

HB

269

<TARGET><BILL>HB 269</BILL><SUBJECT>HB
269</SUBJECT><COMM>HHSS28</COMM></TARGET>

ALASKA STATE LEGISLATURE

Session:
State Capitol Building
Room 500
Juneau, Alaska 99801-2186
Phone (907) 465-3004
Toll Free: (877) 465-3004



Interim:
1292 Sadler Way, Ste. 308
Fairbanks, Alaska 99701
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REPRESENTATIVE STEVE THOMPSON DISTRICT 3

Sponsor Statement HB 269

“An Act providing immunity for certain licensed temporary health care providers who provide free health care services.”

HB 269 was drafted due to liability concerns surrounding an inaugural Alaska Mission of Mercy (AKMOM) event organized by the Alaska Dental Society, and scheduled in Anchorage this coming April. The Mission of Mercy program was started by a group of dentists thirteen years ago in Virginia. The MOM programs provide free dental care to local residents who would not otherwise have access to affordable dental care. To date, the Mission of Mercy Program in Alaska has 187 dentist volunteers, seven from out-of-state. The AKMOM program will provide extractions, fillings and cleanings as well as other procedures that can be appropriately performed in a mission setting. Out-of-State dental professionals will be licensed to provide pro bono services under courtesy licenses issued by the Alaska Board of Dental Examiners. A courtesy license is a medical professional license issued by the Board for the purposes of providing free services and enforcing state disciplinary provisions.

The problem is that there is no clear answer as to whether an out-of-state dental professional issued a courtesy license is covered under Alaska Statute 09.65.300. AS 09.65.300 provides statutory immunity against civil damages resulting from an act or omission of a health care provider who provides free health care services, within the scope of their license. Under AS 09.65.300 a patient must receive written notice of this immunity as well as giving informed consent before any medical service is provided. Under AS 09.65.300 patients still have the right to sue the medical provider for civil damages resulting from the provider's gross negligence, or reckless or intentional misconduct.

Unfortunately, it is unclear whether these out-of-state dental professionals, participating in the AKMOM event qualify under AS 09.65.300, the Volunteer Health Care Provider Immunity Act of 2004. The original purpose of the statute was to allow retired Alaska physicians to volunteer their services. The Department of Law opines that the meaning of the law will ultimately have to be interpreted in a court case.

HB 269 will clarify AS 09.65.300, ensuring that civil immunity is extended to these out-of-state medical professionals who are licensed to provide dental services in Alaska during the Mission of Mercy Event, without having the issue come before a lengthy proceeding before the Court.

Please join Representative Thompson in supporting this legislation.

E-mail Representative_Steve_Thompson@akleg.gov

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REPRESENTATIVE STEVE THOMPSON DISTRICT 3

HB 269 Explanation of Differences version A to version U

“An Act providing immunity for certain licensed temporary health care providers who provide free health care services.”

Section 3 Adds an immediate effective date.

E-mail Representative_Steve_Thompson@akleg.gov

CS FOR HOUSE BILL NO. 269()

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-EIGHTH LEGISLATURE - SECOND SESSION**

BY

**Offered:
Referred:**

Sponsor(s): REPRESENTATIVES THOMPSON, Hughes

A BILL

FOR AN ACT ENTITLED

1 **"An Act providing immunity for certain licensed temporary health care providers who**
2 **provide free health care services; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** AS 09.65.300(a) is amended to read:

5 (a) Except as otherwise provided in this section, a health care provider who
6 provides health care services to another person is not liable for civil damages resulting
7 from an act or omission in providing the health care services if the health care

8 (1) provider is licensed in this state to provide health care services; in
9 this paragraph, "health care provider" includes a health care provider who holds
10 a temporary courtesy license as a health care provider under AS 08.01.062;

11 (2) services provided were within the scope of the health care
12 provider's license;

13 (3) services were provided at a medical clinic, medical facility,
14 nonprofit facility, temporary emergency site, or other facility owned or operated by a

1 governmental entity or nonprofit organization and the health care provider was acting
2 within the scope of the provider's responsibilities in the medical clinic, governmental
3 entity, or nonprofit organization;

4 (4) services were provided voluntarily and without pay to the health
5 care provider for the services, except as provided in (b)(2) and (3) of this section; and

6 (5) provider

7 (A) obtains informed consent from the person receiving the
8 health care services as described under AS 09.55.556, except in the case of an
9 emergency; and

10 (B) provides the person receiving the health care services
11 advance written notice of the immunity provided under this section to a health
12 care provider when providing voluntary health care services as described under
13 this section.

14 * **Sec. 2.** AS 09.65.300(c)(1) is amended to read:

15 (1) "health care provider" means a [STATE LICENSED] physician,
16 physician assistant, dentist, dental hygienist, osteopath, optometrist, chiropractor,
17 registered nurse, practical nurse, nurse midwife, advanced nurse practitioner,
18 naturopath, physical therapist, occupational therapist, marital and family therapist,
19 psychologist, psychological associate, licensed clinical social worker, or certified
20 direct-entry midwife;

21 * **Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

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REPRESENTATIVE STEVE THOMPSON DISTRICT 3

HB 269 Sectional Summary

“An Act providing immunity for certain licensed temporary health care providers who provide free health care services.”

Section 1. Amends AS 09.65.300(a)(1) to include healthcare providers who hold temporary courtesy licenses issued under AS 08.01.062.

Section 2. Amends AS 09.65.300(c)(1) to change the definition of a health care provider in this section by removing the words “state licensed”, since it is covered in Section 1 of the bill.

Fiscal Note

State of Alaska
2014 Legislative Session

Bill Version: HB 269
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB269-LAW-CIV-02-07-14
Title: IMMUNITY FOR TEMP. HEALTH CARE PROVIDER
Sponsor: THOMPSON
Requester: (H) HSS

Department: Department of Law
Appropriation: Civil Division
Allocation: Torts & Workers' Compensation
OMB Component Number: 2719

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2015 Appropriation Requested	Included in Governor's FY2015 Request	Out-Year Cost Estimates				
			FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
OPERATING EXPENDITURES	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Fund Source (Operating Only)

None							
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues

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Estimated SUPPLEMENTAL (FY2014) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2015) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? **No**
If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version:

Initial version, not applicable.

Prepared By:	<u>Loretta Withington, Division Operations Manager</u>	Phone:	<u>(907)465-5427</u>
Division:	<u>Administrative Services Division</u>	Date:	<u>02/07/2014 06:20 PM</u>
Approved By:	<u>Michael C. Geraghty, Attorney General</u>	Date:	<u>02/07/14</u>
Agency:	<u>Department of Law</u>		

FISCAL NOTE ANALYSIS

**STATE OF ALASKA
2014 LEGISLATIVE SESSION**

BILL NO. HB 269

Analysis

Existing law protects health care providers from liability for services they provide voluntarily and without compensation, under certain circumstances. This bill would expand this statutory immunity to cover health care providers who have a temporary courtesy license under AS 08.01.062. This bill has no fiscal impact on the Department of Law.

Fiscal Note

State of Alaska
2014 Legislative Session

Bill Version: HB 269
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB269-DCCED-CBPL-02-06-2014
Title: IMMUNITY FOR TEMP. HEALTH CARE PROVIDER
Sponsor: THOMPSON
Requester: House Health and Social Services

Department: Department of Commerce, Community and Economic Development
Appropriation: Corporations, Business and Professional Licensing
Allocation: Corporations, Business and Professional Licensing
OMB Component Number: 2360

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2015 Appropriation Requested	Included in Governor's FY2015 Request	Out-Year Cost Estimates					
			FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
OPERATING EXPENDITURES								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits								
Miscellaneous								
Total Operating	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Fund Source (Operating Only)

None								
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Positions

Full-time								
Part-time								
Temporary								

Change in Revenues

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Estimated SUPPLEMENTAL (FY2014) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2015) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared By:	Don Habeger, Director	Phone:	(907)465-2536
Division:	Corporations, Business and Professional Licensing	Date:	02/07/2014 10:30 AM
Approved By:	Jeanne Mungle, Director	Date:	02/07/14
Agency:	Administrative Services Director		

FISCAL NOTE ANALYSIS

**STATE OF ALASKA
2014 LEGISLATIVE SESSION**

BILL NO. HB269

Analysis

HB269 amends AS 09.65.300(a) and AS 09.65.300(c)(1) so that a healthcare provider who holds a temporary courtesy license under AS 08.01.062 will not be liable for civil damages arising from an act or omission during the provision of free medical care.

The Division of Corporations, Business, and Professional Licensing does not anticipate fiscal impact from this legislation.

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United Way of Anchorage

February 11, 2014

Representative Steve Thompson
State Capitol Room 500
Juneau, AK 99801

RE: Letter of Support for HB269 - IMMUNITY FOR TEMPORARY HEALTH CARE PROVIDER

Dear Representative Thompson,

The Volunteer Health Care Provider Immunity Act of 2004 has and continues to give Alaska licensed health care providers statutory immunity against civil damages resulting from an act or omission when they provides free health care services, within the scope of their license. This act is a significant support in delivering pro bono services to individuals without insurance or public benefits. Hundreds of Alaskans have received free health care because of this law.

Please extend this immunity to individuals who have acquired a temporary health care provider license to expand the number of individuals able to provide pro bono health services to Alaskans. By extending this immunity the Alaska Legislature will remove one of the roadblocks for health care providers to travel to Alaska and participate in pro bono clinics that provide care for underserved populations. Additionally, the bill would provide members of our military who are serving in Alaska a way to donate their services.

Alaskans have a strong commitment to volunteering. In 2012, the Corporation for National and Community Services reports that 196,310 or 33.2% of Alaska residents volunteer, ranking Alaska 12th among the 50 states and Washington, DC. The average volunteer hours per resident - 52.3 hours. By extending the statutory immunity to volunteers from other locations, Alaska will provide protection for those from other locations who have a calling to volunteer in Alaska as well.

Thank you,



Michele Brown
President



ALASKA NATIVE MEDICAL CENTER



To Whom it May Concern

Southcentral Foundation and Alaska Native Medical Center Dental Service support HB269 which provides immunity for health care providers doing pro bono work. Alaska licensed health care providers already have immunity and extending this immunity to courtesy license holders is a natural extension of AS09.65.300. Despite advances in the number of people with health insurance there remains a sizable population without access to regular health care. By extending this immunity the Alaska Legislature will remove one of the roadblocks for health care providers to travel to Alaska and participate in clinics that provide care for underserved populations.

Sincerely

Dr. Kevin Gottlieb DDS
Vice President
Resource and Development

Dr. Tom Kovaleski DDS
Dental Director

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

February 10, 2014

Honorable Steve Thompson
Alaska House of Representatives
State Capital Room 500
Juneau, AK 99801

RE: House Bill 269

Dear Representative Thompson:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

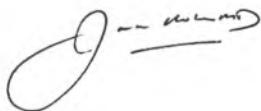
Thank you for introducing HB 269. ASMA supports the effort to clarify current language and asks the Alaska Legislature to pass HB 269.

In 2004, with broad support from the medical community, the Alaska Senate voted 19-1 and the Alaska House of Representatives voted 35-2 to enact House Bill 260 joining over 40 states at the time in providing some immunity for health care services provided free of charge.

We believe the language in HB 269 clarifying that “courtesy licenses” are protected under the current statutory framework is appropriate and consistent with the policy in current law.

Please let us know if there is anything we can do to further support passage of this legislation.

Sincerely,



Jana Cole, MD
President For: The Alaska State Medical Association



THE STATE
of **ALASKA**
GOVERNOR SEAN PARNELL

Department of Law

CIVIL DIVISION

1031 West 4th Avenue, Suite 200
Anchorage, Alaska 99501
Main: 907.269.5100
Fax: 907.276.3697

August 19, 2013

David Logan, DDS
2237 North Jordan Ave.
Juneau, AK 99801

Dear Dr. Logan:

Your June 14, 2013 letter to the Attorney General regarding Alaska's immunity statute for health care providers has been referred to me. I am an assistant attorney general in the Attorney General's Office in Anchorage and I represent the Division of Corporations, Business and Professional Licensing in disciplinary proceedings against licensed professionals, such as dentists.

You have inquired (1) whether a courtesy license issued by the Board of Dental Examiners is considered a State of Alaska professional license, (2) whether a nonresident dentist or dental hygienist who has been issued a courtesy license is considered to be a provider "licensed in this state to provide health care services" under AS 09.65.300(a)(1), and (3) whether, under AS 09.65.300, immunity is extended to professionals who have been issued a courtesy license by the Board of Dental Examiners. With regard to the first question, we answer in the affirmative. As to your second and third questions, we cannot provide you with a definite answer, as the above immunity statute has never been interpreted by the Alaska Supreme Court.

As to your first question, all professional boards may establish criteria for issuing temporary courtesy licensees to nonresidents who enter the state so that, on a temporary basis, they may practice the occupation regulated by that board. AS 08.01.062(a). As you have noted, the Board of Dental Examiners has established such criteria for a courtesy license under 12 AAC 28.955. While limited in scope and time, the holder of the courtesy license is nevertheless obligated to uphold the standards of practice identified in AS 08.32 (which covers dental hygienists) and AS 08.36 (which covers dentists) and is subject to all the relevant disciplinary provisions found in AS 08.32 and AS 08.36 while practicing under the courtesy license. 12 AAC 28.955(g). Therefore, since the holder of a courtesy license is subject to the same standards of practice as a dental hygienist licensed under AS 08.32 or a dentist licensed under AS 08.36, and is subject to the same disciplinary provisions as those hygienists and dentists, we would consider a courtesy license issued by the Board of Dental Examiners to be a professional license. You should also be aware that such disciplinary provisions would apply even if a courtesy license holder were determined not to be liable for civil damages under AS 09.65.300, discussed below.

The answer to your other two questions involve the interpretation of AS 09.65.300, the Volunteer Health Care Provider Immunity Act of 2004. The ultimate interpretation of this statute will have to come from the courts. That interpretation is likely to occur in the course of private litigation, for example between an allegedly injured patient and the patient's dentist. Because the meaning of the law will be interpreted by a court, and not the Attorney General's Office, you should retain private counsel to advise you on the possible outcome of a judicial interpretation.

To assist you and your counsel, we have reviewed the legislative history of AS 09.65.300. As set forth below, the original purpose of the statute was to allow retired physicians to volunteer their services:

The legislature finds that

(1) many of the state's most senior and experienced physicians will be retiring in the next five to 10 years; retiring physicians deciding to reside in Alaska could continue to benefit our local communities by volunteering their medical services;

(2) historically, Alaska has had difficulty in attracting and maintaining adequate numbers of qualified physicians; currently, Alaska ranks 49th in the number of physicians per capita, while Alaska's physicians continue to grow older, reaching an average age of 51 years;

(3) without civil liability protection, retired physicians would be unwilling to provide free services to the indigent and elderly;

(4) 43 states have enacted legislation limiting liability for retired physicians, thus encouraging retired physicians to continue in providing voluntary medical services; and

(5) removing liability requirements for retired physicians would be in the best interests of the state; retired physicians unhindered by expensive malpractice insurance would be more inclined to volunteer necessary and important medical services to all Alaskans.

§ 2, ch. 56 SLA (2004), 2004 Temporary and Special Acts.

This legislative finding adds some degree of confusion. By its terms, AS 09.65.300 provides that a "health care provider" who provides health care services to another person is not liable for civil damages resulting from an act or omission in providing the health care services, so long as five conditions are met, one of them being that the provider is "licensed in this state to provide health care services."

AS 09.65.300(a)(1). Although the legislature only used the word "physicians" when describing its purpose, the plain wording of the statute defines "health care provider" much more broadly than just physicians; it specifically includes dentists and dental hygienists. AS 09.65.300 (c)(1). The legislative findings also only discuss retired

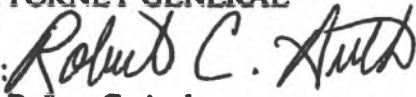
physicians residing in Alaska, not actively practicing out of state professionals who travel to Alaska and obtain a courtesy license for a specific event. On the other hand, the health care provider need only be "licensed in this state to provide health care services" to meet the criteria in AS 09.65.300 (a)(1) and a courtesy license could be interpreted to meet that criteria, especially given our view that a courtesy license is a professional license for the purpose of enforcing state disciplinary provisions. Also, during a legislative hearing on AS 09.65.300, one legislator, in response to a question about what "retired" meant, stated that the legislation meant that the health care provider, "retired or not", was providing services for free. Hearing on H.B. 260, before the House Labor & Commerce Committee, April 28, 2003. We did not find any testimony before any legislative committee that reflected an intent to exclude out of state professionals holding courtesy licenses from operation of the statute.

While we cannot definitively answer your question regarding the interpretation and application of AS 09.65.300(a)(1), we believe a compelling argument can be made that immunity would be extended to out of state professionals who have been issued a courtesy license, based on the plain language of the statute and the legislative history. We appreciate your efforts in organizing the Mission of Mercy event. We also understand that a presentation about the event was made to the Board of Dental Examiners at their May 3, 2013 meeting and, as indicated in the meeting minutes, the Board plans to write a letter of support.

If you have any questions about this letter, you can reach me at 269-5200.

Sincerely,

MICHAEL C. GERAGHTY
ATTORNEY GENERAL

By: 
Robert C. Auth
Assistant Attorney General

RCA/mrr

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101


State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

January 13, 2014

SUBJECT: Immunity for nonresident health care providers who have been issued temporary courtesy licenses (Work Order No. 28-LS1251\A)

TO: Representative Steve Thompson
Attn: Jane Pierson

FROM: Hilary Martin 
Legislative Counsel

This memo accompanies the draft bill you requested to provide immunity for a nonresident health care provider who provides health care services under the conditions set out in AS 09.65.300.

I believe that the amendment is unnecessary because a person who is issued a temporary license to provide health care under AS 08.01.062 would already be considered a licensed health care provider under existing AS 09.65.300(a)(1). Note that the bill provides that the immunity only applies to a health care provider, not to any occupation regulated by a board or department under AS 08.01.062.

Finally, please be aware of the temporary permitting for a locum tenens practice under AS 08.64.275, which allows a member of the state medical board or its executive secretary to grant a temporary permit to a physician or osteopath licensed in another state, territory, or province to substitute for another physician in the state. I am not sure how the temporary licensing and temporary permitting work together, but you might want to include a reference to this section in order to clarify whether a locum tenens is included as a licensed health care provider under AS 09.65.300.

If I may be of further assistance, please advise.

HVM:lem
14-009.lem

Enclosure

FREE DENTAL CARE

Alaska Mission of Mercy (AKMOM)



- Free dental care for up to 2,000 patients in just two days!
- Children and adults
- First come, first served
- No application process, no income limitations
- Patient information at www.akmom.org
- Like us on Facebook! www.facebook.com/AKMissionOfMercy

Friday - April 11, 2014

Saturday - April 12, 2014

Dena'ina Center

6 a.m. to 6 p.m.

600 W. 7th Ave., Anchorage

Bring your own snacks

Brought to you by the Alaska Dental Society



Anchorage Rotary



Alaska Dental Society



The main goal of the Alaska Mission of Mercy is to relieve pain and infection. It's unlikely that all of your dental needs will be met at this clinic. Your most immediate need will be addressed. Multiple procedures such as fillings AND extractions are not likely because we are trying to provide care to as many people as possible. You will receive a list of community dental resources where you can continue your dental care. Your patience and understanding is appreciated.

SERVICES AVAILABLE AT THE CLINIC

1. Cleanings
2. Fillings
3. Extractions (pulling teeth)
4. As time permits, flippers (like retainers with front teeth)
5. As time permits, denture and partial repairs
6. As time permits, root canals on front teeth

SERVICES *NOT* AVAILABLE AT THE CLINIC

1. Implants
2. Braces
3. Impacted wisdom tooth extractions (pulling of teeth not visible in the mouth)
4. Cosmetic porcelain veneers
5. Crowns (caps)
6. Bridges
7. Dentures
8. No narcotics will be dispensed



Alaska Dental Society, Inc.

9170 Jewel Lake Road, Suite 203
Anchorage, Alaska 99502-5390
(907) 563-3003 • FAX: 563-3009
akdental@alaska.net

HB269

Courtesy License Immunity Bill

- **Provides protection for Health Care Providers licensed in another state who do pro bono work in Alaska.**
- **AS 09.65.300 already provides protection for Alaska licensed health care practitioners delivering pro bono care.**
- **Clarifies 09.65.300 covers holders of a courtesy license have protection under 09.65.300.**
 - **Review of 09.65.300 by Attorney General's office indicated it would take a court case to definitively decide if courtesy licenses had protection.**
- **The Alaska Dental Society will be holding a Mission of Mercy event April 11 and 12th.**
 - **Mission of Mercy will deliver dental free care to as many people as we can accommodate over 2 days.**
 - **180 dentists are participating, 7 for outside Alaska**
 - **7 Military dentists from JBER have signed up to participate. Military dentists do not carry malpractice insurance and will be unable to participate without this protection.**
 - **South Central Foundation dentists would like to participate but, like military dentists, they do not carry malpractice and currently are unable to participate.**
- **Immunity under 09.65.300 is not absolute but provides protection for health care providers delivering care under standard of care guidelines.**

**Fairbanks Resource Agency
FY15 \$13.9 million Capital Fund Request
30 bed Senior Assisted Living Facility
2/3/14**

Fact Sheet

- 1) What is FRA's cost per bed? How does this compare to the Pioneer Homes' cost?**
Though the service delivery mirrors the quality Alaskans enjoy from the Pioneer Home model, FRA's annual cost per bed is approximately \$63,000, as compared to \$119,000 in the Pioneer Home system. This equates to \$1,680,000 per year in savings.
- 2) How will this project benefit the State?**
Fairbanks has the fastest growing senior population in the State. FRA's Assisted Living Home proposal creates a public/nonprofit partnership that will save the State millions in future operating dollars by investing one time capital funds. The FY14 State operating budget for the Pioneer Home system is \$60,799M. Through this model, the State will save in both operating and Medicaid funds (see #4, below).
- 3) What is the payback period for the State's investment?**
With annual savings of \$1,680,000, the payback period for the State's \$13.9M investment is about 8 years.
- 4) What are the savings to the Medicaid budget?**
The impact to the Medicaid budget is significantly less than would result from a Pioneer Home expansion as the daily reimbursement rate for non-State operators is nearly two thirds less than the combined subsidy and State rate (\$354.55/day State and \$124.81/day non-State). This equates to a **Medicaid** savings of \$83,856/bed/year. For this 30-bed project alone that equates to \$1,006,272 annual subsidy and Medicaid savings based on an estimated 40% of Medicaid-eligible residents. Extrapolated to the estimated 1,100 beds currently needed in Fairbanks, the State would save \$36M per year.
- 5) How does FRA know its operating budget is sound?**
In addition to working on this project for over two years, FRA has gone through two rigorous reviews of its operating budget. The first was a review by Chi Partners a leader in senior assisted living consulting. The second was a review by the Alaska Housing Finance Company (AHFC) in the course of FRA's application for AHFC senior housing funds. These reports are available upon request.
- 6) What is FRA's revenue source for operations?**
FRA's proposed payer mix in this proposal is 60% private pay and 40% Medicaid. We have been informed that this is a similar ratio to that experienced by the Fairbanks Pioneer Home.

7) What is the location of the proposed Home?

Approximately \$680,000 is included in this request for land acquisition. It is desirable for the Home to be situated in close proximity to FMH. Locations include property adjacent to Raven's Landing and the Fairbanks Pioneer Home's 80 acre parcel. The building footprint requires 1.75 acres of land.

8) How will FRA staff the facility? Is workforce shortage a problem?

Staffing is not seen as a problem. FRA intends to hire certificated personnel; Certificated Nurse Assistances and Personal Care Attendants. Approximately 100 individuals per year are currently being trained in the Fairbanks area. FRA is committed to instituting training certificated training programs if needed. Staffing is estimated to be 21 full time equivalents, including 17 direct service providers.

9) Does FRA have a competitive salary and benefit plan?

Yes, FRA currently employs approximately 400 personnel in the Fairbanks area. FRA provides its employees with a strong package of salaries and benefits including health care and retirement.

10) How was the size of the FRA Home determined? Why isn't it larger since the need is so great?

FRA is relieving the State of operational risk in this proposal. The Board felt strongly about a more cautious approach to ensure an operationally sound facility. The prototypical design can be easily adapted to other locations in the community or even the State. Questions of too small or too large should be answered. However, delay in the overall policy should not be an option.

11) What is the economic impact of the project for the Interior?

In addition to the 21 jobs directly added as a result of the project (see #8, above), using U.S. Bureau of Economic Analysis multipliers, FRA estimates 110 total jobs, and \$5.82M in economic value will be added to the economy as a result of the assisted living development.



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FOR IMMEDIATE RELEASE

Study: Telehealth Expands Access to Health Care

RAND reports Teladoc consultations less likely to require follow-up care than physician and emergency department visits

(DALLAS) Feb. 6, 2013 – Teladoc, the nation’s largest provider of telehealth services, has been shown to expand access to health care and provide cost savings, according to a study released by the RAND Corporation (RAND). With current physician shortages and misuse of the ER for non-emergent issues, the RAND findings show that Teladoc provides convenient access to high quality health care for patients.

According to the press release issued by RAND, “Interest has grown in telemedicine programs because of the shortage of primary care physicians, which will likely worsen as more Americans acquire medical coverage under the Affordable Care Act. Telemedicine is one of the alternatives touted as a way to better provide primary health care without greatly expanding the number of doctors. Patients who used the [Teladoc] service suffered from a wide assortment of acute medical problems such as respiratory illnesses and skin problems, and researchers found little evidence of misdiagnosis or treatment failure among those who used the service. RAND researchers say the finding suggests that health problems were most likely adequately addressed during the Teladoc visits.”

“The RAND study helps quantify the significant value Teladoc brings to the health care delivery system,” said Jason Gorevic, CEO of Teladoc. “Teladoc clearly improves access to care for consumers who are seeking convenient access to quality care, especially during hours when physicians’ offices are closed or the only option is an urgent care center or Emergency Room.”

The study, published in the February edition of the journal Health Affairs, found that more than one-third of visits occurred on weekends and holidays, and patients who used Teladoc were less likely to require follow-up consults, with only six percent doing so compared to 13 percent who visited an office and 20 percent who visited an emergency room. RAND also found telehealth to be a potential entry point to the health care system for people who have difficulty accessing their regular physician, including employees who are unable to take time off work to obtain care. The study points out the distinct advantages of the service because of the use of simple, widely available, inexpensive technologies.

“Teladoc is dedicated to innovation while providing the highest quality of care,” said Gorevic. “This contributes to the cost-savings our clients have seen. The fact that Teladoc patients

(more)

require significantly less follow-up care than those patients seen in the emergency department or a physician's office demonstrates that Teladoc's focus on quality and robust clinical programs are yielding benefits for consumers."

By managing its own provider network, Teladoc has built the first nationally independent physician network in telehealth. Teladoc's physicians are board-certified and state-licensed with an average of 15 years of practice. Teladoc's rigorous credentialing process, proprietary clinical guidelines and ongoing quality assurance efforts ensure the highest quality of care for Teladoc's members. Teladoc is the first and only telehealth provider to receive certification from the National Committee for Quality Assurance (NCQA) for its physician credentialing process.

Recognized as one of *Fast Company's Top 10 Most Innovative Companies in Health Care*; Teladoc leads the health care industry with the only fully integrated clinical, technology and member engagement solution for telehealth. Through Teladoc, patients have on demand access to physicians via phone, secure online video, mobile app or HealthSpot™ Station (a private, walk-in kiosk) to receive treatment for non-emergency medical issues including cold and flu, urinary tract infections, allergies, bronchitis, skin rashes and sinus problems.

To view the complete study, visit: <http://content.healthaffairs.org/content/33/2/258.abstract>

About Teladoc

Founded in 2002, Teladoc is the nation's first and largest provider of telehealth services with 7.5 million members and more than 200,000 consults annually. Teladoc provides 24/7 access to affordable, high-quality medical care for adults and children experiencing non-emergency medical issues via phone, secure online video, mobile app or HealthSpot™ Station – a private, walk-in kiosk. Through a directly-managed network of U.S.-based, board-certified physicians, Teladoc delivers a 95 percent patient satisfaction rate with an average response time of 16 minutes. Teladoc is the first and only telehealth provider to receive certification from the National Committee for Quality Assurance (NCQA) for its physician credentialing process, scoring 100 percent. Recognized by Fast Company as "One of World's Most Innovative Companies in Health Care" in 2013, Teladoc partners with health plans, corporations, organizations and patients that seek accessible and affordable high-quality medical care. For more information, please visit www.Teladoc.com.

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By Lori Uscher-Pines and Ateev Mehrotra

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Analysis Of Teladoc Use Seems To Indicate Expanded Access To Care For Patients Without Prior Connection To A Provider

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Ateev Mehrotra is an associate professor in the Department of Health Care Policy, Harvard Medical School, in Boston, Massachusetts, and a policy analyst at the RAND Corporation in Boston.

ABSTRACT Despite the potential benefits of telehealth applications, little is known about their overall impact on care. This is critical because rising health care costs and a shortage of primary care providers make it likely that telehealth services will play an increasingly important role in health care delivery. To help fill this gap in knowledge, we describe early experiences with Teladoc, one of the largest telemedicine providers in the United States, which provides care directly to patients over the telephone or via the Internet. We analyzed claims data for a large California agency serving public employees that recently offered Teladoc as a covered service. The 3,701 Teladoc “visits” we studied were for a broad range of diagnostic categories, the most common of which were acute respiratory conditions, urinary tract infections, and skin problems. Compared to patients who visited a physician’s office for a similar condition, adult Teladoc users were younger and less likely to have used health care before the introduction of Teladoc. Patients who used Teladoc were less likely to have a follow-up visit to any setting, compared to those patients who visited a physician’s office or emergency department. Teladoc appears to be expanding access to patients who are not connected to other providers. Future research should assess the impact of Teladoc and other telehealth interventions on the quality and cost of care.

Teladoc is one of the largest telehealth providers in the United States, offering patients with minor illnesses around-the-clock access to physicians via telephone or video consultations through the Internet. In 2013 alone Teladoc reported that its six million members nationwide had collectively requested more than 120,000 consults.^{1,2} Along with retail clinics, e-visits, and urgent care centers, Teladoc is one of the growing number of alternatives for acute care that focus on convenience and after-hours access.³

Health plans and employers have contracted with Teladoc primarily to improve access and decrease costs. As with other telehealth applica-

tions, there are several potential benefits and drawbacks to Teladoc.

Because Teladoc uses the telephone and Internet, it can provide medical care at a patient’s home or workplace. This could increase access in areas where there is a shortage of other providers. By replacing emergency department (ED) or primary care visits with a Teladoc visit, patients could save time, potentially improving productivity by taking less time away from work. In addition, Teladoc charges only \$38 per visit. Thus, using Teladoc to replace at least some office and ED visits could generate large savings for health plans.

However, the use of Teladoc could also lead to unintended consequences such as further frag-

mentation of care, and the impact of Teladoc on the quality of care is unclear. Teladoc physicians do not have access to information that is attainable during a face-to-face visit, such as the results of physical examinations or diagnostic testing. In telephone encounters, Teladoc physicians are unable to use visual cues to aid in diagnosis. Together, these limitations could lead to misdiagnosis and higher rates of follow-up visits—findings that have already been demonstrated with e-visits and telephone consultations.^{4,5} It is also unclear whether short delays associated with initiating and participating in a Teladoc consult instead of immediately seeking care in the ED could pose a safety risk for patients with emergent conditions.

Despite the potential benefits and drawbacks of Teladoc, little is known about the overall impact of the use of such telehealth services on care. This is critical because rising health care costs and a shortage of primary care providers make it likely that telehealth will play an important role in health care delivery.⁶

To fill this gap in knowledge, we describe the early experiences with Teladoc of enrollees at a large agency serving public employees across California. We explore the reasons patients sought Teladoc consults and compare the sociodemographic characteristics and care patterns of enrollees who used Teladoc with those of enrollees who used EDs and physicians' offices for similar conditions.

Study Data And Methods

SETTING In April 2012 the California Public Employees' Retirement System (CalPERS) first offered Teladoc as a covered benefit with no copayment to the approximately 300,000 members enrolled in its Blue Shield of California health maintenance organization plan.⁷ CalPERS members enrolled in Medicare Advantage or a Medicare supplemental plan were not offered Teladoc as a covered benefit. CalPERS sent informational materials to its enrollees that promoted Teladoc as an alternative to ED visits for nonurgent conditions.

This study describes CalPERS enrollees' experience with Teladoc in the first eleven months of the program, April 2012 through February 2013.

HOW TELADOC VISITS ARE PROVIDED To initiate a Teladoc visit, patients must first create an online account and enter information about their medical history. When they need care, they request a consult with a Teladoc physician via telephone or the Internet. Patients do not list their symptoms as part of the request, and there are no screening questions to assess the urgency of the complaint.

Teladoc physicians respond to requests twenty-four hours a day, seven days a week. The consulting physician does not have any established relationship with the patient; however, the patient will be matched to a physician licensed to practice in his or her state of residence. The physician receives the patient's request; reviews the patient's medical history; and contacts the patient, usually within twenty to twenty-five minutes after Teladoc receives the request. The visit then occurs over the phone or via video through the Internet. Almost all (98–99 percent) of Teladoc visits for CalPERS enrollees occur by telephone.

The physician diagnoses the patient's condition; discusses the diagnosis and treatment options; and, if indicated, sends a prescription to the patient's preferred pharmacy.

DATA SOURCE For this study, CalPERS supplied deidentified health plan claims data and enrollment information. We obtained the complete medical claims of 2,718 Teladoc users as well as the medical claims of a random sample of 72,191 nonusers of Teladoc from the 306,027 eligible enrollees with Teladoc coverage. We obtained data on all Teladoc users, both children and adults. However, we limited the comparison sample of nonusers of Teladoc to people ages eighteen and older who had been continuously enrolled in their health plan from April 2012 through February 2013 and who were not enrolled in Medicare Advantage or Medicare supplemental plans.

Data provided by CalPERS included enrollees' sex, age, ZIP code of residence, and complete information about health care use—such as site of care, date of service, and diagnoses—from January 2011 through February 2013. We used the data for the period January 2011 through December 2011 to assess enrollees' use of health care before they became eligible for Teladoc and to identify comorbidities.

STUDY VARIABLES The primary *International Classification of Diseases*, Ninth Revision (ICD-9), diagnosis code was available for all visits. In 99.5 percent of all Teladoc claims, only one diagnosis code was listed for each visit. To describe enrollees' use of Teladoc, we reviewed these codes and classified Teladoc visits into the following diagnostic categories: acute respiratory illnesses; urinary tract infections (UTI) and urinary symptoms; skin problems; general advice, counseling, and refills; eye problems; influenza and general viral illnesses; allergies; abdominal pain, vomiting, and diarrhea; vaginitis; back and joint problems; headache; ear infections (internal and external); mental health; vertigo or ringing in the ears; chronic illness; pregnancy-related problems; and other. Specific

codes are listed in the online Appendix.⁸

Acute respiratory illnesses, UTI and urinary symptoms, and skin problems were the three leading diagnostic categories for which adult patients sought Teladoc consults. We identified adult patients who sought care in EDs or physicians' office for these three diagnostic categories during the study period. An ED or office visit was included in our sample if a diagnosis classified as an acute respiratory illness, UTI or urinary symptom, or skin problem was one of the diagnosis codes on the record. Because the same patterns appeared across all three diagnostic categories, we present pooled data in this article.

We calculated the number of comorbid conditions using the Charlson Comorbidity Index.⁹ Because we had data from 2011, we captured comorbidities for a full year before Teladoc was offered as a covered service. To measure enrollees' use of health care before the introduction of Teladoc, we calculated the total number of visits for any reason to any health care provider in 2011. We also obtained data from the Census Bureau on the median income in each enrollee's ZIP code.

To assess the timing of visits, we classified visits as weekend or holiday versus weekday visits. Weekend or holiday visits were those that occurred on Saturday, Sunday, or a national holiday during the study period.

We used follow-up visits as a rough proxy for clinical resolution. We first identified "index visits"—that is, the first visit in a twenty-one-day period in which the enrollee sought care at any location (ED, physician's office, or Teladoc) for a diagnosis of acute respiratory illnesses, UTI and urinary symptoms, or skin problems.¹⁰ If the enrollee had a visit to any location in the twenty-one days following the index visit, we classified the subsequent visit as a follow-up visit. We examined follow-up visits both for a diagnosis in the same diagnostic category as the index visit and for any condition.

ANALYSES In our analyses, the health care visit was the unit of analysis. Therefore, a single enrollee could contribute more than one visit. The one exception is when we compared the characteristics of Teladoc users to those of users of other care settings; for this comparison the unit of analysis was the enrollee.

We first examined patterns of Teladoc use among children and adults. We then compared average monthly Teladoc visits to average monthly ED and office visits among adults (but not children) who sought care for the three leading conditions during the study period.

We compared baseline demographic, socioeconomic, comorbidity, and utilization variables across the three groups of adults in our sample—

Using Teladoc to replace at least some office and ED visits could generate large savings for health plans.

those who visited Teladoc, the ED, or physicians' offices—using chi-square tests and *t* tests. We also used multivariable logistic regression analysis to test for an independent relationship between the type of index visit (Teladoc versus office visit) and follow-up visit to any location within twenty-one days for a diagnosis in the same diagnostic category, adjusting for age, sex, and Charlson comorbidity score.

LIMITATIONS Our analyses have various limitations. First, we describe only the early experiences of CalPERS with Teladoc. Thus, we cannot generalize our findings to entities outside of California. Second, visit patterns might change as enrollees gain more experience with Teladoc.

Third, we limited our comparison to weekend or holiday versus weekday visits when examining whether Teladoc disproportionately served enrollees after hours. Because of data limitations, we probably underestimated the extent to which Teladoc provided after-hours care (for example, care provided at 9:00 p.m. on a Tuesday).

Fourth, we used follow-up visits as a rough proxy for clinical resolution. However, we had no independent contact with enrollees to assess clinical resolution.

Fifth, we adjusted for age and comorbidities in our analysis of follow-up visits. Nonetheless, we cannot rule out residual (incompletely controlled) confounding and thus the possibility that adult Teladoc users had fewer follow-up visits because they were younger and healthier than adult enrollees who received care in other settings.

Finally, we relied on diagnosis codes to categorize visits. It is possible that the codes we used were not always accurate.

Study Results

From April 2012 through February 2013, 2,718 adults and children who were CalPERS members

(0.9 percent of all eligible members) had a total of 3,701 Teladoc visits, with an average of 1.36 visits per Teladoc user. Monthly Teladoc visits remained relatively stable during the study period, although there was a significant dip in the number of visits during the summer months (Exhibit 1).

During the study period, 2,066 (76 percent) Teladoc users had a single visit, and 200 (7 percent) had three or more visits. Across our sample of 74,550 adult enrollees, including both users and nonusers of Teladoc, the average number of monthly visits for all conditions were 291 Teladoc visits, 39,431 office visits, and 883 ED visits. Thus, Teladoc visits accounted for a very small proportion of health care use.

Teladoc users sought care for 395 distinct diagnosis codes overall. The leading three categories of reasons for visits by children and adults were acute respiratory illnesses, UTI and urinary symptoms, and skin problems (Exhibit 2).

The top nine categories accounted for 80 percent of all Teladoc visits. The reasons for the remaining 20 percent of visits included allergies, mental health, vaginitis, vertigo, headache, chronic illness (such as asthma and hypertension), and chest pain. Excluding children from the analysis had no impact on the ordering of the leading nine conditions.

We compared the characteristics and follow-up patterns of adult enrollees who visited Teladoc, the ED, or a physician's office for the three leading diagnostic categories (Exhibit 3). Teladoc users were more likely to be younger than enrollees who visited physicians' offices for similar conditions. Teladoc users were more likely to have fewer chronic conditions and to not have used health care in 2011 compared to enrollees who visited the ED or physicians' offices for similar conditions.

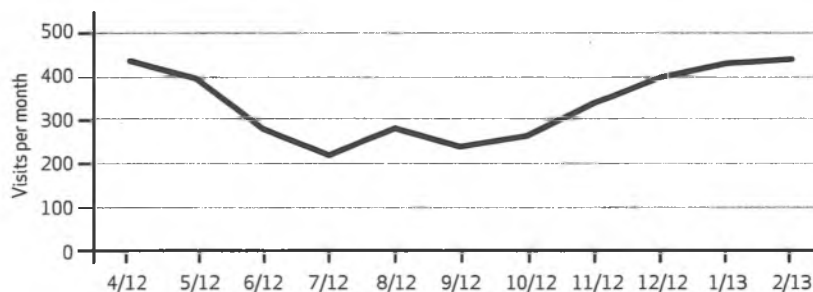
Women made up a slightly larger proportion of Teladoc users, compared to enrollees who visited the ED and physicians' offices (Exhibit 3). And Teladoc users lived in slightly more affluent communities than users of other settings.

We also explored utilization characteristics across the three care settings for the leading diagnostic categories (Exhibit 4). Thirty-four percent of Teladoc visits occurred on weekends and holidays, in contrast to 8 percent of office visits. The timing of Teladoc visits closely resembled the timing of ED visits.

Across the leading conditions, Teladoc visits were less likely than visits to the ED or physicians' offices to result in a follow-up visit for a similar condition in any setting (Exhibit 4). Six percent of Teladoc visits resulted in a follow-up visit for a similar condition, in contrast to 13 percent of office visits and 20 percent of ED visits.

EXHIBIT 1

Monthly Number Of Teladoc Visits Among 2,718 Children And Adults, April 2012-February 2013



SOURCE Authors' analysis of claims data from the California Public Employees' Retirement System.

The lower follow-up visit rate for Teladoc visits versus office visits was also seen after we adjusted for age, sex, and comorbidity score (odds ratio 0.44; $p < 0.01$).

Discussion

Our analysis found that in the first eleven months after Teladoc's introduction, a small number of CalPERs enrollees in California were using Teladoc for a diverse set of conditions. Adult Teladoc users were younger and healthier and lived in more affluent communities than enrollees who visited physicians' offices or the ED for similar conditions. Teladoc users were also less likely to have used health care before Teladoc's introduction.

And contrary to concerns expressed in the literature,^{4,5} the rate of follow-up visits was not higher for Teladoc visits than for visits to other care settings. In fact, enrollees who used Teladoc had fewer follow-up visits than enrollees who

EXHIBIT 2

Leading Reasons For Teladoc Visits By Children And Adults, April 2012-February 2013

Condition	Visits	
	Number	Percent
Acute respiratory illnesses	1,151	31.1
Urinary tract infections and urinary symptoms	439	11.9
Skin problems	335	9.1
Abdominal pain, vomiting, and diarrhea	231	6.2
Back and joint problems	190	5.1
Influenza and general viral illnesses	172	4.7
General advice, counseling, and refills	169	4.6
Eye problems	138	3.7
Ear infections (internal and external)	137	3.7
All others	739	20.0

SOURCE Authors' analysis of claims data from the California Public Employees' Retirement System.

NOTE Percentages do not sum to 100 because of rounding.

EXHIBIT 3

Characteristics Of Adult Enrollees With Teladoc, Office, And Emergency Department (ED) Visits, April 2012–February 2013

	Enrollees who visited for top three conditions					
	Teladoc (n=1,287)		Office (n=20,907)		ED (n=1,099)	
	Number	Percent	Number	Percent	Number	Percent
SEX						
Male	423	33	7,798	37	405	37
Female	864	67	13,109	63	694	63
AGE (YEARS)						
18–30	254	20	3,571	17	336	31
31–50	702	55	9,221	44	443	39
51 or more	331	25	8,115	39	330	30
COMORBIDITIES						
0	1,116	87	16,363	78	741	67
1	143	11	3,312	16	248	23
2 or more	28	2	1,232	6	110	10
MEDIAN ANNUAL INCOME IN ZIP CODE (2011 DOLLARS)						
Less than \$45,000	203	16	3,050	15	182	17
\$45,000–\$65,000	436	34	7,525	36	427	39
More than \$65,000	645	50	10,307	49	489	44
VISITS IN 2011						
0	271	21	1,543	7	116	11
1	93	7	1,307	6	68	6
2 or more	923	72	18,057	87	915	83

SOURCE Authors' analysis of claims data from the California Public Employees' Retirement System. **NOTES** The enrollee is the unit of analysis and is not counted more than once for any single location (Teladoc, office, or ED). The top three conditions are acute respiratory illnesses, urinary tract infections and urinary symptoms, and skin problems. Differences in each category are significant ($p < 0.01$).

visited EDs and primary care offices.

ACCESS Our results indicate that Teladoc might have increased access for the small subset of enrollees who used it, although this finding

requires further investigation. More than one-third of Teladoc visits occurred on weekends and holidays, and 21 percent of Teladoc visits were made by patients who had not used health care

EXHIBIT 4

Follow-Up Care And Timing Of Teladoc, Office, And Emergency Department (ED) Visits, April 2012–February 2013

	Visits for top three conditions					
	Teladoc (n=1,674)		Office (n=39,143)		ED (n=1,215)	
	Number	Percent	Number	Percent	Number	Percent
TIMING OF VISITS						
Weekdays	1,110	66	36,168	92	781	64
Weekends and holidays	564	34	2,975	8	434	36
FOLLOW-UP VISITS WITHIN 21 DAYS AFTER INITIAL VISIT (UNADJUSTED)						
For similar condition	100	6	5,089	13	243	20
For any reason	151	9	18,006	46	631	52
	Odds ratio	95% CI	Odds ratio	95% CI	Odds ratio	95% CI
FOLLOW-UP VISITS WITHIN 21 DAYS AFTER INITIAL VISIT (ADJUSTED)*						
For similar condition	0.44	0.36, 0.55	Ref	Ref	1.72	1.47, 2.01
For any reason	0.12	0.10, 0.14	Ref	Ref	1.30	1.15, 1.48

SOURCE Authors' analysis of claims data from the California Public Employees' Retirement System. **NOTES** CI is confidence interval. Ref is reference. Differences in each category are significant ($p < 0.01$). *Adjusted for age, sex, and Charlson comorbidity score.

Teladoc has distinct advantages because it uses simple, inexpensive technologies that are widely accessible.

in 2011.

Teladoc might have been the entry point into the health care system for people who did not have frequent contact with a primary care provider or had difficulty accessing their regular physician. It might also have served people who could not take time off work to obtain health care.

Increasing access and convenience is important for all patients. However, the population of patients attracted to Teladoc—a more affluent and likely more technologically savvy group—might have fewer access needs than people living in areas characterized by a shortage of primary care or socioeconomic disadvantage. Further research is needed to understand whether Teladoc might be improving access for patients with lower incomes and those in rural areas and, if not, whether it could be positioned to do so in the future.

COST Our analysis did not explore the issue of cost. However, on a per visit basis, it is highly likely that Teladoc visits (which cost \$38 a visit and had very low follow-up rates) are less expensive for payers, compared to visits to physicians' offices and the ED. However, it is unclear to what extent Teladoc visits are substituting for office or ED visits and to what extent they represent new use of health care for conditions that would have resolved themselves without intervention. If Teladoc visits do represent new use, they could lead to increased utilization and costs.

QUALITY Our findings provide some insights regarding the quality of care. First, it is reassuring that Teladoc patients were less likely than enrollees who used other care settings to have follow-up visits to any setting for a similar condition. If we consider follow-up to be a rough proxy for clinical resolution, there is very little evidence of misdiagnosis or treatment failure in Teladoc visits.

This could mean that Teladoc providers are successfully diagnosing and treating a wide

range of illnesses via telephone consultations. However, it is also possible that Teladoc patients are seeking care for complaints that are so minor that follow-up visits are not necessary. Alternatively, the severity of illness might be comparable across care settings, but the threshold for Teladoc patients to seek follow-up care in a face-to-face encounter might be higher.

We found that Teladoc served patients with surprisingly diverse diagnoses. In contrast to retail clinics that have a very limited menu of services, Teladoc does not restrict its care to selected conditions. At retail clinics the top three categories of diagnoses represent 72 percent of their business.¹¹ In contrast, the top three categories of diagnoses represent 52 percent of Teladoc's business (Exhibit 2).

PROS AND CONS There are both potential advantages of and concerns about the Teladoc approach. By serving a broader group of patients with differing needs, Teladoc can play a larger number of roles than retail clinics can. In addition to treating nonurgent acute conditions, Teladoc might serve the roles of triage and education. As such, it could have a much larger impact on the health care system as a whole than retail clinics do.

In contrast to other forms of telemedicine that require specialized equipment, Teladoc has distinct advantages because it uses simple, inexpensive technologies that are widely accessible. Ease of use clearly facilitates the expansion of Teladoc to new groups of patients.

However, because Teladoc's scope of practice is broader, people may present with symptoms that cannot be managed effectively over the telephone. For example, it is unclear to what extent skin problems can or should be treated without the use of photos or videos, or whether strep throat can be diagnosed without a physical exam.¹²

Our results indicate that Teladoc providers saw patients with many diagnoses that typically require a physical exam, diagnostic testing, or both. Without the use of additional technology, Teladoc will continue to be limited in its ability to support the diagnosis and management of many conditions. Additional research is needed to address questions about the quality of care, such as rates of antibiotic prescribing across settings, the management of conditions that require physical exams or diagnostic testing, and the use of Teladoc by patients with potentially emergent conditions.

Conclusion

Additional work is needed to fully explore the impact of Teladoc on access, quality, and costs.

However, our research suggests that Teladoc is offering a useful and potentially cost-effective service.

Because alternatives to the ED and physicians'

offices for acute care, such as Teladoc, are growing rapidly, a clear understanding of early experiences with Teladoc can help predict the likely impact of these alternatives. ■

The research reported here was supported by a grant from the California HealthCare Foundation.

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LEGAL SERVICES

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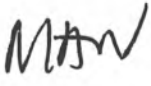
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MEMORANDUM

February 13, 2014

SUBJECT: Immunity for dentists issued temporary licenses
(CSHB 269()); Work Order No. 28-LS1251\U)

TO: Representative Steve Thompson
Attn: Jane Pierson

FROM: Megan A. Wallace 
Legislative Counsel

You have asked for an opinion as to whether a dentist issued a temporary license would have immunity under AS 09.65.300(a) under the current draft legislation.

CSHB 269() explicitly extends the immunity granted in AS 09.65.300(a) to "a health care provider who holds a temporary license . . . under AS 08.01.062." Further, CSHB 269() includes "dentist" in the definition of "health care provider," without regard to whether the dentist is licensed in-state, out-of-state, or under a temporary license.

In its current form, AS 09.65.300(a) reads:

- (a) Except as otherwise provided in this section, a health care provider who provides health care services to another person is not liable for civil damages resulting from an act or omission in providing the health care services if the health care
- (1) provider is licensed in this state to provide health care services;
 - (2) services provided were within the scope of the health care provider's license;
 - (3) services were provided at a medical clinic, medical facility, nonprofit facility, temporary emergency site, or other facility owned or operated by a governmental entity or nonprofit organization and the health care provider was acting within the scope of the provider's responsibilities in the medical clinic, governmental entity, or nonprofit organization;
 - (4) services were provided voluntarily and without pay to the health care provider for the services, except as provided in (b)(2) and (3) of this section; and

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(5) provider

(A) obtains informed consent from the person receiving the health care services as described under AS 09.55.556, except in the case of an emergency; and

(B) provides the person receiving the health care services advance written notice of the immunity provided under this section to a health care provider when providing voluntary health care services as described under this section.

In my opinion, a dentist issued a temporary license would clearly meet the criteria of (a)(1) under CSHB 269(). Therefore, so long as the dentist met the criteria articulated in (a)(2) - (5), the dentist would qualify for immunity under AS 09.65.300(a).¹

Please let me know if you have any other questions.

MAW:lnd
14-056.lnd

¹ Please also see our memorandum on this issue dated January 13, 2014 from Hilary Martin that reaches a similar conclusion.

Julie Morris

From: Timothy M. Lynch <tlynch@northlaw.com>
Sent: Thursday, February 13, 2014 12:59 PM
To: Julie Morris
Subject: Comment on House Bill No. 269

Good afternoon, Rep. Higgins:

Thank you for the opportunity to comment on this proposed legislation.

The concept of expanding the availability of health care services for Alaskans who are uninsured and cannot afford high cost medical care is a very good one. However, this bill, as drafted, raises, in my opinion, serious concerns.

First, how would the “temporary courtesy provider” license envisioned in (a)(1) square with the requirements for a “temporary permit” under AS 08.64.270. In the proposed change to AS 09.65.300(c)(1) the bill removes the requirement for state licensing. Does this mean that someone other than the State Medical Board would have authority to license physicians under this approach? This would seem to create a very ambiguous situation with regard to licensing. And, at the very least, removing the state licensing requirement may prompt a conflict with the State Medical Board and the Alaska Medical Association.

Second, after our telephone conversation I had an opportunity to review in detail AS 09.65.300. I had not done so in some years. Frankly, the limitations that exist are specific and fairly easy to both understand and to apply. I am not certain that the amendment being proposed, particularly the one discussed above will increase the availability of quality health care for Alaskans beyond what is available under the current statute.

I emphasize the word “quality.” State licensing acts as an important gatekeeper on the flow of individuals who would come to Alaska to provide health care to our citizens. I would hesitate to open up an important segment of our population to the risk of less than qualified health care providers who operate without fear of personal professional liability under the protection of a “pro bono” program.

I hope that this will provide you with helpful information for your deliberations.

Tim Lynch

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