COMMONWEALTH *of* VIRGINIA

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VIRGINIA BOARD OF DENTISTRY
Invitation to an Open Forum on
Policy Strategies to Address Teledentistry

Friday, August 14, 2015 - 9:00 am to 12 pm
Board Room 4, 2nd Floor, Perimeter Center
9960 Mayland Drive, Henrico, VA 23233

The Board of Dentistry (Board) requests your assistance in responding to the following questions regarding the need for policies to protect patients in the use of teledentistry as a method of delivering dental treatment in Virginia --

- **What should be the standard for establishing a dentist-patient relationship?**
- **Should there be requirements for communications equipment at remote sites?**
- **What are the risks and costs associated with teledentistry?**

The forum is an opportunity for individuals, institutions and organizations to present their views on the use of teledentistry and the protections that should be in place to promote safe practice within the standard of care.

Speakers will be given up to ten minutes to express their perspective and make recommendations regarding the use of teledentistry in Virginia. Following the presentations, as time permits, attendees will be asked to participate in a question and answer session to allow for exploration and discussion of the recommendations made.

A transcript of the Forum will be made for future reference by the Board. Any policy action the Board decides to take will include the standard comment opportunities required for regulatory action and for advancing a legislative proposal.

Attachments: **Tennessee Senate Bill 1214, pending legislation, addressing teledentistry and Tennessee Code §63-5-115 which would be amended by the bill**
Arizona Senate Bill 1282, passed legislation to be effective July 1, 2015, addressing teledentistry, dental hygienists, and dental assistants
KHN article on When Connecting With A Dentist Doesn't Mean An Office Visit
KHN article on California to Launch Medicaid-Funded Teledentistry
Center for Telehealth and eHealth Law's CTEL Safe Telemedicine Principles
Virginia Board of Medicine's Guidance Document 85-12 Telemedicine

HOUSE BILL 976
By Hill M

SENATE BILL 1214

By Yarbro

AN ACT to amend Tennessee Code Annotated, Title 63, relative to dentistry.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 63-5-115(b), is amended by adding the following as a new subdivision to be appropriately designated:

( ) Teledentistry. As used in this chapter, "teledentistry" means the use of information by technology and telecommunications for dental care, consultation, education, and public awareness in the same manner as authorized for telemedicine and telehealth;

SECTION 2. Tennessee Code Annotated, Section 63-5-115(d)(1), is amended in the first sentence of the subdivision by inserting the language ", federally qualified health centers," between the language "nonprofit clinics" and "and public health programs".

SECTION 3. Tennessee Code Annotated, Section 63-5-115(d)(1), is further amended by inserting the following language immediately after the third sentence of the subdivision:

Under the protocol, the initial and subsequent examinations by the dentist may be accomplished by means of teledentistry technology.

SECTION 4. This act shall take effect July 1, 2015, the public welfare requiring it.

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Tenn. Code Ann. § 63-5-115 (Copy w/ Cite) Pages: **3**

Tenn. Code Ann. § 63-5-115

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*** Current through the 2014 Regular Session and amendments approved at the November 4, 2014 General Election ***

Title 63 Professions Of The Healing Arts
Chapter 5 Dentists

Tenn. Code Ann. § 63-5-115 (2014)

63-5-115. Employment of and practice by hygienists and assistants.

(a) A duly licensed and registered dentist may employ licensed and registered dental hygienists, registered dental assistants and practical dental assistants. Such licensed and registered dental hygienists may practice as authorized in this section or § 63-5-108 only in the office of and under the direct and/or general supervision of a licensed and registered dentist, in authorized public health programs or at other locations otherwise authorized by this chapter. Such registered and/or practical dental assistants may practice as authorized in this section or § 63-5-108 only in the office of and under the direct supervision of a licensed and registered dentist except in authorized public health programs. No provisions in this chapter shall be construed as authorizing any licensed and registered dental hygienists, registered dental assistants or practical dental assistants to practice as such except as provided in this section.

(b) Definitions.

(1) Direct Supervision. As used in this chapter regarding supervision of licensed and registered dental hygienists or registered dental assistants, "direct supervision" means the continuous presence of a supervising dentist within the physical confines of the dental office when licensed and registered dental hygienists or registered dental assistants perform lawfully assigned duties and functions;

(2) General Supervision. As used in this chapter, "general supervision" is defined as those instances when the dentist is not present in the dental office or treatment facility while procedures are being performed by the dental hygienist, but the dentist has personally diagnosed the condition to be treated, has personally authorized the procedures being performed and will evaluate the performance of the dental hygienist.

(c) Licensed and registered dental hygienists and registered dental assistants are specifically permitted to participate unsupervised in educational functions involving organized groups or health care institutions regarding preventive oral health care. Dental hygienists are permitted to participate in health screenings and similar activities; provided, that no remuneration is given by the organized group to any hygienist or the hygienist's employer for participating in these activities.

(d) **(1)** Settings in which licensed and registered hygienists may engage in the provision of preventive dental care under the general supervision of a dentist through written protocol

include nursing homes, skilled care facilities, nonprofit clinics and public health programs. Dental hygienists licensed and registered pursuant to this chapter are specifically permitted to render such preventive services as authorized in § 63-5-108 or by regulation of the board, as prescribed by the supervising dentist under a written protocol. Dental hygienists rendering such services shall be under the general supervision of a licensed dentist as specified in a written protocol between the supervising dentist and the hygienist which must be submitted in advance to the board. No dentist may enter into a written protocol with more than three (3) dental hygienists at any one time nor may any hygienist be engaged in a written protocol with more than three (3) dentists at any one time. The supervising dentist must process all patient billings. Each written protocol will be valid for a period of two (2) years at which time it must be renewed through resubmission to the board. Should a dentist cease to be the employer/supervisor of a dental hygienist where a written protocol is in force and on file with the board, the dentist must notify the board within ten (10) working days by certified mail, return receipt requested or electronic mail that the written protocol is no longer in force.

(2) Licensed and registered dental hygienists working under written protocol, in addition to those requirements enumerated under the general supervision as authorized by § 63-5-108(c)(5), must have actively practiced as a licensed dental hygienist for at least five (5) years and have practiced two thousand (2,000) hours in the preceding five (5) years or taught dental hygiene courses for two (2) of the proceeding three (3) years in a dental hygiene program accredited by the American Dental Association's Commission on Dental Accreditation and completed six (6) hours of public health continuing education within the past two (2) years; provided, that, after satisfying the requirement of this subsection (d), in subsequent years the hygienist may work on a part-time basis.

(3) Each written protocol, required for off-site practice under general supervision, shall be submitted to the board by certified mail, return receipt requested and shall include at a minimum:

(A) The name, address, telephone number and license number of the employer (supervising) dentist;

(B) The name, address, telephone number and license number of the dental hygienist;

(C) The name, address, telephone number and other pertinent identification from all locations where the dental hygiene services are to be performed; and

(D) A statement signed by the dentist that the dentist and the dental hygienist that meets all minimum standards for general supervision as well as those required for practice under a written protocol as stipulated in this section and § 63-5-108.

(4) The board will receive each written protocol submitted and keep those on file which meet the minimum requirements enumerated in subdivision (d)(3). Those received by the board and determined not to be complete shall be returned to the submitting dentist within thirty (30) days of receipt with a request for the additional information required. The dentist may then resubmit an amended written protocol to the board.

HISTORY: Acts 1957, ch. 32, § 16; 1978, ch. 824, § 12; T.C.A., § 63-544; Acts 1988, ch. 635, § 17; 1990, ch. 1031, § 19; 1998, ch. 847, §§ 4, 5; 1999, ch. 405, § 3; 2012, ch. 945, §§ 2, 3.

Assigned to FI & HHS

AS PASSED BY THE HOUSE

ARIZONA STATE SENATE

Fifty-Second Legislature, First Regular Session

AMENDED

FACT SHEET FOR S.B. 1282

teledentistry; dental hygienists; dental assistants

Purpose

Creates Expanded Function Dental Assistants (EFDA), institutes various requirements concerning teledentistry and modifies the dental affiliated practice statute.

Background

The State Board of Dental Examiners (Board) was established in 1935 to regulate the practice of dentistry. It is charged with protecting the health, safety and welfare of the state through examination, licensure and complaint adjudication and enforcement processes. The Board oversees dentists and supervised personnel including dental hygienists (hygienists) and dental assistants. According to the Auditor General's report, there are roughly 8,800 licensed dentists and hygienists in the state.

Statute allows hygienists and dentists to enter into an affiliated practice relationship (APR) to provide dental hygiene services in an affiliated practice setting. An *APR* is a written agreement between the hygienist and the dentist that allows, subject to the terms of the agreement, the hygienist to perform all dental hygiene procedures within his or her authorized scope of practice in an affiliated practice setting (A.R.S. § 32-1289).

Statute outlines the scope of practice for hygienists and dental assistants. In addition to the functions a dental assistant may perform, a hygienist may administer local anesthetics, examine the oral cavity, remove plaque and apply sealant and topical fluoride. Qualified dental assistants may perform x-rays, polish teeth and provide patient care. Any expansion in this scope requires a review through the sunrise process (A.R.S. § § 32-1281 and 32-1291).

On December 17, 2014, the Senate Health and Human Services and the House of Representatives Health Committee of Reference (COR) held a public hearing to review a sunrise application that had been submitted by the Arizona Dental Association to increase the scope of practice for dental assistants by creating the EFDA position. The COR recommended forwarding the sunrise application to the full Legislature for consideration.

There is no anticipated fiscal impact to the state General Fund associated with this legislation.

Provisions

Teledentistry

1. Requires the dentist or dental provider to obtain verbal or written informed consent from the patient or patient's health care decision maker prior to delivery of care through teledentistry.

2. Requires documentation of the consent if it is obtained verbally.

3. Entitles the patient to confidentiality protections outlined in statute and prohibits the dissemination of images or individually identifiable information for research or educational purposes without consent, unless authorized by state or federal law.

4. States all reports resulting from a teledentistry consultation are part of a patient's dental record.

5. Exempts the transmission of diagnostic images to another health care provider or dental specialist or the reporting of diagnostic test results by that specialist from consent requirements.

6. Limits the procedures and requirements concerning teledentistry to within this state and stipulates the procedures and requirements do not expand, reduce or otherwise amend statutory licensing requirements for dentists or dental providers.

7. Requires the Arizona Health Care Cost Containment System to implement teledentistry services for enrolled members under 21 years of age.

Expanded Function Dental Assistants (EFDAs)

8. Expands a dental assistant's functions if the following are successfully completed:
   a) a Board-approved expanded function dental assistant training program completed at an institution accredited by the Commission on Dental Accreditation of the American Dental Association; and
   b) an examination in expanded functions that is approved by the Board.

9. States an EFDA's functions include the following:
   a) placement, contouring and finishing of direct restorations;
   b) placement and cementation of prefabricated crowns following preparation of the tooth by a licensed dentist;
   c) placement of interim therapeutic restorations under the general supervision and direction of a licensed dentist following a consultation conducted through teledentistry; and
   d) application of sealants and fluoride varnish under the general supervision and direction of a licensed dentist.

10. Requires the restorative materials used for the placement of direct restorations and prefabricated crowns to be determined by the dentist.

11. Allows a hygienist to engage in expanded restorative functions with study and examination equivalent to an EFDA.

Affiliated Practice

12. Requires hygienists, in order to be eligible to enter into an APR, to meet one of the following:
    a) be actively engaged in dental hygiene practice at least 500 hours in each of the 2 years immediately preceding the APR, instead of at least 2,000 hours in the 5 years immediately preceding the relationship APR; or
    b) hold a bachelor degree in dental hygiene, have held an active license for at least 3 years and be actively engaged in dental hygiene practice for at least 500 hours in each of the 2 years preceding the APR.

13. Requires the hygienist to consult with the dentist if the proposed treatment is outside the scope of the agreement.

14. Prohibits an affiliated practice hygienist from entering into a contract with, or providing dental hygiene services in, any entity or setting other than the following:
    a) health care organization or facility;
    b) long-term care facility;
    c) public health agency or institution;
    d) public or private school authority;
    e) government-sponsored program;
    f) private nonprofit or charitable organization; and
    g) social service organization or program.

15. Prohibits a dentist in an APR from permitting the provision of services of more than three affiliated practice hygienists at any one time.

16. Removes certain existing requirements included in the APR agreement and applies those requirements to all dental hygiene services provided through an APR.

Miscellaneous

17. Specifies a hygienist may inspect the oral cavity and surrounding structures for the purposes of gathering clinical data to facilitate a diagnosis.

18. Allows a hygienist to perform periodontal screenings or assessments rather than examinations.

19. Defines *teledentistry, assessment, screening, affiliated practice relationship, board, dental provider, dentist* and *health care decision maker.*

20. Relocates the definition of *unprofessional conduct* and statute concerning APRs.

21. Makes technical and conforming changes.

22. Becomes effective on the general effective date.

Amendments Adopted by Health and Human Services Committee

1. Removes requirement for health care insurance entities to cover teledentistry services.
2. Modifies the definition of *teledentisry*.
3. Requires AHCCCS to implement teledentistry services for enrolled members under 21 years of age.
4. Makes technical changes.

Amendments Adopted by Committee of the Whole

- Removes an exception to the consent requirements concerning services provided through teledentistry.

Amendments Adopted by the House of Representatives

- Makes technical changes to address a statutory conflict.

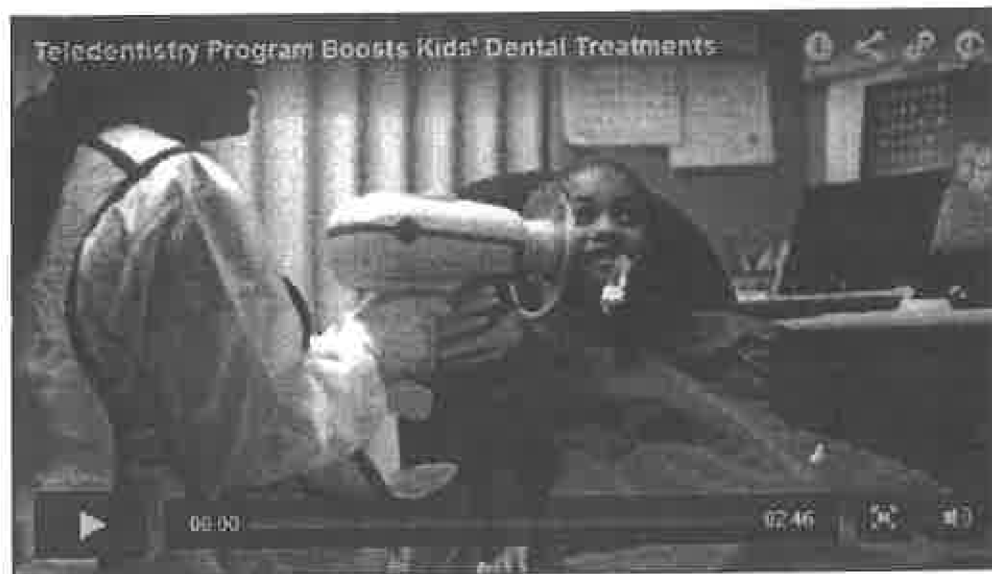
Senate Action				House Action			
FI	2/4/15	DP	6-0-1	HEALTH	3/17/15	DP	4-0-0-2
HHS	2/18/15	DPA	7-0-0	3rd Read	4/1/15		59-0-1

Prepared by Senate Research
April 2, 2015
FB/CB/ls

When Connecting With A Dentist Doesn't Mean An Office Visit

By **Daniela Hernandez** | April 7, 2014

This KHN story was produced in collaboration with the Daily News



Inside a South Los Angeles classroom filled with plastic dinosaurs, building blocks, stuffed animals and Dr. Seuss books, Mireya Rodriguez counts Hendryk Vaquero's teeth and looks for cavities.

At just 4 years old, he already has nine stainless steel crowns and multiple fillings, and his gums show signs of inflammation and infection. Since a check-up more than three months ago, he's lost a couple of teeth, including a capped tooth his mom pulled out after it started bleeding.

"Pero no llore," said the boy, assuring Rodriguez in Spanish he didn't cry.

This was only the second time the dental hygienist examined his teeth, many of which have rotted, in part because he is eating too many sweets and drinking milk before falling asleep. Later, a dentist at the Venice Family Clinic 16 miles away will pull up his records online and consult with Rodriguez on his case – without ever necessarily seeing the patient.

It's all part of a free "teledentistry" program for low-income patients in California who don't have access to regular dental care. Often they're stymied by high costs and a shortage of dentists who treat the poor. Many also face language barriers, lack legal immigration status, are afraid of dentists or have a poor understanding of what causes dental problems.

Hendryk Rodriguez already has nine stainless steel crowns, multiple fillings and signs of infection. This is the second time the four-year-old has been examined by a dental hygienist (Photo by Heidi de Marco/KHN).

"The only thing that they know is that they have to provide for their family and that's the most important thing for them," said Rodriguez, who comes to the Volunteers of America Silva Head Start program on a regular basis. "You have to educate the parents."

Rodriguez is among 15 specially trained hygienists and dental assistants who work online with dentists as part of a $2.5 million experiment designed to deliver preventive dental care and education to underserved populations. Funded for now by grants from non-profits, trade associations and others, the "Virtual Dental Home Demonstration Project" has been launched in 50 locations throughout the state, including Pacoima, Santa Monica, San Jose, Santa Cruz, East Palo Alto, San Francisco, Sacramento and Eureka.

With special permission from the state, the hygienists and dental assistants travel from place to place performing basic procedures not in their scope of practice – for instance, deciding which X-rays to take or installing temporary fillings that help prevent early decay from progressing—then consult remotely with dentists on how to proceed. Sometimes, after doing what they can, they send a patient to a dentist's office.

Operating at community sites ranging from schools to nursing homes, the program is meant to boost access and maximize the expertise and efficiency of the people delivering care.

Dental hygienist Mireya Rodriguez conducts an initial screening on Ammi Alvarez, 4, at Silva Head Start in Los Angeles as part of a pilot program to increase oral health awareness, offer preventive care and provide children early access to treatment (Photo by Heidi de Marco/KHN).

The Virtual Dental Home Demonstration Project "really changes the idea of what the dental team and the dental practice is — from being confined to the four walls of a dental office to now having a team that can be spread out," said Dr. Paul Glassman, a dentist at the University of the Pacific in San Francisco, who started the program.

A bill pending before the state Legislature would expand the Virtual Dental Home approach statewide and require Medi-Cal, the government health insurance program for the poor and disabled, to pay for procedures facilitated by the Internet.

The bill, AB 1174, passed unanimously in the Assembly. It is expected to come up for vote in the state Senate later this year and enjoys wide bipartisan support. Expanding the program statewide would increase costs minimally in the short-term — by upward of $500,000 a year, according to a State Assembly's Appropriations Committee fiscal analysis. If teledentistry takes off, the costs could be higher.

Advocates think the return on that investment could be substantial. For every dollar spent in preventive services like the ones provided through the Virtual Dental Home demonstration project an estimated $50 is saved on more expensive, complicated procedures, said Dr. James Stephens, a Palo Alto dentist and president of the California Dental Association.

"It's a no brainer," he said. "We should spend more money on prevention."

The association, which represents 25,000 dentists, is generally behind the proposed California law because it gives people access to dental care who wouldn't have a way to get it otherwise. The organization is working with legislators to assure it benefits the public as much as possible and is fiscally sustainable, Stephens said.

Dr. Burton Edelstein, a professor at Columbia University and the founding president of the Children's Dental Health Project, a Washington, D.C.-based advocacy organization, said "quality of care can be just as good or even better" in teledentistry if the benefits of better access are factored in.

Some dental organizations around the country have spoken out against letting hygienists, assistants and other mid-level providers do procedures typically reserved for dentists. In Maine, for example, dentists have fought a bill creating a special category of provider called dental therapists – who would perform some of the duties of hygienists and some of dentists, such as filling cavities. Dental therapists already practice in Minnesota and Alaska.

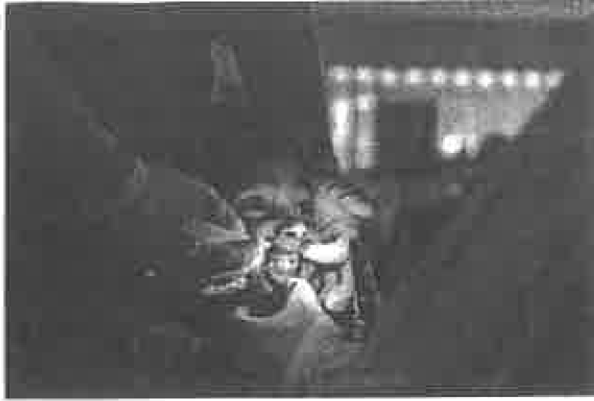
Maine dentists have said creating this role won't solve the fundamental obstacles to treatment.

"It's a crisis of financing, not a crisis of providers," Dr. Jonathan Shenkin, an Augusta dentist and representative of the Maine Dental Association told the Portland Press Herald. "If people can't afford a dentist, they're not going to be able to afford a dental therapist."

In California and elsewhere, the teledentistry effort has been made more feasible in part because equipment and devices are smaller, more portable and less expensive than before. Also, Obamacare has provided a boost with its emphasis on digital technology to improve care and reduce costs.

Out in the field, what matters is a gentle touch with patients — especially those who have never been to a dentist before or have had frightening experiences in the past.

When Rodriguez examines children at Head Start — government-funded pre-schools — she usually brings them up to her work station in pairs. Meanwhile, their friends are singing and playing with each other and the teachers in the background. It's a fundamentally different experience than going to an office.



Using an intraoral camera, dental hygienist Mireya Rodriguez records digital images of 4-year-old Aezon Solis Cueras' teeth (Photo by Heidi de Marco/KHN).

"These kids are getting something that reframes their connection to dentistry," said Terry Press-Dawson, the grant coordinator for several schools in Sacramento, some of which are participating in the Virtual Dental Home project. "They are connecting dentistry with something that is not scary — and that's huge."

After spending weeks coaxing Hendryk Vaquero, the 4-year-old with serious dental problems, into an examination, hygienist Rodriguez was patient and respectful. She asked his permission as she took pictures of his teeth with a camera connected to a laptop and put fluoride on his teeth with a tiny disposable brush. She told him she was proud of him and complimented him on his shoes and Buzz Lightyear T-shirt.

And at the end of the exam, she gave him a baggie with a toothbrush, toothpaste, mouthwash and a two-minute timer so he could take care of his teeth at home with his mom's help.

All the while, 5–year-old Abigail Velasquez was watching. She was up next. She said she'd never been to the dentist.

"We're going to talk to mom so maybe mom can take you to a dentist when you're done seeing us. Because it's very important that you experience that," she told her. "Going to the dentist is quite an adventure."

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California To Launch Medicaid-Funded Teledentistry

By **Daniela Hernandez** | September 29, 2014

California Governor Jerry Brown has signed into law a bill that would require Medi-Cal, the state's insurance program for the poor, to pay for dental services delivered by teams of hygienists and dentists connected through the Internet.

California is among the first states to launch such teledentistry services, which are intended to increase the options for patients in remote and underserved areas. Other states, like Oregon, Colorado, Hawaii and West Virginia, are interested in creating their own teledentistry programs but are farther behind, advocates for the projects said.

The bill, signed by the governor over the weekend, also expands the types of procedures hygienists and certain assistants can perform without onsite supervision by a dentist — deciding what X-rays to take, for instance, or installing temporary fillings that help prevent decay. The hygienists and other workers will consult with a dentist remotely, sharing records online but will refer a person directly to a dentist if more sophisticated procedures are needed.

The legislation will take effect on Jan. 1.

Expanding teledentistry statewide will increase Medi-Cal costs minimally in the short-term — by upward of $500,000 a year, according to a State Assembly's Appropriations Committee fiscal analysis. If teledentistry takes off, the costs could be higher.

Already, the Medi-Cal budget for dental services is slated to grow from $682 million to roughly $940 million by June 2015, thanks to legislation signed in June 2013 that brought back certain dental benefits for adults.

Dr. James Stephens, a Palo Alto dentist and president of the California Dental Association, said that teledentistry could save money down the line, however.

"That's the real key. It's a way of getting people who are outside the system into the system," he said. "Preventive care costs so much less."

The newly signed law is the culmination of years of work and research by hygienists, dentists and patient advocacy organizations across the state. About five years ago, Dr. Paul Glassman, a dentist at the University of the Pacific in San Francisco, started the pilot Virtual Dental Home Demonstration Project to show that teledentistry could provide a means to improve access at low costs.

"We're very very excited. It's a great ending to a long, long adventure here," Glassman said. "The next

challenge is to be able to spread this system."

According to Glassman, as many as 50 percent of consumers eligible for dental services through Medi-Cal don't get care. The idea is to deploy hygienists and dental assistants to schools, nursing homes and other community organizations where underserved populations gather. Glassman and other advocates say that will ease transportation, financial, language and cultural barriers that typically keep people from accessing treatment.

Telemedicine in general has been gaining traction, thanks in part to an increasing number of small Internet-enabled medical devices and consumer health trackers as well as growing interest among venture capitalists. The federal Affordable Care Act has emphasized the use of digital technologies to improve care and cut costs. Recently, a bill was introduced in the U.S. House of Representatives that would allow accountable care organizations to get reimbursed for and use telemedicine more widely.

"Technology has really allowed things that weren't possible before," said Shelly Gehshan, the director of the children's dental policy team at the Pew Charitable Trust. "But it's not like flipping a switch."

Before the promise of teledentistry can be borne out, the state still has to figure out the billing mechanism and payment structure for telemedicine-enabled services. Glassman acknowledged this could be a topic of debate: Providers will want to bill at the same rates as for in-person consultations, while Medi-Cal might opt for lower rates to control costs.

Professional organizations still need to build programs to train hygienists and dental assistants on taking X-rays by themselves, applying temporary fillings, and working as part of a teledentistry team. The bill spells out the type of training that will be necessary.

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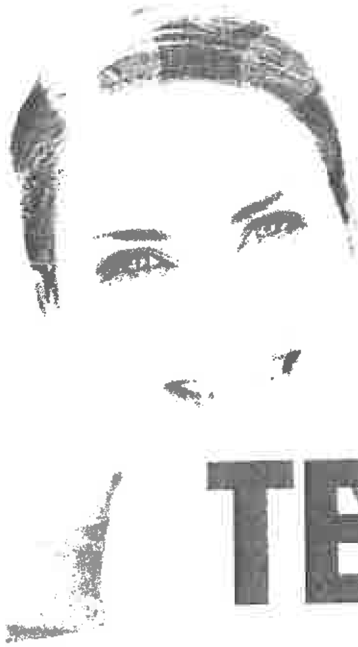

CTEL EXECUTIVE TELEHEALTH SPRING SUMMIT 2015:

CTEL SAFE TELEMEDICINE PRINCIPLES

Telemedicine is a mechanism to deliver safe, effective healthcare.

Telemedicine is the means by which healthcare is delivered. Telemedicine can deliver safe, effective healthcare. Or, not unlike the general practice of medicine, corners can be cut.

Legally recognize an examination through telemedicine technology that provides the practitioner with information equal to or superior to an in person examination.

States commonly require that a physician-patient relationship be established prior to diagnosing and treating a patient. Most states require that first examination to be "in-person" or "face-to-face". Once a physician-patient relationship has been established, the physician may communicate with the patient through whatever medium the physician chooses (e.g. telephone, web camera, email, etc.). Approximately 20 states allow telemedicine technology to be used to establish this first examination between physician and patient. Provided the information exchanged between the practitioner and the patient is equal to the information that would be included in an in-person exam, we believe that state laws and regulations should permit the practitioner to utilize telemedicine technology to conduct the first time examination to establish the physician-patient relationship.

A physician-patient relationship can only be established through an examination by tablet, phone app, or web camera if the examination 1) provides information equivalent to an in person exam, 2) conforms to the standard of care expected of in-person care; and 3) if necessary, incorporates peripherals and diagnostic tests sufficient to provide an accurate diagnosis. A physician-patient relationship cannot be established through an examination by telephone (audio-only) or email.

In order to practice safe telemedicine, the standard of care applied by a practitioner must be the same standard required of the practitioner for an in-person visit. There may be certain diagnosis that can be rendered by a practitioner using any of these mediums. However, we maintain the mere communication between a practitioner and patient using one of these mediums does not ensure either that the telemedicine examination is equal to an in-person encounter or that it conforms to the standard of care. This is particularly true if the diagnosis is rendered without the use of appropriate peripherals or diagnostic tests, if necessary to confirm the diagnosis.

We believe that an encounter mirroring an in-person examination and conforming to the standard of care must incorporate diagnostic tests and peripherals, such as an otoscope and stethoscope, if necessary to provide and confirm an accurate diagnosis. For example, if the standard of care for an in-person encounter requires a visual examination of the patient's tympanic membrane prior to diagnosing, the same should be applied to a telemedicine encounter. Likewise, if a diagnostic test is required for an accurate diagnosis of strep throat or a urinary tract infection, then a diagnostic test should be available to the practitioner prior to diagnosing what are described by some in the telemedicine industry as "uncomplicated" issues.

"On call" language may not be used by a physician to prescribe for a patient never seen by the physician unless there is an established agreement between the patient's personal physician and covering physician, compliant with state law governing on call relationships between practitioners.

The only time that a physician should diagnose through the "on call" language (commonly found in all states) without previously establishing a physician-patient relationship is through an established agreement between the two physicians. We recognize legally-compliant "on call" relationships, but do not believe the patient may self-designate the on-call relationship to a physician designated by the patient, and not designated by the patient's physician.

Virginia Board of Medicine

Telemedicine

Section One: Preamble.

The Virginia Board of Medicine ("Board") recognizes that using telemedicine services in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these services can enhance medical care by facilitating communication between practitioners, other health care providers, and their patients, prescribing medication, medication management, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice. The Virginia General Assembly has not established statutory parameters regarding the provision and delivery of telemedicine services. Therefore, practitioners must apply existing laws and regulations to the provision of telemedicine services. The Board issues this guidance document to assist practitioners with the application of current laws to telemedicine service practices.
These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method used to enable practitioner-to-patient communications. For clarity, a practitioner using telemedicine services in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the practitioner-patient relationship as defined in Virginia Code § 54.1-3303 and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine services as a component of, or in lieu of, in-person provision of medical care, while others are not. The practitioner is responsible for making this determination, and in doing so must adhere to applicable laws and standards of care.

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine services in the practice of medicine. The Board is committed to ensuring patient access to the convenience and benefits afforded by telemedicine services, while promoting the responsible provision of health care services.

It is the expectation of the Board that practitioners who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;
- Adhere to recognized ethical codes governing the applicable profession;
- Adhere to applicable laws and regulations;
- In the case of physicians, properly supervise non-physician clinicians when required to do so by statute; and
- Protect patient confidentiality.

Section Two: Definitions.
For the purpose of these guidelines, "telemedicine services" shall be defined as it is in HB 2063,[1] which was approved by the Virginia General Assembly as an amendment to § 38.2-3418.16 of the Code of Virginia. Under that definition,

> "telemedicine services," as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.
> Va. Code § 38.2-3418.16 (as amended by HB 2063).[2]

Section Three: Establishing the Practitioner-Patient Relationship.
The practitioner-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that practitioners recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a practitioner-patient relationship. Where an existing practitioner-patient relationship is not present,[3] a practitioner must take appropriate steps to establish a practitioner-patient relationship consistent with the guidelines identified in this document, with Virginia law, and with any other applicable law.[4] While each circumstance is unique, such practitioner-patient relationships may be established using telemedicine services provided the standard of care is met.

Specifically, Virginia Code § 54.1-3303(A) provides the requirements to establish a practitioner-patient relationship. *See* Va. Code § 54.1-3303(A).[5]

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

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[1] HB 2063 amended Virginia Code §§ 38.2-3418.16 and 54.1-3303. HB2063 was passed by the Virginia General Assembly during the 2015 Legislative Session and, if signed by the governor, will become law on July 1, 2015.

[2] The Board reserves the right to revisit these Guidelines and in particular this definition should the General Assembly further alter the statutory definition of "telemedicine services" or authorize the Board to provide a definition of telemedicine or telehealth.

[3] This guidance document is not intended to address existing patient-practitioner relationships established through in-person visits.

[4] The practitioner must adhere not only to Virginia law defining a practitioner-patient relationship, but the law in any state where a patient is receiving services that defines the practitioner-patient relationship.

[5] By passing HB 2063, the General Assembly amended Virginia Code § 54.1-3303(A), which amendment specifically addresses the establishment of a patient-practitioner relationship for the purposes of prescribing Schedule VI controlled substances via telemedicine services. Once signed by the governor, this amendment will become law on July 1, 2015. All licensees are responsible for ensuring and maintaining compliance with applicable laws.

Section Four: Guidelines for the Appropriate Use of Telemedicine Services.
The Board has adopted the following guidelines for practitioners utilizing telemedicine services in the delivery of patient care, regardless of an existing practitioner-patient relationship prior to an encounter.

Licensure:

The practice of medicine occurs where the patient is located at the time telemedicine services are used, and insurers may issue reimbursements based on where the practitioner is located. Therefore, a practitioner must be licensed by, or under the jurisdiction of, the regulatory board of the state where the patient is located and the state where the practitioner is located. Practitioners who treat or prescribe through online service sites must possess appropriate licensure in all jurisdictions where patients receive care. To ensure appropriate insurance coverage, practitioners must make certain that they are compliant with federal and state laws and policies regarding reimbursements.

Evaluation and Treatment of the Patient:

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

Informed Consent:

Evidence documenting appropriate patient informed consent for the use of telemedicine services must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following:

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

Medical Records:

The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-practitioner communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine services. Informed consents obtained in connection with an encounter involving telemedicine services should also be filed in the medical record. The patient record established during the use of telemedicine services must be accessible to both the practitioner and the patient, and consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records and Exchange of Information:

Written policies and procedures should be maintained for documentation, maintenance, and transmission of the records of encounters using telemedicine services. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the practitioner addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Prescribing:

Prescribing medications, in-person or via telemedicine services, is at the professional discretion of the prescribing practitioner. The indication, appropriateness, and safety considerations for each prescription provided via telemedicine services must be evaluated by the practitioner in accordance with applicable law and current standards of practice and consequently carries the same professional accountability as prescriptions delivered during an in-person encounter. Where such measures are upheld, and the appropriate clinical consideration is carried out and documented, the practitioner may exercise their judgment and prescribe medications as part of telemedicine encounters in accordance with applicable state and federal law.

Prescriptions must comply with the requirements set out in Virginia Code §§ 54.1-3408.01 and 54.1-3303(A) as amended by HB 2063. Additionally, practitioners issuing prescriptions as part of telemedicine services should include direct contact for the prescriber or the prescriber's agent on the prescription. This direct contact information ensures ease of access by pharmacists to clarify prescription orders, and further facilitates the prescriber-patient-pharmacist relationship.

Section Five: Guidance Document Limitations.

Nothing in this document shall be construed to limit the authority of the Board to investigate, discipline, or regulate its licensees pursuant to applicable Virginia statutes and regulations. Additionally, nothing in this document shall be construed to limit the Board's ability to review the delivery or use of telemedicine services by its licensees for adherence to the standard of care

and compliance with the requirements set forth in the laws and regulations of the Commonwealth of Virginia. Furthermore, this document does not limit the Board's ability to determine that certain situations fail to meet the standard of care or standards set forth in laws and regulations despite technical adherence to the guidance produced herein.