

COUNCIL OF THE CITY OF PHILADELPHIA  
JOINT COMMITTEES ON PUBLIC SAFETY  
AND PUBLIC HEALTH AND HUMAN SERVICES

Room 400, City Hall  
Philadelphia, Pennsylvania  
Thursday, January 16, 2014  
10:15 a.m.

PRESENT:

COUNCILMAN CURTIS JONES, JR., CO-CHAIR  
COUNCILWOMAN MARIAN B. TASCO, CO-CHAIR  
COUNCILWOMAN JANNIE BLACKWELL  
COUNCILMAN WILLIAM K. GREENLEE  
COUNCILMAN DENNIS O'BRIEN

RESOLUTION 130886 - Resolution calling for joint hearings by the Committee on Public Safety and the Committee on Public Health and Human Services to explore alternative health care methods, such as, telemedicine, mobile health care clinics, online therapy, and non-traditional nursing homes for low-income families, disabled, and elderly Philadelphia residents.

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THE CLERK: Good morning. The joint committee hearings by Public Safety and the Committee on Public Health and Human Services, Resolution No. 130886, will be postponed due to the weather at 11 o'clock today. Again, the Resolution 130886 calling for joint hearings by the Committee on Public Safety and the Committee of Public Health and Human Services to explore alternative healthcare methods will be postponed until 11:00 a.m. today.

(Short recess.)

COUNCILMAN JONES: Good morning -- it's still morning -- everyone, and thank you for your patience. We were supposed to start at 10:00 and we had a slight delay to start at 11:00, but we hope to get you in and out of here in an efficient manner. We understand that we have a number of doctors that actually have to see patients this afternoon, and we're going to try to accommodate you.

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2 This is the Committee of Public  
3 Safety along with the Committee of Public  
4 Health and Human Services chaired by my  
5 colleague Marian B. Tasco.

6 And would the Clerk please read  
7 the title of the resolution.

8 THE CLERK: Resolution 130886,  
9 calling for joint hearings by the  
10 Committee on Public Safety and the  
11 Committee on Public Health and Human  
12 Services to explore alternative health  
13 care methods, such as, telemedicine,  
14 mobile health care clinics, online  
15 therapy, and non-traditional nursing  
16 homes for low-income families, disabled,  
17 and elderly Philadelphia residents.

18 COUNCILMAN JONES: Thank you.

19 I'd like to recognize my  
20 Co-Chairman, Councilwoman Tasco.

21 COUNCILWOMAN TASCO: Good  
22 morning, and thank you all for coming out  
23 for this hearing today. I'm very  
24 interested in listening to the testimony  
25 to see what new ideas we can provide to

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2 our citizens and make it easier, since  
3 I'm in that category and if I don't have  
4 to get up and go to the doctor at 8  
5 o'clock in the morning and sit for three  
6 hours waiting for him to come, I can  
7 maybe find some other way to do it.

8 Thank you very much.

9 COUNCILMAN JONES: Also joining  
10 us on the panel is Councilman Greenlee, a  
11 longtime champion for quality, affordable  
12 healthcare in the healthcare paid sick  
13 leave bill, and he's not daunted in any  
14 way. It will resurface some day and  
15 hopefully get a positive determination by  
16 our Mayor and the rest of Council.

17 So with that, today we hope to  
18 learn a little more about healthcare  
19 options. There's a lot of healthcare  
20 talk with the dubbed Obamacare, but how  
21 does it impact the City of Philadelphia  
22 and how does technology impact the access  
23 to healthcare, particularly for seniors  
24 and people who live in low-income  
25 neighborhoods.

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2 A while back we talked about  
3 the use of telemedicine. It is widely  
4 used in rural areas and has been used to  
5 deal with great distances and access from  
6 rural communities to centers of medicine.  
7 There's a city application to that as  
8 well. We found in earlier testimony that  
9 many people leave a lot of money on the  
10 table that would be used for children,  
11 for seniors, for poor people to have  
12 access to quality, world-class  
13 healthcare, but often do not feel  
14 comfortable traveling to it, whether we  
15 talk about our Philadelphia housing  
16 projects or whether we talk about seniors  
17 who often are a little less mobile. So  
18 we want to kind of stretch the envelope  
19 to look at how we can access those  
20 stranded populations often and better  
21 utilize some of the things that are  
22 available to them.

23 When people can't get to the  
24 doctors, when people have low mobility  
25 issues, like our seniors and persons who

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2 live with disabilities or a mother who is  
3 caring for a sick child who has no car,  
4 how can we as healthcare providers be  
5 more efficient in handling non-emergency  
6 issues like colds and rashes. In the  
7 past, we held hearings and had some  
8 success on medical clinics in CVS's and  
9 Rite-Aids and were able to get some of  
10 those clinics and a commitment for some  
11 of those clinics into the City of  
12 Philadelphia. So we're wondering if we  
13 can use technology to reduce emergency  
14 room visits that aren't necessarily of an  
15 emergency nature. So we're looking to  
16 our city, we're looking to the private  
17 sector to learn today how we can employ  
18 these new technologies to better service  
19 the people of Philadelphia and  
20 surrounding communities.

21 So with that, will the Clerk  
22 please read our first panel to testify.

23 THE CLERK: Dr. Younkins,  
24 Dr. Kovarik, and Dr. Gluch.

25 COUNCILMAN JONES: Thank you.

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2 Please come to the table.

3 (Witnesses approached witness  
4 table.)

5 DR. KOVARIK: I'm just going to  
6 turn my PowerPoint on.

7 COUNCILMAN JONES: You're going  
8 to use technology, see, to convey a  
9 thought or idea.

10 Have a seat. Thank you for  
11 coming in. Thank you, and please proceed  
12 with your testimony and welcome.

13 DR. KOVARIK: Would you like us  
14 to go in any particular order?

15 COUNCILMAN JONES: In any order  
16 you're comfortable with. Just state your  
17 name for the record.

18 DR. KOVARIK: My name is Carrie  
19 Kovarik. I'm a dermatologist,  
20 dermatopathologist, and infectious  
21 disease doctor at the University of  
22 Pennsylvania. Today I'm going to talk to  
23 you about our teledermatology  
24 initiatives.

25 Do you want us all to introduce

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2 ourselves?

3 COUNCILMAN JONES: No.

4 DR. KOVARIK: Okay. I'll go  
5 ahead.

6 So I'm very excited to talk  
7 with you about a program called  
8 AccessDerm, which is actually happening  
9 and very successful in the City of  
10 Philadelphia right now. And it's exactly  
11 what you said. You gave me a great  
12 segue. Utilizing technology to provide  
13 access to care to patients who are  
14 medically underserved or in areas where  
15 they have a difficult time getting to  
16 specialty care. So we in 2009 created a  
17 mobile app and website called AccessDerm  
18 in collaboration with the American  
19 Academy of Dermatology, and this mobile  
20 app was developed primarily to provide  
21 dermatology care to underserved  
22 populations in the U.S. Over the past  
23 about four or five years, we've refined  
24 the app to create a very user-friendly  
25 program that we're very happy with.



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2 At the current time, AccessDerm  
3 is a platform that works on a web portal,  
4 iPhone, iPad, and Android devices. It's  
5 very easy to use, takes minimal training  
6 for the providers to understand how to  
7 use it. And I brought these photos  
8 because I think it's easier to understand  
9 what it is if you can see some of the  
10 screen shots on the application. So  
11 AccessDerm is on a mobile app and web  
12 portal. Here you can see side by side.  
13 And basically let me just tell you how it  
14 works.

15 If a provider, say, in one of  
16 the Philadelphia health centers sees a  
17 patient with a rash, they're not sure  
18 what to do with it, they can actually  
19 pull out their personal device -- so one  
20 of their personal smartphones -- enter  
21 the clinical information on the  
22 questionnaire that we've developed, take  
23 photos on their phone that's connected to  
24 the consult, and press send, and that  
25 consult is sent to the group at the

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2 University of Pennsylvania, and we get a  
3 notification that there's a case.

4 Now, all the information on  
5 that app is HIPAA secure. Nothing is  
6 stored on the personal phone. It's all  
7 cloud based. So even if the provider  
8 loses their phone, there's nothing that  
9 can be accessed patient-wise.

10 We get a notification that  
11 there's a case. There's a pool of us at  
12 the University of Pennsylvania that can  
13 log on and answer these cases. We've  
14 also incorporated resident teaching into  
15 these cases. So they can pick up a case  
16 and then the attending can look over it  
17 and send it back to the provider.

18 And so once we look at the  
19 photos and look at the case, we give them  
20 recommendations for the diagnosis and  
21 treatment, send it back to the primary  
22 care provider, and they have these  
23 recommendations.

24 About, I would say, 10 percent  
25 of the time we need to see the patients

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2 in person. So this doesn't completely  
3 eliminate the need for in-person  
4 examinations, but certainly 90 percent  
5 can be handled back at the primary care  
6 home, which is really what we're trying  
7 to do.

8 In 2010, we started thinking  
9 about incorporating this into the  
10 Philadelphia health centers. We had had  
11 it in the Jonathan Lax Center and Sayre  
12 Clinics, which are associated with the  
13 University of Pennsylvania. And finally  
14 in January of 2013, we scaled up to nine  
15 of the ten Philadelphia health centers.  
16 We now have 85 of your primary care  
17 providers trained on this device in  
18 submitting cases. Over the past year,  
19 we've had about 500 consults in  
20 Philadelphia sent, and it's been amazing  
21 to see this transformation in care.

22 So before the most recent app,  
23 which is what I've described as very  
24 user-friendly, we toyed with giving  
25 clinics phones to use, having a dedicated

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2 phone to use, not using personal devices,  
3 and people just didn't go get that phone.  
4 They weren't familiar with how to take  
5 the photos. They always had to make sure  
6 it was charged, who had the phone, where  
7 was it, I don't have time to go get it.  
8 But looking at once we implemented on  
9 personal devices, the spike in consults  
10 has really been amazing, because it's in  
11 their pocket. It incorporates into their  
12 workflow, and it really doesn't take that  
13 much time for them to submit the case.

14 We've done surveys with your  
15 users. They're very happy with this. If  
16 anything, even if they don't get the  
17 exact answer that they want, we have  
18 contact information for the doctors that  
19 answer their consults. So now they have  
20 someone to call if they have additional  
21 questions. So it's even increasing  
22 communication.

23 But the bottom line for this  
24 app is that it's provided dermatology  
25 care to a patient population who really

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2 hasn't had much access to care. And we  
3 asked the providers in the Philadelphia  
4 health center, What do you do with these  
5 patients before AccessDerm, and they  
6 said, Well, some patients we have nowhere  
7 to send them. We do the best we can.  
8 Some they have somewhere to send them,  
9 but it's three to six months wait to get  
10 them in somewhere.

11 And so here's just a map.  
12 We're in all of these health centers. I  
13 would say Health Center 3, 5, 9, and 10  
14 are probably our biggest contributors.

15 And a couple more data points  
16 before I finish. We usually answer the  
17 consults within about 25 hours. So  
18 that's pretty quick. I would say most of  
19 our paying private patients don't get  
20 answers within 25 hours. And if you  
21 exclude nights and weekends, it's  
22 actually about six hours. We have a  
23 group of very dedicated dermatologists.

24 And so this is a graph that  
25 shows what derm input would the patient

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2 have had without AccessDerm. So you can  
3 see 61 percent of them, the PCP estimated  
4 that they wouldn't have been able to get  
5 any dermatology input, and about 32  
6 percent estimated that they may have been  
7 able to get them into care. And so most  
8 of these cases we're able to manage with  
9 teledermatology alone, but some of them  
10 here in this group that we looked at,  
11 about 20 percent were actually seen in  
12 person.

13 And so in summary, we have this  
14 app that's working and functioning in  
15 Philadelphia. I think we've shown that  
16 the primary care doctors really like it.  
17 The patients are getting consults very  
18 quickly. And if we can't manage it by  
19 teledermatology, we find a way to do it  
20 in person. And I think this technology  
21 has great potential for increasing access  
22 to other groups. These consults come  
23 from newborns all the way up to very  
24 senior citizens. So it can be for any  
25 groups.

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2 Thank you.

3 COUNCILMAN JONES: Exciting.

4 Why don't we let everyone  
5 testify and then we'll do Q and A from  
6 our members.

7 DR. YOUNKINS: Thank you very  
8 much. Thanks for having us. My name is  
9 Elizabeth Younkins --

10 COUNCILMAN JONES: Can you pull  
11 that a little closer?

12 DR. YOUNKINS: Absolutely. My  
13 name is Elizabeth Younkins. I'm a  
14 Director at the Children's Hospital of  
15 Philadelphia, and in that role, I  
16 administratively oversee the very new  
17 telemedicine program at CHOP. So what I  
18 want to do today is talk to you about our  
19 program and some of our expansion plans  
20 in the near future.

21 The goal of our telemedicine  
22 program to date has been to increase  
23 access to specialists in the pediatric  
24 field. As we know, well chronicled by  
25 the Academy of Pediatrics, there is a

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2 shortage of pediatric specialists. So  
3 our program to date has focused on access  
4 of those short -- those physicians in  
5 short supply and focus at this point on  
6 hospital-based programs.

7 A new initiative that we're  
8 involved with is with the Philadelphia  
9 Safety Collaborative. It's in  
10 partnership with the City of Philadelphia  
11 and the Philadelphia Children Alliance.  
12 CHOP physicians will provide on-site  
13 medical care as well as establish  
14 telemedicine consultation for victims of  
15 child abuse, child sexual abuse, at a new  
16 co-located facility on Hunting Park  
17 Avenue.

18 COUNCILMAN JONES: Yes; Special  
19 Victims Unit.

20 DR. YOUNKINS: Correct.

21 So this clinic is designed to  
22 provide medical and forensic examination  
23 for children with suspected sexual abuse  
24 and to meet the healthcare needs of these  
25 children and their families. Specialized



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2 exams, testing for sexually transmitted  
3 infections, and emotional and behavioral  
4 support are the mainstay elements of this  
5 clinic. We're very excited to be in  
6 partnership with that and to use  
7 innovative approaches with telemedicine  
8 to help support these children and their  
9 families.

10 One of our existing programs is  
11 to bring pediatric neurology to patients  
12 in the hospital setting. We do that  
13 through a telemedicine format with our  
14 partner at Virtua. Again, we've been  
15 piloting this and plan to expand that  
16 capability to other hospitals in the  
17 Philadelphia area within this upcoming  
18 year.

19 The third program that we have  
20 in place is -- or excuse me. The third  
21 program that we have envisioned is  
22 bringing pediatric genetic support to  
23 hospitalized patients. Again,  
24 geneticists, clinical geneticists in the  
25 pediatric field, are in short supply. So

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2 we will be launching in the spring of  
3 this year a telemedicine genetics program  
4 aimed in Philadelphia hospitals for the  
5 spring.

6 A program that we have  
7 currently up and running is bringing  
8 telemedicine support with critical care  
9 pediatricians. Again, in our pilot  
10 facility with our partner at Virtua in  
11 New Jersey, we are using telemedicine  
12 technology to bring critical care  
13 specialized physician expertise in  
14 consultation to the children in those  
15 hospitals. We plan to expand that  
16 capability through the Philadelphia  
17 market as well.

18 Really in conclusion, our first  
19 approach has been to increase the access  
20 to specialists in a hospital setting.  
21 Through the year we will be exploring  
22 other settings, community settings,  
23 school settings, nursing facilities,  
24 particularly targeted to medically  
25 complex, fragile, and homebound children.

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2 We welcome further dialogue and  
3 partnership to help make that a reality.

4 Thank you.

5 COUNCILMAN JONES: No; thank  
6 you.

7 DR. GLUCH: My name is Joan  
8 Gluch. I'm the Associate Dean for  
9 Academic Policies and the Interim  
10 Division Chief for Community Health at  
11 the University of Pennsylvania, and thank  
12 you for the opportunity to speak about  
13 dental care. So many times it's not as  
14 emphasized in the discussions in  
15 healthcare, and we're really pleased that  
16 the resolution really looked at  
17 especially mobile healthcare or  
18 increasing care, increasing access to  
19 dental care.

20 Now, at Penn Dental Medicine we  
21 provide both general and specialized  
22 dental care at our flagship facility on  
23 40th Street, but we also emphasize the  
24 outreach programs. That's a really big  
25 issue when we speak about how individuals

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2 can access dental care.

3 Our outreach activities include  
4 dental care on a mobile dental van called  
5 PennSmiles that we take to 24 schools in  
6 the West and Southwest Philadelphia  
7 community. Now, we also have a dental  
8 facility at the LIFE facility, Penn  
9 Nursing's LIFE facility where we provide  
10 dental care as part of the comprehensive  
11 care for the elderly as well as Sayre  
12 Health Center. We also have a dental  
13 facility there.

14 Now, we developed these  
15 outreach programs because there are both  
16 financial barriers and non-financial  
17 barriers to care, particularly in West  
18 and Southwest Philadelphia. These are  
19 one of the kind of poorest in the City  
20 and the nation, and the link between  
21 poverty and poor oral health and all  
22 health outcomes has really been  
23 demonstrated. So in our areas we see  
24 higher disease rates, higher dental  
25 disease rates in West and Southwest

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2 Philadelphia than in Philadelphia and the  
3 nation as a whole.

4 Medicaid programs provide  
5 reimbursement for children. It's adults  
6 that's the problem. We've particularly  
7 had some cutbacks with the state's  
8 Medicaid program. They limit one or two  
9 visits per year. They also limit, for  
10 example, dentures. You can get only one  
11 denture per lifetime.

12 So these financial problems,  
13 limited nature of dental services has  
14 really made a difference, posing  
15 financial hardships, and dental schools  
16 provide really low-cost alternatives to  
17 dental care. That's why we're really  
18 fortunate that we are the safety net  
19 dental clinics as well as the health  
20 centers, and having both Temple and Penn  
21 I think really helps the citizens of  
22 Philadelphia access dental care.

23 But, you know, it's not only  
24 the financial barriers. There are a lot  
25 of non-financial barriers, the lack of

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2 transportation, the location of dental  
3 offices, the sense of comfort in a dental  
4 office. Now, our PennSmiles program is  
5 really popular with parents and the  
6 children in the Philadelphia school  
7 system, because once the parents give  
8 permission, we take the bus. It's a  
9 40-foot dental bus, fully functioning  
10 dental office. We provide comprehensive  
11 dental care for the children, and it's  
12 very convenient for parents. We can  
13 ensure that we get quality care to  
14 children who may not be able to have  
15 dental visits.

16 For the elderly and the  
17 community at Sayre, it's very convenient  
18 to have dental care right at your health  
19 center. And so that's an area we're  
20 looking at co-locating dental offices  
21 within healthcare facilities as well as  
22 increasing the mobile dental care to make  
23 really it easier to access care, less  
24 transportation, greater familiarity.

25 See, the nice part about Penn

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2 Dental Medicine is, our mission is to  
3 educate predoctoral and graduate students  
4 in the highest quality clinical and  
5 research environment. So to me, it's an  
6 essential part of learning to be a  
7 dentist, to work into outreach  
8 activities. Students work with a variety  
9 of community sites providing education,  
10 and then we can provide clinical care  
11 both at Sayre, LIFE, and on the  
12 PennSmiles bus. So we really see kind of  
13 a dual mission that we're educating  
14 community response of dentists from both  
15 the local and the global perspective, so  
16 as they graduate, they'll complete more  
17 community activities.

18 So in conclusion, Penn Dental  
19 Medicine is really committed to  
20 increasing the access to dental  
21 healthcare for all Philadelphians. We  
22 have a large flagship facility at 40th  
23 Street that serves as a safety net where  
24 we have many patients providing dental  
25 care as well as emphasize these outreach

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2 activities, particularly with our mobile  
3 bus.

4 I thank you for the opportunity  
5 to speak about PennSmiles and am happy to  
6 answer any of the questions.

7 COUNCILMAN JONES: First of  
8 all, let me start by saying thank you,  
9 thank you, and thank you, because as we  
10 deal with the 50,000 foot view of  
11 healthcare, we have to be laserly focused  
12 on how we provide it at the ground level.  
13 So all of these technologies and  
14 applications of mobility and use of  
15 technology, at one point there was a big  
16 discussion about whether they were  
17 eligible ways to examine by way of  
18 insurances, and maybe five years ago or  
19 so we got through that hurdle, which  
20 opened the door for the advancement of  
21 these kinds of approaches.

22 So I guess what I want to ask  
23 first is, if you can provide dermatology,  
24 you can provide other types of health  
25 services as well. It's the same mode of



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2 technology or means to deliver. Do you  
3 believe that to be true?

4 DR. KOVARIK: There's many  
5 specialties that are amenable to  
6 telemedicine. There's the live  
7 telemedicine where basically you're  
8 sitting in front of a video screen  
9 talking to the patient, and then there's  
10 what we call store and forward, which we  
11 do in dermatology where you take the  
12 history, take the photos, and send it  
13 asynchronously. The visual specialties  
14 are particularly amenable to store and  
15 forward. So we've done work with the  
16 dental school, because you can take  
17 photos inside the mouth. We've done  
18 cervical cancer screening globally,  
19 because you can take photos of that,  
20 radiology. Anything that you can take a  
21 photo or video of can be done like that.

22 But video telemedicine has many  
23 applications, because it's essentially  
24 like sitting there in front of the  
25 patient. And so I feel like we've

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2 developed this platform and we've opened  
3 the door with the City of Philadelphia  
4 for many other specialties to easily come  
5 on board.

6 COUNCILMAN JONES: See, this  
7 goes back to about six years ago when I  
8 told Dr. Schwarz I did not have a medical  
9 center in my district, and rather than  
10 build one, he has come up with uses of  
11 technology, and I thank him for it.

12 I'll give you an example on the  
13 mobility. One of the things that the  
14 Nutter Administration talked about and  
15 has moved forward is co-located uses in  
16 publicly owned buildings. So whether  
17 it's a school or a library or a rec  
18 center, getting the most out of a  
19 municipally insured, municipally lit,  
20 municipally heated building different  
21 markets, whether it's seniors, youth or  
22 parents, but to be able to use those  
23 facilities in an efficient manner. So my  
24 question becomes, if we were talking  
25 about a mobile office, doctors without

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2 borders parachutes in, sets up equipment,  
3 and sees a whole multitude of people,  
4 then parachutes out. In a microcosm, who  
5 will utilize rec centers and bring in the  
6 equipment, be able to in advance tell  
7 people, publicize it, doctors will be  
8 there, and then utilize this technology  
9 so as not to overwhelm the high-end  
10 professional, but for them to be able to  
11 use the technology to provide the  
12 service? How do you see that?

13 DR. KOVARIK: I think that's a  
14 great question, and we face that question  
15 from people globally as well as locally.  
16 The biggest barrier is going to be  
17 ensuring followup of those patients,  
18 because you can almost do more harm than  
19 good if you come, deliver a service, and  
20 then the patients have nowhere to go to  
21 see if their issue is better or who to  
22 ask questions.

23 The other issue is, we advocate  
24 for some sort of healthcare extender to  
25 be providing the care. So whether

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2 it's --

3 COUNCILMAN JONES: Can you  
4 elaborate on that.

5 DR. KOVARIK: Whether it's a  
6 nurse or a nurse practitioner, sometimes  
7 there are programs where they say, Well,  
8 just let the patient send their own data  
9 to a dermatologist. But I just would  
10 like to say that if you set up something  
11 like that, having a nurse be the proxy to  
12 send the data rather than having the  
13 patient do it themselves would be  
14 important. But I think the biggest thing  
15 is ensuring followup, because if you do  
16 it at a rec center and then the patient  
17 is like, well, that's no longer there,  
18 where do I go next. So there would have  
19 to be some kind of communication with  
20 their primary clinic for the followup.

21 COUNCILMAN JONES: Well, I  
22 would imagine that there would be that  
23 system of referral and then followup that  
24 could be employed in this case. The key  
25 for me is, whether it's a rec center or

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2 public housing authority unit, where  
3 people are maybe reluctant to travel, if  
4 it's in that center -- in Abbotsford, we  
5 have a wonderful gymnasium, beautifully  
6 lit and underutilized, in my opinion, and  
7 if we said once a month to the seniors or  
8 to the parents with children that we're  
9 going to have dental care, it's dental  
10 day, and have them come out and we can in  
11 cases where it's just a minor procedure  
12 or a minor referral, we can do that, but  
13 if it's more serious, we can send them to  
14 more permanent facilities. But what I'm  
15 trying to get at is that somebody  
16 somewhere needs to be thinking about how  
17 we take victories like this and weave  
18 them together to come up with a  
19 comprehensive approach, because as the  
20 50,000 foot view gets settled out and  
21 more people sign up and more people have  
22 more demand, we need to be as creative  
23 with technology to apply that.

24 Colleagues?

25 COUNCILWOMAN TASC0: Thank you.

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2 Good morning or afternoon.

3 Thank you so much for your testimony.

4 Dr. Rosenwasser, in terms of the -- are  
5 you the dental?

6 DR. GLUCH: Gluch. I'm the  
7 dental. Gluch.

8 COUNCILWOMAN TASCO: Hi. You  
9 have a dental bus. Is your concentration  
10 mostly in the West Philadelphia area?

11 DR. GLUCH: It is. I'll tell  
12 you, we've become so popular that we've  
13 had to limit it within the scope of our  
14 catchment area. So University of  
15 Pennsylvania has really looked to partner  
16 with the local Southwest and Southwest  
17 community. We're already up to 24  
18 schools, and it's been an area we felt --  
19 and I actually agree with Doctor -- that  
20 we wanted to make sure when we treated  
21 the children, we were able to treat all  
22 the children at that school and ensure  
23 referral back to the dental school. So  
24 we've chosen to more intensively  
25 concentrate in one area with a certain

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2 number of children so not to dilute our  
3 efforts and make sure we're really  
4 delivering the quality care that children  
5 needed.

6 COUNCILWOMAN TASCO: Well, we  
7 have ten health centers in the City of  
8 Philadelphia. Do you have the capability  
9 of -- and maybe Dr. Schwarz is going to  
10 address this -- of serving those health  
11 centers, which are pretty much scattered  
12 throughout the City?

13 DR. GLUCH: I'll defer to  
14 Dr. Schwarz, but I know that dental care  
15 is really an integral part of the  
16 healthcare that's provided, and there  
17 have been a variety -- there are dental  
18 components, and I know he can provide  
19 much more detail regarding that.

20 COUNCILWOMAN TASCO: So on the  
21 telemedicine, Ms. Kovarik, so the purpose  
22 is to provide the process of the system  
23 to the physician that's treating the  
24 patient.

25 DR. KOVARIK: Exactly.

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2 COUNCILWOMAN TASC0: So they  
3 can connect with you.

4 DR. KOVARIK: Yes.

5 COUNCILWOMAN TASC0: And have  
6 you or your department look at the test  
7 or whatever they need to provide him with  
8 information and consultation. So it's a  
9 consultation service.

10 DR. KOVARIK: Exactly. So  
11 we've heard time and time again,  
12 particularly with some of the health  
13 centers in, I think it was, Health Center  
14 No. 10, they say they have 85 languages  
15 spoken there. Patients don't want to  
16 come to Penn to see a doctor. They're  
17 comfortable in their medical home. So  
18 even if the patients have the capacity to  
19 come see us, they're much more  
20 comfortable at their primary care center.  
21 And we also utilize the primary care  
22 doctor sending the consult to be the one  
23 to continue to follow that rash or that  
24 issue, and so it sort of allows us to do  
25 more. So if we assume the care of that



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2 dermatology patient, our clinics would  
3 just get so big, but now we're able to  
4 help them take care of their patients  
5 where they are.

6 COUNCILWOMAN TASCO: Okay.  
7 Well, thank you very much. Thank all of  
8 you very much for your testimony.

9 COUNCILMAN JONES: Thank you.  
10 And if you want to stay, we'd love to  
11 have you. We may call you up again for a  
12 followup, but we're going to keep the  
13 agenda moving.

14 Will the Clerk please read the  
15 next witness.

16 THE CLERK: Dr. Herbert,  
17 Dr. Rosenwasser, and Commissioner  
18 Schwarz.

19 COUNCILMAN JONES: Good  
20 afternoon. No. It's still morning.  
21 Good morning.

22 (Witnesses approached witness  
23 table.)

24 DR. HERBERT: Good morning.

25 COUNCILMAN JONES: Dr. Schwarz,

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2 good morning.

3 DR. SCHWARZ: Good morning.

4 COUNCILMAN JONES: Please  
5 present your testimony in any order.

6 DR. SCHWARZ: Please, go ahead.

7 DR. HERBERT: Good morning.

8 Thank you very much for having me. I  
9 really appreciate it. My name is James  
10 Herbert. I am a Professor and head of  
11 the Psychology Department at Drexel. And  
12 originally I was going to read my  
13 testimony, but I think you already have  
14 copies, but I'll just speak  
15 extemporaneously, if you don't mind. It  
16 will probably be easier.

17 There's a few points I'd like  
18 to emphasize today. First of all, in the  
19 area of psychotherapy, which is what I  
20 want to talk about, the remote provision  
21 of psychological services, things are not  
22 quite as far advanced as some of the  
23 testimony that you just heard. We're  
24 still doing research figuring out what  
25 works and the best applications. But I

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2 think it has great potential to meet a  
3 big gap, to bridge a gap between need and  
4 service provision.

5 So the first point I'd like to  
6 make is that there is major unmet need  
7 nationwide but in the City of  
8 Philadelphia as well. Recent  
9 epidemiological studies suggest that 26  
10 percent of all U.S. citizens will meet  
11 criteria for at least one psychological  
12 disorder in a given year, and in fact a  
13 major study published just last week  
14 suggests that those are underestimates.  
15 So there's tremendous need for services  
16 for people with depression, anxiety, as  
17 well as severe mental illness like  
18 schizophrenia, bipolar disorder, this  
19 sort of thing.

20 There's also research showing  
21 that the majority of people with these  
22 problems don't get any services  
23 whatsoever for those problems, and when  
24 they do get services, the majority of  
25 those people don't get state-of-the-art,

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2 quality, evidence-based services. Often  
3 what they get is medication, typically by  
4 a primary care physician, not by a  
5 specialist, a psychiatrist, for example.

6 And the other point is, what is  
7 most often neglected are state-of-the-art  
8 psychotherapies. So when you think of  
9 psychotherapy, most people think of  
10 traditional psychoanalytic therapy where  
11 you sit and talk about how much you hate  
12 your mother or whatever and it's supposed  
13 to make you better. In reality, over the  
14 past 30 years, we've made tremendous  
15 strides in developing short-term focused  
16 psychotherapies. These are collectively  
17 known as cognitive behavior therapies.

18 Philadelphia is known,  
19 interestingly, as the birthplace of  
20 cognitive behavior therapies. So we have  
21 a much greater presence of those types of  
22 treatments here in the City. With all  
23 three of the major research universities,  
24 Drexel, Penn, and Temple, the psychology  
25 departments focused very much on doing

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2 research and dissemination efforts with  
3 those kinds of treatments. So we're  
4 ahead of the game, if you will, with  
5 respect to other major cities in terms of  
6 the culture of these kinds of providers.  
7 But one remaining problem is that the  
8 majority of psychologists, social  
9 workers, psychiatric nurses,  
10 psychiatrists who do psychotherapy still  
11 are not sufficiently up to speed on these  
12 types of techniques. So what ideally  
13 would be needed is a major training  
14 program. And there are precedence for  
15 this. Unfortunately not in the U.S. So,  
16 for example, in the UK and in Australia,  
17 there are national efforts underway to  
18 train literally tens of thousands of  
19 providers in these very effective  
20 short-term types of therapies.

21 They're not panaceas. I don't  
22 want to mislead you to think that they  
23 are, but on the other hand, studies have  
24 shown, very well controlled studies have  
25 shown, that they work as well, if not

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2 better, than the best available  
3 psychiatric medications for many  
4 disorders, for depression and anxiety  
5 disorders in particular, and they have  
6 lower risk of relapse. So when your  
7 course of therapy is done, the chances of  
8 relapse are lower than if you rely  
9 strictly on medication.

10 So oftentimes dissemination  
11 efforts are focused on medication,  
12 because in some ways it's easier, right?  
13 You just give a pill. But these  
14 approaches have many advantages over  
15 medication, and they also can be used in  
16 conjunction with medication for disorders  
17 where that's appropriate. Again, things  
18 like schizophrenia, bipolar, your more  
19 severe mental illnesses.

20 Now, even if we solve the  
21 problem of provider availability, so we  
22 had enough well-trained providers to  
23 provide these services, you still have  
24 other barriers to care. Some of those  
25 barriers include transportation, people

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2 getting to a therapist's office. There's  
3 a lot of stigma still associated with  
4 mental healthcare. A lot of people don't  
5 want to go see someone especially in a  
6 public venue where they might be seen by  
7 friends or neighbors or family members.  
8 So you've got the stigma issue to deal  
9 with.

10 There's some disorders in which  
11 the nature of the disorder itself tends  
12 to make people reluctant to seek  
13 treatment. So, for example, my own  
14 research, I do a lot of work in something  
15 called social anxiety disorder. Think of  
16 this as an extreme form of shyness, if  
17 you will, and these people are reluctant  
18 to see someone even if all the other  
19 issues are addressed.

20 So one way to begin addressing  
21 this is by using technology, harnessing  
22 the power of technology, and there's many  
23 different ways to do that. You can have  
24 a stepped care model where you use  
25 freestanding websites is the first step,

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2 where we've developed sites, for example,  
3 where patients are narrated through a  
4 series of steps with video clips and  
5 slides, homework exercises. And what we  
6 find is that especially if you couple  
7 that with a very brief once-a-week,  
8 15-minute check-in with a therapist to  
9 make sure the person is still engaged in  
10 the program, answer any questions, that  
11 these can be very, very effective for  
12 many patients.

13 What's especially exciting,  
14 though, is the use of video conferencing  
15 technology, which was mentioned just  
16 before. We've at Drexel done a number of  
17 studies and have shown that -- or at  
18 least our initial results are actually  
19 quite surprising, which is that these  
20 video conference-based interventions work  
21 as well as traditional face-to-face  
22 interventions. And I'm talking about the  
23 very best state-of-the-art CBT type  
24 services.

25 So to give you an example,



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2 patients with obsessive compulsive  
3 disorder, these are the people who maybe  
4 wash their hands a hundred times a day,  
5 this can be a very debilitating  
6 condition. The treatments are very  
7 effective, but they're very, very intense  
8 and they're highly specialized. So you  
9 need to see someone who really knows what  
10 they're doing. Well, we have treated  
11 this through video conferencing with  
12 patients throughout the country, not just  
13 in Philadelphia but across the country.  
14 So we may be sitting at our office in  
15 Drexel treating someone in Nebraska or  
16 whatever. And what we find is that, in  
17 our preliminary research, is that it  
18 works just as well as the traditional  
19 face-to-face therapy where you're  
20 actually walking the person through the  
21 exercises.

22 So one could envision  
23 eventually a situation where -- and let  
24 me back up. What is needed to implement  
25 these are essentially a broadband

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2 connection, high speed Internet  
3 connection, and a computer, personal  
4 computer with a web camera. Now,  
5 obviously many people don't have access  
6 to personal computers and broadband  
7 connections, but the number of our  
8 citizens who do is growing every day. So  
9 more and more people do have access if  
10 not in their homes, at libraries, for  
11 example. Public libraries there's  
12 typically availability. So one could  
13 imagine a situation where you had  
14 well-trained providers who could reach  
15 people ideally in their homes and, if  
16 not, in community centers, in libraries.  
17 What would be needed is a secure private  
18 place. So you can't be talking in the  
19 middle of an open room like this  
20 obviously about these delicate issues,  
21 but if one had a room with a computer  
22 with a web cam, then you could  
23 potentially go to town in that regard.

24 And I would echo what you said  
25 earlier about how initially these

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2 technologies were developed with an eye  
3 towards rural settings, but in fact what  
4 we found is that people right down the  
5 road are often much more willing to seek  
6 treatment if they can do it remotely in  
7 the comfort of their home and their  
8 convenience of their home rather than  
9 having to get up and travel to a clinic.  
10 So I think that they have many  
11 applications for the City as well.

12 So in conclusion, I think the  
13 potential is there. It's very exciting.  
14 We're not quite there yet in terms of the  
15 prime time, ready for dissemination, but  
16 I think with some investment and with  
17 some creative work, we could get there  
18 fairly soon.

19 So thank you very much.

20 COUNCILMAN JONES: Thank you.

21 We love you and you're like on  
22 our home team, so we're going to deal  
23 with our visitors first.

24 But I would not have thought of  
25 therapy through that, and so I guess

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2 that's why we have these hearings. But  
3 as you were talking, it came to mind one  
4 of my children is a school teacher, and  
5 one of the children in her school had a  
6 real bad episode and they were -- they  
7 are counseled on how to approach children  
8 who just have major dramatic episodes and  
9 so -- but it would have been better if  
10 they could have gone in a room, been able  
11 to dial up a professional that is  
12 licensed to be able to observe what was  
13 going on and maybe even offer some  
14 recommendations. Whether we talk about  
15 that application in a public school or  
16 whether we're talking about individuals  
17 that may be in our care under  
18 incarceration, those are the kinds of  
19 interventions that we can take advantage  
20 of professionals and not just rely on  
21 people who have maybe taken a class on  
22 how to restrain someone.

23 So I was fascinated and  
24 intrigued about the potential. But it's  
25 the same cameras, it's the same

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2 technology. It's just how we apply it  
3 and where we utilize it that I think  
4 there's such upside potential and in a  
5 cost-effective manner and in a timely  
6 manner. And our last panel, we  
7 unfortunately sometimes have to wait a  
8 while before we get healthcare, but if  
9 you can get a 24-hour turnaround, I think  
10 we would take that and run with it. So I  
11 want to thank you for your testimony.

12 With that, Dr. Schwarz.

13 DR. SCHWARZ: Thank you and  
14 good morning. You have my testimony.  
15 You've heard from others. I won't read  
16 through my testimony. I will say that it  
17 summarizes, as you've heard, the very  
18 positive experience that our health  
19 centers have had working on  
20 teledermatology issues in partnership  
21 with the University of Pennsylvania,  
22 which is available throughout the City's  
23 system. Since February of 2013, 131  
24 patients have been enrolled and  
25 consultation has been received.

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2 You also heard about dental  
3 vans for mobile units that are available  
4 not only from the University of  
5 Pennsylvania but from Saint Christopher's  
6 Hospital and in partnership with others  
7 who provide dental care.

8 I will say, as I've mentioned  
9 before in this room, that we have for a  
10 long time been using teleradiology for  
11 the health centers. So that we have  
12 digitalized our radiology. So an x-ray  
13 is taken. It's sent electronically to an  
14 outside radiologist, who provides us  
15 within rapid turnaround a report on that  
16 x-ray, because the City doesn't employ  
17 radiologists ourselves. So we found that  
18 both incredibly helpful, timely, and  
19 useful, and it, with teledermatology and  
20 teledental care, as you heard,  
21 illustrates that anything visual is much  
22 easier for that modality.

23 I want to highlight for  
24 Council -- one, I want to salute you for  
25 having this hearing on this issue. I

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2 think that we are at the verge of  
3 something that is going to be much  
4 greater as we move forward, and I don't  
5 even know that we can imagine what  
6 healthcare will be like five or ten years  
7 from now. But I want to highlight for  
8 you a number of issues that have to be  
9 considered that we consider as we think  
10 about new modalities.

11 One is obviously the comfort of  
12 our patients, our clients and  
13 Philadelphians, and I appreciate my  
14 colleague's comments. I think however we  
15 think about rolling out new ways to reach  
16 people, we have to be particularly  
17 concerned, as we have been, about whether  
18 personal services can be received in  
19 remote locations in a way that is  
20 comfortable for people. Not just are  
21 there other people around and is my  
22 confidentiality in some way being  
23 compromised, but also do I prefer this  
24 kind of care to care where I sit face to  
25 face with someone. And if the answer is

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2 people aren't comfortable but it's the  
3 best we can do, then the standard we've  
4 tried to set is let's try to figure out  
5 in the interim what we can do, but let's  
6 try to build in what is most comfortable  
7 for people in the long run.

8 The second issue is continuity,  
9 which you heard about. So that providing  
10 one-off care in remote locations may be  
11 helpful in some situations, but I believe  
12 it's only helpful if it's tied to what  
13 the Affordable Care Act has put at the  
14 center of the new American health system,  
15 which is a medical home. Our eight  
16 health centers are working very hard to  
17 meet all of the federal requirements for  
18 the highest level of medical home, and  
19 we --

20 COUNCILMAN JONES: Could you  
21 elaborate on medical home.

22 DR. SCHWARZ: So the concept of  
23 medical home is that every one of us  
24 should have a place where we go to enter  
25 the healthcare system. Rather than it



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2 being an emergency room or, worse yet,  
3 being an inpatient unit in the hospital,  
4 there should be a place where we have a  
5 relationship, where they have our  
6 longitudinal healthcare records, and  
7 where we can go for an assessment on a  
8 regular basis and have help getting  
9 managed into other needed healthcare in a  
10 timely way, in a respectful way, in a  
11 comprehensive way.

12 That idea of medical home now  
13 is fundamentally centered on electronic  
14 health records. So the idea is that  
15 through technology, we should be able to  
16 have a place that can share our health  
17 records with our permission, receive  
18 other health records back, and be a  
19 repository for all the health information  
20 about us that we also have access to.

21 So our health centers, as you  
22 know, are implementing our electronic  
23 health record, which is --

24 COUNCILMAN JONES: We want to  
25 thank you. I was going to -- you stole

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2 my thunder. I was going to thank you for  
3 that. I've been here long enough to  
4 remember that we had these physical paper  
5 files.

6 DR. SCHWARZ: We still do  
7 unfortunately, but we're making progress,  
8 and thank you for that. And I think it's  
9 a partnership of a lot of folks,  
10 including the Council, that has supported  
11 this.

12 Those electronic health records  
13 we're interconnecting to other providers  
14 in Philadelphia. So that if someone is  
15 seen in the prenatal care clinic at  
16 Health Center 9 and they deliver at  
17 Einstein Hospital, that record is  
18 available at Einstein Hospital with the  
19 person's consent.

20 We're connected to the prisons,  
21 and I appreciate your bringing up the  
22 prisons. So that we know that 35 percent  
23 of people in prison end up receiving care  
24 after they leave the prison in one of our  
25 health centers, and their prison record

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2 has never been accessible. With consent,  
3 we will be able to pull an electronic  
4 record of their healthcare at the prison  
5 directly to the health center to know  
6 what medications they were on, what  
7 healthcare problems they've had, and what  
8 referrals and other specialty care  
9 needed.

10 That's a fundamental use of  
11 technology that is the center of the  
12 medical home concept, and as we finally  
13 finish implementing medical homes in our  
14 health center -- electronic health  
15 records in our health centers, we will be  
16 eligible for full status as medical homes  
17 under the Affordable Care Act. And we  
18 want to combine that with other  
19 modalities. So if we can -- if the  
20 issues -- and there's one more issue I  
21 have to bring up. If the issues are  
22 resolved for other electronic  
23 communication with healthcare providers,  
24 be it psychological services,  
25 neurological services, other services, we

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2 want to be able to enable that to happen  
3 in our health centers so patients who  
4 come to us will have state-of-the-art  
5 care. You've been very supportive and  
6 even I think encouraging of that. I  
7 appreciate it.

8 And the final piece I want to  
9 say to consider is cost-in coverage.  
10 Many of the services you've heard about  
11 today are provided for free, and they're  
12 provided for free because there is no  
13 coverage for that care at the moment. I  
14 believe we have to be very cautious,  
15 particularly in the new Affordable Care  
16 Act environment, that large amounts of  
17 free care are what we base access on. So  
18 if we create all these mechanisms and  
19 insurance companies aren't held to and  
20 government payers aren't held to finding  
21 ways to pay for them, then we haven't  
22 made real change. We've created  
23 Band-Aids for issues where people may not  
24 have access for some period of time. We  
25 haven't fundamentally changed the system

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2 in the way that it should be changed so  
3 that needed services -- if someone is at  
4 home, an elderly person, an older person  
5 is at home and they can't get out, I  
6 don't want their care to be dependent on  
7 charity. If they're insured, their  
8 insurance should pay for a kind of care  
9 that has been proven to be effective and  
10 should be accessible to them.

11 So there's an advocacy piece  
12 here at the moment that we must all push  
13 forward, and I think it's a fundamental  
14 issue that has not yet been resolved.

15 With that, I'll stop and answer  
16 your questions.

17 COUNCILMAN JONES: You know,  
18 you are -- it's been good to watch you  
19 move on this. Again, I see progress and  
20 light at the end of the tunnel, and for  
21 once it's not a train.

22 So with that, who is doing the  
23 strategic planning for all these  
24 converging issues, whether we're talking  
25 about funding streams, whether we're

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2 talking about things that are covered,  
3 and whether we talk about the development  
4 of access through technology? Is there a  
5 panel of folk working on this somewhere?

6 DR. SCHWARZ: So it's not as  
7 formal as you'd probably like it to be.  
8 Dr. Evans for Behavioral Health Services,  
9 me as the Health Commissioner, and our  
10 Director of Ambulatory Health I would say  
11 are the three people who have tracked  
12 this and tried to create partnerships.  
13 So the partnership for teledermatology  
14 exists because of a partnership  
15 specifically with our health centers, and  
16 Dr. Storey represents that.

17 But what you're asking is, is  
18 there a larger ongoing strategic vision  
19 here, and I think the answer is probably  
20 no. And in part that's because we're not  
21 in a place where we have the resources to  
22 stimulate this. So we monitor pretty  
23 closely, and as I've said often, we are  
24 open to new partnerships and --

25 COUNCILMAN JONES: Excuse me a

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2 second. We have Councilwoman Blackwell  
3 join us for the record and Councilman  
4 O'Brien. So I wanted to make sure that's  
5 on the record that they are here.

6 COUNCILWOMAN BLACKWELL: Thank  
7 you.

8 DR. SCHWARZ: So we are the  
9 recipients of good things, and we're open  
10 to them. We're skeptical at times to  
11 make sure that it's safe and comfortable  
12 and so forth, but we've not been in a  
13 position to stimulate or initiate a lot  
14 of this, in part because there is no  
15 funding mechanism, so that we rely on the  
16 goodwill of partners. The exception is  
17 teleradiology where teleradiology is paid  
18 for. It is acceptable.

19 COUNCILMAN JONES: Who pays for  
20 it?

21 DR. SCHWARZ: Insurance  
22 companies. So the radiologists can bill  
23 independently for the service. The fact  
24 that the x-ray is taken at one location  
25 and interpreted at another is acceptable.

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2 All of that has been worked out. And so  
3 we use that technology and insurers use  
4 that technology.

5 Strategically we meet with  
6 insurers now on a regular basis. We talk  
7 about issues and problems. We try to  
8 come up with ways to handle them. But I  
9 think there are fundamental and probably  
10 federal decisions that have to be made  
11 about coverage.

12 One issue that we will get  
13 to -- and it will probably be when we  
14 have this hearing for an update next year  
15 or the year after -- is if you can have  
16 teleservices or distant services, do they  
17 have to be within the jurisdiction? So  
18 we could have a dermatologist, while we  
19 prefer the University of Pennsylvania and  
20 they have been wonderful partners and  
21 served really well the Philadelphia  
22 community, we could have a dermatologist  
23 at some point partnering from Alaska.  
24 That's what "tele" means. The laws on  
25 that nationally in terms of licensure,



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2 malpractice, and other things are still  
3 being worked out. They will be worked  
4 out.

5 So for a behavioral health  
6 professional, why does the behavioral  
7 health professional have to be in  
8 Philadelphia, or likewise, why does the  
9 patient have to be in Philadelphia.  
10 Behavioral health professionals who work  
11 this out from Philadelphia could be  
12 serving people in Uruguay. The world on  
13 the Internet is open. But the  
14 reimbursement mechanisms and the safety  
15 mechanisms and the legal mechanisms have  
16 to be worked out, and they haven't yet.  
17 That's why I say in five years and ten  
18 years I think we'll have a very different  
19 world.

20 I am sure that those issues  
21 will be addressed. They'll certainly be  
22 highlighted, and likely they'll be  
23 addressed. Once they're addressed, I  
24 think we have a very different medical  
25 care system than we do currently. And we

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2 have to keep track of it. I'd like to  
3 say we lead it, but I do believe in the  
4 City there are federal partners who are  
5 going to have to lead this and make  
6 decisions and drive the right kinds of  
7 decisions for care, but we have to be  
8 part of it. We have to be ready for it.  
9 We have to be open to it, and we have to  
10 think about and identify where the needs  
11 are for Philadelphians and then try to  
12 address them.

13 COUNCILMAN JONES:

14 Councilwoman.

15 COUNCILWOMAN TASC0: Thank you  
16 so very much. We appreciate the  
17 testimony and certainly, Dr. Schwarz, we  
18 love you. You do a great job.

19 DR. SCHWARZ: It's mutual.  
20 Thank you.

21 COUNCILWOMAN TASC0: I'm glad  
22 that I haven't gotten any complaints at  
23 all about Health Center 10. It seems to  
24 be moving along.

25 DR. SCHWARZ: Things are

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2 better.

3 COUNCILWOMAN TASCO: Things are  
4 better. Thank you so much. We  
5 appreciate it.

6 This is a very interesting  
7 discussion, very interesting topic, and  
8 the things that you talked about that  
9 need to be worked out, is there a body or  
10 is there someone leading the charge to  
11 address these issues on a national level  
12 that you know of?

13 DR. SCHWARZ: There are a lot  
14 of professional organizations that are  
15 talking about this. So, for instance,  
16 what you heard in passing was that the  
17 conversation about is it nurses,  
18 psychologists, physicians, nurse  
19 practitioners, what level of person  
20 should be on the ground seeing someone  
21 and what level of person should be in the  
22 distance. So the professional societies  
23 are actively discussing this, and not  
24 always productively. Many of the  
25 competitive actions that are going on

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2 across professions in healthcare are very  
3 much coming to the fore in these  
4 conversations and delaying answers to  
5 many of these questions.

6 Licensure is an enormous issue  
7 and barrier across jurisdictions, in part  
8 because if I'm licensed in Pennsylvania,  
9 I can see people in Pennsylvania. I  
10 can't see people in New Jersey or New  
11 York without paying a fee. If the  
12 Internet then enables me to legally see  
13 patients in New York and not pay a fee,  
14 government in New York is losing a lot of  
15 money, and that -- you understand the  
16 fundamental nature of that issue. So the  
17 complexity of these issues is very real  
18 and there's a lot of work that's going to  
19 have to go on to resolve this.

20 COUNCILWOMAN TASCO: Well, it's  
21 very exciting and very interesting, and I  
22 think about just having been involved  
23 with the whole health system lately, I'm  
24 just amazed at how we've come so far in  
25 the whole field of medicine in working

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2 with patients and providing services, and  
3 it's very interesting. And every time I  
4 get a blood test, I think about those  
5 horse needles they used to use years ago.  
6 So we've come a long way. And I thank  
7 you for your testimony and I thank  
8 Councilman Curtis for bringing this issue  
9 forward. It's very interesting.

10 DR. SCHWARZ: Thank you both.

11 COUNCILMAN JONES: So I guess  
12 one of the things at the end of the day  
13 that I would say is that if there's  
14 nothing made more clear than this hearing  
15 is that we need someone dedicated to  
16 strategizing on a number of levels. The  
17 type of technology is a line that we need  
18 to develop. The places that we deploy  
19 that technology, another stream. And  
20 then the end users and technicians to  
21 license professionals that we use along  
22 the way, which is standardized so that  
23 there is a common bar for that  
24 application. We're a long way off, but  
25 as a municipality, I would hope that we

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2 work with the state or the federal  
3 government to create that brain trust to  
4 think this thing through. As a great  
5 colleague of mine said, that you can act  
6 in haste and repent in your leisure. My  
7 colleague always talks about that.

8 So the planning of this I think  
9 is essential. So we're going to be  
10 looking with bated breath and listening  
11 and waiting for you during the budget  
12 cycle to talk about maybe some of these  
13 strategies and strategic partnerships,  
14 because Philadelphia is a place for eds  
15 and meds. And I had the opportunity to  
16 travel over to Israel in August where  
17 they have -- they've placed a great  
18 priority on medical technology and the  
19 business application of that and how much  
20 it meant to their local economy on  
21 utilizing those innovations that they  
22 come up with.

23 So there's no reason why we  
24 can't, with all of the great hospitals  
25 and universities we have, start to put

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2 together a strike force or brain trust to  
3 approach this, and if we do, I think  
4 we'll not only benefit at the end of the  
5 day for the consumers who need these  
6 services but also some of the businesses  
7 that deploy these services. And you're  
8 right, if the insurance companies can get  
9 away with us providing it for free and  
10 not having it as a reimbursable service  
11 provided to the clients, they will. But  
12 I think all of us have to put our heads  
13 together and do what's mutually  
14 beneficial for the City of Philadelphia.

15 So I'm excited, and thank you  
16 very much for your testimony.

17 Councilwoman Tasco.

18 COUNCILWOMAN TASCO: I want to  
19 say to Dr. Herbert, I appreciate the  
20 issue of dealing with the whole mental  
21 health issue. It's been troubling to me  
22 since I've had personal interaction with  
23 people who need help and need services,  
24 and I wish you well as we move forward in  
25 what you're trying to do. It would be

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2 very good if someone felt comfortable  
3 enough -- and we got to help them feel  
4 comfortable enough to pick up the phone  
5 and access a service and get some help or  
6 just talk to someone. And so it's a very  
7 important area of health. The whole  
8 mental health issue is very, very  
9 important to me personally as well as to  
10 the many thousands of people we have in  
11 Philadelphia who are experiencing some  
12 mental health issues. So I thank you so  
13 much for the work you're doing.

14 DR. HERBERT: Thank you. Thank  
15 you very much for having me.

16 COUNCILMAN JONES: So,  
17 Dr. Schwarz, we'll look to see how we can  
18 multiply dermatology, pediatrics, and  
19 psychotherapy to ten maybe services that  
20 can be applied through our health centers  
21 with technology and then some other  
22 creative locations maybe, whether it's a  
23 public school or whether it's a rec  
24 center that we might do a demonstration  
25 project to try to expand that kind of



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2 access. So we're pleased, but, you know,  
3 we want to raise the bar since you so  
4 easily jumped over it.

5 And so with that, do we have  
6 any others to testify?

7 THE CLERK: No, Chairman.

8 COUNCILMAN JONES: With that,  
9 this will conclude our hearing.

10 DR. SCHWARZ: Thank you.

11 COUNCILMAN JONES: And we'll  
12 recess to the call of the Chair.

13 Thank you very much.

14 (Joint Committee on Public  
15 Safety and Committee on Public Health and  
16 Human Services concluded at 12:20 p.m.)

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