Approved: March 10, 2009
Date

MINUTES OF THE HOUSE VISION 2020 COMMITTEE

The meeting was called to order by Chairman Tom Sloan at 1:30 p.m. on February 2, 2009, in Room 711 of the Docking State Office Building.

All members were present.

Committee staff present:
Art Griggs, Office of the Revisor of Statutes
Scott Wells, Office of the Revisor of Statutes
Corey Carnahan, Kansas Legislative Research Department
Chris Courtwright, Kansas Legislative Research Department
Mary Koles, Committee Assistant

Conferees appearing before the committee:
Ryan Spaulding, PhD, KU Medical Center
Marlon Dauner, Preferred Health Insurance Systems
Janell Moerer, Via Christi Health System
Mark Gagnon, Via Christi Health System
Chad Austin, Kansas Hospital Association
Kevin Sanderson, Goodland Regional Medical Center
Tim Vanzandt, Saint Luke's Health System
Dale White, Horton Community Hospital

Others attending:
See attached list.

Chairman Sloan welcomed the conferees and introduced each as they spoke.

Ryan Spaulding, PhD, Director, Telemedicine and Telehealth, KU Medical Center, Kansas City, narrated a PowerPoint presentation. He briefly compared the equipment of the 1990's with that available today and focused on the current priorities of the KU Medical Center and those established in 2008 by the American Telemedicine Association (Attachment 1).

Marlon Dauner, President and CEO of Preferred Health Insurance Systems, Wichita, discussed IT initiatives for health insurance coverage and the potential for telemedicine to be cost effective and provide access to better care (Attachment 2).

Janell Moerer, Via Christi Health System, Wichita, spoke briefly about the Via Christi Health System and introduced Mark Gagnon, Director of ePharmacy, Via Christi Health System. Mr. Gagnon discussed tele-pharmacy and noted the current need in Kansas and projected need nationally for pharmacists (Attachment 3). He reported that work is underway to provide regulations for e-pharmacy in Kansas.

Chad Austin, Vice President, Government Relations, Kansas Hospital Association, testified about current and future benefits of telemedicine (Attachment 4).

Kevin Sanderson, IT Director, Goodland Regional Medical Center, Goodland, described GRMC's four year involvement with telemedicine: initially a telemedicine clinic in Child Psychiatry, most recently the addition of cancer consultation telemedicine. Teleradiology capabilities are in place and telepharmacy services are in active discussion (Attachment 5).

Tim Vanzandt, Director of Public Affairs, Saint Luke's Health System, Kansas City, MO, presented a series of PowerPoint slides portraying telehealth today and driving market forces. He mentioned several measures Kansas could implement to move ahead quickly in the telehealth field (Attachment 6).

Dale White, CEO, Horton Community Hospital, Horton, discussed the benefits that more than a decade of experience with telemedicine has brought to NE Kansas and noted both concerns and opportunities for the future. Telemedicine ER/primary care and home services/monitoring could be offered soon or even now. Barriers to address in order to provide telemedicine services to all rural providers are connectivity, equipment,

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

supply and demand (Attachment 7).

Following the presentations, Chairman Sloan opened the meeting for questions from the committee. Questions were asked by Chairman Sloan and representatives Bill Feuerborn, Tom Hawk, and Kay Wolf.

Responses were given by the appropriate conferees. Several brief discussions occurred.

Chairman Sloan thanked the conferees for their presentations.

The next meeting is scheduled for February 4, 2009.

The meeting was adjourned at 3:15 p.m.

House Vision 2020 Committee Guest List

Date: Monday, February 2, 2009

Name	Representing Client/Authority
Joe Mosimann	Hein Law Firm
David Rowe	KU Med Center
Colin Thomasset	ACMHCK
Berend Koops	Hein Law Firm
Lisa Paxton	Goodland Regional Medical Center
KEVIN W. SANDERSON	" " " "
Tina Goodwin	" " " "
Mark Gagnon	Via Christi Health System
Janell Moerer	Via Christi Health System
Carolyn Smith	VCHS
Margaret Smith	KHPA
Barb Conant	KDOA
Chad Austin	KHA
Chris Hollenbeck	Kansas Ins Dept.
Jessica Schultz	Intern - Tom Hawk
RYAN SPALDING	KU MEDICAL CENTER
Cyndi Smith	SCC Health System
Marla Carpenter	KAHP
Kyle Kessler	KRC

Telemedicine

Vision 2020 Committee
February 2, 2009

Ryan J. Spaulding, PhD
Director
Center for Telemedicine & Telehealth
Kansas University Medical Center

KU MEDICAL CENTER

Focus on "traditional" telemedicine

- Provider-patient consultation
- Interactive videoconferencing technology
- Primarily for rural, underserved areas but some urban projects also exist
- Practiced in Kansas by KU Medical Center since 1991
- Traditional model emphasized by American Telemedicine Association (ATA) since 1993

KU MEDICAL CENTER

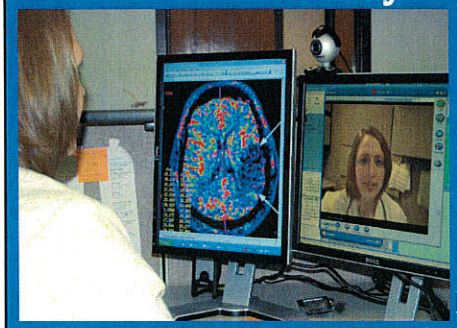
Telemedicine in the 1990s

Telemedicine in the 1990s

- Very few telemedicine programs
- Expensive, bulky equipment
- Expensive telephone lines
- Minimal insurance reimbursement (In Kansas, Medicare and Blue Cross/Blue Shield)
- Limited research

KU MEDICAL CENTER

Telemedicine Today



KU MEDICAL CENTER

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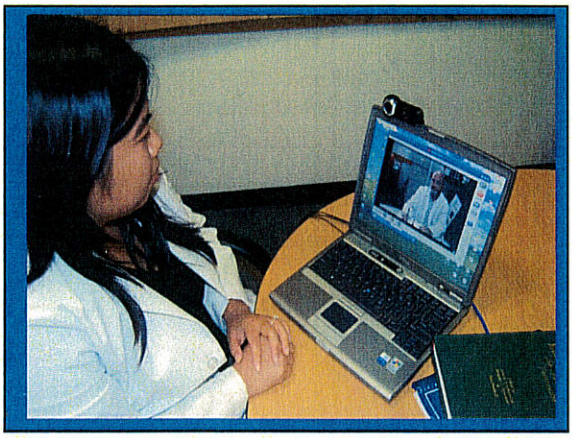
Attachment 1-1

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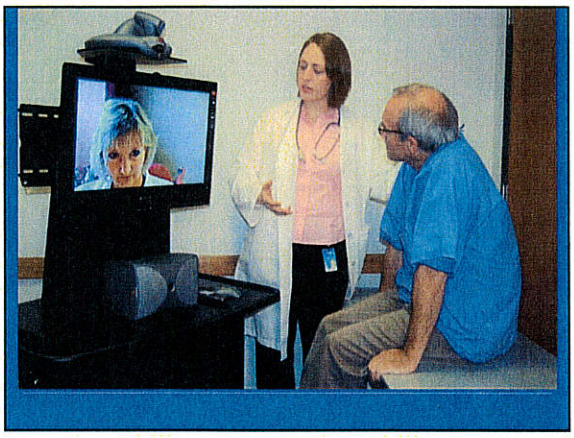
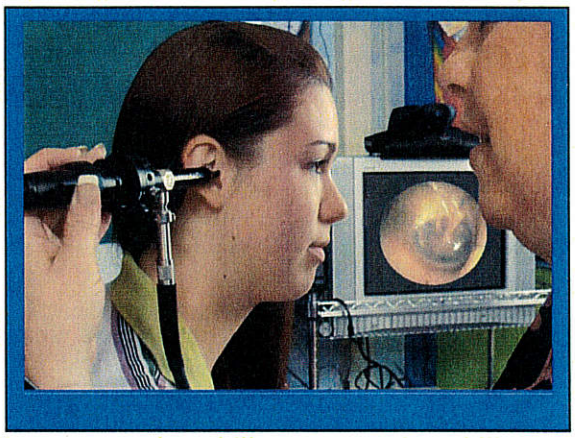
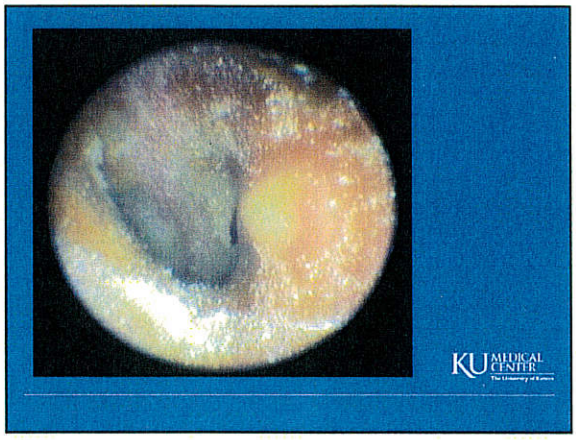
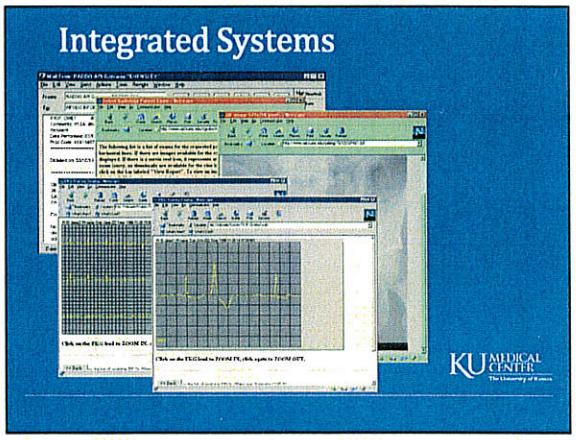





KU MEDICAL CENTER


Integrated Systems
KU MEDICAL CENTER

Telemedicine Today

- Smaller, less expensive equipment
- High quality, high definition (HD) technology
- Less expensive internet connectivity
- Mobile, wireless capability
- Improved insurance reimbursement
- More extensive research
- Specialty care to complement local primary care

KU MEDICAL CENTER

Specialties Provided

- Adult/pediatric cardiology
- Adult/pediatric mental health
- Endocrinology
- Oncology
- Pediatrics
- Rheumatology
- Other medical and non-medical specialties

KU MEDICAL CENTER

American Telemedicine Association 2008 Federal Priorities

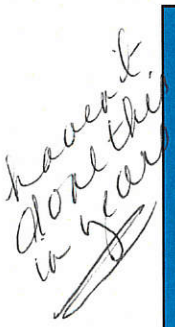
1) Increase Medicare reimbursement for telemedicine
2) Reauthorize the Telecommunications Reform Act
3) Promote Health Information Technology programs and their coordination with telemedicine
4) Resolve legal barriers to telemedicine
5) Institutionalize the use of telemedicine for emergency preparedness and response
6) Support federal programs and initiatives that advance the deployment of telemedicine technology and services

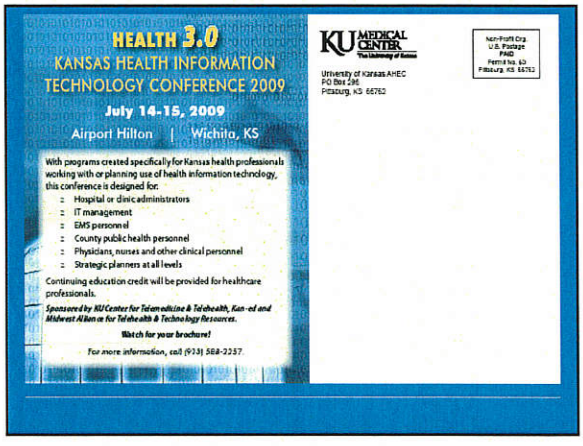
KU MEDICAL CENTER

KU Center for Telemedicine & Telehealth Priorities

- Continued reduction in telemedicine costs
- Refinement of clinical and operations workflow
- Ongoing collaboration with Kan-ed to advance telemedicine infrastructure
- Expansion of current model
- New technologies
- Innovative research

KU MEDICAL CENTER





Testimony

House Committee – Vision 2020 Telemedicine

February 2, 2009

Marlon R. Dauner

Mr. Chairman and Committee Members, my name is Marlon Dauner and I am President and CEO of Preferred Health Systems (PHS). PHS is the largest health insurer in the south central part of the state and the second largest insurer in the state. PHS is headquartered in Wichita. Our primary goal at PHS is provide access to and financing for quality health care services for our employer groups in a manner that is highly customer (member) centric. To that end, we see the electronic tools as a valuable asset for our members and the providers of care. Many questions have been raised about coverage by insurance companies for "telemedicine" services.

It is critical to understand that telemedicine is not a service per se. Telemedicine is a tool or a vehicle for providing services that are rendered today such as a Consultation or an Office Visit. The coding and nomenclature system (Current Procedural Terminology, CPT) used by physicians already identifies codes to bill these services. However, the use of the telemedicine tool does change the format in which these services would be billed to an insurer.

The current coding system permits services to be billed in one of two ways. Radiology is a great example of the optional billing methods. If a physician has an x-ray machine in his office, takes a film of a patient's tibia, and interprets the film, the physician would bill for the ***total*** service using the appropriate code in the CPT book. If the physician sends the patient to the hospital outpatient department for the x-ray and then interprets the film, the physician would bill for the ***professional component, PC*** (interpretation) only and the hospital would bill for the ***technical component, TC*** (equipment). This convention of billing would use the same CPT code for the service, but would have a "modifier" to show that the billing was for the professional component only. The insurer has payment allowances for services when billed as the total service, the professional component only, and the technical component only. Usually, the sum of the allowances for the components equals the allowance for the total service. The typical split between the PC and TC ranges from 60%-40% to 90%-10%, depending on the cost of the equipment.

This coding and billing convention lends itself well to paying for services provided using the telemedicine tools. An office visit or consultation today is usually billed as a total service that includes both the physician's time and the cost of the office. These services can be broken up by the PC/TC and billed independently to cover the physician's time and the cost of the telemedicine tools. The insurance system has the capability and, for the most part, desires to assist in this endeavor where the services can safely and effectively be performed using the telemedicine tool.

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Attachment 2-1

Mark Gagnon

September 8, 2008

Via Christi Health System

VCHS ePharmacy Executive Summary & Overview

Background

Kansas, like many other states in the country, is facing a severe shortage of pharmacists. According to the Pharmacy Manpower Project, by 2020, the national supply of pharmacists is likely to fall short of demand by 157,000. The Kansas Independent Pharmacy Service Corporation reports that currently 6 Kansas counties have no pharmacist and 31 more counties have only one pharmacist. The shortage in Kansas is expected to worsen dramatically in the future for both retail and hospital pharmacists. VCHS made the decision to develop ePharmacy as a way to leverage existing pharmacy expertise across Kansas in an effort to alleviate pains of the shortage already being felt and thereby improve patient safety.

Overview

VCHS defines ePharmacy as the provision of pharmacy services and support through: 1) remote order entry (ROE); 2) two-way video and/or 3) a combination of the two (telepharmacy). ROE is the immediate review of scanned or faxed medication orders and patient records to verify order accuracy and authorize the order to be dispensed by the hospital pharmacy system. Telepharmacy includes ROE plus the ability to supervise technical personnel, verify order accuracy and oversee dispensing of the drug. Presently, ROE is the more widely used model due to receptivity by State Pharmacy Boards, including the KS State Board of Pharmacy.

VCHS has conducted extensive research and review of best practice ePharmacy models. Individuals from the organizations listed below have become thought leaders to VCHS ePharmacy development:

1. North Dakota Telepharmacy Network *(North Dakota)* – A collaboration between the University of North Dakota, the North Dakota Pharmacy Board, and the coalition of retail pharmacists.
2. Sisters of St. Francis Health System Central Remote Order Entry (CROE) Program *(Indiana)* – Health system based ROE network supporting 7 of 10 system hospitals with operations that cross state lines.
3. Marshfield Clinic Telehealth Network *(Marshfield, Wisconsin)* – Serves a large region in WI with true telepharmacy support in physician offices, health clinics and a hospital.

VCHS Business Model

The goal is to develop and implement a financially sustainable ePharmacy network in collaboration with the ePharmacy Steering Committee which is comprised of Pharmacy Directors from Wichita Health Network, Mt. Carmel Regional Medical Center, Mercy Regional Health Center, Salina Regional Health Center and Preferred Health Systems. The acquisition of a small remote order entry pharmacy business, Frontier Pharmacy, is expected to provide much of the groundwork and accelerate model development by at least one year. The pro forma, given the new market rates, is currently being revised.

The development will occur in multiple phases. Phase I includes implementation of a ROE network that connects VCHS Ministries with Remote Hospital Pharmacists that provide ROE support from Remote Home Offices throughout Kansas. Phase I will launch December 15, 2008, within Via Christi Regional Medical Center (VCRMC) in Wichita which includes the tertiary/quaternary center, community hospital and specialty hospitals. Mercy Regional Health Center in Manhattan, Kansas, is scheduled to go-live in February 2009 and Mt. Carmel Regional Medical Center in Pittsburg, Kansas, has a planned go-live date during September 2009.

After the initial launch, VCHS plans to incorporate two-way video and high resolution cameras to enhance communication and prepare the learning curve for the future telepharmacy development. Pending Kansas Pharmacy Board approval, VCHS telepharmacy services will be developed in concert with the Kansas Board of Pharmacy, who does not currently recognize telepharmacy services but has approved ROE. This development is expected to go-live in September 2009.

An ePharmacy staffing pool will be created using outside "moonlighting" pharmacists so the service is able to support existing hospital pharmacists. The ePharmacists will operate from Remote Home Offices with

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Attachment 3-1

computers and equipment provided by VCHS. Phase II is projected to begin 2009 with a focus on an outreach plan with rural communities and hospitals that have limited access to pharmacists.

Strategic Considerations

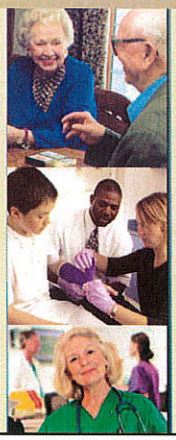
This supports the OneIndeed strategy for transformation in a core operating area.

The benefits from the creation of an ePharmacy network have been identified as follows:

1. Improve patient safety.
2. Improve patient medication safety.
3. Improved clinical coordination of drug therapy.
4. Improved formulary compliance.
5. Increased access to pharmacy services in rural Kansas.
6. Improved staff satisfaction & retention.
7. Creation of a new delivery model that can be applied to transforming services at West Wichita Hospital and the next generation healthcare facility.
8. Develop model for access to Pharmacist for At Home services and physician offices.

VCHS ePharmacy Overview

January 30, 2009



Via Christi Health System

Via Christi Health System

Background

- **National Shortage**
  - It is projected by 2020 that the supply of pharmacists will fall short by 157,000 (Pharmacy Manpower Project)
- **Kansas**
  - 59 counties designated as medically underserved areas
  - 31 counties have 1 pharmacist/pharmacy
  - 6 counties have 0 pharmacist/pharmacy
- **Even Wichita needs more pharmacists**

Goal of VCHS ePharmacy

To **increase access** to a hospital pharmacist in order to **improve patient safety** through enabling technology.

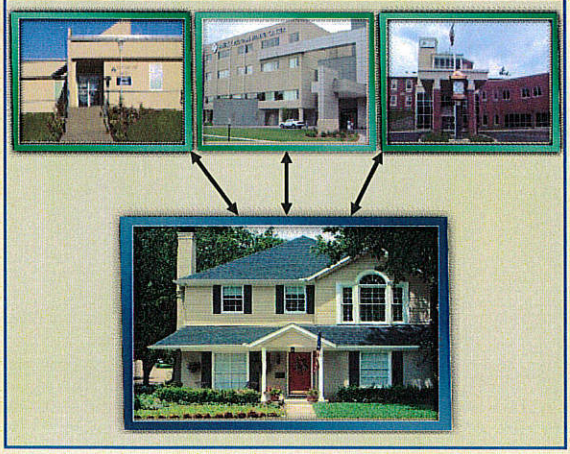
Why ePharmacy at VCHS?

- Improve patient outcomes
- Improve efficient use of hospital pharmacists in light of shortages
- Alleviate pharmacy vacancies
- Create a service to support pharmacy needs in rural hospitals & communities

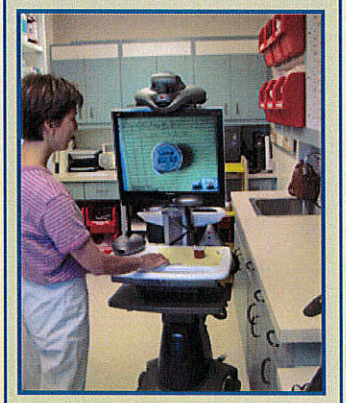
VCHS ePharmacy Model

Two Components Transforming Pharmacy Service

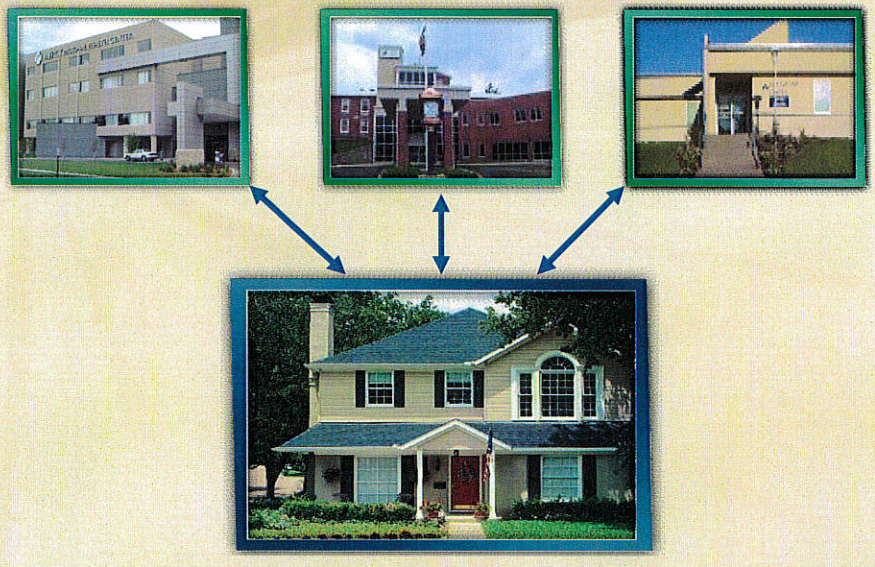
Remote Order Entry



Telepharmacy

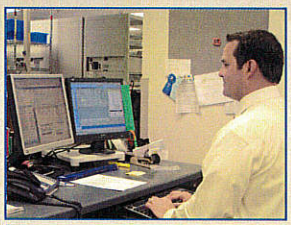


Component 1: Remote Order Entry



Remote Order Entry: How It Works

Medication orders are sent to the main pharmacy via scanning technology.



Pharmacist reviews scanned medication orders.

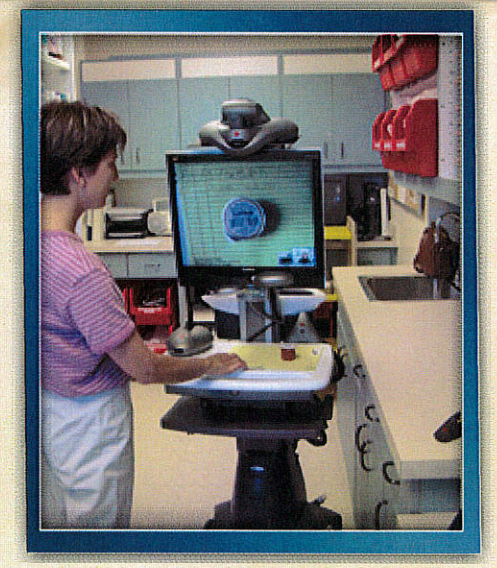
- Dosing
- Allergies
- Interactions
- Disease State
- Duplication

Medication is dispensed by automatic dispensing machine.

ePharmacy ROE Research Study: Validate Value with Data

- **Goal of Study:**
  - To develop useful benchmarks and measures while validating the value ePharmacy ROE brings to the participating hospital operating units
- **VCRMC and MRHC have received Internal Review Board (IRB) approval to participate**
- **Pre & post implementation data will be collected**
- **Study Impact:**
  - Staffing & Workload (RN/RPh satisfaction surveys)
  - Clinical Quality & Patient Safety (Data Collection)
  - Cost & Cost Savings/Cost Avoidance (Financial Analysis)

Component 2: Telepharmacy



Telepharmacy: How It Works

Pharmacist will……

Perform a complete medication profile review.

Perform final check of the medication order prepared by the technician.

Provide final approval & releases the medication for dispensing to the patient care area.

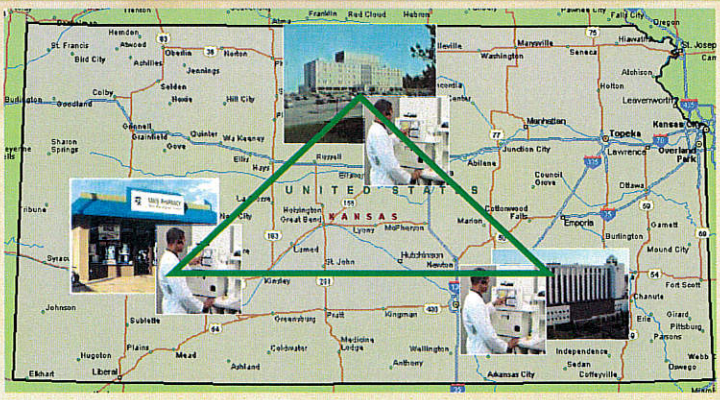
Provide professional consultations to patients, nurses & physicians upon request.

*Supervision covers both pharmacy technicians and designated nurses based on hours of operation.

KS Telepharmacy Task Force

- **Kansas State Board of Pharmacy: Task Force**
  - Create regulations to permit telepharmacy
  - Separate Hospital & Retail Task Forces
- **VCHS Representation on Hospital Task Force**
  - VCHS Director of ePharmacy
  - Mercy Director of Pharmacy
  - VCHS Legal
- **Status Update**
  - Submitted VCHS proposed TeleRX regulations Expect Regulatory approval by Summer '09

Future Development
Local Pharmacy Collaboration



Telepharmacy may improve medication coordination with discharge and first dose needs from hospital to home and community.

KANSAS HOSPITAL ASSOCIATION

Thomas L. Bell
President

February 2, 2009

TO: House Vision 2020 Committee

FROM: Chad Austin
Vice President, Government Relations

SUBJECT: Current and Future Benefits of Telemedicine

The Kansas Hospital Association appreciates the opportunity to provide comments concerning the current and future possibilities of utilizing telemedicine as a tool in the delivery of health care services to Kansans. The integration of telemedicine begins to close the geographic barrier facing our rural and underserved areas to accessible and quality medical care.

Broadly defined, telemedicine is the transfer of electronic medical data from one location to another. This transfer of information using modern technology may be accomplished in several ways, including utilizing those services provided through Kan-ed. The Kan-ed network has allowed many Kansas community hospitals to connect with other locations to provide telemedicine services. At present, more than forty Kansas community hospitals are participating in the Kan-ed network.

Providing health care services via telemedicine also offers many advantages. No longer is it necessary for a physician to only treat a patient in person; nor is it needed for a rural resident to drive across the state in order to access specialty health care. Telemedicine also opens up additional possibilities for the management of chronic conditions and the education or training for rural health practitioners. The benefits also extend beyond the patient and provider. Kansas communities benefit because it keeps health care dollars within the local economy and may serve as a valuable recruitment and retention tool for businesses. It also serves as a benefit for employers since employees may have less "loss work" time since health care services may be delivered locally. In addition, insurance carriers may realize benefits of telemedicine through the early detection of illnesses for beneficiaries as well as a marketing advantage over those insurance carriers that do not offer the benefit.

The future of telemedicine's role in the health care delivery system is tremendous, especially in a rural state like Kansas. It is essential that we keep our rural communities viable and healthy. Telemedicine services contribute significantly to doing just that.

I would be happy to answer any questions.

House Vision 2020
2-2-2009
Attachment 4

Goodland Regional Medical Center

220 W. 2nd
Goodland, Kansas 67735-1602
(785) 890-3625

February 2, 2009

TO: House Vision 2020 Committee

FROM: Jay P. Jolly, FACHE
Chief Executive Officer

RE: A Community Hospital's Perspective on Telemedicine

Goodland Regional Medical Center is a 25 bed Critical Access Hospital in northwest Kansas owned by Sherman County and organized under K.S.A. 19-4601 et seq. The Medical Center participates in several networks affecting the delivery of healthcare services, including its critical access tertiary sponsorship by St. Anthony Central Hospital in Denver, Colorado; participation in Med-Op, a consortium of rural hospitals sponsored by Hays Medical Center in the VHA network; and charter membership in the Midwest Cancer Alliance, a network of community partners and providers serving as the outreach arm of the University of Kansas Cancer Center. Goodland Regional Medical Center is also a long time member of the Kansas Hospital Association.

GRMC's involvement with telemedicine began almost four years ago with a recognition that this approach to patient care delivery could significantly improve the availability of specialty physicians and other providers in communities that either cannot afford to recruit or support full time practitioners, or are unable to find coverage in specialties experiencing severe shortages. Conversely, these same specialists in short supply can greatly increase their productivity by using telemedicine to reach out to a broader range of communities in less time, while eliminating travel time, expense, and hassles for both the physician and the patient. After a period of educating ourselves as an institution on the basics of providing telemedicine services, and with considerable assistance from KU Medical Center and Hays Medical Center, GRMC offered their first telemedicine clinic in February, 2007 in the area of Child Psychiatry. Child Psychiatry was chosen in part because it was technically simple to set up; more importantly, it was the first request of the local family physicians who had no consistent referral option for children in need of psychiatric consultations. The KU psychiatrist and psychologists involved continue to provide weekly telemedicine consultations to this day and the clinic has provided 333 telemedicine consults to 51 patients from five counties in northwest Kansas to date.

The use of telemedicine for cancer consultations began in June, 2008 in partnership with the Midwest Cancer Alliance. Dr. Gary Doolittle, who provides similar cancer outreach services to several other Kansas communities, comes to Goodland once each month for an onsite clinic day and conducts a telemedicine clinic in each of the weeks between onsite visits. The onsite clinics allow for staff education, interaction with local physicians, and the opportunity to meet new cancer patients in person at their first visit to establish a relationship that will enhance the follow up telemedicine clinics. In the first six months of operation the new cancer outreach clinic treated 48 patients which involved 66 onsite consults and 91 telemedicine consults. In Fall, 2008 GRMC partnered with KU to become the first two hospitals in the state to offer high definition video telemedicine services, greatly enhancing the visual component of the service.

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Attachment 5-1

Goodland Regional Medical Center
220 W. 2nd
Goodland, Kansas 67735-1602
(785) 890-3625

Patient acceptance to the telemedicine physician "office visit" has been positive. Comments include: *"This technology is wonderful!"* ; and *"I'm so glad this service is available, I wouldn't be able to drive to Kansas City to see the Dr."* ; or *"I'm so glad I don't have to travel out of town!"* Kids are even more enthusiastic with their reaction: *"This is cool!"* ; *"I'm on TV!"* ; and *"I like talking to the Dr. this way."* Technical issues that had to be addressed included everything from connection speeds and balancing bandwidth demands from competing internal users to making sure the Polycom camera units were placed and adjusted properly to facilitate the perception of eye contact between individuals at either end of the connection. There are also various peripheral devices available for specific needs and staff need to be trained on these items as well, such as electronic stethoscopes. Once staff were fully trained and adjusted to this new approach to physician consults, however, the service rapidly became integrated into the range of routine outpatient services offered in the clinic setting. As a result, requests for additional services using telemedicine as a vehicle are increasing.

We believe this is a natural outgrowth of the advantages this approach to primary care provides. For the patient the benefits of local availability include less travel and the associated expenses of fuel, meals, lost work time, and sometimes overnight lodging. For the elderly and those with physical impairments, getting to another care setting may mean imposing on a friend or family member, or going without needed care.

Telemedicine has valuable potential in other areas as well. Support of internal departments using telemedicine applications in Radiology are commonplace, and allow a wide range of providers in different locations to share diagnostic images to coordinate care and speed up diagnoses. Pharmacy is emerging as another internal operations support application, particularly for smaller facilities that do not have 24 hour on site pharmacist coverage (as we have already heard in previous testimony). Several tertiary facilities in this region and around the country also offer critical care monitoring and support using telemedicine technology. From a rural facility perspective this can provide much more timely and effective consultation from a specialist when decisions need to be made about treatment or transfer options for a critically ill patient, because the combined video and audio capabilities of telemedicine are far superior to a phone conversation in which one physician tries to describe details of the clinical situation to a remotely located specialist who cannot see the patient or the data he or she is being asked to advise on. A better conversation in a rural ER would involve a specialist – maybe more than one – linked in by telemedicine and able to see and speak to the physician, the clinical staff, and the patient (as able) while also viewing x-rays, CT scans, EKGs, and other diagnostic information in real time. The same advantages apply to a surgeon in a smaller facility who may encounter a problem during a case and want to obtain a second opinion from a colleague on how to approach the situation.

At Goodland Regional Medical Center all of the above scenarios are very real. Teleradiology capabilities are already in place, and telepharmacy services are in active discussion with a potential provider of this service. Possible critical care applications, especially in the ER, are also in discussion internally to address several different needs, including cardiac, neurology, and psychiatric scenarios.

Goodland Regional Medical Center

220 W. 2nd
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A visiting surgical group has inquired about conducting post-op rounds via telemedicine. Another likely use of the technology at GRMC is for us to provide outreach support to other area communities for services such as pediatric consultations and home monitoring of patients with high risk conditions that can be monitored for early intervention. Telemedicine in these examples provides a way for smaller rural communities to extend scarce professional resources in the region, possibly on short notice, with the potential for prompt onsite follow up if necessary. It is obvious from all these examples that this same technology facilitates meetings, training, and continuing education for staff as well, reducing the need for travel and related expenses to attend these types of events.

Supporting this type of service requires a substantial information technology infrastructure, at the facility, community, and regional level. Kansas is very fortunate to have the Kan-Ed network available as a backbone for connecting to remote provider partners across the state, such as KU, but our existing clinics, conducted over a reach of 400 miles, proves that this technology is viable and capable of much more. Attempts to provide telemedicine services of a similar nature with our Colorado partners, at only half the distance, has proven much more problematic without a similar statewide backbone to tie into.

Thank you for the opportunity to provide a rural perspective on this versatile technology.

Jim Vanzandt
House Visions 2009
2-2-2009
Attachment 6-1

Saint Luke's Health System

Providing leadership and direction for the advancement of Telehealth services.

Malcolm Baldrige National Quality Award
Saint Luke's Hospital
2003 Award Recipient

Saint Luke's Health System
saintlukeshealthsystem.org

House Visions 2009
2-2-2009
Attachment 6-1

Current State of Telehealth

- Growing list of telehealth services being offered in separate silos.
- No evaluation process exists to assess new opportunities.
- Expansion of telehealth services are being discussed state wide with no definitive/collective direction.
- Payers, Federal and State Government agencies are reimbursing for an increasing number of telehealth services.
- Specialty physician interest in traveling to regional facilities is waning.
- SLHS Telehealth: Garnett, Hays, Overland Park, Leavenworth
  - Cardiology, Pulmonology, Wound Care, Psychiatry, Neurology, DLT, Otolaryngology.
  - Electronic Intensive Care.

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2003 Award Recipient

Saint Luke's Health System
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Driving Market Forces

- CMS is setting the stage for the advancement of telemedicine.
  - CPT codes and G codes are recognized for provider and originating site reimbursement.
  - New announcements regarding reimbursement for inpatients.
- Reimbursement amounts are equal to the current fee schedule for approved CPT's.
- Limited access to specialists.
- Telemedicine technology is more user friendly and decreasing in cost.
- New medical graduates expect health systems to responsibly embrace new technology.
- Grant funding.
- Patients/communities want care close to home. Aging in place.
- Over 100 private payers currently reimburse for telemedicine.
- Sample Reimbursement legislation: *"Healthcare plans cannot deny coverage for health care services provided through audio, video or data communications...."* *"Prohibits provisions in health and accident policies that discriminate against payments for telemedicine."*

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Saint Luke's Hospital
2003 Award Recipient

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Kansas moving at the "Speed of Light"

- Develop a statewide Telehealth advisory council that meets once per quarter.
- Create Kansas Telehealth resource center. Capturing the expertise of KU, St. Francis and Saint Luke's for the advancement of Telehealth.
- Advocate reimbursement by private insurance.
- Review the most underserved areas in Kansas and provide State grant dollars to providers capable of delivering telehealth access.
- Recommend the development and maintenance of a statewide bioterrorism and emergency preparedness telehealth network.
- Encourage placement of telehealth equipment in state ran correctional facilities and reduce or eliminate the difficult transfer issues associated with detainees.
- Develop a Medicaid pilot program that allows for State reimbursement regardless of patient location.

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Questions?

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Vision 2020 Committee
Chairman Tom Sloan
February 2, 2009
Dale White CEO
Horton Community Hospital

Mr. Chairman, Committee members,

Thank you for the opportunity to offer testimony to this committee concerning Telemedicine.

Telemedicine and Teleconferencing offer the most significant advancement of access and economic development for rural Kansas since the advent of Hill Burton. The appropriate application of this tool will revolutionize our hospitals, clinics, and communities in the very near future just as the Rural Electrification projects of old did. Interestingly, the very first REA project in Kansas was at Horton. At the time the thinking was that if wires were run out to these communities and farms the folks would just hang a light bulb at the end of the wire in their barn and call it good. This line of thinking obviously lacked vision. With the birth of the REA cooperatives came a boom time for rural communities and farms. This new "technology" was as much needed and utilized in rural America as it was by our city cousins. It is time for a new revolution in rural technology and thinking.

Horton Community Hospital has been engaged in the delivery of health care services to its patents utilizing telemedicine as a tool for more than a decade. Our partner over this time has been KU Medical Center. Through a combination of grants through KU, RUS, and other sources, as well as our own revenue we have seen this program evolve from its infancy to the reliable tool it is today and look forward to further development in the future.

When we first began working with KU the reliability of the technology and connectivity was at times spotty, the picture quality at times less than optimal. There was also no reservoir of knowledge to train staff on how to present patients from Horton to the specialist and other medical professionals from KU. Over the intervening time, our nurse Sonja Clay has become extremely adept at presenting patients and working with KU to bring KU's resources, our Medical Staff, as well as patients and family together. We have a vibrant program that delivers a diversity of scheduled as well as ad-hoc visits on a regular bases. This enables folks here in NE Kansas to access services in a timely fashion. While at times it has been frustrating, it has more often been very gratifying to see the delivery of big city Medical Center services offered here at home.

I will not spend time going over all the trials of this tools development, but concentrate on where we are and where we hope to be in the near future.

House Vision 2020
2-2-2009
Attachment 7-1

Current:

- Specialty services including Oncology and Cardiology.

- Ad-hoc consultation: We have done many of these over the years including Pediatric Pulmanology, pain management for terminally ill and chronic pain patients, social services, weight management, surgical consultation, Lymph edema consultation for new breast cancer patient, etc.

- Educational meetings: such as - Sepsis Forum, diabetic support group, "I can Cope" program with KU (cancer support group through American Cancer Society), and Nutritional Education for Diabetic patients. Due to the smaller staff size, distance to travel and personnel obligations this is at times a very good way to deliver educational information. We work through the AHEC to deliver other services such as grand rounds

- Business meetings: Frequently I find it necessary to drive to KC, Topeka, or Wichita for meetings. Many times the driving time involved is more than the time spent in meetings. This tool eliminates the necessity of driving, time lost from productivity, and the use of natural resources.

- Benefits:

    - Access to care: It seems obvious that with the utilization of this tool greater access to care and services will become available to rural residents i.e. the REA example.
        - All inductions are that when timely access to care is obtained not only does it improve quality; it reduces severity and need for more advanced care, thus reducing cost. A true win – win in these hard economic times.
    - Transportation: This is a growing issue for rural residents as they age. Traveling to the "big city" can be a big problem. Not only is it very difficult to navigate to the city hospitals and clinics, it is hard to find someone to take you. This tool would significantly reduce the necessity of driving on both ends.
    - Enhanced revenue to rural providers: When the patient is able to stay home we see an increase in ancillary revenues. This is because rather than having diagnostic testing and outpatient treatment in the city, they are able to receive most of these services at home. As this is generally a more inexpensive route it again produces a win – win scenario.
    - Better utilization of specialist and other professionals. There is a clear and growing shortage in many of the medical specialty professionals. This includes doctors, pharmacists, dieticians, therapists, and mental health professionals and so on. These professionals can now in many instances provide consultation, education, and counseling via a PC in their office for a nominal investment (currently about $300 for hardware and software)

Future:

There are a number of services that could be offered now or in the near future including:

Emergency Room/Primary Care:

- A very high percentage of patients who present themselves to the rural emergency room are in fact in need of primary care services. This could be things such as a cold, soar throat, sprained ankle, etc. Sometimes these folks come to the emergency room because it is after hours when they decide they really need to be seen; sometimes they have no insurance so they opt for the ER. In any event they are entitled to at a minimum a "Medical Screening".
- The top reasons physicians cite for leaving a rural practice are "burn out" and "isolation".
- The ER is the most expensive and least effective place to deliver primary care according to national studies
- If a virtual "doctor" visit was available to screen and initiate treatment of these patients, it would be much more cost effective, allow the local provider to rest and eliminate or reduce feelings of isolation and burn out.
- When we do have more critical patients, this service can act as an adjunct to the local providers to enhance quality and timeliness of care.
- This service is currently not covered by Medicare, Medicaid, or Private Insurance that I am aware of.

Home Services/Monitoring:

- There have been a number of pilot programs performed that have clearly shown that this service is cost effective, and reduces office visits and hospitalization.

Others are offering testimony in these and other "near term" services.

Economic/Community Development:

Baby Boomers:

- Currently and for the next almost 20 years the Baby Boomers will be reaching retirement age. Many of these state on surveys that they would prefer to retire to a small community like the one that they grew up in. They do not wish to live in the traditional retirement centers that their parents preferred. This is great news for Kansas. But in order to cash in on this opportunity our rural communities must be prepared to support this emerging trend.
    - Communities must have strong Banks, Churches, Schools (for those who support the retirees), and Health Care Services. These individuals who have lived in larger towns expect the same or similar access to care. This tool will help assure that they do.

- In addition to the "Boomers" a work force of professionals will need to be in place to support them. Again these professionals are used to having access to services and resources found in larger settings, and again current technology can and will make this possible.

Current Barriers:

- Connectivity: There is a wide disparity of what is currently present in small towns across Kansas. Representative Sloan is to be congratulated and thanked for his leadership in helping to bringing this issue forward through such forums as this and his Broad Band summits.
    - There is currently funding available to help eliminate these barriers through such sources as KANED, RUS, OAT grants, etc.
    - We need to all operate out of the same "play book" to make this happen. It is a vital early step for universal access.
- Equipment: As connectivity is sorted out it will be important that all rural health providers possess the same minimum standard of equipment. This will get everyone to the same "starting line" so to speak. This concept is encompassed in past KANED strategic plans. Funding sources listed under connectivity are available for this purpose.
- Supply and Demand: As current barriers to connectivity and Equipment abate this is a next critical step. There is an old maxim that "you don't know what you don't know". As the possibilities are better understood both health wise and economically the demand side should increase. Conversely as the pressures and the growing shortage of professional resources worsens (physician, dieticians, pharmacist, etc), utilizing this tool will become more desirable in the cities to leverage scare resources and time while enhancing revenue through virtual service and increased referrals.

I do appreciate the comities time and the opportunity that these hearings afford to advance the understanding and utilization of this technology. It will increase access, enhance revenue, and spur economic and community development across Kansas. In every setting that I have participated in with regard to Economic development and strategic planning at the State, Regional, and Local levels – Health Care is always at the top of the list. We know hold in our hands the key to unlock our own success, we need only to see with new eyes and speak with one voice.

Thank you all. I am available to answer questions or give further comment on this or any other rural health topic that I can help with. My work number is 785-486-2642 and my email is whited@hhf-ks.org.