

Minutes
April 21, 2017
Telehealth Advisory Council
Agency for Health Care Administration
GuideWell Innovation Center
6555 Sanger Road
Orlando, FL 32827

Members Present

Justin M. Senior, Chair,
Dr. Celeste Philip
Dr. Anne Burdick
Leslee Gross
Darren Hay (virtual)
Dr. Kim Landry
William Manzie
Elizabeth Miller
Dr. Steven Selznick
Mike Smith
Matthew Stanton (virtual)
Dr. Sarvam Terkonda

Members Absent

Dr. Ernest Bertha
Dr. Kevin O'Neil
Monica Stynchula

Staff Present

Nikole Helvey
Pam King
Dana Watson

Others Present

Interested Parties (Attachment A)

Call to Order

Chair Senior called the meeting to order at 12:05 p.m.

Roll Call

Chair Senior welcomed the group and directed Ms. Helvey to call the roll. A quorum was present.

Review and Approval of the Minutes

After review, Dr. Selznick moved to approve the minutes. The motion was seconded by Dr. Burdick and carried unanimously.

Welcome and Opening Remarks

Leslie Heileman welcomed the Council to the GuideWell Innovation Center. She shared the work they are doing in the area of health technology. She introduced Jennifer Pidcock, Director of Telehealth for Florida Blue. Ms. Pidcock reiterated the efforts they are making to increase the overall use of telehealth in Florida.

Panel Discussion on the Use of Telehealth in Public Facilities

Due to transportation issues and unavoidable cancellations, the Council heard from speakers individually.

Nassau County Department of Health

Dr. Eugenia Seidel gave an overview of Nassau County Health Department's tele-dental program study. She noted the closest dentist to Hilliard, a city in Nassau County, was 40 miles away. The study focused on 47 patients from the rural community. They found in many instances the oral exam images superior to in-patient examinations. The on-going implementation barriers for this type of program are cost, training, and bandwidth issues. Dr. Seidel expressed a desire to see telehealth used more prevalently throughout the County Health Departments in Florida for various conditions and treatments.

Dr. Burdick asked about costs for the services offered. Dr. Seidel noted specific telehealth costs were difficult to extract, since reimbursement for these services is through a bundles payment model.

Dr. Selznick questioned whether dental exams had increased since the inception of the program. Dr. Seidel clarified that the dental hygienist initiates any tele-dental examination only if there is a concern.

Ms. Miller asked if the County Health Department was looking to expand telehealth services and if regional projects were in consideration. Dr. Seidel expressed interest in partnerships and noted work with Federally Qualified Health Centers in the Nassau County area.

Dr. Landry asked about the payment model for these services. Dr. Seidel noted the dental hygienist contacts the dentist as part of the cleaning and initial examination; therefore, both the dental hygienist and dentist can bill for their separate portions of the examination.

Break

Nicklaus Children's School Program

Evelyn Terrell, Regional Director of Rehabilitation Services and Telehealth Operations at Nicklaus Children's Hospital shared information about their partnership with their local school system. She explained that Nicklaus Children's Hospital is a not-for-profit, 289-bed, freestanding, pediatric teaching hospital with a network of ten outpatient centers; a nonprofit physician specialty practice subsidiary; a management services organization; an ambulatory surgery center; and an e-commerce line of children's wellness and safety products.

Ms. Terrell shared that Nicklaus Children's Hospital has been providing basic school health services in 12 Miami-Dade County public schools for over a decade. As a way to enhance services delivered in the school system, primary care services were added with the goal of improving access to health care, decreasing absenteeism rate, and increasing overall school performance.

Through the Hospital's school health model, they have the ability to reach children with chronic conditions in their school environment. Furthermore, the Hospital can screen children for chronic conditions and provide the necessary education for those identified for follow up. Through MCH data, virtual school nurses work in collaboration with the onsite Certified Nursing Assistants (CNAs) to complete health appraisals, chronic disease management, medication management, screenings, health assessments, and health education in public schools. Doing so grants children access to necessary medical services from a convenient environment. This program aims to increase access to medical care, improve medication compliance, reduce unnecessary emergency

room and urgent care visits, reduce student absenteeism, and reduce utilization in higher cost service delivery models.

She noted school health program quality indicators include the following: Body Mass Index (BMI) screening and follow-up, documentation of height and weight, BMI plotted on growth chart, documentation of counseling for nutrition, and documentation of counseling for physical activity. The rationale for school telehealth services include: improved access to care for individuals living in underserved areas, the growing body of evidence showing effectiveness in providing equitable services, the critical national shortage of healthcare professionals and specialists; it also increases patient and parent satisfaction, cost savings and avoidance. School telehealth services also benefit the growing telemedicine market; encourages the move toward accountable care models, coordinated and integrated care, comprehensive care management, chronic disease management, and population health outcomes.

Ms. Terrell shared the program results for four Miami Dade County public schools, with 197 unique patients. She discussed the chief complaints of the patients seen, as well as the number of medications ordered. She added that without appropriate clearance by an ARNP or pediatrician, the school nurse would be required to send students home for medical clearance.

The following results were determined based on school district policies regarding communicable diseases. The telehealth consults resulted in a 67% return to class rate. Of the students seen, 39% went home, 2% resulted in a referral to a specialist, and 1% presumably went home due to parent preference. If not for the telehealth consultations, 67% of the patients seen were likely to have gone home that same day. Of those patients and their parents, 32% were likely to have missed two or more days of school and work.

Ms. Terrell went on to share more evidence of the clinical effectiveness, satisfaction, and cost of telehealth in schools. She stated that student health and educational performance are interdependent. A school-based telehealth clinic can bring resources and collaboration to schools located in rural, poor, and medically underserved areas. Telehealth is increasing access to acute and specialty care for children; helping children and families manage chronic conditions; facilitating health education for children, families and school personnel; and increasing the capacity of school nurses and school-based health centers to meet the healthcare needs of students.

Ms. Gross asked how they covered the cost of the service and how they obtained consent. Ms. Terrell advised the program was donor funded and consent was typically oral, by telephone.

Dr. Terkonda inquired about the implementation and per transaction costs. Ms. Terrell shared schools received a suitcase containing tools for telehealth visits costing about \$20,000 each. The suitcases are portable and can be taken and used outside of the school nurses' office.

Dr. Selznick asked if they had documentation of money saved through this project. Ms. Terrell responded that a study in Rochester, Texas shows both positive and negative findings.

Ms. Miller stated that there is a lot of discussion around rural healthcare, and asked if they ever bill insurance for the services. Ms. Terrell responded that Medicaid will provide coverage and some insurance will cover the service. She stated that Wellcare reimburses for treatment pays in four of the 12 schools and provides information to the child's primary care provider or pediatrician. The suitcases use Cerner technology, which documents the encounter in an Electronic Health Records system (EHR).

Mr. Smith inquired whether a formal evaluation of the program has taken place. He suggested looking at the cost benefits. Dr. Landry asked if there has been an increase in the number of students coming to the school clinic for their health care. Ms. Terrell responded that they have not seen a measurable increase in the number of students seen.

Dr. Burdick shared the University of Miami works with a social worker when providing care to students through a telehealth system. This assists the family in getting any needed follow up care. Dr. Philip asked Ms. Terrell if the system she is describing has a mechanism to guide families to the proper resources, and if the nurse asked the students about their health insurance. Ms. Terrell answered that they do not ask the students, but reach out to the parents.

Dr. Selznick inquired about the use of school nurses. Ms. Terrell explained that many of the schools in Miami-Dade do not have full time school nurses. Mr. Manzie noted there are 67 schools in Miami-Dade that do not have medical services. Dr. Philip noted school telehealth provides a great opportunity to offer services where the patients reside.

Ms. Gross asked if Nicklaus provides mental health services, too. Ms. Terrell advised they were currently offering primary care only.

Mr. Smith asked Ms. Terrell where she sees the program in five (5) years. She responded the goal is to keep kids healthy and providing additional services in the most convenient place.

Center for Connected Health Policy

Mario Gutierrez, Executive Director with the Center for Connected Health Policy (a national telehealth policy resource center), spoke to the Council about telehealth policy trends in other states. He encouraged the Council to visit the Federal Office for the Advancement of Telehealth Grants website for more information on funding available for telehealth implementation.

Mr. Gutierrez advised the Council there are 12 regional Telehealth Resource Centers throughout the United States. These regions work together through the Telehealth Resource Centers National Consortium.

Mr. Gutierrez noted the Consortium believes the value proposition for telehealth is that “advances in telecommunication technologies can help redistribute health care expertise and resources to where and when it is needed, and create greater value among consumers, public and private payers, and health systems.” The Consortium suggests there are three areas in which telehealth technology can improve health care. The first is timely access to quality diagnosis and treatment care, using live video or asynchronous store and forward, with primary or specialty care providers for episodic, trauma, and chronic care. Second, the use of enhanced consultation and/or communication technologies for the patient/consumer to communicate with the health care team through a secure portal for email communication or live video using a smart phone, tablet or computer. He noted this also promotes care coordination between the primary care provider and the specialist. The third is the use of remote monitoring of patients, which allows for better management of chronic conditions, as well as allowing elderly patients to age in their home, and providing acute intensive care with tele-ICU.

Mr. Gutierrez reviewed telehealth policies, laws, and regulations in various states. He reported that 44 states have a definition for telemedicine, 33 states have a definition for telehealth and two states have no definition for either telemedicine or telehealth. Medicaid will reimburse live video

technology in 48 states and Washington D.C.; remote patient monitoring in 22 states; and store and forward technology in 13 states.

Mr. Gutierrez discussed parity in payment for telehealth services. He said that 34 states and Washington D. C. have telehealth private payer laws, which require coverage for telehealth services. He noted parity in covered services did not necessarily translate into parity of payment.

Mr. Gutierrez reviewed the laws of several other states, which could serve as templates for a Florida law. He recommended looking at California, Minnesota, and Hawaii's laws on Telehealth. He reminded the Council that along with state laws, states need to consider regulatory and administrative actions needed to implement legislation.

Dr. Selznick inquired if under California law both the patient and provider had to be in the same state. Mr. Gutierrez responded that the Center for Medicare and Medicaid Services requires both to be in state. If the provider is away on vacation, they can, on a limited basis, use telehealth to see a patient. Chair Senior noted the difficulties state Medicaid offices face when trying to audit out of state encounters. He suggested that the Federal Medicaid Integrity Nationwide Center could perform audits for the out of state e-consults. As long as the primary provider is in the state, the specialist can be anywhere. This would keep the patient in their medical home, and reduce the state burden.

Dr. Terkonda asked about challenges regarding liability coverage for physicians when providing care in multiple states. He specifically asked whether there were any liability cases from using telehealth technology. Mr. Gutierrez indicated that his was not aware of any liability cases at this time.

Dr. Burdick commented that Mr. Gutierrez helped Hawaii with their telehealth laws, could he help Florida. Mr. Gutierrez offered to review proposed language. Mr. Manzie asked Mr. Gutierrez how California was able to pass its legislation. Mr. Gutierrez responded that there was a yearlong workgroup prior to the legislation.

Ms. Miller commented that 13 states use store and forward technology for dermatology and ophthalmology. She questioned why more states were not using this technology. Medicare is in opposition to store and forward, because of concern it will increase costs. Ms. Miller remarked that the opposite is true and the empirical proof is available from the studies undertaken.

Dr. Terkonda stated that the state should not start with a disorganized health care system, and simply add telehealth. He suggested that medical schools should require students to train in medical technology.

Dr. Philip asked if any of the states include the homebound population. Dr. Terkonda responded that Medicare does not recognize the home as an originating site. Mr. Gutierrez noted this as one reason there were limited studies on this type of care.

American Telehealth Association

Latoya S. Thomas, Director, State Policy Resource Center, American Telemedicine Association (ATA), advised the Council the ATA members work to fully integrate telemedicine into transformed healthcare systems to improve quality, equity, and affordability of healthcare throughout the world. She shared the ATA is the leading international resource and advocate promoting the use of advanced remote medical technologies.

Ms. Thomas noted there are currently 32 states and Washington D.C. with parity laws for private insurance coverage of telemedicine and eight states with proposed or pending legislation and ten states without parity laws. Ms. Thomas discussed parity policy reforms including insurance coverage and reimbursement. She suggested legislation typically includes the types of services covered, the patient setting, and the eligible provider location. She shared that newer legislation from states tends to include the use of approved technology and any additional requirements for informed consent.

Ms. Thomas discussed the parity laws in Hawaii, Oklahoma, Oregon, and New York. She also shared interstate licensure models for national reciprocity and licensure compacts. She shared a link to the ATA policy resources center where the February 2017 copies of the State Telemedicine Gaps Analysis, Standards and Licensures and State Telemedicine Gaps Analysis regarding Coverage and Reimbursement were available. Additionally, the State Telemedicine Gaps Analysis regarding Psychologist Clinical Practice and Standards and Licensure published in June 2016 is also available from this site.

Dr. Selznick asked if the ATA had a template or outline of the steps the Council could use in developing its report. Ms. Thomas noted the ATA did have a model guideline that might be helpful.

Dr. Burdick asked about informed consent, commenting that she has noticed some states have revoked additional consent requirement. Ms. Thomas responded it was the ATA's opinion consent to treatment was sufficient for all medical care, no matter the modality.

Chair Senior stated that with telehealth, there has to be a clear starting point between the patient and the provider.

Ms. Miller stated Florida Blue is surveying primary care providers to determine what patients want. She said that the public policy needs to require value based care, and some payers support home telehealth parity. Parity works because it derails any discriminatory practices and it allows for payment and coverage. Ms. Miller asked who was opposed to the parity policies. Ms. Thomas responded that the primary opposition to parity laws are the payers in some states, typically where they have a fee for service payment model. Dr. Selznick noted telehealth was a more viable solution for value-based care. He suspects insurers in states with a strong fee for service model insurers would probably not participate without parity laws.

Dr. Burdick asked about the 2015 New York law. She was interested specifically one payer's policy manual, which decreased coverage. She asked Ms. Thomas' opinion on whether there should be a mandate for the use of telehealth. Ms. Thomas strongly advised against mandating telehealth use or pricing. She suggested providers and patients shape the policy, not the legislature.

Public Comment

No public comment given.

Member Discussion and Next Steps

After much discussion about the process for developing the legislative report, Mr. Smith and Dr. Burdick suggested the Council consider starting with defining the terms telehealth/telemedicine. After additional discussion, Chair Senior suggested the Council members send their thoughts on the definition to staff. Agency staff will compile the suggestions to share at the next Council meeting.

Chair Senior indicated the Council would use several hours at the May meeting establish the outline for their report.

Adjournment

There being no further discussion, the Telehealth Advisory Council adjourned at 5:30 p.m.

Attachment A

Interested Parties in attendance at the April 21, 2017 Telehealth Advisory Council Meeting

Interested Parties Present:

Anna Baznik , IMPOWER; Amanda Bolanos, Nicklaus Children's Hospital; Christine Certain, Children's Home Society of Florida; Stuart Clarry, UF Health; Sofia Debs, Nicklaus Children's Hospital; Carolyn Grant, Cardinal Health; Kelly Greene, Adapt Behavioral Services; Joni Higgins, BayCare; Rebeca Hohnstock, Devereux Foundation; Jennifer Kammera, Devereux Foundation; Barbara R. Keene, Everyone's Counseling Center; Aneel Irfan, Trapollo; Lauren Lashbrook, Mend; Lindsay Newton, Devereux Foundation; Carey Officer, Nemours; Jennifer Pidcock, Florida Blue, GuideWell; Prachi Rathi, Prism Health Services, LLC.; Kathy Reep, Florida Hospital Association; Victor Rosenbaum, Orlando Health; Eugenia Ngo-Seidel, Nassau County Florida Department of Health; Deb Stewart, Florida Blue; Evelyn Terrell, Nicklaus Children's Hospital; Lynn Thames, Florida State Oriental Medical Association; Alejandro Toro, AKL Therapy, Inc.; Shayan Vyas, Nemours; Allison Wiman, Florida TaxWatch; Angela Zeringue, Trapollol and Natalina Zisa, Nemours Health System.