Company: **SSA Audio Only Account**

Conference Title: **National Disability Forum**

Moderator: **David Brennan**

Date: **Thursday, 27th October 2016**

Conference Time: **12:00 CT**

Speaker:

Good day, everyone, and welcome to the National Disability Forum. Today's call is being recorded. If you have questions today, please press *1 on your touchtone telephone. We will be hearing from Doug Walker momentarily. Please stand by. You will hear silence until then.

Doug Walker:

Good afternoon, everyone. I'm Doug Walker the Deputy Commissioner of Communication and Social Security and welcome to everyone here in the room and to everyone joining us by phone. Now there are a lot of you out there. I understand that right around 140 was registered to participate by phone today and it feels a little lonely here in this space in this big auditorium but I guess, this telephone thing is finally catching on. Now, who knows? Maybe 150 years from now, we'll be talking about disability policy through Snapchat. And those of you with teenage kids know what I mean when I say hope that day never comes to pass.

And anyway, in all seriousness, regardless of method of participation and we'll be live tweeting today, we are looking forward to an outstanding conversation and in an informative and terrific input from you all on our disability policy making which is all - after all the whole point of the Disability - National Disability Forum sessions.

It's amazing how much technology allows to accomplish together these days without even having to be in the same location. And it just so happens that it's an important consideration for our program and the focus of today's discussion.

Social security is with the people we serve through their life's journey. This includes people with disability as well as those who aren't living today but could potentially quality for social security disability or SSI benefits in the future and so that's pretty much everyone. Most people would be surprised to learn that about one in four twenty year olds will become eligible for disability benefits before they reach retirement age.

Our disability programs provide a basic level of financial protection and helps keep society strong by establishing a floor of economic security for its most vulnerable members. Many of you know that the social security disability program turned 60 this August, that's 60 years of age. Social security disability benefits lifts 3 million people out of poverty every year. While these - payments are modest, less than average - on average of about $1,200 a month, they constitute the primary source of income for most of the people who receive it. SSI payments are much less than that disability benefits on average but they can make a meaningful difference. Together, the social security disability insurance and SSI programs pay benefits to over 14 million people who live with disability. Because the law requires us to define disability very strictly, these are among the most severely disabled people in our country.

Today's forum will focus on leveraging telehealth and telemedicine to enhance our disability programs. I know I don't need to tell anyone here why maximizing efficiency in our disability programs is so crucial. Making ends meet while living with a disability can be extremely challenging even after getting the green light to receive social security disability or SSI benefits.

For many of our claimants, waiting to find out if they will receive benefits or even if they will continue to receive them, adds more pressure to an already stressful situation. Initiatives like our Compassionate Allowances Program help ensure that we get benefits quickly to applicants whose medical conditions are so serious that they obviously meet our disability standards.

We must take full advantage of every tool at our disposal to eliminate unnecessary delays for all of our claimants and that includes the remote technologies that we will be discussing today.

In just a moment, Social Security Chief of Staff Stacy Rodgers will kick off our important conversation but first, a few housekeeping items before we get started. We're recording today's program so for security reasons, please do not mention any person identifiable information, any personal information, particularly, social security numbers. Please don't mention them in your comments today during the discussion or any – in your related communications with us.

Social security will also be live tweeting through the afternoon including photographs of the event. So, if you do not wish to be photographed, please let us know. I'm not going to call you out here but please let me know. Joini Palmer, if you raise, let Joini know and, of course, Alan who will pointing that camera at you. You can let Alan know as well. Please let us know if you wish to be photographed.

You can follow us on @ssaoutreach. That's @ssaoutreach and retweet our messages using the #ssaintheforum. That's #ssaintheforum is the hashtag, no spaces or punctuation marks. For people in the room, please feel free to use the NEAs wifi network. You can log into wifi and select the "Guest Network". You'll find - you'll need to enter and email address and there should be instructions on the table for you to follow for reference.

For people on the phone, if you have questions about our panel, please email them to nationaldisabilityforum@ssa.gov. That's nationaldisabilityforum all one word, no spaces or punctuation nationaldisabilityforum@ssa.gov.

Before I yield the floor, I want to remind everyone about our - about the open enrolment period for the Affordable Care Act Insurance Plans. The open enrolment period for 2017 Health Plans on the Health Insurance Marketplace begins on November 1st and continues through the end of January - January 31st. Visit healthcare.gov for details and please help us spread the word. For anyone who may not have heard - I'm sure you all have - want to mention that the Cost of Living Adjustment came out a little - a short ago at 0.3% for social security and SSI beneficiaries. Cost of Living Adjustment help prevent inflation from eroding the value of these benefit and you will recall that by law, the consumer price index guides, whether there will be an adjustment and the amount of the adjustment as well.

Finally, we will send you an email with a link to complete an evaluation of today's forum and we ask that you please take just a few minutes to complete that. This will help us to plan future disability forums and ensure that we're doing everything that we can to make our time together as productive as possible and we really value your candid feedback.

And with that, I'd like to introduce to Social Security Administration's Chief of Staff, Stacy Rodgers who will be begin today's program. Thank you very much.

Stacy Rodgers:

Thank you, Doug, and good afternoon everyone here in the room as well as colleagues who are joining by phone. It is such an honor to be with you this afternoon. When we began talking about this event, I got really, really excited because I have a personal interest in telemedicine in terms of future healthcare options.

On behalf of our Acting Commissioner Carolyn Colvin, she sends her greetings and her thanks for all that you do to help us as we discuss public policy issues. Carolyn is in Seattle today and was

unable to join us but she, again, extends her welcome and we'll hear a little bit more from Carolyn through technology, through a video that she presented - that she prepared for today's activity.

I, personally, want to thank each of you who had joined us today but I also want to take this opportunity to thank our colleagues and ORDP and Communications and all who helped to put today's program together. This - these efforts really are a testament to the nature of the work in public policy, that it cannot be done in a vacuum, that it must have input from our colleagues, advocates, our beneficiaries, applicants so that we have the full discussion and we have a robust input to the decision making.

And so as we move forward today, for those who are familiar with the terms telehealth, it encompasses a range of virtual health-related content, a topic that, you know, is not new as you'll hear but it is a full range of activities whereas telemedicine refers specifically to practitioners delivering clinical services for patients in another location. Telemedicine is subset of telehealth. That was a good clarification from [inaudible] as well. So, we always want to be knowledgeable of what we are saying.

Our panellist today will provide insights into these exciting areas in touch on rich potential for helping us administer the social security disability and SSI programs. And as I said earlier, I am very, very interested in the topics and just so pleased that we have experts with us today to share more with us.

Before, as I said, I get started, I want to thank you on behalf of Acting Commissioner Colvin, not only for providing this exceptional opportunity to hear your diverse view but also to help us to think outside the box and think more creatively about the challenges we face as an agency, whether it's updating our policies, reflecting changes in the world around us or taking advantage of new technologies to serve our beneficiaries and claimants more efficiently. Social security never operates in a vacuum and we do not want to.

This is why Acting Commissioner Colvin launched the first National Disability Forum over two years ago. She's very proud as I am of what we've accomplished together in such a short time through these discussions and since she couldn't be with us in person today, I'd like to take this opportunity to present a brief video message. For those colleagues on the phone, you should be able to hear the audio on the line but also know [inaudible]-

Carolyn Colvin:

Good afternoon, everyone.

Stacy Rodgers:

Then we will send you an email with the video link so you can actually watch the video later. So, I'll pause here and we will show the video.

Carolyn Colvin:

Because I could not join you in person today, I wanted to be sure I had a chance to share my thoughts with you. It's hard to believe it's been two years since I addressed the first National Disability Forum and this is our fifth gathering. Your input has helped us refine how we consider medical evidence in disability determination; explore new options for helping children who receive SSI transition successfully into the adulthood. Examine how age, education and work experience can affect a person's ability to work while living with a severe impairment and evaluate our criteria for assessing extreme limitations in focusing on work-related tasks.

Today's forum centers around telehealth and telemedicine. I'm excited about the potential of these technologies for helping us gather and respond to medical evidence as quickly and thoroughly as possible. Our goal is to get our claimants an accurate determination as soon as possible. And this is another tool that will help us do so.

Like the previous forum, I'm confident that this will be a productive exchange of ideas. As knowledgeable as social security's experts are, there's no substitute for hearing from the people we serve and the organizations that most understand them. I had made transparency and public engagement top priorities throughout my service as Acting Commissioner because I truly believe that's the best way to get things done well. We have far too much on our plate to miss any opportunity that could help us work smarter or serve the public better and that includes gaining from your perspective.

To paraphrase President Obama, effective governance is transparent, participatory and collaborative. Engagements like these prove that. We value your insight and what we learn here informs our policies. Change is part of the natural order in all organizations. As we transition to new leadership, I want to thank you for demonstrating the power of open government. One of the strengths of our democracy is the changing of the guard with each new administration. I know my successor will appreciate the work we have done here together. The foundation we have built for continued collaboration and the spirit of partnership.

I certainly am tremendously grateful for the privilege of working closely with your organizations and with each of you individually as you help us support the American people through life's journey. Thank you and have a great discussion.

Stacy Rodgers:

We appreciate the Acting Commissioner for taking the time to video tape that message. As Acting Commissioner Colvin just mentioned, we are always looking at new ways to work smarter and serve the public better. This includes keeping pace with rapid changes in medicine, science, technology and the world of work. I'm happy to say we're making substantial progress on these fronts.

For example, we're well on our way to updating and revising all of our medical listings and getting them on a three to five year cycle for future updates. This summer and fall alone, we published updated listings for the respiratory, neurological and mental body systems and more updated - more updates are in the pipeline. And I just want to stop to, again, applaud our colleagues in ORDP because this is not easy work so please join in thanking all of our colleagues in ORDP for making this commitment.

We're also encouraging more healthcare providers to take advantage of our advance health, IT infrastructure to transfer records electronically. Health IT streamlines the disability determination process and reduces the time needed for decisions. That's a plus for everyone involved; providers, our agency, and most importantly, the beneficiaries themselves.

As we've mentioned, today, we're here delving into another area where the worlds of medicine and technology are changing very quickly. A moment ago, I noticed a distinction between telehealth and telemedicine. We'll use the broader term telehealth when talking generally about the wide array of distant help options.

Telehealth isn't entirely new to social security. We hold many disability hearings by video and disability determination services in seven states, also using teleconferencing for some their psychiatric and psychological consulted examinations. Some of them have been taking advantage of this technology actually since 2008. These remote examinations are significantly reducing hardship on claimants who would otherwise have to travel long distances, especially, in sparsely populated states like Alaska, Kansas and Montana, while still satisfying our high-quality standards.

They also speed up the determination process and cut down on the government's travel reimbursement costs. Of course, every advance comes with some - its own set of challenges.

Technical difficulties can arise. Scheduling may not always be as seamless as we would want as the number of participating facilities varied by state.

So, far, we've just dipped a toe into the water with telehealth. Potentially, these technologies can lead to faster and more highly informed disability determinations by furnishing more complete medical evidence earlier in the process, improve access to specialty medical providers for a claimant in rural areas and hasten an informed disability hearings by making medical experts more readily available.

This is some of what telehealth can help us do but we need your input on how these technologies might fit into our work and any potential advantages or disadvantages of adopting them. We're still very much in the exploratory mode at this point and all ideas a welcome. We know there's much we can learn from people and organizations that make greater use of telehealth and as well as from the beneficiaries who will be affected.

For instance, we would like your thoughts on expanding our use of video consulted examinations, any special factors we should take into account when considering medical evidence obtained by using telemedicine, whether adjudicating doctors can be able to question or evaluate claimants remotely. The potential for video training and continuing medical education and using telehealth technologies to support disability hearings.

We also welcome any examples of best practices from organizations that currently use telehealth. And your suggestions about other factors, we shall consider as we develop policies around this rapidly expanding field.

So, I encourage everyone to participate in today's forum and join us identifying areas for further explorations. Please don't hesitate to share your thoughts. We really are here to listen. As researchers, practitioners, advocates, federal and private partners and other stakeholders, you bring a deep knowledge about the realities facing our beneficiaries and claimants. Along with Acting Commissioner Colvin, I, too, want to say what a privilege it has been to work side by side with you as social security works for our - with our national partners to secure today and tomorrow for the American public. It has been my sincere pleasure to serve as the agency's Chief of Staff and prior that the Senior Advisor when Acting Commissioner Colvin was the Principal Deputy. It has, indeed, been a pleasure.

So, let's move on to the program. It is my esteemed pleasure to introduce our moderator for today David Brennan. David is the Director of Telehealth Initiative for the MedStar Institute for Innovation.

David is a prominent telehealth researcher with more than 15 years of experience and we are glad to have him. We are elated to have him and all of our colleagues on the panel today. But for David, for his willingness to guide our panel discussion. So, please join me in welcoming David as we move on with the program.

David Brennan:

Thank you for that very, very warm introduction. I appreciate the opportunity to be here. This is a timely topic. We've got a great line up of speakers. We want to - in the interest of housekeeping - want to keep the program moving. Certainly, we've lots of opportunities. We jokingly said before this panel that we didn't make it easy for people to not be here to be here in this meeting, it would kind of be the ultimate of irony. So, please take every opportunity. If anyone's tweeting, the hashtag again is ssaintheforum. The email for question is nationaldisabilityforum@ssa.gov and if you want to chime in to the operator on the phone, you can hit *1. Again, and I'll try to remind you that a couple of times.

Let's start with an introduction, I work - my name is David Brennan. I work in MedStar Health which is a DC based healthcare network - distributed care delivering network of 10 hospital and a whole host of outpatient sites. My history in telehealth goes back a number of years, close to two decades and I got my start, actually, doing research in the remote delivery or disability-related services at the National Rehab Hospital and that was my first contact we had with SSA, maybe, 12 or 15 years ago focused on doing remote delivery of care and before the advent of 4G and high-speed internet entered the home. So, to watch the filed evolve is phenomenal.

The line up of speakers today is very strong. We have three people on site, we have one who will be participating remotely. So, please think about all of the, you know, vital questions you have. We'll have opportunities to interact during the open Q and A at the end. We want to be quick, try to get about 20, 25 minutes to ask some questions so please get those in. So, again, look forward to the opportunity to discuss how telehealth and remote care delivery can impact SSA and the processes.

Real quick. We're not going to do formal introductions for everyone but seated to my right - we'll go in order - is Kathy Wibberly. Kathy is the Director of Mid-Atlantic Telehealth Resource Center down at the University of Virginia. The group's doing phenomenal work. Her presentation today will talk about establishing the levels that are trying to really get the background out about telehealth and telemedicine, discussing a very experienced and, kind of, the telemedicine 101 of the field.

Kathy's got 20 years' of experience in public health, public policy program development, program evaluation and strategic planning and is just a tremendous resource.

On the phone, we'll be joined by Harrison Tyner. He is the President and CEO of WeCounsel Solutions based out of Chattanooga Tennessee. They're a telemedicine software company and his focus of his presentation will be looking at from the start-ups perspective. Some of the objections that oftentimes occur and that start-up are trying to push forward into a new opportunistic space that really is a paradigm shifting and what are some of the keys to success in starting up a program. I think there's a lot of parallels between the business world and the healthcare delivery world, so we'll share his insights.

Scott Baker is the Business Innovations Manager at InSight Telepsychiatry, a private sector group working on telepsychiatry service provisions so they are actually doing service delivery. I think what will be most, the really important vital aspect to that presentation, Scott's group works closely with insurance payers, healthcare organizations, manage care companies, EAPs and every other organization under the sun. We - I say all the time in this space my background is in engineering. If telemedicine was as simple as just writing a check and buying a thing, we would have been doing it a long, long time ago. So, we can move information, not people. That's a wonderful thing but we have to put people and processes around that. So, I think Scott will share a lot of that.

And, finally, Alan Dinesman. Dr Dinesman's with the Department of Veterans Affairs. He's the medical officer in the Office of Disability and Medical Assessment board certified in total laryngology. Say – I never say right, but I did.

Alan Dinesman:

Good job. Thank you.

David Brennan:

And Head of neck surgery and his current responsibility's is that the VA include working with the disability examination policies, process improvement, communication and education of the Compensation and Pensions Guild. So, I think across the board, we'll have a lot of good - find some good discussions, opportunities to participate. So, tweet your questions in, email them in, chime in on the phone but with that, I will turn it over to Kathy.

Kathy Wibberly:

There's a lag there. Here we go. Alright, so I'm going to be doing the big picture telehealth 101. And so, just to start the discussion going, what is telehealth? Telehealth is simply a mechanism. It's a tool. It's like having a stethoscope or, you know, a CT scanner. It's a tool that can enhance healthcare, public health, health administration and health education delivery and support using electronic communications and information technology. So, just think of it as a tool and not as a service line in and of itself. So, telehealth is delivered in primarily four ways. One is called synchronize and this is - I'm jumping ahead too far – be patient and let it advance – [inaudible]—

The first one is synchronize and this is what people typically think of as telemedicine. It's a live video where a clinician or provider is interacting with the patient directly by video conference live video. So, it's kind of what we call Skype on Steroids. Everyone is familiar with Skype but instead of kind the external public Skype interface, we're looking at HIPAA secure platform, we're looking at, you know, high definition monitors, we're looking at really good quality sound. And so, on the screen, what you see are just various examples of this. Of everything from emergencies for telestroke for in the ambulance to things like telespeech and in the schools with students. Choose the bedside. Patients, you know, doctors doing rounds at the bedside. So, there are a number of and a variety of ways that this is used and it's been around for a long time.

A synchronize is a second way that telehealth is provided and that is when images and other patient information are transmitted but there's not a real time live interaction between the patient and the doctor. So, for those of you who have ever had an X-ray after hours or on weekends, most likely that image is being transmitted to a radiologist, typically, on the other side of the country or on the other side of the world. Because one, it costs – it saves a lot less money when people are already awake and this is their normal hours than to be paying someone, waking them up after hours to look at your image. And so there are a lot of companies now doing teleradiology. That's a very typical standard practice.

But what you also see are things like diabetic retinopathy screening and how do we prevent blindness? How do we do this in places where there's not an ophthalmologist, in rural areas, in remote areas? And so we can take those retinol scans and transmit some to an ophthalmologist who can read them at their leisure, at their time. They have some down time in their office, you know - five minutes, 10 minutes here - we have an ophthalmologist at UVA that basically, has an app. The images come in on his iPhone. He can look at them while walking through the hallways and, basically, has a couple of responses. You know, "this looks normal", "everything's fine" "this patient needs to come in", "we have some abnormalities", "we need to, you know, see this person" or "I can't tell, we need to, you know, that image is not good enough quality, please resend in a

better image". So, there are different ways to do this. We're looking at it for dental care. Oral health is a big issue around the world in terms of there's just not enough dentists, particular, in rural areas. So, how do you we do some of things by transmitting images and letting some assessments take place? So, that's A Synchronism.

The third one is remote monitoring and a lot of you have probably been hearing a lot more about remote monitoring. It's not new. It's been in existence for a long time. The VA has been doing it, some of the best data out there for remote monitoring. So basic what that is is taking patient data, whether that's, you know, a glucose reading, a pulse ox, blood pressure, having that patient being able to transmit those readings on a regular basis to what's typically a nurse managed call center, they're putting in your parameters, so the patient's parameters. So, if you are, normally, you know, your blood pressure's very low, if you go to your physician's office and you get, kind of, what's typically episodic care, so you go when you either have your annual appointment or you're just not feeling well, usually your doctor doesn't know what the transit data looks like because they're not going to be flipping through every page of your medical record to see what's going on. But with remote monitoring, it becomes just regular, continuous monitoring of your blood pressure. And nobody wants to see that many data points so what happens is what's normal in your range gets entered into the system and then a flag goes up if you go out of what's normal for you. So, my mother has very low blood pressure, normally, and so it can be picking up over a period of time and it will still be in the normal and nobody will flag it as abnormal. But for her, it's very abnormal. So, when you are having a monitoring system where, you know, this is your normal range, it goes outside of normal, it gets flagged and a nurse will give you a call. You know, "Mr. Zu, what's going on? We - we're noticing something's going on." And part of what's really important about this is the patient education, patient engagement piece.

So, for example, my blood pressure shoots up all of a sudden and I put on five pounds. I get a call. You know, "Kathy, what's go - what happened in the last 24 hours?" "I forgot to take my meds" or, you know, "I went to this breakfast buffet and had this salt pork, and, you know, bacon and the three eggs, and blah, blah, blah, blah, blah". Okay, well, now you have a receptive patient who is now, you know, your behaviour, specific - directly impacted something that's going on in your body and let's have a conversation about this. So, this is really the power of remote monitoring and what we're finding is places that have done remote monitoring for their high-risk patients have seen pretty a 40 to 60 percent decrease in emergency room readmission, which is huge. So, that's one thing. We also have federally-qualified health centers using remote monitoring for their chronic disease management patients.

So, mobile health is the next big wave and we're seeing a lot of it. That is, basically, taking mobile applications, whether that's your cell phone, your iPad, your tablet, your computer and being able to deliver healthcare services through some of these mobile apps. And it could be as simple as a text messaging app that can help. Most of you probably get appointment reminders via text message now. That's telehealth. It's supporting administration. A lot of you are being able to schedule online, you know, schedule your doctor's visit. Go online, find out when the open slots, pick 30 minutes and, you know, schedule online. But we also have applications that can help you. You know, if you have a skin lesion and you want to take a picture of it and send that, there are applications that do that. There are all sorts of lots of patient education pieces also that come into this. So, there are apps out there all over the place. One of the challenges is kind of vetting these out. Because a lot of the applications are developed app developer and not physicians. So, how do we know what are good apps and not so good apps. So, those are some of the challenges right now.

We also have not trained our clinicians right now in how to use these apps in the clinical setting. And so, some people are playing with that and experimenting but there's not a formal training program. You know, how does the nurse manager or the nurse practitioner in your office, kind of, directs a patient with diabetes and say, "Hey, let's - this is a nutrition app. Let's put this on your phone and, you know, log your food, take pictures of your food, let's find out the calorie content." So, I think that's the next wave so we're not quite there yet on that. Like, you're also seeing things like Pokemon Go, right? So, how do you incentivize exercise behaviour? Well, you make it friendly competition. On - some kids are exercising even though you're not saying it's exercise. And so, it's the same with people with disabilities as well. You want them to engage in proactive healthy behaviors. So, how do we that? A lot of time is making it fun. I have a great who's in a wheelchair and she will love - she loves playing the Wii because it gets her moving and it's fun and that doesn't feel like she's exercising but if you tell her to go to an exercise class, she's like, "Oh, I don't know. I'm tired. I don't really feel doing that." Well, think about how we use technology to incentivize positive behaviors.

So, just a brief history. Necessity breeds invention and telehealth is not new. It's, actually, been around for over 25 years now and it started in rural, primarily, because of the access to care issues, access to specialists. And it was a great fit for rural because, you know, you couldn't get a patient to - especially, in the middle of winter over a mountain range for two hours to go visit a specialist in an urban or, you know, suburban area. So, when first started telehealth, it was like this. It was this hub-and-spoke model and you probably heard this terminology. You know, you have a hub center that where all the specialists were, that connected to smaller rural hospital, rural emergency departments.

Some examples of this hub-and-spoke model that still exists today and that have become just very huge success stories is telestroke. As everyone knows, there's a window of opportunity where you can assess a patient who's having a stroke, typically, about four hours from where the onset of symptom. So, if you're in a rural area and your symptom start, most people don't realize they're having a stroke. So, they're going to go lie down because they don't feel too well and then by the time they realize this is an emergency and call a volunteer EMF in a rural area which are, primarily, volunteer, it could be another 15, 20, 30 minutes before that ambulance shows up at the door. And then to deliver that patient to the rural community hospital that doesn't have a neurologist and then to make that decision, well, this patient needs to go to an urban get the mediflight out there, you have lost that window of opportunity for TPA. So, what we have found and studies have shown now, is rural hospital that do tell a stroke that can connect to a neurologist get the CT scan to the neurologist, they can make that assessment using - meet that same window of opportunity for that four hours for TPA, save that brain, prevent a lot of serious disability and for rural hospital to do this, their TPA administration is equivalent to a patient who comes to a primary stroke center in an urban setting. So, that's huge.

Yup, so some other examples are like Parkinson and other speciality care. So, we're moving now to challenges in the healthcare delivery system and so we all knew about healthcare reform and so what we're seeing now is no longer the hub-and-spoke model but a network of network where, you know, we have - a few ACs connecting to the local hospital to a primary care center and everyone's trying to connect it to each other from facility to facility. And so we're seeing urban telehealth take place and as those of you who live in this Washington metro area, it can be just as challenging to go the five miles as it would be for a rural person to drive the hour or two hours. So, urban telehealth we have things like schools addressing speech therapy. We have culturally and linguistically appropriate healthcare with translation and interpretation services. We have mobile now. Stroke in the ambulance so can we start the assessment early? So, if that ambulance is sitting in traffic in an urban area, you know, for 20 minutes trying to get through, can we start that assessment? And we are doing that.

Again, remote patient monitoring in urban areas. Homeless, getting those iPads out to meet the needs of those are in homeless settings. Project Echo is another way. How do we train clinicians to increase their capacity to deal with difficult issues, whether that's chronic pain or [inaudible] and now the [inaudible] dependent epidemic? So as we set forth, we are now at this point where we are looking at direct-to-consumer telehealth. And so we are seeing these things all over the place. It is a completely distributed network, wherever the patient may be. So, you know, it may seem Star Trek-y and futuristic, but we are literally – by the end of this year, there will be devices –

consumer devices that will be medical quality, that are affordable – can go in the home for about $200 where then the patient can literally send their heart signal – their heart sounds to a stethoscope – an otoscope. All of these things that you would need in a – kind of a primary care setting can be transmitted from the patient directly to the doctor. So we are seeing this into mainstream care delivery, but there is a struggle, and so – broadband is an – is an issue for rural areas. So direct-to-consumer broadband – you know, not all rural people can have that broadband access. But we're also seeing policies starting to shape that. These are some of them.

Reimbursement continues to be an issue. Medicare will only reimburse – and home is not a site of service right now – eligible. But Medicare also has geographic restrictions, so you have to be in rural and you have to be in a rural facility to be eligible for reimbursement, and only for a subset of services. So we do have to deal with that.

Quality and safety is also a concern, and so there are a lot of states – and the Federation of State Medical Boards are really looking at this issue, and has provided guidance documents regarding this issue. But the standard of the care should not change, whether you are delivering a service by telehealth or not. And so, if something is not, you know, amenable for telehealth, it should not be delivered by telehealth. And we do not consider phone-only telehealth, so we need to really think about that. HIPAA security obviously is an issue, and there are technologies, but technology can never be HIPAA-secure – or HIPAA-compliant. They can be HIPAA-secure. HIPAA is dependent on you as a provider and around a lot of other things that come into play.

So we are here – we are Telehealth Resource Centers, and so I just want to give you the resource. We're funded by HRSA, which is a federal agency, and our whole goal is to be able to provide technical assistance for providers – for agencies, organizations – who want to use telehealth to increase access to care. And there are 12 regional resource centers that are there to help you, and there are fliers in the back. And our services are completely free of charge, so if you have questions about policy, about reimbursement, about 'How do we select the right technology?' that is what we are here for. And this is my contact information.

David Brennan:

Thank you so much. I can attest first-hand to the quality of work being done by the TRCs. I'm partial to Kathy's, because they're right in the area. You have a conference in the spring every year. A great, amazing resource, like she said. They're there to serve the public, so private or sector patients – it doesn't matter. If you have a question – want to learn more, the TRCs are a great place to start. If you have questions, we're going to hold them to the end, but please send them in electronically if you've got them. We're going to switch to our next presenter now. Harrison,

I believe, is on the phone. We should be able to hear you. I was told, Harrison, to make sure you're speaking loudly. I think we wanted to make sure that audio was coming through nice and clear.

Harrison Tyner:

Yes, thank you. Hello, everyone. Can everyone hear me all right?

David Brennan:

Yeah, you're good.

Harrison Tyner:

Hopefully that's a yes. I appreciate Social Security Administration for having me on today as a panelist. As you mentioned, I'm going to be talking a little bit about the details of the technology component as it relates to telemedicine, and a little bit about our history and some of the roadblocks that we encounter, some of the use cases that we see consistently – and those are growing every day – and some of the keys to success around launching a telemedicine initiative or project or service line – whatever the case.

But I'll start with just a brief overview of WeCounsel and our background. So I founded WeCounsel in 2011, and that was largely out of an experience seeing the lack of access to behavioral healthcare first-hand through a loved one, and, through more diligent research, seeing that that's really not an uncommon issue – as it came as a surprise to me – and really saw a huge need to bridge the – bridge the gap of access to healthcare. And specifically our mission is focusing in behavioral healthcare. And so WeCounsel sprung out of that experience, and our focus has been on creating a complete, comprehensive online telemedicine solution – yes, with secure video, and also with other client engagement and management tools for a variety of different business models and use cases. So we work with individuals in private practice, group practices, clinics, telemedicine service providers, EAPs, higher education and certainly everything in between. So with that in mind, we do see many different use cases throughout our day-to-day operation, and that's given us a unique perspective on the industry.

Kathy, I think you did a really great job summarizing telemedicine and telehealth generally. I'll just touch on it briefly in the sense – or looking at it from a technology standpoint. From our point of view, telemedicine as an industry really started to break out in the last 2000s and early 2010-11 timeframe. And up until that point, what we were seeing was a little bit of an antiquated legacy

solution as it related to telemedicine – the Tandbergs, the Polycom, Cisco Solutions – that were, at the time, generally fixed in points, with limited ability to go anywhere outside of clinical settings. So you had to bring the patient in to whatever inpatient or outpatient setting that was going to be. It was typically a very expensive proposition for whoever was going to invest in a telemedicine solution, because it was hardware-intensive. So that made for a little bit of a high barrier to entry for everyone to experiment and play in that space early on.

But over the last six years, just seeing it first hand, it's really heartening to see how much telemedicine has expanded and the ways in which it has expanded from a technological point of view. It's now pervasive. Thanks to the Cloud and the Internet of Things, we are less hardware-intensive. It's more agnostic, and we have a myriad of different solutions – devices and Cloud-based software solutions 0 with different focus points to provide these solutions to the providers and healthcare stakeholders that we work with. So the emphasis today is more on mobility, flexibility in the use – in the software or hardware. And we're looking at new and exciting models like on-demand services, in-the-home delivery models. And all of a sudden these are viable, whereas just a few years ago, they really weren't.

And Kathy, as you mentioned, looking at the different models that are supported by these new solutions – asynchronous communication, remote monitoring devices – so that's anything from electric – electronic stethoscopes, video otoscopes, pulse ox monitors, blood pressure monitoring – you name it, there's probably a solution for that. So there's – it's a little bit of a fragmented industry as we see it today, with a lot of different solutions popping up all of the time. But certainly a robust selection today. What WeCounsel focuses on primarily is secure video, live interaction. And we augment that with a variety of different engagement tools, as I mentioned, from instant chat to secure emailing, document sharing and storage, interactive assessments and forms, and the list goes on.

David Brennan:

Harrison?

Harrison Tyner:

Yes.

David Brennan:

Could I ask you to pause? Could we ask you to pause for one second? We're going to adjust your volume. We're hearing some of the other folks on the phone are having a little trouble hearing you. You're fine in the room –

Harrison Tyner:

Okay.

David Brennan: –

want to fix so you're boosted for them.

Harrison Tyner:

Sure.

David Brennan:

Moderator, if you could turn the volume up, I think, in the –

Moderator:

Yes, I am work – I'm doing that right now. Thank you.

David Brennan:

Thank you.

Moderator:

Please go ahead.

David Brennan:

Right, you can go ahead again.

Harrison Tyner:

Okay.

David Brennan:

We'll let you know.

Harrison Tyner:

So, with all that said, we're at a really interesting point in the development of the industry, and, you know, we find ourselves in a situation where we are partnering with healthcare providers that have a whole lot of questions about how to implement a telemedicine solution and service effectively. And I guess that's where I'd like to start – is that first conversation that we have with a potential client that's looking at a telemedicine solution – looking at WeCounsel.

That first conversation that we have with a potential client that's looking at a telemedicine solution, looking at WeCounsel. So, you know, there's several different questions that I tell them to ask themselves when they're considering telemedicine, and really ask themselves, ask their organisations a few key questions. The first is what is your desired outcome? What is telemedicine going to solve and for your business or your organisation? That could be a myriad of different things, depending on who the person it is that we're speaking to. It could be, you know, the most fundamental reason; access - increasing access to care. You know, we work with a lot of private practitioners, so sometimes that's - we want to expand, or they want to expand their reach state-wide, or they want to stay competitive or they want to increase convenience for themselves and for their clients and make it easier to access care. And there's an argument for, well, I want to use this to reduce my no-shows and cancellations. We have a 20% no-show rate, and I think that we can recoup 5-10% of that through telemedicine sessions. And so, you need to understand what that is first, and that's going to be the basis from which we formulate a plan to implement a solution for that particular client.

So that feeds into the next question is, okay, well what's the business model and what is the use case. So again, that varies drastically. The business models that we commonly see are - typically we work with providers and group practices or individual practices, and it's a business-to-consumer, typically in the home, model. But we also work with some larger enterprise businesses, where that's either a direct consumer marketplace for the leveraging of provider network or maybe it's a business-to-business in-patient bedside setting where we're delivering care remotely in that sense. And so, we're trying to figure out what the business model is, what the use case is, and that affects what the workflow is. So what we also do is ask, you know, what part of the workflow is telemedicine going to solve? And one exercise that we ask our clients to do, really almost more for them than us, is to put together a diagram of how you see telemedicine working. And it could be just stick

figures, it could be elaborate; we've seen everything on all ends of the spectrum. But that gives them a great exercise to visualize how they're going to use telemedicine, and we take that back and we will formulate a custom solution based off of that diagram and all the conversation that we have around it. So, you know, we often see providers that walk in the door and they say we're really interested in telemedicine, we get the basic concept, but I have no idea what I'm doing, I have no idea where to store it, or what this is, or if you're going to give me the hardware, or if you're going to give me the patients or what have you. So, you know, typically they haven't done their homework, and it, kind of, falls to us to sit with them, talk with them about all of these different points and see if there's a fit.

I think when you're talking about workflow, you know, the overarching theme is, especially for businesses and practices, I would say, are we going to vertically integrate or is this going to be a horizontal integration, or is there something in between? By vertical integration I mean is there already a solution, or software or app that you are currently leveraging that you're satisfied with and you want to integrate telemedicine or the videoconferencing scheduling piece into that workflow? Or do you want to potentially have our solution running alongside whatever you're currently using? Or maybe you don't have anything and this is a standalone solution. And so vetting that out, understanding what the capabilities are that are needed, what are there today and how do they play with one another is the next level down conversation that we'll have.

David Brennan:

Coming up in about four minutes, just wanted to give you a heads-up.

Harrison Tyner:

Okay, great. So, you know, that's probably the hardest part about the entire process is answering those tough questions. Jonathon Linkous the CEO of the ATA, American Telemedicine Association, said probably the greatest obstacle is figuring out how we're going to integrate telemedicine into an existing workflow. And so once we have that conversation and we gain alignment, that's the biggest hurdle to pass, and from there, you know, we start looking at moving forward.

There are a few other things to consider, especially when it comes to setting. I've already mentioned a little bit of the business model and use case, but the setting, is it going to be exclusively in an in-patient setting, is it going to be an out-patient in the home or a combination of the three, and are these going to be first-time interactions or are they going to be recurring? And, you know,

who's going to be doing the scheduling? Who is going to be checking the patient end of the session? So what are the stakeholders around the table that are going to be affected by this new service, this telemedicine solution? So making sure that everyone understands what that is, and the diagram, once again, helps them understand this, is probably the biggest piece.

I think - just a couple of other things. Resources - I think you've got to ask yourself do you have the resources? Are you serious about this? You know, resource is necessary as far as budget, as far as people able to champion this project is their buy-in. So, you know, that's an honest question. You've got to ask yourself is this the right time for you to do this? I think probably the biggest risk after a telemedicine solution is implemented is failure to adopt and truly integrate that into your workflow. And if there's no one there to champion it and really drive it home and drive the utilisation, then it's probably going to fall flatter at - you know, it's going to get shuttered eventually and you won't see the value out of that. So you've got to know - you've got to have the resources behind it and you also need to know how you're going to promote it and take it to your patients and potentially to a new market. So—

The last piece to that is when you're assessing all of this your requirements today may be different than the requirements for tomorrow. So, you know, this needs to be a long-term planning phase, where typically a lot of the clients that come in the door are piloting; this is their first time trying it. And, you know, maybe they're using a limited set of the capability that we counsel or whatever solution offers today and they want to grow into the rest or they're going to expand into different service lines or use cases over time. And, you know, is there a timeline for that? Does that software meet the needs of the future and not just the needs of the present? So, all good questions to ask yourself.

I'll move along quickly. When you're selecting a vendor there's a few key things to look for. Obviously, if the vendor HIPAA compliant, at least for their portion of the interaction and data storage, so, you know, for us that looks like, you know, is the cloud platform encrypted, is the video encrypted, do we provide business associate agreements, are we doing a third-party risk assessment once a year and are we continually vetting new features that are coming out and making sure that there are information blocks for the right people to see the information they need to see and blocking the rest that probably shouldn't be seeing that information? So it's a continual effort. You know, they should be able to prove that to you or show you policy and procedure around that.

David Brennan:

We're right at about time and I have a couple of notate for you when we get back to the Q&A for you to wrap up on. But you talked a lot about workflow, so I have some questions that I would like to tee up for you later -

Harrison Tyner:

Yeah.

David Brennan: -

But if there's a take-home message to your spot, I'd like to move on to the other folks.

Harrison Tyner:

Okay. The keys to success here for us is you need to define what your success is, what is the desired outcome, know how you're going to integrate with whatever your current workflow is, make sure identifying the right solution for your use case and make sure it meshes with your business as it grows and evolves, know how you're going to promote and adopt this new service offering, and then always evaluate and iterate after the initial launch, because there's always room for improvement and there's always something that could be optimized within that – within that new service line. So, I mean that's it, I suppose. Thank you.

David Brennan:

Thank you very much. We will move down the line to Scott Baker from Insight Telepsychiatry.

Scott Baker:

Thanks, David. Thanks to the Social Security Administration for having me as part of the panel. It's a pleasure to speak to all of you, and I know I'm joined by the other panelists in saying I'm excited to hear what comes in, in the Q&A portion. So, my intent during our presentation is to give you a bit of an idea of who we are, where we came from, some opportunities within the market for mental health care that we have seized upon to improve access to care; as well, some of the obstacles along the way, and some trends, mostly for the favorable as regards some of the obstacles. I tend to have a tone of voice that does not carry well, so I apologize. So, just quickly a bit about who we are.

Insight Telepsychiatry exists to increase access to high quality behavioral healthcare through innovative applications of technology. We were born out of a traditional bricks-and-mortar behavioral health practice 17 years ago. We are the leading telepsychiatry practice in the nation, and we were doing telemedicine and telepsychiatry way before it was cool. You'll see at the top of the slide here 'CFG Health Network' is the behavioral health practice that we were born out of. CFG is located in Southern New Jersey, and owns and operates a number of large outpatient practices for behavioral health, as well as doing a full complement of residential services, inpatient psychiatry work and corrections work. And so, as with many innovations, not just within healthcare, we got started in telepsychiatry out of necessity: the mother of invention, right?

And so, as a fledgling practice in an area where – when a lot of folks think about New Jersey, they think it's the most population-dense state in the nation, which is why I live in Virginia. And the southern area of New Jersey is not really, and they suffer from some of the same shortage of available health providers that many other areas do, and so we were providing boots on the ground coverage to a local hospital emergency department that changed their requirements for covering physicians to require the psychiatrist to live within 30 miles. Not only did none of the providers in our practice meet that standard, no psychiatrist period met that standard, and that's in New Jersey: not that far from Philadelphia, to be honest with you. So, that was our start in the late 90s. From there, we have grown to additional applications in telepsychiatry, as well as grown in our geographic coverage. Today, we provide services in 28 states, truly all across the continuum of care.

Just to set the tone a bit, off of what Kathy mentioned, we provide synchronism, real-time find face-to-face video conferencing with psychiatrists, psychiatric nurse practitioners, as well as a full complement of non-prescribing behavioral health providers. And so, one other point on Kathy's slides that really rang true for me is that, while a lot of folks think of telemedicine as, oh, that's probably great for the rural areas, when it comes to behavioral health, the urban areas struggle with shortages of access to good quality behavioral health providers, just as the rural areas do. In fact, 96 percent of the counties across the entire United States have an unmet need for behavioral health prescribers.

A lot of folks talk about the benefits of telemedicine in general with respect to reduced travel times and travel costs, and that certainly is one benefit. But specific to our experience, and one of the main values, is tapping into a level of expertise and a provider that's not physically within your community, or not physically available to you at the time that you need them. And so, that will come back through in the challenges portion, as we talk about licensure.

This slide highlights some of the settings that we have experienced. You're going to find tele behavioral health quite commonly in hospital emergency departments to reduce psychiatric boarding time. When we're able to provide face-to-face consultation of behavioral health patients within an hour when they walk in the door of an EB, that is a gross improvement from what a lot of patients experienced in urban areas. We also provide these types of services in more outpatient type settings, as well as in home.

So, who we are ultimately is our provider network. We have an employed network of providers, through a web all across the nation. We employ about 225 psychiatrists and psychiatric nurse practitioners, and we also contract with an independent panel of about 200 providers. As telemedicine there's a fast – is growing quite quickly, so is the level of interest among independent providers to practice, which in a field like behavioral healthcare, which suffers from quite a workforce shortage, it's very potentially impactful to have independent providers practicing telemedicine, because that not only increases our utility to patients and the communities all across the nation, but we also get more work out of them because when you're at home, in your private space, not having to travel from one corner to another, you get more hours of service directly with that patient.

One of the questions we were prepped with, and I apologize to David if I'm taking one from his list at the end, but is: how do identify providers? And so, not every psychiatrist in the world is a good fit to practice through telemedicine. And one of the main factors that we pin our sustainable success on is selecting the right type of provider, and setting them up to practice in a way that will enable to continue to provide the same standard of care through telemedicine that they do if they were physically within a clinic or a hospital. How do we do that? We didn't download some program. We didn't go to some seminar. 17 years' of experience is how we can identify what types of characteristics or qualities, background, expertise, education lead to indicators of good success of being a remote provider.

It's another area not just in selecting providers that’s important, but also supporting them, because if you have a provider who goes from Monday to Friday, 8.00am to 5.00 pm, 40 hours a week in an outpatient clinic, they're used to being surrounded by peers, having the opportunity to collaborate with others. And that is one thing that I think a lot of other telehealth programs could stand to benefit from. And something that we do a very good job of is physician and provider engagement, so that they continue to feel surrounded and supported in the ability to collaborate with their peers, and not feeling professionally isolated.

So, briefly, I have three divisions of care. The first, on the left-hand side, is on demand services, where we have a team of psychiatrists available around the clock, as needed. Common applications of this service model are hospital emergency departments and walk-in crisis centers. On the right side of the slide is scheduled services. That is typically where we integrate a single provider within a clinic to be a part of their treatment team, to manage a population of patients on an on-going basis. So, the on-demand services, we have a team of doctors available around the clock. Scheduled services is a consistent provider. At the center, in the middle, is our most recent service launch, where we're providing direct-to-consumer services, where the consumers are oftentimes at home or in another private setting, and oftentimes has access to that type of service through their health insurance benefits.

I'll go briefly into more depth on all of these, but before I do so, I'd also like to highlight that it is never our intent to replace good quality, on site, in person services. We firmly believe that telehealth is to be used as an extension, as a supplement, as a complement, to well thought-out processes and established continuums of care. And so, this should not be necessarily seen as a replacement of good quality existing physician-patient relationships.

And so, the two basic models that we provide is a consult model or a treatment model, so it's not uncommon for our psychiatrists or our therapists to be asked to provide a doctor-doctor level consultation. In fact, in the behavioral healthcare field, we believe collaborative care is the next great horizon to improving access to care and reducing the impact of the workforce shortage. Treatment models are also very possible and very feasible through telemedicine, such that our psychiatrist is able to actually evaluate, write orders, make decisions on that patient and directly provide care to that patient as if they were physically there in person, as opposed to just acting in a consultative role to another provider who may physically be there.

One thing I'd like to highlight with regard to on-demand services is the timeliness of care. It is not uncommon for patients within an emergency department to languish for hours, if not days, if not weeks, and so being able to act as a provider, they may be in New York State, the patient may be in California. As long as that provider has an operating knowledge of the treatment team and services available in the community, we can do a better job of getting that patient to a less restrictive, more appropriate level of care. Scheduled services is a very common model, one that you're seeing a tremendous increase in uptake across the nation in, and quite honestly it's easy to mistake a scheduled services telemedicine model as a staffing alternative. But when it's presented within the scheme of integrating, hand in glove, within the existing model, at an outpatient clinic like a community mental health center or a federally qualified health center, it can be very, very effective to use a remote provider like a psychiatrist or a child psychiatrist to see the patients interact with

treatment team meetings through real-time videoconferencing. It also has the benefit of scalability. A rural clinic may only need a day a week of child-adolescent psychiatry, and so it's not feasible or even practical for them to hire a child-adolescent psychiatrist for that – for just one day a week, and so we can do that, also share services across multiple sites through the power of telemedicine.

Empathy is our at-home care model direct to consumer and I think reflects – the fact that we can say today that this is a successful service line reflects a lot of the great advancements that have taken to reduce barriers to care and reduce obstacles to full implementation of telemedicine recently. There are patients who have access to our psychiatrists and therapists through their health benefit that they get from their employer or on the marketplace. What this actually means to the patients is that lowered stigma – to be able to see your provider from home. You put the kids to bed, you're able to have a session with your therapist after they go to bed. The other thing is healthcare consumerism. How great would it be to be able to choose your psychiatrist, to choose your therapist or other— or other healthcare provider before you actually commit to having a session with them. And so models like we have with Empathy enables a bit of consumer choice and engagement in the process as well.

Factors that impact here. I imagine some of the questions in the future, at the tail end of this presentation will go into that, but reimbursement is one that we've seen tremendous improvements in recently. Today, 35 states have laws that govern private payer coverage, which typically means that private payers do reimburse in those states. 48 states and the District of Columbia provide Medicaid fee-for-service reimbursement. These are all very positive factors. We do need Medicare to make some improvements, though, as Kathy went into. Licensure is a huge expense for us. It's also a huge time-limiting factor for implementation of services, because we can hire a psychiatrist who lives in Los Angeles but the need might be in rural Missouri and it currently takes 12 to 20 weeks to get a license in Missouri. They're happy to license us, they're happy to take our check, but it still means 20 weeks for that provider to be able to provide services.

Before I go on, I want to give a big shout-out to the Interstate Medical Licensure Compact, as well as hopefully what's coming soon, which is a similar design for nurse-practitioners. This is, from our perspective, the most promising advance in allowing states to still have a say and protect their citizenry but also allow provider groups like us, who have a very strict vetting and credentialing and maintenance process to ensure that our providers are good, to be able to do so in a much more streamlined fashion. So we're really excited about that.

So one last piece here I'll tease you with is another obstacle which fortunately we're getting more clarity on, regulations around scope of practice. We're able to use more psychiatric nurse-

practitioners through telemedicine than we would if we were just a traditional bricks-and-mortar practice, because we can oftentimes have collaborative or supervisory relationships with those providers across state lines. Similarly, it is not easy to do business across state lines. You have to know what constitutes the establishment of a physician-patient relationship in each state you provide. We have to know what the professional boards say. You have to know what lawsuits are pending and - that's a little tongue in cheek, but it is still a fragmented market out there. There's just more clarity from the state medical boards and pharmacy boards that are of benefit to us, so right on time.

David Brennan:

That's very accurate. Thank you for that and a good introduction to some of the issues that – Kathy, I'm sure we've all used this in our presentations, as a patient we're required to cross state lines all the time. I live in Virginia, my doctors are at Georgetown, so happy to require me to cross state lines, but electronically a physician can't do that, even though that's really what the consumers demand and that's just the right thing to do.

All right, so we'll close with our last speaker, Dr. Dinesman from the VA. Another request again, make sure you're getting your questions in via Twitter, hashtag, on one of these papers - #ssandforum, nationaldisabilityforum@ssa.gov, or if you're on the phones, *1 to get to the operator. All right?

Dr. Alan Dinesman:

All right. Well, hi. I'm Alan Dinesman. I'd also like to very much thank the Social Security Administration for the kind invitation. Also very much want to thank David for being able to say otolaryngology.

David Brennan:

First time ever.

Dr. Alan Dinesman:

Very nice of him. I also want to thank my specialty organization, which has headquarters in Old Town, Virginia, we're changing our name from otorhinolaryngology, which was even more of a mouthful. I'm going to be speaking a little bit about the experiences we've had in the VA disability and rating processes in the VA system. Unlike the folks that you've heard about, we're really pretty

much early on in a special case for the use of telemedicine. In – right now, where we're at is, it is very useful for a lot of the population that we are dealing with. We do have veterans that are elderly, we have folks that live in rural areas – kind of like myself, I'm from San Antonio. We have people that have to travel great distances. We even have tools trying to figure out where the closest VA facilities for some of our veterans to go to for their examinations. We started out with telemedicine predominantly in 2011 and that was with a memorandum that we were able to work with the Department of Defense that telehealth evaluations were appropriate and adequate for mental health examinations. And you can hear from the discussions today, the mental health arena is a – is ripe for telemedicine and has been a very good – I want to say starting point for lack of a better description, but we have some other challenges when it comes to the other fields.

So what we did in the world of disability and rating, at least from the VA's standpoint, is we looked to pilot what we could do in the world of telemedicine. Now, we have a set of questionnaires that we use in the process called Disability Benefits Questionnaires or DBQs, and so we have a defined set of criteria or factors that we're looking at in an exam process. What we – what our challenge is is that we have to maintain not only medical standards but we also have to maintain certain legal standards as defined by the VA rating – Schedule of Rating Disabilities, or the VASRD, and make sure that everything fits, both the legal definitions of what they need in that schedule. And that's something that VBA or the Veterans' Benefit Administration will be dealing with. And then ultimately we'll end up in the various courts. It may go to appeals in the Court of Appeals for Veteran Claims and if that is still in question could actually go up to the Supreme Court.

So we looked at a pilot program and it was at a limited number of sites, and you can see the sites listed here, and what we looked at first is what examinations or what DBQs lent themselves to the technology that we had at hand for Telehealth and everybody that was involved with this was very much thinking that Telehealth will be, and I think always believed will be a significant component of the future of medicine. And so, what we did was tried to look at this and say, okay, here's how we can get our foot in that door, and start using Telemedicine. And so, we developed a series of protocols. Here are the list; I'm not going to go through them all individually, but these were the list of DBQs or Disability Questionnaires that we thought would be amenable to Telehealth.

And just to give you a kind of an idea. These are 16 – excuse me, individual questionnaires out of a total of 80. So, now you're looking at not a majority of them, but these were fairly straightforward. We also – the audio you'll see that we have some special notes for audio here if vertigo was claimed. You know, that one really did not at this time lend itself to Telehealth, and there were also some issues with some of the pulmonary especially T.B.

The veterans – and going through this again, remember this is unlike standard medical care. This is a legal process and so we really had to look at it very differently, and so we had to provide the veterans with the option of opting in or out. And tell them that you know, if you don't feel that you're getting an adequate examination, we have this methodology we can cancel it and move you on to a face-to-face evaluation.

The – probably we had many people take us up on that, but there seem to be something we were worried about, but I don't think it ends up being much of a problem. The other problem that we had internally we see from – initially on the private sector, and the private sectors we talk about billing. On the VA side, one of the challenges of working out the issue of workload capture which is kind of our own internal equivalent of the billing process.

And the other thing that we had to look at was a fact that the information was being used by somebody else and so we had to make sure that the person on the other end was doing things that were quite you know, physical components. Whether it'd be testing range of motion you know, pressing on a joint that they were carrying it out in the same way that it would be as in a face-to-face evaluation. And basically, we had to – again, there's a lot of things on the slide, but what it came down to is we had to provide essentially the same servicers that you would get in a face-to-face evaluation.

Now, I think my slide ran over a little bit, but some of the things – really, this was mainly more of a learning experience for us and some of the challenges that we see – I think are going to be some of the challenges that maybe seen in other areas besides mental health down the road. I'll start from the bottom, but some of the things that we had were looking at the duties and responsibilities of instruction for the [inaudible] on the other end because what you have is somebody who has to be on the other end with their patient who is going to be doing the range of motion. Doing – you know, using the electronic stethoscope and so we have to train our population on that end. Would there be clinicians or technicians to make sure that they're delivering here and providing a legal examination in the same fashion and of the same quality and repeatability that you would see in a face-to-face setting.

The use of stop codes that we have – and again in the private sector this could be billing issues. But the ability to look at this from a workload application. The other issues that we had and lessons learnt was testing the equipment, and you know – hate to say computers are sometimes are valuable and so it's difficult when you have a patient who maybe in a rural area or somebody whose travelled for you know, to a facility and the machinery is not working. It does cause for a negative experience.

We had to make sure that – yeah, we had to tell the – in this case, the veteran what they would be experiencing. That the person that is doing their examination per se, is not the person who is going to be doing the evaluation or the write-up and so we needed also to set the appropriate boundaries if you can imagine, and also allow them to get a good understanding.

One of the biggest issues that we had was actually coordinating the Telehealth – not only the technicians, but also the location. So for us, what he had was the need to have double scheduling and the scheduling had to be for the clinician to see [inaudible] on one end; on the receiving end and then over on the Telehealth end you had to have the technician, the clinician or technician.

You had to schedule the room and the equipment and then you also had to make sure everything was working and appropriate and so we had – because of the way the VA systems are currently setup; each medical centre may have its own instance or separate system and so having the workload or the scheduling or the process is communicate between distant locations that are geographically separated locations was definitely a challenge.

And so, we look at this as a good experience. We really had a lot of lessons that we learnt and what we learnt is what we need to do for the future, and that is one – technology. We need some sort of devices that will allow us to standardize examination. One of the things that you know, you see from a stethoscope you can listen to the heart and you can record the heart sounds. The otoscope, you can you know, say here's a picture of the eardrum and looks good or looks like this. But when it comes to other issues such as range of motion you know, we have a lot of musculoskeletal claims. How do you say that what was done on that other end was correct? And so you got to be able to standardize it, record it and be able to justify the findings.

Then there's examination procedures and that is how do you do things to make sure that the appropriate information is recorded. One of the things that we see that are unique to the VA disability rating schedule is the discussion of pain. If you look at it like a workman's comp disability, it's based on objective factors; range of motion, you know ability to lift something etcetera. But the VA rating schedule has subjective factors and the biggest one that we struggle with is pain. You know, is a scar tender? Is the joint tender to palpations? Or how do you document that in an appropriate way in the Telehealth environment? You know, is it panning in on the patients facial expressions? Is it panning out of both? You know, the person doing the touching versus the individual themselves does make it very difficult.

Then there is the providers. You know, and the issue that we have on the providers – again at least on the VA is we have to have some duplication in some efforts, and that's just kind of the

nature of the way the VA works and that would be – so if we have somebody who's doing range of motion you have to have a CMP clinician on one end. You have to have somebody whether he'll be a PA or somebody that understands what the Pedic examinations, range of motion etcetera.

So, that's kind of our challenges. How to work out what levels of education are necessary on both sides. And lastly on this is scheduling for us in the VA, and again our challenges that are systems really don't speak to each other across the country in all respects and especially in scheduling. And our scheduling systems – and you'll see I have it here on the next thing that our scheduling system don't talk to each other and so we do need to come up with a way of working through those components.

So our biggest other issue to look at home – to look at Telehealth is do we work with it internally? Or do we use the great experience that we have from our external partners who have accomplished great things? And then other considerations – at least for a government institution is cost. You know, the updating of equipment's staying up-to-date with the newest and the up keeping sort of occasion.

For the disability scenario, we have kind of the unusual component of medical legal aspects. We talk about, you know, documenting joint motion using goniometry, again, the documenting of motions, or things such as pain. Audiometry is a fun one, being an ear, nose and throat doc. That's always been kind of an interest. They do have actual automated audiometers, which are quite interesting. And I dealt with one when I was in private practice – I was in the private sector for 20 years. Very interesting, but, again, the problem comes down to standardization, which is a big difficulty.

I think this really kind of gets back to some of the same things that, really, for the disability setting, what we're dealing with is a legal environment and not only is it a medical component which takes into account a lot of the factors that people have already talked about, but that the legal components really add kind of a whole different layer to it. So I'm even going to try to end a few seconds early.

David Brennan:

15 seconds left, great. Thank you.

Alan Dinesman:

Thank you.

David Brennan:

Well, we did achieve what we set out. Thus far, we're kind of on target. We're going to leave about... Do we still want the panel at the end, James, for closing? Okay, we'll go about five. So we have a good 20 minutes, hopefully, to do some Q&A. We'll start with anyone in the room, we have two microphones, so if you have a question or a comment. We're going to try to keep any comments to about two minutes, and then if it's an appropriate question, we'll respond up to the group. We're going to try to keep things moving pretty quickly. Opportunities to interact beyond this session – if you're watching this recorded, please keep the dialogue going on Twitter with the Twitter handle or email to the address. Yes.

Speaker 1:

Hi, Kathy, you talked about culturally and linguistically appropriate medical care. I was just wondering if you could expound on that a little bit and tell us maybe some industry best practices for serving people who don't speak English? Yeah, thank you.

Kathy Wibberly:

Great question. So one of the things that, you know, [inaudible] really has is that there are some standards, in terms of culturally and linguistically appropriate care. And for the most part, a lot of healthcare organizations are using, like, telephonic interpretation right now for that. And what I am an advocate for is, you know, so much of our communication is non-verbal. So you can capture quite a bit by phone with just the audio, but you are missing a whole world of the non-verbal. And so we are a real advocate for using video-conference if you don't have an onsite interpreter. And the same thing can be done with sign language interpretation for the deaf and hard-of-hearing. So the technology exists and there are actually a lot of companies that are doing video-conference interpretation and so part of it is really vetting those companies and making sure that those interpreters are actually healthcare trained, because there's terminology, there's language, that's specific to healthcare that a standard, you know, general interpreter may or may not understand. So there are some very good industry standards in terms of healthcare interpreting, and bringing that video conference to that same kind of industry really enhances the ability for patient communication and provide a communication to happen.

David Brennan:

Any other comments in the room before we look...

Speaker 2:

On a similar note, are there any systems in place to ensure that the interfaces that the patients are interacting with are accessible to patients who may be experiencing vision loss?

David Brennan:

Go ahead, Scott.

Scott Baker:

Yeah, I can speak to that one, as we have some providers...

David Brennan:

One second. The question there was, in the telehealth world, people are interacting with technology. Are there accommodations or interfaces that accommodate users who may have vision loss or low vision?

Scott Baker:

Yeah, and so, I guess there's two answers to this. Briefly, we do have providers who are visually impaired. And so they have either external software or other devices on their hardware at home that'll allow them as the provider to meet the standards that are necessary. And then similarly, on the patient side, we have options for them to use as well as telephonic options for intake and other supports. So it's very similar to what you would expect in traditional in-person practice as far as...

Harrison Tyner:

Yeah. I could add to that. Now, can you still hear me?

David Brennan:

Yeah, we hear you, Harrison. Go ahead.

Harrison Tyner:

We ran up against a requirement for just that with a university system when they were vetting our software and we had to actually test it with the JAWS software – J-A-W-S – which is a common software for the blind or visually disabled. And you can set up the code to a point where it's

compatible with JAWS and it can be interpreted by those users and they can use other engagement tools in the software outside of the video. They could start the video or use any other communication pieces that we offer, like instant chat or messaging. So that is something that, I think, software companies come up against. And...

David Brennan:

Another question in the room?

Speaker 3:

Yes. So, when we get information that's been done by a telehealth exam in a disability claim for Social Security, would we even know that it has been completed via telehealth or is it going to, for all intents and purposes, going to look like a standard medical examination report? And this is open to any of you.

David Brennan:

The great question was, when information comes in as collected during a telehealth exam, is it flagged or denoted as being something, somewhat different? I wrote down a phrase I use that I think a lot of folks touched on – in this world, I say all the time, when I talk to my clinicians, administrators who are trying to do this stuff, the goal is not to make this different medicine, it's just to make the medicine done differently. So I think this really speaks to that. I know there's some... In the billing world, you do have to denote with that. But maybe we can start at the end. Dr Dinesman, how does the VA handle this?

Alan Dinesman:

Yeah, that is a great question. I know at least in the pilot that we were doing, that it was notated upfront that this was being done via telehealth. And there was a whole bunch of things in the description of the pilot itself on how the various components were documented – everything from getting a consent form all the way to how the exam report, the heading was stated.

Scott Baker:

The billing codes that we use are the same as an in-person practice, but we use a modifier, a GT modifier, to indicate that the service was provided through a telemedicine modality.

Kathy Wibberly:

I don't have much to add, other than, you know, if you have a need to know that, whether for research purposes or not, then go ahead and, you know, put something on your form to note that. But under, you know, standards of care, there really should not be any difference and so there's not a technical need to note whether it's a telemedicine consult or an in-person consult.

David Brennan:

Let's see if we have any questions on the phone. Were there anyone waiting, operator?

Operator:

At this time, there are no questions.

David Brennan:

Well, we will... I wanted to... I think, touching on that previous comment, we have someone from... Jennifer Nottingham from the Montana State DDS is on the line, and if you have a couple of minutes, Jennifer, would you be able to share some of the ways in which you guys have been using telehealth technologies in your processes?

Jennifer Nottingham:

Yes. We use video equipment to complete some mental status evaluations. At this point in time, that is the only type of evaluation that we do. If there's any testing involved, we do not schedule a video one. We are a very geographically large state, with a large portion of it being very rural, so this has allowed us to help the more rural and distant parts of the state where we have very limited providers. Without the video evaluations, we'd have to either pay a doctor to travel for some of these appointments, or pay costs for the claimant to travel for an appointment, which also means that some claimants may not be able to travel due to limited vehicles, or you know, travel limitations themselves. Our state can also be very affected by the weather, particularly in the winter time, so the ability to have mental status evaluations via video has been very helpful with that as well. Since the psychologist does not have to travel, we are able to schedule more appointments, which does help decrease our processing time. One of our video mental status evaluations sites primarily serves one of our large Indian reservations and that's really an area where sometimes we have no-shows, so that can really help with that. We continue to look for more opportunities to expand the use to help underserved populations in the state, and in this past year, we were able to schedule 110 video mental status evaluations.

Speaker:

…to help expand the use to help underserved populations in the state, and this past year we were able to schedule 110 video mental status evaluations. And currently, they are all held in our social security field offices, but we are looking to expand to new locations. And we are certainly continuing to expand; we just recently added a new video location site in another part of the state, where we had a significant need. It is my understanding that we do note on our report that it – the exam was done via video.

David Brennan:

I'll open up a question now, that kind of struck a lot of – a lot of – obviously, at the end of all of this, we talked a lot about workflow, and I want to touch on that, but I want to spend a little bit of time talking about the patient experience. We heard a few different models; some are, you know, care in the home, versus the consult model where you might go to a clinic and have some staff around you. Kathy, looking sort of longitudinally, what trends are you noticing broadly around, Scott used the term consumers, or I believe it was you. What are you noticing in terms of how patients of all stripes, as they access medical care for whatever reason, what are they noticing – Uber is the adjective you put in front of anything now to imply consumerism, but maybe Uber isn't really what the people want. So can you talk a little bit about that – the patient experience?

Kathy Wibberley:

Yeah. It's been kind of interesting. We have a lot of those direct-to-consumer companies out there now. And the utilization has been lower than what has been typically expected for these companies, and I think part of it is, you know, a lot of these models are kind of one-off models, where you – you know, you have a need, you pay your $40 online, you get your consult, but patients really want to have that video interaction with their own primary care physician. They don't want some random strange doctor that they've not met before to do that exam. And so what we're finding is primary care practices who have started to do direct-to-consumer for their own practice are getting a lot more uptake than kind of the random company that is out there doing this. And so we're doing – we're seeing a lot of that.

But I think the other part of the patient experience is that people are – they like who they are comfortable with, and so more and more people are comfortable with technology. They are using videoconference, and so the engagement is much more there in terms of, like if you can get someone on video, it takes usually people about five to eight seconds to get comfortable with it,

and all of a sudden they're talking to you like it's face-to-face. And so patient satisfaction has been very high for people who have been doing their consult this way. And I think one other thing is for remote patient monitoring, what we found is satisfaction is about 95%. And a lot of times the monitoring equipment is only there for 30, 60, or 90 days, to kind of prevent that readmission penalty for a hospital. And what we are hearing and it totally is people don't want the – the equipment to be taken away out of their home, because they – they feel like it's a comfort for them. You know, someone's monitoring, someone is keeping an eye on me. If something goes wrong, I will get a call, and so once they get back, it's like, you know, don't take that away! I want to have that continuous monitoring, I want someone to be watching and notify me when something is wrong. So I think, you know, we are really getting to hear from patients that that is something that they embrace and they like.

David Brennan:

Anything, Scott, that you wanted to add, then I have a question for Dr. Dinesman on –

Scott Baker:

Yeah, just a brief response there is we do see higher patient engagement through lower no-show rates. As well as patients staying with our practice longer, especially in the direct-to-consumer realm. The other point there is just to emphasize is the ability to engage patients outside of direct visits with their doctors. In the mental health field, that can mean regular standardized assessments to get a more longitudinal history, as well as homework items, other patient engagement self-help tools will help the patient get better just outside of medication prescribed or therapy that is conducted.

David Brennan:

Speaking a little bit on that team, Dr. Dinesman we had a question that came in that asks, would you consider care through telehealth the same as delivered in person? Should it be considered the same at a private or public disability? You talked quite a bit about the validity of certain tests; obviously a manual muscle test is very hard to do. I think that speaks a little bit to, you know, is there a trained paraprofessional there, who is the remote hands, eyes, ears? Can you talk a little bit about how you are viewing the – what is it take for, much like the previous question, for a remote session to be considered the same as an in-person session?

Scott Baker:

You know, that's a great question. I think that it really at this point in time is kind of dependent on what type of disability we're talking about. And I'll give an anecdotal experience of my own, you know, being an ear nose and throat doctor, I have a friend who had called me and said, hey, can you talk to my daughter who is in Denver? And I've known them for many years, so I – I called and she says, hi, I have a swelling in my neck and I don't know what it is. And she says, and I have this swelling in my mouth at about the same spot, you know, figure this out. She sent me pictures, and I was able to diagnose the problem right then and there, called in a prescription and took care of it. Now that's an easy one because that's something visually you could document from let's say if you are looking at a disability item, because again, the whole key here is this is a legal process, and so yes, I could document that picture and say, okay, this person had X diagnosis, and here's the evidence.

I think the challenge comes about for items, at least in the disability setting, where there is voluntary action by the patient. And that's why range of motion is so challenging. Or anything where the patient themselves can either over or under perform, and which could change the legal boundaries.

David Brennan:

And do you – do you ever use sort of onsite staff as well to augment the remote provider in some cases, when you're doing an evaluation?

Scott Baker:

In the pilot, we did. But again we tried to use instances where the technology is pretty clear-cut, alright so again, things such as, you know electronic stethoscope etcetera. We still have not figured out some of the – the more complex ones.

David Brennan:

Great. A reminder again, national disability forum at ssa.gov, or #ssandforum if you're on Twitter. Get your questions in. We have a couple minutes left; I want to talk – it came up, Scott you mentioned it, I'm sure all of us were thinking it. Can you talk a little bit about the issue of interstate practice? For all of us here as well, and then I have a question for Harrison and I want to make sure he gets it.

Scott Baker:

Sure, I'll be brief as I'm sure others have. We talked on it as well but, it comes down to licensure and standards of care and practice in that state, and so California can be almost a year to get licensed in; other states are pretty quick. And so it's an issue of having to have an active license and adhered to the TEU requirements of that license in all of those states. As well as when hospital credential comes down, having to back it up with primary source verification, it's a lot of paperwork. And then I think more importantly honestly is the standards of care in those states. Some states allow prescribing through telemedicine after having seen the patient just through videoconferencing; others have different requirements for like an onsite telepresenter, and so you just have to know what those standards are in some states. Some states, it's very grey and there is no official policy, and have those gray areas. Other states have a very explicit policy.

Kathy Wibberley:

Yeah, so just big-picture wise, the standard rule of thumb is that a clinician has to be licensed where that patient is actually getting service. So it's the patient's location and not the provided location that is the point of reference for the license. And so the compact that was mentioned, it's really a compact that's looking at expediting the licensure process for telemedicine providers. The – each state has been adopting that over time since the model language came out, and they are – they have now reached kind of enough states that there really looking at figuring out now how do we put in the language to actually implement this compact. And so I – I don't – I have not heard what the timeline is on an actual formal adoption of this in terms of implementation guidelines, but I anticipate that should be coming out fairly soon, like in the next 12 months or so. But it's not the same as the nursing compact, which is actually true reciprocity. So I get licensed in one state, and other states will accept my license. The physician compact is still related to expediting the process.

David Brennan:

Operator, do we have any questions on the phone?

Operator:

And as a reminder, it's *1 to ask your question. And at this time, there are no questions.

David Brennan:

Alright, well we have about two minutes left, so we still –

Speaker:

[Inaudible]

David Brennan:

Oh, one coming. Waiting in email. There might be a more efficient way than James to email me from 20 feet away. Alright, this is from Jack. Has the system – telehealth in general been used with intellectually/developmentally disabled individuals, and if so, how? Let's go to Harrison, do you have any thoughts on that? You're hamstrung by us not being able to see you, but if you have any thoughts on that, we could start with you.

Harrison Tyner:

Could you repeat that question?

David Brennan:

Telehealth opportunities for intellectually, developmentally disabled individuals?

Harrison Tyner:

Sure, I mean, I think in all, that, that kind of answers you know, what, what type of setting are we facilitating there for the Tone Madison event, you know, typically, you know you need some sort of workflow to cater to that specific use case typically that looks like a, facilitated check-in model where someone – caretaker, nurse or otherwise – can check in to a session, or facilitate that interaction with the patient in the Control Setting. So you know, I would probably say you need to refine and, and limit the, the circumstances in which that patient receives that treatment to make sure that it's effective as possible. Otherwise you could run up against a few issues – it also depends on what the disability is.

David Brennan:

Scott, you guys have first-hand experience?

Scott Baker:

We do, yeah, we, we, we work with a lot of intellectual disabled populations. ust as Harrison said – often times, we're more the extension of the treatment team or a position observer to what's happening than actual just patient / provider relationship.

Kathy Wibberley:

I think, some other things in terms of the disability are there are a lot of really good efforts in terms of working with kids with autism, doing training – parent training. again, we would require that facilitation on that side, so, you know whether it's a teacher or a guidance counsellor, a parent, someone there facilitating that, that counsel.

David Brennan:

Well, we're right up – right up at the – at the bumper at the end of this. Now I want to make sure we have enough time for closing comments, that – okay, great. [Inaudible]. I had an agenda that had [inaudible]. That was my non-subtle [inaudible].

Virginia Reno:

Well thank you very much. This has really been a fabulous discussion, and we greatly appreciate the panel for your – for being here – and for your insight on this challenging new area for the Social Security Disability Program. I'm Virginia Reno, the Deputy Commissioner for Retirement and Disability Policy. So we conduct the research, and we also try to shape the agency's policy and certainly today, in the field of disability policy, this is a bold new area and we're just very excited to be getting some expertise in that field. We clearly are pouring into the telemedicine, is very much still in an exploratory stage. We're exploring how we could use these techniques to better serve our social security disability beneficiaries and also in particular, how to make effective, accurate and timely decisions for people who applied for disability benefits, and they need to amass the appropriate evidence to document their condition so that they must meet the strict test of disability in the law. That's a lot to consider. We recognize the veterans administration also faces similar issues because they both adjudicate disability for cash benefits, and they provide medical care to their, to veterans throughout the country. In our case, it's less about the medical care, except for using that care to help us make the decision of the documentation that we need to help people get the benefits, that they're entitled to.

Now that's why you see such value in the insights that you provided us today. As researchers, as practitioners, and clearly innovators in the field, we're just very grateful for the ideas you've given us and we look forward to staying in touch. I would just like to kind of wrap up by saying as Doug mentioned at the outset, we hope that you give a feedback – all of you who are in the room, all of you who are tuned in electronically. We would be sending you an e-mail to request your evaluation of this forum. We hope you return it, and give us your insights – both about what was useful, about

what you wish had happened that didn't happen, and we also welcome your ideas for, forums like this on other topics related to social security disability issues and policy, because we have these forums periodically, in the future. So we look forward for your ideas about other issues and your feedback on this important topic. before I close, I just want to thank my colleagues from the Office of Disability Policy, especially Gina Clemons – you want to stand up? Lester and Jim Edrington – you guys stand up, guys stand up. And thank you Doug Walker, and your entire team, from the Office of Communications for making this happen. And finally, thanks to all of you. You're going to stand up. The whole team! Whose here from the Office of Communication? Thank you all. This wouldn't happen without, a whole team effort, from our end. So thank you very much. And finally, thank all of you for being here to share in this conversation and we look forward to your feedback on this session. So enjoy the rest of your day, thank you.

Operator:

And that concludes today's call, we thank you for your participation.