Report of the Washington State Telehealth Collaborative

December 2017

Executive Summary

The Washington State Telehealth Collaborative was formed in 2016 as a result of *SB6519* and with a mission to provide a forum to improve the health of Washington residents through the collaboration and sharing of knowledge and health resources statewide and increasing public awareness of telehealth as a delivery mechanism. **Significant achievements** in the last year include: (1) passage of two telehealth bills (Interstate Medical Licensure Compact (*HB 1337*) and expanding access to telemedicine by further defining where a patient may receive the service (*SB 5436*)) that were discussed and agreed upon by the collaborative; (2) development of a frequently asked question document for patients and providers; (3) drafting a summary of telehealth training procedures; and (4) providing input to the Department of Health on a new telemedicine policy regarding continuity of care. The collaborative learned about the free technical and policy assistance available through the federally funded Northwest Regional Telehealth Resource Center. **Innovative care delivery methods** through telemedicine, such as eConsult, Project ECHO and remote monitoring, were discussed. **Significant challenges and barriers** include the proper coding for telemedicine consultations, whether clinicians should be paid an equivalent rate for telemedicine visits as in-person visits (payment parity), and interoperability of telemedicine equipment and electronic health records. In addition, the collaborative and public needs to know what the expected benefits and savings can be from telemedicine. There are currently over 100 telemedicine services offered in Washington State by providers and health systems; as patient awareness increases and processes are improved, it is hoped that telehealth can help Washington residents become healthier.

Telemedicine Success Stories

Following are several stories from across the state on how telemedicine impacted patients' lives.

Story 1: A 55-year-old male with a 50+ pack year history of smoking cigarettes with known chronic obstructive pulmonary disease (COPD) was smoking one pack per day. He was disabled due to his severe lung disease and living with his older adult parents, out of financial necessity. He developed a spontaneous pneumothorax (collapsed lung) as a complication from his COPD and admitted to a hospital on the Olympic Peninsula. Due to persistent air-leak and complicated healing as well as severe COPD, he was transferred to a tertiary medical center in Seattle for management. At this time, he was referred for tobacco cessation counseling and treatment and initiated work-up for lung volume reduction surgery to surgically excise the damaged lung and enhance his ability to breathe. His lungs were stabilized, and he was discharged to his parents' home on the Peninsula. He was able to be seen for surgical and tobacco cessation follow-up at the remote telehealth clinic just a mile from his parent's home and **successfully quit smoking.** Later, he developed a second spontaneous pneumothorax and again transferred to Seattle for surgical intervention and successfully discharged back to his home with post-surgical follow-up via the telehealth clinic. The post-surgery follow-up required a **significant volume of telehealth visits** for the patient with the surgical and tobacco teams. If not for telehealth, these services would have otherwise required in-person visits. The telehealth model was successful in keeping the patient in his community for management of his disease and supporting him in surgical recovery and quitting tobacco.

The use of telemedicine also minimized the patient's costs in time travel to Seattle and finances of gas, ferry rides, and downtown parking.

Story 2: Driven by a backlog of nearly 300 follow-up and new patient consultations in Omak, the Cardiology Service Line implemented telemedicine patient visits from Wenatchee Valley Hospital (the "distant site" or physician location) to the Omak Clinic (the "originating site" or patient location). The program was launched in February 2017 and has already managed to significantly decrease the wait times for an appointment backlog in addition to expanding schedule availability to patients at the Omak Clinic. Previously, cardiologists were traveling four hours round trip from Wenatchee to Omak, but now with the telemedicine program, this time can be utilized for patient care. Currently this service is only available at the Omak Clinic on a limited basis, but plans to expand this service will be pursued as capacity and funding allows.

Story 3: A 45-year-old busy father of two and technology worker in Seattle noticed a painful rash on his face develop on a Friday night. By Saturday night, the pain was unbearable but he didn't feel like dragging his two young children to an Emergency Department, as his wife was out of town. Instead he called a local health system's virtual urgent care service, who saw him via their virtual clinic in 10 minutes while he was at home. The doctor diagnosed him with varicella zoster ("shingles") and started treatment (antiviral therapy and over the counter pain medications) that night. He said, "[I am] thrilled with the service! Excellent listening, communication, and friendly care."

Story 4: Cambia Health Solutions is committed to bringing health care to consumers in the right place and through the right care option. We are committed to getting consumers a diagnosis, treatment, and prescription more conveniently on their terms anywhere, anytime and any way. Compared to last year, we are on track to more than double the number of telehealth visits in 2017, with most of these visits replacing in-person visits. We are also pleased that of those surveyed about their telehealth experience, almost 90% rate their experience as "good" or better.

Meeting Times and Locations

The collaborative met eight times in 2017, rotating meeting locations around the state in order to accommodate the broad geographic representation. Each meeting was at least two hours. Sessions were open to the public and the public's questions, comments, and suggestions were considered in the development of this report. Please see the following table for meeting days and locations.

Date	Location
January 4, 2017	Multicare Tacoma General Tacoma, WA
February 10, 2017	MCC Caucus Room, Washington State Capital Olympia, WA
March 9, 2017	Molina Health Plan Bothell, WA
May 5, 2017	University of Washington Seattle, WA
June 22, 2017	Washington State Department of Health

	Tumwater, WA
August 24, 2017	Seattle Children's Hospital Seattle, WA
September 25, 2017	Multicare Tacoma General Tacoma, WA
November 17, 2017	SeaMar Community Health Center Seattle, WA

Website

A unique website hosting the Washington State Telehealth Collaborative was established in 2016 and has all of the meeting minutes and video recordings in 2017. Additional resources such as best practices and frequently asked questions are available at this website. The website can be found at http://www.wsha.org/policy-advocacy/issues/telemedicine/washington-state-telemedicine-collaborative/

Definition of Home

In prior legislation, "home" was added as a valid originating site for telemedicine visits, although this term was not defined. The collaborative confirmed the desire that this term be as inclusive as possible, recognizing that some patients are homeless or do not have a home that is safe or private enough for a telemedicine visit. Therefore, the collaborative agreed that the concept of home should be expanded to include "home or any location determined appropriate by the individual receiving the service" as an appropriate originating site for telemedicine services under Washington's telemedicine parity law. This language was included in *SB 5436* and was signed into law.

Innovative Methods of Telemedicine

The collaborative set a goal of making recommendations on improving reimbursement and access to services, including originating site restrictions, provider to provider consultative models, and technologies and models of care not currently reimbursed. In 2016, the group learned about the **Project ECHO model** and received an update in 2017. Project ECHO (Extension for Community Health Outcomes) uses case-based learning between a multidisciplinary team at the hub site (usually an academic medical center) and rural or underserved sites where primary care physicians, nurse practitioners and physician assistants work. This is a clinician to clinician consultative model. The sessions usually occur weekly over the noon hour and are focused on one disease or specialty. The session lasts 60-90 minutes and includes a 15 min didactic, followed by de-identified case presentations. Best practices and national guidelines are used to inform decisions and discussions. Presented patients are followed longitudinally.

Figure 1. Project ECHO session

Several members of the collaborative attended the Meta-ECHO conference in Albuquerque, New Mexico. There, they learned about the federal ECHO Act, a law that mandates the Department of Health and Human Services to do an inventory of all ECHO programs in North America, compiling the clinical and financial evidence base for the program. A report is due to Congress at the end of 2018.

Project ECHO is being used to train health professionals at all levels, with particular success in the realm of community health workers. Other fields employing the ECHO model include education and law enforcement. A request was made to learn from other states where ECHO is active (e.g., New Mexico, Nevada and Missouri) and how it was financed and what outcomes were produced.

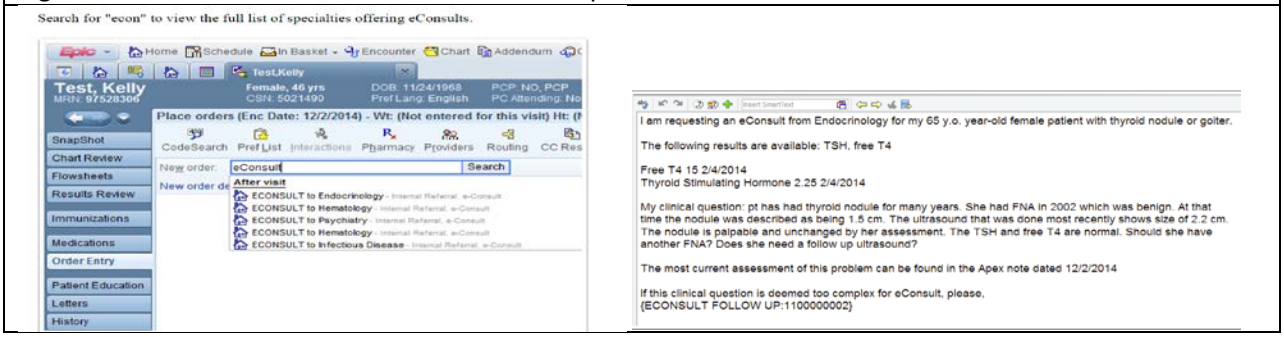
eConsult is a type of store-and-forward technology in which a primary care clinician sends a request for consultation via the electronic medical record and the specialist then reviews within 1-3 days. It is a documented encounter and can replace a face-to-face encounter, saving time and a facility fee. Both Kaiser and the UW use eConsult through their electronic medical record software. The EMR pulls in relevant labs, tests and images. The specialists write back to the primary care clinician and help to interpret lab/test results or imaging, recommend labs/tests/imaging with if/then contingencies for results, provide differential diagnoses, recommend adjustments to medications and/or treatment, recommend watchful waiting with follow-up contingency, validate or recommend changes to primary care clinician's care plan and identify risks or other clinical considerations based on the patient's condition, treatment plan and medical history.

The experience with eConsult was shared by Kaiser, UW and LA County (Dr. Mia Shim, now medical director for Public Health Seattle King County). The LA County system was established four years ago with a centralized data repository. Over 40 specialties are available, and over 10,000 patients receive specialty consultation through this method annually. In the UW's experience 5-10% of the eConsults are either too complex or the patient needs to be seen in person, but the vast majority of patients receive a definitive answer through eConsult. At Kaiser, over 50% of all specialty consultations are done by eConsult, with Neurology and Cardiology being the most popular. The UW has performed over 2000 eConsults in six specialties (Dermatology, Endocrinology, Hematology, Gastroenterology, Pulmonary and Hepatology) resulting in **greatly improved patient access for in-person visits** and reduced no-show rates. Additionally, the patient receives more timely specialty input and obviates the need for an in-person visit. The program is not currently reimbursed by all payers, although there are provisions for store-and-forward in *SB 6519*. Insurance in others states, such as California (Lifewise) does reimburse for eConsults. A comparable eConsult is associated with **a lower cost versus an in-person visit.**

Moreover, it can avoid a facility fee as well. As an integrated health system, Kaiser has decided to credit each eConsult as 25% of what a new patient visit, in person visit would be credited.

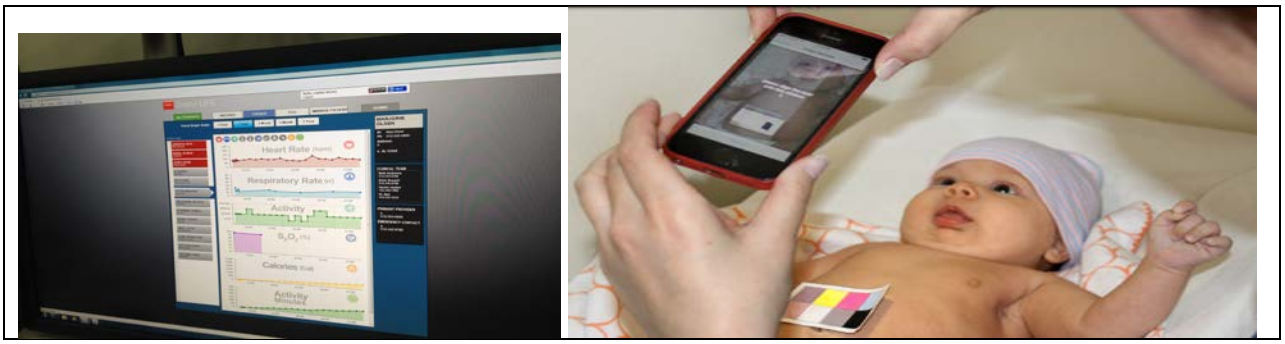
Both specialists and primary care clinicians liked the eConsult system. A survey of 40 primary care clinics at UW found 100% satisfaction with the new system. One said, "I have found it a very helpful way to get answers to my questions and learn at the same time, while getting my patients' needs addressed." From the specialist perspective, one said, "eConsults reduce the length of waiting for in-person consultations…**it is the future of medicine…"**

Figure 2. eConsult screen shot of order set and question



The collaborative also learned about **remote monitoring** as a form of telemedicine that is not currently reimbursed by many payers. It involves the patient having some kind of biometric measurement taken (such as blood pressure, blood glucose, weight) and then this information is sent to the patient's care providers for review and action. Outpatient use cases include management of diabetes, heart failure and emphysema. A large randomized clinical trial in the UK, called the Whole Demonstrator Study (Steventon, et al. *Br Med J* 2012), used a remote monitoring device for half of the study, while the other half got usual care for diabetes, heart failure and emphysema. After 12 months, the mortality and hospitalization rates were 50% and 20% lower, respectively.

Figure 3. Remote Monitoring Examples from TeleICU, smartphone apps



Inpatient use cases include the TeleICU, where patients in the ICU are monitored remotely by a nurse or an intensivist. The monitoring includes continuous vital signs, labs, imaging and the ability to interview the patient in real-time. A study from Massachusetts showed that ICUs that had remote monitoring had a 26% lower mortality and length of hospitalization reduced between 0.5 and 3.6 days, based on admitting diagnosis (Lilly, CM. *Chest* 2014). The innovation is coming in the form of health apps, with over 100,000 apps now available in the Apple App Store alone. Many of these are not FDA approved, however, there are a host of issues to consider with remote monitoring apps, such as medicolegal responsibility, reimbursement and the handling/triage of large amounts of health information by clinicians.

A pilot done in Mississippi using remote monitoring for uncontrolled diabetes mellitus in 100 patients found that remote monitoring boosted medication compliance to 96 percent, while the mean hemoglobin A1c levels decreased by 1.7 percent and compliance with scheduled health sessions reached 83 percent. Patients avoided nearly 10,000 miles in transportation, while the state saved $339,000 in avoided hospitalizations. Mississippi enacted a law in 2014 requiring insurance parity for remote patient monitoring, paying a rate of $16/d or $480/month (https://medcitynews.com/2016/09/mississippi-telehealth-remote-monitoring/). Patients should consent to remote monitoring and understand that they may be required to partially pay for this service.

Compliance and Fraud Prevention in Telemedicine

It is important that clinicians be trained and knowledgeable about the particular requirements of telemedicine, in order to avoid non-compliance issues or even allegations of fraud. The collaborative learned about compliance and fraud prevention from a provider's perspective from Sheila Green-Shook, who reminded the group that telemedicine is just a new method of delivering care. Maintaining compliant billing, coding, documentation and other practices is critical both for in-person health care and for telemedicine. For example, if you are a clinician providing health care, you need to document in the medical record equivalent to the services being provided, whether that service is furnished on an in-person basis or via telemedicine. Further, providers need to understand the billing and coding requirements for telemedicine services in order to avoid allegations or violations under the federal or state False Claims Acts. CMS guidelines are available on the proper billing and coding for telemedicine visits (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf).

Provider Training

Several large health systems have internal training programs for their clinicians and shared their experiences. The training consists of hands-on technology training, plus online training on billing, coding, etiquette and best practices. Once the training is completed, providers may be given special telemedicine privileges and can then officially see patients via telemedicine. The training and privilege is usually good for 2 years. This website has a good quick video on telemedicine etiquette (http://learntelehealth.org/training).

For individuals or smaller organizations, there are two intensive training programs approved by the American Telemedicine Association on the West Coast, the Alaska Federal Health Care Access Network (AFHCAN) and the Arizona Telehealth Network, which offer regular in-person trainings for a fee (http://www.americantelemed.org/main/ata-accreditation/training-programs).

Billing for Telehealth Services

During 2017, several of the commercial insurance plans revised their policies on telemedicine visits, in compliance with recent legislation. The most up to date policies can be found on their respective websites: Regence Premera. The modifier 95 code was created recently by the American Medical Association and is known as the "synchronous telemedicine service rendered via a real-time audio and video telecommunication system." It is similar to the GT modifier that is used for Medicare and other payers. The collaborative recommends using the modifier and place of service code indicated by each patient's payer. The place of service (POS) 2 code is a recently released code by Medicare and describes the location where health services and health related services are provided or received, through a telecommunication system. Both Premera and Regence will accept this code as a telemedicine visit. Of note, clinicians do not need to be in their office or hospital in order to bill for a telemedicine service. Some providers inquired whether the Washington legislation passed previously requires payment parity; that is, a provider is paid the same amount for a telemedicine visit of same complexity and duration as an in person visit. The answer is no. Providers are paid whatever allowed amount is set up in their respective fee schedule agreements and contract terms. However, Washington Medicaid will reimburse at the same rate, if the service is provided, billed and coded appropriately. The clinicians on the collaborative expressed frustration with payment policies that do not ensure parity with outpatient or inpatient services, since they are spending the same amount of time and there are associated overhead fees, such as technology, that are not covered in the encounter. Without payment parity, many expressed doubt that providers would be willing to perform telemedicine visits.

Free Local Resource for Telehealth Technical Assistance (NRTRC)

One of the goals of the collaborative is to improve access to telehealth education and resources for both patients and providers. To that end, the Northwest Regional Telehealth Resource Center (NRTRC) is a federally-sponsored technical assistance center for clinicians, hospitals, clinics, patients and payers in the area of telehealth. Deb LaMarche, the executive director of the NRTRC, based at the Utah Telehealth Network, presented to the collaborative to let everyone know what they can provide. This includes monthly webinars, an annual 3 day conference (this year in Salt Lake City in early May 2018) and up to 10 hours of free technical assistance. It is provider and vendor neutral. Please visit

www.nrtrc.org for more details. In addition, there is a national telehealth technical and policy center, which can be accessed at www.telehealthresourcecenter.org.

Interstate Medical Compact and Telemedicine Policy from Medical Quality and Assurance Commission

Micah Matthews, the Deputy Executive and Legislative Director for Washington State Medical Quality and Assurance Commission, presented several times on changes related to the Interstate Compact. The compact, signed into law in 2017, allows for expedited, proxy licensing for physicians and physician assistants from all other states that have signed the Compact. Locally, the neighboring states of Idaho and Montana are signatories, but not Oregon nor Alaska) In turn, Washington State physicians can be licensed in those states in a few days, as compared to several months. Interested parties need to register on the website (www.imlcc.org), pay a $700 fee, plus any associated state licensing fees (Idaho costs $376 and Montana $500). Key features of the policy include:

- Each state retains authority for disciplinary actions and determination of standard of care
- An interest in promoting safe continuity of care
- Peer to peer consultation

To promote continuity of care while ensuring patient safety, the Commission's proposed policy would permit (if adopted) a practitioner not licensed in Washington to provide medical care to a patient in Washington if the following conditions are met:

1. The out-of-state practitioner is licensed in another state or US territory where he or she resides;
2. The out-of-state practitioner has an established practitioner-patient relationship with the patient and provides follow-up care to treatment previously performed in the practitioner's state of licensure;
3. The continuous or follow up care is infrequent or episodic; and
4. The non-Washington practitioner does not set up an office or place of meeting patients in Washington.

Three particular case scenarios which would meet these criteria are discussed in the draft policy (infrequent border care, university students studying outside their home state, and patients who have had a recent interventional procedure such as surgery or transplantation).

With regards to peer to peer consultations, the Commission proposes to permit a Washington-licensed practitioner to consult on the case of a Washington patient with a non-Washington licensed physician using telemedicine provided that the following conditions are met:

1. The out-of-state physician is licensed in another state or United States Territory where he or she resides;
2. The consultation is infrequent or episodic;
3. The Washington licensed practitioner remains professionally responsible for the primary diagnosis and any testing or treatment provided to the Washington patient; and

4. The non-Washington physician does not set up an office or place of meeting patients, physical or virtual, in Washington.

Please see Appendix 1 for more information. Comments were solicited from the collaborative members and forwarded to the Commission. A final policy is expected in 2018 and the Commission would then ask neighboring states to adopt a similar reciprocal policy.

Frequently Asked Questions on Telehealth

The collaborative wrote two documents which addressed frequently asked questions relevant to telehealth. One is for providers, the other for patients. Please see Appendix 2 for those documents.

Disaster Preparedness and Telehealth

In the initial meetings of the collaborative, several members expressed an interest in examining how telehealth can assist with local and statewide efforts for disaster preparedness and training. In September 2017, Dr. Scott presented to the board of the Northwest Health Care Response Network (Dr. Vicky Sakata is medical lead) about telemedicine in general and how it's contributed to disaster response in recent American disasters, including the hurricanes that struck Texas and Florida this summer. Much of the funding for this group grew out of federal 9/11 response, but the funds have dried up. The group will consider incorporating telemedicine into its planning in the future.

Appendix 1: MQAC Policy Statement on Telemedicine and Continuity of Care

Department of Health
Medical Quality Assurance Commission

Policy

Title: Telemedicine and Continuity of Care POL2018-XX
References:
RCW 18.71.030, RCW 18.71.230, RCW 18.71A, RCW 18.71.011,
Guideline MD2014-03

Policy

The Medical Quality Assurance Commission (Commission) supports the use of telemedicine as a tool that has the potential to increase access, lower costs, and improve the quality of healthcare by facilitating continuity of care. Rapid improvements in this technology are transforming health care delivery. One such transformation, the increasingly common practice of medicine across state lines, has raised regulatory issues for state medical boards. The Commission issues this Policy Statement on the use of telemedicine with specific attention to its role in promoting continuity of care.

The Commission interprets current law to permit, under certain circumstances, non-Washington-licensed practitioners to provide care to patients who visit Washington. The Commission also interprets current law to allow Washington-licensed practitioners to use of telemedicine to consult with practitioners in other states. This Policy Statement is consistent with current law, and strikes the appropriate balance between enhancing access to care and ensuring patient safety.

The Commission also encourages regulators from all healthcare disciplines of the WWAMI[1] region (Washington, Wyoming, Alaska, Montana, and Idaho) and other states, to adopt a similar policy statement and position, thus facilitating and promoting continuity of care by permitting practitioners to consult with one another about patients they have in common. The

[1] WWAMI is a cooperative program with the University of Washington and the states of Washington, Wyoming, Alaska, Montana and Idaho allowing residents of those states to enroll in the University of Washington School of Medicine, but providing a portion of the education in their home states. The program two main goals are to make public medical education accessible to residents of those states, and to encourage graduates to choose careers in primary care medicine and locate their practices in underserved areas of the Northwest.
http://www.uwmedicine.org/education/wwami

Commission Policy Statement simply acknowledges historical norms of medical practice that is merely being facilitated by technological means.

To the extent that this Policy Statement could be interpreted to conflict with the Commission's Guidelines for the Appropriate Use of Telemedicine (MD2014-03), this Policy Statement takes precedence.

Definitions

The term "practitioner" includes allopathic physicians licensed under RCW 18.71 and allopathic

physician assistants licensed under RCW 18.71A.
The term “patient-practitioner relationship” means the relationship between a provider of medical services (practitioner) and a receiver of medical services (patient) based on mutual understanding of their shared responsibility for the patient’s health care. The relationship is clearly established when the practitioner agrees to undertake diagnosis and/or treatment of the patient and the patient agrees that the practitioner will diagnose and/or treat, whether or not there has, or has not been, an in-person encounter between the parties. The parameters of the patient-practitioner relationship for telemedicine should mirror those that would be expected for similar in-person medical encounters.
The terms “established” and “long established” as used in this policy document refer exclusively to patients with existing and ongoing treatment relationships with practitioners licensed by the Commission The use of the term “established” assumes the history and documentation necessary for informed health management. In general, this policy addresses scenarios not considered newly established or newly established through telemedicine modalities. Please refer to the Commission Guidelines on Telemedicine for best practices in establishing new treatment relationships through telemedicine.
In 2015, the legislature enacted legislation requiring health care plans to cover medical services delivered through telemedicine or store and forward technology under certain conditions. The legislation defined telemedicine and store and forward technology as follows:
"Telemedicine" means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, "telemedicine" does not include the use of audio-only telephone, facsimile, or email.[2]
"Store and forward technology means use of an asynchronous transmission of a covered person's medical information from an originating site to the health care provider at a distant site which results in medical diagnosis and management of the covered person, and does not include the use of audio-only telephone, facsimile, or email.[3]
[2] RCW 48.43.735(g).
[3] RCW 48.43.740(f).

For the purposes of this Policy Statement, the term “telemedicine” includes both “telemedicine” and “store and forward technology.”

Background

In 2014, the Commission issued Guidelines for the Appropriate Use of Telemedicine (MD2014-03), establishing general practice standards for practitioners and initiating a patient-practitioner relationship using telemedicine.
Historically, there is little medical or regulatory concern with practitioners providing care to established patients temporarily located out of the jurisdiction in which they normally reside. Because of rapid changes technology and in health care delivery, the practice of medicine is occurring more frequently across state lines, raising a number of regulatory issues for state medical boards and their stakeholders.
In 2017, Washington enacted the Interstate Medical Licensure Compact, joining 22 other states

to facilitate licensure for physicians who practice in multiple states. The compact will increase access to care for patients in underserved areas and allow them to more easily connect with medical experts through telemedicine technologies.[4]

In general, a practitioner who undertakes to diagnose, cure, advise or prescribe for a person located in Washington must be licensed to practice medicine in Washington, unless the practitioner falls within one of the statutory exemptions.[5] RCW 18.71.030(6) exempts from the licensing requirement "the practice of medicine by any practitioner licensed by another state or territory in which he or she resides, provided that such practitioner shall not open an office or appoint a place of meeting patients or receiving calls within this state."

The Commission intends to clarify whether this exemption applies to practitioners using telemedicine to treat Washington patients in established treatment relationships. In the interests of making telemedicine accessible, accountable and safe, the Commission interprets this exemption as allowing the use of telemedicine technology to facilitate continuity of care to established patients who cross state borders and to permit peer-to-peer consultations if certain conditions are met.

The Commission reaffirms the position that establishing a telemedicine presence accessible to Washington patients through a website or other access portal is not exempt from Washington licensure, unless used in conjunction with the parameters in this policy.

Continuity of Care for Established Patients

The practitioner with whom the patient has an established treatment relationship is in the best position to provide care, particularly if enabling technology is available. The Commission views

[4] Chapter 195, Laws of 2017. For information on the compact, see http://www.imlcc.org/

[5] RCW 18.71.011, RCW 18.71.021.

practitioners maintaining continuity of care with established patients in Washington as typical medical practice, whether licensed in Washington or in another jurisdiction, in consideration of the specified conditions and scenarios.

The Commission recognizes the importance of practitioners providing continuous or follow up care to established patients. Patients often have health care needs when traveling outside their home state, or when traveling back to their home state after receiving care outside of Washington. This is particularly important for patients who travel to see a specialist at a major medical center and then return to Washington. If the follow-up can occur via telemedicine, the patient will save time, effort, and expense of traveling back to the out-of-state practitioner's practice.

To promote continuity of care while ensuring patient safety, the Commission interprets RCW 18.71.030(6) as permitting a practitioner not licensed in Washington to provide medical care to a patient in Washington if the following conditions are met:

1. The out-of-state practitioner is licensed in another state or US territory where he or she resides;
2. The out-of-state practitioner has an established practitioner-patient relationship with the patient and provides follow-up care to treatment previously performed in the practitioner's state of licensure;
3. The continuous or follow up care is infrequent or episodic; and

4. The non-Washington practitioner does not set up an office or place of meeting patients in Washington.

Continuity of Care Discussion

The four conditions stated above lend themselves to several common practice scenarios. In all scenarios, primary consideration should be given to continuity of care and patient need.

Scenario One: Infrequent Border Care

In this situation, a practitioner licensed in a bordering state provides medical care for a patient who lives in Washington but travels to the neighboring jurisdiction for appointments and care delivery. At some point the patient calls the out of state practitioner's office regarding a new symptom or management of an ongoing condition. The Commission views the continuity of care as paramount in this situation and would not consider this practice without a license.

Scenario Two: University Student

In this situation, a practitioner licensed in a jurisdiction outside of Washington provides continuity of care for a patient who has relocated to Washington to attend university or other time-limited educational program. As the practitioner has an established relationship and all of the medical history to accompany the management of care, the Commission views the continuity of care as paramount in this situation and would not consider this practice without a license.

The treating practitioner should give specific consideration to the complexity of treatment required by the patient. If the patient has minimal treatment needs, such as annual physical exams and management of one or two medications, there is likely little cause for concern. At the other end of the spectrum of complexity, a patient with multiple chronic conditions or extensive acute mental health management needs would likely be better served by establishing a local practitioner relationship in cooperation with the practitioner in the home jurisdiction.

Scenario Three: Interventional Care Settings

Many Washington hospitals offer bundled care for certain interventions with the majority of recovery occurring in the patient's home. Unless there is close coordination with the primary care practitioner in the home jurisdiction, the practitioners involved in the care intervention are best positioned to provide continuity of care related to the medical event. In situations where a practitioner not licensed in Washington is providing follow up care to the Washington patient specific to the intervention for which they were involved, the Commission views the continuity of care as paramount in this situation and would not consider this practice without a license. Should complications from the intervention or other acute or emergent conditions be discovered, the practitioner should refer the patient to the local primary care practitioner or emergency services as appropriate.

Peer-to-Peer Consultations

Telemedicine technologies are making peer-to-peer consultations a common part of medical practice. This is particularly important for patients in rural or underserved areas who would not normally have access to specialists at major academic medical centers.

In Washington, the University of Washington's Telehealth program provides telehealth services, particularly in rural and underserved areas. Across the WWAMI region, 2300 UW School of Medicine faculty and 4600 clinical faculties are available for consultations using telemedicine technology, including teleconferencing, in-home monitoring, and digital store-and-forward of data, images and videos. UW Medicine Telehealth offers the full range of healthcare diagnostics and treatment, from routine urgent care to care as complex as organ transplantation.[6]

The Commission fully supports innovative models of healthcare delivery and encourages Washington practitioners to use telemedicine technology to make high quality healthcare accessible to their patients. To strike the appropriate balance between enhancing access to high quality care and protecting the public, the Commission interprets RCW 18.71.030(6) to permit a Washington-licensed practitioner to consult on the case of a Washington patient with a non-Washington licensed physician using telemedicine provided that the following conditions are met:

1. The out-of-state physician is licensed in another state or United States Territory where he or she resides;
2. The consultation is infrequent or episodic;

[6] http://www.uwmedicine.org/referrals/telehealth-services

3. The Washington licensed practitioner remains professionally responsible for the primary diagnosis and any testing or treatment provided to the Washington patient; and
4. The non-Washington physician does not set up an office or place of meeting patients, physical or virtual, in Washington.

The Commission does not interpret RCW 18.71.030(6) to permit a practitioner not licensed in Washington to analyze a specimen or read an image and then report findings back to the Washington practitioner. The Commission does not consider this a peer-to-peer consultation but instead a normal specialty consult or over read situation.

Mobile Medical Technology

Mobile medical technologies provide innovative ways to improve health delivery by allowing patients and health care practitioners access to useful information when and where they need it. The Federal Food and Drug Administration (FDA) regulates the safety and efficacy of medical devices, including mobile medical applications (apps) that meet the definition of "device" under the FDA Act, particularly apps that pose a higher risk if they do not work as intended.

The Commission has no jurisdiction over mobile medical apps, peripherals or other devices and will refer complaints to the FDA or other appropriate agency. [7] The Commission advises practitioners who use or rely upon such technology to ensure the technology has received FDA approval and is in compliance with applicable federal law. Additionally, those apps used by practitioner or patient that do not have the data to support their claims may be investigated by the consumer protection division of the Federal Trade Commission[8]. If the Commission receives complaints about such apps or devices that are deemed outside its jurisdiction, the Commission will forward the complaint to the FDA or the FTC as appropriate.

Discipline

The Commission may investigate and take disciplinary action against a practitioner, whether

licensed in Washington or not, who treats a resident of Washington via telemedicine and fails to meet the required standard of care. The Commission may also investigate and take disciplinary action against a practitioner or who does not meet the conditions for consultations or continuity of care. RCW 18.71.230 permits the Commission to discipline physicians practicing in Washington under certain exemptions in RCW 18.71.030. An out-of-state practitioner is also subject to action by the Department of Health for the unlicensed practice of a profession under RCW 18.130.190.

[7] For more information on the FDA's regulation of mobile medical apps, see https://www.fda.gov/MedicalDevices/DigitalHealth/MobileMedicalApplications/ucm255978.htm . The Federal Trade Commission protects consumers from anticompetitive, deceptive or unfair business practices, including false or misleading claims about the safety or performance of a mobile medical app. https://www.ftc.gov/tipsadvice/business-center/guidance/mobile-health-apps-interactive-tool. The Office for Civil Rights within the US Department of Health and Human Services enforces the HIPAA rules, which protect the privacy and security of certain health information. https://www.hhs.gov/hipaa/index.html

[8] https://www.ftccomplaintassistant.gov/#crnt&panel1-1

Conclusion

The Commission interprets current law to permit, under certain circumstances, a non-Washington-licensed practitioner to provide care to patients who visit Washington. The Commission also interprets current law to allow a Washington practitioner to use telemedicine to consult with practitioners in other states. This Policy Statement is consistent with current law, and strikes the appropriate balance between enhancing access to care, while also ensuring secure transmission of personal health information.

The Commission also encourages regulators from all healthcare disciplines of the WWAMI region and other states, to adopt a similar policy statement and position, thus facilitating and promoting continuity of care by permitting practitioners to consult with one another about patients they have in common. In fact, the Commission Policy Statement simply acknowledges historical norms of medical practice that is merely being facilitated by technological means.

To the extent that this policy statement could be interpreted to conflict with the Commission's Guidelines for the Appropriate Use of Telemedicine (MD2014-03), this Policy Statement takes precedence.

Appendix 2: Frequently Asked Questions in Telehealth

FAQ for Providers:

Frequently Asked Questions about Telemedicine: A Clinician's Guide

What is telemedicine?

Telemedicine is the delivery of health care services and clinical information to patients and providers using audio-video conferencing technology. This includes a wide array of clinical services using internet, wireless, satellite, and telephone.

What is the distinction between telemedicine and telehealth?

Strictly speaking, telemedicine is focused on clinical aspects of care, whereas telehealth is a broader term than encompasses clinical care plus health-related education, public health and health administration. The American Telemedicine Association (ATA) uses the terms "telemedicine" and "telehealth" interchangeably. Whether using the term "telemedicine" or "telehealth", both terms can refer to the use of remote health care technology to deliver clinical services.

Can clinicians get paid for delivering telemedicine?

Yes, Washington State Senate Bill 5175 passed during Legislative Session 2015. For contracted healthcare providers, this statute permits billing and mandates reimbursement for medically necessary services, delivered in real-time with the patient, via audio-video communication technology. There may be certain restrictions or reimbursement rates, specific to the insurer being billed.

Restrictions are guided by language in SB 5175 (please see)

http://lawfilesext.leg.wa.gov/biennium/2015-16/Pdf/Bills/Senate%20Passed%20Legislature/5175-S.PL.pdf

The following conditions must be met for reimbursement by **Commercial and Medicaid health plans in Washington State:**

a) The services are medically necessary.

b) The originating (or spoke) site is qualified. In 2017, those sites must be one of the following locations: 1) federally qualified health center; 2) hospital; 3) hospital-based or critical access hospital-based renal dialysis center; 4) skilled nursing facility; 5) rural health clinic; 6) community mental health center; 7) the office of physician or practitioner.

Effective Jan 1, 2018, providers are able to conduct telemedicine visits with patients in their home (please see SB 5436).

c) The distant site (or hub) practitioner is qualified. That means that the practitioner must hold a current license to practice clinical medicine in the state of Washington.

d) Live interactive video or store-and-forward technology is used. There must be an associated office visit between member and the referring practitioner when store-and-forward technology is used.

e) Patient is present at an originating site and able to participate.

The following conditions must be met for reimbursement by **Medicare health plans**:

a) The patient is seen by a live interactive video. Store and forward is only allowed in Alaska and Hawaii.
b) The patient must be located in one of the above facilities listed in "b" above
c) The patient must be in either a designated rural or medically underserved service area. You may visit the following website to determine if a patient resides in an eligible location, https://datawarehouse.hrsa.gov/tools/analyzers/geo/Telehealth.aspx

What technology do I need in order to conduct a telemedicine visit?

It is essential to have a secure, encrypted video teleconferencing service that allows for private conversations which meets HITECH and HIPAA standards. You will also need a stable Internet connection which allows for transmission of audio and video.

In addition to the technology, providers must follow established standards for conducting telemedicine visits, as detailed by the Medical Quality Assurance Commission. Department of Health Medical Quality Assurance Commission Guideline: Appropriate Use of Telemedicine
http://www.doh.wa.gov/Portals/1/Documents/3000/MD2014-03TelemedicineGuideline_approved10-3-14.pdf

Do I need to use a special consent form prior to a telemedicine visit?

No. However, just as patients consent to be seen and treated in the traditional healthcare delivery settings, patients should consent prior to being seen via telemedicine.

It is not always necessary to have a *special* signed document just for a telemedicine visit. However, it is best practice for informed consent for telemedicine to include: (i) reasonable understanding by all parties of the enabling technologies utilized, their capabilities and limitations, and a mutual agreement that they are appropriate for the circumstances; and (ii) the credentials of the practitioner.

You may consider adding telemedicine language in your general consent to care document.

Example: “You have chosen to receive care through the use of telemedicine. Telemedicine enables health care providers at different locations to provide safe, effective and convenient care through the use of technology. As with any health care service, there are risks associated with the use of telemedicine, including equipment failure, poor image resolution and information security issues”.

Do you understand the risks and benefits of telemedicine as I have explained them to you? {Yes/No/Unknown}

Have your questions regarding telemedicine been answered? {Yes/No/Unknown}

Do you consent to the use of telemedicine in your medical care today? {Yes/No/Unknown}

I, Dr @ME@ have reviewed and discussed the information above with the patient, {Yes/No}”

Do I need to document visit occurred by telemedicine?

Yes, because you saw the patient remotely and you will be billing for a remote encounter, you need to identify the visit as such. You may do this by using a simple phrase at the end of your documentation. The following is an example of what could be included in a telemedicine visit note:

Example: “This exam was initially conducted via a secure 128-bit AES encrypted bi-directional video session.”

How can I learn more about telemedicine?

The American Telemedicine Association (ATA) is a reputable authority on telemedicine and national resource. It has webinars and an annual conference. The Northwest Regional Telehealth Resource Center (NRTRC) is sponsored by the US Government and recognized as a reliable resource for Washington State, (https://www.nrtrc.org). Other resources include the Center for Telehealth and e-Health Law (http://www.ctel.org), and the Center for Medicare and Medicaid Services (CMS) (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf).

FAQ for Patients:

Frequently Asked Questions about Telemedicine: A Patient’s Guide

What is telemedicine?

Telemedicine is the delivery of health care services and health care related information using equipment that can allow for communication between patients and healthcare providers and even healthcare providers exchanging information to provide better access to healthcare services. This work is done using technology like internet, satellite, iPhones, or smart phones. The use of telemedicine services can take place in

many situations, including hospitals, clinics, homes and nursing facilities, just to name a few.

Why Should I use Telemedicine?

It is not always easy or convenient for patients to get help for their health care needs. The purpose of telemedicine is to improve the opportunity to get healthcare closer to home, in a convenient location, and more timely way. Telemedicine is another option for receiving care from a provider. The benefit of telemedicine is less waiting and travel time, and time away from work or other priorities. Examples of telemedicine include a video “chat” for mental health care, evaluation of a sick child by video, or taking a picture of a skin problem and sending it to a skin specialist for assessment. [weblink to https://www.youtube.com/watch?v=B9oC8vUjqk8]

What is the distinction between telemedicine and telehealth?

The American Telemedicine Association (ATA) uses the terms "telemedicine" and "telehealth" interchangeably. Whether using the term “telemedicine” or “telehealth”, both terms can refer to the use of technology to deliver healthcare services convenient to you, the patient.

How common is telemedicine?

Around the world, millions of patients use telemedicine to monitor their vital signs, remain healthy and out of hospitals and emergency rooms. Over half of all Washington hospitals and many clinics now use some form of telemedicine. Patients and providers can download health and wellness applications for use on their cell phones to assist in telemedicine. Many employers now offer telemedicine as an added benefit in their health insurance program.

Is telemedicine safe?

Telemedicine is a safe and an effective way to extend the delivery of health care. It may not be appropriate for ALL clinical situations and a medical professional can help you determine if telemedicine is appropriate.

Guidelines exist for telemedicine to ensure safety and quality. Clinicians are held to the same standards of care through a telemedicine visit as an in-person visit. Similarly, the same standards for privacy and confidentiality for an in-person visit apply to telemedicine visits. For more information, you may visit this link: (http://thesource.americantelemed.org/resources/telemedicine-practice-guidelines)

Where can patients get access to telemedicine services?

Patients should ask their employer, health plan, hospital or healthcare provider about telemedicine services that may be available. In many cases, the provider may have access to telemedicine technology and services. There are also numerous private

companies that offer basic telemedicine services, including around the clock access to a healthcare professional, remote monitoring of certain medical conditions.

Do health plans pay for telemedicine services?

Health plans, including Medicare and Medicaid, are covering a wide variety of healthcare services available through telemedicine. To find out if your health plan covers telemedicine services, please contact your health plan.

You may learn more about telemedicine by visiting

http://www.americantelemed.org/about/telehealth-faqs-