Primary Care Cures
Episode 81: Nora Belcher

Ron Barshop:
This episode is brought to you by the MediSearch Institute. What happens when patients cases become too complex to solve in a typical 30-minute visit? Well, we've all had those super thick, super deep patient history nobody's looked at in a long time and gone back through. Well, I'll tell you what happened is those patients bounce around from doc to doc without getting any answers or making any progress. These patients are trapped and lost in a maze.

Ron Barshop:
Well, MediSearch is here for those doctors and for those patients. Their motto is we solve the unsolvable. Their process is rather simple. Dr. Trent Talbot, the founder, assigns a team of medical detectives, typically three MDs and one PhD to each case. They research the latest breakthroughs and clinical trials and they elicit the opinions of 10 to 15 world-leading experts per case. They purposely seek out experts who will come at each case from a different perspective, the Bayesian method. Altogether, they will put in over 250 MD hours for every case. That means 500 times the amount of brain power that typical doctor can afford to offer.

Ron Barshop:

A year and six weeks ago, we invited today's guest and talked telehealth. It then had a 1% adoption rate with patients, and about 20% with docs. And then the game changer, need I say it, a pandemic changed the adoption forever.

Ron Barshop:

Two quick data points that we're going to dig deeper into this today is this spring from March until April, the number of Medicare patients increased from roughly 13,000 a week on telehealth visits, to over 1,000,005. That is a hundredfold bump from February to April. Second data point, just 0.1% of primary care Medicare visits were telehealth, but we've seen a 400 fold increase.

Ron Barshop:

Nora Belcher is the executive director of the Texas e-Health Alliance which is a nonprofit advocacy group. She started 11 years ago to give telehealth stakeholders a voice in public policy. Texas remembers the home to Teladoc, which today announced an $18.5 billion merger with Livongo.

Ron Barshop:

The Texas e-Health Alliance serves as the state's leading advocate from local communities to the national level for the largest telehealth organization in the country by far. Nora, like me as a nerd, and that she proudly owns a hardcover, first edition of Game of Thrones. I don't know, should I congratulate you for the Game of Thrones or for your telehealth success?

Nora Belcher:

As long as you don't hold me responsible for the last season of Game of Thrones where they went off book and it was pretty hurtful to the fans, I think they were disappointed. The books themselves are quite

fabulous. I'll take the credit for the telehealth stuff. I think we've worked really hard in Texas to be well-positioned even though nobody asked for the zombie apocalypse and to be the breakthrough moment, we didn't ask for it, but we're here, and it's working, and it's working really, really well.

Nora Belcher:

The legislature had done some really good things in advance, but still, the numbers that you just cited, Ron, they're quite extraordinary. I have a colleague in the energy sector who told me I'll look back on this period of time as the equivalent of the discovery of fracking, and how fracking changed energy. It's a fascinating time to be in the policy space.

Ron Barshop:

The federal government seems to be embracing at least on the Medicare side, the reimbursements of telehealth, and they're going to permanetize, if that's a word, the reimbursements so that that encourages more of this technology to thrive. Is there anything else going on on telehealth coding so that it makes more sense on a more long-term basis than the short-term pandemic numbers are saying?

Nora Belcher:

Sure. I think there are several things that are going on. First of all, I really think that CMS did an outstanding job being responsive to the need for social distancing and the need for using telemedicine and telehealth in response to the short-term situation.

Nora Belcher:

We have, historically at the federal level, had a congressional budget office problem. In other words, telemedicine and telehealth looks like it increases access in a vacuum, which looks like it makes utilization go up without really showing us more data on things like cost savings, avoiding ER utilization, that sort of thing. The pandemic has really given us an opportunity to measure some of that and really have some better data on what it works for and what it doesn't.

Nora Belcher:

The president had a press announcement yesterday about some of the additional steps CMS is going to take. There is a bipartisan telehealth bill moving through the House at the federal level. I think we're all pretty pleased.

Nora Belcher:

I think the trick with the coding is over time, we're going to need more and more telemedicine-specific codes, because as new innovations come online using things like artificial intelligence to do guided therapies, for example, for certain kinds of treatments, they may not fit neatly into an existing CPT code or an existing HCPCS code.

Nora Belcher:

So there's going to be some work, I think we'll all need to do there to have the coding environment keep up with innovation, which is really going to be a challenge because folks are innovating in this space literally every day.

Ron Barshop:

When you think about e-psychiatry and e-psychology, and it's really taking off in a big way, and that you can get a lot more done over the phone, it certainly not as touchy, feely or warm, or maybe even you can argue it real as being in person talking to a real human being, seeing the gleam in their eyeballs.

Ron Barshop:

Zoom and other platforms has really created an opportunity for mental health which is just taking off. I mean, we don't even know what the numbers look like in terms of mental health issues that are brewing that may not be uncovered for years, but do we have codes for at least that?

Nora Belcher:

We do have codes for that, and part of what they've done in the short-term is that we have a way to do a modifier. So if you're doing an office visit but you're just doing it over video or over the phone, you just bill with a modifier to the code and that tells the payer, "This is what Medicare is doing. This is what Texas Medicaid is doing, and it was a virtual encounter."

Nora Belcher:

In the short-term, most of the states in the federal government have actually sort of thrown telephone calls into the bucket with video calls just because, as you pointed out at the top, most physicians were not ready to do telemedicine in March of this year. I think that may shift some over time, particularly for physical health. But for mental health services where you don't really have to do a full physical exam, laying on of hands of the patient to start having a conversation.

Nora Belcher:

The phone is going to be part of the way that we reach people who may not have access to the internet, may not have the latest smartphone. We have seen some of those issues in Dallas, for example, Parkland Hospital is doing some really great work with telemedicine and telehealth. They're letting me know that they've got patients they're trying to reach, they still only have a landline phone. We've got to be clear about making sure those folks or people we can still get to it as well.

Ron Barshop:

Yeah. Technology is always going to be the issue even as you think adoption is completed. The otoscope, the laryngoscope and the stethoscope are the doctor's favorite three tools to look in the ear, the throat, and to palpate the chest and listen to stomach issues. The issue is that those kits to send them are few hundred bucks for something a patient needs once, maybe twice a year if they're chronic, maybe six times a year. Are there any models out there that are actually finding a way to pay for those tools to get in the hands of the patient so that the doctor can have a remote visit at will with their favorite tools?

Nora Belcher:

Okay. There's a couple of things around devices that I think are really interesting. First of all, I've not priced the stethoscopes and the laparoscopes recently, but you can get a Bluetooth otoscope for under a hundred dollars on Amazon that is reusable, that has reusable tips.

Nora Belcher:

Part of what I would like to see is for that to be part of a newborn's kit that goes home with mom after the birth from the hospital, because we all know that babies like to get ear infections late on Saturday night. [inaudible 00:07:02] in particular, I think could become more ubiquitous.

Nora Belcher:

The trick with giving equipment to people is that you have to comply with Anti-Kickback Law, so either the insurer has to pay for it, or the provider has to pay for it and keep ownership of it. You can't give the equipment to the patient for free, and then let them keep it, they have to pay market value for it or someone has to pay for it. We're starting to already see some rumblings about making sure we're compliant with the law.

Nora Belcher:

That being said, remote patient monitoring is the category where a lot of that stuff could potentially fit, particularly for folks that have a chronic condition. I think it's a little harder to do it for somebody who's having sort of a one-off. But someone who's having regular issues, whether it's a blood pressure cuff or an otoscope, remote patient monitoring is a reimbursed benefit. Medicaid does it, Medicare does it, and I think we're going to see more of it as an alternative to sending a home health nurse into a home.

Nora Belcher:

Now, of course, because of social distancing and the need to protect those healthcare workers and protect the people in the home that might be vulnerable, but also in the long-term using technology to sub for some of those visits is going to be a real thing. I think the challenge is going to be making sure that we do it in ways that don't violate the Anti-kickback rules that ownership of the equipment is really, really clear, who's responsible for it, who's paid for it.

Nora Belcher:

If insurers are smart, they will pay for this stuff because it's a great way to keep people out of the emergency room, keep them out of urgent care, maybe keep them out of a freestanding, ER that they might go to not quite understanding what they're getting into.

Ron Barshop:

I used to believe they wanted to save money and I don't believe that anymore. I think they just don't want to spend a penny more than 85% of their ALR.

Nora Belcher:

Well, that's true, that's a fair point. We want all this stuff to go into that 85%, by the way, and that's been an issue at times. When the coding is not clear, I've certainly seen actuaries try to classify telemedicine as an administrative cost which is a massive disincentive, because then on the wrong side of the ratio.

Ron Barshop:

Are there some carriers that are better than others with telehealth reimbursements, or some of them giving a lot of trouble to the providers out there?

Nora Belcher:

Right now, there are no mandates. You're talking about private insurers in particular, as opposed to the government plans. There's a long list on the AHIP website of the different... so that's America's Health Insurance Plans, their trade association, the different solutions, the different health plans are offering. I think that's a picture that's a little bit in motion.

Nora Belcher:

I will tell you that in Texas, Blue Cross And Blue Shield is doing contracting for telemedicine, united in some places, is very aggressive about it. Superior, which is Centene, one of our Medicaid plans is using

the technology in some pretty aggressive ways. You have to remember that a lot of those private insurers are those employer-based plans and they're regulated by the Department of Labor federally, they actually don't have any mandate to cover telemedicine unlike the plans that are state-regulated.

Nora Belcher:

There's a pretty ferocious debate going on in DC right now about whether or not those plans which are employer-based, 50 state, multi-state plans need to be integrating telemedicine more effectively, and should that be a mandate that Congress puts on them, or should we wait for them to step up and do it on their own? That's a very, very hot topic in Washington right now as the coronavirus packages continue to be debated.

Ron Barshop:

Do you have any favorite companies you'd like to... not companies, but industries you'd like to see bailed out by the federal government, or are you of the opinion that we're putting money into systems that already have giant reserve funds and don't really need these bailouts?

Nora Belcher:

I am not 100% sure outside of the providers which is where I'm focused, who might or might not be getting bailed out. I will tell you where I'd like to see money spent, though, if that's your question, in the public health infrastructure. Our public health infrastructure is terrible. We are running software from the 1970s and we are sending faxes of case reports from local public health to state public health, and then it's manually being data entered and compiled and sent to the CDC.

Nora Belcher:

As a trade association, obviously, I represent my industry and I would like for us to get in selfishly, perhaps. Those are the interests I represent. But I will tell you what is frustrating is to see discussions of pouring money into old models while we have neglected priorities like public health, where we should be moving into using 21st century standardized technology.

Nora Belcher:

We have the technology to do case reporting in real-time on coronavirus, and we're not doing it, because we haven't made the investments and we're still arguing over whether those are good investments. That is just ridiculous.

Ron Barshop:

There was an article in a ProPublica yesterday that a young lady had physician in, I believe in Washington, is doing her own Google searches of obituaries of healthcare workers that died for from C-19. Her numbers are like 10X the numbers that are being reported by CDC. It's not even close.

Ron Barshop:

Then population health experts are weighing in they're going, "Yeah, the infection rates for healthcare workers and the death rates couldn't possibly be the numbers that they're announcing." Do you think it's pernicious or do you think it's just incompetence because of these 1970 software systems that we're working off of?

Nora Belcher:

I believe the principle is called Robert Conquest Law, which is to evaluate the behavior of a bureaucracy by assuming it's controlled by a group of its worst enemies. I don't think there's any malice at the CDC, at state public health, at local public health. I do think there are perhaps conflicting agendas in the politics of it, but I also think if we had a clean standards based reporting system, you wouldn't be able to monkey with it. The fact that it's all manual, I think is casting a lot of doubt on the data.

Ron Barshop:

Look, you've had gigantic Medicare, Medicaid budgets at your fingertips for the state of Texas working for the governor. If you could be queen for a day and mandate how we should be getting ourselves out of this, let me give you my two second prescription. Let's talk about immune health, let's talk about outdoor walking and strengthening your lungs, let's talk about a little vitamin D, let's talk about nutrition, proper sleep, let's talk about hydration. Let's talk about building your immune system so that you aren't half of 1% that are going to fall victim to this, to the fatality.

Ron Barshop:

I don't know our public health officials aren't talking about some of these common sense free solutions, you don't have to join a gym to go walk outside two, three miles.

Nora Belcher:

I completely agree with you. I think a couple of things. I think, first of all, part of what has frustrated the American people to the point of sort of surrender is, "I have two weeks to crush the curve. I have four weeks to crush the curve. I would do this, I would do that. We need masks for healthcare workers. Wait, no, you need to wear a mask. You can do this activity, but you can't do this activity." The messaging has been really inconsistent.

Nora Belcher:

What we also know is that the virus is disproportionately affecting people who have complicated health conditions, not just with the death rates and kind of how they slide upward as folks get older, but also in our Hispanic and African-American populations where we've got health disparities to begin with. Absolutely being healthier overall while it is not a silver bullet is going to improve your odds, not just with COVID, but with any health situation you might be facing.

Nora Belcher:

I look at some of the other countries that I have done some work with, the Netherlands is a great example of this. Their Minister of Health is also their Minister of Sport. By sport they don't mean like the NFL, by sport they mean get on your bike and go for a ride, go be outside. They see physical activity and healthiness as an integral component of their overall healthcare strategy. I was there in the fall and I had no idea that that was part of their thinking. I thought that was really fascinating.

Nora Belcher:

I do think we're missing an opportunity to have a broader discussion about keeping people healthy because the focus really is on trying to shut the disease vector down and getting that contagious spread under control. We may look back on that as a missed opportunity to talk about health in the bigger picture, Ron, I think you're right about that.

Ron Barshop:

I was in Paris a year ago. Just totally observation, nothing scientific. I couldn't find obese people that were natives. I wasn't in the main cities. I mean, I was in Paris, but I was also in the outer lands, and I didn't see

a lot of obesity. Now everybody's smoking, but they're also walking and biking everywhere. I would imagine when you went to the Netherlands, you might have witnessed the same.

Nora Belcher:

Absolutely. In fact, I remember being on a train, taking public transit back to the airport in Amsterdam, and how many people got on the train with their bikes because they were doing a combination of taking public transit someplace and then riding their bicycle. You get a lot of pushback when you bring stuff back from other countries.

Nora Belcher:

The Netherlands is not that big comparatively, I mean Houston is bigger, new York is bigger. All of that is true, but I refuse to believe that American ingenuity can't figure out a way to get people to a better place in terms of their health.

Nora Belcher:

It's not just about health coverage, which is where I think we've been stuck debating for the last 10 years, who has insurance, who doesn't have insurance. I'm not saying that's not important, but we need to start looking at some of these models where fresh food is at the pharmacy, and literally, you can write... the doc will write a prescription for food, fresh fruits and vegetables for a family to take home along with their medication. Because if all you do is give them the medication and no lifestyle changes happen, the odds of improvement are significantly less.

Nora Belcher:

I know this based on the work that you've done for years and years, that we have to look at the bigger picture of health, not just healthcare.

Ron Barshop:

Well, I want to talk in a second about the clinic of the future, what it looks like in terms of people feeling safe again so that telehealth, while it's important, becomes less important, people aren't feeling safe and so telehealth has just been a rush to the safety net.

Ron Barshop:

I've been talking to architects the last couple of weeks about what is the perfect primary care clinic look like, and they're talking about cork floors because they're antimicrobial, and anti-microbial lighting that circulates the air above the light and hits it with the UV killing the microbes. Obviously, touchless everything, so it could just automatically dispenses hand sanitizer and light and air conditioning.

Ron Barshop:

When you walk in a room you can open doors with your foot like [inaudible 00:17:41] some restaurants. Then soundproof booths so people can actually have a quiet place to have a Zoom call and have a doctor consult. Have you thought through like if you were to go to your doctor, what that would have to look like for you to feel safe for you and your kids?

Nora Belcher:

Sure. I actually have thought about it because I've been doing doctor's visits for some ongoing health issues both virtually and then in person. I think one of the things that's getting skipped over in the rush to

virtualize everything is that you still are going to have to do lab tests, blood draws, urine tests, that has got to be a high priority to make people feel as safe as possible to do those things.

Nora Belcher:

I really like everything you were just describing, I think that's a piece of it. I think dirty waiting rooms, even having a sick waiting room in a well waiting room is in the past. We're going to have to really focus on keeping those spaces clean. That's going to be important to me. I think having the flexibility to choose virtual when I needed an in person, when I need maybe go to the lab on a separate date is going to matter and help in terms of helping people flex their time.

Nora Belcher:

I am asking my doctor's offices what precautions they're taking, and the smart ones are advertising that. They're reaching out to their patients, they're saying "we've reopened, this is what we're doing." I think where that's gotten tricky a little bit is in situations where families are going together, as opposed to individuals on their own. That's going to be a little bit harder just like the debate we're having about schools and what we do with children is going to be a little bit harder. People need to wear masks. People need to do hand sanitizer.

Nora Belcher:

I think an underappreciated piece of this is ventilation. I think we really have to have a conversation about air conditioning. I'm not saying I want to get rid of air conditioning, but I think we're probably going to have to have a conversation about air conditioning because there seems to be some evidence that it's contributing to the problem.

Ron Barshop:

There are HEPA filters you can put in each room that are higher end than the ones you buy at the grocery store, I mean at the Walmart.

Nora Belcher:

Right.

Ron Barshop:

There are air filtration systems that are not as expensive if you would imagine.

Nora Belcher:

I think all those things are going to be important, and I think the practice of the future is going to be a hybrid practice, but there are still going to be some times you're going to need to go in, there are going to be some times you're going to need to go get labs, and there's going to be times when you're going to be able to do things virtually.

Nora Belcher:

Finding that balance is going to be a trial and error, and it's going to be different for an orthopedic practice than it's going to be for a urology practice, than from a psychiatry practice. Those are the things that we're going to take some time to assess out.

Ron Barshop:

Can't do surgery by telehealth. I had a friend, half his staff quit on him because they wanted to do telehealth by surgery. They're going, "I'm sorry, you're going to have to just find a new job."

Nora Belcher:

No. So you do have models like the da Vinci robot that's controlled remotely, but... That telehealth, robotic surgery is sort of a different group. I tell people all the time, anyone who tells you that you can do everything with telehealth is trying to sell you something and you should be a little suspicious.

Ron Barshop:

Yeah. Well, let me tell you what it did for my company, and we talked about this last show a year ago. We started telehealth about two and a half years ago, and most of my employees are single Hispanic females, they're on Medicaid. So they had to quit Medicaid to join this telehealth plan, because you can't have both.

Ron Barshop:

What we found is that their pink eye, they could call in now. Their ear infection, they can call in. Now their skin rash for their kid, they can call in now. It turns out 85% of visits can be called in by text, by email, by phone, by call secure with the HIPAA compliance. By cutting out that time suck of having to go to a Medicaid clinic which is a four hour time suck for a five minute script is for the birds, and it's over now for them.

Ron Barshop:

My absenteeism dropped in half. My productivity I can't measure, but I think it helps productivity. Let me tell you what it really did, is that I had zero turnover for the first time in a multi-decade career in healthcare. You don't see no turnover, zero turnover, but it's because they had free healthcare and they had super easy access and low friction.

Ron Barshop:

What telehealth has done for my company is giving me great candidates. Everybody wants to get into a company with free healthcare, but gave me a lot higher productivity because people aren't going to work sick and they're not going to work worried about their kid.

Nora Belcher:

I love hearing that, Ron. I will tell you that I think one of the biggest obstacles that we have in this country is sort of the suck it up mentality, go to work sick. Even with coronavirus, I've heard story after story of people who couldn't afford to not go to their jobs so they took a bunch of Tylenol just to take their fever down, and they went to their job and they spread the virus.

Nora Belcher:

We've got to move to more of a wellness mentality, and I think virtual visits... I mean I don't make a doctor's appointment after 8:00 AM. I have to be desperate, because I don't have four hours to sit in the waiting room and the doctor starts to run behind, and then there's the time of traffic and you have to find a way to park.

Nora Belcher:

Particularly for minor primary care, and I don't mean minor like it's unimportant, I mean minor like it's not major surgery, virtual care models, they really, really work. I think we're seeing the Teladoc merger

today as a great example of you can go so far with primary care, but I think the mergers with a company that's in the chronic care space. Those things sort of go together and you're going to have to have combinations of all of it to keep people healthy.

Ron Barshop:

You talked about time-suck. We actually detailed every step it takes to get a primary care visit and then walk out the door and get your meds. It's a 21 step, Texas 21 step, not a Texas two step. It's a time suck. It's getting in your car, driving somewhere, waiting, filling out a clipboard, waiting some more, making a copay, getting in the door, getting your visit, leaving, making another payment, getting e-bill that doesn't make any sense to you that's completely confusing, going to the pharmacy. I don't want to bore you with it but it's 21 steps.

Ron Barshop:

If you can do that by telehealth with a phone call and an e-script, and now it gets mailed to you, and now the script maybe even comes in a pill packs to take your AM's and your PM's when the nutraceuticals and pharmaceuticals where they go. It get it can't get any worse as a customer experience, it can only get better.

Nora Belcher:

It's a terrible customer experience and you're not feeling good. On top of all that, you are accessing the system when you may not be at your best no matter how bright or experienced you might be as a human being at whatever it is that you do in your day job like you said, that it can still be baffling. I'll add one piece to your streamlining in my perfect world than the drones deliver the drugs to your front door.

Ron Barshop:

Yeah, so that way you can get them real-time if you have an urgency pack need, or you need something like for a fungal infection right away, you don't have to wait in the mail for a couple of days which is-

Nora Belcher:

Exactly. One of the things we're going to work on this legislative session is trying to improve access to telepharmacy, because we have communities that don't have a full-time pharmacy that could support a pharmacy tech with some remote supervision from the pharmacist. We've been expanding that every legislative session, it's a model that works really well in other states, we've expanded it into our federally qualified health centers. Lots of prescriptions never get picked up, we know that-

Ron Barshop:

Yes, about half.

Nora Belcher:

... and that's a problem.

Ron Barshop:

Yeah. Let me ask you. In Texas, we have something like 254 counties and something like 50 of them have no doctor, maybe a vet that can pull a tooth for you or something, but we don't have any doctors at all in many... They're large counties, some of them are as large as States. We also have 50 plus more counties that have maybe a doc. So, when the rural hospital closes and doesn't give birth any more, then a

lot of people fled out of that county into the city. What you're saying with that solution, rural health would be really, really accentuated in a dramatic way by telehealth and by drones.

Nora Belcher:

Yes. I'll give you a rural health example that I'm extraordinarily proud of. The hospital in Van Horn which is literally in the middle of nowhere, was not able to sustain enough staffing to be a part of the state's trauma system, which gives you the extra money which was helping keep them open.

Nora Belcher:

They've entered into an integrated telehealth model for their emergency room where there are 24/7 ER docs online backed up by nurses, documentation specialists. Screens dropped down, mics dropped down and they help the PA, that staff in the ER when the doctor's not there with any emergent care that comes through the door that they need help with.

Nora Belcher:

The medical director told us during the legislative session last year that his team can now evaluate, stabilize, triage, and even get the patient onto the helicopter before he can get his pants on and get to that hospital.

Ron Barshop:

1,901 people in Van Horn, you just use more words than 1,901 I'm pretty sure.

Nora Belcher:

Exactly. Now, we have a number of rural hospitals. We pass some legislation to make sure that any small hospital that wanted to use this model could use it. What the rural hospital folks are telling me is they can't be hospitals anymore, they have to be healthcare. They have to really offer, especially because we do... come these counties that don't have doctors, those hospitals have got to become multifunctional.

Nora Belcher:

They've got to offer some primary care and they've got to offer a dietician. They've got to offer all these bits and pieces that they don't have time to have full-time staff for, telemedicine and telehealth is the perfect solution. It lets you... like a software as a service. Telehealth is a service. You have organizations you can contract with, academic groups, for profit groups, all sorts of groups that will just give you what you need and you pay for that when you need it, rather than having a full-time employee that may only see two patients a week, because you can't afford that, it's unrealistic.

Ron Barshop:

We are, I'm guessing, somewhere around the 40% acceptance level of telehealth, where we were at 1% when we talked June of last year, now we're in August of 2020. Do you have any predictions? First, I almost for sure going to hold at 40% or more, but do you have any predictions what this looks like a year from now when we talk again?

Nora Belcher:

Well, there's two potential scenarios. Scenario one is that we don't get the virus under control and the numbers are kept artificially high because it's just being implemented for social distancing. That's not a scenario I'm terribly fond of. I think there will be practices in the long run that will be completely virtual.

Nora Belcher:

I think that your number of 85% for certain things is an accurate thing. I think there are going to be certain professions, certain types of services, maybe orthopedic surgery is a great example where those first visits are still going to have to be in person because that's just what you have to do to meet the standard of care, because the standard of care is not going away just because we're moving into a virtual world.

Nora Belcher:

I think almost all practices are going to have to offer this in some shape, form or fashion. The consumers that I'm talking to that are doing it have no interest in ever having it taken away from them.

Ron Barshop:

There's two things still in the hitch and the get along. What were a year ago the number one is there has to be an in person standard of care, you can't just start a telehealth visit with a stranger, right?

Nora Belcher:

You can, but you have to meet certain technical standards in terms of what information gets exchanged. Even now under the pandemic, you can do a phone call with the doctor that's never seen you and get a prescription, but that's because of the public health emergency. When the emergency ends, it goes back to the standard of care, and you have to at least do a video visit, the doctor has to at least be able to lay eyes on you. If the condition requires something like a lab test and you don't do it, you are at risk from a regulatory enforcement perspective.

Nora Belcher:

None of that has gone away, we've temporarily put some of it aside to respond to the emergency. But a year from now, assuming we get a vaccine or some other step that brings the spread of the virus under control, providers need to really be mindful that the standard of care is still the expectation. If they're prescribing to a new patient over telemedicine and telehealth, that they've got in mind their P's and Q's and make sure they do all the right things and do the documentation.

Ron Barshop:

Okay. Is there a source they can go to to make sure they know where the P's and the Q's land?

Nora Belcher:

Sure. We've got information on our website, we've got a section that says new to Texas. That's got all the links to all the regulatory requirements. There are also some really great frequently asked questions documents on the Texas Medical Board's website. I always recommend that folks check... Don't just take my word for it, go straight to the regulator and read what they say because they make it, they spell it out pretty clearly. They do, I think, a pretty good job of letting folks know what the expectations are.

Nora Belcher:

Now, I want to make sure I say that's specific to prescribing. Regulated is prescribing. Getting advice, having conversations, doing triage is not regulated at the same level of intensity as prescribing.

Ron Barshop:

Okay. My second question we asked this last year as well is, the VA, you're a doctor in the VA. You can pre prescribe, you can diagnose in any of the 50 states and territories. If you are in the defense health,

same thing, they've expanded the definition of licensing. We were kind of hoping in our call last time, that would expand as well, and it looks like temporarily it has. Do you think that's something that'll take?

Nora Belcher:

I doubt that that's going to take in the long run because of the 10th amendment issues that are involved, that occupational regulation is thought of by the courts as an extension of the police power of the states and it's not something the federal government can do outside federal systems.

Nora Belcher:

I have actually not heard a lot of conversation about creating a national telemedicine license in DC. As a result of the pandemic, people are way more focused on reimbursement, so I'm afraid when the public health emergency goes away, you sort of fall back to state regulation. That being said, we now have 37 states participating in the interstate compact for medical licensure which is a way to really speed up that multi-state licensing process.

Nora Belcher:

The reason that that's important is because if somebody from Harlingen , Texas has a bad outcome and wants to file a complaint against their doctor, if it's centralized in DC, there's a lot of concern that they would never get any help or any relief from their complaint.

Nora Belcher:

Ron, I know you will get this when I say it. Part of what's happened in the pandemic is a rediscovery of the fact that we're actually a federalized republic and not a giant monolithic democracy which is what people think we are, that we're actually not. Both the federal and state constitutions give local certain power, state certain power, the federal certain power.

Nora Belcher:

It would certainly simplify things to have a national telemedicine license or some reciprocity, but the compact, it looks like it's probably the closest thing that we're going to get to right now. I think that the reality of that is clear in the fact that the federal discussion that's happening right now is not including that licensure component, it's not even being talked about.

Ron Barshop:

Nora, how can folks find you at the Texas e-Health Alliance and find that website?

Nora Belcher:

Sure. Our website is www.txeha.org. We've got a form folks can fill out to send an email if they've got questions. We've got information on how the Texas legislative process works, the bills we pass, the things we do. I'm happy to interact with anybody who's got an interest. I need all the friends that I can get. We might be popular right now, but we're competing with education and other folks for resources, time and attention, so it really does take a team to get the stuff done.

Ron Barshop:

The e-Health Alliance is all about telehealth, it's also about any kind of e-health-related bill, any health-related policy.

Nora Belcher:

Yes.

Ron Barshop:

It's a wider expanse than just telemedicine.

Nora Belcher:

Yes. Health information exchange, electronic medical records, cybersecurity, broadband, privacy, innovation, infrastructure, interoperability. We cover the whole waterfront. The Texas Legislature likes to see a lot of agreement, so we work really closely with the provider associations on trying to have joint agendas on legislation. But yeah, we're not just a telemedicine group. If it has to do with digital health and it has to do with making things better for patients, we are interested in it.

Ron Barshop:

Well, we're excited Teladoc and Livongo are merging. It's actually sort of their same size. I mean we have an $18.5 billion valuation for Livongo, and I looked at it today in the market cap of Teladoc is about 18 billion, about $17.5 billion. So they're doubling their size.

Nora Belcher:

Big news. Big, big, big news. Teladoc was the first big IPO in the space, and on behalf of the stakeholders as a collective, I want them to be successful rock stars.

Ron Barshop:

Yeah. Well, their stock has quintupled in the last four months so they are rock stars.

Nora Belcher:

Yeah. It sets the stage for success for everybody else to have them be successful. It's super exciting news. My phone's been blowing up about it all day. [inaudible 00:35:13], everybody's talking about it. Good for them, I think it's really cool. I'm interested to see how the merger plays out.

Ron Barshop:

Yeah, very good. Well, thank you, Nora. We always ask the final question. We asked you last year, if you could fly a banner with a message for all Americans about health, what would that banner be over America right now?

Nora Belcher:

I spent some time thinking about this one, I knew it was coming. I have to tell you, I think it would be go outside and take a walk.

Ron Barshop:

I like that.

Nora Belcher:

Put down your phone, stop doing scrolling, go outside and take a walk. I think if everybody did more of that, our overall health as a country would automatically improve.

Ron Barshop:

That is so true. I've walked six miles a day for the last 30 days and I haven't felt better in 20 years. It's amazing how simple, and it costs me nothing, nothing. It's easy. Listen to your favorite audio book. I've walked with friends the last four days, it's a great way for social outlet when you're feeling isolated. It's wonderful.

Nora Belcher:

It's really, really good for you. My husband laughs at me because I listen to True Crime podcasts while I walk, maybe that's not the absolute healthiest thing you could listen to. I binge Dateline because I'm a true crime junkie. You've got to get out there, and more importantly, you got to put your phones down. I'm afraid that the pandemic has created a lot more screen time more than I would like, so it makes it all the more important for us to get our butts outside.

Ron Barshop:

Yes, ma'am. By the way, there was an interesting data that's just incontrovertible, that of the autopsies they've done on C-19 patients, 4% had adequate vitamin D and 96% had inadequate vitamin D. That's sunshine, baby, it's free.

Nora Belcher:

Yeah, I am right there with you, Ron. You are 100% correct on that one. Everybody should pay attention and take that to the bank.

Ron Barshop:

Yes. Well, thank you, Nora. It's always interesting and wonderful to talk to you. I can't wait to talk again next year when this grows, and let's hope it's not for sake of a pandemic.

Nora Belcher:

Yeah. Same. Ron, I'm always happy to be here. Call me anytime. I was happy to have the conversation. I appreciate you giving me a venue to put our opinions and what we're thinking and working on out there. Also, I'm interested to get annual updates from you on how your business is doing, I think it's pretty great.

Ron Barshop:

Super. Thanks for your time.

Nora Belcher:

Thank you.

Ron Barshop:

Thanks again. Thanks again to our sponsor, the MediSearch Institute. I want to read you a note a CEO friend of mine sent me who used them for a rare childhood disease her daughter had. Dr. Talbot's research was thorough. He provided clear paths of treatment and he gave me access to the best physicians. I'm so grateful for his work. That's the MediSearch Institute.

Ron Barshop:

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