



February 14th, 2023

From: ND Psychiatric Society and ND Medical Association

Re: In Support of SB 2160

Madam Chair Lee, esteemed Committee Members,

My name is Gabriela Balf, I am a psychiatrist in Bismarck who serves patients from everywhere in this state, of ages 11 through 91, with a flexible schedule to accommodate people of all professions, schedule made possible by telehealth availability. I speak on my behalf and also on behalf of NDMA and NDPS.

We are writing you to express our full support for SB 2160. This is such an important bill for our rural state, that has experienced an unprecedented relief in access to care since telehealth was made possible.

We are still learning about the full impact of telehealth availability on patients' health outcomes, satisfaction, decision to seek and stay engaged in therapy, as well as the outcomes on decreasing ED visits, need for hospitalization, etc. There have been recent attempts at quantifying the costs and benefits of telehealth (Hilty et al 2023) and, in US, where reporting rules and insurer coverages vary widely, it has been a complicated proposition. We do not routinely calculate into the costs and benefits the patient's side variables like avoided mortality, increased medical adherence, reduced medical complications, gain in statistical life year value, missed work/school/time away from family, reduced child/family care costs, etc. Nor do we routinely collect data about the provider/healthcare costs: provider's windshield time, avoided referrals, reduced hospital length of stay, etc. There are costs to the healthcare systems like implementing the new systems required for telehealth (largely in place by now), and benefits like increased productivity (less no-shows, etc), increased access to care for special groups like elderly, veterans, rural areas, etc. (see Appendix.)

In countries where there are a single payer and homogenous reporting rules and care guidelines, and in the Veteran Administration System with its contained and well documented care delivery, we have learned that:

- Telehealth used to triage pre-hospital, primary care conditions has resulted in reducing the number of ED visits by 6.7% AND cost savings of \$2,468 savings per ED visit (Langabeer et al, 2017)
- In Australia, a study of pre-hospital video triage of mental health calls for adults over 14 months showed a reduction in ED visits of 17%, and a proportional cost reduction- (a video visit costs half of an ED evaluation) with no negative outcomes (Nehme et al 2022)
- In a recent Ontario-based study (Serhal et al 2020), Telepsychiatry vs Psychiatrist Outreach vs patient travel reimbursement for in-person visits yielded costs of CAD\$360 vs CAD\$558 vs CAD\$620, respectively. In studies using real-data-based Computer simulations, telepsychiatry was the least costly program in 71.2% of the simulations.
- In VA, veterans sought substance use disorder treatment in telepsychiatry vs in person ratio of 58% vs 28%, and remained engaged in the telepsychiatry cohort over 6 months 2.6 more likely than the in-person cohort (Sistad et al 2023)

- In VA, where telehealth for geriatric care was implemented on a large scale since 2014, the degree of satisfaction, quality of life, number of medication adverse effects and diabetes, heart failure, hypertension and mental health outcomes have improved significantly (the [GRECC Connect project](#) VA- Rural Health Outreach 2022)

There are several well-designed and conducted studies that attest the superiority of treating even high-intensity treatment requiring adolescents with eating disorders via telehealth vs in-person, reduction in odds of fatal overdoses due to telehealth availability for medication assisted treatment for opioid use disorder, (Jones et al 2022), etc.

Finally, [Project ECHO®](#) (Extension for Community Healthcare Outcomes) invented in 2003 and now expanded internationally, is an online collaboration specialist-primary care, “Moving knowledge, not people,” that has reduced wait times from months to days. It is currently implemented in ND for Geriatrics, Infectious Diseases, Psychiatry, Pediatrics, Gastrointestinal diseases.

In my experience, I have seen the same costs of running a business on telehealth and in person – since many high costs are fixed: electronic health records, employee salary, employee benefits, malpractice insurance, rent, time spent on prior authorizations etc.

The benefits, however, are huge:

- Increased access to care:
 - o Elderly who otherwise would not be able to come for regular visits;
 - o People who depend on others for transportation;
 - o People who would need to find child or adult care for visits;
 - o Children/adolescents who would need to miss school, and have their parent miss work to bring them to the office;
 - o People with PTSD who avoid crowds, office settings, etc.;
- My no-show rate went down from 10% (usual rate in clinics is 25%) to 1 / year.
- Increased availability on my part- I can now easily offer evening or weekend hours.
- Avoided hospitalizations: I can see a person even daily, without the side effect of this intense monitoring being a financial burden – we have avoided inpatient level of care so many times this way.
- Services offered to patients who otherwise may avoid seeking care: people with substance use disorder, professionals, etc.

Thank you for your proactive thinking in keeping the telehealth available in our rural state.

I stand for questions.



Gabriela Balf, MD, MPH
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 NDPS Past-President

Table 3. Clinical (Patient), Administrative (Provider, System), and Economic Measures and Outcomes for Health Care and Telehealth

	PATIENT/FAMILY/ CARETAKER	UNIT (MONETARY CONVERSION)	PROVIDER/ HEALTH CARE ORGANIZATIONS	UNIT (MONETARY CONVERSION)	GOVERNMENT/ HEALTH CARE SYSTEM	UNIT (MONETARY CONVERSION)
Costs						
Fixed	N/A	N/A	Equipment/technology/ depreciation Facilities/office expenses	\$	Cost to the taxpayer	\$
Variable	N/A	N/A	Maintenance and repairs Telecommunications costs Admin support/staffing Sundry office expenses	\$	Cost to private insurers	\$
Other	Time/money	\$	Travel Stipends Training Promotion	\$	Loss of productivity to employers	Hours of lost productivity (\$ to pay others to complete work)
Outcomes						
Clinical	Reduced morbidity Avoided mortality Increased access to health care Increased health knowledge/ability for self-care Faster/more accurate diagnosis and treatment Increased medical adherence	Change in QALY/DALY/ LYGS (value of a statistical life year from the value of a statistical life)	Reduced length of stay Avoided hospitalizations/ readmission Avoided laboratory costs Avoided patient transport Avoided physician visits Avoided referrals Avoided ED visits Reduced length of visit Increased medical adherence Increased knowledge transfer (between providers) Increased accuracy	Average context- specific charges for hospitalizations/ readmission, ED visit, laboratory tests, patient transport, physician/specialist fee, health care services	Increased productivity	Avoided missed days/hours of employment time (average or minimum context- specific wage rate- hourly/daily)
Nonclinical	Increased earnings Decreased risk of job loss/less time away from work Reduced child/family care costs Increased employment/ leisure/classroom/family time Reduced wait time or consultation time	Missed hours/days work/class/time away from family avoided (average or minimum context-specific wage rate-hourly or daily)	Increased productivity	Wages (\$ by day/ hour)	More efficient access to health for special groups, reduced patient travel costs, and staff costs	Distance to referral facility and days/ hours of work for staff (mileage allowance rate for transportation and average daily/hourly staffing rate)
Travel costs	Avoided travel expenditures (transportation/ accommodation, etc.)	Average cost for hotel, transportation, meals (dollars)	Avoided travel costs, reduced transportation time, avoided travel stipends, or lost income from travel	(\$ by mileage/costs of transportation or accommodations, travel stipends)	Avoided cases of communicable disease or chronic illnesses	Cases of: average medical costs (e.g., health care utilization, per case), average avoided loss of wages, and reduced wages for temporary staff
Satisfaction	Patient satisfaction	Willingness to pay	Provider satisfaction with the model	Willingness to pay		

Adapted from Dávalos et al.¹⁰

DALY, disability-adjusted life year; ED, emergency department; LYGS, life years gained.

Appendix

Hilty, D. M., Serhal, E., & Crawford, A. (2023). A Telehealth and Telepsychiatry Economic Cost Analysis Framework: Scoping Review. *Telemedicine and E-Health*, 29(1), 23–37. <https://doi.org/10.1089/tmj.2022.0016>