Greetings Chairman Lee,

This email is in request of passage of SB 2179, which among other things would provide parity for reimbursement of services delivered via telehealth. I would like to provide 3 current examples from my pediatric practice that illustrate why this is fair as well as making large strides toward our common goal of increasing access to QUALITY care for all North Dakotans.

Example 1: Children's Regional Asthma Clinic branched out to Dickinson via the use of telehealth to increase access to quality asthma services for pediatric patients from western North Dakota. We "see" patients while they are at CHI-Dickinson and we- the clinicians- are at CHI St Alexius Bismarck using audiovisual technology, examining them with digital stethoscopes and otoscopes (which we were able to buy using grant funds from the Center for Rural Health) enabling us to listen to their heart and lungs as well as examine their ears, nose, and throat. This saves hundreds of miles and countless hours of driving, as well as making visits possible when transportation (sometimes due to bad weather) is an issue. At the end of the day, complete assessments completed on these patients via telehealth are equivalent to those assessments completed for patients being seen "live" in our Bismarck clinic. Given the equivalent services provided, why would disparate reimbursement ever be considered?

Example 2: I currently have a special needs patient who does not sleep at night, creating countless behavioral problems that have wreaked havoc on the child and family. With help from my child psychiatrist colleague, I am gradually increasing the dosage of a medication that will help this child sleep through the night. Given the potential for adverse cardiac effects as we gingerly increase the dosage, this medication requires monitoring with ECG in addition to monitoring that is necessary to determine efficacy and any other potential adverse effects. Rather than have the patient miss significant amounts of school frequently, the patient may drop by for the ECG after school, then have an audiovisual visit while the child is at school, minimizing driving and waiting time that would take away from school time. During the visit, we are able to discuss how sleep is going, note any adverse effects, and discuss ECG results. Based on these findings, we are able to make an assessment and plan for medication dosage. The assessment and plan are identical whether this care is delivered via telehealth or live. Why would there be a difference in reimbursement?

Example 3: I have an adolescent patient who came to Bismarck from their rural home to see me for depression with suicidal ideation. At the first appointment, we made a plan that included medication and recommendations for counseling. Given the rural location of this adolescent, it is much better to monitor this patient's depression and medication dosage, as well as to provide counseling services, utilizing audiovisual telehealth rather than have her miss school and her family member miss work transporting her to these frequent appointments. Given parity of services between telehealth and live options, why should reimbursement vary between the two forms of service provision?

I could continue to list many examples of the benefit and equivalence of telehealth care provision when compared with live visits. Reimbursement parity is necessary for sustainability of these services which achieve our goal of improving access to QUALITY care for all North Dakotans. Please support SB 2179. As always, I want to thank you for your time in considering the contents of this email. I am always available for further discussion/questions.

Respectfully, Joan Connell, MD MPH FAAP Pediatrician