ROUNDTABLE DISCUSSION HELD BY
THE NEW YORK STATE SENATE
LEGISLATIVE COMMISSION ON RURAL RESOURCES

ROUNDTABLE DISCUSSION ON

TELEHEALTH / TELEMEDICINE

Legislative Office Building
Hearing Room B
181 State Street
Albany, New York 12247

January 9, 2012
10:00 a.m. to 1:00 p.m.

PRESIDING:

Senator Catharine M. Young
Chair

Assemblywoman Aileen Gunther
Vice Chair

LEGISLATIVE MEMBERS PRESENT:

Senator David Valesky
Ex-Officio Member/Special Advisor
Commission on Rural Resources

Senator Kemp Hannon
Chair, Senate Committee on Health

Assemblyman Richard Gottfried
Chair, Assembly Committee on Health

Senator James L. Seward
Chair, Senate Committee on Insurance

Assemblyman Joseph Morelle
Chair, Assembly Committee on Insurance

LEGISLATIVE MEMBERS PRESENT (Continued):

Senator Neil Breslin
Senator Timothy Kennedy
Senator George D. Maziarz
Senator Thomas O'Mara
Senator Patricia Ritchie

Assemblyman Daniel Burling
Assemblywoman Barbara Lifton
Assemblyman Philip Palmesano

ROUNDTABLE PARTICIPANTS:

Gregory S. Allen
Director, Division of Program Development & Management
NYS Department of Health,
Office of Health Insurance Programs

Rachel Block
Deputy Commissioner of
The Office of Health Information Technology Transformation
New York State Department of Health

Betty (Van Huizen) Couture, RN
Vice President, Business Development
Advantage Home Telehealth, Inc., Buffalo

Dr. Frank Dubeck, M.D.
Vice President, and Chief Medical Officer
Excellus Blue Cross and Blue Shield;

Stewart Gabel, M.D.
Medical Director, Office of Children & Families
New York State Office of mental health

Cynthia Gordon, RN, MSN
Director of Telehealth Services
Rochester General Health System and InterVol
(via teleconference)

Frederick Heigel
vice President, Regulatory Affairs, Rural Health and Workforce
Healthcare Association of New York State

Victoria G. Hines, MPH
President, and Chief Executive Officer
Visiting Nurse Service of Rochester & Monroe County

Thomas E. Holt
president, and Chief Executive Officer
Lutheran Social Services

Michelle Mazzacco, MBA
Vice President, and Director
Eddy Visiting Nurses Association,
St. Peter's Health Partners

ROUNDTABLE PARTICIPANTS, Continued:

Laurie Neander, RN, MS
Chief Executive Officer
Basset Healthcare Network At Home Care, Inc.

Kenneth Oakley,, Ph.D., FACHE
Chief Executive Officer
Western New York Area Health Education Center,
Lake Plains Community Health Network, Inc.

Alexis Silver
Vice President for Clinical Policy
Home Care Association of New York State

Denise K. Young, MBA, HCM, CSP
Executive Director
Fort Drum Regional Health Planning Organization

Mary Ann Zelazny, BA
chief Executive Officer
Finger Lakes Migrant Health

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SENATOR YOUNG: (No audio.)

Some of you have traveled across the state, and it's great to have your experience and your knowledge and your expertise today.

This is telemedicine and telehealth, and putting the pieces together.

As you know, telemedicine and telehealth is interactive two-way participation between health-care providers and patients in real-time.

And, actually, there are about 12 states that have put in place reimbursement mechanisms for telehealth and telemedicine.

In New York State, and it's represented by the people around this table, we have pockets of success. And, so, the challenge is putting the pieces together, because everyone thinks this is a great idea, especially for rural areas.

As you know, we deal with isolation, in many cases, in rural areas. There's limited access, in many cases, to health care. And so we need to put the pieces together.

And so, today, is a free-flowing discussion from these experts in the room, to talk about what policy decisions do we have to make, as a state, in order to take this to the higher level.

So, again, thank you so much for coming.

I'd like to introduce my colleagues.

And, we'll be asking for comments from Vice Chair of the Legislative Rule Resources Commission, and that's Assemblywoman Aileen Gunther, who is to my left;

But we're also joined by the Chairs of the respective Committees of Health, and Insurance, in the Senate and the Assembly.

So we have: Chairman Jim Seward from the Insurance Committee;

And, my colleague Kemp Hannon, who is Chair of the Health Committee in the Senate;

And, we have, also, Richard Gottfried, who is the Chair of the Assembly Health Committee;

And, Joe Morelle, who is the Chair of the Insurance Committee;

We have, Barbara Lifton, from the Assembly. She's also on the Rural Resources Commission, as is Phil Palmesano from the Assembly;

And, we also have, Senator David Valesky, is an ex-officio member of the Commission.

I think I covered everyone.

Vice Chairperson Gunther, would you like to say something?

ASSEMBLYWOMAN GUNTHER: I think -- am I on?

Well, I want to welcome all of you to this important hearing.

I represent both, Orange, and Sullivan, County.

And, I also practiced nursing in Upstate New York for many, many years. I'm not going to tell you how long, because I don't want to date myself, but I know the problems with getting quality care to Upstate New York.

You know, often, we have one cardiologist.

I just met Dr. Gabel, and he's a child psychologist. And, we don't have any in the Sullivan County region.

So, I know how important telemedicine is.

It's cost-effective. It brings quality health care to the areas that need it most, and, reimbursement is key to this issue.

And I think that we have the technology. You know, we're bringing broadband to different areas of New York State that need it most, in rural areas.

So I think now is the time, because we're looking for savings, and we're also making sure that people stay out of the hospital. But we can only do

that if we can offer them primary care.

So, I think this is the way we have to go in New York State. It's cutting edge.

And, you know, we've been collecting data for a very, very long time, and it's time to do something with this data, and know where -- and where, and who needs health care, and primary health care and specialty health care at -- health care in New York State.

So, I thank you for coming, and I will -- I hope it's going be a really interesting discussion.

SENATOR YOUNG: Thank you, Assemblywoman.

Would any of my colleagues like to add anything at this point?

Assemblyman Gottfried.

ASSEMBLYMAN GOTTFRIED: Well -- okay.

Well, I just want to note, that I think all regions of the state have a lot to learn and benefit from on this topic.

And, I am looking forward to learning a lot about where -- what we, as legislators, and as a state, can do to help move this forward.

SENATOR YOUNG: Thank you, Assemblyman.

I'd like to go through the roster of the participants today.

We have, Rachel Block, the deputy commissioner of the Office of Health Information Technology Transformation in the New York State Department of Health;

Gregory S. Allen, director, division of program development and management, the Office of Health Insurance Programs through the New York State Department of Health;

Dr. Stewart Gabel, the medical director, Office of Children and Families, New York State Office of Mental Health;

Kenneth Oakley, chief executive officer, the Western New York Area Health Education Center, Lake Plains Community Health Network, Incorporated;

Frederick Heigel, vice president for regulatory affairs, rural health and workforce, Healthcare Association of New York State;

Alexis Silver, vice president for clinical policy, Home Care Association of New York State;

Frank Dubeck -- Dr. Frank Dubeck, vice president, and chief medical officer, Excellus Blue Cross and Blue Shield;

Cynthia Gordon, RN -- RN, MSN, and she'll be via teleconference -- so we can prove our point --

director of telehealth services, Rochester General Health System and InterVol;

Victoria G. Hines, MPH, president, and chief executive officer, Visiting Nurse Service of Rochester and Monroe County;

Thomas E. Holt, president, and chief executive officer, of Lutheran Social Services;

Michelle Mazzacco, MBA, vice president, and director, Eddy Visiting Nurses Association, St. Peter's Health Partners;

Laurie Neander, RN, MS, chief executive officer, Basset Healthcare Network at Home Care, Incorporated;

Mary Ann Zelazny, BA, chief executive officer, Finger Lakes Migrant Health;

Denise K. Young, MBA, HCM, CSP, executive director, Fort Drum Regional Health Planning Organization;

And, Deborah Robbins, RN, MPA, director, clinical and sales support, Advantage Home Telehealth, Incorporated.

Now, I do realize that some of the participants have brought PowerPoint presentations, which is great, and we will get to

those.

I want to point out, if you can't see the screen over here, there are these gizmos that -- up here, that will be broadcasting also. So, you can look upward as that presen- -- those presentations are going on.

I would like to start with Dr. Ken Oakley, just to give some remarks.

And, really, today is free-flowing information. This is a discussion. It's not just a presentation.

So, if you have facts and figures and data and stories that you want to share, that's wonderful, but, we also want to encourage an exchange.

So, if somebody is saying something, and you want to add, or challenge, do anything like that, please feel free, and I will call on you.

But, Dr. Oakley is someone who I have known for many years. He's been a force in health care in the Western Region, and now to the Central Region.

And he actually has a personal story about the impact that telemedicine has had on his personal life.

So, I'd like for you to share that, if you don't mind, Dr. Oakley.

DR. KENNETH L. OAKLEY: Good morning, everyone.

Can you hear me all right?

Okay.

Again, I originally come from Cattaraugus County, so I have known Senator Young for a number of years.

ASSEMBLYWOMAN GUNTHER: I can't hear.

SENATOR YOUNG: Ken, hold on one second. I don't believe that the mic is on.

SENATOR HANNON: You got to get it turning red. You got to push this button. And it's very hard to see the red light.

DR. KENNETH L. OAKLEY: It was red.

It is red.

Can you hear me now?

SENATOR YOUNG: Yes.

You have to get very close to it.

DR. KENNETH L. OAKLEY: I just have to stay very close it to.

I'm sorry.

Again, I come from Cattaraugus County, and I've known Senator Young for a number of years, as

she has said.

Fourteen years ago, next month, my oldest grandson was born with some severe abnormalities. He had a severe cleft lip and severe cleft palate. They weren't connected, which is extremely rare. He had underdeveloped vocal cords, and underdeveloped ear canals.

He spent the first 11 years of his life really struggling with all kinds of issues, including psychiatric issues.

He was diagnosed with a number of different things. He was put on adult medication when he was 8 years old because it was the only way they thought they could control him at the time.

And he spent 11 years in -- and he -- and over that first 11 years, he probably saw a child psychiatrist twice, because that's the most we could find in the Southern Tier at the time.

He averaged approximately 90 days a year institutionalized either in a hospital or in some other controlled environment, for 11 years.

Finally, three years ago, through the local health department, we were able to arrange a teleconsultation with the experts at Columbia. It was a pilot program going on in the state.

And, my daughter and my grandson and the local medical team spent over three hours, together, doing this consult via telemedicine.

The result of that was, that the experts at Columbia basically said: They blew the diagnosis. There were several diagnosis that were just totally wrong. That he was actually on medication that potentially was going to kill him eventually. It was absolutely the wrong medication that was tearing his body apart.

So, they adjusted his medication. They changed his diagnosis. And, they also totally changed the way they went about his treatment, and his learning plans, and everything else.

Now, that didn't take away the fact that I have a special-needs' grandson. I still do. There's no question about that. But since that telehealth consult, and since those adjusted medications, and the adjustment treatment plans, and everything else, instead of spending 90 days a year institutionalized, he's averaged, over the last three, 7 days a year institutionalized.

That translates into, somewhere between, $40,000 in saved medical expenses just in the last three years.

So, while I have been, and I continue to be, a very, very strong advocate for rural telemedicine, because I'm a health-care administrator, and I grew up in rural Cattaraugus County where we didn't have much -- still, some places don't have much when it comes to professionals -- I also am a person who has seen firsthand that telemedicine, can, and does, work.

And, so, I'm both a professional and a personal advocate.

Thank you.

SENATOR YOUNG: Thank you, Ken.

And, I know that you have worked very hard, secured a lot of grants, to get a network up and going in the Western Region. And I believe it stretches all the way to the Central Region now.

Maybe you could share what you've done in order to accomplish that?

DR. KENNETH L. OAKLEY: Certainly.

One of the critical aspects of this, is -- is, because I'm in health-care administration, I'm not a direct service provider, I really wanted to focus on making the infrastructure possible, to bring telemedicine to life, and to bring advanced [unintelligible] education and training to the more

rural areas.

So, over the last, probably seven or eight years, I've been working on developing a broadband network that is going to link, probably, when it's all said and done, over 40 facilities together with a high-speed broadband fiberoptic network, to really encourage and allow advanced and telehealth and telemedicine.

But beyond that, it doesn't take advanced stuff to do many aspects of telemedicine, particularly when we're focused on primary care.

And, when we're talking about primary care, we need to be able to get it out using standard Internet IP-type addresses, and that kind of stuff.

So, basically, I've been working and advocating the administrative and infrastructure side, to allow facilities, home-health agencies, large health systems, and whatnot, to really do the kinds of applications that they need.

Now, there's also a health-workforce aspect to this because it's a different way of doing business. And -- and, so, as an area health-education center, we're also prepared to work with clinical staff, to work with office staff, to realign work flows and whatnot, to make telemedicine

as efficient and effective as it can possibly be.

SENATOR YOUNG: Thank you.

One of the things that I'd like to throw out there, is that, as you know, we do have successful systems, but they're not statewide.

The question for the participants today, is: What are the barriers that get in the way of having a statewide system?

And, what policy decisions should we make in order to ensure that we can have a statewide system?

So, I'll just throw that out.

Anybody want to jump in?

Yes?

DENISE YOUNG: Is it on?

Okay.

SENATOR YOUNG: You know what? I think what we need to do is, have it close to your mouth.

SENATOR HANNON: And identify yourself.

SENATOR YOUNG: And identify yourself.

You're Denise?

DENISE YOUNG: Denise Young, Fort Drum Regional Health Planning.

We have a rural health-care pilot project from the FCC, funded through USAC. We have 28 sites connected on high-speed fiber.

The real barriers we have to actually launching:

So, we have the infrastructure in place where we could do some pretty comprehensive in a very rural area of New York.

What we need is reimbursement, across the board, for -- if it's not reimbursable, we -- who's going to provide the service?

So, we can have little pockets, and we do reach out whenever we can have a pocket.

For example: OMH has access to a child psychiatrist. We use it, but it's not enough.

So, we need across-the-board reimbursement, all-insure.

And, from not only, because, with the -- and we're very excited about Medicaid covering. Very excited about seeing it cover telemedicine. But, the way I read it, unless I read it wrong, it's only from Article 28 to Article 28.

And, psychiatrists in New York State are at OMH Article 31 clinics; so, therefore, covering psychiatry, we were all set.

We had a clinic in Brooklyn, all set to provide services to our region for child psychiatry, and saw they're not eligible to provide services

because they're an Article 31 clinic under the new Medicaid coverages.

So -- so, we need that to be across the board.

Most of -- in New York, at least in rural New York, many of our specialists are not hospital-employed, so those are independent physicians.

Again, if we're only Article 28, we don't have access to the specialists that we actually need access to because they're not in Article 28s.

So, that reimbursement issue is huge.

And then the second thing is, credentialing.

So, credentialing: Where they are credentialed, how they are credentialed. You know, what credentialing we're recognizing; whether we're recognizing it at the originating site, or we're recognizing it at the -- at the site where the physician is.

If we recognize the credentialing at the site where the physician is, then -- if we're making a referral for any other thing, we're actually sending the person, physically, to that location, then we recognize the credentialing where that provider is.

If -- but, with telemedicine, we say: Well,

they have to be credentialed on both ends.

It -- so, it really does gum-up the system.

So credentialing is a large issue.

And then, the final thing -- as you can see, I thought about this question.

The final thing that is a challenge, is that there -- and I think Ken said it very well, in relation to: It takes people to help physician practices change; to change how we practice medicine, to incorporate telemedicine.

It takes people to champion that.

And, there is no way to pay for those people.

So we need leadership for those people. We need to have those people that are going to be able to do that, and those people will have to have an income.

So -- so we need to figure that out.

So...

SENATOR YOUNG: Thank you. Thanks, Denise.

Greg Allen, would you like to respond to that?

SENATOR HANNON: [Inaudible.]

SENATOR YOUNG: And he's from the New York State Department of Health, Insurance Division.

GREGORY ALLEN: Hi there.

Thanks very much.

First of all, I just want to say, I grew up in Columbia County. And, the second place that I practiced services, as a social worker, was Wyoming County. So, my sense of the lack of availability of things that are available in an urban center comes from personal experience.

So, if anything, at least there's the guilt that keeps on giving, that goes with that experience --

[Laughter.]

GREGORY ALLEN: -- in terms of Medicaid policy.

I'll just say, that, our staff have been, you know, working aggressively on trying to eliminate some of these barriers (a) to pay for the service, and then, (b) to change the things that dance around payment, that make payment availability not really available.

So, the -- on the credentialing side, we heard a lot of comments about, that the spoke site was having trouble having the horsepower to do the credentialing that was available at the hub site.

So we now allow that spoke site to just enter in a contract with the hub site to achieve the

credentialing.

That being said --

SENATOR YOUNG: Could you explain for the neophytes --

GREGORY ALLEN: Yeah, sure, what a "spoke" and a "hub" is?

SENATOR YOUNG: -- what a "spoke" and a "hub" --

GREGORY ALLEN: So, there's a wheel, and then there's these spokes --

SENATOR YOUNG: Right.

GREGORY ALLEN: -- and then there's the hubs. It's --

SENATOR YOUNG: I grew up on a farm, and I have my own concept of what that means.

So, if you could explain it in health-care terms?

GREGORY ALLEN: Yeah, sorry. It's growing close up to the wagon. You know, you just sort of figure everybody --

So, that, the "hub site," in general, is the center that would be offering the consult.

The "spoke site" is the site that would be receiving the consult.

So, very often, the hub site might be located

in the more urban area that may have more access to specialty medicine, specialty behavioral-health services.

The spoke site is the -- is the -- perhaps the rural site that would be receiving those consults, would have the patient at the spoke site.

The hub site, very often, has more resources to be able to do both credentialing and privileging.

So, what we've done for the spoke site, is to allow the credentialing that takes place in the hub site to be available to it, the professional credentialing.

"Is this person properly credentialed to provide the service?" -- we'll make that available to the spoke site through a contract, so that you don't have to duplicate the credentialing.

Recently, Medicare -- so -- and credentialing is really checking in to make sure the person is --

Privileging is another issue, which we're working on.

Medicare just recently -- and we've been drafting behind Medicare, trying to copy the Medicare policies, so that we don't have a different policy in both public insurances.

A remaining issue, and it's in the presentation, so I could skip over it when I get it to save us some time, is the privileging.

The privileging, we would -- we currently require at both sites.

Medicare recently came out with rules allowing the privileging to be facilitated, or fast-tracked -- and we're still learning about this -- at that spoke site. And, we're working on that right now.

There may be some legal impediments, but we're working on those right now.

So -- but our goal, clearly, is to make the reimbursement available so that we can provide the service.

SENATOR YOUNG: So, when you say there are "legal impediments," potentially, you are looking into those, and you'll let the Legislature know what those are?

GREGORY ALLEN: Absolutely.

SENATOR YOUNG: Okay.

GREGORY ALLEN: Absolutely.

And we're actually, just, working on this right now, with counsel, as we speak.

So, we'll -- we'll keep you and

Senator Hannon, certainly, posted on our investigation.

SENATOR YOUNG: Thank you.

SENATOR HANNON: And the question that Ms. Young raised about the Article 31 and the Article 28, and, are we having cross-match here?

GREGORY ALLEN: Yes.

So, right now, we are -- we expanded -- my whole -- I can do my whole presentation through your question, thank you very much.

We --

[Laughter.]

SENATOR HANNON: It's a setup.

GREGORY ALLEN: That's good.

So the -- we expanded the availability outside of the hospital. We had previously had this available, hospital OPD and ER.

We've now may it available to freestanding diagnostic and treatment centers, and other sites, but, we have not yet made it available in the mental-hygiene clinics.

And, I'll take that back from this hearing as an action item for us to work on.

SENATOR YOUNG: Great, thank you.

Okay, who else?

Yes, Frederick.

SENATOR HANNON: How about the director from the mental health?

SENATOR YOUNG: Okay, Dr. Gable, would you like to contribute?

DR. STEWART GABEL: Well, there's many things -- (no audio).

There are many things that we're doing.

I think some of the issues that have been raised are very real.

One of the things that, really, at our programs for children, are designed, essentially, to address the fact that there are very limited numbers of child psychiatrists in Upstate New York areas.

Actually, there's -- there are only about 7,000 -- 7,400 child and adolescent psychiatrists in the country.

And in some ways, New York is very fortunate because it has about one-tenth of them in New York State. However, they are very, very heavily distributed in downstate areas, so there's a tremendous shortage of child and adolescent psychiatrists in upstate areas.

And 20 -- roughly, 20 of the 60 or so

counties in New York State do not have any child psychiatrists, and another 10 to 15 have only one child psychiatrist.

So the question that we've come up with, is: How do you begin to provide child-psychiatrists' services to places where there are no child psychiatrists?

And that's really what's led to our, telepsychiatry, telemedicine, programs. And we do a number of things in that area.

ASSEMBLYWOMAN GUNTHER: May I just interrupt, Dr. Gabel?

DR. STEWART GABEL: Yes.

ASSEMBLYWOMAN GUNTHER: I would be very interested in hearing your whole presentation.

DR. STEWART GABEL: This is essentially it.

ASSEMBLYWOMAN GUNTHER: Our first meeting, I'm very interested.

DR. STEWART GABEL: Okay, well, this is essential -- this is -- I'm kind of going through some of that, if that's okay?

ASSEMBLYWOMAN GUNTHER: I don't want to miss anything, so if you would go through the whole thing, I'd appreciate it.

DR. STEWART GABEL: And -- so, essentially,

what we're doing is, saying:

How do we provide the child-psychiatrists' services when there are no child psychiatrists?

How do we provide the child-psychiatrists' services for the 20 percent of American school children who have diagnosable mental-health disorders?

That's a very large number.

Most of those youth do not get treated, at all. And some get treated in a less-than-adequate way.

So telepsychiatry is a real advance that allows us to bring services to underserved rural areas.

And we do that in three ways:

Firstly: In our psych- -- in the psychiatric -- New York State psychiatric hospitals in upstate areas, that serve mainly adults, several also serve children. They often don't have child psychiatrists treating those children.

We provide telepsychiatry services to those hospitals, to provide child-psychiatrist evaluations on the youngsters who are admitted.

We also provide child-psychiatrist consultations to several of the community

mental-health centers in the upstate rural area, and all are eligible. We don't have equipment at all, but all are eligible for those services.

And when Dr. Oakley mentioned the benefit of the service that his grandson had received, and spoke about the Columbia consultation, I was thinking that's probably an OMH service that, fortunately, was available for your grandson, through the Office of Mental Health.

Finally, what we do, is provide a very unique and innovative program called "Project Teach."

Project Teach is the training and education for the advancement of children's health.

Essentially, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, have basically said, Pediatricians and family physicians are in positions to provide mental-health treatment to children.

They've spoken about that for pediatricians, but it would be true for family physicians too.

But how can a pediatrician and a family physician provide mental-health treatment for children, because there are more of them than there are child psychiatrists.

But there's a strong effort now, across the country, for that to be so.

But, in order for that to happen, the pediatrician, the family physician, need to have available consultation, available support, available education, so that they can do a good job at providing this mental-health treatment that many of them want to do, and that the American Academy of Pediatrics supports their doing.

So we provide consultation -- child-psychiatrists' consultation and training and support to these other providers so that these youngsters in the primary-care practice can receive mental-health services.

We're also now -- from the point of view of telepsychiatry, we have a pilot program, whereby, office-based telepsychiatry units, mobile units, are in a number of practices in the state.

And just beginning now, that if a youngster coming to a private pediatrician's office could be seen by a child psychiatrist, you know, 50, 100 miles away, and receive help and evaluation and diagnosis and recommendations to the pediatrician, to provide that treatment. And, then, periodic follow-up with the child psychiatrist as

well, also by telepsychiatry.

So those are the things we're doing. And we're, really, I think the field is moving.

The field of mental-health treatment for children, in a broad sense, a large part of it, of course, moves toward the kids who never get to see a mental-health professional, but who, in fact, have significant mental-health disorders.

That's the 20 percent -- that's probably most -- 75 percent of that 20 percent that have mental-health disorders, they come to primary-care physicians.

And we have to be able to work with them, and they're not always coming to child psychiatrists, but they will be seeing, probably more and more in the primary-care practice office, and telepsychiatry is becoming a real option for them to be seen in that -- in those practices.

And that's the kind of thing where -- is where the future moves. And, hopefully, I think that will be a great benefit to the youngsters in the state.

SENATOR YOUNG: Dr. Gabel, that's great news.

One of the questions I have: So, you have

this three-pronged system, which seems like it's really bringing and delivering services where they're needed.

How do you pay for it?

DR. STEWART GABEL: Well, these are OMH programs, and they're paid for by OMH funds.

And, in fact, we have contracts, often -- it varies, but we have contracts with, mainly, academic medical centers that provide these services.

So, the services to the community mental-health centers is through Columbia University.

The services to the upstate psychiatric hospitals, OMH hospitals, are through the State University of New York, upstate in Syracuse, and through NYU.

The programs to private pediatric offices that, now, are just beginning the telepsychiatry notion are twofold:

One, through a private hospital, Four Winds Hospital. And, then, through a consortium of five academic medical centers that have banded together to provide this.

So, we now have statewide coverage -- not all

through telepsychiatry, but statewide coverage of consultation to primary-care practices around the state.

And that consortium -- that consortium is a group of five academic medical centers: Buffalo, Rochester, Syracuse, LIJ, and Columbia.

So, that's how we do it.

But these are OMH funds, contracting with these centers.

And I think the issue that was raised earlier, about, "Well, can this be done privately?" well, I think it's -- that's a financial issue, of course, and a difficult one.

And the other question that I think was raised by DOH, of course, is the question of reimbursement.

Pediatricians and family physicians, with appropriate supports, such as we provide, on the clinical side, can be trained, and can be supported, in providing mental-health services to children in rural areas, but they will need to have adequate reimbursements to do that.

There are, 20 percent of the kids who come to the private pediatric or family -- pediatric office, 20 percent of the kids in the country, or the

family physicians who have problems such as this.

ASSEMBLYWOMAN GUNTHER: Dr. Gabel, right now, a lot of the rural pediatricians are already treating mental-health issues.

DR. STEWART GABEL: Right.

ASSEMBLYWOMAN GUNTHER: We have so many children with the diagnosis of the spectrum of autism, and they're giving them Ritalin, and those kinds of medications.

And, beyond the pediatric office, you know, we have a whole thing with education. Like education, our counselors.

And we have this, to me, it's like an epidemic of children on the spectrum.

And, we really have, few and far between, as far as care for these children in my area.

I know where Four Winds is, but that seems that it's already when the child is in an episode, and it's like keeping that child away from Four Winds.

And right now --

DR. STEWART GABEL: Right.

ASSEMBLYWOMAN GUNTHER: -- like tel- -- to me, telemedicine, and having, you know, Columbia Presbyterian being able to intervene before

that kind of -- you know, before you reach Four Winds.

Which, honestly, if I can just throw this in, you know, I represent an area, we had Middletown psych center, and now we have Rockland psyche center.

Sullivan County, I think, has access to three beds.

So, often, these children in Upstate New York are sitting in a regular -- a regular room in a hospital, with constant awareness, for up to two or three weeks.

So, you know, providing the reimbursement, in the long run, will save money. And, you know, getting from Point A to Point B, sometimes, in New York State, takes a very long time.

But I know that, in where I represent, this kind of intervention would be so valuable.

DR. STEWART GABEL: This intervention that I that you're referring to, Assemblywoman Gunther, is, in fact, available throughout the state under Project Teach, in which primary-care physicians can receive consultation for the youngsters in their practices, by child and adolescent psychiatrists.

Now, most of that is telephone.

If it's a serious thing, they can be seen directly face-to-face.

And we're beginning to get involved with telepsychiatry even to the primary-care provider's office. But, that's just beginning now.

But the sense of tele -- of consultation around mental-health problems by a child psychiatrist, for all of the primary-care providers in the state, is now available through Project Teach.

On my presentation, which I've just, fortunately, been able to give you, in new large part, there's a website that tells exactly that. Or, people can call me, or whatever, and we can hook up the right person to get to.

SENATOR YOUNG: Thank you.

Senator Seward had a question.

SENATOR SEWARD: Yes.

Thank you, Senator Young.

I must admit, I come to the table today, both as Chair of the Insurance Committee and as a local senator, with a bias in favor of telemedicine, representing a, basically, rural upstate district.

And, my most direct exposure to this topic is

through Laurie Neander's organization, At Home Care, which services Otsego, Delaware, Chenango, and Herkimer Counties; a good deal of real estate in the upstate region.

But my question is this, to Dr. Gabel, and others that are involved with this issue, is:

As we look at the -- getting over, particularly in that barrier of reimbursements, and possible expansion of a system in New York, what body of evidence is there, that, in terms of the outcomes being comparable to -- between a -- in comparing a regular office visit, and having services rendered, you know, on the face-to-face basis, or through this telemedicine approach?

I mean: Is there -- are there comparable outcomes?

Is there a body of evidence that could be provided, as we move forward, particularly trying to get over the -- this barrier, particularly of reimbursements?

Is it comparable? And, should it be considered comparable? -- in terms of outcomes.

DR. STEWART GABEL: I could take some of that.

It's hard to do a direct experi- -- empirical

study, because the kids [unintelligible] would be different. So, if they're different, you can't quite compare them.

But, there is a body of evidence from around the country that this is a well-received, favorable service, supported by those who provide it, and supported by those who receive it.

And there's no evidence that there's any difference in acceptability, in satisfaction, or in outcome, between psychiatric services provided to youth, direct face-to-face or through telemedicine.

In fact, and by law, as I understand it, in New York State, they're considered comparable services.

If a telepsychiatrist provides, actually -- and this is another advance that we are just beginning to look into also, for rural counties, or for rural hospitals in the rural part of the state: Well, how do you -- one thing, is providing an evaluation so others can follow through. But, many clinics and providers want the actual services, often the medication, to be provided by the psychiatrists, who can follow up regularly, and is more involved with that.

Well, that's a separate issue. That's

actually treatment by telepsychiatry, treatment by telemedicine.

That's also being done now. And could be done.

It's not being done very much in our state by the Office of Mental Health.

But, again, this is all very feasible. And New York State considers, a person who provides telemedicine services, as I understand it, to have a patient, like, as if they were in the same room together.

So, in some sense, it's a comparable service.

SENATOR YOUNG: Thank you.

Dr. Dubeck, from Excellus, would like to respond also.

DR. FRANK DUBECK: Ah, yes.

I'm not in the mental-health field, but I'm aware of at least two pilot studies that were done under grants:

One in Rochester, with school clinics; where school nurses would actually asynchronously send information to a pediatrician, who, by the end of the day, would come back with a diagnosis and treatment plan before the child went home, significantly decreasing ER visits. Saving costs

there;

Another one with Ruth Winestock [ph.] in Syracuse, with diabetics, where she tele-Skyped with them into the North Country, and significantly decreased re-admissions of diabetics, compared to prior.

So, those kind of studies are out there; they're small.

From the standpoint of mental health, especially with child psychiatry, I think what you have to compare, is, this teleconsult with the child psychiatrist versus no access to a child psychiatrist, which is, in reality, what we have.

And, I can't see how that's better.

SENATOR YOUNG: Thank you.

Yes?

DR. KENNETH L. OAKLEY: I just wanted to also reference the work that's being done in Rochester, because I actually met with Dr. Ken McConnecky [ph.], last week, and to talk about his TeleAtrics program.

He has done several studies, actually, that have been peer-reviewed, and published.

And one of his findings was, that -- that while doing those pediatric consults within the

school system, with the kids, the quality was there, the satisfaction was there, but, also, they were able to demonstrate a 22 percent reduction in ER visits, because the kids didn't have to wait until dad or mom got home from work; and, then, when the pediatric practice is closed, say: Oh, guess, what? I really do have a sick kid. I'm going to take them of the emergency room.

By avoiding that; by actually making that services available, the parent was allowed to stay at work, and, there was a significant reduction in evening ER visits from that identified population.

SENATOR YOUNG: Thanks, Ken.

Please give your name.

BETTY (VAN HUIZEN) COUTURE, RN: Yes, my name is Betty Couture [ph.]. I'm from Advantage Home Telehealth.

And, I apologize for the fact that I say, I'm Deborah Robbins, but, she had an emergency come up, and she couldn't make it.

So, basically, what I would like to say, again, is the fact that we do need reimbursement codes.

We like to say, Advantage Home Telehealth, we're a full-service solution company. We use,

really, mobile technology, and, we like to bring the exam room to the patient, whether that's at school, at work, or at home.

And, so, one of the things that we feel is really important, is that we provide the ability for -- if a patient's in the home, to even have that consult there.

And, so, that's what we're working towards.

So, we really need, 3G, 4G network as well, or Internet capability in the home, and we can do a lot with regards to video conferencing.

One of the things, though, if you want to look at just vital-sign monitoring, we are -- we have demonstrated quite a significant reduction in costs.

We did -- we took care of five congestive-heart-failure patients in Kansas.

And, within four months, of those five, one of the patients, we saved around two hundred to two hundred fifty thousand, and, another one, three hundred to five hundred thousand, just in preventing ER and hospitalizations.

So, if you're monitoring blood pressure, weight, blood oxygen, blood glucose, there's so much that you can do.

Our clinical call center calls the patients, and we really work with them, to find out: What it is they're eating. What it is they're doing.

And another key aspect in all of this, is the medication component.

And we have a medication device that, actually, we can view from our call center, to see what medications are in their medication bin, and make sure they're taking the right medication, and, reminding them on how to take their medication.

And, so, that's huge.

And, so, if we have the chance, if anybody wants to speak to us about that.

But, really, what's the barrier for us, is the reimbursement codes.

SENATOR YOUNG: Thank you. Thanks very much.

Yes, Mary Ann.

MARY ANN ZELAZNY: I would like talk what we're doing in the FQHC world.

Out in Finger Lakes Region, we have community and migrant house centers.

And, of course, as many of you know, one of the biggest problems that we're all dealing with now, is the integration of behavioral-health

services into the primary-care setting, because we know it saves money, because we have the patients, through the primary-care docs.

And, so, if we can somehow bring in the behavioral-health specialists, right to where the patient is in a rural area, when people cannot get to where they need to go, which is usually in an urban center, we have been able to see a substantial drop in folks having to enter back into the mental-health system. They are able to get their services through us.

So what we do, is, when a patient comes into one of our health centers, and they -- and we see a lot of diabetics. We see a lot of folks that don't speak English. So, reaching out to -- we have an agreement now with another FQHC downstate, where we have access to their bilingual/bicultural-licensed clinical social workers, who see our patients.

But what we're doing with our regular community patients as well, is, when they come in to see the primary-care doc, and we do their screenings for them as part of the patient-centered medical-home process, they will get screened.

And, if it's determined that they need to see a counselor, the counselor is on site. We have our own licensed clinical social workers. And that patient is able to go to any of our sites, if they need to, and access those counselors through telehealth, because we have access at all our sites.

But then what we do, is, of course, with our patients, they need to have a visit with a psychiatrist, usually about every six to eight months, to go through, and make sure their meds are okay, and to really make sure that we're, as a primary-care center, doing what we need to do to make sure that that person is stable.

So, we have arranged with a hospital that has a psychiatrist, who -- at -- when the patient is referred to the psychiatrist, the patient comes back to his primary-care site where they're comfortable. The counselor sees the patient for the first few minutes. Then the telehealth session begins with the psychiatrist, with the counselor in the room for the first couple minutes, just to introduce, and make sure everything's, you know, going to run smoothly.

The counsel leaves the room, waits outside,

and then the patient is able to meet with the psychiatrist, not on the third floor of the hospital where the mental-health clinic is that a lot of people won't go to, because it means that, "Oh, I have mental-health issues," and, trying to get people to go to the mental-health clinics is a struggle sometimes.

So, the patient will see the psychiatrist.

And, then, at the end of the session, the counselor goes back into the room, with the psychiatrist and the patient. They all go back over the treatment plan, and make sure that everybody's on board with what's going on. And we really try to include the patient in that discussion.

And, then, we have an electronic medical-records system, so that the counselor puts all of those notes directly into the patient chart, and we receive notes from the psychiatrist.

The benefit of this system, is our patients are not having to leave their primary-care setting for care.

It's so hard to get them in anyway. We drive so many patients across the Finger Lakes Region of New York State to get them care. And, to try to bring them to a psychiatrist in Rochester, is just

not feasible all the time because, there's just so many cars, and so many staff members, that can drive patients.

The problem with the whole system is, is that, of course, we can't bill.

So, what we're doing, because, in order for us to keep our patients healthy --

We believe it's cheaper to keep them healthy and in the primary-care setting.

-- we have come into an agreement with the psychiatrists, and he gives you a really good deal on our visits.

But, it isn't so -- it's not sustaining. You know, we can't keep using our own resources, to try to pay for everybody's psychiatric visits. But, we know it does keep people healthier.

And it also keeps us all -- what's really important for -- from the primary-care perspective, is, it's educating our primary-care docs.

We have the learning curve. To understand behavioral-health issues is huge.

So, that -- that telepsychiatry visit gives our counselors and primary-care docs the ability to start to learn the language of what the psychiatrists are saying, because it is pretty

intense sometimes.

And it's been an educational learning moment for us, but it's also been really great for the patient because they don't have to travel to another place. And in rural settings, they're not going to get there.

So, reimbursement is huge for us.

SENATOR YOUNG: Senator Hannon has a few questions.

SENATOR HANNON: In addition to what you're doing in behavioral health, you've really become, as an FQHC, a center for the migrant workers. And, in fact, I think you've started a network around the state.

Maybe you could just tell us a little bit about that, because my guess is, that's a whole different population, even when you come to physical health.

MARY ANN ZELAZNY: Well, we -- what we've done is, we had to get telehealth capabilities because we just do not have the facilities to be able to serve all of the farm workers that come to the New York State area and get them the care they need.

And, you know, language is a huge barrier,

transportation's a huge barrier.

One of the things we do for the migrant children, is that we go into the migrant Head Start centers and provide dental cares as a routine service to the kids.

And we're now starting to go into regular community Head Start programs.

One of the major issues that we all encounter when you deal with little kids in the Head Start sites, is about 40 percent of those children have advanced decay in their mouths.

And when you have a child that has advanced decay in their mouth, they are not able to focus on what they need do. It affects their education. It affects their home life. It affects everything. It affects their health.

So what we did, is, we were -- we had really no choice, we hooked up with Eastman Dental up in Rochester. And, we went to them, and said: Listen, we'll give you a telehealth camera. We need to have access to you.

Because, currently, Eastman Dental, the pediatric center, is one of the few places in New York State, in our region, where children can go and get surgeries done, or nitrous oxide given to

them, so they can get their teeth taken care of.

Little kids, you can't take them to a regular dentist to get those teeth fixed, if you have a dentist available.

So, we hooked up with Eastman Dental.

And now what we've -- the problem with taking a child and referring them to a pediatric dental center, is, it includes at least four visits to get that child taken care of, a completed treatment plan.

So, what we have taken is, the telehealth capabilities, and we've taken four visits down to one visit, which is the day of the surgery.

So, we do three of those visits via telehealth.

And, what's really nice, is that the child is seen at the Head Start center by the pediatric dentist, and the hygienist that sees the child regularly is there providing the actual -- she's presenting the patient to the -- to the pediatric dentist up in Rochester.

And, then, the parent is able to come to that Head Start site as well, if they would like to meet with the dentist, because they can all see everybody. And the child gets to meet the dentist

that's going do the surgery on them that day, so that they're comfortable.

The problem -- one of the biggest problems that this dentist has told us -- the pediatric dentist, is when a kid comes up to his office in Rochester --

And if you've ever been to Eastman Dental, it's a very busy place.

-- and these children are terrified.

It's an urban center. People are uncomfortable going up there. It's very busy.

But their waiting list, once you get seen by a consult, is eight months to get surgery, because they're so busy.

So what we've done, is, been able to get the consults and the pre-op, all that done, so that the child then waits for their surgery, which Eastman has given us slots, so we're down to about four months. So, we're pretty fortunate.

When we started this process, we looked at our data. And, when we would refer a patient before telehealth, we had about a 15 percent success rate, that those children would actually make it up to Rochester and get their teeth taken care of.

Now that we've got this process going in

place, we have 83 children that we have gotten through, either with any nitrous oxide or surgery, and we have a 97 percent success rate.

And we directly attribute that to the use of telehealth.

But, also, we have -- one of the things we've also done, because we're in a rural area, is we have case managers that we assign to all of our kids that end up going through the telehealth process, because there is a lag time between your consults and your surgery.

So, the caseworker calls them, and says:

"Don't forget, your surgery's in a couple of months" -- you know, to keep people on track.

And to make sure, do you -- you know, "Do you have a way up there?"

You know, "What are your barriers to getting that care?"

And, "Do we need to drive you?"

SENATOR HANNON: Yeah.

Who's -- and the revenue stream that's paying for --

MARY ANN ZELAZNY: We pay Eastman Dental for those visits.

SENATOR HANNON: FQHC?

MARY ANN ZELAZNY: Yes, we pay.

And, then, when the child goes up for the day of surgery, they're able to bill child's Medicaid or Child Health Plus.

SENATOR YOUNG: I'd like to point out that we've been joined by Senator George Maziarz, welcome, and, Senator Patty Ritchie.

Thanks for coming.

Okay?

Oh, I'd like to have some remarks from Tom Holt, from Chautauqua County.

THOMAS HOLT: Thanks, Senator.

And, I'm here representing the long-term-care aspect of telehealth and home-based monitoring.

We've been involved in exploring this concept for about six years now. And, I think much of what's already been said around the policy side and the reimbursement sides applies to just about all of us, if not all of us, in terms of some of those barriers.

But one of the challenges that we've found, and Dr. Dubeck made reference it to as well, is that the research that's out there really is not a lot.

And there's a lot of good anecdotal

information, a lot of good anecdotal experiences that many of us have had. Certainly, our organization has had. But, to wait and rely on a preponderance of evidence is going to hold us back.

So, that would just be an observation, or a comment, to make.

But I think even more fundamental for us, despite the successes that we've had, has been the challenge of consumer education and awareness about what telehealth and home-based monitoring systems and technologies are, and what they can do, to encourage independence and to keep people at home longer.

We joke about the fact, that when we give a presentation to seniors, there's universal acceptance. They all point to what we talk about doing, and say: This is terrific, for you.

And then, you know, the 85-year-old turns to the 87-year-old, and says: This technology is going be great for you. I don't need it yet.

[Laughter.]

THOMAS HOLT: So, we have a lot of work to do in terms of educating our senior population, about, how these technologies can really help keep folks independent, and out of hospitals and out of nursing

homes.

And, I think we've got lots of anecdotal experiences to share, and I won't bore with you those today, but I think that issue of consumer understanding, and even provider understanding, about how this technology is emerging, and can be used, is critical to the success.

SENATOR YOUNG: Congratulations on what you've been able to do.

Tom is from my district. And, it's phenomenal, some of the services that can be provided, whether it's monitoring people's blood pressure, their weight, and so on, right in their homes, or in -- wherever they're living.

In an apartment setting, in your case.

One of the issues that you brought forward too, in addition to what you just said, is that some of the seniors feel like Big Brother is watching.

Could you address that a little bit?

THOMAS HOLT: Sure.

The first monitoring system that we put in place is -- we would consider it to be a passive monitoring system. Really, it's about a thumb-sized motion sensor that's located throughout the apartment or the home.

And, we're all creatures of habit. And, very early on, your pattern of behavior becomes known.

And, so, this system really monitors by exception.

When things out of the norm begin to appear, we, as sort of the back office, are notified about what those changes in behavior are.

And, they could be very minor. Or, they could be that someone has not moved for an extended period of time, and require a more active intervention.

The seniors have found that to be difficult, initially, to accept that. You know, despite the fact that it's not active monitoring, there is this sense of Big Brother that's happening.

And I should make mention of the fact, that we just know now opened a new apartment building, which we've called the "Smartman Building," that was funded with HEAL grant.

So, I think a big part of this is access to capital. And I know we've talked about what some of the barriers are.

We would not have been able to do what we're doing in this new apartment building were it not for the HEAL Program, which allowed us to get into this

new style of housing.

But, each of these 14 units come hard-wired with this passive monitoring system in it, so, all the seniors coming into that building are going to have to agree to participate in this monitoring program.

And, so, over the course of next couple of years, I think we're going to be in a position to talk a little bit more specifically about, how the educational process, and the acceptance process, of seniors went. But, certainly, there is a concern about Big Brother watching.

One of the successes that we've had, frankly, has been in trying to market, if you will, to the children of the seniors.

And, the seniors, when it's suggested to them that their kids are gonna be a whole lot more comfortable knowing that there's some kind of monitoring happening, more often than not, the seniors will agree participate if they think that they're doing it to make their kids a little bit more comfortable.

In a small rural county, like Chautauqua County, where I'm at, we're getting older, we're getting poorer, and more and more of

the young folks are moving away.

And, so, the idea of trying to target the kids that have left the area, and keep them connected with the seniors, is something that we're very, very intrigued by.

SENATOR YOUNG: Are the seniors intimidated by the technology, in some cases?

THOMAS HOLT: I would suggest that it's probably like society in general. There are some folks that are very easy to get into technology, and very comfortable with it. And the same applies with seniors.

There's a lot of folks that are really turned on by the technology, and have found, you know, really interesting ways to use them in their everyday lives.

And there's some, that it's not for them.

But I think that's the case with kids and middle-agers, and just about everybody.

ASSEMBLYWOMAN GUNTHER: My mother is 85 years old, and I lost my father last year. They were married 62 years.

And, you know, first time alone in the house, the whole nine yards. They spent seven days away.

So, anyway, we had to get something because

we were afraid she was going to fall.

And I said: Mom, it's like having a roommate, you know.

[Laughter.]

And she was, like, okay with it.

You know, I explained it that way.

And she said, "Yeah." And she was, like, "Okay."

And, you know, we pushed in, and Val came on.

She goes, "Yep, like a roommate."

SENATOR YOUNG: That's good.

ASSEMBLYWOMAN GUNTHER: Yeah, it was good.

SENATOR YOUNG: Alexis Silver, from HANYS [sic].

ALEXIS SILVER: Thank you.

I represent home-care providers, three of whom are with us here today, to talk about some of their remote telemonitoring projects.

I would like to, first of all, point out there is a lot of data available that shows the value of home monitoring as opposed to physician-to-physician or spoke-to-hub. They're really different utilizations of the technology.

Here, in New York, we have almost 100 providers that do home telehealth through the

Medicaid program. This is a program that's been very successful in reducing hospitalizations, and reducing health-care-utilization emergency room visits, and also, in some cases, physician visits, as people can be tended to by their home-care nurse before an event happens.

I would like to mention, to get to reimbursement, that that current program is at risk.

As home care is kind of being dissected, we aren't quite sure how it's going be put back together, but the home telehealth program, which is, actually, a separate funding stream at this time, it is part of the Medicaid-modeled contract.

However, a lot of providers are having difficulty, having -- with their managed-care companies picking up that Medicaid piece for telehealth.

And, also, within managed long-term care, it is not currently being reimbursed by the managed long-term-care program.

So, we'd like to see -- because we have tons of data that support the value of this service, we'd like to see some kind of movement on an alternate funding stream, whether it goes across -- across -- well, I'm not sure what to call

our Medicaid programs now, with telehealth. But, for example, it's not reimbursable for TBI programs; for patients that are -- as the home-care industry becomes, basically, more of a subcontractor, it's going to become more and more difficult for them to provide that service in a consistent stream.

I'd also like to point out, if you're looking for a large data, the V.A. has incredible data. I think they're currently rolling out up to 50,000 units for home telehealth. They found that so successful.

It's really, really credible data. There's also a lot internationally.

So, uhm...

SENATOR YOUNG: Yes, we'll go to Dr. Dubeck.

And, we also are joined, via teleconference, with Cynthia Gordon, who is a nurse at Rochester General, and she has a presentation.

So, we'll go to Dr. Dubeck, and then we'll go to Cynthia.

DR. FRANK DUBECK: I've heard lots of comments about payment, and things like that.

And as one of the payers in the room, I sort

of wanted to get the feel of the room before I spoke up.

[Laughter.]

DR. FRANK DUBECK: We've been following Medicare's outline for telehealth since Medicare went on-line.

Just recently, we passed a policy, internally, for our commercial business.

The biggest hurdle: Is there anything in our member contracts to cover it?

And, we took the position: This is just an office visit. This is for clinician-to-clinician type of office visit.

We were told by our attorneys, we better file rider with the Insurance Department, and that will be coming. But, I think, instead of waiting for that, we wanted to make this available, to help it take off.

It is a way of the future.

And, our concern is, with every new service, there's the potential for it being churned, overused, and draining the system of more money than it's saving.

That is a concern.

The other thing, with emphasis on

alternative-payment mechanisms, between medical home, ACOs:

Do we want to really create another fee-for-service clique?

Or, that this should be some sort of, weekly, monthly, you know, part of the ACO payment, part of the medical-home case-management fee, especially in the primary-care sector, when you're talking primary care to patient maybe in their own home?

The problem with telemedicine, in my mind, it's multi-dimensional, and you have to focus your conversation on what dimension.

We've heard about provider to provider;

I mentioned patient to primary-care doctor.

We've heard about psychiatry.

We've heard about monitoring of home-health agencies.

And, each of these bring their own concerns, in terms of judicious spending of the precious health-care dollar.

But, we are in support of telemedicine going forward, and we're taking steps, on our commercial business as well, as we have been doing with it Medicare.

SENATOR YOUNG: Thank you.

Cynthia, are you ready?

CYNTHIA GORDON, RN, MSN: Yes, we're ready.

SENATOR YOUNG: Okay.

CYNTHIA GORDON, RN, MSN: Can you hear me?

SENATOR YOUNG: Yes, I can hear you; we can see you, which is great.

And, why don't you go ahead with your presentation.

CYNTHIA GORDON, RN, MSN: I'm giving a real quick snapshot overview of what we've been doing for the last five years.

We've developed a pretty multi-disciplinary telehealth network here in Rochester, New York, out of Rochester General Health Systems.

Right now, we're interfacing. Our first program was with our sister hospital, or our affiliate, which is Newark-Wayne Community Hospital, which is where I'm talking from.

In the room here with me today is, Dr. Arun Nagpaul, who is medical director of the hospital at Newark-Wayne Community Hospital;

As well as, Karen Schaffer, who is -- Carol Schaffer, who is our nurse practitioner for our telehealth program.

We, right now, are interfacing with over

14 specialists. When we first started, we started with one.

We're also connected with several nursing homes.

One thing that I'd like to bring up, as we speak about nursing homes, and I have to reiterate other people's concerns as far as reimbursement, and credentialing.

Credentialing, certainly has been eased up over the last few months, with CMS.

But, specifically, when we're speaking about nursing homes, great venue to be able to offer health care and specialty consults to the patients in that community, but, the big problem that we have, is with Medicare reimbursement.

And just to bring it to light so you all understand: If you're in a health-physician shortage area, you can get reimbursed. If you are not, you cannot.

And a simple example: We have a hospital that's close to us, Blossom -- our nursing home, rather, which is Blossom View, which is in Sodus, which is not considered to be a health-physician shortage area. And Sodus, to me, is more rural than Newark; and Newark is.

So, there's a lot of discrepancies in what really is considered rural, and what is not.

And that really needs to be lifted as well, so that we can really do a very good job of being able to offer telehealth to patients throughout the entire state, whether they're in an acute-care setting, a physician's office, or a nursing home.

What I'd like to do is, I'd like to speak specifically about what we've been doing here at Newark.

I'm going to let Dr. Nagpaul speak on that, on our behalf; but, we implemented an ICU critical-care consult service here, in a pilot stage, for the last several months. Something that's been a discussion for a really long time. And, he's going to speak to it, from his vantage point, as far as being, the hospitals here at Newark.

DR. ARUN NAGPAUL: Good morning.

Thank you for the opportunity to talk to you about telemedicine.

You know, it's a challenge for rural hospitals to recruit physicians, in general. And even in Upstate New York, that challenge is even greater.

But, to get specialists to come out to rural hospitals is almost impossible.

So, luckily, with our partnership with Rochester General, we have 14 different specialties that we access via telemedicine. That amounts to, approximately, 50 additional medical-staff members, who don't physically come to our 100-bed hospital or so, but, are able to give care to patients via telemedicine.

One of the prime examples is our ICU.

So, we have a hospitalist team; so, hospital doctors that take care of the ICU patients. But, we don't have an intensive-care doctor. None of the rural hospitals can really afford an intensivist.

But, in our situation, using telemedicine, we have an intensive-care doctor round every ICU patient every day, which offers us support, as far as --

[Telephonic interruption.]

-- [unintelligible] management, and --

Want to answer that?

-- and some of the more high-tech medications that we use.

We went from a 5-bed ICU to an 8-bed ICU over

the last year, because we're taking care of sicker and sicker patients, and keeping them here in the patient's community instead of transferring them -- transferring the patients out.

And, in large part, we're able to do that because we have the backup of the intensive-care doctors.

If there's a problem overnight, we can access the intensivists overnight.

On weekends: Just last week, there was a cardiac arrest in the ICU.

We have very competent doctors, but it was nice to whip up the telemedicine unit and talk to the intensivist, who is in the ICU in Rochester; get some advice.

In addition to that, it's not just physician care that's beneficial, they have an ICU pharmacist available to them, which we don't have on staff here.

So, we were able to use his knowledge in resuscitating the patient, as far as what medications to give the patient.

And when we look back at our data, we've seen that we're keeping sicker patients at our small rural hospital, and our mortality rate has gone

down.

So, I think the telemedicine is part of that success.

I don't know, Carol's been part of the telemedicine program, from the nurse-practitioner standpoint, for years.

Anything to add?

CAROL SCHAFFER, N.P.: We get involved on a consult service, and then we can actually follow the patients, day to day, until they're considered stable enough to release back to the hospitalist care.

So, we're actually interfacing with these physicians, not only through telemedicine, but day-to-day rounding, which makes them feel more comfortable.

And, then, we can see them as outpatients further on down the road.

So, their care doesn't just stop here; it keeps on going, until they're considered stable enough to release.

DR. ARUN NAGPAUL: And, in telemedicine, it isn't just talking to the doctor on the other side.

We have a digital stethoscope, so the doctor's able to hear heart sounds, able to hear

lung sounds.

And, after a while, the patient feels no different than -- interacting with the physician as if they're in the room.

So they really -- they really see past that technology, and accept it, I think.

The other thing it allows us, we also do outpatient visits here.

So, we're about 40 minutes away from Rochester. So, there's some patients in this rural area that feel Rochester is the big city, and they won't go there for a follow-up appointment.

So, we're really bringing the doctors to them, in the outpatient setting. And I think a lot of patients would not have received their care. They would have just ignored the follow-up visits.

But now that we're able to bring the visit to them, I think that's really improved the health care of our community, in general; not just in the hospital, but also on the outpatient side.

And, each month, we're setting a record for more and more consults in telemedicine visits, as -- you know, not only do we need to -- the patients to buy into this, but we need our medical community, the doctors, to refer to the

telemedicine office.

And I think, over the last couple of years, Sidney and Carol, and our system, have done a good job of making telemedicine, you know, a routine rather than something that's novel.

CYNTHIA GORDON, RN, MSN: The one thing I would like to point out here, is this is our tele-ICU cart.

And on the cart, we have a computer that has the technology downloaded on it, so that we have a digital stethoscope.

And, so, our physicians -- I don't know if anybody's aware of the technology that's out there, but anything that's digital can be communicated through any of this televideo-conferencing equipment.

So, we have the digital stethoscope. We have a generalized exam cam, which gives you much more powerful focus and view of the patients, whether it's a wound care, or rash, or whatever.

So, think of anything that's digital, whether it be those two things, or OvaScopes, ophthalmoscope, and it goes on and on and on, it could be attached to these units, so that when you're doing a consult with a patient, with

exception of a psychiatric visit, most other consults need some type of peripheral added to it, to make for a full consult.

One think that we've done in our office, and I'd like to add this to the very end, is, you know, I'm very much involved with The American Telemedicine Association, very much involved with the nursing [unintelligible], as well as other states within that organization.

We were faulted by some of our -- the bigger organizations, like UC Davis, and even, Phoenix, Arizona, where they do a lot of telemedicine, because their telepresenters are registered nurses. And that's great.

But we decided, in our particular environment, we have a nurse practitioner who's the primary person, who's the telepresenter.

We do have a backup RN, but it's because we're doing so many multi-disciplinary rounds on these patients, we're interfacing with so many different types of specialties, we felt it was important to have an advanced-practice nurse.

And, that's really been beneficial to us in our practice.

So, I just would like to share that with you,

because I think it's something that people need to consider when they're putting together a program; that, sometimes you need somebody that has that advanced-practice acumen to be able to do a very good telepresentation for the physician on the other end.

And, so, since we're interfacing with nephrologists, intensivists, and it goes on and on and on, that just helps to make a better consult.

We also do a lot of geriatric consults, which I think speaks to the aging population. And they work out very well for us.

SENATOR YOUNG: Thank you.

Does anyone have any questions?

We want to sincerely thank you.

We wanted to prove the point today, that this actually does work.

We appreciate the demonstration.

We wish you a lot of luck.

And, I personally would like to come out and see things firsthand, someday.

So, thank you so much.

CYNTHIA GORDON, RN, MSN: Any time you'd like to come, we'd love to show you.

SENATOR YOUNG: Thank you.

Laurie's had her hand up three times, Assemblywoman Gunther tells me.

So, Laurie Neander, who's an RN from Bassett Health, could you chip in?

LAURIE NEANDER: Good idea here.

Thank you.

I really appreciate being here today.

And, really, I wanted to expand on some of the comments that have already been made, that the barriers --

Excuse me.

-- related to --

Excuse me.

-- to expansion of telehealth programs, which have been, I believe, proven very successful.

And the evidence -- just to kind of back up, we launched our program, a home community-based program, in 2004. So, quite a number of years ago.

And, initially, we rolled out the program, talking with our Bassett board of directors, and so forth, the hospital executives.

We didn't address it in terms of reducing hospitalization, because that wasn't very popular in '04.

But, we did -- we launched the project, really looking at workforce shortages, which continue to be very acute, of course, in rural areas.

So, actually, over time, our project, we now have 140 units in the field, and they are in the field at all times.

And our telehealth project leaders routinely ask me to invest in more units, because the need continues to increase.

But, what we've been able to demonstrate, is that, ten remote monitoring units is the equivalent of one full-time RN.

And, when you look at the cost of providing direct-care services to a patient who lives in Old Forge or Fishezetti [ph.], areas that we know, the cost to send a nurse on a random basis, based on traditional home health-care models, just doesn't make sense.

So, we've been able to address workforce shortage.

And then, certainly, on the patient-care side, the evidence, and that we've collected over time, demonstrates extreme patient satisfaction.

We never use the word "computer," installing

a unit in an 85-year-old patient home.

We always talk about it in terms of, this is part of your disease-management plan that your physician has prescribed.

And we've very been very successful installing the units, and monitoring these patients for a period of time.

Our evidence is, over time, CMS issued re-hospitalization rates; that, we have reduced our re-hospitalization rate, from a continued statewide and national average of 28 percent of all patients who are served by home health-care providers, at some time during their course of care, end up back in the hospital.

That's a lot of people: 30 percent -- 28 percent.

We've reduced ours to 16 to 18 percent.

So, the evidence demonstrates, and this has been consistent over time, as our program continues to mature.

So, I think you asked about solutions.

I wanted to give you a little bit of information about our history, and so forth.

I think solutions really revolve around, maybe even, just as, over time, the Department of

Health have provided acute-care hospitals, critical-access hospitals, a hybrid type of health-care delivery.

I think, that, because the barriers are so significant in the state, for home care, they are county barriers. You know, that we operate, as Senator Seward mentioned, in four counties. But, heaven help us if we venture into Schoharie.

So -- but there are patients just over the line that really could benefit from these services. So, we know that.

So, if we were to eliminate those barriers that include specific operating regions, expand.

I have thought for a long time, that if we could look at regional telehealth programs, they could be tied to medical home. They could be tied to home-care providers, which are ultimately, I think, tied to home-care providers anyway, because that's what we do in the communities that we serve.

And I think, that, to address the question about -- and there was a concern, I understand, about overuse, is that, you know, we look at providers that have experience; demonstrated experience, demonstrated results. That, we have specific screening criteria.

I know my colleagues at the table, we all do.

We have -- we do not put a unit in every patient home. It's not indicated for every person.

But, for patients who have chronic disease health-care conditions, where we can expand use of the services, I think consumer alignment of incentives is really important, that we demonstrate our results, but, we also engage physicians, providers, referral sources, health plans, and patients. They all have to have some kind of -- something in it for them.

So, for consumers, I think that's a problem everywhere. That, unless consumers are on board, and I think telehealth is a real positive method to do that, repeatedly we hear:

Improved compliance;

Or, if I had only realized -- if I'm a diabetic, if I'd only realized that that cookie I ate last night had such an impact on my condition.

So, maybe we look at, you know: If you want to receive health-care coverage in the state of New York, then you need to participate in your health.

You know: You need to stop smoking. Healthy behaviors.

Or -- I mean, I realize co-payments are difficult.

I could go on and on, but, I think about this all the time.

And it really is in line with everything that the MRT: the recommendations, efficiencies, quality, outcomes.

But, we need to -- reimbursement, sounds like, definitely, to get providers involved.

We need, credentialing, privileging, addressed, I agree. That's what I hear from the medical providers within Bassett Health Care.

I'll stop, because I could go on and on.

ASSEMBLYWOMAN GUNTHER: Seems like you've had a ton of successes.

And I was wondering if you could share some of those statistics about your data that you've collected about, the re-admissions, et cetera.

LAURIE NEANDER: Yeah, I --

ASSEMBLYWOMAN GUNTHER: Also, Bassett Hospital --

LAURIE NEANDER: Sure.

ASSEMBLYWOMAN GUNTHER: -- in Cooperstown --

LAURIE NEANDER: Yes.

ASSEMBLYWOMAN GUNTHER: -- like, what's

your -- around Cooperstown; and, how far do you go? And, how many units again?

LAURIE NEANDER: We have --

ASSEMBLYWOMAN GUNTHER: You used to come to Sullivan County, I know.

LAURIE NEANDER: Only when needed, and authorized. But, we aren't in Sullivan, the home care --

ASSEMBLYWOMAN GUNTHER: No, the home care --

LAURIE NEANDER: -- Bassett, yes, the network.

ASSEMBLYWOMAN GUNTHER: -- you used to do a lot of work with us.

LAURIE NEANDER: Yeah.

Well, as I mentioned, the network, as a whole, is, you know, definitely looking at ACL models and network interrogation, disease-management pathways that are acute care to post-acute care.

We work together, in terms of trying to identify applications for telehealth.

For example: We've had patients in the community that receive home dialysis. And, with additional support monitoring, then they're comfortable, and they can be at home, rather than transporting, you know, to a dialysis center

three times per week.

As an example: We've dabbled in school obesity; children with obesity.

Stroke; one of the problems, just -- I think this is actually something I just recently learned -- the telestroke program, apparently, the hub to, uhm --

Get me terminology correct.

GREGORY ALLEN: "Spoke."

LAURIE NEANDER: -- spoke, the EMT rules prohibit the patient to be transported to the spoke. They have to be transported to the hub.

And, so, there's a conflict between, what we're able to do medically, in treating a patient in a rural area, and a rural hospital remotely using the expertise, just as the ICU expertise you just heard, because of the EMT policy.

So, it just seems so big. It almost seems, to me, that -- I guess that's where I come from, when I mentioned the hybrid model, because there's so many conflicts between so many entities, health care, that -- that, maybe, we just need to transform, to do it quickly, to address what we know is a solution: a separate model that waives -- provides providers waived

privileges. Or --

Do you know what I'm saying?

-- to reduce those barriers.

And, you know, I just think New York State has a real opportunity to take the lead, nationally, there.

SENATOR YOUNG: Assemblyman Gottfried.

ASSEMBLYMAN GOTTFRIED: Can you tell me what the "EMT issue" is that you referred to?

LAURIE NEANDER: I could refer you specifically to the physician, Dr. John May, at Bassett Health Care, who provided me that information, because I consulted with him last week, just to get an update, coming here today.

And, I was not aware of that; but, apparently, the EMTs are required to take -- transport the patient to a stroke center, rather than a community hospital, where the patient might be provided care using video conferencing with a specialist M.D. Neurologist, presumably.

ASSEMBLYMAN GOTTFRIED: Okay. Thank you.

SENATOR YOUNG: Did -- Department of Health, did you want to jump in on that? Greg?

FREDERICK HEIGEL: Would you like me to, Greg?

GREGORY ALLEN: Yeah, go ahead, Fred.

SENATOR YOUNG: Fred Heigel, from --

FREDERICK HEIGEL: Fred Heigel, from HANYS.

And, we've struggled with this, and we're very strong supporters of the expansion of telemedicine in New York State; Supporters of the telestroke initiative undertaken by the Department of Health.

And where the breakdown comes in, is with the emergency medical-services community, because they have certain protocols they need to follow to where they transport patients.

And, in the telestroke program, there's a neurologist at the hub site to view the patient at the spoke emergency department, and make determinations, primarily, of whether or not to -- what drugs to treat the patient with, depending on the type of stroke they're experiencing.

The problem is, though, that there are protocols in the EMS community that won't allow the potential stroke patient to be transported to a non-stroke center facility.

Now, we've worked with the Department positively, with respect to getting stroke-center designation for rural facilities. And, the

Department will accept the neurologist at the hub site as fulfilling that responsibility, but there are a variety of other responsibilities -- the time to get the CT scan, a variety of other things -- that are very -- very challenging for rural hospitals to live up to, given that they have a very small volume of strokes, fortunately, and, that they're -- you know, they don't have an excess of personnel to cover all these different services.

So, we've worked through that gradually.

You know, I know that the goal of the Department of Health is to have, virtually, every hospital in the state become a stroke center, and have that capability.

It's a matter of being able to live up to that capability. Then get that designation, to allow the ambulances then to bring patients there, that will ultimately, you know, make the telestroke demonstration a bigger success.

SENATOR YOUNG: So, Fred, what needs to be done?

FREDERICK HEIGEL: Well, you know, part of it is -- is the shared capacity was out there. You know, it's really not, necessarily -- you know, the technician to run the CT scanner may not be there at

2:00 in the morning on a Sunday morning, sort of thing.

You know, it -- just, the fact that there's not enough to go around, there's not enough demand.

I'm not sure if we're going to be able to solve every situation simply because of the availability of the necessary personnel, versus the standards they have to meet, which are uniformly applied across the state to all hospitals.

So some rural hospitals probably aren't -- and they have to make it at an individual judgment. They certainly can tie into the telemedicine system, but they may not be able to meet the other standards, and that affects the, you know, ability for ambulances to bring patients there.

Now, patients do come without ambulances too. You know, the patients do arrive in a rural emergency departments, and they do get treated, and they do benefit from the -- you know, the telestroke program. It's just not the entire population that could, you know, be served by it.

SENATOR HANNON: So, what's the problem?

You don't have someone to run the CT scan to provide the information to the remote neurologists?

FREDERICK HEIGEL: Yeah, that's just one

example, Senator, yes.

SENATOR HANNON: What other capacity --

FREDERICK HEIGEL: And, you know, there are time frames for each of these things to occur.

SENATOR HANNON: What other capacity is missing?

FREDERICK HEIGEL: Well, you know, there's -- it's -- you know, any hospital can probably call in a technician to run a CT scanner, but, can they do it in enough time to get the results to the neurologist to make a decision in a time frame when there's still clinically beneficial?

SENATOR HANNON: But what's the alternative? Taking the patient to a stroke center?

FREDERICK HEIGEL: That's what happens.

SENATOR HANNON: And, so, suppose it takes longer to get the patient to the stroke center than it is to get the technologist to the rural hospital?

FREDERICK HEIGEL: I suppose that's possible, and does happen occasionally.

You know, I just don't have any data on that.

But, you know, it's not just -- you know, it's -- in order to get the stroke-center designation, you have to have this capacity all the time. You know, and that's a big load for many of

the rural facilities, particularly the smaller rural facilities, to carry.

ASSEMBLYMAN GOTTFRIED: I --

SENATOR YOUNG: Thanks, Fred.

I think the Department of Health wanted to jump in?

Oh.

ASSEMBLYMAN GOTTFRIED: I would think it's relatively simple -- emphasis on "relatively" -- to write a regulation that said -- or protocol, that says, that, if the spoke hospital is, at that hour of that day, clinically, up to what has to be done at the bedside, that the EMT could be told that fairly quickly, while the ambulance is at the scene, and, be authorized to take the patient to the spoke hospital rather than to the hub.

Now, obviously, if the -- if the equipment is not ready to be staffed at the time the patient would get there, that's a different issue.

But, if the spoke hospital has the CT scan and the technician to run it at that time, it would seem to me a pretty simple regulatory change, to tell EMTs to go to the spoke hospital for that patient at that time.

SENATOR YOUNG: Dr. Dubeck, you had --

FREDERICK HEIGEL: I was going to say --

I'm sorry.

SENATOR YOUNG: Go ahead.

FREDERICK HEIGEL: -- that just kind -- that sounds somewhat like -- you know, like a part-time stroke-center designation to me. You know, during select hours.

And --

ASSEMBLYWOMAN GUNTHER: Is there such a thing, in order to become a stroke center, you have to be credentialed as a stroke center, wouldn't you?

FREDERICK HEIGEL: Yes.

ASSEMBLYWOMAN GUNTHER: And you also have to have, like, a certain sample size?

Like, in other words: How many people come in order to be able to say:

Geez, you're doing a great job;

Or, you know: We're not going give that you designation.

It's like, Sullivan County, we transport all of our MIs that need any kind of cardiac intervention down to Westchester, or different hospitals.

FREDERICK HEIGEL: Uh-huh.

ASSEMBLYWOMAN GUNTHER: And what happens to

hospitals, I think they become gun-shy, because, then, usually, we transport all of our viable patients; and, so, you're left with people that, you know, there's not a lot of hope.

And, so, if you have three patients, and two die, makes you look like you're a really rotten hospital. But, they put that out in the press. And you're, like: What, are you kidding me?

FREDERICK HEIGEL: You're right about that.

ASSEMBLYWOMAN GUNTHER: The patient with a 105, and with 900 comorbidities, and, there's no way.

FREDERICK HEIGEL: You're exactly right about that.

And that brings some reluctance on the part of some rural facilities to, you know, even try and be in the game, because the volume is so low, and the risk, as you're describing, is pretty high.

SENATOR YOUNG: Dr. Dubeck, did you --

DR. FRANK DUBECK: Yeah, if it was easy, it would have been done.

SENATOR YOUNG: -- then Vicky --

DR. FRANK DUBECK: One of the problems is, that, stroke patients, when EMTs get there, often look alike. And whether they could be handled

in a spoke hospital with an infusion of the right IV drug, or, whether they need an invasive radiologist to instrument them, which is not typically available at the spoke hospital, there's no way an EMT's training, no way I could do it in the field, without the CT scan.

And, so, there has to be some sort of judgment made, most of the time, where are most patients going to get access to care rapidly, because, with stroke, time is brain.

And that's the overriding principle.

And, so, you know, to put that judgment on an EMT is way above their pay grade.

ASSEMBLYMAN GOTTFRIED: So it -- it -- I mean, there are serious clinical issues that need to be sorted out, but it -- at least, if it would make clinical sense to take the patient to the spoke hospital that is closer by, there shouldn't be a regulatory, or a coverage, obstacle to doing that?

DR. FRANK DUBECK: Yeah, you want to leave it to their judgment as to: Is it quicker to get them to a spoke hospital and get an initial evaluation, and then take them to the stroke center? Or, is it just faster to get them to the stroke center?

We see many calls for air ambulances just

for that, so they can get right to the stroke center.

SENATOR YOUNG: Thank you.

Vicky, would you like to contribute?

VICKY HINES: Thank you.

Can you hear me?

I actually want to follow up on a very important comment that Laurie made about patient engagement, because I think that is an unsung benefit of telehealth that, perhaps, may be more important than all of these other benefits that we're talking about.

And just by way of background: We are -- we're very similar. We're a home-care agency, so we do what I call, both, "traditional" and "non-traditional" use of telehealth.

By "traditional," I mean reimbursable; and by "non-traditional," I mean, not.

So, I won't -- I won't beat that dead horse.

But, we do non-video biometric monitoring for diabetics, heart failure, COPD.

And, like many of the outcomes you've heard around the table already, our minimum outcome is a 25 percent reduction in rehospitalization and ED use; and our max is between 50 and 60 percent

reductions.

So, we've had just some terrific results from that.

We believe that one of the primary reasons we have those results are because of the patient-engagement perspective.

So, this is not clinician to clinician. This is the patient interacting, on a daily basis, with their own health status.

Most of the -- the good technology today is relatively easy to use. And it includes, not just the biometric monitoring, but also some education components.

So, you have a patient who may have been struggling with a chronic illness for a long time, has had access issues; so, doesn't, either, easily get to the doctor, or doesn't make those follow-up appointments that we're so concerned about, and we've heard about today.

But, they have an interaction in their home every single day with the system, that tells them what their A1C level is, or what their blood pressure looks like, and helps them tie it back to what they ate the night before.

And, we have so many just serendipitous

examples of patients who will say: Oh, my gosh. I realized I can't eat baloney sandwiches.

I mean, that's a silly example, but the reality is, these are folks who have been struggling with illnesses for a very long time. And until you put information and some control in their hands, the bells don't go off.

I have been a big and vocal component of, we have to design our health system around making sure that patients feel that they have some obligation, to pay attention, to take care of themselves, to interact with the system in the right way.

And this is -- this technology is one way to make it easy for them to do that; and, frankly, it's really satisfying.

All of the results, certainly, that I know of from home-care agencies that have been using telehealth for quite some time, very high patient satisfaction. And, in part, because, one, it feels good to know that you're being monitored; but, two, it feels really good to know that you have some control, and that you're in a decision-making mode.

And I don't think we have a system designed around making the patient central to their own care,

and this helps us to get there.

SENATOR YOUNG: That's great.

Assemblyman Morelle.

ASSEMBLYMAN MORELLE: Thank you.

And thank you for -- everybody, for being here this morning on a really important topic.

And I just wanted to underscore what Vicky Hines has said.

I've spent a fair amount of time visiting folks that have used the system they have in place.

And, indeed, talking to those individuals, the sense of empowerment that they have over their own well-being, is not only important for the system to work, but it's important for them. And they certainly seem to have embraced it.

And I think that's critically important, as we're trying to get people to take more responsibility in terms of lifestyle, and other things that relate to their own health care.

So, I appreciate that.

But, I just wanted to thank everyone for being here today.

SENATOR YOUNG: Great, thank you.

Michelle Mazzacco.

MICHELLE MAZZACCO: I think it was on, and I

turned it off.

Thank you.

I'm with the Eddy Visiting Nurse Association, and we serve five counties in Upstate New York, two of which, Columbia and Greene, are very rural, and, the other three which have some very rural pieces to them.

We have about 340 patients that we monitor on telehealth on any given day.

And, later, I can share results with you of two studies that we completed:

One of patients who were receiving in-home services, combined with telehealth;

And one where we partnered with an insurance plan, and provided telehealth as a standalone service.

I want to go back to a comment that Lexi made earlier, because, we have been fortunate, unlike much of the discussion around the table today, in home health to have Medicaid funding, thanks to Senator Hannon and others. And that has made an enormous difference.

We have a re-hospitalization rate for our long-term home health-care program patients, who are all eligible to be placed in a nursing home, but

are being cared for at home, that is equivalent to our non-long-term home health-care program patients.

And that really is, because about 20 percent of them are receiving telehealth on any given day.

I was surprised, as we see ourselves moving into a Medicaid and a managed long-term-care system in home health, not to see telehealth as a mandated service.

So that would be one of our suggestions today, is that you look at mandating that, and requiring that telehealth be among the services required by a managed long-term-care program, or a care-coordination model.

It's not included today in the listing of services that are required.

And when you look at the investment that home-care agencies have made, and had some success with, thanks to funding from the State, if that isn't carried over from the long-term home health-care program today into the managed care -- managed long-term-care arena, it will be lost.

It can take years, as a home-care provider today, to get a contract with a managed-care plan.

It can take more years to get use of that contract, once you have it.

So, I think that incorporating it, based on the evidence that we already have, regarding its effectiveness, is important.

And I don't want to forget to mention, that, you know, in rural areas that we look at surveying, one of the opportunities that we see, is to use telehealth in a preventive basis, and, including as a standalone service.

So, for example: We have what are called "kiosk tele-home-care units" that we place in various senior apartment buildings in the area.

We'd like to be able to expand that to, you know, being on Hunter Mountain, at a community center or a church, or whatever building is where seniors congregate, and to be able to allow them to share one piece of technology with swipe cards, which is what we use today in other sites, to monitor their chronic illness and disease management, but, there isn't funding for that.

So, even if that was to be funded on a demonstration or a pilot basis, to gather outcome data, I think it would be very helpful, on a preventive basis.

The two studies that we did, one was in the long-term home-health-care program, and it was

funded by a Department of Health.

There were 31 patients served, who received telehealth for 12 months, and we compared their outcomes, 12 months before, to 12 months during, telehealth.

We had a 31 percent reduction in emergency room visit rates, and a 42 percent reduction in hospitalization rates.

We then enrolled 53 members, in partnership with a local health plan, who received tele-home care only, in a second study.

Their average age was 72, and 56 percent of these members had more than two chronic diseases.

We reduced re-hospitalization rates by 55 percent; emergency room rates by 29 percent. Data provided from the health plan, $1.1 million savings.

The only cost area that they saw increase, was pharmacy costs went up 2 percent, and we attribute that to the fact that we were successful with medication adherence. They were actually taking the meds they were supposed to take.

So, you know, we're kind of beyond the "evidenced" stage of this. We see telehealth as effective in conjunction with home care.

We also see it effective in a preventive mode, separate and apart from tele-home care, as a standalone service.

If we can avoid that acute episode, we often don't need telehealth even after -- afterwards.

And bringing telehealth in rural areas, to community centers, senior centers, churches, in a kiosk-shared format, would be a very cost-effective way, but there has to be a way to pay for the RN time to do the monitoring.

And that's what limits us today.

Thank you.

SENATOR YOUNG: Thank you.

At this time, I'd like to go to Rachel Block.

And, I know Greg Allen also has a presentation, but we'd like to hear from the Department of Health.

RACHEL BLOCK: Thank you.

And I'm not going go through my presentation in detail. I'm just going to pull out a few highlights which I think are relevant to the first question, which you posed, that is really what the Commission wanted to accomplish today, which is: What are some of the barriers, or, potentially opportunities, to develop a statewide capability to

support telehealth?

As I think many of the members, as well as the stakeholders who are here today, know, we've been working for the past five years to develop what we call "The Statewide Health Information Network of New York."

And the basic idea here, was to coordinate, on a statewide basis, but also to facilitate, at the community level, the development of the health-information technology capabilities that are necessary in order to have a patient-centered system, and to really mobilize information at the community level, which are relevant for the particular health priorities of those communities.

So what we think we have accomplished through the governance, technical, and other activities that we have supported, primarily funded through the HEAL New York Program over the last five years, is the statewide identification of key priorities which we want the technology to be able to support.

Telemedicine, currently, is on the radar screen, but it was identified through our consensus process as a little bit more of a longer-term priority.

So, the Commission's input would be very

valuable, in terms of helping us to establish where we should be ranking this in the relative scheme of things of various other things that the stakeholders had already identified.

We also have regional health-information organizations, which many of the stakeholders here today have been active participants in, and they really accomplished two important purposes.

By bringing those community stakeholders together, they can identify the most efficient means to deploy technology across the community.

Instead of having each provider out there trying to figure this stuff out on their own, they can come together and jointly determine what kinds of technology capabilities may be helpful to solve a particular health or health-care problem, and then, jointly support that through funding.

But the other key element, which was really a side benefit, that I don't know that we understood we were facilitating when we started this, is that, each of those RHIOs has brought together the key clinical stakeholders and the key payer stakeholders in their community, to be an active part that collaborative process of determining the priorities.

And, in certain cases, some of these very issues around payment, and the support for various technology and care-coordination models, have actually advanced, to some degree, through those community-based discussions.

So, the RHIOs evolved to be much more than just about technology; but, really, how to facilitate the use of technology, in the community context, in order to help achieve the health priorities for that community.

The other component which the RHIOs have helped to support, though, is what we call "adoption support."

This is really involving, and several of the comments today address this as well, that you don't just put the technology out there and expect it to be used, unless you understand the capabilities that are necessary, in terms of, staffing, the work flow that would be associated with the new technology.

And this would apply, not only to telehealth, but, really, to many other new technologies in health-care settings.

So, one of the things that the RHIOs were able to do, is, identify the resources that can

actually go out and assist those practice settings, in terms of the appropriate use of these tools and technology.

Finally, one important component of this, several comments have been made today, about:

What is the evidence to support this?

And, what kinds of research has already been done?

A key component to the health IT program funded through HEAL has been the independent academic evaluation of the various health-information technology programs that we have implemented.

And, so, we have a whole suite of both qualitative and quantitative studies, focusing on cost, quality measures, outcomes, patient experience, as well as studies that are looking just at the process of implementation, so we can better understand how to improve and make that more efficient.

And it would be, I think, quite reasonable across all of these domains -- the governance, the regional health-information organizations, the technical services associated with the Statewide Health Information Network, the

implementation support capabilities, and, finally, the evaluation -- to work with us, to say: Here's how we would like to really integrate telehealth as a key component across all of the domains of what the infrastructure that we have already developed.

So, I thank you for being here today.

It's actually been extremely informative for me as well.

And, if there are any questions, happy to take them; but, also, to have follow-up discussions with the members if you would like to pursue this further.

SENATOR YOUNG: Rachel, how can the Commission get the studies that you referenced?

RACHEL BLOCK: I can -- in the slides, there's actually a listing -- a high-level listing of all of the different studies which are currently being conducted under the health IT program.

And, we could certainly arrange a briefing, or a webinar, with the lead investigators, if you would like more detail.

SENATOR YOUNG: Okay, great.

And, I want to point out, if people brought supporting information or presentations, we'd like to have copies for the Commission.

If you could make sure that we get those before we leave today.

Greg, did you have a presentation that you would like to give also?

GREGORY ALLEN: I will spare us the pain of doing my presentation, but I will also just do, quickly, some comments.

SENATOR YOUNG: Senator Hannon said, if you're not allowed to do your presentation, you're going to kill Senator Hannon.

So, we don't want that to happen.

So --

GREGORY ALLEN: I can also publicly promise, no death to Senator Hannon.

[Laughter.]

SENATOR YOUNG: Thank you.

SENATOR HANNON: Well, let me just give you background.

The State is going through the Medicaid Redesign Team.

And, the key leader of assembling a vast number of recommendations in the studies to support that, falls at Greg's feet.

And, it's been done quite well, and there's lots more to be done.

But, the interesting part, for what the Commission has done, is to take rural health, take telemedicine and telehealth, and give it a priority that, probably, it did not have.

So, this is very useful. And it's where -- it's a mutual, I think, learning experience for the Commission, and for Mr. Allen.

SENATOR YOUNG: Thank you.

GREGORY ALLEN: Thank you very much, Senator Hannon.

I'd just say, that, you know, as part of Medicaid redesign, we -- we, at the Health Department, took this seriously. We've been working on going in collaboration with the hospital associations, our legislative colleagues, and many of the folks around this table, to try to utilize, in many ways, to get out of the way; and, also to, not only just pay, but make sure that we didn't create barriers around that payment.

I just want to reflect for a second on what I heard today in our take-homes, if that's helpful, and then just a quick list of a couple of opportunities that might not have been mentioned here today.

The first thing I heard, is that, we really

need be flexible in terms of who's in the program; and that includes mental-health clinics, and also physician and practitioner offices.

So, I'm going take that as a take-home to our policy team, to add to our Medicaid redesign proposal here, to take a look at including those entities importantly in this.

The other is, that we should look aggressively at privileging; to do whatever we can do to eliminate barriers on privileging, like we did on credentialing. And, we'll that back as homework as well.

I know there's a lot of activity and a lot of discussion on the EMT issue. I know many smart folks have been engaged in that, outside of the payment-policy window that I look at, but we'll continue to engage with Fred and his colleagues, in trying to do whatever we can do to help on the EMT issue.

The other I heard was, paying for non-physician time, for monitoring, and other activities.

I know that we -- you know, we do pay for the doc time, the nurse-practitioner time.

I heard RN time is an issue. We'll take that

back as well.

I also heard that we need to take a look at regionalizing this availability, and looking at getting rid of, sort of, boundaries that get in the way -- potentially, of service-area boundaries that might get in the way.

And I think that that sort of keys back to my "opportunity" list.

The first big opportunity is another piece that the MRT launched, which is the health homes.

Health homes really are a building on the patient-centered medical home. It's a way to take a multi-disciplinary-, multi-institutional-layered look at our highest-need patients, and provide care management in a different way.

I think telemedicine and telehealth can be critical strategies in achieving the goals of those projects.

And may -- I took the comment of: Do we really want to add this as one more fee-for-service clique, or should we try to create some kind of consolidated payment opportunities?

And the health home may be the structure from within which to think about consolidated payments for population-based health, again, so that we can,

maybe, get out of having to invent a rule for every payment, and then watch that.

And that -- that really sequences well with our desire to get out of fee-for-service, and to get into a more of a care-management mode, and paying for care managements.

The other opportunity is connected with health home. We've been trying to do some flexible certification, potentially across behavioral-health services, mental-health, substance abuse, and physical health care.

I think that can remove some of the barriers we talked about, in terms of Article 31's playing. And, we might be able to do something quickly on that.

And the last is, a -- really a stop-gap. And it's outside of the space of this, but it's a commercial; and that is, that the Medicaid program pays for transportation.

And as part of the Medicaid Redesign Team, we've installed transportation managers in many counties. We're eventually going to go statewide.

Many rural counties are currently covered by this.

And the job of those managers is where this

is not installed, where we really cannot plug somebody into local health, that we can bring them to the health care that they need, and that Medicaid will pay for that.

And we're working very hard to get those managers to do a good job with being sensitive to the needs.

And then the last stop-gap I'll mention is, "call us."

When -- what it -- really, we don't like to hear are special stories of unique patients, that, because of a payment rule, or an individual-access problem, we couldn't get somebody the care they need.

Our staff worked very hard on individual circumstances, to get services for patients that need it, as do our health plans.

So, I would just encourage people, that, as special circumstances come up, and special patients come up, that those be -- we be made aware of those, and how our policy might be conflicting with providing good care or timely care.

With that, you know, I appreciate the opportunity.

I learned an awful lot here today. I thought

this was tremendously valuable.

ASSEMBLYWOMAN GUNTHER: I have one question about the health homes.

Would that limit the usage of telemedicine now?

Like, in other words: Would it be only a specific population that you're saying, because about the clique and the payment?

So, you know, when I was listening to Laurie talk about, like the dialysis patient, and I think about being on Medicaid, and we're paying the transportation to go to the facility for the dialysis, and, we're saving because they're not getting infections because they're in a community situation; versus, like, creating another, like, limitation of smart and cost-effective medicines.

So, I don't know that -- you know, I understand what Frank said about the -- you know: Do we want to have another clique?

And I think, you know, this is personal.

And, sometimes, when I think about, you know, the practitioners, and you listen and you listen, that we're so afraid, you know, to spend a little bit of money to get a lot of results; and, so, that we end up limiting because we're afraid.

And, in all honesty, it's like the best way to deliver care.

So, when I think about, like, framing it to, like, a home-health model, or a health home model, again, you know, we do that, right now.

And, you know, I think about, like, my patients that go to dialysis. The money that we spend to transport that patient, when Laurie's doing it in the house, and preventing infection, it's just, like, amazing stuff.

And I -- you know, I hope that, you know, New York, we're doing so many great things.

So, I'm hoping that we'll do the same thing in the care -- the delivery of health care.

And, you know, I think that -- I always believe, when I worked in a hospital, and -- you know --

And not that I'm an expert at all. I just was lonely old nurse.

-- but they -- when we created policies and procedures, we always went from the bottom, up; not from the top, down. -- because, it's these men and women that are in the field, that can really teach us how to, like, deliver the best quality, but cost-effective.

And they know.

They know. And they, like -- I remember -- I know, that when the home-health folks come and visit me, they're beating their head against the wall, because they know they've got it.

But, they want someone to take what they have and they -- you know, you have all of this data-driven information.

I mean, this is, like, the coolest stuff around.

And, I think that, you know, let's go with it.

SENATOR YOUNG: Well, could he respond to what Assemblywoman Gunther said?

GREGORY ALLEN: Thank you.

I think those are apt concerns.

I would say, on the concern about creating another layer that actually produces a barrier, rather than facilitates, is an apt one.

The health homes really are targeted to people with multiple chronic conditions.

So, I believe that they're a very appropriate structure for us to think through, removing some of these barriers, and trying to figure out an entity to attach some form of a global payment to.

There are other entities. It is just one I mentioned as one opportunity among many.

There's also our -- the growth of health plans, the special-needs' plans of ACOs, that may also offer similar opportunities to, sort of, crack this nut.

In terms of the -- just the comment, I think, is just that it's very hard to just keep adding individual fee-for-service elements, then with a control element on top of those.

And, really, what we ultimately want to do, I think, is vest the decision-making as far down in the service-delivery chain as we can, again, so that those "lonely old nurses" can influence the policy about what needs to be delivered to a patient.

And, as far as that gets away from my desk, and is more -- and as more of that localizes, and people feel the impact of good decisions and poor decisions, relative to resource allocation, locally, I think we're probably a little closer to achieving population health.

SENATOR YOUNG: Thanks, Greg.

Senator Seward.

SENATOR SEWARD: Yes, I would agree with Assemblywoman Gunther; this is cool stuff that we're

talking about here today.

And, unfortunately, I need to leave to conduct a committee meeting.

But, before I do, we've heard, in terms on the reimbursement issue, you know, is involved with the Insurance Committee. I guess we're on the payer side of the equation. That, we've heard through Director Allen, in terms of what's happening in the public programs in New York, and the Excellus policy in terms of commercial policies.

Other than that, is it safe to say, it's pretty uneven out there, in terms of private insurance carriers, in terms of what is covered in terms of these telemedicine services?

I mean, is it --

FREDERICK HEIGEL: It varies, and it's inconsistent, between payers.

That was one of the points I was going to make, you know, that consistency would help, because, you know, when you treat a patient, you don't necessarily differentiate based on payer. You look at what they [no audio].

So, there is that variation.

You know, and if I may, also, if I could pick up on that: What we tried to do, from the

association perspective, is really a two-pronged approach, and you maybe think of one prong.

One is, we're trying to educate our members with respect to what you can do in New York State. And that continues to change, and improve, but there's old myths out that there that create, almost, their own barriers. You know, we can't do that in New York; and, oh, yes, you can.

And what we have tried to do, is, we brought in folks, like Cynthia, and like Ken, and I visited Laurie, and I know Mary, to showcase their operations. To show what can work in New York State, and it can be done here, in an effort to, you know, knock down some of those myths.

But, at the same point in time, what we're trying to do, is address the barriers that our membership raises.

And our membership is statewide, so we hear a whole range of different things.

We worked very closely with Greg and his folks.

I see Ron Bass over there, in the Medicaid Office.

They've been very good working with respect to Medicaid. They've assisted us in working with

the surveillance people at DOH, with respect to the credentialing issues, and Medicare shifted into that in the last year or two.

But it seems, like, every time we identify and address a barrier, well, the next one down the road comes up.

And Greg was talking about that on the credentialing of -- privileging piece. There's also a requirement that hospitals do, quality assurance peer-review.

And in the hub-and-spoke monitor he described, for example, well, the spoke is linked to the hub because they don't have that specialist at -- you know, at the spoke; and, so, how are they going to do quality assurance without some kind of very elaborate, expensive process?

That's kind of one of the next hurdles we have to, you know, figure out a way to address.

And as I mentioned earlier, in response to Senator Steward [sic], there is an inconsistency between payers.

So, as I think we've heard, you know, a common theme here today, that, you know, the barriers are, reimbursement and credentialing.

And, as we move through those, and work

through that, they will be addressed, and, hopefully, in short order.

A couple of things we haven't really addressed, though, is, you know, there are telemedicine providers from out of state.

Most of what we talked about here were really within New York State. There are telemedicine opportunities for New York State facilities, you know, from firms out of state.

I know that brings in some competitive element, but -- to apply New York State standards to out of state. You know, it varies, by state to state.

So that really raises, for example, the credentialing issues, you know, and how far you have to look back, for example.

And, so, the mismatch between some of the New York State requirements, with the federal requirements, certainly with other states, is somewhat of an impediment for expanding telemedicine to include, you know, these national providers, some of them are international providers, in fact. And, to bring specialty services, and access, and quality, you know, to some degree, even addresses the physician shortage we're seeing in this state.

But I do think -- you know, we've heard a common theme, and we certainly believe that it's -- telemedicine and telehealth is part of the health-care delivery system of the future. And there's a substantial potential there, I think a very real potential, to save the delivery system a fair amount of money, and improve quality at the same time.

And I thank you for the opportunity to be here today.

SENATOR YOUNG: Thank you.

Yes --

ASSEMBLYMAN GOTTFRIED: Question?

SENATOR YOUNG: -- Assemblyman Gottfried.

ASSEMBLYMAN GOTTFRIED: I have a question for Greg Allen.

In home health-care and managed long-term care, how does Medicaid, or does Medicaid, and if so, how, cover costs of telehealth, telehealth monitoring?

I know there has been a concern about home-health agencies' costs of providing these services, taking up space under their administrative cap, rather than being treated as a treatment cost.

How do you sort all of that out?

And are -- can we expect some new thoughts, or actions, in that area?

GREGORY ALLEN: Assemblyman Gottfried, thanks for the question.

I'm definitely pinch-hitting when it comes to telehealth and managed long-term care.

I'll give you what I know, and I'll take the rest back.

We do pay for telehealth services for folks that meet certain risk profiles in Medicaid. And, we've done that through demonstration funding.

We've got three levels of funding.

And, actually, the uptake of those services is much larger than our telemedicine uptake has been. It's been a -- an area that we think there could be a lot more volume, but there's pretty decent volume there on most of it, on the home-health monitoring side.

Some of which is what we heard about today, has been funded by Medicaid, and paid for through that demonstration.

I have to take back the interface between that and the managed long-term-care product, in terms of what's paid for there, because I don't know the answer to that.

It's an excellent question, and I apologize. I just don't know the answer.

ASSEMBLYMAN GOTTFRIED: Okay, thank you.

SENATOR YOUNG: Okay.

Senator Hannon.

SENATOR HANNON: Yeah, as we're discussing the topic of the roundtable, was telehealth and telemedicine.

And,I think Mr. Allen's point is -- is, I think the tip of an iceberg, because, we have two different, really, topics here that we've had to explore.

Obviously, there's a number of problems that need to be resolved, and addressed, in regard to telemedicine.

Telehealth is a lot simpler.

You don't have credentialing. You don't have privileges. You don't even need a lot of the new programs that have come forward to advance the regional health-informational networks. We don't have electronic billing as a problem.

What it does offer, as I think Michelle said, from the Eddy, is the fact that there are statistics that prove you can save money.

The problem has been, is we don't have enough

take-up in New York State.

To the extent that you are a payer, whether it's the State as Medicaid, or whether you're a private payer, you're very afraid of the "build a field and everybody will come," and you have an overutilization.

There is a need to take a hard look at what's been done, and to say: Wait a minute, you can have an immense amount of savings to the health-care system by using telehealth.

I think your point, with the migrant worker, the dental, you decreased the number of visits from four to one.

That's a serious -- going for a dental operation is very serious, but statistics prove it can lead to enormous health complications unless addressed; health complications a system will also have to pay for.

So, I think there's a need to focus on what we have, as, kind of, maybe an elementary infrastructure, and say: What do we do to make this something that's a useful infrastructure? And go from there.

And that would be the first take-away.

The other problems -- I think, telemedicine

itself offers such great hope.

I had not known, at all, the extent to which child psychiatry was needed, and can be addressed by telemedicine.

The questions of stroke are just, you know, obviously, a lot of good minds have been working very hard to try to figure that out, but that's for better care.

So, I would just want to differentiate that we have a lot of advances. And I think this has been a most, most useful roundtable.

And, thank you very much.

SENATOR YOUNG: Thanks, Senator.

Thank you.

Yes, Rachel.

RACHEL BLOCK: Just one follow-up to Kemp's point.

One of the things that we have heard, is a barrier to telehealth expansion; and, also, the related issue of, sort of, broader mobile-health applications, personal health records.

There's lots of different ways that you could describe utilizing existing technical capabilities to share information in new and different ways.

But, there are three attributes of the Statewide Health Information Network, which we believe are going to be critical in order to facilitate that expansion.

And one of the things that people are very concerned about, is, whether you can appropriately identify the individual patient, and have a means of verifying that that patient is who we think that patient is supposed to be.

And that's, both, on the consumer side, as well as on the provider side, the ability to accurately identify the correct provider who is supposed to receive that information, or to transmit that information.

And, then, building into that the capability to authenticate the identity of those consumers and/or of those providers.

And those attributes, which are key features of our security, and the core services that we're enabling through the Statewide Health Information Network, would greatly increase the trust that both consumers and providers would have in utilizing telehealth, along with many of the other health IT things that we have.

SENATOR HANNON: At risk of correcting a

commissioner, that's telemedicine.

Telehealth allows a lot of the home-health agencies, who already know their patient, who are the providers, and are supervised quite fiercely by the State and local Social Service Districts, to provide, and actually save on the order of, thirds -- three-quarters of the amount expended by State and federal government -- State, federal, and local governments.

So it's -- that's what I call "telehealth."

You're describing, because you do have a real problem with all of those things that are legitimate open questions, with telemedicine.

And, so, if we separate out, the easier path for earlier resolution, is with telehealth.

The more difficult one, or all of the problems articulated, with telemedicine.

And we haven't even begun to deal with the -- what Mr. Heigel talked about, the "interstate" questions, because, we're certainly not the geniuses of the world when it comes to health care.

RACHEL BLOCK: So perhaps one of the benefits of this exchange, is that one of the things the Commission might do, is advance a little more specificity in the definition of those terms.

I was using "telehealth" in a broader context, to capture information that might be exchanged, not just between two hospitals and physicians, but the broader community, and also linking to the consumer.

SENATOR HANNON: That's why I wanted to clarify.

Thank you.

(Pointing) Right there, Mary Ann.

SENATOR YOUNG: Yes, Mary Ann.

MARY ANN ZELAZNY: One of the things that I just want to bring up, and, you know, I am a huge proponent of telehealth, telemedicine...anything that will get our patients seen.

But I got to tell you, one of the biggest barriers we have: We have a clinic in Cayuga County, which is 20 minutes from Ithaca, which is a -- you know, Cornell University.

We can't get Internet.

So --

ASSEMBLYWOMAN GUNTHER: You can't get Internet.

MARY ANN ZELAZNY: So, there's a lot of places in this great state of New York that we can't use our EMR system because we don't even get the

Internet that we need.

So, I think that, you know, as we stand, talking about telehealth, there's a lot of rural communities that have no access to Internet.

Or, you know, cell-phone technology is good for some pieces of telehealth, but not all. And for video streaming, it doesn't work.

So, it's a huge problem for all of us, that we have to keep in mind as we talk about this.

ASSEMBLYWOMAN GUNTHER: You're right.

They're doing some expansion in my area.

We have many places. You can't use a cell phone in my house.

MARY ANN ZELAZNY: My house, I can't. I don't have a cell -- it's sort of nice, but --

[Laughter.]

MARY ANN ZELAZNY: -- you know.

SENATOR YOUNG: Senator Hannon just remarked that --

SENATOR HANNON: I think your -- that the point you made, is -- I saw on the agenda, for the Executive Office of Technology to address, and the question.

But, I think you bring home, you know, in the context of this roundtable, something as a big need.

SENATOR YOUNG: That's exactly right.

I mean, you look at my district --

SENATOR HANNON: I mean, when they talk, at a national level, of, "Oh, we need everyone to have access to broadband," we think it's, Wyoming, or Montana, or something.

MARY ANN ZELAZNY: No. It's King Ferry, New York.

SENATOR YOUNG: Yep.

Great.

Anyone else?

I would like to close --

BETTY (VAN HUIZEN) COUTURE, RN: I just want to --

SENATOR YOUNG: Oh, sorry.

Betty.

BETTY (VAN HUIZEN) COUTURE, RN: I just wanted to make a comment to -- with regards to the telehealth technology, there is so much innovative products that are out there.

We're launching a program in California, with the kiosk. And they -- the population is elderly, and they can't log in to a computer; and, so, we're using facial recognition and voice activation.

And, as well, we have the capability for

mobile kiosk. And, there's so much Bluetooth technology out there.

They were talking about the Bluetooth stethoscope, or the -- sorry -- the digital stethoscope.

We can make that Bluetooth, so a nurse can actually go in and transfer the cardiac sounds, or the lung sounds, and send them to a cardiologist, if they feel that there's a problem with this patient.

And so, again -- and Michelle mentioned prevention.

I think that's just really key, that when you start seeing somebody that has elevated blood glucose, if you monitor them, and teach them, we won't have the renal dialysis happening further down the road.

And, so, Catharine mentioned, just a little bit of spending can save a lot.

And I really believe that we can do that.

SENATOR YOUNG: Great.

I'd like to close, and thank all of the participants today.

I think this was extremely valuable.

And, the entire purpose of the Commission on Rural Resources, is to identify the needs in rural

areas, and bring services and improved quality of life.

And, certainly, by expanding and elevating telemedicine and telehealth, be able to do that for patients across upstate who may not have access to quality services right now.

So, what we're doing is extremely important.

And I want to thank you, because, what we'll be doing now, is interfacing with the Department of Health.

But, all of you, if you have additional information, or want to communicate with us, I would urge you to do so, because I'll be working with my colleagues on the Commission, my colleagues on the Health Committee and the Insurance Committee, to bring these issues forward, and figure out:

Okay, we've identified the barriers. How do we get over those barriers?

And I want to thank the Department of Health, because I know they've been working diligently in this area.

So, I look forward to continuing to work with all of you.

And, just want to thank you for your participation, and for all of your expertise.

(Whereupon, at 12:26 p.m., the roundtable discussion, held by the New York State Legislative Commission on Rural Resources, concluded.)

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