HOD ACTION: Council on Medical Education Report 6 adopted as amended and the remainder of the report filed.

REPORT 6 OF THE COUNCIL ON MEDICAL EDUCATION (A-16)
Telemedicine in Medical Education
(Resolution 330-A-15)
(Reference Committee C)

EXECUTIVE SUMMARY

The use of technology in patient care has increased exponentially in recent years, and telemedicine—in its various formats—is no exception. This increase in use is supported by patient demand, provider interest, and recognition by insurers that care delivered via this technology can, in certain circumstances, reduce costs and improve access to care. Despite increased implementation of telemedicine in medical practice, however, specific training dedicated to its use has lagged.

Telemedicine in practice covers a wide range of patient care, including teleconsultations among physicians and patients; electronic communications; synchronous and asynchronous review of information; remote transmission of vital signs; call centers; and patient health applications, to name a few. Telemedicine has been shown to increase access to care, provide physicians the opportunity to receive guidance from remote colleagues, shorten patient travel times, improve management of chronic conditions, and increase patient adherence to treatment.

Despite demonstrated benefits, however, numerous barriers to full implementation of telemedicine exist. Medicare, Medicaid, and private insurance payer policies vary; interoperability of health information technology is limited; interstate licensing and practice laws are variable; financing for necessary technological investments is lacking; and broadband data transmission capabilities are insufficient. All these issues contribute to the current patchwork of available telemedicine services in the United States.

Currently, formalized training in the use of telemedicine in clinical practice is lacking across the educational continuum. Telemedicine is certainly used in various ways in undergraduate medical education (UME), graduate medical education (GME), and continuing medical education/continuing professional development (CME/CPD), but instruction dedicated to incorporating such technology into practice to enhance delivery of patient care is largely absent from curricula.

This report focuses most specifically on the status of telemedicine in GME training. It describes the current state of telemedicine in GME; provides examples of its use; discusses its incorporation into GME residency program accreditation requirements; delineates barriers; and discusses quality and effectiveness of telemedicine in training. Additional research regarding the learning outcomes of utilizing telemedicine technologies in medical education, including clinical skills and impact on patient care, is imperative to developing telemedicine's full potential in training and in expanding its use in practice.

HOD ACTION: Council on Medical Education Report 6 adopted as amended and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-A-16

Subject: Telemedicine in Medical Education (Resolution 330-A-15)

Presented by: Darlyne Menscer, MD, Chair

Referred to: Reference Committee C (Albert M. Kwan, MD, Chair)

Resolution 330-A-15, Telemedicine in Graduate Medical Education, introduced by the Resident and Fellow Section and referred by the American Medical Association (AMA) House of Delegates (HOD), asks that our AMA: 1) advocate for educating resident and fellow physicians during their training on the use of telehealth technology in their future practices; and 2) study the barriers to optimizing the use of telehealth technology for the purposes of tele-education and specifically tele-precepting in Graduate Medical Education and the solutions to overcoming these barriers.

Testimony heard by Reference Committee C was largely in favor of studying the barriers to optimizing the use of telehealth technology for the purposes of tele-education and, especially, tele-precepting in graduate medical education (GME). Some testimony opposed the creation of a curricular mandate in GME on the subject. Also, some felt that aspects of this topic fell outside the purview of the AMA, such that collaboration with an outside stakeholder(s) might be appropriate.

BACKGROUND

What Is Telemedicine?

The terms telemedicine, telehealth, and telehealth technology have been defined variously. Telehealth technology is often described as a broader category that encompasses these other, related terms. Despite these literal differentiations, however, the terms are often used interchangeably, and telemedicine is the term employed most frequently. Therefore, for the purposes of this report, the term telemedicine—as defined by the American Telemedicine Association—will be used: "The use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status."[1] Telemedicine uses existing communication networks to deliver health care services and medical education across geographic areas.[2] The American Telemedicine Association notes that a wide variety of modalities fall under the umbrella of telemedicine services, including wireless technologies, smart phones, chat, video, email, and other developing platforms that enable both synchronous and asynchronous communication between health care providers, systems, and patients.

Telemedicine aims to seamlessly blend remotely delivered patient care and physician education into the established protocols of hospitals, physicians, home health providers, and patient-centered medical homes, as well as to patients where they live and work. Patient encounters and educational opportunities can occur through video conferencing, digital image sharing, patient portals, remote transmission of vital signs, call centers, and patient health apps, all of which contribute to the growing world of telemedicine.

Services Delivered via Telemedicine

Telemedicine is effective in delivering a wide range of health-related services. Often, telemedicine is used to provide a patient or colleague with diagnostic or consultative assistance through interactive video, audio, or static images. The communication of vital signs or other patient data allows for real-time or delayed review in the context of clinical consultation and care. Telemedicine also allows for patient monitoring from a distance. Home devices can collect and transmit data, such as vital signs, blood glucose levels, and electrocardiograms, to another location for interpretation. Telemedicine can be used by patients and caregivers to obtain specific health information, participate in health-related virtual chat rooms, and provide support to other individuals with shared diagnoses or health concerns. Finally, telemedicine is widely used to provide lifelong learning to health care professionals.

Advantages of Telemedicine

Telemedicine can offer multiple benefits,[1] arguably the most important of which is improved access to care. For patients located outside of urban centers, or those in urban centers who lack adequate transportation, telemedicine can provide access to specialists in multiple fields. [2, 3, 4, 5, 6, 7, 8, 9] Regardless of setting, telemedicine presents physicians with the opportunity to collaborate with specialist colleagues or interpreters. Telemedicine can also offer cost savings through enhanced management of chronic conditions and shortened patient travel times.[3, 10, 11] Younger physicians especially are very comfortable working with technology and have demonstrated enthusiasm to implement telemedicine in practice.[12, 13]

Multiple studies demonstrate that telemedicine can improve the quality of care, [14, 15, 16, 17] and the quality of health care services delivered via telemedicine is often comparable to that provided in-person in terms of patient satisfaction, physician satisfaction, and health care outcomes. A final benefit of telemedicine relates to consumer demand. Telemedicine can be more convenient for patients, which may lead to better adherence to recommended treatment[18] and patient satisfaction.[19]

Limitations of Telemedicine

Important drawbacks must also be acknowledged. Not all patients and providers are inherently comfortable utilizing technology in this manner, and the digital divide between those who have access to technology and those who do not is real.[3] If inappropriately applied, telemedicine also has the potential to disrupt continuity of care.[20] Finally, licensing laws, payment policies, broadband capabilities, interoperability of health information technology, and the inability to finance necessary technological investments all contribute toward limiting the widespread implementation of telemedicine.

CURRENT STATE OF TELEMEDICINE IN PHYSICIAN TRAINING

Technology in Physician Training

Telehealth technologies applied in medical education generally fall into two categories:

1. Tele-education refers to the use of technology for teaching, learning, and supervising, particularly when the learner is located in a site remote to the teacher. This can be applied to all levels of physician medical education—undergraduate, graduate, and continuing—along with the education of other health professionals. Many specialty societies have policy regarding the application of telemedicine technologies to education. The American

Academy of Pediatrics (AAP) writes that "[p]roviders of educational programming should be encouraged to use telemedicine technologies to provide education to remote members of the health care team and clinical sites, such as Area Health Education Centers and Rural Health Clinics,"[3] while the American Academy of Family Physicians (AAFP) states that "[b]y creating ready access to information, telemedicine can provide physicians with current medical information that may not otherwise be available in a given setting."[21]

2. The second category, telemedicine, is the clinical application of patient care and consultation that students and trainees learn about and train in during their clinical training. The AAP also addresses this category in their policy recommendations, stating that "[t]opics related to telemedicine, including ongoing quality assurance and training in the uses of such technologies, should be expeditiously integrated into existing medical school and residency curricula, as well as CME programming."[3]

Examples of Telemedicine in GME

Residency and fellowship programs in a number of fields have current initiatives/curricula related to telemedicine that may serve as models for further dissemination of telemedicine technology in GME. In the field of psychiatry, for example, studies have demonstrated improved access to mental health services for rural and underserved populations across North America through telepsychiatry. In 2014, Sunderji and colleagues reviewed the status of telepsychiatry in GME and summarized current objectives utilized in training as well as barriers to further implementation of telepsychiatry.[22] They found that while psychiatry residents were generally very eager to be trained in telepsychiatry, few programs had incorporated it into their curricula. Even fewer had evaluated outcomes to determine the best method of instruction in telepsychiatry. In this arena, the University of Arkansas for Medical Sciences has been a frontrunner, via its Telemedicine Child Psychiatry Service rotation, which imparts skills to residents in the Child and Adolescent Psychiatry GME program.[23]

The intensive care unit (ICU) represents another area active in the instruction of the clinical applications of telemedicine. Lilly and colleagues reviewed the current state of ICU telemedicine and its impact on trainees.[24] Overall, they found that the availability of such technology enhanced learning and provided important supervision for patient management questions. Residents to whom ICU telemedicine was available felt it also improved the patient care they were able to give.

Many current GME trainees favor asynchronous learning (education that is not delivered in real time or in person), often utilizing technology. In a 2014 survey of emergency medicine residents in twelve training programs regarding their extracurricular studying, respondents reported on average one to four hours a week learning asynchronously. They favored podcasts (35%), followed by textbooks (33%) and Google searches (21%). Podcasts were rated the most beneficial (70%).[25]

Tele-Precepting

In rural areas, barriers to accessing specialty care and retaining supervisors to train learners how to provide that specialty care are challenging and important issues. Telemedicine technology can overcome many barriers presented by a rural setting. Cameron and colleagues[26] assessed an Australian program of supervising junior medical officers (comparable to fellows) in oncology as they provided care to patients in satellite rural clinics. Their faculty supervisors (senior medical officers) were able to observe the interactions via teleconferencing and provide input on patient care and feedback to the learners. Both the junior and senior medical officers were positive about the interactions and learning when surveyed. They felt similar experiences would be beneficial for

other specialties. Challenges identified included training in the technology and the inability of the supervisor to confirm physical findings on the patients. Despite these limitations, participants felt it was worthwhile continuing to develop such technology because it benefited both trainees and patients.

Program Requirements Applicable to Telemedicine

Section VI.D of the Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements, which apply to all ACGME-accredited programs, outlines the requirement for supervision of residents and fellows. The language of the requirement follows:

> The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients… Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member… Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.[27]

Thus, the current requirements do allow for supervision by "means of telephonic and/or electronic modalities," which could potentially include tele-precepting if it were appropriate for learning and safe for patients.[27]

Recently, DeJong and colleagues proposed explicit core competencies for telemedicine to be added to the existing ACGME core competencies.[28] The table in Appendix A, reproduced from their article, includes competencies for all six domains defined by the ACGME. Regardless of whether these competencies are added officially to ACGME program requirements, support from the medical education community for their review and potential enhancement could guide more programs to embrace the opportunities presented by this growing field.

The U.S. Department of Veterans Affairs provides training to more than 30,000 residents annually.[29] A 2012 update of the Veterans Administration (VA) policy for resident supervision was undertaken in part to "reflect new standards for supervision and documentation of supervision for telemedicine or telehealth patient encounters."[30] While the policy authorizes residents to provide telehealth care to remote patients when VA standards allow such care, it specifies that supervising faculty must be in the general vicinity and available to provide direct supervision when required. It does not allow a resident to provide care at a remote site without faculty being present at that site. Thus, the VA currently does not allow tele-precepting as defined in the previously described study by Cameron et al.,[26] in which the supervising physician was not in the same physical location as the trainee.

Point of Reference: Telemedicine in Undergraduate Medical Education

While Liaison Committee on Medical Education (LCME) standards do not explicitly address the use of telemedicine in undergraduate medical education (UME), several do govern its use. Standard 7.8, "Communication Skills," requires that "faculty of a medical school ensure that the medical curriculum includes specific instruction in communication skills as they relate to communication with patients and their families, colleagues, and other health professionals."[31] Thus, any medical school with learning objectives for the use of telemedicine communication must ensure that it is taught effectively and used properly.

The annual Association of American Medical Colleges (AAMC) graduation questionnaire is completed by a large portion of students graduating from allopathic medical schools in the United States; several items on the questionnaire relate to technology. In previous years, one item specifically focused on telemedicine. From 2009 through 2014, 43% to 46% of students agreed or strongly agreed with the statement "I am confident I have the knowledge and skills to use telemedicine."[32, 33] However, when asked about "use of computer-based clinical record keeping" or "point-of-care technologies," respondents agreeing or strongly agreeing were 94% and 73%, respectively.[32, 33] Thus, while a surprisingly high portion of students agree about their ability to use telemedicine (without further definition), it is still much lower than with other more commonly used technologies.

One example of the manner in which telemedicine has been used at the UME level can be found at the Oregon Health & Science University (OHSU) School of Medicine, one of the medical schools involved in the AMA's Accelerating Change in Medical Education initiative. OHSU faculty have identified competencies in clinical informatics for medical education.[34] They address informatics competencies quite broadly and do specifically include telemedicine. Suggested competencies in this domain include the ability to:

1. Provide clinical care via telemedicine, and refer those for whom it is necessary;
2. Function clinically in telemedicine/telehealth environments; and
3. Learn and understand the appropriate use of telemedicine and telehealth (such as e-visits), both for remote locations and as a convenient option locally in patients' homes and other settings.

Faculty suggest that, at present, these competencies might best be achieved on community and rural rotations and assessed with an objective structured clinical exam simulation of a telemedicine encounter.

Point of Reference: Telemedicine in CME and CPD

Many of the telehealth technologies used for learning in the GME environment are also applicable to continuing medical education/continuing professional development (CME/CPD). Telehealth technologies in CME/CPD have been used in a variety of ways, including access to online journal articles, webinars, podcasts, etc., and this type of learning has increased in recent years. However, the education of practicing physicians is also found in the instruction of physicians and other health care clinicians by physician specialists in other locations. Physicians located in areas distant from specialized services can benefit from having the specialist available via telehealth technology during a patient visit to participate in care delivery. A number of academic health centers and VA facilities have teleconference access to remote sites, enabling specialists to consult and subsequently provide recommended care.[16, 35] Such applications are likely to expand as the technology becomes more widely available and as payment policies evolve.

BARRIERS TO THE USE OF TELEMEDICINE IN PHYSICIAN TRAINING

From the data published on the use of telemedicine in physician training, it is clear that trainees in many specialties have high interest in gaining telemedicine skills. However, as evidenced in this report, curricula and resources for training residents and students in telemedicine are available in limited numbers of institutions and programs. Barriers to broader availability that have been identified include:

1. Physician and health system payment for provision of clinical services via telemedicine is lacking in many locations;
2. Onsite investment in technology is needed;
3. Regulatory and legislative issues related to licensing and credentialing differ from agency to agency and state to state;
4. Technological issues, such as the availability of broadband networks and the interoperability of electronic health records, impact adoption; and
5. Professional issues, such as the ethics regarding the physician-patient relationship in telemedicine encounters, are still being fully explored.

QUALITY AND EFFECTIVENESS OF TELEMEDICINE IN TRAINING

Overall, there is a paucity of data on the outcomes of utilizing telehealth technologies in medical education. This is an area in which additional research is acutely needed to assess learning outcomes, including clinical skills and impact on patient care.

The data that does exist is largely favorable. Tomlinson and colleagues[36] reviewed the literature comparing outcomes of tele-education with other methods of education delivery for health professions students, many of whom were medical students and residents. Most of the studies substituted teleconferencing for face-to-face lectures over a variety of topics. They found that, overall, knowledge increased and other important learning outcomes were as good or better in the groups that utilized tele-education. While some learners still preferred face-to-face learning, tele-education was highly acceptable.

Faculty at a medical school in rural Australia have studied the use of tele-education for medical students distributed to several rural sites.[37] The tele-education sessions were for small groups of students and focused on clinical skills. Students and faculty were highly satisfied with the tele-education sessions and felt they were of equal quality to other methods of teaching. Aspects of the training that they felt contributed the most to learning were the high quality of the teleconference transmissions, the ability to interact with others in their small group, convenience at the rural site, and ease of use. Planned improvements included movable cameras and improved audio equipment to capture all of the interactions.

RELEVANT AMA POLICY

While our AMA has not specifically studied the use of telemedicine in GME, it has researched other aspects of telemedicine that may have bearing on this topic. Policy H-480.974, Evolving Impact of Telemedicine, compels our AMA to stay abreast of changes to telemedicine legislation, urges the federal government to fund demonstration projects to evaluate the effect of telemedical care, and requests the development of appropriate reimbursement mechanisms for care delivered via telemedicine. Policy D-480.970, Access and Equity in Telemedicine Payments, asks our AMA to advocate that the Centers for Medicare & Medicaid Services pay for telemedicine services for patients who have problems accessing physician specialties that are in short supply in areas that are not federally determined shortage areas, if that area can show a shortage of those physician specialists. Policy H-480.961, Teleconsultations and Medicare Reimbursement, demands that CMS reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various "fee splitting" or "fee sharing" reimbursement schemes. Appendix B lists additional related policies.

SUMMARY AND RECOMMENDATIONS

In summary, innovation in health care delivery and technology, in addition to important scientific advances, must be addressed in the education and training of future physicians. Indeed, rapid technological changes over the past half century have radically changed the way that medicine is taught, learned, and practiced. Telemedicine is no different; it is a technological care delivery advance that should be incorporated into physician education.

Telemedicine has demonstrated significant value in patient access to care, physician and patient satisfaction, health outcomes, and the reduction of health care costs, yet its full potential remains unexplored. An essential component of developing this potential will be exposure to and evidence-based instruction in telemedicine's capabilities and limitations at all levels of physician education. Additional research regarding the learning outcomes of utilizing telemedicine technologies in medical education, including clinical skills and impact on patient care, will be imperative to the accomplishment of this goal.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 330-A-15 and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support the appropriate use of telemedicine in the education of medical students, residents, fellows and practicing physicians. (New HOD Policy)

2. That our AMA encourage appropriate stakeholders to study the most effective methods for the instruction of medical students, residents, fellows and practicing physicians in the use of telemedicine and its capabilities and limitations. (Directive to Take Action)

3. That our AMA collaborate with appropriate stakeholders to reduce barriers to the incorporation of telemedicine into the education of physicians and other health care professionals. (Directive to Take Action)

4. That our AMA encourage the Liaison Committee on Medical Education (LCME) and Accreditation Council for Graduate Medical Education (ACGME) to include core competencies in telemedicine in undergraduate medical education and graduate medical education training. (Directive to Take Action)

5. That our AMA reaffirm policies H-480.946, H-480.974, D-480.970, and H-480.968, which can reduce some of the barriers to telemedicine education, which have been identified. (Reaffirm HOD Policy)

Fiscal Note: $2,500

APPENDIX A: SUGGESTED TELEMEDICINE-RELATED ENHANCEMENTS TO ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION CORE COMPETENCIES [28]

Table. Suggested Telemedicine-Related Enhancements to Accreditation Council for Graduate Medical Education Core Competencies

Core Competency	Suggestions for Telemedicine-Related Additions to Subcompetencies	Illustrative Examples
Medical knowledge	Recognize the limits of safe telemedicine	Understand exclusion criteria by patient presentation and comorbidity; support designated referral networks
Patient care	Perform a virtual physical examination	Use evidence-based remote examination techniques, such as those taught at the Southern California Telemedicine Learning Center[6]
	Conduct virtual home assessments	Review a patient's medicine cabinet via videoconferencing, or assess his or her home for fall risks
	Assess and use telemedicine devices	Gather useful clinical information from home blood pressure cuffs and nurse-guided otoscopes or stethoscopes
Interpersonal and communication skills	Collaborate with remote clinical mediators	Guide a patient and his or her home health aide through basic physical examination maneuvers
	Recognize a patient's level of technological literacy and use telecommunication for rapport-building and evaluation	Use of standardized patients to simulate a rural telemedicine encounter, such as Oregon Health & Science University's TeleOSCE program
Practice-based learning and improvement	Identify gaps in personal performance in conducting telemedicine evaluations and seek evidence-based best practices to address them	Access free online educational tools at the American Telemedicine Association Learning Center[7]
Professionalism	Recognize the essential elements of a medical encounter	Health Insurance Portability and Accountability Act compliance; adequate appointment time, with physician discretion to extend the visit; protocols for testing and follow-up; electronic record exportable to primary care
	Hold partners to professional standards	Read disclaimers to ensure that partners take adequate legal responsibility for patient safety Solicit information about quality improvement processes
Systems-based practice	Understand reporting practices	Report unprofessional organizations to the American Telemedicine Association or Federal Trade Commission
	Support the appropriate use of telemedicine	Educate patient panels about the benefits and risks of telemedicine; contribute to public awareness through editorials or social media
	Ensure appropriate legal protections	Demonstrate understanding of multistate licensing and the legal limits of e-prescribing (eg, controlled substances)

APPENDIX B: RELEVANT AMA POLICIES

H-480.946: Coverage of and Payment for Telemedicine
... 7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines. (CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14) ...

H-160.937: The Promotion of Quality Telemedicine
... (1) The AMA adopts the following principles for the supervision of nonphysician providers and technicians when telemedicine is used: (a) The physician is responsible for, and retains the authority for, the safety and quality of services provided to patients by nonphysician providers through telemedicine. (b) Physician supervision (e.g. regarding protocols, conferencing, and medical record review) is required...

H-480.974: Evolving Impact of Telemedicine
... Our AMA: (1) will evaluate relevant federal legislation related to telemedicine; (2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship; (3) urges professional organizations that serve medical specialties involved in telemedicine...

H-480.969: The Promotion of Quality Telemedicine
... (1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:...

H-225.962: Medical Staff Membership Category for Physicians Providing Telemedicine
...The AMA recommends that organized medical staffs, as part of their responsibility for the quality of professional services provided by individuals with clinical privileges, identify to the governing body of the hospital/medical care organization those clinical services that can be provided by telemedicine; and recommends that organized medical...

D-480.970: Access and Equity in Telemedicine Payments
...Our AMA will advocate that the Centers for Medicare & Medicaid Services pay for telemedicine services for patients who have problems accessing physician specialties that are in short supply in areas that are not federally determined “shortage” areas, if that area can show a shortage of those physician specialists. (Res. 818, I-14) ...

D-480.974: Professionalism in Telemedicine and Telehealth
...The Council on Ethical and Judicial Affairs will review Opinions relating to telemedicine/telehealth and update the Code of Medical Ethics as appropriate. (BOT Rep. 22, A-13) ...

H-480.968: Telemedicine
...The AMA: (1) encourages all national specialty societies to work with their state societies to develop comprehensive practice standards and guidelines to address both the clinical and technological aspects of telemedicine; (2) will assist the national specialty societies in their efforts to develop these guidelines and standards; and urges national private accreditation organizations (e.g., URAC and JCAHO) to require that medical care organizations which establish...

D-480.999: State Authority and Flexibility in Medical Licensure for Telemedicine
...Our AMA will continue its opposition to a single national federalized system of medical licensure. (CME Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: BOT Rep. 3, I-14) ...

D-275.996: Creation of AMA Data Bank on Interstate Practice of Medicine
... (2) explore the provision of information on physician licensure, including telemedicine, to members and others through the World Wide Web and other media; and (3) continue to make information on state legal parameters on the practice of medicine, including telemedicine, available for members and others. (BOT Rep. 6, I-99; Reaffirmed: CLRPD Rep. 1, A-09) ...

G-615.035: Technology and the Practice of Medicine
...Our AMA encourages the collaboration of existing AMA Councils and working groups on matters of new and developing technology, particularly electronic medical records (EMR) and telemedicine. (Res. 606, A-14) ...

D-330.914: Face-to-Face Encounter Rule
...to monitor legislative and regulatory proposals to modify Medicare’s face-to-face encounter policies and work to prevent any new unfunded mandatory administrative paperwork burdens for practicing physicians. 2, Our AMA will work with CMS to enable the use of HIPAA-compliant

telemedicine and video monitoring services to satisfy the face-to-face requirement in certifying eligibility for Medicare home health services. (CMS Rep. 3, I-12; Appended: Res. 120, A-14) ...

H-480.961: Teleconsultations and Medicare Reimbursement
...Our AMA demands that CMS reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various "fee splitting" or "fee sharing" reimbursement schemes. (Res. 144, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed...

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