Virginia Department of Health Professions
VIRGINIA BOARD OF HEALTH PROFESSIONS
Ad Hoc Committee on Telehealth

REPORT ON THE PRACTICE OF TELEHEALTH ACROSS STATE LINES STATE REGULATION

September 15, 1998

Virginia Department of Health Professions
6606 West Broad Street, Fourth Floor
Richmond, Virginia 23230-1717
www.dhp.state.va.us

Department of Health Professions
BOARD OF HEALTH PROFESSIONS
Ad Hoc Committee on Telehealth

Report on
Practice of Telehealth Across State Lines and State Regulation

Department of Health Professions
6606 West Broad Street, Fourth Floor
Richmond, Virginia 23230
www.dhp.state.va.us

Board Members with Committee Members noted

* Barbara A. Cebuhar, Chair
Charles M. Bristow, Jr., F.S.L.
Timothy E. Clinton, L.P.C., Ed.D.
Delores C. Darnell, R.N.
Janice S. Golec
Dennis L. Hawley, Ph.D.
* Krishan D. Mathur, Ph.D.
* Isabelita M. Paler, R.N.
Sharon H. Patterson, Ph.D., L.C.P.
Gary L Pillow, M.A.
Julia Beatrice Reed, Esq.
* Clarke Russ, M.D., Chair, Ad Hoc Committee
Samuel C. Smart, O.D.
Conway F. Stanley, R.Ph.
William A. Truban, V.M.D.
* William M. York, Jr.

* Ad Hoc Committee on Telehealth

Staff

Robert A. Nebiker, Executive Director
Elizabeth A. Carter, Ph.D., Deputy Executive Director
Elaine Yeatts, Senior Regulatory Analyst

TABLE OF CONTENTS

INTRODUCTION

On September 12, 1997, the Director of the Department of Health Professions requested that the Board study certain issues related to telehealth. This resulted from a review of critical agency issues, by the Secretary of Health and Human Resources. Specifically he wished to see a policy developed which accounted for and promoted the application of this new technology for the benefit of consumers as well as an opportunity for the provider community to extend their practice. The request specifically asked the Board to address the "proper role, jurisdiction and operation of state regulation" in dealing with "practice across state lines".

This effort is consistent as well with the recommendations of the 1997 Report of the Council on Information Management on "Barriers to the Implementation of Telemedicine in Virginia." In that document, it recommended the Board of Medicine be encouraged to adopt a policy for practice which will achieve maximum quality of care for as many citizens of the Commonwealth as possible.

Also, the issue of telehealth clearly emerged in the Board's recent "Study of the Appropriate Criteria in Determining the Need for Regulation of any Health Care Occupation or Profession." As discussed in the section dealing with the health care market, "The emergence of telehealth practice as a means of delivering health care services means that professionals and patients can be in different states or even nations, during the care process..." It means that workers will deliver services in organizations whose management, credentialing, and privileging entities are remote from the site of actual service delivery. The Board adopted two specific recommendations in regard to telehealth:

- The Board of Health Professions should encourage consistency in the Virginia health professions regulatory scheme, including increasing the consistency of Virginia's entry-to-practice requirements for out-of-state providers among the health regulatory boards.

- The Board of Health Professions should encourage a coordinated and consistent regulatory approach among its constituent Boards with regard to interstate telehealth activity.

The Committee identified several global issues or concerns regarding its approach to the study:

1. Consumer Protection

   What is the appropriate regulation that should exist to provide for patient or consumer protection? How will key safeguards that provide for safe practice, patient confidentiality, disclosure to patients be addressed in the context of telehealth? The consumer interest may be defined in terms of quality health care which is accessible to the maximum number of citizens. These objectives, however exist in tension with one another.

2. Accountability

   How may the practitioner be held accountable for actions which occurred in the context of telehealth? With whom can a consumer report substandard care and seek damages in a malpractice action? How will regulation be administered, subpoenas and notices be served, hearings conducted, etc? How may a state enforce its laws regarding criminal conduct?

3. Locus of Practice

   Where does practice occur? Is it where the practitioner is located or where the patient is located? The answer to this question could resolve many telehealth concerns if it is determined the patient is "transported" to the jurisdiction of the practitioner and the practitioner is therefore subject to jurisdiction of the practitioner's location. If it is determined that practice occurs where the patient is located, state regulatory boards may face new operational challenges and will need to be prepared to work in cooperative ways to a much greater degree.

Determining the proper role of state regulation will ultimately be decided by the state legislatures, Congress or the courts. Like the technology surrounding this difficult policy issue, any law governing practice may be played out in multiple policy making arenas. This report attempts to evaluate how state regulation may be effectively employed in this changing environment.

What is Telehealth and Its Range of Activities?

There are many definitions of telehealth, as well as telemedicine or telepractice. In a report of the Joint Commission on Health Care to the 1997 Session of the General Assembly it broadly defined telemedicine as the "use of telecommunication technology to deliver health care services and health professions education from a central site". However, typical of many initial state reviews of telehealth, it has focused on applications

such as specialized care being delivered from state supported institutions. Often those applications require expensive capital outlays, and seek to use publicly owned telecommunications networks in underserved areas and often to state correctional facilities. Telehealth is proving to be much more than this. The Council on Licensure Enforcement and Regulation (CLEAR) more broadly defines telehealth as "interactive long distance health care delivery in which the consumer is in one location and the health care professional in another".

To some extent health care has been delivered in this manner since the development of the telephone over 100 years ago. However, the growth of telecommunication, robotic, video, and computer technologies has greatly expanded the capacity and capability to practice or receive care over distance. When practiced across state lines, the effectiveness and efficiency of a regulatory system traditionally based on geography is profoundly challenged.

This study does not propose to address all public policy questions that exist relative to telehealth. Issues dealing with funding, reimbursement, specific applications, communication charges, etc. merit examination. This effort attempts to deal with proper role jurisdiction and operation of state laws. For the purpose of this study, **"telehealth" means interactive, interstate health care delivery and the exchange of data in which the patient (consumer) is in one jurisdiction and the practitioner is in another.** Current law clearly covers telehealth that is practiced intrastate, where both the practitioner and the patient are located in the same state.

Telehealth is "high tech" and "low tech". In some cases telehealth involves the application of digital imaging technologies combined with robotics to perform invasive procedures including surgery. In high tech cases, some jurisdictions have constructed intrastate communication networks to support the delivery of specialty care to underserved areas. Private concerns can perform surgery from the United States to facilities on the Asian Continent. Conversely, a pediatrician can "call forward" telephones to nurses in other states to triage patients with problems after normal office hours. With a basic internet service, homebound patients can have access to nurses, physicians, pharmacists and other allied health care providers on a twenty-four hour basis. The product of a biopsy in a difficult case may be mailed to a pathologist in another state for diagnosis. A psychologist may continue to provide psychotherapy to a patient newly arrived in another state through a common Internet connection or telephone. A pharmacist from another state can, by mail, fill a prescription for a patient in Virginia and consult with the patient by telephone concerning dosage, interaction and effects or related health problems.

All of the activities described above would, without question, require appropriate licensure in Virginia if it occurred entirely within the Commonwealth. Virginia law or regulation governing standard of practice, patient abuse, quality of care, informed consent, advance directives, drug control, patient and medical records and malpractice would apply as well. Where telehealth is practiced across state lines, do those provisions of accountability and consumer protection apply as well?

There have been a number of cases before Virginia health regulatory boards which relate to telehealth or practice taking place outside Virginia's borders. Action has been taken where substandard care (or practice in violation of law) was evident and the practitioner held a Virginia license. Such cases may not involve a citizen or resident of Virginia nor even acts committed in Virginia. Currently, the Code (§54.1-2409) requires summary suspension of the license of a health care provider whose license is suspended or revoked in another state regardless if the underlying conduct involves acts committed in Virginia or that the patients(s) involved were residents or citizens of the Commonwealth.

Locus of Practice

Perhaps no question is more critical to the notion of a state role in regulation of telehealth than the notion of locus of practice. **Is practice occurring where the patient is located or where the practitioner resides?** It can resolve many issues about jurisdiction over interstate practice.

If practice occurs where the patient is located as the provider delivers care, it may be presumed that the practitioner should be licensed or otherwise legally qualified to practice in the patient's jurisdiction. This would assure that the patient has redress within his state government and may obtain whatever relief is available in terms of regulatory and malpractice recovery. There may be greater concern for the patient's interest and lower cost for the plaintiff. It would seem to require that a practitioner who delivered services in this fashion be licensed in each jurisdiction in which he may telepractice. It also presumes that the patient does not "present" to the practitioner, rather it is the practitioner that is being transported to the patient. It seems to imply that law or regulation governing drug control, confidentiality, standard of care, reimbursement, record ownership and disclosure would vary from patient to patient depending on the location of the patient with each telepractice encounter.

An opposing view is that practice occurs at the location of the provider. Here the implication is that redress addressed to regulatory agencies or state courts is remote from the patient, and he would be reliant on a "foreign" government. Greater concern for practitioner interest and higher costs for patients as plaintiffs may exist in this paradigm. In this construct, the patient is transported to the practitioner and "presents" to the

provider in the traditional sense. The practitioner would not be required to be licensed in each jurisdiction where patients may be located, and law and regulation of a single state governing drug control, confidentially, etc. may prevail. Regulation governing practice is consistent from patient to patient as it is based on the locus of the practice.

This question is unsettled. It may resolve many issues related to the role of state regulation of telehealth if it is determined that practice occurs where the practitioner is located. Some state legislation assumes the answer is the otherwise. In developing its model for interstate compacts, the National Council of State Boards of Nursing choose not to answer this question. It may be resolved by the courts in dealing with telehealth or like issues (such as interstate gambling on the Internet) or by federal legislation.

Benefits of Telehealth

Telehealth, in its broadest sense, is new technology that has the potential to deliver substantial benefits to consumers in terms of quality, access and lower cost. Health care providers have historically embraced new tools that are viewed as in the best interest of patients and the technology associated with telehealth appears to have gained significant acceptance. Indeed, since the organization of the Board's study, new applications seem to appear weekly. In most cases this application achieves benefits in all three areas noted above.

Access is most often cited as a benefit of telehealth in its many practice areas and technological manifestations. Telehealth has often been promoted by state and national government as a way to extend specialized medical care to geographically remote and underserved areas. Examples exist of documentation projects at the medical schools at the University of Virginia and Virginia Commonwealth University which are intended to extend highly specialized medical care into rural areas. These applications often employ costly high end computer and telecommunication applications to achieve real time access and high resolution interactive audio and video. At the direction of Congress, the Health Care Financing Administration (HCFA) now provides for reimbursement in like circumstances. In several states, including Virginia, telehealth as a state run effort is extended to correctional facilities. While some of these efforts are intrastate, much care such as pharmacy, crosses state boundaries. Examples of expanded access include "ordinary" Internet connections to connect patients with their primary care providers. For a cost as low as $50 per month, home bound chronically ill patients have audio and video access to a network of physicians, pharmacists and nurses. In this sense access is changed in a dramatic way as patients present to providers at a time determined primarily by their changing health status and not scheduled appointments.

Benefits of telehealth are often described in terms of general quality. For example patients and providers find themselves in a position to deliver and receive care on a more timely basis. Diagnoses and delivery earlier in a disease process often results in better outcomes. Information about health care is greatly expanded in the emerging telehealth landscape, not only between patient and provider but by providing for a more informed and educated patient population. There is anecdotal evidence that patients use an Internet service to research their health issues and select their providers. Practice groups or networks of providers sharing common telehealth systems have better information about their patient's total health status. At a minimum, practitioners have the opportunity to coordinate the care of their patients.

Additionally, benefits may be described in terms of lower cost or more efficient delivery. Even the high-end and technological applications of telehealth, such as specialty care over T1 networks, involving specialists and costly hardware, have been found to be cost-effective for the purchaser. Out of pocket patient costs, lost wages due to travel etc. are also likely avoided. As cost and quality of health care remain critical national issues, the advantages of care delivered through telehealth will remain attractive to patients, policy makers, purchasers, managed care and integrated delivery systems.

Risks of Telehealth

There may be risks associated with telehealth as well. These include an attempt to employ technology beyond its capacity to treat certain health concerns, lack of accountability and redress for patients, security of patient records and competence of practitioners to safely use new technology.

Telehealth offered across state lines may make it difficult for patients to seek redress because the licensing board is remote. The lack of access to a complaint or reporting mechanism may lessen practitioner accountability and place the public in jeopardy. Being totally unstructured, telehealth can occur outside of existing mechanisms which promote quality. In addition, many features of practitioner monitoring are based on state enforced law such as required reports of hospitals, nursing homes, peer review entities, professional associations, other state agencies (health departments) and health maintenance organizations.

Also, uncertain are issues related to patient records. While it is possible that telehealth has the potential to create rich records about patients and the capacity to move that information effectively from one provider to another, there are questions regarding security, retention, access, confidentiality and integrity. In some cases telehealth care and information is delivered over the Internet which is subject to interception by unauthorized third parties not unlike cellular telephone transmissions. However, it is possible as

encryption protocols are implemented this aspect of security may achieve a level comparable to traditional record keeping systems. Records, in traditional systems are moving to automated media in ever increasing volumes. In a telehealth environment records may reside in only databases remote from patients to which patients have little access. In 1997, a large chain sold over one hundred pharmacy operations in the Commonwealth. All prescription records existed in a centralized database in another state. The purchasing chain had only limited access to microfilmed records and the result was that thousands of Virginia residents found themselves, absent any warning, without access to pharmacy care.

Telehealth is a tool for the practitioner to deliver care. However, it may prove to be one which requires additional skills for practitioners to use safely and effectively. Surgery involving robotics, imaging and technical assistance at remote sites will require new proficiencies.

Alternatives

The alternatives listed below may result in very different action to implement. Some may require single state action, some multiple state and other federal. Also, court action may be required for resolution.

A. Interstate compact for mutual recognition. This would allow a single state professional license to authorize practice in multiple states.

- Modeled after the proposal for National Council of State Boards of Nursing which was designed to facilitate interstate mobility.
- State retains authority to discipline practitioner (revoke multistate licensure) under applicable state laws and regulations. Practitioner is obligated to comply with practice laws of Virginia if the patient is located in Virginia.
- Locus of care is where the patient is located.
- Such an agreement should include provision which promotes accountability, consumer protection, address patient records and information sharing between states.
- No states have adopted this model; Utah has proposed legislation.

B. Registration of nonresident practitioners for telehealth with certain restrictions. This would require "mini licensing" in all states from which patients access a telehealth provider.

- Requires registration of nonresident practitioners practicing on patients in Virginia if they are licensed in their state of residence & subjects them to certain requirements and fees.
- Includes exceptions for consultation, etc. similar to those above.
- Prohibits the nonresident practitioner from having ultimate authority over the care or primary diagnosis of a patient in Virginia; must be an "affiliated" in-state practitioner. Provides for all medical information transmitted by telepractice to be maintained as a part of the patient's medical record with the patient's Virginia health care provider.
- Would require verbal and written consent for telehealth treatment, provided the patient is not directly involved in telehealth interaction.
- Laws and regulations on confidentiality and reporting would be applicable to practitioners registered for telepractice in Virginia.
- Registration program established by the board would include: (a) standards for confidentiality, access and retention of medical records; (b) registration and renewal fees; (c) enforcement of standards for professional conduct.
- Model legislation in California (Chapter 864) - similar legislation in Arizona.

C. Full licensure for health professionals practicing telehealth on patients in Virginia.

- Allows for complaint by Virginia patient to be made to Virginia board & subjects the nonresident practitioner to disciplinary action by that board. Would include issuance of a temporary license upon submission of credentials & pending approval for full licensure.
- Excludes episodic or periodic consultation with a licensed practitioner in Virginia; a second opinion provided to a licensee in Virginia; consultation services to a medical school; follow-up treatment of Virginia patient originally provided in state of licensure by practitioner; and emergency cases.
- Grants access to courts of Virginia for medical malpractice claim against nonresident practitioner.
- States which have enacted such legislation include: Illinois, North Carolina, Georgia, Arkansas, Nebraska, Mississippi, Texas. Pending in Ohio, Colorado, Maryland, Missouri and Rhode Island.

D. Federal Legislation Which determines that practice occurs where the practitioner is located

- Could provide for special assistance to state regulatory boards.
- Would resolve question of locus, give clear direction to states, practitioners and patients.

- Would promote Telehealth
- Patient would be remote from regulatory authority and would need to take grievance to other state.

E. Federal Licensure

- Like the licensing of pilots the establishment of a Federal agency to regulate the practice by health care providers. Many practitioners currently hold a registration through the Drug Enforcement Administration. It would provide for uniform national standards and greatly facilitate the practice of telehealth.
- States could maintain some roll, and have some latitude in administration of licensing of practitioners and taking disciplinary action

Public Comment

On March 16, 1998, the Committee held a public hearing at which no one choose to comment on the alternatives presented in the report. The Committee did receive two comments in writing from the Virginia Hospital and Healthcare Association and the Medical Society of Virginia. Copies of these are found in Appendix VI.

Findings and Final Recommendations

After review and discussion of the alternatives, the Committee adopted the posture that practice occurs where the patient is located. It is believed that this would best assure that the consumer would have recourse through their state regulatory authority.

The Committee recommended to the Board two alternative ways the Board should endorse as regulatory mechanisms to address telehealth:

> Interstate Compact – As outlined above, an interstate compact for mutual recognition was endorsed. Appendix VII contains a copy of the compact as proposed by the National Council of State Boards of Nursing together with an explanatory letter delivered to the Governor.
>
> Limited Licensure – As described above, limited licensure was also endorsed. Limited licensure would permit someone to practice in the Commonwealth from a remote location but be subject to disciplinary action by the appropriate health regulatory board. Limited licensure for physicians has been proposed by the Federation of State Medical Boards.

At its meeting on June 9, 1998, the Board voted to accept the recommendations of the Ad Hoc Committee. While no specific legislation was endorsed, it is expected that individual health regulatory boards would make proposals as each deemed appropriate.

BIBLIOGRAPHY

Ace Allen, M.D., Douglas A. Perednia, M.D. "Telemedicine Technology and Clinical Applications". *JAMA*. February 8, 1995.

Urias A. Almagro, Hongyung Choi, Bruce E. Dunn, Daniel L. Recla. "Dynamic-Robotic Telepathology On-Line: Summary of First 200 Cases". *Cell Vision*. 1996.

Robert J. Alpino, EVMS. Memorandum to Isabelita M. Paler, R.N., M.S.N., Ad Hoc Committee on Criteria. January 20, 1997.

Bill Number TX74RHB 2669. Texas Legislation. May 16, 1995.

Pam Brinegar and Melissa McGinley. "Legislatures Consider Telepractice". www.clearhq.org/teleleg197.htm. August 28, 1997.

Anne E. Burdick, M.D., M.P.H. Response to a Telemedicine Inquiry from the Florida House of Representatives. February, 1996.

Linda Carroll. "Telemedicine: Changes the Way Physicians Practice". *Medical Tribune-Family Physician Edition*. October, 1996.

Elise Chidley. "Telemedicine: The Legal Obstacles". *For the Record*. October 7, 1996.

"Continuum of Models for Regulating Multistate Nursing Practice: February 1997:, National Council of State Boards of Nursing, Inc.

Council on Information Management. "Barriers to the Implementation of Telemedicine in Virginia". House Document No. 31. 1997.

Council on Information Management. "Reimbursement for Telemedicine Services". House Document No. 51. 1997.

Bruce E. Dunn et. al. "Dynamic-Robotic Telepathology: Department of Veterans Affaiars Feasibility Study". *Human Pathology*. January 1997.

R. Peter Ericson and Robert F. Pendrak. "Telemedicine May Spawn Long-Distance Lawsuits". *National Underwriter, Life and Health Insurance Edition*. November 4, 1996.

Erin P. Exton. "Three States on the Health Information Frontier". Www.csg.org/health_policy/summer_97_2.htm.

Federation of State Medical Boards of the United States, Inc. "A Model Act to Regulate the Practice of Medicine Across State Lines". Adopted August, 1996.

Federation of State Medical Boards of the United States, Inc. "A Model Act to Regulate the Practice of Medicine Across State Lines". Executive Summary.

Federation of State Medical Boards of the United States, Inc. *Telemedicine: A Discussion of the Practice of Medicine Across State Lines*. A Symposium. January 17, 1996.

Lynn R. Fleming, Assistant Attorney General of Virginia. Letter to Dr. Warren Koontz, Executive Director, Virginia Board of Medicine. July 10, 1995.

Henry D. Foster, Jr., Administrator of the South Carolina Department of Labor, Licensing and Regulation. Letter to James R. Winn, M.D. of the Federation of State Medical Boards. January 5, 1996.

Dana R. Fuqua. "Legislative Services September, 1996 Report". Memo. The Federation of State Medical Boards of the United States, Inc. October 18, 1996.

Dana R. Fuqua . Letter to Dr. Warren Koontz. The Federation of State Medical Boards of the United States. August 13, 1997.

Francoise Gilbert. "Comments to the Proposed Model Legislation Regarding Licensure Drafted by the Federation of State Medical Boards". Altheimer and Gray. 1996.

Stephen A. Horan, Ph.D. *Telemedicine—HJR 455*. Joint Commission on Health Care. June 1995.

Institute of Medicine Studies. "Evaluating Telemedicine: Clinical, Economic, and Policy Issues". August, 1995.

Joint Commission on Health Care. *Study of Telemedicine Pursuant to HJR 455 of 1995*. Jane Norwood Kusiak, Executive Director. 1996.

John A. Kitzhaber, Governor of Oregon. Letter to James R. Winn, M.D. of the Federation of State Medical Boards of the United States. January 9, 1996.

Medical Society of Virginia. "MSV Resolution".

Melissa McGinely. "Eight States Pass Telemedicine Laws". www.clearhq.org/8statespass.htm. August 28, 1997.

Memo. "Telemedicine". Health Policy Tracking Service. December 15, 1996.

Minutes from Virginia Board of Medicine. February 8, 1996.

Minutes from Telemedicine Committee of the Board of Medicine. December 12, 1996.

National Council of State Boards of Nursing, Inc. "Supplemental report of the Board of Directors" August, 1997.

National Institutes of Health, National Library of Medicine. "Secretary Shalala Announces National Telemedicine Initiative". Press Release. October 8, 1996.

"Report of the Multistate Regulation Task Force". *National Council of State Boards of Nursing, Inc.* 1997.

Bill Richards. "Hold the Phone". Wall Street Journal. January 17, 1996.

Jay H. Sanders, M.D., Jonathan S. Sanders, Esq. *Telemedicine: Challenges to Implementation.* November 1994.

Jay H. Sanders, M.D., Francis J. Tedesco, M.D. "Telemedicine: Bringing Medcial Care to Isolated Communities".

Ed Schafer, Governor of North Dakota. Letter to James R. Will, M.D. of Federation of State Medical Boards. January 8, 1997.

Polly Schneider. "Telemedicine". *Healthcare Informatics.* October, 1996.

Karyn Snyder. "Telemedicine: The New Frontier". Drug Topics. August 4, 1997. pp. 61-66.

John Staed. "Telemedicine license". *Birmingham Post-Herald.* November 19, 1996.

Telemedicine Act. Texas. 1995.

Telemedicine Sourcebook. 1996-1997.

"Telemedicine connects patients, practitioners electronically". A.O.A. News. November 11, 1996.

"Telemedicine: A Discussion Of the Practice of medicine Across State Lines". A Commentary for the Federation of State Medical Boards of the United States.

"Telemedicine: Legislative Options".

"Telemedicine Report To Congress". January 31, 1997.