ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
February 24, 2009
3:04 p.m.

MEMBERS PRESENT

Representative Bob Herron, Co-Chair
Representative Wes Keller, Co-Chair
Representative John Coghill
Representative Bob Lynn
Representative Paul Seaton
Representative Sharon Cissna
Representative Lindsey Holmes

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

PRESENTATION: TELEMEDICINE

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

MELODY PRICE-YONTS, Division Director
Behavioral Health
Southeast Alaska Regional Health Consortium (SEARHC)
Juneau, Alaska
POSITION STATEMENT: Presented a Power Point and answered questions on the TeleBehavioral Health Program.

STEWART FERGUSON, Ph.D.
Director of Telehealth
Alaska Native Tribal Health Consortium (ANTHC)
Anchorage, Alaska
POSITION STATEMENT: Presented a Power Point and answered questions on the Alaska Federal Health Care Access Network (AFHCAN) telehealth program.

ACTION NARRATIVE

3:04:39 PM

CO-CHAIR BOB HERRON called the House Health and Social Services Standing Committee meeting to order at 3:04 p.m. Representatives Herron, Keller, Seaton, and Coghill were present at the call to order. Representatives Lynn, Cissna, and Holmes arrived as the meeting was in progress.

Presentation: Telemedicine

3:05:05 PM

CO-CHAIR HERRON announced that the only order of business would be a presentation on Telemedicine.

3:05:58 PM

MELODY PRICE-YONTS, Division Director, Behavioral Health, Southeast Alaska Regional Health Consortium (SEARHC), gave a Power Point presentation entitled "SEARHC Southeast Alaska Regional Health Consortium- TeleBehavioral Health Program." [Included in the members packets.] She stated that SEARHC had been offering the TeleBehavioral Health program since 2003. She referred to slide 3, "What is TeleBehavioral Health," and explained that it was used to provide psychiatric, mental health, and substance abuse treatment to services in the remote villages because of the difficulty to bring patients in from remote villages. She explained that it was supplied by a video signal over a dedicated phone line. She referred to slide 4, "Mission," and said the mission was to

> Expand psychiatric and behavioral health services and related activities via live videoconferencing to remote villages to provide high-quality behavioral health care.

She stated that, slide 5 "Vision," was for

> A virtual community mental health collaborative that is decentralized and distributed. Each site has equal opportunity to contribute to other sites needs, working together as a team to meet behavioral health needs.

3:08:26 PM

MS. PRICE-YONTS explained that the "Videoconferencing Components," slide 6, included cameras, video displays, microphones, and speakers. She showed slide 7, "Main camera," and said that the camera eye could follow movement. She showed slide 8, "The Video display," and said the display could be used with a television or flat screen monitor. She said that the "Audio Components," slide 9, included microphones and speakers. She described the "Add-on components," slide 10, which included a document camera, a VCR or DVD, and an electronic whiteboard.

3:09:24 PM

REPRESENTATIVE SEATON asked what a document camera was.

MS. PRICE-YONTS explained that a document could be placed under the screen so that the viewer could see it. She added that the electronic whiteboard served like the old paper easels.

3:10:14 PM

MS. PRICE-YONTS explained slide 11, "Why TeleBehavioral Health?" and stated that it offered year round access to remote areas.

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CO-CHAIR HERRON asked if the cameras were able to get close enough to be of use in telepsychiatry.

MS. PRICE-YONTS agreed that it was possible for the camera to view emotions.

3:12:10 PM

REPRESENTATIVE SEATON asked if the camera lens was preset or capable of zoom.

MS. PRICE-YONTS camera replied that the camera was capable of zoom from either location.

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REPRESENTATIVE LYNN asked if each person could see the other.

MS. PRICE-YONTS said that it was a two way camera.

REPRESENTATIVE CISSNA said that she had watched a school board meeting with numerous community groups, and she asked if it was possible to include many groups.

MS. PRICE-YONTS said that SEARHC was designing an Out-Patient treatment program which would include many sites simultaneously.

3:15:34 PM

MS. PRICE-YONTS pointed out that slide 12 and slide 13, "TeleBehavioral Health Services," listed some of the uses which included psychiatric services, mental health assessment, substance abuse, psychotherapy and prevention services. She explained that SEARHC was able to provide clinical supervision on a continuous basis with the program.

3:17:00 PM

REPRESENTATIVE SEATON asked if psychotropic medication refills, listed on slide 12, included new prescriptions.

MS. PRICE-YONTS said that both were available. She said that the program allowed SEARHC to provide continuing education to its field staff.

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MS. PRICE-YONTS pointed to slide 14, "Map of communities served by Telebehavioral Health," and named the communities which offered the program, including Skagway, Hoonah, Kake, and Hydaburg.

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MS. PRICE-YONTS turned to slide 15, a graph of "Jan 04 to Dec 05 TeleBehavioral Health Encounters," and pointed out the increased use of the program.

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MS. PRICE-YONTS referred to slide 16, "Telebehavioral Health Program," and stated that it was designed to empower the remote community and enhance the provider skills in the villages.

3:19:11 PM

MS. PRICE-YONTS moved to slide 17, "Telebehavioral Health Program, Goals:" and indicated that it increased access to Behavioral Health services, empowered the local providers, and decreased costs.

MS. PRICE-YONTS explained that trainings, peer review, clinical supervision, and consultation were all designed to "Empower Village Provider's:" slide 18.

MS. PRICE-YONTS directed attention to slide 19, "Educational Programming to Village Providers," and listed consultation, grand rounds, case conference, monthly seminars, and special programming.

3:19:50 PM

REPRESENTATIVE SEATON asked if the program was effective in the early detection and allowed people to stay in their community for treatment.

MS. PRICE-YONTS agreed.

REPRESENTATIVE SEATON asked if it had effectively reduced referrals and crises.

MS. PRICE-YONTS said that her instinct said yes, but that she did not have any data to support it.

3:22:24 PM

MS. PRICE-YONTS turned to slide 20, "A Virtual Community Mental Health Collaborative!" and explained that the community was decentralized and distributed.

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REPRESENTATIVE CISSNA asked if this program allowed providers to do a better job, by removing the emotional isolation.

MS. PRICE-YONTS replied that there was a virtual talking circle for dealing with the vicarious trauma. She said that SEARHC was very cognizant of its providers residing in remote sites.

3:24:11 PM

MS. PRICE-YONTS noted that slide 22, "Best Practices in Video-conferencing," included tips for maintaining eye contact and appropriate on-camera position.

MS. PRICE-YONTS explained slide 23, "Prepare for the Worst Case Scenario," and suggested to contact the person who handled difficult technical problems, designate a remote facilitator, and develop a contingency plan for the remote site and share it with the remote facilitator.

3:25:28 PM

MS. PRICE-YONTS concluded her Power Point with slide 24, "Contact Information," which listed contact personnel at SEARHC.

3:26:03 PM

REPRESENTATIVE COGHILL asked for her comments on the performance of the dedicated lines and the infrastructure.

MS. PRICE-YONTS said that the T-1 lines in all locations were all doing well.

3:26:58 PM

STEWART FERGUSON, Ph.D., Director of Telehealth, Alaska Native Tribal Health Consortium (ANTHC), offered to give a quick demonstration of the Alaska Federal Health Care Access Network (AFHCAN) telehealth system. He said that SEARHC was a statewide leader. He said that the AFHCAN system was designed to use fifth grade language, so that it could be easily translated into foreign languages.

3:28:53 PM

MR. FERGUSON said that he would use Co-Chair Keller's personal data to fill in the example. [He connected to an on-line database.]

3:30:51 PM

MR. FERGUSON reflected that the demonstration connection was not working properly. [He disconnected the demonstration.]

3:32:57 PM

MR. FERGUSON presented a Power Point titled "The Impact of Telehealth in Alaska," [Included in the members packets.] which showed a 7 year retrospective of the program.

MR. FERGUSON referred to slide 2, "AFHCAN Telehealth," and said that this was a federally funded project begun about 10 years ago, and designed to create telehealth solutions for the federal partners in Alaska.

3:33:56 PM

MR. FERGUSON referred to slide 3, "Telemedicine..." and explained that telehealth defined a use of telecommunications to provide health care.

MR. FERGUSON pointed to slide 4, "Case Originated...," that pictured the origination of a case as capturing the data and sending it. He showed in slide 5, "...Case received," that a consultant can review the data and respond.

3:34:37 PM

CO-CHAIR KELLER asked if there was any necessary training.

MR. FERGUSON agreed that it was best to have someone trained to use the medical devices, as well as the software. He said that the use of the devices was straightforward.

CO-CHAIR HERRON asked how many AFHCAN carts there were in the state.

MR. FERGUSON said that there were about 400.

3:35:54 PM

MR. FERGUSON pointed to slide 6 "A Primary Care Tool," and explained that Alaska focused more on primary care whereas, the lower 48 focused more on specialty care. He noted that 75 percent of the Alaska medical cases originated with a health aide and concluded with a family physician. He listed ear and heart disease, respiratory illness, vital signs, dental problems, and trauma as the most often used cameras and monitors.

3:36:42 PM

MR. FERGUSON moved on to slide 7, "ANMC Departments now accepting Telehealth cases, " which listed specialists who used the AFHCAN program, including cardiologists, dermatologists, and urologists.

3:37:12 PM

CO-CHAIR KELLER asked to clarify that the consultants were doctors in urban areas.

MR. FERGUSON, in response to Co-Chair Keller, said that health aides wanted to use the AFHCAN technology. He said the difficulty was with process reengineering, figuring out how to fit this program in, and then demonstrating its value. He opined that the measureable success was that so many departments were now using the system.

3:37:58 PM

REPRESENTATIVE COGHILL asked if there was a communication protocol.

MR. FERGUSON replied that the AFHCAN program had standardized forms and templates for the information.

REPRESENTATIVE COGHILL asked about the quick response action issues.

MR. FERGUSON said that a health aide typically had a protocol, regardless of using the AFHCAN program. He explained that telehealth was just an additional tool to capture the data and send it. He said the most important thing was for the system to work quickly and efficiently. He reported that the AFHCAN telehealth program system was ready with three touches to the screen. He noted that it was necessary to call the recipient and alert them to the incoming information.

MR. FERGUSON explained slide 8, "Telehealth Cases Created," and said that the majority of telehealth systems see a decline of usage because most people, after seeing a number of cases, have no need for a consultation. He said that this AFHCAN program was always adding specialties, equipment, and technology, so that the number of users and patients had also increased.

3:42:04 PM

MR. FERGUSON referred to slide 9, "Store & Forward versus Real-Time Telemedicine" and explained that these were different tools. He gave examples of the types of procedures that most often used "store & forward" procedures, which included radiology and dermatology. He also offered examples for "real-time" procedures, which included psychiatry and neurology. He explained that the "trick" with telehealth was to find the right tool for the specialty.

3:42:37 PM

MR. FERGUSON explained slide 10, "Ear Tube Follow Up," and slide 11 picturing a bitten lip, which were both examples for use of the AFHCAN program as a communication tool for information exchange.

3:43:40 PM

MR. FERGUSON addressed slide 13, "Medicaid Study," and compared the travel expense savings to Medicaid when telemedicine was used.

MR. FERGUSON analyzed slide 14 "Impact of Telehealth on Preventing Patient Travel," and compared primary care and specialty care. He shared that patient travel was prevented in 75 to 80 percent of all specialty care cases, and in 20 percent of all primary cases.

3:45:21 PM

MR. FERGUSON moved to slide 15, "Impact of Preventing Patient Travel," and said that the savings in air travel expenses during 2007 was about $3.5 million. He said that this did not include the additional travel expenses for lost work time, hotels, meals, etc.

MR. FERGUSON assessed slide 16, "Impact of Telehealth on Causing Patient Travel," and said that about 8 percent of telehealth cases revealed a necessity for travel to receive care. He noted that many of these cases were instrumental in providing early treatment and in saving lives.

3:47:07 PM

MR. FERGUSON spoke about slide 17, "Improving Access," and noted that it was less expensive to send a mid level provider, instead of a specialist, to rural sites for screenings. He gave an

example on slide 18, "Traveling Audiologist," which reflected the savings for patient travel to those patients who were waiting to see a specialist.

3:48:18 PM

MR. FERGUSON explained that slide 19, "Outcomes," showed the value of the AFHCAN telehealth program as a screening tool, and he noted that 27 percent of the patients were screened out after the initial visit.

3:49:15 PM

MR. FERGUSON pointed to slide 20, "Specific to Medicaid Patients," and said that the AFHCAN telehealth program saved travel expenses for 83 percent of the Medicaid patients, most of whom would have required a parent or guardian to travel with them.

3:50:06 PM

MR. FERGUSON directed attention to slide 21, "Telehealth Impact on Backlogs and Average Waiting Times," and observed that the wait time had been cut by almost two thirds with telehealth.

MR. FERGUSON offered slide 22 "Telehealth Impact on Extended Waiting Times, (> 4 months)," and revealed that AFHCAN telehealth had lowered the "more than four month appointment wait time" from 47 percent of patients to 3 percent.

3:52:02 PM

MR. FERGUSON furnished slide 24, "ANMC: Access to Care," which reviewed the turnaround time for specialist response. He reported that 4,457 cases were reviewed in a two year period, and that 65 percent were turned around in the same business day, with half of those completed in sixty minutes.

3:53:39 PM

MR. FERGUSON commented on slide 25, "Originating vs. Consultant Time," which was a study of the consultant response time for more than 8,500 cases.

MR. FERGUSON briefed that slide 26, "Dermatology CME Visits," explained how the AFHCAN telehealth program allowed for more patients each year, and dramatically reduced the waiting times.

3:56:22 PM

MR. FERGUSON examined slide 27, "Provider Responses," which listed provider responses to AFHCAN telehealth values, and he noted that the highest response, 88 percent, agreed that this program helped the patient communicate with the doctor.

3:57:08 PM

MR. FERGUSON said that slide 28, "In Development," reported on new AFHCAN telehealth capabilities that were being developed, which included retina imaging for diabetics.

MR. FERGUSON discussed slide 29, "New Consultative Models," and shared a new care delivery system used by the Alaska Native Medical Center, which referred all initial consultations through the institution instead of through the department.

3:59:05 PM

MR. FERGUSON showed slide 30, "Reimbursement is critical for..." and he said that telehealth is a technology, not a project. He said that the system needed to grow and be sustained.

MR. FERGUSON noted on slide 31, "Alaska enjoys a very supportive..." that telehealth had a very supportive reimbursement climate, especially with Medicaid, in Alaska. He explained that AFHCAN telehealth relied on a standard coding system. He pointed out that for most doctor visits, the patient would receive a complete examination, and the doctor could justify a higher level fee; whereas, telehealth captured focused information that did not justify a high level consult fee. He said that AFHCAN telehealth required a large infusion of technology and training, especially for the rural provider. He said that there was not a reimbursement structure for the rural provider, only for the consultant.

4:01:30 PM

MR. FERGUSON spoke about slide 32, "Exporting Alaska Solutions." He said that the AFHCAN system, software, and carts were developed and built in Alaska, so they all had the "Made in Alaska" logo. He said that the system was now being deployed outside Alaska.

4:03:44 PM

MR. FERGUSON, in response to Representative Cissna, said that there was a home AFHCAN telehealth project in Alaska, with a nurse able to monitor the patients from a central location.

4:04:36 PM

REPRESENTATIVE CISSNA asked about the cost savings.

MR. FERGUSON explained that the home telehealth model was based on managing costs, not on reimbursement. He said that managed care systems were interested because of the savings.

4:05:54 PM

REPRESENTATIVE COGHILL asked if it was federal guidelines or the state Medicaid health plan that restricted the aforementioned reimbursement issues. He asked if these were capital expense or payment issues.

4:06:30 PM

MR. FERGUSON replied that there was a Medicare Level 2 Healthcare Common Procedure Coding System (HCPCS) code, Q3014, which allowed for the origination of a telehealth encounter. He explained that the code was typically for reimbursement to a videoconference presentation, but he proposed that the same code not be limited to video, but also to create a telehealth case. He qualified that people are paid for procedures that are funded, but that packaging and sending a telehealth case was not funded.

REPRESENTATIVE COGHILL said that he wanted more information. He opined that the Medicaid rules might have flexibility through the state health plan to CMS.

4:08:34 PM

MR. FERGUSON, in response to Co-Chair Herron, said that AFHCAN funding came through Indian Health Services (IHS), and that IHS was budgeting additional funds to develop the AFHCAN interface to its electronic health records. He noted that Alaska Native corporations had spent more than $1 million for additional technology, as opposed to relying on federal funds.

4:09:33 PM

CO-CHAIR HERRON asked what was needed to push this along.

4:10:11 PM

MR. FERGUSON said that this was a communication technology for moving health care data to deliver care. He said that there was a huge initiative for electronic health records. He said that viewing this as a business model revealed that the reimbursement issue was an incentive and a key component. He said that there was not a need for a lot of equipment, but a need for operations.

4:12:17 PM

MS. PRICE-YONTS, in response to Representative Coghill, said that SEARHC was already using electronic records which were designed to interface with the state system.

4:13:36 PM

CO-CHAIR HERRON asked if there was any money in the stimulus package for telemedicine.

MR. FERGUSON said that he was not aware of money in the state stimulus package. He offered that there was federal money for health information technology, but that it was unclear if that would be designated for telehealth.

4:15:21 PM

CO-CHAIR KELLER asked about the incentive for a 6 minute response.

4:16:28 PM

MR. FERGUSON explained that this was a problem-focused consultation, which allowed for a prompt response, and he opined that it was not driven by the reimbursement.

4:17:11 PM

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 4:17 p.m.