
Utah Telehealth Study – Summary Report

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

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As specified in the Request for Proposals (RFP) for this study, its objective is to provide greater understanding of telehealth services provided by licensed health care professionals in practice and law. The goal is to help inform public policymaking relative to the public safety, healthcare enhancement and economic implications of telehealth. This phase of the project presents an overview of the findings derived from the four project report sections as well as an analytical discussion of the findings as requested in the RFP.

The four report sections of the study and their respective areas of focus are:

1. Major trends, drivers and data points relative to the adoption of telehealth services with focus on public safety considerations and economic impacts;
2. State law and regulations governing the administration of telehealth services delivered by licensed health care professionals;
3. Federal law and regulations governing telehealth services delivered by health care professionals including federal Medicare/Medicaid provider reimbursement policy and federal guidance on telehealth services delivered by licensed health care professionals;
4. Policy positions of national stakeholder groups with an interest in telehealth services delivered by licensed health care professionals.

For the purposes of this project, the term “telehealth” broadly encompasses diagnosing, treating and monitoring patients remotely (versus co-located with a provider) using information

and communications technology (ICT), also referred to as “telemedicine.” This definition closely follows that adopted by the World Medical Association in 2009, defining telehealth as the use of information and communications technology to deliver health and healthcare services and information over large and small distances.

There are three basic categories of patient information communicated in the practice of telehealth by licensed health care providers:

1. Interactive, real time, two-way communications between patient and provider;
2. Store and forward: patient data shared between patients and providers and in consultations among providers;
3. Remote monitoring of patient data such as by intensivists of critical care patients in a distant hospital.

There are three primary modes of patient communication with providers:

1. Connection to remote provider from an institutional setting such as a clinic or hospital;
2. Connection to remote provider from patient’s private home;
3. Connection to remote provider from patient’s mobile device.

Section 1: Major trends, drivers and data points relative to the adoption of telehealth services

In this phase of the project, a large quantity of mainstream and specialty media, industry reports and academic journal articles were reviewed and industry experts queried to identify major trends, drivers and data points relative to the adoption of telehealth services and related public safety considerations and economic impacts.

As this report was being prepared in the first half of 2014, the activity level in the practice and policy environment relating to telehealth increased significantly. The overall impression is that of a topic that is highly fluid and dynamic, characteristic of emerging developments that undergo a relatively long periods of development and then approach a tipping point or threshold kicking off a new, heightened phase of development.

The 2000s represented a decade of startup activity setting the stage for the next phase of telehealth beginning around 2011-12. Around this time, a number of factors began to converge sparking interest in telehealth including public and private reforms of health care financing and delivery and population demographics. The baby boomer cohort began moving into its senior years and boosting demand for ongoing care and monitoring, particularly those with multiple

chronic medical conditions. The millennial generation of young adults with native digital literacy expects to be able to conveniently access information and most any service online including health care.

A development closely related to telehealth practice is the increasing use of electronic health records (EHRs). The federal Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 appropriated more than \$20 billion to encourage hospitals and health care facilities to digitize patient data and make better use of information technology. In 2013, the National Ambulatory Medical Care Survey (NAMCS) EHR Survey showed that about 78 percent of office-based physicians used an EHR system, with adoption of basic EHR systems increasing 21 percent between 2012 and 2013.

By various estimates, telehealth practice is poised for rapid growth. The number of worldwide patients receiving telehealth services is forecast to increase from less than 350,000 in 2013 to roughly seven million in 2018, according to a report published by IHS Technology. According to IHS, telehealth will be driven by employers, private insurers and the federal Patient Protection and Affordable Care Act, which makes doctors and hospitals more accountable by moving medical care providers away from fee-for-service medicine where they are paid based on volume of services to reimbursement based on the value of care they provide.

As Internet-based information and communications technology (ICT) became more widely available in the late 1990s and early 2000s along with the subsequent introduction of Internet-enabled mobile devices such as smartphones and tablets in the following decade, the level of practitioner and regulatory interest in telehealth grew along with it. A *Harris Interactive/HealthDay* online survey of 2,050 Americans aged 18 and older conducted between May 22-24, 2013 found more than one-third of respondents said they were "very" or "extremely" interested in using smartphones or tablets to ask their doctors questions, make appointments or get medical test results. Similar numbers of respondents were eager to use mobile phones and tablets for actual health-care services -- such as monitoring blood pressure or blood sugar, or even getting a diagnosis.

However, since mobile devices have been in widespread use for a relatively short period of time -- spawning the term mobile health or "mHealth" as a remote form of accessing medical care -- not enough time has passed to assess it. "We really found limited evidence that mHealth in and of itself has shown its effectiveness," observes Keith Toussaint, executive director of business development, Global Health Solutions, at Mayo Clinic.

With the increase in the robustness of Internet connections and free or inexpensive two-way videoconferencing, remote face to face interactive visits between health care professionals and

patients are now more accessible. That enables a wider scope of communication beyond voice telephone calls and emails. It expands direct patient access to telehealth services without the need for patients to travel to an institutional setting such as a clinic or hospital to consult with a health care professional at another location. In that regard, telehealth is another form of patient empowerment with the potential to transform health care just as webmd.com and other sources of online medical information that allow patients to access a virtual library of medical information at their fingertips. Now patients can access both health related information and health care providers quickly and conveniently. This defines the second – and current -- generation of telehealth services.

Some veteran practitioners believe the addition of two-way video is the key technological development setting the stage for the next generation of telehealth growth. Steven J. Davidson, MD, senior vice president and CMIO at Maimonides Medical Center in Brooklyn, New York, notes that the addition of interactive video has advanced telehealth practice to the point where it can eliminate the need for 60 percent of co-located physician-patient interactions.

However, since the adoption of two-way video primarily using a patient's home Internet connection rather than via a mobile device outside the home is still relatively new and many homes lack sufficient landline Internet connectivity to support it, growth could be slow and take place over the next two to three decades. Brendan Carr, MD, assistant professor of emergency medicine at the University of Pennsylvania's Perelman School of Medicine, notes research shows the lag time between research and integration in the inherently conservative practice of medicine can take up to 17 years.

Telehealth is emerging as a crucial building block in the delivery of care, according to panelists at a forum hosted in early 2014 by the Robert Graham Center for Policy Studies in Family Medicine and Primary Care. The implementation of the Affordable Care Act is leading to increased demand that physicians interact with more patients, speakers noted, pointing to telemedicine as a potential solution. This section of the Utah Telehealth Study found telehealth services are being provided in a variety of settings and delivery modes including primary care, hospitals and follow up care, emergency services, preventative care and institutions such as prisons and schools.

Primary care

Telehealth is being practiced in the context of non-urgent primary care by online clinics including Teladoc, Stat Health Services and American Well that connect patients by phone and online to doctors licensed in patients' state of residence. A major impetus for these services is access and convenience compared to an in-person visit to a doctor's office or clinic or waiting for an appointment during normal business hours. Teladoc, which began by offering simple,

phone-based consults with a doctor, is expanding into online solutions, virtual onsite clinics (making use of kiosks) and physician-facing portals. In the context of primary care, telehealth not only bridges distance. It breaks down the longstanding time barrier to access to care since most primary care providers maintain standard Monday through Friday business hours.

Primary care telehealth services are also being adopted by employers. According to an article appearing in *BloombergBusinessweek* in early 2014, hundreds of employers of all sizes are contracting directly or through their insurers with telehealth providers to cut medical costs and give workers 24-hour access to doctors and nurse practitioners. Insurer WellPoint partnered with Boston-based American Well to offer telehealth services to 3.5 million of its health-plan subscribers last year and intends to extend the service to another 32.5 million over the next 12 to 18 months. UnitedHealth Group began a pilot program in January 2014, providing 310,000 subscribers in Nevada with virtual physician visits.

Consults among providers

One of the more established forms of telehealth is consults among providers. One example involves a patient with a severe case of scoliosis — an abnormal curvature of his spine. This led to severe chronic pain, anxiety, depression and sleep apnea. To develop a treatment plan, a physician assistant remotely presented the case to University of New Mexico experts in psychiatry, internal medicine, neurology, physical therapy and rehabilitation medicine. The health care providers took turns asking questions and discussing the patient. Together, they came up with a course of treatment that resulted in the patient sleeping through the night and getting his anxiety under control, improving his quality of life.

Emergency services

Telehealth is also being practiced by first responders. At Oregon's Clackamas Fire District #1, tablet computers are on every fire engine and responders carry wireless hot spots with them. District Director Kyle Gorman estimates as many as 30 percent of emergency calls could be handled with a physician Skyping the patient, avoiding a trip to a hospital emergency room.

Institutions

- At the Louisiana Department of Corrections telemedicine enables remote physician services, clinic scheduling for routine check-ups, emergency consultations and scheduled visits.
- Students at Ossun Elementary School in Lafayette, Louisiana (which operates a municipal fiber optic telecommunications network) with minor medical issues such as earaches, sore throats or other common ailments will be seen on the elementary school campus by a doctor in an exam room about five miles away at Carencro Middle School's school-based health center. Using Bluetooth-enabled stethoscopes, otoscopes and

ophthalmoscopes, a pediatrician will examine patients at the elementary school as part of a telehealth program partnership between the Lafayette Parish School System and Lafayette General Health and its foundation. The goal is to test the telehealth model and explore a more cost-effective way to expand school-based health services across the district.

Hospital and hospital outpatient care

Telehealth is being employed in hospital and hospital outpatient settings. For example, intensivists remotely monitor patients in critical care units of distant hospitals. A study found that the number of U.S. hospitals using telemedicine in ICUs increasing, growing by an annual average of 8.1 percent from 2010 to 2014.

Chronic disease management and home-based care to avoid hospitalization

- In the United Kingdom, more than 100 telehealth projects are running across National Health Services (NHS) organizations to address patients with chronic conditions such as congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and diabetes. According to InMedica, a division of IMS Research, 308,000 patients around the world were monitored remotely by providers in 2012 for congestive heart failure, chronic obstructive pulmonary disease, diabetes, hypertension and mental health conditions.
- In Florida, tablet computers are being used to monitor cardiac patients at home recovering from surgery. Florida's Memorial Regional's Home Health Services credits the program for reducing its 30-day hospital readmission rate among cardiac patients to less than 2 percent — far lower than the 22.8 percent national average and Memorial's overall 19.9 percent readmission rate.
- At the Mid-Appalachia Telehealth Project in East Tennessee, diabetes patients in need of close monitoring are given home-based telehealth equipment to record and forward daily glucose readings and other vital statistics to nurses in local health departments and community health centers.
- The Delta Health Partnership provides comprehensive diabetes care for an underserved population of predominantly African American patients in rural areas of the Mississippi Delta region. Funded by the federal Office for the Advancement of Telehealth, the project uses videoconferencing to link local nurse practitioners, physician assistants, and pharmacists with a multidisciplinary diabetes team for patient consultations, patient and provider education, case management, and quality assurance.
- Between July 2003 and December 2007, the Veterans Health Administration (VHA) introduced a national home telehealth program to coordinate the care of patients with

chronic conditions and avoid their unnecessary admission to long-term institutional care.

- Essentia Health of Minnesota is using telehealth to home monitor and prevent the hospitalization of patients with heart problems as part of accountable care organization (ACO) created under the Affordable Care Act.

Home-based primary care of the elderly to avoid institutionalization

A new school of thought is emerging relative to health care for the elderly, particularly those with multiple chronic conditions that can result in very costly institutional care that prolongs their lives but does not improve quality of life. A new approach keeps these patients in their homes through the provision of intensive, coordinated primary care. Given an expected increase in those suffering from Alzheimer's and other forms of dementia as the baby boomer demographic ages, telehealth home monitoring of these patients could prove beneficial and help mitigate institutionalization. A 2007 study found televideo monitoring could improve medication self-administration accuracy and improve mood for persons with mild dementia who live alone or spend a significant amount of their day alone.

Mental health care

According to a recent estimate, psychologists, psychiatrists, and clinical social workers accounted for 49 percent of the health care professionals who provided 10 or more telehealth services in Medicare.

David Pruitt, M.D., director of the Division of Child and Adolescent Psychiatry at the University of Maryland, notes shortage of pediatric specialists will deepen with the Affordable Care Act, which is expected to bring in large numbers of new Medicaid recipients, 40 percent of whom will be children.

In an institutional application, veterans returning from deployments to the Middle East are being provided mental health care via telehealth through the Veterans Administration.

Quality of Care and patient safety

There exist few studies on the quality of care and patient safety for patients who received telehealth services provided by licensed health care professionals. Those that were identified are positive, including one finding quality of care was rated higher by physicians and patients. Another found telehealth could result in fewer medication errors in rural emergency departments.

Some practitioners however note telehealth remains relatively new and warrants prudence. Concerns are raised in terms of making accurate diagnoses remotely for conditions that require testing and follow up care. Other practitioners emphasize the need for a primary care physician relationship, noting that a telehealth consult with a physician where there is no pre-existing provider-patient relationship cannot wholly replace the need for a primary care medical home.

Researchers caution that more research is necessary to further assess the quality and safety of primary care delivered by telehealth services. There are concerns that its expanded use may lead to fragmentation of care since physicians do not have access to information (due to the lack of integration of EHRs) that can be gathered during a patient exam or diagnostic testing. Some providers fear these and other limitations can lead to misdiagnosis and higher rates of follow-up visits. A 2010 study suggests remote care of primary care patients is more appropriate for follow up care than initial visits.

Some practitioners have different methods for how they assess patients remotely versus co-located with the patient in person. Some believe practitioners must be able to spot red flags that signal the need for referral to an ER or urgent care center. “There are some things where someone needs to lay eyes on you,” one physician observes. Many practitioners see the benefit of using telehealth to treat patients in rural areas, but nevertheless see limitations. While ailments like poison ivy and minor colds are treatable using only telehealth, some practitioners believe many diagnoses must be made with a face-to-face, co-located office visit.

Some observers foresee a broader risk associated with the growing use of health telematics that does not involve providers laying hands on patients. They point to an increasing reliance upon technology and the “de-skilling” this may entail for medical professionals that some similarly believe airline pilots operating modern aircraft with automated controls can experience relative to hands on piloting skills.

Standard of care for telehealth

As telehealth more closely approximates the traditional, co-located provider-patient encounter with the introduction of real time videoconferencing, questions arise as to what standard of care should govern. For example, should the same standard of care apply uniformly regardless of whether the patient encounter occurs in a co-located setting or remotely via telehealth? Or should new and additional standards be developed for the new, online-enabled generation of telehealth?

Some maintain existing clinical risk management and patient safety processes within legacy healthcare platforms offer the structure, process and outcomes that are necessary to ensure telehealth programs are implemented and sustained in a safe, appropriate and effective way.

Others believe that in order to ensure telehealth services maintain current levels of patient safety, underlying clinical, technology and business processes should be standardized as part of a systems approach to healthcare transformation.

These concerns were highlighted by the authors of a study of a large California agency serving public employees who engaged in remote telehealth visits with primary care providers. The findings, published in early 2014 in the journal *Health Affairs*, represent the first assessment of a telemedicine program offered to a large, diverse group of patients across the United States. “Although telehealth is, in many respects, a fundamentally different model for providing health care, very few standards have been developed to guide practitioners on how to safely and effectively administer telehealth services,” the authors opine. “This includes, for example, standards and protocols to prevent transmission errors that could cut off remote communications, standards on how to properly use telehealth equipment (such as imaging devices), and standards relating to the informed consent process in the telehealth setting.” The authors assert it is “imperative that hospitals and health systems develop protocols and standards around their telehealth practice, and supply patients with information upfront that highlights the medical risks associated with telehealth.” Moreover, they write despite the potential benefits of telehealth applications, little is known about their overall impact on care.

The study authors found providers saw patients with many diagnoses that typically require a physical exam, diagnostic testing, or both. They additionally found patients using the primary care telehealth provider Teladoc were less likely to have a follow-up visit to any setting, compared to those patients who physically visited a physician’s office or emergency department.

One academic paper acknowledges the significant potential benefits of home monitoring telehealth services for patients with multiple chronic conditions including decreased rates of mortality, improved quality of life and savings for third party payers. But the current regulatory process does not provide adequate oversight and standards for these systems that transmit and process data (telehealth systems) critical for patient management, the paper’s authors argue. Home telehealth vendors must address the possibility that increased utilization increases their risk of liability due to patient safety issues including effectiveness of patient management, evidence-based outcomes, regulation, cost effectiveness and reimbursement and certification to ensure reliability.

Sections 2 and 3: Federal and state law and regulations governing the administration of telehealth services delivered by licensed health care professionals

Federal and state statutes and regulations pertaining to telehealth services by licensed healing arts practitioners were compiled and reviewed. The scope generally excluded telehealth-related authorities pertaining to health care facilities, state medical assistance programs, state telehealth initiatives, and public and private health insurance. In addition, a Lexis/Nexis search of federal court decisions was conducted to identify federal common law mandates on states pertaining delivery of telehealth services.

The federal government defines and regulates the delivery of telehealth services in these contexts:

1. Medicare and Medicaid and practitioner reimbursement;
2. Home and community-based services for elderly and disabled individuals;
3. Food and Drug Administration law relative to online pharmacy; and
4. Federal health care programs including the Public Health Service, Indian Health Service, and the Veterans Health Administration.

These federal programs employ differing definitions of telehealth or telemedicine. Relative to Medicare, federal statute (the Social Security Act) defines “telehealth service” as “professional consultations, office visits, and office psychiatry services...and any additional service specified by the Secretary.” The Social Security Act also defines telehealth services using location-based parameters including “originating site” (where the patient is located when receiving services) and “distant site” (the location of the practitioner while patient services are being delivered) as well as the scope of practitioners who may provide telehealth services.

Medicare rules define “telehealth services” as encompassing an interactive telecommunications system using multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. The definition also includes the “store and forward” transfer of patient information to another provider for confirming a diagnosis and/or treatment plan.

Medicaid program guidance states “telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.” The web site also defines “telehealth and telemonitoring” as “the use of

telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.”

Regulations promulgated by the Drug Enforcement Administration (DEA) define the “practice of telemedicine” as “practice of medicine in accordance with applicable Federal and State laws by a practitioner (other than a pharmacist) who is at a location remote from the patient and is communicating with the patient, or health care professional who is treating the patient, using a telecommunications system...”

In the context of federal health care centers, federal statute specifically recognizes the definition of telehealth as including mental health service and broadly defines it as “the use of electronic information and telecommunications technologies to support long distance clinical health care, patient and professional health-related education, public health, and health administration.”

For the purposes of Medicare, the law contemplates telehealth services as serving areas where there are fewer available practitioners, limiting their delivery to rural Health Professional Shortage Areas, either located outside of a Metropolitan Statistical Area (MSA) or in a rural census tract or counties outside of a MSA. Notably, the statute specifies originating sites can only be physician offices and specified health care facilities.

Federal law defines the types of practitioners who may be reimbursed under Medicare for telehealth services are listed in two categories. The first is physicians, broadly defined as:

- Physicians and osteopaths
- Dentists
- Podiatrists
- Optometrists
- Chiropractors

The second category is defined in statute as “practitioner” and includes:

- Physician assistants, nurse practitioners, or clinical nurse specialists
- Certified registered nurse anesthetists
- Certified nurse-midwives
- Clinical social workers
- Clinical psychologists
- Registered dietitians or nutrition professionals

Notably, professionals are required to be licensed in the state in which they perform functions within the scope of their licensure. Medicare regulations specifically require the physician or practitioner at the distant site be licensed to furnish the service under state law.

Wide variation among states

There is a wide variation among state statutes and regulations governing the delivery of telehealth services by healing arts licensees. Some states have relatively extensive bodies of law including five states (New Hampshire, New Mexico, Nebraska, Oklahoma and California) that have enacted omnibus telemedicine or telehealth statutes, while other states have been minimally active in this area.

Several states have not enacted any statutes or promulgated regulations pertaining to the delivery of services via telehealth by licensed health care practitioners. Nearly all states regulate telehealth practice by physicians and osteopathic physicians, although a small number do not (such as Ohio and South Dakota) where telehealth laws solely govern other licensed healing arts. Many states specifically regulate telehealth practiced by licensees including nurses, physician assistants, mental health providers, audiologists and speech pathologists, physical therapists, optometrists and dentists.

States vary in how they define telehealth (some use the term “telemedicine”). Several (Alaska, Arizona, Louisiana, Oklahoma) define it as a practice of health care delivery when provider and patient are not physically co-located using information and communications technology. California has adopted a relatively broad definition, defining telehealth as “the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.” One state (Montana) defines telehealth as practiced exclusively by out of state practitioners for patients within the state, while others limit its use to in-state licensed practitioners.

Consistent with model policy issued by the Federation of State Medical Boards (FSMB) as this review was being completed, nearly half of all states define telehealth in the context of a live interaction between patient and provider.

Two states (South Dakota, Vermont) limit the definition of telehealth to the monitoring of patients in their homes. One state (Maryland) regulates telehealth provided by physicians by establishing rules that specifically apply to physicians using websites for the delivery of telehealth. Most states exclude telephone, facsimile and electronic mail communications from the definition of telehealth other than to augment telehealth care.

While most states with telehealth laws include a form of telehealth known as “store and forward” (use of information and communications technology to transmit data, images, sounds or video from one care site to another for evaluation) in the definition of telehealth, some exclude it. California includes both synchronous patient-provider interactions and asynchronous store and forward transfers in its definition of telehealth.

Only one state, West Virginia, has law specific to the practice of pharmacy in the context of telehealth. The law defines the practice of “telepharmacy” as the provision of pharmacist care by properly licensed pharmacists located within the United States through the use of telecommunications or other technologies. A face-to-face physical examination adequate to establish the medical complaint must be performed by the prescribing practitioner.

Standards of practice in state law

A handful of states have codified relatively extensive standards of practice regulating the use of telehealth by licensed health care professionals including Florida, Kentucky, Louisiana, Maryland and Texas. These as well as other states have adopted threshold requirements providers must meet in order to establish a telehealth provider-patient relationship before care is provided including:

- Informed consent to receiving care by telehealth;
- Verification of patient’s identity;
- Written patient notification of provider’s privacy practices;
- An initial patient examination;
- Disclosure to patient of risks, consequences and benefits of telehealth, right to withdraw consent, how to receive follow-up care or assistance in the event of an adverse reaction to treatment or if there is a telemedicine equipment failure
- Notice of how to file a complaint against the provider;
- Access to pertinent portions of the patient's medical record and;
- Support staff trained to conduct telehealth patient visit, implement physician orders, identify where medical records generated by the visit are to be transmitted for future access, and provide or arrange back up, follow up, and emergency care to the patient.

In most states, there are ongoing provider requirements to ensure patient safety that govern the delivery of care via telehealth including:

- Protocols to prevent fraud and abuse through the use of telehealth medical services;
- Adequate security measures to ensure that all patient communications, recordings and records remain confidential;

- Procedures to prevent access to data by unauthorized persons through password protection, encryption, or other means;
- Policies on how quickly patients can expect a response from the physician to questions or other requests included in transmissions and;
- Maintenance of a complete record of the patient's care.

Notably, only some of these standards appear in the April 2014 FSMB model policy: verification of the patient's identity, informed consent and security of patient data.

Louisiana delineates the elements that define establishment of a physician-patient telehealth relationship including evaluation (review of any relevant history, laboratory or diagnostic studies, diagnoses, or other information deemed pertinent by the physician); diagnosis of the patient's disorder, illness, disease or condition and the reason for which treatment is being sought or provided; treatment plan and a plan for follow-up care provided to the patient in writing and documented in the patient's record.

For patients seen at other than an established medical site, Texas requires physicians to conduct initial patient visits at the same location with the patient except when the patient has received an in-person evaluation by another physician who has referred the patient and the referral is documented in the medical record. Texas also requires a co-located physician-patient visit be conducted at least annually in the context of providing care via telehealth.

Texas employs an information-based parity standard relative to medical practice. Physicians must be able to obtain all pertinent clinical information in the context of a telehealth encounter that a health care provider exercising ordinary skill and care would deem reasonably necessary for the practice of medicine at an acceptable level of safety and quality. If all the necessary information cannot be obtained in the context of a telehealth encounter, Texas law requires physicians to advise patients prior to the conclusion of the telehealth encounter of the need for additional in-person evaluation.

As with the FSMB model policy, Maryland law recognizes the establishment of a physician-patient relationship without an initial, co-located face-to-face interaction provided physicians incorporate "real-time auditory communications or real-time visual and auditory communications to allow a free exchange of information between the patient and the physician performing the patient evaluation."

Several states (Colorado, Florida, Hawaii, and North Carolina) incorporate a parity standard into their laws and regulations governing telehealth, explicitly stating standards of practice and professional misconduct apply equally to care provided patients via telehealth and in settings

where patient and provider are co-located. Colorado statute specifically includes telemedicine within the definition of practice of medicine. One state (Wisconsin) requires telehealth be “functionally equivalent to face to face contact.”

Telehealth and practice across state lines

Most states prohibit practitioners licensed in other states from delivering services via telehealth to patients residing within their jurisdictions. In about half the states, however, the law is silent on delivery of telehealth services by health care professionals licensed in other states.

In the context of telehealth, several states exempt from physician licensure requirements consultations between physicians, typically relative to “store and forward” telehealth consultations among practitioners, where patient diagnostic information such as imagery is transmitted to an out of state physician for review and medical opinion. Oregon law allows telehealth monitoring by physicians licensed in other states in a single circumstance: to monitor surgical patients. Under this provision, Oregon health care facilities must grant privileges to these physicians and request the state medical board grant them active telemonitoring status.

Apparently in recognition of interstate telehealth practice by physicians, nine states issue specialized telehealth licenses or certificates that permit a practitioner licensed in another state to practice within their jurisdictions under certain conditions. States authorizing special telehealth licensure for physicians licensed in other states include:

- Alabama
- Louisiana
- Montana
- New Mexico
- Nevada
- Ohio
- Oklahoma
- Tennessee
- Texas

Minnesota allows physicians licensed in other states to practice telemedicine with patients located in Minnesota if they register with the medical board and refrain from opening an office in the state or meeting with or receiving calls from patients while both provider and patient are in Minnesota.

Hawaii allows physicians licensed in other states to practice telehealth on Hawaii residents if they have a pre-existing provider-patient relationship. However, Hawaii law prohibits the use of

telehealth to establish a physician-patient relationship with a resident of Hawaii without a Hawaii license.

Some states allow out of state physicians to practice within their jurisdictions if they hold licensure in adjoining states or by reciprocal licensing with other states. States allowing practice under specified conditions by physicians licensed in bordering states include Texas, Pennsylvania, Maryland and Washington. Only three states (Alabama, North Dakota and South Dakota) have reciprocal licensure laws. These border state practice and reciprocal licensure laws effectively permit the limited interstate practice of telehealth within their jurisdictions.

Section 4: National stakeholder group positions

In this report section, the public policy positions of national stakeholder groups with an interest in telehealth services were researched. Stakeholder organizations with 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.

Timely to the Utah Telehealth Study was 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 enable visual interaction using secure videoconferencing.

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. This parity principle mirrors Texas law as well as the World Medical Association's (WMA) Standards of Practice/Quality of Clinical Care guidelines for physicians who use telehealth to provide health care services.

The stated policy intent of the FSMB model policy 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." It defines telemedicine as:

[T]he 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.

The FSMB model policy also defines "telemedicine technologies" that enable telemedicine and 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.

Notably, the FSMB model policy does allow 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 and other conditions are met.

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.

The ASWB model act 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. Interestingly, the ASWB model act devotes a section to “telepractice” but does not define it per se and instead recommends states instead 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.

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

In some respects, the issue of regulation of telehealth services delivered by licensed health care professionals and the appropriate standard of care has been framed as a larger policy issue: whether states should retain plenary regulatory authority over health care professionals who practice telehealth. The American Telemedicine Association (ATA) views state licensure as an obstacle to telehealth practice, a view 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.

However provider groups – most notably the AMA – as well as the NCSBN, NABP and ASWB and the American Pharmacists Association (APhA) -- have adopted policy positions respecting state licensure authority over health care professionals, with flexibility to accommodate delivery of telehealth services by practitioners licensed in other states. For example, the AMA supports 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.

The NABP Model Act incorporates the “practice of telepharmacy across state lines.” Like the FSMB model policy, the NABP Model Act places substantial emphasis on the establishment of a patient-practitioner relationship that meets specified conditions that ensure prescribing occurs in a medical context and that a health care practitioner ensures a bona fide patient medical complaint exists.

Association of State and Provincial Psychology Boards (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.

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

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

Research conducted during this phase of the project found 10 practitioner organizations that have no public policy positions on telehealth:

- 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)

Policy questions presented/topics for further study

1. To what extent do patients require care by health care professionals licensed outside patients' state of residence in terms of type, amount and frequency?
2. To what extent does state licensure create obstacles to the delivery of care via telehealth by health care professionals to patients outside their states of licensure?
3. Are these obstacles having a significant adverse impact on patients' ability of to obtain needed care?
4. Does existing law provide sufficient leeway for health care professionals to provide services to patients located outside their jurisdiction of licensure?
5. Is telecommunications infrastructure sufficiently developed to enable nationwide application of the FSMB model policy guidance that defines telemedicine as "typically involv[ing] the application of secure videoconferencing..." If not, when will it reach that point?
6. As an alternative or interim mode of flexibility to accommodate the interstate practice of telehealth by licensed health care professionals as policy and technological developments play out, should states consider 30-day "temporary privileging" for practitioners licensed in other states as proposed in the ASWB model act?