MINUTES

Leverage Telehealth and Telemedicine Task Force

Senator Deb Soholt, Chair
Representative Herman Otten, Vice Chair

Second Meeting, 2019 Interim
Tuesday, August 27, 2019

Room 413 – State Capitol
Pierre, South Dakota

The second meeting of the Leverage Telehealth and Telemedicine Task Force was called to order by Senator Deb Soholt (Chair) at 10:00 a.m. CDT, on August 27, 2019, in Room 413 of the State Capitol, Pierre, South Dakota.

A quorum was determined with the following members answering the roll call: Senators Deb Soholt (Chair) and Jim Stalzer; Representatives Linda Duba and Herman Otten (Vice Chair); and Public Members Brian Erickson, Amy Hartman, Rebecca Kiesow-Knudsen, Susan Kornder, Dr. Melita Rank, Kelly Serr, and Tiffany Wolfgang. Representative Tamara St. John joined the task force after roll call.

Staff members present were Clare Charlson, Principal Research Analyst, and Rachael Person, Senior Legislative Secretary.

NOTE: For purpose of continuity, the following minutes are not necessarily in chronological order. Also, all reference documents distributed at the meeting are attached to the original minutes on file in the Legislative Research Council (LRC) office. This meeting was webcast live. The archived webcast is available at the LRC website at sdlegilsature.gov.

Approval of Minutes

A motion was made by Representative Otten, seconded by Representative Duba to approve the minutes of the Leverage Telehealth and Telemedicine Task Force meeting held on Wednesday, July 17, 2019. Motion prevailed on a voice vote.

Opening Remarks

Senator Soholt welcomed everyone to the meeting and thanked everyone engaged and active in the mental health access arena for being a tremendous help to the task force. At the first meeting, the task force began the process of trying to determine where the state is in relationship to existing telemental health access and structures. Senator Soholt outlined the second meeting as an extension of the first with a goal of starting to talk about what is happening statutorily, answering questions produced from the first meeting, looking at some of the benchmark practices happening across the country, and getting a strong sense of what the development trajectory is in relationship to the infrastructure on the ground. Senator Soholt emphasized that in many respects South Dakota is a tremendous leader in this arena, crediting Senator Larry Pressler and the state of South Dakota in getting engaged early on in the process of telemedicine. She stated that even though the process is always growing and maturing, it is important to not wait for perfection before imagining what is possible.

Practices Across the States

Ms. Sydne Enlund, Policy Specialist, NCSL, presented an in-depth summary regarding the use of telehealth for mental and behavioral health services and offered examples of practices utilized in other states (Document 1).

Ms. Enlund stated utilizing telehealth services to increase access to necessary mental health care is important for individuals who experience additional barriers when obtaining care in certain settings such as rural communities, correctional facilities, and emergency rooms. In rural areas, telemental health not only helps to overcome numerous workforce and access barriers, it also has the potential to reduce patient costs and burdens associated with lost work time, transportation, child care, and other difficulties those in rural communities with limited access face.

Utilizing telehealth in correctional facilities increases access to behavioral health treatment for inmates, especially those in remote areas. The National Bureau of Justice reported that 50% of inmates in correctional facilities have a diagnosable mental illness including substance abuse. Allowing inmates to meet with a psychiatrist via telehealth allows for greater access to treatment for the inmate and the continuity of care without compromising public safety and losing security, as well as increases the number of behavioral health providers working with incarcerated populations.

In emergency departments, telehealth helps reduce challenges such as overcrowding and limited psychiatric providers in emergency rooms. In addition, telehealth technology can allow hospitals to decrease bed delays and the waiting period for psychiatric consultation.

Ms. Enlund provided examples of practices utilized by other states in regard to training and licensing and processes of expediting the licensure process for interstate compacts. She highlighted Project ECHO which builds capacity among primary care providers based in rural and underserved areas and allows providers to consult with one another across state lines without running into licensure issues.

Senator Soholt asked if any states or certification bodies have begun to offer credibility in relationship to becoming a provider in the area of telemental health. Ms. Enlund responded there are discussions regarding trying to incorporate telehealth into medical school and residency training so the providers are already prepared to provide telehealth services once they graduate and go into the field.

Senator Soholt inquired whether the process of expedited licensure was being applied to psychiatry. Ms. Enlund said it is applied to psychology. The interstate psychology compact was approved in 2015 and states have been joining slowly, but Ms. Enlund did not have specific information on psychiatry being expedited.

Access to Mental Health Care in Tribal Communities

Mr. J.R. LaPlante, Director of Tribal Relations, Avera Health, shared information on the access to mental health care in tribal communities and the development of the Pine Ridge Children's Telehealth Network (Document 2). Social determinants of health are very different on the reservations than other parts of the state. One of the areas with the biggest difference is the access to preventative care. Chronic diseases such as diabetes, cancer, heart disease, infant mortality, and suicide are nearly twice as high than in urban areas, and in mental health screens the numbers are higher across the board for those living on reservations. Mr. LaPlante stated it is no surprise to see healthcare crises taking place on the reservations in South Dakota.

In 2015 a rash of suicides among the young members of the Oglala Sioux Tribe led to a public/private partnership that became the Pine Ridge Children's Telehealth Services Network. The program was created through a grant provided by the Office for the Advancement of Telehealth, Health Resources and Services Administration and is geared towards children in school environments. Mr. LaPlante explained the work of creating the program, the tremendous amounts of communication involved, and the process of preparing the schools to be originating sites for telebehavioral health clinical services.

Representative Tamara St. John praised the project and asked if other tribes are currently interested in or starting to move in the same direction. Mr. LaPlante responded not at this time, but it is their hope to create a replicable and sustaining model that will allow other tribes to embrace and replicate it in their communities.

Senator Soholt inquired about the numbers of children accessing the behavioral health services, if there were any preliminary gains or outcome data to share. Mr. LaPlante said he did not have any outcome data at this time and stated the first three years of the project were spent on building infrastructure and stability within the tribal school. He also mentioned, due to the shortage of providers on the reservations, they have had to recruit providers from outside of the reservation. The program currently has five behavioral health agencies in Rapid City that are part of the project, but this created another obstacle when it came to billing. After working through these barriers, they are now in a position to move forward. The services are currently going live, and he hopes to come back in a year with a positive report to share.

Representative St. John asked if there will be grants for which other tribes can apply. Mr. LaPlante said this grant was unique, but the Health Resources and Services Administration (HRSA) is very interested in partnering with tribes and tribal communities.

Mr. Brian Erickson noted this was not an easy task to do and a lot of people and organizations have been involved in making this sustainable so it is not simply a grant funded project, but something the schools and providers will be able to continue.

Senator Soholt commented how the discussion demonstrated what has to be in place in order for a project such as this to really work. In addition to having connectivity, communication, relationships, and memorandums of understanding, all have to be established, and these considerations have to be in place not only in reservation communities but in the isolated communities in South Dakota as well.

Follow-up Discussions

Ms. Rebecca Kiesow-Knudsen, Vice President of Community Services, Lutheran Social Services (LSS), provided outcome data showing Telehealth Completion Rates for Fiscal Year 2018 (Document 3). For Fiscal Year 2018, LSS served 70 individuals through telehealth, and 104 individuals were served statewide. Ms. Kiesow-Knudson mentioned the skepticism from providers about whether or not a therapeutic bond could occur in a virtual environment. The data and anecdotal experiences show that technology does not pose a barrier to creating that bond or the ability to have a functional group dynamic.

Mr. Brian Erickson, Behavioral Health Officer, Avera eCARE, presented some follow-up data and offered a multitude of eCARE Research and Evaluation statistics (Document 4). Mr. Erickson stated that in the last year, 6,062 encounters occurred that were behavioral health-related. Of those, 2,200 were IHS in an outpatient scheduled basis, 3,832 were on-demand crisis situations. Sixty percent of the patients were saved from being admitted to a facility. Mr. Erickson also referred to the discussion from the first task force meeting on whether telemedicine is the same as in person, and remarked the physicians feel it is better for them because the degree of separation allows the individuals to open up and speak more freely and not have to worry about seeing their physician in their local areas.

Ms. Tiffany Wolfgang, Director, Division of Behavioral Health Services, Department of Social Services (DSS), spoke briefly on different ways DSS is looking at how telehealth can be leveraged to expand access to services which traditionally haven't been available to some communities. Ms. Wolfgang mentioned the Medication-Assisted Treatment (MAT) component DSS is working on through the opioid funding and being able to do that via telehealth

(Document 5). They are also working on Project ECHO, two projects being supported by Project ECHO; the Avera Health teleECHO Hub, and the University of South Dakota teleECHO Hub (Document 6). Ms. Wolfgang also drew attention to the Peer Recovery Support project DSS has in partnership with Face It TOGETHER, which allows them to provide virtual peer support services to individuals across the state (Document 7).

Senator Soholt asked if any statutory barriers existed for telehealth prescribing. Ms. Wolfgang responded that is not her area of expertise. Senator Soholt mentioned statutory barriers should be a follow-up. In closing, Ms. Wolfgang provided a handout showing a five-year look back at services for clients served via telehealth through the publicly funded system (Document 8).

Mr. Pat Snow, Commissioner, SD Bureau of Information and Technology (BIT), provided a document containing statistics and details regarding broadband in South Dakota (Document 9). He wanted the committee to note that most data is reported on a census block level, so if a customer on a census block level has access to a speed in broadband, it will be reported as available on that census block. This can present gaps in reporting.

Commissioner Snow gave an overview of carrier plans in the state and showed a number of maps representing the broadband in the state (Document 10). Currently, 88.3% of South Dakota's population has fixed broadband services available to them. The gap consists of about 100,000 people not in that group.

Senator Soholt commented this was a significant number of people and asked when Commissioner Snow was predicting the majority of South Dakota citizens would be covered. Commissioner Snow said it could be 2023, however, there will still be some gaps due to areas that have not been built out to at this point. Some areas will be easy to build out to and some will make it more difficult to hit the 2023 estimate. Funding presents a massive challenge as well. In best cases, it costs about $16,000 per square mile to run fiber to the rural areas. In larger areas with more populations, or places like the Black Hills, estimates can rise to about $60,000 per square mile.

Commissioner Snow pointed out that digging into the granular details is necessary when it comes to understanding where some of the opportunities for closing the gaps exist.

Connectivity in South Dakota

Mr. Greg Dean, Director of Industry Relations, SD Telecommunications Association (SDTA), touched on Commissioner Snow's comments about funding challenges and how much it can cost to build out capital networks (Document 11). The cost of construction per mile, per resident in rural South Dakota is in excess of $3,500. If that same mile of fiber is placed in Sioux Falls, due to population density, the cost goes down exponentially even though the cost is about four times as much. Mr. Dean said, from the beginning of 2013 to the end of 2017, the 18 member companies of the SDTA collectively spent almost $400 million on improving and building out their capital networks, and plan to spend an additional $300 million or more in the next 4 years.

By the end of 2017, 65% of the homes and businesses in SDTA's service areas were connected by fiber. It is projected that 93% of the locations will be connected by fiber by the end of 2021, with that number growing past the 2021 projection until 100% are connected.

The Federal Universal Service Fund (FUS) allows companies to invest in their networks and bring affordable and comparable services to people in rural America as well as urban areas. In rural areas, compared to urban areas, the cost of bringing services to the area residents would be exorbitant without the aid of the FUS. The FUS Fund allows companies like those in SDTA to not only provide services in high cost areas, but also build within their service areas as well. Connect SD grants are being used to build outside of service areas.

Ms. Julie Darrington, Vice President of Consulting, Vantage Point Solutions, added to Mr. Dean's discussion of the FUS fund and explained the Connect South Dakota Grant Award and the ReConnect Program which will help target areas that are unserved or underserved.

Ms. Darrington also gave a high-level overview on Low Earth Orbit Satellites (LEOs) which may be an option for hard to reach areas in South Dakota, or high cost areas. She mentioned South Dakota is in a much better situation as far as connectivity goes than many states primarily because of the focus of the small rural exchange carriers and what they have done in terms of putting fiber in the ground.

Mr. Kelly Serr asked if the companies are making sure the pipe going in the ground is big enough to expand for the future or if that is an issue that will need to be addressed. Mr. Dean said that is a continual conversation the companies and leadership face. He mentioned one of the biggest challenges for the companies will be the life expectancy of the fiber which is generally 20-30 years, and this will create a constant evolution of maintenance and construction.

Representative Herman Otten referred to the maps presented and asked why some rural areas have more connectivity than more urban areas. Mr. Dean said the answer to that question is unknown, however, it is likely due to strategic decisions made by the service providers in those areas.

Suggestions for Statutory Changes

Mr. Scott Peters, JD, Sioux Falls, gave a comprehensive overview of his recommendations for necessary changes to current South Dakota statutes (Document 12). His recommendations include adding language of audio/video conferencing to SDCL 27A-10-20(3) which will allow mobile crises to be done electronically; amending the language of direct supervision in SDCL 27A-10-21 which currently causes barriers for providing services electronically; making sure SDCL 27A-10-23 provides immunity to clinics or hospitals in which Qualified Mental Health Professionals (QMHPs) provide services and not just the QMHPs providing the service, as well as other language to allow for electronic capacity for engagement with de-escalation and assessment via electronic means.

Mr. Erickson commented how important this was for Avera eCARE because they have wanted to do mobile crisis but felt current statutes were hindering them from doing that, especially with the liability issue, and these recommendations are great suggestions.

South Dakota Area Health Education Centers Grant

Ms. Erin Srstka, Grant Specialist, Family Health, USD, provided information on the Area Health Education Centers (AHECs) supplemental grant received from HRSA last year. The application for the grant was tailored to utilize grant funding to implement telemental health for first responders. Ms. Srstka said a steering committee was created with a focus on researching models across the nation and bringing that information together to decide which model best fit the state and really honing in on the de-escalation with first responders and specifically EMS responders. The committee made a site visit to Charleston, South Carolina where crisis de-escalation in the field with EMS responders has already been implemented and found to be highly successful. Currently the steering committee is interested in what the task force and the other 2019 interim mental health task forces have to offer, as well as looking for a community interested in and willing to provide the resources necessary to pilot the project.

Mr. Erickson asked if Ms. Srstka knew what the driving force behind South Carolina's model was and what they were trying to solve. Ms. Srstka answered that finding the earliest intervention and getting people on track as early

as possible was the driving force. A lot of focus has been on law enforcement across the nation for this sort of crisis immediate response, but law enforcement may not be the first to appear after a 9-1-1 call or in a crisis. They saw a need to make sure all first responders can identify a crisis as early as possible and get people on the right path to the right services.

Senator Soholt asked how far in maturity the South Carolina model is. Ms. Srstka said they have been implementing the program for about a year so it is still a new program and they are working through some of the same challenges the steering committee has faced such as funding and how billing will be handled.

Project AWARE

Ms. Jacque Larson, Project AWARE Director, Department of Education (DOE), shared information on a young project DOE is working on called Project Aware (Document 13). Project AWARE is possible through a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) and allows DOE to increase and improve access to mental health services for school-aged youth across South Dakota through partnerships with school districts, educational cooperatives, and community mental health centers. It also equips educational professionals with the tools necessary to recognize and respond to behavioral health issues among their students, and allows them to conduct outreach and engagement with school aged-youth and their families to promote positive mental health and increase awareness of mental health issues.

Ms. Larson commented the project has been very well received. So far 481 adults have been trained in mental health awareness, 3,817 students have received training in prevention or mental health promotion, and 14 organizations have entered into agreements to improve mental health-related practices and activities consistent with the goals of the grant. As they go forward with the grant, DOE hopes to explore access to other supports such as telehealth.

Mr. Erickson highlighted the opportunities when students are getting screened and asked who is doing the screening. Ms. Larson answered they are using the Social Academic Behavior and Emotional Risk Assessment (SAVERS) screener. The faculty directly involved are trained in the use of that tool, and the student's parents have the option of opting out of the screening if they wish.

Senator Soholt inquired about the areas of the grant specifically geared towards providing telemental health service in K-12. Ms. Larson responded that the telemental health aspect of the grant is a blank slate at this time. It was written into the grant because schools need, and are asking for, access, but at this time there is not a strict vision for the telehealth component. Senator Soholt pointed out the program has the resources available to leverage telehealth in an environment working with students and asked Ms. Larson what she believed it would take to make the telehealth component happen. Ms. Larson said expertise in helping to plan it and informing the schools of what their responsibilities are and what needs to be provided up front.

Ms. Wolfgang offered some insight as DSS is a partner with DOE on the project. They are carefully taking a look at the models being implemented from a telehealth standpoint but an important aspect to keep in mind is the implementation is dependent on the schools they are working with. So far, the telehealth component has not been explored.

Lewis and Clark Behavioral Health HRSA Grant Update

Ms. Wolfgang provided an update on the grant through HRSA which Lewis and Clark Behavioral Healthcare and Southern Plains Healthcare jointly applied for. They have yet to hear if the grant has been awarded. However, if it

is awarded, the plan is to equip 24 rural schools in South Dakota and develop two telehealth service hubs, one in Yankton and one in Winner, to serve the schools. The goal would be to provide rapid access to crisis intervention and stabilization services, as well as providing telemedicine to make counseling services more readily available and reduce the existing wait times. The counties impacted by the grant would be Bon Homme, Charles Mix, Clay, Douglas, Hutchinson, Union, Yankton, Gregory, Mellette, Todd, and Tripp. A partnership with the Rosebud and Yankton Sioux Tribes would also exist. Ms. Wolfgang said if the grant is awarded, they will be able to impact, collectively, 31 sites and roughly 9,600 students or more.

Statewide Shortages

Ms. Clare Charlson, Principal Research Analyst, Legislative Research Council, presented information from the Department of Health on the Mental Health Professional shortages across the state (Document 14). Shortages are seen across the state with the exception of Rapid City, Sioux Falls, and Fall River County. The primary factor used to determine area shortage designation is the number of health professionals relative to the population. For a mental health professional shortage to occur, federal regulations stipulate the population ratio needs to be 30,000 to 1. Shortage area designations are selected by HRSA and based on applications received by the primary care office in the state which, for South Dakota, is the office of Rural Health in the SD Department of Health.

The only health professionals the office of Rural Health uses in determining shortage areas in mental health are psychiatrists. This allows the state to be more competitive for federal benefits as designation as a shortage area is a prerequisite to a number of federal benefits. Each of the areas are given a score by HRSA between 0-25 with 25 representing the highest need. The scores are determined using a number of factors but is primarily based on the population/provider ratio. According to the HRSA statistics, about 450,000 people live in shortage areas in South Dakota and only about 11.6% of their mental health needs are currently being met. Based on projections, it would take another 43 working psychiatrists to take away the shortage need in the state.

Statewide LMHC and LPC

Ms. Jennifer Stalley, Executive Secretary, Board of Examiners for Counselors and Marriage and Family Therapists, gave an overview of counseling licenses in the state and emphasized all of the categories are pre-requisites for the QMHP designation under the mental health statutes (Document 15).

Licensed Professional Counselors (LPCs) are considered the entry level license in counseling. The individuals in this area have a master's or doctorate in counseling. After they graduate, they have 2,000 hours of post graduate supervision with an approved supervisor. Ms. Stalley mentioned it was particularly important to understand that during the time LPCs are under supervision, even though they are not yet fully licensed, they are able to see patients and have full practice rights. From there, an individual can become a Licensed Professional Counselor– Mental Health (LPCMH). LPCMHs have a masters or doctorate, have held an LPC level license, and have above and beyond the 2,000 hours of post-graduate supervision, including another 2,000 hours of direct client contact under a plan of supervision. In both cases, these licensures also require the passage of certain national exams.

The other category of licensure is the Licensed Marriage and Family Therapist (MFTs). Ms. Stalley said the name can be misleading, but these therapists are also involved with mental health counseling and are not confined to marriage and family therapy. They too, are master's or doctorate prepared, have passed national examinations, and have 1,700 hours of post-graduate plan of supervision in which they have full practice rights.

South Dakota currently has 504 LPCs with 99 open plans of supervision; 323 LPC-MHs with 100 plans of supervision, and 95 MFTs with 6 plans of supervision. Ms. Stalley showed a breakdown of the number of licensees per license

category in the state and mentioned the takeaway is the largest percentage of licensees are located in 9 cities in the state, with the majority being in the Sioux Falls and Rapid City areas, which means the remainder of the licensees are trying to cover the rest of the state. The numbers serve to highlight the lack of counselors in the rural areas.

Another area of struggle lies in the age range of licensees. Approximately half of the licensees in each category are 50 years of age or older. Ms. Stalley said the question then becomes, how do we keep up the workforce? Along with that, the general trend for new applicants is continuing to be the same as the current trend where more applicants are being drawn to the larger communities versus the smaller, rural communities.

Ms. Stalley pointed out some of the challenges that exist for telehealth counseling. Confirmation of a patient's identity is different when a third party is not present to verify that the person on the end of the electronic communication is who they say they are. It is also important to make sure the patient's privacy is not being violated, so the platform and the security level that could be used becomes a concern. Also, counselors who could be hundreds of miles away from a person threatening suicide need to know what options are available to them as the American Counseling Association (ACA) code of ethics requires a plan to be in place in those situations.

Closing Remarks

Senator Soholt emphasized how the information brought forward shows trends toward shortages and rural access. She informed the committee it was time to start talking about benchmark legislation, the changes that could be made, and what kind of business modeling and funding it will take to get there. She asked the group to think about sustainable infrastructure, pointing out that grants are a tremendous help, but eventually the grants go away, and solutions will still need to exist. While it is an easy thing to focus on, Senator Soholt advised the committee to not let money be the base, but to look at what could be done to meet the needs of the citizens of South Dakota.

Ms. Korndер remarked that she appreciated how much hope existed for what can be done and the ability to improve what is in place.

Adjourn

A motion was made by Representative Duba, seconded by Senator Stalzer, that the Leverage Telehealth and Telemedicine Task Force be adjourned. The motion prevailed on a voice vote.

The meeting adjourned at 3:10 p.m.