Telehealth testimony

House Human Services Committee

SB 2179

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Chairman Weisz and committee members:

I am Eric L. Johnson, M.D., a physician in Grand Forks. I am a Professor at the University of North Dakota School of Medicine and Health Sciences and an Assistant Medical Director of the Diabetes Center at Altru Health System. I have been doing telemedicine for over 7 years, primarily in partnership with Heart of American Medical Center in Rugby, but also with clinics in Carrington, Cavalier, and Devil's Lake, providing diabetes care services. My entire practice is specialty diabetes care. I am also working on a telehealth teaching project for the American Medical Association at the national level to create an understanding of quality, appropriate telehealth to be delivered by students, residents, and providers.

Let's briefly review different types of telehealth encounters for patients:

Telehealth refers to any electronic interaction between provider and patient. This can include secure messaging and telemedicine visits.

There are 3 basic types of telemedicine visits:

- E-visit: Short encounters usually focused on a single uncomplicated problem such as a rash or a urinary infection. I

don't do these, as they are generally not appropriate for complex chronic disease care such as diabetes management.

- Virtual Visit: A more complex encounter between provider and patient. The patient may actually be in their home, as they are usually on their own device. These approach a traditional clinic visit. Some of these patients have other supportive technology in their home, infrastructure such as an electronic stethoscope or cardiac monitor. Many patients also do things like checking their own blood pressure. In my diabetes care practice, we often review insulin pump and continuous glucose monitoring data as well as other lab values. A complete history is reviewed as well as other elements of a traditional clinic visit.

- Classic Telemedicine visit: This type of visit is almost identical to a regular in person visit, and can almost always substitute for a regular clinic visit. In this case, the patient goes to a remote clinic, in my example, usually in Rugby. In the clinic setting, electronic stethoscopes are available, along with high quality cameras, or other exam devices. Again, we often review insulin pump and continuous glucose monitor data as well as other lab values. This type of visit is very suitable for complex diabetes care visits.

All of these visits require clinic infrastructure, but that is especially true for the virtual visit and classic telemedicine visit since they can almost always be a substitute for a regular clinic visit. Patients are actually in a remote clinic. Of course, for all of these,

we need the electronic medical record, nurse support, other professionals such as social work, dietician, diabetes educator and lab. I have some patients who live west of Rugby, some over a 100 miles away who come to Rugby to be seen. Prior to my doing diabetes telemedicine, many of them were not receiving specialty care.

Reasons telemedicine to the region is important

- preventative and chronic disease care
- travel, day care and other costs are reduced. Some of these patients were taking up to 2 days off for an appointment with me in Grand Forks.

As well,

- Telemedicine is made possible due to reimbursement by payers
- Our costs do not change or reduce by going virtually
- Patients may have more of a cost share for a telemedicine visit as opposed to in person due to decreased rate of reimbursement if not paid as parity

Telemedicine visits are not just brief Facetime visits where a medical problem is discussed. To do this well and give the patient high quality care, the provider, such as myself, is really creating a clinical experience

In a rural state like North Dakota, with a shortage of specialty providers, it's important to have many specialty services are available via telehealth. I know for a clinic like Rugby, that really supports their primary care services to have these specialties available.

I don't use telehealth as a chance to increase the number of visits to increase costs. I still see my diabetes patients via telemedicine remotely 2 to 4 times a year, which is what we do with in-person visits, and is the American Diabetes Association recommendation. Again, we need to think about the different types of visits and how they are used for appropriate patients, not just to have a bunch of video calls which may or may not be helpful for chronic disease management. The goal is to create a clinic-like atmosphere to deliver quality, not quantity. Anybody who is serious about telemedicine knows this.

Many rural distance patients have told me they will no longer want to do in-person visits with me for diabetes care as it is just too inconvenient to do in-person. Rural critical access hospitals will have send patients sometimes great distances for specialty care that could've been provided via telemedicine on-site- that is certainly cost effective.

I also have positive outcome data to share. We studied patients who had diabetes care via telemedicine in Rugby versus those who didn't. The common blood test marker A1C, which measures blood sugar control over 3 months was studied. Those in Rugby who had at least one telemedicine visit had better blood sugar control as measured by A1C, and this study was presented at the American Diabetes Association's annual meeting in 2018

Finally, I am also a patient with type 1 diabetes, and I have been served by telemedicine care during the pandemic. It's been interesting to see it from the patient side, and I can understand why patients like it.

Thank you very much for the opportunity to testify today.