Thinking Points

Ideas for Leaders Developing the Maryland Telemedicine Network

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The Federation of State Medical Boards held an invitational symposium in Washington, D.C. on March 10, 2011 to discuss the future of telemedicine. More than 100 physicians and lawyers from across the country met to share their experiences, perspectives and ideas. We would like to provide you with a brief overview of the major themes and ideas that were discussed. ***This is not intended to be a comprehensive report on all the ideas that were articulated during the symposium, but merely a brief list of "thinking points" that might be relevant to the discussion in Maryland.***

Dr. Sachin Jain, Senior Advisor in the Office of the Administrator at CMS, presented a keynote address in which he discussed the four barriers to telehealth, as he sees them.

1. **Providers are hesitant to adopt and use technology** – The availability of technology is not as much of an issue (rural broadband access not withstanding); however, most providers and institutions have not embraced technology for use in their practices nor have they found innovative ways to use it.
2. **The culture in medical education and practice does not encourage physicians to embrace technology** – Medical education still follows the traditional method of academic instruction that emphasizes a hands-on model with patients. It does not encourage physicians to "infuse" the use of technology and integrate it into their practices. This norm is shifting by student curiosity and personal usage, but the general academic culture may not change until the current generation of medical educators retires, and medical schools change their curriculum to include integrated technologies.
3. **Policy standards and governance are barriers** – There are still many grey policy areas that need to be addressed, related to how telemedicine can be a safe, regulated form of practice, including many concerns related to licensing and credentialing.
4. **Payment and delivery shortcomings** – A lack of reimbursement, or low reimbursement, prevents providers from using technology (or being open to using it) because they don't get paid for it. The Medicare/Medicaid payment system needs to change. Historically, major changes have required an act of Congress. The American Reinvestment and Recovery Act and the Affordable Care Act may provide a platform for reimbursement of services through demonstration projects.

Repeating Themes: Two ideas and topic areas came up repeatedly throughout the symposium.

1. **Adopt a nationally standardized definition of telemedicine/telehealth**, without using "tele." Get rid of the term "telemedicine." There was consensus in the group that by adding "tele" to any form of medicine delivered from a distance has become its own barrier in progressing forward. Telemedicine is regular medicine, delivered over distance when the doctor and the patient (or the consulting doctor) are physically separated, whether they are a room away or thousands of miles away. It should be treated as any other form of practice and not singled out. The emphasis should be on determining what constitutes a "tele" patient consultation and ensuring that care standards are delivered appropriately.
2. **Licensing and credentialing** needs to be easier, faster and portable, but a comprehensive verification system (i.e., accountability) is imperative in order to ensure that bad actors are identified and disciplined quickly, no matter where they are. Licensing should not be watered down or separated from disciplinary authority because it is the first line of defense for patient safety.

Panel Discussions: During the symposium, there were three panel discussions in which presenters gave their input into the topic area before opening the floor to a facilitated discussion. Below are of the ideas discussed.

Panel One -- Technology: What gaps exist in the current technology environment that must be addressed to ensure access, safety and quality in telemedicine?

- Identify technical standards necessary to deliver telemedicine services so that both health care providers and broadband carriers know what technical specifications (i.e., speed, redundancy, connectivity etc.) are required to communicate necessary information across states and regions; ensure these standards have flexibility in order to keep up with advancing technology.
- Establish a common language and adopt national definitions of certain words and phrases, like "patient site" and "legitimate patient relationship."
- Develop standards that describe how much information a physician needs to make an accurate diagnosis and how much of that information can reliably be conveyed electronically.
- There should be standards in health care delivery, not necessarily technology. If the health care standards are clear and the integrity of the information being communicated is sound, the technology will follow.

Panel Two – Patient, Providers and Payers: What gaps exist in the concurrent structure of the health system that must be addressed to ensure access, safety and quality in telemedicine.

- Telemedicine doesn't always result in an overall cost savings because it often increases access to care for more people. It will reduce the per-person cost, but not necessarily the over-all cost.
- The patient perspective is rarely represented when discussing how best to use telemedicine. Patients are looking for "relief from uncertainty" and "knowledge about their condition." Those concerns need to be in the forefront of all telemedicine advancements.
- Different patient populations need to be taken into consideration when new technologies are introduced, especially elderly people who are not comfortable with it and often feel that technology isn't as good as a face-to-face.
- Telemedicine networks were being considered in 2001 and we have failed to deliver a robust system to the marketplace because there is "a lack of organized action" to make telemedicine uniform across the country. We need organized action to address regulatory barriers and safety concerns. This uniform action should include education and outreach to key stakeholders, potential users and patients receiving care through the application of telemedicine.

Panel Three – Licensure and Regulation: How can the licensing and regulatory challenges of 21st century telemedicine be addressed? (See repeating themes above)

- Licensing and credentialing for providers who are working across state lines through telemedicine raises questions around :
    - Reimbursement -- which state/facility would pay who, under what circumstances;
    - Disciplinary authority -- which state would be the disciplinary body; how are differences in background standards and practice standards dealt with in the regulatory/disciplinary environment;
    - Liability -- which provider is liable from a malpractice standpoint, especially if a critically ill patient is transported to another facility and/or a facility across state lines (If a doctor has telemedicine privileges at a hospital, is he on staff and is the hospital liable?)
    - Legal authority -- which state laws govern providers in different states.

- Scopes of practice regulations among providers, not just physician, haven't kept pace with the technology. It is unclear what some of them can do with technology, especially in integrated systems. Clarifying those issues should be done through rule-making rather than legislation to maintain flexibility.

The Federation of State Medical Boards (FSMB) intends to publish a white paper that captures the full scope of the symposium discussions. The FSMB is also creating an action plan based on break out session feedback to actively focus on telemedicine both at federal and state levels resulting in new resources and information for general use. We will pass it on when it is complete