health**policy**brief

The Health Policy Institute of Ohio's
Telehealth Leadership Summit
Key findings and considerations

Ohio has potential to be a national leader in telehealth adoption. However, a number of policy, regulatory, and practice challenges have hampered implementation of telehealth across the state. Efforts to navigate these challenges have been fragmented and slow moving. To educate, mobilize, and unify telehealth stakeholders, the Health Policy Institute of Ohio (HPIO) held a Telehealth Leadership Summit ("Summit") on July 16, 2013.

HPIO invited key telehealth stakeholders from across the state to participate in the Summit discussions. The 57 Summit participants included providers, employers, public and private insurers, state agencies, and telehealth technology developers.

The goals of the Summit were to:
- Develop a common understanding of telehealth policy, regulatory and practice challenges at the state level
- Facilitate the development of ideas and recommendations on how to address identified telehealth policy, regulatory and practice challenges at the state level
- Foster the development of relationships among different parties at the state and regional level to further telehealth implementation in Ohio

Why telehealth?
Ohio is grappling with significant health care challenges. Specifically, Ohio lags behind other states in population health outcomes[1] and is ranked 19th in highest per capita health spending.[2] Further, hundreds of thousands of Ohioans live in areas where there are shortages of health care professionals.[3] Strategies that tackle these health care challenges and create sustainable health solutions are in high demand.[4] Telehealth has emerged as one such strategy.[5]

Research suggests that in specific settings and under certain parameters, telehealth enables more effective and efficient care delivery.[6] For example, some studies found that telehealth can decrease patient waiting time for specialty services,[7] while other studies found the use of an eICU can reduce mortality and patient length of stay.[8] Home telehealth for patients with chronic conditions can be effective in reducing bed days of care and hospital admissions,[9] and a number of studies have demonstrated that telehealth can lead to provider, payer, purchaser, and consumer savings.[10]

What led to the HPIO Telehealth Leadership Summit?
HPIO identified telehealth as a promising practice that cuts across two of HPIO's strategic objectives – ensuring access to care for all Ohioans and aligning public and private payments with better health outcomes. Over the past year, HPIO's work around telehealth has helped inform and mobilize stakeholders to engage in policy and practice decisions around telehealth. A summary of HPIO's strategic work around telehealth is outlined below:
- **July 2012** — HPIO hosted a forum, "Moving telehealth forward in Ohio." More than 150 stakeholders convened from across the state to discuss telehealth challenges and opportunities in Ohio.
- **July 2012 to March 2013** — HPIO hosted a series of stakeholder meetings around telehealth policy development. Participants included the State Medical Board of Ohio, the Ohio Board of Nursing, providers, payers, technology developers, state agency representatives and members of the Ohio General Assembly.
  - Participants requested clarity on Ohio Administrative Code (OAC) rule 4731-11-09 regarding prescribing to persons not seen by a physician and the application of the

rule to telehealth. On September 13, 2012, the Medical Board of Ohio approved **new interpretive guidelines** clarifying that providers may prescribe non-controlled substances to remotely located patients, when the physician has never personally examined and diagnosed the patient, if they obtain a history and perform a physical examination using diagnostic medical equipment capable of transmitting patient information in real-time; providers are still required to perform an in-person examination when prescribing controlled substances. The new guidelines clarified that a physician may prescribe to a remotely located patient without examination only if there is an already established physician/patient relationship and such prescribing is consistent with standards of care.[11]

◦ Convened telehealth stakeholders in July 2012 identified reimbursement as the primary policy barrier to telehealth implementation in Ohio. In November of 2012, legislation was proposed in the Ohio House to address telehealth reimbursement. That same month, the Ohio Senate heard testimony on previously proposed telehealth reimbursement legislation. A revised version of the House legislation, HB123, was introduced in the 130th General Assembly. In June 2013, the House passed a **substitute version of HB123** requiring Medicaid to establish standards around telehealth service reimbursement.

◦ Convened telehealth stakeholders presented questions to the Ohio Board of Nursing regarding nurse scope of practice issues and the ability of nurses to diagnose and palpate when being supervised via telehealth. Additional guidance on the issue was released by the Ohio Board of Nursing.

• **April 2013** — HPIO released a policy brief: "**Looking Ahead: Understanding Telehealth in Ohio**" (click title to view, pdf, 18 pages). The brief provides an introduction to telehealth and an overview of the national and state telehealth policy landscape.

• **April 2013** — HPIO launched a **Telehealth resource page** (click title to view)

Stakeholders continued to express the need to align telehealth policy priorities and identify realistic reforms and policy guidance that could further the implementation of telehealth in Ohio. HPIO's Telehealth Leadership Summit sought to meet this need.

The challenges of paying for telehealth

Although the Summit addressed many issues surrounding telehealth, payment for telehealth services continued to rise to the top of the agenda. Stakeholders recognized that movement away from a fee-for-service payment system towards capitated, accountable care or shared risk models may make payment for telehealth a non-issue in the future. However, stakeholders noted that to sustain current telehealth services and to continue telehealth innovation, there is a need to pay for telehealth in the current fee for service environment.

Standard of care
Throughout the Summit discussions, stakeholders emphasized that telehealth was not a specific service, but rather a tool for care delivery that does not change the care being provided. Consequently, stakeholders agreed a provider is held to the same "standard of care" for telehealth services that they are held to for services delivered in a face-to-face visit.

Stakeholders took time to discuss the challenges of paying for telehealth. They noted specifically that the value of telehealth has been centered on cost. Stakeholders identified a need to communicate the value of telehealth beyond a focus on cost to include outcomes, quality, efficiency, and access.

Stakeholders also noted that payer member cycles typically run two to three years. Consequently, by default, long-term cost savings for provision of telehealth services are not valued as highly as short-term cost savings. While telehealth services can lead to short term savings, a large portion of potential savings to the system derived from telehealth take time to accrue. This is particularly true for disease prevention, early intervention and disease management via telehealth. Moreover, increased utilization of telehealth may lead to long-term cost savings but drive up short-term costs.

The Summit discussions also highlighted a need to increase direct communications between providers and payers. There was wide consensus among stakeholders that payers should be involved in structuring telehealth pilot projects so that findings and end goals are shared. Stakeholders noted that Medicaid's "statewideness" requirement restricts Medicaid's ability to implement telehealth pilot

projects. However, Medicaid managed care organizations were identified as having greater flexibility to pilot telehealth programs. Generally, there was agreement that strengthening communications between providers and payers around telehealth could help stakeholders identify those services that are most effective in improving patient outcomes while driving down patient costs.

Structuring the Summit conversation

At the Summit, stakeholders were divided into six workgroups to discuss telehealth as it applies to three principal domains:

- **Hospital and specialty care** — individuals within this workgroup examined the use of telehealth for hospital-based or specialty care services, including tele-ICU, tele-stroke, tele-hospitalist, tele-trauma, tele-x-ology (cardiology, neurology, pediatric –ologies, etc.)
- **Primary care, mental health, substance abuse and integrated care (i.e. patient centered medical homes and accountable care organizations)** — individuals within this workgroup will examine the use of telehealth for the purpose of integrating mental and physical health care, extending and enhancing primary care, and organizing care around the patient. Examples include use of telehealth in primary care settings, patient centered medical homes, accountable care organizations and other integrated care models, extension clinics at skilled nursing facilities and other locations, retail and work site clinics, kiosks, tele-mental health, and alcohol and drug addiction services.
- **Care transitions, home health and remote monitoring** — individuals within this workgroup will examine the use of telehealth for the purpose of ensuring the coordination and continuity of health care as patients transfer between health care settings or between levels of care within the same health care setting. Examples include home health and remote monitoring, readmission reduction, discharge follow up and patient education, tele-triage, enhanced EMS services, hospital at home, and aging in place.

Workgroup questions for the Telehealth Leadership Summit

1. **Value proposition.** What specific programs and services can best realize the value of telehealth in your healthcare domain? What metrics will best demonstrate the value of telehealth in improving access, integration, coordination, quality, efficiency and reducing costs?
2. **Fraud and abuse.** What specific fraud, abuse, or overutilization risks are increased through the use of telehealth? What policies or safeguards can be put in place to limit these risks most effectively?
3. **Payment.** What forms of payment are most appropriate for telehealth services in your domain? Are current payment mechanisms appropriate for these services, or are new mechanisms needed? Are originating site fees appropriate?
4. **Documentation and consent.** What additional documentation or consent is necessary for telehealth services beyond what is currently required of patients and providers in this domain?
5. **Provider regulation.** Do in-state and out-of-state providers need to be regulated separately in this domain?
6. **Care coordination, patient safety and quality**. What specific safeguards or metrics would be most useful to establish/ensure the safety, effectiveness, efficiency and quality of services provided via telehealth beyond what is currently required?

Within the workgroups, stakeholders were prompted by a set of questions (see workgroup questions box) to discuss concrete, realistic, and specific ways to use telehealth to improve access, integration, coordination, and quality of healthcare services, while also enhancing efficiency and lowering costs. Facilitators who had been trained on the workgroup structure and questions were assigned to each workgroup to help guide discussions.

Key Summit findings and considerations

During the Summit workgroup discussions, participants explored a number of issues surrounding telehealth including documentation, informed consent, payment, provider regulation, fraud and abuse, and patient safety. Although the value of telehealth, availability of reimbursement, and current regulatory challenges differed some among the three principal workgroup domains, stakeholders expressed many commonalities in their discussions. The key findings and considerations from the discussions are outlined in the chart starting on page 4.

Key stakeholder findings and considerations

Current status	Findings and considerations
Documentation	
Licensees practicing telepsychology are required to conduct a risk-benefit analysis and document findings specific to: • Whether the client's presenting problems and apparent condition are consistent with the use of telepsychology to the client's benefit • Whether the client has sufficient knowledge and skills in the use of the technology involved in rendering the service or can use a personal aid or assistive device to benefit from the service[12]	• Documentation of a telehealth visit should occur at both the site where the patient is located and the site where the provider is located. • To ensure seamless documentation of a patient's medical history and reduce fragmentation of the delivery system, telehealth providers can be required to communicate/share documentation with a patient's existing primary care provider.
Informed consent	
• "Informed consent" is generally understood to mean the patient understands the pertinent medical facts and information as well as the risks involved with the use of telehealth. • There is limited regulation in Ohio pertaining specifically to telehealth and informed consent. • Ohio does require that practitioners providing counseling, social work or marriage and family therapy via electronic service delivery obtain patient informed consent by providing the patient with information defining electronic service delivery and the potential risks and ethical considerations associated with it.[13] • Licensees practicing telepsychology must obtain a patient's written informed consent prior to providing telepsychology services and document consent for the use of non-secure communications.[14]	• Patients need to be clearly informed on whether/how their telehealth visit will be recorded and any risk associated with online information sharing. • General consent forms may be revised to incorporate telehealth in the consent language. Forms could also be standardized across hospitals/providers.
Payment	

• Ohio Medicaid provides limited telemedicine reimbursement to:
  ○ Certified community mental health centers for certain services rendered via interactive videoconferencing, such as:
    ▪ Behavioral health counseling and therapy services
    ▪ Mental health assessment service
    ▪ Pharmacological management
    ▪ Community psychiatric supportive treatment
  ○ Certified Ohio Department of Mental Health and Addition Service providers for some case management, group counseling and individual counseling services rendered through real-time audiovisual communications.[15]
• Ohio does not require private insurers to pay for services rendered via telehealth. Payment by private insurers for such services is limited.
	• Without payment for telehealth services, many telehealth projects initiated by providers are unsustainable.
	• There is a need to balance payment for telehealth services between paying for some services and paying for all services.
	• Payers are not going to pay for more – i.e. for additional facility fees.
	• Flexibility in payment arrangements/mechanisms for telehealth is encouraged.
	• Providers who are financially "at risk" for the costs of providing health care services to a population have greater incentive to utilize telehealth services to improve efficiency, outcomes and lower costs.
	
	Payment parameters:
	• Payment for telehealth services could be linked to appropriate documentation of a telehealth visit.
	• Payment for telehealth services should account for telehealth delivery that increases health care access to patients in poor socio-economic environments, both urban and rural, so as not to exacerbate socio-economic disparities in health.
	• Payment for telehealth may not need to be at the same rate as face-to-face care, but needs to be set at a level that is sustainable and does not impede telehealth service delivery or innovation.
	• Payment needs to encourage and sustain telehealth in the current fee-for-service environment until integrated payment systems/payment reforms develop. Payment mechanisms discussed include:
	  ○ Blended payment mechanisms
	  ○ Tying payments to patient outcomes
	  ○ Integrating telehealth into the overall CPT code and fee structure for a service such that payment is based on the service being provided, rather than the delivery vehicle
	  ○ Pay for performance
	  ○ Shared savings
	  ○ Care coordination fee
	  ○ Per member per month

Key stakeholder findings and considerations (continued)

Current status	Findings and considerations
Provider education	
• Providers have access to continuing education classes that may address the use of telehealth or telemedicine and related policies. • Licensees practicing telepsychology must establish and maintain current competence in the professional practice of telepsychology through continuing education, consultation, or other procedures that conform with prevailing standards of scientific and professional knowledge.[16]	• Providers need to be educated on the value of telehealth. • Telehealth needs to be more widely incorporated into training and continuing education for all licensed healthcare providers. Training and education should focus on application of telehealth technology, ensuring that the appropriate standard of care is met, and communicating telehealth regulatory requirements.
Provider regulation	
• Out-of-state physicians providing telehealth services through the use of any communication, including oral, written, or electronic communication, must obtain either a (1) full certificate to practice or (2) a telemedicine certificate. If the holder of a telemedicine certificate wishes to physically practice in the state, they either need to obtain a full certificate to practice or a special activity license. • In-state physicians only need a current Ohio medical license.[17] • To practice telepsychology in Ohio, one must hold a current, valid license issued by the Ohio board of psychology or be a registered supervisee of a licensee being delegated telepsychology practices in compliance with OAC 4732-13-04.[18]	• Generally, current provider regulations adequately address requirements for in-state and out-of-state physicians practicing via telehealth. • Stakeholders suggested that some mechanism be implemented to identify health care providers engaged in telehealth service delivery. • There is a need for additional guidance or clarity regarding provider scope of practice and the roles of licensed health care providers in telehealth service delivery (what can providers do via telehealth; who can do what.)
Research and data	
Data around telehealth is fragmented and is not easily accessible.	• Telehealth outcomes research data needs to be collected into a single repository for the state. Data collection can help stakeholders identify gaps in telehealth research more readily. • There is limited data available on the value of providing telehealth services for acute care conditions. • There is a need to collect and analyze data on non-health care cost savings from telehealth intervention (e.g., impact on work productivity and school absenteeism).
Regulation, fraud and abuse	

• There is generally limited regulation in Ohio pertaining specifically to telehealth fraud and abuse.
• Ohio rules outline more specific requirements for licensees practicing telepsychology.[19]
	• Provider compliance with current health care standards (i.e. around HIPAA compliance, the secure transfer of patient data and information, documentation, and provider licensure) is critical.
	• Over-regulation may impede innovation.
	• Stakeholders cautioned that episodic telehealth interactions may lead to over-prescribing of antibiotics.
	• **Mechanisms for addressing telehealth fraud and abuse**:
	  ○ Requiring providers who engage in telehealth to undergo a certain level of training or continuing education
	  ○ Requiring management software that verifies a patient's identity for services provided via telehealth
	  ○ Requiring that providers of telehealth services be separately credentialed
	  ○ Instituting third party peer review (i.e. a third party credentialing body is charged with the monitoring and periodic review of telehealth providers)
	  ○ Requiring medication prescribing via telehealth be linked to the Ohio Automated Rx Reporting System (OARRS)
	  ○ Encouraging communications with a patient's primary care provider

Note: The information in this chart provides an overview of state telehealth laws and regulations for informational purposes only. It is not intended to be a comprehensive statement of telehealth law, be used for legal advice or be relied upon as authoritative. Independent verification of the information is recommended as laws may change.

Telehealth's value proposition

Stakeholders spent a great deal of time discussing the value of telehealth and the importance of articulating the impact of telehealth on total cost of care, quality of care and patient outcomes. Stakeholders noted that cost savings for telehealth are often system-wide, accruing to the provider as well as the patient, and can be seen both inside and outside of the health care system. Further, stakeholders noted that with telehealth, the value accruing to the patient is often greater than what is seen by the provider or payer network.

To better demonstrate the value of telehealth, there is a need for more programs in Ohio that test where and how telehealth technology can be used most effectively. Stakeholders were clear that telehealth is not a "one size fits all" solution. Technology applied in one area may not work in another, and further research needs to be conducted on how different delivery models can be applied to different services.

Measuring the value of telehealth for improved access, utilization, quality, outcomes, efficiency and cost

Stakeholders were asked to identify specific metrics that can be used to demonstrate the value of telehealth services. Identified metrics focused on how telehealth can improve healthcare access, utilization, quality and health outcomes. Further, stakeholders identified metrics to describe the impact of telehealth on health costs for patients, providers, payers and purchasers (see box below).

Health system performance	Patient experience	Health care workforce	Cost of care	Community benefit	
				Health related	**Non-health related**

• Improved clinical outcomes
• Reduced avoidable hospital readmissions
• Reduced emergency department visits
• Reduced urgent care visits
• Reduced hospital bed days
• Reduced length of stay
• Shorter time to care; door to tPA*
• Reduced complication rates
• Reduced exposure to hospital acquired infections
• Decreased "no show" rates
• Timely and accurate diagnosis
• Beds saved for higher acuity patients
	• Increased patient satisfaction
	• Increased patient compliance
	• Increased patient flexibility
	• Avoidance of stigma associated with face-to-face visits
	• Increased family member or care giver participation in care
	• Increased patient engagement and self-management
	• Reduced travel time to and from medical appointments
	• Promotion of "health and aging in place" among older adults and complex patients
	• Increased care coordination
		• Increased provider knowledge (through increased opportunity for interaction and communication among providers)
		• Increased opportunity for provider partnerships and collaboration
		• Opportunity to recruit and retain providers
		• Opportunity to increase supply of active health providers ((i.e. retired physicians conducting e-consults)
			Patient
			• Reduced travel costs (transportation, lodging, food)
			
			Provider
			• Increased revenue to local hospitals (due to keeping patients local)
			• Reduced provider travel costs
			
			Payer and purchaser
			• Reduced transport costs
			• Reduced costs associated with providing care in non-institutional settings
			• Reduced costs from reduction in provider utilization
			• Reduced costs from early intervention, preventative care and improved disease management
				• Improved access to care
				• Reduced morbidity
				• Reduced mortality
					Employer
					• Decreased work absenteeism (lost work days)
					• Increased work productivity
					• Increased employer satisfaction
					• Improved workplace morale
					
					School system
					• Decreased school absenteeism (missed school days)
					• Improved school readiness
					• Improved school performance
					
					Social and criminal justice system
					• Opportunity to monitor the patient's home setting and caregiver interactions
					  ◦ Prevention or decrease in child abuse
					  ◦ Prevention or decrease in elderly abuse

* Administered for stroke treatment

Summit recommendations and next steps for telehealth stakeholders

1. Incorporate telehealth into the educational curriculum and training of health care providers and increase the number of continuing education (CE) classes focused on telehealth. Training and CE should focus on:
   - The value of telehealth
   - Application of telehealth technology
   - Approaches for ensuring that providers use the same standard of care used for face-to-face visits when using telehealth
   - Federal and state telehealth regulatory requirements
2. Explore requiring telehealth providers to undergo specific training or CE related to telehealth.
3. Explore the feasibility of collecting telehealth outcomes data into a single repository for the state. Make telehealth data readily accessible to payers, purchasers and state policymakers.*
4. Seek additional guidance from Ohio professional healthcare licensing boards to clarify the role of their licensees in telehealth service delivery.
5. Explore standardization of patient general consent forms to include consent language for delivery of services via telehealth.
6. Encourage direct communications between providers, payers and purchasers on paying for telehealth and structuring telehealth pilot projects so that end goals are shared and aligned.
7. Encourage payment that sustains telehealth in the current fee-for-service environment but also moves towards more integrated payment systems and payment reforms.
8. Ensure that telehealth visits are properly documented at both the patient and provider sites.
9. Develop a statewide tracking tool to identify providers engaged in telehealth.
10. Encourage the use of telehealth in a way that does not perpetuate or contribute to fragmentation of care.
11. Explore mechanisms for mitigating telehealth fraud and abuse, as outlined in the chart on page 5.

* The Ohio Hospital Association is in the process of compiling Ohio hospital data to demonstrate how telehealth can lead to improved outcomes.

Notes

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11. State of Ohio Medical Board Interpretive Guideline on Rule 4731-11-09, Adopted September 13, 2012
12. OAC 4732-17-01(I)
13. OAC 4757-5-13
14. OAC 4732-17-01(I)
15. OAC 5101:3-27-02(F)(5); OAC 5122-29-03(F); OAC 5122-29-04(C); OAC 5122-29-05(C); OAC 5122-29-17(J); OAC 4737-17-01(I); OAC 4732-17-01; OAC 3793:2-1-11
16. OAC 4732-17-01(I)
17. ORC 4731.296; ORC 4731.294
18. OAC 4732-17-01(I)
19. OAC 4732-17-01(I)

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Telehealth Leadership Summit planning committee
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Planning committee members:

Sam Chapman	Ohio Department of Health
*Kimberly Conkol	Nationwide Children's Hospital
*Lori Criss	The Ohio Council of Behavioral Health & Family Services Providers
Aly DeAngelo	Ohio Hospital Association
Tom Dilling	Ohio Board of Nursing
Harvey Doremus	Ohio Department of Health
*Beth Ferguson	Ohio Department of Mental Health and Addiction Services
Jessica Foster	Ohio Department of Health
Andrew Hertz	University Hospitals Rainbow Babies & Children's Hospital
Karen Jackson	Ohio State University Wexner Medical Center
Michael Miller	State Medical Board of Ohio
*Jonathan Neufeld	Upper Midwest Telehealth Resource Center
*Tom Reid	Reid Consulting Group, LLC
Caroline Ridgway	HealthSpot
*Kerry Rosen	Nationwide Children's Hospital
Michael Slaper	Nationwide Children's Hospital
Ann Spicer	Ohio Academy of Family Physicians
Craig Strafford	State Medical Board of Ohio
Craig Thiele	CareSource
Jon Wills	Ohio Osteopathic Association

* These individuals also facilitated the Summit workgroup discussions.

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