



ATA STATE TELEMEDICINE TOOLKIT

WORKING WITH MEDICAL BOARDS:
Ensuring Comparable Standards for the
Practice of Medicine via Telemedicine



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Tens of millions Americans benefit from remote health services every year and many of them are not aware of it. These interventions address everything from acute primary care to emergent medical needs. Given the challenges of modern care delivery which often include limited access and new opportunities such as the proliferation of new tools, licensing boards can advance quality care options for citizens of their state by facilitating the integration of new solutions, such as telemedicine, into existing care paradigms.

Telemedicine is used for a diverse range of health applications and circumstances for patients and providers and across the entire continuum of care. Evidence-based research highlights the use of telemedicine as a supplement to quality screening, diagnosis, and treatment of patients. In addition to this telemedicine adds value to the ever changing health care payment and service delivery system.

There are 70 state medical and osteopathic licensing boards in the United States and territories. These boards are the agencies that license medical doctors, investigate complaints, discipline physicians who violate the medical practice act, and refer physicians for evaluation and rehabilitation when appropriate. The overriding mission of medical boards is to serve the public by protecting it from incompetent, unprofessional, and improperly trained physicians. In addition, there are hundreds of other state boards and regulatory authorities that regulate nursing, mid-level and allied professions, pharmacies and prescribing and other areas that affect the use of telemedicine within a state.

Most medical boards are primarily composed of physicians appointed to the position for a limited term. Often board members have limited knowledge of telemedicine as it is commonly used today and few may have limited contact with programs using telemedicine within their own state. Therefore, one of the goals of this toolkit is to provide practical information to help board members better understand the broad array of medical services that use telemedicine, its effect on improving care as well as the established guidelines, and practices used by health professionals that deploy telemedicine technologies.

This chapter of ATA's state toolkit is a resource for individuals looking to develop and/or provide guidance about telemedicine professional practice and licensure policies at the state level. It includes talking points and a guide for promoting discussion and action for telemedicine policy changes. Although much of this document is directly related to medical boards many of the points are also applicable to licensing and regulatory boards for other health professionals.

Good Doctors + Telemedicine = Good Medicine

Telemedicine is a tool used in the delivery of health care. It is not a service or separate clinical specialty and should not require a unique license. Telemedicine is the provision of health care services to a patient from a health care provider who is at a site other than where the patient is located using telecommunications technology. It is simply a means through which health care is delivered.

It can take the form of video-conferencing, remote patient monitoring, or remote image capturing solutions just to name a few. Telemedicine is also supported by digital diagnostic medical device peripherals including an otoscope, pulse oximeter, glucometer, stethoscope, and blood pressure cuff. In fact, physicians are using a variety of popular consumer devices to provide quality care including smartphones and tablets.

Telemedicine is an important part of the delivery of integrated care and prevention and can be practiced with the assurance of quality and safety for the public, allowing many health care services to be delivered to anyone anywhere. Some clinical areas where telemedicine is most established are mental and behavioral health, primary and urgent care, dermatology, cardiology, neurology, maternal and fetal medicine, radiology, and pathology.

Despite the growing body of evidence supporting telemedicine adoption, some are unconvinced to the effectiveness of diagnosing and treating a patient remotely. When a physician uses telemedicine they are simply augmenting the sound clinical training and education that they have received to perform a clinical encounter. Performing patient and environmental assessments, obtaining medically necessary clinical histories, and providing culturally and linguistically competent patient education, and are all components of the standard medical practice with or without telemedicine.

A physician using telemedicine, a 21st century approach to enhance the delivery of care, must comply with the same standards established for in-person medical practice, and is accountable to the respective medical boards in which he or she is licensed.

Making the Case for Telemedicine

State medical boards have a role to assure patient safety. As such, given the challenges of modern care delivery and new opportunities from advancing technology, licensing boards stand in a unique position to advance the availability of health care by facilitating the integration of new solutions into the regulation of medical practices.

However, given the array of different state regulatory bodies and the broad applications of telemedicine affecting different medical professions, states may choose to review and adapt their policies and procedures to address the needs of patients wishing to access care from physicians providing services via telemedicine. Individual physicians are not the only ones impacted by the network of patchwork policies. Patients and health care partnerships, which foster care coordination, are also subjected to confusing and restraining laws that have the consequence of limiting patient choice and provider collaboration.

The impact goes beyond the health care professions. Patients lead mobile lives. They travel within-state and out-of-state for personal reasons including work, leisure, education, and to engage in commerce. As a result, they often receive services from more than one physician, including providers across state lines. Large health care systems have responded to this need for more accessible care by establishing provider networks across multiple states.

Accommodating dynamic clinical models and patient preferences for 24/7/365 on-demand access to care will require a more malleable understanding and expansive envisioning of 21st century health care. Just as innovation is blossoming in genetics, biotechnology, and telemedicine so too must innovation occur in regulation. Educating your state medical board and legislature will be a crucial part to advancing telemedicine.

The best approach for making the case for telemedicine is with a state-based coalition. Assembling a broad coalition of stakeholders involved or interested in telemedicine can provide a convenient base to start a conversation with the medical board about the issue of telemedicine. Health plans, hospital networks, private practice groups, consumers, companies and institutions providing direct-to-consumer health services and allied vendors are all potential members of such a coalition. Having leaders of such a coalition that are practicing physicians is critical as they are considered as having standing with a medical board. One way to start - ATA members can access the Association's members-only web site (the HUB), state forums, and a directory of all the members in each state.

Uncovering Current Practices

It is no secret but because many forms of telemedicine have become so ubiquitous and integrated into the practice of care, most people, even leading providers, regulators and health care administrators may be shocked to see how many telemedicine services are already being

provided throughout their state. Telemedicine today is in use in many forms in every state and in practically every hospital and health system. A first step in demonstrating this is to gather together evidence of current practices in the state and develop an ongoing dialogue with the various players. Here are a few examples of the type of services and providers:

- Teleradiology – Including radiology departments, outsourced (nighthawk) specialty companies and individual radiologists that occasionally work from home.
- Urban to rural telemedicine networks – These may involve large tertiary care hospitals and smaller rural clinics.
- Correctional care – Prison systems and contracted health providers
- Veterans Administration Services – Many facilities use telemedicine and remote monitoring which are provided to veterans throughout the nation.
- Emergency departments and critical care centers – Many hospitals use telestroke and other specialty services such as tele-ICU. About 125,000 patients will be seen this year by a neurologist using telemedicine and almost 500,000 patients in the ICU will be remotely monitored by a specialist.
- Remote cardiac monitoring – Cardiologists and implantable device companies provide remote monitoring for patients with an arrhythmia and with pacemakers.
- Remote intraoperative neurophysiological monitoring - Approximately 750,000 surgical procedures use such monitoring nationally, of which the majority are performed via telemedicine.
- Direct to consumer services – This year there will be 800,000 consultations provided over the Internet through an increasing array of providers. These include stand-alone private services, health systems and insurers and local group practices.

What are the Issues for the Appropriate Regulation of Telemedicine?

- Understanding the state of clinical applications of telemedicine and the established practice guidelines
- Understanding the current uses of telemedicine in the state
- Identifying appropriate clinical standards for physicians using telemedicine
- Identifying appropriate standards for prescribing from a distance

One size does not fit all

Just like health care delivered in-person, the range of service needs and care circumstances for telemedicine varies too widely for a “one size fits all” model. The nature of any clinical encounter can differ between episodic urgent care, on-going primary care, infrequent biometric monitoring, or medical emergencies requiring a specialist. As such, some uses of telemedicine are very short-term in nature such as the involvement of a specialist or multi-disciplinary care

team while other uses involve repeated remote engagement between mental health professionals and patients.

All medical encounters, whether conducted in person or remotely, should be based on the provider's medical competence and professional decision making using sufficient, appropriate clinical and non-clinical information to provide the medical service. It is generally understood that the frequency, duration, and makeup of the patient encounter should be determined by the physician and patient and not the licensing board. Unfortunately, some new and proposed state laws and rules were not created to accommodate existing clinical models but to restrict remote clinical care and result in stifling care coordination and patient access to care.

Some misconceptions about telemedicine that have shaped state policies, including the following:

- “No one is using it in my state”;
- Telemedicine requires a set of rigorous and distinct practice standards compared to in-person services; and
- A physician needs medical board authorization to use it.

The most common use of telemedicine is for remote interpretative services of diagnostic or treatment information, such as a radiologist interpreting a CT scan, a pathologist interpreting a tissue specimen, or a dermatologist treating a skin lesion or monitoring wound treatment. These services have been in practice for over 40 years and are used in a majority of hospitals throughout the country.

Let's look at some clinical applications that challenge traditional patient care situations:

- A patient is admitted to the emergency room and requires a telestroke consult with a neurologist to administer blood clotting medication;
- A patient at home initiates an unscheduled video conferencing session for a flu diagnosis and treatment;
- A patient at work uses a high-resolution camera to take an image of a wound and electronically sends that image to a dermatologist for consultation;
- A parent at home initiates video conferencing so that their child, diagnosed with autism spectrum disorder, may receive treatment or counseling;
- A parent and child receive urgent care services from a telemedicine kiosk at a retail clinic. The kiosk is equipped with the necessary digital medical peripherals to support clinical decision making; and
- A physician uses video conferencing pre- and/or post-surgery to consult with their patient.

In all these cases, just as it occurs with in-person treatment, a patient is seen, diagnosed, and/or treated by a licensed physician. Similarly, patients retain their rights concerning privacy

and secured health information, access to their medical records, and information about benefits, risks, and alternatives to proposed treatments or procedures. Additionally these clinical cases are effectively provided in the absence of a scheduled appointment and previously established physician-patient relationship. These clinical examples highlight the intricate nature of patient-centered care in the 21st century and prompt the need for consistent and comparable medical practice standards for telemedicine.

Telemedicine in the States

Health care providers in every state are using telemedicine. Sometimes telemedicine is the only alternative when no traditional in-person care is readily available. It is important that regulations not hinder patients from getting the best that can be done under extenuating circumstances.

Medical boards in Massachusetts, and Minnesota have demonstrated the importance of streamlining medical practice standards for telemedicine providers. The boards broadly define telemedicine and provide no distinct rules, protocols, or standards for telemedicine providers to follow. In contrast, licensed physicians in Texas must follow a separate standard of practice when using telemedicine, oddly practicing under two different standards of care for patients in the same state. Physicians in this state must consider scheduled in-person visits, patient locations, unique patient informed consents or the presence of another health care provider treating in-person and telemedicine encounters separately.

Appropriate Standards for Telemedicine

Some states have established different clinical practice rules for telemedicine than in-person practice. Examples of some areas that yield dissimilar policies patient setting, established patient-provider relationship and/or in-person examination, provider type, applicable technology, and patient consent. These rules may be arbitrary, very prescriptive, and provide no consideration for professional medical discretion, provider shortages or patient limitations.

Separate and unequal standards for telemedicine hinder patients' access to needed care. For example, a rule for a prior physical examination may hinder urgent care or mental health counseling.

Some states have specific telemedicine medical practice proposals which require a physician to obtain a medical or drug history, perform a physical exam, or see the patient in-person to fulfill the provider-patient relationship. Other states simply require that the physician "personally know" the patient.

Some important principles for medical boards to regulate telemedicine and in-person care comparably are the following:

- The most critical factor is whether the physician has sufficient, appropriate clinical and other information to provide a specific medical service under the particular circumstances. Physicians should be allowed to use video conferencing and asynchronous methods to obtain medical information to establish a clinical relationship.
- Telemedicine encounters should not be restricted to medical facilities, nor should a physician or patient be constrained with mandatory health settings if not medically necessary. Requirements for a prior physician-patient relationship or medical exam prerequisite should have an exception for emergent cases. Important uses of telemedicine include patients' medical emergencies, natural disasters and other types of emergencies affecting a locality.
- Rules for telemedicine should accommodate interpretive services that can be rendered without direct interaction with a patient, such as radiology, pathology, dermatology, and ophthalmology.
- The presence of a facilitator or telepresenter, while often critical to rendering an accurate diagnosis is not always required and, in fact, may be detrimental, such as in the case of telemental health counseling. The use of a telepresenter should be left to the professional judgment of the physician.
- When required, allow the use of telehealth in collaborative practice agreements and the remote supervision of other health professionals using telecommunications. In some states, the supervising physician is responsible for all medical services provided by a physician assistant (PA) or advanced practice nurse (APRN) under his/her supervision and for following each patient's progress. Medical boards should allow physicians to remotely supervise PAs and NPs using telemedicine as long as the scope of practice and any supervision law limits are upheld.
- Non-clinical matters, such as the use of electronic medical records and patient informed consent, should be the same for in-person and telemedicine services.

Licensure and Specialty Certification

There is an increasing belief that the existing system of requiring a medical license each time a physician or other health provider examines and treats a patient located in another state needs repair. Change is also needed to accommodate a variety of innovative service models featuring a multi-disciplinary team approach to provide and coordinate a patient's care, such as health systems which serve multi-state regions.

Examples of increasingly typical issues of state-by-state licensure include the following:

- Physician-to-Physician Consults – Some medical boards require that an out-of-state physician be licensed in their home state as well as the state where they are providing

remote consultation even if a patient is not involved in the consult. Licensing should not be a barrier for a professional merely getting a second opinion, such as from a colleague with more knowledge or experience about a diagnosis or treatment. In fact, consultations and care coordination should be encouraged beyond the limited scope of “infrequent or cross call coverage” especially if facilitated by telemedicine.

- Traveling Physicians and Patients – Patients and physicians travel within-state and out-of-state for a number of personal reasons including work, leisure, and to engage in commerce. To ensure patient safety and continuity of care, physicians traveling to another state should be able to serve a patient in their home state without needing an additional license. Alternatively, patients traveling to another state who may need to engage in a telemedicine encounter with their home physician should feel confident that they can continue seeking care from their preferred physicians, without the need for such physician to be also licensed in the state of transit. Special considerations should especially be given to physicians licensed in border or regional states.
- Medical Emergencies and Natural Disasters –Medical boards should allow out-of-state physicians medical privileges when encountered with such unforeseen circumstances including medical emergencies and natural disasters.
- Physicians working with or employed by a traveling sports team – Physicians who accompany sports teams, in-person or remotely, during interstate competition are hired as an initial point of care to immediately assess the severity of an injury as they often have important data about the individual given pre-established relationships, care delivery, and monitoring of the patient. These providers ensure clinical access to teams who compete on many levels, including youth, school, amateur, and professional, when they are away from a home.
- Employed or enrolled with Federal agencies – Physicians contracted or employed to offer correctional care and health care services provided to active and veteran military service members, federal employees, or Medicare beneficiaries should be permitted to practice with just one license.

Internet Prescribing and Dispensing

Telemedicine, when used appropriately, can be an appropriate method of prescribing and dispensing medication to patients. Some medical boards allow, at a minimum, licensed physicians to use video conferencing as a means of gathering clinical information and establishing a provider-patient relationship necessary to prescribe certain pharmaceuticals. In these instances a physician may use a video connection to properly assess a patient and prescribe medication according to their treatment plan. A physician may also use a video connection to remotely supervise other health professionals, such as a nurse practitioner or PA, while they dispense a medication according to a physician’s orders.

In other instances, a licensed physician may be permitted to use clinical information collected from a store-and-forward transmission, online adaptive interview, or phone call if they have a

prior relationship with their patient or offer cross call coverage. However for prescribing based on a telephone session with a patient with no prior relationship and no medical record there are differences of opinion and few independent, validated studies. ATA published a set of peer reviewed practice guidelines in December 2014. The *ATA Practice Guidelines for Live, On Demand Primary and Urgent Care* are designed to assist providers in adhering to ethical standards and legal compliance when engaged in the practice of primary and urgent care which may include prescribing.

Telemedicine providers are in the best position to educate medical boards on the safe and appropriate clinical uses of telemedicine for prescribing and dispensing. Boards will be better positioned to streamline their practice standards to accommodate current clinical practices if presented with the following information and guidance:

- Work with pharmacy boards to ensure that prescribing and dispensing laws are consistent and congruent;
- Identify appropriate clinical standards that enable physicians and legitimate telemedicine programs to prescribe remotely to their established patients;
- Ensure patient access to licensed physicians who are authorized to prescribe non-controlled sub via telemedicine. The provider must document the prescription in the patient's medical record, and take actions to assure the prescription is accurate and medically necessary and the patient is appropriately able to take the prescribed medication; and
- Incorporate references to scheduled drugs or controlled substances which recognize other federally-sanctioned medical sites under the Ryan Haight Online Pharmacy Consumer Protection Act (Public Law 110-425), notably the provision codified at 21 USC 802(54).