
Committee Meeting

of

SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

*“The Committee will hear testimony from invited guests
regarding the current and potential applications of telemedicine services in New Jersey”*

LOCATION: Committee Room 1
State House Annex
Trenton, new Jersey

DATE: November 9, 2015
1:00 p.m.

MEMBERS OF COMMITTEE PRESENT:

Senator Joseph F. Vitale, Chair
Senator Fred H. Madden Jr., Vice Chair
Senator Robert M. Gordon
Senator Ronald L. Rice
Senator Jim Whelan
Senator Dawn Marie Addiego
Senator Robert W. Singer



ALSO PRESENT:

David Drescher
Adaline B. Kaser
Office of Legislative Services
Committee Aides

Marcela Ospina Maziarz
Senate Majority
Committee Aide

John Gorman
Senate Republican
Committee Aide

Meeting Recorded and Transcribed by
The Office of Legislative Services, Public Information Office,
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey



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COMMITTEE NOTICE

TO: MEMBERS OF THE SENATE HEALTH, HUMAN SERVICES AND SENIOR
CITIZENS COMMITTEE

FROM: SENATOR JOSEPH F. VITALE, CHAIRMAN

SUBJECT: COMMITTEE MEETING - NOVEMBER 9, 2015

The public may address comments and questions to David Drescher, Adaline B. Kaser, Committee Aides, or make bill status and scheduling inquiries to Chantal C. Bailey, Secretary, at (609)847-3860, fax (609)943-5996, or e-mail: OLSAideSHH@njleg.org. Written and electronic comments, questions and testimony submitted to the committee by the public, as well as recordings and transcripts, if any, of oral testimony, are government records and will be available to the public upon request.

The Senate Health, Human Services and Senior Citizens Committee will meet on Monday, November 9, 2015 at 1:00 PM in Committee Room 1, 1st Floor, State House Annex, Trenton, New Jersey.

The Senate Health, Human Services and Senior Citizens Committee will meet to hear testimony from invited guests regarding the current and potential applications of telemedicine services in New Jersey.

Issued 10/30/15

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SENATOR JOSEPH F. VITALE (CHAIR): Good afternoon, everyone. The hearing will come to order.

Call the roll, please.

MS. KASER (Committee Aide): Certainly.

Senator Singer.

SENATOR SINGER: Here.

MS. KASER: Senator Addiego.

SENATOR ADDIEGO: Here.

MS. KASER: Senator Rice is present, but not in the room.

Senator Whelan.

SENATOR WHELAN: Here.

MS. KASER: Senator Gordon.

SENATOR GORDON: Here.

MS. KASER: Senator Codey is not here, I don't believe.

Senator Madden.

SENATOR FRED H. MADDEN (Vice Chair): Here.

MS. KASER: And Chairman Vitale.

SENATOR VITALE: Here.

MS. KASER: You have a quorum.

SENATOR VITALE: Thank you.

Again, good afternoon. We're meeting today to have invited guests testify on the current potential applications of the telemedicine services in New Jersey. We have a pretty robust panel of experts and others who would like to offer their comments and testimony.

This is a very interesting topic for the members. We don't intend to-- While we have draft legislation, we don't intend to move the

legislation until the new session, after the first of the year. We want to spend the next month or two discussing it publicly. There will be other public hearings, of course, if and when those bills are ready for public consideration.

But we'll continue to meet as a Committee, and individually, to understand the issue and to embrace the principles we think are important for, really, a new generation of the delivery of certain types of health care here in New Jersey -- including telepsychiatry and telemedicine.

So with that, our first panel is Judy Lane of Robert Wood Johnson Hospital in New Brunswick; Amy Smith, who is a parent; and Dr. Chris Haines, the Chief Medical Officer of Children's Specialized Hospital in New Brunswick.

We don't have a high chair, sorry. But--

SENATOR GORDON: Sometimes we really need one.
(laughter)

SENATOR VITALE: Well, I was going to say we do, sometimes, need one. (laughter) But I'm glad you said it and not me, Senator.

Thank you.

Welcome.

C H R I S T O P H E R H A I N E S, M. D.: Good afternoon, Mr. Chairman and members of the Committee. My name is Dr. Christopher Haines; I am the Chief Medical Officer at Children's Specialized Hospital.

Children's is a place that takes care of children who are 0 to 21 years of age. We're the largest pediatric rehab in the country. We have 13 sites in New Jersey that range from Bayonne to Egg Harbor. We take care

of the children who are the most medically complex in the United States and in New Jersey. These are the top 5 percent of kids who utilize about 80 percent of the resources, both in this area and across the country.

Our children represent kids who have been involved in traumatic brain injuries, spinal cord; have complications from neonatal intensive care and a variety of different illnesses. These children have gotten through an initial assault to their bodies; they have gotten through acute care; and they have made it to rehab as well.

So I wanted to, at least, start with that, and then I want to talk to you a little bit about the current state of pediatrics, both in New Jersey and in the United States.

There are about 80 million children in the United States requiring some specialty care. There are about 28,000 subspecialist pediatricians; and those numbers really don't match. What's happening as a result is that we are having increasing wait times. According to the AAP -- the American Academy of Pediatrics -- subspecialty wait times are anywhere between three months and two years, with many people, even within New Jersey, driving a long way to get to a subspecialist.

So we've started -- and we've worked very hard to try to find a solution to some of this problem in this current landscape. And telemedicine has been a solution to that problem for us. We developed two pilots; one of our pilots we call a *Telemedicine Transition Program*; and we've done telepsychiatry to date. And all these have really allowed us to achieve the Triple Aim: better health; better care, so better quality; and lower cost.

I want to start by really focusing on the Telemedicine Transition pilot program that we did. This is a program for -- that we

started using for infants and toddlers. These are kids who have complications from a neonatal intensive care unit. They're in the hospital for a really, really long time. My friend, here, is a great example. (indicates) And they come to us, and they've never been home. Many of these kids have tracheostomies; many of these kids have ventilators. As I look at my friend here, she was born at 25 weeks gestation. So if I were to put my hand out (indicates), that was the size that she was born. The amount of blood that she had in her body was the amount of water that is in this bottle (indicates) -- so the tiniest and most medically complex of our children.

So when we were ready to go home with my friend here, we developed this pilot program. And what this pilot program does is, it delivers a telemedicine module home, with the child. We call it our *VGo robot*. It's about six pounds; it's made out of PVC and it allows us to do telemedicine videoconferencing and do physical exams on the other side.

They go home with the child; we're able to do an exam that following week in that most-risky transition period before they get to their primary care doctor. We do two to three visits; and at that point-- We have now been able to do this for 46 patients over approximately a year. We've done somewhere in the vicinity of 65 telemedicine visits through this. And I think, of note, what's most important is we believe that we've averted approximately 31 ED visits; we've served each one of our parents as we go through. And we believe that we may have averted multiple admissions to the hospital, as these children are the most medically complex and are likely to get admitted.

It's important to note that an ED visit is about \$412 per visit; a typical hospital stay, according to AHRQ -- the Association for Health Related Quality (*sic*) -- is about \$10,000 per hospital stay. So not only is it the cost savings; we surveyed our families and found that they were satisfied 100 percent with the telemedicine service that we've provided. The first time we did this, one of the child's tracheostomies popped out and the doctor was able to coax them back through it, reconnect it to their ventilator, and most likely saved an ED trip and, potentially, a hospital stay if there had been a bad outcome.

In addition, in that transition period, there tends to be difficulty getting these children around. They cannot go in a normal car; they're required to go by ambulance -- which is between \$600 and \$1,000, each way -- sometimes round trip. But if we were to try to do this and actually move the patient, it really wouldn't work. The key with telemedicine is really moving information and not moving the people.

So I think it's really important to kind of wrap up with this. This is done all over the country. It's estimated that by 2018 there will be 7 million telemedicine visits or encounters. We hope that, through this testimony, that we've at least elucidated the cost effectiveness; we've shown that it can deliver high-quality health care; and that it will certainly transform the way that we can do health care for the smallest and the most vulnerable of the medically complex in the U.S.

And we hope that, with your increased support, that we can do more. And I thank you for your time.

I'm going to hand off to Ms. Amy Smith, who is one of our patients (*sic*).

SENATOR VITALE: Excuse, me, Doctor. Senator Madden would like a question.

DR. HAINES: Yes, sir.

SENATOR MADDEN: I just have a real quick--
Children's -- where are you headquartered?

DR. HAINES: We're in New Brunswick and Mountainside. Initially, we were in Mountainside; we're about 125 years old. But mainly our inpatient rehab is in New Brunswick.

SENATOR MADDEN: And the Children's that's in Philadelphia -- is that associated with yourself?

DR. HAINES: It is not.

SENATOR MADDEN: And what's the farthest that -- geographically, the farthest one of your patients have been, that have used this?

DR. HAINES: Globally; globally. We've received--

SENATOR MADDEN: Just for the benefit of the Committee, these are not necessarily people who live in -- across the border in Pennsylvania, or anything, that you're dealing with?

DR. HAINES: Far and away, the majority are from New Jersey, although we do get patients from all over the world.

SENATOR MADDEN: Through this telemedicine network?

DR. HAINES: All the patients who we've done for the telemedicine program have been in New Jersey -- have been patients from New Jersey.

SENATOR MADDEN: What does the patient need on their end to participate?

DR. HAINES: They are discharged home with what I call the *telemedicine robot*. It's a HIPAA-secure way to do videoconferencing. As I described, it's about six feet tall; it's made out of PVC; and it is very light. We discharge it home with the patient, in their car, through the ambulance. And what's nice about it is it works off of 4G network, or it may work off of Wi-Fi. So if the family doesn't have Wi-Fi, we can use 4G. And, at that point, we do several visits, and then we'll recover it either through our security or through FedEx.

SENATOR MADDEN: Is it all covered by health insurance?

DR. HAINES: It is not covered by health insurance.

SENATOR MADDEN: Where does the money come from for the patient?

DR. HAINES: So our telemedicine equipment was given to us by our foundation and individuals who donated. And we have done the service for free because we feel that it's vitally important for our patients during that transition period.

SENATOR MADDEN: A ballpark, Doctor? High and low -- what does the equipment cost?

DR. HAINES: The telemedicine module itself is between \$6,000 and \$8,000 -- maybe \$10,000 on the high side. We currently have four of them, and we rotate them through.

SENATOR MADDEN: Thank you for your time.

DR. HAINES: Thank you.

SENATOR VITALE: You had someone--

A M Y S M I T H: Hello, good afternoon.

My name is Amy Smith; this is my daughter, Nivea. As you can see, she has a lot of medical issues. We live in Phillipsburg; actually, kind of close to Pennsylvania -- eastern Pennsylvania. So we live in Phillipsburg. It is like in the middle of nowhere.

Travelling with her is a big deal; it's hard. You have to bring a lot of things with us. We have a (indiscernible) G-tube equipment for her to eat; oxygen -- just a lot of materials that you have to travel with. It is not good for her to be around -- especially when she was smaller -- to be around a lot of different germs, a lot of different people.

She was, like he said, 25 weeks -- born at 25 weeks old. We stayed in the hospital for six month, and we were finally able to go home on February 4. And then, on February 19, her trach came out of her neck. I didn't know what was wrong, I just saw that she was crying -- well, you can't hear her, so she was making the crying face. And so I panicked trying to figure out what was wrong, trying to put the trach back in. But in order to put the trach back in, you need an-- It's like a hard thing that goes inside the trach to put it back in her throat.

She still wasn't breathing, and she was turning blue and stiff. And so I had to give her CPR and then, after that, we got admitted back into the hospital. So after that, two weeks later, we were trying to figure out what was the best routine, or the best route to go for her -- because I was scared now. So that's how we ended up with Children's Specialized Hospital.

And they were like a breath of fresh air. With everything they offered, all their treatments, and the therapies -- to see her grow and learn different things, and -- grow so fast and learn so much. So after about two

or three months of staying there, I was finally ready to go home. And I was still kind of scared because I didn't want that to happen again -- like, to see your child turn blue and go stiff is a traumatic experience. But they offered the machine -- the robot thing -- to come home with me, and that made me feel a little bit better. It was good to know that the doctors that I had been working with for so many months would see me in her atmosphere and they would be able to coach me through anything. That made me feel good.

And so we went home, and everything was all right. And just traveling with her is a lot. I don't know if you can imagine packing up so many things every single time you have to go out -- and especially in bad weather.

I don't know -- but I think it's a good system, and it can work.

SENATOR VITALE: Okay, thank you.

Any questions? Are there any questions from the members?

(no response)

Thank you.

MS. SMITH: Thank you.

SENATOR VITALE: Did someone else want to testify as well?

Do you have another?

Please.

J U D I T H L A N E: Hi, good afternoon, Chairman Vitale and members of the Committee.

My name is Judy Lane, and I am the Director of Neurosciences for Robert Wood Johnson on their New Brunswick and Somerset campuses.

So back in 2014, it was probably the spring, I came to our senior administration with a wild and crazy idea that we wanted to launch a

telemedicine program for teleneurology and telestroke. I think we all know the prevalence of stroke in the United States -- the fifth-leading cause of death, but the leading cause of adult disability. And part of that is because people do not receive treatment in a timely manner.

So it was probably late spring that I came to them with this proposal -- that I wanted them to spend a lot of money on some devices, but we weren't quite sure what the outcome was going to look like. There is not a lot of information related to return of investments out there for telemedicine -- at least, in New Jersey.

And they approved it, because they believed in the model of it. So in October of 2014, we launched our first site -- and it was on our Somerset campus, here in New Jersey. And two days from launching it, we had a patient come in. And we can sit here and talk about telemedicine and tell you about it, and testify against it, but when you see it work, and you see that patient come in who cannot speak, who cannot move the left side of their body -- whose family is nervous and panicking around them -- they're young, they're the caregiver or the breadwinner for their family; and you do not have a neurologist on site to help treat them-- Time is brain.

So with the help of the telemedicine device, we were able to get a physician on the video screen within 15 minutes of them coming to the hospital. They were able to do an examination; able to prescribe the lifesaving drug -- which is TPA -- and the patient received the medication within 47 minutes of being in Somerset Hospital. From there, she was actually transferred to our New Brunswick campus because her stroke was so severe.

At the New Brunswick campus, we were able to bring her into our interventional suite and actually put a device up into her brain to pull the clot out.

She actually walked out of the hospital.

So when you see something like that work, you become a believer. You know, telemedicine was not something that I knew I was this passionate about until we started on the journey of it. And again, when you see things like our little friend over here (indicates), you do become a believer in it.

Robert Wood is-- Telemedicine, our teleneurology, telestroke was really our first endeavor into the world of telehealth. We're looking at-- Now, we actually have a pilot going on at the hospital for patients who have chronic conditions like congestive heart failure. They're discharged from the hospital with a kit. The kit contains an iPad with software in it that is linked to a Bluetooth blood pressure cuff, a Bluetooth oxygen simulator, a Bluetooth scale, so patients can take their blood pressures and measure their weight; and it goes directly to a care management team at the hospital, who can then manage their care remotely and these patients don't have to come back into the hospital. So it will reduce readmission rates with the organization.

And then there's the ability for the videoconferencing. So the physician can come on the video and explain what's going on, or if they're having trouble with something.

So it's really a timely -- it's very timely that we're sitting here, discussing this. You know, they're predicting -- our forecasting companies that the hospital uses are predicting a 20 percent decrease in neurologists

over the next 10 years. So there are companies that are out there -- they call themselves *PSOs*, which are Physician Service Organizations -- which are third-party physicians who come together to form these groups that will help offer telemedicine. So in an age-- We're paying these PSO groups, but again, there is no reimbursement on the actual consultation itself. So our program for telehealth or for teleneurology is mission-based. So we do provide the equipment and the service at no charge for our sites. We have five sites up and running now.

So it has proven to be extremely successful; we have had over 700 consults on it in about a year. And our TPA administration rate for stroke is at 18 percent for our teleneurology program, which is-- The national average is anywhere from 4 to 5 percent. So the docs are making a difference, and we are treating these patients. But then it's what's going to happen with them once they leave the hospital, once they leave the acute setting. And that's where telemedicine can come in -- again, much like Children's Specialized is doing: monitoring these patients on an outpatient basis.

So I just wanted to thank you guys for the opportunity for you all to come here and tell you our stories and what we're doing with telemedicine and telehealth. And regardless of what happens, and where the direction we go, I know it's not something that we're going to stop with. It is the wave of the future.

SENATOR SINGER: Mr. Chairman?

Just for the information for the Committee, to have some idea--

You know, we've been doing this for a long time, in different Committees. NightHawk was probably one of the more common ones. NightHawk was--

MS. LANE: Radiology.

SENATOR SINGER: Yes, radiology. In other words-- One thing we should know. This has a greater effect on community-based hospitals because they don't have the depth of staff that Robert Wood has, or Children's might have on staff, 24/7. NightHawk was one -- and there are other ones -- but NightHawk was a way for small hospitals to have radiologists read their films in the middle of the night and not have to have someone sitting there. NightHawk was done out of, I think, Australia.

MS. LANE: I think it was Israeli-based.

SENATOR SINGER: There were a couple of different ones. They would actually read the radiology report right away instead of having to worry about having a radiologist sitting in the hospital at 3 o'clock in the morning.

We also moved on with-- I'm on the Board of a mental health hospital; and you know, we have the largest PES unit in the state in Lakewood. We just couldn't get psychiatrists to come in at 3 o'clock, and you would have to keep a patient sitting there because you couldn't make a diagnosis. Whereas, now with telecommunications, we're able to make that diagnosis right away, and that patient can get help.

All these things, really, as I said, play an important role for community-based hospitals because, for example, neurologists are maybe on staff, but they're not physically in the hospital. And that's such a key factor. So if a community-based hospital doesn't have it, they might have

to transfer to the trauma center. The breakdown of time from when that patient comes in with a stroke until they're transferred to the trauma center is a difference about being successful -- as you've heard -- or not being.

So I would-- The importance of this -- even though it's very important for the teaching-type facilities -- but it's so important for a majority of our hospitals -- the community-based, smaller hospitals that just don't have the depth of staff today. And very honestly, the shortages are in things like neurology; psychiatrists are at a tremendous shortage; and also orthopedics are very difficult. Those three are probably the biggest shortfalls that we're seeing today in community-based hospitals.

Thank you, Mr. Chairman.

SENATOR MADDEN: Any further questions or comments from the members? (no response)

Thank you.

MS. LANE: Thank you.

SENATOR MADDEN: Okay, the next presentation will be from-- This will be from Rita Landgraf, the Delaware Cabinet Secretary for the Department of Health and Senior Services (*sic*). So once we get through and make the connection, you keep focused on the screen in front of you.

(Committee Aide David Drescher dials in for Secretary Landgraf)

UNIDENTIFIED STAFF: Good afternoon. Office of the Secretary; this is Pam speaking. How may I help you?

MR. DRESCHER (Committee Aide): This is the New Jersey Senate Health, Human Services and Senior Citizens Committee. Would you connect us to Secretary Landgraf, please?

UNIDENTIFIED STAFF: Absolutely. One moment, please.

S E C R E T A R Y R I T A M. L A N D G R A F: Good afternoon, Chairman Vitale. (laughter)

SENATOR MADDEN: Good afternoon, Madam Secretary. This is actually Senator Madden, the Vice Chair of the Health Committee. Senator Vitale had to step out of the Committee room to take care of an issue; he'll be back shortly.

SECRETARY LANDGRAF: Thank you, Senator Madden.

SENATOR MADDEN: I wanted to welcome you to--

So we have a room full of very interested individuals and stakeholders. We have a Committee here that's comprised of a number of legislators.

We just had an initial or opening preamble -- comments made regarding telemedicine within the State of New Jersey, from one of our local hospitals that primarily focuses on children, ages newborn up to the age of 21 -- Children's Specialized Hospital in New Brunswick, in northern New Jersey. We've had a mother here with her child, expressing her experiences with a child who was born at 25 weeks of gestation and was in the hospital until she was about 10 weeks before she was released; and the challenges of going back and forth since the baby was released from the hospital.

And then an overview about some of the history here, and analogies between telemedicine and other activities that have either taken place -- in radiology treatments throughout New Jersey or in the country.

So I want to welcome you here to today's Committee. And one of the first questions-- I mean, having you here right out of the gate, one of the thoughts on our mind is, we know Delaware had recently passed the telemedicine bill -- and we want to thank you for being here today with us -- but what does the bill seek to accomplish within the state of Delaware?

SECRETARY LANDGRAF: And thank you, Senator Madden.

We just signed -- or Governor Markell signed this bill into law in July of this year. And that makes Delaware the 28th state to have telemedicine parity signed into our law, requiring insurers to reimburse for normally covered services when they are delivered using telehealth/telemedicine technologies.

So this new law actually permits the use of telehealth in the delivery of services for most of our healthcare professions in our state. And it also allows the site of origin to include that patient's home. We do expect the new law, and the accompanying expansion of telehealth into various healthcare practices -- what it will do: one -- I think that you've heard this earlier -- it will increase access to health services, especially with providers who may be in short supply in some areas of our state, and even some professions -- especially in the area of neurology and behavioral health; two, it will reduce transportation issues, including cost, and save time for the consumer and for that provider; three, we believe it will improve adherence to treatment plans because of that increased access to care; four, then it will improve the individual's health outcomes by providing access to services more readily and at an earlier stage of an individual's disease; and five -- which is probably a rather significant one,

especially for us as state leaders -- potentially reducing costs in the long run with this improved access to healthcare services.

Now, as Secretary of Delaware's health systems, I am a believer in the care that can be delivered via telehealth technology, especially when we think of access to specialty care, and especially when we think of, in Delaware, access to underserved areas of our state. As you know, Delaware is much smaller than New Jersey; but our Sussex County, which is the lower county of our state, is very rural. Delaware's Strategic Action Plan for telehealth is coordinated by a coalition that we put together some years ago. It's called the *Delaware Telehealth Coalition*, and it is made up of a diverse group of healthcare stakeholders who are, indeed, dedicated to implementing the latest telehealth technologies in order to continue to provide optimal health care and overcome challenges associated with our healthcare delivery system.

We actually formed this coalition back in 2011, and today it has more than 80 members. And it is led by my Department of Health; we created actually, at the Department, a Director of Telehealth Planning and Development. And so she actually leads the work of the Coalition.

Now, my strong belief in the benefits of telehealth is also one of the reasons that I had my Medicaid program begin reimbursing for telemedicine-delivered services back in July 2012. And actually, what really got my attention was when we had a family member, whose wife is challenged by Parkinson's disease, advocate that the state reimburse and look at telehealth as an opportunity for individuals to not have to be transported to Johns Hopkins in order to visit their doctor for wellness checks in Parkinson's disease. So we were able to really bring this to the

ground and offer our citizens an opportunity to not only save travel costs, but they were also telling me of family members -- that they would become very exhausted from doing that day of travel. And many times the Parkinson's disease, then, would flare up because of that.

So across our state in Delaware, the growth in telehealth is clear. We see it with my Department's Mobile Crisis Staff in our Division of Substance Abuse and Mental Health. They use telepsychiatry to actually assess individuals, to evaluate and work closely with a hospital and our federally qualified health centers in our southern part of the state -- which, again, is our most rural county. At the largest healthcare system in our state, telemedicine is used to remotely monitor ICU patients. Our Children's Hospital has more than 30 telemedicine carts in use in various programs. And at our University of Delaware, the Nurse Managed Health Center has a Parkinson's disease telehealth clinic that is really bringing care to the people directly, wherever they are. And again, we will allow the telemedicine to have access in a person's home.

Now, you did ask me, also, about what are the obstacles. So I would like to mention a few of the challenges.

In Delaware, distance site providers must be licensed by our Division of Professional Regulations to practice telehealth here. We have encouraged the Division of Professional Regulations to look at a more streamlined application and approval process. We've heard that that process is rather lengthy and complicated. So we are working closely with them to look at how we can streamline that process.

Secondly, the use of technology is, indeed, growing, but not widely adopted. As with any new technology, there are early adopters --

I've mentioned a few here in Delaware. Most providers continue to watch, to learn about the benefits of telehealth and telemedicine; and are waiting to see, as early challenges get worked out and the process is streamlined.

Third, we know some patients may not be comfortable seeing a provider this way. You know, I have found that young people who are used to Skype and FaceTime may actually be more comfortable than our older generation in adopting telehealth technologies. But despite that, we still believe that, through usage, people will become more comfortable; and again, especially if they have the ability within their own home. And so we are beginning to see an expansion in the use of telehealth.

And some of our providers initially saw it as a threat to their revenue streams. The new law, in our state, will help to reduce some of that concern that used to be prevalent here in Delaware.

I do expect even greater adoption of telehealth and telemedicine as the years progress. Through our Coalition, we expect to bring in more providers from various disciplines, including our primary care practices. We will seek out applications, including at-home use for Delaware's fast-growing aging population and the state's underserved rural areas. We know, by the year 2030, Delaware will have the 9th highest proportion of people age 65 and older, of all the states. We expect that telehealth will be used for at-home wellness checks for seniors with chronic conditions, and follow-ups for individuals relative to adherence to their treatment plans.

So it is clear to me that telehealth actually can advance to promote healthier outcomes for our citizens. And across the health spectrum, we do expect increased use of telehealth to manage chronic

conditions, as supported by the Affordable Care Act. I also know that Dr. Rheuban -- I believe, from the University of Virginia -- will be on following me. And actually, she was also very convincing when she came here to Delaware prior to my even -- in 2012 -- having Medicaid reimbursed for telehealth; and really sharing with me the value of this technology in really bringing forth not only a greater access, but also bringing forth healthier outcomes.

SENATOR VITALE: Thank you, Madam Secretary.

I'm going to ask-- Senator Whelan has a question for you.

SENATOR WHELAN: Thank you, Mr. Chairman.

Madam Secretary, thank you for getting on, and we appreciate your insights.

You talked about a case where one of your residents would have been going to Johns Hopkins over in Baltimore, but now they don't have to. Then you said the licensing is a problem. How does it work with the out-of-state facilities? Do you require-- If Johns Hopkins is going to do telemedicine in Delaware, do they have to get licensed in Delaware? Or is having a Maryland license is a qualifier? How does that work?

SECRETARY LANDGRAF: No. I thank you, Senator, for your question, because indeed that is one of the barriers -- that the physician must be licensed in Delaware. And part of our complication, relative to that, is even that licensing process and what physicians have to go through in order to attain a license in Delaware. That's where we're trying to work very hard in streamlining that process. But the requirement right now, for Delaware, is they must have a Delaware license.

SENATOR WHELAN: Okay. Are you aware of what other states are doing? Because clearly, New Jersey and Delaware -- I mean, we're neighbors; a lot of our medical care -- not a lot -- but some of our medical care in South Jersey spills over into Philadelphia; some spills into Delaware. I mean, Nemours is world-class--

SECRETARY LANDGRAF: Right.

SENATOR WHELAN: I'm sure you have Jersey-- I'm willing to bet you have Jersey kids there right now. And North Jersey spills into New York. So are you aware of how other states are addressing this?

SECRETARY LANDGRAF: I cannot speak on behalf of other states. I do know that this is something that the Coalition does, indeed, want to address so that we cannot only streamline, but also promote greater access -- especially when you're thinking about specialty care and some of the limitations that states might have relative to attracting those specialists. But I believe Dr. Rheuban, through her experiences, might be able to give you even deeper feedback, relative to other states.

SENATOR WHELAN: Well, thank you. We'll ask her when we have a chance to talk with her.

Thank you.

Thank you, Mr. Chair.

SECRETARY LANDGRAF: Thank you.

SENATOR VITALE: Madam Secretary, you had mentioned earlier in your comments about the time you spent reconciling the reimbursement issues with the medical community. Can you expand on that a little bit, and tell us what it was that were some of the initial concerns and how you began to try to resolve that issue?

SECRETARY LANDGRAF: Relative to the reimbursement under the Medicaid program, I don't believe -- I believe a lot of those initial challenges have actually been worked out. And again, Medicaid began offering reimbursement for telehealth back in 2012. So now we do have some experience relative to that under our belts.

Now, this law promotes that all insurers can. But the Governor just signed this law in July, so that we're still bringing this forward on the ground with all the insurers in Delaware.

SENATOR VITALE: Okay, thank you.

Any other questions? (no response)

Thank you again, Madam Secretary. I know that there are three colleagues with you today from Delaware Health and Social Services: Rita Landgraf--

MS. KASER: No, that's her.

SENATOR VITALE: Oh, that's you. I'm sorry, Rita. (laughter) This is Rita? We're going here?

MS. KASER: Yes.

SENATOR VITALE: I'm sorry; Karen Rheuban, who is the Medical Director of the Office of Telehealth, University of Virginia. She's on next, right? Is she on? She's not on the slide.

MS. KASER: No, on the TV.

SENATOR VITALE: Okay.

See, this is why we had to have a conversation about telehealth, because I don't know what the heck I'm doing. (laughter)

Are there any other questions? (no response) We're good?

Madam Secretary, thank you for taking the time out of your day to help us with this issue, and we look forward to talking to you again.

(no response)

SENATOR SINGER: I guess she hung up on you.

SENATOR VITALE: I can't blame her. (laughter)

SENATOR SINGER: That was the technology.

MS. KASER: David, is Karen next?

SENATOR VITALE: Karen's next, yes.

KAREN RHEUBAN, M. D.: Can you hear us?

SENATOR VITALE: Yes, we can -- Dr. Wibberly and Dr. Rheuban.

DR. RHEUBAN: Oh, good. This is Karen Rheuban. I think we might have timed out. I was watching it, and I was able to hear Secretary Landgraf. So glad the technology works when we need it to. (laughter)

So, Mr. Chairman and members of the Committee, thank you for the invitation to provide testimony regarding the opportunities for broader integration of telehealth into health care for the citizens of New Jersey.

My name is Dr. Karen Rheuban, and I direct the Center for Telehealth at the University of Virginia. I am a pediatric cardiologist, and a past President of the American Telemedicine Association. I serve as Board Chair of Virginia Medicaid; and I am a Principal Investigator of the Mid-Atlantic Telehealth Resource Center, serving nine states from North Carolina to New Jersey.

You'll be hearing from Dr. Kathy Wibberly, the Executive Director of our Mid-Atlantic Resource Center, shortly. She herself is a native of New Jersey. And I was particularly pleased when New Jersey was added to our grant service area, because my mother resided in Monroe Township, New Jersey. She herself was a beneficiary of a telehealth service at Princeton Hospital.

Telemedicine is not a new specialty, a new procedure, or a new clinical service; but rather, the use of technology designed to enable the provision of health care at a distance. Twenty-first century telemedicine can be provided live and interactive, using high definition video conferencing supported by high-quality peripheral devices; or provided asynchronously using store and forward technologies; or through the use, as you heard from Secretary Landgraf, through remote patient monitoring tools.

Telemedicine improves patient triage, clinical outcomes, and lowers the cost of care. Telemedicine helps to overcome geographic disparity faced by rural patients and other serious disparities faced by all patients. As you heard, we and others offer emergency active (indiscernible) stroke neurologists, avoiding critical delays in patients in rural communities being afforded access to the clog-busting medications at the same rate as patients who show up in our emergency department at the University of Virginia. We offer high-risk pregnant women remote care by obstetrical specialists, resulting in fewer missed appointments, reduced premature delivery, decreased NICU hospital admissions, and most importantly, better outcomes for babies.

Improved access to mental health services in the face of serious provider shortages and disparities is greatly facilitated through telemedicine; and you have a wonderful group there in New Jersey that you'll be hearing from shortly, InSight. Indeed, telemental health is our number one request for services.

Diabetic patients -- for whom the standard of care is an annual eye exam to identify retinopathy, the number one cause of blindness in working adults -- can be screened remotely in primary care settings through telemedicine partnerships with retinal specialists. Remote monitoring allows us to care for patients after hospital discharge, reducing hospital readmissions, and better patient outcomes with very high rates of patient satisfaction.

You heard about provider shortages. The use of telemedicine can improve our efficiency, and is good for patients. The consumer demand for telemedicine is growing, even beyond my wildest imagination. Regardless of the model chosen, it's imperative that practitioners take into consideration all relevant Federal and State policies, and specialty societies best practices impacting telehealth -- which can present significant challenges to adoption, as you heard from Secretary Landgraf. Examples include inconsistencies in reimbursement, to include limited fee for service reimbursement by Medicare, and varying degrees of reimbursement by State Medicaid programs and private payers.

As of this date, 28 states and the District of Columbia have advanced private-pay legislation, and we are grateful to the Secretary and to the Governor of Delaware for their progressive approach.

Some of the private payers have chosen to cover telehealth services, but after the mandate, coverage decisions tend to be inconsistent.

As we migrate toward alternative payment models, important opportunities for providers to integrate telehealth to better manage patients and populations are growing. Variable board regulations across the state also present obstacles. Some boards of medicine require an in-person visit prior to a telemedicine encounter; but what stroke patient necessarily has seen a stroke neurologist before their first stroke?

Others have set guidelines that support the use of video-based services as establishing a doctor-patient relationship. That has happened in Virginia within the scope of practice. Most states, as you heard from secretary Landgraf, require full licensure of practitioners providing telehealth services. It is a challenge, and it is a burden.

The Federation of State Medical Boards has launched a new process to expedite licensure for providers, but it is still a time consuming and expensive process for practitioners. Credentialing and privilege regulations are important; Stark and anti-kickback laws in regard to the acquisition of telehealth equipment and technology; adherence to HIPAA privacy and security regulations; and informed consent -- all imperative.

Processes by which telehealth practitioners communicate with the patient's primary care provider are also important, as is malpractice coverage.

In many communities, even the broadband infrastructure to support telemedicine services is insufficient and must be expanded. Imagine the power of greater mobile connectivity for emergency medical service providers and, of course, for patients in any setting.

Practitioners must also be aware of evolving technology platforms, issues related to device interoperability, FDA regulations, and the role of electronic medical records and health information exchange. And lastly, we must ensure sufficient training for health professionals as to the most appropriate-use cases for telehealth, standards of practice, and develop evidence-based models of care.

In conclusion, telehealth is an essential tool to improve access to high-quality care for patients, to mitigate workforce shortages, to improve population health, and lower the cost of care. There are many opportunities for small practices and hospital systems to integrate telehealth models into everyday practice; however, managing and navigating the complex legal and regulatory environment, which impacts the use of telehealth, can be challenging. Thus, it's imperative that we create and promulgate policies that foster certainty, transparency, high quality, secure and sustainable solutions that empower patients, providers, and payers to adopt 21st century models of care.

And I'd be pleased to answer any questions. And I thank you for your consideration of this important issue in the great State of New Jersey.

SENATOR VITALE: Thank you very much, Doctor.

Any questions from the members, at this point? (no response)

If you can stay with us, we'd like to hear from your colleague next; and then we'll have additional questions.

Thank you.

DR. RHEUBAN: You're welcome.

KATHY H. WIBBERLY, Ph. D.: Thank you, Chair.

Chairman Vitale and members of the Committee, my name is Kathy Wibberly, and I am the Director of the Mid-Atlantic Telehealth Resource Center, also housed at the University of Virginia. Telehealth Resource Centers -- or *TRCs* -- are funded by the U.S. Department of Health and Human Services' Health Resources and Services Administration in the Office for the Advancement of Telehealth. It's part of the Federal Office of Rural Health Policy.

And TRCs support telehealth program development and sustainability. Its services are available at no cost to those wishing to use electronic information and telecommunication technologies to support clinical health care, health-related education, public health, and health administration at a distance.

The first small group of TRCs was funded in 2006; the success experienced by these programs, as well as the increased interest in telehealth, supported the slow expansion of the TRC program. As of 2012, there are now, nationally, 14 TRCs; 12 Regional Centers, whose combined coverage reaches all states and the Pacific Islands; and two National Centers, one with a focus on technology assessment, and the other on telehealth policy.

TRCs work collaboratively and participate in a consortium, known as the National Consortium of TRCs. Last year alone we had over 8,200 organizations and individuals come to us, requesting technical assistance.

Our resource center -- the Mid-Atlantic one -- partners with the Northeast TRC to ensure that all citizens of New Jersey have access to TRC support.

TRCs offer services such as a central website that has resources and tools for program development, monthly national webinars on key topics by telehealth leaders from around the country, policy analysis, and technology assessment. One of the websites for the National Policy TRC has a searchable index of all national and state policies related to telehealth. We have tools and templates; we have training for the telehealth workforce; educational materials; and we also offer state, regional, and local strategic planning.

You heard from Secretary Landgraf, and their state plan was facilitated by our TRC.

Telehealth has been in existence for well over 20 years. It has its roots in rural health because it provided a lot of the solutions to rural health challenges, as noted by Dr. Rheuban. And many of you probably understand that the beginnings of telehealth were primarily the traditional hub-and-spoke model, where small rural and community hospitals, called *spokes*, connected to larger, typically tertiary care centers, called *hubs*. The beginnings were really rough 20 years ago. Prices were high, bandwidth was low, best practices had not been developed. And in spite of that, we saw some incredible successes.

As time passed and technology improved, bandwidth increased, costs went down, health professionals began to realize that telehealth was not just for rural specialty care. It had applications that could address some of the most pressing challenges for healthcare delivery systems -- whether

rural, urban, or suburban. These included challenges such as chronic disease management, fragmented and compartmentalized services, aging of the population, cost of care.

The past decade we've seen telehealth start to play a significant role in the Patient Centered Medical Home for allowing people to age-in-place; for facilitating better safety and better quality; for care coordination and integration; and for enhanced active continuity of care.

As a result, over the past decade we have witnessed a move from a traditional hub-and-spoke model to one that has become a network of networks. Networks for primary care providers, and community-based facilities, and clinics are all connected with each other, with hospitals, with emergency rooms, with emergency medical services, and with specialty care practices.

Today we are on the precipice of another major paradigm shift in telehealth. The concept of care anywhere is rapidly coming to fruition. And you have already heard today, instead of patients having to go to a particular facility to receive care, telehealth is enabling care to go wherever the patient is -- whether that's at the patient's home, at the school, or at the workplace.

There's a recently published book whose title is *The Patient Will See You Now*. It captures the emerging future of health care. The future of telehealth is to make the possibility of the right care, in the right place, at the right time a reality.

Although telehealth has been around for decades, it's not yet achieved its full potential. Telehealth is not about technology; it's simply a tool. Telehealth is really about the people, the workforce, and workforce

training that has to come into play; the processes, whether that's protocol, procedures, or business model; and the policies, laws, and regulations that need to come into full alignment with each other.

As Dr. Rheuban so eloquently stated, it's imperative that we create and promulgate policies that foster certainty, transparency, high quality, secure and sustainable solutions that empower patients, providers, and payers to adopt 21st century models of care. We're living in a time of rapid advancements in technology. We need to take care to ensure that any policies we put into place are nimble, so that these policies do not ultimately become an impediment that keep us from using the tools that are at our disposal for improving patient experience of care, improving health of populations, and reducing the per capita cost of health care.

Thank you very much.

SENATOR VITALE: Thank you very much.

Senator Madden has a question for you.

SENATOR MADDEN: My question, actually, is for Dr. Rheuban.

Doctor, can you comment on telemedicine for consultation, versus telemedicine for treatment? Should it be used both ways, or--

DR. RHEUBAN: Absolutely. So telemedicine can be used for consultation across a broad range of specialties. Here at the University of Virginia, we have some 60-odd -- 62 different subspecialties of health care that participate in our program to provide consultation. Generally, the patients are referred by a referring provider, be it a nurse practitioner, primary care provider, or even another specialist in another community.

When we treat patients by telemedicine, we generally tend to do so in partnership with the referring provider so that we don't bypass the patient's primary medical home.

SENATOR MADDEN: If I may, it's my understanding in Virginia -- a lot of the usage is in the rural areas of the state. And one of the questions that has come back and forth in preliminary discussions is, simply, does it belong in just the rural areas? Should there be a distance model established when this is in place? Either yourself or Director Wibberly -- could somebody make a comment and give us some input on that, please?

DR. RHEUBAN: Let me give you a bit of history in Virginia.

We started in rural for two reasons: number one, as one of the state safety net hospitals, we had a long-standing history of driving to see patients in rural communities -- in far southwest Virginia, and in other regions as well. Once telemedicine became an available tool to us, it was very clear that we could provide those same services 24 hours a day, 7 days a week -- not just when we could drive down there, or when an ambulance could bring a patient.

Although we began in rural, we have many, many collaborations with urban sites and settings as well. The UVA telemedicine network -- and that's just UVA; there are other healthcare systems that have deployed telemedicine -- connect to 155 sites, from the Eastern Shore all the way to the far southwest Virginia, and within the cities in between. So it's not just for rural anymore, although that is certainly where we got our start.

DR. WIBBERLY: As I had mentioned in my testimony, just because it started in rural, it has urban, suburban implications throughout.

And as a former resident of Bergen County -- and all of you who know the traffic conditions there (laughter) -- there are as many issues with accessing care in urban and suburban areas as there are in your rural areas. And travel time, across a small county like Bergen -- ha ha (laughter) -- can be in excess of hours and hours. So access to care is not just about rural.

SENATOR MADDEN: And lastly, Director or Doctor -- the patient on the receiving end, should he or she be accompanied by a healthcare professional during the telemedicine or telehealth practice?

DR. RHEUBAN: So that's a great question; thank you for asking it.

I think it very much depends on the type of service. So when you're talking about a specialty, or subspecialty consultation, it is very, very helpful to have an originating site provider participate in the encounter. It does not have to be the physician; it could be an advanced practice nurse, a physician's assistant, an RN -- to help facilitate the use of some of the devices that are often included in the encounter.

Mental health is somewhat different from that. And to ensure patient confidentiality and privacy, there really is not a need; but one needs to have protocols and processes in place if there are challenges. And I'm sure Geoffrey Boyce will speak to that issue as well.

Now, the direct-to-consumer phase, in the home -- that is very different. And you don't need, necessarily, to have a practitioner in the home to support this encounter. And again, it depends on the type of service that is being offered. There are some pretty phenomenal tools that can even be deployed in the home setting. In full disclosure, I'm on the Advisory Committee of one such start-up that has a device, that can be used

by a parent that has an otoscope, a stethoscope, a camera, a thermometer; and patients can be trained to use to themselves in the home setting.

So I think it very much depends on the type of service. And we don't necessarily need to have a provider in every setting, but that's where practice guidelines set by the specialty societies are very relevant.

SENATOR MADDEN: Along the way, have-- If you conceptually think about it, when we're crafting a bill, we would have individuals who are being expected to be potentially in their home -- depending on where the language of the bill winds up -- but let's just think of someone in their home who is a senior citizen or any individual who has -- their cognitive abilities are not the sharpest, but sharp enough to get through their day-to-day maneuvers. And through the telemedicine, there's treatment or instructions being given from a physician or a physician's assistant, nurse practitioner. Has anyone from the medical society wing expressed any of their concerns regarding potential liability, where things could be misconstrued because they're giving verbal instructions, nothing's in writing? Could you comment on that particular piece -- if it's been put before either of you along the way?

DR. RHEUBAN: Sure, I can comment.

I think it's very important that practice guidelines be adhered to, and that we set in place standards that are appropriate for the care of patients.

So I do think that there is opportunity to use these technologies to better understand the conditions in which the patient lives. So what better way than even to do an evaluation of the home setting somewhat remotely. We've done some evaluations where we've identified

patients are being sent home in oxygen, with a wood burning stove next door.

So yes, I think the specialty societies will and are developing these guidelines; but I don't believe it should be just confined to the practitioner's location. But it is important that we have clear guidelines and standards of care to address the very challenges that you have identified.

SENATOR MADDEN: Thank you.

Thank you, Director, and thank you for your time, Doctor.

Mr. Chairman.

SENATOR VITALE: Yes, thank you.

For either one of you: I don't know what your laws are in Virginia with respect to nurse practitioners or advanced practice nurses. In New Jersey, we amended the law, just a few years ago, to permit nurse practitioners to diagnose and prescribe; it's still a collaborative agreement with physicians, but they're pretty much on their own now, working in the field. Can you tell me what your laws are like in Virginia, and how that applies to your telemedicine process? Are they working collaboratively? Are they able to diagnose and prescribe?

DR. RHEUBAN: Kathy, do you want-- You came from the Virginia Department of Health. And then I can add to that.

DR. WIBBERLY: There is a supervisory relation that is required by law in Virginia. But they do have, within their scope of practice, the ability to diagnose and prescribe -- at least, within that supervisory relationship.

SENATOR VITALE: Okay. Can you tell me what the-- Just give us the 101 on this, or the fundamental process on how this works.

There certainly are private entities that organize telemedicine in a variety of different states around the country. Do you find that the majority of those who are participating in this -- in telemedicine, in Virginia -- are-- How do they access the process? Are they doing this independently, are they working with a consortium of other providers? Are they doing it through a private entity that organizes all that?

DR. RHEUBAN: All of the above. (laughter)

SENATOR VITALE: Can you break it down by just, sort of -- by percentage? Is there a general feeling for what piece of that is greater than the other?

DR. RHEUBAN: So in general, the specialty care is primarily the healthcare system that has developed their own telemedicine program. And that has been advanced by our legislation in 2010 -- the parity reimbursement legislation -- and that was updated in 2015. So by and large, most of the healthcare systems are offering telemedicine services. That being said, we do have capacity challenges, and so there are relationships with telemedicine services companies that have contracted with hospital systems as well. As an example, there's a company called *Specialists On Call*, which is one of the nation's largest telestroke services. They have contracted with community hospitals, as opposed to going out on their own and providing a service -- well, your patient shows up at the emergency department, so they have to have a relationship. And there are Federal regulations that require credentializing and privileging; obviously a licensure, as well.

That being said, another whole sphere that even we are still struggling to get our arms around is the direct consumer movement. Quite

frankly, I felt like it was a light at the end of the tunnel with the delivery of specialty care and telemedicine, with all the private parity reimbursement and Medicaid expansion. But that light at the end of the tunnel was the oncoming freight train of direct-to-consumer telemedicine. In other words, companies that have negotiated contracts with payers, and employers, and even subscriptions by patients to have what's called *direct-to-consumer* -- some video-based, on telephone only -- and getting our arms around that is a bit of a challenge. Because there is a tension between providers and the specialty societies about the quality of care that's delivered in that environment. And the evidence is being collected and disseminated, and we have to see where that leads us.

But that's a very different model than the specialty care model that we have been discussing here today.

SENATOR VITALE: On the primary care side, are you collecting-- Maybe you just answered this question, or at least in part. Are you tracking the-- I don't know how long this process has been in place in Virginia, but are you tracking the outcomes of telemedicine versus usually what we consider to be the traditional delivery of medicine in New Jersey or Virginia, which is face-to-face? Are there studies being conducted that we could look at, and that you can talk about?

DR. RHEUBAN: Absolutely. The literature is just replete with the evidence, and we are-- What we believe is really important is that we continue to gather that evidence. So just as you heard from your colleagues from Robert Wood Johnson, we had our connections with our telestroke partner hospitals. Those were hospitals that never gave TPA to a patient who showed up with a stroke. And by and large, when those patients got to

us, they were far outside that window of opportunity for care. As I mentioned in my testimony, those hospitals now provide TPA at the same rate as we do in our emergency department. And the providers that never would have given TPA in those hospitals include a critical access hospital, whose ER provider is a family physician; or a community hospital emergency department, where the ER physicians never felt comfortable because of the risk. So there's a lot of data in the stroke environment; there's quite a lot of data in the pediatric world, and in my field of pediatric cardiology. There's a lot of data about remote patient monitoring and hospital readmissions prevention for a large number of different service lines, quite frankly. Teledermatology -- there is quite a bit of data.

Teleophthamology -- every diabetic patient is supposed to have an annual eye exam, but they don't. And you know, as Board Chair of Virginia Medicaid, I am very much aware of what our managed Medicaid agencies are able to do. So our managed care organizations only meet metrics at about 60 percent of the time. But with teleophthamology and the Veterans Health Administration experience -- which is well-published -- those patients can get access to retinol screening programs.

So lots of opportunity, lots of evidence -- and all you have to do is ask, and we'll send you the data.

DR. WIBBERLY: And our sister TRCs -- the Northeast TRC, that also covers New Jersey, has a searchable database of all published evidenced-based articles on telehealth. And so that is one area; and a resource available to you.

SENATOR VITALE: Thank you, both.

Any questions from any of the members? (no response)

Thank you for taking the time of your day. This has been very informative and helpful for all of us on the Committee. And I'm sure that we'll be speaking again in the future.

And good luck with your program.

DR. RHEUBAN: Thank you so much, and thanks for the great work.

SENATOR VITALE: Next, we have Latoya Thomas, American Telemedicine Association. Latoya is coming to us from Washington.

Ms. Thomas, can you hear us? (no response) (laughter)

L A T O Y A S. T H O M A S: I can hear you, yes.

SENATOR VITALE: Great, thank you. (laughter) I thought we had scared you off. (laughter)

MS. THOMAS: No, no, not at all.

SENATOR VITALE: You're the Director of the State Policy Resource Center for American Telemedicine Association?

MS. THOMAS: Yes.

SENATOR VITALE: Okay. Thank you, and welcome to the Committee. Thank you for taking the time to join us today.

MS. THOMAS: Thank you.

SENATOR VITALE: So you can begin your testimony.

Thank you.

MS. THOMAS: Thank you so much.

Thank you for the opportunity to speak to this Committee about the importance of advancing telemedicine legislation in New Jersey.

I'm Latoya Thomas, the Director of the State Policy Resource Center at the American Telemedicine Association. ATA is a nonprofit

organization that promotes telemedicine -- sometimes referred to as *telehealth* or *telepractice* -- and resolves barriers to its deployment.

Founded in 1993, members of ATA include over 8,000 physicians, administrators, and other healthcare professionals; as well as over 300 health systems, and vendors of telecommunications and advanced technology.

Today, for the Committee's consideration, I would like to highlight three policy issues that any state, including New Jersey, should address to remove artificial barriers, and to ensure that healthcare providers and patients can fully integrate telemedicine into their care plans.

The first is health insurance coverage parity for all State-regulated health plans, including private insurance, Medicaid, State employee health plans, and workers' compensation; the second is ensuring comparable practice standards for all State-licensed healthcare professionals; and the third is licensure portability.

We believe that the Committee has a strong and vital interest in taking advantage of healthcare delivery innovations that improve quality, reduce cost, improve timely access to needed care, and improve consumer satisfaction. Telemedicine is an innovative delivery method used to complement in-person care. It is not a separate service, nor a clinical specialty, and should not be treated with different or unbalanced standards.

ATA believes that New Jersey residents and healthcare providers should not be penalized for using such cost-saving and quality-improving methods -- like telemedicine -- to enrich population health. The truth is that telemedicine today is in use in many forms in every state and in practically every hospital and health system. It can take the form of

videoconferencing, remote patient monitoring, or remote image capturing solutions, just to name a few.

Telemedicine is also supported by digital diagnostic medical device peripherals such as an otoscope, a pulse oximeter, a glucometer, stethoscope, and blood pressure cuff. In fact, physicians are using a variety of popular consumer devices to provide quality care, including smart phones and tablets. Some clinical examples include telemental and behavioral health, primary and urgent care, teleICU, dermatology, cardiology, neurology for stroke diagnosis, maternal and fetal medicine, teleradiology and pathology, and correctional care.

This year alone seven states enacted telemedicine parity laws. This brings us to 29 states and Washington D.C. with enacted parity laws which prevent private insurers from engaging in discriminatory practices -- like the nine claims because telemedicine was used in lieu of an in-person encounter to provide a covered service. Almost half of these states have 10 years or more successful experience with telemedicine. Moreover, telemedicine parity provisions act as consumer protection against deviant industry practices.

If a health insurance company states that they will cover a healthcare service, then a consumer should expect for that service to be covered -- whether delivered in-person or via telemedicine. These statutes also prevent private insurers from instituting arbitrary barriers that impede access to telemedicine, such as requiring higher deductibles, co-payments, or co-insurance than that of in-person services.

And here are a few notable telemedicine trends across the country: Some of your own healthcare plans have proactively included

telemedicine coverage. New Jersey individual health coverage and small employer health benefits programs this year approved new language covering telemedicine, e-visits, and virtual visits under individual health and small employer plans. These new policies will go into effect for plans issued or renewed in 2016.

In Pennsylvania, to address public health issues such as high-risk pregnancy and high infant mortality, Pennsylvania Medicaid's plan has reimbursed for telehealth-provided consultations by maternal, fetal, and medical specialist since 2007. The Agency instituted this policy reform due to the statewide shortage of maternal fetal specialists, and also to improve the quality of care for expectant mothers.

In New York, the state enacted a telemedicine parity law in 2014. The law was leveraged largely on the success of innovative telemedicine demonstrations covered under the Medicaid program. To address the burgeoning Medicaid costs for the state's most chronically ill residents, New York enacted legislation covering home telehealth services. This would include monitoring a patient's vital signs, patient education, medication management, and also a review of patient trends and/or other changes in the patient's condition.

The state's Home Care Association studied telehealth programs of four homecare agencies over the course of one year, and the results were impressive. There was an average of a 13 percent decrease in avoidable hospital readmissions, as well as an average annual savings of over \$217,000. In fact, half of the state Medicaid programs reimbursed for telehealth-provided services in the home, and 16 of them reimbursed for services provided in school.

Finally, one other example: In an effort to reduce inmate population and the rate of recidivism, the state of South Dakota has implemented a telehealth substance abuse treatment program for nonviolent adult offenders. The program connects drug and alcohol treatment counselors with those on parole and probation for individual and group counseling. They connect to services using smart phones, tablets, and laptops, and even use sites like public libraries for assistance.

Now, accommodating dynamic clinical models such as these and patient preferences for 24 hours, 7 days, 365, on-demand access to care will require a more malleable understanding and expansive envisioning of 21st century health care. A clinician using telemedicine, a 21st century approach to enhance the delivery of care, must comply with the same standards established for in-person medical or healthcare practice; and is accountable to the respective boards in which he or she is licensed.

ATA strongly supports the mission of state licensing healthcare professional boards to ensure the protection of the public's health, safety, and welfare; as well as other mechanisms that assure patient safety and promote that all healthcare services delivered -- either in person, or via telemedicine -- are of the highest quality and provided in a safe manner. Specifically with regard to clinical practice rule, we believe that, as much as possible, the practice of telemedicine should not be regulated differently from in-person care. And while there are important clinical differences, it should be recognized, allowed, and appropriately regulated. The provision of telemedicine should not be held to a different standard than in-person care.

The impact of telemedicine goes beyond healthcare professionals, of course. Patients are mobilized; they travel within New Jersey and out of New Jersey for personal reasons, including work, leisure, education, sports, and also to engage in commerce. As a result, they often receive services from more than one healthcare provider, and large healthcare systems have responded to this need for more accessible care by establishing provider networks across multiple states. There is an increasing belief that the existing system of requiring a healthcare license each time a healthcare provider examines and treats a patient located in another state needs repair.

In closing, we know that inequities in coverage for telemedicine delay the adoption of cost-savings and quality improvement measures available through advanced technology. They also restrict consumer access to specialized services in underserved areas. This Committee can take immediate steps to prevent discriminatory practices against telemedicine users by requiring comparable professional practice standards and coverage parity for telemedicine-provided services to that of in-person practice. This would be seen as a proactive step to alleviate New Jersey's prevailing health disparities.

Thank you for the opportunity to present these comments. I and members of ATA are happy to be a resource to you and to other members of the Committee to make advances and reform policies in order to help the residents of New Jersey take advantage of the promise of telemedicine.

Thank you.

SENATOR VITALE: Thank you, Latoya.

Any comments?

Senator Whelan.

SENATOR WHELAN: Thank you, Mr. Chairman.

Ms. Thomas, we appreciate you being here, and we thank you.

As the national association on this, you talked about the licensing problem -- if I could just call it that. But I'm sure as we get into this we'll find that our surrounding states -- New York, Delaware, Maryland -- each may have a slightly different version. As the national association, how can we work to sort of smooth that out so that there's sort of one standard, and that what we're doing here doesn't conflict with New York? Because a lot of our patients -- or a lot of their patients may be using telemedicine based in Jersey; or, again, our patients may be using New York centers; and the same thing vis-à-vis Delaware, Maryland. How do we get everybody on the same page, I guess?

MS. THOMAS: Sure. I think, one, it takes some endorsement on the part of the state licensing boards in those various states. I can tell you that regions, like the region that I live in right now -- D.C., Maryland, and Virginia -- the nurses and also the physicians in the states have reciprocal regional agreements in which they realize that they're (indiscernible) to, or sometimes living in D.C. but they might work in Virginia, or they may work in Maryland. And so the licensing professional boards in this regional area have come up with a regional reciprocity, in that healthcare providers, as long as they're clearly capable and duly licensed, and have no disciplinary marks against them, are able to cross those lines seamlessly -- those regional lines -- without the need for an additional license. So that's one example of regional reciprocity.

There have been some national approaches for a more national compact approach, if you will. The nurses -- the National Council of State Boards of Nursing has a national compact arrangement in which a state can agree to minimum terms for registered nurses. And I believe that they have also passed, and are probably going to introduce next year, legislation allowing for the same kind of compact licensure arrangement for nurse practitioners throughout the country. Currently, there are 26 states engaged in that kind of compact. And so we're looking forward to seeing an additional 26 states allow for nurse practitioners and advanced nurse practitioners to do the same. The Association for Psychology Boards has created a similar model to that of the nurses -- again, allowing for cross-state licensure or licensure reciprocity without the need for an additional license.

So there are some approaches out there, and I imagine they'll be introduced in legislatures next year.

SENATOR VITALE: Senator Madden

SENATOR MADDEN: Yes. Hello, Director.

In the opinion of the ATA, by way of example, do you have some states that you could identify for us that have, in the ATA's opinion, good policy regarding telemedicine?

MS. THOMAS: Sure. The first states that come to my mind in terms of good policies are those states that are clear, concise, simple, and, to a large extent, stay out of the way of over-regulating telemedicine or looking at it differently. New Mexico has a very good policy when it comes to coverage and reimbursement of telemedicine under private insurance and Medicaid; telemedicine is covered under the state's Medicaid fee-for-service and managed care plans. There are no restrictions on where a patient needs

to physically be; or be prevented from the patient setting. They can be in their home, their school, or their work in order for that service to be covered under private insurance or Medicaid. You have states like Mississippi -- which often ranks last when it comes to health outcomes or healthcare disparities -- but it's a state that's been quite proactive in ensuring that its residents throughout the state have some kind of access to available healthcare providers using these telecommunications, wherever they might be. And then you have a state like Tennessee that, last year, enacted a telemedicine parity law for private insurance and Medicaid; but then went one step further this year to make sure that state licensing boards wouldn't be able to regulate telemedicine differently than that of in-person service, and enacted a statute to do just that. So there are some notable states with good, clean, and concise policies.

SENATOR MADDEN: Thank you.

SENATOR VITALE: Thank you.

Are there any other questions from members? (no response)

Ms. Thomas, thank you so much. And we will be in touch and work with you a little bit. We have legislation that we drafted, and there are a few different pieces of legislation that are in the system. We wanted to spend the next couple of months looking at all our options and learning from experts in the field, like you and others.

Thank you so much for being a resource. We look forward to more of that.

MS. THOMAS: Thank you for having me.

SENATOR VITALE: Sure; thank you.

MS. THOMAS: Thanks.

SENATOR VITALE: Our next witness is Geoffrey Boyce, InSight Telepsychiatry.

G E O F F R E Y B O Y C E: Hi, there. Thank you very much for the opportunity to be here today.

My name is Geoffrey Boyce; I'm the Executive Director of InSight Telepsychiatry. Some of my colleagues in the room might know me from our sister company, Center for Family Guidance, PC. We are a New Jersey-based behavioral healthcare provider; we work out of Marlton, New Jersey. And we are one of the nation's largest providers of telepsychiatry services.

We got our start back in 1999 when we actually did the first telepsychiatry encounter in New Jersey at the South Jersey Hospital/ Bridgeton location. We did that in 1999 through a series of collaborations with the State to gain approval for bringing telepsychiatry into the psychiatric screening process.

Since then, we've conducted around 300,000 telepsychiatry encounters within New Jersey, within the psychiatric screening process. Last year, all in all, we conducted around 125,000 telepsychiatry encounters across about 20 different states. We are one of those PSOs -- Physician Services Organizations -- that my colleague from Robert Wood Johnson mentioned a little bit earlier.

Our practice model is generally that we employ psychiatrists and advanced practice psychiatric nurse practitioners. And we allow them to work from home through secure video conferencing technology that we supply and support. We set them up to serve facilities where their services

are needed most. Often those are hospital emergency rooms or clinics in underserved areas.

Our model is to integrate those providers into the sites and the systems that they serve. We are never looking to replace good quality, in-person care with telepsychiatry services. Rather, our goal is to complement the existing behavioral health services within those facilities by adding some additional capacity, and adding some additional expertise; or bringing behavioral health into new areas.

We operate under three basic operational models. Our first one is what we call our *on-demand services* for those acute evaluations -- really, to figure out the right level of care. That's where telepsychiatry is often used within the psychiatric screening process.

We also have a scheduled service model of delivering care where we provide a consistent provider into a facility to manage a caseload for ongoing treatment.

We also have a *direct-to-consumer model* -- that's our Inpathy telehealth platform -- where we offer all forms of behavioral health; not just psychiatry, but counseling, and therapy, and psychology as well.

As I thought about my comments today, I really wanted to try to address the question of why is telemedicine so powerful. So within our rapidly changing healthcare environment, where we're all moving into the era of accountable care, why is telemedicine significant?

I think there are three main points that I'd like to make first. I believe that telemedicine enables us to better allocate our scarce healthcare resources. As we're going after that Triple Aim, telemedicine really does enable us to have more options to deliver the right care, at the right time,

from the right provider. It also enables us to use those resources more efficiently. We're able to get a provider where they're needed without having to waste their time driving or moving around otherwise.

Telemedicine also enables us to extend our workforce of providers. That's particularly important within the field of psychiatry, where more than half of the practitioners are over age 55 at this point and new programs are seeing declines in enrollment. With telepsychiatry, we're able to allow these providers to work longer into their careers and to ease their way into retirement sometimes. We're also able to allow providers to work in times in their lives where they might not otherwise be available within the workforce. New parents are a great example of that.

I think the second reason why telemedicine is so powerful is because it enables collaboration and a sharing of expertise to providers. Senator Madden asked a great question earlier about what's the difference between consultative and evaluative forms of telemedicine. And with that consultative model, really, any provider, any health system anywhere can have access to the right level of care or the absolute expert on that particular case in the moment. Telemedicine really shows a lot of promise on that idea of collaboration and expertise sharing.

And I think one of the final points about telemedicine, that I find to be most powerful, is that it engages patients in the treatment process. It gives consumers -- as we like to call them within behavioral health -- more options on how they receive their services: more options for scheduling, more convenience, and ultimately more ownership in the care that they are getting.

When I think about what might happen if New Jersey doesn't take some action on this, and we don't create an appropriate framework for conducting telemedicine in New Jersey, I worry that patients are going to face unnecessary barriers to timely care. I worry that outcomes might be lower, that our access to expertise might be limited, that we'll see less compliance with the treatment plans that our providers are laying out there, and that many issues might go undiagnosed or unaddressed and they might escalate into larger issues.

I also worry that if we don't act, providers will be forced to practice with an unclear environment. Right now, there's not a lot of clarity within New Jersey about what is and what isn't telemedicine, telehealth, telepsychiatry, or otherwise. Providers need this clarity, and if we don't give it to them some are going to grow even more risk-averse and limit their practice. Some might also pursue more inappropriate forms of telemedicine without appropriate structure and guidance; and some might just leave the workforce.

I also worry that if we don't act, New Jersey's resources might be diverted elsewhere. Providers want to do telemedicine and consumers want to receive it. And if we don't create an environment here that is favorable to telemedicine, our New Jersey providers are going to send their services elsewhere, and applicants who might be seeking an education in telemedicine might apply to schools that have an emphasis in that. Right now, we are not keeping our talent in New Jersey -- by not embracing telemedicine -- and I think that's a challenge and a risk.

So I also wanted to look very specifically at where we have seen telemedicine move the needle in a positive direction, particularly when it

comes to telepsychiatry. What are some of the outcomes that we've really seen in our last 17 years of providing telepsychiatry within New Jersey and across the country? And I wanted to highlight a couple of outcomes.

Number one: Through telepsychiatry, we have a reduction in inappropriate psychiatric commitments, because we're able to get that highest level of expertise involved in the equation early and we're able to avoid inappropriate admissions.

We have also, through telemedicine, been able to conduct a timely evaluation within a hospital emergency room, which ultimately enables us to reduce the overall length of stay for that consumer in the ED. We're also able to initiate some treatment while folks are in the emergency room waiting for placement. While in the ED, we can follow back up on them, we can initiate home meds, we can help stabilize their behaviors; and oftentimes, we're able to triage those individuals to a lower and more appropriate level of care with telepsychiatry -- and that's particularly important.

Within the corrections realm, we've also used telepsychiatry to make some significant impacts. We've seen improved use of officers' time within the field and their use of overtime; often our officers are involved in psychiatric commitments, transporting individuals to emergency rooms for evaluation, and that's not the best use of their time. Telepsychiatry can enable those officers to use their time well to reduce offsite transports and to get those individuals triaged to the right level of care in the moment.

Within corrections, we've also seen significant reductions in formulary costs within the county jails within New Jersey, by bringing in

true psychiatric expertise that is sensitive to their correctional environments and the limited formularies that are available in that space.

And overall, we're able to see shorter wait times for outpatient appointments within psychiatry. We're also able to bring child psychiatry into areas where it's needed most; and we're able to do that via telemedicine, where we can get better psychopharmacology by a working collaboration with pediatricians and primary care practitioners. That's particularly important within New Jersey and all the way across the country.

So I thank you for the opportunity to offer my comments. I'd be happy to field any questions.

SENATOR VITALE: Any questions from members? (no response)

I do. On the behavioral health issue, where in New Jersey-- Do you know where some behavioral health telemedicine is being applied today?

MR. BOYCE: So I think largely telepsychiatry is being used within the psychiatric screening process within New Jersey. So presently, most of the psychiatric crisis centers within New Jersey use telemedicine for their after-hours evaluations, which is a little bit of an interesting system. It uses a waiver system that has to be granted specially. And normally those waivers are only allowed to apply after, like, midnight and until 8 a.m. the next morning. It's kind of a strange thing, in that you have to have special permission to be able to use telepsychiatry within the commitment any time after midnight. So a clinic-- The same evaluation that's valid at midnight

via telepsychiatry right now, you have to have a waiver and you're not allowed to do it during business hours -- which is a little abnormal.

It's used in limited function within residential programs and outpatient clinics. I think some of the limitations to using telepsychiatry within that scheduled services model within New Jersey is largely the way that the Medicaid reimbursement policies are structured. They require a licensed, in-room facilitator, which is an additional resource that can be expensive. And particularly when you're dealing with Medicaid rates that are limited, that additional resource kind of pushes it over the edge where telepsychiatry doesn't often make a lot of sense in a regularly scheduled outpatient model here in New Jersey.

SENATOR VITALE: What about commercial payers? So, someone with a drug treatment program -- to an outpatient drug treatment program, does telepsychiatry exist now or telehealth exist now for providing that kind of care?

MR. BOYCE: It does not, in New Jersey; there is really, obviously, no mandate for a commercial carrier to pay in New Jersey, and there hasn't yet been a lot of programs that have volunteered to do that. As you heard some of the other folks speak, too, that is not the case in many other states -- 20 or more states have adopted telemedicine parity for commercial insurance reimbursement. And so, yes, I think New Jersey has some opportunity there.

SENATOR VITALE: Yes, that's part of the bill.

Okay, great. Thank you.

Anyone else? (no response)

Thanks for your time.

MR. BOYCE: Thank you.

SENATOR VITALE: The next set of witnesses -- Dr. Gary Rosenberg, Dr. Solhkhan, and Malia -- I think it's C-O-R-D-E, if I'm spelling it correctly -- from Meridian Health.

If you could just say your name for the record as you speak so we can get it right; I don't think I did.

Thank you.

G A R Y B. R O S E N B E R G, M. D.: Hi, I'm Gary Rosenberg, child analyst and psychiatrist. I am representing the New Jersey Council of Child and Adolescent Psychiatry; and the Primary Care Child Psychiatry Collaborative project, which has been in existence since 2010. It's a multidisciplinary coalition of providers that has a strong working relationship with Senator Gordon and his aide, Jennifer Mancuso, who I will give kudos to.

We have been trying, for the last five years, to develop a program in this state that exists in 35 other states in the country. We allow pediatricians or other primary care providers -- primarily pediatricians -- to have almost immediate access to a child and adolescent psychiatrist or a social worker who can provide advice about programming and resources available in the area of that pediatrician.

The child psychiatrist will advise the pediatrician on treating a child who's in their practice. And I'll back up a step by stating that about 20, 25 percent of children in our country have some kind of mental health disorder; 50 percent of that number never receives any treatment. Of the 50 percent who do receive treatment, anywhere between 50 and 60 percent of those people -- those kids are getting treatment from their pediatrician.

Our pediatricians are the *de facto* mental health system for children in our country and in our state as well. A lot of factors go into this, some of which have already been mentioned in terms of the shortage of child and adolescent psychiatrists. But there are other factors, too, why some parents and children prefer to get their care from their primary care physician. Primary care physicians, pediatricians also acknowledge that they don't have the education and training. They didn't know they were going to end up being child psychiatrists when they elected to become pediatricians. So the program also provides a significant amount of education and training for those pediatricians.

Of the 35 states in the country that have this program, a fair number of them utilize telehealth -- especially out in the state of Washington and other states with large rural populations. It's one way to gain access to and allow the child to have a direct face-to-face consultation with a child psychiatrist. Most of the encounters with the pediatrician around the kids are a telephone consultation. So we're providing assistance in that way. But sometimes some kids do need to be seen face-to-face in order to get a better sense of what's going on, and that's where telehealth comes into the mix.

Here in New Jersey, with the help of Senator Gordon and everybody else involved, we finally got some money to have a pilot project that started a little over a year ago -- into the second year -- housed at Meridian in Monmouth and Ocean counties, and Cooper down in--

RAMON SOLHKHAN, M. D.: Camden and Burlington.

DR. ROSENBERG: --Camden and Burlington, right. Dr. Solhkhan will address their progress in that project, but right now we're also

in the process of establishing two more regions in the state. So we'll have a total of four different sites in the state that are providing services to pediatricians. The ultimate goal, of course, is to have a statewide program. We hope we can roll this out more quickly than the next three or four years, if we go at the present pace. But at that point, we really want to be able to utilize all services available to provide a quality experience for those kids who need care, and the pediatricians who are providing that care.

M A L I A C O R D E: Good afternoon, and thank you for having us today.

My name is Malia Corde, and I am the Director of Medical Home Initiatives at the Statewide Parent Advocacy Network. We are an advocacy organization that works with families across systems.

I am the sibling of an adult brother who grew up with bipolar disorder; and I am also now a mother of two sons who have been diagnosed with depression over the past 12 months. I can tell you firsthand how much this program means to families who have children who have mental health and behavioral challenges. It allows families to get their children screened earlier; it allows families to get services earlier for their children. It also helps families to get the educational supports and services that their children need through the school system. It also helps healthcare providers better support the patients who they're working with. As Dr. Rosenberg said, many healthcare providers do not have the training or expertise to patient a child who may have some behavioral or mental challenges. So it's important to support healthcare providers because that is where their children's medical homes are; it's important to integrate the mental health services so that we can have a true medical home for that child. So there is

a team approach; there is a holistic approach to the child, not just focusing on the child's overall health, but mental health as well.

It also provides resources that the healthcare providers do not know about because they don't have the time or the staff to identify where those resources are. So that social worker is there to support and provide a lot of the information that healthcare providers, unfortunately, are not able to do. It's a team approach; it's shown to have a lot of positive impact on not only building capacity within the families, but also to build capacity for the healthcare providers who are serving the families.

I so appreciate the funding that has come forward in the pilot projects, and I continue to hope that you will fund future projects in order for this to become a statewide program.

Thank you.

SENATOR VITALE: Thank you for your testimony.

Sir.

DR. SOLHKHAN: Good afternoon. I'm Dr. Ramon Solhkhan; I'm the Chairman of the Department of Psychiatry at Jersey Shore University Medical Center, and the Corporate Medical Director of Meridian Behavioral Health Services. Like Doctor Rosenberg, I'm also a child and adolescent psychiatrist by training.

And we at Meridian use telehealth -- and telepsychiatry in particular, as was stated earlier, in our crisis service. It's an interesting paradox that we have a waiver in Ocean County so that some of our hospitals are able to access that service for PES screening, but not at our Monmouth County hospitals. So it certainly speaks to some of the

challenges across the state, just with two counties that are next to each other, in managing these services.

Most recently, I have been on as the Medical Director for the Department of Children and Families-funded project related to the pediatric and psychiatry collaborative, which is designed to provide consultation services to pediatricians in the community, as well as to other primary care providers, to extend the reach of child psychiatry. As Dr. Rosenberg said, child psychiatry is the most underserved of all the medical specialties. And even in New Jersey and in the Northeast Corridor, where we have the most rich number of child psychiatrists, we're still underserved; and we'll be underserved for many, many years, going forward. So the only way we can provide these services is by using the child psychiatrists and the other psychiatrists we have more efficiently. And telehealth is certainly the way to do that.

SENATOR VITALE: Thank you.

Comments? (no response)

Thank you very much.

DR. SOLHKHAN: Thank you.

MS. CORDE: Thank you.

DR. ROSENBERG: Thank you.

SENATOR VITALE: Before I call our next panel, I just want to acknowledge the Chairwoman, Assemblywoman Pam Lampitt, is here. I just wanted to thank you for being here today. I know you'll be helping us to marshal this to the Assembly as well. So thank you, Chairwoman.

Dr. Stephen Scheinthal, Tim Martin, and Mishael Azam.

M I S H A E L A Z A M, Esq.: Thank you, Chairman. Thank you for having us today.

I was going to do a quick overview on our policy, generally, and then turn it over to Dr. Scheinthal for specifics in psychiatry; but we're going to reverse because he has to leave.

Thank you.

S T E P H E N M. S C H E I N T H A L, D. O.: Thank you, Chairman Vitale and the Committee. And thanks for getting the pronunciation right; it's not an easy name.

Steve Scheinthal; I'm Chairman of the Rowan University Department of Psychiatry. We're the largest academic psychiatry department in the State of New Jersey, employing over 68 psychiatrists and nurse practitioners, serving the eight counties of southern New Jersey.

I went to the former UMDNJ School of Osteopathic Medicine; I stayed for my residency and I did a fellowship in geriatric psychiatry. And in fact, the vast majority, I think, as you may all be aware of -- more than half of the Rowan SOM students stay in New Jersey; but it's more than 80 percent of our psychiatry graduates stay in southern New Jersey to provide direct care.

We are very much in support of telemedicine. This is definitely the wave of the future. There are pilot products currently in our sister medical school, Cooper Medical School at Rowan University, as well as exploratory projects within our own Department of Psychiatry in providing integrative care. The Cooper project is linking child psychiatry with primary care offices in southern New Jersey; and at Rowan SOM we're looking at not only linking our faculty practice plan offices with psychiatric

providers, but also within our hospital networks we serve eight hospitals in the southern region in terms of linking their primary providers with behavioral health care. And that's not always easy to do on site.

I do want, though, to talk about some of the challenges and the safeguards that need to be in place in order to move telemedicine into the future in New Jersey.

With regard to behavioral health care -- and we do prefer, in psychiatry, to refer to our patients as *patients*, not as *consumers*; the American Psychiatric Association and the American College of Osteopathic Neurology and Psychiatrists prefer the term *patients*. *Consumers* diminishes what they actually are in the system. But we need to make sure New Jersey, which has always erred, for behavioral health patients, on the side of patient rights -- that that continues to stay firmly in place.

Our experience in Cumberland County, which we've been in for a year, has been most dramatic. And since we started in Cumberland County, the Division of Mental Health and Addiction Services has actually put a stop on waivers for behavioral health care for telepsychiatry. The reason for that being that prior to Rowan University entering into Cumberland County, Cumberland County had the highest commitment rate in the State of New Jersey, running at -- about 50 percent of patients presenting to the emergency department for psychiatric issues were committed.

Since the switch in October of last year to the University-based model -- which incorporates some telemedicine, but mainly relies on live interactions -- that commitment rate dropped to just below 30 percent, and is now back in line with other screening centers in New Jersey.

We are aware of a case in Gloucester County that I, unfortunately, got intimately involved with. A gentleman, who was Spanish speaking, could not consent to telemedicine, could not use the language line. He was, in fact, medically delirious; it was not a psychiatric illness. He wound up committed via telemedicine. His rights-- Well, I won't go there. But we need safeguards in place for these types of issues.

Third, and finally, what I would like to point out is, in my credentialing role in our healthcare systems -- I do credential some of the telemedicine providers -- one gentleman had a PAP -- Physician Assistance Program -- note on his record, so I did a telephone interview with him. This is someone who is licensed in New Jersey, but located in another state. He had a very innocent explanation: He was partying after graduating and got pulled over with a DUI. And that was, like, five or six years ago. And I happened to ask this physician, "When was your last drink?" And he said, "Six months ago, when I realized I was an alcoholic." Our concern is that no one will lay eyes on this physician in an emergency department, and the risk for impaired physicians treating our patients is -- unfortunately, that potential is there.

Finally, I do -- if I can indulge you -- just want to let you know I got an e-mail, just while I was sitting here, about yet another case that presented to Bridgeton Hospital -- where a patient from another county in southern New Jersey was screened, and the patient said, "They screened me while I was intoxicated." And, in fact, when the records were reviewed -- and I was copied on this e-mail -- the patient's blood alcohol level was well above the legal limit to be interviewed, or even assessed, for involuntary commitment. And adding insult to injury was that the bachelors-level

screeener filled out most of the commitment paper -- the doctor did a couple parts of the commitment paper -- and the Cumberland County Mental Health judge has flagged this case. And I understand there are other cases as well.

So I do trust all of you to do the right thing to continue to protect the rights of New Jersey residents. But telemedicine is definitely the future, and we need to do it right in New Jersey and consistent with the way we protect patients' rights, historically.

Thank you.

SENATOR VITALE: Mishael.

MS. AZAM: Thank you very much, Chairman.

So I just wanted to, kind of, go over MSNJ and AMA's policy around telemedicine.

So far you've heard about one model of telemedicine -- which is an enhancement of what physicians, and hospitals, and facilities are doing in New Jersey already. We fully support that kind of enhancement of patient care. What we're concerned about is the replacement, as opposed to an extension. We are concerned about promoting telemedicine that is a kind of separate industry in which patients are seen by doctors who only do telemedicine, and don't necessarily have a connection to New Jersey or a presence in New Jersey.

So a few basic concerns: First is that -- it was touched on a little bit earlier. Telemedicine -- in general the premise is that it happens where the patient is located. So with that, we do support telemedicine when it's provided in New Jersey, that the provider have full licensure in New Jersey and nothing less; otherwise it's a disservice to the patient that

they're seeing somebody with a special license or a limited license. With that license comes medical liability requirements, the same regulations and licensure requirements that comes with anybody who is licensed in the state.

And then, again, most medical societies agree on the standards for telemedicine. It's really simple: It has to be necessary, safe, effective, medically appropriate, and provided in accordance with the excepted standards of medical care. We just shared with you the AMA policy on the standards, which are pretty clear-cut about record keeping and consent, etc.

The other major issue which has been mentioned a lot here is pay parity. We support pay parity. Over 40 Medicaid programs are paying for telemedicine now; over 30 states require commercial payers to pay; Medicare is paying. And we actually-- There was a survey done in 2014 about physicians who are in New Jersey already, about whether they want to or engage in telemedicine. And the study showed that 33 percent of physicians surveyed said that they were already using some form of telemedicine; 29 percent said they were planning to; so about 62 percent want to or will use telemedicine.

But then the survey went on to ask doctors if they're being paid for that service, and the answer was only about 19 percent said they were being paid. So as you know, there are bills in New Jersey, including yours, that would require payment both from private carriers and from Medicaid, and we support that legislation.

The nuance here -- again, going back to the difference of the industry that does only telemedicine -- is, our concern is that the money is going to that industry, rather than to our doctors who are already providing

services in New Jersey. So carriers are narrowing and tiering networks, and making it harder for our physicians to practice -- but then partnering with telemedicine companies and providing payment to those providers instead of our New Jersey doctors who are well-trained and provide quality care.

So I know there's a perception that patients and consumers want this service, but we have to keep in mind what's in their best interest. And we know that we are going towards outcome-based care. Our measures are more about value and outcome. And we're trying to get away from fragmented, stand-alone, episodic care. Even if a telemed visit may cost less than a real-life visit, that doesn't mean that the patient's health, in the long term, is going to cost less if the care is fragmented. So we want to continue the collaborative team-based model that we've already been working towards.

We want patients to have medical homes; I think the estimate is that about only 50 percent of our patients here have primary care providers and medical homes. And so our concern is that telemedicine, if it's meant as a separate industry, is going to continue to take patients away and not encourage them to have medical homes. I know some of the telemedicine companies say that, "We are only here as a Band-Aid, and that we encourage patients to find doctors in that state." I'm just not sure how much it really happens.

The other issue is that if it is done separately and not as an extension of the care that's provided, our concern is that you're going to see things that may be easy to diagnose -- but aren't really. So if you think it's a basic ailment, the whole point of a physical examination is that it may show that it's much more than a basic ailment. A urine infection could, in

fact, be mental illness. And these are things that you aren't going to see over telemedicine.

And that also gets to the point of cultural competency. Our physicians here and our hospitals are moving towards having more culturally sensitive care. There was an article just last week about a hospital in North Jersey that has a Korean maternity program. We are a diverse state, and we want our providers to know their patients. If a patient does telemedicine and that doctor on the other end doesn't know that the university just had a MRSA outbreak, or that patient lives in an area that was affected by Sandy and may be suffering from depression or may have exposure to mold -- those doctors may not know any of that, about what's going on in New Jersey, where that person lives, what their environmental circumstances are.

That same study -- the 2014 study -- when it went back to when doctors feel that telemedicine is appropriate, it said that 68 percent of the doctors said that 0 percent of initial visits are appropriate for telemedicine; 18 percent said that one-fifth or less of initial visits are appropriate; and only 8 percent said that only follow-up visits are appropriate. So that's how we want it to be -- an extension of our doctors' work here, rather than a replacement.

As for quality of care -- again, we want cultural competency. But there's also regulations in New Jersey that do protect patient, that we want to make sure stay in place. These are patients who require the establishment of a bona fide patient relationship, that require a physical before medicine is prescribed. I appreciate the American Telemedicine Association's comments, but in their written comments they have said that

requiring an in-person exam to establish a patient relationship is an artificial barrier; and they call it *obstructive*. These are protections that we already have in place in New Jersey. And I beg to differ that they are artificial or obstructive. I think they're important patient protections that we need to keep in place.

So the last thing is -- just the issue with, again, the insurers partnering with the telemedicine companies, rather than supporting our physicians here. One of the companies says that the product that they offer through the exchange -- that the doctor will call you back, and diagnose you over the phone, and e-prescribe medication. And apparently, one of the companies here already thinks that is doable and safe. And we just, kind of, disagree -- that that convenience is actually at a larger cost of the patient's well being, in the long term.

So we are only one of a couple of states that don't have a definition of telemedicine yet. The Small Employer Health Board did try to cobble together a few different definitions, based on what the carriers provided. So we hope we do come up with a definition here; we just don't want that definition to exclude the establishment of a patient relationship.

And finally, to end on a positive note. I have seen some of the really good work that telemedicine has done here. At Virtua, in particular, you're going to hear from -- we've seen their pediatric neurology. We have seen the work that Dr. (Indiscernible) is doing, and the collaborative that Dr. Rosenberg is doing. So we know that telemedicine is an important and integral part of patient care; we just don't want it to be separated and fragmented, with a lack of integration and collaborative care.

SENATOR VITALE: Any questions? (no response)

Thank you.

MS. AZAM: Thank you.

SENATOR VITALE: Thanks a lot.

We'll next bring up Sarah Adelman, New Jersey Association of Health Plans.

S A R A H M. A D E L M A N: Good afternoon, Chairman Vitale and members of the Committee.

I am Sarah Adelman with the New Jersey Association of Health Plans. Thank you very much for the opportunity to comment today on telemedicine in New Jersey.

We echo many of the comments you've heard today about the promise of telemedicine. We believe that telemedicine will reduce wait times for primary care and behavioral health in New Jersey; will potentially reduce low acuity emergency room utilization; can help bridge geographic distances to reach certain specialists; and can leverage emerging technologies to help solve healthcare access challenges that exist. Moreover, telemedicine offers the opportunity to provide high-quality, secure, convenient, and cost-effective care.

For commercial insurers, the original application of telemedicine in New Jersey had been offered as a service -- as a value-added service, not as an insured benefit -- kind of like nurse hotlines have been, historically. But this technology is rapidly improving, and consumer access is expanding. As a result, carriers are increasing the ways in which telemedicine is employed, and have begun increasingly building it into their insured benefits with a telemedicine option.

As a reflection of this -- and you've heard this mentioned a few times today -- the Small Employer Health Benefits Program Board -- the regulatory body that drafts the standard contracts for insurers in New Jersey -- recently proposed and adopted a health benefit plan policy form language to allow carriers to add the option of telemedicine to the policies offered in New Jersey. So there had been some questions about coverage and these things. This is a new development, as of last month.

And so what you'll see is that health plans typically will use vendors like TelaDoc and American Well to create networks of teledoc and telemedicine providers, and then will leverage technology that's available through the vendor to offer this service to insured individuals.

So the health plans also share many of the key principles you've heard outlined today around telemedicine -- particularly that regulatory policy which is developed in New Jersey should not create new barriers to accessing telemedicine, but that it should remove barriers to access telemedicine. In our written testimony we've provided a number of our principles and some commentary on the bills that have been introduced in New Jersey.

A few notes on our principles that I would leave with you are: that around treatment standards, we believe that telemedicine should be held to the same standards of practice as those in the traditional setting; and that, by requiring those treatment standards, telemedicine is an appropriate avenue to establish the physician-patient relation. We also believe that patients should have the ability to choose physicians through telemedicine to the extent possible; and that licensed providers should be able to prescribe, as appropriate, through telemedicine.

One key objection, that's come up a few times, that we have is around mandating equal payments or payment parity between telehealth and in-person care. Facility and administrative fees are lower when the service is provided through telehealth. Telehealth visits have lower overhead costs, and telehealth can help to address rising medical costs, but not if payment parity is mandated in law. So as I mentioned, the health plans are using vendors to begin negotiating contracts and to bring telehealth providers into their networks. We believe that government rate setting would hinder the proliferation of telemedicine in the state, and would blunt its effectiveness at increasing access and reducing cost for consumers.

Thank you very much for hearing our comments.

SENATOR VITALE: Thank you.

Do you know what it's like -- the experiences in other states and the insurance -- most of the insurance issues? So in terms of payment parity, are there states that have parity and states that don't have parity?

MS. ADELMAN: Yes. I believe that 29, maybe a couple of more states now have passed some kind of regulatory guidance so that telemedicine can be provided in their state. And some of the states have considered laws that require mandating payment parity. I think in New Jersey the health plans are eager to provide telemedicine services; they don't need to be mandated to do so. And we would recommend that you allow the market to dictate the payment levels for telehealth.

SENATOR VITALE: Maybe this is a question that I should have asked, or I could still ask those who are going to testify after -- particularly for the -- maybe the folks from Virtua would know.

I mean, it's clear, I think, if we think about this and without knowing too much detail, a provider providing telehealth from their office-- Now, whether it's-- So a traditional doctor's visit is when you come in, you see the receptionist or the assistant to the provider, and there's a physical space and all the expenses that go in to being a provider -- insurance, all the rest. But in terms of telehealth -- maybe I'll ask this of others -- but do you know-- I mean, do they provide it in a different space? Do they do it from their home? Can they do it from somewhere where the cost is less, the overhead is less, and then, therefore, the cost to the system is less?

MS. ADELMAN: I think that's the goal -- is that, certainly, however the care is provided, it's in a setting that is potentially less costly than the in-person setting. I think in our-- The principles that we set forth, we talk about allowing a physician or a health care provider to offer these services from any location and allowing a patient to access these services from any location. In terms of our principles or objectives for the potential action, I don't think we would have you specify where those locations should be.

SENATOR VITALE: It's probably unlikely that there are providers that do this exclusively -- not in this state, but in other states where telehealth has been happening for a number of years -- that they are exclusive telehealth providers; meaning that they could literally sit, say, at home, but sit in a much smaller office facility where the resources are much more limited than they are today in a traditional setting. But I would think they would probably not; it would not be the best way in which to provide care to a patient, if it is that it's only -- if it's all telehealth, there is no opportunity for in-patient contact or person-to-person contact.

But thinking about this -- I know we had comments earlier that pay parity was important, or necessary -- and then your comments that it may not always be necessary in certain circumstances. So that's an issue we're going to have to get into. I'm sure that will be one of the barriers to moving this forward.

Thank you, Ms. Adelman.

MS. ADELMAN: Thank you.

SENATOR VITALE: Anyone else? (no response)

Thank you.

Linda Schwimmer, New Jersey Health Care Quality Institute.

If we can get -- just so we can round out the witness table today and finish up-- We also have Mary Abrams, New Jersey Association of Mental Health and Addiction Agencies; and Tarun Kapoor, from Virtua.

Ms. Schwimmer, you're next.

L I N D A J. S C H W I M M E R, Esq.: Good afternoon, Senator Vitale and other Senators. Thank you for having me here today.

The New Jersey Health Care Quality Institute is a regional improvement collaborative, with all of the stakeholders in New Jersey in our membership; and it's consistent with our mission of improving quality, improving access, and controlling costs. We're very supportive of telemedicine and would like to see it proliferate here in New Jersey.

I think one of the other speakers who came in via the computer said, "The patient is here to see you now." And I think that that statement, really, is emblematic of the opportunity in the future for telemedicine in our healthcare system. We talk a lot about patient-centered care, but we still live in an age where we have to call physician's offices and other providers

and hang on the phone on hold; you guys have all heard that music. We make appointments the old fashion way, and get care within banking hours. Clearly not the way of the future.

And telemedicine really offers an opportunity to increase access and convenience for all New Jersey residents -- particularly those who are elderly, whether they're homebound, or in nursing homes, or disabled, and lack transportation; also, though, for busy working families, professionals, and really all of us in the middle of the night. I think we've all experienced the need to and the desire to have some sort of face-to-face interaction, or to be able to show a medical provider a rash or an allergic reaction, or something that is not necessarily complicated and not necessarily something that needs to have a prior relationship -- but certainly something that needs to be addressed immediately. And if there is a way to do so without always having to rush to an emergency room, that's an opportunity for the patient and their caregiver to have a much better interaction with the health care system, to get much more immediate care, and certainly to reduce costs.

Also, as we move forward into value-based purchasing, the payment arrangements now are very different. So, for instance, primary care providers -- whether it's through commercial plans or, hopefully, Medicaid one day here, but definitely Medicare already -- providers are being paid a per-member, per-month comprehensive payment to take care of their members, their patients. So they're being paid extra money every month to really provide additional services to keep their patient population healthy. And what that means is having extended, greater access, which includes this 24-hour interaction with their patients and the availability. So whether it's through their office, or whether it's through a company that

they might partner with, or other healthcare providers in New Jersey that they're partnering with, telemedicine holds a lot of promise to really achieve the goals of patient-centered care.

It also-- There was a lot of testimony today, which I agreed with wholeheartedly, around behavioral health. And I am sitting next to some behavioral health experts, so I'll skip onto the rest of it. But all of us know that we have a lack of behavioral health providers here in New Jersey. And so to the extent that we can provide greater access, and we can scale them both through direct care, or have them be an adjunct to their other medical colleagues -- so that they can integrate with primary care and other care, and really provide better behavioral health and substance abuse care along with primary care -- it would certainly be beneficial to the residents of New Jersey.

And I think I touched upon the reduction of costs. I mean, that is a real issue here, and there are real examples across the country where money has been saved, better outcomes have been achieved, and it holds great promise for New Jersey. I'll just mention one, in the interest of time. There was a study in *Health Affairs* which talked about a nursing home project in Massachusetts where residents were able to connect through a two-way camera with outside physicians using conferencing equipment. And there was a great reduction in trips back to the emergency room. It's certainly better for the patients, and Medicare saved significant amounts of money.

We had a speaker from the University of Washington, Dr. Jürgen Unützer, come and present at a recent Quality Institute event, and he talked about the importance of integration of behavioral health. And

they had a 6 to 1 return on investment where primary care providers -- the full team of the primary care providers, working with integrated behavioral health providers who would work with the team but do so remotely -- were able to improve the lives of their patients as well saving significant dollars.

Lastly, I think it's important that providers, and payers, and everyone have clarity here in New Jersey. And so I think it's important, and it's great to see that you are going to be moving forward with some amended pieces of legislation.

I do think that it's important not to be too prescriptive on the payments, and not to think of it as fee-for-service; but in one location versus another. Because as I said, with value-based payments and with different and new ways of paying for things, you don't want to box yourselves into an old mechanism of reimbursement when that's really not where the rest of the country is going.

And thank you.

SENATOR VITALE: Thank you.

MARY ABRAMS: Good afternoon, Chairman Vitale and members of the Committee. Thank you for this opportunity.

I'm Mary Abrams with the New Jersey Association of Mental Health and Addiction Agencies -- otherwise called *NJAMHAA*, for short. *NJAMHAA* represents 160 hospital-based and freestanding nonprofit mental health care and substance abuse treatment providers who treat New Jersey residents with mental illness, addictions, or co-occurring disorders -- as well as the families of these individuals.

Our membership represents organizations in every county and almost every community statewide -- nearly 98 percent of the behavioral

healthcare market in New Jersey. And collectively, our members serve over half-a-million children and adults annually.

We fully support the move towards telehealth and, of course, particularly, telepsychiatry. The promises are great, as we've heard here, both on the medical and on the behavioral health side. One of those things that it does is lower hospital admissions.

Many in the mental health field have anticipated that telepsychiatry would be a cost-effective way to address the critical shortage of psychiatrists, particularly child psychiatrists. Unfortunately, the practice has had little impact on the Division of Medical Assistance and Health Services goal of improving access to psychiatric services. We were very pleased, and our members were pleased when the Division -- DMAHS -- made it possible to bill Medicaid for telepsychiatry as face-to-face visits. The capital costs, though, and the inadequate rates have kept providers from taking advantage of this technology. I will insert here what you heard today. Several people, very large health systems -- they're doing things, their foundation gave them the equipment; others are operating under grants. I spoke to several of our members -- it seems that the only ones that can maintain telepsychiatry services are those that are getting either State or foundation funds.

The basic equipment for telemedicine can be purchased at relatively moderate prices. But there are many other costs that come into play. Under Medicaid, primary among them is the need for the private space -- and we've heard a lot of references to space. So under Medicaid, you must be in a licensed facility on both ends. So for those rural areas, you're trying to save that transportation and all those difficulties that

people might have transporting themselves, and they have to still get to a clinic of some sort. So we hope that something can be done about that regulation.

A lot of people have spoken today, too, about the buddy systems -- working with the primary care practices. And, again, the shortage of child and adolescent psychiatrists is, across the nation, even more stark than for psychiatrists in general. So we certainly want to see the telepsychiatry grow, and assist those collaborations and foster the growth of such collaboratives. But those that have managed to (indiscernible) the capital costs of providing in these services have found the reimbursement rates -- the Medicaid reimbursements rate too low to maintain it. New Jersey's Medicaid rates across the board are known to be among the lowest in the country. And the ability to optimize resources through telehealth is just one more casualty of those low rates.

So adding to the challenges of optimizing the technology is the fixed capacity of psychiatry time. And of course we have increasing demand with Medicaid expansion, and the ACA, and the marketplace. Telepsychiatry is supposed to stretch the supply of psychiatrists. But as one psychiatrist very plainly put it, every patient that he sees remotely is a patient he doesn't see face-to-face. So with full support for maximizing the use of telemedicine, to increase to the extent possible access to psychiatrists, NJAMHAA recommends: one, a grant program for the capital costs of equipment and space renovations; two, changes to the limitations on where a client may take part in a telepsychiatry visit; three, an increase in the Medicaid reimbursement for face-to-face visits that will support the continued use of the telepsychiatry; and key, and maybe outside the

parameters of a discussion on telemedicine, we need more resources, including loan repayments, devoted to encouraging entry into psychiatry, providing financial support to students of psychiatry, and encouraging service in the nonprofit community-based system of care.

Thank you for this opportunity.

SENATOR VITALE: Thank you. Thank you for the work you're doing, by the way. It's good stuff.

Any questions from the members who are still here? (no response)

Thank you, though, everyone for taking the time to be here today. This is a process for this Committee and for, I know, Chairwoman Lampitt.

MS. KASER: (Indiscernible)

SENATOR VITALE: Is there more? Did I miss someone? (laughter)

Just that guy in the middle, huh? (laughter) I thought you were her assistant; I'm sorry.

TARUN KAPOOR, M. D.: And then my closing comments--

SENATOR VITALE: Doc, just take your time; I'm sorry.

DR. KAPOOR: Chairman Vitale and Committee members, thank you very much for the invitation.

My name is Tarun Kapoor; I'm a practicing internist, as well as the Vice President and Senior Medical Director for Virtua Medical Group in the southern part of New Jersey -- part of the Virtual Health System.

Thank you for the opportunity to talk to you about telemedicine services. We know in health care, access is absolutely

pinnacle; and with more New Jerseyans gaining healthcare coverage, their desire for access to care -- whether it be through traditional mechanisms or through telemedicine -- is on the increase.

We've been providing, at Virtua, telemedicine services for over a decade, and we wanted to share a little bit of our experiences as well as a little bit about what we're thinking about in the future with regards to telemedicine.

Over the past few years, Virtua continues to invest very heavily in new technologies, ranging anywhere from electronic medical records to modern communication systems. And no different, in those investments, are investments into telemedicine. What I would like to do is tell you a little bit about our experiences, as well as really what we plan to focus on in the upcoming 12 months in the telemedicine space.

In 2014, as well as in year-to-date, in 2015, Virtua continues to provide thousands of consultations in telemedicine, in multiple-medical disciplines ranging from psychiatry, to neurology, to pediatrics. Many of my colleagues here today have spoken in detail about neurology and behavioral health; as well as, we've had some experience with pediatrics, partnering with the Children's Hospital of Philadelphia, where we can actually have a pediatrics subspecialist see a patient in one of our pediatric emergency departments, thereby actually sometimes saving the patient and their family across the river from having to leave the state for those services.

We also made considerable investments in home monitoring devices. Again, we've talked a lot about that today, and we've included all the information about Virtua's experience in that area over the last 10 years in our written testimony.

What I would really like to spend time speaking about, though, is some of the technologies that are on the horizon and some of the challenges that we've been thinking about. At Virtua, we already use a concept called *store and forward*. Earlier today, Senator Singer talked about the NightHawk experience. At Virtua, we have been participating with that for a number of years. On average, we send nearly 700 images. We performed a study, locally at a Virtua facility. Whether it be a CAT scan, a plain x-ray, or an MRI -- forwarded it on to an interpreting radiologist; and get the report back in very quick time. We've been using that, and that's been very, very successful.

Technology that we have not fully implemented yet at Virtua, but is under consideration, is the using of digital photography of certain conditions and, thereby, storing and forwarding those images onto interpreting physicians -- as an example, a wound care specialist or a dermatologist.

One of the possible advantages we see in this technology is, obviously, getting the ability of expertise that's not readily available in the hospital in real time; but also that these images now are being highly pixilated in high resolution that can actually be manipulated, and actually a little bit better than the naked eye at times. And that is actually something that can also be stored and then looked at over and over again, and re-interpreted.

But another very important new area of telemedicine that we are looking into, and actually working on, involves a real-time communication between a patient and a physician. This involves a patient who is communicating with a physician -- either via video or via audio --

and, in 2016, our Medical Group plans on offering this service to established patients within our Medical Group at a scheduled appointment time. In effect, this telemedicine visit could replace certain in-office visits -- only for certain circumstances, however. These visits would be available by either telephone or video, and augmented by our online EMR system -- Electronic Medical Record. At this time, we have not established a fee schedule for this, and we are aware that this method of seeing patients is not currently being reimbursed by insurance companies.

In a similar scenario, Virtua has contracted with a telemedicine provider to offer telemedicine consultations to Virtua patients and Virtua employees through our Virtua Employee Benefit Plan. Ten of our physicians inside of the Medical Group have contracted with TelaDoc to be part of TelaDoc's New Jersey license-based physician pool, who will conduct these telemedicine visits for our patients who declare Virtua as their medical home. In other words, we have a relationship with them. This is a coverage agreement for our patients who are already being seen by us, and we hope to be -- it is a new and innovative way for us to be available to our patients 24 hours a day, 7 days a week, 365 days a year. This service will start on January 1.

Actually, last year Virtua had approximately 200,000 emergency room visits; of these, approximately 44 percent of these visits were relatively low acuity and could have been better served in other settings, such as a primary care physician's office or in one of our urgent care centers. If these patients had utilized a lower-cost setting -- such as primary care, urgent care, or even, potentially, telemedicine -- the cost

savings to the health system as a whole could have been in the tens of millions of dollars.

Also, when we think of today's high-deductible healthcare plans, consumers sometimes avoid going to the doctor, or an urgent care, or an emergency room visit because of the financial implications. It's no longer just a co-pay for these patients; it's the entire cost of the visit until they hit either the \$2,000, \$3,000 or 4,000 deductible. If I can treat a patient over the telephone, or with a video conference, and get them the help they need -- for example, helping them with an asthma medication refill -- then I think that's a better and more cost-effective use of their resources than having them go to the emergency room in the middle of the night.

As an internal medicine physician for 12 years, I practice very differently today than I did when I came out of training. At Virtua Medical Group we do not work a typical 9 to 5, Monday through Friday, no holidays, no weekends schedule. The reason, quite simply, is that in the medicine of today, we have to get to our patients on their schedules. We would like very much for our patients to come into our offices around our availability and our schedules; but in fact in reality, that simply just doesn't work. Many of our patients have transportation limitations, caregiver responsibilities, or jobs that either require them to take paid time off or, in many cases, unpaid time off just to come to a physician's office.

Today we're talking about telemedicine as an extension of the care that we already provide as physicians. Some would argue -- myself included -- that telemedicine has been around since 1875, the year that Alexander Graham Bell invented the telephone. (laughter) In the last year,

Virtua Medical Group itself received over 100,000 phone calls about medications, medication questions, medical problems, and requesting advice. These calls all occurred, and there were conversations between a patient and a clinician to help resolve these issues. And again, we often use coverage agreements within our own Medical Group in order to offer these 24-hour-a-day responses to our patients.

We, as clinicians, talk on the phone all day with patients, nurses, and patient's caregivers. As healthcare professionals, we are responsible for delivering effective and safe care to patients reaching out for help. There are numerous cases where a face-to-face visit and a physical examination are needed to offer effective and safe care. However, there are just as many non-emergent clinical scenarios where a conversation between a physician and a patient can answer questions such as a medication reaction, a persisting cough, or a question as to whether a patient's child should stay home from school that day.

A telemedicine consultation is similar to a low-level urgent care visit, where a patient is accessing care for a low-level acute condition and taking advantage of the convenience and the cost factor.

Just some final thoughts: One of the surprising points that we have learned about is that when patients are given the opportunity for either an audio or a video visit, when the price is of no difference to them -- exactly the equal -- they pick an audio-only visit or audio interaction 90 percent of the time.

In the future, we would like to see telemedicine services grow for patients who are living in our communities. Moving forward, we support legislation that supports reimbursement for telemedicine services

and also provides oversight to ensure quality. Virtua would also support telemedicine legislation that modernizes our laws and promotes the advancement of telemedicine so that we can improve the quality and access that we need to.

We also recommend that any legislation not exclude audio-only from the definition of telemedicine. There are populations of people, like seniors and the underserved, who do not readily have available access to high-speed Internet or who do not necessarily feel comfortable using video technology; they may not have a smart phone, or even a home computer. The telephone, however, is a universal way to communicate. And the legislation passed by our neighbors in Delaware has defined telemedicine to include audio-only.

As this Committee considers telemedicine policy and legislation, please consider Virtua as a resource to you.

Thank you very much for the opportunity to speak.

SENATOR VITALE: Thank you.

Any questions or comments? (no response) None?

Earlier this year, I did visit Virtua, at your Voorhees campus, and did a tour with Fred and your boss to see your robotics -- your robot -- and some of the telemedicine that you're already doing. And there was one particular piece of it that was impressive. You were sending tablets home with patients, with the cuff and with some other forms of monitoring, so that you could do that over -- through the tablet, through your own telemedicine process; as opposed to having them come back and forth to the hospital or doing some level of follow-up care in the home -- as opposed to them having either someone go to their home or them come back to a

provider -- not just so much the hospital, but another provider, for some follow ups. So that was pretty impressive.

Does anyone know -- maybe, on this panel -- if there are, in any other states, telemedicine programs with universities or schools? Is there anything that you know about?

DR. KAPOOR: Countrywide?

SENATOR VITALE: Well, yes -- not in New Jersey, but in other states. Are there any programs or telemedicine that work specifically with colleges or universities?

MS. ABRAMS: The UBHC does do a lot of the work with our providers and their screening centers. So I don't know if that's what you're getting at, or if you have ever spoken with them -- Rutgers University Behavioral Health Care. So they are, I think, involved in the pilots, possibly, too, with the--

SENATOR VITALE: Because there are centers -- health centers at universities across the country and across the state.

MS. ABRAMS: Yes, this is, I know, for the psychiatry.

SENATOR VITALE: Right.

MS. ABRAMS: And for that, you know, just behavioral health side -- that they were heavily involved in programs that are continuing to operate.

SENATOR VITALE: On the behavioral side.

MS. SCHWIMMER: The program that I mentioned with Dr. Unützer is out of the University of Washington. And I know that that program also involves the state of Washington, and some direct purchasing.

And they saw some significant savings there. And that was using telehealth for behavioral health in an integrated model.

DR. KAPOOR: And not a university setting, but Kaiser Permanente certainly has been using telemedicine for quite some time. They actually released their statistics: Last year they had about, I think it was, 14.7 million patient encounters; 53 percent of them last year were electronic.

SENATOR VITALE: Terrific, great.

Well, it was a great start; thank you for your time.

And for everyone who testified today, we look forward to seeing you again.

Thank you.

(MEETING CONCLUDED)