Utah Telehealth Study - Phase 4 Report

Prepared by Pilot Healthcare Strategies for the Utah Division of Occupational and Professional Licensing

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Executive summary and overview

This phase of the Utah Telehealth Study outlines public policy positions of national stakeholder groups with an interest in telehealth services, particularly as they apply to public safety and economic impacts. Timely to this phase of the project is the release of model policy governing the use of telehealth in medical practice by the Federation of State Medical Boards (FSMB) in April 2014. This policy seeks to blend traditional practice -- where physicians develop a face-to-face doctor-patient relationship -- with advances in information and communications technology that would enable visual interaction using secure videoconferencing. A physician might, for example, conduct a videoconference patient visit while the patient's pulse and blood pressure are measured using remote devices and the data forwarded to the physician and stored in the patient's electronic health record. Or the physician might send lab test results to the patient for discussion and development of a prevention or treatment plan during the videoconference.

A key component of the FSMB model policy is a standard of care parity principle. In the context of a telehealth physician-patient relationship, physicians must be able to obtain sufficient patient information in order to develop a diagnosis and treatment plan in order to meet the

standard of care that would apply to patients seen in a traditional co-located physician office setting.

Stakeholder organizations having detailed policy positions relative to the delivery of health care services via telehealth include the American Medical Association (AMA), the American Telemedicine Association (ATA) and the Alliance for Connected Care.

Some practitioner groups have developed model law incorporating telehealth including the National Council of State Boards of Nursing (NCSBN), the National Association of Boards of Pharmacy (NABP) and the Association of Social Work Boards (ASWB). The NCSBN supports state-based licensure but has adopted an interstate compact approach to facilitate the provision of care by telehealth across state lines.

Other professional organizations have opted for a model compact (the Federation of State Boards of Physical Therapy, influenced by the NCSBN compact) and interstate licensure reciprocity (the Association of State and Provincial Psychology Boards).

The AMA is scheduled to reaffirm at its June 2014 annual meeting its longstanding policy position that physicians be subject to state licensure in states where they treat patients and opposing federal licensure. The AMA however does support a special telemedicine license category covering compensated services where a medical opinion by a physician licensed in another jurisdiction is used in patient diagnosis or treatment. By contrast, the ATA sees state licensure as an impediment to the wider adoption of telehealth although it does not specifically endorse federal licensure or any other policy approach.

The ATA's view of state licensure as an obstacle to telehealth is shared by a recently formed advocacy organization, the Alliance for Connected Care. The Alliance calls for the elimination of state regulatory and licensure barriers to the practice of telehealth that prohibit providers from furnishing telehealth services to patients across state lines as well as the establishment of a multi-stakeholder process to develop a standard definition of safe, high quality telehealth services and connected care.

Another organization, the Information Technology and Innovation Foundation (ITIF), urges Congress to create a federal standard for telehealth that states should adopt. If states fail to do so, Congress should adopt a uniform national license for telehealth that would be required to be accepted in all states.

Notably, many stakeholder groups have no defined policy positions on the delivery of services by telehealth and are listed at the end of this report.

Methodology

The websites of the national stakeholder groups specified in the RFP and Item 10(g) of the contract Scope of Work (Attachment B) were searched using the terms "telehealth" and "telemedicine." In addition, where these organizations' sites had policy or advocacy sections, these sections were reviewed for relevant content.

In addition, keyword searches combining the names of the organizations and the search terms "telehealth" and telemedicine" were conducted as well using the search terms alone to identify other national organizations that have adopted policy positions the delivery of telehealth services by health care professionals.

Positions of stakeholder groups

Federation of State Medical Boards (FSMB)

As this review was being conducted, the Federation of State Medical Boards (FSMB) issued a model policy to guide state medical boards on the regulation of telehealth in physician practice.[1] Its stated purpose is to "provide(s) guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educate(s) licensees as to the appropriate standards of care in the delivery of medical services directly to patients via telemedicine technologies." The stated policy intent is "to offer a model policy for use by state medical boards in order to remove regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while ensuring the public health and safety."

The model policy defines telemedicine thusly:

"Telemedicine" means the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient.

[1] *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine; Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup*, April 26, 2014.
http://www.fsmb.org/pdf/FSMB_Telemedicine_Policy.pdf

This definition is consistent with the findings of Phase 2 of the Utah Telehealth Study that surveyed state law and regulations governing delivery of telehealth services. That review found nearly half of all states define telehealth in the context of a live interaction between patient and provider. In addition, the review noted most states exclude telephone, facsimile and electronic mail communications from the definition of telehealth other than to augment telehealth care.

The FSMB model policy's definition of "telemedicine technologies" recognizes the need for secure communications between physicians and patients, consistent with provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) regulating the use and disclosure of Protected Health Information (PHI) held by "covered entities" including medical service providers:

"Telemedicine Technologies" means technologies and devices enabling secure electronic communications and information exchange between a licensee in one location and a patient in another location with or without an intervening healthcare provider.

The model policy states that physicians should meet or exceed applicable federal and state legal requirements of medical/health information privacy, including HIPPA compliance and state privacy, confidentiality, security, and medical retention rules.

The FSMB model policy is strongly based on the principle of establishment of the physician-patient relationship as fundamental to the provision of "acceptable medical care" via telemedicine technologies:

A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient. Where appropriate, a patient must be able to select an identified physician for telemedicine services and not be assigned to a physician at random.

In accordance with the substantial emphasis placed on the establishment of a physician-patient relationship, the FSMB model policy requires the following elements as a minimum standard defining informed consent to care:

- Identification of the patient, the physician and the physician's credentials;
- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, appointment scheduling, patient education, etc.);
- The patient agrees that the physician determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

Initial in person physician-patient encounter not required: The FSMB model policy does permit a new physician-patient relationship be established without an initial co-located, in person visit through the use of telemedicine technologies with the proviso the standard of care is met. A physician solely providing services using telemedicine technologies with no existing physician-patient relationship prior to the encounter must document the encounter using telemedicine technologies easily available to the patient, and subject to the patient's consent, any identified care provider of the patient immediately after the encounter.

Relative to the standard of care, the model policy stipulates the use of telemedicine technologies requires physicians to be able to develop a diagnosis and treatment plan and prescribe medications as they would if consulting with a patient without the use of telemedicine technologies:

A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

In addition to the establishing a patient-physician relationship in the context of care provided through telemedicine technologies, the FSMB model policy contemplates once a relationship

has been established, it can be maintained in order to provide continuity of patient care. Under the model policy, patients should be able to easily seek follow-up care or information from the physician or physician's designee who conducts an encounter using telemedicine technologies. In addition, physicians providing services via telemedicine technologies must develop an emergency treatment plan and provide it to the patient when a referral to an acute care facility or ER for treatment is necessary for the safety of the patient. The emergency plan should include a formal, written protocol appropriate to the services being rendered via telemedicine technologies.

Guidelines governing prescribing, physicians held to same professional standard for both in-person and telemedicine prescriptions: The FSMB model policy requires in a telemedicine physician-patient encounter where medications may be prescribed, measures must be implemented to "uphold patient safety in the absence of traditional physical examination."

These should include:

- A guarantee that the identity of the patient and provider is clearly established and that detailed documentation for the clinical evaluation and resulting prescription is both enforced and independently kept;
- Measures to assure informed, accurate, and error prevention prescribing practices (e.g. integration with e-Prescription systems);
- To further assure patient safety in the absence of physical examination, telemedicine technologies should limit medication formularies to ones that are deemed safe by the medical board.

The FSMB model policy defers to the discretion of the physician as to the indication, appropriateness, and safety considerations for each telemedicine visit prescription and notes that professional discretion must be evaluated by the physician in accordance with current standards of practice. Consequently, the model policy notes, prescribing via telemedicine carries the same professional accountability as prescriptions delivered during an in-person patient encounter.

The FSMB model policy incorporates professional and ethical practice standards. "Physicians are encouraged to comply with nationally recognized health online service standards and codes of ethics, such as those promulgated by the American Medical Association, American Osteopathic Association, Health Ethics Initiative 2000, Health on the Net and the American Accreditation HealthCare Commission (URAC)," the model policy states, adding there should be parity of ethical and professional standards applied to all aspects of a physician's practice. In

addition, the model policy notes a physician's professional discretion as to the diagnoses, scope of care, or treatment should not be limited or influenced by non-clinical considerations of telemedicine technologies. Physician remuneration or treatment recommendations should not be materially based on the delivery of patient-desired outcomes (i.e. a prescription or referral) or the utilization of telemedicine technologies, according to the FSMB model policy.

Under the model policy, physicians using online services such as web sites are required to make specified site disclosures regarding specific services provided, contact information for physician, licensure and qualifications of physician(s) and associated physicians, fees for services and how payment is to be made, and financial interests other than fees charged in any information, products, or services provided by a physician and appropriate uses and limitations including emergency health situations.

In addition, physicians must disclose response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies, to whom patient health information may be disclosed and for what purpose, rights of patients with respect to patient health information, information collected and any passive tracking mechanisms utilized.

In addition, the model policy calls for patients to be provided "a clear mechanism" to:

• Access, supplement and amend patient-provided personal health information;

• Provide feedback regarding the site and the quality of information and services; and

• Register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s).

American Telemedicine Association (ATA)

The American Telemedicine Association (ATA) is a broad-based advocacy organization of healthcare health professionals, researchers, healthcare institutions and industry partners to promote "the global deployment of telemedicine." It asserts the existing state-based system of health professional licensure and practice regulations limit patient access and choice. "Requiring duplicate licenses and maintaining separate practice rules in each state has become an impediment to the use of telemedicine," the ATA states. "Such state-by-state approaches prohibit people from receiving critical, often life-saving medical services that may be available to their neighbors living just across the state line," the ATA declares. "They also create economic trade barriers, restricting access to medical services and artificially protecting

markets from competition. They cost health professionals and taxpayers hundreds of millions of dollars each year. Such requirements are outdated and restrain progress in the practice of 21st century medicine."

Noting a number of approaches have been put forward regarding licensure reform including interstate compacts, mutual state recognition and national licensure of health care professionals to further the adoption of telehealth, the ATA states it doesn't favor any particular approach. Instead it urges policy makers to move forward quickly with reforms. "Prolonged delay or regional solutions only exacerbate the problem," the ATA asserts.

As noted previously, the telemedicine model policy recently issued by the Federation of State Medical Boards (FSMB) embodies a parity principle where remote care rendered by the use of telemedicine technologies is held to the same standard of care as co-located, in-person care. But the ATA complains state medical boards are adopting practice rules with higher specifications for telehealth than in-person care and requirements that solely apply to telehealth. For example, the ATA points to requirements that a patient must be an established patient of the physician or has had an in-person physical examination from that provider before receiving services via telehealth.

Regarding online prescribing, the ATA argues state regulations should not interfere with the ability of a duly licensed healthcare provider from using telemedicine to provide a prescription to a patient with a pre-existing relationship, regardless of the patient's location, with the exception of federally controlled substances requiring an in-person patient consultation.

The ATA also advocates for reform of Medicare and Medicaid rules including permitting telehealth services provided to patients in their homes as a recognized and reimbursable component in the provision of home health care and providing reimbursement for on-line assessments, computerized clinical data analysis, and the collection and interpretation of physiological data. Noting several of these reforms are contained in H.R. 3306 (the Telehealth Enhancement Act), the ATA advocates for the amendment of Social Security Act 1834(m) to allow Medicare telehealth services for:

- Medicare beneficiaries who live in a metropolitan areas;
- Store-and-forward telehealth services, such as for wound management and diabetic retinopathy;
- Provider services otherwise covered for Medicare, such as physical therapy, occupational therapy and speech-language-hearing services;
- Services delivered wherever the beneficiary is, including home or mobile; and

- Any already-covered health procedure code possible by telehealth.

The ATA also calls for the federal government to take a greater role in promoting telehealth adoption including funding telemedicine projects and innovations, and regulating devices, services and related applications utilized in the provision of telehealth services. The ATA states it will urge the administration and Congress to implement policies including:

- Federal reimbursement to federally-funded health providers (such as community health centers) for telehealth services;
- Coordination of telehealth policy based on an Executive Order and with high level leadership for programs, regulations, and funding to maximize the federal return on investment; and
- Use of telehealth to achieve many of the federal government's interests, such as reducing health costs, improving population health, sustaining world leadership in innovative job and business sectors, reducing carbon emissions, and global health security.[2]

American Medical Association (AMA)

At its interim annual meeting in November 2013, the American Medical Association (AMA) resolved to "support the continuation of telemedicine licensure by individual states and opposes efforts to change such to federal licensure of telemedicine." That resolution becomes AMA policy once approved by the AMA House of Delegates at the 2014 annual meeting being held June 7-11, 2014. At that meeting, the AMA House of Delegates will also consider reaffirming existing policy that medical boards of states and territories require a full and unrestricted license for the practice of telemedicine involving patients within their jurisdiction.

Telemedicine licensure category: AMA's policy favoring state licensure of physicians carves out an exception for "other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory." According to the policy, telemedicine licensure should apply in situations where there is a telemedical transmission of individual patient data from the patient's state that results in either provision of a written or otherwise documented medical opinion used for diagnosis or treatment or the rendering of treatment to a patient within the state.

[2] American Telemedicine Association 2014 Telemedicine Policy Priorities. http://www.americantelemed.org/docs/default-source/policy/ata-federal-policy-priorities.pdf

In addition, the policy calls for telemedicine licensure application requirements that are "non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices." The telemedicine licensure category would not apply to traditional informal physician-to-physician consultations provided without expectation of compensation or for emergent or urgent circumstances as determined by attending and consulting physicians taking into account the views of the patient.

At the AMA's June 2014 annual meeting, it is also scheduled to reaffirm policy urging the FSMB and states to recognize that a physician practicing certain forms of telemedicine such as teleradiology must sometimes perform necessary functions in the licensing state such as interacting with patients, technologists, and other physicians and that telemedicine must accommodate these "essential quality-related functions."

Federal policy regarding Medicare telemedicine services: AMA policy supports the provision of telemedicine to provide access to health care for Medicare beneficiaries in remote geographic locations as well as the proposed addition of smoking cessation and genetic counseling to the list of approved Medicare services where telecommunications can substitute for in person patient encounter.

AMA cautiously supports the Center for Medicare & Medicaid Services' (CMS) evaluation of the telehealth comparability category. This process is used by CMS to evaluate requests to add services to the approved telemedicine list that are not similar to services currently on the approved telehealth list of services reimbursable under Medicare rules based on evidence of diagnostic findings or therapeutic interventions delivered through telehealth compared to in-person delivery. AMA notes that while no service has been approved in the last decade utilizing the comparability standard, it recommends CMS carefully evaluate the impact of the proposed new standard identified as the "clinical benefit" standard. AMA expressed concern that Medicare beneficiaries in remote areas could receive a lower level of care if clinical benefit has no relationship to the equivalent of an in-person visit.[3]

[3] AMA policy documents were reviewed on the AMA web site but links are not provided since access to AMA policy documents requires user registration.

Alliance for Connected Care

The Alliance for Connected Care seeks to create a statutory and regulatory environment in which health care providers are able to deliver and be adequately compensated for providing safe, high quality care using what it terms "connected care." Members include insurers, retail pharmacies, technology and telecommunications companies and health care entrepreneurs; the Alliance states it is advised by patient and provider advocacy organizations.

The Alliance's legislative framework entails the following principles:

- Elimination of state regulatory barriers to the practice of telehealth. The Alliance contends state regulatory frameworks hinder the use and reimbursement of telehealth.
- Elimination of state licensure barriers to the practice of telehealth that prohibit providers from furnishing telehealth services to patients across state lines. The Alliance notes state medical boards regulate the practice of medicine within its state and that in order to practice telehealth from one state to another, a physician must be licensed to practice medicine in each state. "A solution is needed to enable licensed physicians and other practitioners to deliver telehealth services to patients who need it, even if the patients are located in a different state," the Alliance argues.
- Expanded patient access to telehealth services by removing Medicare rules creating geographic and care site limitations to enable patients to communicate remotely with their providers regardless of location.
- Appropriate reimbursement of providers for the delivery of telehealth, regardless of payer.
- Including telehealth, remote patient monitoring and other connected care technology in new models of care and payment, such as medical homes and Accountable Care Organizations.

The Alliance calls for the establishment of a multi-stakeholder process to develop a standard definition of safe, high quality telehealth services and connected care, eliminating restrictions that hinder access to those services, including limits on applicable technology. This definition would serve as non-preemptive guidance to states and policymakers. The Alliance notes there is no legislative or regulatory definition that adequately describes modern technologically-supported care health care delivery mechanisms and existing definitions are disparate and imprecise, resulting in a patchwork-approach that has made it difficult to implement consistent policies that would make connected care available to all Americans.

The Alliance also advocates for the development and proposal of a robust consensus-based anti-fraud construct that will help ensure the secure delivery of medically appropriate telehealth services to patients and serve as guidance to state, federal, and private payers. Privacy and data security protections should be incorporated into any connected care innovations to ensure patients and providers are following best practices to safeguard patient information, according to the Alliance. [4]

National Council of State Boards of Nursing (NCSBN)

In a recent article in its newsletter, the National Council of State Boards of Nursing (NCSBN) framed telehealth in the context of borderless health care delivery, asserting regulatory solutions are needed to make it possible while ensuring public safety.

Telehealth has the attention of the nation's lawmakers and this new political influence will impact the state-based licensure system. NCSBN and its member boards will have to wrestle with defining the nurse licensure regulatory framework for borderless health care delivery. NCSBN must be vigilantly aware of the legislative process in order to know when to become involved and/or facilitate the process so that public protection remains paramount.[5]

The NCSBN promotes uniformity and the adoption of NCSBN uniform licensure requirements for registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs). "Uniform licensure requirements across all states will increase the mobility of nurses, facilitate telehealth and improve access to care," it states. In addition, it assures the public that every nurse in the U.S. and its territories has met the same requirements."

The NCSBN supports state-based licensure and the power granted to the states by the U.S. Constitution to formulate their own state laws and rules related to health care regulation. It opposes federal preemption of state laws related to nursing regulation.[6]

APRN compact: The NCSBN recently issued a call for public comment on draft language for an interstate licensure compact covering advanced practice registered nurses (APRN).[7] The NCSBN

[4] Alliance for Connected Care Advocacy Principles. http://www.connectwithcare.org/overview/

[5] *In Focus*, Winter 2014. https://www.ncsbn.org/InFocus_Winter2014.pdf

[6] NCSBN Public Policy Agenda, 2011. https://www.ncsbn.org/PublicPolicy2011_14.pdf

[7] Call for Comment: APRN Compact. https://www.ncsbn.org/4912.htm

has also drafted proposed compact regulations that would cover recognized APRN roles including certified registered nurse anesthetists, certified nurse midwives, clinical nurse specialists and certified nurse practitioners.[8]

According to the NCSBN, the model APRN compact was initially drafted in 2002 and subsequently adopted in 2004 by Utah and Iowa followed by Texas in 2007. Cited obstacles to adoption include disparity in APRN eligibility and practice laws among the states. This is an area in flux as states look to APRNs and other mid-level practitioners to address a projected shortfall of primary care physicians as federal Affordable Care Act health insurance reforms and an aging population are expected to increase demand for primary care services.

According to the NCSBN, under current law, APRNs are subject to redundant application processes in each state of practice and must sort through widely varying laws relating to licensure, education, certification, and scope of practice between jurisdictions. "An additional barrier to interstate practice is the potential for disciplinary action against APRNs participating in telehealth across state borders," the NCSBN observes, adding some state practice laws depart from the prevailing position of the regulatory community. As with physician licensure, the NCSBN notes there is increased pressure for federal intervention in APRN licensure as a solution.

The NCSBN states that while many stakeholders have expressed valid concerns related to the practice of APRNs in their states without the assurances provided by independent review of eligibility, adoption of a compact and promulgation of interstate rulemaking would result in greater authority retained by the states than what would result from federal intervention.[9]

National Association of Boards of Pharmacy (NABP)

The National Association of Boards of Pharmacy (NABP) has created a model practice act based on the recognition that "protection of the public health should extend across state borders." Accordingly, the NABP Model Act incorporates the "practice of telepharmacy across state lines" within the scope of the "Practice of Pharmacy" defined as follows:

[8] Proposed Advanced Practice Registered Nurse Compact Rules, Revised: January 2014. https://www.ncsbn.org/011314_Rules_1-2014.pdf

[9] Key Elements of the Proposed APRN Compact and Rules, January 6, 2014. https://www.ncsbn.org/011314_Key_Elements_of_the_APRN_Compact.pdf

"Practice of Telepharmacy" means the provision of Pharmacist Care by registered Pharmacies and Pharmacists located within US jurisdictions through the use of telecommunications or other technologies to patients or their agents at distances that are located within US jurisdictions.

"Practice of Telepharmacy Across State Lines" means the Practice of Telepharmacy when the patient is located within a US jurisdiction and the pharmacist is located in a different US jurisdiction.

The NABP Model Act respects state-based regulation and recognizes the location of the patient determines the state of jurisdiction:

The provision of Pharmacist Care services to an individual in this State, through the use of telecommunications, the Internet, or other technologies, regardless of the location of the pharmacist, shall constitute the Practice of Pharmacy and shall be subject to regulation.

The NABP Model Act also defines a "Valid Patient-Practitioner Relationship" means the following have been established:

(1) The patient has a medical complaint;

(2) A patient medical history has been taken;

(3 A face-to-face physical examination adequate to establish the medical complaint has been performed by the prescribing practitioner or in the instances of telemedicine through telemedicine practice approved by the appropriate practitioner board; and

(4)Some logical connection exists between the medical complaint, the medical history, and the physical examination and the drug prescribed.

Under the NABP Model Act, an in person physical examination is not required to establish a valid patient-practitioner relationship if the prescribing practitioner is issuing a prescription through a telemedicine practice approved by the appropriate state agency that provides health care delivery, diagnosis, consultation, or treatment by means of audio, video, or data communications. Consistent with the FSMB model policy and policy adopted by many states, the model law declares "standard telephone, facsimile transmission, or both, in the absence of other integrated information or data, do not constitute telemedicine practices."

In addition, the NABP Model Act bars pharmacists from dispensing prescription drugs if the pharmacist knows or reasonably should know that a prescription drug order was issued solely

on the basis of an Internet-based questionnaire, an Internet-based consultation, or a telephonic consultation without the establishment of a valid patient-practitioner relationship.[10]

Association of Social Work Boards (ASWB)

The Association of Social Work Boards (ASWB) has developed the Model Social Work Practice Act, which deems the provision of social work services through telephonic and electronic means as social work practice as defined in state statute. The Act recognizes social work practice via telephonic and electronic means is growing in the health care and behavioral science fields while affirming the premise that in-person client contact is the most effective and preferred method of providing client assessment, treatment, and appropriate referral services.

At the same time, the Act notes social work practice other than in-person service is limiting to both the practitioner and client. "Therefore, all parties providing and utilizing telephonic, teleconference, and Internet electronic social work services should exercise extreme caution in determining whether such practice is the appropriate vehicle for competent and ethical social work practice." The Act devotes a section to "telepractice" but does not define it per se and instead recommends states address it as a temporary privileging for practitioners not licensed in their jurisdictions:

Rather than attempting to define "telepractice" or create a limited license to address out-of-state practitioners, it is recommended that legislatures address these technologically driven practice issues through a temporary practice approach. This temporary practice language is intended to address sporadic practice within the jurisdiction irrespective of whether it is electronically rendered or rendered in person. The privilege of practicing temporarily (no more than 30 days per year) is only granted to individuals duly licensed to practice social work in another jurisdiction.

This policy also incorporates a license by endorsement principle, provided requirements for licensure in the jurisdiction of licensure are substantially similar to the requirements for licensure in the temporary practice jurisdiction. This principle is based on uniformity in accredited educational programs and the ASWB national examinations to assure that minimum competence in one jurisdiction is reasonably equated to minimum competence in another jurisdiction. [11]

[10] *Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy*, August 2013. http://www.nabp.net/system/rich/rich_files/rich_files/000/000/186/original/model-act-1-27-14.doc

[11] *Association of Social Work Boards Model Social Work Practice Act, Model Law Task Force*, 1996 - 1997

According to the National Association of Social Workers (NASW), the Act was adopted by Oklahoma in 2007.[12]

Federation of State Boards of Physical Therapy (FSBPT)

In 2011, the Federation of State Boards of Physical Therapy (FSBPT) began to explore the feasibility of establishing a multistate compact for physical therapy licensure, taking into account potential fiscal and legal impact on state jurisdictions. Noting 24 states have enacted the Nurse Licensure Compact to improve practitioner mobility and streamline the endorsement process, the FSBPT noted the compact could benefit patients, consumers, and licensees by facilitating short-term mobility and telehealth consultation for physical therapists. It could also enable member states to share investigative data.[13] No updated information on the status of the inquiry was found in a review of the organization's web site.

Association of State and Provincial Psychology Boards (ASPPB)

Association of State and Provincial Psychology Boards (ASPPB) is the alliance of state, provincial, and territorial agencies responsible for the licensure and certification of psychologists throughout the United States and Canada. The ASPPB has developed an the ASPPB Agreement of Reciprocity (AOR) that encourages states and provinces to enter into a cooperative agreement whereby any individual holding a license in one AOR participating jurisdiction may obtain a license to practice in another AOR participating jurisdiction. [14]

States or provinces must demonstrate that their requirements for licensure meet the standards required by other AOR participating jurisdictions. Under the reciprocity approach to mobility, all licensed psychologists in AOR participating jurisdictions are eligible for licensure in all other AOR participating jurisdictions.

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with amendments, 1998 – 2012. www.aswb.org/wp-content/uploads/2013/10/Model_law.pdf

[12] National Association of Social Workers, *State Social Work Law and Regulation.* http://www.socialworkers.org/ldf/legal_issue/2007/200704.asp

[13] Federation of State Boards of Physical Therapy , *Feasibility of Establishing a Multistate Compact For Physical Therapy Licensure Report to the Delegate Assembly on 2010 Delegate Assembly Motion DEL-10-05*. www.fsbpt.org/download/2011DH_MultistateCompactReport.pdf

[14] Association of State and Provincial Psychology Boards, Agreement of Reciprocity (AOR). http://www.asppb.net/?page=AOR

According to the ASPPB, the following jurisdictions are party to the AOR:

- Arkansas
- Manitoba
- Missouri
- Nebraska
- Oklahoma
- Ontario
- Texas

The ASPPB in conjunction with the American Psychological Association (APA) has developed *Guidelines for the Practice of Telepsychology* defined as the provision of psychological services using telecommunication technologies.[15]

American Pharmacists Association (APhA)

The American Pharmacists Association (APhA) supports the pharmacist as the only appropriate provider of telepharmacy services for which compensation should be provided. Telepharmacy is defined as the provision of pharmaceutical care to patients through the use of telecommunications and information technologies.

APhA policy states it shall participate in the ongoing development of the telehealth infrastructure, including but not limited to regulations, standards development, security guidelines, information systems, and compensation.

APhA acknowledges that state boards of pharmacy are primarily responsible for the regulation of the practice of telepharmacy. It encourages appropriate regulatory action that facilitates the practice of telepharmacy and maintains appropriate guidelines to protect the public health and patient confidentiality.[16]

[15] Guidelines for the Practice of Telepsychology, Joint Task Force for the Development of Telepsychology Guidelines for Psychologists. *American Psychologist*, December 2013. Vol. 68, No. 9, 791–800 DOI: 10.1037/a0035001

[16] American Pharmacists Association Policy: Telemedicine/Telehealth/Telepharmacy. http://www.pharmacist.com/policy/telemedicinetelehealthtelepharmacy-13

The Information Technology and Innovation Foundation (ITIF)

The Information Technology and Innovation Foundation (ITIF), a non-partisan research and educational institute, weighed in with a May 2014 position paper on the regulation of telehealth services. It recommends the adoption of a standard national definition for telehealth services, noting states vary widely in how they define telehealth with conflicting definitions creating an unnecessarily complex legal environment for providers, payers, and patients.

To address this issue, the ITIF states Congress should create a federal standard for telehealth that states should then adopt. The ITIF notes H.R. 3750, the Telehealth Modernization Act of 2013, would accomplish this by defining telehealth to include health care delivered by real-time video, secure chat, secure email, or telephone. It also specifies conditions under which health care providers licensed in a state should be allowed to provide telehealth services. These include having access to patient records, fully documenting the medical encounter, and providing patients access to their professional credentials. In addition, the states adopting this guidance would be encouraged to limit telehealth providers from prescribing controlled substances (those listed on schedule II, III, or IV).

Signaling impatience, the ITIF argues states have had sufficient time to produce a widely-accepted solution. “If states fail to adopt an interstate agreement within the next 18 months allowing health care providers with out-of-state licenses to practice medicine nationally, then Congress should adopt a uniform national license for telehealth that would be required to be accepted in all states,” the ITIF argues. To respect states’ rights, the legislation could have a sunset provision if states later create a multi-state compact adopting a nationwide licensing standard, it adds. [17]

Parkinson's Action Network (PAN)

The Parkinson's Action Network supports pending federal legislation, the Veterans E-Health and Telemedicine Support Act of 2013, contending it would allow the Department of Veterans Affairs (VA) health professionals to practice telemedicine across state lines and will remove the artificial restriction that requires veterans to travel to a federally-owned facility to receive health care by telemedicine.

[17] Daniel Castro, Ben Miller, and Adams Nager. *Unlocking the Potential of Physician-to-Patient Telehealth Services.* The Information Technology and Innovation Foundation, May 2014. http://www.itif.org/publications/unlocking-potential-physician-patient-telehealth-services

PAN also supports H.R. 3077, the TELEmedicine for MEDicare (TELE-MED) Act of 2013. According to PAN, the legislation would allow doctors to see Medicare patients in different states via telemedicine without having to obtain multiple state licenses.[18]

Stakeholder organizations with no defined public policy positions on telehealth services

Policy positions of the following groups specified in the project RFP and Item 10(g) of the contract Scope of Work (Attachment B) were researched with no references found:

- American College of Nurse Midwives (ACNM)
- American Association of Nurse Practitioners (AANP)
- American Nurses Association (ANA)
- American Association of Marriage and Family Therapy (AAMFT)
- Association of Marriage and Family Therapy Boards (AMFTRB)
- American Psychological Association (APA)
- American Mental Health Counselors Association (AMHCA)
- National Board of Certified Counselors (NBCC)
- National Association of Alcohol and Drug Abuse Counselors (NAADAC)
- National Association of Social Workers (NASW)

[18] http://www.parkinsonsaction.org/federal-initiatives/current-telemedicine-legislation