

3rd AGENDA

BOARD OF NURSING February 13, 2014 – 8:30 a.m.

Room 474 (Fourth Floor)
Heber M. Wells Building
160 E. 300 S. Salt Lake City, Utah

This agenda is subject to change up to 24 hours prior to the meeting.

ADMINISTRATIVE BUSINESS:

1. Sign Per Diem
2. Call Meeting to Order.
3. Review and approve January 9, 2014 minutes

BOARD BUSINESS:

- 8:45 a.m.** – Sara Calderas, non-compliant
9:00 a.m. - 10:30 a.m. - Informal Agency Action – Nina Manning
10:30 a.m. - Penny Johnson, application review
10:45 a.m. - Cheryl Jensen, her request
11:00 a.m. - Kenneth Cook, renewal application
11:30 a.m. - Break

WORKING LUNCH: 12:00 NOON – 1:30 P.M:

- **Presentation: Kelly Lundberg, Ph.D.,
Assessment and Referral Services, University of Utah**

PROBATION INTERVIEWS:

Please note: The compliance report, report from Committees and probation interviews may result in a closed meeting in accordance with §52-4-205(1)(a).

1:30 p.m. - Connie Call, Compliance report, probationer requests/miscellaneous

Group 1 Room 474:

- 2:00 p.m.** Tracy Schroeder, New Order
2:30 p.m. Micheal Josh Ludwig, New Order
3:00 p.m. Holly Wilson, New Order
3:30 p.m. Tyler Bauer, New Order

Group 2 Room 475:

- Erin Rasmussen, New Order
Laena Young, New Order
Julie Porter, New Order
Christopher Singer, Non-compliant

BOARD BUSINESS:

- 4:00 p.m.** - Kolby Andersen, application review
Report from Committees
Environmental Scan:
 - Review Forbes article regarding Telehealth
 - NCSBN Call participation
 - APRN to RN downgradeStipulation and Order clarification
Review Utah Action Coalition State Survey

NEXT MEETING: March 13, 2014

Meetings scheduled for the next quarter: April 10, 2014; May 8, 2014 and June 12, 2014

Note: In compliance with the Americans with Disabilities Act, individuals needing special accommodations (including auxiliary communicative aids and services) during this meeting should notify, Dave Taylor, ADA Coordinator, at least three working days prior to the meeting. Division of Occupational & Professional Licensing, 160 East 300 South, Salt Lake City, Utah 84115, 801-530-6628 or toll-free in Utah only 866-275-3675

Guests - Please sign

Date: 2-13-14

BOARD OF NURSING

NAME: (Please Print)

REPRESENTING

Laura Sombathy

student MSW Weberstate

Annie Sullivan

BSN WSLU

Anisette Ann Phelan

BSN/WSU

Kelly Lundberg

UAFU

McCall Mason



The Apothecary, With Avik Roy

INSIGHTS INTO HEALTH CARE AND ENTITLEMENT REFORM.

PHARMA & HEALTHCARE | 12/28/2013 @ 12:09PM | 6,248 views

Top Health Trend For 2014: Telehealth To Grow Over 50%. What Role For Regulation?

 **John R. Graham**, Contributor

For many years, telehealth advocates have accused payers of being unwilling to reimburse for proven telehealth interventions, which can significantly reduce medical costs.

Well, we have crossed that chasm, and telehealth is about to experience explosive growth. RNCOS Business Consultancy Services has just released

a report predicting 18.5 percent annual growth in telehealth *worldwide* through

2018. The U.S. will outpace the rest of the world. *Forbes* contributor Bruce Japsen recently interviewed an analyst at another market research firm, IHS, who predicts that the U.S. telehealth market will grow to \$1.9 billion in 2018 from \$240 million today, an annual growth rate of 56 percent. This is explosive, and it has led to increased political activity.



Dr. Wen Dombrowski speaking at the #DoMoreHIT Think Tank (Photo credit: Dell's Official Flickr Page)

Given the risk of unintended consequences of legislation and regulation, it's a good time to have a look at how the major players are shaping policy.

According to Mr. Japsen's interview with Roen Roashan of IHS, much of the dramatic growth in U.S. telehealth will be driven by Accountable Care Organizations (ACOs), in both Medicare and among the privately insured. Although there are different models of ACO, all move beyond the traditional Fee-For-Service (FFS) payment system by implementing incentives to reduce costs while increasing quality. For example, if a physician in an ACO meets certain quality indicators that evidence suggests will reduce the risk of a patient being hospitalized, she will be rewarded by the ACO. In the old (but still dominant) payment model, her income would not have suffered for failing to meet these quality indicators. ACOs are found all over the country, with different levels of penetration, according to research by Leavitt Partners.

The jury is still out on whether ACOs will succeed. My own expectation is that

early experience will not result in a “general theory” of ACOs, just like the previous experience of managed-care, which ramped up in the 1970s and peaked in the late 1990s, did not lead to a “general theory” of HMOs. A few worked and many did not, with leadership and commitment by all interested parties being critical to success. The ACO experience will likely be similar. Nevertheless, new technology has the potential to increase the likelihood of success. For example, remote monitoring of diabetic patients’ blood glucose from home can trigger an early intervention – maybe a phone call from a nurse on the care-team – that reduces the risk of hospitalization.

Traditionally, Medicare pays FFS via fee schedules. A certain code is attached to a certain procedure (the result of a cumbersome and confusing process) and this allows claims to be reimbursed. Medicare covers certain telehealth services, especially in remote rural areas. However, one of the most important telehealth services, sending a digital image to be stored at another site and read by a specialist (i.e. without the patient and physician speaking with each other over the phone), is not generally covered. Medicare coverage of telehealth tends towards mental health and behavioral interventions.

Previously, telehealth advocates have lobbied for Medicare to cover more telehealth services by adjusting the billing codes. However, in an [interview](#) last August with *MobiHealthNews*, Charles Linkaus of the American Telemedicine Association, which advocates for the telehealth industry, said that the ATA is “de-emphasizing its longtime efforts to secure reimbursement for telehealth technology” in favor of “a model where hospitals can also share in the savings when they successfully reduce re-admissions.”. This change is a positive development. Providers’ resistance to this kind of reform has always been problematic.

Although every provider of a medical service *claims* to reduce costs somewhere else in the system, they tend to shun payment reform that actually takes them at their word. Instead, they fall back on simply demanding increases to reimbursement for billing codes, and adding new codes for new products and procedures. This forces costs into silos and makes it difficult to incentivize cutting overall costs – or even to understand the relationship between different cost drivers. If the ATA is moving away from this model and actually lobbying for reimbursement that reduces total health costs while increasing quality, it is a move in the right direction.

Hopefully, the ATA will also take this approach in its advocacy for coverage by private insurance. According to a 2013 [background document](#) from the ATA, twenty states plus the District of Columbia mandate that private insurers cover telehealth. This means that if a benefit can be delivered either in person or via telehealth, it must be covered. Medicaid coverage is all over the map: As with Medicare, Medicaid coverage of mental telehealth is most common. Convincing state legislators to force private insurers or Medicaid to cover telehealth is one way to guarantee revenue to the industry, but it is inferior to a system where the incentives line up so that providers adopt telehealth on their own, to reduce costs and increase quality.

In 2013, two bipartisan bills were introduced in Congress, designed to encourage telehealth, and pushed by the [Health IT Now Coalition](#), a group that has a broader membership than the ATA:

- HR 3077, the TELE-MED Act, would permit certain Medicare providers licensed in a state to provide telehealth services to Medicare beneficiaries in a different state.

- HR 3750, the Telehealth Modernization Act, would promote the provision of telehealth by establishing a federal standard for telehealth, and inducing all states to adhere to it.

Neither bill imposes a huge burden of federal control. Obviously, any service that uses telephony invites some federal role. However, the Health IT Now Coalition is careful to point out that these bills do not interfere with state sovereignty over the licensing of medical and allied health professionals. This has long been an obstacle to telehealth. Traditional licensing laws did not envision a physician in one state treating a patient in another state. While telehealth advocates have long lobbied for inter-state licensing of physicians and other health professionals, this is still a point of friction, which hinders rapid adoption.

Nevertheless, citizens wishing to preserve the constitutional order should be concerned about too much Congressional initiative in this area. A law that would allow Medicare providers to treat out-of-state patients via telehealth (HR 3077), notwithstanding state laws, certainly *looks* like it interferes with state's power over professional licensing.

There is another approach, which achieves the same goal without Congressional overreach: The Federation of State Medical Boards has promised that it is very close to agreeing on language for an interstate compact for physician licensing, which has already been achieved for nurses. A compact is a constitutionally approved method for states to make treaty-like commitments to each other. It is a very appropriate tool to accommodate mutual recognition of professional licensing for the purpose of inter-state telehealth.

It is especially important for states to maintain the initiative in this matter, because failing to do so will cause advocates to invest in lobbying for federal control. Congressional overreach would have unintended consequences that are properly dealt with by state law. For example, states have sovereignty over medical-malpractice laws and which health professionals have the power to prescribe drugs (as analyzed by the Robert J. Waters Center for Telehealth & eHealth Law). Responsible development of telehealth incorporates these and many other factors, requiring constant readjustment of regulatory priorities. Decentralized control at the state level ensures less likelihood of an inflexible and quickly dated regulatory regime, which often happens when Congress takes the lead.

Nevertheless, as we enter a year where telehealth is likely to change much of what happens in U.S. health care, we should be optimistic that both advocates and politicians are endorsing an approach that will allow providers, patients, and entrepreneurs to develop and adopt telehealth with minimal political interference.

If only we could say that about the rest of the system.

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Investors' note: Corporations belonging to the Health IT Now Coalition

include include Aetna (NYSE:AET), AmeriSourc Bergen (NYSE:ABC), Boeing (NYSE:BA), Intel (NASDAQ:INTC), UnitedHealth Group (NYSE:UNH), Verizon (NYSE:VZ), WellPoint (NYSE:WLP), and WebMD (NASDAQ:WBMD).

This article is available online at:

<http://www.forbes.com/sites/theapothecary/2013/12/28/top-health-trend-for-2014-telehealth-to-grow-over-50-what-role-for-regulation/>