THE LEONA M. AND HARRY B.
HELMSLEY
CHARITABLE TRUST

February 2, 2015

Ruth Martinez
2829 University Avenue SE
Suite 500
Minneapolis, MN, 55414

Dear Ruth,

The Rural Healthcare Program of The Helmsley Charitable Trust works in seven states (SD, ND, MN, IA, NE, MT, WY) to improve access to quality care for rural residents. We partner with critical access hospitals, healthcare providers, regional health systems that serve rural areas, state departments of health, universities, and other organizations to carry out our work. One tool that we have found to be impactful and successful is telemedicine.

We are excited about the interstate licensure compact developed by the Federation of State Medical Boards and the impact it will have on improving healthcare in under resourced areas. It is our understanding that Minnesota has introduced legislation (SB 252)featuring this compact.

The Helmsley Charitable Trust has been working in the upper Midwest for the last five years, and approximately one-third of the support we have given in this region is to telemedicine projects ($68 million to telemedicine of $240 million total). We have ample evaluation information, including external grant reviews and independent research that shows the benefits of telemedicine to include:

- Improved access to care
- Improved access to specialists and sub specialty care
- Improved quality of care
- Reduced unnecessary transfers
- Expedited transfers when necessary, reduced time to transfer
- Improved recruitment and retention of providers
- Increased job satisfaction of RN's
- Increased comfort in ED coverage by non-physician providers
- Decreased medication errors
- Decreased adverse medical events due to pharmacy oversight
- Decreased length of stay in ICU
- Decreased mortality in ICU

One of the ongoing challenges to telemedicine is the necessity to license physicians in each state in which their patients reside. Our partnership with the Avera Health eCare model necessitates physicians employed by the hub to get licensed in 8 states.

We support timely adoption by states of the interstate compact to allow states to expedite medical licensure and facility multi-state practice. If we can provide any information on our telemedicine projects or findings that may prove helpful to you, please contact me.

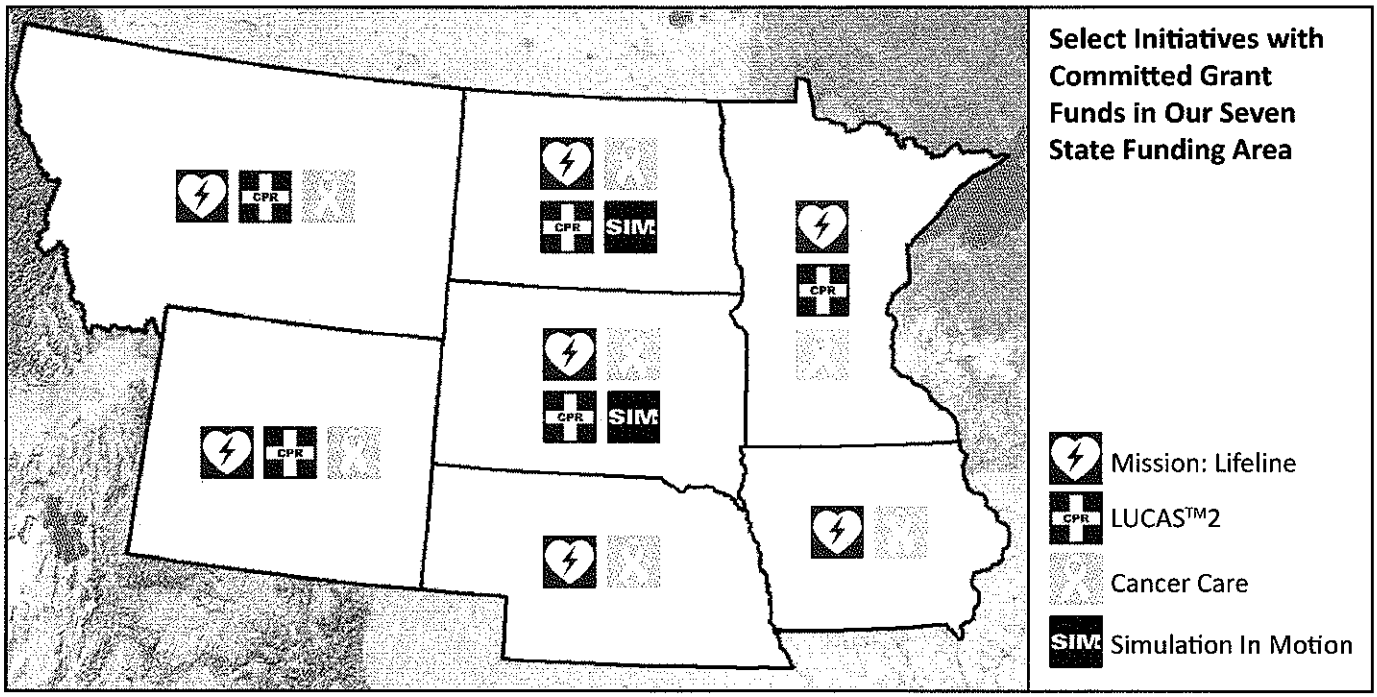
Sincerely,

Shelley Stingley
Program Director

enclosures

The Helmsley Charitable Trust Rural Healthcare Program

$244 million • 220 Grants • 7 States



Mission: Lifeline • $36.8 million
12-leads with transmission capabilities distributed to EMS and hospitals statewide to enhance diagnosis of STEMI heart attacks to expedite necessary transfers to cath labs, improving the cardiac system of care

LUCAS™2 • $15.7 million
Life-saving CPR equipment that provides high quality automated chest compressions, working towards statewide systems of cardiac care

Cancer Care • $88.6 million
Radiation Therapy: Access to linear accelerator and treatment within a 100 mile drive ($52.3 million, 6 states, 15 sites)

Digital Mammography: New or updated technology to full-field digital mammography within a 60 mile drive ($36.3 million, 7 states, 68 machines)

Simulation In Motion (SIM) • $11 million
Statewide mobile education training programs utilizing high fidelity human patient simulators

Healthcare Disparities • $2.7 million
"638": One grant with Sanford Health and the Lower Brule tribe to study feasibility and plan to negotiate for self-determination for tribe's healthcare, including creation of a tool kit for all tribal use ($557,751)

American Indian Public Health Resource Center @ NDSU: Creation of a resource center to work toward health parity through technical assistance, policy development, self-determination feasibility analyses, education, research, and programming in partnership with tribes (in partnership with the State of ND, $1.4 million)

Endowed Scholarship for American Indian MPH Graduate Students @ NDSU: The Education Program of the Trust is endowing a scholarship for American Indian students to pursue a Master in Public Health at North Dakota State University ($750,000)

Public & Mental Health • $1.9 million
South Dakota Statewide Mental Health Survey: A health needs assessment that provides representative data across the state's geography and demographics (Survey work by Oregon Health & Sciences University, OHSU, $1.4 million)

Project IMPACT: Implement collaborative depression care model at Southwest Montana Community Health Center (FQHC) in Butte, Montana and at Bighorn Valley Health Center (FQHC) in Hardin, Montana (In partnership with the John A. Hartford Foundation and Social Innovation Fund, $557,751)

2014 AVERA

eCARE

POLICY PRIORITIES

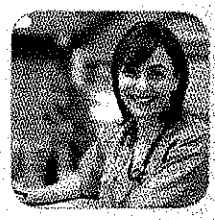
Avera *e*CARE is a telemedicine model developed specifically to address the quality performance and workforce shortages in rural America, providing rural residents with access to the highest quality health care services within their local communities. Through *e*CARE:

- 208,000 patients in the Upper Plains have received enhanced access to care
- $139 million in health care savings has been achieved
- 1,105 lives have been saved
- 21,000 serious safety events have been avoided
- 30 minutes have been shaved off the median door-to-transfer time for cardiac patients

Despite this success, significant public policy barriers continue to challenge widespread adoption of telemedicine. To address these barriers, Avera recommends support for the following issues:

1. Support comprehensive telemedicine legislation that would:

- Reduce or eliminate the burden of multi-state licensure for physicians.
- Allow telemedicine providers to see patients in provider-based clinics without being credentialed and privileged at the provider-based clinic.
- Clarify the definition of curbside consult to include sub-specialty telemedicine consults that occur when the local provider is 1) present during the telemedicine consult, 2) requesting recommendations from the consultant 3) writing any related orders, and 4) managing the patient's overall care, thereby removing questions about the need for additional credentialing and privileging.
- Establish a federal policy of reimbursement for covered services when they are provided through telemedicine.
- Eliminate separate Medicare billing procedures for telemedicine, stating that no medical benefit covered shall be excluded solely because it is furnished via a telecommunications system.
- Lift the geographical patient requirements of receiving care in areas.
- Allow Accountable Care Organizations (ACOs) to use telemedicine as a substitute for in-person care.
- Adjust reimbursement guidelines for home health to better facilitate remote patient monitoring.



2. Expand telemedicine services to skilled nursing facilities (SNFs) by:

- Allowing SNF recertification visits to be conducted via telemedicine.
- Expanding the Federal Communication Commission's (FCC's) Rural Health Care Program to include skilled nursing facilities, allowing SNFs to access broadband connectivity at competitive urban rates.

3. Expand reimbursement for eligible medical services delivered via telemedicine, including:

- Covering eligible services provided by therapists (physical, respiratory, occupational, speech) social workers, master-level counselors and other ancillary clinicians including diabetic educators.
- Providing reimbursement for proven store-and-forward applications, such as diabetic retinopathy screening or dermatology.
- Update the Originating Site Fee (Q3014) set in 2000 (Benefits Improvement and Protection Act) to be more reflective of costs.