ENFORCEMENT DATA AND REPORTS.

BOT ENFORCEMENT STATISTICAL REPORT
April 1, 2016 – June 30, 2016

Total Complaints-Received: 83

Conviction/Arrest Investigations: 41
(included in total complaints above)

Complaints-Closed: 37

Total Complaints-Pending: 529 (Oldest: 10/09/13)

DOI Investigations Initiated: 1

DOI Investigation Reports Received: 2

Formal DOI Investigations Pending: 3

Applications Denied pursuant to Business and Professions Code 480/485: 0

Cases Pending with the Attorney General (AG): 13

Transmitted	Complaint No	Type	Current Status
03/16/15	OT 2012-448	Accusation	Accusation filed 11/02/15; NOD rcvd 01/30/15; Stipulated Settlement in process
04/01/15	OT 2012-545	Accusation	Accusation filed 08/28/15; NOD rcvd 09/17/15; Hearing 07/21/16
08/18/15	OT 2014-485	Accusation	Accusation filed 11/02/15; NOD 11/17/15; Bd rejd Stip 06/23/16; rev stip pending
08/28/15	OT 2012-404	Accusation	Accusation filed 02/10/16; NOD rcvd 02/22/16; Stip Settlement in process
10/28/15	OT2014-223	Accusation	Accusation filed 05/17/16; no NOD, default being drafted
11/13/15	OT2014-320	BPC 820	Petition for Mental Evaluation; Evaluation completed; No action TBT; closed 07/27/16
11/16/15	AR2015-4	SOI	Lic denied 09/15/15; Appeal rcvd 11/13/15; SOI filed 03/29/16; Hearing 10/06/16
12/29/15	AR2015-90	SOI	Lic denied 09/23/15; Appeal rcvd 10/05/15; SOI filed 06/16/16; Hearing 02/01/17
02/23/16	1002145006	Accusation	Accusation filed 06/08/16; NOD rcvd 06/22/16; Hearing 10/19/16
02/23/16	1002154080	Accusation	Accusation filed 07/29/16; NOD rcvd 08/03/16; Hearing TBS
02/29/16	1002052064	PETP/PMOD	Board heard petition at May 19, 2016 meeting; decision terminating probation effective 8/6/2016
03/09/16	1002044419	Pet Revoke Prob	Acc&PTR filed 07/15/16; no NOD, default being drafted
03/24/16	2016000011	Accusation	Accusation to be drafted

Statement of Issues filed: 1
Petition to Revoke Probation filed: 0
ISO Issued: 0

Accusations filed: 2
Accusation & Petition to Revoke Probation filed: 0
PC23 Issued: 0

Final Decisions: 3

Effective	Name	Type	Complaint Received
06/03/16	Knoefler, Kolee	Three (3) year probation (stipulated settlement)	12/29/14
06/03/16	Powell, Diana	Three (30 year probation (stipulated settlement)	01/02/15
06/23/16	Lombardo, Patricia	Three (3) year probation (by hearing)	04/07/14

Cease Practice Orders (BPC 315.2) Issued: 0

Cease Practice Orders Lifted: 0

Report updated 08/09/2016

Citations Issued
3/1/2016 - 7/31/2016

#	LICENSURE CLASSIFICATION			VIOLATION						CIT. #	FINE (OT)	OT Fine Modified	GRAND TOTAL FINE DUE (OT)	FINE (OTA)	OTA Fine Modified	GRAND TOTAL FINE DUE (OTA)	DATE ISSUED	Appeal Rcvd		PAYMENT				
	OT	OTA	No Lic	FDC	UPC	CC	ULP	PDU	AD									ICR	ADMIN	Pymnt Date	Pd in Full	Pymnt Amnt	Bal (OT)	Bal (OTA)
	1			1						16-000014				$250		$250	03/11/16	1		04/13/16	1	$250	$0	$0
	1							1		OA 2014-533				$250		$250	03/11/16						$0	$250
1								1		OT 2013-499	$250		$250				03/29/16			Withdrawn			$0	$0
1	1						1			OT 2014-91	$600	$150	$450				04/26/16	1					$600	$150
1	1						1			OT 2015-106	$2,200		$2,200				04/26/16			05/02/16	1	$2,200	$0	$0
1		1						1		OA 2014-644				$250		$250	05/04/16			05/16/16	1	$250	$0	$0
1	1						1			OT 2014-392	$350		$350				06/24/16						$350	$0
1	1						1		1	OT 2014-523	$1,150		$1,150				06/24/16						$1,150	$0
1	1							1		OT 2014-730	$600	$0	$0				07/06/16	1		Dismissed			$0	$0
1	1							1		OT 2015-79	$600	$0	$0				07/06/16	1		Withdrawn			$0	$0
1		1						1		OA 2015-81				$600	$0	$0	07/06/16	1		Withdrawn			$0	$0
1		1						1		OA 2015-210				$600		$600	07/06/16						$0	$600
1	1							1		OT 2014-662	$250		$250				07/15/16						$250	$0
1	1							1		OT 2014-663	$600		$600				07/15/16						$600	$0
1	1							1		16-000049	$600		$600				07/15/16						$600	$0
1	1							1		OT 2015-209	$600		$600				07/15/16						$600	$0
1	1							1		OT 2015-208	$600		$600				07/15/16						$600	$0
1	1							1		OT 2015-134	$250		$250				07/15/16						$250	$0
1	1							1		OT 2015-237	$250		$250				07/15/16						$250	$0
1		1						1		2014-697	$250		$250				07/15/16						$250	$0
1		1						1		2015-155	$600		$600				07/15/16						$600	$0
1		1						1		2014-662	$600		$600				07/15/16						$600	$0
1		1						1		2014-661	$600		$600				07/15/16						$600	$0
1		1						1		16-000027	$600		$600				07/15/16						$600	$0
TOTALS:																								
22	15	8	0	1	0	0	4	19	1		$11,550	$150	$10,200	$1,950	$0	$1,350		5	0		3	$2,700	$7,900	$1,000

Practitioners Currently on Probation or Other Court Orders

NAME	LICENSE #	LENGTH OF PROBATION	EFFECTIVE DATE
Allen, Cornell Jr.	OT 9187	n/a	07/10/13
Brown, Charles Stanley	OT 5525	n/a	08/12/15
Cox, Charlotte	OTA 3400	2 Years	12/07/15 12/28/15
Darrow, Colleen	OT 11844	4 Years	06/26/14
DeMena, Alan	OTA 466	3 Years	06/27/14
Gaeta, Adriana	OTA 1404	3 years	06/18/15
Hanvey, Megan P.	OT 2222	3 Years	08/30/13
Kelley, Anjuli	OT 11168	3 Years	01/16/14*
Knoefler, Kolee	OT 8115	3 Years	06/03/16
Lombardo, Patricia	OT 2792	3 Years	06/23/16
Martinez, Sharon	OTA 3067	3 Years	01/13/15
Meyer, Lisa M	OT 14107	3 Years	02/13/14
Mustafa, Feras A.R.	OT 13960	3 Years	11/12/13
Necesito, Dennis B.	OT 7360	4 Years	08/30/13
Neff, Heather L.	OT 7629	3 Years	07/11/14
Ngo, Nicole U.	OT 14773	3 Years	10/27/14
Perez, Thomas J.	OTA 2470	5 years	01/09/13
Powell, Diana C.	OT 6367	3 years	06/03/16
Retuya, Tristan	OT 12378	3 years	12/04/13
Schmidt, Rebecca	OT 8291	3 Years	11/27/09 *
Sweeney, Lynette	OT 10550	2 Years	09/27/13

* Probation "tolled" or extended beyond original expiration date.

Executive Officer's Report.

a. **Operational Report**
b. **Budget Update**
c. **BreEZe Update**
d. **Future Agenda Items**
e. **Other Informational Items – No Board discussion or action**

Date: August 10, 2016

To: CBOT Members

From: Heather Martin, Executive Officer

Subject: Executive Officer Report – Board Meeting August 18-19, 2016

Items covered:

a) Operational Report
b) Budget Update
c) BreEZe Update
d) Future Agenda Items
e) Other Informational Items

a) Operational Report

The Board recently filled a vacancies in Licensing and in Enforcement and hired a Retired Annuitant to assist with preparation of the Sunset Report, and the filling of the six Enforcement vacancies. The recruitment efforts for Enforcement include advertising, screening, interviewing, hiring, on-boarding, training, etc. for:

- Three (3) staff services analysts (SSAs) in Enforcement;
- One and one-half office technicians in Licensing;
- Reclassification of one analyst position to a Manager position, followed by
- Two (2) associate governmental program analysts (AGPAs) in Enforcement

We are about to begin the recruitment process for an additional position to assist in Licensing.

b) Budget Update

The 2015/16 final revenue and expenditure information was not available as of 8/10, however, may become available by the date of the meeting; if so, handouts will be provided.

c) BreEZe Update:

The Board has successfully transitioned to the new BrEZe system on Tuesday, January 19th. As more people, become familiar with the system, more applicants and licensees are submitting transactions (renewals, initial license applications, address changes, name changes, duplicate license requests, etc.) on-line in BreEZe.

Data regarding the number of transactions submitted on-line will be provided verbally.

d) Future Agenda Items

The items shown below will be addressed at a future meeting.

1. Ad hoc committee's recommendation regarding occupational therapists performing the physically invasive components of a swallowing evaluation.
2. Development/review of Sunset Review report.
3. Practice Committee appointments.
4. Practice Committee's recommendation on records retention requirement for an occupational therapy business that closes or is sold or if the practitioner is no longer in private practice.
5. Review/update of Board Member Administrative Manual.
6. Review/update of Board Member Disciplinary Resource Manual.
7. Review/update of Board's Disciplinary Guidelines (requires regulatory amendments).

e) Other Informational Items

- *Health Workforce Projections: Occupational Therapy and Physical Therapy* by the US Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis
- *Health Workforce Projections: Healthcare Support Occupations* by the US Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis
- *Telehealth: Policy Trends and Considerations* by the National Conference of State Legislatures

DEPARTMENT Or CONSUMER AFFAIRS

CA BD OF OCCUPATIONAL THERAPY

BUDGET REPORT

AS OF 6/30/2016

FM 13

RUN DATE 8/11/2016

CA BD OF OCCUPATIONAL THERAPY

	DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
PERSONAL SERVICES								
SALARIES AND WAGES								
003 00	CIVIL SERVICE-PERM	354,000	431	279,382	0	279,382	74,618	
033 04	TEMP HELP (907)	4,000	2,070	15,021	0	15,021	(11,021)	
063 00	STATUTORY-EXEMPT	82,000	0	87,341	0	87,341	(5,341)	
063 01	BD/COMMSN (901,920	20,000	0	1,500	0	1,500	18,500	
083 00	OVERTIME	0	0	4,343	0	4,343	(4,343)	
TOTAL SALARIES AND WAGES		460,000	2,501	387,587	0	387,587	72,413	15.74%
STAFF BENEFITS								
101 00	STAFF BENEFITS	0	46	46	0	46	(46)	
103 00	OASDI	34,000	0	22,193	0	22,193	11,807	
104 00	DENTAL INSURANCE	2,000	0	1,531	0	1,531	469	
105 00	HEALTH/WELFARE INS	92,000	0	51,578	0	51,578	40,422	
106 01	RETIREMENT	103,000	0	92,122	0	92,122	10,878	
125 00	WORKERS' COMPENSAT	10,000	0	0	0	0	10,000	
125 15	SCIF ALLOCATION CO	0	0	3,658	0	3,658	(3,658)	
132 00	NONINDUST DISABLTY	2,000	0	0	0	0	2,000	
133 00	UNEMPLOYMENT INSUR	3,000	0	0	0	0	3,000	
134 00	OTHER-STAFF BENEFI	0	0	22,569	0	22,569	(22,569)	
134 01	TRANSIT DISCOUNT	0	0	130	0	130	(130)	
135 00	LIFE INSURANCE	0	0	83	0	83	(83)	
136 00	VISION CARE	1,000	0	639	0	639	361	
137 00	MEDICARE TAXATION	5,000	0	5,400	0	5,400	(400)	
TOTAL STAFF BENEFITS		252,000	46	199,950	0	199,950	52,050	20.65%
TOTAL PERSONAL SERVICES		712,000	2,547	587,537	0	587,537	124,463	17.48%
OPERATING EXPENSES & EQUIPMENT								
FINGERPRINTS								
213 04	FINGERPRINT REPORT	22,000	2,744	20,923	0	20,923	1,077	
TOTAL FINGERPRINTS		22,000	2,744	20,923	0	20,923	1,077	4.90%
GENERAL EXPENSE								
201 00	GENERAL EXPENSE	20,000	0	0	0	0	20,000	
206 00	MISC OFFICE SUPPLI	0	0	6,630	98	6,727	(6,727)	
207 00	FREIGHT & DRAYAGE	0	0	132	0	132	(132)	
213 02	ADMIN OVERHEAD-OTH	0	153	2,220	0	2,220	(2,220)	

CA BD OF OCCUPATIONAL THERAPY

	DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
217 00	MTG/CONF/EXHIBIT/S	0	0	993	0	993	(993)	
223 00	LIBRARY PURCH/SUBS	0	0	3	0	3	(3)	
TOTAL GENERAL EXPENSE		20,000	153	9,978	98	10,075	9,925	49.62%
PRINTING								
241 00	PRINTING	6,000	0	0	0	0	6,000	
242 02	REPRODUCTION SVS	0	0	3	0	3	(3)	
242 03	COPY COSTS ALLO	0	0	1,940	0	1,940	(1,940)	
242 04	EDD PRODUCTIONS	0	0	2,541	0	2,541	(2,541)	
242 05	METRO PRINT/MAIL	0	886	3,659	0	3,659	(3,659)	
244 00	OFFICE COPIER EXP	0	0	880	500	1,380	(1,380)	
TOTAL PRINTING		6,000	886	9,023	500	9,523	(3,523)	-58.71%
COMMUNICATIONS								
251 00	COMMUNICATIONS	6,000	0	0	0	0	6,000	
253 00	CENT COMM (CALNET,	0	0	1,099	0	1,099	(1,099)	
257 01	TELEPHONE EXCHANGE	0	0	1,097	0	1,097	(1,097)	
TOTAL COMMUNICATIONS		6,000	0	2,195	0	2,195	3,805	63.41%
POSTAGE								
261 00	POSTAGE	11,000	0	0	0	0	11,000	
262 00	STAMPS, STAMP ENVE	0	0	1,904	0	1,904	(1,904)	
263 05	DCA POSTAGE ALLO	0	1,167	7,348	0	7,348	(7,348)	
263 06	EDD POSTAGE ALLO	0	(900)	4,334	0	4,334	(4,334)	
TOTAL POSTAGE		11,000	267	13,587	0	13,587	(2,587)	-23.51%
TRAVEL: IN-STATE								
291 00	TRAVEL: IN-STATE	16,000	0	0	0	0	16,000	
292 00	PER DIEM-I/S	0	3,770	12,090	0	12,090	(12,090)	
294 00	COMMERCIAL AIR-I/S	0	0	9,556	0	9,556	(9,556)	
294 02	BAGGAGE FEE	0	0	75	0	75	(75)	
296 00	PRIVATE CAR-I/S	0	0	2,519	0	2,519	(2,519)	
297 00	RENTAL CAR-I/S	0	505	2,830	0	2,830	(2,830)	
301 00	TAXI & SHUTTLE SER	0	0	82	0	82	(82)	
305 00	MGMT/TRANS FEE-I/S	0	0	378	0	378	(378)	
305 01	CALATERS SERVICE F	0	85	294	0	294	(294)	
TOTAL TRAVEL: IN-STATE		16,000	4,359	27,824	0	27,824	(11,824)	-73.90%
TRAINING								
331 00	TRAINING	2,000	0	0	0	0	2,000	

CA BD OF OCCUPATIONAL THERAPY

	DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
332 00	TUITN/REGISTRATN F	0	1,000	1,000	0	1,000	(1,000)	
TOTAL TRAINING		2,000	1,000	1,000	0	1,000	1,000	50.00%
FACILITIES OPERATIONS								
341 00	FACILITIES OPERATI	45,000	0	0	0	0	45,000	
343 00	RENT-BLDG/GRND(NON	0	0	79,206	0	79,206	(79,206)	
347 00	FACILITY PLNG-DGS	0	135	1,624	0	1,624	(1,624)	
TOTAL FACILITIES OPERATIONS		45,000	135	80,830	0	80,830	(35,830)	-79.62%
C/P SVS - EXTERNAL								
402 00	CONSULT/PROF SERV-	26,000	0	0	0	0	26,000	
404 05	C&P EXT ADMIN CR C	0	0	3,793	12,049	15,842	(15,842)	
409 00	INFO TECHNOLOGY-EX	0	0	1,430	0	1,430	(1,430)	
TOTAL C/P SVS - EXTERNAL		26,000	0	5,222	12,049	17,271	8,729	33.57%
DEPARTMENTAL SERVICES								
424 03	OIS PRO RATA	215,000	(2,159)	212,841	0	212,841	2,159	
427 00	INDIRECT DISTRB CO	94,000	(99)	93,901	0	93,901	99	
427 30	DOI - ISU PRO RATA	3,000	(51)	2,949	0	2,949	51	
427 34	COMMUNICATIONS PRO	6,000	0	6,000	0	6,000	0	
TOTAL DEPARTMENTAL SERVICES		318,000	(2,309)	315,691	0	315,691	2,309	0.73%
CONSOLIDATED DATA CENTERS								
428 00	CONSOLIDATED DATA	0	1	118	0	118	(118)	
TOTAL CONSOLIDATED DATA CENTERS		0	1	118	0	118	(118)	0.00%
DATA PROCESSING								
431 00	INFORMATION TECHNO	4,000	0	0	0	0	4,000	
445 00	SOFTWARE-IT PURCH,	0	0	2,717	0	2,717	(2,717)	
446 00	HARDWARE-IT PURCH,	0	0	1,295	0	1,295	(1,295)	
449 00	ELECT WASTE RECYCL	0	0	6	20	26	(26)	
TOTAL DATA PROCESSING		4,000	0	4,018	20	4,038	(38)	-0.96%
CENTRAL ADMINISTRATIVE SERVICES								
438 00	PRO RATA	66,000	0	65,704	0	65,704	296	
TOTAL CENTRAL ADMINISTRATIVE SERVICES		66,000	0	65,704	0	65,704	296	0.45%
EXAMINATIONS								
404 03	C/P SVS - EXT SUB	0	500	3,575	4,817	8,392	(8,392)	
TOTAL EXAMINATIONS		0	500	3,575	4,817	8,392	(8,392)	0.00%

DEPARTMENT Or CONSUMER AFFAIRS

CA BD OF OCCUPATIONAL THERAPY

BUDGET REPORT

AS OF 6/30/2016

FM 13

RUN DATE 8/11/2016

CA BD OF OCCUPATIONAL THERAPY

	DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
ENFORCEMENT								
396 00	ATTORNEY GENL-INTE	133,000	7,977	69,050	0	69,050	63,950	
397 00	OFC ADMIN HEARNG-I	1,000	9,522	20,974	0	20,974	(19,974)	
414 31	EVIDENCE/WITNESS F	0	500	3,107	2,500	5,606	(5,606)	
414 34	EVIDENCE	0	200	200	0	200	(200)	
418 97	COURT REPORTER SER	0	500	1,090	0	1,090	(1,090)	
427 31	DOI - INVESTIGATIO	41,000	(679)	40,321	0	40,321	679	
TOTAL ENFORCEMENT		175,000	18,020	134,741	2,500	137,240	37,760	21.58%
MINOR EQUIPMENT								
226 00	MINOR EQUIPMENT	8,000	0	0	0	0	8,000	
226 10	MIN EQPMT-GEN-ADD'	0	0	1,053	0	1,053	(1,053)	
226 15	MIN EQPMT-GEN-REPL	0	0	4,212	0	4,212	(4,212)	
226 40	MIN EQPMT-DP-ADD'L	0	0	1,295	0	1,295	(1,295)	
226 45	MIN EQPMT-DP-REPL	0	0	0	3,375	3,375	(3,375)	
226 50	MIN EQPMT-PHONE-AD	0	0	0	3,173	3,173	(3,173)	
TOTAL MINOR EQUIPMENT		8,000	0	6,560	6,548	13,108	(5,108)	-63.85%
TOTAL OPERATING EXPENSES & EQUIPMEN		725,000	25,757	700,980	26,531	727,521	(2,521)	-0.35%
CA BD OF OCCUPATIONAL THERAPY		1,437,000	28,304	1,288,526	26,531	1,315,057	121,943	8.49%
		1,437,000	28,304	1,288,526	26,531	1,315,057	121,943	8.49%

DEPT OF CONSUMER AFFAIRS - REGULATORY BOARDS
RECEIPTS BY ORGANIZATION AND SOURCE
AS OF 06/30/16

ENY: 15 FFY: 15
SECTION: 11 CA BD OF OCCUPATIONAL THERAPY
SUB-SECTION: 00
UNIT: 00
SUB-UNIT: 00
SUB-SUB-UNIT: 00
INDEX: 1475 CA BD OF OCCUPATIONAL THERAPY

PROGRAM PG EL CMP TSK	PCA	DESCRIPTION				
REF	SOURCE	ASRC	DESCRIPTION	PLANNED RECEIPTS	ACTUAL RECEIPTS CURRENT MONTH	ACTUAL RECEIPTS YEAR-TO-DATE	BALANCE
67 00 000 000		73017	REIMB - CA BD OF OCCUPATIONAL THERAPY				
001	991937	01	FINGERPRINT REPORTS	22,000.00	0.00	23,258.00	1,258.00-
001	991937	02	EXTERNAL/PRIVATE/GRANT	0.00	0.00	5,875.00	5,875.00-
*TOTAL SOURCE 991937				22,000.00	0.00	29,133.00	7,133.00-
001	995988	01	UNSCHED-INVESTIGATIVE COST RECOVE	0.00	0.00	2,899.00	2,899.00-
*TOTAL SOURCE 995988				0.00	0.00	2,899.00	2,899.00-
*TOTAL PROG 67				22,000.00	0.00	32,032.00	10,032.00-
*TOTAL REFERENCE 001				22,000.00	0.00	32,032.00	10,032.00-
67 00 000 000		83017	REVENUE CA BD OF OCCUPATIONAL THERAPY				
980	125600	CU	OTA DUP LIC FEE-$15.00	0.00	0.00	2,640.00	2,640.00-
980	125600	CV	OTA DUP CERT FEES-$15.00	0.00	0.00	675.00	675.00-
980	125600	FT	CITATION/FINE FTB COLLECTION	0.00	0.00	249.64	249.64-
980	125600	00	OTHER REGULATORY FEES	33,000.00	0.00	0.00	33,000.00
980	125600	18	CITATION & FINE FEE COLLECTED-VAR	0.00	0.00	15,675.00	15,675.00-
980	125600	90	OVER/SHORT FEES	0.00	0.00	7.00	7.00-
*TOTAL SOURCE 125600				33,000.00	0.00	19,246.64	13,753.36
980	125700	OC	OT INITIAL LIC FEE-$VAR	0.00	0.00	117,281.00	117,281.00-
980	125700	OD	OTA INITIAL CERT FEE-$VAR	0.00	0.00	43,144.00	43,144.00-
980	125700	OE	OT LIMITED PERMIT-$75.00	0.00	0.00	3,900.00	3,900.00-
980	125700	OJ	OTA LIMITED PERMIT $75.00	0.00	0.00	600.00	600.00-
980	125700	UE	OT RETIRED STATUS FEE-$25	0.00	0.00	375.00	375.00-
980	125700	UG	OTA RETIRED STATUS FEE-$25	0.00	0.00	125.00	125.00-
980	125700	UM	OT APPLICATION FEE-$50	0.00	0.00	54,898.00	54,898.00-
980	125700	UN	OTA APPLICATION FEE-$50	0.00	0.00	19,898.00	19,898.00-
980	125700	00	OTHER REGULATORY LICENSES AND PER	242,000.00	0.00	0.00	242,000.00
980	125700	90	OVER/SHORT FEES	0.00	0.00	616.99	616.99-

DEPT OF CONSUMER AFFAIRS - REGULATORY BOARDS
RECEIPTS BY ORGANIZATION AND SOURCE
AS OF 06/30/16

ENY: 15 FFY: 15
SECTION: 11 CA BD OF OCCUPATIONAL THERAPY
SUB-SECTION: 00
UNIT: 00
SUB-UNIT: 00
SUB-SUB-UNIT: 00
INDEX: 1475 CA BD OF OCCUPATIONAL THERAPY

PROGRAM
PG EL CMP TSK PCA DESCRIPTION

REF	SOURCE	ASRC	DESCRIPTION	PLANNED RECEIPTS	ACTUAL RECEIPTS CURRENT MONTH	ACTUAL RECEIPTS YEAR-TO-DATE	BALANCE
980	125700	91	SUSPENDED REVENUE	0.00	490.00-	8,307.00	8,307.00-
980	125700	92	PRIOR YEAR REVENUE ADJUSTMENT	0.00	0.00	85.00-	85.00
*TOTAL SOURCE 125700				242,000.00	490.00-	249,059.99	7,059.99-
980	125800	BP	OT INACTIVE RENEWAL LIC FEE-$25.0	0.00	0.00	9,100.00	9,100.00-
980	125800	BQ	OTA INACTIVE RENEWAL CERT FEE-$25	0.00	0.00	1,225.00	1,225.00-
980	125800	C1	AUTOMATED REVENUE REFUND CLAIM	0.00	35.00-	0.00	0.00
980	125800	00	RENEWAL FEES	983,000.00	0.00	0.00	983,000.00
980	125800	2W	BIENNIAL RENEWAL-OT $150	0.00	0.00	794,000.00	794,000.00-
980	125800	2X	BIENNIAL RENEWAL-OTA $150	0.00	490.00	162,815.00	162,815.00-
980	125800	90	OVER/SHORT FEES	0.00	0.00	22.50	22.50-
*TOTAL SOURCE 125800				983,000.00	455.00	967,162.50	15,837.50
980	125900	TM	DELINQ BIENNIAL-OT-$75	0.00	0.00	14,025.00	14,025.00-
980	125900	TN	DELINQ BIENNIAL-OTA $75	0.00	0.00	2,250.00	2,250.00-
980	125900	00	DELINQUENT FEES	15,000.00	0.00	0.00	15,000.00
*TOTAL SOURCE 125900				15,000.00	0.00	16,275.00	1,275.00-
980	141200	00	SALES OF DOCUMENTS	0.00	0.00	22.00	22.00-
*TOTAL SOURCE 141200				0.00	0.00	22.00	22.00-
980	142500	00	MISCELLANEOUS SERVICES TO THE PUB	21,000.00	0.00	0.00	21,000.00
980	142500	90	MISC. SER TO PUBLIC - GENERAL	0.00	0.00	22,295.00	22,295.00-
*TOTAL SOURCE 142500				21,000.00	0.00	22,295.00	1,295.00-
980	150300	00	INCOME FROM SURPLUS MONEY INVESTM	8,000.00	4,164.84	13,638.25	5,638.25-

DEPT OF CONSUMER AFFAIRS - REGULATORY BOARDS
RECEIPTS BY ORGANIZATION AND SOURCE
AS OF 06/30/16

ENY: 15 FFY: 15
SECTION: 11 CA BD OF OCCUPATIONAL THERAPY
SUB-SECTION: 00
UNIT: 00
SUB-UNIT: 00
SUB-SUB-UNIT: 00
INDEX: 1475 CA BD OF OCCUPATIONAL THERAPY

PROGRAM PG EL CMP TSK	PCA	DESCRIPTION				
REF	SOURCE	ASRC	DESCRIPTION	PLANNED RECEIPTS	ACTUAL RECEIPTS CURRENT MONTH	ACTUAL RECEIPTS YEAR-TO-DATE	BALANCE
*TOTAL SOURCE 150300				8,000.00	4,164.84	13,638.25	5,638.25-
980	161000	00	ESCHEAT OF UNCLAIMED CHECKS,WARRA	1,000.00	0.00	0.00	1,000.00
980	161000	02	REVENUE CANCELLED WARRANTS	0.00	0.00	949.00	949.00-
*TOTAL SOURCE 161000				1,000.00	0.00	949.00	51.00
980	161400	91	DISHONORED CHECK FER-VAR	0.00	0.00	500.00	500.00-
*TOTAL SOURCE 161400				0.00	0.00	500.00	500.00-
980	164300	00	PENALTY ASSESSMENTS	20,000.00	0.00	0.00	20,000.00
980	164300	99	PENALTY ASSESSMENTS	0.00	0.00	16,446.00	16,446.00-
*TOTAL SOURCE 164300				20,000.00	0.00	16,446.00	3,554.00
*TOTAL PROG 67				1,323,000.00	4,129.84	1,305,594.38	17,405.62
*TOTAL REFERENCE 980				1,323,000.00	4,129.84	1,305,594.38	17,405.62
*TOTAL INDEX 1475				1,345,000.00	4,129.84	1,337,626.38	7,373.62
*TOTAL SEC 11				1,345,000.00	4,129.84	1,337,626.38	7,373.62

Health Workforce Projections: Occupational Therapy and Physical Therapy

KEY FINDINGS

Between 2012 and 2025:

- Supply is estimated to grow by 46 percent for occupational therapists and 33 percent for physical therapists.
- Demand is estimated to grow by 20 percent for occupational therapists and 23 percent for physical therapists.
- The projected supply of individuals in each occupation exceeds the projected growth in service demand for occupational therapists and physical therapists.

This fact sheet presents the national supply and demand for occupational and physical therapists between 2012 and 2025 using HRSA's Health Workforce Simulation Model (HWSM).[1] While the nuances of modeling supply and demand differ for individual health professions, the basic framework remains the same. The HWSM assumes that demand equals supply in the base year. For supply modeling, the major components (beyond common labor-market factors like unemployment) include characteristics of the existing workforce in a given occupation, new entrants to the workforce (e.g., newly trained workers), and workforce decisions (e.g., retirement and hours worked patterns). For demand modeling, the major components include population demographics, health care use patterns (including the influence of the Affordable Care Act insurance coverage), and demand for health care services (translated into requirements for Full-Time Equivalents). Over the period studied, the model assumes that current national patterns of labor supply and service demand remain unchanged within each demographic group.[2] These projections do not account for the geographical distribution of providers which may impact access to care in certain areas/communities.

BACKGROUND

Occupational therapy is a health, wellness, and rehabilitation profession that helps individuals maximize their performance and functioning throughout the lifespan. Occupational therapists are prepared at the Master's or Doctoral level. They assess and treat people who are injured, ill, or disabled and help them to recover, improve, and develop skills needed for daily living and working. Examples of common occupational therapy interventions include: helping people recovering from strokes to regain life skills, supporting elderly individuals with cognitive-behavioral or physical impairments to improve their functionality, and helping children born with disabilities to fully participate in daily activities.

Physical therapists are professionals providing rehabilitation, habilitation, preventive, and risk reduction services for patients. New physical therapists are now prepared at the doctoral level. Physical therapists help assess, maintain, restore, and improve movement, activity, and health to enable individuals to enjoy optimal physical function.

[1] This model uses a micro-simulation approach where supply is projected based on the simulation of career choices of individual health workers. Demand for health care services is simulated for a representative sample of the current and future U.S. population based on each person's demographic and socioeconomic characteristics, health-related behavior, and health risk factors that affect their health care utilization patterns. For more information on data and methods, please see http://bhw.hrsa.gov/healthworkforce/supplydemand/simulationmodeldocumentation.pdf.

[2] Ono T, Lafortune G, Schoenstein M. "Health workforce planning in OECD countries: a review of 26 projection models from 18 countries." *OECD Health Working Papers, No. 62*. France: OECD Publishing; 2013:8-11.

CA Board of Occupational Therapy

Applications Approved

Trans #	Transaction Type	Feb	Mar	Apr	May	June	July	Total for 6 months	Avg per Month
1021	Initial License	92	128	117	106	147	136	726	121
2020	Renewal	393	494	485	544	534	495	2,945	491
8020	Address change	179	204	180	223	209	261	1,256	209
8030	Verification	34	37	52	43	64	76	272	45
5001	A/P – hands	0	3	5	2	8	1	19	3
5002	A/P – PAMs	0	12	12	0	10	2	36	6
5003	A/P - Swallowing	3	7	4	0	8	2	24	4
Monthly Trans Total		701	885	855	918	980	973	5,278	880

* More info to be provided (received and approved) at next meeting and on-going

FINDINGS

Between 2012 and 2025, supply is estimated to grow by 46 percent for occupational therapists and 33 percent for physical therapists (Exhibit 1). The demand for occupational therapists is projected to grow by 20 percent and demand for physical therapists is projected to grow by 23 percent. Thus, the projected growth in supply exceeds the projected growth in demand for services for both occupational therapists and physical therapists. These projections suggest that the U.S. should have a more than sufficient supply of occupational therapists and physical therapists to meet the projected growth in demand for services by 2025.

EXHIBIT 1. Estimated Supply and Demand for Rehabilitation/Habilitation Services in the U.S., 2012-2025

	Occupational therapists	Physical therapists
Supply		
Estimated supply, 2012	86,300	191,600
Total supply growth, 2012-2025:	39,900 (46%)	62,600 (33%)
New entrants	58,200	96,500
Changing work patterns(e.g., part time to full time hours)	(2,510)	(1,030)
Attrition (e.g. retirements, mortality)	(15,790)	(32,870)
Projected supply, 2025	126,200	254,200
Demand		
Estimated demand, 2012	86,300	191,600
Total demand growth, 2012-2025	17,600 (20%)	43,500 (23%)
Changing demographics impact	17,200 (20%)	40,800 (21%)
ACA insurance coverage impact	400 (0%)	2,700 (1%)
Projected demand, 2025	103,900	235,100
Adequacy of supply, 2025		
Projected supply (minus) projected demand	22,300	19,100

Several factors that influence demand are included in the HWSM. The aging and growth of the U.S. population, the Affordable Care Act's emphasis on wellness and prevention, and current initiatives to better manage chronic illness—including diabetes and heart disease—suggest that demand for occupational and physical therapy services will remain high, and were factored into the projections discussed here. A limitation of the model is that it does not account for other factors that might influence demand, such as the increasing recognition of the needs of disabled Americans, including veterans and those returning from foreign wars.

About the National Center for Health Workforce Analysis

The National Center for Health Workforce Analysis informs public and private-sector decision-making related to the health workforce by expanding and improving health workforce data, disseminating workforce data to the public, improving and updating projections of the supply and demand for health workers. For more information about the National Center for Health Workforce Analysis please visit our website at http://bhw.hrsa.gov/healthworkforce/index.html.

National Center for Health Workforce Analysis

Health Workforce Projections: Healthcare Support Occupations

KEY FINDING

Between 2012 and 2025:

- All five healthcare occupations presented in this fact sheet will experience an increase in demand.
- Demand will grow by 20 percent for respiratory therapy technicians, 17 percent for pharmacy technicians, 17 percent for pharmacy aides, 23 percent for occupational therapy assistants and 24 percent for physical therapy assistants.

This fact sheet presents the national demand for select healthcare support occupations for 2012 through 2025 using HRSA's Health Workforce Simulation Model (HWSM).[1] Supply projections are not included due to lack of sufficient data to provide reliable estimates of future supply. Occupations discussed in this fact sheet include respiratory therapy technicians, pharmacy technicians, pharmacy aides, occupational therapy assistants and physical therapy assistants. While the nuances of modeling demand differ for individual health professions, the basic framework within the HWSM remains the same. The HWSM assumes that demand equals supply in the base year. For demand modeling, the major components include population demographics, health care use patterns (including the influence of the Affordable Care Act health care coverage), and demand for health care providers (translated into Full-Time Equivalents). Over the period studied, the model assumes that current national patterns of service demand remain unchanged within each demographic group.[2] These projections do not account for the geographical distribution of providers which may impact access to care in certain communities.

BACKGROUND

Five healthcare support occupations are discussed in this brief: respiratory therapy technicians, pharmacy technicians, pharmacy aides, occupational therapy assistants, and physical therapy assistants. Respiratory therapy technicians assist respiratory therapists and physicians and provide medical treatment to patients with breathing and cardiopulmonary problems such as asthma or emphysema. Under the direction of other health professionals, they can also provide medical aid to adults that have lungs problems or babies with undeveloped lungs. Respiratory therapy technicians require an associate's degree and need to be registered.

Pharmacy technicians help licensed pharmacists dispense prescription medication. They generally have a high school diploma and learn through on the job training. Pharmacy technicians are regulated in many states. Pharmacy aides perform administrative and customer services tasks in a pharmacy such as recording drug inventory and filing prescriptions, and have no formal education requirements.

Occupational therapy assistants have direct involvement in providing therapy to patients and work under the direction of occupational therapists. Occupational therapy assistants must have an associate's degree and may be certified. In most states, occupational therapy assistants must be licensed. Physical therapist assistants work under

[1] This model uses a micro-simulation approach where supply is projected based on the simulation of career choices of individual health workers. Demand for health care services is simulated for a representative sample of the current and future U.S. population based on each person's demographic and socioeconomic characteristics, health-related behavior, and health risk factors that affect their health care utilization patterns. For more information on data and methods, please see BHW HRSA Health Workforce Supply and Demand Simulation Model.

[2] Ono T, Lafortune G, Schoenstein M. "Health workforce planning in OECD countries: a review of 26 projection models from 18 countries." *OECD Health Working Papers, No. 62*. France: OECD Publishing; 2013:8-11.

the direction and supervision of physical therapists, implementing components of patient care plans, helping obtain outcomes data from physical therapy interventions, and modifying therapies to progress the patient or to ensure patient comfort and safety. Physical therapist assistants must have an associate degree, and many states require licensure.

FINDINGS

There were approximately 13,500 respiratory therapy technicians, 334,400 pharmacy technicians, 42,600 pharmacy aides, 29,500 occupational therapy assistants and 76,500 physical therapy assistants nationally in 2012. Demand for both pharmacy technicians and aides is projected to grow 17 percent between 2012 and 2025 (Exhibit 1). During this same time period, demand for respiratory therapy technicians is projected to increase by 20 percent and occupational therapy assistants by 23 percent. Physical therapy assistants are expected to see the most growth in demand at 24 percent.

Exhibit 1. Estimated Demand for Selected Health Support Occupations in the U.S., 2012 – 2025

	Respiratory therapy technicians	Pharmacy technicians	Pharmacy aides	Occupational therapy assistants	Physical therapy assistants
Demand					
Estimated demand, 2012	13,500	334,400	42,600	29,500	76,500
Total demand growth, 2012-2025:	2,700 (20%)	54,600 (17%)	7,200 (17%)	6,900 (23%)	18,400 (24%)
Changing demographics impact	*2,500*	*45,900*	*6,000*	*6,600*	*17,300*
ACA insurance coverage impact	*200*	*8,700*	*1,200*	*300*	*1,100*
Projected demand, 2025	16,200	389,000	49,800	36,400	94,900

Factors that influence demand are integrated into the HWSM, including the aging and growth of the U.S. population and the implementation of the Affordable Care Act. The growing elderly population will lead to increased incidence of illness and chronic conditions and greater demand for health care as well as pharmacy services. The Affordable Care Act's emphasis on wellness and prevention will lead to increased use of health resources (impacting all health care occupations overall), and the increase in the number of Americans with prescription drug coverage will lead to increased use in pharmacy services (impacting primarily the pharmacy occupations). Together, these two factors suggest that demand for pharmacy, respiratory, occupational, and physical therapy services will remain high.

About the National Center for Health Workforce Analysis

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Telehealth
Policy Trends and Considerations

National Conference of State Legislatures

NCSL Partnership Project on Telehealth

In December 2014, NCSL brought together state legislators, legislative staff and private industry representatives to discuss telehealth adoption and barriers. The group met for one year and focused its attention on three policy areas: reimbursement of telehealth encounters, licensure for telehealth providers, and patient privacy, safety and security. This white paper represents the outcome of those discussions and provides options for state policymakers in those three areas.

Steering Committee Co-Chairs

Elizabeth Steiner Hayward, State Senator, Oregon
Dave Heaton, State Representative, Iowa

Steering Committee Members

Sue Beffort, State Senator, New Mexico
Anna Broome, Legislative Analyst, Office of Policy and Legal Analysis, Maine
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American Medical Association

Anthem

Blue Cross Blue Shield Association

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Philips

EXECUTIVE SUMMARY

Telehealth presents one strategy to help achieve the triple aim of better health care, improved health outcomes and lower costs. It is widely acknowledged for its potential to ameliorate health care workforce issues by creating efficiencies and extending the reach of existing providers. With the potential to overcome access barriers, telehealth is also viewed as a means to reduce health disparities for aging and underserved populations, as well as reduce costs and burdens for patients.

Telehealth is a tool that capitalizes on technology to remotely provide health services. The federal Health Resources and Services Administration (HRSA) defines telehealth as "the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration." It encompasses health-related services, including patient education, provider consultation and training, and remote care and home monitoring.

The adoption and expansion of telehealth across the nation poses various challenges, some of which present policy questions for state leaders. This report focuses on the following three primary policy issues related to telehealth.

- **Coverage and Reimbursement:** Differences in payment and coverage for telehealth services in the public and private sector, as well as different policies across states, remain a barrier for widespread telehealth use. States have enacted various policies related to Medicaid, and in many cases, private payers. State policy typically determines what constitutes telehealth; the types of technologies, services and providers that are eligible for reimbursement; where telehealth is covered and how; and other guidelines.

- **Licensure:** With technology's ability to span state borders, provider licensure portability is a key issue that states are examining to expand access and improve efficiency in the existing workforce. Policymakers are addressing practice across state lines through various mechanisms, including reciprocity with other states and interstate compacts.

- **Safety and Security:** Ensuring safe telehealth encounters for patients, as well as privacy and data security, has become an increasingly important issue as telehealth has grown. Some states are ensuring patient safety by defining which services are appropriate to be delivered remotely, creating guidelines for establishing a patient-provider relationship and mandating certain informed consent requirements.

Policymakers are working to craft frameworks that capitalize on the benefits of telehealth, while maintaining an appropriate level of oversight to safeguard state investments and ensure effective health care delivery and health outcomes.

Legislators can ask questions to learn more about benefits, opportunities and challenges related to telehealth in their states. Leaders can guide policy discussions that center on telehealth as a way to extend existing health care services.

In considering telehealth policies, legislators may want to convene a variety of stakeholders from all sectors and perspectives. Policymakers modifying or creating policies may consider the level of oversight needed to ensure that services are effective in terms of costs and outcomes, and balance those needs with potential unintended consequences or future hurdles as telehealth continues to develop. Reimbursement, licensure and patient safety—along with new challenges and opportunities—will continue to be issues for state leaders to consider.

POLICY CHECKLIST

Legislators may wish to explore these areas when examining telehealth policies.

- [ ] **Examine existing policies** related to telehealth reimbursement and coverage in your state. Ask questions such as: Which providers can be reimbursed? For which services and telehealth modalities? Where must a provider or patient be located to ensure payment or coverage? What other policies affect coverage and reimbursement?

- [ ] **Consider existing definitions** of telehealth, and to what extent they may enable or constrain telehealth. *Explore other states' definitions*; weigh benefits and obstacles to promoting consistent language across states to help standardize telehealth.

- [ ] **Look at Medicaid and state employee reimbursement policies** and, if appropriate, consider expanding covered services.

- [ ] **Evaluate the benefits of telehealth expansion** within the context of other state needs. Consult with stakeholders and/or consider studying the potential initial costs associated with increased service utilization versus other state budget needs and the potential to save money in the future.

- [ ] **Work with private carriers** to determine if private payer requirements would help promote telehealth in your state. If so, consider the level and *requirements of parity*.

- [ ] **Consider the role for legislation** related to licensure and workforce issues in telehealth. Consult with stakeholders, including provider boards, providers, payers (who are responsible for creating adequate networks) and consumers. Consider language in legislation to help provide appropriate guidance to boards.

- [ ] **Look at current workforce or access gaps** and consider ways to facilitate coverage through telehealth. Assess opportunities for allowing providers to practice across state lines, including reciprocity or joining interstate compacts.

- [ ] **Assess the role of licensure** in *existing or new payment and delivery* reforms. If applicable to your state, examine ways to streamline licensure.

- [ ] **When creating legislation, consider language** that includes or can apply to all provider types, including those who may provide telehealth services in the future.

- [ ] **Study existing statutes** to see whether and where clarity might be needed to help guide safe telehealth policies and practices. For example, look at definitions of patient-provider relationships or examinations, and consult with stakeholders about changes or considerations.

- [ ] **In looking at existing or new legislation, balance the constraints** being placed on telehealth with the need to safeguard patient safety and security.

- [ ] **Examine how data are collected** on health care services delivered by telehealth. Data collection that includes a telehealth-specific identifier for billing helps in evaluating programs and in monitoring for fraud and abuse.

DEFINING TELEHEALTH

Telehealth is defined differently by nearly all states and even by different entities within the federal government. The federal Health Resources and Services Administration (HRSA) defines telehealth as "the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration."[1] Telemedicine typically refers to clinical services, whereas telehealth encompasses health-related services more broadly, including patient education, provider consultation and training, and remote care or home monitoring. However, telehealth and telemedicine are often used interchangeably.

Definitions of telehealth affect the services covered and reimbursed in each state. Some states limit telehealth definitions to certain types of technologies, while others allow more flexibility through broad definitions. In addition, most states exclude—or do not specify inclusion of—email, telephone and fax in their definitions of telehealth.

- **Georgia** Code Annotated § 33-24-56.4: "'Telemedicine' means the practice, by a duly licensed physician or other health care provider acting within the scope of such provider's practice, of health care delivery, diagnosis, consultation, treatment, or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient or which are used to transfer medical data obtained during a medical visit with a patient. Standard telephone,

OVERVIEW

Telehealth offers one potential strategy to help achieve the triple aim of better health care, improved health outcomes and lower costs. States spend a significant portion of their dollars on health care, and despite a recent slowdown, new projections estimate that health care spending in the United States will increase by an average of 5.8 percent per year from 2014 to 2024.[2] While examining cost drivers, state leaders are looking to leverage resources in a cost effective manner that improves health for the population.

Telehealth is a tool—or means—of delivering care that capitalizes on technology to remotely provide health care and other health services. It brings the services directly to the patient, changing the way patients and their families can interact with providers and the health care system.

With this mechanism for care delivery on the rise, many advocates and experts believe telehealth will continue to grow and gain acceptance. Use of telehealth services is expected to grow from 250,000 patients in 2013 to 3.2 million patients in 2018.[3] This trend is playing out in state legislatures, as more than 200 telehealth-related bills were introduced in 42 states in 2015.[4] State leaders are grappling with how to leverage the potential of telehealth while also ensuring appropriate use, health outcomes and safety. This report describes some of the trends and issues in state telehealth policies, and key considerations for lawmakers.

The roots of telehealth have been linked to innovative ideas from the late 1800s and early 1900s, as evidenced in an 1879 Lancet article that cited using the telephone to reduce unneeded office visits.[5] Over the past few decades, telehealth has been largely viewed as a means to reach rural communities, which typically face additional barriers to accessing care, such as fewer providers and greater travel distances. However, telehealth is increasingly being viewed more broadly as a way to reach multiple populations in different settings and to address various health care issues.

Telehealth is widely acknowledged for the po-

facsimile transmissions, unsecured email, or a combination thereof do not constitute telemedicine services."

- **Minnesota** Statute § 62A.671: "'Telemedicine' means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, email, or facsimile transmission does not constitute telemedicine consultations or services. A communication between a licensed health care provider and a patient that consists solely of an email or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care."

- **Nevada** AB 292 (2016): "'Telehealth' means the delivery of services from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail."

Sources: Center for Connected Health Policy; NCSL

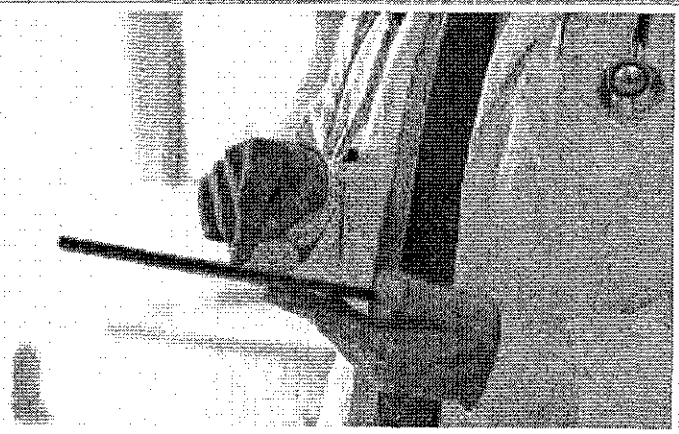
tential to ameliorate health care workforce shortages and maldistributions. Though it does not increase the size of the provider workforce, it can help better distribute providers by creating efficiencies and extending the reach of existing providers. With its potential to overcome workforce and access barriers, telehealth is also viewed as a means to reduce health disparities for aging and underserved populations, as well as reduce costs and burdens for patients associated with lost work time, transportation and child care.

Telehealth can increase health care access in other ways, including, for example, the ability to access care outside typical provider office hours or in different settings such as homes, long-term care facilities, schools, workplaces or prisons. By improving access to lower-cost primary and necessary specialty care, telehealth could provide timely, accessible care in lower-cost environments and help reduce expensive emergency room (ER) visits. For older people, telehealth may assist family caregivers, support aging in place and reduce institutional care. And certain telehealth modalities may be especially helpful in managing chronic conditions at home, thereby reducing ER and hospital readmissions.

The possibility to improve health,[6] along with consumer demand for convenience, is also a driving factor for many health leaders and providers to invest in telehealth programs. For example, 74 percent of consumers reported that they were likely to use online services.[7]

EFFECTIVENESS AND VALUE

Telehealth can help achieve the goals of the triple aim—improving care, bettering health and lowering costs—by improving access to appropriate, lower-cost services, such as timely primary or specialty care, or through lower-cost settings, including clinics, homes or workplaces. For example, it is viewed as a beneficial tool to support patients and family caregivers in home health care for older Americans, who are a growing population and account for about 75 percent of health care costs. The Centers for Medicare and Medicaid Services (CMS) notes



TELEHEALTH APPLICATIONS

Four modes, or modalities, are typically included in the definition of telehealth. The first three are most often seen in states' policies, whereas mobile health is less common in policies, but is a rapidly growing field.

- **Real-time or Live Video:** Real-time or synchronous audio and video communication between a patient (and/or family member) and provider; e.g., visiting with a specialty care provider in real time over video.
- **Store and Forward:** Transmission of data, images, sound or video from one care site to another; e.g., tele-radiology or teledermatology, where images are sent to specialists for evaluation.
- **Remote Patient Monitoring:** Services in which a patient's vital signs and other data are collected at home or outside a clinic and transferred to a provider for monitoring and response, if needed; e.g., at-home monitoring of patients with diabetes or blood glucose levels and other vital signs.
- **mHealth (mobile health):** Health education, information or public health services provided by a mobile device; e.g., health education applications (apps) on cell phones, wearable devices or reminders to take medications. This area is much broader than the prior three modalities, and is still developing.

Telehealth is often associated with increasing access to primary care services.

However, it includes, but is not limited to, numerous other applications such as:

- Acute care, such as trauma, telestroke and tele-ICU programs
- Chronic care management
- Behavioral health care, such as telepsychiatry
- Long-term services and supports
- Home health care
- Dental care
- Specialty medical services, such as dermatology and radiology

For more information on specific uses of telehealth, please see resources such as the American Telemedicine Association's case studies.

that telehealth is viewed as a cost-effective alternative to traditional service delivery.[8]

Telehealth is often cited as effective for providing comparable—or no difference in—patient care and outcomes compared to traditional care delivery. The American Telemedicine Association, a telehealth advocacy organization, suggests that much of the research has found care provided through telehealth to be comparable to in-person care without differences in the ability to obtain necessary information, make a diagnosis or develop a treatment plan.[9] A recent review of 93 randomized control trials—the gold standard of research—found similar or better outcomes through telehealth alone or telehealth with usual care, as compared to usual care alone, for patients with a variety of health issues.[10] The findings were primarily related to patients with heart failure and diabetes, but some evidence supports comparable outcomes in areas such as mental health and dermatology.

In terms of clinical outcomes and cost effectiveness, many note that more research is needed. The review of randomized control trials concluded that effectiveness of telehealth may depend on different factors, including patient population (e.g., disease or condition), how telehealth is used (e.g., clinical visit, remote monitoring), and the health care providers or systems involved in delivering telehealth. The review noted that limited data were available on patient and provider satisfaction, as well as costs. Similarly, a stakeholder group convened by the Center for Connected Health Policy concluded that "larger, longer, more rigorously designed controlled studies" were needed to better evaluate telehealth.[11]

Many of the peer-reviewed, rigorous studies of telehealth cost effectiveness are only recently emerging,[12] and there are multiple challenges associated with measuring and making generalized conclusions about cost effectiveness. The studies in this field are each limited to different telehealth modalities, settings, diseases or conditions, or patient groups.[13] This makes it difficult to make a broad statement about cost effectiveness in telehealth as a whole. The rapid pace of technological change in the field,[14] as modalities and use change, also create challenges to keeping the research relevant.

Researchers, states and other groups are trying to measure the effects of telehealth on costs. For example, among 12 peer-reviewed studies published since 2007, most of the research found cost savings or no difference in telehealth compared to traditional care delivery (see box on page 10 for examples).[15] In addition, in a report required by legislation, Maryland's Department of Health and Hygiene found that Medicaid expenditures using a "hub and spoke" telemedicine model could increase costs for the state between $500,000 and $700,000 through increased service use. The report also suggested the projected increases were relatively small and would likely be offset by the reductions in ER visits and transportation costs. In a different context, an analysis of various private payer data found cost savings of approximately $126 for each commercial telehealth visit, compared to in-person acute care.[16] It also estimated that Medicare could save around $45 per telehealth visit.

Data on outcomes and cost effectiveness are vital to policymakers seeking to invest state resources wisely and will continue to be important moving forward. State leaders can support collecting and measuring data on telehealth services to help strengthen the evidence base. Relevant data may include service, cost and health information found in claims data, pharmacy records and patient medical records. Even data from remote patient monitoring or wearable electronics (such as activity trackers) may provide valuable information. Data analytics, including a comprehensive strategy for collecting and using data among multiple health care stakeholders, is increasingly important to understand cost drivers and manage the population's health. State reforms, including alternative payment and delivery models, will also likely have implications for the use, outcomes and costs associated with telehealth. Policymakers may wish to consider the roles of telehealth, along with availability and integration of data, when examining system reforms.

EMERGING COST-EFFECTIVENESS RESEARCH

Some newer studies related to cost effectiveness in telehealth have found comparable costs or cost savings compared to traditional care delivery.

A study of a private nursing home chain that switched from on-call physicians to telemedicine physician coverage during off-hours looked at hospitalizations and the level to which nursing homes were engaged in telehealth service.[17] Among other things, the researchers found that facilities that used telehealth to a greater extent realized a significant decline in hospitalizations. They found the average savings to Medicare would be $161,000 per nursing home per year for the more engaged facilities. The authors also acknowledge that Medicare better incentivizes reducing hospitalizations, while nursing homes may have a financial disincentive to invest in telehealth to prevent hospitalizations for long-term Medicaid patients. This is because, instead of Medicaid payments, the facility will often receive a higher skilled-nursing benefit from Medicare when patients return post-hospitalization.

An analysis of a Veterans Health Administration chronic disease management program that included care coordination with home telehealth monitoring devices to help veterans age in place and prevent nursing home admissions found positive results.[18] The findings included that the care coordination home telehealth group, in comparison to the usual care group, had significantly lower health care costs and smaller increases in Medicare costs. The group also had a greater increase in pharmacy costs attributed to better medication management and adherence. These findings built on a 2008 study, which found a 25 percent reduction in numbers of "bed days," a 19 percent reduction in hospital admissions, and a cost of $1,600 per patient per year, substantially less than other non-institutional care programs and nursing home care.[19]

An evaluation of the Hospital at Home model to serve aging Medicaid and Medicare patients with chronic diseases also found benefits for the telehealth group.[20] The Hospital at Home group had a telehealth unit in the home and a remote telehealth nurse to monitor conditions, as well as more extensive services such as physician and nurse visits. The study found 19 percent cost savings, similar outcomes and higher patient satisfaction in Hospital at Home, compared to similar inpatients.

POLICY ISSUES

Telehealth adoption and expansion across the nation bring various challenges, some of which present policy questions for state leaders. For example, lack of broadband and cellular connectivity, and availability and affordability of devices for consumers and providers can hinder telehealth. The telehealth field is changing rapidly, and in some cases, technology may be getting ahead of policy. Policymakers are working to craft frameworks that capitalize on the advancements and potential for telehealth, while maintaining an appropriate level of oversight to safeguard state investments and ensure effective health care delivery and their constituents' health outcomes.

This report focuses on the following three primary policy issues related to telehealth often cited by advocates, providers and lawmakers.

- **Coverage and Reimbursement:** Differences in payment and coverage for telehealth services in the public and private sector, as well as different policies across states, remain a barrier for widespread telehealth use.
- **Licensure:** With technology's ability to span state borders, provider licensure portability is a key issue that states are examining to expand access and improve efficiency in the existing workforce.
- **Safety and Security:** Ensuring safe telehealth encounters for patients, as well as privacy and data security, has become an increasingly important issue as telehealth has grown.

COVERAGE AND REIMBURSEMENT

Coverage and payment are important pieces for all parties involved in telehealth. Health care professionals may be concerned about adequate payment for providing services remotely, and lack of payment could affect their ability to invest in telehealth technologies.[21] Similarly, differences in coverage may leave some patients without access to services that could be delivered via

telehealth. Federal policies have consequences for telehealth under the Medicare program, but states have a great deal of flexibility in other areas. States have taken different paths in reimbursement policies for Medicaid programs and, in some cases, for private carriers.

Medicare

Medicare, the federal insurance program for people age 65 and older and younger people with disabilities or certain conditions, began covering telehealth on a limited basis in 1997.[22] Though Medicare is a federal program, it affects what states can do for vulnerable populations, including those dually eligible under Medicare and Medicaid. Over time, the program has expanded its scope in terms of telehealth, but many limitations remain in place.

Medicare specifies reimbursement only for certain telehealth modalities, services and locations, including geography. It limits coverage to live-video (real-time audio and video technology) telehealth for office visits, office psychiatry services and provider consultations.[23] Store and forward methods are only covered in Alaska and Hawaii, the two exceptions to the live video policy, and remote patient monitoring is not covered at all.

Reimbursement for telehealth under Medicare is also dependent on the location of the beneficiary, or patient, receiving the services. The site of the patient—also known as the originating site— must be a rural location, which is defined as a Health Professional Shortage Area (HPSA) or in a county that is outside of a Metropolitan Statistical Area (MSA).[24] In addition, while the provider can be remote, the originating site must be a medical facility, which includes certain settings such as hospitals, provider offices, critical access hospitals, rural health clinics, federally qualified health centers, skilled nursing facilities and community mental health centers.[25] This restriction excludes settings such as patients' homes.

States have the ability, through the Affordable Care Act (ACA), to use telehealth in integrating coverage for the dually eligible under both Medicare and Medicaid. Currently, Georgia, New York and Virginia cover telehealth services for their dually eligible populations through the Centers for Medicare and Medicaid Services (CMS) Capitated Financial Alignment Model for Medicare-Medicaid Enrollees.[26] And under CMS approval, Virginia has waived some of the Medicare barriers to telehealth. For example, Virginia allows plans to use and reimburse for telehealth in rural and urban settings, including store and forward and remote patient monitoring services.

At least two pending congressional bills would affect telehealth practices for Medicare. The Medicare Telehealth Parity Act (HR 2948), one of several proposed federal pieces of legislation, would expand telehealth under the Medicare program. Among other things, it would amend the definition of an originating site and direct the Government Accountability Office to study the effectiveness and savings of certain telehealth services. The Telehealth Enhancement Act (HR 2066) also seeks to expand telehealth under Medicare, including by expanding originating sites and authorizing accountable care organizations to include telehealth and remote patient monitoring as supplemental health care benefits, as well as in a national pilot on payment bundling. Both bills were introduced in 2015 and remain under consideration at time of publication.

Many state policymakers and telehealth stakeholders view the Medicare policies as burdensome barriers to telehealth growth. Because of the restrictions, many states are now leading the way with innovative policies for programs that fall under their purview.

Medicaid

States have significant control and flexibility in their Medicaid programs, unlike in Medicare, including the ability to decide Medicaid coverage and reimbursement for telehealth. According to CMS, "states are encouraged to use the flexibility inherent in federal law to create innovative payment methodologies for services that incorporate telemedicine technology."[27] State policy typically determines what constitutes telehealth; the types of technologies, services and providers that are

CONNECTIVITY INFRASTRUCTURE

Broadband, cellular networks and availability of smartphones and devices—which allow users to connect to the Internet at high speeds—are important when considering how patients can access the growing availability of telehealth services. Smartphone use among Americans is at about two-thirds and around 70 percent have broadband access at home. Yet there are disparities. The broadband numbers dip when looking at older adults and those with lower education levels, limited incomes, chronic health conditions or disabilities, or who live in rural areas. And some—around 20 percent in 2013—have neither a smartphone nor broadband. Even access to smartphones or broadband does not necessarily guarantee access to services because of speed or data limitations.

Providers, especially rural or smaller clinics or practices, may also face challenges in connectivity. This is particularly important for those who want or need to connect to larger or other health care systems. Nearly all states have enacted legislation to support broadband in some way, including promotion, coordination or funding. The federal government is also involved in expanding broadband. The Health Care Connect Fund, for example, provides support to expand access to broadband services for health care providers, particularly in rural areas, and encourages the formation of state and regional broadband networks. This may be one avenue for states and providers to leverage in order to expand provider connectivity. The Federal Communications Commission created a National Broadband Plan, which also cited the need to expand broadband to enable health-related technologies, including in rural areas.

Sources: Pew Research Center's Internet Project; NCSL

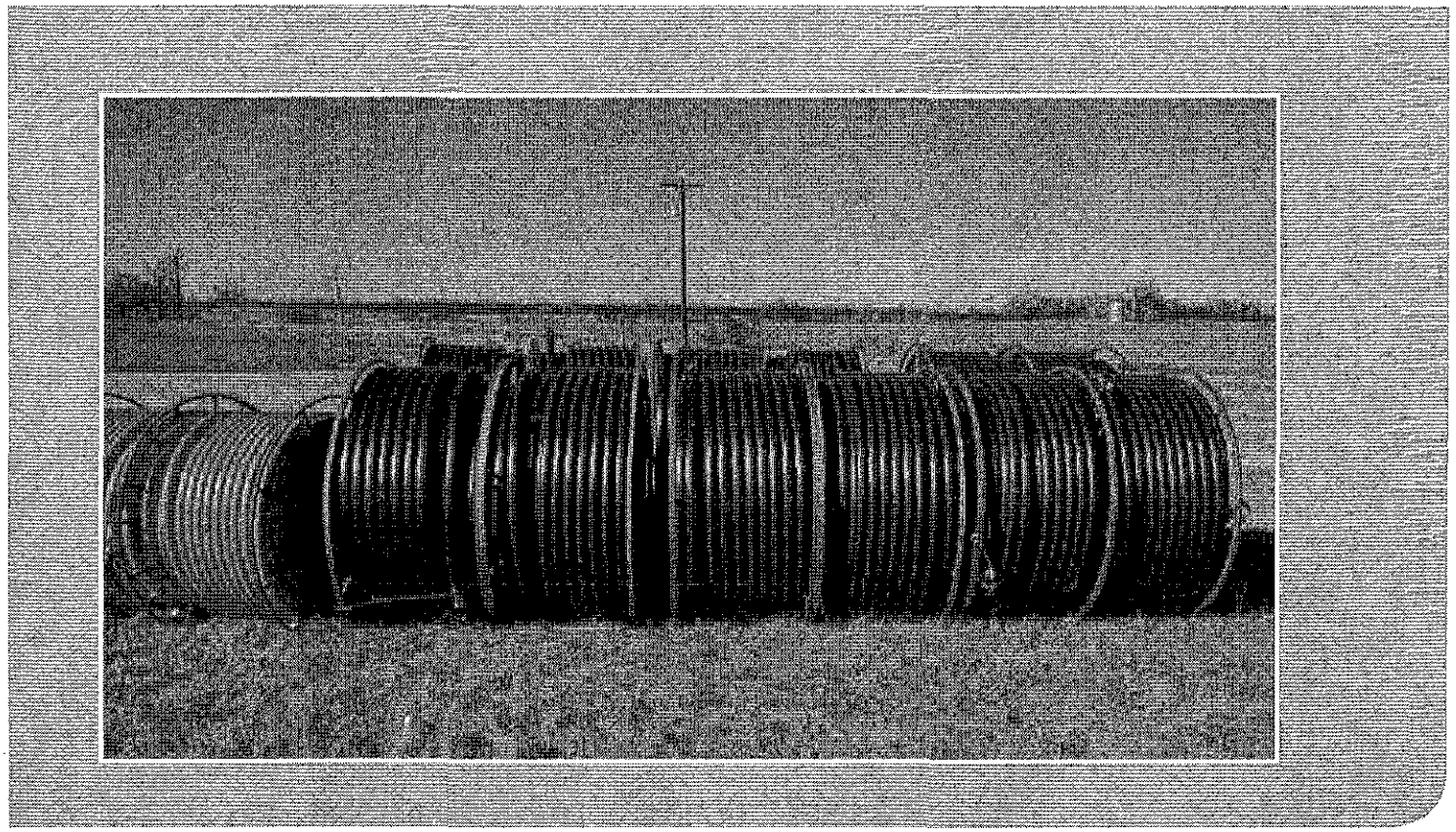
eligible for reimbursement; where telehealth is covered and how; and other guidelines.

Based on analysis from the Center for Connected Health Policy, the American Telemedicine Association and NCSL research, telehealth coverage and reimbursement in state Medicaid programs vary considerably:[28]

- Almost all states (49) and the District of Columbia have some coverage for telehealth.
- Nearly all reimburse for live video telehealth.
- Nine states—Alaska, Arizona, California, Illinois, Minnesota, Mississippi, New Mexico, Oklahoma and Virginia—reimburse for store and forward services.
- At least 17 states have some reimbursement for remote patient monitoring (RPM) in Medicaid: Alabama, Alaska, Colorado, Illinois, Indiana, Kansas, Louisiana, Maine, Massachusetts, Minnesota, Mississippi, New York, South Carolina, Texas, Utah, Vermont and Washington, plus Pennsylvania and South Dakota, who reimburse for RPM through their departments of aging.
- Most states specifically exclude—or do not specify inclusion of—email, phone and fax in their definitions of telehealth services that can be reimbursed.

Within these reimbursement structures, there are many nuances among states. For all modalities, states may restrict the types of services and specialties, the types of providers and the location of the patient in order to be eligible for reimbursement.[29] For example, 48 states have some coverage for mental or behavioral health services provided via live video, whereas eight states reimburse for telehealth under their home health services.[30] In addition, 19 states allow fewer than nine provider types to receive reimbursement for telehealth (including four states that allow reimbursement only for physicians), while 15 states and the District of Columbia do not specify the type of provider.[31]

Though some states created geographic limits similar to Medicare, requiring that patients be located in rural settings, the trend increasingly is for states to remove these restrictions: The majority of states do not currently have rural requirements. For example, Nevada, Michigan



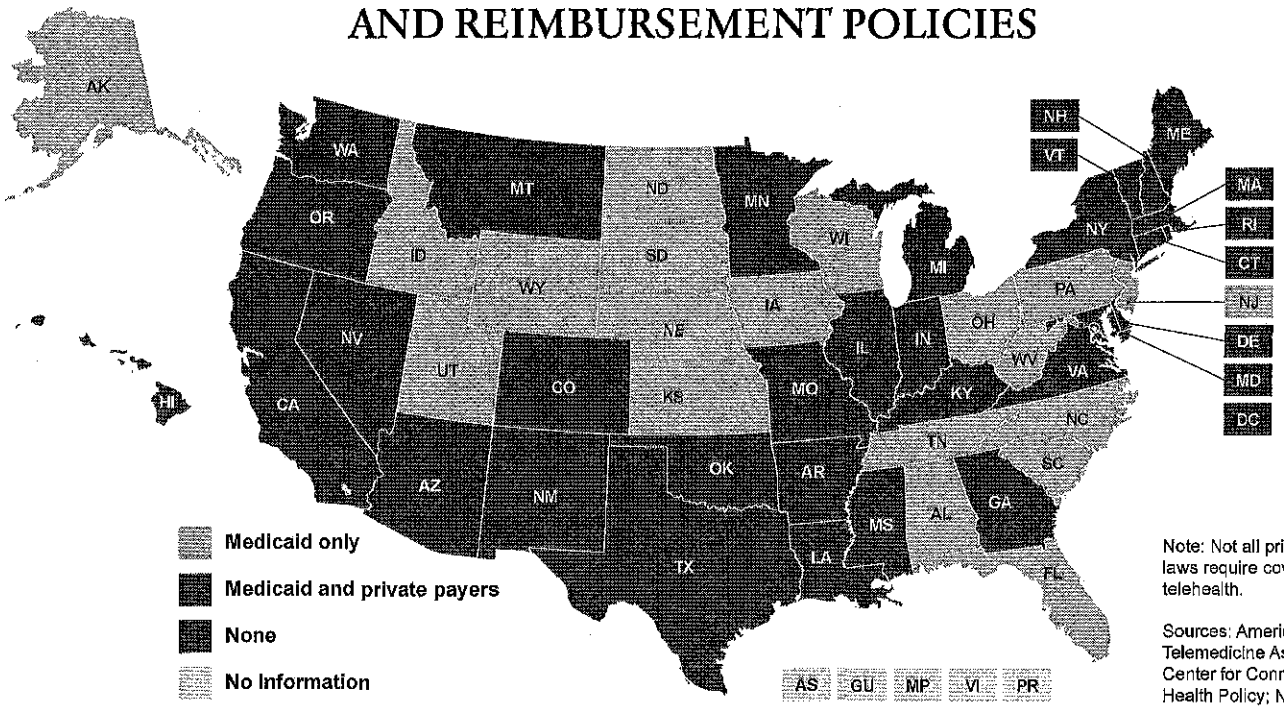
and Missouri removed their geographic restrictions in recent years, and Colorado (HB 1029) removed its requirement during the 2015 legislative session.

States may also require other conditions for Medicaid reimbursement for telehealth. They include, for example, the type of site that can be an originating site (where the patient is located) or distant site (where the provider is located), and whether another provider must be present with the patient as a "telepresenter." Currently, states are relatively split in regard to these requirements. Twenty-four states and the District of Columbia do not specify a patient setting or patient location as a condition of payment.[32] Half of all states allow a patient's home to serve as an originating site, and 16 recognize schools or school-based health centers.[33] And 28 states and D.C. do not require a telepresenter during the telehealth encounter or on the premises during the service.[34]

As states continue to transform the ways they deliver and pay for care, telehealth is one tool that may be deployed within state reforms. For example, 24 states allow telehealth services under Medicaid managed care.[35] In some respects, alternative models such as Managed Care Organizations (MCOs) and Accountable Care Organizations (ACOs) that typically have capitated payments (e.g., per member, per month) or global payments for patient care have greater ability to cover telehealth. These approaches often emphasize care coordination, and the payment models share risk while providing incentives for positive outcomes and value of care over volume of services. These models may offer more flexibility and incentive to offer services via telehealth. In fact, some argue that the fee-for service model is a barrier to telehealth.[36] The global payment structure in MCOs and ACOs may allow hospitals, clinics and other providers the ability to invest some resources in telehealth, and realize the benefits and cost savings in the future.[37]

States can experiment with some of these alternative approaches through Medicaid state plan amendments, waivers and grants. Alabama, Iowa, Maine, New York, Ohio and West Virginia have used state plan amendments that include telehealth in their health home proposals. Kansas, Pennsylvania and South Carolina have

MEDICAID AND PRIVATE PAYER COVERAGE AND REIMBURSEMENT POLICIES



Note: Not all private payer laws require coverage of telehealth.

Sources: American Telemedicine Association; Center for Connected Health Policy; NCSL

used waivers to cover remote patient monitoring for long-term care services.[38] In addition, components of Vermont and Oregon's State Innovation Model (SIM) grants from the Center for Medicare and Medicaid Innovation (CMMI) included telehealth pilots. Massachusetts uses SIM funds to support behavioral health integration in primary care, including through telehealth. Hawaii also received support from CMMI for its State Innovation plan, which included expanding telehealth services, and Arkansas similarly included telehealth as a tool to increase availability and access to services. As lawmakers examine telehealth, they may consider it within the context and goals of any of these experiments, or within other state delivery or payment system reforms. Telehealth policies around reimbursement in particular may need to be examined or developed to promote reform goals—aligned with the triple aim—of containing costs and/or better coordinating care to improve health.

Private Payers and State Employees

Many states have adopted policies related to private payers, including coverage and reimbursement of telehealth in order to facilitate wider access and adoption. State laws governing private payers vary: Some stipulate certain criteria if payers choose to cover telehealth; some require coverage of telehealth for certain services, certain populations or all beneficiaries; and others require certain payment for telehealth.

In states that mandate reimbursement, some require that reimbursement is "equivalent to" or at the same rate as in-person services. Others—such as Colorado, Missouri and Virginia—require payment "on the same basis," as in-person services, which some argue may better take into account cost differences that could be achieved through telehealth, such as lower facility and administrative fees. Currently, 32 states and the District of Columbia have telehealth parity laws, some of which will go into effect in 2016 or 2017.[39] Full parity—which exists in at least 23 states and the District of Columbia, according to the American Telemedicine Association—is considered when both coverage and reimbursement are comparable to in-person services.[40] Many states with parity laws stipulate that telehealth services are subject to the terms and conditions of the contract, or similar language.

CENTER FOR TELEHEALTH AT THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

The University of Mississippi developed a telehealth program with rural hospitals and clinics in 2003 in order to increase access to health care and specialty services throughout the state, particularly for rural Mississippians. The Center for Telehealth at the University of Mississippi Medical Center uses telehealth video technology to provide remote medical care—including more than 30 different specialties—as well as health education and public health services to 200 clinical sites in three-quarters of Mississippi's counties. The center has served more than 500,000 rural residents. It keeps patients in their home communities and helps improve rural facilities' workforce and bottom line. In addition, projections of savings for Medicaid from the use of UMMC's remote monitoring program for chronic disease management is estimated to be in excess of $1.89 million per year. Mississippi's program can serve as a model for other states and rural hospitals with specialty care shortages.

Source: The Center for Telehealth at the University of Mississippi Medical Center

Regardless of parity laws, some private insurers choose to cover telehealth services for all or a select segment of their members. For example, through Live Health Online, Anthem offers online live video telehealth visits with providers as a covered benefit for members in most of their commercial markets. These services are also available for a fee to non-members.

All states provide health insurance coverage for their employees. While there is significant variation between individual states, states collectively paid about $25 billion in 2013 to insure their employees.[41] State employee health coverage is a significant portion of state health spending, second only to Medicaid.[42] Twenty-four states allow some type of coverage for telehealth in state employee plans, with 21 extending the coverage through their parity laws.[43]

For states considering health care reforms, including telehealth implementation, employee plans can provide a model for other employers[44] or serve as a demonstration for potential new policies and services. North Dakota, for example, recently enacted legislation (HB 1038) to pilot telehealth in its employee health program.

Coverage and Reimbursement Policy Checklist

- Examine existing policies related to telehealth reimbursement and coverage in your state. Ask questions such as: Which providers can be reimbursed? For which services and telehealth modalities? Where must a provider or patient be located to ensure payment or coverage? What other policies affect coverage and reimbursement?
- Consider existing definitions of telehealth, and to what extent they may enable or constrain telehealth. Explore other states' definitions; weigh benefits and obstacles to promoting consistent language across states to help standardize telehealth.
- Look at Medicaid and state employee reimbursement policies and, if appropriate, consider expanding covered services.
- Evaluate the benefits of telehealth expansion within the context of other state needs. Consult with stakeholders and/or consider studying the potential initial costs associated with increased service utilization versus other state budget needs and the potential to save money in the future.
- Work with private carriers to determine if coverage requirements would help promote growth of telehealth in your state. If so, consider the level and requirements of parity.

LICENSURE

Licensure, and license portability, is an important issue for states looking at expanding provider networks beyond its borders through telehealth or other means. Licensing policies can also help address existing workforce shortages and the greater provider workloads resulting from more insured patients through the ACA.

Licensure is the responsibility of each state, which determines the qualifications to be licensed providers within its borders and the services and circumstances for health care practice. Through licensing, states have the authority to protect patients located in their borders and hold health care providers accountable to their practice, patient safety and liability laws. Telehealth can be delivered under current state licensure laws. Licensure is based on the location of the patient—providers abide by laws and requirements in the state where the patient receives services—which poses challenges for providers and states seeking to expand access across state lines, particularly through telehealth.

Licensing Options

Most providers are licensed in the state in which they practice health care, and providers wishing to practice in other states can apply for full licenses in those states. Credentialing, which is discussed on page 19, is another issue in telehealth related to licensure.

In order to provide services via telehealth across state lines, some states grant temporary licenses, telehealth-specific licenses or have reciprocity with neighboring states. Wyoming, for example, offers a temporary, expedited license for telehealth for physicians and physician assistants. Nine states—Alabama, Louisiana, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Tennessee and Texas—have special licenses related to telehealth.[45] These allow physicians to provide services remotely across state lines, and typically include certain terms, such as agreeing not to set up a physical office in the state. Other vehicles for out-of-state practice, though used less often, include reciprocity and endorsement. Some states, such as Alabama and Pennsylvania, have agreements with other states to grant a license to out-of-state physicians that reciprocally accepts the home-state license. Endorsement, as in Connecticut, simply allows an out-of-state physician to obtain an in-state license based on his or her home-state standards.[46]

Interstate compacts are another avenue for cross-state licensing that may promote and expand telehealth. Compacts are formed when a certain number of states enact the same legislation, with specific language that must be adopted. Joining a compact is voluntary on the part of the provider in compact states. States maintain their authority to monitor and discipline providers in their states, and both the home and other compact states have jurisdiction to do so over the health care professionals providing care within their borders. Compacts have the ability to expand provider networks, facilitate expedited help from out-of-state providers in the wake of disasters, and allow states to share information about bad actors. On the other hand, some parties may resist compacts for fear of losing authority, and others are concerned about costs for the state or providers related to implementing compacts.

Licensure compacts have been created for providers such as physicians, nurses and advanced practice registered nurses. The Federation of State Medical Boards' (FSMB) Interstate Medical Licensure Compact for physicians was first introduced in 2015. This compact creates an expedited process for eligible physicians to apply for licensure in compact states. It is intended to allow for a less onerous and time-consuming process for physicians seeking licenses in multiple states. Though the compact enables full licensure not specific to telehealth, one of the goals was to increase access to care through telehealth. Eleven states (Alabama, Idaho, Illinois, Iowa, Minnesota, Montana, Nevada, South Dakota, Utah, West Virginia and Wyoming) passed the medical licensure compact language in 2015, all by large margins in their legislatures—more than the minimum number of seven required to put the compact into effect.

Two representatives from each state that approves the compact sit on the Interstate Commission, which will provide the administration and oversight, including developing and enforcing rules.[47] The commission met for the first time in October 2015.

Other providers also have interstate compacts, which allow practice—including telehealth— across state borders. The Nurse Licensure Compact preceded FSMB's physician compact; it has been in existence for about 15 years with 25 states participating. The Nurse Compact creates a multi-state license similar to a driver's license, where the license is recognized in the home state and other compact member states.[48] This is different from the medical licensure compact that has an expedited approval process but still requires physicians to obtain licenses from each state where they practice. The model language for this compact was recently revised, and beginning in 2016, existing states and those wishing to join will need to pass the new language. Many of the modifications to the language were made based on feedback from states. The compact will go into effect after 26 states join or by Dec. 31, 2018, whichever occurs first. Similar to the Nurse Licensure Compact, an Advanced Practice Registered Nurse Compact

PROJECT ECHO

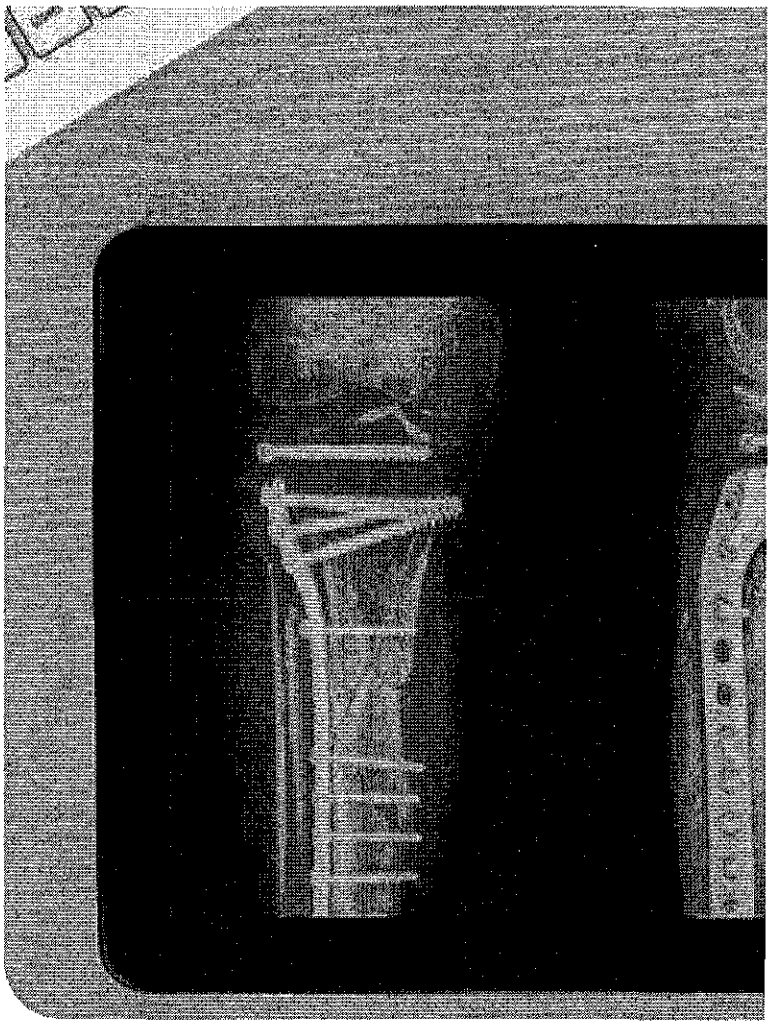
In some cases, providers can consult with each other across state lines without running into licensure issues. Project ECHO (Extension for Community Healthcare Outcomes) is an example of a provider consultation model using telehealth. The project began in New Mexico as a way to build capacity among primary care providers based in rural, underserved areas. Through weekly teleECHO (telemedicine) clinics, primary care clinicians receive support and advice from a specialty care team. In addition to building primary care providers' knowledge and efficacy in certain diseases, the model reduces the isolation of rural providers, increases their satisfaction, expands patient access, and has been shown to achieve care comparable to that delivered in a specialty clinic. There are now 89 ECHO hubs operating in 22 states. For example, during the 2015 legislative session, Missouri appropriated funds to support ECHO clinics.

Source: University of New Mexico School of Medicine, Project ECHO

will also be new in the 2016 sessions. Other examples of interstate compacts include EMS personnel, which was introduced in 2015 in seven states, and pending compacts for psychologists and physical therapists.

Federal Efforts

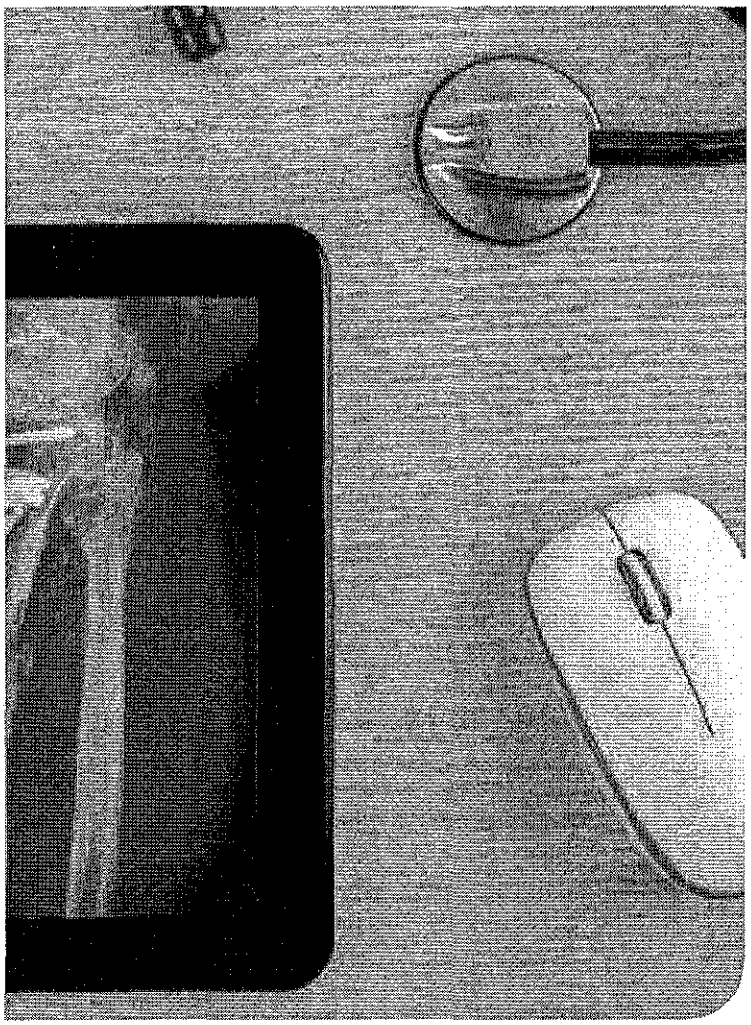
Two pieces of legislation that would affect licensure in Medicare and the Veterans Administration (VA) have also been introduced in Congress. These acts would supersede state requirements around licensure, laws and regulations, and essentially create one license (similar to the driver's license model) in the Medicare and VA programs. The TELE-MED Act (TELEmedicine for MEDicare Act of 2015; SB 1778 and HB 3081) would allow some Medicare providers to offer telehealth services to other Medicare beneficiaries across state lines. The jurisdiction would lie with the licensing or authorizing state. The Veterans E-Health & Telemedicine Support Act of 2015 would allow a health care professional authorized to provide care through the Department of Veterans Affairs and licensed in any state to provide services via telehealth, regardless of where the provider or patient is located.



Related Issues

Outside the licensure realm, several other issues may be of interest to legislators. Some of these issues may be contentious and, according to an Institute of Medicine (IOM) report, "practice standards, scopes of practice and other regulatory issues are increasingly polarizing stakeholders."[49] In many cases, state lawmakers may wish to stay informed about these issues, and in a handful of cases, states are taking action in these areas.

- **Liability:** Most providers may be covered for telehealth under existing liability coverage; however, much of this area is still unsettled and could be a barrier to telehealth. In fact, some of the unresolved issues (described later) involving patient-provider relationships, informed consent and practice standards relate to liability.[50] For example, state requirements around informed consent for telehealth can have liability implications. State policies on liability also differ and can create issues around interstate practice. Legal issues related to liability also include policy coverage for care via telehealth and for patients in other states; applicable state and federal privacy and security laws; and record retention policies. Lawmakers may want to be aware of existing legal considerations and differences in the application of telehealth, as well as new liability considerations that may arise.
- **Scope of Practice:** Scope of practice describes what a health professional can and cannot do to or for a patient. A professional's scope of practice is often based on the education, training and experience typical for that profession. Scope of practice is defined by state professional regulatory boards, often with guidance from state legislatures, and therefore regulations vary by state. Telehealth laws do not change a provider's existing scope



Licensure Policy Checklist

- Consider the role for legislation related to licensure and workforce issues in telehealth. Consult with stakeholders, including provider boards, providers, payers (who are responsible for creating adequate networks) and consumers. Consider language in legislation to help provide appropriate guidance to boards.
- Look at current workforce or access gaps and consider ways to facilitate coverage through telehealth. Assess opportunities for allowing providers to practice across state lines, including reciprocity or joining interstate compacts.
- Assess the role of licensure in existing or new payment and delivery reforms. If applicable to your state, examine ways to streamline licensure.
- When creating legislation, consider language that includes or can apply to all provider types, including those who may provide telehealth services in the future.

of practice; telehealth can be practiced with a state's existing scope of practice for all provider types. Providers may need to be aware of applicable standards of care and laws on supervision and collaboration through telehealth. While separate from licensure, some states may need to look at scope of practice for some disciplines as they address out-of-state providers, workforce shortages (especially behavioral health) and interstate compacts because of differences in state laws.

- **Credentialing and Privileging:** Credentialing and privileging are undertaken by health care facilities to verify providers' proficiency and expertise through data collection.[51] This can be an issue in telehealth when a provider needs credentialing and privileging at each health care facility at which he or she is treating patients via telehealth. Facilities in some cases can allow credentialing and privileging by proxy, relying on the decisions of the other facility. This issue is often being handled by facilities themselves, but some states have gotten involved to help facilitate telehealth. Oregon, for example, enacted legislation in 2013 requiring the Oregon Health Authority to adopt uniform documentation requirements for credentialing providers using telehealth.
- **Provider Training and Education:** Many assert that to improve telehealth adoption and use, students and providers in health care professions need to be trained in telehealth modalities. While telehealth training may occur in pockets, some stakeholders argue that it is not keeping up with the pace of telehealth. Incorporating training into education could help more students leave with the knowledge and skills to work effectively with patients remotely. Providers already delivering care may also need support to understand and implement new technologies. State policymakers may want to consider ways to encourage state-sponsored education that includes telehealth or examine mechanisms to support ongoing provider training.

SAFETY AND SECURITY

Telehealth is widely used in a number of contexts and for a number of services. In some cases it may ensure or improve patient safety by providing high-quality care that is more timely, accessible or appropriate. Remote patient monitoring, for instance, may be especially beneficial for seniors by keeping them safe and healthy in their homes. Live video counseling with a provider, or even an avatar (an image that represents another person), can help some patients with mental health disorders feel more comfortable. New technologies can also improve care, as in new pill bottles, for example, that can help remind patients about taking medication and allow providers to monitor adherence from a distance.

With excitement about the potential for telehealth has also come concerns for ensuring that services provided remotely are as safe and comprehensive as in-person care. Some argue that this concern needs to be addressed without holding telehealth to a stricter standard than traditional health care delivery. Many policymakers are balancing the rapid acceleration of technology and telehealth and its potential benefits with the responsibility to ensure safe, quality care for their constituents.

The standard of care—what another similarly trained and equipped provider would do in a similar situation—applies to health care providers regardless of the means of service delivery. Therefore, the standard of care and best practices for each health care profession should similarly govern safety in telehealth. In other words, because telehealth is simply a modality of delivering care, the standard of care for each type of service still applies. Some assert there is little or no need for other additional safeguards because the standard of care, as well as best practices and malpractice contingencies, will rein in any outliers in telehealth. As it is further employed, the standard of care of telehealth is likely to evolve.

Best practices and practice guidelines are also, according to the IOM, the "key to the future of telehealth"[52] and will similarly grow as evidence and use advances. Some state regulatory boards have adopted guidelines around standards for providing care via telehealth. In addition, several organizations—including the American Medical Association (AMA), the American Telemedicine Association (ATA) and the Federation of State Medical Boards—have also put forward best practice guidelines for safe use of telehealth. For example, the AMA developed model state legislation, which provides guidance on establishing a provider-patient relationship. The ATA has a set of practice guidelines that cover different health care services in telehealth. FSMB's guidelines provide guidance for state medical boards.

Some states are also getting involved in ensuring patient safety by defining which services are appropriate to be delivered through telehealth (as described in the reimbursement section), creating guidelines establishing a patient-provider relationship, and mandating certain informed consent requirements.

Patient-Provider Relationships and Prescribing

In telehealth, as with other modes of care, patients should trust that providers will offer necessary information for patients to make decisions about care. They should also expect competent care, assurance of privacy and confidentiality, and continuity of care. Providers' ethical responsibilities remain the same with telehealth, but differences in possible patient-provider interactions in telehealth have brought accountability and the patient-provider relationship to the forefront in discussions about telehealth safety. Some states are examining specific guidelines for those relationships. In many cases, these requirements seek to ensure that providers have adequate information about a patient prior to treatment. As an avenue for service delivery, telehealth ideally would be integrated into regular, coordinated care and services. However, there is some concern about fragmented care from different providers or duplication of services. With that is concern that certain providers could deliver care without the proper medical history or information, which could endanger patients and also jeopardize the growing telehealth field. On the other hand, there remains

KAISER PERMANENTE NORTHERN CALIFORNIA

Kaiser Permanente Northern California implemented new technology and telehealth tools in 2008, including internet and video communication. Kaiser offered secure email services and phone appointments with providers, both of which were rated highly by patients—more than 80 percent of members in surveys reported that the communication with providers using these technologies was very good or excellent at meeting their needs. Kaiser also used video visits for some services, including after-hours medical care. Providers could refer patients to in-person emergency care as needed, but largely these visits helped avoid more costly ER visits. Physicians also reported that the online tools helped them provide better care. From 2008 to 2013, the number of virtual visits grew by more than 6 million.

Source: R. Pearl, "Kaiser Permanente Northern California: Current Experiences With Internet, Mobile, And Video Technologies," Health Affairs 33, no. 2 (2014): 251-257.

unease about creating higher standards for telehealth that can inhibit access to care.

At the crux of the patient safety issue are questions about whether and how a patient-provider relationship can be established via telehealth. The majority of states allow a patient-provider relationship to be established via telehealth. Some states have laws requiring an initial "face-to-face" visit or an exam; however statutes are not always clear whether "face-to-face" means in-person or via live telehealth interaction. In these cases, it is often up to provider boards to interpret and set policies. A few states specifically require an in-person visit or exam. Arkansas, for example, enacted legislation in 2015 (SB 133) that designates specific requirements for determining a professional relationship, such as conducting a prior in-person exam or "personally [knowing]" the patient.* Alabama, Georgia and Texas also require an in-person follow-up after a telehealth visit.[53] Many stakeholders are wary of requiring in-person visits because of the additional burden placed on the patient to seek in-person care, which could help recreate some of the barriers telehealth seeks to remove.

The patient-provider relationship also comes into play in prescribing medication. Federal law—the Ryan Haight Act—governs controlled substance prescribing via telehealth. State laws also govern a provider's authority to prescribe, including provider board rules and regulations that set the standard of care for prescribing. State pharmacy practice acts also regulate the standard of care for pharmacists. The accepted standard of care is for a provider to conduct a medical exam prior to prescribing a medication.[54] As with telehealth in general, some states allow the exam through telehealth. However, almost all states specifically do not allow an online questionnaire alone to count as an exam, because it relies solely on patients to provide their medical history and other applicable information for a provider, which is not keeping with the standard of care.[55] For example, Idaho's 2015 legislation (HB 189) that defined professional relationships included a clause that treatment based solely on an online questionnaire does not constitute an acceptable standard of care. Most stakeholders agree that if providers can prescribe and dispense medications via traditional means, they should be able to do so via telehealth as well, provided they can establish a relationship and gather the necessary information.

Informed Consent

Informed consent is a process by which a patient is made aware of any benefits and risks

** At the time of publication, the Arkansas State Medical Board had a proposed rule pending that would allow establishment of the patient-physician relationship via telehealth in certain circumstances.*

CARE AND DATA COORDINATION

Information and data from telehealth visits, along with integration with a patient's medical record, present additional considerations for continuity of care, patient safety and health. Many hope that telehealth is integrated in a patient's regular care and coordinated with primary care and other providers. On the other hand, as with services like urgent care, there are some concerns about patients accessing services and/or prescriptions online without their primary care providers' knowledge, which could have implications for the patients' usual care. In either instance, questions remain about whether the responsibility to share data among multiple providers rests with the provider or patient.

Connecticut (SB 467) passed legislation in 2015, for example, requiring providers to ask patients to consent to disclose records from the telehealth interactions with their primary care provider, and if consent is granted, to do so in a timely manner. Alternatively, Anthem's Live Health Online offers the patient a record from the visit that he or she can give to his or her primary provider. Other data challenges include creating policies around data storage and retention, ensuring that data are interoperable between platforms and providers, and managing large volumes of data created from modalities like remote patient monitoring and wearable devices.

associated with a particular service or treatment, as well as any alternative courses of action. Many consider this type of knowledge to be good practice regardless of the service delivery mechanism. Informed consent also relates to providers' liability and legal exposure. In the case of telehealth, it may be particularly beneficial for patients to know the potential risks and understand that a condition or treatment may require a provider to defer to in-person services. In terms of informed consent, some states are creating policies specifically related to telehealth.

Currently, 29 states have some type of informed consent policies.[56] This requirement may apply to different arenas—e.g., all providers or just the Medicaid program, or even specific services, depending on the origination (statute, administrative code, Medicaid policy) and intent of the policy.[57] States that require informed consent also vary in whether they require written or verbal consent. Less than 10 states require some type of written consent.[58]

Informed consent also provides patients the option to decline a service or treatment. In Colorado, for example, the law requires providers using telehealth to give patients a written statement of informed consent that includes their right to refuse services delivered by telehealth at any time without losing or withdrawing treatment.

Related Issues

Telehealth considerations often bring related issues such as fraud, abuse, data security and the federal Health Insurance Portability and Accountability Act (HIPAA) to the discussion. Some argue that privacy and security must be addressed to advance telehealth and ensure providers' and patients' trust in telehealth.[59]

Fraud and abuse of services delivered through telehealth can be monitored in the same ways as other health care services. The risk of provider abuse or fraud in telehealth may not necessarily be higher than any other mechanism of care. One provider who bills for a disproportionate amount of telehealth services may warrant an audit, for instance, just as it would be justified for a provider with outlying data in any service provided through traditional care. Including a unique identifier in the data can help stratify telehealth so it can be monitored separately. As telehealth expands, the implications of various federal and state fraud and abuse laws could create more liability concerns for providers[60]

and may be an area to watch.

Security of patient health data and compliance with HIPAA are also considerations. Patient privacy, confidentiality and data security need to be protected at all stages of a telehealth encounter, as it would be in traditional forms of care delivery. Telehealth services need appropriate protocols and measures to protect patient security and integrity of data at the patient end of the electronic encounter, during transmission, and among all health care professionals and other personnel who may be supporting the technology. Audio, video and all other data transmission should be secure through the use of encryption that meets recognized standards. Security features such as multi-factor authentication and the ability to remotely disable or erase personal health information are also examples of ways to protect mobile device use.

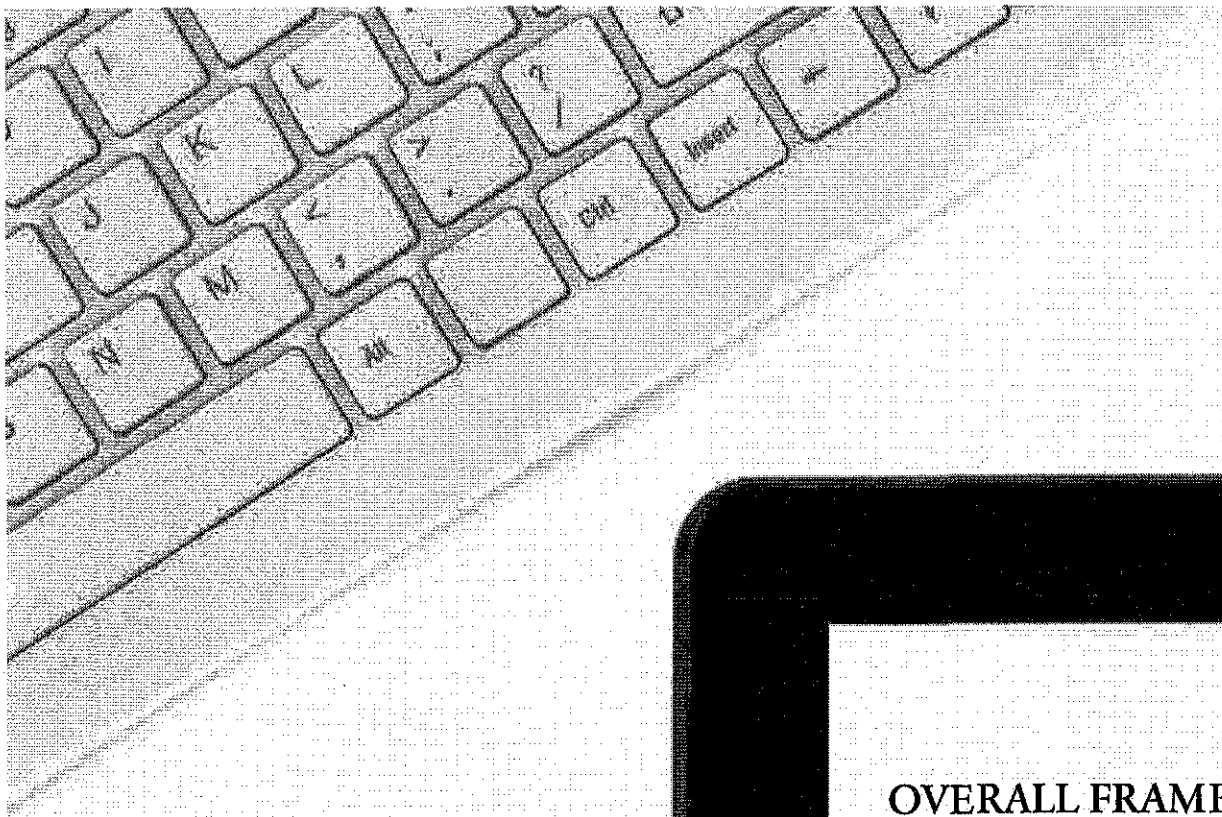
Some providers and others are paying particular attention to HIPAA compliance in telehealth technologies and electronic health records systems. However, using telehealth does not change existing security guidelines or responsibilities under HIPAA, and entities such as providers and insurers are subject to the same standards as in-person care.[61] Business associates, such as technology services that help deliver health information, are also defined under HIPAA and may need to be examined under telehealth protocols and policies. Whether, and the extent to which, state policy is needed is still emerging. However, some stakeholders also believe the federal law—which supersedes state law, except in the cases of more stringent state laws—provides enough guidance.

Safety and Security Policy Checklist

- Study existing statutes to see whether and where clarity might be needed to help guide safe telehealth policies and practices. For example, look at definitions of patient-provider relationships or examinations and consult with stakeholders about changes or considerations.
- In looking at existing or new legislation, balance the constraints being placed on telehealth with the need to safeguard patient privacy, safety and security.
- Examine how data are collected on health care services delivered by telehealth. Data collection that includes a telehealth identifier for billing purposes (as Medicare does) helps in evaluating programs and monitoring for fraud and abuse.

CONCLUSION

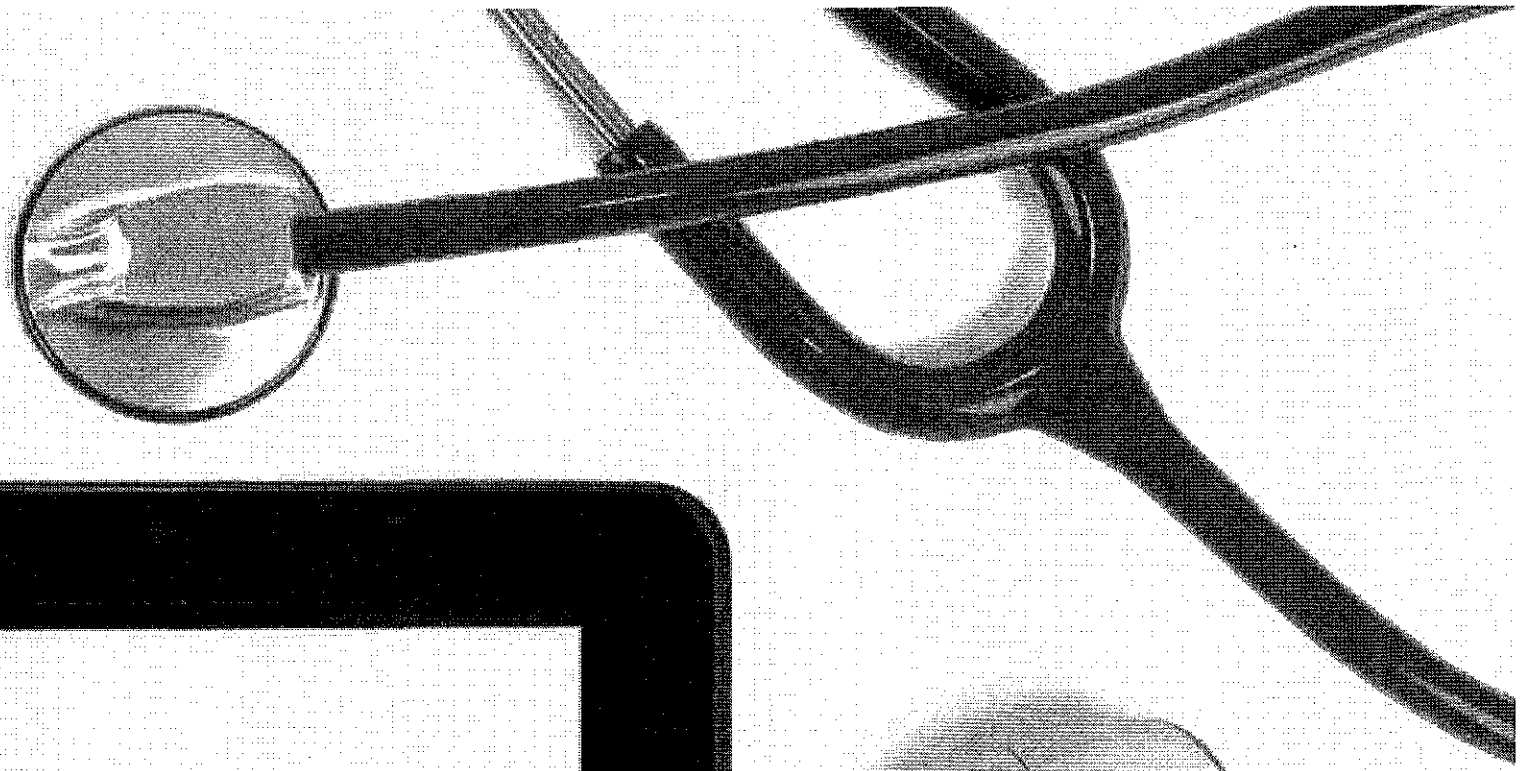
Telehealth is a rapidly growing field that has the potential to help states leverage a shrinking and maldistributed provider workforce, increase access to services, improve population health and lower costs. State leaders are grappling with how to capitalize on this potential while safeguarding state investments in telehealth and ensuring patient outcomes and safety. Reimbursement, licensure and patient safety will continue to be issues for state policymakers to consider, along with new challenges and opportunities, as telehealth grows and develops.

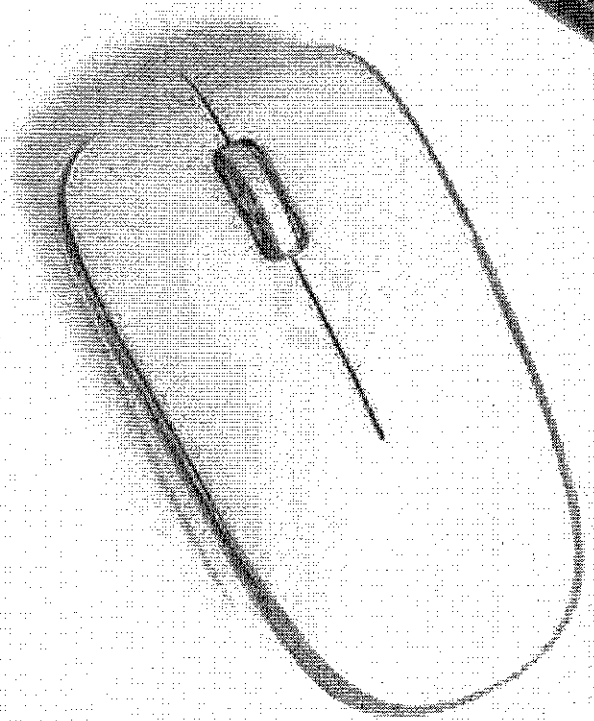


OVERALL FRAMEWORK FOR CONSIDERING TELEHEALTH

- Telehealth is a tool for delivering care. Help guide policy discussions that center on telehealth's ability to extend existing health and long-term care services with technology, versus describing telehealth as a new service.

- Conduct a needs assessment to find out where telehealth services are already being used and where investing in telehealth may be most effective. Identify model programs that may be replicable in your state (e.g., university, private hospital systems, etc.). Study existing laws and best practices that may also apply in telehealth (e.g., standard of care).





- Convene a variety of stakeholders from all sectors and perspectives to help ensure the best information is available when considering policy decisions. Consider all types of health care providers (e.g. physicians, nurse practitioners, physician's assistants, psychiatrists, etc.), state boards, community health centers, hospitals and payers, as well as consumers, patients and family caregivers.

- Telehealth is changing and growing rapidly. Consider the level of oversight needed to ensure that services are effective in terms of cost and outcomes, and balance those needs with potential unintended consequences or future hurdles as telehealth develops.

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