PA 15-088

SB0467

Public Health	949-952, (981), (983), 1045-1046, 1047-1049, 1195-1212, 1299-1300, 1301-1319, 1328-1341, 1792, (1812), (1813)	67
Senate	1455-1460, 1462-1463	8
House	5142-5171	30
		105

JOINT
STANDING
COMMITTEE
HEARINGS

PUBLIC
HEALTH
PART 3
917 – 1412

2015

REP. ADINOLFI: Thank you, Mr. Chairman. Just a quick comment. I believe a few years ago that all schools were required to have CPR equipment on hand, so I don't think they'd have to go buy any equipment. They probably already have it, or they should. Thank you.

REP. RITTER: Good. Okay. Are we all set? Any more questions from the Committee? Senator, thank you very much for your testimony.

SENATOR FORMICA: Thank you very much for your courtesy and the opportunity to testify this morning before the Committee.

REP. RITTER: Absolutely. Has Senator McLachlan returned? Okay, we'll put him on hold until he comes back. So Julie Starr is up, followed by Senator Looney. Julie Starr. You're stuck back there. Just got to push people out of the way, you know.

JULIE STARR: Senator Gerratana and esteemed members of the Public Health Committee, my name is Julie Evans Starr. I'm the Executive Director of Connecticut's Legislative Commission on Aging, and for those of you who don't know, we're a nonpartisan public policy and research office off the Connecticut General Assembly. We're located on the fifth floor of the State Capitol.

And as you know, you have bills before you today that would establish standards and safeguards regarding the practice of Telehealth, Senate Bill 246, Senate Bill 467 and House Bill 6487, and those same bills, two of them, would allow health care providers to collect reimbursement from private insurers for services delivered via Telehealth, so there's Senate Bill 246 and Senate Bill 467.

Now if Connecticut were to establish health insurance coverage for Telemedicine, it would join at least 21 other states and Washington, D. C, which has already enacted Telehealth parity legislation.

So, when we talk about the needs, why should we do this? That's the real question, right? We know that access to health care has expanded dramatically in Connecticut. Tens of thousands of people now have access to health care through the Affordable Care Act, and we talk about demographics.

Everybody knows the population is aging, right? We're the seventh oldest population in the country, the third longest lived constituency. We know that it's growing between 2010 and 2040. Our 65 plus population is going to increase by 57 percent.

So then we think of the capacity of the health care system, right? So we have to think of new ways and to adopt ways that will meet the needs of this growing population.

There's not only that but it's the need. There are great health outcomes that happen with Telehealth. People have better access and health equity. They have improved health outcomes through medication adherence and reduced hospital admissions and re-admissions.

It facilitates care coordination. It saves patients, provider and payers money. It helps the local economy. It offers a patient-centered approach. It optimizes the providers' time and it compliments and enhances face-to-face provided by health care professionals.

We've consulted some national leaders. This last summer we did some research in this area on Telehealth policy. I'm not going to read all the recommendations we would put forward specific to this legislation. That's on the third page of my testimony. I know a lot of people want to talk to you today about a variety of issues.

But I would just say, if you are able to set the framework for definitions and standards and safeguards for Telehealth in what is kind of evolving to be a challenging Session, that would be quite an accomplishment and I'd offer the services and the expertise of the Commission on Aging to help you be able to do so. Thank you.

REP. RITTER: Thank you very much for your testimony. Are there any questions from the Committee? Senator Gerratana.

SENATOR GERRATANA: Thank you so much for coming and testifying on the bill today. I do appreciate it. Your testimony isn't on line, but that's okay. I know if you submitted it we'll be able to get a copy of it. I would be anxious, or rather looking forward to reading the recommendations that you have to make.

I know we're trying to come up with a way that would at least regulate or establish a framework in statute, you know, at this point, since it's very ubiquitous --

JULIE EVANS STARR: Right.

SENATOR GERRATANA: -- and all the points that you made are exactly what we had in mind. So thank you so much for your testimony. I appreciate it.

REP. RITTER: Any other questions from the Committee? Thank you very much for your testimony and we'll look forward to work with the Commission on Aging on this.

Is Senator Looney here? I don't see the Senator, so moving long. Senator Hwang. Okay. Senator Bye. We are 0 for 4 on State Senators today. Representative Dillon. Anybody? Representative Kokoruda. I know I saw her. All right. She's lucky. There you go. Yay. (Inaudible) of applause in the audience for you, Representative. Absolutely not.

REP. KOKORUDA: That gives me 15 minutes, is that correct, Representative? Good morning. I appreciate being here today. Senator Gerratana, Representative Ritter, Senator Markley, Representative Srinivasan and all distinguished members of the Public Health Committee, I'm here to speak on H.B. 6709, AN ACT CONCERNING THE RIGHT TO TRY EXPERIMENTAL DRUGS.

I did give my testimony in, and I know you have a long list. If I knew I had 15 minutes, I would have prepared more, but I just wanted to, a quick, quick overview.

This year alone, this is in my testimony, over 5,000 people will be diagnosed with ALS, as we know, Lou Gehrig's Disease. And I'm not going to read my testimony, but this summer all of us got involved with the ALS challenge. It was a lot of fun. A lot of excitement. I think it educated people. It raised money, did good things.

But what it didn't really identify was the real challenge, and I think what this bill does is, talks about options and I ask each of you to imagine anything in your life being told there

REP. RITTER: Okay. Any more questions? Thank you. Thank you, Senator.

SENATOR HWANG: Thank you very much for your time.

REP. RITTER: I did see Senate President Looney. Is he still here? Yes. So it will be Senate President Looney and then we will go to Mr. Bunting, and I apologize, Mr. Bunting. Thank you.

SENATOR LOONEY: Good morning, Senator Gerratana, Representative Ritter and members of the Public Health Committee. My name is Martin Looney. I represent the 11th District and I'm here to testify in support of two bills on your agenda this morning.

(SB246)
(SB467)
(HB6487)

First, House Bill 6709 AN ACT CONCERNING THE RIGHT TO TRY EXPERIMENTAL DRUGS and secondly, Senate Bill 471 AN ACT REQUIRING RESIDENTIAL CARE FACILITIES TO CARRY LIABILITY INSURANCE.

First, House Bill 6709 would offer hope to terminally ill patients who suffer from diseases for which there is no effective approved treatment.

Unfortunately, recent federal court decisions have held that terminally ill patients do not have a constitutional right to try experimental treatment, meaning that to have access to it. In certain circumstances there has to be a statutory right created.

As the response to these decisions, a number of states have passed right to try laws to give these patients access to potentially life-saving therapy.

I urge passage of this legislation, which would offer hope to patients afflicted with terminal illness and are desperately casting about for options when all of the traditional and conventional options have proved fruitless.

Senate Bill 471 would require all residential care facilities to carry liability insurance of at least one million dollars per occurrence. The insurance would cover injury to residents or guests caused by the negligent acts or omissions or neglect by the facility or its employees, and this legislation would protect both residents and the facilities.

A study done in the State of California on this issue prior to passage of a similar bill there, show that the average monthly cost to a small, six-bed facility would amount to approximately $50 per month per resident. This hardly seems like too high a price to pay for this kind of protection.

In addition, I'm pleased that your agenda today includes several bills regarding the regulation of Telemedicine. This is an emerging field that requires our careful attention. Currently, our state displays a low level of usage and inadequate regulation of Telemedicine and I look forward to working with this Committee to establish a robust, regulatory framework for this essential specialty. (SB246) (SB467) (HB6487)

Thank you for hearing these important bills today. Thank you, Mr. Chairman, Madam Chairman.

REP. RITTER: Always a pleasure to see you, Mr. Senate President. Any questions for Senator Looney? Yes, Representative Betts.

MICHAEL PAPA: Yes.

REP. SAYERS: One of the problems that we are experiencing now is because of the increased amount of organic farming. We're getting much more nitrogen runoff into our ponds and streams and an increased amount of algae growing that's really having, creating problems in the water, but that's a result of organic farming because it's much more nitrogen rich.

MICHAEL PAPA: Absolutely. You're absolutely right.

REP. SAYERS: What would you suggest we do about that?

MICHAEL PAPA: Even though I'm organic person, but I can attest to you that, you know, organic is not completely the answer. So technically, you need to be more of a straight shooter. It's like more a physician type agriculture, more of testing, more of teaching, education. You know, organic, it doesn't mean is the answer, you know. Organic could be more polluted than non-organic if it's not done right. So you're absolutely right. I'm glad you got the observation.

REP. SAYERS: Thank you. Thank you.

SENATOR GERRATANA: Thank you, Madam. Are there any other questions or comments? If not, thank you, Mr. Papa again for coming and testifying before our Committee. Take care, sir. Next is Senate Bill 681 and Tracy Wodatch.

SB467 SB246
HB6487

TRACY WODATCH: Thank you. Senator Gerratana and Representative Ritter and the rest of the Public Health Committee. My name is Tracy Wodatch. I'm the Vice-President of Clinical and Regulatory Services at the Connecticut

Association for Health Care at Home. We represent the licensed and certified home, health and hospice agencies in the state. I'm also an RN with over 30 years' experience in home health hospice, long-term care and acute care.

Our association represents 62 licensed and certified agencies and our focus is really to provide services in home and community-based settings to keep people in the environment that they prefer to be, which is their own home.

I'm here today to talk briefly about Bill 681 AN ACT CONCERNING BACKGROUND CHECKS FOR HOME HEALTH AGENCY EMPLOYEES to now include fingerprinting.

I also have submitted testimony on three of the Telehealth bills, Telemonitoring bills and I didn't know if you wanted me to talk about both at the same time. I can do so quickly, if that's easier for you.

SENATOR GERRATANA: Usually we, of course allow about three minutes you know, on each issue, in fairness to others, you know, that are going to testify. I'm happy to give you that ability.

TRACY WODATCH: Okay, thank you.

SENATOR GERRATANA: Very quickly. We do have your written testimony, and I mentioned it already.

TRACY WODATCH: I heard you did and I'm sorry I wasn't here. Thank you for mentioning that. So my written testimony on the background check bill, Proposed Bill 681, I think it's pretty clear. We've been working with the Department of Public Health.

SENATOR GERRATANA: Yes.

TRACY WODATCH: It's outlined with the statute, et cetera.

SENATOR GERRATANA: Yes. Yes.

TRACY WODATCH: I think it's duplicative.

SENATOR GERRATANA: Yes, and I thank you for that. That was very helpful.

TRACY WODATCH: Okay. So, next I just wanted to speak to the three bills on Telemedicine. Senator Fasano was here prior. SB467 SB246 HB6487

SENATOR GERRATANA: Did you submit written testimony on it, Tracy?

TRACY WODATCH: I did. I did.

SENATOR GERRATANA: Thank you. Thank you.

TRACY WODATCH: So a couple of things that came up with questions about actual definitions of Telemedicine, I've included definitions within my testimony, but also have a request.

Telemedicine and Telehealth can be used interchangeably in today's practices. However, I think Telehealth really incorporates the broader scope of remote monitoring and I gave you the definition according to the American Telehealth Association and I've also included several examples of different types of Telehealth.

I think what's really important here is what Senator Fasano was speaking to, I think really focuses primarily on physician practice. Telehealth, Telemonitoring, Telemedicine.

What I'd like to speak to you briefly on is the use of Telemonitoring in home health and Telemonitoring is currently used and has been for almost two decades.

We've outlined several standards at the end of my testimony and it's very similar to what Senator Fasano stated, practices to ensure HIPAA compliance that the person is identified to a criteria that you absolutely have some face to face of some type, whether it's the physician in conjunction with the home health agency making visits. There definitely needs to be some best practice standards put in place. And I can answer any questions regarding that.

As far as the comment about replacing physician visits or replacing a home health nurse visit, that's not the intent of Telemedicine. The intent truly is to use it efficiently and cost effectively to optimize the ability of providers to be able to give proper care to the citizens of Connecticut.

It's really to be able to use in conjunction with visits, in conjunction with physician practice being able to see their patients.

SENATOR GERRATANA: Right. Thank you so much for pointing that out. Actually, Representative Cook and I were having that discussion and there is a difference between Telehealth and Telemedicine. It comes all under the realm of the electronic communication, which is very common.

But I think, you know, Senator Fasano was very clear. There has to be some protocol, you know, particularly when you're dealing with a patient and that, you know, goes to the diagnosis and treatment part. So we're

focusing in on it. Thank you. Thank you for your --

TRACY WODATCH: There were questions about whether you could prescribe using Telehealth and you can --

SENATOR GERRATANA: Uh-huh.

TRACY WODATCH: -- from our purposes, we always do it in collaboration with the physician and ensure that the physician has the full picture of what we're seeing remotely.

SENATOR GERRATANA: Right.

TRADY WODATCH: And then the other piece, I think that whatever you move forward, I put in here as well. It's important I think that you use the broader term Telehealth instead of Telemedicine.

SENATOR GERRATANA: I see.

TRACY WODATCH: Because if we're situating ourselves for the future, we really want to make sure we're incorporating the technology --

SENATOR GERRATANA: Right. Right.

TRACY WODATCH: -- that's before us to be able to fully optimize care for all of our citizens.

SENATOR GERRATANA: It's a very good point. Thank you so much. Are there any questions? No. Thank you, and you submitted your written testimony?

TRACY WODATCH: Yes.

SENATOR GERRATANA: We appreciate it. Go and have a good day.

REP. SRINIVASAN: And that's how you maintain your certification.

LOUISE SANCHIONE: By providing that information and then there's a fee also.

REP. SRINIVASAN: Right. Thank you. Thank you, Madam Chair.

LOUISE SANCHIONE: All right. Thank you very much for the opportunity.

SENATOR GERRATANA: Thank you, too. Thank you. Next to testify is Joseph Bisson, followed by Dr. Laine Taylor. We're on Senate Bill 246 now.

JOSEPH BISSON: Good afternoon. My name is Joe Bisson and I'm Vice-President of Business Development at Yale-New Haven Health System..

Thank you for the opportunity to provide testimony on S.B. 246, S.B. 467 and H.B. 6487. We support these bills as they seek to remove barriers to health care by establishing standard and safeguards and payment options for the practice of Telemedicine, through the use of technology.

Yale-New Haven Health System comprising Bridgeport, Greenwich and Yale-New Haven Hospitals is Connecticut's leading health care system. With over 20,000 employees and over 6,000 medical staff, we are among the largest employers in the state.

Yale-New Haven Health provides comprehensive cost-effective advanced patient care characterized by safety, quality and service. We offer our patients a range of health care services from primary care to the most complex care available anywhere in the world.

Yale-New Haven Hospital affiliates continue to be a safety net for our communities and we provide care 24 hours a day, 7 days per week. In addition to being economic engines for our communities, Yale-New Haven Health Hospitals care for more than one-quarter of the state's Medicaid patients and provide millions in free and uncompensated care to those who need our services and have no ability to pay for them.

With an aging baby boomer population and a limited supply of primary care and specialty trained physicians, Telemedicine is rapidly expanding as a convenient, and less costly alternative to the traditional doctor's office visit.

Electronic visits or Telemedicine, are typically comprised of electronic document exchanges, telephone consultations, e-mail or texting and video conferencing between patients and physicians or other licensed providers. These include physician assistants, nurse practitioners, registered nurses and mental health professionals.

Nationwide, states are recognizing the benefits of Telemedicine and are enacting provisions such as those intended by the Connecticut Legislature, to extend the limited number of licensed professionals.

We applaud the insight of the Connecticut Legislature and we agree that all Telemedicine providers should be properly licensed to practice medicine in Connecticut as credentialing is absolutely essential to ensuring physician practice standards are appropriate and patient care of the highest quality is provided.

We also support the establishment of a registry of out-of-state credentialed providers to be created and maintained by the Department of Public Health.

In addition, we believe that evidence documenting appropriate patient informed consent for the use of Telemedicine technologies for routine or non-emergency services must we obtained and maintained to ensure mutual understanding of both the patient and provider.

At a base line, we respectfully suggest the documentation include the following. Identification of a patient, the physician and the physician's credentials, types of transmissions permitted using Telemedicine technologies, patient agreement that the physician will determine whether the condition being diagnosed or treated is appropriate for a Telemedicine encounter, details on security measures to be taken with the use of Telemedicine technologies, the holding harmless for information, the hold harmless clause for information, law suit or technical failures, and requirements for patient, for express patient consent to forward patient identifiable information to a third party.

We must, however, be reminded that when consent is implied, it is during emergency and intensive care environments. Documentation of written or verbal consent of Telemedicine service must often be waived in that situation.

Telemedicine is often a gatewide, gateway to establishing a relationship with a primary care provider. We agree that the best practices for physicians to link to a patient's medical record in advance of scheduled visits.

However, Telemedicine appointments often fill a void where there's no access to direct face-to-face evaluation and management. Requiring face-to-face evaluation initially limits access to care, thus negating Telemedicine's benefits of reduced wait times in a more appropriate, less expensive setting.

Physicians who solely provide services using Telemedicine technologies with no existing physician/patient relationship prior to the encounter, must make documentation of the encounter using Telemedicine technologies that are easily available and agreed upon by the patient or her identified health care provider immediately after the encounter.

Additionally, the patient record created during the use of Telemedicine technologies must be accessible to both physician and patient and be documented using format that is consistent with established laws and regulations governing patient health care records.

Again, we applaud the Public Health Committee and the Legislature for considering these important measure.

SENATOR GERRATANA: Thank you, Mr. Bisson. We appreciate your testimony today. Does anyone have any questions? Representative McCarty.

REP. MCCARTY: Yes, just very quickly. Thank you for being, thank you, Madam Chairman and thank you for being here. Could you just quickly say when you would waive Telemedicine services? I think you touched on that in your testimony.

JOSEPH BISSON: I think it was the question of waiving written consent and it would be the same standard for emergency services or you know, life-threatening types of care.

It doesn't tend to be applicable for Telemedicine. It's a different modality that you're not tending to use that --

REP. MCCARTY: Right.

JOSEPH BISSON: -- you know, for that level of care, but just, it's an important area for clarification.

REP. MCCARTY: All right. Okay. That's what I thought. Thank you.

SENATOR GERRATANA: Thank you. Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madam Chair. Thank you very much for your testimony this afternoon. Earlier in the day, much earlier, we had testimony from Senator Fasano, who when he talked about Telemedicine, Telehealth, made the point that Telemedicine would not be less expensive than going to a physician's office in a face-to-face kind of an interview and evaluation and treatment.

But you seem to imply, I caught it about a couple of times at least in your testimony, that this is going to be a less expensive way of delivering medicine. That seemed to be quite different from what we heard earlier in the day.

JOSEPH BISSON: Yeah, with all respect to the Senator, I would say there are numerous studies that do show that it's, that there's a decreased cost to Telemedicine and there are a number of studies nationally and in large health, for instance, throughout the United States.

In addition, I think the real key for Telemedicine services is the access it provides for patients and I think those two factors combined are really compelling arguments for why it's important to continue A), regulating this appropriately and B) pursuing these types of innovative types of treatment.

REP. SRINIVASAN: I do understand the access part. Obviously, it's probably nice because you've got a wider registry so you're probably going to be able to access and get help at 8:00 P.M. and 10:00 P.M. when conventional offices will not be open. I get that.

JOSEPH BISSON: Right.

REP. SRINIVASAN: But how is it less expensive. You talked about it, but I don't get it. If the charges are, unless the charges are significantly less for Telemedicine than are face to face, come face to face.

JOSEPH BISSON: It's a good question. I think part of the answer to the question lies in the definition of Telemedicine. There are a wide variety of applications of Telemedicine and Telehealth, anywhere from Tele-ICU technologies or Tele-Stroke capability for the diagnosis and rapid treatment of stroke to much lower levels of care and much less security on an outpatient setting where, you know, literally you could be providing just routine care for patients who are even at a level before an urgent care physician's office, whether it's a respiratory infection or things of that nature.

So there's a wide range and I think some of the details are important in terms of determining what the cost is. Overall, just the fact that you're using technology and you don't have some of the hard costs of transporting patients back

and forth in a variety of situations, you know, speaks of the capability to bring the costs down, and we think it's going to be an important driver of decreased costs over the course of its development.

REP. SRINIVASAN: Thank you. My final question to you is, would one be going to an out-of-state provider only if an in-state provider has not been able to provide the Telemedicine services or Telehealth services?

JOSEPH BISSON: Potentially. I think in our situation in Connecticut, I mean, I think it could be a mixture of both. I think there are large Telemedicine groups who are very well schooled in providing this type of service.

I think the key for us is that they're appropriately credentialed and licensed in the State of Connecticut, and I think from our perspective what the Committee is pursuing and what the Legislature is pursuing in that regard is very appropriate.

REP. SRINIVASAN: Thank you. Thank you, Madam Chair.

SENATOR GERRATANA: Certainly. Thank you and thank you for coming today and giving your testimony --

JOSEPH BISSON: Thank you.

SENATOR GERRATANA: -- and waiting around to do so.

JOSEPH BISSON: I'm happy to do it. Thank you.

SENATOR GERRATANA: Thank you. Dr. Laine Taylor, followed by Dr. Bob Russo.

A VOICE: Laine has left.

SENATOR GERRATANA: Laine has left? Okay. I take it you're Dr. Russo. Welcome.

ROBERT RUSSO: Good evening. Dr. Bob Russo, the President of the Connecticut State Medical Society. I represent 6,000 physicians practicing in Connecticut. I applaud you all for your endurance.

I'm here from the State Medical Society in support of the Telemedicine bills, the Senate Bill 246, Senate Bill 467 and House Bill 6487.

Basically, I have submitted written testimony in many different venues, but I thought today the best thing to do would try and describe our need for Telemedicine.

The physicians now have invested a great deal of money in electronic medical records and things like that and the concept that came out with the ACA Obama Care about team medicine, the approach of medical homes, health neighborhoods and things like that, and Telemedicine, we realized that this paradigm shift from the old Marcus Welby days to the new Star Wars type is coming.

You've heard many times today about the rapidity of the changes in medicine. Our problem is, once you get to the Internet, you're getting into the Wild West, and we actually believe that you cannot just say Telemedicine's okay, that you have to come up with guidelines and regulations for patients' safety interest.

That being the relationship between the doctor and the patient and the ability to have that encounter and episodic encounter into the medical records.

There are some commercial payors in Connecticut that are now referring clients to systems that have no workup and very little, if any, follow up and we're very concerned about that because our doctors can look at a medical record now with the newer epic (inaudible) systems that are out there. You can see the patient's medical records. You can see the drugs they're on. You can see the reasoning behind their treatment.

If you simply go to the Internet and Skype a physician that has no relationship with you and may not have a further relationship with you and there's no follow up, no written document, no doctor-to-doctor communication, that's bad medicine and we really believe that the rules and regulations that need to come out of these bills protect the patients.

Where there is a relationship between a patient and a doctor the patient knows that they can get back to that doctor if there's complications and that the patient's usual primary care or doctor mechanism is going to be available, that the doctor can get follow up about what was done.

We're worried about Telemedicine changing prescriptions. We're worried about Telemedicine providing medication without telling anybody else on the health care team exactly what happened.

So the rest is in the testimony but I appreciate your listening.

SENATOR GERRATANA: Thank you. Thank you so much. Representative Ritter.

REP. RITTER: Thank you, Senator Gerratana. My one question was, one concern I have with Telemedicine, and this actually is going to sound funny coming from a lawyer, but the diagnosis is different. So you're not seeing someone in person and you diagnose something and you get it wrong, or you get it not all the way, you get it half right.

Trial lawyers have been known to find fault with that and sue, and so I honestly, as we try to expand health care it's really important I think in rural Connecticut, seniors, how much you could expand their ability to be cared for and yet, I worry that if they got something wrong looking at a TV, you know, looking through a TV camera essentially, a video --

ROBERT RUSSO: Skype.

REP. RITTER: -- it's different. It is. I've skyped, you know, with my relatives. It's different.

Have you seen higher rates or incidents of that or any concern on the Medical Society about that issue at all?

ROBERT RUSSO: Well, there's a great concern about liability and the action it's taken in a ten-minute interview on Skype, especially since if it's written down, nobody else gets to see it.

So the question becomes, how do we know? And if it's a complicated case, a cancer patient or somebody that's changing their medical care. A primary example, diverticulitis. You can get treated for it three or four times and then surgery is recommended.

Now, some people don't want the surgery. So now you've Skyped somebody and says, look, I'm

still having the same pain I've always had. I can't get to the doctor. Give me the medication.

Well, if you get the medication, that means you could what, have it eight or nine times when the recommendation was to have it in three. Who's liability is that and where is that doctor?

Now, you have to be licensed in Connecticut and that demands some malpractice insurance. But does it demand that that physician that was on the skype is available? Suppose it's out of the country.

So there's a lot more to what's about ready to happen. There's not a lot of experience yet because these systems aren't selling well. Patients are, they have faith in their doctors. They have trust in their doctors. They know the system. They'd rather go there.

The question is, can they be diverted because there's an interest by some to not have them go to the emergency room, not go to a mini clinic or something that's local. What will the influence be and how will they react to it? I mean, there's a million questions about liability.

REP. RITTER: Yeah, well, we'll have to look into that, so --

ROBERT RUSSO: Yes. The Senator is chairing the meeting, so.

SENATOR GERRATANA: Thank you. Were there other questions? Yes, Representative Sayers, followed by Representative Srinivasan.

REP. SAYERS: My understanding is that for a physician to treat someone and prescribe to someone, they actually need to see them and assess them, and I don't know if Skyping someone is the same as actually seeing somebody and is probably not clear.

We're talking about definition of surgery. Maybe we need to define what we need to do, whether it needs to be face to face or Skype would count for that assessment because physicians have lost their license in Connecticut because they have treated someone, and I could think of a seven-year-old boy that got treated over the phone and he was in another state and never seen by the physician and that physician is no longer licensed in Connecticut.

ROBERT RUSSO: And he shouldn't be.

REP. SAYERS: Absolutely not. You're right.

ROBERT RUSSO: But to answer your question, if you look at the AMA standards and the Federal of Medical Boards, they've done a lot of work on this and they've come up with recommendations that cover those issues.

Senator Fasano, it seems just like yesterday he was here, he brought that point up. He said specifically there has to be an introduction into a health system face to face with a physical exam and then you could use it.

If you look at the VA system, especially the one in New Haven, it's crackerjack. They do a very good job. Yale does an outstanding job of follow up with Telemedicine. If you look at their site people, they see their patients and then they can follow their patients through Telemedicine.

What's wrong is what you mentioned, which is somebody that has no relationship, no record, no intent of secure follow up treating somebody, or changing the treatment that's already been designed for a patient.

So that's what your point is, why these are here asking for rules and regulations so we don't fall into that trap.

REP. SAYERS: Right, and that's exactly as I envisioned Telemedicine that you have that assessment, but then the follow up is facilitated through the Telemedicine.

ROBERT RUSSO: Exactly.

REP. SAYERS: So thank you.

ROBERT RUSSO: Thank you.

SENATOR GERRATANA: Representative Srinivasan.

REP. SRINIVASAN: Thank you, Madam Chair. Thank you very much for your testimony. In this scenario that you kind of talked to us about walking us through that, in the diverticulitis example that you gave using Telemedicine, but three episodes became eight episodes and surgery was not done, because surgery is recommended after X number of episodes.

How is that different just because that person used Telemedicine, then you will be calling a large group of GI specialists and each time you get another person who's on call or a third person on call who doesn't know you, but is a part of the group and orders all these things over the phone for you, how is that different the way it's practiced right now?

ROBERT RUSSO: That's the whole theory behind the electronic medical record, that all the specialists, all the physicians and allied health care people, GLAD, ex-ray, all these people that put into the record that you as the next treating physician open the record and see what has happened.

In these Telemedicine, I don't want to say scheme, but I do want to say scheme, in these schemes, not of that information is available. I would be able to see that my partners or some other GI physician saw the patient in October, saw him again late November, in February and surgery is the standard that we should be going toward, the Telemedicine doctor with no previous records has no idea that all that would have happened before, especially when the patient is trying to avoid surgery or something like that.

So it's being part of a team approach, the medical homes, the health network. It's everything the Obama Care and the ACA is about, which is having a team work on somebody and then be able to follow and study. What are the complications?

I mean, if there's no record, there's, you know, you can't score what you can't see.

REP. SRINIVASAN: So am I to understand then, that if I am a physician practicing in California but have a license, Telemedicine license to practice in the State of Connecticut, that when this patients calls me from Connecticut and I'm California based, that I have no access to the records at all when I talk, when I Skype the patient and take care of the patient?

ROBERT RUSSO: You have no access to the previous family history or medical record. No.

REP. SRINIVASAN: Thank you. Thank you.

SENATOR GERRATANA: Thank you. Are there any other questions? Representative Conroy.

REP. CONROY: Thank you, Madam Chair and thank you for coming for your testimony today. I just have a couple of questions for you, and thank you for the shout out to the VA. I actually retired from there when they were starting up this Telemedicine.

Are there other states, and I'm thinking, you know, usually things are more rural like Alaska, that are using Telemedicine now and doing it successfully?

ROBERT RUSSO: Yes. There are many instances of successful Telemedicine. There's not a lot of instances of uncontrolled Telemedicine. It isn't part of a network system.

This is, it's new in the sense that Google is thinking about doing it and some others offering these services, which would get us into those arguments about the corporate practice of medicine. Who's really practicing medicine when an insurance company says, call this website and you'll get treatment.

I'm not quite sure where that liability lies. There are laws against the corporate practice of medicine. The argument comes in reverse, which is well, we're not responsible. The doctor that talked to you on the Skype is responsible.

But if I got there through somebody else, I'm not really sure how that's going to work out.

REP. CONROY: Well thank you, and I look forward to working further on this because I do believe that Telemedicine is going to be that new wave of the future, but we do want to make sure those protections are in this for all our residents.

ROBERT RUSSO: The perfect example is the VA.

REP. CONROY: Thank you.

ROBERT RUSSO: I trained there, too.

REP. CONROY: Thank you, Madam Chair.

ROBERT RUSSO: Thank you.

SENATOR GERRATANA: Thank you. Are there any other questions or comments? If not, thank you, Dr. Russo --

ROBERT RUSSO: Thank you.

SENATOR GERRATANA: -- for sticking around and giving your testimony today. We do appreciate it. Next is Dr. Brian Lynch.

BRIAN LYNCH: It's been a long afternoon (inaudible) for giving me the opportunity to talk again.

SENATOR GERRATANA: Thank you.

SB 246
SB 467
HB 6487

BRIAN LYNCH: I did submit written testimony, which you have in front of you. I will abbreviate it for you. Connecticut General Statute 17-b-245 contains a number of components that would be worthy of inclusion in a new law establishing the standards of Telemedicine.

The definition required that medical services such as diagnosis and advice be done with the use of an interactive audio and video and not

audio only, telephone or facsimile. We agree that the standards for the Telemedicine should be limited to the interactive real time audio/video interactions and we urge that these be used in drafting your legislation.

The bill should require that the transmission stored, and records are kept safe with all federal laws currently in existence to protect the patient's right to privacy.

The bill should require that providers using Telemedicine technology have s valid Connecticut license and while the benefits of Telemedicine are self evident, maintaining the quality of care must always be our prime concern.

Connecticut's existing policies prohibit interference with a patient's choice of physicians or optometrists and should be reflected in the provisions of this legislation.

We believe that the relationship between a patient and a health care provider needs to be established prior to any medical care being given via Telemedicine. The bill should reflect that safeguard.

Finally, we believe that Telemedicine guidelines for each of the different professions within the healing arts community need to be reviewed by the respective state boards.

In summary, there are obvious benefits, better access, lower costs. Its use could significantly improve quality of care, but its use will require some major changes on how health care providers deliver services and are paid for those services.

The Connecticut Association of Optometrists on behalf of our patients and members, look forward to participating in the process to develop these standards. Thank you very much for your time.

SENATOR GERRATANA: And thank you for your testimony. We do appreciate that. I'm looking for your testimony. I don't know where it's been filed, but if we need it I guess I'll get it from you. Are there any questions? If not, thank you so much for coming today.

BRIAN LYNCH: Thank you for your time and patience.

SENATOR GERRATANA: Thank you. Okay. Next, we are going to Senate Bill 855 and the first person to testify is Mary Jane Williams.

MARY JANE WILLIAMS: Good afternoon, Senator Gerratana --

SENATOR GERRATANA: Good afternoon.

MARY JANE WILLIAMS: -- and all the Public Health Committee. Thank you for this opportunity to present testimony on behalf of the Connecticut Nurses Association related to nurse staffing levels.

I am Mary Jane Williams, Chairperson of Government Relations to speak in strong support of Raised Bill 855 AN ACT CONCERNING REPORTS OF NURSE STAFFING LEVELS.

During my ten years as Chair of Government Relations I have worked on staffing bills since 2001. In 2007, a staffing bill passed that addressed similar concerns.

Office of the
Healthcare
Advocate
STATE OF CONNECTICUT

Testimony of Victoria Veltri
State Healthcare Advocate
Before the Public Health Committee
In support of SB 246 & SB 467
February 23, 2014

Good afternoon, Representative Ritter, Senator Gerratana, Senator Markley, Representative Srinivasan and members of the Public Health Committee. For the record, I am Vicki Veltri, State Healthcare Advocate with the Office Healthcare Advocate ("OHA"). OHA is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

Senate Bill 467 would require the establishment of minimum standards of practice for telemedicine in Connecticut, and requires that insurers provide coverage for services delivered via telemedicine. This represents an important element in the development of a comprehensive, equitable and innovative delivery and reimbursement model. As individuals integrate the digital environment into daily life, telemedicine represents a logical extension of this trend, and it is reasonable that Connecticut should be at the forefront of this movement.

Telemedicine has been integrated into healthcare treatment for well over a decade, especially for chronic disease management, and exponential advances in computing power and bandwith technology are rendering it increasingly easy to access and share information in virtual environments. CMS has recognized this and began providing for basic coverage of telehealth services in 1999. Routine

reassessments of the benefits to health, access and cost using this model has resulted in a gradual but continuing expansion of this assessment methodology. Through proper utilization of telemedicine, consumers will benefit in a multitude of areas. From increased informed decision making capability and enhanced quality of care, telemedicine has the potential to save lives through increased access to remote consultation for routine, chronic or acute care, resulting in earlier diagnoses and intervention.

This technology has been utilized for chronic homebound patients for years, with dramatic results. A pilot study linking homebound patients to remote monitoring systems resulted in a reduction of hospitalizations by 54%, with substantially better patient outcomes and drastic cost savings. Another study of pregnant women in rural areas found better compliance with medical treatment planning as well as a 66% cost savings for those utilizing telemedicine services. The expansion of access to telemedicine services will impact a wide array of demographics – the elderly, vulnerable, rural, and those suffering from mental health issues chief among them.

There are other factors of significance as well. For those people with access to care issues, due either to transportation or financial barriers or available provider access due to distance, the use of telemedicine in medically appropriate circumstances can dramatically increase the likelihood of compliance by mitigating the associated costs of seeking medical treatment, including time off of work, travel and its associated costs, perhaps difficulty arranging childcare and more.

While telemedicine holds great promise for innovation and increasing consumer's access to and quality of care, it is important to understand that this approach is still in its infancy. It is important to clearly define what interactive telemedicine means, does it include email, or only real-time communications. More importantly, there should be clear utilization guidelines so that consumers know what services they are entitled to and providers know what services they can provide, as well as who may provide these services and how. Ambiguity could have a substantial chilling effect on the implementation for the populations most likely to derive significant benefit.

SB 246 requires the development of such standards. The requirement that any person receiving telemedicine services must have first been evaluated in person by either the telemedicine provider or by a referral from the treating provider serves to ensure that each patient's diagnosis is based on the most complete information. Once a diagnosis and treatment plan have been developed, and the utilization of telemedicine as an integral element of that plan has been determined appropriate, qualified providers in

compliance with appropriate standards of care may continue to follow the patient virtually. Each patient must receive effective and informed consent concerning the treatment and implications of utilizing telemedicine services. Further, the telemedicine provider must have access to the patient's medical record and health history so that they have the patient's available and relevant medical information to ensure continuity in care.

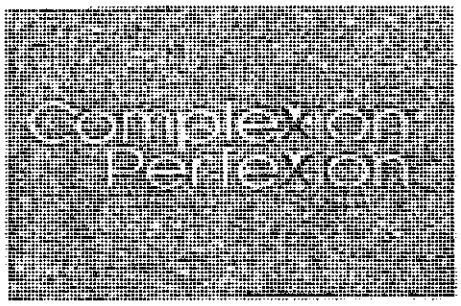
In addition, SB 246 adds an extra layer of protection for consumers by requiring that any out of state providers providing telemedicine services in the state to register with the Department of Public Health, who shall maintain a registry of these providers.

As Connecticut continues to lead the way forward in improving healthcare systems, as evidenced by the initiatives promoted by the State Innovation Model Initiative, telemedicine is an important tool. Given the promise for innovation and consumer access to quality care, clear definition of what interactive telemedicine encompasses and the processes under which it shall operate is critical to the effective integration of telehealth into our healthcare systems. Further, concerns that the requirement of insurance coverage of telemedicine services may construe a new state mandate are unfounded. The Centers of Medicare and Medicaid Services has issued guidance affirming the importance of this initiative and clarifying that they "do not consider...state requirements relating to service delivery method (e.g., telemedicine) to be state-required benefits."[1]

Both SB 246 and SB 467 are important and complimentary initiatives that are support the future of healthcare in our state and nation, and are representative of our state's innovative leadership in healthcare reform.

Thank you for providing me the opportunity to deliver OHA's testimony today. If you have any questions concerning my testimony, please feel free to contact me at victoria.veltri@ct.gov.

[1] http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html



SB 246

TESTIMONY PRESENTED BEFORE THE PUBLIC HEALTH COMMITTEE

FEBRUARY 23, 2015

BILL #6487, AN ACT CONCERNING STANDARDS FOR TELEMEDICINE SERVICES,

BILL # 467, AN ACT CONCERNING THE FACILITATION OF TELEMEDICINE,

BILL #246, AN ACT DEFINING AND ESTABLISHING STANDARDS FOR THE PRACTICE OF TELEMEDICINE

Senator Gerratana, Representative Ritter, Representative Srinivasan, Senator Markley and distinguished Members of the Committee:

My name is Christine Zarb and I am an Adult and Geriatric Nurse Practitioner. I am here to respectfully request that the proposed telemedicine bills clearly state that an APRN may be a provider for telemedicine services. Bill #6487, An Act Concerning Standards for Telemedicine Services clearly fails to recognize APRNs as telemedicine providers.

Respectfully,

Christine Zarb, APRN-BC, MPH

SB 246

YALE NEW HAVEN HEALTH

TESTIMONY OF YALE NEW HAVEN HEALTH SYSTEM
PRESENTED TO THE
PUBLIC HEALTH COMMITTEE
MONDAY, February 23, 2015

SB 246, An Act Defining And Establishing Standards For The Practice Of Telemedicine

SB 467, An Act Concerning The Facilitation Of Telemedicine

HB 6487, An Act Concerning Standards For Telemedicine Services

Good Afternoon, my name is Joseph Bisson, and I am Vice President, Business Development at Yale New Haven Health System. Thank you for the opportunity to provide testimony on **SB 246, An Act Defining And Establishing Standards For The Practice Of Telemedicine, SB 467, An Act Concerning The Facilitation of Telemedicine, and HB 6487, An Act Concerning Standards For Telemedicine Services.** We support these bills, as they seek to remove barriers to healthcare by establishing standards and safeguards and payment options for the practice of telemedicine through the use of technology.

Yale New Haven Health System (YNHHS), comprising Bridgeport Greenwich and Yale-New Haven Hospitals, is Connecticut's leading healthcare system. With over 20,000 employees and over 6,000 medical staff, we are among the largest employers. YNHHS provides comprehensive, cost-effective, advanced patient care characterized by safety, quality and service. We offer our patients a range of healthcare services, from primary care to the most complex care available anywhere in the world. YNHHS hospital affiliates continue to be a safety-net for our communities, and we provide care 24 hours per day, seven days per week. In addition to being economic engines for our communities, YNHHS hospitals care for more than one quarter of the State's Medicaid patients and provide millions in free and uncompensated care to those who need our services and have no ability to pay for them.

With an aging Baby Boomer population, a sharp increase in the number of Americans with health insurance, and a limited supply of primary care and specially trained physicians, telemedicine is rapidly expanding as a convenient and less costly alternative to the traditional doctor's office visit. Electronic visits or telemedicine is typically comprised of electronic document exchanges, telephone consultations, email or texting, and videoconferencing between patients and physicians or other licensed providers, including Physician Assistants, Nurse Practitioners, Registered Nurses, and even mental health professionals.

Nationwide, states are recognizing the benefits of telemedicine and are enacting provisions such as those intended by the Connecticut legislature to extend the limited number of licensed professionals and accommodate the increasing number of patients covered under the Affordable Care Act. We applaud the insight of the Connecticut legislature, and we agree that all telemedicine providers should be properly licensed to practice medicine in Connecticut, as credentialing is absolutely essential to ensuring physician practice standards are appropriate and patient care of the highest quality is provided. We also support the establishment of a registry of

out of state, credentialed providers, to be created and maintained by the Department of Public Health. Not only does this ensure transparency of services occurring within the state, but it gives patients an independent outlet to raise questions or voice concerns about their care.

In addition, we believe that evidence documenting appropriate patient informed consent for the use of telemedicine technologies for routine or non-emergency services must be obtained and maintained to ensure mutual understanding of both the patient and provider. At a baseline, we respectfully suggest that documentation includes the following:

- Identification of the patient, the physician, and the physician's credentials
- Types of transmissions permitted using telemedicine technologies (prescription refills, appointment scheduling, patient education)
- Patient agreement that the physician will determine whether the condition being diagnosed or treated is appropriate for a telemedicine encounter
- Details on security measures to be taken with the use of telemedicine technologies, including data encryption, password protected screen savers and data files. Additionally, suggestions on utilization of other reliable authentication techniques as well as potential risks to privacy would be appreciated
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a 3rd party

We must however be reminded that when consent is implied, as during emergency and intensive care environments, documentation of written or verbal consent of telemedicine services must often-times be waived.

Telemedicine is often the gateway to establishing a relationship with a primary care provider. We agree that the best practice is for physicians to link to a patient's medical record in advance of scheduled visits. However, telemedicine appointments often fill the void where there is no access to direct face-to-face evaluation and management. Requiring face-to-face evaluation initially limits access to care, thus negating telemedicine' s benefits of reduced wait times and a more appropriate, less expensive setting.

Physicians who solely provide services using telemedicine technologies with no existing physician-patient relationship prior to the encounter must make documentation of the encounter using telemedicine technologies that are easily available and agreed upon by the patient and her identified healthcare provider immediately after the encounter. Additionally, the patient record created during the use of telemedicine technologies must be accessible to both physician and patient and be documented using a format that is consistent with established laws and regulations governing patient healthcare records.

Again we applaud the Public Health Committee and the legislature for considering these important measures.

Thank you, and I will be happy to answer any questions you may have.

LeadingAge Connecticut

Testimony to the Public Committee

Submitted by Mag Morelli, President of LeadingAge Connecticut

February 23, 2015

Regarding

Senate Bill 246, An Act Defining and Establishing Standards for Practice of Telemedicine
Senate Bill 467, An Act Concerning the Facilitation of Telemedicine
House Bill 6487, An Ac Concerning Standards for Telemedicine Services

LeadingAge Connecticut is a statewide membership organization representing not-for-profit provider organizations serving older adults across the continuum of aging services, including not-for-profit skilled nursing facilities, residential care homes, home health care agencies, hospice agencies, adult day centers, assisted living communities, senior housing and continuing care retirement communities. On behalf of LeadingAge Connecticut I am pleased to submit the following testimony to the Public Health Committee on the bills before you today regarding the practice of telemedicine.

LeadingAge Connecticut supports the advancement of aging-services technologies and believes they can transform the aging experience and enhance care and services for older adults. Safety technologies, health and wellness technologies, social connectedness technologies and electronic documentation technologies are all important aspects of aging services technologies.

LeadingAge Connecticut believes that technology and telemedicine will play a crucial role in the future of aging services. While this is promising, we do remain cautious and believe that precautions must be in place to ensure a standard of care in telemedicine that is the same as that required of all providers by state statute and regulation. We therefore commend the Committee's effort to ensure an appropriate standard of care for telemedicine in the state. We also urge the Committee to consider the future potential for technology and telemedicine when you draft a final bill so as not to place unnecessary barriers to appropriate advancements in patient care.

For the Committee's information, the following is a link to the *LeadingAge Center for Aging Services Technologies (CAST)* website which includes information and resources regarding the development, evaluation and adoption of emerging technologies that can improve the aging experience: http://www.leadingage.org/CAST.aspx

Thank you for this opportunity to submit testimony on this issue. Please consider us to be a resource to you as you consider this and other issues related to aging services.

Mag Morelli, President of LeadingAge Connecticut
mmorelli@leadingagect.org, (203) 678-4477, 110 Barnes Road, Wallingford, CT 06492

B 246

Quality is Our Bottom Line

Public Health Committee Public Hearing

Monday, February 23, 2015

Connecticut Association of Health Plans

Testimony in Opposition to

SB 246 AA Defining and Establishing Standards for the Practice of Telemedicine
SB 467 AAC the Facilitation of Telemedicine
HB 6487 AAC Standards for Telemedicine Services

The Connecticut Association of Health Plans respectfully opposes SB 246 and urges the Committee's caution with respect to SB 467 and HB 6487.

Given the "proposed" status of the legislation, the intent of SB 467 and HB 6487 is somewhat vague, but to the extent that any of bills propose to restrict access to telemedicine services and/or to mandate a particular rate reimbursement structure like ***the companion bill reported out of the Insurance Committee (SB 5)***, the Association would respectfully urge the Committee's rejection.

Health insurance carriers very much ***support*** the concept of telemedicine or telehealth which can be employed in a variety of ways including:

- Virtual visits: medical evaluations, psych assistance, or clinical peer to peer consultation.
- Case or care management under medical home delivery models.
- Adjuncts to home care service: electronic or telephonic monitoring for blood sugar, weight etc.
- Teleradiology: expert consultation in interpreting radiology reports.

Health plans are exploring some or all of the various initiatives outlined above and are bringing technology and social media to bear on behalf of their members. Carriers are looking to be innovators in the field of telemedicine, but fear passage of overly restrictive legislation that may impede their ability to expand access to quality, effective health care in a way that's affordable and convenient for consumers.

In addition, health plans are still navigating the practical considerations of telehealth such as assuring that services are delivered as indicated, that confidentiality of treatment is provided in accordance with the appropriate national and state standards and that outcomes actually prove beneficial. It's important that legislation not compromise these quality assurance efforts which unfortunately could be the unintended result if some of the proposals before you move forward.

We ask that the Committee hold the bills as noted. Many thanks for your consideration.

280 Trumbull Street | 27th Floor | Hartford, CT 06103-3597 | 860.275.8372 | Fax 860.541.4923 | www.ctahp.com

Connecticut State Medical Society — Founded in 1792

Connecticut Chapter ACP — American College of Physicians — Internal Medicine | Doctors for Adults

Connecticut Urology Society

E N T Society

Testimony Regarding the Provision of Telemedicine Service
Public Health Committee
Senate Bill 246 An Act Defining and Establishing Standards for Telemedicine
Senate Bill 467 An Act Concerning the Facilitation of Telemedicine Services
House Bill 6487 An Act Concerning Standards for Telemedicine Services
February 23, 2015

Senator Gerratana, Representative Ritter and members of the Public Health Committee, on behalf of the physicians and physicians in training of the organizations listed above, thank you for the opportunity to present this testimony to you today in support proposed legislation before you today seeking to set standards, establish guidelines and facilitate to proper provision o telemedicine service to our patient.

Increasingly, within the transformation of our health care system and with the advent of new technologies, physicians are spending more time providing services to patients outside of the traditional face to face encounter in the office setting. Unfortunately, as these new forms of care delivery develop, no standards or guidelines exist in state statute. However, many efforts have been initiated both locally and nationally to ensure the proper use of telemedicine services when they are in the best interest of a patient and proscribed by the treating physician to supplement and not supplant or replace existing local care options and modalities. National entities such as the Federation of State Medical Boards and the American Medical Association have spent significant time and resources developing policy for the appropriate use of telemedicine services in medicine. Any comprehensive legislation on telemedicine must put in place guidelines for its appropriate use and delivery in order to maximize patient safety while attempting to increase access to health care services.

Connecticut State Statute currently and appropriately requires any physician providing telemedicine services to hold a Connecticut license through the Department of Public Health (DPH). Obviously, this makes sense because standards of practice and care that are in place in Connecticut may not be as rigorous or specific elsewhere. However, should the use of telemedicine services for medical care in Connecticut proliferate, it is foreseeable that a significant amount of medical services be provided by physicians licensed in the state, but with no connection to the state or tie to our communities- both in terms of patients and their treating local physicians. With no clear guidelines for use of telemedicine services in place in Connecticut, some commercial insurers are unfortunately using their own telemedicine models. Yet, these telemedicine models present a scenario in which no connection or relationship exists between physician and patient. In addition, no real connectivity exists to the local healthcare system and no parameters exist for such critical aspects of care such as the prescribing of medications, transparency of who is providing evaluative services online or the ability for the patient and his/her Connecticut treating physician to get access to medical records of the online encounter. In some systems currently in use the ability to reach again that online physician for follow up care or questions does not exist.

Shifting a significant amount of medical care out of state, and even out of country, is not in the best interest of Connecticut's economy, health care delivery system or Connecticut residents and could result in further access barriers for the patients of Connecticut. As we all work hard to try to encourage newly

trained physicians to come to Connecticut, as well as retain those presently practicing or receiving training in Connecticut, what message does it send that we allow the proliferation of care provided from outside of the state for our patients? If nothing else, we want to highlight that the need and demand for in state care is great and will support more well trained and qualified physicians in primary care as well as medical specialty areas of clinical focus to address the increasing demand for medical services with the associated reduction in supply of qualified physicians.

The use of out of state resources for the provision of telemedicine services also raises questions how it may, or rather would impact the existing physician patient relationship associated with the provision of medical care in Connecticut. First, its use should require the establishment of a physician patient relationship. In most situations it should require a face to face care episode first for patients, especially patients with chronic conditions that require additional care management and care coordination at the local level. Parameters should exist for follow up care and the continuity of care if telemedicine is employed. In all situations there must be transparency as to who is providing the care through telemedicine services. Patients must know the credentials, license level, and even location of any person providing services. Consideration must also be given to the frequency of follow up face to face in encounters to ensure that the care modality or treatment regimen is both being followed and effectively treating the medical condition identified. Telemedicine services should be seen as an adjunct to comprehensive, integrated care, not a substitute- it is to supplement the ongoing and necessary medical care of a well trained and qualified local physician or other health care professional. There is already a concern that the electronic medical record has taken away from patient communications and patient care. How will telemedicine services fit in and work so that the patient is not further removed from the local treating physician and the evaluation of the treatment plan?

Although not contemplated in the proposed legislation before you today, important issues that need to be considered relate to the location of both care and billing. Acceptable locations for services to be provided to patients such as in a home or office setting or simply another, remote care facility that would presume to have a connection should be specified. There must be some provision for documenting and preserving the critical elements of the encounter so they may ultimately be integrated into the patient's medical record, either in commonly used Electronic Medical Record (EMR) format or by preservation of the entire video interaction. Also, the need exists for a contract or employment arrangement with the physician providing telemedicine services. Specific guideline would answer such questions as could a patient simply sign on to their computer from their home and receive these services or would and should other clinical and care professionals be included in the telemedicine episode so that the patient has some local evaluation and if necessary medical care. Also, if medical care is to be provided at a remote care site, guidelines should identify the party responsible for the appropriate billing for services, the physician providing remote services or the facility in which the patient was located when receiving services. More specifically, how in-network and out of network situations work if the telemedicine physician is remote and in another state while the patient is at a health care facility in state and in network must be addressed. Whatever model is eventually employed for telemedicine services for patient encounter or physician consultation, in network physicians should not be limited from providing these services locally. The benefits of a robust local network with physicians of all specialties and subspecialties, should not be diminished or further degraded by allowing access only to an out of network telemedicine benefit.

Telemedicine services must be integrated in to the current and evolving health care delivery and payment system in Connecticut. Services must also include parity in services available that many of us have strived to obtain for behavioral and mental health services. Telemedicine services provided properly can offer a cost effective and efficient manner for the provision of necessary and timely care when it can be done safely through indirect patient care with appropriate communication services that offer patient privacy, security and confidentiality protections. Telemedicine services could also be used to supplement and support medical trials, reducing the amount of time and distance to get into the study facility for evaluation of treatment modalities and the impact of experimental treatment options. However, the use of

telemedicine services must be clearly defined and in the best interest of patients and include the physicians of Connecticut who provide their care. We do not want any disincentive for physicians to remain in practice in Connecticut or come to this great state to provide patient care services. Furthermore, as we all work hard to develop a highly integrated and equitable healthcare system, we must not create a subset of the patient population, whether that subset is defined by geography, condition or socioeconomic status (income), to receive one level or form of patient care while another segment receives more direct and face to face medical care. The last thing we want to do in Connecticut is further bifurcate the health care delivery system and more specifically access to medical care services provided by well trained and experienced physicians.

The Connecticut State Medical Society (CSMS) welcomes the opportunity to work with members of this committee in the development of legislation that addresses need for the establishment of appropriate standards and guidelines for the delivery of telemedicine services.

Yale Medical Group

THE PHYSICIANS OF YALE UNIVERSITY

Testimony of Paul A. Taheri, MD, MBA
Deputy Dean for Clinical Affairs and
CEO, Yale Medical Group
Submitted to the Public Health Committee Concerning
SB 246, An Act Defining And Establishing Standards For The Practice Of Telemedicine
SB 467, An Act Concerning Facilitation of Telemedicine
HB 6487, An Act Concerning Standards For Telemedicine Services

Dear Senator Gerratana, Representative Ritter, and Members of the Public Health Committee,

I appreciate the opportunity to provide testimony in support of the Committee's effort to draft a bill to establish minimum standards of practice and health insurance coverage for telemedicine.

As a large physician group practice that is committed to the care of Connecticut residents, we see telemedicine as an innovation in healthcare delivery with a proven ability to improve access to and reduce the cost of care while maintaining, and even, improving quality of care. As such, we are strong supporters of telemedicine and have adopted it in a number of clinical areas in our practice as a mean's of supporting patients, as well as, physicians in hospitals where access to specialists may be limited. In addition, there is patient/consumer demand for telemedicine which is evidenced by the growing number of private companies, insurers, academic medical centers (in other states), and technologies that have entered the market to provide telemedicine services.

According to a recent survey amongst physicians of Yale University, the single biggest obstacle to adoption of this promising innovation is lack of reimbursement. There are currently 15 states that have telemedicine parity laws for private insurance, and policies that authorize state-wide coverage, without any provider or technology restrictions. We hope, that the proposed bill will allow Connecticut to join the 47 states where Medicaid programs have some type of coverage for telemedicine. In fact, the Public Health Committee and the Connecticut's Legislators can advance healthcare in Connecticut by introducing telemedicine parity laws and mandating coverage for telemedicine by all state-run health insurance programs, including Medicaid, CHIP and state employee plans.

We acknowledge that certain standards will need to be met to obtain reimbursement. We would hope, however, that the Committee does not impose standards that are in excess of what is currently required for an in-person service/visit. We ask you to consider telemedicine another mode for delivering care and a strictly medical decision. We are concerned that making reimbursement conditional on such non-medical factors as:

- A prior in-person visit,
- Written informed consent,
- Distance and population restrictions, as well as,
- Provider/patient setting requirements,

would defeat the purpose of telemedicine and ultimately hinder its adoption in ways that could improve patient care and help to promote efficiencies in the use of healthcare resources.

Thank you for your consideration of this testimony.

HB 246

TESTIMONY WITH REGARDS TO:
Proposed S.B. No. 246 AN ACT DEFINING AND ESTABLISHING STANDARDS FOR THE PRACTICE OF TELEMEDICINE.
Proposed S.B. No. 467 AN ACT CONCERNING THE FACILITATION OF TELEMEDICINE.
Proposed H.B. No. 6487 AN ACT CONCERNING STANDARDS FOR TELEMEDICINE SERVICES.

My name is Mary Goehring, CEO of Transcription Plus, LLC, located in Bristol, CT. Please accept my testimony regarding my concerns about the drastic decline in the accuracy of health records, the costly transition of physicians into very high-priced clerical workers, which has resulted in the disintegration of the doctor/patient rapport, as well as the lack of transparency and rightful access to these records by physicians and their appointed staff. The development of the Electronic Health Record unquestionably is not providing the intended results in numerous aspects. With the advent of Telemedicine, it is imperative that similar missteps are not replicated.

Healthcare providers should be afforded straightforward awareness of all EHR and Telemedicine use alternatives; including (but not limited to) the ability to incorporate transcription into the patient note via an interface. Without transcription, EHR is costing small and large practices, medical conglomerates and State/Federal/Military facilities billions of dollars, causing wrongful injury/death and accruing damaging lawsuits. In addition, tens of thousands of middle class medical documentation specialist jobs have been abolished, putting people on the unemployment payrolls.

It is necessary for all authorized healthcare staff within a given facility to have full and uncontrolled entry capability into EHR and/or Telemedicine systems based on practice management stipulation of what is necessary to conduct operations. Off-site transcriptionists and medical billers are an integral part of the office staff; they are not considered a 3-party entity. In no way should any EHR or Telemedicine vendor issue decrees regarding access by providing false information related to limited systems and/or gross manipulation of exorbitant access or transfer fees. It is the responsibility of the EHR and/or Telemedicine vendor to supply a system that networks in the most functional manner to obtain the greatest value for the medical end-user and their patients. The practice of controlling the function of medicine by holding the medical staff and patient records captive is critically amiss.

In addition to being the ONLY medical transcription company included in the Connecticut Transcription Services for all Using State Agencies, Political Subdivisions and Not-For-Profit Contract Award # 12PSX0118 [August 1, 2012 through August 31, 2017] http://www.transcriptionplus.net/TP_Pricing_012_0118.pdf, as well as contracting with State and Federal government departments, the U.S. Military, municipalities, State's Attorney Offices and Yale's Schools of Business and Medicine, Transcription Plus, LLC has a proven 8-year-history of having been granted access to and successfully working directly within UConn Medical Center's Electronic Health Records system (with no additional associated license fees); substantiating the fact that off-site transcription access to EHR is a plausible and valid option.

It is compulsory that standard restrictions and regulations be placed on EHR and Telemedicine vendors nationally, as well as state-wide. Physicians certainly should not be shut out from access to the medical records of their own patients; nor should there be additional transfer expenses. Those records are owned, not by the EHR or Telemedicine vendors, but by the healthcare facility and the individual patient.

Transcription Plus, LLC has been in business in Bristol, CT (doing business nationally) for 26 years and has securely archived millions of patient documentation. At any instance, 26 years of records are available to any past and current healthcare provider who initially requested that we process them – at absolutely no additional cost. Those records do not belong to my company. We have always provided a convenient storage option – a service based on good will.

It is entirely unacceptable for access to be locked or for records to be 'held hostage' by any vendor and that practice should be against the law.

The jurisdiction that EHR and Telemedicine vendors have empowered themselves with have been exceptionally destructive to small medical practices and the origin of billions of dollars in reported fiscal losses for large medical facilities – costs that are added to medical services that we all pay for out of our own pockets.

Sincerely,

Mary A. Goehring
CEO, Transcription Plus, LLC

860.583.2818
Please visit our website: www.transcriptionplus.net

CHA CONNECTICUT HOSPITAL ASSOCIATION

TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
PUBLIC HEALTH COMMITTEE
MONDAY, FEBRUARY 23, 2015

SB 246, An Act Defining And Establishing Standards For The Practice Of Telemedicine

SB 467, An Act Concerning The Facilitation Of Telemedicine

HB 6487, An Act Concerning Standards For Telemedicine Services

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **SB 246, An Act Defining And Establishing Standards For The Practice Of Telemedicine, SB 467, An Act Concerning The Facilitation Of Telemedicine, and HB 6487, An Act Concerning Standards For Telemedicine Services.** With clarifying changes, CHA supports these bills.

Before commenting on the bills, it's important to point out that Connecticut hospitals treat everyone who comes through their doors 24 hours a day, regardless of ability to pay.

This is a time of unprecedented change in healthcare, and Connecticut hospitals are leading the charge to transform the way care is provided. They are focused on providing safe, accessible, equitable, affordable, patient-centered care for all, and they are finding innovative solutions to integrate and coordinate care to better serve their patients and communities.

SB 246, SB 467, and HB 6487 are intended to enhance non-emergent, physician office-setting interactions with patients to improve healthcare access and outcomes using telemedicine. CHA applauds the goal of these bills, but seeks to have clarifications made to avoid the potential unintended effect of reducing the current necessary services and technologies now used in a variety of care settings.

Hospitals and other specialty care practice settings must rely on the types of technologies discussed in the bills. Various care settings use these interactive audio, visual, and data communications technologies to expand their ability to provide rapid consultation with specialists when surgery, urgent care, or emergencies require instant communication, and to supplement coverage for radiology interpretations. Often there are no other options, and the

delivery of care depends on use of these technologies, particularly during emergency situations. Unfortunately, the text of the bills is broadly written and sweeps in vital healthcare services accidentally, potentially creating patient quality and safety problems.

With respect to the technology standards and security rules, Connecticut should not deviate from the national standards set forth under HIPAA, including HIPAA guidance and interpretations. The federal government is taking the lead in setting the technological framework for an interoperable and widely accessible healthcare environment, as discussed in a January 30, 2015 draft report released by the Office of the National Coordinator for Health Information Technology, which presented a major report on national health IT planning: *Connecting Health and Care for the Nation, A Shared Nationwide Interoperability Roadmap.* The Office of the National Coordinator is part of the U.S. Department of Health and Human Services, and is the principal federal entity charged with coordinating nationwide efforts to implement use of the most advanced health information technology to facilitate the electronic exchange of health information.

Additionally, a growing body of evidence indicates that telemedicine can be a successful tool to address health disparities (e.g., *Journal of Healthcare for the Poor and Underserved*, (2011), pp. 804-816, "Improving Diabetic Retinopathy Screening Through a Statewide Telemedicine Program at a Large Federally Qualified Health Center"). With serious gaps in ambulatory community care in Connecticut adversely affecting racial and ethnic minorities and the poor, all strategies and tools should be developed to their fullest to improve care. Implementing telemedicine should be one of those strategies. Too many restrictions on telemedicine may further reduce Connecticut's ability to reach these vulnerable populations.

To avoid these unintended consequences, CHA respectfully requests that the following concepts be included in any telemedicine bill's language to clarify that the bill is not intended to apply to settings outside of non-urgent, physician office care.

- Telemedicine laws should not interfere with, or negate, the provision of services as set forth in section 20-9(d) of the Connecticut General Statutes, particularly those services that are routinely provided by indirect care providers who rarely, if ever, have direct patient contact (e.g., lab, imaging).

- Telemedicine rules for connectivity, privacy, and security should be consistent with HIPAA Security Rules and other federal rules for health information technology.

- Telemedicine must not reduce the ability to improve access to care for the underserved or ethnic minority populations.

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.

Connecticut Association of Optometrists
35 Cold Spring Road, Suite 211
Rocky Hill, CT 06067
860 529-1900
www.cteyes.org

Testimony of Brian T. Lynch, O.D.
February 23, 2015
SB 246, ~~SB 467~~ and HB6487
Acts concerning the establishing of standards for and the facilitation of Telemedicine.

My name is Dr. Brian T. Lynch and I am a practicing Optometrist in Branford, CT and also Legislation Chairman for The Connecticut Association of Optometrists

I thank you for giving me the opportunity to share some thoughts on these three proposed bills,

The legislature, with the passage of Public Act 12-1 in the December 2012 special session, created a process for the development of a demonstration telemedicine program for Medicaid. However, it appears that the department is not yet ready to launch it and is still developing design options.

That law, C.G.S. 17b-245c, contains a number of components that would be worthy of inclusion in a new law establishing the standards for telemedicine.

- C.G.S. 17b-245c defined Telemedicine. That definition required that medical services such as diagnosis and advice be done with the use of interactive audio and video and not audio-only, telephone or facsimile. We agree that standards for telemedicine should be limited to interactive real time audio-video interactions and we urge the use of that definition in the drafting of your bill.

- The bill should require that the transmission, storage and dissemination of data and records when using Telemedicine should be in compliance with the existing federal and state laws regarding the privacy and confidentiality of patient's records. C.G.S. 17b-245c contained such protections and we suggest that this bill include similar protections.

- The bill should require that providers using telemedicine technology have a valid Connecticut state license. While the benefits of Telemedicine are self-evident, maintaining the quality of care must always be our prime concern.
- Connecticut's existing policy prohibiting interference with the patients' choice of physicians or optometrists (see C.G.S. 20-138b) should be reflected in the provisions of the bill.

- We believe that the relationship between a patient and a health care provider needs to be established prior to any medical care being given by the use of Telemedicine. The bill should reflect that safeguard.

Finally, we believe that telemedicine guidelines for the each of the differing professions within the healing arts community need to be developed and approved by their respective State Boards or Commissions.

In summary, there are obvious benefits to Telemedicine: better access by patients to health care and lowers costs. Its use could significantly improve the quality of care. But its use will require some major changes in how health care providers deliver services and are paid for those services.

The Connecticut Association of Optometrist on behalf of our patients and members, look forward to participating in the process to develop the standards for telemedicine.

Connecticut's Legislative Commission on Aging

A Nonpartisan Public Policy and Research Office of the Connecticut General Assembly

Testimony of
Julia Evans Starr
Executive Director
Connecticut's Legislative Commission on Aging

Public Health Committee

February 23, 2015

Senators Gerratana and Crisco, Representatives Ritter and Riley, and esteemed members of the Public Health Committee, my name is Julia Evans Starr, and I am the Executive Director for Connecticut's Legislative Commission on Aging. I thank you for this opportunity to comment on several bills before you today relating to telemedicine.

As you know, Connecticut's Legislative Commission on Aging is the non-partisan, public policy and research office of the General Assembly, devoted to preparing Connecticut for a significantly changed demographic and enhancing the lives of the present and future generations of older adults. For over twenty years, the Legislative Commission on Aging has served as an effective leader in statewide efforts to promote choice, independence and dignity for Connecticut's older adults and persons with disabilities.

Bills concerning telemedicine

- **Proposed Bill No. 246, An Act Defining and Establishing Standards for the Practice of Telemedicine**
- **Proposed Bill No. 467, An Act Concerning the Facilitation of Telemedicine**
- **Proposed Bill No. 6487, An Act Concerning Standards for Telemedicine**

As you know, there are proposed bills before you that would establish standards and safeguards regarding the practice of telehealth (Proposed Bill Numbers 246, 467 and 6487) and that would allow health care providers to collect reimbursement from private insurers for services delivered via telehealth (Proposed Bill Numbers 246 and 467). If Connecticut established health insurance coverage for telemedicine, it would join at least 21 states and Washington D.C., which have already enacted telehealth parity laws.[1]

[1] American Telemedicine Association. State Telemedicine Gaps Analysis: Coverage and Reimbursement. September 2014.

The need to increase adoption of telehealth services in Connecticut is more urgent than ever. The Affordable Care Act has in the past year or so expanded health care coverage to approximately 75,000 uninsured residents in Connecticut. Moreover, Connecticut is the 7th oldest state in the nation with the 3rd longest-lived constituency, and between 2010 and 2040, Connecticut's population of people age 65 and older is expected to grow by 57%. The health care needs of this burgeoning population of older adults, combined with the needs of the newly insured population, will rapidly outpace the ability of traditional models of health care delivery to adequately meet those needs.

Telehealth provides an exciting opportunity to address some of health care's greatest rising challenges. In illustration:

- **Access to Care / Health Equity**. Telehealth is a means of ensuring that all individuals can appropriately and more quickly access care, regardless of economic means, age, physical ability or geographic proximity to providers.
- **Quality and Outcomes**. Telehealth can improve health outcomes as measured by improved medication adherence, reduced hospital readmissions, improved public health surveillance and delivery and a variety of other indicators. Its recordable nature also improves documentation and verification.
- **Care Coordination**. Telehealth facilitates collaborative care management when patients, providers and other caregivers are in distant locations. Local providers can also gain support and learn new skills from distant clinicians.
- **Cost-Effective**. Telehealth services typically save patients, providers and payers money, compared with traditional approaches of providing care.
- **Local Economic Health**. Telehealth can help the local economy by keeping the source of medical care local, maintaining health care infrastructure and preserving health care-related jobs.[2]
- **Patient-Centered**. Offering telehealth services is a patient-centered approach. It empowers consumer choice, allows care to be provided where a patient is located, and provides flexibility. Benefits include better continuity of care, reduction of lost work time and travel costs, and ability to remain within support networks.[3]
- **Provider Shortages**. Telehealth can be used to optimize providers' time, especially in specialty areas where there are current and projected shortages.

Several national thought leaders on telehealth policy have thoroughly discussed the importance of provisions that seek to optimize the profound potential of any telehealth legislation (including the American Medical Association, the Federation of State Medical Boards, and the Center for Connected Health Policy), while simultaneously providing patient safeguards.

---

[2] Center for Connected Health Policy. Advancing California's Leadership in Telehealth Policy: A Telehealth Model Statute and Other Recommendations.
[3] *Id.*

Based on our research from these and other sources, as the Committee potentially moves forward with drafting bill language, among other considerations, we recommend:

- That for all proposed bills, the term "telemedicine" be updated to "telehealth" and its definition broadened. Telehealth is a term that includes telemedicine but also includes the use of technology beyond health care settings, such as for public health surveillance and delivery, education and support of providers and other caregivers, collaborative care management and other non-medical uses.[4] Telehealth can also represent a critical component of disaster relief efforts.[5]
- That for all proposed bills, regarding the term "telemedicine," its definition should include the three generally recognized categories of telemedicine technologies: (1) interactive services (providing face-to-face interaction between patient and provider through real-time audio and video technology), (2) remote monitoring (to capture health indicators, often to help manage a wide range of conditions), and (3) store-and-forward (involving transmitting medical data from an originating provider to a professional colleague for consultation or a medical specialist for assessment). Currently, Proposed Bill No. 6487 limits telemedicine's potential, by only considering interactive services.
- That in Proposed Bill No. 6487, the requirement for "the primary care physician to have personally seen the patient" be removed or allow, as in Proposed Bill No. 246, the provision of telemedicine services, as long as they have been requested by a Connecticut licensed health care provider who has personally seen and examined the patient. Telehealth is simply a means of delivering a given health care service to a patient. Statutory restrictions interfere with the discretion of provider and patient to determine whether and when services should be rendered via telehealth.
- That all bills more fully clarify that:
  - Patients receiving care through telehealth services have the same choice of provider, same transparency of information (e.g., patient cost-sharing responsibilities) protections and same access to health care practitioner credentials as those receiving care through traditional delivery systems.
  - Telehealth service delivery must abide by laws addressing privacy and security of patient information.
- That the bills recognize that telehealth is evolving and dynamic, and that bill language allow flexibility to integrate new technologies, going forward, into health care delivery and payment mechanisms.
- That the bills require telehealth equipment and software vendors who contract with the State of Connecticut to meet current telehealth industry interoperability, to avoid uncertainties in compatibility.

Thank you for opportunity to provide comment today. We are thankful to this committee for considering these important bills and would welcome the opportunity to work with members of this committee and other valued partners to help ensure its passage.

[4] Center for Connected Health Policy. Advancing California's Leadership in Telehealth Policy: A Telehealth Model Statute and Other Policy Recommendations. February 2011.
[5] Connecticut State Office of Rural Health. Telehealth in Connecticut. December 2013.

CBIA CONNECTICUT BUSINESS & INDUSTRY ASSOCIATION

TESTIMONY BEFORE THE
PUBLIC HEALTH COMMITTEE
LEGISLATIVE OFFICE BUILDING
FEBRUARY 23, 2015

My name is Jennifer Herz and I am Assistant Counsel for the Connecticut Business & Industry Association (CBIA). CBIA has been representing Connecticut's employers for 200 years and our goal is to foster a dynamic business climate. Our members include businesses from across the state of all sizes and industry types and we are proud to say the vast majority of our members are small companies employing less than 50 people.

CBIA has concerns with the 3 telemedicine bills on today's agenda including SB 246 AA Defining and Establishing Standards for the Practice of Telemedicine, SB 467 AAC the Facilitation of Telemedicine and HB 6487 AAC Standards for Telemedicine Services.

While CBIA certainly appreciates the value of telemedicine we are concerned that restricting this practice so early in its development may hamper its progress. The current bills are in proposed bill form so it is somewhat challenging to provide specific comments but our general concern is the impact on cost and quality of healthcare in Connecticut.

Connecticut's employers are very concerned with the cost and quality of healthcare. In a recent survey, CBIA's members listed healthcare costs as among the top 3 issues keeping them up at night – right behind national and state economy.[1] Connecticut's employers contribute to their employees' premiums and rising premiums make it more and more difficult for employers to help pay for their employees healthcare. Equally important, employers' value the bottom line contribution of healthy employees because that means a productive, innovative workforce. In this regard, CBIA is concerned that setting prices and other barriers when telemedicine services are still developing may hinder progress in this field.

We also wish to highlight a similar bill approved by the Insurance and Real Estate Committee - SB 5 - that also may impact progress in this developing sector.

Telemedicine certainly has a promising future to help address cost and quality issues in healthcare but over-regulation prior to understanding this new and exciting field may be detrimental to its success.

CBIA urges you to not act on SB 246, SB 467 and HB 6487 at this time.

Thank you for the opportunity to submit CBIA's comments.

---

[1] See 2014 Survey of Connecticut Businesses, page 5: http://www5.cbia.com/newsroom/wp-content/uploads/2014/09/BlumShapiro_14.pdf

BA Healthcare Consulting

Written Testimony of Beka Apostolidis, RN, MS
Owner BA Healthcare Consulting/Telehealth Solutions

Before the Public Health Committee
February 23, 2015

Testimony in Support of:

Proposed Bill SB No. 467, An Act Concerning the Facilitation of Telemedicine

Senators Gerratana and Crisco, Representatives Ritter and Riley, and honorable members of the Public Health Committee,

My name is Beka Apostolidis and I have been a registered nurse in the state of Connecticut for over nineteen years. I am here to testify regarding the SB 467, An Act Concerning the Facilitation of Telemedicine as well supporting SB 246 An Act Defining and Establishing Standards for the Practice of Telemedicine and HB 6487 An Act Concerning Standards for Telemedicine. I am currently owner of BA Healthcare Consulting/Focused on Telehealth Solutions. Previously, I worked for ten years at Hartford Healthcare at Home as the Cardiac Program Manager. My position including overseeing the telehealth program which utilized over 300 telemonitors.

First, I would like to address the language used in the bill. Telemedicine and Telehealth are, at times, used interchangeably, however, Telehealth incorporates a broader scope of remote monitoring. The American Telemedicine Association (ATA) is the national leading organization of remote patient monitoring and composed of diverse members including healthcare providers, academics, and policymakers The ATA defines telehealth as "the use of medical information exchanged from one site to another via electronic communications to improve a patient's health status. Telehealth includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools and other forms of telecommunications technology. [1] As mentioned in testimony provided by the Executive Director of Connecticut's Legislative Commission on Aging, I also recommend the language of Telemedicine be updated to Telehealth in the bill.

[1] American Telemedicine Association, Core Operational Guidelines for Telehealth Services Involving Provider-Patient Interactions (May, 2014). www.americantelemed.org

The continued growth of Telehealth is a reflection of the current changes in our healthcare system as we move towards caring for more patients in a fiscally responsible manner while maintaining quality care. Reports predict an 18.5 percent annual growth in telehealth worldwide through 2018. The United States will lead the telehealth market by increasing to $1.9 billion in 2018 from $240 million today, with an annual growth rate of 56 percent.[2] The expansion of Telehealth utilization has also led to more states and insurance companies providing reimbursement for these services. Currently, approximately 13 states have remote patient monitoring coverage for Medicaid patients. This includes three New England states, New Hampshire, Vermont and Maine. In addition, 22 states and the District of Columbia require that private insurers cover telehealth the same as they cover in-person services.[3]

Numerous studies have shown telehealth provides quality, cost effective care and is something patients are willing to use. There are numerous benefits regarding the use of Telehealth. Agencies utilizing telehealth are able to provide improved quality outcomes. Telemonitors are frequently used for chronic conditions, such as cardiac and pulmonary disorders. to improve care and reduce readmissions. Heart failure, a common cardiac homecare condition, is the leading cause of hospitalization for adults over the age of sixty-five with more than 1 million hospitalizations per year. [4] The mean cost of readmission for a heart failure patient is $13,000 with a 25% readmission rate. [5] Recent studies at VNA Healthcare (now Hartford Healthcare at Home) in conjunction with the University of Connecticut School of Nursing have shown that the use of telemonitors along with specific nursing interventions on heart failure patients can statistically improve quality of life, reduce depressive symptoms and help reduce hospital readmissions. Another telemonitor study by Geisinger in 2014 showed a 44% readmission reduction in 30 days for heart failure patients as well as a savings of $3.30 for every $1 spent. [6]

With the continued growth and reimbursement, it is important for agencies utilizing Telehealth to establish standards of practice. This will help to ensure agencies use best practice and maintain program integrity. Standards of practice for a Telehealth program should include, but are not limited to:

Patient Standards:

- Defined patient inclusion/exclusion criteria
- Informed Consent prior to deployment of equipment
- Privacy and Confidentiality maintained during duration of monitoring
- Home assessment to determine potential environmental barriers
- Patient Education to ensure correct understanding and use of monitoring equipment

---

[2] Forbes, Top Health Trend For 2014: Telehealth To Grow Over 50%. What Role For Regulation? (Dec. 2013). www.forbes.com

[3] American Telemedicine Association, About Telemedicine. www.americantelemed.org

[4] American Heart Association, Rehospitalization for Heart Failure, Predict or Prevent. (2012) www.circ.ahajournals.org

[5] Infection Control & Clinical Quality, 6 Stats on the Cost of Readmission for CMS tracked conditions (Dec. 2013) www.beckershospitalreview.com

[6] Healthcare Informatics, Geisinger Study Finds Telemedicine to Cut Readmissions, Costs for Heart Failure Patients. (Oct. 2014) www.healthcare-informatics.com

Monitoring Guidelines:

- Specify data monitoring available to patient, i.e. pulse oximetry, weight, blood pressure, pulse, ekg, blood sugars
- Patient parameters defined by organization as well as policies and procedures if parameters fall outside defined norm
- Define skill level of licensed personnel monitoring patients and provide continued education for telemonitoring staff
- Define specific time of monitoring patients, should include seven days a week, as well as information provided to patient of who to contact after hours
- Limit outsourcing of monitoring patients i.e. out of state, out of country remote monitoring

Outcomes:

- Define measurable outcomes- ie patient satisfaction, equipment utilization, rehospitalization rates
- Develop reports to measure defined outcomes
- Establish criteria of time frame to run reports, i.e. monthly, quarterly, annually
- Maintain minimum standards of telehealth outcomes

In addition to Telehealth guidelines, it is important for practitioners to rely on their professional expertise and experiences to ensure delivery of quality telehealth monitoring.

Thank you for the opportunity to testify today and consideration of this bill.

Regards
Beka Apostolidis

Connecticut ORTHOPAEDIC Society

Written Testimony of the Connecticut Orthopaedic Society

Opposing *Senate Bill 467 An Act Concerning the Facilitation of Telemedicine*

Public Health Committee – February 23, 2015

Senator Gerratana, Representative Ritter and distinguished Members of the Public Health Committee, on behalf of the more than 250 orthopaedic surgeons of the Connecticut Orthopaedic Society, thank you for the opportunity to submit written testimony in opposition to *Senate Bill 467 An Act Concerning the Facilitation of Telemedicine.*

In the constantly changing and advancing technology in health care, there are potential benefits of telemedicine in communities where urgent medical care in extreme rural areas is not readily available however in Connecticut this is not a significant issue.

The American Academy of Orthopaedic Surgeons position on telemedicine identifies problems associated with telemedicine including venue, licensure, standard of care and informed consent and this bill lacks clarification, details and criteria for the practice of telemedicine in Connecticut. In addition, privacy and confidentiality is the bedrock of the physician patient relationship and any discussion of telemedicine must include ways to ensure that the technological component of telemedicine cannot be breached.

The move to incorporate the appropriate use of telemedicine into the practice of medicine must be given careful consideration and the orthopaedic surgeons in CT would welcome the opportunity to meet with the sponsors of this bill and the other telemedicine related bills to discuss clear, concise, criteria specific language that would ensure that only state licensed practitioners practicing within our state's scope of practice statutes be considered for telemedicine privileges.

Thank you.

Submitted by:
Ross A. Benthien, M.D.
Connecticut Orthopaedic Society – President
Orthopaedic Associates of Hartford, Hartford, CT

DermAesthetics,
info@DermAestheticsCT.com
Occupational and Aesthetic Care
33 Bullet Hill Rd, Suite 204
Southbury, CT 06488

LLC

www.DermAestheticsCT.com
(203) 233-7681

PUBLIC HEALTH COMMITTEE PUBLIC HEARING – FRBRUARY 23, 2015

TESTIMONY IN SUPPORT OF CONCEPT OF PROPOSED BILL No. 467
AN ACT CONCERNING THE FACILITATION OF TELEMEDICINE

LouAnn Perugini, ACNP, FNP, DcNP, CANS

Senator Gerratana, Representative Ritter, Representative Srinivasan, Senator Markley and members of the Committee

As an Army veteran with 10 years' experience as a military medical provider to an entire battalion of Special Operations Aviators during both Operation Iraqi Freedom and Operation Enduring Freedom, I have been fortunate to have first-hand experience utilizing Military Telemedicine Services to provide remote care to my soldiers via telemedicine in many situations. I functioned as the sole provider for a battalion of over 1000 personnel where I was responsible for the medical readiness and performance of perpetual and uninterrupted Special Operations missions. Our soldiers were continuously deployed to 3 or 4 continents simultaneously for several ongoing remote operations in areas where there were no health care providers or health care facilities. Using internet digital x-ray technology, satellite communication linking, video telecommunications and web-based electronic medical records; I was consistently able to effectively triage, assess and diagnose conditions, disposition and arrange for medical management of soldiers in their remote theater of deployment from my office in the continental United States. While remote physical assessment obviously has limitations, telemedicine supported the ability to safely provide quality remote care within acceptable medical standards of care in situations where it was otherwise limited or nonexistent. When considering SB 467, please keep in mind the APRN scope of practice and include APRNs in the verbiage of the bill. By including APRNs to provide care according to the outline of the bill, you will be increasing access, availability and adding to the quality of care for Connecticut patients.

Thank you for your consideration,

LouAnn Perugini, APRN
MAJ., ANC, USAR(R)
louann.perugini@gmail.com

CONNECTICUT NURSES' ASSOCIATION

377 Research Parkway 2D
Meriden, CT 06450
203-238-1207
FAX (203) 238-3437
www.ctnurses.org

TESTIMONY RE: SB. NO. 467 An Act Concerning The Facilitation of Telemedicine

Public Health Committee
February 23, 2015

Good Day, Senator Gerrantana, Representative Ritter and members of the Public Health Committee.

Thank-you for the opportunity to provide testimony on behalf of the Connecticut Nurses' Association (CNA), the professional organization for registered nurses in Connecticut, for SB. NO.467 An Act Concerning The Facilitation of Telemedicine

I am Mary Jane Williams Ph.D., RN current chairperson of Government Relations Committee for the Connecticut Nurses Association and professor emeritus from Central Connecticut State University.

I speak in support of SB. NO. 467 An Act Concerning The Facilitation of Telemedicine.

"Telemedicine" refers to the use of electronic communication and information technologies to provide or support clinical care at a distance. More broadly speaking, the term "telehealth" is often used to refer to a diverse group of health-related activities, such as health professional's education, community health education, public health, research, and administration of health services. According to the American Nurses Association the "Tenth Amendment to the U.S. Constitution, each state is empowered to establish laws to protect the citizens of the respective state." "A component of this "public protection" mandate is the state responsibility for

establishing standards for health care professionals who provide services for citizens of that state."

Therefore, I speak in support of SB. NO. 467 **An Act Concerning The Facilitation of Telemedicine and** look forward to the development of Standards of practice at the State level that will support the practice of Telemedicine. However, I recommend that an "Advisory Committee" be set up to deal with the issue of establishing Standards of Practice utilizing the available resources and research to establish a sound set of standards for the health care professionals who are and will be involved in the provision of health care via electronic technology.

Thank you

Mary Jane M Williams PhD., RN

542 Hopmeadow Street
PMB #143
Simsbury, CT 06070-5405
www.ctaprns.org

PUBLIC HEALTH COMMITTEE PUBLIC HEARING FEBRUARY 23, 2015

PROPOSED BILL No. 467 AN ACT CONCERNING THE FACILITATION OF TELEMEDICINE.

Testimony of Laima Karosas PhD, APRN representing the CT ADVANCED PRACTICE REGISTERED NURSE SOCIETY (CTAPRNS)

Senator Gerratana, Representative Ritter, Representative Srinivasan, Senator Markley and members of the Committee

Thank you for raising this bill and issues regarding telemedicine services.

I am the Co-Chair of the Health Policy Committee for the Connecticut Advanced Practice Registered Nurse (APRN) Society and ask that as you progress with establishing a telemedicine approach to care that you also take care to address inclusion of APRNs in telemedicine legislation.

Given that APRNs are duly licensed and practicing health care providers in the state, we ask that state law be written to include providing coverage by APRNs for telemedicine services for APRN patients, under the same guidelines and restrictions as other providers. We agree that properly administered telemedicine can provide valuable care to the patient for timely delivery of clinical health care services which facilitates the assessment, diagnosis, consultation, treatment, education, care management, and self management of a patient's health care.

Thank you for considering this request and for the opportunity to raise our concerns.

Laima Karosas, PhD, APRN
Co-Chair, Health Policy Committee
CT APRN Society

Nurse Practitioner with West Haven Medical Group, LLC, West Haven, CT.
Director of Nurse Practitioner Programs at Quinnipiac University, Hamden, CT.

CONNECTICUT PHYSICAL THERAPY ASSOCIATION
A COMPONENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION
15 NORTH RIVER ROAD, TOLLAND, CT 06084
(860) 246-4414 • FAX (860) 656-9069
www.ctpt.org

Testimony of James P. Leahy, CAE
Executive Director, CT Physical Therapy Association

In support of
S.B. 467, AAC the Facilitation of Telemedicine

Before the Joint Committee on Public Health
February 23, 2015

Chairperson Gerratana, Chairperson Ritter, Members of the Public Health Committee. My name is James Leahy and I am the Executive Director for the Connecticut Physical Therapy Association. I am here today to testify in support of S.B. 467, AAC the Facilitation of Telemedicine.

First, I would like to thank the Committee for allowing us the opportunity to testify on this issue. The use of telemedicine services and its impact on how we are able to care for our patients is an emerging issue for physical therapists and other health care professionals. We believe that access to this service delivery system will allow for care that can be critically important to a patient's long-term health.

The complex US health care system is under a tremendous amount of pressure. Many traditional health care business models are designed to allow high-volume, low-cost procedures to offset the costs of low- volume, high-cost procedures. An upward shift in the aging population is projected to result in a large increase in demand for health care, and new legislation such as the Affordable Care Act has added uncertainty to the future of health care business models and payment. Telehealth is projected to grow worldwide to 1.8 million users by 2017, according to the World Market of Telehealth.

In physical therapy, our patients/clients are asking for more time-efficient and less costly care models. Their busy lifestyles also can make it difficult for them to attend traditional appointments.

Applications of telehealth in physical therapy already have roots that expand throughout patient/client care and consultation, as it allows PTs to better communicate with patients/clients and provide more flexible care. We urge the committee to pass the bill and to ensure that non-physician providers are included in the scope of work allowed.

Thanks for the opportunity to testify.

American
Physical Therapy
Association

CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME

TESTIMONY
Delivered by Tracy Wodatch, Vice President of Clinical and Regulatory Services
Before the Public Health Committee

February 23, 2015

To SUPPORT

- **Proposed Bill No. 467, An Act Concerning the Facilitation of Telemedicine**
- **Proposed Bill No. 246, An Act Defining and Establishing Standards for the Practice of Telemedicine**
- **Proposed Bill No. 6487, An Act Concerning Standards for Telemedicine**

Senators Gerratana and Crisco, Representatives Ritter and Riley, and esteemed members of the Public Health Committee, my name is Tracy Wodatch, Vice President of Clinical and Regulatory Services at the Connecticut Association for Healthcare at Home. I am also an RN with over 30 years experience in home health, hospice, long term and acute care.

The Association represents 62 Connecticut DPH licensed/Medicare certified home health and hospice agencies that foster cost-effective, person-centered healthcare in the setting people prefer most – their own home.

Collectively, our agency providers deliver care to more Connecticut residents each day than those housed in CT hospitals and nursing homes combined. As a major employer with a growing workforce, our on-the-ground army of 17,000 home health care workers is providing high-tech and tele-health interventions for children, adults and seniors.

Our Association and its members support the use of telemedicine, the reimbursement of telemedicine (both commercial insurance coverage and Medicaid coverage as outlined in bills before Insurance and Real Estate Committee and the Human Services Committee) and established standards of practice for telemedicine.

Telemedicine and Telehealth are, at times, used interchangeably, however, Telehealth incorporates a broader scope of remote monitoring. The American Telehealth Association (ATA) defines telehealth as "the use of medical information exchanged from one site to another via electronic communications to improve a patient's health status. Telehealth includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools and other forms of telecommunications technology.

The use of telehealth has spread rapidly and is now becoming integrated into the ongoing operations of hospitals, specialty departments, home health agencies, private physician offices as well as consumer's homes and workplaces.

CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME

Examples include:

- Transmission of medical images (wound photos or xrays) between healthcare centers for diagnosis across distance
- Tele-consultation: Provision of knowledge or experience of an expert across distance (e. g. teleradiology)
- Diagnosis at distance: Diagnosis of a patient by a physician at distance (e. g. telecardiology)
- Telemonitoring: Supervision of a patient and his data at distance, who is not in the hospital and/or clinic (e. g. diabetes patients, patients with heart insufficiencies)
- Tele-learning: Education and training of patients and/or professionals at distance (Health coaching)

For all three proposed bills, we recommend replacing the term "Telemedicine" with the broader term "Telehealth" with reference to the broader definition as outlined by the ATA. The examples listed are not all inclusive as this technology continues to expand. We also recommend that any language addressing telehealth allow for expansion and further technologic advances.

For nearly two decades, several of our licensed home health agencies have been using telemonitors (a form of telemedicine) in their clients' homes to remotely monitor blood pressure, weight, blood glucose and oxygen levels. Through close monitoring and communication with the physician, we can catch an early warning sign, such as a sudden rise in blood pressure or weight, and treat it before it becomes a bigger problem usually resulting in a hospitalization.

Although the language in both SB 246 and HB 6487 are more focused on the use of telehealth to supplement/complement physician practices, we ask that the language for any standards be more flexible to include telehealth not only in primary care, but also in home health care, outpatient care, hospitals, etc. Be inclusive of all care settings to allow for the anticipated expansion of the technology and to promote the most cost-effective care to meet the goals of the Triple Aim.

Standards for telehealth practice should include defined patient inclusion/exclusion criteria, informed consent prior to use; HIPAA compliance; assessment prior to implementation of any telehealth equipment/technology; patient education to ensure correct understanding and use; and limited outsourcing for monitoring purposes (e.g., the home health agency or physician office should be primarily responsible for oversight and monitoring of patients using telehealth in order to promote patient-centered, informed plans of care).

Thank you for the opportunity to offer comments on these bills. Please reach out to us as a resource for additional information at any time.

ConnOTA

From the Hills to the Sound
The Connecticut Occupational Therapy
Connection Since 1926

Testimony of
The Connecticut Occupational Therapy Association (ConnOTA)
By
Morgan Villano, Board Member for Government Affairs
Regarding
Telemedicine Bills: Senate Bill 467; Senate Bill 246; House Bill 6487
Before the
Public Health Committee
February 23, 2015

A response to: proposed bill 467 "An Act Concerning the Facilitation of Telemedicine"; proposed bill 246 "An Act Defining and Establishing Standards for the Practice of Telemedicine"; and proposed bill 6487 "An Act Concerning Standards for Telemedicine".

On behalf of the Connecticut Occupational Therapy Association, we would like to impress upon members of the Public Health Committee the role and impact of telemedicine for those patients who receive occupational therapy services as well as the role telemedicine has in the provision of occupational therapy services. The Connecticut Occupational Therapy Association proposes their *support of telemedicine* in Connecticut and *respectfully requests to be included in the language* of proposed bills 467, 246 and 6487 should these bills move forward.

Telemedicine is an opportunity to provide medically necessary services in the event that a patient and a provider are physically in different locations, with informed patient consent. The World Federation of Occupational Therapy supports telemedicine when an in person evaluation, intervention and/or supervision of medically necessary occupational therapy services are not available to a patient or geographical and/or environmental

370 Prospect Street, Wethersfield, CT 06109

Phone: (860) 257-1371

Email: info@connota.org

www.connota.org

challenges to receiving in person occupational therapy services are significantly taxing to the patient and would ultimately impact the timeliness of service provisions affecting the health of the patient. The definition of occupational therapy includes providing client centered interventions that promote health and well being through the medical assessment of and treatment specific to an individual's perceived values, or their occupations. Furthermore, the 2011 World Report on Disabilities, developed by the World Bank and the World Health Organization, supported the use of telemedicine for occupational therapy service provision (International Journal of Telerehabilitation, Vol. 6, Num 1, Spring 2014, 10.5195/ijt.2014.6153).

In 2014 The International Journal of Telerehabilitation published an analysis of states that have telemedicine provisions and regulations; the report strongly suggested that implementation of the Affordable Care Act would result in a significant need for occupational therapy services across the age continuum and the use of telemedicine would support or act as an adjunct in the timely implementation of occupational therapy services, specifically as it relates to patient centered care and multi-disciplinary team based approaches (The International Journal of Telerehabilitation, Vol. 6, No. 1 Spring 2014 • (10.5195/ijt.2014.6141). This impact is felt now in Connecticut, most often in the provision of home health services, where occupational therapists, physical therapists and nurses work to ensure patients manage their daily health safely given the nature of home health does not always indicate daily treatment. The home health multi-disciplinary team works with the patient, often using a telehealth monitoring tool that the patient accesses in the home providing the home health team pertinent medical information regarding vital signs and answers to how a patient is feeling on a daily basis. Clinicians are receiving information specifically regarding daily compliance with medical protocols and procedures such as weight monitoring for the patient with a diagnosis of congestive heart failure, blood sugar readings for a person with a diagnosis of diabetes or feedback on the impact of depression symptoms on a person's daily functioning and engagement in their daily routine. The nature of home health is intermittent weekly treatment based on the acuity of a patient's diagnoses and the use of telehealth monitoring allows the home health professional, such as the occupational therapist, the ability to access critical

370 Prospect Street, Wethersfield, CT 06109

Phone: (860) 257-1371

Email: info@connota.org

www.connota.org

ConnOTA

From the Hills to the Sound
The Connecticut Occupational Therapy
Connection Since 1926

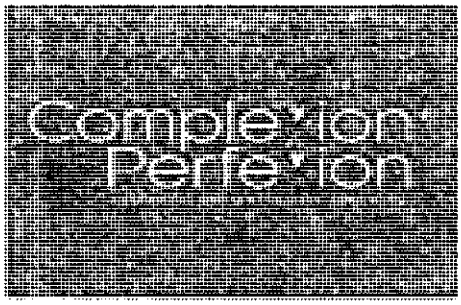
medical values that directly correlate to the degree and type of in-home medical treatment a patient needs to remain in the community successfully and healthily.

Given that the State of Connecticut is considering defining the practice standards for and definition of telemedicine as it relates to Connecticut constituents, the determination of who would be a telemedicine licensed provider, clarification of the standard of care and decision regarding insurance coverage, the Connecticut Occupational Therapy Association proposes their *support of telemedicine* in Connecticut and *respectfully requests to be included in the language* of proposed bills 467, 246 and 6487 should these bills move forward. Thank you for the opportunity to comment and ConnOTA looks forward to working with the Committee on these measures.

JOINT
STANDING
COMMITTEE
HEARINGS

PUBLIC
HEALTH
PART 5
1788 – 2213

2015



HB 6487

TESTIMONY PRESENTED BEFORE THE PUBLIC HEALTH COMMITTEE

FEBRUARY 23, 2015

BILL #6487, AN ACT CONCERNING STANDARDS FOR TELEMEDICINE SERVICES,

BILL # 467, AN ACT CONCERNING THE FACILITATION OF TELEMEDICINE,

BILL #246, AN ACT DEFINING AND ESTABLISHING STANDARDS FOR THE PRACTICE OF TELEMEDICINE

Senator Gerratana, Representative Ritter, Representative Srinivasan, Senator Markley and distinguished Members of the Committee:

My name is Christine Zarb and I am an Adult and Geriatric Nurse Practitioner. I am here to respectfully request that the proposed telemedicine bills clearly state that an APRN may be a provider for telemedicine services. Bill #6487, An Act Concerning Standards for Telemedicine Services clearly fails to recognize APRNs as telemedicine providers.

Respectfully,

Christine Zarb, APRN-BC, MPH

SENATOR MARTIN M. LOONEY
PRESIDENT PRO TEMPORE

Eleventh District
New Haven, Hamden & North Haven

February 23, 2015

State of Connecticut
SENATE

State Capitol
Hartford, Connecticut 06106-1591
132 Fort Hale Road
New Haven, Connecticut 06512
Home: 203-468-8829
Capitol: 860-240-8600
Toll-free: 1-800-842-1420
www.SenatorLooney.cga.ct.gov

(SB246) (SB467) (HB6487)

Good morning Sen. Gerratana, Rep. Ritter and members of the Public Health Committee. I am here to testify in support of HB 6709 AN ACT CONCERNING THE RIGHT TO TRY EXPERIMENTAL DRUGS and SB 471 AN ACT REQUIRING RESIDENTIAL CARE FACILITIES TO CARRY LIABILITY INSURANCE.

HB 6709 would offer hope to terminally ill patients who suffer from diseases for which there is no effective approved treatment. Unfortunately, recent federal court decisions have held that terminally ill patients do not have a right to try experimental treatment[1]. As a response to these decisions, a number of states have passed "right to try" laws to give these patients access to potentially life-saving therapy. The legislation before you would allow drug and device manufacturers to make investigational drugs and devices available to certain terminally ill patients. This would allow qualifying patients access to experimental treatments. Qualifying patients must have considered all other treatment options currently approved by FDA, been unable to participate in a clinical trial for the terminal illness within 100 miles of home , received a recommendation from the treating physician for the experimental treatment, and have given written, informed consent.

While some argue that access to experimental treatments poses a significant risk of harm to the patient, it would seem that this danger is far less than that posed by the certain death due to

[1] Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach, 495 F.3d 695, 696 (D.C. Cir. 2007) (en banc), *cert. denied*, 128 S. Ct. 1069 (2008).

the underlying illness. This bill strikes a reasonable balance; it contains numerous safeguards and allows access to these treatments only to terminally ill patients. It does not require that insurance companies cover these treatments and it allows but does not require the manufacturer to make the products available. I urge passage of this legislation which would offer hope to patients afflicted with terminal illness.

SB 471 would require all residential care facilities to carry liability insurance of at least one million dollars per occurrence. The insurance would cover injury to residents or guests caused by the negligent acts or omissions of, or neglect by the facility or its employees. This legislation would protect both the residents and the facilities.

A study done on this issue in California[2] (prior to passage of a similar bill) showed that the average monthly cost to a small, 6-bed facility would amount to approximately $50 per month per resident. That hardly seems like too high a price to pay.

In addition, I am pleased that your agenda today includes several bills regarding the regulation of Telemedicine. This is an emerging field that requires our careful attention. Currently our state displays a low level of usage and inadequate regulation of telemedicine. I look forward to working with you to establish a robust regulatory framework for this essential specialty.

(SB 246)
(SB 467)
(HB 6487)

Thank you for hearing these important bills.

[2]http://rcfereform.org/news/Governor_Brown_Signs_Into_Law_AB_1523_RCFEs_Must_Now_Carry_Liability_Insurance

S - 683

CONNECTICUT
GENERAL ASSEMBLY
SENATE

PROCEEDINGS
2015

VOL. 58
PART 5
1340 – 1655

Thank you. Will you remark further on this bill? Will you remark further on this bill? Senator Looney.

SENATOR LOONEY:

Thank you, Madam President. Madam President, also speaking in support of the bill, obviously tax incremental financing has been used in a variety of projects over the years in a different way. Often it was used with a - new sales taxes or other new revenues that were developed from the creation of economic development entities to justify state funding in certain areas.

This will be, as the Chair said and as Senator Linares said, an important tool for municipalities to also identify development districts and have the resources to fund improvements in those districts by recognizing that the new taxes created by the economic development can, in fact, be used to help pay off the bonds that become part of the undertaking for the infrastructure to make those developments possible. So I think it's a new and creative way for municipalities to undertake, especially reclamation in areas that have been in substantial need of a new stream of potential capital. Thank you, Madam President.

THE CHAIR:

Thank you. Will you remark further? Will you remark further? Senator Osten.

SENATOR OSTEN:

Yes, Madam President. If there are no objections, I would remove this to the Consent Calendar.

THE CHAIR:

Seeing no objection, so ordered, ma'am. Mr. Clerk.

CLERK:

Page 51, Calendar No. 414, Substitute for Senate Bill No. 467, AN ACT CONCERNING THE FACILITATION OF

TELEHEALTH, Favorable Report from the Committee on Public Health.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Madam President, good evening, Madam President.

THE CHAIR:

Good evening. Very – well, almost morning. Keep going.

SENATOR GERRATANA:

Well, I move acceptance of the Joint Committee's Favorable Report and passage of the bill.

THE CHAIR:

The motion's on acceptance and passage. Will you remark, ma'am.

SENATOR GERRATANA:

Thank you, Madam President. Madam President, before I explain the underlying bill, I do have an amendment. Actually, the Clerk has one. If he would call LCO No. 7710 and I be allowed to summarize.

THE CHAIR:

Mr. Clerk.

CLERK:

LCO No. 7710 will be designated Senate Schedule "A."

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. I move adoption.

THE CHAIR:

The motion’s on adoption. Will you remark, ma’am?

SENATOR GERRATANA:

Thank you, Madam President. Madam President, this amendment makes some changes to the underlying bill to some of the definitions that we use. It also adds in some licensed healthcare providers under who would be included in TeleHealth. And it also just clarifies about patient’s primary care provider and the relationship with the patient and the primary care provider in terms of consent when TeleHealth is given. Thank you, Madam President.

THE CHAIR:

Thank you. Will you remark? Will you remark on Senate “A?” Senator Hwang. No. Seeing none, I’ll try your minds on Senate “A.” All those in favor of Senate “A,” please say aye.

SENATORS:

Aye.

THE CHAIR:

Opposed? Senate “A” passes. Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. Now we’re on the main bill. TeleHealth is a mode or platform of healthcare delivery in this country. I was very surprised to find that it is quite ubiquitous, certainly ongoing right here in our own state. Many, many different healthcare plans, companies offer - also companies and businesses through their healthcare plans - offer TeleHealth as a mode and a way of delivering healthcare.

It certainly is not new, as I said. Right now, 46 other states actually have legislation. Many people talk to me and said isn’t it too soon for us to set up some sort of framework, which the underlying bill

does, and I said no. [laughs] We're a little bit behind the times, if you will. So it's appropriate that Connecticut take these steps.

I wanna talk about three different modes of – types, if you will – of delivery of healthcare under the bill. The first is synchronous. And synchronous is one that you probably think about when you think about TeleHealth, and that is an interactive relationship that you have with the provider. People would be probably more familiar with something called Skype or FaceTime when you sit down in front of a computer – computer, excuse me – and actually have an interactive discussion with the healthcare provider. It's always done in a situation where it's remote. You, as a patient, may be at home or somewhere else, and the provider is at another site.

We also have what is called asynchronous. These are all terms that are commonly used now around the country and have particular meetings – meanings – and this is regarding what we call store and forward transfers. These kinds of transfers are usually patient test results, lab results, x-rays, that sort of thing. Very often, perhaps you have heard of consultations that are done between maybe healthcare institutions and even between countries where you have a particular expert who is going to read an x-ray and then looks at it through a store and forward method or the asynchronous method and is able to look at this and consult with and weigh in on perhaps a patient's particular test that was done.

And then finally, there's remote patient monitoring. And this is done very often in cases when a patient may be at home – may be homebound. Has to be checked in on every single day and this is a way, also, for the patient very often to hook him or herself up to a telemonitor which can relay healthcare information to a provider. So these are the various ways that TeleHealth are delivered every single day.

Now, in working on the legislation, we worked with the healthcare plans, 'cause part of this bill also not just identifies what TeleHealth is but it also sets up coverage of TeleHealth in Section 2 of the bill. And in working with a lot of providers, I was also able to

talk with a lot of TeleHealth providers that contract with these health plans that work with our citizens every day. And it was quite interesting to understand how this mode of healthcare is delivered.

Also just wanna make clear a couple of things in the underlying bill. And there was a lot of discussion, excuse me, I'll just go to page 4 in the bill – no – page 5 in the bill. In Lines 109, and this goes to the coverage in Section 2. We have Section 2 and Section 3, which are the insurance coverage details. One for group plans. One for individual plans. And we talk about such coverage shall be subject to the same terms and conditions applicable to all other benefits under such policy.

The discussions that I had were with the LCO attorney, Kumi, I believe, is her first name, who usually does legislation in the insurance statutes. And just to be clear, we are talking here that when we refer to policy in that line and also in Line 136, it is that which is the member agreement and does not pertain in any way to the level of reimbursement. There was lots of discussion about how this would be reimbursed. We're saying that this is coverage. We're not talking about the level of reimbursement.

There was also discussion on Line 37 in the underlying bill, and this has to go into a definition of what telemedicine is not. It is – does not include the use of facsimile, audio-only telephone, texting, or electronic mail. We want to make sure that people understand that. We define what a TeleHealth provider is, and there are other conditions in the bill that are delineated. TeleHealth is here. This bill sets up a framework to understand – for us to understand what TeleHealth is and how it is delivered. Thank you, Madam President.

THE CHAIR:

Thank you. Will you remark on the bill? Senator Markley, good evening, sir.

SENATOR MARKLEY:

Good evening, Madam President. Thank you very much.

I'll just say briefly that this is clearly a development that we need to deal with that I think will bear good fruit for us in coming years. And I believe the bill we have before us, which is the result of some consideration, is admirably modest and not overreaching in what it can accomplish and will put us on a path to take advantage of a technology that can be both a service to those who need healthcare and hopefully a cost savings as well. So I will support it and urge others to do so. Thank you.

THE CHAIR:

Thank you, Senator Markley. Will you remark further on the bill? Will you remark further on the bill? If not, Senator Gerratana.

SENATOR GERRATANA:

Madam President, if there's no objection, I would like this item placed on our Consent Calendar. Thank you.

THE CHAIR:

Seeing no objection, so ordered, ma'am. Senator Duff. Good evening, sir.

SENATOR DUFF:

Good evening, Madam President. I'd like to place some items on the Consent Calendar please.

THE CHAIR:

Please proceed, sir.

SENATOR DUFF:

Thank you, Madam President. On Calendar page 10, Calendar 293, Senate Bill 1057. I'd like to place that item on the Consent Calendar.

THE CHAIR:

So ordered.

SENATOR DUFF:

Thank you, Madam President. On Calendar page 13, Calendar 362, Senate Bill 1102, I'd like to place that item on Consent Calendar.

THE CHAIR:

Seeing no objection, so ordered, sir.

SENATOR DUFF:

Thank you, Madam President. Calendar page 26, Calendar 496, Senate Bill 1056. I'd like to place that item on the Consent Calendar.

THE CHAIR:

Seeing no objection, sir, so ordered.

SENATOR DUFF:

Thank you. On Calendar page 39, Calendar 139, Senate Bill 523, I'd like to place that item on the Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR DUFF:

Thank you, Madam President. On Calendar page 45, Calendar 292, Senate Bill 1055. I'd like to place that item on the Consent Calendar.

THE CHAIR:

Seeing no objection, so ordered, sir.

THE CHAIR:

Thank you, Madam President. If the Clerk can now call the items on Consent Calendar, and then we can have a vote on our first and only Consent Calendar of the day.

THE CHAIR:

Thank you. Mr. Clerk. Will you please call those items on the Consent Calendar please?

CLERK:

Page 1, Calendar 448, House Joint Resolution 101. Page 2, Calendar 87, Senate Bill 877. Page 6, Calendar Bill 221, Senate Bill 103. Page 8, Calendar No. 260, Senate Bill 739. Page 8, Calendar No. 263, Senate Bill 931. Page 10, Calendar No. 293, Senate Bill 1057. Page 13, Calendar No. 379, Senate Bill 917.

Page 13, Calendar No. 366, Senate Bill 981. Page 13, Calendar No. 362, Senate Bill 1102. Page 16, Calendar No. 427, Senate Bill 900. Page 20, Calendar No. 460, House Bill 6717. Page 21, Calendar No. 464, House Bill 6991. Page 22, Calendar No. 469, House Bill 6671. Page 23, Calendar No. 476, House Bill 6913.

Page 26, Calendar No. 496, Senate Bill 1056. Page 38, Calendar No. 114, Senate Bill 865. Page 39, Calendar No. 139, Senate Bill 523. Page 42, Calendar No. 201, Senate Bill 445. Page 44, Calendar No. 244, Senate Bill 481. Page 45, Calendar No. 291, Senate Bill 1054. Page 45, Calendar No. 292, Senate Bill 1055.

Page 48, Calendar No. 349, Senate Bill 361. Page 50, Calendar No. 412, Senate Bill 677. Page 51, Calendar No. 433, Senate Bill 1114. And page 51, Calendar No. 414, Senate Bill 467.

THE CHAIR:

Thank you, sir. Please call roll call vote. The machine will be opened on the first and last Consent Calendar.

CLERK:

An immediate roll call vote has been ordered in the Senate for Consent Calendar 1. An immediate roll call vote has been ordered in the Senate.

[pause]

THE CHAIR:

If all members have voted, all members have voted, the machine will be closed. Mr. Clerk, will you please call the tally.

CLERK:

Consent Calendar No. 1

Total Number Voting	35
Necessary for Adopted	18
Total voting Yea	35
Total voting Nay	0
Absent/not voting	1

THE CHAIR:

The Consent Calendar passes. [gavel] Senator Duff. Senator Duff. Can somebody put Senator Duff on please. Thank you. Thank you.

SENATOR DUFF:

Thank you, Madam President, and despite the human cry to do even more bills tonight –

THE CHAIR:

Yeah, right.

SENATOR DUFF:

I think it is time for us to call it a night and to advise our Senators and staff that we'll be back at noon tomorrow. We will go straight in. We will not caucus first. Or pass go. We'll just go right in at noon tomorrow. And we - make sure that everybody has a very safe ride home tomorrow, and we'll ask if anybody has any points or announcements before we adjourn.

THE CHAIR:

Points of personal privilege? Senator Martin.

SENATOR MARTIN:

H –1216

CONNECTICUT GENERAL ASSEMBLY HOUSE

PROCEEDINGS 2015

VOL.58
PART 15
4903 – 5253

your seats. The machine will be open.

CLERK:

[bell ringing] The House of Representatives is voting by roll. The House of Representatives is voting by roll. Will members please report to Chamber immediately.

[pause]

REP. ORANGE (48th):

Have all members voted? Have all members voted? Please check the board to determine if your vote has been properly cast. If so, the machine will be locked and the Clerk will take a tally.

Will the Clerk please announce the tally.

CLERK:

Senate Bill 575, as amended by House "A," in non-concurrence with the Senate

Total Number Voting	144
Necessary for Passage	73
Those voting Yea	144
Those voting Nay	0
Absent and not voting	7

REP. ORANGE (48th):

Bill, as amended, in non-concurrence with the Senate, passes.

Will the Clerk please call Calendar No. 584.

CLERK:

On Page 38, House Calendar 584, Favorable Report of the Joint Standing Committee on Insurance and Real Estate. Substitute Senate Bill 467, AN ACT CONCERNING THE FACILITATION OF TELEHEALTH.

REP. ORANGE (48th):

Representative Matthew Ritter, you have the floor, sir.

REP. RITTER (1st):

Thank you, Madam Speaker, for the full name. You don't always get that up here. I move acceptance of the Joint Committee's Favorable Report and passage of the bill in concurrence with the Senate.

REP. ORANGE (48th):

The question is acceptance of the Joint Committee's Favorable Report and passage of the bill in concurrence with the Senate.

Representative Ritter.

REP. RITTER (1st):

Thank you, Madam Speaker. And I'd like - the

Clerk is in possession of an amendment, LCO No. 7710. I would ask the Clerk call it and I be called granted leave of the Chamber to summarize.

REP. ORANGE (48th):

Will the Clerk please call LCO No. 7710, which has been previously designated as Senate Amendment "A."

CLERK:

Senate "A," LCO 7710 as offered by Looney, Duff, et al.

REP. ORANGE (48th):

The Representative seeks leave of the Chamber to summarize. Without objection. Representative Ritter.

REP. RITTER (1st):

Thank you, Madam Speaker. This just makes some definitional changes and some other clerical errors that were found. So I would urge adoption of the amendment. And then we can talk about the underlying bill. Thank you.

REP. ORANGE (48th):

Will you care to remark further on Senate "A?" Representative Srinivasan on Senate "A." Okay. Would you care further on Senate "A?" If not, let

me try your minds. All those in favor, please signify by saying aye.

REPRESENTATIVES:

Aye.

REP. ORANGE (48th):

Those opposed, nay. The ayes have it.

[gavel]

The amendment is adapted. Will you care to remark further on the bill as amended? Representative Ritter.

REP. RITTER (1st):

Thank you, Madam Speaker, now to the underlying bill. As the title, one can see it here, is Telehealth is a new wave in medicine, not only here in the State of Connecticut but across the country. I think to give a real world example works best for me and hopefully works best for everybody. Those of us who have children often know that something happens, there's a rash or your child gets sent home with something, and you have to go see the doctor in person. You have to go see your pediatrician.

For many of you, you know it can be a long wait. It could be a long time to get them on the

telephone. Or you could just be an adult and you get a rash at the beach on a Saturday and you're home on a Sunday, there's no one you can go see. More and more, we're able to utilize Telehealth for certain things to get a doctor to tell you over, you know, video chat or something like that what is wrong with you, perhaps give you a diagnosis.

Here's what the bill does not do, it does not replace your traditional primary care doctor, doesn't replace the traditional medicine you receive from doctors, they can't prescribe Schedule I, II, or III drugs. They have to know who your primary care doctor is, the doctor at the other end of the line. We have protections in place to make sure we're not replacing medicine but we're augmenting the practice of medicine here in the State of Connecticut.

And more and more I think this service could be useful to a lot of us, useful to our family members and to our constituents, and it's being utilized. So I think this is a really good step in the right direction for medicine in the 21st century. It's a heck of a lot different than what we did in 1950. There's no question about it.

But the end of the day, it's not replacing your doctor. It is giving you a supplemental service that might be useful on the weekends or, you know, at midnight or something like that. And our hectic daily lives, I think it'll be a great change going forward. And I would urge adoption, Madam Speaker.

REP. ORANGE (48th):

Question is on adoption. Will you care to remark now Representative - the good Representative, Ranking Member Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Chair. Thank you very much. Good to see you there, Madam Chair.

REP. ORANGE (48th):

Good to see you too.

REP. SRINIVASAN (31st):

Madam Speaker, through you, Madam Speaker, a couple of questions to the proponent of the bill as amended.

REP. ORANGE (48th):

You may proceed.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker. Through you, Madam

Speaker, what services through Telehealth? You know, you talked about - the good Chairman, you talked about a rash, you talked about the - a child, you know, the parents calling up. What other services do you think that this Telemedicine will be able to provide us? Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Ritter.

REP. RITTER (1st):

Thank you, Madam Speaker, and through you, I was hoping the doctor could give me a more long list of that than I could. But I think that that hits it on the head. And the key I think for everybody when you think about this is you have to conform to your standard of care. So if you're the doctor at the other end of the video chat, you know your standard of care. You're not going to exceed that. You're going to be cautious.

If you see something you can't diagnose or order an anti-inflammatory for, you have to be careful because you would be violating the statute if you went beyond that. So I think that's really the check here. So I can't give you every rundown

of every list. But I think those types of things, smaller things, is what you're going to be treating.

Obviously if someone has a broken leg, Telemedicine or Telehealth is not going to be the appropriate use of that for something of that purpose. Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Srinivasan.

REP. SRINIVASAN (31st):

Madam Speaker, when you see a patient, the face of the patient, the skin of the patient, and the nails, just those three parts of our body tell the story of the patient's illness. You can look at the patient and you can easily tell the status, is it chronic? Is it acute? Same thing with the nails. And same thing with the skin.

So in Telemedicine, fortunately, you know, all of that can be seen by the person on the other side who is on the chat. So through this system, as the good Chairman said, a lot can be accomplished. And obviously the person who is on the other end will be able to know what their limitations are and at what point in time they have to be informed that

this is not within the realm of Telemedicine and they need to move on and be seen either in a walk-in clinic or in an emergency room as necessary.

Through you, Madam Speaker, for clarification purposes. Does this provider of Telehealth medicine, does he have to be - obviously he or she will have to be licensed. But does that person have to reside or does the service have to be provided by somebody in our state or could it be outside the state limits as well? Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Ritter.

REP. RITTER (1st):

Through you, Madam Speaker. They have to be licensed in the State of Connecticut but they could live outside the state. Through you.

REP. ORANGE (48th):

Representative Srinivasan.

REP. SRINIVASAN (31st):

So through you , Madam Speaker, somebody living Midwest, far West, California, could apply, get a license to - through the proper channels, be

licensed in the State of Connecticut, and then be a provider? Through you, Madam Speaker, on the Telehealth medicine.

REP. ORANGE (48th):

Representative Ritter.

REP. RITTER (1st):

That is correct. Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker. Can a retired health care professional who still has - maintains, retains their active license but is retired from their practice, whether it be in Connecticut or outside the state, can they still be a provider? Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Ritter.

REP. RITTER (1st):

Through you, Madam Speaker. Looking at Section - line 39 - I'm actually not in the amended bill but of the original bill - the definition of Telehealth provider, as long as they are physician licensed under Chapter 370 of the general statutes,

they can provide it. Through you.

REP. ORANGE (48th):

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker. We have seen large groups, you know, multi-speciality groups in our state. So through you, Madam Speaker, will this Telemedicine be provided by those groups for their patients? So in a patient - what I'm trying to say, Madam Speaker, is if a patient of a large group calls the answering service, the answering service will tell them this is a doctor on call and this is you - this is the person that you talked to, you know, he or she who is going to be providing services.

But in Telemedicine, will it be a group that in this large group, multi-speciality group, will it be through them that this person, this patient will see - will seek Telemedicine or could they just go and call anybody? Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Ritter.

REP. RITTER (1st):

Through you, Madam Speaker. I think this way this will work in practice is you'll have your insurance card and they will list for you where you can take advantage of the Teleservices and you would call the number and they would connect you. A couple things in the bill that are important, though, for the Telehealth provider.

For the first interaction, they have to inform the patient of the limitations of Telehealth, they also have to get consent from the person to whom they're going to provide the Telehealth services. So that initial exchange, although maybe someone you never - clearly never met but you've never video chatted with or whatever, there are some standard operating things we put into the statute to sort of make sure you're professionalizing that relationship on the first call.

But as I understand it, you would call up the company and they would connect you with the right person. And they would have their own internal mechanisms to figure out who the best person for whom you to speak to in this particular situation might be. Through you.

REP. ORANGE (48th):

Representative Srinivasan.

REP. SRINIVASAN (31st):

So through you, Madam Speaker. If a large multi-speciality group decides not to participate for their - whatever the reasons, does not - decides not to participate in Telemedicine. And when this patient of theirs calls this number - the number on the card - then as I understand it, they will go through the channels and probably talk to somebody in that group but not who is a part and parcel of that large multi-speciality group. Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Ritter.

REP. RITTER (1st):

Through you, Madam Speaker. And if I'm not answering the question, please let me know. I think the way that we're trying - the way the bill's drafted - is what we're saying is an insurance carrier has to cover Telehealth the same way they would the inside visit. But we're not requiring physicians or anybody to participate in Telehealth if they don't want to. Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker. Yes. And that is exactly what I was trying to drive at. And I did get the answer. So a physicians group can opt in or opt out to provide such a service and is not mandated that they do so.

Through you, Madam Speaker. As I see this, is this any different at Telemedicine than going into a walk-in clinic or an emergency room? But obviously far more convenient where you may not see your own provider, your health care provider. You see somebody who takes care of you on an emergency basis - walk-in clinic, emergency room - and then that information that they have got at that visit will be conveyed back to the primary care physician. Through - in Telemedicine, will that information will then go back to the primary care provider? Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Ritter.

REP. RITTER (1st):

Through you, Madam Speaker. That's exactly

right. It's not a lot different, except there is one more protection that I would point out . When you're receiving the Telehealth service, you have to have access to the patient's medical records to provide that and know who their primary care doctor is.

I don't know when you walk into an urgent care clinic if they might have access to your records, which is another issue for another bill. So I think this actually goes one step further. But besides that, yes, in all - for all intents and purposes, it's the same thing other than you're sitting on your couch potentially. Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Srinivasan.

REP. SRINIVASAN (31st):

And through you, Madam Speaker. The way that the primary care provider will get that information of this visit or this chat on Telemedicine is because they are all connected in that one system? Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Ritter.

REP. RITTER (1st):

The way the definition reads is that the medical record be provided by the patient or the patient would provide the primary care physician and maybe there could be a request of that record. Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker. Is there anywhere in this bill in the language that will prohibit or prevent such a physician becoming the primary care provider, wherein the patient does not go to see their primary care on a regular routine basis and just uses this service on an ongoing basis? Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Ritter.

REP. RITTER (1st):

I would say there's nothing that limits the number of times you can utilize this service, nor do we require that anyone go see their physician by law. There might be - your individual insurance plan might require you to go see your primary care

doctor in person once every three years or something like that. So I don't think the bill speaks to that issue.

But what I would say is the protections in place on what they can diagnosis, the warnings they're giving, the scope of practice stuff, leads me to believe that it's not going to replace traditional medicine that you might go see. And I think very clearly to make sure - if I was providing Telehealth, which would be a scary thought - but if I were, I would make sure I was giving those warnings out to make sure that patients really understood you need to go see a doctor in person and knowing what my limitations are to diagnosis certain things over a video chat or something like that. Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker. When we go into a conventional health care provider, I mean, Telemedicine now - if we call it relatively unconventional, I'm sure it will become very

conventional over time. But for the time being, if you call it unconventional then you go to a walk-in clinic, you go to an emergency room or a primary care, that provider, if needed, if that's how the process is, can order tests, whether it be lab tests, x-rays, so on and so forth.

How will that happen through Telemedicine? Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Ritter.

REP. RITTER (1st):

Through you, Madam Speaker. I think if they wanted to order something they would have to be in contact with their primary care physician that you provided them and then they would go through those steps. But I don't see anything in here that lets them take the ability to start ordering x-rays. They'd have to make that communication to the primary care doctor. Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Srinivasan.

REP. SRINIVASAN (31st):

So through you, Madam Speaker. So as I understand that at the time of the Telemedicine

visit or a chat or whatever we call that, at that particular time that provider cannot order lab tests and x-rays because he or she has not touched base with the primary care provider yet. Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Ritter.

REP. RITTER (1st):

Through you, Madam Speaker. I am going to say I - that's a - the bill doesn't get exactly into that level of detail about ordering lab tests. And I might find that different than an x-ray. Again, I think you have to be within your scope of practice, which I think is the most important thing for trying to figure out what they could order.

And the other limitation may also be if they are only licensed in Connecticut and there's no, you know, connection to the medical, you know, medical world in Connecticut, so to speak. They may also not exactly know where to go with that. So I think they'll have some limitations too.

And I think that at the end of the day, the way the statute is written it provides some flexibility for them to diagnosis. But again,

there are controls on what they can order on things like what drugs they can prescribe. I don't see anything here that allows for x-rays, more minor stuff like a blood test. They might recommend you go see that. I think that would be okay. And I think, you know, those are kind of the fine lines that they'll have to figure out in their scope of practice. Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Srinivasan.

REP. SRINIVASAN (31st):

Through you, Madam Speaker. The good Chairman said that very appropriately that, as this is work in progress and as we work out, as this bill moves forward, is when we will realize how those tests are going to be ordered in course of time. Because those tests are critical in evaluating a patient.

If a patient were to call up on Telemedicine and tell them, tell the provider that I'm a diabetic, I'm an established diabetic, and suddenly I'm feeling extremely dizzy and I feel tired and weak, one of the requirements would be what is your blood sugar level at that particular point in time.

And to get that level, to get the blood sugar,

I think, you know, as you can well imagine, Madam Speaker, that blood test will have to be ordered.

And as we move forward, that might be an area we may need to tighten up as to how those lab tests appropriate to that visit, appropriate to that chat, so that proper diagnosis is made and proper treatment is rendered to that patient at that particular time. And through you, Madam Speaker, reimbursement. The good Chairman did mention that.

And I just want to clarify that when a person goes to and gets this Telemedicine service, the provider, the physician will be compensated or the health care provider no differently than if the person were to go and see that health care provider at their offices. Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Ritter.

REP. RITTER (1st):

That is correct. Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Srinivasan.

REP. SRINIVASAN (31st):

And through you, Madam Speaker. You know, when patients go and visit their primary care

physicians, there are some limitations as to how often they can go and how often certain procedures and so on and so forth can be done. So, I mean, obviously we are not into procedures here yet. But as far as number of visits, will it be clearly spelled out to the patient that this is - you've reached your limit, this is your co-pay, and you cannot be using these services more than X number of times in the next six months or the next year? Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Ritter.

REP. RITTER (1st):

Through you, Madam Speaker. This would communicate the benefits as they do with any other benefit I think in their insurance policy. Through you.

REP. ORANGE (48th):

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker. This bill is definitely a bill in the right direction for us in Connecticut. You know, we all live extremely busy lives. And sometimes in the lives that we live,

whether it be right or wrong, is a debatable issue. But the reality is, in the busy lives, we tend not to do certain things, which are important. We tend not to take care of ourselves as well as we should.

And this gives us one additional tool. And it is up to the patient to decide whether they want to go with a conventional treatment, whereas they go to see the physician at their office, or at their convenience, 24/7/365, can they get this kind of a service so that their concerns and their questions are answered.

So as I see us moving forward into this century, this is definitely cutting edge. And I think this is a service we need to provide to our patients here in Connecticut. And I want to thank the good Chair for his answers. Thank you, Madam Speaker.

REP. ORANGE (48th):

Thank you, sir. Will you care to remark further? Representative Davis.

REP. DAVIS (57th):

Thank you, Madam Speaker. Through you to the proponent of the bill, if I may ask a question.

REP. ORANGE (48th):

You may.

REP. DAVIS (57th):

Thank you, Madam Speaker. As I read the bill as amended, I believe in lines 128 through 137, it calls for the insurance company to pay the same cost - or pay the provider the same as if the individual was in an in-person visit as they are in a Telemedicine visit. That is correct? Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Ritter.

REP. RITTER (1st):

Through you, Madam Speaker. As long as Telehealth is properly being provided for whatever the illness is, that is correct. Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Davis.

REP. DAVIS (57th):

Thank you, Madam Speaker, and through you. Is it the purpose of the Telehealth in some circumstances, perhaps, to reduce the cost of an in-person visit? Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Ritter.

REP. RITTER (1st):

Through you, Madam Speaker. I don't think the goal of this was to reduce cost, I think it was more of a convenience thing. Through you.

REP. ORANGE (48th):

Representative Davis.

REP. DAVIS (57th):

Thank you, Madam Speaker. In other states or other areas that have used Telehealth, have they adopted similar statutes that require them to pay the same amount of money for an in-person as well as a Telehealth visit? Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Ritter.

REP. RITTER (1st):

Through you, Madam Speaker. I'm not sure what other states have done in regard to that particular section. Through you.

REP. ORANGE (48th):

Representative Davis.

REP. DAVIS (57th):

Thank you, Madam Speaker, and through you. Was there any consideration given to perhaps trying

to adapt Telehealth not only for a convenience issue but also maybe for a cost savings measure for consumers and for our insurance providers to - and perhaps make it available more often for doctors and they can have more of these visits and increase their money? Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Ritter.

REP. RITTER (1st):

Through you, Madam Speaker. I think the Committee certainly considered a lot of different factors and, again, tried to put together a bill that could earn the most bipartisan support and at the same time, get through the General Assembly in a timely fashion. I think this is the product we came up with. Through you, Madam Speaker.

REP. ORANGE (48th):

Representative Davis.

REP. DAVIS (57th):

Thank you, Madam Speaker. And I thank the kind gentleman from Hartford for his answers. I will continue to support the bill. I supported it in the Insurance Committee, I will continue to support it today. However, I do feel that moving

forward that we should probably consider the benefits of Telehealth towards the cost of health care here in the State of Connecticut. And if we're going to adopt this measure, perhaps reviewing this section of the bill that requires that the insurance provider pay the same amount for an in-person visit as a Telehealth visit.

Often times from my understanding through a Telehealth visit, can be much shorter, a doctor could perhaps have many more of those Telehealth visits within an hour or whatnot compared to in-person visits that then require all the back office and various other things that go into have having an actual office visit.

It could be perhaps a way for us to reduce costs here in the State of Connecticut for health care delivery. And I certainly encourage the Public Health Committee to perhaps look into that in the future. Thank you, Madam Speaker.

REP. ORANGE (48th):

Thank you, sir. Will you care to remark further? Representative Sampson.

REP. SAMPSON (80th):

Thank you, Madam Speaker. Just to piggyback

off Representative Davis and some of his comments for more or less the same reasons I'm going to oppose the bill before us. We had this bill come before the Insurance Committee and we heard some testimony from the insurance industry. We heard testimony from experts. We heard testimony from physicians.

And one thing became very clear and that was that there is certainly a battle for how Telemedicine will go forward in the future. And this bill is going to pick a side. And I think it's the side of the physicians. And I think that that's unfortunate because I think that the bill should be much more even handed and I think it should be more patient centric. It should be concerned about making sure we deliver the best possible health care at the best possible cost.

And to me, this bill basically guts what Telemedicine is and has been as we have slowly but surely tried to adopt it in our state. The industry has been actively trying to pursue this technology and find ways to get services to consumers and patients and to do it with a cost savings. And unfortunately, this bill eliminates

both of those provisions. The two things that this bill does as amended are to essentially say that there's going to be no cost savings for using Telemedicine. And I would say, Madam Speaker, why are we doing it then?

The second thing that does is it makes it extremely difficult for other physicians to be accessible to patients because we have put such requirements and limitations on who can actually communicate with these patients that ultimately they're going to be driven back to their own network of physicians, which is fine except the purpose of Telemedicine that I was explained when this first was introduced was to expand those horizons to reduce costs, to create more opportunities, and to give access to physicians across the country and maybe across the world to patients that might need to speak with them.

And for those reasons, Madam Speaker, I'm going to oppose the bill before us. Again, this is a step backwards. This undoes what we said Telemedicine was set out to do. And I would urge my colleagues to vote against it. Thank you, Madam Speaker.

REP. ORANGE (48th):

Thank you, sir. Will you care to remark further on the bill as amended? Will you care to remark further on the bill as amended? If not, staff and guests please come to the Well of the House. Members, take your seats. The machine will be open.

CLERK:

[bell ringing] The House of Representatives is voting by roll. The House of Representatives is voting by roll. Will members please report to the Chambers immediately.

[pause]

REP. ORANGE (48th):

Have all members voted? Have all members voted? Please check the board to determine if your vote has been properly cast. If so, the machine will be locked and the Clerk will take a tally please.

Representative Esposito.

REP. ESPOSITO (116th):

Thank you, Madam Speaker. It appears my