NEWS & VIEWS

THE NORTHWEST REGIONAL Telehealth RESOURCE CENTER

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Featured photo: Landscape Arch, Arches National Park, Utah. Photo courtesy of R.L. Wolverton Photography. rlwphoto.com

Tom's Corner

By Tom Brewer, Project Manager, NRTRC

WELCOME to what is truly my inaugural column. In all my years in the service industry, this is my first opportunity to write a column. Our goal is to make this newsletter informative and timely so I will start with this in mind.

Responding to member technical assistance requests is the main purpose of the TRC. You can make a technical request by calling the TRC phone number (888.662.5601), e-mailing us (Tom@nrtrc.org or Sara@nrtrc.org), or sending a message through the NRTRC website asking for help with some aspect of telemedicine. What happens next? The answer to that is what makes this position so much fun!

Requests fall into several categories.

LEVEL 1 The first type involves general questions about what telemedicine is and/or how to get started. We can direct them to the NRTRC website, or a more specific source of information. When the request is a little more specific, NRTRC staff can provide an initial consultation along with direction to proper resources.

LEVEL 2 The second type of request is from a health-care provider or CAH (Critical Access Hospital) who would like to receive or provide specific telemedicine-based services. TRC can furnish technical requirement information for providing the service and specific resources for developing that service. This process can involve discussions, staff research and referrals to members with the appropriate expertise. Recently, most of these requests pertained to tele-psychology and tele-speech pathology.

LEVEL 3 The third level of request is usually from a member network. This request may be more specific and deal with a variety of issues. Assistance on network requests may require some in-depth research by NRTRC staff or outreach to a variety of sources. An example might be a state official requesting a report for their legislature on the number of monthly telehealth consults conducted in the state. A report of this type might be used to request support for legislative changes or financial support of telemedicine.

LEVEL 4 The fourth level of request involves long term support for starting a telehealth program or network of services. NRTRC has been fortunate over the last six months to support several entities as they grow their programs.

For further information on technical support available from NRTRC, I invite you to view our re-charged website at www.NRTRC.org. You can join a forum, start a discussion on a subject you feel passionate about or help us add content for the rest of our friends! We look forward to the New Year with all the challenges and changes it will bring to our world of Telehealth.

Inside this issue:

Spotlight

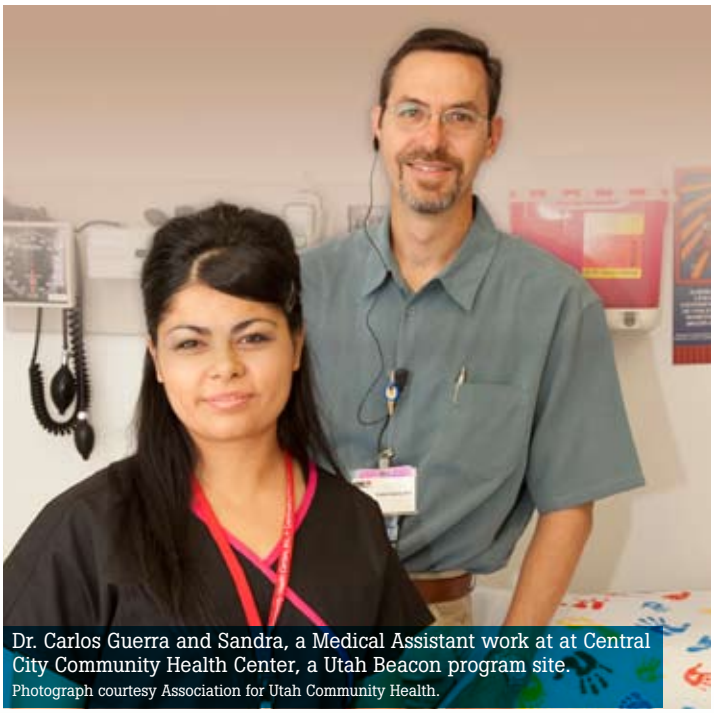
Beacon Project: Utah and Washington

By Victoria Cech

The Beacon grants recently awarded by the U.S. Department of Health and Human Services are an instructive model for everyone interested in using technology to improve the delivery of healthcare. Two Beacon grants have been awarded in NRTRC's region; one in Utah and one in Washington.

Utah

I recently spoke with **Dr. Michael K. Magill**, Department Chairman, University of Utah Department of Family and Preventive Medicine and Executive Medical Director, Community Clinics, University of Utah Hospitals and Clinics, about the University of Utah's role in this very large project. The University of Utah is a subcontractor within this project, which serves the large Salt Lake City MSA; the lead institution is HealthInsight, a quality improvement organization (QIO) serving both Utah and Nevada.



Dr. Carlos Guerra and Sandra, a Medical Assistant work at at Central City Community Health Center, a Utah Beacon program site. Photograph courtesy Association for Utah Community Health.

Dr. Magill noted that the Utah Beacon effort (known as IC3, Improving Care through Connectivity and Collaboration), facilitates redesign and rethinking how care is delivered in the state. The Community Clinics already use a robust electronic medical record (EMR), as do relatively many Utah physicians. Using as a platform the Utah Health Information Network, which has been in place for ten years as a central financial/billing data exchange, the Beacon project will facilitate transfer of clinical data between EMRs at different medical practices and hospitals. This will help primary care practices use the "medical home" model as the basis of their patient care; while patients may have health or prescription data from multiple sources, linkage to information from other providers and hospitals will allow the "home" clinic immediate access to the patient's data and appropriate modification of care plans.

Beyond that basic function of the EMR, however, is a more profound change in how patients are cared for and empowered to manage their own health. Dr. Magill remarked that the creation of a comprehensive EMR, large though that task is, is only "half the battle" – what should flow from that is a complete redesign of healthcare professionals' jobs, what happens in a patient visit, and subsequent oversight of care. He anticipates development of a "Care Manager" program through the Beacon project, in which nurses or social workers can be assigned to populations of especially fragile patients suffering from chronic conditions. The EMR will allow, first of all the identification of such patients, and will then enable the Care Manager to review the record to ensure that these patients are getting the right tests and medications; getting check-ups on a regular basis, and provide appropriate education to such patients to help them "self manage" their own care. In distinction from a navigator, who helps individuals find their way through a system, the EMR will enable Care Managers to help keep individuals with chronic conditions receive proper care to avoid unnecessary visits to emergency rooms and hospital admissions, and to maintain their quality of life as much as possible.

A health educator counsels a patient with diabetes as part of the INHS Beacon Communities Program. Photo courtesy of INHS Beacon Communities Program.

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Beacon Project

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Does telehealth enter this picture? At present, Dr. Magill suggests that the operation of telehealth and the Beacon project resembles a Venn diagram – areas of overlap, but not complete integration. However, the opportunities to use telemedicine to assist with home monitoring and specialist or consultant outreach, supported by a comprehensive EMR, are substantial. Home monitoring technologies could provide an additional tool for the Care Managers described above; remote consults and care can offer specialist review of patient care at the patient's rural or distant medical "home." Telehealth and the electronic storage and management of healthcare information together have the potential to reduce cost and improve quality – and that, Dr. Magill emphasizes, is the ultimate point of the Beacon projects. As he notes, compared to most industrialized nations, we offer our national population lower quality care at higher costs; using technology to manage increasing populations more effectively can help us reverse that.

Washington

The Washington project brings a slightly different mix of populations and regions to their project, which is coordinated by Inland Northwest Health Services (INHS). This project serves both eastern Washington and northern Idaho, and is largely rural with some urban communities. Patients routinely travel between the rural and urban settings to obtain healthcare. **Jac Davies**, Director of the Beacon Communities of the Inland Northwest Project, and Nancy Voorhees, COO of INHS and board member of the NRTRC, noted that care and management of diabetes is the primary focus of this effort. The aim is to create, from the multiple healthcare participants (over 1,000 providers and more than 20 independent hospitals), a framework that will allow members of a patient's care team to receive information and share decision making, regardless of where the patient or the team members are located. The result from both the patients' and providers' perspectives will be a virtual "medical home" distributed across multiple rural and urban organizations, all of which function as a team to provide care.

Comprehensive data is critical to this effort. Shared health information will enable both the distributed management of patients' chronic health issues, and will also allow quality assessment of their on-going care as well as measurement of ultimate outcomes: numbers of admissions to emergency rooms and numbers and duration of in-patient hospital admissions from diabetes-related complications. Prior to receipt of the Beacon grant, a robust system of information sharing among hospitals had been in place for some time. The expansion pursued through this opportunity is the transfer of information among physicians outside the hospitals, and from the physician practices to the hospitals. Data is no longer unidirectional (originating only from the hospitals outward.)

At this point, the use of telehealth is primarily to provide diabetes education and patient assessment to rural locations, and to support planning and organizational meetings among members. Ultimately, the hope is to provide web portals through which patients can access or review their own healthcare data – a goal shared by the Utah project.

Ms. Davies stressed that the data-sharing aspect of this project is critical for telehealth as well as for the evolution of healthcare management nationally. To practice and expand telehealth, a comprehensive array of patient data available to all involved providers is essential. She pointed out that together, a complete EMR and access to telehealth create a very powerful tool for improving patient care. ■

Telehealth meetings such as this one at INHS will help support the Beacon Communities Program.
Photo courtesy of INHS Beacon Communities Program

The message from both programs is clear – that shared data is key to providing better healthcare and empowering patients to manage their own health better. Telehealth has an opportunity to integrate the tools of distance communication and data collection into expanding information systems nationally – and perhaps to assist data networks in expanding their potential reach.

A video on the Washington project may be viewed at http://www.inhs.info/sub.aspx?id=1598

Feature

Telehealth Policy and Legislation

What to Expect in 2011

By Catherine Britain

It's a new year, and with it comes renewed optimism for policies and funding that will finally provide telemedicine with the traction it needs to begin the process of becoming fully integrated into our health systems. Based on the past year, there would seem to be some basis for that optimism. **Jon Linkous**, CEO of the American Telemedicine Association, indicated in his January 3 blog post that "for telemedicine, 2010 appears to have been a watershed year – the point when many in charge of government healthcare programs finally started to seriously consider the benefits of such technology." He cautions, however, that there is still a long way between the pronouncements of 2010 and the action needed from leadership in Washington. He believes that 2011 will be the critical year when we find out whether those leaders will follow-through with specific actions.

The ATA has published **"Six Fixes the Administration Can Make to Improve Healthcare Delivery Using Telemedicine."** Mr. Linkous referred to those "six fixes" in his Open Mic presentation for NRTRC on December 1, 2010. Slides from that presentation can be found at www.nrtrc.org/education/open-mic-recordings/ and an issue brief on each of the changes can be found at www.americantelemed.org/ under the Public Policy menu. ATA is currently discussing these changes with appropriate agencies in the Administration.

ATA is also working with several Congressional offices to draft an omnibus bill for telemedicine. As described by Mr. Linkous, the bill will be used as "a holding vehicle where we can draw out specific provisions that can be added, by amendment, into other bills that stand a better chance of passage." When that activity begins to occur, NRTRC members may be asked to help educate their Congressional delegation about the importance of these provisions and solicit their support.


Jon Linkous, ATA

Mr. Linkous also identified six primary issues that will have an impact on telehealth providers in 2011 for consideration:

- Implementation of the Center for Medicare and Medicaid Innovation (CMMI)
- Development and/or expansion of Accountable Care Organizations (ACOs) and other bundled payment systems
- Efforts to pass state Medicaid regulations and state laws requiring payer reimbursement for telemedicine
- Federal Communications Commission's (FCC) broadband plan implementation
- Food and Drug Administration (FDA) regulation of mHealth
- Federation of State Medical Board's actions related to licensure portability.

How do NRTRC and its members impact these issues? What roles can we play in our states and in our region? The impact of NRTRC and its membership on some of these issues such as implementation of the CMMI, the FCC's broadband plan implementation, and the FDA's regulation of mHealth, will likely be limited to providing information to our constituencies regarding the proposed actions of these organizations and providing feedback to these agencies when requested.

There are however, more active roles to be played by NRTRC and its membership with regard to the remaining issues. The issue affecting most members is reimbursement for services delivered telemedically by both state Medicaid and private payers.

In Utah, for example, the **Utah Telehealth Reimbursement Taskforce** is having discussions with third party payers about reimbursing for telemedicine activities beyond the limited Medicare payment policy. According to Patricia Carroll, Outreach Coordinator for Utah Telehealth Network, as a result of one these discussions, Utah Regence Blue Cross/...

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Telehealth Policy and Legislation

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...Blue Shield has agreed to remove the urban/rural distinction from their language. They also agreed to include tele-speech therapy and diabetic retinal screening with electronic transmission of retinal images in their payment contracts.

The Telehealth Alliance of Oregon is gathering members of its reimbursement workgroup together a year after SB 24 became law to discuss the impact of the law on both payers and providers and to work on any problems that may have been encountered. SB 24 requires private payer reimbursement for services delivered telemedically.

Similar activities are going on in many of our member states, and we anticipate hearing much more about these activities in 2011.

Another issue being discussed in NRTRC member states is that of cross-state licensure of physicians. While not solely the purview of telemedicine, in many instances the robust use of telemedicine to deliver services is directly related to cross state licensure regulations. Two of NRTRC's most active member states with regard to this issue have been Utah and Wyoming. In both states the Medical Boards have been working with the Federation of State Medical Boards (FSMB) to create standardized on-line application and credentialing verification forms. To hear a recording of the **NRTRC Open-Mic session on State Licensure** held on October 7, 2010, go to www.nrtrc.org/education/open-mic-recordings. This issue will be further explored at the Utah Health Information Technology Conference in June 2011.

A final issue that members should consider in 2011 is that of **Accountable Care Organizations** (ACOs) and other bundled payment systems. As these organizations are developed members need to explore the role that telemedicine could play particularly in rural areas. Members also need to assure that these bundled payment organizations are willing to pay for services delivered telemedically. NRTRC will be offering more information on ACOs via webinars and forums throughout the year. You can learn more by visiting the NRTRC website at www.nrtrc.org.

One of the exciting things that NRTRC is doing to promote policy awareness both at the state and federal levels is the creation and support of an **on-line policy forum**. We are currently gathering names of those considered to be knowledge experts in each state and those working on telehealth policy to help us create this forum. We are posting a list of people who have agreed to be policy points of contact from all of our member states on the website as a resource (www.nrtrc.org/). For more information on the new forum or to indicate you interest in participating, please contact Cathy Britain (csbritain@gmail.com) or Tom Brewer (tom@nrtrc.org). You can sign up for the forum directly by going to www.nrtrc.org/forum/policy-and-reimbursement/. ■

Grant Tips

Introducing Grant Tips

By Victoria Cech

Give Consideration to Impact, Partners and Scope

In this space, News & Views plans to bring you a short column called Grant Tips. We hope to provide comments on budgeting, evaluation methods, directions in federal and private funding, and other potentially useful topics. Please let us know if you find these useful – and if there are topics you'd like us to address!

Recent Trend on Grant Awards

For this first column, I'll start with a comment on an overall trend: successful grant projects appear to be getting bigger in many senses of the word. Many of the larger private foundations (such as Paul Allen, Gates, and the Northwest Area Foundation) are directing domestic funding toward national and regional pilot projects that can offer solutions for sweeping problems such as poverty, education, and access to health care – and many of their initiatives are by invitation only.

Organizations hoping to secure significant levels of grant dollars for non-research initiatives – such as improving clinical services to impoverished populations, for example – need to assess their community and regional partnerships and expand them wherever possible. In both the private and federal arenas, loners are getting fewer dollars.

Meanwhile, many of the smaller foundations that used to support single organizations and projects have temporarily or permanently suspended funding due to asset fluctuations. The upshot? Organizations looking for project dollars for non-research endeavors need to think more broadly about impact, partners, and scope. On a federal level, the Beacon grants highlighted in this issue are a great example: fewer dollars means reluctance to invest in single institutions.

Upcoming Events

February – May 2011

By Sara Rivera

February

Open Mic Forum:
Accountable Care Organizations
Presented by Barbara Gray
February 14, 2pm MST

Open Mic Forum:
Tele-Ophthalmology
Presented by Libbey Chuy
February 17, 2pm MST

March

Challenges of Telemedicine: Hospice and Palliative Care
March 8, 2pm MST
Presented by Charlotta Eaton, Deborah Randall and George Demiris

May

Spring Primary Care Conference
Seattle, Washington
May 21-24

ATA Annual Conference
Tampa, Florida
May 1-3

For more information on upcoming events, please go to www.nrtrc.org.

Event Submissions:
Please forward event information to Sara@nrtrc.org

Article and Photo Submissions:
If you would like to write an article or provide photographs for this publication, please contact Cathy Britain (csbritain@gmail.com or 541-910-7366)

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About Us

The Northwest Regional Telehealth Resource Center leverages the collective expertise of 33 telehealth networks in Alaska, Idaho, Montana, Oregon, Utah, Washington and Wyoming to share information and resources and develop new telehealth programs.

NRTRC Services

- Provide technical assistance for new programs and applications
- Increase exposure to telehealth as a health care delivery tool
- Improve access to specialty care through regional collaboration
- Develop information on best practices and telehealth toolkits
- Address regional regulatory, policy and reimbursement issues
- Professional consultation services for telehealth programs and applications

NRTRC Staff

Tom Brewer ..... PI & Project Manger
Sara Rivera.... Administrative Assistant
Doris Barta ..... Grants Manager

Northwest Regional Telehealth Resource Center

175 N. 27th Street, Suite 803
Billings, Montana 59101
888-662-5601 or 406-237-3618

News & Views Staff

Cathy Britain ..... Editor
Contributor
Tom Brewer .. Project Manager Column
Victoria Cech ..... Grant Writing Tips
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