



Telehealth & Patient-Centered Care

By Ronald E. Bachman



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Executive Summary

With the expansion of telehealth, we are entering a new phase of disruptive technologies that will further alter the health delivery landscape by putting consumers/patients in charge of where, when, with whom and at what price they will pay for medical services.

A new generation of patients is comfortable with using technology and mobile devices.

- The telehealth market in the United States is expected to grow from \$240 million in revenue in 2013, to \$1.9 billion in 2018.
- It is expected that half a billion smartphone users worldwide will be using a health care app by 2015.
- Thirty-one percent of Americans have already used cell phones to look up health or medical information online.
- Thirty-seven percent have used apps to track or manage their health, up from 17 percent in 2010.
- It is estimated that telemedicine has already been used by more than 36 million Americans.
- It is estimated that up to 70 percent of doctor visits can actually be handled over the phone.

Telehealth has the potential to improve access and quality and reduce health care costs.

Access: Without telehealth, access might otherwise be delayed, denied or otherwise not available. For the patient, telehealth provides savings in time and money and can reduce the stress from delayed or denied face-to-face medical care.

Quality: A study in 2012 developed by the Johns Hopkins University Schools of Medicine and Public Health showed that telemedicine's quality of care and clinical outcomes were equal to or better than in-hospital care.

Cost: A 2011 study of the use of telemedicine in the treatment of chronically ill patients showed a 30–53 percent annual savings in health care costs. Telehealth could potentially save U.S. companies a whopping \$6 billion, according to a [new study](#) by Towers Watson. Swapping face-to-face physician and urgent care visits with telemedicine interactions to achieve these savings "requires a shift in patient and physician mindsets, health plan willingness to integrate and reimburse such services and regulatory support in all states," said Allan Khoury, MD, senior consultant at Towers Watson.

To date, Georgia has been at the forefront of telehealth. Georgia's public health departments (224 sites) are all wired for telemedicine applications. More than half of Georgia's hospitals are equipped for telehealth, ranking the state 16th in the nation.

Because of the relative newness of telehealth and its potential, it is difficult to know which policy approaches may facilitate increased adoption. Free markets are best at allocating resources and capital to develop new products and services. Consumers in competitive markets are best at selecting and paying for services they value. States play a role in allowing those market forces to work free of stifling or burdensome laws and regulations.

Georgia is arguably the leading state in telehealth law and practices, but clearer definitions, guidelines, laws and regulations may be needed. In Georgia, for example, telehealth is clearly allowed as a follow-up for existing patients of a provider. It is less clear that a new patient can be served without an initial “face to face” physical exam.

In true consumer markets, the success of disruptive innovations is controlled by consumer acceptance and their ability to purchase new products. Too often existing self-interest groups, established guilds and status quo advocates can stifle disruptive innovations. Georgia has a great opportunity to improve access, enhance quality and lower the cost of health care by continuing to lead in the field of telehealth.

Telehealth & Patient-Centered Care

“With most businesses you are asked to sit in a reception area; only with health care are we asked to sit in a waiting room.” – Anonymous

I. Introduction: Tele-A to Tele-Z

Common features of telehealth and patient-centered care are convenience, choice, self-care, personalized care, cost transparency and personal responsibility. Technology and free market entrepreneurs are converging on the \$2.7 plus trillion health care economy to meet these consumer demands. As we move from “Health Insurance Reform” to “Health Care Reform” new medical and health delivery models are forming – and telehealth is at the forefront.

A new generation of patients is comfortable with using technology and mobile devices. Among the new services are telehealth, telemedicine, telecare, mobile health, mHealth and eHealth. Many new health and health care services are developing as creative entrepreneurs utilize inexpensive communication devices and high-quality, wide-band internet.

The language of this new world is still evolving. While “telemedicine” is frequently used, “telehealth” may be the most appropriate term to convey the consumer benefits of health and wellbeing inherent in these alternatives. The telehealth market in the United States is expected to grow from \$240 million in revenue in 2013 to \$1.9 billion in 2018. It is expected that half a billion smartphone users worldwide will be using a health care app by 2015.

Below are some accepted definitions. Although each term may have some nuanced meaning, this paper will use “telehealth” to represent all of the areas below:

Telehealth: the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education. (Health Resources and Services Administration)

Telemedicine: the use of medical information exchanged from one site to another via electronic communications to improve a patient’s clinical health status. (American Telemedicine Association)

Telecare: remote care of elderly and physically less able people, providing the care and reassurance needed to allow them to remain living in their own homes. (Wikipedia)

mHealth: Short for mobile health. The term is most commonly used in reference to using mobile communication devices, such as mobile phones, tablet computers and personal data assistants (PDAs) for health services and information. (Wikipedia)

eHealth: the use of information and communication technology, such as computers, mobile phones, communications satellite, patient monitors, etc., for health services and information. (Wikipedia).

Individuals are demanding options that empower them to make personalized health and health care decisions. Tapping into the health care consumerism megatrend requires developing products and services with the end user – the patient/consumer – in mind (rather than providers of care, physicians, hospitals, employers or insurers). It is the actual delivery of lower cost, convenience and quality care that is driving the consumer-oriented, patient-centered movement.

II. Health care Consumerism History & Background

A. Health Insurance Reform. Market reforms are changing the way consumers purchase health and health care services. The health care consumerism movement began with “health insurance reform.” In 2001 an IRS ruling allowed consumers to carry forward unused tax-advantaged dollars (Health Reimbursement Arrangements or HRAs) from year to year to pay for medical services. The movement continued with the 2003 passage of Health Savings Accounts (HSAs). HSA-eligible High Deductible Health Plans and HRAs have grown rapidly because results have clearly demonstrated the value of financially empowering informed patients in making health and health care purchasing decisions.

It is critical that the “consumer of services” is the “customer who pays” for the service. Too often third parties (e.g. insurers, employers, governments) pay for the services and distort normal purchasing economics. Account-based plan designs allow the individual to be the customer rather than the third party. The patient-centered movement minimizes third-party reimbursements, while maximizing patient control and security with a combination of savings and insurance.

B. Health Care Reform. “Health insurance reform” is now giving way to “health care reform.” We are moving to a system that combines consumer-centered plans with patient-centered medical services. Health care reform will focus on improving the patient-provider relationship and new care delivery systems.

A great example of patient-centered health care began in 2000 when the founders of QuickMedx began a fast, convenient, localized medical service that offered diagnosis, treatments, cost transparency and prescriptions for certain common medical conditions. QuickMedx ultimately became the CVS MinuteClinics. The consumer demand spurred other national pharmacies to compete by developing their own on-site health services (e.g. Walgreens’ Take Care Clinics).

The savings and convenience were so quickly evident that it didn’t take long for those services to be widely accepted and reimbursed under health plans as options to patients going to more expensive locations (e.g. Urgent Care centers or a private doctor’s office).

With the expansion of telehealth, we are entering a new phase of disruptive technologies that will further alter the health delivery landscape by putting the consumer/patient in charge of where, when, with whom and at what price they will pay for medical services.

III. A New “Millennium” World

The use of alternative care and social media information sources has a generational aspect to it. According to a survey by the Pew Internet and American Life Project in 2012:

31 percent of Americans used cell phones to look up health or medical information online
37 percent used apps to track or manage their health, (up from 17 percent in 2010).

According to Fiscal Times, “Telemedicine has already been used by more than 36 million Americans.” It is estimated that up to 70 percent of doctor visits can actually be handled over the phone.

Providers are also getting on board with alternative care connections. In recent surveys reported by Health IT Outcomes, it was found that approximately:

- 89 percent of primary care physicians used smartphones to communicate with staff,
- 70 percent of doctors viewed patient information on mobile devices,
- 65 percent used mobile devices to look up non-patient health information,
- 51 percent used tablets to access independent medical references and perform Internet research,
- 48 percent used mobile health devices to educate and train, and
- 42 percent used mobile devices to obtain clinical information.

Dr. Farzad Mostashari, former National Coordinator for Health IT, stated "... most of what affects people's health doesn't happen in the hospital or in the clinic. It happens when they're home, when they're out and about, and being able to engage with them effectively is no longer going to be optional."

Dr. Mark Blatt, Global Medical Director for Intel, says the hospital of the future may very well be the consumer's living room. Others support the concept that we will at some point see more office visits in the "living room" than the "waiting room."

IV. The Health Reform Challenge

Any health care reform, including telehealth, must meet three basic medical challenges to prove its value: Access, Cost and Quality.

A. Access: Telehealth opens up a new world of access for personalized patient-provider relationships. Telehealth services can be delivered through a variety of devices including web cams and multi-port video teleconferencing applications, email, smartphones, wearable monitoring devices, patient portals, text messaging and wireless tools. Developing facial recognition software can even accurately identify pulse, blood pressure, cholesterol levels and other medical metrics.

Without telehealth, access might otherwise be delayed, denied or otherwise not available. For the patient, telehealth provides savings in time and money and can reduce the stress from delayed or denied face-to-face medical care.

There are many reasons why patients may not be able to meet on-site with their health care providers, including poor weather conditions, remote locations, conflicts in scheduling, no available transportation, the patient is homebound or is simply too ill to travel to their physician. Telemedicine can also offer consumers new or better services such as:

a. Primary Care - Telehealth is a convenient two-way, real-time, interactive communication with providers, especially applicable to many primary care services. We are already seeing the development of primary care "concierge" home visits with a medical technician or nurse at the patient end connecting to physician via telemedicine. Telemedicine has been particularly successful with online access dealing with stress, depression, Post Traumatic Stress Disorder (PTSD) and other mental illnesses.

b. Specialty Care - Telehealth consultations between primary care and health care specialists provide optimal care without the hassles of juggling schedules, travel expenses, lost or missing data

or lack of access. A virtual treatment team can quickly decide on the best medical options for their patients, coordinate services and deliver care in the most efficacious manner possible.

Below is an example of how telehealth can provide specialty care to rural areas. The Georgia Telemedicine Program is lead by Paula Guy. According to the Web site,

“The Georgia Telemedicine Program has almost 50 sites in Georgia from which patients can access advanced medical care without traveling more than 30 miles. It currently facilitates 150 consultations per month (excluding tele-radiology), providing access to 60 specialists in 40 fields.

The program provides a collaborative learning opportunity between the presenting clinician and specialist while allowing patients to maintain their relationship with their local primary care provider. It has proven to expedite care, screening, diagnosis and treatment and has addressed major needs such as diabetes education, nutrition counseling, stress testing, perinatal level 2 ultrasounds, pediatric genetics, and child, adult and geriatric psychiatry.

Using high-speed phone lines, computer equipment, specialized medical cameras and encryption technology, the Telemedicine Program makes it possible to send images, medical records and data rapidly and securely, and facilitates live video encounters between patients and remote specialists. It also can be used to access medical grand rounds, Continuing Medical Education activities and staff training opportunities remotely.”

B. Quality: With telehealth, quality improvements include both medical care and lifestyle support. A February 2014 Rand Corporation study that examined a telemedicine program follow up and a July 2013 study by researchers at University of California Davis Children’s Hospital found telemedicine improved the quality of health care for children in rural areas.

A study in 2012 developed by the Johns Hopkins University Schools of Medicine and Public Health showed that telemedicine’s quality of care and clinical outcomes were equal to or better than in-hospital care, and garnered a savings of 19 percent over inpatient costs.

Patient monitoring by way of telehealth devices can save both providers and patients travel expenses, time, unnecessary diagnostic tests and procedures, and avoidable trips to the physician’s office or emergency room (ER). Monitoring can provide up-to-the-minute information about patients and reduce the need for emergency measures after the patient is already in crisis. Monitoring can detect post-discharge health problems early enough to mitigate and reduce readmissions.

Patient monitoring of health and sickness metrics can be facilitated using patient-centered telehealth devices such as on-body health care sensors, smart jewelry, smart watches, display devices, and an array of sensors embedded in clothes and shoes. Whether sent to health care providers, hospitals or other diagnostic facilities, this information can be monitored and reviewed in real time. If needed, care can be provided without the patient ever having to leave the comfort of home.

C. Cost: The main selling point of telehealth is its potential cost savings. Studies conducted over the last decade have given evidence of the cost benefits provided by telehealth.

1. A 2011 study of the treatment of chronically ill patients in the Northwest showed a 30–53 percent annual savings in health care costs, due primarily to telemedicine’s coordination of patient care and early detection services, which allowed health care providers to be alerted to changes in patient status and provide timely interventions.
2. A study that ran from 2008 through 2010 reported a 160 percent return on investment when companies used telehealth as compared to those who did not.
3. A study by the Center for Information Technology Leadership determined that cutting down on emergency room transports (moving patients from one emergency department to another) by using telemedicine could save \$537 million per year and avoid 850,000 transports.
4. Health Affairs researchers found that chronically ill Medicare enrollees that used telehealth reduced their spending by 7–13 percent per quarter (\$312 to \$542 per person) more than those who did not.

More than 2 million patients are transported between emergency departments every year, costing \$1.39 billion. Telehealth clinics can help control costs by cutting ER visits and helping to monitor chronic care patients between office visits and keeping them healthier. But it can also relieve time pressure on overworked doctors, and those with limited hours on weekends.

Carena, a Seattle-based mobile care company, piloted a telehealth initiative where savings were generated and patient calls dropped 44 percent for on-call physicians.

“We really looked at it as a way to expand capacity for our primary care network,” said Cliff Robertson, an executive with the Franciscan Health System. “More importantly, we saw it as a tool that was vital as we transition from a fee-for-service reimbursement model into a risk-based model. [We looked] at this virtual primary care as a tool that we would absolutely need if we were to manage a population of patients in a more cost-effective, lower-cost setting.”

V. Expanding Telehealth - The Federation of State Medical Boards

State Medical Boards control the professional standards for practicing medicine in their respective state. Their rulings are in many ways more powerful than state laws because provider certifications and professional designations may be at risk for those violating the Medical Board requirements. To standardize state requirements, the Federation of State Medical Boards (FSMB) has been reviewing the use of telehealth.

On April 26, 2014, the Federation adopted a Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (http://library.fsmb.org/pdf/FSMB_Telemedicine_Policy.pdf). The Model Policy sets standards for establishing a physician-patient relationship, appropriate online medical care, HIPAA compliance and patient privacy and prescribing drugs based on a telehealth encounter.

Individual state medical boards are not required to adopt the Model Policy, but many boards are likely to use it to guide their thinking on telehealth.

VI. Expanding Telehealth - State Legislation

States control whether or not to embrace telehealth services, the definition of those services, the execution of those services, and the reimbursement of those services as long as they meet the federal government's minimum HIPAA and HITECH¹ requirements.

The Centers for Medicare & Medicaid Services defers to States for the joint federal/state Medicaid program: "Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-to-face consultations or examinations between provider and patient). As such, states have the option/flexibility to determine whether (or not) to cover telemedicine; what types of telemedicine to cover; where in the state it can be covered; how it is provided/covered; what types of telemedicine practitioners/providers may be covered/reimbursed, as long as such practitioners/providers are "recognized" and qualified according to Medicaid statute/regulation; and how much to reimburse for telemedicine services, as long as such payments do not exceed the Federal Upper Limit."

To assure standardized access, clinical quality and cost effectiveness, the American Telemedicine Association (ATA) supports "The Telemedicine for Quality Improvement and Health care Modernization Act." The Act is aimed at distilling the 50 different state definitions and policies concerning telehealth and clarifying them into one concise, direct and clear standardized policy that could be applicable across all states.

The ATA state policy tool kit for legislators and model state legislative language can be found at: <http://www.americantelemed.org/docs/default-source/policy/ata-state-policy-toolkit.pdf?sfvrsn=6>

The following is a link to the National Conference of State Legislatures listing of state-by-state laws governing telehealth: <http://www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx>

VII. Expanding Telehealth - Federal Legislation

Some federal agencies have controlling authority over the delivery of certain medical services:

1. Federal Drug Administration (FDA):
 - a. Regulation of medical apps "whose functionality could pose a risk to a patient's safety if the mobile app were to not function as intended."
 - b. Mobile medical app guidance.
2. Federal Trade Commission (FTC):
 - a. App developers meet standards for product liability.
 - b. FTC has authority to oversee data security.
3. Federal Drug Enforcement Administration (DEA) :

Under the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (Pub. L. no. 110-425), the Drug Enforcement Administration (DEA) has regulations governing practitioners that prescribe a controlled substance relating to the practice of telehealth.

¹ Health Information Technology for Economic and Clinical Health

The lack of federal or multi-state licensing and medical certification reciprocity hampers the expansion of telemedicine. In most states, only a physician licensed in that state acting within his/her scope of practice can provide telemedicine services or write prescriptions. Many providers are leery of federal licensing and legislation as having the potential for intrusion into the patient-provider relationship.

To address the growing need for national standards supporting telehealth, ConnectWithCare, a new bipartisan Washington-based association, has been formed by ex-U.S. Senators Lott, Daschle and Breaux. It is dedicated to expanding federal reimbursements for telemedicine, broadening the number of providers and covered services by unifying national standards for telehealth.

Sen. Daschle stated he wants to, "... ensure that our regulatory environment appropriately balances the exciting advances in technology for patients, while still maintaining safeguards that allow innovation." The Alliance's Board members include representatives of Verizon, WellPoint, CVS, Walgreens, Teladoc, HealthSpot, Doctor on Demand, Welch Allyn, MDLIVE, Care Innovations and Cardinal Health.

At present there are two pending bipartisan bills that would expand the "one state license" practice to federal interstate telehealth programs. With the passing of these bills, a health care professional would need only one state license to serve patients in any location who are covered by a federal health program. The bills are:

1. H.R. 2001 for the Department of Veterans Affairs with the VETS Act (Veterans E-Health & Telemedicine Support Act) introduced by Charles Rangel (D) and Glenn Thompson (R) with a total of 49 sponsors.
2. H.R. 3077 for Medicare with the TELE-MED Act (TELEmedicine for MEDicare Act) introduced by Devin Nunes (R) and Frank Pallone (D) with a total 30 sponsors.

In addition, Rep. Mike Thompson (D) has proposed the Telehealth Promotion Act (<http://www.gpo.gov/fdsys/pkg/BILLS-112hr6719ih/html/BILLS-112hr6719ih.htm>) which expands federal reimbursement for telehealth services and allows physicians to provide telehealth services nationwide.

Telehealth may be a solution for many other medical concerns. Senators Amy Klobuchar (D) and John Thune (R) have re-introduced the "Fostering Independence Through Technology Act" that will promote remote monitoring technology of patients with chronic illnesses.

VII. Georgia – A Leader in Telehealth Legislation

Because of the newness of telehealth and its potential, the best approach for government is hands-off. Free markets are best at allocating resources and capital to develop new products and services. Consumers in competitive markets are best at selecting and paying for services they value. But, states play a role in oversight while allowing those market forces to work free of stifling or burdensome laws and regulations.

To date, Georgia has been at the forefront of telehealth. Many have suggested that California has the most up-to-date and pro-telemedicine laws. (The full California law can be accessed at: http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_0401-0450/ab_415_bill_20111007_chaptered.pdf) However, Georgia is arguably the leading state in telehealth law and practices. For instance, under the Georgia Telemedicine Act (O.C.G.A. § 33-24-56.4), private insurance is required to pay for telehealth

services, but this is not required in California. Also, though California has many telehealth programs, they are uncoordinated; whereas Georgia has institutions such as the Georgia Partnership for TeleHealth working to advance the interoperability of telehealth throughout the state as well as partner with other states, all with the aim to provide synchronized, seamless telehealth services across the nation.

In 2013, Georgia Public Health Commissioner Brenda Fitzgerald announced that every county health department in Georgia would be wired for teleconferencing. Kathryn Cheek, a member of the Georgia Board of Public Health, is also supportive, citing that Georgia's telehealth project could remove barriers so that all patients across the state could get the care they need. This project is now complete, with 224 public health departments wired for telemedicine applications.

There are changes worth debating to further expand Georgia's telehealth industry and the Georgia Telemedicine Act. For example:

1. GA Comp. R. & R. 360-3-02 states that no Georgia physician may provide telehealth services without first doing a history and physical examine of the patient. The application and interpretation of this law can slow the growth of telehealth services and innovations.

In Georgia, telehealth is clearly allowed as a follow-up for existing patients of a provider. It is less clear that a new patient can be served without an initial "face to face" physical exam. The consideration seems to be around whether or not a telehealth provider can examine a new patient to the same or higher standard than a "face to face" physical exam.

Advocates of telehealth point to the available advanced technologies that can store and retrieve high-definition exam results (e.g. eyes, ears, nose and throat). Using proper equipment, the physicians have the ability to listen to heart rates, get blood pressure readings and take more time to talk to the patient. The traditional provider community questions these capabilities and wants to restrict telehealth to follow-up visits.

2. The requirement for out-of-state physicians to have a Georgia license (O.G.C.A. section 43-34-31) perpetuates the limits and financial burdens inherent in current-day telehealth. However, Georgia law does ease this burden by not requiring a Georgia license if the physician was only "consulting" or using the data for "educational purposes."

The explosion of online telehealth services, however, raises the concern and confusion regarding when medicine and clinical services are being provided and when services are purely consulting and educational. Some contend that already-widely used online telehealth services may be a violation of Georgia law. Others argue they have not crossed the line from information to medical care. Clearer definitions, guidelines, laws and regulations may be needed.

Conclusion

Health care Consumerism and Telehealth are here to stay. Both offer tremendous benefits to health care professionals and patients. There are improvements in the quality of health care over traditional care systems. For the insurers, employers and other telehealth vendors the substantial return on investment garnered in both the short and long-term far outweighs any initial start-up investment of time, capital or resources.

In true consumer markets, the success of disruptive innovations is controlled by consumer acceptance and their purchases of new products. Too often existing self-interest groups, established guilds and status quo advocates can stifle disruptive innovations.

It is impossible to stop a mega-trend. Alternative medical delivery systems, including telehealth, are the future for health care. They focused initially on helping physicians to serve rural areas and connecting physicians to a network of specialists for consultation. The next steps will be more consumer-focused uses for remote primary care services, “concierge services,” child care (wellness checkups), pre-natal care and follow-up-visits for most diagnoses. It is the cutting-edge future of health care worldwide. Telehealth, in its various forms, will provide convenient medical services because consumers will demand it.

The role government plays in providing oversight and clarity is important to prevent litigiousness and overregulation from holding Georgia, Georgia’s patients and physicians back in an era of growing needs and limited resources.

ATTACHMENT A
An Overview of legislation from the American Telemedicine Association

MEDICAID: All states allow reimbursement for physician services that do not require direct interactions with a patient, such as for radiology or reading an EKG. Forty-five states have some Medicaid coverage for other remote video or store-and-forward services, usually for services in rural areas. The details of state Medicaid coverage vary widely and are seldom the same as in-person coverage for a specific service.

- 40 states have some coverage for telemental health: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, **Georgia**, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.
- 19 states have some form of coverage for home telehealth: Alabama, Alaska, Arizona, Colorado, Indiana, Kansas, Kentucky, Massachusetts, Minnesota, Mississippi, New Mexico, New York, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, and Wisconsin.
- 13 states have some form of coverage for remote patient monitoring: Alabama, Alaska, Colorado, Kansas, Massachusetts, Minnesota, Mississippi, New York, Pennsylvania, South Carolina, South Dakota, Texas and Washington.
- 8 states have some form of coverage for store-and-forward based services: Alaska, Arizona, California, Illinois, Minnesota, Mississippi, Oklahoma, and South Dakota.

PRIVATE INSURANCE COVERAGE: Considerable progress has been made over the past few years, but not without its challenges. Many commercial insurers continue to oppose legislative proposals that require them to cover telehealth-provided services at a rate comparable to that of in-person services, even when they offer such services themselves.

Twenty-one states and the District of Columbia have enacted laws mandating the coverage of telehealth-provided services under private health insurance plans:

Arizona (2013)	Maine (2009)	New Mexico (2013)
California (1996)	Maryland (2012)	Oklahoma (1997)
Colorado (2001)	Michigan (2012)	Oregon (2009)
Georgia (2006)	Mississippi (2013)	Tennessee (2014)
Hawaii (1999)	Missouri (2013)	Texas (1997)
Kentucky (2000)	Montana (2013)	Vermont (2012)
Louisiana (1995)	New Hampshire (2009)	Virginia (2010)
		Washington, DC (2013)

Some insurance companies are already establishing services for the insured who utilize telemedicine services rather than visiting the doctor's office in person. Such services typically cost less than an office visit. Some are finding that up to 70 percent of doctor visits can actually be handled over the phone.

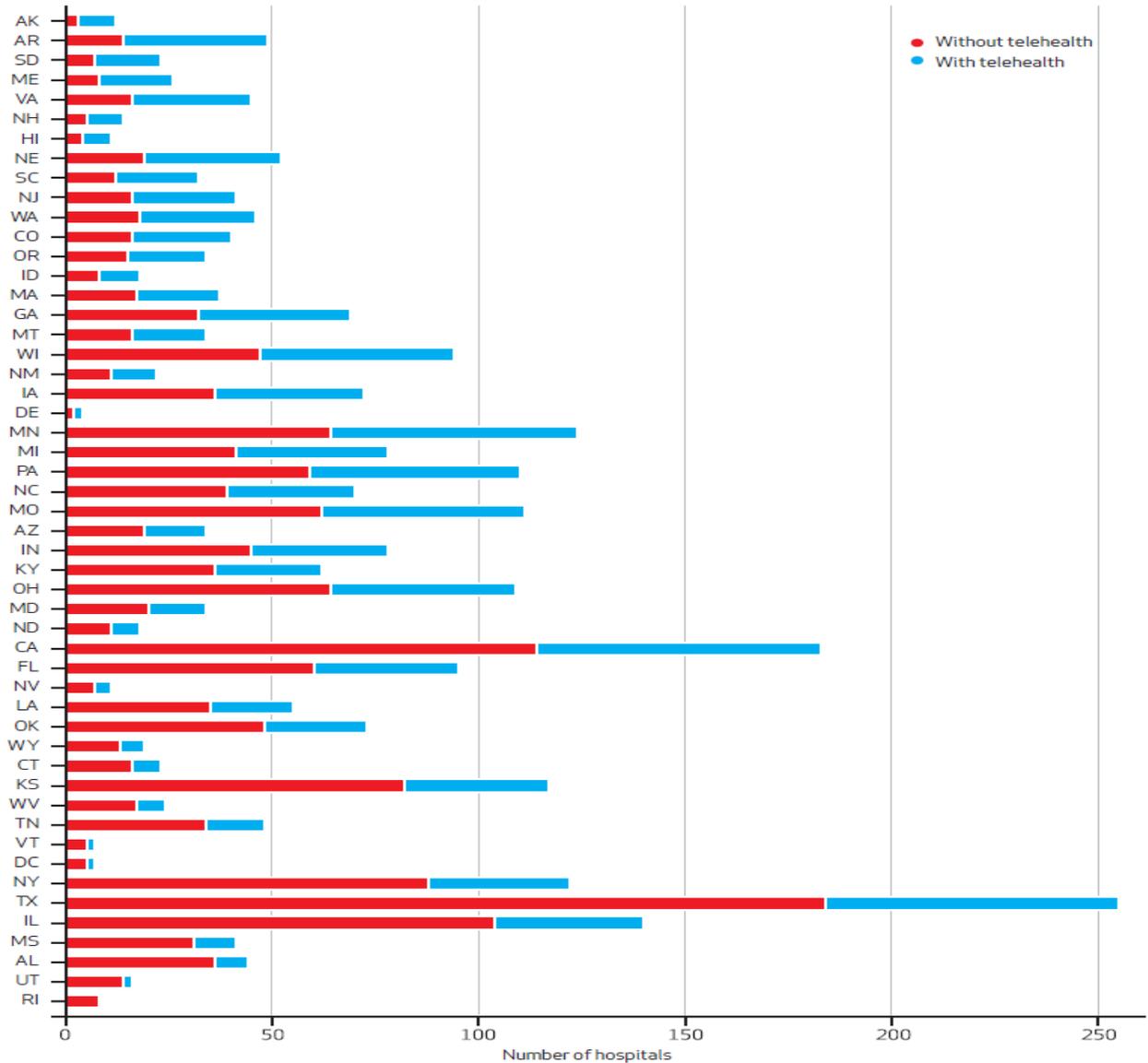
MEDICARE: Unfortunately, Medicare coverage is restricted by an outdated law. Medicare currently only reimburses doctors for telehealth services if patients are located outside city limits or in an area with a shortage of providers. As the nation's largest single payer for health care, Medicare is often used by other payers for guidance. Some states follow Medicare's statutory and regulatory guidance on telehealth services when devising their own state plans, which may result in the authorized coverage of only real-time audio-video interactions, while excluding remote monitoring and store-and-forward transmissions, or coverage in only rural areas or limited clinical settings.

ATTACHMENT B Hospital – Reduction in Acute Stays

Telehealth can reduce hospital admissions by supporting population health, wellness and early intervention. Once a patient is hospitalized, a hospital can provide superior medical care by networking with expertise not otherwise available to them (rural to urban; state to state; country to country).

According to the national data on hospital adoption of telehealth 42 percent of U.S. hospitals have telehealth capabilities. Key characteristics of hospitals’ adoption of telehealth include: (1) Adoption of other advanced technology, (2) System affiliation, (3) Teaching hospital and (4) private, not-for-profit medical centers. Large competitive patient markets with significant rural areas are also key drivers to telehealth adoption.

Hospitals’ Telehealth Participation, By State, 2012



Some of the leaders as a percentage of hospitals in the state with telemedicine systems are Alaska (75 percent), Arkansas (71 percent), South Dakota (70 percent), and Maine (69 percent). Georgia ranks 16th with a little over 50 percent of its hospitals equipped for telehealth.

ATTACHMENT C
Frequently Asked Questions

1. Who are the winners & losers under telemedicine?

Winners –The patient who gets access to care, choice, convenience, quality services and lower costs. Employers who support and encourage lower cost alternative medical care. Physicians who adapt to the developing virtual medical capabilities and expand their practice with the convenience cost advantage of an internet business.

Losers – Providers wanting to maintain the status quo, are not technically capable and/or do not want to invest in the future. Vendors wanting to control and limit the expansion of new medical delivery systems, and not wanting to see the high cost of basic medical services disrupted and lowered by alternative providers. States that lag others in allowing multi-state or cross-state licensing reciprocity.

2. What organizations might fight implementation of certain telehealth laws?

Insurance Companies – many do not want to pay the same rates for telemedicine services as they do for in-person services. A reason stated is that there is no standardized documentation across all states for telemedicine services, so the services are difficult to monitor and control and thereby have an increased risk of fraud.

Another reason stated is that the expansion of services, as well as the convenience to patients, will encourage an onslaught of over-use of benefits. Many insurance companies pay for some telemedicine services, but don't want to be required to pay for more or all telemedicine services.

Malpractice Insurers – fear that telemedicine increases a provider's medical liability. However, since telemedicine actually increases and improves in-depth documentation and verification of medical services, providers (and patients, alike) are actually more protected from malfeasance, miscommunications, abuse and fraud. In fact, with more and more states mandating telemedicine services, *not* covering those services could be grounds for lawsuits.

3. Can telehealth reduce Emergency Room Visits?

Telehealth can eliminate many unnecessary emergency room visits, especially occurring during physician after hours and weekends. For example, the Franciscan Health System in Tacoma, Wash., contracts after-hours care to Carena, a telemedicine clinic provider, in an effort to deal with limited primary care physician staff. In the Franciscan system the telehealth results are rapidly emailed to the primary care physician. The next day by 10 a.m., the Franciscan physician gets a digest update on the previous night's treatments, ER referrals or appointment changes, if there were any.

A Veterans Health Administration (VHA) study that ran from 2003 to 2007 showed telemedicine provided a 25 percent reduction in number of bed days of care, a 19 percent reduction in the number of hospital admissions and a mean satisfaction score of 86 percent after enrollment in a telemedicine program.

Telemedicine can save state correctional medical costs. A 2007 study found an accumulated savings of more than \$1 billion a year just from reducing the transportation costs involved in transferring patients from correctional facilities, physician offices or other emergency departments to the Emergency Room.

ATTACHMENT D
Diagnoses Commonly Treated by Telemedicine

New technologies and remote devices are now available that simulate traditional medical devices and facilitate a wide and growing spectrum of telehealth services. Below is a study results from Teladoc on the distribution of services they provide based on their patients' conditions.

Patterns of Usage Among Teladoc Patients:

<u>Condition</u>	<u>Percentage of Telehealth Visits</u>
Acute Respiratory Illnesses	31%
UTI and Urinary Symptoms	12%
Skin Problems	9%
Abdominal Pain, Vomiting and Diarrhea	6%
Back and Joint Problems	5%
Influenza and General Viral Illnesses	5%
General Advice/Counseling/Refills	5%
Eye Problems	4%
Ear Infections (Internal and External)	4%
All Other Conditions	20%
 Total of the 8 Most Common Conditions	 80%

Frequency of telehealth visits:

One Visit	76%
Two Visits	17%
Three Visits	4%
Four+ Visits	3%

ATTACHMENT E

Recent Federal & State Legislative Initiatives

Currently, there is a new wave of legislative initiatives focused on reciprocal licensure. From “Open Minds” publications, here is a quick update.

Federal – As of September 10, 2013, **H.R. 3077: TELE-MED Act of 2013** has been introduced and referred to House Committee on Energy and Commerce and House Ways and Means. This bill would allow a Medicare participating physician or practitioner to provide a telemedicine service to a Medicare beneficiary in a different state without obtaining a license in that state.

Alaska – As of March 19, 2014, **SB 80** has been referred to the Senate Committee on Rules. The bill would allow the Medical Board to issue a license to out-of-state physicians or podiatrists to practice telemedicine in Alaska.

Florida – As of February 10, 2014, **SB 1646** has been referred to the Senate Committee on Appropriations. This bill would allow an out-of-state physician to consult through telemedicine with a Florida-licensed physician.

Hawaii – As of March 7, 2014, **HB 2411** failed its first crossover deadline. The bill exempts a commissioned medical officer, a commissioned behavioral health professional or a contracted behavioral health professional employed by the U.S. Department of Defense from Hawaii licensing requirements.

Louisiana – As of March 10, 2014, **SB 501** has been referred to the House Committee on Health and Welfare. This bill would require the Louisiana Medical Board to establish requirements for telemedicine licensure.

New York – As of February 25, 2014, **SB 2904** is in the Senate Committee on Higher Education. This bill would require genetic counselors to have New York licensure in order to provide telehealth services.

Rhode Island – As of March 13, 2014, the Rhode Island Senate Committee on Health and Human Services has recommended **SB 2513** be held for study. This bill would restrict a physician not present in Rhode Island from providing consultation to a patient without an established physician-patient relationship.

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