AMA Advocacy Insights webinar series: The future of telemedicine

Featured topic and speakers

The onset of the COVID-19 pandemic and the subsequent national public health emergency led the use of telemedicine technologies to skyrocket. Legislators and regulators now have the opportunity to make permanent policy that supports many of these advancements throughout the pandemic and beyond.

To address this dramatic increase in telemedicine use, the Federation of State Medical Boards (FSMB) House of Delegates adopted “The Appropriate Use of Telemedicine Technologies in the Practice of Medicine” (PDF) at their annual meeting in April, an update to their 2014 guidelines. The new document provides guidance to state medical boards on the use of telemedicine in the health care setting and can serve as a model policy for the permanent adoption of telemedicine at the state level. It addresses a number of concerns related to the continued implementation of telemedicine, including licensure, equitable access and the appropriate standard of care.

In this AMA Advocacy Insights webinar, experts from the FSMB provide an overview of the updated telemedicine policy. In addition, speakers discuss current state licensure laws regarding telemedicine and continued solutions that can be implemented moving forward.

Speakers

- Lisa Robin, MLA, chief advocacy officer, Federation of State Medical Boards
- Shawn P. Parker, JD, FSMB Board of Directors, chair, FSMB Telemedicine Workgroup

Moderator
Dr. Resneck: I'm Jack Resneck, I'm a dermatologist in San Francisco and president-elect of the American Medical Association. While telehealth certainly isn't new, many patients and physicians were really frustrated in the pre-pandemic years by extremely limited coverage, both from government and commercial insurers. The massive coverage expansions that organized medicine pushed for and really achieved early in the face of COVID-19 led physicians around the country to integrate telemedicine into their practices, advance our knowledge about when it's best deployed versus when it's best to actually see a patient in person, to improve patient access and convenience, reducing stressors related to transportation, work absences, childcare, and to try to address inequities not only in rural areas, but even in big cities as well. But there is still work left for us to do. Legislators and regulators have the opportunity now to make policy changes that support long term adoption of seamless telehealth. Telehealth that's integrated into health care delivery with patients existing health care teams.

Part of that has to do with stable insurance coverage to ensure that we don't lose the access that we've recently expanded. We're certainly pushing for that, but the other part is related to licensure and to regulation, and that's really what we're here to discuss today. Last year, the Federation of State Medical Boards, or FSMB, convened a work group to review and update telemedicine guidelines that had last been revised way back in 2014, based on lessons learned during the pandemic.

As a member of that group, I have the pleasure of working alongside colleagues from across the country, including two that you'll meet today. Last month, the FSMB voted unanimously to accept the work group recommendations and update their model telemedicine policy. Broadly that policy provides guidance to state medical boards on the use of telemedicine, serves as a model for state legislatures and regulatory bodies, and addresses a number of concerns related to the continued implementation of telemedicine, including licensure, equitable access and the appropriate standard of care.

Many of those revisions are things that the profession has been calling for and very supportive of and are in line with AMA policy. I know we'll be coming back to some of the details later this morning. Two esteemed colleagues from FSMB are with us as panelists. And I want to take a moment to introduce them. First, Lisa Robin is the chief advocacy officer for the FSMB and oversees their Washington D.C. office. During her tenure at FSMB, Lisa has been active on issues, including health regulatory board authority and structure, medical license portability, telemedicine, opioid prescribing, and addiction policy, medical marijuana, and physician health and wellness. In addition to her role representing the
FSMB in Washington, she assists individual medical boards in achieving their state legislative agendas. I also want to introduce Shawn Parker. Shawn's a health care attorney, a member of the FSMB Board of Directors, and did a fantastic job chairing the FSMB telemedicine work group.

He also serves as the public member on the North Carolina Medical Board and as general counsel and chief of staff for the North Carolina Academy of Family Physicians in Raleigh, North Carolina. Before I turn the microphone over, I wanted to let you know we’re recording this webinar and we will email all registrants a link once it's available. Lisa and Shawn are going to begin with opening presentations. And after that, I'll be asking them a few questions. And finally, we really look forward to taking your audience questions. Please enter those into the Q&A feature on Zoom during the session. Lisa and Shawn, welcome. And I'm going to turn it over to the two of you.

Robin: Thank you, Dr. Resneck. We are happy to be here today. Just before we get started, I thought we would spend just a minute of how we got here and why we decided to look at our telemedicine policy. This will be brief so we can spend lots of time discussing how we move forward. Next slide please. For those of you that are not familiar with the Federation of State Medical Boards, we've been around a long time. We were founded in 1912, we’re a national non-profit organization representing all 70 of the state medical and osteopathic boards across the United States, the territories. Our mission really is to support our boards as they achieve their statutory mandate to protect the public through the appropriate licensing, disciplining and regulations of the more than 1 million physicians and physician assistants in the country. Many of our member boards also regulate other health care professionals. The FSMB offers a variety of services for our member boards and consumers through education, assessment services, research and advocacy, promoting regulatory best practices across states.

It is our goal to help guide our boards in coming up with consensus documents and consensus policies, so we're very hopeful that this new telemedicine policy will really gain traction across the country. Next slide, please. The FSMB has been involved in telemedicine regulation for many years, beginning in 1996 when our house of delegates adopted a model act to regulate the practice of medicine across state lines. This was really in the early stages and we were really seeing it mostly with radiology and pathology, but this was a model that would create an abbreviated licensure system specifically for telehealth, and it would not be where you could be physically located, but did allow a simpler system to be able to come under the jurisdiction of the medical board and provide those virtual services. Through the years this policy work has evolved and in 2014, our most comprehensive policy was our telemedicine policy in 2014. And that really has been widely accepted by our member boards. And they have used that document as they have done their policy work in telemedicine.

However, then COVID-19, the public health emergency, happened, which we were ill prepared for in the light of having to pivot very quickly in certainly a unique situation that we found ourselves in, not only operationally with our medical boards being able to pivot to a complete virtual environment for their operations, but also how we were going to treat patients and keep patients from having to go to
the doctors’ offices and to the hospital. During this period of time, we immediately established a work group on emergency preparedness and response. We saw that in the first few months of the public health emergency, I believe virtual telemedicine visits increased by about 2,000%. So obviously we looked at how we were going to move forward after this because clearly some of our existing restrictions, as far as telemedicine, really did not apply.

And we were recognizing that college students were home, not in college, so they were not able to seek in-person treatments with their own physicians and other health care professionals. This work group on emergency preparedness did provide some recommendations to our house of delegates. And one of those that there was certainly a need to work very quickly to look at our existing telemedicine policies and make some revisions to that, so as Dr. Resneck mentioned, we established the telemedicine work group and very, very grateful for his contributions and participation with this work group. This policy was unanimously adopted by our house of delegates then last April. So now we will work to try to promote this throughout the states and look forward to your assistance in that endeavor. Next slide please.

Parker: And Lisa, if I could add here.

Robin: Sure.

Parker: While the COVID-19 crisis certainly was a catalyst for review, just the advances in technology and really the more familiarity of both physicians and patients with this kind of technology would’ve generated, I believe we would’ve probably been looking at the policy either way, but certainly we were thrown into it. And it did give us a lot of more perspective to look at not just the modality of use, but really how is it regulated. And I think that’s what the work group got a better chance to hear from stakeholders and concentrate on; thank you.

Robin: Thank you. And yes, and this work group was certainly ably led by Shawn. This slide just shows the charge of the work group. And as they worked diligently, they met at least four times over the course of the year and then did a lot of work on their own, on wordsmithing our policy, and finally coming up with a good consensus document. Next slide, please. This policy does supersede our 2014 policy. And Shawn, I'm going to turn it over to you since you were chair of this, if you want to talk just a minute about the work group and how they came to these conclusions.

Parker: Thank you. So again, the work group was kind of composed, it was a unique FSMB work group where we did have directors from the FSMB and state board directors, but we also sought input from a lot of stakeholders, so we had representatives from multiple people. Is that on the next slide, on who is a component? Can we move one slide ahead, perhaps? And if not, again, it was a variety of stakeholders that had input, so multiple associations, including those in the industry, physician groups, we had state medical board staff, as well as people within the FSMB to get a broad example of what are all the issues we're trying to address. And I think some of the early findings is that telemedicine is
not like a unique specialty, it's not a different level of care. It's a component of the delivery of medicine through the modality of telemedicine technologies.

And so I think that was one of the focuses where often we get it kind of out on the framework like, well, how is this different? We could focus more on really, how is it the same? And then that makes much more sense from a regulator's perspective. We also address things that I would say were more an articulation of exceptions to the general rule, so as medical boards evaluate care, they do so on a case-by-case basis. Never really, is there such a black and white that “you’ve done this,” or “you haven't done it.” There are some circumstances, but really there are always acceptable exceptions to the rules. That's why we have that due process in place.

And what I think the policy did a good job is articulating what our known exceptions to the general rule, so we'll go into that a little bit further. And then finally, which we kind of go back to, that this is still medicine it's just delivered through a different modality. And so therefore the same standard of care needs to apply and professional ethics will apply. And we look at this in the circumstances. Again, when you deliver care to your patient, it doesn't matter who the payer is, there's no change in standard of care, the locality doesn't change, so really the method in which you deliver medicine would not change. We hold to say that there's not a distinct exception of the standard of care and certainly your professional ethics would be the same in any setting. Ms. Robin?

Robin: Thank you. Next slide. And I think that's it. And then we can begin the discussion.

Dr. Resneck: Well, I want to thank you both for that great overview. Shawn, before we sort of get into a deeper dive on some of the details of what FSMB has done … As I think about this, there's sort of different places where this regulatory policy can be placed in stone, state legislatures, operating procedures of state medical boards. What's your sense of what belongs best in state medical board control versus legislative control and why?

Parker: The FSMB crafts this policy, so that each of the 71, I believe now, state and territorial boards have a resource to use, and then we certainly hope that they will adopt the policy in a manner that works for their state or territory. Truly this type of policy is best held at the occupational board level, at the medical board level, as we've discussed, or as we've seen, medicine is quite fluid and health care delivery is fluid. And just the process for making policy changes, it makes more sense to be doing so in this setting. While it's within the purview, I suppose, of a state legislature, since medical boards are kind of body politic that are created in statute, it just is not conducive for them to be able to adjust.

Policymakers have a hard enough time staying on top of things. When you put into making it into a law, it just makes more sense that your occupation board, your medical boards are the one giving this guidance. And that's really again, what it is. It is guidance to the licensees and what we believe will be appropriate for care. And therefore you as physicians and PAs, and others that fall under the medical boards have understanding on what is the expectation.
Dr. Resneck: Lisa, anything to add on sort of the role and scope of state medical boards here specifically related to telehealth regulation?

Robin: No, I mean, I totally agree. I believe that this policy would be as best maintained at the state board level. And also, I think that we would think that there's a lot of this that would also pertain to other health care professionals as they move forward with regulation, it wouldn't just be applicable to physicians. However, there are areas of telemedicine policy that will have to be legislated as you speak to rules around payment and those type of other issues that are all going to have to come together to get a system where we really are achieving a safe system and yet look at access equity and the other issues related to telemedicine.

Dr. Resneck: I'd love to focus for a little while on sort of the geography of licensure. And when I look back to those first weeks after COVID-19 hit, there was just understandable concern about how physicians could quickly and efficiently implement telehealth in the places where care was desperately needed. We had physician offices closed, we all wanted to get patients care in any way that we could. And Lisa, in your opening, you mentioned this pivot that occurred. And at that time, a lot of states passed temporary measures that allowed physicians to practice across state lines, both in terms of in-person care and via telemedicine, providing care to patients in jurisdictions where they were not licensed. And many of those temporary licensure exceptions have now ended.

For either of you that wants to take this first. What did you learn from those temporary relaxations about how physicians implemented telehealth in their practices and how does that really help to inform policy going forward?

Robin: Well, I can start. I think we saw that state boards were really flexible and the states were really flexible because you saw nearly every jurisdiction with these emergency orders that were applied somewhat differently and trying to mobilize physicians across the country to hotspots. Early on, we saw that there were some issues with this because we tried to provide some assistance to states as they were trying to vet these people that were volunteering. And unfortunately, as we’ve seen with other disasters, sometimes the people that are volunteering maybe would not be those that should be volunteering. And so we were able to try to assist with some of that. I think the pandemic, it certainly pointed to a need to have a better system, to be able to very immediately confirm the licensure and qualifications of health professionals going in to volunteer.

The Federation was fortunate to have received a grant from HRSA that allowed us to build a technical platform that will do that emergency vetting with issuing a digital certificate. And I won't go into the details of that, but I think that we found that's certainly very important if you are trying to mobilize physicians and allow people to practice across state lines without really any structure in place of oversight. That is particularly important for these hospitals and other facilities that are inviting people in to practice. We immediately set up a website designed to assist physicians in navigating those various
emergency orders because they were different.

Some of them were in person, some of them were telemedicine. I think that, that was just the nature of how our country is structured. But some states, I think probably had a better system in place to manage that. Some states, the emergency orders kind of divorced the medical board really from being even involved in the process, so they’re really not aware of who came in and when, so what we’re trying to do now is gather some data to see what some of those outcomes are. What did the complaints look like and how is that managed?

**Dr. Resneck:** I think those data will be really useful in preparing for the next emergency or pandemic. Shawn, anything you want to add on this front?

**Parker:** I think the key is that the state boards were responsive. They recognized the need to make sure there was access to care and they did not want to be derelict of their duty to say, well, any access is good access. It’s access to quality appropriate care. And one other unique component is not every state acted the same. Our state never had a waiver, we have an emergency licensure place because we believe for our people who live in North Carolina, that process is more appropriate. And so I think that’s an important component on that. State boards were responsive, they understood the need and what they need to do, they did want to maintain their duty, what their statutorily designed to do. And lastly, they did it in a way that worked best for the people in their state.

**Dr. Resneck:** Well, as you both know, the AMA has policy that supports maintaining state licensure and defining care as really occurring where the patient is located and requiring physicians to have unrestricted licenses in the states where they provide care. And as we look, even during the pandemic, most physicians who are engaged in telehealth are providing it primarily to established patients located in their own states.

We did hear, however, about some specific licensure pain points that warranted some exceptions, narrow exceptions to those rules, and the FSMB’s model includes a number of those types of exceptions. Lisa, let me throw it back to you. Can you just walk us through some of those locality exceptions, what they address, why they were seen as reasonable? They happen to align really closely with a lot of things I know the profession and the AMA have been asking for, so we’re excited about these.

**Robin:** Well, I think first and foremost is that we recognize that this was certainly critical for physicians to be able to take care of their established patients. And whether it was ongoing workups, or monitoring, or screening for prospective patients to recognize that these were situations that it made sense to be able to better take care of your patients, so some of these exceptions really have had to do with that, make sure it was that existing relationship. There were some specific exceptions, one would be physician-to-physician consultations. We saw a lot of that happen during the pandemic, and that this would allow as long as there was a physician in the jurisdiction where the patient was located,
that actually took responsibility for the care, those physicians-to-physicians specialty consultations would not require a license under our recommendations.

Also, looking at prospective patients like for centers of excellence, for patients with special conditions, that to see a patient in order to determine if their referral was appropriate, then that out-of-state physician could handle those situations as well. The other would be episodic care, if a patient is temporarily located outside, this would have to do grabs with college students. We saw a lot of college students displaced and away from their health care providers, and to be able to maintain that relationship. Also follow up after some sort of surgical treatment or specialty care to go to one of these systems. I know that the Mayos and the Johns Hopkins and these centers were able to take care of their patients remotely, and for them not have travel during this period of time. The last thing I would mention were clinical trials. And I think what we recognized to be able to better get a population, a broader population for clinical trials, that it made sense that this could be an exception to that licensure requirement.

**Dr. Resneck:** I think this episodic follow up issue for established patients is one that there’s just a great thirst for among physicians to have really clarified. I think this will be enormously helpful, because a number of us obviously take care of patients who we’ve seen in our states locally that are away for college, or traveling for work, or away on vacation and reach out to us for medication adjustments or other things regarding an established condition that we’re taking care of them for, so I think just to have that sense of knowing that the medical boards understand that’s really ongoing care, as opposed to practicing across state lines will be a huge help. Shawn, any other practical examples that you’ve bumped into?

**Parker:** I think the work group noticed that often the continuity of care is probably more appropriate than the patient having just to go to an urgent care, to see a physician or a PA for the first time over a treatment. The fact that you have that relationship, you already understand what they’re going through I think improves the care, so we certainly were very supportive of that being included or again, articulated. In my time on the board, I don’t recall ever disciplining anyone for treating someone who was at UNC for college, so I think some of these rules were well established, but great to have them articulated to give a better understanding across the board.

**Dr. Resneck:** You have a sense … I know that this wasn't sort of inked or set in concrete for, at what point as a physician thinks about a patient that they're continuing to take care of who has traveled across state lines, maybe living somewhere else. Like at what point should they hand off care to a local physician where the patient now is residing? Sorry to put you on the spot and maybe that's more specific than …

**Parker:** I would say you'd still rely on, what's the appropriate standard of care, at what point in time, if they were within your state, would you transfer that care or would say, I really need to see you, I can't continue just to keep prescribing, come on into the office. I think that's the basis that you should be
making your decision. When your clinical judgment cannot make a decision based on the environment, or circumstance, or the length of time of the last time you saw them. That's probably the time when you need to transition that care to someone who could make that judgment.

**Dr. Resneck:** Lisa, when I'm out talking to policymakers about telehealth policy, I sometimes hear, and I'm sure you hear the same thing, these calls to just do away with state licensure and federalize medical licenses. And on its surface, sometimes that can sound kind of easy and appealing. How do you respond to those calls and what are your concerns?

**Robin:** You know, after this many years, I should be able to respond quickly because this is not something new, but I think it is important to understand that really the complexities, our entire system of health care is built on this state-based system really. And you have closed systems for instance, in the Department of Defense or the VA, but they are closed systems where one license is allowing that person to treat their patients in whatever location they are. We don't have any information or data to support that you could take a system based on a closed system and then apply it broadly when you have multiple payers and you have so many different issues that really there's not the support structure to have that in place. And for patients to have that regulation locally and to have the ability to go to their medical board, if there was one license, would that patient be required to go to either across the country to file a complaint?

And for investigation, there's a lot of complexities, legal complexities to being able to subpoena records from outside the jurisdiction, so really we believe that there's mechanisms, there's licensure schemes, such as compacts that would allow to achieve that national priority, but keep it at a state-based system with the sovereignty lying at the state. But also to make it a more portable system, so that's really kind of how we answer that question. I don't really believe that there is truly an appetite for a federal system, but it sounds really convenient for some, but then when you really look into it and look at, you know not everybody is practicing at the highest standard, if you will. And there really needs to be someone who has the oversight to be able to protect the patient.

**Dr. Resneck:** As I start to think about a federal license and thinking about patients having to call Washington, when they have a concern that they think that their health care, the clinician or physician who's taken care of them, that they have concerns with. That seems a little scary. And also the rules of the road of how we practice medicine are really currently set through state medical practice acts, and the thought of doing away with all those and federalizing our policies around end-of-life care and medical marijuana and reproductive access. That is a little terrifying. You mentioned the interstate compact, any more you want to say about that and maybe just briefly let our audience know for those who don't, what that is.

**Robin:** Sure.

**Dr. Resneck:** And how many states have adopted it?
Robin: Well, the interstate compact really has been relatively young, it did not become active until 2015. And we now have 36 states plus the district of Columbia and Guam that have joined the compact. It has been a successful project in that they've issued over 35,000 licenses through the compact process. It's basically an expedited process that would allow you to get additional licenses based on a letter of qualification from one state, so really the states are depending on their sister state to verify that the physician is qualified to go through that process. But we do know that more than 80% of the physicians in the country would qualify to take advantage of that expedited process.

We believe that to truly achieve greater portability that it needs to be adopted in all the states, so we're working and very much appreciate the support that we've had from the AMA in this compact. And I think right now there's about nine of the health professions that have started some sort of a compact, so it's kind of recognized as a good mechanism to achieve this portability and yet not run into any of the pitfalls that you would happen with it with only either a federal license or one license.

Dr. Resneck: It seems like in the places where it's been adopted it's working well, it's such an easy way for physicians to be able to get license in multiple states, without having to send off a lifetime of transcripts everywhere. And yet it sort of retains a state medical board's ability to oversee the care provided in their states and look into issues when they come up. If I'm sitting in a state that hasn't adopted it, what can I do to try and get a state to move ahead?

Robin: We encourage you to work with your state associations as well as really some of the biggest drivers have been the health care systems, the large systems have been really supportive of this, as have the medical societies in many states, so I think it really is a benefit to the state. There's a lot of, we're happy to help with any sort of data to show what it really brings, some of the states are seeing at least 20% of their new licensees coming in through the compact system. It doesn't cost the state any, there's no assessment to the state, which makes it attractive to some of the legislators, and yet really can get needed physicians into the state. But not only that, it also allows the physicians in the state to export their services, so if anyone needs any assistance with the advocacy piece, please, my contact information is available.

Dr. Resneck: Thank you. All right, so we talked about the geographic and licensure issues. I want to turn a little bit to another piece of the model policy, which is the standard of care provisions, including the guidelines for really properly evaluating and treating a patient through telemedicine. And I think the model policy provides some really important guidance here. Shawn, can you walk us through some of those provisions, especially related to proper evaluation and treatment via telehealth and any additional steps if they're going to be prescribing via telehealth?

Parker: As we kind of led off, we don't believe there should be a distinguishable difference. The standard of care is going to be the standard of care that you would deliver regardless of the modality. However, taking that into mind that in the setting of a telemedicine visit, there are some differences, and you want to be sure you account for it, so certainly within the same concepts of record keeping...
and anything else that you would do along that context. You want to also be sure that you can access or evaluate the patient where whereby you utilize your clinical judgment to make the diagnosis. There’s a difference in what you can see, and feel and hear. And again, where we found over time that maybe some of the concerns we had like, well, can you truly make a diagnosis of not being face to face?

The answer is, well, yes, certainly there are circumstances and including in cases where you're not even visually seeing the patient, there's an audio-only component that can be appropriate if, again, you have the other things available for assessment to make a diagnosis. A key again, whether it's in person or digital, you want to make sure you're gathering patient history, so that attributes. If you're going to utilize questionnaires as part of your component of it, that we advise against using static questionnaires, we feel that they don't lend themselves for further inquiry from either side, either from the physician following up with the patient or from the patient, saying, maybe not being fully clear of what the question's asking. And so I think that we suggest that your ability to inquire upon the patient, or even if you're using a questionnaire lends itself for that dialogue or some engagement. You're prescribing, certainly you have to follow whatever the national federal and state laws would require on it.

But we think you would want to be able to take the same steps that you would if a person’s in person. So, if urine drug screening is the standard in your community, and you're about to prescribe, then you have to find a way to accommodate something like that. We can trust some entrepreneurship or ingenuity … well let me see in your hand, how many pills for a pill count. Now, there's plenty of ways you can go about it, but we believe that you can't just say, because this is telemedicine, I'm going to pass on the steps I would've taken if they were in person.

**Dr. Resneck:** I was really happy to see some of those things called out in there. And in addition to those sort of some basic transparency, so patients know the credentials of the clinician who's treating them, is it a physician, is it a PA, is it an MP, is it somebody else? Where are they? What's their specialty? Are they board certified? And as you sort of alluded to this notion that if it's a large mass provider of telehealth and a hundred percent of the time just based on what a patient submits on a static questionnaire, they're getting the prescription they asked for, or the diagnosis they thought they had. And when we see patients in person, it's an iterative process to take a history, the patient says something, it makes you think of another question. And telehealth can do that quite well, we have good evidence that can be done in a high quality, safe way via telehealth. There were also some provisions in there around ensuring patients have access to follow-up care or emergent care if needed or local options to go somewhere if they need bloodwork or a biopsy.

**Parker:** That's right. The informed consent component. Again, many things that are just taken, I wouldn't say, taken for granted, but are just assumed to be correct when you're in person. Like, well, what would happen if the technology failed in the middle of the evaluation? How do you account for
that? What if the circumstances progressed? If you were there in person, you would take these steps, so you need to account for those. And I certainly like how you say that because of geographic distance that telemedicine allows, you then need to account for not being able to be right there with the patient.

Dr. Resneck: We’re getting close to our time for audience questions and I’m looking forward to those. I do want to get to one more thing first. Shawn, you mentioned earlier audio-only telehealth. And I know during the public health emergency, there was really a significant increase in the use of that. It was particularly important when viewing telehealth through an equity lens, I was quite surprised and learned a lot about how many people, again, not just in really distant rural areas from me, didn't have broadband access, didn't have access to a high-quality device that would allow them to do live interactive video. But obviously it's not our first choice to do audio only. How does FSMB’s new policy really address this audio only issue and balancing those things?

Parker: And that was probably one of the greatest change in the policy from 2014. It was the change in definition where prior you would've read the definition that it does not include audio only, what the policy covers as, and probably under the indication that audio only was not a component of telemedicine at the time it was early on and probably the payers may have driven this sum, if no payer was reimbursing then it was something less regulated for what people are doing. Although I have a lot of doctors tell me, they've always talked to their patients on the phone, and that goes back as far as phones have been available for care. But I think that the key is that we change the policy to say telemedicine does include audio only. And we utilize the standard, when your clinical judgment allows for you to make the same type of diagnosis.

And then we put a further caveat that, and you should benefit because to the extent that the patient is unable to use a technology even beyond telehealth, or doesn't want to, or can't. And I think that's part of that informed consent component of the physician-patient relationship, so if the circumstances don't allow for them to have it, whether it's poor technology, broadband, or it's something in their home setting that they prefer not to have showing behind the scene, what's going on about them, we should respect that. And therefore audio only can be appropriate. And sorry, the last bit was, yeah... we didn’t want to exasperate the disparity that you just described, so why would telehealth only be available to communities that have the technology advances or people who can afford them, so I think by ensuring that we include audio only, then we can keep a level playing field in that aspect.

Dr. Resneck: Lisa, last question for me before we open it up to the audience. I'm a physician practicing some telemedicine, sitting in a state and I look at this great new model policy and all of a sudden I've got a patient who wants to come see me in state at a center of excellence. And the policy says, well, great, we're moving towards this era when maybe they can do one telehealth visit before they decide whether to travel to California, but my state medical board hasn't necessarily spoken on this policy, or my state legislature … like what are the steps that need to happen next? And how do
physicians interpret this time period we're in?

**Robin:** I think, this policy was adopted just a few weeks ago, actually, and now it's really on our office, and on our partners, and other stakeholders to try to really push this at the state level and try to really actually make this policy a reality in many states. I think that there's a lot of interest. There's been a lot of interest, I will say in the session that we had at our annual meeting. I've had requests for the recordings of that session. I think that the boards are going to be talking about this, that they've recognized how this was used and not only that patients can be taken care of and probably have access to their physicians on a more regular basis actually, and in their own home setting. And that they're going to have to look at their own policies and try to remove some of these restrictions.

I think it will vary from state to state as to how much the legislature is involved in this, because you see it both ways. We would encourage the boards to adopt a policy, some have a little more authority to do that than others. But I think this is a great area where it's really important for the AMA and your member societies to really come forward and work with the boards on these telemedicine policy. Because I do think there's an appetite for it. And I'm really very encouraged with what we've seen as far as the interest in it. I mean, the policy was unanimously adopted, I think that's important, that doesn't always happen.

**Dr. Resneck:** Yes. So we're going to move on audience questions. I see we've got a bunch. If you still want to submit one, use the Q&A feature. I'm going to pull in some help from Kim Horvath. Kim is one of our senior legislative attorneys at the AMA Advocacy Resource Center. Kim, are we ready?

**Horvath:** We are. Thanks Dr. Resneck. The first one I think is just a clarifying question, so you are clear on treating college students across state lines. What about patients on work-related trips, assignments, or patients out of state on vacation? I think this fits within the episodic and follow-up care exception, but if you can just clarify for the audience, that would be great.

**Robin:** Yes, it was not. A college student was just an example, but I think for a number of reasons, you have that, people that travel and maybe want to go spend a month here or there, and they have their relationship with their physician. I will say the only thing I would encourage people to be sure that in those, the physician would have to be responsible for making sure that the condition is something that they really can treat in that. And if not, to be able to help with the patient, try to identify someone in the area where they're located to go to a different provider and maybe work together. But I think that it certainly was not limited to … work, snowbirds, so many reasons that we now are able to travel. And with work from home, I think this is only going to be more apparent because we have staff that have decided to go maybe work from the mountains when it's very, very hundred degrees in Texas.

**Horvath:** Great, that's helpful. Dr. Resneck were you going to add something?

**Dr. Resneck:** No, go ahead.
Horvath: Okay, so staying on the topic of the exceptions to licensure, there was one question about some states that have created exceptions, but they've also been limited in terms of the number of visits, the length of time, et cetera. For example, Vermont just enacted a legislation that creates a telehealth registration system and allows for follow-up care by physicians outside the state for patients in Vermont, but it limits it to 10 patients in 120 days. I'm just wondering if you can comment on kind of these types of approaches, as opposed to kind of just more of a broader approach?

Robin: I would say that's left in the discretion of the medical boards, but as you see our policy did not get into that sort of detail. There's a number of approaches, in addition to like the compact approach that some states are doing a registration process, some are doing more of a reciprocity, some may be even more regional, so I think you're going to see some creativity around this.

Most of the ones that are just for telemedicine though really are just limited to virtual care and not coming into the state, so I think from the reality of our position would be whatever system that the board believes is the best system to bring that physician under the jurisdiction of the medical board, so there is some accountability. And however they feel that they could manage that best, I think would be something that you would support. The big issue is that there must be a means of accountability and that the patient has some recourse, and that you can take that privilege away, whether it be a registration or whether it be a full license.

Dr. Resneck: Kim, just to clarify, would it be fair to say from our AMA standpoint that we feel like we're not terribly excited about sort of special telehealth licenses. And we really think if you're going to be seeing new patients across state lines, you should get a license in the state where you're doing that. If you're going to be utilizing the exceptions from this new FSMB policy, then it's our view that you shouldn't have to have any kind of licensure in the state where you're utilizing those exceptions, as long as you're licensed in your home state where you established a relationship with those patients.

Horvath: Definitely, Dr. Resneck, definitely. Thanks for that clarification. And I think building off Lisa, what you just said. Here's a question about kind of just that issue of if a physician cares for a patient right outside of the state, and let's say an adverse event happens, or the physician deviates from the standard of care, how will the patient then have effective recourse over that, through the state medical board? And I think you kind of just answered that, but if you can maybe just delve a little bit into that process. I don't know Shawn or Lisa, who would be best to address that question?

Robin: Well, maybe as an attorney, Shawn should take that one.

Parker: Well, I think that's almost one of the key components on why we are so adamant on the geographic restrictions is that a patient needs redress and needs to have recourse. And in some of the circumstances that Lisa was speaking to, that allows for it. Where there's an exception to the rule, so this is a temporary episodic care. We believe the patient still has recourse because they're going to go back to the state in which they're from where that patient relationship was established and utilize the
board in that state, so if I'm visiting in Virginia over the weekend, and then I have care for my physician here in North Carolina, and there's, that's an exception, he's not licensed in Virginia and there's an adverse reaction. Well, my recourse is still through the North Carolina board where he's licensed and where I typically am.

Horvath: Thanks for that. Dr. Resneck I'm going to throw a question to you, keep you on your toes. There have been a couple questions on examples of how to practice telehealth. Without kind of getting into that more broad, maybe can you help delineate in your own practice, some of the appropriate uses of telehealth, either from a new patient or for an existing patient providing kind of that follow-up care?

Dr. Resneck: Well, one of the things that I think happened over these last two years as more and more physicians across the country deployed telehealth as part of the expansion during the pandemic, was we all learned a lot about when this works best and when it doesn't. And I think at the AMA, we've really looked to each specialty to help develop those guidelines specific to neurology, or orthopedic surgery, or in my case, dermatology. And in some specialties had a big evidence based building up already, and some have been newer to this. In my own practice as a dermatologist, it became pretty clear quickly that if I was seeing a patient with severe psoriasis who was on a biologic medication and just needed a follow-up visit to fine tune their medications, and I knew them well, and they lived three hours away, that was an awesome opportunity to use a tele-visit and not make them get childcare for their kids, miss a day of work, hop in the car, drive to my office.

If I had a patient who'd had three skin cancers and needed a full body exam to make sure they didn't have a new melanoma, the technology's not there yet, and I felt really nervous about missing things, and the camera was moving, and the images were blurry, and the dog is running by in the background, and I'm not actually even seeing the spot on their skin I think I'm looking at. So we've learned a lot and I think now it's just about kind of putting that into practice and figuring out for ourselves and our own practices, and for each specialty, what works best.

Horvath: Great. Somebody asked, can the panelists elaborate on any possible unintended consequences that were discussed during your meetings and are there any mechanisms to monitor these issues? And I'm thinking Dr. Resneck, you might want to jump in here too, but I'm thinking there was some discussion kind of around the standard of care issues and ensuring that patients know for example, who is providing their care. Ensuring that physicians have in place, if a patient does need in-person care, kind of the steps in order to make sure that happens. And if maybe we can elaborate a little bit more on those aspects?

Dr. Resneck: I'm happy to jump in first, but curious to see if Lisa and Shawn have anything to add. I mean, we see really fantastic, innovative, excellent uses of telehealth and it's really at its best when it's coordinated, seamless care from people who already in many cases, know the patient, have access to their medical records. And we see some lousy telehealth out there, I have patients who

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show up at my emergency department because they've got a side effect of a medication they got from some big corporate telehealth provider for their acne, and they have a bad side effect to the medication, and they sort of get abandoned by that corporate provider and have nowhere to go and no local recourse. And I think from the AMA perspective, we want this to be available and utilized by physicians taking care of their patients.

We want this to address where there are real gaps in health care for chronic disease like diabetes, and hypertension, and mental health, that list goes on and on. We don't need more and more telehealth for convenience care for people who just want to go online and buy antibiotics when they have the sniffles and they really have a viral URI, that's not where the gap in care is, and frankly we can do harm in those situations.

I think what the FSMB has tried really hard to do here is to strike that balance between making sure we open up and create the room for innovation for the good telehealth, and that we try to sort of discourage the massive growth maybe of the things that don't contribute to health, or that cause harm, or that exacerbate inequities. Because telehealth like many new technologies can ameliorate or exacerbate equity issues, so it's important to think about that too, up front as well. Lisa? Shawn?

**Robin:** I would just add that, I think what we tried to do is to remove some of the obvious barriers or restrictions from a physician being able to take care of their own patients. However, what we also did not want to do was create a system that further fragments the care that one could say is already too fragmented. And so I think that, that's what we tried to do with this policy and clearly it's not perfect and we will learn. And I think we have to monitor, the boards are going to need to monitor what we're going to look at. What kind of complaints are we getting? Where are we seeing those cases where maybe there's loopholes, maybe the guardrails are not tight enough, or maybe they're too tight. I think this is something that we're going to have to really monitor and work with our boards and other stakeholders on.

**Horvath:** Great. And I think we have time for maybe one more question, maybe we can fit another one in. But we'll try this one. There were lots of questions, and I've heard this as well, on physicians providing care via telehealth while the physician is located in another country. Do you care to comment on that kind of scenario?

**Robin:** Well, I think that we have physicians that are licensed in the United States that are in other countries and have for some time. Now how that's regulated that might be a question that Shawn could answer, because you may have some of your licensees that may be located in Australia or other places, but I mean they still technically have to have a license in this country.

**Parker:** Right. I think that's the key, where it's where the patient is where treatment is and that's what we're regulating, but they're probably plenty of great academic conversations on HIPAA or anything else that might transcend the small village we are creating technology wise.
Dr. Resneck: We have seen, I guess we want to separate the sort of physician who gets licensed in the state of Nevada and they radiologists, but happens to go sit somewhere in Australia, but follows all rules of the state where they're licensed and makes themselves available to questions or investigation if that happens versus, and I've seen this in my own specialty, some offshore websites that are making diagnoses and the clinician who's offering those diagnoses to my patients is not licensed in the U.S. And it's so hard, I've called up my state medical board about some of those, but it's really hard for them to investigate, because there's no local licensee to go after.

Horvath: I think that's it for questions. I'll kick it back to you Dr. Resneck to wrap it up.

Dr. Resneck: Well, I just want to really thank Lisa and Shawn for contributing to this really important and timely discussion on telehealth. I know it's an issue on a lot the minds of many, many physicians and for the steadfast work that you both do on behalf of patients. To our audience, thanks for joining us, thanks for your thoughtful questions. Sorry, we didn't get to more of them. And thanks for making the time to be here and to ask them.

As I mentioned earlier, we are going to email you all with a link to a recording of this webinar once it's available. And please do join us for our next AMA Advocacy Insights webinar this summer, details are coming soon. Have a great rest of your day. Take care.

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