to receive care. *(I'm thinking of the VA and Medicaid in particular);*
- Redistribution of the healthcare workforce to locations and patients where care is needed;
- Progress toward achieving the triple aim:
  - *Improving the patient experience of care (including quality and satisfaction);*
  - *Improving the health populations; and*
  - *Reducing the per capita cost of health care.*

Thank you, and welcome to the meeting.

Welcoming Remarks

Robin Jenkins, Executive Director, Allied Health Boards, District of Columbia Health Regulation and Licensing Administration

I'd like to welcome you all. CLEAR offers resources to its members to help them perform their mission to help better protect the public. One of our goals for this year is to continue to build upon the relationships we have with our various constituents and develop new ones. We have had a good solid relationship with CAC over many years and are glad to have the opportunity to cosponsor this meeting. We look forward to continuing to strengthen our relationship with CAC and we hope to have additional opportunities to sponsor events like these.

Thank you, and have a wonderful conference.

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Keynote Speaker

Kathy Britain, Executive Director, Telehealth Alliance of Oregon

It is a pleasure to speak to people focused on the regulatory environment for telehealth. We have a wonderful champion here in Oregon medical board executive director, Kathleen Haley.

I became involved with telehealth in mid-career. I was working for a state mental healthcare agency and having a difficult time because people were not getting the care they needed. We served 13 counties with nine mental health clinics but no psychiatrists. We had a population that was small but scattered over 64,000 square miles and it was difficult to get psychiatric care for

those folks. This changed when we started a program to use satellites to deliver mental health care to Oregonians in the Eastern side of the state. This program, dubbed "Rodeonet," was funded by a pioneering telemedicine grant from the federal Office of Rural Health Policy.

In Oregon, we have a small number of cities and most of the folks who live in rural areas don't have good access to technology. We adopted this philosophy to support using telemedicine to provide services to rural and underserved urban areas: "The care is the care, no matter where."

We wanted our telehealth to be responsive to what patients need. We wanted to make sure people who suffer strokes in rural areas can receive the same care as Portland residents do; infants who need resuscitation to have caregivers who are as skilled as urban nurses; mothers facing healthcare problems in the middle of the night to get consultation; HIV patients to receive counsel about their medications; people in rural communities to get dental care. We have a dearth of primary care in Eastern Oregon so we contracted with a service in Seattle to provide primary care during the hours that a local provider isn't operating.

How do you get from philosophy to actually putting telehealth into practice? We want to help provide easier access to affordable, quality care, consistent with patient and provider satisfaction. We want to deliver care to patients wherever they are when they need it – in school, at a workplace, at home. Traveling to get care is difficult, particularly for lower income people whose bosses may not be tolerant. We don't want people to have to travel long distances to get specialty care. Medically fragile patients in nursing homes may require an ambulance ride to access care.

The guiding principle is that "telehealth should move knowledge, not people." A good example is the "Step Forward" program that originated at the Oregon Sciences University. Through this program, a gentleman who was recovering from a stroke was able to check in with his surgeon and stroke specialist and nurse for follow up care without leaving home. Step Forward enabled the husband of an elderly woman with complicated diabetes was able to consult with caregivers in Oregon and at Mass General for advice without leaving home.

Barriers to developing these programs were huge when we first started. They involved licensure, credentialing, reimbursement, and everything else you could think of. We have whittled away at those and new delivery models are helping. Today the primary barriers are CMS reimbursement policies. Cross-state licensure is still difficult, although we have a champion in Kathleen Haley who works tirelessly with us to find ways to make it better. Credentialing has been a problem, but we are trying to get credentialing legislation in place. We have excellent private-payer reimbursement and support from the public organizations.

In terms of cost-effectiveness, delivering "non-urgent" care via telehealth means people need not go to an emergency room or doctor's office for care that doesn't need to be delivered in those locations. This represents a big savings, particularly when we are talking about an emergency room. We have seen a phenomenal growth in non-urgent telehealth care. Our local physicians want to extend their ability to care for patients by providing telehealth care. Institutions that provide non-urgent care are seeing that they can provide it telemedically. Large national organizations, such as American Wells and Teledoc are advancing this trend.

We are working to bring behavioral healthcare services into the state because we don't have enough caregivers in those specialties, particularly psychiatry. If we can find a good

organization that is willing to come into Oregon and provide these services using telehealth modalities, I think our private-pay and Medicaid reimbursement environments encourage that.

We can use telehealth to reduce readmissions into hospitals for patients with chronic conditions. The hospitals bought into this when it became apparent they would be penalized for readmissions. We have a telehealth champion in a seventeen-bed hospital in a rural area. The CEO is adamant that his patients won't be transferred out of his hospital unless it is necessary. So, he uses a range of telehealth services, including nocturnists in Paris and Israel who provide services to his patients during their daytime hours.

We want to do is save the patient time and money. For example, a provider called "Express Care" provides services at the state capitol. All state employees can see Express Care nurses, nurse practitioners, or physician assistants conveniently at the workplace. It is very cost-effective for the state because there is no sick time pay. Similar services are provided to prisons, saving the expense of transporting prisoners to hospitals and contracting with hospitals to be on call. They provide care to private employers and to individuals. The barriers to doing this are the CMS regulations barring Medicare reimbursement.

Telehealth care improves the quality of care, but we don't yet have the numbers to confirm this. Telehealth providers collect the data, but don't have the resources to analyze it. We need to encourage and subsidize research that will document the ways telehealth improves the quality of care. We believe telehealth positively affects clinical outcomes, particularly in well-done home-based programs.

A study recently published in the Journal of Pediatric Care found that delivery of pediatric acute care to children in school-based health settings is very effective. Telehealth that can provide specialty care results in significantly improved patient care. We have that data because of the Extension for Community Health Outcomes (ECHO) projects. This was begun by a doctor at the University of New Mexico who wanted to treat HIV patients throughout the state in a cost-effective way that enabled primary care physicians to learn and become more effective caregivers. He extended this to hepatitis C patients. ECHO is a process whereby providers at the University meet with groups of primary care providers who want to acquire information that will help them with complicated cases while also earning CME credits. Oregon benefits from ECHO projects out of the University of Washington. OSHU is beginning to offer ECHO projects is adult psychiatry, pediatric psychiatry, opioid use, and complex obstetrical cases. Legislation under consideration in Congress would provide more funding for ECHO projects.

Telehealth services have high satisfaction rates among patients and providers. An example is patients who are not able to travel with their family members. One big factor in healing is for patients to have a support system around them. When babies have to go to neonatal intensive care units in another city and the mother can't go, it is possible to set up telecommunication between the mother and baby 24 hours a day. When someone is hospitalized for psychiatric care, the family can interact with the in-patient therapy session without having to be there.

The Telehealth Alliance of Oregon began as a committee of the Oregon Telecommunications Coordinating Council set up by the governor in 1999. We broke away in 2001 and incorporated in 2005. The alliance is composed of volunteers who believe that telehealth should be viable anywhere in Oregon and we figure out ways to make that happen. We were particularly interested in establishing telecommunication services for rural areas. In 1999, the public utilities

commission was facing fines for poor public service. We used the pool of fine money to build a broadband communication structure for the state.

We have many members, hospitals, health systems, clinics, providers, associations, individuals, vendors. We haven't really penetrated coordinated care organizations. Our goals for the next year are to establish collaboration with public health systems and tribes.

We are a volunteer organization. I am the Executive Director because I am retired, but I work between 40 and 60 hours a week for this organization. We receive funding from our membership and from vendor champions. Unlike the fourteen national Telehealth Resource Centers, we can do that. The vendors are the ones who invent new products, so we encourage vendors to participate actively. When you go to the legislature, it is helpful to be able to say that somebody like AT&T or QUALCOM supports you. We have a summit funded by registration fees. We receive small amounts of grant funding and we do contract work.

TAO holds an annual meeting and maintains a website. A grant from the Oregon Health Authority funds a portal that shows telehealth use throughout the state and a review of telehealth law and policy at the state and federal level. We invite ourselves to meetings and maintain a resource service. We look at practice activity. We learn a lot from vendors. We post a weekly digest on a ListServ.

We also do policy work. This is the service for which people come to us the most. We are finally seen as the go to service for telemedicine information. We work with the Oregon Health Authority and neighboring states. We convene policy forums. We remain absolutely neutral in the playing field. We have been instrumental in helping good telehealth legislation to pass and in stopping bad legislation. One bill acknowledged that telemedicine needs to be subsidized. Another requires private providers to pay for telehealth.

We have an excellent working relationship with the medical board. We want to establish similar relationships with other boards.

Thinking about moving telemedicine forward in Oregon, we plan on continuing what we have been doing, working with more policymakers, helping develop regulations that keep pace with what is happening, being more inclusive, and increasing our board membership and our footprint. Telehealth is only valuable if it meets patient needs. We need to evolve and meet the changing needs of our constituents.

Question – Do you use telehealth for social services, such as family therapy?

Britain – We try to, but it is not always reimbursed so some providers aren't interested in providing this kind of service.

Question – Critical care nurses offer TeleICU. It seems reasonable to me as a former regulator that the license should be where the patient is. What is your perspective?

Britain – We believe the license should be where the patient is. If you want to practice telemedically in Oregon, you must apply for a telemedicine license. It is a simple process. Physicians in Oregon who practice telemedically in other states are governed by the laws in the state where the patient resides. Similarly, you must be credentialed in the hospital where the patient is receiving the service.

Question – You mentioned something positive about MACRA (Medicare Access and CHIP Reauthorization Act of 2015). Please elaborate. Secondly, how do patient copays work with telemedicine?

Britain – MACRA opened up opportunities for providers to be reimbursed by Medicare for services delivered telemedically. Examples include patients with two or more chronic conditions. Also, hip replacement patients can now be reimbursed for follow-up services or assistance with the surgery. It is a start. It allows for innovative payment models, which we hope will encourage CMS to consider paying for other things.

Copays are handled by whoever is paying for the service. If a private payer is paying, the same copay usually applies. If they are providing the physician-to-patient service, they will often build it in a benefit to members. So, if you are a member and you receive this particular service for your non-urgent care need, it will be covered 100%. If you are not a member, you can pay a copay to receive the service. If there is a copay in an institution, it usually works the same way as it would if the service were provided in person.

Question – To what degree are the electronic data stored and available to the patient or the clinician after the service has been provided?

Britain – EHRs did not originally take telehealth into consideration, but some systems are starting to integrate telehealth records into their platforms. Records are usually available, but not immediately when the information has to be entered by hand.

Question – Most of our therapists are unwittingly violating state laws when the practice teletherapy. What is your experience with visas to practice single family therapy sessions without the intent to begin practice in a state? Have you any experience with certification programs that might allow that to happen?

Britain – Oregon offers a full license and a telemedicine license. There aren't many good ways that I know of for providing a single service without a telemedicine license. The process is easier in states that join the licensure compact.

Consumer Perspectives

Mario Guiterrez, Executive Director, Center for Connected Health Policy

We are the national Telehealth Resource Center, an independent public interest organization created for the purpose of improving access for the underserved by using emerging telehealth technology. We are one of fourteen Telehealth Resource Centers funded by the Office of the Advancement of Telehealth for the past 12 years to provide cost-free technical assistance and training related to telehealth, knowing that the laws and regulations have been way behind the times. The federal government allows us to provide nonpartisan pubic interest information about anything related to telehealth at the state and national levels. We are not supported by vendors and do not receive money from any commercial organization so we can maintain our objectivity and be trusted by policy makers. We provide information they can use to develop laws and regulations. We are not an advocacy organization like the American Telemedicine Association. If we advocate for anything, it is in favor of improving access for the underserved. We do have a point of view when it comes to advancing laws that related to telehealth.

We have the most comprehensive available website with everything you would want to know about telehealth. We issue a newsletter on a regular basis with issues and themes around

telehealth. Telehealth Resource Centers are all over the country. I encourage you to use those resources. The TRCs have an interactive website they use to find answers to the thousands of questions they receive. Within 24 hours, even the most esoteric questions about telehealth are answered.

When we think about policy, we put it in the context of the true value of telehealth. Kathy did a good job of putting it very simply - gaining the greatest efficiency and greatest value possible from the limited resources and expertise we have in this country. The value will be realized by health systems, by payers and by consumers.

We think about the value to consumers in four ways. One is diagnosis and treatment services, ranging from episodic primary care to emergency care to direct to consumer. What is really important is that this brings care to the consumer, where that individual is located. This opens the door to providing better care. We know community health centers are using telehealth to serve the homeless using iPads for nurse practitioners.

We talk about the cost of the system to government and the consumer. Having the notion of going to the doctor is going to be outdated in the next five to ten years. You go to the doctor when you need care, but you don't need to be seen in person. You spend time sitting in the waiting room; take off time from work; take a child out of school. Someone actually did a study and determined this equates to $43 worth of lost time per visit.

The second area of value is enhanced communication and consultation. A great example of that is physician to physician or physician to patient secure portals for sharing information that enhances practice and provides better care. We have the ability to do things that increase efficiency and enable people to be treated by their primary care provider with the advice of a specialist. "E-council" is a project we are currently working on with a major health foundation to look at the ability of a primary care physician to enhance his or her practice by being able to consult with a specialist using secure web-based technology before making a referral. Many referrals entail an unnecessary cost to the patient and an inefficiency for the specialist if the patient doesn't really need to be seen in person. The idea of using E-council has been tested and there are model programs in Connecticut, California, and Colorado. Unfortunately, there is no CMS code for something like this.

The third area of value is in remote monitoring. We heard about ICU telemonitoring that allows rural hospitals to remain viable. This saves lives, reduces the impact of a stroke, and also allows the hospital to be connected with a system. Aging in place is a value of monitoring. This avoids expensive institutionalization and allows a health system to monitor on a regular basis or even continuously if needed.

The fourth value is the incredible world of mobile health. Activity monitors have become a part of healthcare delivery and behavior modification related to such things as exercising or dieting. According to the last information I saw, mobile applications now exceed over 100,000, which makes it difficult for the FDA to even monitor what is efficacious and what is not.

Where is the consumer in the policy discussion? Usually the biggest influence is from technology companies and vendors. Every politician will ask to see evidence to uphold the policy they are asked to support. There hasn't been very much emphasis on the voice of the consumer. We as a national policy center shifted our focus to work with AARP, Families USA,

and other national consumer organizations to help align their policy work so that telehealth is a critical part of how they achieve their goals.

In that light, we had a convening this past year for California consumer advocacy groups. We had three goals. One was to educate about telehealth. It is still an enigma for many folks. Secondly, we wanted to establish that it is not about the technology; it is about achieving healthcare equity by using this resource. There are laws and regulations that prevent this from happening. Finally, we wanted to develop an action plan so that while there are barriers in the way of using telehealth, the consumer voice is active and strong along with that of other stakeholders.

We asked how telehealth can advance their own organization's policy goals. It was eye opening to think about how telehealth can enhance services for non-English speaking folks. We asked what can be done to increase appreciation for the value of telehealth. We are underutilizing the media, including social media for that purpose. The consumer advocates raised questions about privacy issues.

We know from vendors and payers and insurance companies that policy should be community-based and be incorporated into a system of coordinated care. It is not just about medical services; it also about how we wrap around all the services connected with care.

What about evidence? A resource tab on our website contains evidence on which consumers and policy makers can base their advocacy for laws and policies. We posted six consumer catalogues specifically focused on the three arms of the triple aim. All of the studies in our catalogues have taken place in the U.S., been published since 2007, and have a rigorous sample size.

We just completed one on consumer satisfaction. We did a wide search and found nineteen studies of consumer satisfaction. The bad news is that this is a small number compared to the total universe of studies. Most come from medical centers and clinics.

Here are the results of the studies we looked at: telehealth patients are highly satisfied with their care and found no significant difference between inpatient care and virtual care. One controlled study found that virtual care is *better*. Patients like convenience. There are technical difficulties, which produced negative findings. There are gaps in research. We need to make it a priority of academic research. We still lack diversity in terms of population groups.

We need to remember that legislation is only a first step that is followed by a regulatory process. Sometimes, the regulations don't mirror the legislation. An example is the comprehensive change in California telehealth regulation in 2011. The law was passed unanimously and signed within one year. We all celebrated having the most comprehensive legislation in the country. The problem is that the regulators responsible for Medical made very few changes to expand the billing codes related to telehealth. So, the advocates have to educate the regulators.

The courts are playing a big role. There is a case related to Teledoc in Texas. The issue here and in other states such as Arkansas is whether an in-person visit needs to happen first before telehealth services can be provided. It seems kind of silly in this day and age, but that's where Texas is right now.

Where are going in the next decade? A few things are clear. We are moving slowly but surely from a physician-centered system of healthcare to one of team-based coordinated care, with the patient at the center. The system will involve all the community resources, whether it is a family

caregiver, primary care provider, care coordinator, or specialty provider. The key to making this work is to have virtual connectivity, communication, coordination, and support.

The second thing that is clear is that technology is moving so fast that every time I do a presentation on technology, it is about to be obsolete. It's getting smaller, faster, cheaper, and it's in the palm of your hand. We look at Kaiser Permanente as a model of virtual primary care. They have the advantage of being fully integrated, with their own physicians and facilities and healthcare coverage. All of their incentives are keeping people healthy and keeping costs down. They expect that in less than a year over half of their patients in Northern California will be doing their visits using virtual means – email, phone, or video chat. That is the foretelling of where healthcare is going in the future, as things become more integrated and value-based care becomes more dominant.

Commercialization of healthcare is a fact of life. It has become a huge industry because patients like it. There are concerns about the quality and continuity of care, but the fact is that with high deductibles, patients have a choice whether they do it from home using their computer or go to an emergency room or the family doctor and pay a high deductible.

There are benefits and risks. Convenience needs to be weighed against potential misdiagnoses. Lack of continuity is the one thing driving commercial insurers to think about how to incorporate virtual care into their payment mechanisms when a physician is not available to see the patient.

Some of you may know about Mercy Virtual. The hospital was destroyed by a tornado about five years ago. Real visionaries thought about what healthcare would look like in the 21st century. They decided to build the first hospital without beds. It is totally virtual, serving four states, providing everything from routine monitoring to TeleICU. It's a real model that will help us learn how we shift to high quality virtual care.

Kristin Bork

Lead Policy Analyst, Oregon Health Authority, Office of Health Information Technology

Oregon was one of six states to receive a state innovation model grant. We decided to use a portion of the funds for innovative models for telehealth. Working with the office of rural health, we selected five projects, which have been running about a year and a half. One is the HIV Alliance, which has been providing telepharmacy services via collaborative practice agreements with primary care providers who have HIV patients but don't have a lot of experience with the disease. The collaborative practice agreements have allowed pharmacists to visit virtually with patients and providers to teach the providers about the medications and help provide follow up to patients.

Trilliam provides psychiatric care for children and adolescents. Their initial idea was to help transition from in-patient to community-based services. During their grant period, there were few transitions out, so they modified the grant to provide psychiatric services within school-based clinics and help with family therapy for inpatients.

Act-on, located at Oregon Health Sciences University, provides telehealth services for patients with Alzheimer's. They have seen great success with tests and follow up visits with patients. Not having to travel for testing and treatment lessens stress for patients and caregivers.

Tillamook regional Medical Center has a community paramedics program. A large proportion of their patients are over 65 and many seek services at the ER. Because follow up and communication between the ER and primary care providers are deficient, patients return to the ER within a short period of time. Under the grant, community paramedics visit patients with a laptop or tablet so they can access the patient's record and communicate with a care coordinator or urgent care provider if necessary.

All these projects have demonstrated the potential for telehealth here in Oregon. They have also revealed the challenges, including reimbursement, issues around regulations and policies, communication between providers and patients, and IT requirements.

The last grant is Capitol Care Teledentistry, where dental hygienists are sent to the schools. Linda will tell you about that project.

Linda Mann

Director of Community Outreach, Capitol Dental Oregon

Capitol Dental is one of the largest dental organizations in Oregon. We treat 35 - 40% of Medicaid dental patients. We have long wait lists, so access is a big problem. My quest for the last five years has been to bring the virtual dental home model to Oregon. We have completed our first year of providing services in a school environment.

An expanded practice hygienist and a dental assistant go into the community and set up portable equipment to take x-rays and intraoral photographs, chart the conditions of the mouth, and provide other services within their scope of practice, including cleaning and applying dental sealants and fluoride. The information they gather is sent to a cloud-based electronic dental record and a dentist off-site reviews the information within 24 - 28 hours, so if the child has urgent needs, we can follow up promptly with the parent.

The project has been a collaboration between Capitol Dental, the Oregon Health Sciences University, and the University of the Pacific in California. The project is focused in Polk County, which is very rural. About 30% of the kindergartners through second graders had never had a dental exam. Even though the distance is not great, it is an inconvenience to take a child out of school for a half day to go to an appointment in the nearest town, Salem.

In 2000, the U.S. Surgeon General released the first oral health status report that concluded that while oral health is improving in the U.S., this is less true for low-income populations. We conduct an Oregon Smile Survey, which was last done in 2012. It found that low-income children were twice as likely to suffer from urgent and early dental needs than higher income children, and that Latino communities have significantly higher rates of disease. Independence OR has a high percentage of Hispanic residents, so because the project is located in that community, we see disease rates much higher than we anticipated.

An entire California Dental Association Journal is devoted to the virtual dental home, written by Dr. Paul Glassman. One finding is that people with the most dental disease are those who do not access dental care. How can we reach that population? Using telehealth is the way.

A goal of our project is to demonstrate that telehealth-connected teams can reach people in the community setting. We wanted to undertake onsite data collection and perform prevention services on-site. We hoped to demonstrate it is not necessary for most children to be seen by a dentist in a stationary dental practice or clinic. If we can keep healthy kids healthy by keeping

their preventive care going in the school setting, it will open up more access for kids needing more restorative care to get it done in brick and mortar dental settings. We also wanted to achieve the triple aim in oral healthcare and develop lessons that can be used to institutionalize the virtual dental home throughout Oregon. We will be expanding our reach next year to another country where we will focus on special needs children.

How well are we doing? Our target was to collect 70% of the consent forms we distributed. We actually exceeded that goal and received 83% of the consent forms. We were very visible at health fairs, PTA meetings, and open houses and that made a difference. Ninety percent of the children who returned a yes consent form have received services. We didn't reach our goal for having 60% of the children maintain their oral health in the school setting; we only reached 47%. We didn't anticipate the dental needs in this setting to be as high as they were because so many kids had not had prior dental care.

At the end of our first year, we provided care to 415 kindergarten through second grade students in three schools and two head start centers. We had an above average consent form return rate. We were able to keep half of the kids healthy in the school setting.

The dental hygienist and the off-site dentist work closely together, with the hygienist following the dentist's recommendations. Typically, we take bitewing and frontal x-rays. If the dentist sees a particular area of concern, the hygienist will take more x-rays. The hygienist goes through tooth-by-tooth and marks down her assessment on the electronic dental record. She takes intra-oral photographs by quadrant. She knows that the dentist is relying on her to see what is going on in that mouth. I have found that the hygienists actually over-document things to be sure the dentist has a comprehensive view. The dentist can blow up the photographs to a size that makes it easier to diagnose that it is in person.

We will continue the program in Polk County next year even though the grant has ended. We are looking for funds to help with research. We hope to extend the model of care into other communities. Lincoln County on the coast has high dental needs and barriers to care so it is a good candidate for teledentistry. We would like to conduct a more detailed financial outcomes assessment. We know that providing care in a community setting is less expensive, but we would like to have concrete numbers to prove that.

The dental world is stuck right now paying for services provided rather than for outcomes. Changes to the payment structure would be helpful, especially being able to pay for case management, including reaching the parents to plan follow up care. There is a new ADA code for case management.

Because we are providing the kids with access to care they have never had before, when we do their cleanings and sealants and refer them on the restorative treatment, the dentists in the community are noticing that the kids are less fearful because they have already experienced care in their school setting and learned that it is no big deal.

We had a few technology glitches, but those were minor. We had some challenges related to the school's expectations of how long we would be there. Typically, a sealant program keeps us in a school for about a week. But, with the teledentistry program, we were there for 2 - 3 months. We would set up our equipment and each child's appointment would take about 45 minutes. There are difficulties getting parents to arrange follow up care.

Among the lessons learned: it's all about relationships. Getting the buy-in of upper level school administration really helps. It is important interacting with students and their parents.

Comment – I hope you are evaluating the teledental program for the impact you have on children's grades and overall health and decreased ER visits. Complications from an abscessed tooth can be grave.

Question – How portable is your equipment? Could it be used in a third world country, for example? Secondly, do you talk to the children about soda consumption and other preventive measures?

Mann – The equipment fits in the trunk of a compact car. The software is very user-friendly. The hygienist spends about 45 minutes with each child so she can cue in on preventive measures she needs to talk to the kids about. We are also doing an introductory session where the hygienist talks about the basics of oral health.

Question – Mario, in your experience, is the regulatory and policy atmosphere here in Oregon atypically hospitable to telehealth compared to other states?

Guiterrez – Some states are open and others really restrictive. I think Oregon is progressive and having groups like Kathy's group here is what it is all about. Having leadership to increase awareness across the spectrum of payers, providers, and consumers is important. The states that have more repressive laws related to telehealth are the ones where nobody is out there advocating. A great example is Mississippi. One of the poorest states in the country had an incredible advocate in Christy Anderson who was able to convince their legislature to enact one of the most progressive telehealth laws in the country. Leadership and perseverance are important.

Question – I am a mental health therapist and my insurance agent said that in California, the board that regulates the mental health professions sent a notice to consumers saying that if they travel outside of Oregon, their therapist will be out of compliance if they talk to you. So, if you travel to Washington or New York and want to talk to your therapist, you shouldn't be doing that. I'm very concerned about that board's action and the ripple effect it could have.

Guiterrez – I'm not aware of that, but will look into it. There has to be some give and take between what a board does to protect the interests and safety of a patient and the desirability of expanding access in areas where there is a dearth of providers. People are mobile. Medi-Cal used to reimburse for telehealth services provided by a California-licensed physician. This year, they adopted a policy saying that practitioners have to be physically in the state to be reimbursed. The regulations have to be consistent with the intent of the statutes.

Provider Perspectives

Latoya Thomas, Policy Director, State Health Policy Resource Center, American Telemedicine Association

The American Telemedicine Association (ATA) has been around since 1993 so we have seen both technology and policy evolve. We are the leading resource when it comes to promotion of the use of technology in the healthcare space.

Our membership includes every stakeholder with a vested interest in telehealth - all healthcare professions and disciplines that employ and deploy telemedicine and telehealth in their

respective spaces. We represent the patients and caregivers, healthcare systems, providers, and technology venders and telecom. Unlike some associations, we don't have state chapters. We are comprised of thirteen special interest groups organized around issues and topics such as mental health, nursing, remote patient monitoring, and telehealth rehabilitation in physical and occupational therapy and speech language pathology and audiology. We also convene meetings, including an upcoming state policy town hall in New Orleans.

We are one of the only organizations that has developed a series of peer reviewed practice guidelines and recommendations related to the clinical practice of telemedicine. There is one on diabetes and another on home care patient monitoring. We are one of the few organizations that accredit platforms that deliver online-based care.

State policy is currently very fragmented. But, with a population that is mobile for work, leisure, and other reasons, state barriers can interfere with the delivery of services. Lawmakers are getting a better understanding that policies should be flexible, adaptable, and accommodating to this dynamic clinical model.

How do we define telemedicine, telehealth, telepractice? All the tele-terms capture healthcare services that are provided from one location to another location through the use of telecommunications. The delivery of these healthcare services can come from a healthcare provider to a patient, from one provider to another, or in the form of supervision. We encourage lawmakers and regulators to embrace the broader concept of delivering services remotely and to appreciate its value and breakdown barriers. Telehealth helps to alleviate professional shortages and disparities in care. In addition to quality of care, telehealth enables people to stay in their communities rather than being unnecessarily admitted to the hospital, thus saving on costs.

Technology is evolving and so are clinical models. Clinical models like ECHO (Extension for Community Health Outcomes) improve population health and quality outcomes. Unique clinical models are based on the condition of the patient, the scope of the healthcare provider, the types of modalities leveraged for a particular encounter. Models are also based on the location of the patient – whether it is a healthcare facility, a residence, or a school.

We have seen a shift in the thought process of lawmakers, providers and patients in that we are seeing more adaptability in the home, whether it is treating chronic diseases or accommodating the patients' convenience and choice. For example, in three years we have doubled the number of states that allowed Medicaid agencies to cover services in the home. Of those 36 states, about 17 cover services delivered directly for home monitoring. The tide has shifted because policymakers see better outcomes for the population being served. They see costs driven down, reduced ER visits.

In addition to home-based care, telehealth is delivered in healthcare facilities. One of the more interesting models is project ECHO, a collaborative interdisciplinary program. It is so effective Congress is looking at how to expand it. Other models relate to triage, timely stroke diagnosis and treatment, ICU monitoring, psychiatry, remote image interpretation. School based care is another model for delivering things like dental and behavioral healthcare. It is not easy for parents to take time off from work to transport their children to receive care and not desirable to take the child out of school. This requires access to reliable broadband connectivity.

To be able to leverage telehealth there are a few important concepts to keep in mind. One is about knocking down government barriers at federal and state levels. It is also important to keep

in mind the concept of promoting value, particularly in terms of service delivery. Finally, keep in mind addressing care delivery problems, whether cost, access, outcomes, or productivity. Three areas affect this: licensure portability, developing provider-insured networks, and looking at coverage and payment. State lawmakers are more responsive to the needs of providers and patients than federal lawmakers. At the federal level, policy barriers are more statutory. Medicare is a poor payer of telehealth because of a provision of the Social Security Act that limits the way in which Medicare enrolls healthcare providers to be paid for services rendered through telehealth. Healthcare providers are limited based on the location of the patient; the patient cannot receive services at home or in healthcare facilities deemed not appropriate by CMS. There is also a menu of healthcare providers who are considered appropriate to render such care. Ironically, health professionals like speech language pathologists and audiologists, physical therapists and occupational therapists are not permitted to tele-treat Medicare beneficiaries under the statute.

At the state level, Medicaid agencies have used the flexibility CMS has given them to innovate at a faster pace. Medicaid does not proscribe what a provider can and cannot do. States have announced they see no difference between services delivered via telehealth versus in person. Forty-nine states authorize some type of coverage for telehealth services. The one state with no coverage is Rhode Island, which considered but defeated a law to allow commercial insurers to provide insurance. The states have been incubators of innovation in leveraging the technology.

Until recently, there was no way for states to learn from one another. In 2014, ATA created two "gap" reports. One on coverage and reimbursement compares approaches to private insurance, state health plans and Medicaid. Another looks at physician clinical practice and licensure. We compared Medicaid and Medicare leveraging of telehealth. Most of the state Medicaid programs are way ahead of Medicare in terms of restrictions on patient location, acceptable technologies, and types of care. No state Medicaid agency employs geographic restrictions. Medicare is the only federal program that restricts the type of services covered for telehealth based on geography. Using our reports, states are learning about how their statutes compare to other states.

It is interesting that commercial insurers have been able to leverage the success and flexibility of the Medicaid program. Three years ago, we had a lot of uptick of telehealth in Medicaid throughout the country, but we had about 15 states that would only allow their private insurers to reimburse for services via telemedicine. There were many issues around the concept of discriminating against those who were providing services via telemedicine versus those who were not. We would see feedback from insurers saying, "We don't have to pay for that service because it was conducted via video, or there was no face-to-face interaction. What we see today, as opposed to what we saw three years ago, is an indication that law makers get it, that insurers now get it. This is a result of the work of providers and patients showing the value of telemedicine. In the course of three years, we have seen a number of states double the coverage of telehealth. We want to be sure that no patient is left holding the bag because services were rendered via telemedicine. There are now 31 states and DC that have laws in effect.

California, Louisiana, Oklahoma, and Texas have over two decades worth of experience in telemedicine parity. Now we have 31 states that have removed discriminatory practices that don't allow patients to choose to receive services via telehealth.

What can or cannot professionals do in the state in which they are licensed? Over 400 health professional boards in the country authorize some kind of scope of practice for various disciplines. If you can imagine those same boards coming up with unique language and sometimes more stringent language for how professionals are using telehealth tools, that is exactly the kind of landscape we are looking at. When we talk licensing boards, it is your job to license healthcare professionals based on their competence and the rigorous standards you employ. Telehealth is a tool; it is a way of delivering care. It is not a separate service. We believe a licensing board should uphold standards of care when a healthcare provider is leveraging the technology using telehealth and not create a separate or harsher standard for professionals using telehealth.

Some things to consider as you look at regulatory policy include the extent to which telecommunications can be leveraged to deliver care and the extent to which a clinical action establishes a provider-patient relationship. In the past few years, some boards have attempted to create a separate standard for telehealth providers that they are not expecting those who provide in-person services to abide by. We encourage boards to create parity when it comes to standards for licensed clinical professionals. I would also encourage you to look at the extent to which there are barriers obstructing the use of technologies for initial healthcare encounters or arbitrary requirements for follow up encounters. Are there any statutory requirements that might warrant the healthcare provider to lean on a facilitator to be present with the patient when they are using telehealth? Do regulations overlook the patient's right to determine how they want a clinical encounter to occur – do they want another provider to be present with them when they are experiencing, for example, a counseling session?

We encourage boards to adhere to the same clinical practice requirements and informed consent for telehealth. We encourage you not to be overly prescriptive about where a provider and a patient should be in order to have services rendered via telehealth. Nor should there be prescriptive language about the types of technology that is permissible because technology is evolving so rapidly. Licensed professionals should be authorized to use their own discretion.

We are seeing a lot of confusion about prescribing and dispensing. The language should ensure that telehealth is an appropriate way to have a relationship with a patient, and also a way of rendering a prescription. We have seen some success with medical boards recognizing that telemedicine can be used in an initial encounter. As of last month, we finally got the final state (AK) to say yes.

License portability is an important area. Numerous bills have been introduced at the national level that would allow for a national licensure concept. This would mean that one state license would be applicable throughout the entire country. Bills S2170 and HR2516, and Medicare Bills S1778 and HR3081 would enable healthcare providers enrolled in a Medicare program and the VA to have one license and operate nationally without state-by-state barriers to providing care to Medicare and VA beneficiaries. What we are seeing at the state level is a bit more nuanced. The FSMB compact based on an expedited licensure model is gaining traction in the states. Another licensure portability model is mutual recognition, exemplified in nursing, psychology, and physical therapy.

States can use our staff analyses to compare what they are doing with what other states are doing, and to plan for the future. We have issued reports for physician practice and licensure and psychologist clinical practice and licensure. We looked at several indicators: barriers associated

with clinical encounters, requirements unique to telehealth providers, and informed consent. For psychologists, we looked at three indicators: encounter, informed consent, licensure models. As a result of our analysis, we are happy to report that eight states have reexamined their policy landscape (MS, MS, NE, NV, OK, TX, WV, and WI).

Question – Please explain parity of laws related to private insurance.

Thomas – Parity of laws refers to parity between private insurance and Medicaid to ensure that in-person services and services provided via telemedicine are reimbursed the same way. We don't believe insurers should be able to deny coverage just because a patient has chosen to receive services via telehealth.

Question – What American Telemedicine Association resources do you think would be most useful to the regulators in the room?

Thomas – The gaps reports on physician and psychologist clinical practice and licensure are good resources to determine how your state compares to other states and what areas you should look at to ensure comparable standards for licensed professionals regardless of the technology they use. Another resource I recommend is the Tool Kit for Medical Boards. We focused a lot on medicine because physicians are in a position to leverage telehealth more than other professions.

What is the Federal Trade Commission Up To?

Karen Goldman, Attorney Advisor, Office of Policy Planning, Federal Trade Commission

The views that I am expressing today are my own. They don't necessarily reflect the views of the FTC, any individual commissioner, or the FTC's Office of Policy Planning. The mission of the FTC is to prevent business practices that are anti-competitive, deceptive, or unfair to consumers and to enhance informed consumer choice and public understanding of the competitive process. The mission is broken down into two areas: consumer protection and competition. The FTC Act covers both of those. It provides that unfair or deceptive acts and practices and unfair methods of competition in or affecting commerce are unlawful. The FTC also deals with conduct that violates other anti-trust laws, such as the Sherman Act, which prohibits monopolization and attempted monopolization, and also agreements in restraint of trade. This presentation will focus on the competition mission.

Competition benefits consumers, especially in industries like healthcare that are undergoing rapid change. Competition promotes innovation, expands the supply of practitioners, and improves quality and efficiency and therefore value. It can help to control costs and prevents harmful accumulation or exercise of market power.

We have a range of tools to use in regard to industries such as healthcare. One is law enforcement. Many of you are familiar with *North Carolina State Board of Dental Examiners v. FTC*. You may not be as familiar with the FTC's research and scholarship, which leads to such things as the 2014 and 2015 "Examining Healthcare Competition" workshops and earlier workshops in 2003 and 2004 which resulted in a 2004 report, "Improving Healthcare: A Dose of Competition." Because of all these activities in the area of healthcare, there is significant healthcare expertise at the agency in both the competition and consumer protection areas.

Competition advocacy consists of comments on proposed state laws or regulations. Usually, we receive a request from a state official, such as a legislator, to review a proposed law or regulation. Sometimes we develop comments in response to an open comment period.

Competition advocacy comments are usually a joint effort by staff. They are voted out by the Commission, but they are considered to be staff-level comments. The Office of Policy Planning, the Bureau of Competition and the Bureau of Economics can contribute to them. They analyze and comment on proposed regulations, and also provide a framework for thinking about the public policy issues from a competition perspective. They usually ask about the likely competitive impact of the proposed law or regulation, how it will affect consumers, are there any legitimate justifications to restrict competition and are there less restrictive measures to achieve the same goals. The idea is to protect consumers and fulfill other public policy goals while not unnecessarily restricting legitimate business goals, especially those that promote competition. It is possible that the underlying reason for a proposed law or regulation characterized as a consumer protection measure may be to protect incumbent market participants from competition.

Much of the FTC's past advocacy has involved comments on scope of practice and supervision. There are certain principles and underlying themes. One is to allow healthcare practitioners to practice to the top of their licenses and perform all of the many functions in which they have been trained and which the state practice act allows. Another is to avoid unnecessary supervision requirements that might allow one group of professionals to restrict market access by competing professionals. If there are unnecessary and broad restrictions on scope of practice and supervision, that can have negative effects on access, cost, and innovation. Past comments have involved several professions, most notably advanced practice registered nurses (APRNs). Other professions include dental hygienists and dental therapists.

The roots of telehealth advocacy go back to the 2004 report: https://www.ftc.gov/reports/improving-health-care-dose-competition-report-federal-trade-commission-department-justice.

That report has one chapter that considers the competitive effects of state restrictions on the interstate practice of telemedicine. Many of the conclusions are still applicable today. For example, when used properly telemedicine has considerable promise as a mechanism to broaden access, lower costs, and improve healthcare quality. And, the practice of telemedicine has crystalized tension between the state's role in ensuring patients have access to quality care and the anti-competitive effects of protecting in-state physicians from out-of-state competition.

More recently, in 2014, the FTC held a workshop examining healthcare competition at which a panel on innovations in healthcare delivery covered retail clinics and telehealth. The panel discussed a number of regulatory barriers. One is the burdensome multi-state licensure requirement. Another is unnecessary reimbursement restrictions, such as geographical location and originating site restrictions that allow reimbursement only when the patient is at a particular type of medical facility. Another barrier is rigid in-person physical examination requirements. These laws or rules may tend to benefit in-state practitioners.

This year, we followed up on the 2014 workshop and began to undertake actual telehealth advocacy regarding proposed state laws and regulations. The first one was issued March 25, 2016 when FTC staff from the Office of Policy Planning and the Bureaus of Economics and Competition commented on the telehealth provisions of Alaska Senate Bill 74. This was in response to an open comment period. The bill would remove barriers to the provision of

telehealth services by out-of-state physicians by eliminating an in-person physical examination requirement that was applicable only to out-of-state physicians.

There had been a 2014 law that allowed Alaska licensed physicians located in Alaska to prescribe drugs without a physical examination. That law had restrictions on out-of-state practitioners, but it was attempting to open up the possibility of telehealth because the state medical board previously had promulgated a regulation that, with certain exceptions, made it unprofessional conduct for any physician to prescribe drugs without an in-person physician examination. So, the 2014 law opened it up to physicians within Alaska and SB 74 would extend that opportunity to out-of-state physicians.

Alaska is a state that relies on telehealth to address provider shortages and provide care in remote regions. Alaska ranks 49th among the states for meeting care needs and 48th for mental health. So, actually, they had relied on telehealth for a long time and the 2014 law was viewed as affecting longstanding providers (such as the Department of Corrections and the Department of Health which had long contracted with out-of-state providers to provide behavioral health services which ordinarily don't require a physical examination) as well as new virtual telehealth companies that wanted to provide services in Alaska.

What kind of benefits might there be from eliminating the restriction on out-of-state providers? Potentially, it could double the supply of practitioners who could provide telehealth services. There are about 2,000 Alaska-licensed physicians located out-of-state – about equal to the number located in state, so there is the real potential to increase competition, enhance quality, and reduce cost. Reimbursement in Alaska is much higher than in other states, which is thought to be due in part to insufficient competition. Medicare reimbursement is higher because of geographic adjustment factors. There is also the potential for substantial savings in Medicaid transportation costs.

There appeared to be a lack of credible justification for the restriction on out-of-state practitioners. Sometimes the restriction was justified as a safeguard on the grounds that follow up care from in-state physicians might be better. This isn't necessarily true. Many out-of-state physicians had previously worked in the state and because Alaska is so big, it is hard to understand how an in-state physician is necessarily going to provide better follow up care. In fact, Seattle physicians are closer to some parts of Alaska than physicians in Anchorage are. The out-of-state physicians would still be held to the state's existing standards of care and other licensure requirements.

The advocacy comment said the telehealth provisions of SB74 appeared to be a competitive improvement in the law that would benefit healthcare consumers. Ultimately the bill did pass.

In August 2016, the FTC staff developed a couple of advocacy comments related to Delaware's 2015 law that added telehealth and telemedicine into the practice acts of each healthcare profession. At this point, the boards are coming out with proposed implementing regulations. FTC staff commented on the proposed occupational therapy regulations on August 4, 2016, (https://www.ftc.gov/news-events/press-releases/2016/08/ftc-staff-comment-delaware-occupational-therapy-board-proposal), and dietetics and nutrition on August 17, 2016, (https://www.ftc.gov/news-events/press-releases/2016/08/ftc-staff-comment-delaware-dieteticsnutrition-board-proposal)

The proposed regulations differed regarding the use of telehealth versus an in-person visit for evaluation.

The occupational therapy regulation avoided rigid in-person examination requirements. It made licensees responsible for determining whether telehealth is appropriate, consistent with in-person standards of care. A number of organizations (including the FSMB and American College of Physicians) have endorsed the standard that an initial visit can be by telehealth. It can establish a physician-patient relationship, but the practitioner is held to an in-person standard of care.

The Board of Dietetics and Nutrition's proposed regulation would allow licensees to determine whether to use telehealth treatment and hold them to existing in-person standards of care, however it would require that all initial evaluations be carried out in person. FTC staff evaluated the proposal and concluded it is possible that an in-person evaluation may not be necessary. In dietetics and nutrition, there is often a referral from a physician that frequently includes an evaluation and lab data. Some visits may be at nursing facilities, in which case there would be health professionals available to assist in providing information. In other cases, self-reported data might be sufficient. So, requiring an in-person evaluation might not be necessary, but could discourage the use of telehealth and restrict consumer choice. So, we asked whether legitimate health and safety justifications support the restriction, or would allowing licensees to decide better promote competition and access to safe and affordable care.

This sums up the latest in healthcare advocacy in the area of telehealth. Speculating about future directions for telehealth advocacy, my personal view is that it is possible there will be interest in licensure. At this point, a number of licensure compacts are being considered. This means there is a lot of legislative activity going on and possibly opportunities will arise for advocacy. Another area is limiting reimbursement to rural areas when telehealth services may be needed in urban areas as well. Originating site restrictions may also be challenged.

Finally, let me tell you about a recent development. On September 9, 2016, the Department of Justice and the FTC submitted an amicus brief supporting Teledoc in the 5th Circuit Court of Appeals in *Teledoc v. the Texas Medical Board*. The appeal relates to the Texas Medical Board's argument that the case should be dismissed on the basis of the state action doctrine. The district court denied the dismissal. The Texas Medical Board appealed the dismissal. The question is whether the appeal can go forward. The DOJ-FTC brief argues that the court of appeals lacks jurisdiction because the district court order denying the board's motion to dismiss on the basis of the state action doctrine is not a final judgment that is immediately appealable. On the other hand, the brief states that if the court does find jurisdiction, it should reject application of the state action doctrine because the active supervision requirement has not been satisfied and that is what the district court order said. The brief does not take a position on the merits of Teledoc's anti-trust claim but it does acknowledge that FTC staff is investigating the underlying actions that are the subject of the appeal.

Editorial Note: The Medical Board has since withdrawn its appeal.

Response Comment

Barbara Safriet, Professor of Health Law and Policy, Lewis & Clark Law School

Thank you, Karen, for your presentation and thank you to the FTC for what it has done in the area of healthcare in the past decade by emphasizing that while some regulations *may* promote quality, they may also have demonstrable negative effects on access and cost. The basic issue for telehealth as I see it is how you reconcile the utilization of virtual, boundary-less healthcare modalities with geographically-bounded legal restrictions. It has always puzzled me that healthcare professionals who attend the same national educational programs and take the same national examinations and meet the same national certification requirements can have their authority to practice vary so much based on something quite artificial which is state boundaries. Telehealth is highlighting the inevitable difficulties of state-based licensure. I am not here to advocate national licensure, but even if there were national licensure, there would continue to be a very important role for state-based licensure boards.

Utilizing boundary-less virtual modalities certainly challenges state-based licensure and its ever-varying scope of practice. For example, my respiratory system's health is no different here than it would be if I popped in the car and drove five or six miles across the Columbia River into Washington State. But, the legal regulatory regime controlling who can do what to whom could change dramatically. To use a very technical term, I think that's kind of goofy. Telehealth is forcing us to grapple with that issue.

Telehealth is also making us grapple with the continued appropriateness of what some have called "legacy" regulatory frameworks which were enacted in the early twentieth century and remain mostly the same since that time. It is no wonder, for example, that face-to-face assessment is an issue. That is all there was when the regulatory framework was created. But, healthcare delivery has changed while many regulations have not. Now, technologically enabled and driven practice is focusing attention on unnecessary, outdated restrictions, or regulations that do little to promote the public's health but continue to insulate licensees from capable competitors.

It is amazing to me that healthcare professions don't think in terms of competition. Competition can have many benefits. Largely through the efforts of the FTC, we have begun to question the assumption that any regulation passed by a licensing board has a legitimate basis. We are also beginning to question that assumption in agencies, state legislatures and the courts. Before you impose a restriction on people's occupational activities, you should identify a real need, not a hypothetical need for the restriction. You should also assess the likelihood that the solution you are choosing will address that need. If it does, you should ask if there are other ways to meet this need that would have fewer negative effects on access and cost. The final step is to continue to reevaluate the need and appropriateness for that restriction. I have argued this for forty years.

I think that the FTC's work on scope of practice and telehealth highlights the vital role of protecting the public's health and safety through legislative and regulatory board actions. But let's be a bit clearer about whether there is a real problem and a real need. Under the current constitutional standard, you can come up with a post-hoc justification for a law. But we are getting beyond that and I think that's good. Telehealth, which raises constitutional and anti-trust questions, state regulatory issues, and scope of practice questions, makes us come back to this fundamental question: Do we care about what's done and how well, or about who or what is doing it and where?

The best healthcare advice and diagnosis may well come from machines or unlicensed people. For example, you might want a biochemist to diagnose a cancer. I think the only way to grapple

with these issues is to start with the basic questions: how do we reconcile geographically founded regulation with boundary-less treatment modalities and what is the real question? Is it what's being done and how well, or is it who or what's doing it a where? These questions don't have easy answers, but they give a framework for addressing protection of the public with as little as possible restriction on competition, access, and cost.

The veterinarians, optometrists, physical therapists, nurse practitioners, all say face-to-face is important. I ask why? Studies have shown that virtual modalities can do some things just as well as an in-person optometrist can. What if the studies can demonstrate that the provision of care virtually provides the exact same quality or even better – and cheaper and more convenient? They say, "No, it is really important to have face-to-face encounter because you need to have, for example, a comprehensive assessment." I would then ask, "If I come into your office having already self-diagnosed pink eye, will you do a comprehensive assessment – dilation, refraction, etc.?" They say "Of course not." So I say, "You have to be a little consistent with your reasoning." They say, "We're used to doing things the way we are used to doing things." That might have carried weight years ago, but now we have so many options. Telehealth is pushing regulators to articulate the rationale for any restrictions very clearly.

Goldman – Thank you Barbara for that insightful description of the issues. As I said, licensure is an area for possible FTC advocacy in the future, although that is pure speculation. I think Barbara is correct that telehealth has crystalized the issue of different licensing schemes in different states and how burdensome it can be … there is a conflict between a geographically based system vs a virtual system that can easily be available anywhere. Her comments about the legacy of face-to face requirements are also quite true. It is hard to pin things down in regulation. That is the beauty of leaving practitioners to decide while making them accountable by holding them to existing standards of care.

Guiterrez – I go around the country speaking to legislators and testifying before committees and organizations and I have never heard a more common sense description of the dilemma we are in. I will be speaking later about the absurdities of Medicare regulations related to telehealth. You mentioned that some of the areas the FTC may look at in the future might have to do with the location where the beneficiary has to be. Do you have authority regarding Medicare, or would that have to go through CMS?

Goldman – No, we do not have authority over Medicare. I want to emphasize that my comments about future advocacy are purely speculative based on the kinds of comments we heard at the 2014 workshop. We usually do comments in response to requests from state officials or open comment periods, so I really have no idea whether there would be any opportunity for the FTC to comment, nor do I have any idea how the Commission might feel about it. But, geographic restrictions are raised repeatedly as a barrier.

Comment – Nursing has been working since 2004 to help the states standardize education, certification, licensure, and accreditation. For example, to go from Missouri to Kansas, you just have to cross the street. In Missouri, direct supervision by a physician is required for advanced practice nurses whereas it is totally different in Kansas. These things are frustrating.

Some of us were talking last night about benefits for consumers. For example, it takes a long time to establish a therapeutic relationship with your mental health provider, so if you move, it certainly makes sense for a person to continue that relationship via telehealth. Because of the

cost, time, and mental anguish required to reestablish a therapeutic relationship with a new provider, it makes sense for your insurer to allow you to maintain the original relationship.

Question – You said several times that competition leads to lower costs, better access, and higher quality. I believe the part about cost and access, but where is the evidence that says that competition leads to improved quality?

Goldman – I can't give you a citation offhand, although I'm sure my colleagues could. I think the notion there is that many times in healthcare it is covered by insurance, so the dimension that is available for competition really is quality.

Safriet – There is actually quite a bit of evidence, but I would rephrase the question in the context of regulation: If increased competition positively affects cost, access and convenience of choice, and it doesn't *reduce* quality, why shouldn't it be there? The argument used in connection with scope of practice restrictions is that removing them would reduce quality. Although, as many groups have demonstrated, we don't have evidence-based support for a lot of what we do in healthcare. It seems to me it is rational regulation if you can demonstrate maintenance of the same quality that has been there, then look at cost and access.

Views from State Health Professional Regulators – Part I

David Benton, Executive Director, National Council of State Boards of Nursing;
Susan Layton, Chief Operating Officer, Federation of State Boards of Physical Therapy;
Alex Siegel, Director of Professional Affairs, Association of State and Provincial Psychology Boards

Layton – Telehealth used to be calling a doctor's office or nurse help line to see whether one should see a doctor. How many of you are familiar with the technology that exists today related to telehealth? Maybe a third of the audience. It is far beyond the phone or face time. When you think about regulating telehealth, it would be better if there were a heightened understanding of available technology and services.

I am with the Federation of State Boards of Physical Therapy (FSBPT). I am neither a physical therapist nor a regulator. I represent an organization made up of regulators. We work towards getting our state regulators to talk to each other about uniform standards; what should we be doing about telehealth?

My background is operations. So, I think about how to do things cheaper; get better access; and achieve at least as good if not better quality. To do this, it makes sense to use technology. When the FSBPT looked at telehealth, we asked our members what we needed to think about. They told us this is not about a scope of practice. This is simply a delivery method. The practitioner's responsibilities and the standards of care are the same. Informed consent is still the same, but there may be a special emphasis on explaining to the patient how the technology and patient interface will work.

There are some things that are different. One is privacy. How do you ensure the safeguards are there to ensure the patient's privacy? It is not just a phone; it is more complex if you are using

the latest in telehealth. There also needs to be a plan for emergency preparedness if something bad happens at a remote location.

Karen commented about licensure in multiple states being overly burdensome. Physical therapy thinks licensure is important because the care happens where the patient is and the provider needs to understand the requirements in that jurisdiction. The provider needs to be licensed there, but the licensure process does not need to be burdensome. So, physical therapy has developed a compact.

We should avoid overregulation generally and where telehealth is concerned, regulation should not get into unnecessary detail about different delivery methods and technology components to be able to adapt with changes in technology. In physical therapy, we are seeing that states are slow to write new regulations. We have only about five states that have addressed the topic specifically.

We belong to the International Network of Physiotherapy Regulatory Authorities, which is doing a multi-part series of webinars on telehealth. The research I find most compelling comes out of Australia. The Center for Research Excellence in Telehealth partnered with the University of Queensland. They looked at outcomes and efficacy. Two studies related to musculoskeletal issues looked at diagnostic accuracy and found that it was comparable for both in-person and telehealth. They did note some areas of difficulty via telehealth, but they focused on being sure that the consumer had access to the technology and that it was easy for the consumer to use; that is, the patient had to do only one thing to engage in the therapy session. On the PT's end, it is very complex; it is a system that helps them measure range of motion, high definition access. The next study was a level three research based on therapeutic outcomes. They found comparable outcomes whether the patient is seen in-person or via telehealth.

Benton – When preparing for this presentation, I thought about whether I should give you a detailed explanation of the nurse licensure compact or offer some insights into the bigger issues I think we need to face. I decided on the latter. There have been a couple of references to the fact that regulation may be out of step with where we are. My grandmother was born at the end of the nineteenth century and lived almost a hundred years. It was a time when professional regulation was just starting. She lived, married, and died within a 40-mile radius. This is not the world we live in today. Regulation was designed for an industrial age while we are now living in a digital society. The need to work within the legal frameworks is real and we need to find ways of facilitating the advantages of using these technologies and facilitating the mobility that all of us have today. The NCSBN has a vision that is about advancing regulatory excellence worldwide. Like the previous speaker, I would encourage us to look at the global literature and learn from each other.

The Nurse Licensure Compact is a mutual recognition model. It is analogous to a driver's license; you can cross a state line and continue to drive. But, as you cross that state line, you need to be conscious of the fact that the rules may change. Here is an example from Europe. There are parts of Europe where there are no speed limits. You couldn't possibly drive at the same speed on some of the roads in Scotland. So, we need to acknowledge that there may be different requirements in different geographical locations. We need to ask whether these differences are an artifact of history or whether we actually need them in today's world. There is sometimes a need to be geographically bound, but we need to keep asking the question.

Mutual recognition has a global dimension. The World Trade Organization has set out four routes of supply and we need to think about the way we deliver services across jurisdictional boundaries. The World Health Organization, the United States Government, the Canadian Government, all of the other governments around the world met in Geneva this year and passed a resolution in relation to human resources for health strategy 2030. They recognized that delivering healthcare is going to need to change radically. One thing they acknowledged is that we need to fundamentally redesign regulatory processes to provide services to a changing demographic.

Learning and using some of these leverage points is important. Our speaker from the Federal Trade Commission made reference to the North Carolina Dental case. The premises enunciated by the Supreme Court were agreed to by governments through the Organization on Economic Cooperation and Development over thirty years ago. Those principles are out there for us to learn from.

The nurse licensure compact is focused on the patient. Care happens where the patient is. What if I am a nurse sitting in Chicago, and my medical colleague is sitting in Michigan, and my physical therapy colleague is in Florida? Unless we all agree that care happens where the patient is, how can we agree on a single point of accountability? We need to know what can or cannot be delivered in that person's reality. The Tri-regulatory group (Nursing, Pharmacy, and Medicine) issued a statement that makes this very clear.

Patient-centered care is what it is all about. We need to be able to improve safety through universal licensure requirements. The next generation of the advanced compact recognizes that there were variations that needed to be removed to protect the public. That's why things like criminal record checks need to be part of regulation so we can be sure practitioners are not a danger as they move around the system.

We know that the mutual recognition system can reduce administrative costs associated with care. Just a week ago, I spoke with an insurance company that is providing services through telehealth in thirty-one states. They have 3,500 nurses delivering under the current regime. They need 30,000 licenses to enable that to happen. That costs $3 million just for the licenses and another $175,000 for the finger printing and photographs and 18 whole time equivalents to run that part of the system. That does not make sense, so we need to push ahead with mutual recognition along the lines of the nurse licensure compact.

We know we can improve access. In Scotland where I come from, we have many inhabited islands were there are no healthcare services so we have been using telehealth for many decades to provide services in those environments. We also need to use them to enable continuity of care based on the therapeutic relationship established with a mental health provider.

The original nurse licensure compact, which was developed in 1998, stalled at 25 states. The reason was about information flow and accountability. We needed to make sure there were wider universal requirements and that is what the enhanced compact has done. In its first year of operation, sixteen states came forward and ten have written the legislation into law. In 2017, there will be twenty states.

The compact is currently focused on how we deliver care. I would argue in today's world, if I go on holiday to Europe, I might want my mental health provider to follow me there as well. So, the challenge is truly global. We need to look at how our colleagues in Europe have dealt with

issues of mobility and exchange of information while protecting the integrity of the data and enabling contemporary services to be delivered.

I would argue there are huge opportunities for all of us, and that we actually need to think about what is coming not what is or what has been. I am able to control my home in the UK over the internet. We can also change drug prescriptions using that methodology. We are living in a connected world. Therefore, the regulatory regime from the industrial era is not appropriate. We need to think about moving in a digital society where we can facilitate and access services when they are needed.

Siegel – I am with the Association of State and Provincial Psychology Boards (ASPPB). We have a compact in the United States. To involve Canada in a compact would require a treaty. But our Canadian colleagues are working on a mutual program that will enable someone in the U.S. to provide telepsychology in Canada. I agree with what my colleagues have said about the need for and value of compacts.

Our compact differs from some of the others. Psychology is considered a stepchild in healthcare. Reimbursements are different that physical health. Regulations are more difficult, now there are 31 states and DC that have passed laws mandating that insurance companies must reimburse for telehealth services if they reimburse for in-person services. There are still barriers to where those services can be provided. It has to be hospital-based; it cannot be delivered to a person's house.

Psychologists believe that care is where the license is, not where the patient is. Our compact says if you are licensed in a compact state, you need a license only in the state where you are located in order to provide services electronically to patients in other compact states. The home state has ultimate authority over disciplinary matters.

It is necessary to know the laws in other compact states. For example, we are mandated to report child abuse. If I make a report within my state, I have immunity, but that immunity does not follow me across state lines. If you report child abuse and it is unfounded, you could be sued. Also in mental health, we have duty to warn. If a patient tells me they plan to harm someone else, I have to warn that person. Not all jurisdictions have that law, so do I apply the law where I am licensed or the law in the state where the patient is located? The compact allows the states to work together to resolve conflicts of law. Our compact permits psychologists living in border states to travel to a neighboring state for up to thirty days to do consultation. We developed guidelines and standards we expect psychologists to follow if they are going to participate in interjurisdictional practice.

We are also discussing an international compact with Australia and New Zealand, which already have a compact between themselves. We have a long way to go to decide how to recognize credentials in other countries, how to resolve disciplinary issues, and protect health and safety. The European Psychological Association is considering how they can provide psychological services across Europe. Everyone in psychology is beginning to see the need to provide better access to care for people who cannot come to us. You may have heard about a condition where people are afraid to leave the house. Also, nursing home residents have difficulty getting to a psychologist's office. The same is true for people in rural areas. We believe our compact will help address these situations. Telehealth is also a way to deal with adolescents who don't like visiting a shrink. Psychologists can use texting to build a relationship with the goal of eventually having an adolescent come into the office.

Swankin – CAC has endorsed all of your compacts. The least of our concerns was whether the regulatory boards would lose money, but that might have been the major concern of some boards. Compacts were originally designed for mobility rather than telehealth. They have become instruments to facilitate telehealth.

Siegel – Our compact is not for mobility. Fifty-six jurisdictions allow for expedited licensure so we already have that in place. Our compact was created solely for telepsychology. This is how we differ from medicine and nursing because we figured with one license, a person should be able to go anywhere. One forensic psychologist who specializes in death penalty cases and mental retardation is licensed in 26 states. He has a full-time assistant just to keep up with his continuing education and other licensure requirements. It is untenable to require psychologists to do this in order to treat patients in multiple states. It is also untenable for jurisdictions not to know who is practicing within their boundaries. So, our focus has always been on the telehealth dimension and it is a compromise between the psychologist and the licensing boards.

Layton – The FSBPT learned from compacts created before ours. We looked at what we knew nursing had struggled with. We looked at medicine's expedited licensure model. Ultimately, we decided PTs will have a single license, but all member states will be notified when an out-of-state PT is practicing there so they know what is going on within their states. PTs wanting to practice in another state notify that state and comply with its laws. It would be great if there were more similarity between compacts, but professions have to work with what their licensing boards and legislatures want.

Benton – As healthcare needs become more complex, care delivery requires more than a one-to-one relationship. It requires team practice. So, we were keen for find a solution that enabled the patient's location to be the critical nexus for care delivery. NCSBN has invested in the Nursys system, which places information from the state boards into a common framework so you can see where any given nurse is licensed and privileged to practice across the country.

Question – Please comment on the advantages of a compact when it comes to discipline, sharing investigations, and so on.

Benton – We have specific provisions related to sharing information about disciplinary activities. Criminal background check legislation is also important.

Layton – Yes, increased information sharing related to discipline is definitely a benefit of the compact. The compact also ensures we can get information about investigations, which is an improvement over waiting until disciplinary action is final.

Siegel – I agree, and would add another thing: With our compact, when a patient files a complaint against a practitioner located in another state, the compact allows the patient to present evidence electronically. Compacts force jurisdictions to work together and resolve issues. If someone is providing substandard care across state lines, they are probably also doing it in their home state.

Question – I am with a board of nursing and have oversight of research and education. It seems to me that in the conversations related to telehealth, we forget that educational standards are fundamental for ensuring some consistency.

Siegel – One of the hallmarks for psychology is that education is central to the compact.

Question – Nursing's original compact is being revised. What did you learn from the first round?

Benton – Some things that are common and others are unique to the individual states. With the revised compact, we are able to address all of the things we can agree on. We also need to recognize that things have changed a lot in twenty years. The power of our technological tools has increased enormously. We must track and adapt to the changes in the world in order to serve our licensees and their patients. I don't anticipate that this will be the final version of the compact because society's demand will change as will technology.

Views from State Health Profession Regulators - Part II

Rick Orgain, Vice President, Association of Regulatory Boards of Optometry; Cody Wiberg, Executive Director, Minnesota Board of Pharmacy Kathleen Haley, Executive Director, Oregon Medical Board

Haley – One of the things I take away from this conference is that we need to clarify terms. In Oregon, we talk about telemedicine at the medical board rather than telehealth. A July 2016 article in the *New England Journal of Medicine* uses the term telehealth.

In Oregon, we have been supporting telehealth for over a decade. We know there are inequities and disparities in the delivery of healthcare as we do it now. So, we should all applaud a modality that will increase access and reduce disparities. And regulators don't want to be luddites. Only 58% of adults over 65 use the internet, so that's a group of people we need to get to in order for telehealth to be successful.

Oregon was like Texas when we started out. We required the initial visit to be face-to-face. Over time, we decided that is no longer necessary and went back to the legislature and removed that provision of the law. We also adopted a statement of philosophy in January 2012, which is much less detailed than the Federation of State Medical Board's model policy:

> The Oregon Medical Board considers the full use of the patient history, physical examination, and additional laboratory or other technological data to all be important components of the physician's evaluation to arrive at a diagnosis and to develop therapeutic plans. In those circumstances when one or more of those methods are not used in the patient's evaluation, the physician is held to the same standard of care for the patient's outcome. See http://www.oregon.gov/omb/board/philosophy/Pages/Telemedicine.aspx.

As we move forward with telemedicine, we need to be careful not to fragment healthcare. We need to be sure there is adequate communication if a patient is seen by multiple providers or is seen remotely at one time and in-person another time.

Finally, we are seriously interested in proceeding with the FSMB's interstate compact and commission, but when we saw the final language, we realized it isn't going to work for us at this time. The reason is that the language says that if someone is licensed in a compact state, under the commission rules, we would have to license them automatically. We were under the impression we could ask our personal history questions. Theoretically, if Washington were a compact state and a licensee there is terminated from a couple of jobs for whatever reason but doesn't report it, we would have no way of knowing about the terminations and, potentially, would have a flawed candidate for licensure. We have had a couple of applicants recently who

we declined to license, but would have been required to if we were part of the compact. So, until those issues are cleared up for us, we need to hit the pause button.

Wiberg – I will talk about telepharmacy in our state and how we regulate it. We have been offering telepharmacy since at least 2001 - 2002. One of the first telepharmacy situations we encountered involved a town of maybe 2,000 people in rural Minnesota that used to be able to support a full-fledged brick and mortar pharmacy, but nobody wanted to take over when the pharmacist retired. A pharmacy chain was interested but didn't think it would be economical to station a pharmacist in the store. The pharmacy is now open, and it stocks and dispenses drugs. It is staffed by certified pharmacy technicians who are supervised remotely by pharmacists who communicate via a two-way audio-visual real-time link between a hub and the rural sites. The supervising pharmacists can also counsel patients. There about a dozen telepharmacies of this type around the state.

In Minnesota, we handle these pharmacies via a variance to our rules. The main rule that needs a variance is the requirement that a pharmacist has to be on duty at all times. Variance request approvals can contain conditions. We think we have had enough experience with telepharmacies that we may promulgate rules in the next year or two so they won't have to go through the variance process if they meet the required standards. Other states allow telepharmacies – North Dakota, Iowa, Texas and a few others.

There are other telepharmacy modalities that don't actually involve dispensing in a non-patient setting. The Joint Commission has a standard that prior to administering a drug to a patient in a hospital a pharmacist should review the order. We have hospitals where the pharmacy is not open 24 hours a day. A system has evolved where a pharmacist located remotely logs in to the hospital's system and reviews the orders before a nurse administers the drug. In my mind, that's a type of telepharmacy. We have dozens of hospitals in Minnesota that utilize this type of service.

The final area is the provision of clinical services. In Minnesota, the only two things that have to take place within a licensed pharmacy are dispensing and compounding. Clinical services, such as medication therapy management or assessing a person's medication needs and making recommendations do not have to occur within a licensed pharmacy. Pharmacists within and outside the state are providing medication management via telepharmacy.

I want to mention what we call "crossover." Minnesota passed a law in 2007 called Justin's Law, which focuses on drugs being sold illegally over internet pharmacies when patients fill out a questionnaire, a physician in another state reviews it, and a pharmacist dispenses the drugs. Justin was buying drugs in this manner and over-dosed in 2006. The intent of the law was to ensure that at least for controlled substances, there was an in-person physical examination at some point. This allowed for the formation of a company called "Zipnosis" which employs a smartphone app for minor conditions, such as a sore throat. Patients can log in for $25 and fill out a detailed questionnaire that is analyzed by clinical algorithms and sent to an advanced practice clinical nurse at a major healthcare system who decides whether treatment is appropriate. If it is, a prescription is sent electronically to a pharmacy of the patient's choice. At this point, most of the major healthcare systems have their equivalent service.

Should telepharmacy be regulated in the same manner as a regular pharmacy? Our answer is that it depends. To the extent services are being provided in the identical or very similar manner, I agree there shouldn't be different regulations. To the extent that services are being provided in a

different manner, we do need different regulations. We have a guidance document that deals with some of these situations. We specify principles, such as the requirement that telepharmacists use equipment of sufficient quality that the receiving pharmacist or technician can read a prescription or other instruction. A policy statement looks at a safety continuum or spectrum. We consider some dispensing practices safer than others, but lack of access to pharmacy services is a problem as well. So, our statement basically says that pharmacy services can be provided in alternative manners, with a reasonable assurance of safety, especially in medically underserved areas. We reserve the right to evaluate delivery processes and develop regulations as necessary. The statement concludes with this: "The board is committed to establishing the least restrictive guidance policies and rules but must put patient safety first."

Should out-of-state providers be permitted to provide services to residents of Minnesota? Our answer is yes. For example, there is a hub in Fargo that services pharmacies in Minnesota. We believe the nexus of care is where the patient is. So, we require out-of-state facilities involved in ordering and dispensing to be licensed by us as pharmacies and we require pharmacists to be licensed by us as pharmacists.

I don't think we have anything comparable to a compact, but it is relatively easy to get a license in another state simply by taking the law examination. Pharmacy has been practiced across state lines for decades. Mail order pharmacies dispense drugs across the country. For clinical activities, we require the pharmacist to be licensed, but they do not have to be in a licensed facility in the other state.

Should provision of telepharmacy services limited to medically underserved areas? In our state, it depends on what we are talking about. For dispensing medications, we do use the federal standard for defining a medically underserved area. We allow clinical services to be delivered anywhere.

My parting thought is that I don't think regulators should be impeding innovation or progress, but we sometimes need to pause and make sure what we want to do is safe.

Orgain – I represent the Association of Regulatory Boards of Optometry, which is comprised of regulatory boards in the U.S., Canada, Australia, New Zealand, and our protectorates. Think of optometrists as your primary entry point for eyecare. In Tennessee where I practice, we have been held to the standard of ophthalmology since 1992. We can use any drug rational to the treatment of the eye, do surgical procedures limited to the eyelid and foreign bodies, use any controlled substance rational to the treatment eyes, and use diagnostic lasers. It has been a profession in transition for a number of years. Close to 75% of eye examinations in this country are performed by optometrists.

What does that have to do with regulation? There is a website you visit to obtain an eye examination. The first question is about shoe size supposedly so the patient can measure a distance and come up with some sort of refractive result. You could also take the refraction results from my eye exam, go online, and order glasses from China. Studies have found that 58% of those glasses are not made correctly. Do any of these things need regulation? The FTC would probably say no. Open the borders and let people spend their money wherever they want.

We are talking about telehealth and regulation. This topic is complex and multi-leveled. In Tennessee, Blue Cross wants to take pictures of the retinas of diabetic patients. I already look at their retinas. Why is Blue Cross doing this when these people have access to a comprehensive

eye exam? Maybe it is to save money. A non-dilated picture of the retina will expose only about half of the back of the eye. What about the other half? Kaiser in California has been taking retinal photos for years. They can save money, time, and effort on the part of patients and if these pictures show issues, those people can be referred to appropriate care.

Is access to poorer care really a benefit to the public? If those pictures discover something, it is a benefit. If those pictures don't discover something, the patient will have a false sense of well-being. I regularly receive pictures on my phone from patients who want to know whether they have pink eye. Do I call in a prescription for that? No. I go into the office for an in-person examination and treatment of the patient. Patients treated in emergency rooms for eye issues are told to call their eye doctor in the morning because ERs don't have the proper instrumentation.

ARBO is trying to look at all the regulatory aspects. We don't have answers yet.

Question – We are talking about change that seems to be accelerating. How are your board members thinking about all this change? And how will you as board executives manage that?

Haley – Years ago when we were first looking at telehealth, one of our board chairs said to me, we may want an initial patient-provider visit, but that's not going to be the case a few years from now. He was way ahead of the curve. I think it is the leadership and foresight of board members that can set the tone. In Oregon, we have a company named Zoomcare, which came to us early on. They use mainly physician assistants and nurse practitioners with a hub of physicians who consult off-site. I applauded them for coming to meet with us proactively rather than having us react to them. We encouraged them to use Skype or Facetime or other modalities for more remote practice. Any regulators that stand in the way of this might as well be standing in front of a train. I think board members worry some about losing the value of face-to-face examinations.

Wiberg – For Minnesota, board members and staff believe that innovation is important and we don't want to stand in its way, but also realize that every idea is not necessarily great. We need to work with innovators to make their ideas even better from a patient safety perspective.

Question – Do you see any difference in the way public members and licensee members address telehealth?

Wiberg – No. Both are willing to embrace change so long as there is a reasonable assurance of public safety. In rural areas where lack of access is also a public health issue, we might have to consider something a little less fully regulated.

Orgain – Whenever someone goes into a boardroom, their professional hat needs to stay outside. Every decision made needs to be for the benefit of the public. You can't stop the train, but you may be able to guide it.

Haley – I've heard of pharmacies barely hanging on in rural Oregon. Do you or do you not see as your obligation to maintain some of those brick and mortal pharmacies for those populations?

Wiberg – Ideally, there is value in interacting with a pharmacist. However, reimbursement is such that these pharmacies can't make it in smaller towns. The next best thing is to have a pharmacist there remotely. There are three cameras: the document camera focuses on the prescription being filled; the counseling camera focuses on that; the security camera watches the technicians. Because of the counseling camera, the pharmacist can talk to the patient one on one. It is key for small towns. Cities want to maintain pharmacies for the sake of the economy of the town, so they want us to facilitate telepharmacy to keep brick and mortar establishments open.

Question – We are talking about telemedicine being the same quality of care when the distance factor is erased by technology. There is something else going on. "Commercial" healthcare is being provided by technology, but the consumer looks at it and doesn't see a difference. If you can get an eye exam online, you can also get orthodontics online. I am troubled by assuming that quality is fixed and cost and access are what we need to change. When the public cannot judge quality, I hope we don't blur the distinction between telemedicine and online commercial medicine.

Orgain – Corporations have moved into healthcare – eye care – and consumers think they are receiving the same level of care they would get in a private office. I guess it depends on what the problem is, but consumers think their problem has been taken care of and then they come to me to really correct the problem.

Wiberg – There is a difference between a genuine telehealth operation and one that is commercially motivated. Before Zipnosis came along, there were many supposed internet pharmacies. One in our state was disciplined because it had become a fulfillment center for an online website that responds to patients' requests for drugs and gets a physician's approval. Zipnosis evaluates whether a medication is needed.

Question – What is our goal? If we could articulate that, different professions can find their own way to get there.

Haley – When I see burdensome regulations, I think that goes against our basic mission of patient safety. Some regulation is necessary, but we don't want to overdo it. I'm intrigued by the Minnesota idea of guidance. Maybe that's what our policy documents accomplish. We share your concerns about safety. At the same time, I can say that in the years we have had telehealth licenses, we have not had complaints relative to this type of practice. I'd like to see a lot more interaction with the innovative service providers.

Question – I suspect patients have learned they have to be active in their healthcare if they are going to get good quality. Is telehealth what a lot of people want? Is the consumer voice adequately expressed in the process?

Wiberg – We have nine board members; three are public. After our public members go through a few disciplinary hearings, they take a different view of getting their prescriptions filled. We do take consumer needs into account, although we don't get as much direct consumer input as we would like.

Comment – This is a room full of regulators. Can you be a regulatory agency and also provide information that helps the people you regulate to do a better job? Some would say you can't be both the hard-nosed regulator and the quality improvement advocate. I like the idea that regulators are here not to be a barrier, but to make the system work. I like the idea of working case by case with the people who have the innovative ideas.

Comment – In critical care, there is a virtual ICU where nurses in a remote location monitor patients in critical care units across state lines. Our certification requires hands-on bedside practice hours to be certified. The virtual ICU nurses asked to be certified to show their skills, so we did a job analysis of their practice and found they were doing the same things but in a different way. The needed the same clinical judgment and problem-solving. They were coaching the nurses at the bedside. They are improving patient care.

Fixing Medicare and Medicaid

Mario Guiterrez, Executive Director Center for Connected Health Policy

The Center is a public interest policy center focused on how telehealth can advance access and quality of care for the underserved. Our only special interest is the consumer. Please use our website: http://www.cchpca.org. It is the most comprehensive source in the country for what is happening in the states and the federal government related to telehealth. The regulations governing the use of telehealth will determine how it will evolve while protecting public health and safety. We publish regular policy briefs and other resources.

We believe the key driver of telehealth is how to use limited resources to get quality healthcare to the most people in the most efficient way. We are moving into a world of better health outcomes and better quality and away from a world where profit is the driver. Healthcare is a multi-billion dollar business in this country. There is a reason why the Walgreens and CVS's and Walmarts are getting into healthcare delivery, and that is because it is profitable.

Telehealth advances the triple aim. This is the key to all of our work – advancing better quality, improved patient experiences, and better health outcomes. Two years ago, we convened a panel of 40 experts – a cross section of academics, healthcare providers, politicians, and consumer groups. The results of the convening are on our website.

Our fifty-state map displays the different laws, policies, regulations, and administrative in every state. For example, Oregon has a law that defines telehealth. The only regulation we found is from the board of physical therapy, which has its own definition. The Medicaid program has yet a different definition. There are administrative policies in the Medicaid program related to live video. The only store and forward that is governed by a law is in the behavioral health services manual.

An advanced search function enables you to compare your state laws to those of other states. We also look at such things as reimbursement, online prescribing, private payer parity laws, location of services laws and regulations, and so on. Many are based on antiquated notions. In our initial review of laws related to remote patient monitoring, for example, we found that Utah allows for payment for remote patient monitoring, but the patient and provider have to demonstrate that they would have had to travel more than 50 miles on a paved road to get care.

Only five states have laws and regulations that take full advantage of telehealth.

Most states reimburse for live video, which is the most common but least efficient form of telehealth. Only nine states reimburse for store and forward. This should be allowed in every state. (Store and forward technologies allow for the electronic transmission of medical information, such as digital images, documents, and prerecorded videos through secure email transmission.) Store and forward is very useful in ophthalmology and even psychiatry. A social worker or nurse videotapes a question and answer session with the patient. The tape is sent to a remote psychiatrist who listens, watches, and makes a diagnosis.

We do a quarterly trend analysis. Things are pretty stagnant when it comes to live video. There still a few states that have not adopted a definition for telehealth. Store and forward has not increased at all. Where we see increases in remote patient monitoring, it is mainly in demonstration programs in the office of aging.

The Federation of State Medical Board's interstate licensing compact is controversial. It was a response to pressure to deal with the question of cross-state licensing. They decided to create a compact that is essentially very specific boilerplate language that has to be adopted verbatim. There is not license portability. This only allows for a physician in one state to apply for a license in another state. Theoretically, it is supposed to be simpler and cheaper, although there is no indication yet that that will be the case. Seventeen states have now joined and the administrative commission has been formed, but they have yet to enact the compact. They have run into a big snag because the FBI has called into question whether the commission can do the kind of investigative work that needs to be done into the background of a physician in order to be licensed. Mostly rural and contiguous states have joined.

Parity payment is essentially a mandate to private insurance plans to cover telehealth with the same benefits whether care is delivered in person or via telehealth. Twenty-seven states have passed a parity law, but most laws do not require the parity of payment, or if they do, it is "subject to the conditions of the plans," which basically negates the parity. So, there are only seven states that have a very clear parity law that applies to payment, benefits, and services.

There is a lot of activity in the states. Even though we haven't seen changes in the laws, lots of bills are being introduced, and we think that has to do with the National Conference of State Legislatures' report. The regulatory process has as much if not more impact on how these laws are actually carried out.

We track non-medical boards – occupational therapy in Texas; RNs and dental in Colorado allow or are considering allowing for supervision of non-licensed personnel for patient referral and follow-up care. Typical language we see at the regulatory board level ensures that care conforms to laws and standards of practice.

At the Federal level, things are moving at a snail's pace. The Social Security Act passed in 1965 allows for spending Medicare dollars for the provision of basic telehealth services. There have been very few amendments since. This is outdated discriminatory legacy legislation. It only reimburses for a limited number of services under Medicare Part B. It will only reimburse for live video when the beneficiary is located in a rural facility as defined by the federal government. This ignores a large part of the country. It is old thinking that the only way to be underserved is to live in a rural community. The chair of the Ways and Means Subcommittee on Health has declared that they will look at changing the law in 2017. CMS does not have the authority so it is up to Congress to make those changes.

There has been some movement in the Medicare Advantage Plans. Telehealth coverage is a supplemental benefit not covered by Medicare, so it is up to the plan. To our knowledge, the University of Pittsburgh Medical Center and one Anthem plan will provide telehealth services as of 2016. There is one glimmer of hope for the Accountable Care Organizations that CMS is now overseeing. Twenty pilots to be funded around the country will allow for home visits; skilled nursing facilities will allow for benefit enhancements; telehealth will be encouraged regardless of the geographic location. Again, we are looking at another two years before CMS decides to do something, but at least they are testing to see whether telehealth can be a benefit.

MedPac is a commission charged by the federal government with determining whether to make changes in the Medicare laws. Their latest report reluctantly said that maybe they will consider making changes, but only to what they consider the low-hanging fruit, such as services that have low potential for unnecessary use, such as telestroke. They will also consider allowing primary

care providers to provide telehealth under per patient per month guidelines, expanding the rules related to ACOs, and allowing the supplemental benefits I talked about before. CMS has not acted on these recommendations to date.

Change is going to happen as we move from volume-based to value-based care – paying for results, shared risk, coordinated care partnerships, and improved wellness care. Telehealth is the tool that will move the consumer to the center of healthcare by allowing your nutritionist, social worker, behavioral therapist, with your physician and dentist to communicate and be full-service care providers.

There are bills on the landscape but they have been stuck in committee for years. Mike Thompson's bill is the most comprehensive, and would reform Medicare to allow for greater use of telehealth. His position is that he will continue introducing this bill as a way to inform members and keep pressure on Medicare to change the way it delivers care.

Representative Nunez of California introduced a bill last year that would change the locus of authority and responsibility to where the physician is rather than where the patient is. That would allow for cross-state services, but there are issues related to patient safety, quality, and liability. The only bill that has any chance of passing this year is Senator Schatt's bill called the Connect Act. It allows for the use of telehealth to meet some of the requirements of MACRA (Medicare Access and CHIP Reauthorization Act: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html. After the elections, we expect a lot of activity and fundamental changes in 2017 - 2018 in Medicare and Federal government policy.

The Congressional Budget Office is authorized by Congress to verify that any law is budget neutral. What happens is that the CBO does a very narrow passive analysis. So even though we know telehealth will save billions of dollars in the future, they only look at the very narrow fact that you are adding more billing codes, which will add more cost to the government, so the bill cannot move forward. CBO estimates that allowing Medicare Advantage plans to use telehealth will save nothing, while the White House says it will save over $160 million. The finance committee chair is going to try to influence the CBO to think of telehealth savings in a broader way.

The Office of the National Coordinator was created as part of the ACA. https://www.healthit.gov/newsroom/about-onc. It has no real authority, but is looked to for the advancement of policy related to healthcare technology. They recently issued a strategic plan in which they recommend increased use of telehealth, virtual care, and mobile health. Just recently, the Office of the National Coordinator published a white paper on consumer-centered telehealth design requirements. They put together a group of consumer advocates to advise them on what this should look like. They made nine recommendations. One that jumped out at me is that there must not be friction for the user. They also recommend team-based care that includes smart triggers. They recommend the real world and online world must converge. They recommend integrating technology into the human interaction in a physical world.

Other consumer organizations across the country – AARP, Families USA, and others will bring the pressure on Congress. But, it is time we lift up the voice of consumers.

MACRA is very complicated, but it does require Medicare to develop programs that involve alternative payment models or global payments as part of a merit-based incentive payment system. Telehealth is one vehicle for meeting the requirements. All they will be doing during the next two years is collecting data. In 2019, they will begin implementation of MACRA at which time health plans and health systems will begin to use telehealth to meet the requirements. High resource users will be dinged. Again, MACRA did call for two studies to be done by the OMB on the uses of telehealth. The real innovation and responsiveness to consumers will be at the state level.

Question – It seems like the biggest impediment is the need for budget neutrality. Is there a realistic plan in place to try to overcome that?

Guiterrez – The committee chair has stated his goal that CBO do a more active and complex evaluation of costs and benefits. They have asked us to help put together the evidence.

Question – Since it appears all of the action is taking place at the state level, is the National Governor's Association or any other state-based organization confronting issues associated with telehealth?

Guiterrez – We have not been able to get the attention of the National Governor's Association. Some advocacy organizations, such as the National Rural Health Association, and the National Conference of State Legislatures are paying attention. It will take support from the national organizations to increase awareness of the benefits and limitations of telehealth. Given the pressure to move to value-based care to husband limited resources, we have the answers at our disposal. We need to figure out how to address the issues associated with safety and negativity and the issues associated with commercialization.

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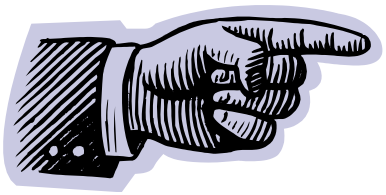

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