Idaho Patient Centered Medical Home (PCMH)
Webinar – (August 17, 2016)
Transcription

Date: August 17, 2016 **Time: 1:30pm E/T**

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Notes

Jean Glossa: I am going to spend a little bit of time talking about why we are talking about telemedicine; why is this an interest and where is this attention coming from? We will go over some specific youth cases against some descriptions. Everyone probably has an idea in their mind of what telemedicine is, so perhaps you will see things that you have not thought of. I hope by the end of this you will be able to recognize the importance of clearly developing a defended youth case for your business model. I will spend a little time near the end looking at the national landscape of what is going on in telemedicine and specifically in terms of payment reform.

This graphic will hopefully give you some kind of examples or understanding of what telemedicine is and what it is not. The models in this diagram all have some elements of using technology to provide health care; they are all distinctly different. When we talk about telemedicine, most people think of the virtual visit, which is what is at the top. In America, telemedicine Association defines telemedicine as the use of medical information exchange from one site to another via electronic communication to improve a patient clinical health status. This is very broad, and note that telemedicine is not a particular medical specialty, but it needs to be thought of as a morality to provide care perhaps you are already providing in a different way. These other examples of technology-related morality use platforms solutions or invitations to get patients, providers, and payers on how the health care should be provided. None of these were available when I started medical school, but perhaps with the exception of a video consultation.

The definition of telemedicine and telehealth; these are generally used interchangeably where telemedicine will usually refer to direct clinical services where telehealth will be more broad. The ray of technology-based healthcare orientational moderating, providing health education, or test for mabye any of those things we are using technology for health care. Be careful, though, because states, specifically like Texas, they define this very differently. Each of them is tied to a profession and can use them in a how they can be built. In some cases they are very different. I felt the telehealth definition is more together, and telemedicine is telemedicine/telehealth when it comes to Medicaid. MHealth: M is for mobile, so we are talking about cell phones, apps, fitness trackers, a remote, and the originating site. Those are two words that are really important for you to then legislate and determine how things are going to get paid and a lot of people get them mixed up. The originating site is where the care originates from and that is where the patient is. They may think that the patient is in a remote site, so it must be a remote site but it actually is not. The originating site is where the patient is; remote is just where the provider is. Store and forward refers to what we call asynctritive telemedicine, something like teledurn where it is not live; it is a video visit, where it is just medical information like picture of a rash and sent to be looked at elsewhere. Going back to their facility, that again is a very assured type word, the amount that the assurer pays the facility where the patient is located. Paying the originating fee so that the site gets some kind of stipend for hosting that visit even though the professional fees are linked to the physician who is at the distant site. Telepresenter is a healthcare professional loosely defined, perhaps a Medical Assistant, it is not always very clear. It general means that there is someone there with the patient who is physically present who will help facilitate the interaction between their remote provider and the patient. Some payers do require a telepresenter if the condition of payment for the facility. Telepresenter's time, per se, is usual not separately reimbursed. Telepresenter again can be like a medical student that is trained on how to use the equipment. A few points here to consider, if you are thinking of doing telemedicine in something

like behavioral health, telepresenter may not be as important as if you are going to do visits for some type of urgent care or something where perhaps the positions need to listen to heart sounds or looking at a patients ear. There are all kinds of plugins for those, they are called peripheral. It would be very difficult for a patient to be able to but the camera up to their ear, so in cases like that you would need a top boss, a telepresenter. You have to think about that person's position; it is not necessarily going to be reimbursed. Would they be with the patient anyway if it were onsite and that is part of the thing you are going to look at in terms of what the cost would be to have a telemedicine program with a telepresenter. One last note on this slide is on telephonic care. The true definition of telemedicine would include telephonic care. They do put it in there, including about fax and phones, but in the fine print where most states will specifically exclude telephonic care and Idaho does specifically exclude telephonic care in telehealth.

The next slide goes over the array of telehealth applications. The first one I think I already mentioned: to think about the virtual visits; if it is clinic-to-clinic or prep the clinic to the specialist office, or clinic to hospital. It is a live type of teleconferencing; it has a doctor on one end and a patient on another. Hospitals using telemedicine is one of the oldest, most common one. You can really benefit both parties. If there is a patient that might need to be transferred to a higher level of care for maybe a stroke, they will get their evaluation early. There might be a decision about TBA, but if a patient does not need all of that today in the rural hospital, and that rural hospital does not lose that patient to the other area site, they can stay in a hospital near their home. Remote patient monitoring, that is anyone that has a fitbit on, you are doing your own patient monitoring, and you are sending it some type of vitals. Perhaps a patient is at home and their glucose monitor is Bluetooth and it enables it to download it to some kind of database that a nurse will look at and the outline values will go to the physician. You can put these kinds of monitors on a pill box and if they do not open their medicine by a certain time of day then that can give a message saying that they have not taken their medicine. Some of that is reimburseful. Store and forward: like I talked about earlier, that is many less options to get paid for. Direct to consumer is a very common terminology if we think about a patient sitting in at home and they log into one of the telemedicine vendors and they are able to get in touch with the physician and have a consultation for a fee or their health plan might cover that. That is a direct-to-consumer; you are doing it individually and it is most often from your home. Retail medicine is a huge industry in terms of CVS or Walgreens; they are all getting into this minute clinic. They are partnering with telemedicine vendors, offering these solutions both in their stores as well as on their apps. Project ECHO is not telemedicine; the patient is not specifically involved in this visit, so it is talking about healthcare over the airways from a distant site with specialties on one end and primary care doctors on another. It started at the University of New Mexico and it has been very effective for things like diabetes or hepatitis C, where it all started. It is not telemedicine but it has those features to it. It can be very useful for certain youth cases and situations. I encourage you to look at their Website; we have gone through the training and we are able to give you more specific features about the Project ECHO, if you think that would be a good option for you.

One of the things the Affordable Care Act definitely puts mechanisms in place by rewarding efficient of care and rewarding value over volume. We look at things like support for telemedicine on states that have dual, such as Michigan, New York, and Virginia, their health home state amendment plan. Then home and community-based wavers, such as Kansas, Pennsylvania, and South Carolina. In all of those models you are using telemedicine in some way. Probably more so than the Affordable Care Act, it would be Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) is really going to push the needle with Merit-Based Incentive Payment System (MIPS) points with clinical practice approval activities and for alternative payment models. The focus will be again on value over volume and that is going to drive this even more. The next is the par shift for patients; this is the role of a consumer that has choices and they want access. This is a very text savvy generation coming up; they want convenient care. They do not understand why they have to go in person to show a doctor their rash. The next time you sign up for your benefits and what your choices might be, that director to consumer telehealth you will have access to a physician from your own home. If you can do that for

the same or less cost, wouldn't that kind of drive you that way as a consumer of your health care? Over half the country has some type of pairing legislation that requires private payers to cover telemedicine at the same extend as an in person visit. Also, it is very important to Idaho as it is rapidly expanding broadband, wireless communication, and network. It definitely opens up the door to more opportunities, but many areas are still lacking adequate coverage needed for the telehealth program. Another driver that we have really seen it pick up is in correctional medicine. Correctional facilities have a federal mandate to provide appropriate care for individuals detained and incarcerated. Movement of those inmates is very cost affective, telemedicine has been very cost adequate in providing quality care. Lastly is the shortage of positions for both primary care and specialty care. The source of Association of American Medical Colleges of 2016 put out an update of physician supply and demand. This graph shows that no matter what variable that you factor in early retirement of position, the average age of positions are going up and retiring earlier. No matter how you play with the retirement age, no matter how many residents come in, the millennium work hours, they are not going to work as long. No matter how you factor all of those things in concisely those solid lines of demand are over the dotted lines. When you think about how long it takes to train new physicians you realize the remedies of this. When you start to think about this, it takes ten years to get college and then the residency; we really need to focus on this now so that we have the workforce that we need. The next slide is from perca and it shows again you're probably already feeling the primary care shortage per capita workforce 2014 and you're in Idaho in the lowest grouping. Focusing on psychiatrist specifically, so use this is as a hospital referral. This slide is from a recent article in Health Affairs, discussing the shortage of mental health providers. We generally see the same pattern that was in the last slide; note that there is a substantial variation with large considerations of psychiatrist in the New England area, mid-Atlantic, and Pacific reigns. In a ten-year period from 2003 to 2013, there was a ten percent decrease in psychiatrists, so not increase but decrease. So we are moving in the wrong direction, in general these are hospital referrals and if you look at the counties, over 50% of counties in the United States are without any kind of psychiatric services. This leaves a pretty big gap to fill for access to mental health, specifically access to providers.

The next slide is on the millennials; they are really driving the adoption of technology-based health care. Those cell phones that they carry, that is how the millennials want to get their health care information. Gone are the days of staying a whole extra ten minutes to make an appointment, to only go to the doctor to wait 15 minutes in the waiting room just to show your doctor a picture of a rash. Why would you do all of that when you can take a picture of your rash, send it to your physician, and text back and forth and have that medical interaction while you are off at work. This next slide is an example of what I have had sent to me in the last year for me to take a look at.

How is Telemedicine transforming healthcare? This is from a recent article from the Wall Street Journal, sighting data from the American Health Medicine Association. Look at the increase in virtual visits from a million in 2015 to 1.2 million in 2016. 72% of hospitals and 52% of submission groups are already using telemedicine in this program. By the end of this year 74% of large employers will be offering telemedicine. These are not small numbers; this is now a billion-dollar industry and I would argue, even though earlier I called some of those platforms innovated, I would say that telemedicine is difficult to use the word innovated when it is a billion-dollar industry over 50% of the market is using it; can we really call it innovated when it is really not telemedicine anymore; it is just medicine. The next slide is on retail medicine, I talked a little about it; before CVS and Walgreens, it used to be supplies and outpatient primary care, the health care arena, they were provider groups and then hospitals. Now it is retail medicine, minute clinic; all of them are now in that private practice space, private primary care. Seeing their reach by using telemedicine both in the stores as well as app at home. Walgreens recently partnered with telemedicine vendors such as MD Live to offer telemedicine services in 25 states. This is something that an individual could access as well as they are partnering with health plans to make available to their members. The next slide is another telemedicine partnership. CVS, Walgreens, and CVS Minute Clinics offer telemedicine in available markets; hopefully in Ohio, they have announced an energy first collaboration with a very prominent telemedicine company called

American Well. They partnered with physicians from clinics, both online and mobile doctor visits. So a patient as a consumer can go into a CVS Minute Clinic and have a visit with the physician from the legal clinic. CVS has also partnered with three telehealth companies; American Well, Teladoc, and Doctors on Demand. Significantly on telehealth capabilities, again through these model consumers can go into the store as well as from home.

Next slide is about those the employed sponsored telemedicine benefits. An example is Home Depot, who recently partnered with the telemedicine vendor to offer home visits for primary care complaint, as well as mental health visits, and even nursing mothers support through telemedicine. Care is available twenty-four-seven for Home Depot and their families; prescriptions can be sent directly to the pharmacy. In many cases the first visit is free, which is a great incentive to drive uptake. When we talked about the commercial payers and health plans, but what about the Medicaid? How contacted are those patients, will they really use telemedicine? Do we know whether or not those Medicaid patients have cell phones and are they smart phones? Do they use them to access the internet? The answers to most of this are yes. You may already have that experience like I mentioned before; something like text for babies. 91% of Americans have cell phones; out of those 69% have smartphones, 10% of Americans rely specifically on their smartphones for internet connectivity. They got rid of their home phone and laptop, and they use their cell phone. 86% of Americans with an annual income below 30,000 own a cell phone. 83% of adults with less than a high school education own a cell phone. You get all the way down to the patients you see in the emergency room that have experienced homelessness, they have cell phones and you use that to reach them after they leave. There was an interesting study down on Yale in 2013; they evaluated patients presented to the emergency department and who have experienced being homeless in the past year. If they have they inquire if they have a cell phone and what kind, and if they were interested receive health information this way. 70% of emergency department (ED) patients who had experienced homelessness in the last year had a cell phone verses 86% of the patients that did not experience homelessness. 43% of the patients who had a cell phone had a smart phone, and interestingly it was more likely to be an android. Furthermore they were more interested in receiving health information in this way than those emergency room patients that did not experience homelessness. It is a small study but it highlights in this perception the safety net around homeless patients might not be connected.

Again, 60% of adults are accessing the internet through their smart phone; they can use this to interact with their physicians for messaging, making an appointment, canceling an appointment, accessing the portals, and getting results of their labs. This is all from their smartphone. This kind of connectivity results in lots of opportunity, even in lower income. This last slide about cell phones, in the middle group you will see the levels lowered. They are using their cell phone more likely for internet or e-mail on their smartphone verses home. Clinical evidence for telemedicine; does this work? Can we really provide quality care in the same way? Here is a couple random sampling of a couple of issues that have been treated by telemedicine, what we are looking for here; we need to be very careful. The bar is generally set that if telemedicine is just as good, somethings may show that it is not. We wanted to be careful not to hold telemedicine to higher expectations. The question is, can I provide care to my patients just as good by virtual visit as I can if they are sitting in front of me? Telestroke, I have already mentioned that, is a program. This is one of the most utilized methods for telemedicine, telestroke program. It has shown to be safe, feasable, and expectable in acute stroke management. Using telemedicine to manage patients with congestive heart failure; there is a lot of attention here because of readmissions. Studies have shown no differences in all cause of mortalities, and in one study it shows significant improvement in patients in telemedicine compared to the control group. That was probably factored around that; they were able to get help in their home and not have to go back and forth to their doctor's office to talk about their medication. One study looked at antibiotics; there is a lot of visibility on this, particularly with the vendors out there. Is it just going to open up where you go home and have a conference call and pay your $39? They want to make you happy as the consumer. Studies are looking to make sure that that does not happen. Results of this study show patients treated for acute respitory infection by a doctor on telephone or live video would

be just as likely to be prescribed an antibiotic for a visit that was face-to-face. However, patients treated virtually are more likely to get a broad spectrum antibiotic verse a generic. There is a note for both of them that, even though the rate of prescribing was similar for the two groups, both of them the rates were too high. Basically, they are over prescribing, whether we do it by telemedicine or in person. Telederm; there was another study that came out earlier this year, showing a bunch of different Telederm visits that were done and the diagnoses were wrong a high percentage of the time. That was not a good vow of confidence for telemedicine, but there was no good control for that because you do not go into the doctor's office and just show a picture of your arm. So it is difficult to a control but still it did not pretend well that these physicians got text pictures wrong. The issue around Telederm, I think, is a patient asking about what you think of this mole, is it cancer? I might be able to make a pretty good diagnosis on that picture but the value of when you go to a dermatologist or any provider and you show them that mole and they say it does not look like cancer, but let's see what else you have. Having the patient preselect what they think are suspicious helps to miss that overall care.

The next slide is on the Veterans Administration (VA). We have had the privilege of hearing the secretary of health of the VA. We all know that the VA is under fire for their long wait times, and the VA is increasingly trying to serve the patient population. The agency aims to have that same-day medical and general health services at every VA hospital by the end of 2016. The new same-day visits will include telemedicine in order to meet that goal. Telemedicine is vital to many veterans who choose to live in rural areas. The VA is a model for where we are going. The VA is probably that largest integrated delivery system in the country; they do not have to focus on payment models for reimbursement, fee for services, or who is going to pay for that. They can just look at it as a tool to perform high value of care to the location of the patient and a solution to access issues to a broad array of services. Their use of telemedicine and access to care is really remarkable. I think it is an example of using technology-based health care to see patients where they are.

The next slide is about who pays for telemedicine. Starting with Medicare, yes, but there are very strict limitations on Medicare. The patient must be in health care provided shortage area and not in a metropolitan area. In other words, they have to be in a rural area with a shortage of doctors. They must meet both of these criteria, it is not an "or" it is an "and." They specifically cannot be at home; they must be in an excepted facility such as a provider office. It must be real time. Medicaid, yes, but you have to get into how they sign it, where the practioner is, where the originating site is. There is a lot of detail, so in general I would say yes. Private insurance; yes, they talked about parity laws, consumers definitely pay for this. Logging on they will pay their $39 for their direct-to-consumer consultation in their home. Schools are getting in to this; it might be a program that is great to be funded. It kind of starts out that way and then they will start billing Medicaid. This is very popular, they have shown attendants rates at schools would actually come up, if they have a rash, cough and cold, their ear hurts. A parent does not have to take off. The program that we went to look in Maryland is really neat where you can conference in the parents, so the parent can conference in at their desk with the nurse, student, and a picture of the eardrum. That is better in some ways; better than an in-person visit. Nursing homes are starting to pay for this. I am working with a company where we are doing telephyciatry visits in secured nursing facilities and lots of different models there. Correction facilities are definitely doing it; I had a visit at Cook County Jail. They are using it there for both their medical as well as mental health care. Remember, jails are the largest mental health facilities in the country, so they are using telemedicine to increase access to mental health as well as medical care.

The next slide touches on managed care. In 2007, manage care companies teamed up with these telehealth companies to offer that direct-to-consumer care for either urgent or behavioral health care. You can get it from your laptop or smartphone. Overall, these health plans are being much more creative and resourceful in using telemedicine applications to increase access to care and increase value-based care for their members. State governments across the United States are leading telemedicine expansion. According to studies by the Center of Mental Health Policy during 2015

legislative session more than 200 pieces of telemedicine related legislation were introduced to 42 states. Currently, 29 states and the District of Columbia have enacted laws requiring that health plans cover telemedicine services. In 2016, we will see more bills supporting health insurance coverage for telemedicine-based services introduced in various state legislatures. The next slide comes from the Center for Connected Health policy. Every time I give a presentation like this, I have to go back and update the slide; it is just a little snapshot of where all the states are. I have mentioned most of these in some way. The 29 states that require some sort of informal consent, and there are some states that require a separate consent that a patient sometimes it is verbal or written. Idaho does have a requirement for written consent. So that is something that you definitely want to take a look at to how that is going to be facilitated in your visits.

So back to Medicare for a moment: these are the CPT codes related to telemedicine. Specifically the CPT codes for chronic care management 99490 and transitional care 99495 and 99496 with mod or high medical decision complexity can be paid for via telehealth. But remember the restrictions on geographic location of the patient - not at home, in a HCPSA and not in a MSA. The next slide is a snapshot out of MACRA; there are multiple references in there to telemedicine and telehealth. This is just one of them. Like I said, it goes to the clinical practice to improvement activities part of MIPS. MACRA is the Medicare Access Chip Reauthorization Act; in 2015, the most important thing, if you do not know anything about MACRA, is that the first reporting year is 2017. With payment adjustment starting in 2019, so if this is unfamiliar with you in regards to telemedicine or not, MACRA is something that everyone will understand by taking a look at. Again, MACRA requires the Government Accountability Office (GAO) to draft two reports to be submitted to Congress within two years of MACRA's enactment; the first report will pertain to the Medicare telehealth program, and the second will focus on remote patient monitoring technology and services.

200 telehealth bills were introduced in 42 states in 2015. This means requiring insurers to reimburse licensed health care providers for services delivered remotely at the same rate they would pay if the visit were in-person. There should be no financial incentive to treat a sore throat in person versus with a telemedicine consult; because the reimbursement to the provider should be the same. Currently, only 29 states and D.C. have party legislation, and of those only 15 do not have provider or technology restrictions. One of the most interesting states to follow now is Texas in regards to the legislation, for the impact of the Texas medical board having on their practice of medicine by retail medicine, specifically teledoc. The medical board determined that an in-patient exam required establishing a doctor patient relationship. Or a teleprestenter must be present at a telemedicine visit, and the visit must be the specific location. Most notably left home off of that list. There are some exceptions for mental health, but basically they really put the restrictions down which kind of made it impossible in a lot of ways for a patient who is in a very remote area able to dial into teledoc and have medical visit. A relationship cannot be established that way, according to Texas medical board. This is a spot light, the whole country is looking at this, and the interest in telemedicine is really looking to see what happens in Texas to see what the fall out is going to be. In other states there has been a lot of controversy here on teledoc saying that this is unnecessary and we practice medicine and there are some physician groups that feel that way. Other physician groups do not, there is some feeling that is restricting access to the rural patients, but the Texas medical board testimony is saying that they are not restricting trade; they are trying to make sure that there is certain minimal quality of care that is practiced in their state.

On the next slide is the Connect for Health Act; there is a federal law or proposed legislation that you want to keep an eye out for. It has very big significant bipartisan support called the creating opportunities now that are necessary for effective health care terminology. This is one to definitely follow; it is going to chip away at a lot of those restrictions on Medicare. Right now, I think a commodity is being looked at for that big black hole. I think what they are specifically looking at is to make sure that they have budget mortalities; it cannot cost more. I think that is a lot of the concern about opening up a lot of telemedicine opportunities to the Medicare population. Is that someone

again, like my dad might have a visit at home asking to speak to his doctor, and then tomorrow still go in and see his doctor? Is it actually going to create more cost rather than avoid cost? Next, I want to comment on standards. If anyone is watching what is going on and there are organizations out there that are in telemedicine. The association definitely has their seal of approval; they look at things like consumer safety education, provider licensing, privacy, security, and coordination of care and they will put their seal on it; the same with Utilization Review Accreditation Commission (URAC). You want to be sure that you are venturing this out; you are dealing with an organization that provides their psychiatrist for their physician. That they have adequate credentialing, just as if it were an in-person visit. You do not want to get a group of providers that are perhaps having trouble getting licensed or credentialing in some way. They say that they will moonlike as a telemedicine provider and kind of get by that way. There are telemedicine trainings out there, and again these are commercial and again you just have to be careful of the quality if you are really learning something that is useful. To be a telepresenter you can go to a telepresenter training course, but there is nothing that requires you to have a license.

The next slide is about the Federation of State Medical Boards license in Idaho. The implications are much broader in telemedicine, but it certainly opens up opportunities for physicians to practice across state lines. There could be an entire webinar about the controversies and the issues behind it. Where does it work and not work? Where is it crossing a line and do all kinds of things and establishing relationships? These are defining how you can do that; do you need continuity of care? Can you really take care of a patient if you do not have access to their record; then you do not know if you are going to have problems. When I was seeing patients in my practice, patients came into me very empty handed with no previous record, and after they left my office I never knew if I was going to see them again either. We are looking to hold telemedicine at that particular standard. A lot of those things happen in a person visit anyway. As you look at these controversies, you really have to look and see are we already dealing with these issues for in-person visits and can we try to lump it all together and solve that so they follow up with coordination?

Considerations; licensure, credentials, privacy, and security; so ask “are these visits recorded and how secure, and how long do we save them?” My question is why are you reporting them? Every time you think of telemedicine you should have a parallel thought process of how do we do this in person? We do not consent someone in person, or if we do we need to do that for telemedicine. Privacy and security is not only for the medical records but you are going to type in hold, but the privacy of the patient visit, are you doing it in a room where patients really have privacy over it? That is very important. Then everyone knows about Health Insurance Portability and Accountability Act (HIPAA). The other issues down there are about fee splitting and sharing. One of the last slides here is building the youth cases, and I think that the most important slide is this one. There was a client that we had talked to who had got some grant funding to do telemedicine and they went out and they talked to a vendor and they got the great telemedicine equipment. Then everyone went home and equipment went to the clinic and everyone said what do we do with this? In a lot of ways the purchase of the equipment is the easier part. It is building the youth cases, and figuring out sustainability. It might sound jazzy to do but you need that particular access and then need it for something else. Do you have a facility for it? All of those different things before you put a dollar down to buy equipment; you have to tighten up that youth case as best as you can so that you are not one of those stories; how you spent grant funding. There was another one where they had a great program for six months, and when the grant funding went out they literally boxed the technology back up and it is in a closet. This picture is a demo at a school with the doctor on the screen in one, and the dad in another. The next slide is telemental health; I just wanted to point out we are not looking at big video conferencing that takes up a lot of room and create a lot of heat. We use this telepresence unit right there and we wheeled it around on a cart. We did not have a particular telemedicine room; we just wheeled it around where ever the visit was. I am going to stop at this point so we have enough time for questions.

Questions	Answers
Sara – I know that you mentioned MACRA quit a few times. My question is how does MACRA impact FQSC since most of our payments come from Medicaid?	Jean Glossa– MACRA definitely starts off with Medicare, but we know that most of us that have been in healthcare for a long time knows where Medicare goes are where everyone else goes. This whole movement of two value-based payment, MACRA starts off with most payments will be in MIPS, which is what I call itemized. You can use telemedicine to increase access to care and get points there. The long term goal for CMS to get alternate payment models; that is where the better rates are going to be. To become an advanced payment model, your payment has to come through alternate payment models. It is like value base payment models. That threshold is going to go up over the years and they start to include more Medicare-related value-based payments in there. Initially you might be sheltered from it but I would not think that for very long.

We have several project managers in the SHIP, but my position is the only one that was extracted out of the SHIP group and put into the bureau health. The idea from the visionary of this project from a few years ago was that telehealth is the purpose and goal of telehealth in SHIP is to regain health care in the rural areas. Idaho is 96% primary care shortage area and the whole Idaho is a behavioral health shortage. Pretty much it applies to the whole state, but there is a reason I am sitting in the bureau of rural health. By now I hope that most of us are familiar with seven goals of the SHIP. My project management profile contains three and four. Goal three: the region of collaboration. I work closely with public health district and their SHIP staff. Today we are focusing on the goal of four, where telehealth actually divides. Where you see goal four is very specific to rural patients. I really like this slide because it gives us specific insight in to how a SHIP would be pulled off. You as the clinics know it is a form of how you deliver care to this patient. In the same rank, we have the visual-centered medical home. First thing that I would like to say about the virtual is that, as we got into it, we realized there was nothing visual about it. It is just label that we applied to a PCMH and they will be working with us. Another thing that I would like to clarify; SHIP is what we call our state-wide health innovation plan in Idaho. We are a recipient of the Stem Grant, there are several states that have received the same funding before us, and there are some states in the same group as us. The visual PCMH in our mind is basically just a PCMH that will be working with us and willing to adopt and test because this is a test grant to test additional functionality in different modules. There are three pieces as a clinic if you work with us, we can give you the destination of virtual PCMH.

To go back to that design piece, which is a virtual PCMH. As you can see, of these three pieces but within the telehealth, what we want to do in the SHIP is to expend the youth and provide some equipment. Without going into too much detail we are still working on how to make the designation a visual. What makes a PCMH be a visual within the SHIP contact? The point is incentive with that designation and it is $2,500; we know that it is not enough but certainly helps at least a little bit to implement these three. To provide a contacts in which telehealth is in the SHIP develop and run at this point. It started with telehealth counsel who is in governor's appointed body to help Idaho basically put some utility in telehealth and start using it. We were lucky within the ship that we did not have to start with a clean slate and figure out all of these things. We were basically adopted by Idaho telehealth counsel. Now within the counsel, we established a committee, so counsel has several goals and goal two is dealing specifically with telehealth within the SHIP. We established a work group; we meet as a

sub committee monthly. As you can see, there is a very simple goal to our sub committee, we try to basically figure out and create some kind of approach to extending telehealth. What is important? Is it within the SHIP? So you as a SHIP clinic are the only ones that can access those?

Is there a place to get the slide deck for this presentation?	Laurence Brown (PCMH Team) – We do have a copy that we can send out to you after this presentation.
What is the timeline for the application?	Jean Glossa - Certainly within the month we will have a much better picture of the actual timeline. I would assume by October we are going to have a Q&A session and then in November we may open the application.