MEDICAL BOARD OF CALIFORNIA
Executive Office

Interested Parties Meeting: Implementation of AB 329 Telemedicine Pilot

Medical Board of California
Lake Tahoe Room
2005 Evergreen Street
Sacramento, CA 95815

April 23, 2009

MINUTES

Agenda Item 1 Welcome – Introductions

Ms. Johnston, Executive Director of the Medical Board of California, welcomed participants. Notice had been sent to interested parties.

Board Members Present:
Shelton Duruisseau, Ph.D.

Staff Present:
Barb Johnston, Executive Director
Kimberly Kirchmeyer, Deputy Director
Susan Cady, Enforcement Program Manager
Candis Cohen, Public Information Officer
Kurt Heppler, Staff Counsel
Armando Melendez, Business Services Office
Cheryl Thompson, Executive Assistant
Linda Whitney, Chief of Legislation

Members of the Audience:
Larry Carlos, Accenture
Sergio Fluieraru, Russian American Media
Jane Fox Garcia, UCD, Family & Community Medicine
Margaret Handley, PH.D., UCSF
Mike Hewitt, Caldorado Group
Don Hilty, M.D., UCD, Rural Program in Medical Education
Bridget Levich, UCD, Chronic Disease Management Program
Jim Matteoni, Intel
Jim Nuovo, M.D., UCD, Family & Community Medicine
Sandra Shewry, California Center for Connected Health
Shelley Palumbo, UCDHS, Center for Health & Technology
George Wu, UCDHS, Center for Health & Technology

Agenda Item 2 Overview of AB 329 and Purpose of Meeting

Ms. Johnston stated the Medical Board is very concerned with patient access to care, addressing this concern in both its mission statement and strategic plan. She thanked Assemblyman Nakanishi for his sponsorship of the AB 329 Legislation.

Ms. Whitney provided an overview of the history of AB 329. The Legislature gave the Medical Board significant flexibility in establishing a telemedicine pilot program, specifying the need to bring together a working group of interested parties to guide the Board in the pilot program and requiring a formal report after a set period of time. Ms. Johnston indicated the Board had been searching for a program for the past 18 months and was pleased to locate a program that met the criteria for the pilot. She reported Abbie French is the Board's Telemedicine Manager who will be the lead on the project.

Agenda Item 3 Presentation of Proposed Telemedicine Pilot Program

Dr. Nuovo, UC Davis' lead for the project, provided an overview of the pilot program which is entitled "Development of a Diabetes Self-Management Education Program Via Telemedicine for Patients in Rural or Underserved Communities in California". He stated this was, in essence, an extension of UCD's Chronic Disease Management Program that would incorporate telemedicine and outreach to underserved rural areas.

Dr. Nuovo reported Type II Diabetes is a world-wide epidemic, with 300 million people expected to have the disease by 2020, disproportionally affecting vulnerable populations. He stated the old way of treating of diabetes was ineffective, providing sporadic, un-centered care. He introduced the Chronic Care Model and provided handouts detailing the model. Dr. Nuovo indicated the goal of the model is to structure care such that the patient is educated about their medical condition and is proactive and participatory in addressing their health needs. The innovative technology supported program will also focus on improving health outcomes specifically for Hispanic and African Americans who suffer disproportionally far greater than other groups. The model also incorporates a proactive practice team, self management support, and clinical information systems, including telemedicine and electronic medical record registries, all of which help improve outcomes. He stated this model was a paradigm shift in the way care is delivered to patients with diabetes or any other chronic health problem.

UC Davis' team for the pilot includes the Chronic Disease Management Program which has been implementing the Chronic Care Model for the past eight years. During this time, they have learned a great deal about teaching self-management support, providing classes and helping physicians provide better care.

Dr. Nuovo stated the pilot program had two goals: first, to test a model for improving access to diabetes self-management training and resources via telemedicine technology for patients in rural and/or medically underserved communities; second, to develop a method, utilizing telemedicine technology, of providing primary care physicians in rural and/or medically underserved areas with information on best practices for diabetes management and care. Dr. Nuovo provided an Executive Summary which detailed these goals and described how the project would be evaluated to determine its impact. He indicated the Center for Health Care Policy and Research will assist in the evaluation, looking at the effectiveness of health education via telemedicine systems, patient coaching in various formats, and other practices.

Shelley Palumbo, UC Davis Center for Health and Technology (Center), indicated her team would assist in the educational classes and continuing medical education courses via telemedicine. The Center has the resources necessary to address any technology issues that might emerge during the pilot. The plan for the pilot calls for working within UC Davis' 33 county service areas with programs that already have well established telemedicine programs. Ms. Palumbo reported an inquiry was sent to the sites the Center works with to determine interest in participating in the pilot program and received a very positive response, with 14 sites immediately expressing their interest in participating.

Bridget Levich, Director of the UC Davis Chronic Disease Management Program (Program), explained the Program's mandate is to work with patients with chronic illness within their health system to improve their health. The Program, which provides self-management support, education and training to these patients, operates with the understanding that everyone self-manages, making daily decisions that will positively or negatively affect their health. Self management support operates via non-judgmental interactions with patients to effect behavior change when the patient is ready. During a previous UC Davis pilot of a two hour telemedicine class, Ms. Levich reported she was able to effectively connect with patients, even those at offsite locations. The feedback from this pilot class was very positive, with participants eager to attend future offerings. A 2-hour class entitled "Let's Get Started", which provides a foundation for diabetes self-management, will likely be the first telemedicine course offered in the pilot, with many other courses to follow.

Ms. Levich indicated coaching by health educators will also be a component of the pilot program. Cultural specificity will likely be addressed by hiring a bilingual health educator and possibly a "cultural broker" who understands the lifestyle and diet within various cultures.

Jane Fox Garcia, UC Davis Family and Community Medicine, addressed the evaluation of the pilot. Ms. Garcia stressed the importance of conducting a rigorous evaluation in order to understand what was effective and the impact of the pilot program. Ms. Garcia also expressed the need for flexibility within the project and the latitude to experiment a bit with the schedule and frequency of course offerings. The Center for Health Care Policy and Research at UC Davis has agreed to collaborate in the design, implementation, and analysis of project outcomes. The analysis will answer questions such as: Are patients willing to participate in this sort of program? Will attendance at the telemedicine classes increase participant's knowledge base about diabetes? Will participants change their health behavior? Will there be improved clinical outcomes? What is the impact of health coaching? Which patients are interested in health coaching and what kinds of coaching are they most interested in receiving? Are providers satisfied that the program is worthwhile for their patients?

Agenda Item 4 Discussion of Proposed Telemedicine Pilot Program

Ms. Johnston asked Dr. Don Hilty, an experienced telemedicine physician who has written extensively on the subject, for his opinion on what would incentivize physicians and patients in the target communities to participate in the program. Dr. Hilty indicated patient satisfaction with telemedicine services has been broadly documented. He stated the video component of telemedicine was critical in establishing a much needed human connection between people, stressing the difference between speaking over the phone versus through a live visual videoconferencing technology. In his own work comparing patients and doctors in rural versus suburban settings, he found that rural patients and doctors were more interested in participating in studies because they wanted access to excellent physicians and treatment programs that might not otherwise be available to them or

that would require extensive travel. Dr. Hilty did not anticipate any difficulty in finding physicians and patients who would be willing to participate in the pilot.

Dr. Hilty spoke briefly about the Rural PRogram in Medical Education (Rural-PRIME), where medical students prepare for careers in rural communities and receive extensive training on the use of telemedicine and simulation equipment. Some of the sites for the telemedicine pilot may have residents who are part of the Rural-PRIME program. Dr. Hilty felt UC Davis' telemedicine sites, particularly the "Centers for Excellence", would be favorable locations for the pilot, since the opportunities for collaboration and teaching of students would be beneficial.

When asked about the timeline for the pilot, Dr. Nuovo explained it is a three-year project. The initial phase is focused on the education component that he and Jane Fox Garcia reported on. They want to make sure they bring in a sufficiently large number of participants for the education portion in order to conduct and evaluate the program effectively. He noted the target number of participants over the three year pilot period is approximately 1,000. Dr. Nuovo indicated the education portion of the pilot program was already well developed within UC Davis' chronic disease management program, can be customized to be language and culture specific, and is recognized by the American Diabetes Association. Dr. Nuovo stated this part of the pilot was ready to start at any time.

As soon as the team members feel confident that the first phase is working successfully, then the second phase, which is health coaching, would start. The final phase will involve the teaching of physicians and will be headed up by Dr. Tom Balsbaugh, UC Davis Residency Director. During this final phase, instruction will focus on helping physicians understand the chronic care model, teaching them how to provide culturally sensitive self-management support, educating them in diabetes drug management, and addressing other common issues.

Ms. Levich indicated in the coaching phase, the health coaches will be the same persons as the health educators, so the coaches will have previously met and worked with the patients, either in person or via telemedicine. In addition to the contact with patients by telemedicine, Dr. Nuovo reported there will also be outreach with site visits in order to ensure personal contact with patients and to create familiarity with staff at the various sites.

Ms Levich stated the plan currently calls for working with six sites per year. They are looking at which sites will strongly support the program and encourage patients to sign up for the education classes. Ms. Levich reported they anticipate reaching between 300 – 350 patients each year through the pilot. During the physician teaching portion of the pilot, telemedicine and CME courses will be transmitted to those physicians who are participating in the program.

Dr. Duruisseau asked about incentives to patients to maintain their participation in the program. Ms. Fox-Garcia reported they will probably offer incentives since it appears that they may be necessary in order to achieve the participation needed for useful outcome data. These incentives, probably a $10 gift card to a grocery or retail store, will likely be offered at the start of the program and again at the end when the patient completes the evaluation tools. A stipend for the participating sites or practices is also likely.

Sandra Shewry, California Center for Connected Health, asked if it was anticipated that third party payers would reimburse for the services during the study. Ms. Johnston indicated this was an excellent point. She stated if the pilot is able to improve health outcomes and control costs, it would be beneficial to involve

policymakers, through education and outreach, to address issues such as who should pay, and whether there are systems in place already that fit well with a program of this nature.

Ms. Shewry reported it is the goal of the California Center for Connected Health (CCCH) to push for telehealth to be more broadly adopted into the California delivery system. The California Health Care Foundation currently provides CCHS's funding and have asked them to look at obstacles in the healthcare system that prevent telemedicine from fulfilling its promise and ability to improve access, deliver high quality care, and possibly provide a more efficient delivery system. These systemic barriers fall into three categories: health facility licensure laws and regulations, professional licensure (including issues such as scope of practice), and reimbursement policies. She stated the telemedicine pilot dealing with chronic disease management was absolutely vital, since most of the previous research has focused on acute and emergency response applications. She indicated self-management is the frontier and where telehealth will blossom. The CCCH's role is not to provide or fund telehealth, but, rather to build a coalition to advocate for policy change.

Ms. Shewry provided a copy of her report entitled Connecting California: The Impact of the Stimulus Package on Broadband and Telehealth Expansion to attendees. In addition to providing funding for electronic medical records through Medicaid and Medicare, stimulus dollars are available for broadband and telehealth. Ms. Shewry reported on the California Telehealth Network, currently being administered by the University of California, which is a cooperative of 500-700 non-profit health care providers throughout California whose broadband costs will be subsidized by the Federal Communications Commission (FCC). CCCH would like the state of California to ask for Broadband Technology Opportunities Program (BTOP) monies in order to expand the number of subsidized sites up to 2000. Although traditionally targeted to rural settings, sixty percent of the network sites will probably be underserved, non-profit health providers in urban cores that cannot afford broadband. Hence, there will be both rural and urban applicability for the BTOP funds.

Ms. Shewry also reported on the Distance Learning, Telemedicine and Broadband Program (DLTB) administered by the USDA Rural Utility Service, which also provides states and organizations with significant resources for broadband, telehealth, and distance learning in rural areas. CCCH believes these funds could be used in conjunction with the California Telehealth Network to set up training programs and regional resource centers on how to implement telemedicine. Lessons that were learned from the telemedicine pilot would be helpful in setting up these programs and centers. It is likely that "detailers" will be necessary to visit telehealth sites in order to assist in the technical and application components of the program.

Ms. Shewry reported the Indian Health Service (IHS) has received appropriations from the stimulus program for health IT activities such as electronic records and telemedicine broadband capabilities. In addition, Federally Qualified Health Centers (FQHCs) have also received capital funding for equipment and improvements in the health centers.

Ms. Shewry summarized by stating a large amount of money will be channeled to community clinics through the stimulus bill, with enormous opportunity to implement technology based innovations that would help them deliver better care and improve outcomes for their members.

Mike Hewitt, Caldorado Group, noted the pilot program under discussion targets a very small population over a very long period of time. He asked if the program was adjusted a bit if it would qualify for some of the stimulus funds Ms. Shewry spoke about in order to implement the program on a wider scale at a faster pace. Mr. Hewitt

felt the questions about the effectiveness of telehealth had already been answered by previous studies. Ms. Johnston responded that the Governor's Office has not decided who will be managing the stimulus money; once this issue is decided and infrastructure within the government is in place, then discussion and negotiations can begin. For now, Ms. Johnston stated the pilot will be conducted within the parameters and requirement of AB 329. Should stimulus money become available in the future, it would be possible to expand the pilot. Ms. Johnston indicated this pilot was a "shovel ready" project with many components already in place.

Ms. Johnston asked Jim Matteoni if there was anything Intel was doing that might prove complementary to the goals of the pilot program. Mr. Matteoni with Intel asked, in addition to the pilot's goals of providing patient education, self-management, and establishing connectedness between the patient and caregiver, if it was possible to explore the possibility of accomplishing these goals from the patient's home. He stated the technology for this is currently available. He'd like to see a comparison between a patient going to a telehealth clinic or site versus attending and accessing this same type of information from their own home via a device that allows them to view the education program whenever they wanted. Mr. Matteoni said a personalized care plan, which could incorporate the "Decision Wheel" currently being used in the health consultations and coaching, could also be accessed through a home device. He thought a parallel project would be particularly interesting.

Dr. Nuovo asked Dr. Margaret Handley, UC San Francisco, about Automated Telephone Disease Management Program, particularly for non-English speakers in their safety net clinics. Dr. Handley reported UCSF has conducted projects that compare outcomes for patients who come to a clinic versus those who receive automated telephone support in their homes. In this model, the patient receives an automated query each week in their language at a time of their choosing where they answer seven questions related to their diabetes self-management activities. During the call, they can also opt into narratives about issues they might be struggling with. Those responses are relayed back to a centralized center and are reviewed by a nurse care manager to look for red flags for patients who might require follow-up calls. These patients are then engaged by a nurse care manager who, in their language, counsels them toward action plans or specific behavior change activities to work on in the next two weeks with follow-up. This methodology had been particularly effective in reaching patients who do not speak English well. Dr. Handley thought this might be a good coaching option to offer to patients in the pilot who have difficulty getting to the pilot sites. They have found this to be a cost effective model with strong self-management behavior change. Dr. Handley reported the State Diabetes Program is also interested in promoting telemedicine smoking cessation programs and others that complement diabetes management.

Sergiu Fluieraru, who introduced himself as a member of the Russian American Media, was in attendance and was welcomed by Ms. Johnston who was pleased to have found a contact person for the Russian speaking community. Dr. Nuovo noted UCD has a fairly large Russian population in their practice and have conducted group visits for Russian patients. Ms. Levich reported that shared medical appointments and classes, mostly nutrition based, have been conducted for Russian speaking patients with a Russian interpreter. She noted that it is often difficult to engage the Russian patients in attending classes and felt it would be more effective to take the educators out to the community to churches or community centers where the patients might feel more comfortable. Ms. Johnston described the previous success of a program that set up telemedicine in a Korean church in San Francisco; the program grew from a single system that was offered once a week after Sunday services, to one that eventually included ten telemedicine systems and was offered seven days a week.

Ms. Johnston thanked everyone for participating and closed the meeting by expressing her desire to continue the communication on telemedicine.

Agenda Item 5 Adjournment