Primary Care Task Force Oversight Committee Meeting Summary
July 15, 2015

Committee Members Present

Kim Malsam-Rysdon, Chair	Sandy Diegel	Gale Walker
Robert Allison, MD	Mary Nettleman, MD	
Sen. Corey Brown	Sen. Billie Sutton	

Staff Present

Halley Lee	Josie Petersen
Tom Martinec	Susan Sporrer

LivingWell@Home Demonstration

Sherrie Peterson, Director of the Good Samaritan Society (GSS) LivingWell@Home welcomed the Oversight Committee to GSS. LivingWell@Home is a remote patient monitoring system designed to help people live as well and as independently as possible. LivingWell@Home allows clients and their caregivers to take proactive steps to maintain and enhance well-being. LivingWell@Home currently has customers in 17 states ranging in age from 9 to 100. LivingWell@Home includes monitoring of vital signs, sleep patterns, movement, medication adherence, and activity with information provided to both formal and informal caregivers. Customers are those with multiple chronic illnesses (i.e., diabetes, cardiovascular disease, respiratory disease, mental health), contributing factors (i.e., poor social support, lower socio-economic status), and who are frequent users of the health care system. Remote patient monitoring is provided by a team of registered nurses and non-clinicians who review wellness data seven days a week. The cost of LivingWell@Home depends on the services provided but is typically about $172 per month per member. Service outcomes include: (1) increased engagement with their own health; (2) reduced ER visits and hospitalizations; (3) more efficient appointments with primary care providers; and (4) decreased unnecessary visits. GSS shared information from services provided at two clinics in Minnesota. From January to April 2015, LivingWell@Home served a total of 60 patients and during that time period was able to prevent 12 hospitalizations which they estimate saved about $457,500 of billed charges. A full evaluation of the program is being completed and the results available in March 2016.

Telehealth in South Dakota

Mary DeVany with the Great Plains Telehealth Resources Center (gpTRAC) and Danielle Hamann and Mandy Bell with Avera Health met with the Oversight Committee to talk about telehealth services in South Dakota as well as barriers to utilizing telehealth more fully in the state. gpTRAC works to improve access to quality healthcare through technology. They are funded through a HRSA grant to work with healthcare providers and organizations to build telehealth awareness, promote education, provide individualized consultation, and provide data specific to telehealth services in the region. gpTRAC serves Minnesota, Iowa, Nebraska, North Dakota, South Dakota, and Wisconsin.

While many early challenges to implement telehealth services have been overcome, reimbursement remains a challenge for providers with some services not reimbursable if they are provided via telehealth. Medicare reimbursement policy has traditionally not been proactive regarding reimbursement for Medicare patients. The South Dakota Medicaid program pays for physician services at the same rate whether the services are provided in person or via telehealth. Several surrounding states have passed telemedicine parity bills. Minnesota passed full parity (all health

plans including Medicaid) while Iowa and North Dakota have passed partial parity. Susan will forward the Minnesota parity legislation to Oversight Committee members.

Mandy Bell provided an update on Avera's efforts to implement eEMS. While they are still looking at how this might be feasible, there are issues with connectivity between the ambulance and the healthcare facility as there are still areas of South Dakota where cell coverage is not adequate to support eEMS. Mandy also talked about the emergence of direct-to-consumer telehealth technologies (typically supported by insurance companies) and how this can be appropriately utilized to best serve the individual. Avera is looking at implementing direct-to-consumer telehealth services but working to make sure the services are integrated with the primary healthcare team so as not to fragment services.

Updates from April 30th Meeting

- *Rural Healthcare Facility Recruitment Assistance Program* – Halley Lee provided an update on the Rural Healthcare Facility Recruitment Assistance program. Applications are currently being accepted with about 46 approved. The reason some applications had not been selected is the individuals had previously participated in the program or had been employed longer than nine months. Based on discussions from the previous meeting, the Oversight Committee supported the addition of Masters of Social Work and speech-language pathologists to the list of eligible professions. There was also discussion about increasing the size of community eligible for participation in the program from the current 10,000 population to 15,000 population. This would add Huron, Pierre, Spearfish, and Yankton to the list of eligible communities. There was some concern expressed that adding the larger communities would limit the number of slots that would be available to the smaller communities that the program was originally intended to address. Discussion focused on either limiting the number of slots available to larger communities or adding additional slots. There was also discussion about modeling the program after the J-1 visa program to make any slots available to larger communities after a certain date if they had not been used by smaller communities. Halley will look into this further for discussion at the next meeting.
- *My Clinical Exchange* – One of the original recommendations of the Primary Care Task Force was the development of a clearinghouse for rural health experiences to assist facilities to coordinate the multiple requests received from students for clinical experiences. *My Clinical Exchange* was selected as a pilot program to test with the SDSU Nurse Practitioner Program and the USD Physician Assistant Program. The PA program expressed concerns regarding *My Clinical Exchange* so withdrew from the pilot. The pilot is moving forward with SDSU.

Residency Program Discussion

Dr. Mark Huntington with the Sioux Falls Family Residency Program and Dr. Kurt Stone with the Rapid City Family Residency Program joined the Oversight Committee to continue discussions about potential expansion of family medicine residency programs in South Dakota.

The Oversight Committee reviewed the information provided in response to the questions for additional financial details for the residency programs. Both Dr. Huntington and Dr. Stone indicated that establishing a standalone residency program would be more expensive per resident than expanding an existing program or adding a rural residency track to an existing residency program. They also indicated that if a residency program is full and wanted to add slots, it would require a site visit and approval from ACGME because it would be considered a substantial change to the program. Adding a rural residency track would also require a site visit and approval from ACGME. The Sioux Falls program is currently at capacity and would only be able to support a rural track. Rapid City has the capacity to add 1-2 residents to its existing program.

With regards to revenue, it was estimated that each resident generates about $82,000 each year. Revenue from first year residents would not be available to the rural training track location because the resident would not be at the rural training site until years 2 and 3. In estimating additional revenue, South Dakota would need to assume that Medicare GME would be zero. The amount of Medicaid GME would be dependent on what hospital the residency program was based in.

The Oversight Committee asked Dr. Huntington and Dr. Stone about the feasibility of potential communities in South Dakota to support a rural training track. Pierre, Spearfish, Aberdeen, Mitchell, Watertown, and Brookings were mentioned as possibilities. The biggest challenge to community eligibility would likely be sufficient patient volume and service mix as well as whether obstetrical services are provided by family medicine physicians or obstetricians. These are governed through the accreditation of residency programs. Dr. Huntington and Dr. Stone were asked to look further at Pierre, Spearfish, Winner, and Aberdeen sites to determine if they would meet basic eligibility criteria and then approach the medical community in those locations about their willingness to consider serving as a rural training track site. That information will be provided at the September meeting. The DOH will also work with the financial information to clarify additional questions as well as include revenue estimates in the spreadsheet for discussion at the next meeting.

Wrap-Up
Sandy Diegel mentioned recent Helmsley Foundation's *Focus on South Dakota: A Picture of Health* report. The report has a behavioral health focus but contains a lot of good information on health care and health care access across the state. The DOH will get copies of the report for distribution to the Oversight Committee members. There was also discussion about inviting a representative to a future meeting of the Oversight Committee to discuss the report.

Next Meeting
The next meeting of the Primary Care Oversight Committee will be September 30th from 1-5.