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**MEDICAL EXAMINING BOARD  
TELEMEDICINE RULE COMMITTEE  
Room 121A, 1400 East Washington Avenue, Madison  
Contact: Tom Ryan (608) 266-2112  
May 18, 2016**

*The following agenda describes the issues that the Committee plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Committee.*

**AGENDA**

**10:30 A.M. OR IMMEDIATELY FOLLOWING THE FULL BOARD MEETING**

**OPEN SESSION – CALL TO ORDER – ROLL CALL**

**A. Adoption of Agenda (1)**

**B. Minutes of March 16, 2016 – Review and Approval (2-3)**

**C. Legislative and Rule Matters – Discussion and Consideration (4-109)**

- 1) Review Background Materials
- 2) Proposals for Med 24 Relating to Telemedicine

**D. Deliberation on Items Added After Preparation of Agenda:**

- 1) Introductions, Announcements and Recognition
- 2) Election of Committee Officers
- 3) Appointment of Committee Liaison(s)
- 4) Administrative Updates
- 5) Nominations, Elections, and Appointments
- 6) Education and Examination Matters
- 7) Credentialing Matters
- 8) Practice Matters
- 9) Legislative/Administrative Rule Matters
- 10) Liaison Reports
- 11) Informational Items
- 12) Appearances from Requests Received or Renewed
- 13) Speaking Engagement(s), Travel, or Public Relation Request(s)

**E. Public Comments**

**ADJOURNMENT**

**TELEMEDICINE RULE COMMITTEE OF THE  
MEDICAL EXAMINING BOARD  
MEETING MINUTES  
MARCH 16, 2016**

**PRESENT:** Carolyn Ogland Vukich, M.D.(*via GoToMeeting;*) David Roelke, M.D.; Kenneth Simons, M.D.; Robert Zondag

**STAFF:** Tom Ryan, Executive Director; Nifty Lynn Dio, Bureau Assistant; and other Department staff

**CALL TO ORDER**

Kenneth Simons, called the meeting to order at 11:30 a.m. A quorum of four(4) members was confirmed.

**ADOPTION OF AGENDA**

**MOTION:** David Roelke moved, seconded by Carolyn Ogland Vukich, to adopt the agenda as published. Motion carried unanimously.

**ELECTION OF OFFICERS**

**COMMITTEE CHAIR**

**NOMINATION:** David Roelke nominated Kenneth Simons for the Office of Board Chair.

Tom Ryan called for nominations three (3) times.

Kenneth Simons was elected as Chair by unanimous consent.

**VICE CHAIR**

**NOMINATION:** Kenneth Simons nominated David Roelke for the Office of Vice Chair.

Tom Ryan called for nominations three (3) times.

David Roelke was elected as Vice Chair by unanimous consent.

**SECRETARY**

**NOMINATION:** Kenneth Simons nominated Carolyn Ogland Vukich for the Office of Secretary.

Tom Ryan called for nominations three (3) times.

Carolyn Ogland Vukich was elected as Secretary by unanimous consent.

<b>2016 ELECTION RESULTS</b>	
<b>Committee Chair</b>	Kenneth Simons

<b>Vice Chair</b>	David Roelke
<b>Secretary</b>	Carolyn Ogland Vukich

**ADJOURNMENT**

**MOTION:** David Roelke moved, seconded by Robert Zondag, to adjourn the meeting.  
Motion carried unanimously.

The meeting adjourned at 12:37 p.m.

DRAFT

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  <b>Dale Kleven</b> <b>Administrative Rules Coordinator</b>		<b>2) Date When Request Submitted:</b>  <b>5/6/16</b> Items will be considered late if submitted after 12:00 p.m. on the deadline date: ▪ 8 business days before the meeting	
<b>3) Name of Board, Committee, Council, Sections:</b>  <b>Telemedicine Rules Committee of the Medical Examining Board</b>			
<b>4) Meeting Date:</b>  <b>5/18/16</b>	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> <b>Legislation and Rule Matters – Discussion and Consideration</b> <b>1. Review Background Materials</b> <b>2. Proposals for Med 24 Relating to Telemedicine</b>	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>	
<b>10) Describe the issue and action that should be addressed:</b>			
<b>11)</b> <i>Dale Kleven</i>		Authorization  <i>May 6, 2016</i>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
<b>Directions for including supporting documents:</b> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

**Please review the following links to articles and guidelines relating to Telemedicine in other States:**

- [Independence, Technology, and Connection in Older Age](#)
- [Online Eye Exams](#)
- [American Telemedicine Association - Practice Guidelines](#)
- [American Medical Association - Policy Outlines](#)
- [AMA - Adopts Telemedicine Guiding Principles](#)
- [Modern Healthcare Article - Telemedicine](#)
- [AAFP Article - Telemedicine](#)
- [Teladoc, Inc., Appellant v. Texas Medical Board](#)
- [RAND - Teledoc Artical](#)
- [Texas Medical Licensing Law Blog](#)
- [Ohio Administrative Code 4731-11](#)
- [Federal Trade Commission on Telehealth](#)
- [Report of the FSMB Workgroup on Telemedicine Consultations](#)
- [Center for Telehealth and E-Health Law](#)
- [Consortium of Telehealth Resource Centers](#)
- [Northwest Regional Telehealth Resource Center](#)
- [Northeast Telehealth Resource Center](#)
- [California Telehealth Resource Center](#)
- [HRSA's Office for the Advancement of Telehealth](#)
- [Centers for Medicare & Medicaid](#)



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## Board Revises Florida's Telemedicine Practice Rule for Physicians

Florida Board of Medicine - [www.flboardofmedicine.gov](http://www.flboardofmedicine.gov)

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# FLORIDA | Board of Medicine

*January 1st, 2016*

### Board Revises Florida's Telemedicine Practice Rule for Physicians

Effective March 7, 2016, the Board of Medicine's revised Telemedicine Rule, Rule 64B8-9.0141, F.A.C., goes into effect. The amended rule reads:

(1) "Telemedicine" means the practice of medicine by a licensed Florida physician or physician assistant where patient care, treatment, or services are provided through the use of medical information exchanged from one site to another via electronic communications. Telemedicine shall not include the provision of health care services only through an audio only telephone, email messages, text messages, facsimile transmission, U.S. Mail or other parcel service, or any combination thereof.

(2) The standard of care, as defined in Section 456.50(1)(e), F.S., shall remain the same regardless of whether a Florida licensed physician or physician assistant provides health care services in person or by telemedicine.

(3) Florida licensed physicians and physician assistants providing health care services by telemedicine are responsible for the quality of the equipment and technology employed and are responsible for their safe use. Telemedicine equipment and technology must be able to provide, at a minimum, the same information to the physician and physician assistant which will enable them to meet or exceed the prevailing standard of care for the practice of medicine.

(4) Controlled substances shall not be prescribed through the use of telemedicine except for the treatment of psychiatric disorders. This provision does not preclude physicians from ordering controlled substances through the use of telemedicine for patients hospitalized in a facility licensed pursuant to Chapter 395, F.S.

(5) Prescribing medications based solely on an electronic medical questionnaire constitutes the failure to practice medicine with that level of care, skill, and treatment which is recognized by reasonably prudent physicians as being acceptable under similar conditions and circumstances, as well as prescribing legend drugs other than in the course of a physician's professional practice.

(6) Physicians and physician assistants shall not provide treatment recommendations, including issuing a prescription, via electronic or other means, unless the following elements have been met:

(a) A documented patient evaluation, including history and physical examination to establish the diagnosis for which any legend drug is prescribed.

(b) Discussion between the physician or the physician assistant and the patient regarding treatment options and the risks and benefits of treatment.

(c) Maintenance of contemporaneous medical records meeting the requirements of Rule 64B8-9.003, F.A.C.

(7) The practice of medicine by telemedicine does not alter any obligation of the physician or the physician assistant regarding patient confidentiality or recordkeeping.

(8) A physician-patient relationship may be established through telemedicine.

(9)(a) Nothing contained in this rule shall prohibit consultations between physicians or the transmission and review of digital images, pathology specimens, test results, or other medical data by physicians or other qualified providers related to the care of Florida patients.

(b) This rule does not apply to emergency medical services provided by emergency physicians, emergency medical technicians (EMTs), paramedics, and emergency dispatchers. Emergency medical services are those activities or services to prevent or treat a sudden critical illness or injury and to provide emergency medical care and prehospital emergency medical transportation to sick, injured, or otherwise incapacitated persons in this state.

(c) The provisions of this rule shall not apply where a physician or physician assistant is treating a patient with an emergency medical condition that requires immediate medical care. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention will result in serious jeopardy to patient health, serious impairment to bodily functions, or serious dysfunction of a body organ or part.

(d) The provisions of this rule shall not be construed to prohibit patient care in consultation with another physician who has an ongoing relationship with the patient, and who has agreed to supervise the patient's treatment, including the use of any prescribed medications, nor on-call or cross-coverage situations in which the physician has access to patient records.

*Rulemaking Authority 458.331(1)(v) FS. Law Implemented 458.331(1)(v) FS. History—New 3-12-14, Amended 7-22-14, 10-26-14.*

Sincerely,  
Board of Medicine

Sent to [t.e.s.t\\_@example.com](mailto:t.e.s.t_@example.com)

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Florida Department of Health - Board of Medicine  
4052 Bald Cypress Way | Bin C-03  
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April 27, 2016

### [Professional Regulatory Review Committee Created in Delaware](#)

A professional licensing review committee was established in Delaware to ensure that the state's professional licensing regulations are instruments of opportunity rather than arbitrary and expensive barriers to entry into the job market. The committee will include members of Delaware's regulated professions, heads of executive agencies, members of the General Assembly and community advocates. The committee is charged with conducting a comprehensive analysis of the composition, state oversight and licensing requirements of all commissions, boards and agencies that are regulated by the Delaware Division of Professional Regulation.

The committee is scheduled to issue a report by Oct. 14, 2016, which will include:

- Recommendations of any legislative or regulatory changes that may be needed to alleviate the risk of antitrust liability identified by the Supreme Court in *North Carolina State Board of Dental Examiners v. Federal Trade Commission*;
- Recommendations for legislative or regulatory action that will remove unnecessary or burdensome licensing or certification requirements;
- An examination of the relative burdens of licensing and certification requirements of regulated professions in Delaware as compared to those in neighboring states;
- Recommendations as to whether Delaware's current system of professional regulation could or should be replaced by an alternative methodology; and
- Recommendations regarding the process by which the state considers proposed regulatory or legislative changes that would either add a new profession to the regulated professions list or increase the licensure or certification requirements for existing professions.

### [Telehealth Laws and Reimbursement Policies Report Released](#)

The Center for Connected Health Policy recently released a new edition of its comprehensive [report](#) on state telehealth laws, regulations and Medicaid policies that includes up-to-date telehealth information for all 50 states and the District of Columbia. The report found that while many states are starting to expand telehealth reimbursement, others continue to restrict and place limitations on telehealth delivered services.

Some significant findings from the report include:

- Massachusetts, Rhode Island and Utah do not have reimbursement of any type for telemedicine in public programs;
- 47 states and Washington D.C. provide reimbursement for some form of live video in Medicaid fee-for-service;
- Nine states reimburse for "store and forward" delivered services;
- 16 states reimburse for remote patient monitoring;
- 30 states provide a transmission and/or facility fee;
- 10 states have geographical/rural restrictions; and

- 23 states limit reimbursement to a specific list of facilities, with eight states adding such a list to their policy in the past nine months.

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# THE OPTOMETRIC SOCIETY

To: Wisconsin Department of Regulation & Licensing Medical Examining Board  
1400 E. Washington Ave.  
Madison, WI 53703  
P.O. Box 8935 (Mailing Address)  
Madison, WI 53708-8935  
Phone: (608) 266-2811  
Fax: (608) 261-7083

From: The Optometric Society  
PO Box 8288  
La Jolla, CA 92038  
Date: November 26, 2014  
RE: Opternative

Opternative is an “online refractive eye exam” after which a glasses or contact lens prescription is given, signed by an ophthalmologist. Expected to launch this winter, this technology does not include a “eye health exam.” This would be recommended, though not required, with the prescription already in hand.

We would like to bring to your attention the following concerns:

1. While ophthalmologists can delegate the refraction to another trained professional, it is the well established and accepted standard of care, that a refraction is not to be independent from an ocular health exam. This is vital for the detection of eye diseases that result in permanent vision loss as well as serious systemic diseases. Telehealth providers should be evaluated according to the standard of care applicable to those in traditional, in-person settings, according to specialty.
2. Under The Fairness to Contact Lens Consumers Act, the expiration date of a contact lens prescription must be specified based on the medical judgment of the prescriber, with respect to the ocular health of the patient. Contact lens complications such as corneal neovascularization, warpage, and infiltrates indicate compromise of ocular health, for which no symptoms may be reported. Neither a prior contact lens prescription nor a close-up photo of the patient's eyes can confirm ocular health for established contact lens wearers.
3. No one under 18, over 40, or with specific medical conditions such as diabetes, hypertension, known eye diseases, will qualify to receive a prescription. However, the use of online questionnaires is inadequate to establish the patient's age and medical/ocular history. The patient record established by online eye exams should be consistent with existing laws and regulations governing patient health care records. Age should be verified by acceptable means of identification. We would expect that medical history be verified with a dated copy of a completed physical examination and ocular history

be verified with a dated copy of a completed eye examination.

4. The risk with all telehealth is substandard or “cut-rate” professional services. With the promise to save people the commute, the wait, the time, and the money, standards of care can be significantly compromised. It is expected that all physicians who provide telehealth place the welfare and health of the patients first. A prescription should not be given after an online eye examination, unless a dated copy of a recent ocular health examination (within 6 months) is part of the patient’s record.

Telehealth is the way of the future and we agree that it is a powerful tool in medical practice, but not a separate form of medicine. We would expect that physicians who provide medical care, whether in-person or via telehealth, comply with acceptable, appropriate, and professional standards of care. While we support technology, increased access to care, and patient choice, we do not support the use of online eye exams to give prescriptions without an accompanying ocular health exam. This does not adhere to current standards of care and therefore represents a compromise to the health and safety of the public and our patients. We appreciate your consideration of this important matter and look forward to communicating with you.

Sincerely,

The Optometric Society Board of Directors

Lisa Shin, O.D.

Gary Litman, O.D., F.A.A.O.

James Sanderson, O.D.

Michael Santarlas, O.D.

Bryan Wolynski, O.D., F.A.A.O.

contact: **The Optometric Society** Lisa Shin 505-662-9681 lshin87@gmail.com

**Wisconsin Optometric Association**

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## Key Telemedicine Legislation Legislative Report – 2/5/16

Bill	Intro Date	Progress	Summary	Comments
<b>Florida HB 7087</b>	1/21/2016	Introduced	Provides practice standards & registration requirements to provide telehealth services in this state; requires AHCA, DOH & OIR to collect certain information & for AHCA to report such information to...	<p>(a) "Telehealth" means <u>the use of synchronous or asynchronous telecommunications technology</u> by a telehealth provider to provide health care services, including, but not limited to, patient assessment, diagnosis, consultation, treatment, and monitoring; transfer of medical data; patient and professional health-related education; public health services; and health administration. <u>The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.</u></p> <p>(4) Registration of out-of-state telehealth providers.— (a) A health care professional not licensed in this state may provide health care services to a patient located in this state using telehealth <u>if the telehealth provider annually registers with the applicable board</u>, or the department if there is no board, and provides health care services within the relevant scope of practice established by Florida law or rule.</p>
<b>Hawaii HB 1944</b>  <b>Hawaii SB 2395</b>	1/25/2016  1/22/2016	Introduced Hearing: 2/5/16  Introduced Hearing: 2/9/16	Requires the State's medicaid managed care and fee-for-service programs to cover services provided through telehealth. Specifies medical professional liability insurance policy requirements.	"Telehealth" means the use of telecommunications services, as defined in section 269-1, to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which <u>shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange</u> , to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of

				delivering enhanced health care services and information while a patient is at an originating site and the health care provider is at a distant site. <u>Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this section.</u> "
<b>Hawaii SB 2469</b>	1/22/2016	Introduced	Requires patient approval prior to the delivery of any medical services through telehealth. Prohibits health insurance companies from limiting the setting where telehealth services are provided.	(i) <u>No health insurance provider group, hospital, or medical service plan regulated under article 10A of chapter 431 or article 1 of chapter 432 shall:</u> <u>(1) Require that in-person contact occur between a physician and a patient before the delivery of any services via telehealth;</u> <u>or</u> <u>(2) Limit the type of setting where telehealth services are provided for the patient or by the health care provider."</u>
<b>Indiana HB 1263</b>	1/11/2016	Passed House 2/3/16	Sets forth requirements that must be met before a prescriber may prescribe medicine to a patient receiving telemedicine services. Prescriptions and telemedicine. Sets forth requirements that must be...	Sec. 2. (a) As used in this chapter, "telemedicine" means the delivery of health care services using electronic communications and information technology, including: <u>(1) secure videoconferencing; and</u> <u>(2) interactive audio-using store and forward technology; between a health care provider in one (1) location and a patient in another location.</u> (b) The term does not include use of the following: <u>(1) Audio-only communication.</u> <u>(2) A telephone call.</u> <u>(3) E-mail.</u> <u>(4) An instant messaging conversation.</u> <u>(5) Facsimile.</u>  Sec. 3.(a) <u>A prescriber may issue a prescription to a patient who is receiving services through the use of telemedicine even if the patient has not been seen previously by the prescriber in</u>

				<p>person if the following conditions are met:</p> <p>(1) The prescriber has done the following:</p> <p>(A) <u>Established a provider-patient relationship with the patient.</u></p> <p>(B) <u>Satisfied the applicable standard of care in the treatment of the patient.</u></p> <p>(C) <u>Generated and maintained a medical record for the patient that indicates the prescription being prescribed.</u></p> <p>(2) The issuance of the prescription by the provider is:</p> <p>(A) within the prescriber's scope of practice and certification; and</p> <p>(B) in accordance with any applicable law or rule.</p> <p>(3) The prescription is not for a controlled substance (as defined in IC 35-48-1-9).</p>
<b>Michigan SB 495</b>	9/16/2015	Introduced	Insurance; health insurers; telemedicine; include asynchronous store and forward action as method of interaction.	<p>(E) "Telemedicine" means the <u>use of interactive audio, video, or other telecommunications technology by a health care professional to deliver health care services between a distant site and an originating site for diagnosis and treatment</u></p>
<b>Mississippi SB 2071</b>	1/26/2016	Introduced	An act to define telemedicine in the medical practice act and to provide standards for providing treatment via telemedicine services; to authorize the Mississippi board of medical licensure to promul...	<p>(1) Telemedicine is the practice of medicine using electronic communications, information technology or other means, <u>including, but not limited to, secure videoconferencing or interactive audio using asynchronous store and forward transfer technology, between a provider in one location and a patient in another location, with or without an intervening healthcare provider.</u> Telemedicine is a method of practicing medicine as defined by Section 73-25-33, and is not a separate form of medicine.</p> <p>(3) <u>If a provider offering telemedicine services in his or her practice does not have an established provider-patient relationship with a person seeking such services, the provider may use his or her professional judgment within the standard</u></p>

				<p>of care to take appropriate steps to establish a provider-patient relationship by use of appropriate telemedicine technologies, including, but not limited to, the use of interactive audio using asynchronous store and forward technology or videoconferencing. The technological method by which the provider-patient relationship is established shall be within the discretion and medical judgment of the provider, but shall comply with the applicable medical standard of care.</p> <p>(9) <u>The Mississippi Board of Medical Licensure is authorized to promulgate rules relating to telemedicine; provided, however, that any such regulations shall be consistent with and no more restrictive than the provisions contained herein.</u></p>
<a href="#">Missouri HB 1923</a>	1/6/2016	Introduced	Changes the laws regarding the provision of telehealth services.	<p>191.1145. 1. As used in this chapter, the term “telehealth” or “telemedicine” shall mean the delivery of health care services by means of information and communication technologies consisting of telephones, remote patient monitoring devices, real-time two-way electronic audio-visual communications, and other electronic means, including the application of secure video conferencing and asynchronous store-and-forward technology, to provide or support the delivery of health care services that facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while such patient is at an originating site and the health care provider is at a distant site.</p>
<a href="#">New Jersey AB 1464</a>	1/27/2016	Introduced	Authorizes health care practitioners to provide health care services through telemedicine. This bill would authorize health care practitioners in the	<p>“Telemedicine” means the delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the gap between the health care practitioner who is located at one site, and a patient who is located at a different, remote site, either with or without the assistance of an intervening health care provider, and which typically involves the provision of health</p>

			State – including physicians, nurse practitioners...	<u>care services through the application of secure, two-way videoconferencing or store-and-forward technology that is designed to replicate the traditional in-person encounter and interaction between health care practitioner and patient by allowing for interactive, real-time visual and auditory communication, and the electronic transmission of images, diagnostics, and medical records. “Telemedicine” does not include the use of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.</u>
<b>Rhode Island HB 7160</b>	1/14/2016	Introduced	This act would require health insurance policies, plans or contracts issued, reissued or delivered on or after January 1, 2018, to include provisions for the reimbursement of telemedicine services in...	(12) "Telemedicine" means the delivery of clinical health care services <u>by means of real time two-way electronic audiovisual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, treatment, and care management of a patient's health care while such patient is at an originating site and the health care provider is at a distant site, consistent with applicable federal laws and regulations. Telemedicine does not include an audio-only telephone conversation, email message or facsimile transmission between the provider and patient.</u>
<b>South Carolina SB 1035</b>	1/28/2016	Introduced	To facilitate the use of telemedicine by establishing certain recordkeeping requirements; to amend section 40-47-20, relating to definitions used in chapter 47, title 40, so as to provide definitions...	(53) 'Telemedicine' means the practice of medicine <u>using electronic communications, information technology, or other means including, but not limited to, secure videoconferencing or interactive audio using asynchronous store and forward transfer technology</u> between a physician in one location and a patient in another location, with or without an intervening health care provider. <u>Telemedicine does not include an audio-only telephone conversation, email or instant messaging conversation, or facsimile.</u>
<b>Tennessee HB</b>		Prefiled	As introduced,	(6) "Telehealth" or "telemedicine" means the <u>use of real-time</u>

<b>2331</b> (SB 2373)			eliminates the requirement that a healthcare services provider be at a hospital or other qualified site for the services to be considered telehealth services for insurance purposes; re...	<u>audio, video, or other electronic media and telecommunications technologies that enable interaction between the healthcare services provider and the patient, or also store-and-forward telemedicine services,</u> for the purpose of diagnosis, consultation, or treatment of a patient in another location where there may be no in-person exchange, within the scope of practice of the healthcare services provider;
<b>Vermont HB 543</b>	1/12/2016	Introduced	An act relating to insurance coverage for telemedicine services delivered in or outside a health care facility.	<u>A health insurance plan shall not impose limitations on the number of telemedicine consultations a covered person may receive that exceed limitations otherwise placed on in-person covered services.</u>
<b>West Virginia SB 47</b>	1/13/2016	Introduced	Relating generally to practice of medicine; rewriting licensing requirements for practice of medicine and surgery or podiatry; making exceptions; providing for unauthorized practice; requiring notice...	"Store and forward telemedicine" means the asynchronous computer based communication of medical data and/or images between a patient and a physician or podiatrist at another site for the purpose of diagnostic and/or therapeutic assistance. "Telemedicine" means the practice of medicine <u>using tools such as electronic communication, information technology or other means of interaction</u> between a licensed health care professional in one location and a patient in another location, with or without an intervening healthcare provider. <u>The utilization of electronic communication in on call, cross coverage and emergency services situations is not telemedicine.</u>
<b>West Virginia SB 320</b>	1/19/2016	Introduced	Relating generally to practice of medicine; permitting the practice of telemedicine; establishing	"Store and forward telemedicine" means the asynchronous computer-based communication of medical data and/or images from an originating location to a physician at another site for the purpose of diagnostic and/or therapeutic assistance. "Telemedicine" means <u>the practice of medicine using tools</u>

			<p>requirements; making exceptions; defining terms; and authorizing rulemaking.</p>	<p><u>such as electronic communication, information technology, store and forward telecommunication, or other means of interaction</u> between a physician in one location and a patient in another location, with or without an intervening healthcare provider.</p> <p>----</p> <p>(b) Licensure. --</p> <p>(1) <u>The practice of medicine occurs where the patient is located at the time the telemedicine technologies are used.</u></p> <p>(2) A physician who uses telemedicine technologies to engage in the practice of medicine on patients located in this state <u>shall be licensed to practice medicine in the State of West Virginia and shall be subject to regulation by the West Virginia Board of Medicine or the West Virginia Board of Osteopathy.</u></p> <p>-----</p> <p>(c) Establishing a Physician-Patient Relationship Through Telemedicine Encounter. --</p> <p>(1) <u>A physician-patient relationship may not be established through:</u></p> <p><u>(A) Audio-only communication;</u></p> <p><u>(B) Text-based communications such as e-mail, Internet questionnaires, text-based messaging or other written forms of communication; or</u></p> <p><u>(C) Any combination thereof.</u></p>
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**Telemedicine Practice Standards**  
*State by State Overview*

	State License Required	Requires Physical Exam	Requires Pre-existing Relationship	Allows Physical Exam/Relationship to be established via Telemedicine	Technology Specified
AL	√* <sup>1</sup>	- <i>* Telemedicine Rules Suspended</i>	-	-	-
AK	√	√	√	√	√
AZ	√	√	√	√	√
AR	√	√	√	-	√
CA	√ <sup>+2</sup>	√	√	√	√
CO	√	-	-	√	√
CT	√	-	-	√	√
DE	√	-	√	√	√
DC	√	√	√	√	√
FL	√	√	√	√	√
GA	√	√	-	√	-
HI	√	√	√	-	√
ID	√	-	√	√	√
IL	√	-	-	-	-
IN	√	-	√	√	√
IA	√	√	-	√	√
KS	√	-	-	-	-
KY	√	-	-	√	√
LA	√*	√	√	-	√
ME	√ <sup>+</sup>	-	-	√	√
MD	√ <sup>^3</sup>	√	√	√	√
MA	√	-	-	√	-
MI	√	-	-	√	√
MN	√ <sup>+</sup>	-	-	√	-

<sup>1</sup> √\* denotes that a state may issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines to allow for the practice of telemedicine.

<sup>2</sup> √<sup>+</sup> denotes that a state requires physicians to register if they choose to wish to practice medicine across state lines.

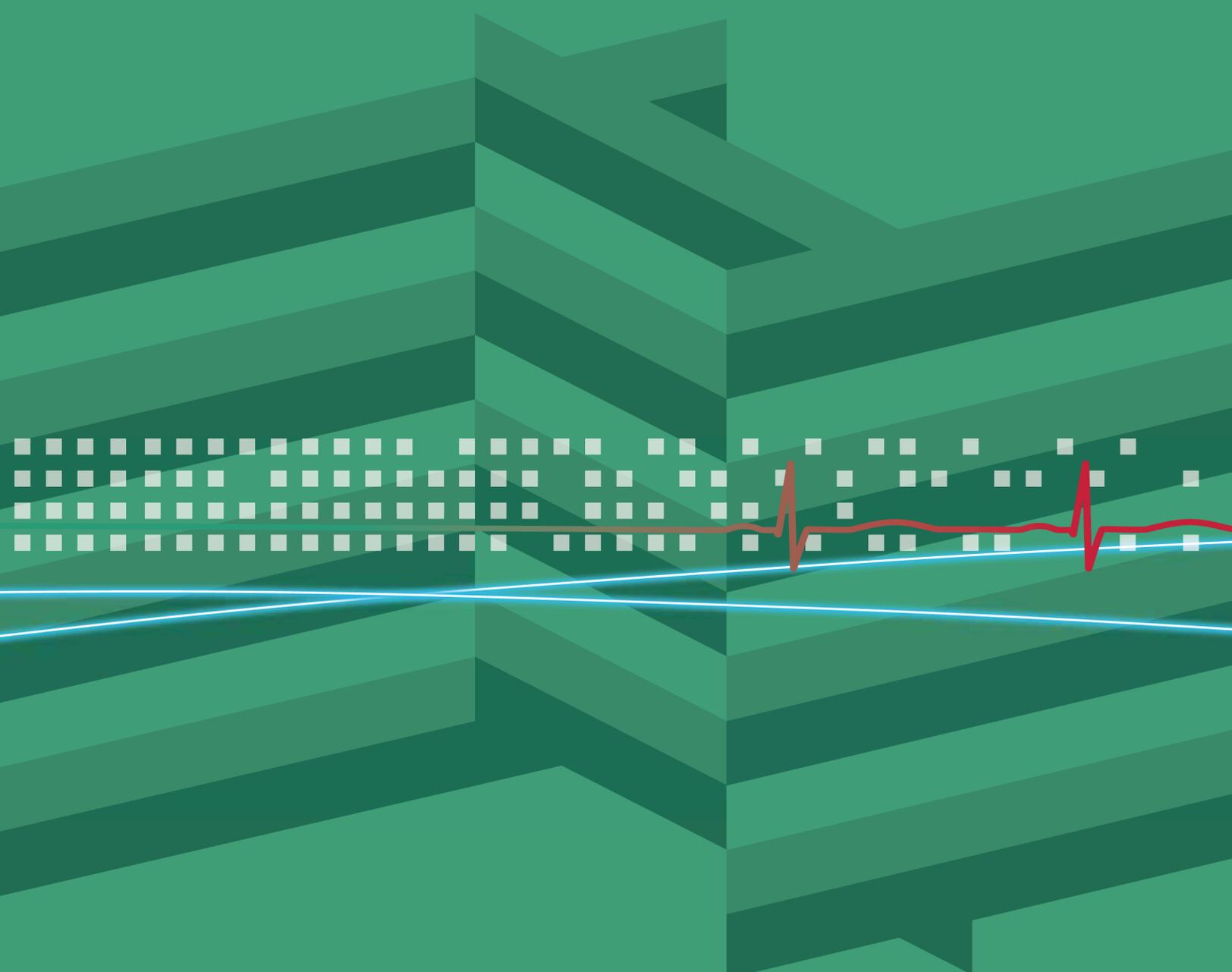
<sup>3</sup> √<sup>^</sup> denotes that Maryland Revised Statutes § 14-302 exempts physicians licensed in adjoining states from being required to obtain a Maryland license.

MS	√	√	√	√	-
MO	√	√	√	-	-
MT	√	-	-	√	√
NE	√	√	√	√	√
NV	√*	√	√	√	√
NH	√	-	-	√	√
NJ	√*	-	-	√ <i>*Telepsychiatry only</i>	-
NM	√*	-	-	√	-
NY	√	-	√	√	√
NC	√	√	√	√	-
ND	√	√	√	√	-
OH	√*	√	-	√	√
OK	√	√	√	√	√
OR	√*	-	-	√	-
PA	√*	-	-	√	-
RI	√	-	-	√	-
SC	√	-	-	√	-
SD	√	-	-	√	-
TN	√*	√	-	√	√
TX	√*	√	√	√ <i>*Only at established medical sites</i>	√
UT	√	-	-	√	-
VT	√	√	-	√	√
VA	√	√	√	√	√
WA	√	√	√	√	√
WV	√	√	√	√	√
WI	√	√ <i>*Telemedicine Rules Pending</i>	√	√	√
WY	√	-	√	√	-

*For informational purposes only: This document is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. Non-cited laws, regulation, and/or policy could impact analysis on a case-by-case or state-by-state basis. All information should be verified independently.*

# Core Operational Guidelines for Telehealth Services Involving Provider-Patient Interactions

May 2014



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# Core Operational Guidelines for Telehealth Services Involving Provider-Patient Interactions

(An Update of the February 2008 “Core Standards for Telemedicine Operations”)

## Table of Contents

Preamble.....	3
Scope.....	4
Definitions.....	4
Administrative Guidelines.....	5
Clinical Guidelines.....	7
Technical Guidelines.....	8
Appendix: References.....	11

## **PREAMBLE**

The American Telemedicine Association (ATA) brings together diverse groups from traditional medicine, academia, technology and telecommunications companies, ehealth, allied professional and nursing associations, medical societies, government, military, regulatory and others to overcome barriers to the advancement of telemedicine through the professional, ethical and equitable improvement in health care delivery.

ATA has embarked on an effort to establish practice guidelines for telemedicine to advance the science, to assure uniform quality of service to patients, and to promote reasonable and informed patient and provider expectations. The guidelines are developed by panels that include experts from the field and other strategic stakeholders, and are designed to serve as both an operational reference and an educational tool to aid in providing appropriate care for patients. The guidelines generated by ATA undergo a thorough consensus and rigorous review including an open public commentary period, with final approval by the ATA Board of Directors. Existing products are reviewed and updated periodically.

The purpose of these guidelines is to assist practitioners in pursuing a sound course of action to provide effective and safe medical care that is founded on current information, available resources, and patient needs. The guidelines recognize that safe and effective practices require specific training, skills, and techniques, as described in each document. The resulting products are properties of the ATA and any reproduction or modification of the published guideline must receive prior approval by the ATA.

The practice of medicine is an integration of both the science and art of preventing, diagnosing, and treating diseases. Accordingly, it should be recognized that compliance with these guidelines alone will not guarantee accurate diagnoses or successful outcomes. If circumstances warrant, a practitioner may responsibly pursue an alternate course of action different from the established guidelines. A divergence from the guidelines may be indicated when, in the reasonable judgment of the practitioner, the condition of the patient, restrictions or limits on available resources, or advances in information or technology occur subsequent to publication of the guidelines. Nonetheless, a practitioner who uses an approach that is significantly different from these guidelines is strongly advised to provide documentation, in the patient record, that is adequate to explain the approach pursued.

Likewise, the technical and administrative guidelines in this document do not purport to establish binding legal standards for carrying out telemedicine interactions. Rather, they are the result of the accumulated knowledge and expertise of the ATA workgroups and other leading experts in the field, and they are intended to address the technical quality and reliability of telemedicine encounters. The technical aspects of and administrative procedures for specific telemedicine arrangements may vary depending on the individual circumstances, including location of the parties, resources, and nature of the interaction.

**NOTE ON THIS UPDATE**

This update has four key modifications: 1) enhances guidance on educating patients about telehealth treatment; 2) adds several new items related to verification of patient/provider identity and service delivery location; 3) provides guidance related to mobile devices and services delivered to patients in non-facility settings; and 4) expands guidelines on privacy and security requirements.

**SCOPE**

The following guidelines are fundamental requirements to be followed when providing medical and other healthcare services using telecommunications technologies, and any other electronic communications between patients, practitioners and other healthcare providers. The guidelines apply to individual practitioners, group and specialty practices, hospitals and health care systems, and other providers of health related services where there are telehealth interactions between patients and service providers for the purposes of health care delivery. These guidelines may apply to specialty services, but other guidelines and standards addressing specific specialties have been and continue to be developed by separate workgroups within the ATA and other professional societies. When guidelines, position statements, or standards from any professional organization or society exist, health professionals should also review these documents and, as appropriate, incorporate these into practice. These guidelines pertain primarily to healthcare professionals and patients located in the United States. In situations where either or both parties are not within the US, these guidelines may be referred to but any local guidelines that are in place **shall** be referred to and take precedence over these. [1,2]

**DEFINITIONS**

Terms and definitions that are commonly used in telehealth/telehealth are available on the ATA website. [3] For this document there are several terms that need to be defined specifically:

*“Telehealth”* - telehealth is the use of medical information exchanged from one site to another via electronic communications to improve a patient’s health status. Telehealth includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools and other forms of telecommunications technology. Telehealth is not a separate medical specialty. It is a delivery tool or system. Closely associated with telehealth is the term “telemedicine,” which may be used interchangeably with telehealth, but is sometimes used to encompass a broader definition of health care that uses telecommunications technologies. Videoconferencing, transmission of still images and other data, e-health including patient portals, m-health, remote monitoring, continuing medical education, and medical call centers, are all considered part of telemedicine and telehealth (ATA, 2007).

*“Organization”* - includes organizations, institutions, and business entities, including online service entities.

*“Health professionals”* - refers to individuals.

*“Shall, should, and may”* - This document contains requirements, recommendations, or actions that are identified by text containing the keywords “shall,” “should,” or “may.” **“Shall”** indicates a required

action whenever feasible and practical under local conditions. These indications are found in bold throughout the document. “**Should**” indicates an optimal recommended action that is particularly suitable, without mentioning or excluding others. “**May**” indicates additional points that may be considered to further optimize the healthcare process. “**Shall not**” indicates that this action is strongly advised against.

## **ADMINISTRATIVE GUIDELINES**

### ***Organizations***

1. Organizations providing services via telehealth **shall** follow the standard operating policies and procedures of the governing institution. If the telehealth operation is a sole entity or part of a solo practice, that entity or solo practice **shall** have policies and procedures in place to govern all administrative functions that responsibly include and address aspects of telehealth with regards to:
  - a. Human resource management
  - b. Privacy and confidentiality
  - c. Federal, state, local, and other regulatory agency and ethical requirements
  - d. Fiscal management
  - e. Ownership of patient data and/or records
  - f. Documentation, including use of electronic health records
  - g. Patient and clinician rights and responsibilities
  - h. Network and data transmission, storage and access security
  - i. Use of equipment, devices and technology including peripheral devices, network hardware and associated software.
  - j. Research protocols (if applicable)
  - k. Technical and medical competence in the service provided, including training of all personnel involved in the telehealth operations (i.e., healthcare professionals, technical, administrative and other relevant staff)
  - l. Evaluation criteria
  - m. Availability of organization information (e.g., ownership, location, website, contact information)
2. Organizations providing telehealth should have in place a systematic quality improvement and performance management process that encompasses quality assurance and quality control and complies with any and all organizational, regulatory, and accrediting requirements for outcomes management. This process should be reviewed and updated as appropriate on a regular basis.
3. Organizations and health professionals providing telehealth services **shall** ensure compliance with relevant local, state and federal (or international if appropriate) legislation, regulations, accreditation and ethical requirements for supporting patient/client decision-making and consent, including protection of patient health information. [4-9]
4. Organizations **shall** have a mechanism in place for ensuring that patients and health professionals are aware of their rights and responsibilities with respect to accessing and providing health care via telehealth technologies (whether within a healthcare institution or other environment such as the home, school or work), including the process for communicating complaints.
5. Organizations **shall** respect patients’ requests for in-person care whenever feasible.

6. Prior to the start of the telemedicine encounter, the provider **shall** inform and educate the patient in real-time of all pertinent information such as: discussion of the structure and timing of services, record keeping, scheduling, privacy and security, potential risks, confidentiality, mandatory reporting, billing, and any information specific to the nature of videoconferencing. The information **shall** be provided in language that can be easily understood by the patient and/or caregiver, especially when discussing technical issues like encryption or the potential for technical failure. These topics may be provided orally or in writing.

Additionally, the provider or designee should set appropriate expectations in regard to the telemedicine encounter. This may include for example prescribing policies, scope of services, communication and follow-up. The information **shall** be provided in language that can be easily understood by the patient. This is particularly important when discussing technical issues like encryption or the potential for technical failure.

Key topics that **shall** be reviewed include: confidentiality and the limits to confidentiality in electronic communication; an agreed upon emergency plan, particularly for patients in settings without clinical staff immediately available; process by which patient information will be documented and stored; the potential for technical failure, procedures for coordination of care with other professionals; a protocol for contact between visits; and conditions under which telemedicine services may be terminated and a referral made to in-person care.

7. Organizations providing and/or receiving telehealth services that establish collaborative partnerships **shall** be aware of applicable legal and regulatory requirements for appropriate written agreements, memorandum of understanding, or contracts. Those contracts, agreements, etc., **shall** be based on the scope and application of the telehealth services offered, and **shall** address all applicable administrative, clinical and technical requirements. All parties involved in such agreements should have an appropriate legal review conducted on the documents prior to signing.

### ***Health Professionals***

1. Professionals **shall** conduct care consistent with the jurisdictional regulatory, licensing, credentialing and privileging, malpractice and insurance laws and rules for their profession in both the jurisdiction (site) in which they are practicing as well as the jurisdiction (site) where the patient is receiving care, and **shall** ensure compliance as required by appropriate regulatory and accrediting agencies.

2. Health professionals using telehealth **shall** be cognizant of establishment of a provider-patient relationship within the context of a telehealth encounter, whether interactive, store-and-forward or other mode of communication/interaction is used, and they **shall** proceed accordingly with an evidence-based standard of care. Health professionals should refer to existing specialty guidelines to determine whether specific definitions of “patient-provider relationship” and/or “encounter” exist.

3. Health professionals providing telehealth services **shall** have the necessary education, training/orientation, licensure, and ongoing continuing education/professional development, in order to ensure the necessary knowledge and competencies for safe provision of quality health services in their specialty area.

4. Healthcare professionals providing telehealth services should insure that workspaces are secure, private, reasonably soundproof, and have a lockable door to prevent unexpected entry. Efforts **shall** be made to ensure privacy so provider discussion cannot be overheard by others outside of the room

where the service is provided. If other people are in either the patient or the professional's room, both the professional and patient **shall** be made aware of the other person and agree to their presence.

### CLINICAL GUIDELINES

1. The health professionals providing care via telehealth **shall** be aware of pertinent professional discipline guidelines and standards that **shall** be upheld in the telehealth encounter, with consideration of the specific context, location, timing, and services delivered to the patient.

2. Health professionals **shall** be guided by professional discipline and national existing practice guidelines when practicing via telehealth, and any modifications to specialty-specific clinical practice guidelines for the telehealth setting **shall** ensure that clinical requirements specific to the discipline are maintained.

3. Means for verification of provider and patient identity **shall** be implemented. For services with the patient at a healthcare institution, the verification of both professional and patient identity may occur at the host facility. When providing professional services to a patient in a setting without an immediately available health professional (e.g., the patient's home), the telehealth provider **shall** provide the patient (or legal representative) with his or her qualifications, licensure information, and, when applicable, registration number (e.g., National Provider Identification). The health professional **shall** also provide a location for verifying this information. Patients **shall** provide their full name, date of birth, and contact information including telephone, email, and mail contact information prior to the initial encounter. Professionals may ask patients to verify their identity more formally by providing a government issued photo ID. In cases where there is an existing established relationship between patient and healthcare professional and this documentation already exists, this process may be omitted.

4. The organization and health professionals **shall** document (e.g., in the electronic health record) provider (e.g., clinical association, town, state) and patient location, as required for the appropriate payment of services. However, it is not necessary for the health care providers to reveal their specific location to the patient, especially if a provider is located at home at the time of service. Verification of location is critical for complying with relevant licensing laws in the jurisdiction where the provider is physically located when providing the care, as well as where patient is located when receiving care. This information is also needed if an emergency arises and a management protocol must be implemented.

5. The organization and health professionals **shall** review with the patient expectations regarding additional contact between patient and provider (e.g., whether or not the provider will be available for phone or electronic contact between sessions and the conditions under which such contact is appropriate). This review should also include a discussion of emergency management between sessions.

6. Health professionals providing telehealth services **shall** be familiar with the use of any devices and software employed in delivering care over distances. This may include receiving specific training in such devices and software prior to providing patient services.

7. The professional should be familiar with local in-person health resources and travel requirements and should exercise clinical judgment to make a referral for additional health services when appropriate. The professional should also know the preferred healthcare system for the patient's insurance to avoid unnecessary financial strain for the patient.

8. When a professional sees a patient via personal computer and/or mobile device outside the patient's home (e.g., local facility, community-based outpatient facility, school site, library) or other facility where dedicated staff might be present, the professional should become familiar with emergency procedures. When the patient is in a setting without clinical staff, the professional may request the contact information of a family or community member who could be called upon for support in the case of an emergency. This person, called the "Patient Support Person" **shall** be selected by the patient or legal guardian prior to any telehealth services. In some cases, the facility will not have procedures in place. In cases where emergency procedures are not in place, the professional should coordinate with the clinical/Patient Support Person to establish basic procedures. The basic procedures may include: 1) identifying local emergency resources and phone numbers; 2) becoming familiar with location of nearest hospital emergency room capable of managing emergencies; and 3) having patient's family / support contact information. The professional may also learn the chosen emergency response system's average response time (e.g., 30 minutes vs. 5 hours) and the contact information for other local or regional professional associations, such as the city, county, state, or provincial.

9. In case of medication side effects, elevation in symptoms, and/or issues related to medication noncompliance, the professional should be familiar with the patient's prescription and medication dispensation options. Similarly, when prescribing, the clinician should be aware of the availability of specific medications in the geographic location of the patient. If services are provided in a setting where a professional is not immediately available, the patient might be at risk if there is an acute change in his or her medical and/or mental health condition. Therefore, the professional should be familiar with whom the patient is receiving other medical services.

10. Professionals **shall** be culturally competent to deliver services to the populations that they serve. Examples of factors to consider include awareness of the client's language, ethnicity, race, age, gender, sexual orientation, geographical location, socioeconomic, and cultural backgrounds. Health professionals are encouraged to use online resources to learn about the community in which the patient resides including any recent significant events and cultural mores of that community.

## **TECHNICAL GUIDELINES**

### ***Communication Modes & Applications***

All efforts **shall** be taken to use communication modes and applications that have appropriate verification, confidentiality, and security parameters necessary to be utilized properly. Software platforms should not be used when they include social media functions that notify users when anyone on a contact list logs on. When there are situations where multiple participants at different sites (i.e., more than 2) are involved such as with virtual care team conferences or two consultants interacting with the patient simultaneously, the guidelines apply to all participating sites.

### ***Devices & Equipment***

Both the professional and patient site should when available use high quality cameras (video and/or still as clinically appropriate for the intended application), audio, and related data capture and transmission equipment that is appropriate for the telehealth clinical encounter, and which meet any existing practice-specific guidelines. Devices **shall** have up-to-date security software per the manufacturer's recommendations. Health professionals/organizations should use device management software to provide consistent oversight of applications, device and data configuration and security. In the event of a technology fault or failure the organization and health professionals **shall** have a backup plan in place that outlines an alternate method of communication between sites. The plan **shall** be communicated to the patient or referring provider prior to commencement of the initial treatment encounter, and it may

also be included in the general emergency management protocol. The professional should review the technology backup plan on a routine basis.

In addition, organizations **shall**:

1. Ensure that equipment sufficient to support diagnostic needs is available and functioning properly at the time of facility encounters.
2. Have strategies in place to address environmental elements of care necessary for safe use of telehealth equipment.
3. Comply with all relevant laws, regulations, and codes for technology and technical safety.
4. Have infection control policies and procedures in place for the use of telehealth equipment and patient peripherals that comply with organizational, legal, and regulatory requirements.
5. Have processes in place to ensure the safety and effectiveness of equipment through on-going maintenance.
6. Meet required published technical standards and regulations (e.g., Food and Drug Administration) for safety and efficacy for devices that interact with patients or are integral to the diagnostic capabilities of the practitioner when and where applicable.

#### ***Connectivity for Real-Time Interactive Encounters***

1. Healthcare processes that provide one-way or two-way live video services through consumer devices that use internet-based video conferencing software programs should provide such services at a bandwidth of at least 384 Kbps in each of the downlink and uplink directions. Such services should provide a minimum of 640 x 480 resolution at 30 frames per second. In some circumstances, as determined by the health professional, lower or higher bandwidth and frame rate may be used. Depending on the service provided, higher bandwidth speeds may be needed, as determined by the health professional. Because different technologies provide different video quality results at the same bandwidth, each end point **shall** use bandwidth sufficient to achieve at least the minimum quality shown above during normal operation.
2. Where practical, providers may recommend preferred video conferencing software and/or video and audio hardware to the patient, as well as providing any relevant software and/or hardware configuration considerations.
3. The provider and/or patient may use link test tools (e.g., bandwidth test) to pre-test the connection before starting their session to ensure the link has sufficient quality to support the session.
4. Whenever possible, each party should use the most reliable connection method to access the Internet as determined by the health professional or IT team. [10]
5. The videoconference software should be able to adapt to changing bandwidth environments without losing the connection. Organizations **shall** have appropriate redundant systems in place that ensure availability of the data transmission infrastructure for critical connectivity.

#### ***Privacy***

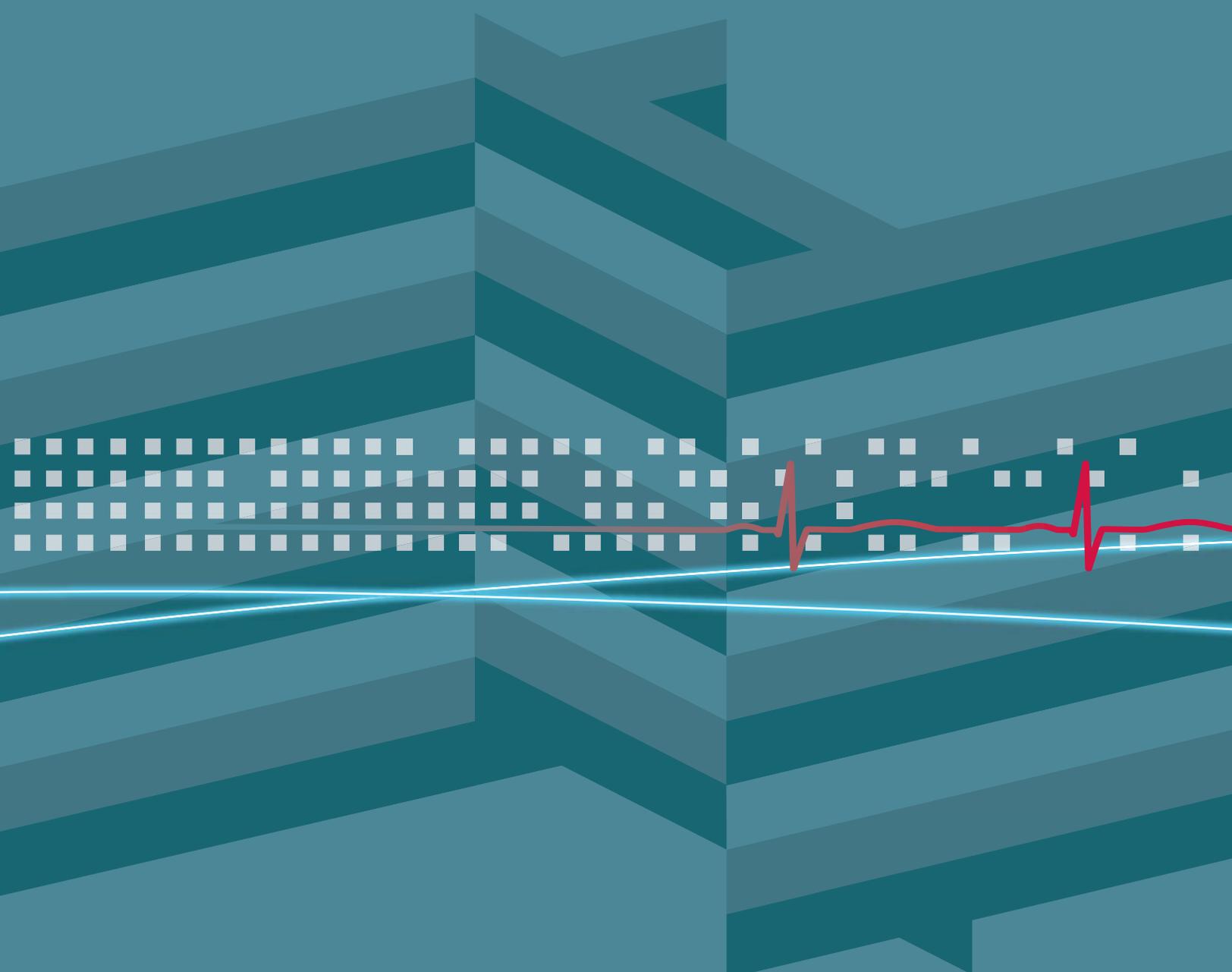
1. Audio, video, and all other data transmission **shall** be secure through the use of encryption (at least on the side of the healthcare professional) that meets recognized standards.
2. Individuals in charge of technology should familiarize themselves with the technologies available regarding computer and mobile device security, and should help educate the patient with respect to such issues as privacy and security options. Videoconferencing privacy features should be available to both the provider and patient. Privacy features should include audio muting, video muting, and the ability to easily change from public to private audio mode.

3. When the patient and/or provider use a mobile device, special attention should be placed on the relative privacy of information being communicated over such technology.
4. Providers should ensure that access to any patient contact information stored on any device is adequately restricted. Devices **shall** require a passphrase or equivalent security feature before the device can be accessed. If multi-factor authentication is available, it should be used. Devices should be configured to utilize an inactivity timeout function that requires a passphrase or re-authentication to access the device after the timeout threshold has been exceeded. This timeout should not exceed 15 minutes. Mobile devices should be kept in the possession of the provider when traveling or in an uncontrolled environment. Unauthorized persons **shall not** be allowed access to sensitive information stored on any device, or use the device to access sensitive applications or network resources. Providers should have the capability to remotely disable or wipe their mobile device in the event it is lost or stolen. Providers and organizations may consider establishing guidelines for periodic purging or deletion of telehealth related files from mobile devices.
5. Videoconferencing software **shall** allow only a single session to be opened, although the session may include more than two sites/participants. If there is an attempt to open a second session, the system **shall** either log off the first session or block the second session from being opened. Session logs stored in third party locations (i.e., not on patients' or providers' access device) **shall** be secure. Access to these session logs **shall** only be granted to authorized users. This does not preclude the use of multiple cameras during the same session (e.g., videoconferencing camera plus hand-held examination camera).
6. Protected health information and other confidential data **shall** only be backed up to or stored on secure data storage locations. Cloud services unable to achieve compliance **shall not** be used for personal health information (PHI) or confidential data. Professionals may monitor whether any of the transmission data is intentionally or inadvertently stored on the patient's or professional's computer hard drive. If so, the hard drive of the provider should use whole disk encryption as providing acceptable levels of security to ensure security and privacy.
7. Professionals should provide information to patients about the potential for inadvertently storing data and patient information, and they should provide guidance about how best to protect privacy. Professionals and patients **shall** discuss any intention to record services, how this information will be stored, and how privacy will be protected.
8. When organizations and health professionals make recordings of telehealth encounters, they should be encrypted for maximum security. Access to the recordings **shall** only be granted to authorized users and should be streamed to protect from accidental or unauthorized file sharing and/or transfer. The professional may also want to discuss his or her policy with regards to the patient sharing portions of this information with the general public. Written agreements pertaining to this issue can protect both the patient and the professional. If services are recorded, the recordings **shall** be stored in a secured location. Access to the recordings **shall** only be granted to authorized users.

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# Evidence-Based Practice for Telemental Health July 2009





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AMERICAN TELEMEDICINE ASSOCIATION

EVIDENCE-BASED PRACTICE FOR TELEMENTAL HEALTH

TABLE OF CONTENTS

1. PREAMBLE .....	4
2. SCOPE .....	5
3. GUIDELINE DEVELOPMENT PROCESS .....	5
4. INTRODUCTION .....	6
5. CLINICAL CODING METHODOLOGY .....	7
6. EVIDENCE.....	8
a. Mental Health Evaluations .....	8
1. Setting .....	8
a. Outpatient .....	8
b. Inpatient .....	8
c. Physical Surroundings.....	9
2. Diagnostic Interview .....	9
a. Provider-Patient Relationship .....	9
b. Diagnosis .....	10
c. Disposition .....	10
d. Psychiatry Specific.....	10
1. Medication Management.....	10
2. Medical Conditions.....	10
3. Procedures and Laboratory Studies .....	11
e. Psychological Assessment .....	11
1. Diagnostic Instruments and Scales .....	11
2. Personality Assessment.....	11
3. Neuropsychological Assessment .....	12
f. Psychiatric Nurse Practitioner, Physician Assistant, and Psychiatric Nursing Specific.....	12
g. Social Work/Counselor Specific.....	12
b. Ongoing Mental Health Care .....	12
1. Psycho-Education .....	12
2. Individual Psychotherapies .....	13
3. Group Psychotherapies .....	13
4. Marital and Family Psychotherapies.....	14
c. Populations of Special Focus .....	14
1. Geriatrics.....	14
2. Children and Adolescent.....	15
a. Evaluations.....	15
1. Setting .....	16
a. Physical Surroundings and Staff .....	16

b. Outpatient.....	16
c. Inpatient.....	16
d. Other Settings.....	17
2. Diagnostic Interview .....	17
a. Provider-Patient Relationship .....	17
b. Assessment and Diagnosis.....	17
c. Disposition and Continuity of Care.....	18
b. Treatment .....	18
1. Medication Management .....	18
2. Psychotherapy .....	18
3. Seclusion and Restraint.....	19
4. Emergency Assessments.....	19
5. Involuntary Commitments .....	19
6. Incarcerated.....	20
6. SUMMARY.....	20
7. REFERENCES .....	21

## 1. PREAMBLE

The American Telemedicine Association (ATA), with members from throughout the United States and throughout the world, is the principal organization bringing together telemedicine practitioners, healthcare institutions, vendors and others involved in providing remote healthcare using telecommunications. ATA is a nonprofit organization that seeks to bring together diverse groups from traditional medicine, academia, technology and telecommunications companies, e-health, allied professional and nursing associations, medical societies, government and others to overcome barriers to the advancement of telemedicine through the professional, ethical and equitable improvement in health care delivery.

ATA has embarked on an effort to establish practice guidelines and technical standards for telemedicine to help advance the science and to assure the uniform quality of service to patients. They are developed by panels that include experts from the field and other strategic stakeholders and designed to serve as both an operational reference and an educational tool to aid in providing appropriate care for patients. The guidelines and standards generated by ATA will undergo a thorough consensus and rigorous review, with final approval by the ATA Board of Directors. Existing products will be reviewed and updated periodically.

The practice of medicine is an integration of both the science and art of preventing, diagnosing, and treating diseases. Accordingly, it should be recognized that compliance with these guidelines will not guarantee accurate diagnoses or successful outcomes. The purpose of these standards is to assist practitioners in pursuing a sound course of action to provide effective and safe medical care that is founded on current information, available resources, and patient needs. The practice guidelines and technical standards recognize that safe and effective practices require specific training, skills, and techniques, as described in each document. The resulting products are properties of ATA and any reproduction or modification of the published practice guideline and technical standards must receive prior approval by ATA.

If circumstances warrant, a practitioner may responsibly pursue a course of action different from the guidelines when, in the reasonable judgment of the practitioner, such action is indicated by the condition of the patient, restrictions or limits on available resources, or advances in information or technology subsequent to publication of the guidelines. Nonetheless, a practitioner who uses an approach that is significantly different from these guidelines is strongly advised to provide documentation, in the patient record, that is adequate to explain the approach pursued.

This document is an educational tool to aid practitioners in meeting the practice guidelines set forth in companion document, ATA's Practice Guidelines for Videoconferencing-Based Telemental Health. The Evidence Based document provides the reader with an analysis of current published literature and documents qualitative and qualitative research focused on video-conferencing based mental health services and telemedicine/telehealth. The document does not serve the purpose of outlining what should or should not be done by a mental health practitioner, but, does provide reference and support for decision making in developing and providing telemental health services. Interested practitioners and/or telehealth organizations shall refer to ATA's Practice Guidelines for Videoconferencing-Based Telemental Health for the specific methods with which to comply with the published standards and guidelines for telehealth and telemental health.

## 2. SCOPE

These guidelines are designed to serve as both a consensus operational best practice reference based on clinical empirical experience and an educational tool to aid practitioners in providing appropriate telehealth care for patients. The term telehealth indicates an inclusion of all health professionals, ranging from medicine to mental health, to educators, and to nurses. The use of telehealth also refers to the broader scope of e-health and distance education. Telemental health therefore, is the practice of mental health specialties at a distance. The practice of medicine is an integration of both the science and art of preventing, diagnosing, and treating diseases. It should be recognized that adherence to these guidelines will not guarantee accurate diagnoses or successful outcomes. The purpose of these guidelines is to assist practitioners in pursuing a sound course of action to provide effective and safe medical care that is founded on current information, available resources, and patient needs. The guidelines are not meant to be unbending requirements of practice and they are not designed to, nor should they be used to, establish a legal standard of care. The American Telemedicine Association advises against the use of these guidelines in litigation in which the clinical decisions of a practitioner are called into question.

The primary care or managing practitioner is responsible for the decision about the appropriateness of a specific procedure or course of action, considering all presenting circumstances. An approach that differs from the ATA guidelines does not necessarily imply that the approach varied from the standard of care. If circumstances warrant, a practitioner may responsibly pursue a course of action different from these guidelines when, in the reasonable judgment of the practitioner, such action is indicated by the condition of the patient, restrictions or limits on available resources, or advances in information or technology subsequent to publication of the guidelines. Nonetheless, a practitioner who uses an approach that is significantly different from these guidelines is strongly advised to document in the patient record information adequate to explain the approach pursued.

## 3. GUIDELINE DEVELOPMENT PROCESS

The telemental health videoconferencing guideline project was initiated in 2006. A volunteer member of the Telemental Health (TMH) Special Interest Group (SIG) was appointed to chair the project at the 11<sup>th</sup> ATA Annual Meeting. A working group of clinicians, health care staff and health administration personnel was formed from the ATA membership. During the first year the group decided on limiting the scope of the project to interactive videoconferencing, addressing administrative, clinical and technical issues, deciding on the general format and beginning the literature search. Working group membership changed over the course of the guideline development. A literature search was conducted in November 2006 using PUBMED while committee members were also encouraged to search familiar literature, textbook and personal contacts for additional entries. Search terms used were:

telemedicine or interactive television or teleconferencing or teleconsultation or teleconsultations or video phone or videoconferencing or mental telehealth or telemental health or telepsychiatry or tele psychiatry or telepsychology or tele psychology or interactive videoconferencing or tele hypnosis or tele hypnosis or telepsychotherapy or tele psychotherapy or telecounseling or tele counseling or telenursing or tele nursing

Querying the broad terms led to approximately 9,300 listed articles. Approximately 5,300 articles were attributed to the word telemedicine alone and therefore most of the listed articles were non-telemental health in origin. Evidence tables were constructed according to the telemental health application, and consisted of setting, diagnostic interview, consultation-liaison, disposition, psycho-education, pharmacotherapy, individual psychotherapy, group psychotherapy, restraint/seclusion, incarceration,

evaluation, family, substance abuse, geriatrics, child & adolescent, nursing, and psychology. Evidence tables for clinical applications included the headings of setting, bandwidth, interactive video technology used, outcome and sample size when available. Articles in the evidence table were classified according to the quality of the evidence; e.g. randomized clinical trial, longitudinal study, case report, etc. Members of the group wrote the initial sections of the guidelines based on their area of expertise. The sections were then consolidated into the first draft, which was sent to three consultants. An editorial committee was formed with the chair and co-chairs to review the consultant input and make initial changes to the document. A second draft was then sent to 12 expert reviewers (clinicians and other stakeholders in the field of telehealth or mental health). The editorial committee then reviewed, discussed and made changes to the draft based on reviewer feedback and the document was sent to a second set of 9 expert reviewers. The editorial committee again reviewed, discussed and made changes to the third draft document. The fourth draft document was forwarded to the ATA standards and guidelines committee for review. The editorial committee reviewed, discussed and made changes to the fourth draft document. A public comment period of 60 days was open for comments on the fifth draft document. Final revisions were made and the document was approved by ATA's Standards and Guidelines Committee, and was forwarded to the ATA Board of Directors for final approval and publication.

#### **4. INTRODUCTION**

Telemental health, like telemedicine<sup>1</sup>, is an intentionally broad term referring to the provision of mental health care from a distance. The prefix “tele” can refer to geographical, time, or even circadian distance when providing care across time zones. Telemental health (TMH) includes mental health assessment, treatment, education, monitoring, and collaboration. Patients can be located in hospitals, clinics, schools, nursing facilities, prisons and homes. TMH providers and staff include psychiatrists, nurse practitioners, physician assistants, social workers, psychologists, counselors, primary care providers and nurses. Thousands of clients and patients have experienced access to mental health care via telemental health technologies. The goal of the telehealth provider is to eliminate disparities in patient access to quality, evidence-based, and emerging health care diagnostics and treatments. General information regarding telemental health can be found in review articles<sup>2,3,4,5,6</sup> practice parameters<sup>7</sup> and textbooks<sup>8,9</sup>.

Mental health professionals and practitioners continue to develop new ways to leverage technology to provide services to those needing expert care. This best practice recommendation document focuses on two-way, interactive videoconferencing as an alternative medium for clients and patients to directly engage with their mental health providers. The use of other modern technologies such as virtual reality, electronic mail, remote monitoring devices, chat rooms, and web-based clients were considered but these technologies are not currently included. There was little published literature on asynchronous methods for providing telemental health services at the time the document was written. The primary goal of the guideline is to distill the evidence from the published literature on interactive videoconferencing into a pragmatic reference for those engaged or about to engage in providing interactive TMH care. A secondary goal is to develop a clinical coding system for TMH clinical recommendations. Like other areas of telemedicine there is a growing, yet still limited amount of rigorous scientific research upon which to draw conclusions and set public policy for the use of telemental health. As the telemedicine field advances, researchers are striving to meet scientific standards and provide more guidance concerning evidence-based telemedicine practice in the future<sup>10, 11</sup>. When guidelines, position statements, or standards exist from a professional organization or society such as (but not limited to) the American Psychiatric Association<sup>12</sup>, American Psychological Association<sup>13</sup> or National Association of Social Workers<sup>14</sup>, the guidelines, position statements, or standards shall be reviewed and incorporated into practice.

In response to the needs and requests of providers, organizations and the ATA membership interested in or engaged in telemental health activities, the TMH SIG formed a committee to develop evidence based TMH guidelines. The broad nature of the mental health field along with an unlimited number of ways to

use technology in mental health services led the committee to limit this guideline to interactive video conferencing applications.

Appreciating the broad range of providers and settings involved in TMH, a method for coding the literature upon which the practice recommendations in this document are based was developed. When feasible the relevant published data were organized by patient age, types of treatment, treatment setting and provider specialty. When reviewing the literature and formulating the recommendations, the following confidence ratings were used: considerable confidence, reasonable confidence, and limited confidence based on a specific application [for more detail see next section, clinical coding methodology]. The use of the rating scale is in line with the confidence rating structures used by other organizations (e.g., the American Psychiatric Association) and is familiar to mental health clinicians. However, in order to allow for the broad range of videoconferencing equipment used and disparities in bandwidth availability, the recommendations are subject to specific application situations. Thus a second coding variable was introduced to identify the technology used. The purpose of the second coding variable was to be inclusive and appreciative of the technical and social performance of all interactive videoconferencing technologies currently in use and to not exclude niche populations or applications. It is anticipated and hoped that the coding system will encourage more specific descriptions of the technology used for future TMH interactive videoconferencing research and methods publication.

## **5. CLINICAL CODING METHODOLOGY**

Mental health clinicians refer to clinical guidelines when in need of evidence based recommendations and/or expert consensus regarding mental health diagnosis, medication and psychotherapy treatments, levels of appropriate care and social support information. TMH as a communication medium between provider and client/patient introduces an additional layer of variables into mental health care provision (e.g., effect of bandwidth, resolution and display size on the assessment and/or treatment interaction). The purpose of TMH evidence-based practice document is two-fold, 1) to provide evidence based recommendations and/or expert consensus regarding the effects of a particular video communication technology on the mental health diagnostic and treatment process, and 2) provide evidence based recommendations and/or expert consensus when TMH may be uniquely suited to enhance diagnostic clarification and/or treatment provision.

Three technological variables (bandwidth, resolution, and display size) are each believed to significantly influence the video interaction with mental health clients/patients. A TMH clinical recommendation coding scheme must be flexible enough to allow for a variety of video communication scenarios and yet be limited enough in classification to be readily understood. Bandwidth, using the H.264 video compression standard<sup>15</sup>, is classified in this guideline as high ( $\geq 256$  kbps), medium ( $\geq 128$  kbps but  $< 256$  kbps) and low ( $< 128$  kbps). Display size is the diagonal measurement of the non-anamorphic picture. Video resolution will be referenced to High Definition (HD) and while Common Intermediate Format (CIF) and Source Input Format (SIF) will be considered equivalent standard definition (SD) formats. One-quarter CIF (QCIF) and one-quarter SIF (QSIF) are sometimes used on videophones.

The Evidence-Based Practice for Telemental Health utilizes a letter (A, B, C, D) and number (1, 2, 3) format. The letter indicates minimum requirements for bandwidth, display size, and resolution for a particular VTC (video tele-conference) application, and the number indicates the level of clinical confidence for that application. Bandwidth, display size, and resolution parameters must all be met for the particular video application code to apply. For example, sufficient research and expert consensus may provide a clinical confidence recommendation of 2 for cognitive therapy conducted at high bandwidth on a room-sized standard definition display, which would be coded as [B2], but may provide a clinical confidence recommendation of 3 if conducted via an analog videophone, and thus be coded as [D3]. This does not mean that a particular mental health application via analog videophone will always score lower,

but rather that sufficient consensus or evidence-based data to support a higher clinical rating for the application was not supported in the literature. Clinicians are free to determine on a case by case basis, what evidence is relevant and how to proceed when little or no evidence exists. Ultimately, serving the patient safely and accurately is the goal of using any technology or method not well supported in the literature. The final decision rests with the clinician. The coding scheme is summarized below:

Video Application Coding:

A - High Bandwidth; Resolution HD; Display  $\geq 16$ "

B - High Bandwidth; Resolution  $\geq$  SD; Display  $\geq 26$ "

C - Medium Bandwidth; Resolution  $\geq$  SD; Display  $> 16$ "

D - Low Bandwidth; Resolution  $\geq$  QCIF/QSIF to CIF/SIF; Display  $< 16$ "

Clinical Confidence Recommendations:

1 - with considerable confidence

2 - with reasonable confidence

3 - may consider depending on the particular clinical objective and application used

## 6. EVIDENCE

### a. Mental Health Evaluations

#### 1. Setting

**a. Outpatient.** The majority of telemental health has been conducted in the outpatient setting<sup>16,17,18,19,20</sup>. Access to care has been the driving force, both geographically for rural communities and for the underserved in urban environments. Community mental health centers and medical clinics frequently lack enough clinicians, including child services and psychiatrists. It has been demonstrated that patients can be reliably assessed, diagnosed, and treated with pharmacology and psychotherapy in outpatient clinics with a variety of videoconferencing equipment and communications protocols [B1, C2, D3]. School-based programs have been increasing in number as convenient locations for patients, parents, and school officials to participate in mental health-related prevention, assessment, and care<sup>21,22,23,24</sup>. These natural settings are ideal locations to reach children and adolescents with mental health, developmental, and behavioral issues [B/C2, D3]. Other natural or innovative settings not usually considered for mental health services can reach at-risk and needy adults, such as women in shelters. There has been minimal published literature regarding the usefulness of telepsychiatry assessment in the emergency room<sup>25</sup>, so more work describing how telemental health consultation can help emergency room clinicians is needed. Likewise, further published work is needed regarding assessments, pharmacotherapies, and psychotherapies delivered in the patient's residence via home telehealth technologies.

**b. Inpatient.** Reports of inpatient care in general psychiatric units have been limited to consultative psychiatric services<sup>26</sup> and experimental investigations of acceptance<sup>27</sup> and diagnostic instrument accuracy<sup>28</sup>. One report of inpatient gero-psychiatric unit demonstrated patient and family satisfaction and perceived benefits with the telepsychiatry service<sup>29</sup>. While inpatient psychiatric care may be amenable to telehealth technologies, there has been little investigation describing the routine assessment or treatment on acute inpatient psychiatric units [B/C3] or for consultative psychiatry [B/C3]. One report indicated that inpatients with bipolar disorder, manic, had favorable opinions and engaged easily in videoconferencing assessments<sup>30</sup>. Uniqueness of assessment and treatment via videoconferencing has been

considered to play a beneficial role. Whether uniqueness continues to have such a beneficial effect needs to be seen as telemental health becomes more commonplace. Despite many articles and activity involving geriatrics, there were limited evidence-based outcome data on the provision of psychiatric services to geriatric patients in nursing facilities.

**c. Physical Surroundings.** Evidence is limited regarding the furnishing of either provider or patient offices<sup>31</sup>, although various program guidelines mention the importance of furnishings<sup>32</sup>. The literature states that as with in-person assessments, rooms used for telemental health should be safe, adequately lighted, and provide comfortable seating, with interruptions from electronic devices mitigated. Privacy, considered the ability to keep auditory and visual interactions from being seen or heard beyond the designated participants, is considered essential. VTC privacy features should be available to both the provider and patient. Privacy features should include audio muting, video muting, and the ability to easily change from public to private audio mode. Additionally, units should have features to improve the video clarity (e.g., brightness and contrast) and audio controls to adjust microphone and speaker volumes to reduce technology-based interruptions. All VTC-related features at the originating sites should also be controllable by the provider at the distant site. Providers should consider wearing pale solid colors such as blue, because patterned and striped clothing requires more bandwidth to update a more dynamic picture and may be distracting or disturbing to the patient.

## 2. Diagnostic Interview

**a. Provider-Patient Relationship.** Establishing rapport and a therapeutic alliance is as important in interactive videoconferencing as it is in face-to-face (FTF) care. Rapport allows for the patient to be more forthcoming with past and current history, cognitive experience, emotional experience, and symptoms. Good rapport leads to a therapeutic working alliance where the patient and provider engage cooperatively in a treatment plan to cure, manage, or mitigate unhealthy symptoms, behaviors, and emotional states. There is significant evidence that patients quickly adapt and establish rapport with their teleprovider<sup>33,34</sup> and are able to provide information via TMH as they would in person<sup>35,36</sup>. Clinicians should note that patients may present differently via telemental health, such as being more courteous or meticulous about their appearance<sup>37</sup>. It is also imperative for the clinician practicing mental health from a distance to have cultural competency in the population he or she is serving<sup>38,39</sup>. Adjusting to the medium may also require flexibility and creativity in conferring empathic gestures. Use of VTC appears to have minimal effect on the therapeutic working alliance [B/C2, D3]. There also is anecdotal evidence that for some disorders (e.g., post traumatic stress disorder, agoraphobia, and eating disorders), VTC may provide some “distance” that allows the patient to feel safer and in control of the therapeutic situation<sup>40,41</sup>. Another important consideration for video-based telemental health is gaze angle. Gaze angle is the angle between the participant’s local camera and where the participant looks at the distant onscreen participant (eye contact). The vertical location of the participant on the screen will affect gaze angle. Gaze angles of approximately 5 to 7 degrees are imperceptible to most people<sup>42,43</sup>.

**b. Diagnosis.** Establishing rapport and rendering a good diagnostic assessment are paramount during the initial session(s) with clients/patients. Effective treatment planning begins with an accurate diagnosis. The diagnosis is what enables the provider to refer to evidence and expert consensus-based treatments for that particular culmination of unhealthy emotions, thoughts, and behaviors. There is a fair amount of literature regarding VTC diagnostic assessments demonstrating their acceptance, utility, and accuracy in clinical

practice<sup>44,45,46,47,48,49,50</sup>. Limitations of VTC such as indirect eye contact due to camera-monitor placement need to be considered in assessing mental status. Adult diagnostic assessments conducted via VTC are comparable to FTF [B1, C2, D3]. While technical variables introduced by VTC assessment include bandwidth and display size, clinical VTC experience is another variable that should be appreciated. Providers who have significant experience using VTC for diagnostic assessments have little issue with the validity of diagnostics performed at medium bandwidth, while providers with less experience may encounter some difficulty (e.g., motion artifacts). This is an example where additional factors, in particular circumstances, may cause the recommended clinical confidence rating to increase or decrease. A wide range of patient diagnoses and settings lend to the generalization of accurate diagnostic assessments via VTC. There are limited data supporting diagnostic accuracy or utility at low bandwidth<sup>51,52</sup>.

**c. Disposition.** Disposition planning, typically from an inpatient or day hospital mental health or substance abuse program, has been reported as part of program descriptions, both while reporting on other videoconferencing applications and as a particular focus of telemental provision<sup>53</sup>. One study, involving child and adolescent telepsychiatry indicated the importance of clear recommendations, involvement of local care providers, availability and stability of local agencies and cooperation of the client and guardian as key to successful implementation of teleprovider recommendations<sup>54</sup>. Coordination between levels of care may be a particularly beneficial application to improve continuity and adherence to care<sup>55</sup>, particularly for suicidal or potentially aggressive patients who may need emergent interventions including pharmacotherapy. Continuity of care was particularly effective between a rural long-term care facility for dementia and an urban academic acute psychiatric hospital<sup>56</sup>. VTC also has been used to screen and coordinate transfer of patients to and from general inpatient units to a high acuity inpatient unit<sup>57</sup>. The use of videoconferencing in patient disposition planning between levels of mental health care is beneficial [B/C2, D3]. The attendance of the patient, when practical, is strongly encouraged and may help with patients who have propensity to splitting behavior.

#### **d. Psychiatry Specific.**

**1. Medication Management.** There are descriptions of telepsychiatry programs and collaboratives<sup>58</sup>, clinical trials, and case reports where medication management is an integral part of the care provision, outcome, and satisfaction of the VTC service<sup>59,60,61</sup>. There is little information regarding the effect of medication management via videoconferencing, although one retrospective study reported a trend toward prescribing more medications via videoconferencing<sup>62</sup>. Telepsychiatry, including medication management, has been the principle driving force of providing access to specialty care for remote and underserved populations. Access to psychiatric medication management, practiced in compliance with state regulations, in a timely manner and in keeping with local telemedicine protocols, is a particularly significant benefit of telemental health [B/C2, D3]. Most telepsychiatry programs use a combination of telephonic or facsimile ordering for remote sites and most are moving toward electronic prescribing. RCTs and case studies of VTC to increase adherence to mental health regimens have also been described<sup>63,64</sup>.

**2. Medical Conditions.** Psychiatry often does not require the hands-on physical assessment that other areas of medicine require. The lack of physical exam as a component of care has made videoconferencing particularly well suited for psychiatry. Provisions for routine or emergent local medical management, however, should be

included in any local operating procedure or protocol. Consultations for inpatients should be reviewed by the telepsychiatrist via remote health record access or facsimile.

**3. Procedures and Laboratory Studies.** Ordering and receipt of results of pertinent laboratory studies *should* be outlined in any local operating procedure or protocol. Like medical consultations, laboratory or procedure results *should* be reviewed by the telepsychiatrist via remote health record access or facsimile. Telepsychiatry consultants need to have access to relevant clinical data as if they were seeing the patient in person.

**e. Psychological Assessment.** The most common psychology-related evaluation is in relation to the diagnostic interview and the use of diagnostic rating scales as part of this process. Two other categories of psychological assessment are personality assessment and intelligence or cognitive assessment.

**1. Diagnostic Instruments and Scales.** A good deal of investigation has examined psychiatric assessments that are based on clinician interview, such as the Brief Psychiatric Rating Scale (BPRS)<sup>65,66</sup> or psychiatric interviews based on the Structured Clinical Interview for the Diagnostic and Statistical Manual<sup>67</sup>. There is some support for the reliability and validity of VTC in the administration of the Brief Psychiatric Rating Scale, possibly depending on bandwidth<sup>68,69</sup> [B2,C/D3]. Comparability between face-to-face and VTC also is demonstrated for the Hamilton Depression Rating Scale for depression<sup>70,71</sup> [B2].

One study demonstrated that BPRS ratings based on verbal report are more reliable than symptoms requiring visual observation<sup>72</sup>. Similarly, a largely positive study comparing teleconference to face-to-face found lesser reliability for the Scale for the Assessment of Negative symptoms using a bandwidth of 128 kbps<sup>73</sup>.

Remote diagnostic consultation has been widely applied as a way to provide expert opinion for patients in underserved areas. Most studies have demonstrated feasibility and satisfaction, but fewer reliability and validity studies have been conducted<sup>74</sup>. Two studies<sup>75,76</sup> demonstrated high reliability in the administration of the Structured Clinical Interview for DSM-III-R.

**2. Personality Assessment.** To the best of our knowledge, there has not been any examination of the use of telemedicine in personality assessment. One reason for this may be challenges to using paper-and-pencil measures at remote sites, although adjunctive technologies such as web-based measures may assist with this in the future. There is no information about projective testing over VC, possibly because of the decreased use of such measures in traditional face-to-face practice.

**3. Neuropsychological Assessment.** Neuropsychological assessment is a subtype of psychological assessment. It is most commonly performed by asking patients to perform cognitively oriented tasks such as remembering a list of 20 words or counting backwards from 100 by 7s. Much of the research on remote neuropsychological assessment demonstrates feasibility<sup>77,78</sup>. Patients can understand the tasks they need to complete and then do so through video teleconferencing (VTC). Many studies also demonstrate comparability of scores between remote and face-to-face assessment<sup>79,80</sup>. However, some research also demonstrated differences on test scores<sup>81,82,83</sup>. Cognitive assessments examined and validated include the CAMCOG<sup>84</sup>, the MMSE<sup>85</sup>, The National Adult Reading Test, and the Adult Memory and Information Processing Battery<sup>86</sup>. One study

found that scores were comparable for expressive word knowledge tasks but varied widely for tests of visual-spatial processing.

It appears that VTC neuropsychological assessment is possible and often valid [B/C/D3]. However, it is recommended that research begin to develop new norms so that the thresholds used for impairment are valid when compared with face-to-face administration<sup>87</sup>. Until this is accomplished, remote neuropsychological assessment will be able to provide a broad indication of areas of impairment, but may lack the same degree of resolution that face-to-face assessment provides. In addition, specific cognitive tests, such as those testing visual-spatial processing, may need to be modified for VTC administration.

**f. Psychiatric Nurse Practitioner, Physician Assistant, and Psychiatric Nursing Specific.**

Psychiatric Nurse Practitioners are educated and prepared to provide the full complement of psychiatric services, including primary mental health care services<sup>88</sup>. It is quite reasonable to assume that psychiatric mental health nurses working in clinical areas, both rural and urban, could benefit from telehealth care. However, a review of literature shows few published randomized clinical trials (RCTs) seeking answers to innovative care provided through videoconferencing, telephone and other telehealth technologies<sup>89,90,91,92,93,94,95,96,97,98,99</sup>.

**g. Social Work/Counselor Specific.** The literature is limited regarding the use of interactive videoconferencing by social workers, although many articles may reference social workers in the broader term of therapists<sup>100</sup>. There are no clinical trials or research in the use of videoconferencing specifically by social workers. Often, rural sites have social workers providing therapy and working in concert with urban specialists, often psychiatrists, to provide treatment to their clients. Social workers, like other mental health providers, often have mixed levels of exposure, experience, perceptions, and attitudes about the use of telemedicine technologies, but realize the need to understand and participate in the use of such modalities for their client populations<sup>101,102</sup>.

Literature addressing substance abuse treatment by a telehealth addictions counselor was only represented by two original articles<sup>103,104</sup>, both of which demonstrated positive results. It is understood that many patients treated by telemental health for other mental disorders also have co-morbid substance abuse issues and illnesses. VTC cognitive assessments of persons with a history of alcohol use disorders were similar to face-to-face assessments; participants were satisfied with the videoconferencing examination<sup>105</sup>. More research data will be necessary to determine the risks and benefits of treating the substance abuse population before specific recommendations can be made.

**b. Ongoing Mental Health Care.**

**1. Psycho-Education.**

Providing psycho-education via video is a broad area. Grand rounds and case presentations to mental health and non-mental health providers has been a burgeoning area of educational benefit for years. This guideline will limit its focus to direct mental health teaching to patients<sup>106</sup>, education directly or indirectly to on-site providers as part of the clinical consultation<sup>107</sup>, and clinical supervision<sup>108,109,110</sup>. Teleconsultation to providers in rural practices is thought to help through specialist collegial support, bringing the latest information from academic centers and reducing the isolation of rural providers. Mental health knowledge and skills imparted to rural providers have been beneficial [B/C2,D3], with

some limitations<sup>111</sup>. While imparting knowledge via VTC consultation was mentioned in a number of papers, there have been little forthcoming data on actual mental health patient outcomes. Supervision and training of mental health physicians, therapist trainees, and physician assistants has been demonstrated to be beneficial<sup>112,113,114,115,116</sup>.

## **2. Individual Psychotherapies.**

As in the face-to-face setting, therapists using VTC come from a range of theoretical orientations and use a variety of psychotherapeutic strategies. Standard practice guidelines for therapy should guide psychotherapy services within the telemedicine setting. Guidelines concerning evidence-based practice and empirically supported treatments may be particularly relevant as therapies are adapted to new contexts such as VTC<sup>117,118,119,120</sup>. Even in the in-person environment, research into applications and outcomes of these psychotherapies is an ongoing challenge in today's evidence-based and often managed mental health care environment. There are several publications describing case reports and clinical trials of individual psychotherapy conducted via VTC. Supportive<sup>121</sup>, exposure<sup>122</sup>, cognitive behavioral<sup>123,124,125,126</sup>, and hypnosis<sup>127</sup> have all been reported. There were two case reports of Eye Movement Desensitization and Reprocessing therapy conducted via video<sup>128,129</sup>. Psychotherapy via VTC has included the treatment of bulimia nervosa, panic disorder, agoraphobia, obsessive compulsive disorder, depression, and post traumatic stress disorder, as well as ability to provide culturally sensitive expertise<sup>130,131,132,133,134,135,136</sup>. Therapist's adherence and competence in the practice of manualized cognitive behavioral therapy via VTC has proven effective<sup>137</sup>. Psychotherapy appears to be amenable to the VTC communication medium [B/C2,D3], with the majority of the individual psychotherapy VTC literature describing cognitive behavioral therapy applications [B/C2, D3]. There are no specific recommendations to exclude types of psychotherapy to be utilized via telemental health VTC. As previously mentioned, some mental disorders, e.g., eating and trauma disorders, may benefit in their treatment from the geographic and/or interpersonal distance patients/clients may experience while engaged in psychotherapy via VTC<sup>138,139</sup>. Future research will provide guidance on the best person-setting-therapist matches for the various VTC contexts.

## **3. Group Psychotherapies.**

Similar to individual psychotherapies, there are many different types and approaches to group psychotherapy in both inpatient and outpatient settings. Standard practice guidelines for group therapy should guide VTC services<sup>140,141,142,143</sup>. Multipoint videoconferencing offers the possibility to provide small numbers of patients in rural areas with the opportunity to attend outpatient groups that are more homogeneous and stable in nature. Witson mentioned in his earliest reports of video group therapy that the dynamics of the group depended more on the therapist and the makeup of the group than using VTC as the treatment medium<sup>144</sup>. Multipoint groups could be particularly advantageous for patients suffering trauma<sup>145</sup>, eating disorders, or other diagnoses or circumstances that are potentially isolating [B/C/D3]. While this may be a very powerful tool, there is limited published literature regarding videoconferencing group therapy. There were two clinical trials comparing videoconferencing to in-person group therapy for veterans with PTSD. One study involved a coping skills group<sup>146</sup> and the other a cognitive behavioral therapy group<sup>147</sup>. Satisfaction between group participants, level of retention of information, and attendance were similar. Future research will provide guidance about the best group therapy applications within the VTC context.

#### **4. Marital and Family Psychotherapy.**

Marital and family therapies could be considered specialized types of group therapy because sessions involve the interaction of two or more clients with a therapist(s). Like group therapy, the more members involved, the greater the likelihood that all members may not be physically co-located. Standard practice guidelines for marital and family therapy should be consistent with applications in the VTC context<sup>148</sup>. While there were no published research trials of family therapy conducted via VTC, there were a few articles describing unique applications, benefits, and limitations utilizing videoconferencing technologies. There is evidence that the use of TMH family therapy with inpatients may be particularly beneficial for the patient and may reduce the length of stay<sup>149</sup>. It was suggested that some patients may feel safer expressing themselves in session when communicating with family members via video<sup>150</sup>, while other families/members may experience extended family sessions as not “real”<sup>151</sup>. Two articles pointed out that the transmission delay they experienced was helpful to the therapy process as it made clear when family members talked over one another and were not demonstrating adequate listening skills<sup>152,153</sup>. Telemental health family therapy via a satellite connection proved helpful to this family in resolving their deeply held conflicts<sup>154</sup>. While there are limited data regarding family therapy via videoconferencing, early reports indicate excellent acceptance and primarily beneficial outcomes [B/C3].

There also are reports of medical teams using videoconferencing to communicate with the families of children recovering from or dealing with severe medical illness<sup>155,156,157,158</sup>. These sessions did not involve mental health therapists, but were mental health as well as somatic in nature. There also are reports of the benefit and support nursing home residents experienced through videoconferencing with their families<sup>159</sup>.

#### **c. Populations of Special Focus.**

##### **1. Geriatrics.**

The elderly population may benefit significantly from improved access to specialty mental health care that can be provided via videoconferencing<sup>160,161</sup>. Many elderly individuals have multiple health problems in addition to mental health problems; the medical problems may complicate or even precipitate mental health problems. Thus, the elderly often are high users of health services and often present complex issues.

For any elderly individual, accessing necessary care can present many challenges, from the frequency of visits for needed care to transportation for such care. For the rural geriatric patient, the challenges are greatly increased. The frequency of need for and the cost of transportation to the nearest urban area, which may be quite distant, can be prohibitive, even if the individual is insured for the actual care. For many, the cost and complexity of planning and locating such care in busy, traffic-intense urban centers are overwhelming. Many simply do without.

The trend toward accessing basic care in the home setting via simple videoconferences over video phones or computers is a welcome tool for increasing accessibility, especially for those who have mobility limitations or transportation limitations. Connecting local hospitals, health care clinics, nursing homes, and mental health facilities to remote specialists via high quality, secure videoconference connections is a technology that is now available and the number of such partnerships is increasing.

However, the literature on geriatric telemental health is quite sparse. There have been relatively few controlled studies of outcomes in the geriatric population<sup>162,163</sup>. There have been case studies and opinion essays<sup>164,165</sup> while some literature involves psychometric instruments<sup>166</sup>, usually involving patients in long-term care facilities. There is some limited evidence-based support for the provision of psychiatric services to geriatric patients in nursing facilities [B/C/D3].

The concept of increasing accessibility of care via videoconferencing seems obvious and appealing. Further study must be done to provide reliable evidence. Such studies must also specifically address the challenges the elderly face in dealing with videoconferencing. Sensory deficits, especially visual and auditory, can impair their ability to successfully interact over a videoconference connection<sup>167</sup>. The patient end must have large monitors, good audio capabilities, and high bandwidth and video resolution to make sure there is a large and clear picture connecting the elderly patient/client to the care giver.

Another challenge for this age group is the prevalence of dementia, with deficits in cognitive capability and often accompanied by psychiatric symptoms such as depression and delusions. The elderly are the least likely to be familiar with new technology and, with dementia as an added factor, it can theoretically be a challenge to assure that the interaction with the service provider is understood to be real rather than just a figure on a television or a hallucinatory experience. An additional issue is that any videoconferencing approach must include all appropriate aspects of a full diagnostic evaluation. One article developed a protocol for diagnosing Alzheimer's disease utilizing videoconferencing<sup>168</sup>. The geriatric patient often has multiple medical problems, many of which affect their cognitive/behavioral state, and thus deserves a full workup, including all appropriate laboratories, radiologic, and other diagnostic procedures.

## **2. Children and Adolescents.**

Recommendations for child and adolescent telemental health (CATMH) build on information and recommendations presented above for telemental health (TMH) with adults. Throughout this document the term “parents” refers to the youth’s primary caretakers, regardless of whether they are biological parents, adoptive parents, or legal guardians. The terms “youth” and “young people” refer to mixed samples of children and adolescents. When specific developmental groups are intended, the terms “toddlers,” “preschoolers,” “children,” and “adolescents” are used. The guidelines are applicable to the evaluation and treatment of youth from preschool to 18 years old and developmentally impaired young adults up to 21 years old with emotional and behavioral difficulties.

CATMH programs have been successfully implemented in multiple diverse settings such as pediatric clinics<sup>169</sup>, community mental health centers<sup>170</sup>, rural schools<sup>171,172</sup> urban daycare<sup>173</sup>, corrections<sup>174</sup>, and private practice<sup>175</sup>. CATMH is applicable with youth of minority ethnicity, such as African-American<sup>176</sup>, Hispanic<sup>177</sup>, Hawaiian<sup>178</sup>, Native American,<sup>179,180</sup> and Alaska Native<sup>181</sup> youth.

- a. Evaluations.** VTC procedures for the evaluation and treatment of youth follow the same guidelines presented for adult with modifications to consider the developmental status of youth, such as motor functioning, speech and language capabilities, and relatedness. The following recommendations are in addition to the evidence listed for adults.

## 1. Setting.

**a. Physical Surroundings and Staffing.** Families should be informed during scheduling to prepare their children for a VTC appointment. The room is positioned and remote camera control is available so the practitioner is able to view and adequately observe children's motor skills as they move about the room, play, and separate from their parents<sup>182,183</sup>. A table may provide a surface for the child to draw or play while the parent relates the history, but it should not interfere with communication or viewing the youth's motor skills. Some simple toys should be provided both to occupy the child and to allow assessment of skills.

**b. Outpatient.** The literature on CATMH is sparse. Published work has predominantly described care in outpatient settings<sup>184,185,186,187,188</sup>. Most of these studies have measured parent and provider satisfaction<sup>189,190,191,192</sup> and have found that parents and providers are very satisfied with CATMH care. Although satisfaction does not equate to efficacy, it does imply acceptability and informs directions for future work<sup>193</sup>. Other reports have described successes and challenges of program implementation<sup>194,195,196,197</sup>. One recent study described improvements in children's affective states and oppositional behaviors after CATMH<sup>198</sup>.

No absolute inclusion or exclusion criteria for CATMH have been established. Applications of CATMH have been described across most developmental groups and diagnostic categories [B/C1]. School-aged children comprise the modal treatment group, similar to usual outpatient care<sup>199,200,201,202,203,204,205</sup> but children as young as 3 years old have been evaluated and treated<sup>206,207,208</sup>. Thus, diagnosis is not a determining factor in deciding to treat a youth through CATMH. Rather, it is providing a system of care in the patient's community that matches the services the telepsychiatrist will deliver and resources at the patient site to help manage challenging youth that best determines inclusion or exclusion for CATMH. Their care and the clinical procedures used in CATMH should follow the practice parameters developed by the American Academy of Child and Adolescent Psychiatry.

**c. Inpatient.** There are no reports of CATMH in inpatient settings, nor any indication as to whether any work is being done in this area. However, CATMH may be helpful to inpatient settings needing child and adolescent psychiatric consultation [B/C/D3]. Such units may be predominantly staffed by pediatricians or family physicians who then receive teleconsultation from a psychiatrist.

**d. Other Settings.** One advantage of CATMH is the ability to readily reach youth in rural naturalistic settings such as schools<sup>209,210</sup> or in distant residential sites such as corrections<sup>211</sup>, and long term treatment centers<sup>212,213</sup>. VTC-mediated meetings can be especially helpful in bringing together youth at the residential setting with family and professionals in the youth's home community for treatment planning<sup>214</sup> [B/C2, D3]. One caveat is that adolescents in correctional settings may not be forthcoming if accompanied to the CATMH session by correctional staff. When afforded appropriate privacy and time alone with the telepsychiatrist, incarcerated youth express high satisfaction with their telepsychiatric care<sup>215</sup> [B/C2].

## 2. Diagnostic Interview.

**a. Provider-Patient Relationship.** The teletherapist must establish a therapeutic alliance not just with the youth, but also with the parent and other participating adults, and must work within the parent-child relationship. Satisfaction data indicate that parents readily establish rapport with their teletherapist<sup>216,217,218</sup>, thereby suggesting that VTC does not interfere with the therapeutic alliance [B/C2, D3].

Emerging information from work with adults suggests that a more casual clinical style optimize rapport<sup>219,220,221</sup> and this is likely true for youth as well [B/C2]. When working with youth with cognitive limitations<sup>222,223</sup> or with youth of different cultural backgrounds, a more casual style could be problematic and the technological limitations might make it difficult to distinguish clinically relevant issues. Thus, it is important to adjust communication to patients' needs [B/C2].

Because youth are evolving their interpersonal sensitivities and skills, but do not have access to the usual nuances of interpersonal relatedness, the teletherapist must devise ways to engage youth. Rapport-building can be facilitated by showing the youth how to use the remote control to obtain a close-up of the teletherapist or scan the teletherapist's room to make it appear more real or to demonstrate the picture-in-picture box in the corner of the monitor to obtain a close-up view of himself/herself or his/her parents<sup>224,225,226,227</sup>.

**b. Assessment and Diagnosis.** It seems intuitive that higher bandwidth should provide the most accurate clinical assessment, but there are no data to support this assumption. Bandwidth and resolution must be sufficient to detect subtle aspects of the mental status examination, such as tics, dysmorphia, or abnormalities in relatedness [B/C2].

Recent encouraging results suggest that diagnoses made in CATMH are reliable and valid<sup>228,229</sup>. The accuracy and relevance of assessment conducted through VTC is further supported by the success of functional behavioral analysis of developmentally impaired young children in leading to effective classroom interventions<sup>230</sup>.

The American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters for the Psychiatric Assessment of Children and Adolescents<sup>231</sup> recommends that some time is spent interviewing the youth alone. In general, teens and older children with good impulse control, adequate verbal skills, and the ability to separate are amenable to interview alone [B/C2, D3]. Younger, developmentally impaired, or impulsive youth need a modified approach, likely including an adult in the room, e.g., a staff member at the clinic [B/C2]. Such decisions should be individualized to the youth.

The recommendation for a traditional play session with younger children<sup>232</sup> may be challenging. One approach includes observing the child interacting with a staff member in either a free-form or structured play session. Some limited direct play with the child may be possible over the telemonitor. For example, while parents provide history, children often enjoy drawing pictures and sharing them with the teletherapist. The teletherapist also may receive the picture electronically, via fax or a document reader. Another possibility, although not yet explored, is that the child might draw on an electronic tablet that could be immediately transmitted via VTC.

The teletherapist can then build on the child's actions by exploring the themes present in the pictures. Similarly, the teletherapist can develop a play scenario or story together with the child, or use puppets to facilitate play over the telemonitor. Sometimes the therapist may work with on-site personnel or parents to facilitate these interactions. Some time in a play session should be incorporated into the assessment and the treatment as indicated and tolerated [B/C3].

CATMH has been reported with preschoolers as young as 2.5 to 3 years old<sup>233,234,235,236</sup>. The AACAP Practice Parameter for the Psychiatric Assessment of Infants and Toddlers<sup>237</sup> recommends multidisciplinary sources of information regarding the child's functioning in multiple settings. The parameter recommends direct observation of the child during his/her interactions with parents and preferably with an unfamiliar adult. Another recommendation is that the psychiatrist has direct interaction with the child. This interaction can be accomplished while the child remains in a room with a parent and/or a staff person [B/C2]. Some preschoolers can be directly engaged over the monitor, e.g., by asking them to point to body parts, to demonstrate skills such as counting, or to talk about his/her pets. However, it is helpful to have an adult present with the child to provide input regarding a very young child's level of attunement, pleasure in the interaction, or spontaneity in play.

**c. Disposition and Continuity of Care.** The needs assessment conducted prior to the establishment of a CATMH practice identifies collaborating clinicians and system-of-care so that the teletherapist will have a clearly defined role within the youth's treatment and know whose assistance to elicit as need arises<sup>238</sup>. The community should have the resources to follow up recommendations by the telepsychiatrist<sup>239</sup>. Ongoing treatment of unstable youth may only be possible in a community with a comprehensive system of care that can provide appropriate wraparound services<sup>240</sup>.

## **b. Treatment.**

**1. Medication Management.** Expert pharmacotherapy is the most frequently requested CATMH service<sup>241,242</sup>. Various methods have been employed to provide medication management, including: a) the telepsychiatrist consults to the referring primary care physician (PCP) who prescribes; b) the telepsychiatrist works with a mid-level professional at the patient site who writes the prescriptions; and c) the telepsychiatrist directly prescribes. In this last scenario, clear procedures are established and communicated to all parties regarding the method for obtaining initial prescriptions and refills and reporting adverse effects. CATMH sites located in non-medical or non-mental health sites, such as schools or shelters, may not be able to provide medication service and/or will need considerable modifications to usual practice, particularly for controlled substances such as stimulants.

**2. Psychotherapy.** Standard of practice guidelines should be followed in psychotherapy evaluation and treatment with children<sup>243,244</sup>. As described with telepsychiatry, standard of care consultation with the child's primary care provider or the child's medical home is encouraged when possible. Ongoing psychotherapy requires time alone with the youth. How to accomplish ongoing individual therapy in CATMH has not been systematically studied, but individual case reports of therapy with youth have been described<sup>245,246,247,248,249</sup>. The only therapy outcome study<sup>250</sup> showed comparable improvements with cognitive behavioral therapy supporting a role for CATMH in

psychotherapy with youth [B/C2]. A telepsychiatry counseling service to juvenile detention facilities suggested an improved rate of family and behavioral goals attainment<sup>251</sup>. In general, teletherapists may attempt to engage in therapy adolescents and older children with good verbal skills who are not aggressive, severely oppositional, or otherwise dysregulated [B/C2].

### **3. Seclusion and Restraint.**

Reduction in the use of seclusion and restraint has been a priority of providers, facilities, and the Substance Abuse and Mental Health Services Administration. One clinical trial looked at the use of videoconferencing in place of in-person assessment following restraint and seclusion of pediatric patients at a private hospital<sup>252</sup>. Remote assessment was felt to be rapid and reliable.

### **4. Emergency Assessments.**

Emergency evaluation of patients with mental health disorders may be an area of particular value to emergency departments, especially in remote geographic locations. Emergency evaluations are defined as evaluations that require assessment of patients where there are questions of imminent risk of harm to self or others or where acute psychosis is present. Useful VTC software features such as remote unit startups, auto answering, and camera power controls should be included when selecting a VTC unit for emergency assessment. Psychiatrists are often contacted by phone to consult on patients in the emergency room who have been seen by the emergency room physician, mental health professional, or paraprofessional and disposition is in question. The psychiatrist also may consult in person the following day when patients thought to need admission by the emergency room providers are still in the emergency room due to lack of inpatient beds. Consultation by psychiatrists via interactive video may provide the expertise to determine disposition, e.g., outpatient or day hospital treatment, more quickly and reduce the length of emergency room stays for patients with mental health issues. When patients are located in remote areas this also may eliminate the need to transfer patients to regional or urban hospital centers, disrupting their lives even more. There are a few papers discussing emergency telepsychiatry. Two papers describe outcomes for patients who received emergency telepsychiatric evaluations and remained as outpatients<sup>253,254</sup>. There also are descriptions of performing emergency evaluations or secondary opinions on patients already admitted<sup>255,256,257</sup>, providing medical clearance in the emergency room for psychiatric patients<sup>258</sup>, and a set of emergency management guidelines<sup>259</sup>. Special attention should be given to determining how assessment and disposition by videoconferencing can safely meet the needs of suicidal and aggressive patients<sup>260</sup>.

### **5. Involuntary Commitments.**

Commitments involve both clinical and legal issues. Patients thought to be in imminent danger of harming themselves or others are assessed by providers according to State regulations and can be involuntarily admitted to a medical facility. These acute admissions are time-limited so that a legal hearing can be coordinated and a judge will render a decision whether to continue the involuntary admission or release the patient. Often legal hearings are avoided when patients change their decision and sign a voluntary admission request. While it is believed that involuntary commitments and legal hearings are being done in the United States via videoconferencing, little is mentioned in the literature. There is a case report of using videoconferencing to complete a psychiatric assessment under the mental health act in Australia for involuntary admission and use of depot antipsychotic medication<sup>261</sup>. Using VTC to interview

patients for this combined clinical/legal proceeding would depend on local laws and the local administrative law judge.

## **6. Incarcerated.**

Telemental health, like other applications of telemedicine, has been one of the earliest routine applications of telehealth. The main driving force behind this is access, especially of the pre-trial populations detained in the nation's jails. Jails typically have high suicide rates due to their role in acute incarceration, risks of substance withdrawal, and social consequences. Additionally, on-site mental health care is usually only available at the larger jail complexes. Getting the patient transported to an appropriate provider is encumbered by costs, staffing levels, and safety concerns. Monies saved in escort costs are used to purchase VTC equipment, pay for administrative coordination, and provide on-site nursing or ancillary clinical staff attendance at videoconferencing appointments. Telepsychiatry treatment has been provided to both jails<sup>262,263,264</sup> and prisons<sup>265</sup>. There has been limited discussion regarding the use of forensic telepsychiatry<sup>266</sup>. Two studies investigated the use of VTC for forensic evaluations; the resultant inter-rater reliabilities were good to excellent<sup>267,268</sup>. Several studies have proven acceptability<sup>269</sup> and limited clinical evidence of effectiveness with the incarcerated population [B2,C/D3]. Because detained persons are a vulnerable population, teleproviders should be confident that incarcerated patients are referred for videoconferencing evaluation appropriately rather than solely to avoid costs.

## **6. SUMMARY**

This document was prepared in response to the needs and requests of providers, organizations and the ATA membership interested in or engaged in telemental health activities, for the development of evidence based telemental health guidelines. The broad nature of the mental health field along with an unlimited number of ways to use technology in mental health services led the committee to limit this evidence based document to interactive video conferencing applications. Appreciating the broad range of providers and settings involved in TMH, recommendations are organized by patient age, types of treatment, treatment setting and provider specialty. The coding system was developed to encourage more specific descriptions of the technology being used in TMH interactive videoconferencing research and methods publication. It provides recommendations based on clinical confidence derived from the published literature, committee members and expert reviewers. The committee hopes the users of this document will benefit from the recommendations, literature references, and the development of a clinical/technical coding system. The document structure and headings were selected in anticipation that users will note the clinical applications that are in most need of additional evidence based research and perhaps select these areas as a focus of future research.

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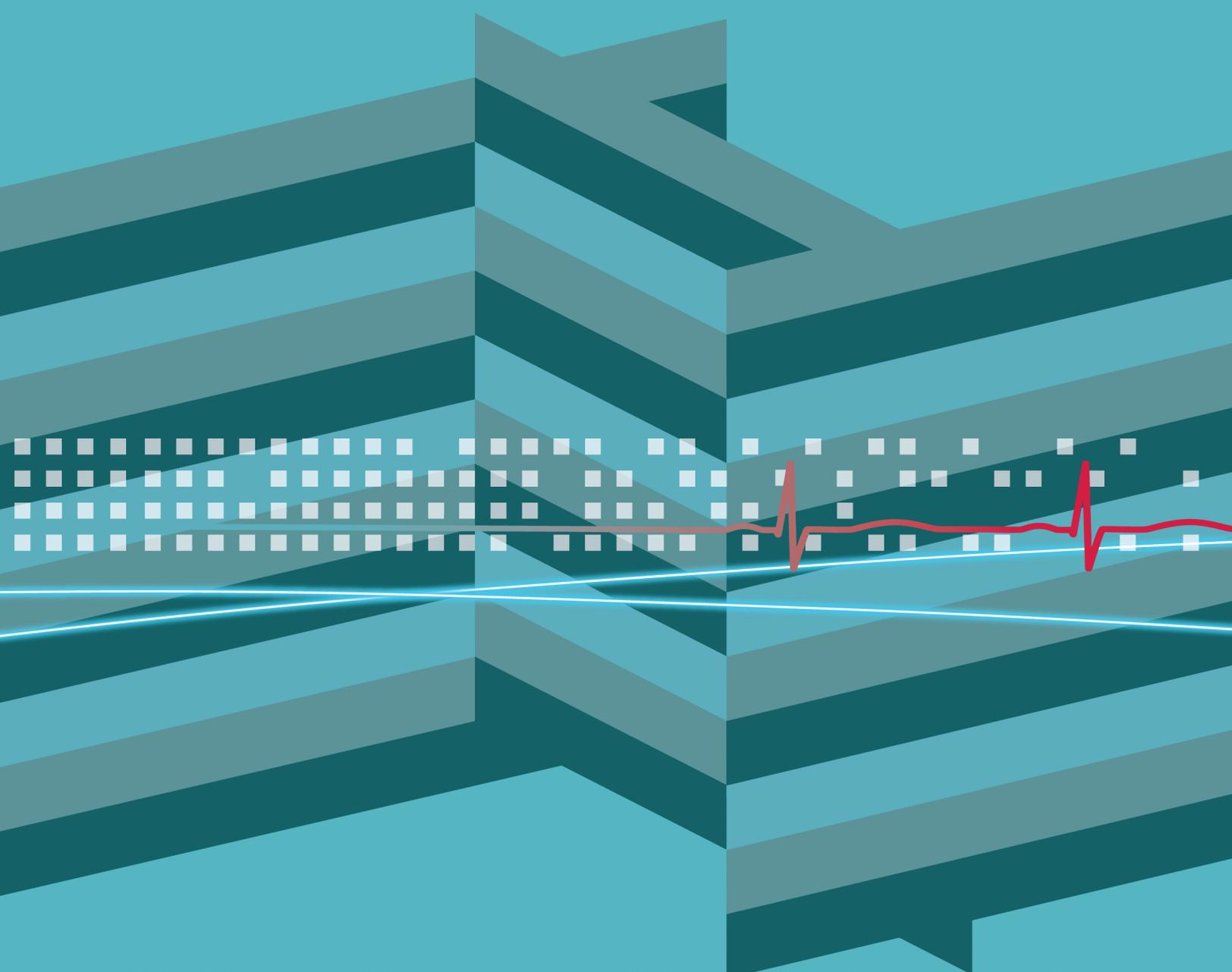
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Expert Consensus Recommendations for  
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**VIDEOCONFERENCING-BASED TELEPRESENTING EXPERT CONSENSUS  
RECOMMENDATIONS**

**TABLE OF CONTENTS**

1. PREAMBLE.....	4
2. INTRODUCTION.....	5
3. VIDEOCONFERENCING-BASED TELEPRESENTING PRACTICE RECOMMENDATIONS	
a. Administrative Core Standard.....	6
1. Scheduling	
2. Preparation	
3. Quality and Safety	
b. Technical Core Standard.....	7
1. Preparation and Operations	
2. Maintenance	
c. Clinical Core Standard.....	7
1. Preparation of Environment	
2. Patient Preparation and Support	
3. Follow-up	
APPENDIX A: References .....	9

## 1. PREAMBLE

The American Telemedicine Association (ATA), with members from throughout the United States and throughout the world, is the principal organization bringing together telemedicine practitioners, healthcare institutions, vendors and others involved in providing remote healthcare using telecommunications. ATA is a nonprofit organization that seeks to bring together diverse groups from traditional medicine, academia, technology and telecommunications companies, e-health, allied professional and nursing associations, medical societies, government and others to overcome barriers to the advancement of telemedicine through the professional, ethical and equitable improvement in health care delivery.

ATA has embarked on an effort to establish practice guidelines and technical standards for telemedicine to help advance the science and to assure the uniform quality of service to patients. They are developed by panels that include experts from the field and other strategic stakeholders and designed to serve as both an operational reference and an educational tool to aid in providing appropriate care for patients. The guidelines and standards generated by ATA undergo a thorough consensus and rigorous review, with final approval by the ATA Board of Directors. Existing products are reviewed and updated periodically.

The practice of medicine is an integration of both the science and art of preventing, diagnosing, and treating diseases. Accordingly, it should be recognized that compliance with these guidelines will not guarantee accurate diagnoses or successful outcomes. The purpose of these standards, guidelines, and practice recommendations is to assist practitioners in pursuing a sound course of action to provide effective and safe medical care that is founded on current information, available resources, and patient needs. The practice guidelines and technical standards recognize that safe and effective practices require specific training, skills, and techniques, as described in each document. The resulting products are properties of ATA and any reproduction or modification of the published practice guideline and technical standards must receive prior approval by ATA.

If circumstances warrant, a practitioner may responsibly pursue a course of action different from the guidelines when, in the reasonable judgment of the practitioner, such action is indicated by the condition of the patient, restrictions or limits on available resources, or advances in information or technology subsequent to publication of the guidelines. Nonetheless, a practitioner who uses an approach that is significantly different from these guidelines is strongly advised to provide documentation, in the patient record, that is adequate to explain the approach pursued.

This expert opinion consensus document focuses on interactive videoconferencing-based telepresenting. The purpose of this document is to inform and assist individuals and organizations in providing effective and safe telepresenting services.

## 2. INTRODUCTION

Traditional delivery of health care involves patient and provider communication and interaction in a real time, in-person encounter. At this encounter the provider obtains the history of the chief complaint, performs a physical assessment, and obtains any needed diagnostic testing. From the information collected, the plan of care is formed.

New challenges and opportunities for the provider have been created by the expansion of communication technologies and new health care delivery models, as a means to enhance delivery of health care. The use of telemedicine/telehealth has extended the reach of the provider, but also may create situations in which assistance is needed in facilitating clinical data transfer from the remote patient setting. A telepresenter (presenter) is frequently used, although not always required, to address the challenges that the consulting provider faces when conducting a physical examination using telemedicine and to ensure efficient information exchange. The presenter is an individual, located at the patient remote site that provides support to the patient and the telemedicine consulting provider, in completing the physical examination and/or telemedicine activity.

The role of presenter will continue to evolve as telemedicine and technology advance, however, presenters are frequently employed to assist with real-time, interactive videoconferencing based consultations between a health care provider and a patient. Presenters may include licensed professionals, parents, spouses, or allied health professionals, depending upon resources within the community and the expertise required to achieve an adequate portrayal of the patient's mental and physical condition. Requirements for a presenter vary widely, based upon the specific patient care settings, the clinical specialty, and expertise of the telemedicine providers. The most qualified telepresenter may in reality, be a lay individual in a community trained in the use of telemedicine technology and who is able to assist the patient. In addition, the evaluating provider must be skilled in leveraging the telemedicine resources to guide the remote assessment and obtain necessary information for determining diagnoses, treatments, and/or care directives.

This expert opinion consensus document focuses on interactive videoconferencing-based telepresenting for health care professionals who are competent in skills and knowledge required to assist the remote provider, and serves as a guide for health professionals engaging lay presenters, such as family members. The purpose of this document is to define the requirements for serving as a telepresenter, as well as identifying key points to be considered throughout the process of telepresenting. The document is divided into administrative, technical, and clinical domains.

Telemedicine has transformed the delivery of healthcare, yet, successful use of technology is dependent upon efficient information exchange. It is the presenter who supports communication and physical requirements of both the patient and evaluating provider throughout the tele-encounter process.

### **3. VIDEOCONFERENCING-BASED TELEPRESENTING PRACTICE RECOMMENDATIONS**

#### **a. Administrative Core Standards**

Specific administrative procedures and policies of an organization will govern the activities of a presenter. At a minimum, any person functioning in the presenter role *shall* be aware of all organizational policies and procedures that govern clinical practice and how said policies and procedures apply.

##### **1. Scheduling**

The presenter *shall*:

- be knowledgeable of scheduling procedures and policies for his/her organization
- identify and schedule resources required for a successful tele-encounter, including local personnel, local facility space, remote provider, remote evaluating provider, remote evaluating provider's facility, equipment, conductivity, and/or any combination thereof
- ensure that the evaluating provider who attends the virtual consultation is the scheduled, legitimate provider for the patient and is credentialed to provide the services being offered

##### **2. Preparation**

The presenter *shall*:

- identify the evaluating provider's clinical goals for the encounter, including reviewing requested pre-consultation forms and testing
- establish and follow a procedure for contacting patients prior to the consultation to remind them of the appointment, give directions, and provide patient education
- establish a back-up plan and be prepared to enact it if there are technical problems
- develop and implement patient protocols with the remote provider to ensure that information is available at the beginning of the encounter

##### **3. Quality and Safety**

The presenter *shall*:

- obtain a telemedicine consent form, if required
- understand and adhere to HIPAA regulations
- understand and adhere to state and federal regulations related to telepresenting and transfer of patient information electronically
- understand and adhere to accrediting organization's standards for interactive tele-encounters
- evaluate and articulate outcomes and make suggestions for improving future tele-encounters
- evaluate the quality of data transmission and interactions during the tele-encounter to support and optimize the remote provider's capacity to examine, diagnose and develop an appropriate plans of care

## **b. Technical Core Standards**

Technical knowledge and support of the tele-encounter by the presenter are essential. At a minimum, any person functioning in the presenter role shall ensure that all aspects of technical performance are considered, including issues of patient safety and confidentiality.

### **1. Preparation and Operations**

The presenter *shall*:

- ensure that all equipment has been tested and checked to be in safe working order
- establish connection with the remote provider with sufficient time to troubleshoot any technical issues that may impact the encounter
- ensure that the provider and patient can see and hear each other clearly
- control any extraneous noises (e.g., fan, telephone, etc.) near the microphone
- provide accommodations for appropriate lighting, including back lighting (e.g., windows, lights, etc.)
- follow connection procedures to initiate and maintain the tele-encounter
- maintain a list of contact information for key personnel at the remote connecting end, including technical support

### **2. Maintenance**

The presenter *shall*:

- ensure that a service and maintenance plan for all equipment used to support the encounter is established
- perform routine system tests to ensure that equipment is in safe and working order
- document and maintain a log of all technical problems or issues
- follow up with technical support immediately following encounter, if any problems occur

## **c. Clinical Core Standards**

Clinical aspects of the presenter role are both generalizable and specific to the type of service being provided to the patient. The presenter acts as a patient advocate to optimize the exchange of clinical information between the provider and patient.

### **1. Preparation of environment**

The presenter *shall*:

- provide the evaluating provider with any available and necessary information regarding the patient (e.g., history and physical, radiographs, lab work, etc.), prior to the tele-encounter
- have contingency plans in place for loss of connectivity and be prepared to implement these plans
- confirm that all necessary equipment (including peripheral devices and supplies for the tele-encounter) are accessible in the exam room
- remove personal identifiable health information from the area of the encounter that is not specific to the patient
- assess and implement an appropriate plan for cultural, language, and/or disability issues

## **2. Patient preparation and support**

The presenter *shall*:

- always be a patient advocate
- educate the patient/family as to what to expect during a tele-encounter, including the potential for an audio-video delay
- be knowledgeable and competent in health care needs being addressed
- provide opportunities for questions and answers
- be knowledgeable about how to turn on video equipment, initiate a call, and resources available for obtaining technical assistance
- identify microphone and camera locations to the patient
- anticipate exam requirements, including appropriately positioning and preparing of the patient for physical examination (e.g., gowning or uncovering body areas)
- adhere to universal precautions
- ensure that the patient is aware of and introduced to all individuals in their room the remote evaluating provider's location
- be alert and sensitive to nonverbal body language
- provide any needed support for the patient/family
- ensure the patient/family is comfortable with the tele-encounter and is aware of their right and ability to terminate a tele-encounter at any time

## **3. Follow-up**

The presenter *shall*:

- review any instructions or information conveyed during the tele-encounter by the remote evaluating provider after the session has concluded, as appropriate, based on the presenter's level of professional practice
- provide patient/family with the evaluating provider's contact information, if needed for follow-up
- encourage the patient/family to complete any evaluation forms after the tele-encounter
- schedule follow-up appointments, treatments, etc., as ordered
- provide the primary care physicians and/or other appropriate individuals involved in the patient's care coordination with necessary documentation from tele-encounter and as requested by the patient

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# Practice Guidelines for Live, On Demand Primary and Urgent Care

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# Practice Guidelines for Live, On Demand Primary and Urgent Care

## Table of Contents

Preamble.....	5
Scope.....	6
Introduction.....	6
Guidelines	
Practice Guidelines.....	8
Technical Guidelines.....	15
Administrative Guidelines.....	17
Appendix: References.....	20

## **PREAMBLE**

The American Telemedicine Association (ATA) is a membership-based organization composed of a diverse set of members including healthcare providers, academicians, program administrators, industry, and policymakers. ATA collaborates actively with related health professional organizations, as well as the public and private sectors in promoting the safe and effective use of telemedicine to promote the health and wellbeing of people.

ATA has embarked on a mission to establish practice guidelines in many areas of telemedicine practice to promote patient safety, uniformity and quality of services provided via telemedicine. The guidelines were developed by panels of experts in this field and are designed to assist providers of care in adhering to ethical standards and sound business practices. They are intended to serve as guides for patients and their caregivers in assuring their rights and protecting their health.

The development of these guidelines entailed a rigorous process of peer review and analysis to ensure their appropriateness, relevancy, consistency, and comprehensiveness. They were enacted after full review and approval by the Board of Directors. In view of changing circumstances and developments, these guidelines are reviewed periodically and updated as indicated.

Compliance with these guidelines alone will not guarantee accurate diagnoses or successful outcomes. The practitioner should rely on their best professional experience and expertise when faced with unexpected circumstances or new developments in technology. When this occurs, the practitioner is strongly advised to document their rationale in the patient record.

The framers of these guidelines do not purport to establish legal standards for telemedicine services but focus on the quality, safety and effectiveness of telemedicine encounters.

## SCOPE

These guidelines cover the provision of patient-initiated primary and urgent care services by licensed healthcare providers using real-time, interactive technologies, including mobile devices. Healthcare providers include individual practitioners, group and specialty practices, hospitals and healthcare systems, triage or call centers, and other licensed providers of telemedicine services. They do not address communications between healthcare professionals and patients via short message service, email, social network sites, or online “coaching”, or the use of telemedicine for primary care when facilitated by a provider connecting to another provider.

The guidelines address three aspects of service delivery: clinical, technical and administrative. Under each set, the guidelines are classified into three levels of adherence: “**Shall**” indicates required action whenever feasible and/or practical. “**Shall not**” indicates a proscription or action that is strongly advised against. “**Should**” indicates a recommended action without excluding others. “**May**” indicates pertinent actions that may be considered to optimize the telemedicine encounter. These indications are found in bold throughout the document.

ATA urges health professionals using telemedicine in their practices to familiarize themselves with these guidelines, and other position statements or standards from their professional organizations and societies and incorporate them into telemedicine practice. They pertain to the United States (US) when both patient and provider are within the US. Others may use them at their discretion.

## INTRODUCTION

Telemedicine enables providers to extend their reach, and improve their efficiency and effectiveness while still maintaining high quality care and attention to patient safety. These guidelines pertain to telemedicine in primary and urgent care encounters initiated by patients. As with the practice of medicine in general, users must adhere to strict ethical and professional standards to assure quality of care and patient safety. ATA has developed a series of guidelines including Core Guidelines for Telemedicine Operations (8). However, this guideline focuses on the use of telemedicine services to connect providers and patients in the delivery of primary and urgent care.

The development of these guidelines followed a rigorous process of evidence review and expert assessment of more than 600 studies regarding the practice of telemedicine in primary and urgent care. Several studies within and outside the US have demonstrated the safety, efficacy, and quality of telemedicine in primary and urgent medical care for uncomplicated conditions. (3, 12, 14, 15, 27) These studies report outcomes often on par with in-person encounters, high patient satisfaction and reduced costs of care depending on the attributes of the intervention and the metrics studied. (1, 4, 10, 12-15, 17, 18, 40-49)

Practitioners must be mindful of all relevant statutes and regulations when choosing to provide care to patients via telemedicine, and in particular when considering prescribing medications.

## Telemedicine in the Practice of Primary and Urgent Care

For purposes of this document, primary and urgent care is defined as the delivery of basic non-specialty care outside a hospital emergency department when a patient is deemed in need of immediate medical attention. This type of care is typically unscheduled and episodic, and is not always provided by the patient's regular primary care provider. Primary care typically implies a longer-term relationship between patient and provider, wherein the provider is usually familiar with the patient's health history.

Both acute and chronic conditions may present with symptoms that range from mild to severe. Examples of acute medical conditions that may be managed effectively by video-based telemedicine and as appropriate other interactive technologies supported by peripheral devices and ancillary tests necessary to establish a diagnosis, include uncomplicated cases of allergy/asthma, chronic bronchitis, conjunctivitis, genitourinary conditions, low back pain, otitis media, rashes, and upper respiratory infections. (10, 12, 13, 15, 27, 34) Chronic medical conditions addressed by telemedicine within primary care practices may include mental illness and behavioral health, chronic obstructive pulmonary disease, congestive heart failure, diabetes, and hypertension. (4, 11, 17-21, 23, 26, 28) The virtual medium is also an appropriate tool for consultations regarding prevention and wellness services such as immunizations, smoking cessation, diet and physical activity.

Prescribing is generally accepted (given local and federal regulations) within the context of real-time videoconferencing sessions when information can be provided that approximates the in-person exam. Prescribing is also generally accepted based on telephone-only consultations with a patient where there is a prior relationship by the provider or with providers offering weekend coverage with access to the patient's medical record. 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. One recent study, conducted in a health system outside of the United States (Denmark) concluded that prescriptions made during telephone consultations conducted under that system were feasible and that practitioners who had access to the patient's medical record were conservative in the encounters, being less likely to offer prescriptions when cases are severe or involve children (30), with no differences in prescription rates between contacts due to new episodes and exacerbation of chronic disease. Antibiotics, analgesics and medications for the respiratory system are the most commonly prescribed drugs. (30) Other published data, however, have demonstrated higher rates of prescribing for patients with complaints of urinary tract symptoms evaluated and treated via non video-based visits without laboratory testing. (26) For isolated patients with no other means to access a provider, an audio-based consult may be the only alternative. The prudent practitioner should be aware of and follow all relevant statutes and regulations regarding the modality of technology used when choosing to provide care to patients via telemedicine, and in particular when considering prescribing medications.

Despite some overlap between acute and chronic diseases, there are several common attributes of primary/urgent care in traditional, in person practice and video-based telemedicine, including timely service, a trust relationship and opportunity for follow-up. These are identified in the primary care medical home model. (20, 22, 24) The Agency for Healthcare Research and Quality (AHRQ) defines the medical home not simply as a location but as an organization that delivers the core functions of primary healthcare. (2)

## PRACTICE GUIDELINES

Many conditions lend themselves to a virtual visit as defined in this document. Currently there is a growing body of evidence regarding the effectiveness of video and audio-based interventions for a variety of acute and chronic conditions seen in primary care, such as diabetes, asthma, heart failure and hypertension. (4, 10-13, 15, 17-21, 23, 24-29, 31, 33) Typically these include conditions for which there is a reasonable level of certainty in establishing a diagnosis and generating a treatment plan, especially when visual information coupled with access to a medical record with diagnostic studies and imaging is available. (15, 26, 29)

In general, conditions that are not suitable for telemedicine are those for which an in-person visit is required to evaluate the patient due to the severity of presenting symptoms, the necessity of haptic information, the need for protocol-driven procedures, or the need for aggressive interventions. Other circumstances that are not suitable for telemedicine include some patients with cognitive disorders, intoxication, language barriers, emergency situations that warrant escalation to an ER visit or 911 or when patients do not have the requisite technology to complete a virtual visit.

These practice guidelines identify primary and urgent care services that current information indicates can be provided safely and effectively using telemedicine. They are not intended to substitute for the independent medical judgment, training, and skill of the practitioner. Therefore, providers **shall** exercise their professional judgment when deciding whether or not to use telemedicine, taking into account the patient condition, mitigating circumstances, available resources, and their own comfort level and expertise in using telemedicine. Providers **shall** be aware of all relevant state and federal regulations related to the use of telemedicine to include those that govern prescribing as it relates to the establishment of a doctor-patient relationship. In addition, practitioners **shall** be aware of relevant practice guidelines developed by the specialty societies as they relate to both in-person and telehealth practice.

### I. Preliminary Considerations

#### A. Regulatory and Licensure Requirements

Providers **shall** follow federal, state and local regulatory and licensure requirements related to their scope of practice, and **shall** abide by state board and specialty training requirements. Providers **shall** ensure that the patient is physically located in a jurisdiction in which the provider is duly licensed and credentialed. Providers **shall** practice within the scope of their licensure and **shall** observe all applicable state and federal legal and regulatory requirements.

#### B. Informing and Educating the Patient

Prior to the initiation of a telemedicine encounter, the provider or designee **shall** inform and educate the patient (either in writing or verbally) about the nature of telemedicine service compared to in-person care. This **shall** include discussion of the nature of a telemedicine encounter, timing of service, record keeping, scheduling, privacy and security, potential risks, mandatory reporting, the credentials of the distant site provider and billing arrangements. The information **shall** be provided in simple language that can be easily understood by the patient. This is particularly important when discussing technical issues like encryption or the potential for technical failure.

More specifically, this information **shall** include the limits to confidentiality in electronic communication; an explicit emergency plan, particularly for patients in settings without access to clinical staff; a process by which patient information will be documented and stored; the potential for technical failure; procedures for coordination of care with other professionals; a protocol for contact between visits; prescribing policies including local and federal regulations and limitations; and the conditions under which telemedicine services may be terminated and a referral made to in-person care.

Finally, the provider or designee **should** set appropriate expectations regarding the telemedicine encounter, including for example, prescribing policies, scope of service, communication, and follow-up. To reduce the risk of overprescribing, the provider **shall** follow evidence-based guidelines and all federal, state and local regulations.

### **C. Physical Environment**

The provider **shall** determine the minimal acceptable levels of privacy, lack of distraction and background noise, and other environmental conditions that may affect the quality of the encounter, in particular when video-based services are offered. The provider's and the patient's room/environment **should** ensure privacy to prevent unauthorized access. Seating and lighting **should** be designed for both comfort and professional interaction. Both provider and patient **should** be visible and heard. Patients receiving care in non-traditional settings **should** be informed of the importance of reducing background light from windows or light emanating from behind them. Both provider and patient cameras **should** be placed on a secure, stable platform to avoid wobbling and shaking during the videoconferencing session. To the extent possible, the patient and provider cameras **should** be placed at the same elevation as the eyes with the face clearly visible to the other person.

### **D. Referrals and Emergency Resources**

The provider **shall** have an emergency or contingency plan that is communicated to the patient in advance of the telemedicine encounter.

The provider **should** be familiar with, or have access to available medical resources in proximity to the patient in order to make referrals or request transfers when indicated.

### **E. Cultural Competence**

Telemedicine providers and their staff **shall** deliver services in a culturally competent manner that takes into account the patient's age, disability status, ethnicity, language, gender, gender identity and sexual orientation, geographical location, language, religion, and socio-economic status.

Provider and patient or patient-representative **should** be able to converse in a language comfortable and familiar to both parties allowing the provider to obtain a clear history and the patient/representative to understand the recommendations provided. If necessary, a translator (or signer for deaf/hearing impaired patients) **should** be used.

## **II. Telemedicine Management of the Patient**

Telemedicine providers **shall** determine the appropriateness of telemedicine on a case-by-case basis, whether or not a telemedicine visit is indicated, and what portion of the examination must be performed and documented in conformance with appropriate standards in evaluating the patient. Wherever possible, diagnostic interventions **should** be

supported by high quality evidence. Where evidence is lacking, providers **shall** use their professional judgment, experience and expertise in making such decisions. Conditions for use of telemedicine are likely to change to reflect new evidence from future research and the evolution of the enabling technology.

Telemedicine providers **shall** be cognizant of establishment of a provider-patient relationship in the context of a telemedicine encounter, whether using synchronous or asynchronous modes of communication/interaction makes a difference, and they **shall** proceed accordingly with an evidence-based standard of care. If not previously established, a provider-patient relationship **may** be established where the provider is guiding the process of care. The provider **shall** use their professional judgment and conform to all state and federal regulations in determining whether a provider-patient relationship has been established and whether it is sufficient to proceed with an encounter and make diagnostic and treatment decisions including prescribing. In the event the patient does not have a primary care provider, the provider **should** recommend options to assure continuity of care for the patient. Provider practices **should** establish standard operating procedures and workflows for telemedicine visits consistent with prevailing norms.

Telemedicine management of the patient **may** involve establishment of a diagnosis and treatment plan, or it **may** result in a referral to a medical facility for further evaluation and/or treatment.

Clinical protocols **should** be developed for live, on demand services. Such protocols are beyond the scope of these guidelines and practitioners are advised to review specialty society guidelines and the evidence published in the peer-reviewed literature. However, protocols **should** include the following components:

1. Named condition and corresponding ICD code;
2. Scope of condition amenable to treatment by telemedicine based on medical evidence, or at a minimum, precedent for successful management based on peer-reviewed guidelines or expert opinion;
3. The mode of intervention required to diagnose and treat the condition (i.e., under what circumstance and regulatory framework is telephonic care adequate, is videoconferencing required, are peripheral devices needed or other diagnostic tests, or is an in-person visit needed);
4. Documentation required to appropriately assess the patient's condition including history and any video-based examination including required components needed to visualize, demonstrate or test;
5. Parameters under which the condition can be treated;
6. Parameters under which the condition may not be treated and require referral to alternate modes of management; and
7. Parameters under which prescribing can and cannot be done.

#### **A. Patient Evaluation**

Patient examination should be commensurate with the level of assessment required to manage a patient, taking into consideration the technical quality and extent of information that **may** be elicited remotely. This evaluation **should** be supported by clinical history, access to the patient's medical record where possible, diagnostic data (e.g. obtained via self-report or access to store and forward databases) and laboratory test results and peripheral devices for patient physical examination when appropriate.

Audio-based evaluation **may** be used for consultation, if and only if the evaluation, diagnosis and treatment of conditions can be made reliably on the basis of complete medical history, full understanding of presenting symptoms reported by the patient or caregiver and be consistent with established clinical protocols, state and federal laws and regulations related to audio-based evaluations, in particular when such evaluation results in prescribing.

The telemedicine provider **should** obtain all the data necessary for a diagnosis and treatment plan. Necessary items include:

1. Identifying information
2. Source of the history
3. Chief complaint(s)
4. History of present illness (including location, description, size, quality, severity, duration, timing and context modifying factors)
5. Associated signs and symptoms
6. Past medical history
7. Family history
8. Personal and social history
9. Medication review
10. Allergies including medication, nature and severity of reaction
11. Detailed review of symptoms
12. Provider-directed patient self-examination to include the use of peripheral devices as appropriate.

Documentation **shall** be performed following each patient encounter and **shall** be maintained in a secure, HIPAA (Health Insurance Portability and Accountability Act) compliant form and location (e.g., paper/fax, server, cloud).

Following every visit, the provider **shall** communicate results of the encounter to the patient's primary care provider or other specialty providers using secure methods (e.g., email/fax, secure email, transmit to EMR), as well as to the patient, unless, the patient has requested a limitation on such communication. An appropriate disposition **shall** also be discussed with the patient including any required follow up and discussion of clinical signs that would signify a significant escalation. Laboratory tests, including diagnostics ordered in the usual course of evaluation **shall** be followed up in a timely manner with the patient and any additional providers as needed.

## **B. Physical Examination**

The provider **shall** perform a virtual physical examination as indicated by the patient complaint and medical history and other relevant information reported by the patient conforming to the standards of medical practice, and provided by a credentialed and qualified practitioner. This examination **may** include a demonstration or an explicit physician-guided self-examination which, as appropriate, **may** include peripheral devices. Where additional diagnostic testing is required to confirm the diagnosis, the provider **shall** recommend to the patient that such testing be performed in accordance with standards of medical care.

## **III. Quality**

The provider **shall** employ a coordinated quality improvement program or clinical oversight process.

## A. Quality Review

Quality review **should** be conducted on a periodic basis to identify specific risks and qualify failures. It **should** include assessment of:

- equipment or connectivity failures
- number of attempted and completed visits
- patient and provider satisfaction with the virtual visit
- patient or provider complaints related to the virtual visits (e.g., via surveys)
- measures of clinical quality such as whether the visit was appropriate for a virtual encounter
- recommendations consistent with appropriate standard of care

Unless there is an external requirement for recording a virtual visit, the provider **may** opt not to record the visit. If he/she chooses to record the encounter for quality or training purposes, it **shall** comport with appropriate consent and privacy/security measures (see Technical Considerations below).

## B. Provider Training and Mentoring

Provider orientation and training should entail a thorough review of history taking skills and physical examination skills as they pertain to the evaluation of a patient through telemedicine. Providers **shall** know current local and state laws as they pertain to telemedicine practice. They **shall** obtain the necessary training and education for themselves and/or staff to ensure maintaining technical and clinical competence in accordance with their discipline. Providers **should** conduct several “dry run” visits with test “patients” to become familiar and comfortable with the technology of virtual visits, and be generally familiar with the nature of the technology the patient is using to direct and assist with minor technical questions and potential problems that may arise. The provider **should** also be familiar with and proficient with a satisfactory default mode for patient engagement should technology fail during a patient encounter. Those new to telemedicine are encouraged to identify a mentor to observe during telemedicine encounters. This can also be done post hoc by a video recording. Proctored visits **should** include a variety of conditions, and modes of encounter (e.g., phone, web, mobile). Protocols regarding indications when care should be escalated, and provision for escalating patients when necessary to alternate modes of care should be established, documented and communicated as part of the provider orientation process. The effectiveness of these guidelines should be assessed routinely by the provider entity as part of their standard quality review process.

## IV. Ethical Considerations

Practicing at a distance requires the same attention and adherence to professional ethical principles—as would an in-person encounter. Telemedicine providers **should** incorporate ethical statements and policies into their standard operating procedures.

The following are the ethical guidelines for health professionals’ engaged in telemedicine:

1. A practitioner **shall** uphold the code of ethics for their profession and be aware of the codes for other professional disciplines.
2. A practitioner **shall** abide by all federal, state, and jurisdictional laws and regulations, and institutional policies.
3. Telemedicine **shall not** be employed as a means of preferentially avoiding in-person encounters based on geographic location, socio-economic status, disease or disability,

gender, gender preferences or sexual orientation, behavioral factors, ethnicity, religion, etc. An exception to this rule **may** be the avoidance of in-person visits during epidemics or pandemics to avoid the spread of infectious disease.

4. Payment made by the patient **should not** be conditional on receiving a certain diagnoses or particular treatment, such as receipt of a prescription.
5. Providers **should** abide by a strict conflict of interest policy that deters the use of telepractice for the sole purpose of enhancing income.
6. Providers **shall**:
  - a. Apprise patients of their rights when receiving telemedicine, including the right to suspend or refuse treatment.
  - b. Apprise patients of their own responsibilities when participating in telemedicine.
  - c. Inform patients of a formal complaint or grievance process to resolve ethical concerns or issues that might arise as a result of participating in telemedicine.
  - d. Discuss the potential benefits, constraints and risks (e.g., privacy and security) of telemedicine.
  - e. Inform patients and obtain their consent when students or trainees observe the encounter.
7. Providers **should** have a policy in place concerning the disclosure to patients of technology or equipment failures during service sessions, the contingency plans in case of technical failure, and document such events in the patient's health record.

## V. Emergencies

### A. Definition of Emergent Conditions

An emergent condition is an illness or injury that poses an immediate threat to a person's life or long-term health. Such conditions are outside the scope of a primary and/or urgent care telemedicine practice.

### B. Emergent Patient Evaluation and Referrals

The provider **shall** assess a presenting patient's condition to determine severity and acuity of the patient's condition, and when indicated, refer the patient to the appropriate level of care accessible to the patient. The telemedicine provider **shall** be responsible for triaging the patient to the appropriate level of care (e.g., PCP, specialist, urgent care, ED). Providers **may** consider incorporating standard triage protocols in their telemedicine practices.

### C. Documentation of Emergent Encounters

The provider **shall** document the process for treating emergent situations which **may** include phoning the receiving facility in advance of the patient's arrival.

Providers **shall** document all referrals to EMS (Dialing 911) including the medical indication/basis for the recommendation, and nature of the problem.

Providers **should** document the location of the patient at the start of the encounter.

Providers **should** document any extenuating circumstances or adverse events, be they technical or clinical, which occurred during the encounter.

Documentation **should** adhere to all medical-legal standards of care, and if appropriate, insurance requirements for future review and audit.

## **VI. Follow-Up**

As noted previously, follow-up is a critical aspect of patient safety and continuity of care and **should** include the following:

### **A. Knowledge of the Patient’s Healthcare Network**

The provider **should** have knowledge of the patient’s healthcare network whenever possible, to be able to facilitate timely access to recommended specialty consultations or referrals.

### **B. Provision of Clinical Reports to Referral Sources**

The provider, to the extent possible while being remote, **shall** make available relevant clinical reports to the referral institution or specialist absent a request by the patient to the contrary.

### **C. Transmission of Home Monitoring and Electronic Data**

If feasible, the provider **should** facilitate transference of any home monitoring or electronic data and discuss with the patient how and if such data will be stored.

### **D. Patient Requests for Records**

The provider **shall** establish an explicit process for patients to request copies of their telemedicine encounters at their request and to facilitate specialty care, where indicated.

## **VII. Special Populations**

Virtual visits can be conducted with patients with unique needs such as those with communication disorders, mental or physical disabilities, sensory disorders, or special needs related to age, gender, culture, rare diseases or location of care. Some **may** need a translator or facilitator that calls for non-medical personnel during the visit. These populations often require special considerations to ensure their engagement in the care process and follow-up and their needs are met appropriately. For instance telemedicine providers in the United States **shall** be in compliance with the American Disabilities Act of 1990 (ADA) and other legal and ethical requirements, described elsewhere. A useful reference to identifying and responding to these populations can be found in the ATA Practice Guidelines for Videoconferencing-Based Telemental Health. (9)

### **A. Pediatric**

The literature contains examples of clinically effective pediatric telemedicine programs (42-46). Such pediatric encounters require the presence and/or active participation of a caregiver or facilitator, including parent/guardian, nurse, and/or childcare worker. In certain cases involving adolescents with behavioral or mental health issues a facilitator would not remain in the room for part of or for the entire duration of the visit. Nonetheless, the practitioner **shall** obtain consent from the parent or legal representative of the child as required by law in the respective jurisdiction. If the parent/guardian is not present at the time of the visit, a process **shall** be established for prompt communication of the results of the visit with the parent/guardian.

## B. Geriatric

Here again, the literature contains examples of clinically effective geriatric telemedicine programs. (19, 38) The evidence indicates frequent monitoring for chronic diseases tends to reduce the need for office visits, transportation, as well as reduce stress and increase access to care for homebound patients. (5, 33, 36, 39) Providers also report benefits from the ability to observe the patient in their home environment. (39)

In designing a system for virtual geriatric visits, providers **should** consider the special needs of the elderly, including vision and hearing difficulties and limited physical dexterity or mobility. These **should** be taken into account when designing and choosing equipment and systems. In cases where a patient demonstrates substantial confusion or anxiety during a telemedicine encounter, the practitioner **should** exercise judgment concerning the continuation or termination of the visit. The presence of facilitators family members/caregivers, and nurses would facilitate the process and ultimate decision making. However, providers **should** have the patient affirm consent to that person's participation in the visit. A practitioner should obtain the patient's consent regarding the presence/participation of facilitators. In cases of questionable mental competency, practitioners **should** ensure appropriate consent from a legal proxy or representative. In circumstances where the patient is in a care facility or senior living community, a trained technician **may** assist in collecting relevant clinical information, including medical records, lab or diagnostic testing, and access to caregivers and staff.

In managing patients with dementia, providers should ask for the patient's durable power of attorney for healthcare decisions, and use that as the legal guardian.

## C. Locus of Care

The literature contains examples of clinical effectiveness of successful telemedicine programs in a variety of settings including patient homes, childcare centers, schools, chronic care facilities, the workplace, and prisons. (19, 20, 22, 25, 27, 31, 38) All legal and regulatory requirements and ethical considerations **shall** be used in these settings.

## TECHNICAL GUIDELINES

### I. Security and Privacy

Providers and healthcare organizations **shall** comply with privacy and confidentiality requirements stipulated by HIPAA and other applicable laws. They should also familiarize themselves with security arrangements for their systems and their limitations.

This **shall** include appropriate disclosure to patients about sharing their personal healthcare information (PHI). Providers **shall** document medical records as thoroughly as if the patient participated in an in-person visit. Storage of medical records **shall** be accomplished using methods that are compliant with all laws pertaining to medical record storage. Access to patient information **shall** follow standard HIPAA privacy provisions. If an intermediary or third party entity is engaged for the collection, storage, transmission or processing of PHI, a Business Associate Agreement (BAA) should be executed as stipulated under HIPAA.

Patients **shall** consent prior to any recording of the encounter, and such recording be available for the patients upon request. Release of such recordings data **shall** require written patient authorization or court order in a legal proceeding.

Access to the recordings **shall** only be granted to authorized users, and **should** be protected from accidental or unauthorized file sharing and/or transfer.

Data security **shall** be assured by prevailing encryption methods, including FIPS 140-2, known as the Federal Information Processing Standard. Providers **should** familiarize themselves with the technologies available regarding computer and mobile device security, and **should** share such information with their patients as appropriate. Special attention **should** be placed on the privacy of information being communicated via mobile devices.

Mobile devices used for clinical purposes **shall** require authentication for access to them, as well as timeout thresholds and protections when lost or misplaced. Mobile devices **should** be kept in the possession of the provider when traveling or in an uncontrolled environment. Unauthorized persons **shall not** be allowed access to sensitive information stored on the device, or use the device to access sensitive applications or network resources. Providers **should** have the capability to remotely disable or wipe their mobile device in the event it is lost or stolen. Videoconference software **shall not** allow multiple concurrent sessions to be opened by a single user. Should a second session be attempted, the system **shall** either log off the first session or block the second session. Session logs stored in 3<sup>rd</sup> party locations (i.e., not on providers' or patients' access device) **shall** be secure and access to these logs **shall** only be granted to authorized users.

Protected health information and other confidential data **shall** only be backed up to or stored in secure data storage locations. Cloud services unable to achieve HIPAA compliance **shall not** be used for PHI or confidential data.

## **II. Communication between Organizations**

Providers of telemedicine **shall** meet the same standards for communication between patient and provider, and between provider and other organizations, as those for in-person encounters.

## **III. Remote Monitoring Devices and Data**

Numerous studies in the US and elsewhere have confirmed the reliability and effectiveness of remote monitoring. (6, 7, 16) This evidence reveals the benefits of remote monitoring in reducing hospitalization/re-hospitalization, greater patient compliance with medication management, timely diagnosis and initiation of treatment, and improved health outcomes.

The provider **should** be aware of data trends or current evidence in remote monitoring to the extent possible. Data gathered from remote monitoring **should** be incorporated into the visit record.

When using a personal computer (including laptops, iPads, and other mobile devices), both the provider and patient devices should, when feasible, use professional grade or high quality cameras and audio equipment. Devices **shall** have up-to-date antivirus software and if feasible a personal firewall installed (at least on the provider's device). Providers should ensure their personal computer or mobile device has the latest security patches and updates applied to the operating system and any 3<sup>rd</sup> party applications.

## A. Provider Organizations

Provider organizations **should** provide adequate resources for hardware, software, and network management, including installation, maintenance, troubleshooting and replacement, as well as effective security arrangements. Special attention **shall** be paid to verify the secure and reliable networks, including successful information exchange.

## B. Connectivity

Connectivity **shall** have adequate bandwidth, resolution and speed for clinical consultations. Bandwidth **shall** be set at a minimum bandwidth of 384 Kbps in both the downlink and uplink directions. Resolution **shall** be set a minimum of 640X360, and speed at 30frames per second. Where practical, providers **may** recommend preferred video conferencing software and/or video and audio hardware to the patient. The provider and/or patient **may** use link test tools (e.g., bandwidth test) to pre-test the connection before starting their session. Each party **should** use the most reliable connection method to access the Internet, including wired (e.g., Ethernet) connections when available. The videoconferencing software **should** be able to adapt to changing bandwidth environments without losing/dropping the connection.

In the event of a technology breakdown, causing a disruption of the session, the professional **shall** have a backup plan in place. The plan **shall** be communicated to the patient prior to commencement of the encounter, and it **should** be included in the general emergency management protocol.

The plan **should** include calling the patient via telephone and attempting to troubleshoot the issue together. It **may** also include referring the patient to another provider, or completing the encounter by voice only.

Professionals and patients **may** opt to use cameras that pan, tilt, and zoom for maximal flexibility in viewing.

## ADMINISTRATIVE GUIDELINES

### I. Verification of Service Eligibility

Prior to any telemedicine encounter, the provider or staff **shall** determine the appropriateness of telemedicine for the specific encounter, and also gather information on medical history, presenting symptoms/problems, reimbursement method, and usual provider.

### II. Provider and Patient Identity Verification

The provider **shall** introduce him/herself and any attendant personnel (e.g., residents, fellows, students) to the patient and document those present. The patient **should announce** those in attendance at his/her end (e.g., guardian, family). This information **shall** become part of the encounter document.

The full name and credentials of the provider and the full name of the patient **shall** be verified by birthdate, address, and insurance status.

### **III. Provider and Patient Location Documentation**

The provider **shall** document the location of the patient and the communication tools. The locations of the provider and patient **may** require documentation for reimbursement and licensing purposes.

Most states require that licensure requirements are based on the location of the patient when service is rendered. Therefore, providers **shall** be aware of the state where the patient is located at the time of service to assure they are licensed in that state.

Emergency management protocols are entirely dependent on where the patient receives services.

### **IV. Contact Information Verification for Provider and Patient**

Contact information **shall** be obtained from the patient including address of usual residence, address at time of consultation, telephone, mail, and email addresses. Similarly, provider contact information **shall** be exchanged with patient including telephone, practice address and email. It is not necessary for the health provider to reveal their specific location to the patient, especially if the provider is located at home at the time of service.

### **V. Credentialing and Licensing**

All providers **shall** abide by the same local and regional credentialing policies as required for a traditional in-person visit as mandated by state and federal law.

Providers **shall** abide by all qualifications of licensure, board eligibility, or certification as required for traditional in-person visits according to by state and federal laws. The scope of care provided **shall** be consistent with the provider's level of training (e.g., MD/DO, ARNP, PA, RN, etc.). Providers **should** be cognizant of oversight requirements and auditing standards that **may** be applied to telemedicine patient visits as if the patient visit occurred in person. Where telemedicine/ telehealth laws require or permit different credentialing, compliance **shall** be maintained with those provisions.

### **VI. Organizational Policies and Procedures**

Healthcare organizations **should** develop and implement organizational policies and procedures governing the use of telemedicine. Providers **shall** adhere to all applicable laws and regional and local practice as to Patient Informed Consents and Disclaimers. As part of organizational policies and procedures, healthcare entities **should** promulgate standards for patient and provider verification and authentication.

### **VII. Coding and Documentation**

Coding and medical record documentation **should** be accurate in reflecting the content of the medical visit rather than enhancing reimbursement.

Medical record and procedure coding **should** follow prevailing coding practices based on state and national guides such as the AMA Coding Requirements.

### **A. Electronic Medical Record**

Providers **shall** generate and maintain an electronic medical record (when feasible) for each patient for whom they provide remote care. All communications with the patient (verbal, audiovisual or written) **should** be documented in patient's unique medical record on par with documentation standards of in-person visits.

### **B. Access to Analytics and Clinical Information at Point of Care**

The provider should ensure that the patient's clinical record is available during or prior to a visit whenever possible, and that sufficient time is allotted to update the patient history; if possible with the patient's primary care provider or other relevant healthcare entity.

### **C. Payment and Billing**

Prior to providing patient services, the patient **shall** be made aware of the patient's cost of the service to be provided, if any. Arrangement for payment should be completed prior to the delivery of the service. Special consideration must be made for Medicare patients participating in telemedicine care. Providers **shall** follow Medicare rules (such as the Medicare Opt Out election) for billing patients outside of standard Medicare reimbursement.

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STATE OF WISCONSIN  
MEDICAL EXAMINING BOARD

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IN THE MATTER OF RULEMAKING	:	PROPOSED ORDER OF THE
PROCEEDINGS BEFORE THE	:	MEDICAL EXAMINING BOARD
MEDICAL EXAMINING	:	ADOPTING RULES
BOARD	:	(CLEARINGHOUSE RULE )

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PROPOSED ORDER

An order of the Medical Examining Board to create chapter Med 24 relating to telemedicine.

Analysis prepared by the Department of Safety and Professional Services.

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ANALYSIS

**Statutes interpreted:**

None.

**Statutory authority:**

Sections 15.08 (5) (b), 227.11 (2) (a), and 448.40 (1), Stats.

**Related statute or rule:**

None.

**Explanation of agency authority:**

Section 15.08 (5) (b), Stats., provides examining boards, “shall promulgate rules for its own guidance and for the guidance of the trade or profession to which it pertains. . .”

Section 227.11 (2) (a), Stats., sets forth the parameters of an agency’s rule-making authority, stating an agency, “may promulgate rules interpreting provisions of any statute enforced or administered by the agency. . .but a rule is not valid if the rule exceeds the bounds of correct interpretation.”

Section 448.40 (1), Stats., provides that the Medical Examining Board “may promulgate rules to carry out the purposes of this subchapter, including rules requiring the completion of continuing education, professional development, and maintenance of certification or performance improvement or continuing medical education programs for renewal of a license to practice medicine and surgery.”

**Plain language analysis:**

The current administrative code is silent with regards to telemedicine practice. The proposed rule will define telemedicine, explain how a valid physician-patient relationship can be established in a telemedicine setting, and identify technology requirements for physicians who use electronic communications, information technology or other means of interaction with patients who are not physically present. The proposed rule will specify out-of-state physicians to hold a valid Wisconsin medical license in order to diagnose and treat patients located in Wisconsin.

**Summary of, and comparison with, existing or proposed federal regulation:**

2015 HR 691 - Telehealth Modernization Act of 2015 – the proposed bill seeks to establish a federal standard for telehealth and serve as guidance for states, subject to a number of specified conditions.

**Comparison with rules in adjacent states:**

**Illinois:** Illinois statutes require an individual who engages in telemedicine to hold a medical license issued by the state of Illinois. Telemedicine is defined as including but not limited to rendering written or oral opinions concerning diagnosis or treatment of a patient in Illinois by a person located outside the State of Illinois as a result of transmission of individual patient data by telephonic, electronic, or other means of communication from within this State. Telemedicine specifically does not include periodic consultations between a licensee and a person outside the State of Illinois, a second opinion provided to a licensee; and the diagnosis or treatment services provided to a patient in Illinois following care or treatment originally provided to the patient in the state in which the provider is licensed to practice medicine (225 Ill. Comp. Stat. Ann. s. 60/49.5). The telemedicine provisions are scheduled to be repealed on December 31, 2015.

**Iowa:** Iowa Administrative Code 653-13.11 establishes the standards of practices of physicians who use telemedicine. Similar to the proposed rule, Iowa Administrative Code defines telemedicine, explains how a valid physician-patient relationship can be established in a telemedicine setting, and identifies technology requirements for physicians who use electronic communications, information technology or other means of interaction with patients who are not physically present. The rule requires out-of-state physicians to have a valid Iowa medical license in order to diagnose and treat patients located in Iowa.

**Michigan:** Michigan statutes and administrative code are silent with regards to the provision of telemedicine services. The standards are the same as in-person care.

**Minnesota:** Minnesota does not have any unique laws regulating the practice of telemedicine. Standards are the same as in person care (Minn. Stat. s. 147.032).

**Summary of factual data and analytical methodologies:**

Other states' requirements as well as the Federation of State Medical Boards model policy were reviewed when drafting the proposed rule change.

**Analysis and supporting documents used to determine effect on small business or in preparation of economic impact analysis:**

The rule were posted for public comment on the economic impact of the proposed rule, including how this proposed rule may affect businesses, local government units, and individuals, for a period of 14 days. No comments were received.

**Fiscal Estimate and Economic Impact Analysis:**

The Fiscal Estimate and Economic Impact Analysis document is attached.

**Effect on small business:**

These proposed rules do not have an economic impact on small businesses, as defined in s. 227.114 (1), Stats. The Department's Regulatory Review Coordinator may be contacted by email at Eric.Esser@wisconsin.gov, or by calling (608) 267-2435.

**Agency contact person:**

Katie Vieira, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8935, Madison, Wisconsin 53708; telephone 608-261-4472; email at Kathleen.Vieira@wisconsin.gov.

**Place where comments are to be submitted and deadline for submission:**

Comments may be submitted to Katie Vieira, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8366, Madison, WI 53708-8935, or by email to Kathleen.Vieira@wisconsin.gov. Comments must be received on or before the public hearing on January 20, 2016 to be included in the record of rule-making proceedings.

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TEXT OF RULE

SECTION 1. Chapter Med 24 is created to read:

CHAPTER MED 24

TELEMEDICINE

**Med 24.01 Authority and purpose.** The rules in this chapter are adopted by the medical examining board pursuant to the authority delegated by ss. 15.08 (5), 227.11, and 448.40, Stats., and govern the standards of practice for the practice of medicine using telemedicine.

**Med 24.02 Definitions.** For the purposes of this chapter:

(1) “Asynchronous store-and-forward transmission” means the collection of a patient’s relevant health information and the subsequent transmission of the data from an originating site to a health care provider at a distant site without the presence of the patient.

(2) “Board” means the medical examining board.

(3) “In-person encounter” means that the physician and the patient are in the physical presence of each other and are in the same physical location during the physician-patient encounter.

(4) “Licensee” means an individual licensed by the board.

(5) “Telemedicine” means the practice of medicine using electronic audio-visual communications and information technologies or other means, including interactive audio with asynchronous store-and-forward transmission, between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine includes asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services, including teleradiology and telepathology. Telemedicine shall not include the provision of medical services only through an audio-only telephone, e-mail messages, facsimile transmissions, or U.S. mail or other parcel service, or any combination thereof.

(6) “Telemedicine technologies” means technologies and devices enabling secure electronic communications and information exchanges between a licensee in one location and a patient in another location with or without an intervening health care provider.

**Med 24.03 Practice guidelines.** A licensee who uses telemedicine shall utilize evidence-based telemedicine practice guidelines and standards of practice, to the degree they are available, to ensure patient safety, quality of care, and positive outcomes. The board acknowledges that some nationally recognized medical specialty organizations have established comprehensive telemedicine practice guidelines that address the clinical and technological aspects of telemedicine for many medical specialties.

**Med 24.04 Wisconsin medical license required.** A physician who uses telemedicine in the diagnosis and treatment of a patient located in Wisconsin shall hold an active Wisconsin medical license.

**Med 24.05 Standards of care and professional ethics.** A licensee who uses telemedicine shall be held to the same standards of care and professional ethics as a licensee using traditional in-person encounters with patients. Failure to conform to the appropriate standards of care or professional ethics while using telemedicine may be a violation of the laws and rules governing the practice of medicine and may subject the licensee to potential discipline by the board.

**Med 24.06 Scope of practice.** A licensee who uses telemedicine shall ensure that the services provided are consistent with the licensee's scope of practice, including the licensee's education, training, experience, ability, licensure, and certification.

**Med 24.07 Identification of patient and physician.** A licensee who uses telemedicine shall verify the identity of the patient and ensure that the patient has the ability to verify the identity, licensure status, certification, and credentials of all health care providers who provide telemedicine services prior to the provision of care.

**Med 24.08 Physician-patient relationship.** The physician-patient relationship begins when a person with a health-related matter seeks assistance from a licensee, the licensee agrees to undertake diagnosis and treatment of the person, and the person agrees to be treated by the licensee whether or not there has been an in-person encounter between the physician and the person. A licensee who uses telemedicine shall establish a valid physician-patient relationship with the person who receives telemedicine services. A valid physician-patient relationship may be established through any of the following:

(1) An in-person medical interview and physical examination where the standard of care would require an in-person encounter.

(2) A consultation with another licensee, or other health care provider, who has an established relationship with the patient and who agrees to participate in, or supervise, the patient's care.

(3) Telemedicine, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.

**Med 24.09 Medical history and physical examination.** A licensee shall perform a medical interview and physical examination for each patient. The medical interview and physical examination may not be in-person if the technology utilized in a telemedicine encounter is sufficient to establish an informed diagnosis as though the medical interview and physical examination had been performed in-person. Prior to providing treatment, including issuing prescriptions, electronically or otherwise, a licensee who uses telemedicine shall interview the patient to collect the relevant medical history and perform a physical examination, when medically necessary, sufficient for the diagnosis and treatment of the patient. An Internet questionnaire that is a static set of questions provided to the patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview, does not

constitute an acceptable medical interview and physical examination for the provision of treatment, including issuance of prescriptions, electronically or otherwise, by a licensee.

**Med 24.10 Nonphysician health care providers.** If a licensee who uses telemedicine relies upon or delegates the provision of telemedicine services to a nonphysician health care provider, the licensee shall ensure that all of the following are met:

(1) Systems are in place to ensure that the nonphysician health care provider is qualified and trained to provide that service within the scope of the nonphysician health care provider's practice.

(2) The licensee is available in person or electronically to consult with the nonphysician health care provider, particularly in the case of injury or an emergency.

**Med 24.11 Informed consent.** In accordance with ch. Med 18, a licensee who uses telemedicine shall ensure that the patient provides appropriate informed consent for the medical services provided, including consent for the use of telemedicine to diagnose and treat the patient, and that such informed consent is timely documented in the patient's medical record.

**Med 24.12 Coordination of care.** A licensee who uses telemedicine shall, when medically appropriate, identify the medical home or treating physicians for the patient, when available, where in-person services can be delivered in coordination with the telemedicine services. The licensee shall provide a copy of the medical record to the patient's medical home or treating physicians.

**Med 24.13 Follow-up care.** A licensee who uses telemedicine shall have access to, or adequate knowledge of, the nature and availability of local medical resources to provide appropriate follow-up care to the patient following a telemedicine encounter.

**Med 24.14 Emergency services.** A licensee who uses telemedicine shall refer a patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in the case of an emergency.

**Med 24.15 Medical records.** A licensee who uses telemedicine shall ensure that complete, accurate and timely medical records are maintained for the patient in accordance with ch. Med 21, including all patient-related electronic communications, records of past care, physician-patient communications, laboratory and test results, evaluations and consultations, prescriptions, and instructions obtained or produced in connection with the use of telemedicine technologies. The licensee shall note in the patient's record when telemedicine is used to provide diagnosis and treatment. The licensee shall ensure that the patient or another licensee designated by the patient has timely access to all information obtained during the telemedicine encounter. The licensee

shall ensure that the patient receives, upon request, a summary of each telemedicine encounter in a timely manner.

**Med 24.16 Privacy and security.** A licensee who uses telemedicine shall ensure that all telemedicine encounters comply with the privacy and security measures of the Health Insurance Portability and Accountability Act to ensure that all patient communications and records are secure and remain confidential. Written protocols shall be established by the licensee meet all of the following:

- (1) Written protocols shall address all of the following:
  - (a) Privacy.
  - (b) Health care personnel who will process messages.
  - (c) Hours of operation.
  - (d) Types of transactions that will be permitted electronically.
  - (e) Required patient information to be included in the communication, including patient name, identification number and type of transaction.
  - (f) Archiving and retrieval.
  - (g) Quality oversight mechanisms.

(2) The written protocols should be periodically evaluated for currency and should be maintained in an accessible and readily available manner for review. The written protocols shall include sufficient privacy and security measures to ensure the confidentiality and integrity of patient-identifiable information, including password protection, encryption or other reliable authentication techniques.

**Med 24.17 Technology and equipment.** The board recognizes that three broad categories of telemedicine technologies exist, including asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services. While some telemedicine programs are multispecialty in nature, others are tailored to specific diseases and medical specialties. The technology and equipment utilized for telemedicine shall comply with the following requirements:

(1) The technology and equipment utilized in the provision of telemedicine services must comply with all relevant safety laws, rules, regulations, and codes for technology and technical safety for devices that interact with patients or are integral to diagnostic capabilities.

(2) The technology and equipment utilized in the provision of telemedicine services must be of sufficient quality, size, resolution and clarity such that the licensee can safely and effectively provide the telemedicine services.

(3) The technology and equipment utilized in the provision of telemedicine services must be compliant with the Health Insurance Portability and Accountability Act.

**Med 24.18 Disclosure and functionality of telemedicine services.** A licensee who uses telemedicine shall disclose all of the following information to the patient:

(1) Types of services provided.

(2) Contact information for the licensee.

(3) Identity, licensure, certification, credentials, and qualifications of all health care providers who are providing the telemedicine services.

(4) Limitations in the drugs and services that can be provided via telemedicine.

(5) Fees for services, cost-sharing responsibilities, and how payment is to be made, if these differ from an in-person encounter.

(6) Financial interests, other than fees charged, in any information, products, or services provided by the licensee.

(7) Appropriate uses and limitations of the technologies, including in emergency situations.

(8) Uses of and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies.

(9) To whom patient health information may be disclosed and for what purpose.

(10) Rights of patients with respect to patient health information.

(11) Information collected and passive tracking mechanisms utilized.

**Med 24.19 Patient access and feedback.** A licensee who uses telemedicine shall ensure that the patient has easy access to a mechanism for the following purposes:

(1) To access, supplement and amend patient-provided personal health information.

(2) To provide feedback regarding the quality of the telemedicine services provided.

(3) To register complaints. The mechanism shall include information regarding the filing of complaints with the board.

**Med 24.20 Financial interests.** Advertising or promotion of goods or products from which the licensee receives direct remuneration, benefit or incentives other than the fees for the medical services is prohibited to the extent that such activities are prohibited by state or federal law. Notwithstanding such prohibition, Internet services may provide links to general health information sites to enhance education; however, the licensee should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, licensees should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of a preferred relationship with any pharmacy is prohibited. Licensees shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit from the pharmacy.

**Med 24.21 Circumstances where the standard of care may not require a licensee to personally interview or examine a patient.** Under the following circumstances, whether or not such circumstances involve the use of telemedicine, a licensee may treat a patient who has not been personally interviewed, examined and diagnosed by the licensee:

(1) Situations in which the licensee prescribes medications on a short-term basis for a new patient and has scheduled or is in the process of scheduling an appointment to personally examine the patient.

(2) For institutional settings, including writing initial admission orders for a newly hospitalized patient.

(3) Call situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient.

(4) Cross-coverage situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient.

(5) Situations in which the patient has been examined in person by an advanced registered nurse practitioner or a physician assistant or other licensed practitioner with whom the licensee has a supervisory or collaborative relationship.

(6) Emergency situations in which the life or health of the patient is in imminent danger.

(7) Emergency situations that constitute an immediate threat to the public health including, but not limited to, empiric treatment or prophylaxis to prevent or control an infectious disease outbreak.

(8) Situations in which the licensee has diagnosed a sexually transmitted disease in a patient and the licensee prescribes or dispenses antibiotics to the patient's named sexual partners for the treatment of the sexually transmitted disease as recommended by the U.S. Centers for Disease Control and Prevention.

(9) For licensed or certified nursing facilities, residential care facilities, intermediate care facilities, assisted living facilities and hospice settings.

**Med 24.22 Prescribing based solely on an Internet request, Internet questionnaire or a telephonic evaluation—prohibited.** Prescribing to a patient based solely on an Internet request or Internet questionnaire such as a static questionnaire provided to a patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview, is prohibited. Absent a valid physician-patient relationship, a licensee's prescribing to a patient based solely on a telephonic evaluation is prohibited.

**Med 24.23 Medical abortion.** Nothing in this rule shall be interpreted to contradict or supersede the requirements under ch. Med 11.

SECTION 2. EFFECTIVE DATE. The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin administrative register, pursuant to s. 227.22 (2) (intro.), Stats.

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(END OF TEXT OF RULE)  
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Dated \_\_\_\_\_

Agency \_\_\_\_\_

Chairperson  
Medical Examining Board