

Arkansas' struggle with telemedicine mirrors the nation's

By David Pittman

7/18/14 1:33 PM EDT

When it comes to telemedicine — technology that allows doctors to consult at a distance — Arkansas is a state at war with itself and a microcosm of the growing pains health IT is enduring across the country.

On one end of Little Rock, the state medical board is trying to crack down on the use of telemedicine.

About a mile down the road, the state Medicaid program is working to spread its use, to increase access to scarce doctors.

Across the country, advocates of telemedicine note its potential to substitute less expensive virtual doctor visits for costly hospitalizations or trips to the emergency department. They point out that it can bring healthcare to places that just don't have doctors.

Advocates also note data like [that from Florida](#), which found that if telemedicine could help reduce hospitalizations or emergency room visits by even 1 percent, it could save the state \$1 billion.

At the federal level, a major lobbying push is underway — led by former Senate Majority Leaders Tom Daschle and Trent Lott and their newly formed [Alliance for Connected Care](#) — to try to free Medicare's telemedicine spending, a mere \$12 million last year.

Meanwhile, many state medical boards feel the technology threatens their oversight, some doctors fear for their pocketbooks, and both are pushing back. They claim that telemedicine could lead to bad medicine, such as doctors prescribing powerful drugs to patients they've never seen.

The issue is playing out differently in various states. In Virginia and Wyoming, the technology has found clear sailing and is saving each state money for budget-crunching Medicaid programs. In Idaho, meanwhile, officials have cracked down.

The battle lines are drawn sharply in Arkansas, a largely rural state where telemedicine might seem like a natural choice.

The Arkansas State Medical Board is sending menacing letters to doctors it learns are using telemedicine, asking them to appear before the board to provide more detail on their services. In some cases, the board has directed providers to stop seeing patients via telecommunications.

It remains to be seen whether the board plans to take on the University of Arkansas, whose telemedicine program greatly benefits Medicaid patients, saving the state money while improving access to care for Arkansas's poorest people.

"I think everybody has acknowledged telemedicine is coming. I think our board is trying to figure out how to regulate it," said Kevin O'Dwyer, attorney for the Arkansas State Medical Board. "It's a slippery slope. The potential for abuse is off the charts."

‘TREATING’ PATIENTS VIA TELEMEDICINE

Chris Schach, a dermatologist in Fayetteville, was more than a little taken aback in April when his practice received a letter from the Arkansas State Medical Board that essentially killed its smartphone application.

The [Ozark Dermatology Clinic app](#) virtually connects patients and doctors, allowing them to communicate, share pictures, diagnosis skin conditions and prescribe medication. The board put the kibosh on the program after hearing about it on a television news broadcast.

The doctors appeared before the board, but their pleas were denied. “Telemedicine cannot be used to establish the Doctor/Patient relationship,” an April 14 letter from the board to the dermatologists read. “This relationship is to be established prior to ‘treating’ patients via telemedicine in this state.”

The Arkansas State Medical Board believes [state law](#) dictates that a health provider must preform an “in-person physical examination” before prescribing medication or diagnosing a condition.

“The board’s role is to protect the patient’s safety. They don’t believe being able to call a doctor is a safe way to practice,” O’Dwyer said. “If you’re going to be prescribing drugs, you’re going to have to see them in person.”

But that interpretation of state law flies in the face of a model telemedicine program.

The University of Arkansas for Medical Sciences started its [ANGELS program](#) in 2003. ANGELS — short for Antenatal and Neonatal Guidelines, Education and Learning System — was created by specialist Curtis Lowery after Medicaid was expanded to cover more than half the births in the state. Low-birthweight infants and infant mortality were on the rise in Arkansas.

After a grant from the Centers for Medicare and Medicaid Services that helped put video equipment in hospital nurseries and delivery units, the rate of babies born with low birthweight fell from 13.1 percent in 2009 to 7.0 percent in 2010.

The network has since expanded to treat mental health, stroke, some cardiology and HIV care, and other services.

Patients have about a 40 percent lower chance of dying of stroke after Arkansas’ tele-stroke program was started in 2008.

The state Medicaid program hopes it can achieve the same level of success in psychiatry, linking rural sites with psychiatrists in Little Rock.

Such patients are rarely seen by the treating physician, Lowery said, and that conflicts with the medical board’s in-person first rule. But the Arkansas Medicaid patients are referred by a health care provider, who relays information about them to the tele-physician. O’Dwyer said the medical board’s actions are aimed at out-of-state doctors, or telemedicine services that offer direct-to-consumer care.

Lowery, who appeared before the medical board in April to explain his group’s work, said “you could argue” that the Arkansas medical board is selectively enforcing this face-to-face provision.

STANCE ‘NOT EXTREME’

The issue of how states should handle telemedicine has been a hot topic in recent months as influential bodies like the Federation of State Medical Boards and the American Medical Association weighed in.

The federation in April [adopted a policy](#) that said some patients could be seen and treated electronically rather than face-to-face. It has not taken a hard line on whether a patient has to be seen in person first. The AMA voted last month [to adopt a policy](#) that accepts all encounters via telemedicine in some circumstances.

[The Center for Telehealth and e-Health Law](#), which serves as a watchdog to the telemedicine industry, believes if telecommunications can give a doctor the same information as they would have otherwise, then a visit can be done via telemedicine.

“We’re not against harmonizing between the medical board and Medicaid program. It just has to be harmonizing in a way that’s safe medicine,” Executive Director Greg Billings said.

CTeL conducted a survey in 2000 of what states deemed an acceptable first visit and found 39 said it must be done in person. Today, Billings said about 20 states allow the physician’s first encounter to be via telemedicine.

[Idaho, meanwhile, recently restricted](#) telemedicine services offered by companies like Teladoc and MDLIVE, where consults are delivered primarily via telephone.

Tennessee, like Arkansas, proposed a policy this spring that would require doctors to see patients in person before treating them via telemedicine. However, a backlash led the Tennessee Board of Medical Examiners to promise to readdress the issue.

OTHER STATES MORE FRIENDLY

You can count the number of child psychiatrists in Wyoming on one hand. Five child psychiatrists serve the 9th largest state, by area, in the country.

As a result, doctors not trained to handle mental illness were treating too many kids in residential psychiatric programs, and they were prescribing a lot of strong drugs to very young kids. “It was physically impossible to provide timely psychiatric care to those needing it,” Wyoming Medicaid Medical Director Jim Bush said.

The state devised a plan to use telemedicine to offer psychiatric consults and couple them with second opinions. In four years, Wyoming has seen the number of children admitted to residential treatment cut in half and the average length of stay fall from 389 days to 221.

The Medicaid program has saved nearly \$2 for every \$1 it has invested in the program, a savings of nearly \$1.7 million, Bush said. The psychiatric telehealth program has been such a success that the state is expanding it to include adult psychiatry and chronic diseases.

And the program is supported by the medical board.

“This board recognized at some point in the past that whether you’re face-to-face in the same room or you’re connected via some sort of electronic communication, that doesn’t change the standard of care,” said Kevin Bohnenblust, executive director of the Wyoming Board of Medicine.

Virginia was one of the first states to start widely using telemedicine when the University of Virginia established its program in 1995.

Doctors in Charlottesville conducted more than 5,000 telemedicine visits last year. The program operates in 126 sites, including community hospitals, jails and prisons and health centers. About a third of UVA’s telemedicine patients are covered by Medicaid, which began coverage in 2006.

A remote patient monitoring program has helped cut hospital readmissions by more than half in patients with health failure, pneumonia and chronic obstructive pulmonary disease. Neonatal ICU stays have fallen from more than 22 days to more than 13 in those where telemedicine was used.

The program has also helped slash Virginia Medicaid’s \$54 million budget on taxi and ambulance rides for clients needing transportation help.

“I’m deeply confident what we are doing is good, quality medicine,” said Karen Rheuban, director of the Office of Telemedicine at the University of Virginia.

The state hasn’t done an analysis on potential savings, but the savings seem clear, and there is no evidence of fraud, said Virginia Medicaid Director Cindi Jones.

There’s little rationale to require doctors see a patient in person before treating them via telemedicine, says Rheuban.

“When would a stroke victim have ever seen a neurologist?” Rheuban asked. “It just doesn’t make sense.”

This report is part of an ongoing series focusing on eHealth reforms in Medicaid. Reporter David Pittman is pursuing the project as part of an [Association of Health Care Journalists’ Reporting Fellowship on Health Care Performance](#). The fellowship program is supported by The Commonwealth Fund.

To view online:

<https://www.politicopro.com/go/?id=36400>