

VIRGINIA BOARD OF MEDICINE
AD HOC MEETING ON TELEMEDICINE

DATE: October 1, 2014
TIME: 10:00 A.M.
PLACE: The Department of Health Professions
9960 Mayland Drive, Suite 201
Henrico, Virginia, 23233
PRESIDING CHAIR: Kevin O'Connor, MD
PRESENT: Siobhan S. Dunnavant, MD
Lori D. Conklin, MD
Barbara Matusiak, MD
Colanitha Morton Opher
Alan Heaberlin
Jennifer Deschenes
Erin Barrett, JD
Greg Billings
Eddie Bowles
Tamara Broadnax
David Brown, MD
Varun Choudhary, MD
Henry DePhillips, MD
Jay P. Douglas, RN
Stuart Henochowicz, MD
Kyon Hood, MD
Caroline Juran
Jennifer Lee, MD
Karen Remley, MD
Karen Rheuban, MD
Carol Russek
David Trump
Kathy Wibberly

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the parking lot to the fence at the end of the lot and wait there for further instructions.

Just a couple other housekeeping items. If you have a cell phone, please turn it on to vibrate. Also we do have a court reporter here for this and so if you--when you speak, if you'd let us know who you are so the court reporter can identify you for the record. And at that point we'll go ahead and welcome everybody and take roll call.

(Roll call was taken.)

MS. O'PHER: We have a forum.

THE CHAIR: Thank you very much. This is a relatively new group. Many of us don't know the others. So what I'd like to do is start with me and go around and just tell us who you are with and what you do.

I'm Kevin O'Connor. I'm chair of this committee. I'm a member of the Board of Medicine. I'm in private practice in urology in northern Virginia.

DR. CONKLIN: I'm Lori Conklin. I'm a member of the Board of Medicine and also an

THE CHAIR: Call the meeting to order. This is the Board of Medicine's ad hoc meeting on telemedicine. We thank everybody for coming. Before we start I'll do some housekeeping. Please listen to following instructions about exiting these premises in the event of an emergency.

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You may also exit the room using the side door. Turn right out the door and make an immediate left, follow the corridor to the emergency exit at the end of the hall. Upon exiting the building proceed ahead to

anesthesiologist with the University of Virginia.

DR. DUNNAVANT: I am Siobhan Dunnavant, a member of the Board of Medicine and OB-GYN here in Richmond.

DR. HENOCHOWICZ: And I am Stuart Henochowicz. I am the Vice Chair of the Health and Public Policy Committee of the Virginia chapter of American College of Physicians, and I am a practicing internist and allergist in Burke in northern Virginia.

MS. DOUGLAS: I'm Jay Douglas. I'm the Executive Director of the Board of Nursing. As you probably know, the Board of Nursing and Medicine jointly regulate the practice of nurse practitioners in Virginia.

MS. JURAN: I'm Caroline Juran. I'm the Executive Director for the Board of Pharmacy.

MS. WIBBERLY: I'm Kathy Wibberly, Director of the Mid-Atlantic Telehealth Resource Center based at UVA Center for Telehealth.

DR. HOOD: My name is Kyon Hood. I'm

1 the Director of Pediatric Emergency
2 Medicine at Spotsylvania Regional Medical
3 Center, and I also practice telemedicine as
4 well.

5 MS. BOWLES: I'm Edie McRee Bowles, and
6 I'm a consultant working on rural health
7 projects. I have worked on several
8 projects in Virginia.

9 MR. BILLINGS: I'm Greg Billings. I'm
10 the Executive Director of the Robert J.
11 Waters Center for Telehealth in Washington
12 D.C.

13 MS. RUSSEK: I'm Carol Russek. I'm a
14 former prosecutor for the Board of
15 Medicine. I am now retired, but volunteer
16 to bring a rehabilitative viewpoint to this
17 discussion.

18 DR. DEPHILLIPS: A retired prosecutor
19 is the best kind.

20 Doctor Henry DePhillips. I'm a board
21 certified family physician. I'm also Chief
22 Medical Officer of Teladoc, which is the
23 largest primary care telemedicine company in
24 the U.S. I currently work from my home
25 office on a farm just outside of Nashville,

1 Rheuban. I am the Director for the Center
2 for Telehealth at the University of
3 Virginia. I'm a practicing in pediatric
4 cardiologist. I'm board chair of the
5 Virginia Telehealth Network.

6 DR. REMLEY: Karen Remley, pediatric
7 emergency physician, currently Chief
8 Medical Director at Anthem and former
9 commissioner under Governors Kaine and
10 McDonald.

11 MS. MATUSIAK: Barbara Matusiak,
12 Medical Review Coordinator for the Board of
13 Medicine.

14 MR. HEABERLIN: I'm Alan Heaberlin,
15 Deputy Director for Licensure, Board of
16 Medicine.

17 MS. OPHER: And I'm Colanthia Morton
18 Opher. I'm currently the Operations
19 Manager for the Board of Medicine.

20 THE CHAIR: So welcome everybody. I
21 see we have a wide array of opinions and
22 experience. And so the purpose of this
23 meeting is really to help the Board
24 understand the issues in telemedicine as we
25 move forward in developing a guidance

1 Tennessee.

2 MS. BROADNAX: I'm Tamara Broadnax.
3 I'm Director of Telemedicine at VCU Medical
4 Center.

5 MS. BARRETT: I'm Erin Barrett. I'm
6 board counsel for the Board of Medicine
7 from the AG's office.

8 MS. DESCHENES: I'm Jennifer Deschenes,
9 and I'm the Deputy Executive Director for
10 the Board of Medicine.

11 DR. LEE: I'm Jennifer Lee. I'm Deputy
12 Secretary of Health and Human Resources.
13 I'm an emergency physician by training, and
14 I serve on the Board of Medicine.

15 DR. BROWN: David Brown. I'm the
16 Director of the Department of Health
17 Professions.

18 DR. TRUMP: Good morning. Dave Trump.
19 I'm the Chief Deputy Commissioner with the
20 Virginia Department of Health, public
21 health physician, family medicine trained.
22 And we also have oversight of our local
23 health districts in some of the remote
24 counties in jurisdictions here in Virginia.

25 DR. RHEUBAN: Good morning. I'm Karen

1 document that we can use to help our
2 legislators and help the board understand
3 how telemedicine will affect our patients.

4 I think for everybody what we're trying
5 to strike is the balance between access and
6 between access and safety. And I think in
7 each state that balance is probably tipping
8 one way or the other. I think there are
9 some unique issues to the Commonwealth, and
10 that's what we're here to sort of ferret
11 out.

12 I do need to adopt the agenda which is
13 before you. I'll ask Ms. Conklin for a
14 motion.

15 DR. CONKLIN: I have a motion to adopt
16 the agenda.

17 (The motion was seconded and
18 carried unanimously.)

19 THE CHAIR: We'll go ahead and proceed.
20 We do have time for public comment. We've
21 actually had 14 people sign up for public
22 comment. We initially saved just 15 or 20
23 minutes for this, but to give everybody
24 their fair shake what we'll do is we'll go
25 through in order of sign up.

1 Let me see. Michele Satterlund from
2 Teladoc would like to speak. I guess she's
3 the first and only to sign up to speak as
4 opposed to just be here and get a copy of
5 the agenda. So welcome.

6 MICHELE SATTERLUND: Thank you
7 everybody. Michele Satterlund with McGuire
8 Woods on behalf of Teladoc. I'm pleased to
9 be here this morning. Thank you for giving
10 us this opportunity to comment.

11 Telemedicine, which has long been a
12 component of health care in Virginia, is
13 receiving greater attention. Teladoc
14 is--and we're very pleased to be part of
15 this important conversation. Teladoc is the
16 nation's largest and oldest provider of
17 telemedicine services, and we've performed
18 over 250,000 consults in 2014.

19 Teladoc is a cross coverage service
20 that provides telemedicine services to
21 patients who cannot access a primary care
22 physician. The service is provided via
23 secured video or telephone, as is chosen by
24 the patient.

25 Teladoc is the first and only

1 is critical that the guidelines that are
2 created by this committee do not impede
3 access to care. Telemedicine is a cost
4 effective alternative that is providing more
5 Virginians with access of quality health
6 care and now is not the time to impede or
7 hinder health innovation and access.

8 Telemedicine is not new to Virginia.
9 And, in fact, it is an area of health care
10 where Virginia is excelling, as noted by the
11 recent A grade given to Virginia by the
12 American Telehealth Association. But more
13 work can still be done to insure greater
14 access for more Virginians.

15 For instance, Virginia's law that
16 requires a physical exam or the use of
17 electronic equipment prior to issuing a
18 prescription is not in keeping with the
19 recommendation of the Federation of State
20 Medical Boards. This is an impediment that
21 hinders the effectiveness of telemedicine in
22 Virginia. The FSMB recognizes the
23 importance of prescription access and
24 recommends that as long as safety
25 considerations are made and proper standards

1 telehealth provider to receive certification
2 for its physician credentialing process from
3 the National Center For Quality Assurance.
4 And it is important to note that Teladoc
5 only provides telemedicine services for
6 common ailments. All physicians are board
7 certified and have an average of 15 years
8 experience.

9 Teladoc is a sponsored program, which
10 means our services are offered through a
11 patient's employer or health plan. We are
12 not accessible directly by consumer.

13 Teladoc has more than 160,000 members
14 in Virginia, and we have yet to see a single
15 malpractice claim. As the committee moves
16 forward with its discussion of telemedicine,
17 we would urge caution and ask the committee
18 to make its decisions based on verifiable
19 evidence of medical need.

20 I need water. I didn't get a drink
21 before I came up here. Sorry about that.

22 The telemedicine laws and rules in
23 Virginia should be technology neutral and
24 focus on doctors satisfying the standard of
25 care for the illness presented. Further, it

1 of practice are adhered to, a physical
2 examination is not required prior to
3 prescribing. The focus must be on insuring
4 the same standard of care regardless of how
5 the consultation is conducted.

6 While we recognize that Virginia's
7 current physical exam prescriber law is
8 statutory, we would still urge this
9 committee to be thoughtful in its
10 deliberations and to insure that it does not
11 add additional regulatory burdens that
12 hinder access to care.

13 Thank you again for your time, and the
14 water, and we look forward to working with
15 you.

16 THE CHAIR: Thank you very much.

17 There are actually two other people who
18 have expressed interest in speaking. The
19 next is Mike Charles from Sentara. Welcome.

20 MIKE CHARLES: Thank you. I appreciate
21 you allowing me to talk. I'm Mike Charles,
22 family practitioner and board certified
23 from Virginia Beach. I've practiced for 20
24 years. I'm with Sentara for 20 years, and
25 I'm also now--for the past few years I've

1 been Medical Director for Clinical
2 Effectiveness at Sentara.

3 I'm just going to read--you have the
4 full statement. I'm not going to read the
5 full statement. I just wanted to read the
6 first few paragraphs and then I wanted to
7 spend the rest of my time just talking about
8 a little bit of my personal experience with
9 telemedicine.

10 So the statement--many providers like
11 myself have sought ways to transform care
12 and provide the right care at the right time
13 for the right cost. Luckily, there are many
14 technologies, like telehealth, that allows
15 for care of more patients in a safe and
16 increasingly efficient way.

17 Sentara, for example, has adopted
18 various telehealth innovations to help
19 physicians like me to care for my patients.
20 While Sentara engages traditional
21 telemedicine using--and point-to-point
22 technologies, providers also back those more
23 cost effective telemedicine solutions. One
24 of those technologies are e-visits via the
25 Epic platform and consults via a live video

1 There's a lot of work that goes on after out
2 of the office after hours. A lot now is
3 done through the computer electronically.
4 And we're starting within Sentara to work a
5 little bit more with telehealth.

6 I'm a member of--well, certified for MD
7 Live. So I've got some MD Live visits.
8 Those are more for acute visits, not high
9 acuity, but things that you can handle for
10 patients that you might not already have
11 that physician/patient relationship. So
12 that is done through a secure portal with
13 video and audio. So I think that it is
14 important to develop that relationship with
15 those kind of visits.

16 We also do e-visits which we already
17 have a relationship with our patients there.
18 Those are our patients that we take care of.
19 We have the records in the EMR so we can
20 look at things and follow through with
21 things, but also it's a nice way of managing
22 the population which we're going to have to
23 do more and more of nowadays.

24 So that's one of the things just to
25 talk to--MD Live has that one ability to

1 chat that's HIPAA compliant and secured
2 platform.

3 Sentara recommends the principals
4 governing the use of telemedicine and allow
5 health care providers continued use of those
6 telephonic and e-visit consults. Provider
7 consults are done through a platform that's
8 HIPAA compliant and secure and uses quality
9 protocol and safeguards, i.e. allowing the
10 visit to be recorded.

11 The platform must also allow the
12 physician patient health history and
13 relevant medical files and to exchange
14 messages so that a bona fide
15 physician/patient relationship can be
16 formed. When these secure platforms are
17 used, physicians can continue to have
18 discretion to prescribe non-narcotic
19 pharmaceuticals when medically appropriate.

20 So I just wanted to talk a little bit.
21 Again I'm family practice. I practice 50
22 percent of the time. The other time is
23 administrative. As a lot of you all are
24 familiar, 50 percent in the office is not
25 the end of my taking care of the patients.

1 take care of these acute visits. But we're
2 also looking at MD Live because of this
3 secure video portal of taking care of our
4 patients in nursing homes.

5 So we have nursing home patients. The
6 director of nursing homes has come to us and
7 said, well, we've got patients in the
8 nursing home. A lot of time we're
9 transporting them via ambulance to a
10 specialist visit. Wouldn't it be great if
11 we could do that electronically or virtually
12 with a secure platform? We're going to look
13 at MD Live do to that.

14 Down the line it would be nice to even
15 get maybe our EIC board--EICU board
16 protocols involved and have our hospitals
17 involved managing some of these nursing home
18 patients. What we could do then is prevent
19 them from going to the ER, prevent
20 re-admissions for these patients. There are
21 a lot of opportunities we can see down the
22 line for telehealth and virtual care that
23 way.

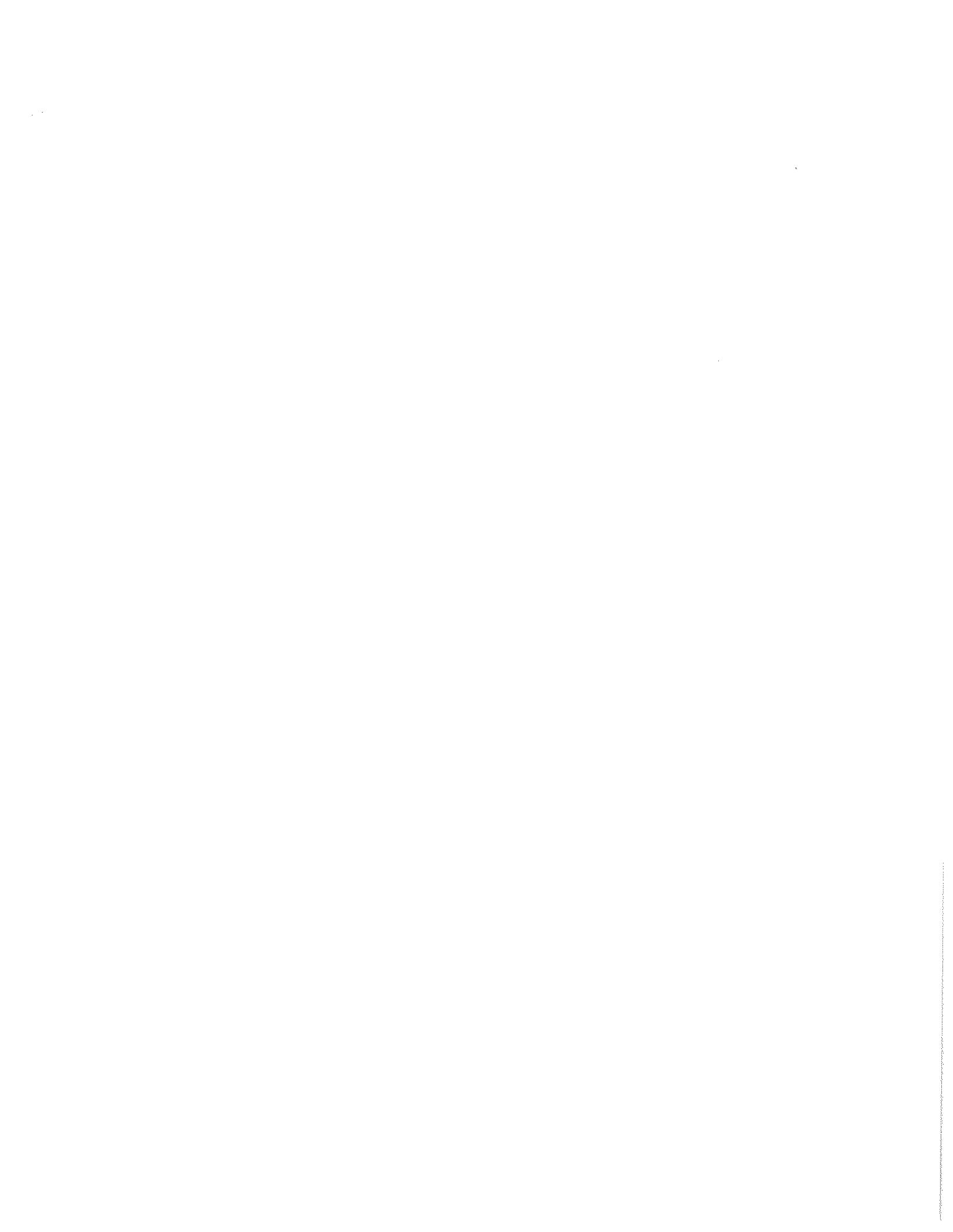
24 And then the last thing I'll say is
25 just a quick shout out for Asynchronous

1 Communication. I don't want that to be lost
 2 in the shuffle. I know there's a lot of
 3 push towards that face-to-face, but in the
 4 EMR, especially with our e-visits, a lot of
 5 the communication I do with my patients is
 6 Asynchronous. I'll send an e-mail through
 7 my chart. They'll e-mail me back. We'll go
 8 back and forth with lot of a management.
 9 And there's a lot of care that's being
 10 managed that way.
 11 We want to really push forward our
 12 e-visits. Right now we're doing e-visits
 13 for acute chronic--acute situations, but
 14 we'd really--I'd like to them push forward
 15 to chronic management of patients that are
 16 under good control. You know, they can get
 17 their blood pressures electronically sent to
 18 me. Their sugars can be sent to me
 19 electronically. I can manage that, order
 20 labs, get labs. We can manage a lot of that
 21 population without bringing them physically
 22 into the office. So I'd really like to for
 23 you all to consider that as we move forward,
 24 that Asynchronous part.
 25 Again these are patients that I already

1 information and thoughts to allow the Board
 2 members to come up with a policy to present
 3 to--these Board members to come up with a
 4 policy for the full board for action.
 5 The questions that we're going to
 6 discuss today are by no mean exhaustive.
 7 They're just some points, some launching
 8 points for discussion. I think the way we
 9 should do it today is that we'll just
 10 introduce each topic briefly, open it up for
 11 discussion in an orderly way, ask any
 12 questions from any board members, and then
 13 we'll just see where it takes us.
 14 We do have--Doctor Choudhary, would you
 15 like to introduce yourself.
 16 DR. CHOUDHARY: Good morning everyone.
 17 I apologize for being late. My name is
 18 Doctor Varun Choudhary. I'm currently the
 19 Medical Director at Magellan, but I am also
 20 a telepsychiatrist and a practicing
 21 telepsychiatrist since 2004, and for a
 22 period of a few years it was pretty much a
 23 full-time position. But I continue with
 24 weekly work for a company doing
 25 telepsychiatrist work.

1 have a relationship with. These are my
 2 patients. All their information is in the
 3 EMR. When I stay within that EMR platform,
 4 I can use the safety features of the
 5 EMR--drug to drug interaction, check my
 6 problem list, check my past history and all
 7 those sorts of things. So just a quick
 8 shout out for that.
 9 One of the things that we are pushing
 10 at Sentara Medical Group is access, quality,
 11 and patient satisfaction. The last thing
 12 I'd say is that telehealth is going to be a
 13 big part of that as we move forward. Thank
 14 you.
 15 THE CHAIR: Thank you very much.
 16 There's someone who thought they might
 17 want to speak. Mr. McMenamin.
 18 JOE MCMENAMIN: No, sir. I was simply
 19 asking would it be possible later. Nothing
 20 at this time.
 21 THE CHAIR: Okay. Then we'll move
 22 forward. You see the agenda items under
 23 New Business. The charge of the committee,
 24 we're going to discuss the tool to
 25 synthesize all of the state holders'

1 THE CHAIR: Welcome. When the board
 2 solicited information, we got a lot of
 3 reference material, and we're trying to
 4 synthesize it in a packet. Two umbrella
 5 documents--we have incorporated the
 6 Federation statement, the AMA statement, a
 7 review of state by state policy and
 8 licensing for telemedicine, as well as
 9 Virginia law and some other telemedicine
 10 models. So we thank everybody for their
 11 input. What's not included here is
 12 available at the back with the reference
 13 material. I'd encourage you to do that.
 14 So I'll start with really a basic
 15 question. What constitutes telemedicine?
 16 And I'll just start by reading from the
 17 Federation.
 18 Telemedicine means the practice of
 19 medicine using electronic communications,
 20 information technology or other means
 21 between a licensee in one location and a
 22 patient in another location with or without
 23 an intervening healthcare provider.
 24 Generally, telemedicine is not an
 25 audio-only, telephone conversation, e-mail.



1 instant messaging conversation, or fax. It
2 typically involves the application of secure
3 videoconferencing or store and forward
4 technology to provide or support healthcare
5 delivery by replicating the interaction of a
6 traditional encounter in person between a
7 provider and a patient.

8 I would throw that out. It seems very
9 reasonable. And I guess I'd first ask the
10 commercial providers of telemedicine what
11 their thoughts are on that. Go ahead in any
12 order.

13 DR. DEPHILLIPS: Yes. Good morning
14 again.

15 THE CHAIR: Please introduce yourself
16 for the--

17 DR. DEPHILLIPS: Henry DePhillips,
18 Chief Medical Officer for Teladoc.

19 So Teladoc's position on the FSMB
20 definition is as follows. It's not yes, no.
21 It's plus and minus. On the plus side we
22 think it's great that they can be the
23 consensus group for essentially both,
24 similar to what's happened in the industry.
25 I think this is a fantastic exercise.

1 encounter, multi-faceted, the prior
2 in-person visit requirement no longer serves
3 a purpose like that. So the FSMB was very
4 clear in their model guidelines that the
5 prior in-person visit sort of needs to go
6 away for telemedicine to move forward and
7 Teladoc agrees that that's the case.

8 The areas where Teladoc has a little
9 bit of a difference of opinion are really
10 two areas. Number one is--and I guess I
11 would urge the medical board members and
12 even the legislators of the state to think
13 about this. Telemedicine is not the
14 practice of medicine. It's not a separate
15 specialty like neurology. Telemedicine is
16 just the use of a particular set of tools in
17 the practice of medicine, no different than
18 using a stethoscope as a tool, using a scale
19 to measure someone's weight as a tool. It's
20 just another way to gather information about
21 a patient during the time a doctor
22 makes--you know, considers a differential
23 diagnosis and creates a treatment plan.

24 And so Teladoc's position--and where we
25 differ a little bit from the FSMB, number

1 I wholeheartedly support it. I also think
2 that--we also think that some of the things
3 they did were very important. The prior
4 in-person visit requirement is a
5 show-stopper for most of telemedicine. And
6 so just so that--some of the folks in the
7 room may not know the allusion to that, so
8 let me just take 30 seconds to talk about
9 that.

10 So back in the late 1990s, for those of
11 you with gray hair like me and older, you
12 probably remember the Internet prescribing
13 stuff with the online questionnaire and meet
14 the GPA controlled substance--excuse me--the
15 DEA--the FDA indication for a certain drug.
16 You were prescribed that drug without even
17 having any kind of visit at all.

18 Most of the medical boards around the
19 country, if not all, instituted a prior
20 in-person requirement to do away with that
21 terrible practice of medicine and it served
22 the purpose. It put that industry to bed.

23 But if you fast forward 15 years to
24 today with the advent of telemedicine and
25 much higher quality care and quality

1 one, is that the regulatory groups I think
2 needs to be--should--I recommend that--we
3 recommend that they be silent on the
4 technology used, not the least of which by
5 the way is by the time you get around to,
6 you know, commenting on technology and
7 regulation it's going to change again
8 anyway.

9 I mean, there are virtual stethoscopes
10 that are arguably better than laying a
11 stethoscope on a chest. I'll give you an
12 example. If you take a digital diagram, put
13 it on a patient's chest remotely, take that
14 signal, digitize it, filter it, clean it,
15 and amplify it, and send it to a remote
16 physician's ears, an argument could be made
17 that that's a superior alternation to laying
18 a stethoscope on a patient's chest. I'm not
19 making that argument, but that argument
20 could be made. So there's just one example.

21 With Apple Health Kit--as you know, it
22 was pulled out this year. There are a
23 number of apps and devices that you will be
24 able to attach to your iPhone that will
25 transmit some of the information that the

1 Sentara physician who spoke previously
2 talked about.

3 So the technology is going to continue
4 at a dizzying pace. So I would urge the
5 regulatory folks that are here to consider
6 the standard of care being met and a quality
7 patient encounter and what constitutes a
8 quality patient encounter, elements like
9 having a comprehensive medical record that's
10 shared between the patient and physician,
11 things like that, and not be as concerned
12 about how the physician gathers that
13 information or how that physician interacts
14 with that patient or how that information
15 gets to the physician.

16 Last comment--I need to be brief here.
17 Last comment is there's one provision in
18 there that has a lot of people scratching
19 their heads, and that's this whole concept
20 of this PCP selection process. Teladoc as
21 an organization strives to stand--to step on
22 the toes of the existing PCP/patient
23 relationship as little as possible.

24 And let me give you an example. ZocDoc
25 is a service that does short notice

1 least in our world, between the physician
2 and patient. So those are the two areas
3 where we would disagree.

4 THE CHAIR: Doctor Rheuban, did you
5 want to make some comments about
6 telemedicine in general or could you give
7 us your thoughts on this?

8 DR. RHEUBAN: Sure. So currently
9 as--in most of the telemedicine academic
10 settings both models have been deployed.
11 It's interactive video teleconferencing
12 connecting the provider at the distant
13 site, which is the consultant site, with a
14 patient at the originating site, generally
15 supported by a health professional at the
16 remote site. It could be, you know, an
17 LPN, an RN, a nurse practitioner.

18 And at UVA and VCU that's pretty much
19 the model that we've deployed. We use it
20 across all the disciplines. We've supported
21 services and we have 45 different
22 specialities. Again mostly video based.

23 We do some store and forward
24 telemedicine as well, especially in the
25 fields that have been very image intense.

1 appointment scheduling for, you know, docs
2 who have some room on their schedule and
3 people who are traveling in various cities
4 like Richmond. And as soon as ZocDoc put
5 pictures and bios up on their website to
6 allow people to choose a physician that way,
7 80 percent of the visit requests went to
8 attractive female physicians.

9 So, number one, that's an interesting
10 commentary on our society. But, number two,
11 the message in there is really clear.
12 People when you give people that kind of
13 information are choosing a physician not
14 necessarily based on the highest clinical
15 quality. I'll just leave it at that.

16 So this whole PCP selection process we
17 would argue is not a good idea. When you go
18 to an urgent care center or the emergency
19 room, you're going to get the doc that's
20 there on that shift. You don't have a
21 choice.

22 And so at least primary care
23 telemedicine is sort of more of a cross
24 coverage situation, and we really don't want
25 to establish an ongoing relationship, at

1 Dermatology is an example. Wound care is an
2 example. Radiology, teleophthalmology,
3 screening for diabetic retinopathy.

4 We have not delved into the primary
5 care space, quite frankly, and so I'm very
6 interested in learning more as well. I
7 would say that telemedicine services we
8 provide require some element of physical
9 examination, but it is not the same as an
10 in-person. It is face-to-face because it's
11 video-based. It's the provider seeing the
12 patient, but we rely on the support services
13 of a provider at the originating site to
14 help do that.

15 I am just as interested in learning how
16 we can use this in primary care, whether
17 it's through the individual practitioners
18 who are providing services to the existing
19 patient versus models of cares our Teladoc
20 partners and others who have shared as well.

21 But I do believe, you know, the
22 standard of care should be met for every
23 encounter with a patient, whether it's
24 specialty care or primary care, and the
25 question is for this board to decide what is

1 the standard of care.

2 THE CHAIR: Maybe we can take the first
3 agenda items together. And help me
4 understand what your sense of appropriate
5 technology is. What--on that scale you
6 obviously use face-to-face
7 videoconferencing. Have you thoughts about
8 other technologies?

9 DR. RHEUBAN: We are actually looking
10 at providing some virtual visits through
11 our Epic portal. And so we're exploring
12 those. Those are for our existing patients
13 already. So I guess it's somewhat similar
14 to what we heard from our Sentara colleague
15 that already have access to the patient's
16 record and they are already patients within
17 our practice environment.

18 THE CHAIR: How do you assure the
19 security of those interactions?

20 DR. RHEUBAN: Well, we only use HIPAA
21 compliant videoconferencing and other
22 portals. HIPAA compliant and FDA approved.

23 THE CHAIR: I guess we have our
24 friends--do you have--

25 DR. CONKLIN: One question I have

1 an operator orient you or go online
2 yourself.

3 So we use current standard technology
4 to validate the patients. Number one, they
5 have to be preloaded. They have to provide
6 a number of different data points, no
7 different than when you call up your bank.
8 What's the last four of your social? What's
9 your age? What's your address? By the time
10 you get through three or four of those,
11 you're not a hundred percent sure you have
12 the right person, but you're fairly sure.

13 Is it perfect? No.

14 But you mentioned the example of being
15 dishonest in presenting who you are in an
16 effort to get drugs. So some of the
17 guardrails we have in place is no DEA
18 controlled substances ever and no lifestyle
19 drugs ever. So that wipes out most of the
20 people trying to be dishonest since we don't
21 have any of the things they would want to
22 get anyway.

23 Lastly, that's not a problem that's
24 unique to telemedicine. There are aplenty
25 of accounts in the papers in Virginia and

1 is--and anyone involved in telemedicine can
2 answer it. If the initial
3 patient/physician contact is not required
4 and you're not using videoconferencing, how
5 can you be certain that the person that's
6 on the other end of that phone is indeed
7 the person that has the problem? How can
8 you verify and identify?

9 It's--that would be my concern. Secure
10 access. You can be secure from the HIPAA
11 standpoint, but how do you know that who
12 you're talking to isn't somebody that's just
13 trying to get medication for someone else?

14 DR. DEPHILLIPS: I'll take a stab.

15 Henry DePhillips from Teladoc again. So in
16 our world--it's a very good question. In
17 our world we have--first of all, it's a
18 sponsored-only program. Your employer has
19 to buy through the employee's--the health
20 plan is provided for the members and they
21 have it. So we have already preloaded all
22 of the information on each of the members
23 who are able to use the service.

24 We also have a platform that handles
25 all this. You can call in and you can have

1 elsewhere, Tennessee where I live, of people
2 who get in an accident in a car, go to the
3 emergency room, and they quickly are offered
4 their friend's health insurance I.D. so they
5 have insurance coverage for that emergency
6 room visit. It unfortunately happens
7 throughout our system.

8 I think at least in the flavor of
9 telemedicine that we have out there we think
10 we've been able to minimize it using
11 state-of-art identification matching
12 technology.

13 THE CHAIR: Why don't we just go around
14 and start here and see what the thoughts
15 are basically on what you consider or your
16 specialty or your personal practice
17 considers telemedicine and what
18 technologies you might find acceptable from
19 anything from videoconferencing to iPhones
20 to questionnaires. I mean, things through
21 spectrum. Go ahead.

22 DR. HENOCHOWICZ: Yes. Stuart
23 Henochowicz with the American College of
24 Physicians. And we are very excited about
25 technologies that are developed to help our

1 patients through telemedicine. We however
 2 feel very importantly about the
 3 professionalism in medicine and the use of
 4 professionalism in medicine for the quality
 5 of care for our own patients. And we feel
 6 very strongly that an initial in-person
 7 requirement is something that's essential
 8 to delivering quality care in medicine.
 9 And certainly audio-only certainly--but
 10 even beyond that. So we think that it's
 11 important to have a patient/physician
 12 relationship that's developed in person at
 13 any point.

14 So Doctor Rheuban and the members of
 15 the American College of Physicians have kind
 16 of tried to flush this out. But certainly
 17 from a kind of environment where the patient
 18 calls in or comes in remotely to the
 19 telephysician, we feel that that's not
 20 a--that's not consistent with
 21 professionalism and that's not consistent
 22 with quality care.

23 And I will make a plug also--you know,
 24 I have the vision of Sir William Osler
 25 always in internal medicine. And the idea

1 Minute Clinic where you come in for these,
 2 you know, evaluations is just inappropriate
 3 from a professional standpoint. And that
 4 was the feeling of the Virginia Chapter of
 5 American College of Physicians.

6 THE CHAIR: Okay.

7 MS. DOUGLAS: Jay Douglas from the
 8 Board of Nursing. I'd just say that we're
 9 certainly aware that nurse practitioners
 10 and registered nurses and licensed
 11 practical nurses are involved in
 12 telemedicine in a variety of settings. I
 13 think you have in your packet the statement
 14 from the National Council of State Boards
 15 of Nursing in terms of providing some
 16 general guidance to boards about this
 17 issue.

18 And I think that the Board of Nursing,
 19 more specifically, is focused on the
 20 authority for the nurse to practice where
 21 the patient is located. One of the
 22 mechanisms that are being used to address
 23 that is nurse licensure component and the
 24 current development of nursing components.
 25 I'll leave it to the experts on the

1 that the physical exam is an impediment just
 2 kind of is not something that I would teach
 3 my medical students. You know, that's not
 4 something that I would teach medical
 5 students.

6 I would add as a final note that I did
 7 discuss this with one of my medical students
 8 yesterday who's a 20-something person from
 9 the Bay area, who both parents are computer
 10 scientists. And she was just kind of taken
 11 aback by the idea that you wouldn't do a
 12 physical examination.

13 So, yes, I'm, you know, a middle-aged,
 14 gray-haired physician who's quoting a 19th
 15 century internist here. But, you know,
 16 there needs to be some professional
 17 standards that are maintained here, and I
 18 would really want the board to keep that in
 19 mind in these deliberations.

20 I mean, technology is wonderful. What
 21 Doctor Rheuban does with, you know, virtual
 22 medicine is wonderful. I mean, these things
 23 are wonderful. They help our patients. But
 24 to have a patient come in and calling--you
 25 know, kind of like a second generation

1 technology on that.

2 THE CHAIR: Doctor Choudhary, what do
 3 you consider telemedicine and what kind of
 4 technologies would you consider
 5 appropriate?

6 DR. CHOUDHARY: Well, in my experience
 7 I really see--and I currently see patients
 8 who are either already in the hospital, at
 9 correctional facilities or CSP. So as far
 10 as telepsychiatrist goes, from my
 11 perspective it's been used as consultative.
 12 So usually there is an examination done on
 13 the other side. And there is usually
 14 someone who is coordinating on the other
 15 side as well. There is a licensed mental
 16 health professional or a licensed health
 17 professional. So there's a person there in
 18 case any kind of safety risks or issue that
 19 comes up.

20 And with the telepsychiatry, it may be
 21 a little bit different than with the other
 22 specialties because our physical exam
 23 involves more of a cognitive evaluation.
 24 And with somebody on the other side we can
 25 do an abnormal mood disorder scale with the

1 use of either a nurse or licensed
2 professional on the other end. So we are
3 able to look at comprehensive service.
4 Prescriptions go through usually the primary
5 care physician or it's facility-based.

6 THE CHAIR: It seems to me that
7 psychiatry--this could be a stretch--is the
8 only subspecialty that might lend itself to
9 audio-only telemedicine. What are your
10 thoughts on that?

11 DR. CHOUDHARY: While that could be
12 possible, I think we shouldn't
13 underestimate the importance of looking at
14 and examining patients. The concern I
15 would have for audio-only would be that you
16 couldn't see them. You couldn't see any
17 muscle stiffness. You couldn't see a
18 dilated pupil. You really are working with
19 a loss of visual aid. So I would be
20 cautious with audio-only.

21 MS. JURAN: With respect to the
22 pharmacists, the National Association
23 Boards of Pharmacy doesn't have a policy,
24 as well as other national associations with
25 respect to telepharmacy. It is currently

1 MS. WIBBERLY: Kathy Wibberly. I think
2 my position is also to urge caution as to
3 not to make technology the center of the
4 issue. I think as mentioned before
5 technology is a tool. And as has also been
6 mentioned, technology advances much quicker
7 than policy ever advances. And so, you
8 know, my caution would be not to make
9 policy that limits growth of technology and
10 new technologies currently being used.

11 With that said, I think we view
12 technology as a tool. And so it's always
13 back to the clinician or the clinician
14 adequately turning to that and able to
15 provide that consultation or whatever
16 service that's being provided. So they have
17 to use their clinical judgement.

18 Is the technology enabling and
19 providing the amount of information they
20 need to make a sound judgement? If not,
21 then that should not be, you know,
22 acceptable means of doing the consult or
23 exam or whatever service is being provided.

24 So in terms of technology and secure
25 privacy, all of that is critical in terms of

1 being used in some states, and it is
2 construed that the pharmacists would have
3 to hold licensure in the state in which the
4 patient is located. That's not consistent
5 with how the FSA interprets the guidelines
6 with respect to telemedicine.

7 The other thing that's very interesting
8 taking from these discussions is the fact
9 that there is law corresponding
10 responsibility of pharmacists in determining
11 the validity of prescriptions, and certainly
12 the validity of prescriptions and a
13 pharmacist/patient relationship is an
14 integral part of that.

15 So it's very informative to pharmacists
16 to determine what specifically is going to
17 be defined as a bona fide patient
18 relationship so as to assist in determining
19 the validity of prescriptions. We need some
20 guidance.

21 THE CHAIR: As we go through this
22 topic, the pharmacists really are up
23 against a road. You're welcome to come
24 back to that.

25 Ms. Wibberly.

1 whether it's an iPhone or an iPad or, you
2 know, whatever mobile device that's the next
3 generation, or traditional
4 videoconferencing. I would not put
5 limitations on the technology, but more on
6 the security of the patient's privacy and
7 the things that surround that.

8 THE CHAIR: So what are your thoughts
9 on audio-only encounters?

10 MS. WIBBERLY: I think it goes back to
11 that same clinical judgment piece. You
12 know, I think it needs to not create any
13 barriers between the patient's medical
14 consult. So there has to be some
15 relationship with primary care and on
16 directing the patient to primary care.

17 I think the medical record and patient
18 history--there needs to be some access to
19 that. Otherwise you can't make a good
20 clinical assessment based on what the
21 patient tells you. We all know people lie.
22 And I think that with those pieces in place
23 and with, you know, some safeguards in terms
24 of being able to prescribe, being what you
25 can prescribe, those safeguards in place,

1 I'm a little more comfortable with that.
 2 My preference obviously would be for
 3 video because there's so much that can be
 4 determined through the visual contact. You
 5 know, as Doctor Choudhary was saying, you
 6 can see so much in terms of a patient's
 7 demeanor, their body language, that they
 8 don't necessarily tell you by phone.

9 THE CHAIR: Is there a distinction
 10 between initial consultation and subsequent
 11 follow-up consult? Do you think there's a
 12 spectrum there for--I mean, when I review
 13 all this material, basically they
 14 discourage audio-only. I'm trying to
 15 ferret that out, whether there would never
 16 be ever be a role for that in--

17 MS. WIBBERLY: I mean, I think there's
 18 always been a role for telephone. Every
 19 physician contacts--you know, patients
 20 contact the physician's office and they
 21 have those consults. So again it goes back
 22 to do you have records from the patient's
 23 history, the background.

24 You know, this is your established
 25 patient. I think almost every physician

1 Then you have the virtual, you know,
 2 urgent care if you will. A lot of the
 3 national telemedicine companies find models
 4 that they're using. And those are important
 5 because I think in some of the instances the
 6 patients don't have insurance despite, you
 7 know, Obama Care and the requirements.

8 A lot of patients don't have current
 9 insurance. They can't reach their doctors
 10 or they can't get an appointment for two,
 11 three, four days with their physician. So
 12 the alternative now in these instances will
 13 be telemedicine or possibly going to the ER.

14 And you don't have to always make a
 15 definitive diagnosis in seeing these
 16 patients through telemedicine. Sometimes
 17 they're just calling saying, look, this is
 18 the situation. We're not trying to diagnose
 19 pneumonia versus bronchiolitis obviously
 20 either through video or audio-only. But to
 21 give a patient guidance. Okay. This is
 22 what sounds like is going on. These are the
 23 symptoms and signs you want to look for.

24 And in these instances you can offer
 25 supportive care and anticipatory guidance or

1 would say I'm pretty comfortable talking to
 2 that patient by phone and making some
 3 clinical decisions. If it's, you know, your
 4 first contact and you don't know anything
 5 about this and you don't have any record,
 6 you don't have a patient history, you
 7 haven't verified identity, I would not be as
 8 comfortable with that.

9 THE CHAIR: Any comments, Doctor Hood?

10 DR. HOOD: Yes. I just think that we
 11 need to consider, the board should
 12 consider, we should consider all the
 13 different venues. You know, we're talking
 14 about different models. That was one of
 15 our focuses here. We've got to look at
 16 different models and discuss different
 17 models, and they vary in setting.

18 You know, I think we should look at the
 19 primary care or the subspecialty offices
 20 that have established patients that will use
 21 telemedicine as an extension of their
 22 practice and their office setting. And so
 23 in those instances clearly you're going to
 24 have an established visit and be seen in
 25 person prior to any follow-up consultations.

1 you can direct them to the ER depending on
 2 the situation. So it's case by case.

3 There are certain things where I think
 4 audio-only if they don't have access to
 5 care--you know, they live in a very rural
 6 area. They don't have a primary care
 7 physician, or they can't get an appointment,
 8 and they don't have video capabilities.
 9 They just have a telephone. They don't have
 10 a computer. I think there are certain
 11 individual cases and chief complaints where
 12 you can manage.

13 You know, the vast majority of the
 14 times I diagnose sinusitis and treat for
 15 sinusitis, you know, it's 90 percent
 16 history. Yeah. You can palpate the sinuses
 17 for tenderness and see that that helps, but
 18 the vast majority of diagnosing sinusitis is
 19 per practice guidelines and meeting
 20 criteria, and the majority of that is by
 21 history.

22 So, you know, I think there are certain
 23 instances where audio-only would be
 24 acceptable without deviating from the
 25 standard of care and compromising quality.

1 The other--the next venue is
 2 subspecialty clinics. My hope is to
 3 increase access to subspecialty services for
 4 patients that live in the rural areas or
 5 communities like mine in Fredericksburg
 6 where they either have to drive an hour or
 7 hour and a half, depending on traffic, south
 8 to Richmond, or an hour or hour and a half
 9 north to D.C.

10 And if you had like a telemedicine
 11 clinic where patients could come in and have
 12 a physician, you know, see them, either mid
 13 level or other physician provider see them,
 14 you know, do the complete exam, and then
 15 have telemedicine through subspecialty, you
 16 know, services. You know, subspecialists
 17 complete the exam. And this would be with
 18 the otoscope, the stethoscope, you know,
 19 with all of these, to use some example
 20 machines, where they could actually hear the
 21 heart sounds and listen to the lung sounds
 22 and then offer their subspecialty service
 23 advice without the family having to leave
 24 town. You know, sometimes families have to
 25 take an entire day off, you know, to go see

1 do you think the options are?

2 DR. HOOD: Well, it would be an
 3 option--you know, it would be an option to
 4 do a consult from home versus to go out to
 5 urgent care or ER setting where the cost is
 6 more and maybe difficult for them to get
 7 there. In some instances, you know, they
 8 might have a pharmacy that's closer by to
 9 them than urgent care or, you know, a
 10 health clinic.

11 And in the middle of winter, you know,
 12 they maybe not have access. Roads would be
 13 blocked, etcetera. So it's just increasing
 14 access. That's the balance here is trying
 15 to increase access without compromising care
 16 clearly.

17 MS. BOWLES: I'm Edie McRee Bowles, and
 18 I have managed telehealth projects in rural
 19 areas of Virginia, primarily the Middle
 20 Peninsula and Northern Neck and Eastern
 21 Shore. Our network, Bay Rivers Telehealth
 22 Network, has worked with the University of
 23 Virginia and VCU, and primarily we set up
 24 clinics in rural areas so that patients
 25 could come and see a specialist or

1 these subspecialists out of town.

2 And, of course, the in-patient
 3 settings, you know, where subspecialists are
 4 used through telemedicine again through
 5 higher technology where you're going to have
 6 the otoscope or the stethoscope, access to
 7 that, not just through video and audio-only
 8 telephone.

9 THE CHAIR: Questions?

10 DR. CONKLIN: If one of the goals of
 11 telemedicine is to increase access to rural
 12 Virginians--your point on some people may
 13 not have an iPad or an iPhone or laptop or
 14 web access because of financial means. So
 15 these people will then go to outlying
 16 offices or shopping malls or grocery
 17 stores? What--

18 DR. HOOD: I think the options for them
 19 are either to go to, you know, like a
 20 urgent care clinic or, you know, the
 21 closest emergency room unless they have the
 22 option for telemedicine as a service for--

23 DR. CONKLIN: Right. That's what I'm
 24 asking. So as far as telemedicine goes,
 25 how is that extent of their options? What

1 subspecialist using traditional video
 2 teleconferencing. We have required exams
 3 on the patient's side, and the patient
 4 history has been communicated usually a few
 5 weeks ahead to the consultant physician.

6 In the cases of the PCP, one of the
 7 purposes of a particular project that I
 8 managed was to reinforce the relationship
 9 between the patient and their PCP and the
 10 PCP and the specialist. That is an
 11 opportunity that we found did occur over
 12 three years, four years of doing that
 13 particular project. And the prescriptions
 14 did go through the PCP from the specialist,
 15 through the PCP who followed up with the
 16 patient. Usually that was recommended.

17 In the case of patients--an example of
 18 a patient who benefited was a young person
 19 who needed to see a dermatologist and they
 20 would have to come to Richmond. The mother
 21 didn't drive, so the father had to take off
 22 of work. So that's an example of the kind
 23 of person in a rural area that it does
 24 benefit and it helps a lot in a number of
 25 ways.

1 The other project that has been done in
 2 these rural areas has to do with
 3 telemedicine, particularly geriatric, to
 4 nursing homes where the geriatric physician
 5 was not able to get to those nursing homes
 6 because they were too distant. He did visit
 7 some of them, but in the group of nursing
 8 homes we were working with--there was one on
 9 the Northern Neck, one in the Middle
 10 Peninsula, and one on the Eastern Shore that
 11 never saw a patient.

12 The day after we started this in August
 13 of 2012 the administrator of the nursing
 14 home over on the Eastern Shore just said
 15 this is incredible. We have had a problem
 16 with getting the right diagnosis for this
 17 patient and this is really making a big
 18 difference.

19 So it is the opportunity to--also in
 20 those cases visual is very important and
 21 also the opportunity for the communication
 22 between a caregiver at the skilled nursing
 23 facility who knows that person well to be
 24 able to communicate with that specialist,
 25 and there are nuances that happen in those

1 relationship you have established with the
 2 first one extend to the second one? Does
 3 the doctor need you to come in? So I'm not
 4 going to get into that.

5 Generally speaking, it goes to the
 6 other part of how we view it. I would agree
 7 with Doctor Phillips. Telemedicine is only
 8 a medium. You know, safe telemedicine is
 9 safe telemedicine. But it really starts
 10 with safe medicine. And our principles
 11 which are located in the document sort of
 12 will set forth the facility-based process
 13 that has been talked about here by Doctor
 14 Rheuban and others.

15 Then moving away from that, we believe
 16 that legally a state, whether Virginia or
 17 any state, should recognize a telemedicine
 18 encounter provided a number of circumstances
 19 get met. Number one, does the physician,
 20 the practitioner, feel that the encounter is
 21 equivalent or superior to an in-person
 22 examination? Can they conduct--Doctor
 23 Rheuban conduct an examination from afar and
 24 feel comfortable that she has all the
 25 clinical information to make a decision?

1 interactions. And we have found that that's
 2 been very helpful to patients.

3 THE CHAIR: Mr. Billings, any comments?

4 MR. BILLINGS: Greg Billings, Center
 5 for Telehealth. First of all, to answer
 6 your question Doctor Juran, or Ms.
 7 Juran--in my former world on Capitol Hill
 8 it would be Mr. Chairman, right?

9 I do want to go back to the Sentara
 10 physician. It is our view at C-Tel looking
 11 at all 50 states, the statute--I can't say
 12 that I have Virginia on recall, but there is
 13 a distinction between once that
 14 physician/patient relationship has been
 15 established, what can go forward from that
 16 point on.

17 So you asked a question would it be
 18 appropriate to have telephone calls.
 19 Ms. Kathy said--it is our position once that
 20 has been established we're out of it. Now
 21 there may be some legal issues. I'm not
 22 aware. I don't practice on--but if you
 23 present to a doctor for one issue, then you
 24 call the doctor three months later for a
 25 different issue, does the physician/patient

1 Second of all, does his or her decision
 2 conform to the standard of care?

3 I realize that's like a bowl of jello.
 4 Good luck to you all to figure that one out.

5 DR. DEPHILLIPS: That's why they get
 6 paid the big bucks.

7 MR. BILLINGS: And third of all, this
 8 is where we digress from the guidelines the
 9 Federation put out. We think--I have
 10 communicated this directly to them, so it's
 11 not anything I haven't said. We think they
 12 are remiss for not including peripheral
 13 diagnostic tests. Peripheral diagnostic
 14 tests being strep test or urine test if
 15 necessary to confirm the diagnosis.

16 We worked with the CDC. The CDC cited
 17 practice guidelines from other special
 18 societies that say in order to confirm
 19 diagnosis of strep you need a strep test.
 20 So the question then comes down to when you
 21 get away from the institutional based and
 22 you get down to the primary care based.

23 The question that needs to be asked is:
 24 Does that encounter--is that encounter
 25 equivalent to an in-person encounter? Is

1 that physician doing the same thing that
2 physician would do if a patient walked in
3 the front door and sat in their office? Can
4 you diagnose an ear infection over the phone
5 or through a web exam without an otoscope?

6 Would that be the equivalent to a
7 mother bringing a baby into the
8 pediatrician's office, and the pediatrician
9 walked in the room and asked a few questions
10 and says sounds like your baby has an ear
11 infection and writes an antibiotic and sends
12 them out the door without picking up an
13 otoscope?

14 What tools does the doctor use? Again
15 we're talking about the first time the
16 patient encounters. We're not talking about
17 established patients. The first time that
18 patient walks into the office and sits down.
19 The physician has never met, seen, or heard
20 from the patient before. What would that
21 physician do to diagnose strep? What would
22 that physician do to deal with the so-called
23 common issues of UTI, strep, sinusitis?

24 THE CHAIR: I'd just ask that how do
25 you respond if--in the normal course of

1 folks in traditional telemedicine who are
2 using otoscope and diagnostic tests, if you
3 think you have tough regulations now, wait
4 until that press story hits.

5 THE CHAIR: What do you think
6 about--you're a pediatrician--I mean,
7 sinusitis, strep?

8 DR. HOOD: Without the otoscope you're
9 eliminating a large part of how you're
10 going to make that diagnosis. Then it's
11 going to be up to the individual provider I
12 guess in that setting. You know, what--at
13 this point you're looking at statistics and
14 odds.

15 If you had a kid that has cough and
16 congestion several days and now has, you
17 know, a fever and ear pain, chances are they
18 have otitis. But just statistics, chances
19 are it's going to be viral anyway, you know,
20 even a physician that is seeing the patient
21 in the office.

22 Now I know because I see them for
23 follow-up from the emergency room all the
24 time. You know, the doctor said my ear
25 was--child's ear was red, so they give an

1 evaluation for strep throat would be
2 getting a strep test. Tell me how the
3 standard of care applies a thousand miles
4 away.

5 MR. BILLINGS: It's very difficult.
6 When I give speeches I say (inaudible) for
7 two reasons thanking CDC medical providers.
8 They indicated how many adults--percentage
9 of adults that self diagnose themselves
10 with strep actually have strep. They said
11 it's ten percent. Very difficult to do.

12 From C-Tel's perspective we take a very
13 conservative position to the extent that
14 having--don't hold this against me--having
15 worked on Capitol Hill 28 years, I know how
16 the press operates. Right now stories are
17 very favorable and sexy about telemedicine.
18 Isn't it wonderful? However, should there
19 be something happen bad, God forbid, I could
20 almost guarantee the headline is not going
21 to be doctor didn't conform to standard of
22 care, Doctor didn't conduct appropriate
23 examination. The headline is going to be
24 telemedicine hurt me. And when that happens
25 you all are going to hear about it. I tell

1 antibiotic. I see them a day later, several
2 hours. It was probably red because they had
3 a fever. They didn't have true otitis.

4 My approach to ears would probably be
5 the same in practice. You know, supportive
6 treatment. You know, Tylenol, Motrin,
7 analgesics. If the symptoms are worsening,
8 need follow up with primary care in a couple
9 days, come back in several days and I'll
10 look at the ear again. It's really hard to
11 attempt to meet the standard without the
12 otoscope.

13 THE CHAIR: Is there ever a time where
14 you could make--you consider a telemedicine
15 encounter to be appropriate where it was
16 just facts on a questionnaires or e-mails
17 as the initial meeting?

18 MR. BILLINGS: Initial encounter?
19 Uh-uh.

20 MS. RUSSEK: Carol Russek. I'm one of
21 these patients who likes to self diagnose
22 before I go to a physician, but I wouldn't
23 hesitate to utilize telemedicine for a
24 minor ailment. My insurer probably--you
25 know, we have to register online. You can

1 go visit a doctor on--I have a huge
2 deductible plan anyhow. That's very
3 enticing to me. I really wouldn't hesitate
4 to try for a minor problem.

5 I would expect that the physician on
6 the other end, he or she would conform to
7 the standard of care and know whether or not
8 they could handle me through secure
9 videoconferencing where I felt secure and
10 very safe doing that. Safety is important.

11 THE CHAIR: Ms. Broadnax.

12 DR. DEPHILLIPS: I didn't know if you'd
13 let me speak again.

14 THE CHAIR: One more.

15 DR. DEPHILLIPS: Just a couple quick
16 comments. This dialect has been phenomenal
17 in quality. So my comments probably answer
18 a couple questions probably to explain
19 things a little bit for the group.

20 First comment is as you've found out
21 already telemedicine comes--it's like going
22 to Baskin Robbins for ice cream. There are
23 31 different flavors. I think the group
24 should be clear in the comments about what
25 type of telemedicine we're talking about

1 group who wants to see it. Rand Corporation
2 published a study on patients and
3 telemedicine, and there's a very well done
4 study by Harvard Medical School and research
5 about primary telemedicine that talks about
6 primary care--delivers back in the
7 hands--huge savings. It will knock your
8 socks off. There is also very good data on
9 patient safety in walk-in encounter
10 telemedicine programs.

11 Just last two quick comments. One of
12 the things that our company conducts is a
13 high level of academic review for--putting
14 together a series of clinical guidelines for
15 remote treatment of common, uncomplicated
16 medical problems. But all the doctors that
17 work with us have access to them as part of
18 QA program under board process. And they
19 really define standard of care the most
20 important part of those guidelines.

21 There's red flags component--you know,
22 if I see or hear or sense anything about the
23 encounter that makes me uncomfortable, all
24 of the docs in our world are able to refer
25 that patient to an in-person visit. This

1 exactly.

2 Doctor Rheuban is in charge of an
3 extraordinary program with the University of
4 Virginia. Specialty physicians can transmit
5 their superior expertise out in rural
6 hospitals in areas where that expertise is
7 just not found. So that's one flavor of
8 telemedicine.

9 Another flavor of telemedicine, the
10 type that our company does, which is just
11 provide remote access to PCPs for treatment
12 of common, uncomplicated medical problems
13 when you cannot get to your own PCP. That's
14 all we do. That's another different flavor
15 of telemedicine.

16 So I would encourage the group to keep
17 in mind all of the other versions of
18 telemedicine. Other than what we do seems
19 to be fine and work great. Our seems to get
20 scrutiny. That's okay.

21 Number two is there is--as mentioned to
22 you before the meeting, that there is a fair
23 amount of really third party data on primary
24 care telemedicine. There is another round
25 of information that will be provided to the

1 happens about four percent of the time.
2 There is no financial compensation. One way
3 or the other they get paid regardless. I
4 wasn't sure I'd go there, but I think will.

5 I'll get--how to diagnosis strep
6 remotely. Superficially you think rapid
7 strep test and culture. Good idea. I don't
8 disagree with that. If you review the
9 medical literature, there are very well done
10 studies. One study of--that indicates very
11 clearly that there are certain diagnostic
12 criteria for strep throat.

13 If you have zero with your diagnostic
14 criteria where the chance of having strep is
15 so low, it's a waste of time. I mean
16 sometimes a rapid strep or culture--if you
17 have all of these diagnostic criteria, it's
18 a waste of time to do strep test or culture
19 because the odds of having it are so high
20 you could just treat. It's really a subset
21 of patients that have only two or three
22 hallmarks or criteria where rapid strep and
23 culture is indicated. That's where a
24 patient would be referred to in-person
25 visit.

1 I used--but I just wanted to speak a
2 little bit about details about that
3 particular issue because I have been asked
4 it.

5 THE CHAIR: Ms. Broadnax, what are you
6 doing at VCU?

7 MS. BROADNAX: Thank you. Can everyone
8 hear me okay?

9 DR. DEPHILLIPS: I can.

10 MS. BROADNAX: That helps. At VCU we
11 have been doing telemedicine for 25 years.
12 So primarily clinical video telemedicine is
13 how we see our patients. I can tell you
14 prior to coming to VCU I worked at the VA
15 or Department of Veteran Affairs. We did a
16 lot of telemedicine, and I can tell you in
17 terms of telemedicine there it's a
18 distinction between telemedicine and, say,
19 telehealth.

20 Telehealth kind of incorporates
21 everything else that's electronic. It's a
22 way that you can interact with a patient.
23 But what's pretty widely accepted--three
24 forms of telemedicine. First one is remote
25 home monitoring which is--which is what

1 requires that the patient be present during
2 the encounter. It's supposed to mimic what
3 happens in a face-to-face encounter.

4 So I agree that telemedicine is not a
5 separate brand of medicine, but an extension
6 of practice for the physician.

7 So we also used e-consults at the VA.
8 The interesting thing about e-consults, you
9 couldn't bill for it because there was no
10 patient participation. You know, it's--a
11 doctor can set a consult, ask for
12 recommendations, but when you try to bill a
13 patient for a telemedicine visit it's
14 required that the patient is present and
15 they have some participation.

16 In terms of the telephone, we have
17 telephone triage services. I'm a nurse
18 myself. I can tell you there is
19 certification of telephone nurses out there,
20 telehealth certifications. So the issue
21 with--telephone triage is not considered
22 telemedicine, but you are allowed to
23 certainly interact with patients and to a
24 certain extent take care of some of their
25 needs, but it's not a traditional form of

1 Doctor Charles was talking about at Sentara.

2 In the VA they have done remote home
3 monitoring for well over ten years, a model
4 based on the patient being at home with a
5 monitor and they put in vital signs and they
6 are being monitored for chronic medical
7 conditions--diabetes, COPD. There is
8 usually a nurse coordinator who receives
9 that. There are--there are alarms that
10 pretty much tell you what the patient is
11 doing at home. It's very a effective way
12 and cost effective to treat patients and
13 keep them out of the emergency room and keep
14 them at home.

15 The bill is not quite the same as your
16 face-to-face. I can't bill where
17 that--remote home monitoring, it does work.
18 We're actually looking at starting a remote
19 home monitoring program at VCU, particularly
20 CHT.

21 Another type that's pretty much--high
22 resolution image that's forwarded to the
23 specialist for diagnosis later. Diabetic
24 retinopathy, dermatology. Those all work
25 really well. But with clinical video it

1 telemedicine.

2 So I guess my biggest concern is with
3 the type of technologies that are being used
4 out there, because there's a lot of
5 technologies. It's the security that's
6 involved with the technologies. Obviously
7 we don't allow our patients to use Face
8 Time. We don't allow them to use Skype
9 because those aren't secure.

10 We have to think about HIPAA
11 compliance. So all of the patient
12 encounters done are HIPAA compliant. So I
13 do have concerns about websites where people
14 can click on a link because I don't know if
15 those encounters are encrypted or they have
16 security that meets the HIPAA requirements.
17 So those are just some observations that I
18 wanted to address.

19 THE CHAIR: Yes.

20 DR. DUNNAVANT: Doctor DePhillips, what
21 kind of information do you get from primary
22 care doctors for patients that connect with
23 you on the phone?

24 DR. DEPHILLIPS: So there is a medical
25 record that has to be established before

1 the encounter can happen on our platform.
 2 If for example we get--many of--we get
 3 health information through the patient's
 4 health plan based on information that's
 5 provided in the medical history. The
 6 patient is compelled to fill out a personal
 7 health record prior to the first consult,
 8 no different than what happens when you go
 9 see your physician.

10 DR. DUNNAVANT: So you may or may not
 11 have information from the primary care?

12 DR. DEPHILLIPS: That's correct. We do
 13 get--we do--we send a copy back. That
 14 requires their permission to do. But a
 15 good amount of time we get permission and
 16 we'll send it back so the patient's own
 17 physician's record is complete.

18 DR. DUNNAVANT: So what percent of the
 19 time would you correspond--getting through
 20 all those thresholds that you had to get
 21 through, their permission and you obtaining
 22 the record, how often do you have a record
 23 on the patient?

24 DR. DEPHILLIPS: You're talking pre
 25 patient or out?

1 DR. REMLEY: I'm going to give my
 2 multiple hats. First as payor, we have
 3 been paying for telemedicine for store and
 4 forward a very long time. If you can think
 5 of radiology. About the time that I quit
 6 putting up plastic films, looking at it on
 7 the box, and noticed how the radiologists
 8 weren't coming in at night anymore to do it
 9 unless they had to do a procedure. They're
 10 home doing it there. We have been paying
 11 for that a long time. There really wasn't
 12 much discussion with if you pay store and
 13 forward. That just sort of happened
 14 seamlessly.

15 Then they moved toward electronic ICU.
 16 We paid for that. Anthem happens to cover
 17 the prison population in the state. And
 18 there is a lot of telemedicine that happens
 19 with VCU with those individuals.

20 And then when I was Commissioner--put
 21 on another hat--of Public Health, I--to
 22 mandate the commission when Ms. Rheuban came
 23 and argued mandated coverage for
 24 telemedicine benefits for health insurance.

25 So we look at telemedicine as what's in

1 DR. DUNNAVANT: Pre--

2 DR. DEPHILLIPS: It's going up.
 3 Percentage wise it probably is still under
 4 half. It's not majority--

5 DR. DUNNAVANT: Outgoing.

6 DR. DEPHILLIPS: Outgoing. Fifty
 7 percent of patients indicate they don't
 8 have a PCP. Which the patients who do
 9 indicate they have a PCP, probably half
 10 will give us permission to send it. We are
 11 trying to make user interface a whole lot
 12 easier for the default physician for a
 13 patient to give us permission to send it.
 14 We just want to make sure that we don't
 15 betray legal requirements to get that
 16 permission to send. We are in favor. We
 17 want to encourage patients to give
 18 permission.

19 DR. DUNNAVANT: So half of your
 20 patients do not have a PCP?

21 DR. DEPHILLIPS: That's
 22 the--information back in the health plan to
 23 take a look at patients that's a
 24 percentage.

25 THE CHAIR: You want to make--

1 the law. We see it as a tool. As Kathy
 2 said, we are always encouraged when people
 3 are thoughtful and as a provider that they
 4 do the appropriate thing at the right time
 5 in the most efficient way.

6 I can speak now as a provider of
 7 telemedicine services. Anthem is out of the
 8 parent company. I had the opportunity
 9 yesterday to talk to the chief medical
 10 officer who described virtual practice and
 11 that model, what they're doing with Live
 12 Health online. They're credentialed, have a
 13 committee, quality committee. They have a
 14 number of protocols, clinical guidelines.

15 We talked for quite a while because as
 16 a fellow pediatrician--but for example
 17 there's something called an audit. When do
 18 you give a patient an x-ray on their ankle
 19 and when you don't? You carefully--he says,
 20 you know what we try to do is have a patient
 21 help us with the physical exam if they can.
 22 We ask and if we can say full in confidence
 23 they don't need an x-ray, then they'll
 24 mostly like have a strain and don't need it.
 25 If we can't do it, then we send them out. A

1 nurse practitioner audits at least five
2 percent of the chart. They have a secret
3 shopper program where they go around and
4 have people go and be visitors as he
5 described it.

6 We're learning as we work through this
7 process what are diagnoses that make sense
8 and what are diagnoses that don't. There
9 are different times during an encounter
10 where you can as a physician can say just by
11 reading this history that's been written
12 down, I really don't think this is
13 appropriate for a telemedicine visit. So
14 they don't--you just kind of stop before you
15 ever walk in the door. You can after you've
16 taken a history say I really don't think
17 this is appropriate for me. We need to stop
18 now. I'm not going to help you and have
19 them end the visit.

20 Anecdotally, what he explained is they
21 had a woman who had surgery on her knee.
22 Six days earlier she was home. She called
23 in thinking she had bronchitis. They said,
24 you know, we think you're having pulmonary
25 embolus, not bronchitis, from what you

1 doctor from Rhode Island was essentially
2 diagnosing the worst hour of his life, tells
3 him he had a stroke, asks him to move his
4 leg and do things. He was doing it. He
5 didn't have an in-person relationship. He
6 had person-to-person. But again that's a
7 physician with his own license was trying to
8 decide what to do.

9 Then just because I--today I think we
10 all need to also think about making sure we
11 think widely because of things like H1N1.
12 If we had had more telemedicine, we may have
13 been able to take care of more children
14 outside of the ER so they wouldn't fill up
15 our ERs. I hope--I think, you know, Tom
16 Frieden hopes that ebola will stay in one
17 patient in Texas. But if I were a doctor
18 that had the opportunity and could triage
19 those patients through the telephone instead
20 and keep isolated in their home.

21 There are a lot of different things we
22 can think about how to use. As Kathy said,
23 this is a tool because it's technology. It
24 doesn't replace the rigor that we have
25 around our license and our responsibilities.

1 described. It was him--he said I could look
2 at it. She said I'm a little short of
3 breath, but it was obvious she was very
4 short of breath. He said, you know, we stop
5 this visit. You need to go to the emergency
6 department and be evaluated. But it's
7 very--it's relatively policy driven, so slow
8 process.

9 In my public health hat, I can't tell
10 you what a difference it has meant as far
11 as the southwest. I think it's really
12 important what you think that
13 person-to-person means. There can be a
14 nurse, public health nurse, who may be
15 seeing a child with cerebral palsy and
16 seizures who's connecting with a child
17 neurologist at UVA who can fundamentally
18 manage those medications. That neurologist
19 may never have actual physical contact in
20 the room with that child there. We've been
21 doing this seems like ten years where we
22 don't have enough neurologists in our state.

23 We have been doing teleneurology for
24 stroke, which I had a friend--three weeks
25 and said, you know, the robot came in. This

1 THE CHAIR: What do you see in the
2 spectrum of technology? I keep coming back
3 to this. You know, live videoconferencing.
4 That's great. That's pretty much you and
5 me talking right here. As you go down the
6 scale of store and forward, audio-only,
7 just filling out surveys, where do you see
8 the line being drawn? Is it disease
9 specific? Is it--

10 DR. REMLEY: It's an interesting
11 question. I'm going to put on my prudent
12 Virginia doctor hat because that
13 question--I think it really becomes as a
14 prudent Virginia doctor.

15 When I was in the ER and the
16 radiologist was no longer there for me to go
17 talk to, at first I was really put off.
18 Wait you need to show me right on the x-ray,
19 you know, where you found this interesting
20 ligament fracture. But then when I realized
21 I could call him on the phone and we could
22 look at it together on the computer, I was
23 fine with that as a prudent Virginia doctor.
24 As a prudent Virginia doctor I am
25 comfortable with it. It took me a while to

1 get there to be honest.

2 But the idea that a teleneurologist who
3 makes the diagnosis of stroke in an ER gets
4 somebody life saving TPA quickly--part of
5 the reason is there aren't a lot of
6 neurologists running around looking for a
7 job.

8 So some of this is access, but I'm also
9 becoming much more comfortable looking and
10 hearing from people like Teladoc, like Live
11 Health Online, how they're staying within
12 the confines of what their practice should
13 be and what they have to say they should be
14 and defining where those roles should be for
15 all of us as a prudent Virginia doctors.

16 I have a unrestricted license. I could
17 do crazy things as a pediatric doctor that
18 would make no sense, but I know that I need
19 to police myself and the Board of Medicine
20 will police me to do that.

21 So I see--that's where areas I think
22 video is good. I think phone--you know, I
23 stood up in front of the General Assembly
24 four or five years. We tried to say that
25 you could prescribe medicine during the

1 minutes. We have talked about telemedicine
2 and technologies. So are there any
3 questions regarding those two topics from
4 anybody in front? Doctor Brown, question?

5 We'll go ahead and take a ten minute
6 break. We'll meet back at 11:35 and then
7 we'll talk about physician relationship,
8 documentation, and history.

9 (A break was taken.)

10 THE CHAIR: I'd like to try to address
11 the next three topics as a group. I think
12 they're really critical to the Board's
13 understanding of when--what the
14 expectations of the physician and what the
15 expectations of patients are. Really when
16 is the patient/physician relationship
17 established?

18 The physical and history requirements,
19 we touched a little bit on that. I think
20 it's probably disease dependent, technology
21 dependent. The requirements for
22 documentation--and I also wrote in here that
23 whether you think informed consent
24 specifically for telemedicine is required or
25 is necessary. Maybe we'll go backwards.

1 meningococcal meningitis outbreak without
2 established patient/physician relationship,
3 to give the local health director that
4 authority because it was this time limited
5 period. The local health director has all
6 of the information from the epidemiologist
7 and nurses. Our General Assembly said no.

8 I hope that doesn't mean that children
9 will die, some died because they weren't
10 able to get ahold of their doctor and have
11 the doctor talk to the health department and
12 find out what was needed or go to the health
13 department and nurse calls the local health
14 department.

15 What I worry about, the prudent
16 Virginia doctor, is that we make sure our
17 discussions are with us as much as they can
18 be because when they move--when they move
19 and the General Assembly starts to practice
20 medicine--they haven't spent the years doing
21 what we all do. So I hope--that was kind of
22 rambling, but prudent Virginia doctor is
23 where I go.

24 THE CHAIR: I guess for--I think we're
25 going to take a break for about ten

1 Start over here.

2 DR. REMLEY: Well, informed consent in
3 terms of--there is always informed consent
4 when you're with your physician verbally
5 or--you know, we all get it signed before
6 they come in.

7 THE CHAIR: Is there something that's
8 above and beyond, unique, required for the
9 telemedicine aspect of it? Do you
10 think--do get an informed consent for
11 physician/patient relationship that's--you
12 know, it's evaluation and treatment. Is
13 there anything above and beyond that you
14 think is required when it's a different
15 medium?

16 DR. REMLEY: I'm not going to speak as
17 a payor, but as a prudent Virginian
18 physician I'd want to say upfront to that
19 person who--if it's a kid with a cold, you
20 know, I cannot look in your child's ear.
21 So here's the things that I can't do for
22 you. So it's an informed consent that I'm
23 telling you upfront what I can do and what
24 I can't do, which is--again as an ear
25 doctor, sometimes obviously--you know, I

1 don't know your whole history so I'm going
2 to try and get as much as I can. This is
3 what we can do tonight.

4 So it's an informed conversation
5 consent that that patient understands the
6 inherent limitations of a two-way video
7 conference versus an in-person, if that
8 makes sense.

9 THE CHAIR: Yeah. That's--and then I
10 think we established the requirements for
11 documentation are essentially the same as
12 it would be a face-to-face encounter.
13 There's no difference.

14 I guess one of the things that occurred
15 to me is if you have that video technology,
16 should realtime visual video be part of the
17 medical record? Should that actual
18 encounter be part of the medical record?

19 DR. REMLEY: That sounds more like the
20 police now.

21 THE CHAIR: It's--it's available. Why
22 not put it in the medical records?

23 DR. REMLEY: But then people would say,
24 well, should I do--if I'm a pediatrician
25 and I send a child to Doctor Rheuban for

1 follow-up. Or this kid is absolutely fine
2 and I know that a copy of the record will go
3 in the mail to them, and they'll get it a
4 week later, and they'll know that they were
5 here for whatever rash.

6 And so I, as a busy ER doctor, every
7 night kind of triaged. Do I call--you
8 couldn't call for every--every patient you
9 saw in the ER on a shift you couldn't call
10 the primary care doctor. They would not be
11 happy if you did call for everyone. But you
12 had to make that decision and you had to
13 make sure that loop finished up in some way.

14 THE CHAIR: Where do you see the
15 requirements for follow-up if your
16 relationship is purely virtual?

17 DR. REMLEY: That's interesting. I'm
18 going to speak now--this is again I'm still
19 being that prudent Virginian physician. If
20 I saw--and I don't do telemedicine. But if
21 I saw somebody with a disease process that
22 I thought needed to have careful
23 re-evaluation in 12 hours, I would feel
24 obligated to tell that individual that and
25 so to say I would like your permission to

1 evaluation of a heart murmur, should I get
2 that realtime video instead of--I guess you
3 could say is that--is that an appropriate--

4 THE CHAIR: I'm just asking. I don't
5 have an opinion on--

6 DR. REMLEY: It's very interesting, you
7 know, because that could replace electronic
8 health records some day. Well, I'll just
9 watch. But it could be hard to--it could
10 be very time intensive.

11 I think that informed consent--and all
12 of us as clinicians use the informed
13 limitations of what it is I know and what it
14 is I don't know.

15 I would also say, because I know
16 there's been a lot of talk, as a pediatric
17 ER doctor for 25 years, one of my big goals
18 was to always say, Who's your doctor? Where
19 do you go for care? How can I get this
20 information back to them?

21 And I inherently triage a really sick
22 kid. I want to call this doctor tonight
23 because I'm going to send them home, but I
24 need to make sure somebody makes sure that
25 the first thing tomorrow morning they get a

1 call your physician to share with them what
2 I did tonight or today or whatever it was
3 so that they will know when they see you
4 tomorrow. And again that's within my
5 license of scope of practice that I do a
6 good effective hand-off if I think this is
7 a patient that needs that additional care.

8 THE CHAIR: And then to come back to
9 the first part when you were talking about
10 establishing a bona fide patient/physician
11 relationship. It's easy when you're
12 talking to somebody. In the sort of store
13 and forward world, where does that start?

14 DR. REMLEY: And that's fascinating
15 because--I should go back. What I talked
16 about just a minute ago, I'm not sure that
17 people in telemedicine see those kinds--if
18 they see those kinds of patients, they may
19 be saying you need more than I can give you
20 right now. You should go to an urgent care
21 center or to an ER because I can't do the
22 12-hour follow-up. I don't know how that
23 works.

24 The store and forward, it's hard. I
25 would bet that everybody here--we call them

1 in the payor world blind providers. How
 2 many of us have a patient/physician
 3 relationship with the radiologist who read
 4 their CAT scan? Very few people actually
 5 even meet their anesthesiologist anymore
 6 before they have surgery. Very frequently,
 7 you know, the cardiologist who reads the EKG
 8 is in the hospital.

9 So there's--I don't know where that
 10 line is. And I think the person who's
 11 smarter about this would probably be Karen.
 12 But that's the hard part for all of us. I
 13 don't know how you draw a line in the sand
 14 and decide how that changes.

15 THE CHAIR: Doctor Rheuban.

16 DR. RHEUBAN: It's always a pleasure to
 17 sit next to Doctor Remley because she's
 18 right on target right here. And, you know,
 19 I think the doctor/patient relationship is
 20 established once you agree to evaluate a
 21 patient via any format. And I would say it
 22 does occur in the store and forward world
 23 as well.

24 I dare say that my colleague who
 25 screens patients for diabetic retinopathy,

1 credentials of that individual would be so
 2 they're insured the comfort of knowing that
 3 the person they are seeing is the person
 4 they are hoping to see and they're
 5 appropriately credentialed to do it.

6 THE CHAIR: Is there a choice in
 7 telemedicine?

8 DR. RHEUBAN: There should be. That's
 9 one of the values of it. I won't speak to
 10 some of the live health online models
 11 because I believe there is choice there in
 12 doing that. You know, we have on call
 13 services for our telemedicine programs so
 14 you get the person who is on call, but you
 15 have a choice whether want to participate
 16 in telemedicine with that service.

17 I would also like to make sure we
 18 emphasize the distinction between in-person
 19 and face-to-face because in-person implies
 20 in the office or in the emergency, in the
 21 facility, and face-to-face is live
 22 interactive video-based.

23 THE CHAIR: Ms. Broadnax, you want to
 24 take a shot at it?

25 MS. BROADNAX: Yeah. I was going to

1 an ophthalmologist who's looking at store
 2 and forward images that are transferred to
 3 him and who arranges follow-up for those
 4 patients, has established that
 5 doctor/patient relationship when that
 6 imagine of that patient is sent to him for
 7 evaluation and he makes a determination
 8 about what happens next.

9 I fully support informed consent. And
 10 I do believe that telemedicine informed
 11 consent is a little bit different than
 12 face-to-face in-person care, and that is
 13 because of the very same issues that Doctor
 14 Remley addressed. That there are limits to
 15 what can be done and the patient needs to be
 16 advised as such.

17 I also believe that there needs to be
 18 an emergency process that is developed at
 19 the time of the initial encounter so
 20 patients are made aware of where they should
 21 go if that provider feels they cannot
 22 provide that service or if it was an
 23 emergency. And transparency is very
 24 important as well, that it's made clear to
 25 them who they are seeing, what the

1 say the patient should always have the
 2 right or have informed consent because they
 3 have the right to refuse. We do a lot of
 4 correctional telemedicine, and even our
 5 inmates can refuse a visit if they want.

6 But I know you don't want to set up a
 7 situation where a patient walks in and
 8 thinks that he's going to see a provider and
 9 then after the encounter he'll say, well, I
 10 never consented to this, I didn't realize I
 11 wasn't going to see a doctor in person, this
 12 kind of thing. So upfront it's always a
 13 good idea to get that informed consent.

14 I will tell you we don't record any of
 15 these sessions. We tell our patients that
 16 upfront. If you want to record the
 17 information, you have to have that consent
 18 from the patient. We also have to meet
 19 certain requirements in terms of where you
 20 store those encounters and we give them that
 21 assurance that they aren't being recorded
 22 and their encounter won't end up on the
 23 Internet when we do these telemedicine. So
 24 we tell them that as well.

25 I also forgot to mention that there is

1 no reimbursement from home now. So I know a
2 lot of people want to pay directly from
3 home. But the way CMS reimburses for these
4 types of encounters the patient has to be in
5 a medical facility or in a place where they
6 can get some sort of attention if there is
7 an emergency.

8 I can tell you at the VA they are doing
9 visits at home, but they are very careful to
10 make sure that they have the emergency
11 contact information from the veteran prior
12 to connecting into the home so that if they
13 witness some sort of event with the veteran,
14 they can call 911 or they can call the
15 responsible person to go and respond to that
16 patient when they are in the home so--

17 THE CHAIR: Is the veteran's access
18 secure?

19 MS. BROADNAX: Absolutely. Yeah.
20 It's--it's pretty airtight if you're going
21 to a veteran's home.

22 THE CHAIR: Doctor DePhillips.

23 DR. DEPHILLIPS: On the subject of
24 informed consent--

25 THE CHAIR: Yes. There are three

1 the platforms. If you don't record it, it
2 would be direct with the patient. So it
3 speeds up the response time. Our response
4 time actually as we scale has come down and
5 so that's less of an issue and so we're
6 revisiting the recording issue. But at the
7 moment we don't.

8 As far as the documentation, our
9 requirement of our physicians is that a
10 comprehensive physician note be established
11 in the system. That case has to be written
12 and closed out before (A) the physician gets
13 paid and (B) before the physician can accept
14 another consult.

15 So we have no problem with overdue
16 medical records in our world. And a
17 comprehensive note in SOAP format is what we
18 require, which appears to be the same as the
19 standard of care in a bricks and mortar
20 practice. That's where we are today.

21 On the subject of informed consent
22 we--I would have to say our company is
23 probably neutral. If it's required, in the
24 virtual world it's not hard to get. You add
25 into the terms of service that the patient

1 things on--the next three things on the
2 agenda which talk about how we establish
3 bona fide patient relationship, informed
4 consent, the history and physical and how
5 you document, or what do you think the
6 documentation requirement should be.

7 DR. DEPHILLIPS: Sure. I would agree
8 with Doctor Rheuban that the
9 physician/patient relationship is
10 established when the patient elects to be
11 treated by a physician and when the
12 physician agrees to treat a patient
13 regardless of the medium used. So similar
14 to bricks and mortar I guess.

15 What were the other two?

16 THE CHAIR: The history and physical
17 requirements of how you document.

18 DR. DEPHILLIPS: We--you know, it's
19 funny. I'm happy about being transparent
20 about this. We actually don't record
21 consultation at the moment. That was a
22 conscious business decision a while back,
23 mostly to facilitate how quickly the
24 patient and physician get together.

25 If you record it, it has to go through

1 has to read before accepting to use the
2 technology or whatever.

3 On the other side of the coin our--I
4 think our overall contention is that it's
5 really the standard of care that should be
6 spoken to, not the means to get there, if
7 you will. So to the extent that informed
8 consent is required in a bricks and mortar
9 practice, we would argue that that's the
10 exact same extent to which informed consent
11 should be required for a telemedicine
12 consult.

13 THE CHAIR: More appropriate in the
14 Teladoc world, what do you do with
15 follow-up?

16 DR. DEPHILLIPS: Sure. So there's two
17 major things that we do with follow-up.
18 Number one is at the end of every
19 consultation it's always follow up with
20 your family physician in 24 or 48 hours.
21 The same kind of instruction you get when
22 you leave an emergency room or leave urgent
23 care. That's number one.

24 Number two is, as I mentioned before,
25 we try to get permission a hundred percent

1 of the time, but we always try to when we
2 can to get a copy of the record of the
3 meeting back out to the doctor using a
4 secure means to transmit that.

5 And then, number three, we actually
6 have a 72-hour period where there's online
7 connectivity with the patient and the doc at
8 no additional charge. The patients are
9 welcome to recontact us if there's an
10 ongoing issue and the doctor is always also
11 in our world welcome to recontact the
12 patient. You know, is the fever down? It's
13 been 24 hours or whatever. So it's two-way
14 communication that goes for three days after
15 the consult.

16 DR. HENOCHOWICZ: You know, I
17 actually--this is with regards to
18 circumstances that have occurred over my
19 practice over the last, you know, many
20 years. You know, we participate in health
21 plans. And there have been times when, for
22 example, the HMOs--on a weekend after hours
23 we get a call from a patient saying that,
24 you know, you're my primary care physician.
25 I've never been to the office before, but I

1 practicing physicians is that a
2 doctor/patient relationship has not been
3 established just because I'm on a list, you
4 know, and--

5 THE CHAIR: Has that changed if you're
6 part of a coverage group for you or a
7 practice group--

8 DR. HENOCHOWICZ: Right. But then I'm
9 covering for someone who has a
10 doctor/patient relationship. And if
11 there's ever is a question--and it's
12 certainly in my context, in practice
13 context, I can always call that physician
14 and ask them, you know, whether this is
15 appropriate or not. But certainly no phone
16 contact with a stranger, complete stranger,
17 who calls me and says I'm on your--I'm on
18 your health--you're on my list here. You
19 know, they're not my patient.

20 THE CHAIR: I know what we would do in
21 our practice. We don't have the technology
22 to be able to do--they don't have the
23 ability to--

24 DR. HENOCHOWICZ: So if you could see
25 them in person would that matter? If you

1 have such-and-such problem or I need
2 such-and-such prescription.

3 And it's been the standard--I mean, I
4 haven't even discussed this, but it's been
5 the standard among all physicians to say I'm
6 sorry. I haven't seen you before. You have
7 to establish a relationship before I can
8 prescribe this medication or before I can
9 discuss your problem. This is--that's
10 something that's been understood I think by
11 everyone who has handled patients like
12 these.

13 Over time has that changed now? Is
14 that appropriate now to have a stranger call
15 me on a Sunday morning and say I'm
16 such-and-such. Even if I had all the
17 facilities in front of me to--since we're
18 talking about the fact that technology
19 doesn't matter. I'll say the technology was
20 available and I got to see the patient
21 in--you know, face-to-face.

22 So is that now appropriate to do? Not
23 for me, but I mean I'm just asking. Is it
24 another circumstance that--you know, my
25 feeling was and I think the feeling of most

1 could see them on videoconferencing?

2 THE CHAIR: -- answer to that.

3 DR. HENOCHOWICZ: Yeah. I mean, I
4 think that's another context of looking at
5 it. I'm just raising that point just for
6 practicing physicians. The comfort level,
7 you know. That's all.

8 THE CHAIR: Mr. Russek, any comment?
9 We'll go around that way.

10 MS. RUSSEK: Yes. The issue of
11 recording the videoconference is
12 interesting to me because I think I--that
13 would have to be part of the informed
14 consent I believe. I believe as a patient
15 that might violate my expectation of
16 privacy. I would probably not agree to it.
17 So I don't think it's something that should
18 be required by law or statute.

19 THE CHAIR: Mr. Billings?

20 MR. BILLINGS: Nothing.

21 THE CHAIR: Dr. Choudhary, anything?

22 DR. CHOUDHARY: I just wanted to
23 comment on informed consent. The American
24 Telemedicine Association has been looking
25 at telemedicine for decades now and

1 strongly recommended to physicians that a
2 separate telemedicine informed consent
3 performed to explain the limitations of
4 technology and what the procedures would be
5 for safety. But also in this if the
6 technology fails, for example, what's the
7 back up?

8 So explaining all of these things and
9 letting the patient know their rights and
10 the fact that this is an elective situation
11 where they can choose not to go through the
12 telemedicine venue. That's going to be
13 important.

14 As far as when a patient/physician
15 relationship is formed, from my perspective
16 I would say looking at telemedicine as a
17 tool, there should be face-to-face and live.
18 It should be--psychiatry should be pretty
19 much the same thing. So the same way you
20 make the doctor/patient relationship
21 face-to-face is how it should be live. It's
22 just done via telemedicine. It's just a
23 matter of using that telemedicine as a tool.

24 THE CHAIR: Any questions from the
25 board?

1 in fact a true effort to streamline the
2 process and take out a lot of the burden of
3 the--that's in there now. So with that we
4 would be supportive.

5 THE CHAIR: The second was the
6 requirement--some states require somewhere
7 along the line the relationship being
8 face-to-face contact.

9 MR. BILLINGS: A good number of the
10 states have that statutory language. Then
11 the question comes down to the folks like
12 you. Is the statutory language that says
13 face-to-face--does that mean in the office
14 face-to-face or can that mean through
15 telemedicine? I would argue probably when
16 it was phrased--I told one of the board
17 members when the phrase face-to-face was
18 put in the statute, I don't think they
19 meant sitting in--but certainly the
20 question is now is how is it being
21 interpreted. I think I'd go back to what I
22 said earlier and that is the examination
23 should be permitted through telemedicine
24 provided it's structured.

25 There's also another aspect of it and

1 Why don't we move down to the next
2 couple of things. I'm particularly
3 interested actually, Mr. Billings, what your
4 thoughts are on licensing requirements and
5 requirements of face-to-face contact with
6 respect to telemedicine. So, I mean,
7 licensing requirements within--where does
8 the physician need to be licensed to be able
9 to take care of those patients,
10 understanding that right now there is no
11 compact with respect to across state lines
12 in the practice of medicine.

13 MR. BILLINGS: Well, I think in the
14 telemedicine community there's a lot of
15 debate that goes on about where the legal
16 requirements for point of service shall be,
17 where the physician is located versus where
18 the patient is located, which is obviously
19 the way the law reads now.

20 At C-Tel we've spent a few board
21 meetings talking about that, but never
22 really gotten a formal position or have a
23 formal position on that. We have
24 communicated with the Federation that we
25 support a compact, provided the compact is

1 that is at what point does a physician--an
2 unlicensed physician, normally out-of-state,
3 in what circumstances can they provide
4 telemedicine services in the state without
5 being licensed? And obviously as you can
6 could probably imagine every state has a
7 different auspice on how they view that.

8 Generally the state in the consultation
9 area, as long as the physician with the
10 patient retains the ultimate care and orders
11 for the patient, the out-of-state physician
12 can provide consultative services to that
13 in-state patient without having to be
14 licensed internally.

15 And some states say that can done
16 occasionally. Some states say they're to be
17 done frequently. Some states define
18 occasionally and frequently. But generally
19 the out-of-state physician can provide those
20 consultative services provided the in-state
21 physician provides care of the patient.

22 THE CHAIR: What's your thoughts of a
23 special telemedicine license, like a
24 certificate to be able to do--some guy is
25 in Wisconsin, wants to be a neurologist to

1 take care of people in southwest Virginia.
2 Doesn't have a Virginia license, but we
3 offer them a telemedicine certificate with
4 different criteria for that certification.

5 MR. BILLINGS: Again I don't know that
6 our board has ever taken a formal position
7 on that that I'm aware of. We have at
8 least one board member in the group, so she
9 can speak up. You know, I think ultimately
10 our goal and objective is to reflect the
11 Federation's language, which is if we're
12 going to have that state licensing,
13 streamline the process.

14 I talked to one entity--I'll give you
15 an example. I talked to one entity that is
16 a licensed physician in a particular state.
17 The physician was a veterinarian for a
18 number of years before he went back to
19 medical school to get his medical degree.
20 And when he applied for his licensing
21 out-of-state, they asked for all the
22 documentation for his veterinarian services
23 just as if he had been a doctor.

24 Now maybe there's a logical reason for
25 it. I'm not going to second guess anybody.

1 psychiatric care, that that program has to
2 be compliant with state law as well.

3 So there are only a limited number of
4 states that have recognized telemedicine in
5 the nation. And so I have tried to get
6 clarification from the DEA. Does that mean
7 the other states are not complying with
8 federal law because they're not complying
9 with state law? Something to keep in mind
10 as the board is thinking about telehealth as
11 to controlled substances. That is really
12 unclear at this point. And I'm talking
13 about the program like doctors here.

14 THE CHAIR: Ms. Bowles, did you want to
15 say something?

16 MS. BOWLES: No.

17 DR. REMLEY: I was going to say as a
18 payor in order to be paid you have to be
19 credentially licensed in the state in which
20 the member is. So that would be a barrier.

21 And then in my old public health hat,
22 the honor of being able to be a physician in
23 the state provides we use certain
24 responsibilities, whether it be reporting of
25 reportable diseases or participation in

1 But streamlining that kind of nonsense is
2 what our objective would be.

3 THE CHAIR: Doctor Choudhary, do you
4 see people outside of the state of
5 Virginia, the Commonwealth?

6 DR. CHOUDHARY: Yes, I do. I've got
7 nine different licenses. One of those
8 licenses is specifically a telemedicine
9 license. Louisiana offers that. It isn't
10 certification. It's actually a license.
11 But I believe that it is a less cumbersome
12 process than going to get a full license.

13 MR. BILLINGS: Mr. Chairman, could I
14 say something?

15 THE CHAIR: Yeah.

16 MR. BILLINGS: Because we have been
17 doing a little bit of work with prescribing
18 controlled substances. And we're looking
19 to the Rienhite (spelled phonetically) Act
20 and the federal statute, the DEA, and so
21 far they have not been helpful in answering
22 questions. But my reading of the statute
23 basically says in order to engage in
24 telemedicine prescribing through--a
25 controlled substance to someone under

1 prescription monitoring program or
2 continuing education requirements. Which
3 again I think it would be--if we are going
4 to go down that path, that careful process
5 of what do you want every physician who's
6 going to see patients in the state to do to
7 make sure that patient has the best
8 experience?

9 I don't know the answers to any of
10 those questions. But there's a lot more
11 that goes to having a license than just a
12 piece of paper that says you're licensed, as
13 you all know better than anybody.

14 THE CHAIR: As a payor what--is there
15 an expectation for somewhere along that
16 physician/patient relationship to have
17 physical contact?

18 DR. REMLEY: That was changed with
19 the--the law. Senator Wampler's bill said
20 that--I don't have the language that's in
21 there. I think Karen probably has it
22 memorized. And I think what's hard for me
23 when I hear people talk about
24 patient/physician relationships.

25 There is the legalistic definition of

1 what a--when does the responsibility start,
2 which we as physicians always think about.
3 But it's also what do I consider as a
4 physician a good relationship with my
5 patient? They're kind of two different
6 things and we keep kind of crossing over.

7 THE CHAIR: Well, I mean there are some
8 states that require that and we're trying
9 to--the Commonwealth is trying to sort out
10 whether it's something we want.

11 DR. REMLEY: Legally want it. Right.

12 THE CHAIR: And I'm not sure if there's
13 benefit to it. I'm just trying to
14 understand what your general thoughts were.

15 DR. REMLEY: What is the--in the code?

16 THE CHAIR: Go ahead.

17 DR. RHEUBAN: So as used in this
18 section telemedicine services as it
19 pertains to the delivery of health care
20 services, means the use of interactive
21 audio, video, or other electronic media
22 used for the purpose of diagnosis,
23 consultation, or treatment. Telemedicine
24 services do not include an audio-only
25 telephone, electronic mail message, or

1 would want potentially the same licensing
2 standard to be in place.

3 DR. CONKLIN: I guess the point I would
4 have regarding another licensure would be
5 as an anesthesiologist would I be able to
6 practice telemedicine as an internist? I
7 mean, we do a lot of internal medicine as
8 anesthesiologists. We have of all the
9 different diseases before we take a patient
10 to the operating room.

11 And if I don't--is there not going to
12 be any protection if the orthopedic surgeon
13 wants to moonlight as a telemedicine doctor
14 or a urologist wants to moonlight as a
15 telemedicine doctor? If we don't have some
16 sort of oversight, I feel like we would be
17 opening up the board to getting a lot more
18 people before us that, you know, perhaps
19 shouldn't have been practicing telemedicine,
20 but they were doing it to help pay off their
21 student loan debt.

22 THE CHAIR: Doctor Hood, what do you
23 think about the requirements requiring
24 patient to physician contact as part
25 of--somewhere in that relationship?

1 facsimile transmission. An insurer,
2 corporation, or health maintenance
3 organization shall not exclude a service
4 for coverage solely because the service is
5 provided through telemedicine services.

6 THE CHAIR: Ms. Juran.

7 MS. JURAN: I just wanted to offer an
8 opinion and comment with respect to the
9 idea of a license. The argument is that
10 this physician is offering the same level
11 of standard of care as in an office. I'm
12 not quite sure why we would give them a
13 different license than a full-fledged
14 medical license in that state. It seems to
15 be a substandard licensing ability which
16 might put the patients in that state
17 unusually at risk. It would seem to set up
18 a two-tier licensing process.

19 I'm sure it would be less cumbersome
20 for the actual physician who is trying to
21 practice in that state. I can understand a
22 reasonable attempt to try to lessen that
23 burden, but if the argument again is the
24 same standard of care whether in office or
25 through telemedicine, it would seem that we

1 DR. HOOD: As far as informed consent?

2 THE CHAIR: No. Just if you are
3 treating a person through telemedicine.
4 You've seen them six times. Should you be
5 required one out of every six times to see
6 that patient in person, not through a video
7 link, but actually see them? And the only
8 reason--there are states that require it.
9 We're just trying to figure out where we
10 need to be.

11 DR. HOOD: Yeah. I know one state, for
12 example, I think you have see them the
13 first visit and then the fourth visit. And
14 it varies. But, I mean, I think again it
15 goes back to the disease, if it's for a
16 chronic illness, if it's for hypertension
17 or something where you want to have vital
18 signs that are accurate and, you know, it's
19 being taken right way.

20 If it's for something just like sinus
21 infection or cold, they just want advice on
22 something that's not, you know, a chronic
23 problem, then I don't think necessarily you
24 have to see them every however many visits.
25 But if it's for a chronic condition, I would

1 think you'd want to follow them up and have
2 an in-patient exam, you know, physical exam,
3 vital signs, everything complete.

4 MR. BILLINGS: May I ask what is the
5 commonly accepted practice outside of
6 telemedicine?

7 THE CHAIR: Are you--

8 MR. BILLINGS: Well, if I haven't gone
9 to my doctor in a year for follow-up to get
10 my prescription renewed.

11 THE CHAIR: Every practice is
12 different. In our practice if you're not
13 seen in a year, you don't get your
14 medicine. And I don't know if that would
15 be the same--

16 MR. BILLINGS: I'm not saying it ought
17 to be statute. I'm just curious what the
18 common practice of the standard--

19 THE CHAIR: Doctor DePhillips, what are
20 your thoughts about licensing?

21 DR. DEPHILLIPS: Thank you for asking.

22 So our model--and for reasons that it's
23 more expensive and harder to administer, we
24 think that medical boards should be
25 overseeing the practice of medicine in every

1 talked about having simpler licenses. My
2 home state of Tennessee is actually doing
3 away with the separate telemedicine license,
4 partly because the implication is that
5 there's a separate licensing pathway and
6 therefore sort of separates standard of
7 care. It's an implication. I don't think
8 it's real.

9 But we agree with that position. And
10 the position is that the Board of Medicine
11 is responsible to license physicians and
12 compel them to practice at a certain level
13 of standard of care and there can only be
14 one. That's just sort of our opinion.

15 Regarding the face-to-face, I agree
16 that the distinction Doctor Rheuban made
17 between the face-to-face using video versus
18 in person. It's important to clarify in the
19 language of whether it's legislation or
20 regulation.

21 I would say that--you know, here's the
22 discussion. We offer video consults and we
23 offer phone consults. Every patient has got
24 a choice. There's a couple states that have
25 a regulation. But for the most part we've

1 state, which includes telemedicine. The law
2 currently is you need to be in our world
3 licensed in the state where the consult
4 request comes from. We--so we comply with
5 that. We have physicians in all 50 states
6 licensed and resident in all 50 states.

7 That latter part--one of the things we
8 do electively--it's not required by law, but
9 we think it's a good idea is we also favor
10 physicians who are a resident in the state
11 of the consult request in addition to being
12 licensed in the state of the consult
13 request.

14 We still think that to some degree is
15 local. If there's an outbreak, you know,
16 some local knowledge we think is important
17 to doctors who are treating patients in
18 whatever state. Telemedicine otherwise can
19 have that level of local knowledge. So,
20 yes, it's a more expensive program to
21 administer, but we just made a conscious
22 business decision to license resident
23 physicians in all 50 states.

24 I agree with the representative, whose
25 name escapes me, from the nursing board who

1 done over 600,000 consults with another--the
2 trajectory is another 300,000 this year. So
3 we're pushing a million consults at this
4 point. And over 95 percent of patients ask
5 for phone. It's just what the market
6 demands.

7 And so there's a couple of interesting
8 conversations about face-to-face. We're not
9 part--we offer it. So we're required to
10 offer face-to-face. Fine. Just turn off
11 the choice of the telephone.

12 The challenge is two-fold. Number one
13 is, as the board member to your right
14 mentioned earlier, there's folks that--you
15 know, there's a lot of places in rural
16 Virginia that don't have bandwidth to
17 support video signal. Never mind the
18 socioeconomic aspect of having a video
19 device. So you're going to start to exclude
20 access if you begin to require a video
21 consultation.

22 So it's a value judgment. In our world
23 most people pick phone, and that gives
24 access to people in the county where there's
25 no bandwidth, nothing other than a land line

1 and no PCPs, you know, within two counties
 2 away or whatever. So there is a balance.
 3 The second thing I want to share
 4 is--I'm now talking about the data. And I
 5 have to tell you--I'm going to phrase it
 6 this way. I'm not aware that there is any
 7 outcoming data that speaks to the
 8 superiority of a face-to-face visit over a
 9 telephonic visit without a video component.
 10 I'm not aware of any study that has
 11 shown that a patient with a prior
 12 relationship with a physician--in our world
 13 common, uncomplicated treatment of a medical
 14 problem like sinusitis, which is the most
 15 common--that the outcomes are at all
 16 different than the treatment of a patient
 17 who does not have a previous face-to-face
 18 encounter with a physician or a prior
 19 in-person relationship. If there is data
 20 around, I'd love to see it. But we're not
 21 aware that that exists.
 22 And we have almost a million consults
 23 worth of data at this point without a
 24 medical liability claim and within the
 25 company because of the guardrails we have in

1 need to.
 2 And, finally, I'd like to make the
 3 point that it's incumbent upon the
 4 person--it's incumbent upon the people who
 5 are trying to do something different to
 6 prove noninferiority, not the other way
 7 around. So with regards to Doctor
 8 DePhillips point, it's incumbent on
 9 telehealth to demonstrate noninferiority
 10 rather than the other way around.
 11 The standard of care is the standard of
 12 care. If you want to establish new
 13 standards of care, you need to demonstrate
 14 noninferiority, not the other way around.
 15 Thank you.
 16 THE CHAIR: I'm trying to break about
 17 12:30 for lunch. I'd like to skip to the
 18 bottom of the agenda. This sort of
 19 dovetails into what we're talking about. I
 20 wonder--I'd ask Doctor Rheuban is
 21 there--before someone embarks on
 22 telemedicine, is there special training
 23 that you think should be required? Should
 24 there be CME for telemedicine, the provider
 25 providing the telemedicine services? Is

1 place--guidelines, DEA controlled
 2 prescribing, state resident, licensed
 3 physician, etcetera. I would argue that
 4 face-to-face requirement is probably not
 5 necessary based on the data.
 6 DR. HENOCHOWICZ: Yes. Let me just
 7 first since we're talking about sinusitis
 8 so much put on my allergist hat here and
 9 say that acute bacterial sinusitis is among
 10 the most over diagnosed conditions in the
 11 United States, and it's not quite as simple
 12 as all that. And, yes, the physical
 13 examination does make a difference.
 14 Nasal--I don't think can be seen virtually.
 15 The distinction between allergic rhinitis
 16 and acute bacterial sinusitis in seasons is
 17 certainly something that needs to be
 18 diagnosed by physical examination.
 19 It also brings up another point, which
 20 is the over prescribing of antibiotics, and
 21 I think there's data here discussing this
 22 with respect to urinary tract infections. I
 23 don't know whether in fact if you diagnose a
 24 so-called sinusitis virtually whether you're
 25 going to be using antibiotics more than you

1 there something unique about it? Is there
 2 anything about the technology that we
 3 should require?
 4 DR. RHEUBAN: Thank you for asking
 5 actually because I'm an associate--at UVA
 6 as well.
 7 THE CHAIR: We'll be signing everyone--
 8 DR. RHEUBAN: Well, in fact, the
 9 Virginia Health Workforce Development
 10 Authority has established a training
 11 program in telehealth to create certified
 12 telehealth presenters. And we welcome--and
 13 we've done this in collaboration with a new
 14 college, an institute in Martinsville. And
 15 it's been a really great program. We've
 16 trained almost 300 providers in the last
 17 year to teach them how to use the tools and
 18 to teach them appropriate use of tools.
 19 So, you know, do I think it's a
 20 requirement? I don't think there is any
 21 requirement anywhere in the nation, but I
 22 think it's an interesting concept and it's
 23 certainly something we embrace in terms of
 24 certified telehealth presenters, to teach
 25 them how to use the tools, teach them about

1 HIPAA, make sure--these are
2 generally--almost everybody we have trained
3 have been health professionals. So it
4 ranges from CNAs to physicians.

5 So great concept, interesting to
6 discuss. And certainly UVA would be pleased
7 to do and I'm sure my colleagues at VCU
8 would be supportive as well.

9 THE CHAIR: Doctor Choudhary.

10 DR. CHOUDHARY: I actually just wanted
11 to reiterate that point. I've taken that
12 course and it is very useful.

13 DR. RHEUBAN: Oh, great. Thank you.

14 THE CHAIR: Ms. Broadnax, at the VA do
15 you require any--when you were at the VA,
16 did you require before they embarked on
17 taking care of patients virtually that they
18 had some sort of additional--

19 MS. BROADNAX: Yes. There is a
20 national standard. Every provider had to
21 go through some sort of certification.
22 When we were surveyed, we had to show the
23 certificate in cases for the physicians
24 using telemedicine.

25 THE CHAIR: Can you describe what it

1 standards are for telemedicine.

2 THE CHAIR: Ms. Wibberly, do you have
3 any comments?

4 MS. WIBBERLY: I think there's that
5 balance between creating a barrier and
6 creating quality. And so I don't--I would
7 not want to see a certification process
8 become a barrier to keep people doing
9 telemedicine just because we've got such an
10 access of--but I definitely see the
11 advantage to that training and you're
12 involved in that training. And there's
13 everything from the technology end to the
14 etiquette end. How you present on the
15 camera. How you set the lighting and all
16 that. And that is critical to quality of
17 the encounter. So that is kind of a
18 delicate balance right there.

19 THE CHAIR: Doctor Juran.

20 MS. JURAN: This is actually changing
21 the subject slightly. So if you'd like to
22 discuss this perhaps a little later that's
23 fine. But I don't have the firsthand
24 experience of seeing how the imagery comes
25 across in telemedicine. It just makes me

1 was. I mean--

2 MS. BROADNAX: Well, there's a course.
3 There's a return demonstration and--

4 THE CHAIR: Five days? Six hours?
5 Eight hours? Two hours?

6 MS. BROADNAX: Well, I know in the
7 state of Virginia we were offering a course
8 that was online. Part of it was online and
9 then a return demonstration piece. It may
10 take a physician a few hours. I mean, it's
11 hard to get physicians to break up the time
12 during the day. But it is required.

13 I will tell you the VA, after they did
14 that initial certification, that we sent
15 that down to the credentialing office and
16 that was added to the physician's record to
17 show they had some formalized training.

18 So I personally believe it's a good
19 idea if you're going to have a physician or
20 provider that's going to do telemedicine,
21 that they have some sort of formal
22 instruction. We just don't want anyone
23 sitting in front of a camera and seeing a
24 patient without knowing, you know, how to
25 operate the equipment and how to--what the

1 wonder if there are variations in the
2 quality of the various software
3 technologies that exist. I think there is
4 a credible body for this type of
5 technology.

6 I keep hearing reference to the effect
7 that it's HIPAA compliant. I can only
8 assume that that speaks to the security and
9 encryption of information. But is there
10 anything that's addressing the quality of
11 the technology and the imagery itself, and
12 am I naive to assume that there is probably
13 variation out there? Perhaps there is not.
14 But at some point could we possibly explore
15 that?

16 THE CHAIR: Yes. Ms. Bowles, you want
17 to take a shot at it?

18 MS. BOWLES: Well, it can be very
19 dependent somewhat on if there is a
20 broadband, for example. But most of the
21 telehealth programs that I've worked with
22 use standards based equipment that is
23 generally consistent as much as possible so
24 it's to the highest quality that is
25 available on the market, at least for

1 video.

2 THE CHAIR: Does any state require a
3 certain type of technology that you have to
4 have this camera with that bandwidth or--

5 MS. BOWLES: No.

6 THE CHAIR: Doctor Hood. Before you
7 start, did you take any training before you
8 started doing virtual medicine?

9 DR. HOOD: Yeah. Each telemedicine,
10 you know, entity has some type of
11 orientation. Now whether that translates
12 to CME--and for the purposes of, you know,
13 regulation and for the board I think it
14 would need to translate to CME for the
15 board to decide to make that requirement.

16 But I think it's very important to have
17 that orientation, if you will. Because as
18 she said, the lighting--you know, you want
19 to make sure it's a secure, you know, HIPAA
20 compliant location. I mean, you know, with
21 telemedicine you can in theory do it
22 anywhere, you know, if you have a mobile
23 device or laptop. So you want to make sure
24 you're not doing anything in the food court
25 at the mall. You know, that seems, you

1 know the exact number of hours but--

2 MS. WIBBERLY: There's two
3 certification courses. There are about
4 three to four hours online, depending on
5 how quickly you go, and then there's
6 another half day of hands-on.

7 DR. DUNNAVANT: You mentioned an entity
8 that you were working with for
9 telemedicine. Are there telemedicine
10 providers that are not associated with any
11 organized entity that might provide an
12 orientation and if so--

13 DR. RHEUBAN: That might require an
14 orientation or provide it? So I know that
15 like, for example, Specialist On Call,
16 which is our nation's largest telestroke
17 provider in the country, they're Virginia
18 based. They use providers from around the
19 country. They have their own training
20 programs for theirs. I imagine Doctor
21 DePhillips might want to comment about what
22 he does for his providers.

23 DR. DUNNAVANT: Actually I'm just more
24 curious are there providers that are
25 providing telemedicine that are not working

1 know, intuitive.

2 But you want to make sure you remind
3 each and every individual provider of the
4 standards that need to be met and quality
5 assurance and the measures that need to be
6 taken. I think that should be before
7 they're credentialed with the individual
8 company requirement.

9 DR. DUNNAVANT: I do have a couple
10 questions. I just want to know, Doctor
11 Rheuban, do you know how many CMEs--I'm
12 sure you do--if there are CMEs tied to your
13 orientation process?

14 DR. RHEUBAN: We've not been in that
15 category, although we certainly could.

16 DR. DUNNAVANT: Do you know how long in
17 general it takes just out of curiosity?

18 DR. RHEUBAN: The training programs?

19 DR. DUNNAVANT: Yes.

20 DR. RHEUBAN: Well, we have a
21 combination of online, a certain hours of
22 online training, as well as in-person
23 training on the equipment. We've also done
24 some video-based training as well. So it
25 really depends. Kathy, I don't know if you

1 through an organized, structured program?

2 DR. RHEUBAN: I would guess yes.

3 DR. DUNNAVANT: So those are the
4 entities that we're going to have to worry
5 about getting orientation, etcetera. And
6 so what percentage of telemedicine would
7 you say is being provided outside of a
8 structured entity?

9 DR. RHEUBAN: It's really hard for me
10 to know quite frankly. You know, through
11 the Virginia Telehealth Network we identify
12 several hundred originating sites, but I
13 don't know about individual practitioners.
14 It might be an interesting survey for the
15 board to establish to find out who's doing
16 what.

17 DR. REMLEY: Just only looking at
18 Anthem Virginia records we--ours were the
19 major players. You know, UVA, VCU,
20 Riverside, Sentara. We didn't identify any
21 individual single providers who were
22 themselves doing telemedicine yet.

23 THE CHAIR: Obviously clearly that's a
24 concern. You have these structured
25 organizations, publicly traded companies,

1 structured training programs. That's--that
2 gives us a level of comfort. But when
3 there's a guy in his garage flipping up his
4 laptop and he's Doctor X treating somebody
5 in a booth someplace, that's where it
6 becomes a little more troubling.

7 DR. RHEUBAN: The malpractice payors,
8 they may know as well actually, because I
9 know you're supposed to declare when you
10 apply for the malpractice insurance whether
11 or not you provide a telemedicine service
12 in those cases. So they may have some
13 information as well.

14 DR. DUNNAVANT: But as of yet we don't
15 know of any malpractice companies or
16 insurance industry companies that are
17 requiring any kind of credentialing or
18 orientation before they either provide
19 coverage or reimbursement for telemedicine?

20 BRENDA DINTAMIN: You really can't get
21 malpractice just for telemedicine. There's
22 a thought that you would be able to--

23 THE CHAIR: Identify yourself, ma'am.

24 BRENDA DINTAMIN: I'm sorry. I'm
25 Brenda Dintamin. This is my twentieth year

1 12-year-old company. From the inception of
2 any and all telemedicine service we
3 actually have a liability insurance carrier
4 that's very well-known nationally that
5 covers the liability insurance for the
6 telemedicine component of the physicians
7 who work with us. All of them have bricks
8 and mortar practices by the way and have
9 back since the beginning of time. So our
10 policy covers just telemedicine as well as
11 all the physicians in the 50 states. And
12 it's had a fairly low premium level. So
13 it's fairly low risk perception so--

14 THE CHAIR: Before we break do you want
15 to say anything or comments about the
16 licensing requirements. You said you have
17 CMEs for your physicians.

18 DR. DEPHILLIPS: Yeah. Briefly we
19 do--we're neutral on whether the board
20 should require or not require. We
21 certainly will comply if you don't. We
22 have one anyway to Doctor Rheuban's point.
23 So there's two components to it. Number
24 one is our credentialing program. We're on
25 a certified credentialing. So there's

1 in practicing dermatology. I'm very exited
2 about teledermatology.

3 But what we found is that you have to
4 be a practicing physician, and the
5 malpractice allows you to provide
6 telemedicine as part of your malpractice.
7 There's not even a special rider because in
8 their mind--I can only speak for
9 teledermatology--it's actually less risk,
10 the kind of care we're providing, where
11 we're getting the history, the actual
12 pictures. We're not providing care just by
13 phone consultation with someone describing a
14 picture.

15 So teledermatology is different, but
16 the point is that it's--they're not
17 requiring a rider to this point in Virginia.
18 But they do want you to have a full license.
19 So you're not sitting in your garage and
20 just decided you wanted to be a telemedicine
21 doctor. You have to show that you've met
22 all the qualifications like you would for
23 the board or--

24 DR. DEPHILLIPS: Sorry. Just a point
25 of clarification. So our organization is a

1 obviously a bar. You have to be board
2 certified. And then there's two components
3 to the training program. It takes about
4 two hours to go through. It's all self
5 directed and web based, so it's technology
6 enabled of course.

7 There are two major components to it.
8 Number one is the facility with using the
9 technology and demonstrated competence with
10 the use of the technology. Then number two
11 is familiarity with 103 evidence-based
12 clinical guidelines, specifically where your
13 physician may be transitioning from 100
14 percent practice face-to-face visits to a
15 percentage of remote visits. That's some of
16 the things. There's a test that the
17 physician has to actually pass in order to
18 be let on the network. That's what the
19 training program looks like today.

20 THE CHAIR: Anybody want to make any
21 other comments regarding those issues? If
22 not, we're taking a break for lunch. We
23 can come back and talk about prescribing,
24 limits to scope of practice, mid level
25 providers. Why don't we break and meet

1 back here at one.

2 (A lunch break was taken.)

3 THE CHAIR: Welcome back from lunch. I
4 think we'll start the afternoon--and our
5 intent is to finish--we're scheduled to go
6 to three. I intend to finish before that
7 hopefully.

8 I would also say there's more
9 information that has been provided by our
10 friends from Teladoc. You're welcome to it
11 if anyone wants to read it. The agenda as I
12 said when we started is not exhaustive. So
13 there are probably topics we didn't touch
14 on. I would offer the ability of anybody to
15 send more information for consideration to
16 the board through the board office.

17 Our plan is to meet back as a committee
18 of the board sometime in the next two or
19 three weeks to formulate a document to give
20 to the full board for adoption. So just
21 keep that in mind of terms of a time table.

22 I would like to start with--we have
23 four agenda items left. I think we can do
24 them as sets of two. The first is
25 prescribing ability and limitations and

1 prescribers, a nurse, different
2 prescribers--who's on the phone with them as
3 to what has transpired.

4 Sometimes it's the patient in front
5 them and they will ask the patient. Because
6 sometimes the prescription is from an
7 out-of-state physician, and the patient
8 clearly didn't travel out of state and
9 somehow that is communicated to the
10 pharmacist. So it begs the question for the
11 pharmacist to sort of delve a little bit
12 further into how the prescription came to be
13 so that they can feel comfortable that it is
14 indeed a valid prescription.

15 And oftentimes it's an online
16 questionnaire. It's audio-only. And so
17 this causes them to pause since I did
18 mention earlier that there is a requirement
19 of law that they have a responsibility to
20 insure the validity of the prescription,
21 particularly with respect to the Schedules 2
22 through 5. That's sort of a separate issue.

23 But they are looking for direction I
24 think for the Board of Pharmacy. We
25 certainly have had some internal

1 along with that limits to scope of practice,
2 things that probably would not lend--or may
3 not lend themselves to telemedicine.

4 And I'd like to start with prescribing
5 issues. And Doctor Juran can tell us what
6 the Board of Pharmacy thinks about
7 telemedicine and prescribing and what we
8 should do and what we shouldn't do.

9 MS. JURAN: Well, officially the Board
10 of Pharmacy hasn't deliberated on this
11 subject, so they don't have an official
12 opinion or position on it. I can tell you
13 that as board staff I do occasionally
14 receive calls from pharmacists who are
15 practicing who are concerned with
16 prescriptions that were presented in one
17 form or another that were seemingly as a
18 result from some type of telemedicine
19 process. And the question is always: Is
20 this a valid prescription?

21 And it seems to come down to the
22 establishment of a bona fide
23 practitioner/patient relationship. And
24 depending on who they're speaking to, they
25 hear different things. You know,

1 communication over the last few years on the
2 subject between Board of Pharmacy staff and
3 Board of Medicine staff. I'm glad that
4 we're finally sort of trying to work through
5 this because I think that the licensees for
6 the Board of Pharmacy would appreciate clear
7 guidance as to how one defines that bona
8 fide practitioner/patient relationship so
9 that they can make their job a little easier
10 in terms of validity of prescriptions.

11 With respect to the law, I would assume
12 that as this discussion advances there would
13 be some need for staff to research perhaps
14 the federal limitations, if any exist. It's
15 my very informal thought that the Rinekey
16 (spelled phonetically) Act necessitates
17 physical examination for prescribing
18 Schedule 2 through 5, but I say that very
19 informally and unofficially.

20 And so in this stage as the Board of
21 Medicine has these discussions with respect
22 to telemedicine, I would think that you
23 would want to be informed with respect to
24 any state or federal limitations as it
25 relates to prescriptions.

1 THE CHAIR: When I look at the issues
 2 for telemedicine and prescribing, they seem
 3 to fall into a couple different categories.
 4 One is potential over prescribing
 5 antibiotics based on--you know, assume you
 6 had strep throat or UTI. The second is
 7 obviously you have the Schedule 2 through 5
 8 drugs; and, third, are what we call
 9 lifestyle drugs. Envision the abuse of
 10 that and envision reasons for abusing that.

11 So my question is--I guess I'll leave
 12 those questions for the people who are
 13 prescribing. But for you--backtrack a
 14 little bit. You envision that--if a
 15 pharmacist has a question about a
 16 prescription, usually in communicating they
 17 pick up the phone and call the guy or woman.
 18 What's--how does that work in the virtual
 19 world? Do you have any sense of that or--

20 MS. JURAN: Well, they are required
 21 under state and federal law to provide
 22 contact information on their prescription
 23 as it comes across. So I think
 24 theoretically you would still have that.
 25 You could call a prescriber. It's just in

1 the age of prescription drug abuse--there's
 2 an AG summit tomorrow on this very issue.
 3 The governor just announcing last week the
 4 commission of a prescription task force.
 5 Obviously this is a high priority issue.
 6 It's a national epidemic as termed.

7 That causes concern for the
 8 pharmacists, and I think they're being extra
 9 careful in the review and determining the
 10 validity of prescriptions. Sometimes it's
 11 just contacting the prescriber may not
 12 necessarily be sufficient because if the
 13 prescriber is unscrupulous, he's going to
 14 tell you whatever you need to hear. So
 15 simply contacting the prescriber isn't
 16 necessarily a full assurance that this is a
 17 valid prescription.

18 THE CHAIR: I'd like to hear from the
 19 practicing physicians in the room as to
 20 what their prescribing habits are and what
 21 their thoughts are with respect to
 22 telemedicine and prescribing. Doctor Hood.

23 DR. HOOD: Yes. First of all, most of
 24 the telemedicine entities or companies that
 25 I'm familiar with, they don't allow any

1 prescription writing for schedule--DEA
 2 scheduled medications or lifestyle
 3 medications and, you know, antidepressants,
 4 of course. So it's, you know, then
 5 basically supportive, you know,
 6 medications, i.e. for pain. Sometimes for
 7 fever it's going to be recommended Tylenol
 8 or Motrin or over-the-counter medication.

9 And then the antibiotics. I mean
 10 that's the biggest concern. At what point
 11 does the patient meet criteria in a
 12 telemedicine consult to be prescribed
 13 antibiotics? It's just on a case-by-case
 14 basis. You know, patient history, what the
 15 symptoms are, when they were last seen by a
 16 doctor. You have to look at the whole case.
 17 You know, their access.

18 You know, do you have a 95 percent or
 19 90 percent suspicion, you know, that this is
 20 the diagnosis, but you can't confirm it
 21 because you can't--you know, you don't have
 22 the physical exam and can't get a look in
 23 the throat. You can't see the ears. You
 24 know, you have to weigh that--treating that
 25 empirically versus, you know, their access.

1 If they can get to a physician and they
 2 have access to a provider within the next
 3 day or two, then I would defer treatment
 4 certainly in those instances. If it's a
 5 patient that lives in rural Texas, for
 6 example, you know, has a family practice
 7 doctor, doesn't have an appointment for a
 8 week, and I have a relatively high
 9 suspicion, you know, that the patient could
 10 and probably does have otitis, I'd be a
 11 little more inclined to prescribe, you know,
 12 an antibiotic for that patient.

13 So it's really a case-by-case and
 14 situational, by situation. Not even just
 15 medical history, but the overall, you know,
 16 socioeconomic, you know, medical home
 17 situation for each individual patient.

18 THE CHAIR: Doctor Choudhary.

19 DR. CHOUDHARY: In my experience as I
 20 said previously doing a consultative
 21 service it was recommendations that I'd
 22 give. Now I think part of this would be
 23 tricky if, for example, I was a child
 24 adolescent psychiatrist who was seeing a
 25 patient in the rural southwest Virginia and

1 there was a need for, say, something like
2 Adderall. So I think that is a gray area
3 there.

4 I know there are practices where a
5 patient will be seen and they will mail out
6 a physical prescription to that specific
7 patient. So that's still something that's
8 going on. But the face-to-face is all
9 videoconferenced. It's not a physical
10 interaction. But there are prescribe--there
11 are prescription centers that FedEx because
12 they actually have written prescriptions.

13 THE CHAIR: And many prescriptions that
14 psychiatrists use are pretty powerful. Do
15 you feel comfort prescribing the whole
16 spectrum of those virtually?

17 DR. CHOUDHARY: I don't. No. And the
18 organizations that I work with also don't
19 look at it as we are prescribing these
20 medications. There are recommendations
21 made that emergency physicians that
22 dispense the medications and that--that
23 model is a consultative model. However,
24 there are psychiatrists who are practicing
25 psychiatry out there--I don't know of any

1 the absence of initiating doctor/patient
2 relationship, that really one should not
3 prescribe--one should not prescribe
4 medication. I mean, obviously once you
5 have, once you've developed a relationship,
6 you can have various means.

7 You know, people have been prescribing
8 over the phone for decades, you know. But
9 again we--in the context of an unknown
10 patient who you have not seen and examined
11 and done the appropriate
12 evaluation--certainly we don't do it in an
13 office setting like in a setting where
14 somebody calls me and says you're on my HMO
15 list or something. But certainly in the
16 telehealth context we feel pretty strongly
17 that it's not okay.

18 Right, Karen? That it's not okay.

19 DR. RHEUBAN: It depends on the
20 physical exam. It depends on the
21 situation, why you're seeing them.

22 DR. HENOCHOWICZ: In the future it
23 would be okay, but right now it's not okay.
24 In other words if you could do--if you
25 could do everything that you could do in

1 individual home providers. Everyone is
2 some kind of organization or group. There
3 are rules and regulations to follow.

4 THE CHAIR: How about nurse
5 practitioners?

6 MS. DOUGLAS: I think unfortunately I
7 don't think we have something here that
8 represents nurse practitioners, but
9 certainly I think the nurse practitioners,
10 you know, are involved in these type of
11 encounters. I'm concerned about patient
12 safety issues. And I think, you know, the
13 verification of, you know, insuring that
14 it's the patient really dealing with the
15 interaction with the pharmacist would
16 certainly occur related to the
17 prescriptions.

18 DR. HENOCHOWICZ: So, you know, the--

19 THE CHAIR: I'm not sure these are on.

20 DR. HENOCHOWICZ: I don't think any of
21 these work.

22 THE CHAIR: I can hear you.

23 DR. HENOCHOWICZ: The ACP, the American
24 College of Physicians, we discussed this
25 and we feel pretty strongly that, you know,

1 person, then it's okay; but in the present
2 it's--generally it's not okay. That's the
3 feeling that the ACP has.

4 THE CHAIR: Doctor DePhillips.

5 DR. DEPHILLIPS: So a couple comments.
6 First of all, some data points to help the
7 discussion. We just acquired a company
8 earlier this year that had an overall
9 prescribing rate, a telemedicine company,
10 of 98 percent. So there are some companies
11 out there that have very, very high
12 prescribing rates that's not appropriate.

13 Our overall prescribing rate is
14 currently running at 77 percent. The bricks
15 and mortar average for the same in similar
16 diagnoses that we treat is currently running
17 at 82 percent in the United States. So we
18 are at or potentially significantly below
19 the overall prescribing rate for primary
20 care telemedicine physicians.

21 Our overall antibiotic prescribing rate
22 is currently running 27 percent. I don't
23 know what the national average is, but I
24 suspect because we're compliant with CDC
25 guidelines for prescribing for infectious

1 diseases, I suspect we're at or below the
2 bricks and mortar national average.

3 So although it would be interesting to
4 see the data point, about a hundred percent
5 or whatever it was, of UTIs that had a
6 prescription, it's interesting. It
7 certainly wasn't done on Teladoc's
8 population. We're the oldest and largest.
9 It would have been nice if they had picked
10 us instead of whoever they picked to make
11 their point.

12 THE CHAIR: Are there medications you
13 don't prescribe?

14 DR. DEPHILLIPS: Oh, yeah. Yes. I
15 think I mentioned earlier. I'll happily
16 mention again. No DEA controlled
17 substances ever through our platform and no
18 lifestyle drugs are ever allowed through
19 our platform.

20 THE CHAIR: You said earlier, if I
21 heard that right, that 80 percent of your
22 encounters are telephone only. Is that
23 right?

24 DR. DEPHILLIPS: It's over 95 percent.
25 And that's by consumer request. We give

1 about whether I'm truly a prudent Virginia
2 physician.

3 THE CHAIR: I truly--I mean, it's kind
4 of a no-brainer. It can't--you shouldn't
5 be prescribing narcotics over the phone or
6 via telemedicine, but there are clearly
7 other--there are two other categories of
8 things we talked about. Lifestyle drugs.
9 You can understand where that would easily
10 be abused. And overuse of antibiotics,
11 which is a real important issue in this,
12 telemedicine. It is important. So where
13 do you--

14 DR. REMLEY: And I think I'm listening
15 to Doctor DePhillips, and what I'm hearing
16 is they're using CDC guidelines. The part
17 I would have a hard time with is--I really
18 would want to get a urine because I'd
19 really want to know before I gave the
20 antibiotic whether that was their--we're
21 getting into the details here, but is it
22 their twentieth urinary tract infection and
23 they also have renal problems underlying?
24 A kid, you know, you worry about, you know,
25 malformation or something else going on

1 everybody the choice. Over 95 percent
2 telephone only.

3 THE CHAIR: So 95 percent of the
4 patients that you see, you give 77 percent
5 of them prescriptions over the phone?

6 DR. DEPHILLIPS: That is correct. Top
7 three diagnoses are sinusitis, bronchitis,
8 UTI. Top three classes of drugs--98
9 percent generic prescribing rate by the
10 way. Top three classes of drugs are
11 generic antibiotics, generic allergy
12 medication, and generic inhalers. And
13 those three diagnoses and those three
14 classes of drugs constitute the majority of
15 consults nationwide.

16 THE CHAIR: Doctor Remley, you want to
17 make any comments? I'm really sort
18 of--what you think about--we're going to
19 get through the whole thing so be ready.

20 DR. REMLEY: Do you want to know--you
21 mean as a payor? As a provider? As a
22 public health--

23 THE CHAIR: You can answer as a prudent
24 Virginia physician would. The--

25 DR. REMLEY: The room might debate

1 that was there first.

2 If those are all the nuances--I think
3 what's hard for me with this is I feel like
4 we're in this brave new world like Star
5 Trek, Star Trek 3 or 4. Technology is here
6 and we're trying to figure out what's safe
7 and what's not.

8 THE CHAIR: When you're giving
9 antibiotics, if somebody's got renal
10 failure, you don't know. You do blood work
11 on them and they have a--

12 DR. REMLEY: Yeah. Exactly. So what
13 we're uncomfortable with is--Doctor
14 DePhillips has policies and procedures in
15 place to help protect against that. The
16 part of what we'd want--we might be doing
17 it intuitively, but we don't have that
18 structure. I think it's that structure
19 that's hard for us to visualize and see how
20 that works, the kind of model that makes
21 sense. I think that's the hard part.

22 And are there hard spots? You know,
23 because in all of medicine--again I'll go
24 back to with my license. If I could get
25 anybody stupid enough to insure me for it or

1 let me do it, I could do C-sections. Would
2 that be the craziest thing in the world for
3 me to do? Absolutely.

4 DR. DUNNAVANT: Yes.

5 DR. REMLEY: Why do you think I said
6 it. And I would never want to do sedation
7 or general anesthesia, but my license from
8 the state says I can.

9 So we're having a hard time, and I'm
10 having a hard time as I listen to these
11 discussions figuring out with new technology
12 what's excellent medicine, what's good
13 medicine, and what's okay medicine. How do
14 we sort through that? And are there never
15 never events kind of things too?

16 THE CHAIR: It kind of goes to the next
17 question. What things should we not allow
18 to be done via telemedicine? Are there
19 things that we just now say we shouldn't be
20 doing?

21 DR. HENOCHOWICZ: Can I just make a
22 point.

23 THE CHAIR: Yes.

24 DR. HENOCHOWICZ: Again as an allergist
25 I'm a little--I don't think anyone should

1 MS. BROADNAX: Sure. The way we
2 usually look at it is that the standard of
3 care has to be the same, the same in
4 telemedicine as it is in a face-to-face
5 encounter. So if you need to do something
6 that requires, you know, injections with
7 the patient or some sort of physical
8 manipulation with the patient, it's
9 probably something that needs to be done in
10 the office. But as long as you meet the
11 standard of care through telemedicine,
12 reimbursement should be the same.

13 So what happens is on the patient's
14 side there are the peripherals that allow
15 you to complete the exam over distance.
16 Those peripherals aren't available when the
17 patient is at home. So even when the person
18 is videoconferenced at home they don't have
19 a stethoscope. They don't have an otoscope
20 to aid the physician in helping them make
21 that diagnosis.

22 So for us pretty much when we're trying
23 to decide what we can offer through
24 telemedicine, we try to keep the standard of
25 care the same.

1 get an inhaler over the phone, period. I
2 don't know why that happens, certainly
3 without a physical examination. And as we
4 know all the--it's a very old saying. All
5 that wheezes is not asthma. Especially in
6 bronchitis, there's plenty of evidence to
7 show that inhalers do no bit of good for
8 so-called asthmatic bronchitis.

9 I'm alarmed, frankly, that people
10 prescribe inhalers based on a telephone
11 conversation. I think that--and
12 understanding unfortunately that epinephrine
13 inhalers are available over the counter,
14 which is Primatene Mist, which we've never
15 understood. But I think that's a perfect
16 example.

17 I mean who does that? I think that's
18 just wrong. And there's no way you can say
19 that it's medically appropriate to prescribe
20 an inhaler based on a telephone
21 conversation. I can't see it. You have to
22 show me how that's appropriate.

23 THE CHAIR: Ms. Broadnax, are there
24 things that you don't do through
25 telemedicine?

1 THE CHAIR: Doctor DePhillips, do you
2 ever say no?

3 DR. DEPHILLIPS: The doctors in our
4 program say no. Yes. Of course. Yes.

5 But back to the question on the table.
6 I believe we started this conversation by
7 saying, Is there anything that should be
8 excluded from telemedicine? I guess I would
9 urge the group to think about going back to
10 that comment that was made by me and others
11 earlier on, and that is I think the role of
12 the board is to be sure that physicians are
13 licensed and following the standard of care.
14 I think how the physician gets to the
15 standard of care to some degree needs to be
16 left up to the physician.

17 If the physician--you know, I'll have
18 this conversation after 3:00 today with the
19 doctor to the left in front of me. But if
20 the patient has had a comprehensive workup,
21 and the entire evaluation is complete, and
22 they have a sort of fixed pattern, if you
23 will, of an ongoing sort of nonacute,
24 nonemergent disease process, then it's
25 easier to get to the standard of care being

1 met without being physically in the presence
2 of the person than someone who hasn't done a
3 workup. So that would be a great example of
4 somebody who I'd suggest probably needs to
5 be an in-person visit.

6 I can't--and I'm really trying to be
7 open-minded and just put my thinking cap on
8 here. I really can't think of a basis for a
9 regulatory organization to say this can't be
10 done by telemedicine. I can't think of a
11 basis that would be applied that would be
12 objective and would be universal in that
13 regard.

14 THE CHAIR: Ms. Russek, as a citizen
15 member anything you would feel
16 uncomfortable having done by telemedicine?
17 Where would you--

18 MS. RUSSEK: It's hard for me to
19 separate, you know, my prosecutor hat
20 from--

21 DR. DEPHILLIPS: Well, you said you
22 were retired.

23 MS. RUSSEK: I probably would want to
24 exclude controlled substances, and that's
25 what my thought was up until today.

1 where the individual described shortness of
2 breath being one thing, but then when it was
3 visually seen by the prescriber through a
4 video exchange, he clearly described that
5 and interpreted it very differently than
6 what the patient had described. And I think
7 therefore that's--I can see that happening
8 frequently depending on the diagnosis and
9 the medical condition.

10 And it just seems natural and common
11 sense that you want to lay eyes on the
12 patient to verify that indeed what they're
13 representing to you is seemingly validated
14 through some type of visual interaction with
15 the patient. Then the other thing is I
16 don't think the law currently allows for
17 that.

18 Granted I am not an attorney. Someone
19 else can weigh in on that. But, I mean,
20 when I looked at 54.1-3303 where it talks
21 about physical examination--either
22 physically or by instrumentation and by
23 diagnostic equipment through which images
24 and medical records may be transferred
25 electronically.

1 THE CHAIR: No sense of a medical
2 condition that you think--the guy gets on
3 the phone, on the phone. I have this set
4 of symptoms. You should immediately say I
5 can't help you?

6 MS. RUSSEK: Well, I probably--you
7 know, I think that's dependent on the area.
8 I probably wouldn't get on the phone if I
9 couldn't be helped. That might just be me.
10 I don't know.

11 MS. JURAN: It seems analogous to
12 what's currently happening. Obviously each
13 individual provider is making a
14 determination in their professional
15 judgment as to whether he can adequately
16 treat that patient or not. I'm not sure
17 that treating the patient through
18 telemedicine would really be any different
19 than treating a patient in the office. You
20 still must use your professional judgment
21 to determine if you can adequately treat
22 that patient.

23 Where I find pause is the discussion
24 with audio use only. I think it was very
25 telling the example that Doctor Remley gave

1 It would seem that you're going to have
2 to use instrumentation or diagnostic
3 equipment, the results being some type of
4 image that's going to be electronically
5 transmitted. I'm not sure that audio
6 telephone conversation alone gets you in
7 compliance with the current law. That's
8 just my two cent.

9 THE CHAIR: One of the other things--we
10 talked about ancillaries. When we see
11 patients in the office, we have those and
12 other things available. Blood work. Blood
13 pressure. You know, vital signs. You
14 don't--you're missing that component of it
15 when you talk about prescribers and certain
16 limits and in the--you don't have that in
17 telemedicine. That's one of the things
18 that gives me a little bit of pause.

19 Do any of you have any thoughts on--

20 MR. BILLINGS: You do have it in some
21 forms of telemedicine, starting with Doctor
22 Rheuban. All of the clinical--stethoscope,
23 diagnostic tests. It's when you get down
24 to the direct consumer you--you lose the
25 otoscope, the stethoscope.

1 Again I--and Doctor DePhillips and I
 2 have a few things we disagree on, but we do
 3 agree on one fact, and that is the standard
 4 of care. You all as the medical board will
 5 be called upon to enforce that. In
 6 particular, if you see an encounter press
 7 story example describing a certain course of
 8 action does it--is it equivalent to an
 9 in-person examination? Does it conform to
 10 the standard of care?

11 DR. RHEUBAN: So the other group I want
 12 to call into this discussion is the
 13 American Medical Association, which itself
 14 is now testing specialty societies to help
 15 them understand the standard of care as it
 16 applies to telemedicine. I think that is
 17 an important body that has begun to embrace
 18 telemedicine, recognizing the challenges of
 19 access.

20 And, of course, professional judgment
 21 is important. That's why Doctor Remley
 22 isn't doing C-sections even if the law says
 23 she could.

24 I will say in our UVA program for the
 25 most part our services are consultative with

1 throwing it out. So help me understand how
 2 the UVA program uses non MDs, DOs, if they
 3 do, and how they use midlevel providers with
 4 BAs and MBs at initial and subsequent
 5 follow-ups.

6 DR. RHEUBAN: Well, most of our
 7 engagements with midlevel providers have
 8 been at the originating site where they are
 9 telepresenters and referrers of patients,
 10 community health centers and other
 11 environments. There's a whole moment. The
 12 Virginia Oral Health Coalition. Dentists
 13 are becoming more engaged because of the
 14 challenges in some of the under represented
 15 areas.

16 We have some midlevels who also
 17 participate as the distant site providers at
 18 UVA as well. And I dare say Medicare allows
 19 them as eligible practitioners as well. So
 20 we certainly don't want to be more
 21 conservative than Medicare in the
 22 Commonwealth of Virginia.

23 We also believe that this supports a
 24 professional practice. Telemedicine is a
 25 wonderful tool to do so, especially where

1 some follow-up visits, and we mostly are
 2 prescribing done in partnership with the
 3 community practitioners with whom we work.
 4 However, I have heard from our own child
 5 psychiatrists actually that they were--some
 6 of them are credentialed and privileged at
 7 the community service boards themselves and
 8 they have--there's been concern articulated
 9 about their ability to prescribe some of the
 10 medications that are scheduled for their
 11 patients because there is no other child
 12 psychiatrist in the community.

13 So it's just something we need to be
 14 thinking about. Yeah.

15 THE CHAIR: Doctor Wibberly, you wanted
 16 to say something earlier?

17 MS. WIBBERLY: No.

18 THE CHAIR: So the last group of things
 19 I wanted to talk about--maybe we'll start
 20 with Doctor Rheuban. The use of midlevel
 21 providers both as initial consultants and
 22 follow-up consultants. And then should
 23 groups of providers be excluded? Dentists,
 24 chiropractors, podiatrists.

25 I mean, can a chiropractor do--I'm just

1 there are under resourced areas in the
 2 Commonwealth of Virginia, whether urban or
 3 rural.

4 THE CHAIR: Doctor Trump, you want to
 5 make any comments on that?

6 DR. TRUMP: Yeah. Just a follow-up.
 7 From the public health side of it, the
 8 health department side, I think our issue
 9 is--one of our issues obviously is access
 10 of care, meeting the needs for uninsured,
 11 uninsurable, and low income individuals
 12 through the Commonwealth.

13 We certainly know we have partnerships
 14 with local health departments and programs
 15 that meet the special health needs, the
 16 health care needs of children with special
 17 needs, statewide that rely upon, you know,
 18 telemedicine to provide some of that. And
 19 so I think my interest in being here was
 20 just, you know, to hear where we're going
 21 with this.

22 And there is a need I think for, you
 23 know, the communities, especially in many
 24 parts of this state, to have alternate ways
 25 of accessing care. So provide UVA, you

1 know, the programs for high risk maternity
2 care. Obviously not the first, but interim
3 visits. Provide that consultative services
4 so that they don't have to travel 200 miles
5 to get, you know, the best place for that
6 high risk OB care.

7 And so just how we think about those
8 needs both from--and what I'd ask in sort of
9 closing to the providers too, our health
10 departments are relying more and more on
11 nurse practitioners, on public health
12 nurses, and just ask as we think about this
13 to make sure we harmonize what we're doing
14 with, you know, the Board of Medicine, the
15 Board of Nursing and scope of practice and
16 where we may have--may not be another--may
17 not be a PA or nurse practitioner at the
18 other site. We have a nurse or someone
19 who's facilitating and sort of being the
20 hands-on to provide that, you know,
21 facilitate that physical assessment.

22 The other piece we have is licensure
23 and certification providing the nursing home
24 or home health visit services. How do we
25 think about the nurses who are out there

1 be providers that saw somebody and billed
2 for a level three office visit and that they
3 didn't put on they did it by telemedicine.
4 We wouldn't be able to know that. But right
5 now, no. The code--I don't know that--I'm
6 looking at Karen again.

7 DR. RHEUBAN: So those are the eligible
8 Medicare providers. And so for--well, this
9 is the national.

10 DR. REMLEY: But I mean for our state.
11 In our state who are we mandated to--I
12 should know that. Any licensed
13 practitioner--

14 DR. DUNNAVANT: Doctor Rheuban, would
15 you read the list, please.

16 DR. RHEUBAN: Sure. On the
17 Medicare--so eligible Medicare providers
18 and services. Physicians, osteopaths.
19 Physicians and osteopaths. Dentists,
20 podiatrists, optometrists, chiropractors.
21 Categories defined as practitioners. So
22 physician assistants, nurse practitioners,
23 clinical nurse specialists, certified
24 registered nurse anesthetists, nurse
25 midwives, clinical social workers, clinical

1 providing home health services and what role
2 they may or may not have as being a
3 facilitator of telemedicine consultation in
4 the delivery of, you know, quality care in
5 the home setting for that patient, who if
6 they can facilitate that visit may not have
7 to be going to a doctor's office either a
8 distance away or an ambulance visit away
9 because that's the only way it will happen.

10 THE CHAIR: I mean, the very exciting
11 part of telemedicine is the expansion and
12 access. That's what makes it so exiting.
13 We're trying to figure out a way to make it
14 safe.

15 As a payor, are you paying for
16 chiropractors, podiatrists, nurse
17 practitioners to be seen by telemedicine?

18 DR. REMLEY: No. I say no without
19 looking, but when I asked them to pull all
20 our telemedicine claims--and to be fair,
21 the way it's identified is there's a
22 modifier than goes on the claim. So the
23 people who are used to doing telemedicine
24 put the modifier on.

25 I can't tell you that there might not

1 psychologists, registered dietitians,
2 nutrition professionals. So that's for
3 Medicare. And I'm trying to look through
4 the code to see. We say health care
5 provider.

6 THE CHAIR: So there would be no reason
7 to have--there would be no limitation. A
8 dentist can do it if it meets the same
9 standards.

10 DR. REMLEY: Is that the way you think
11 the code reads? Because I don't see a
12 definition here yet, what a health care
13 provider is. Was it in the--

14 DR. RHEUBAN: No. It was not
15 articulated specifically.

16 DR. REMLEY: It was not in there. So I
17 would turn to the Attorney General's office
18 and say we don't. I don't know. No one
19 has come to us to my knowledge to ask us
20 to. And what I don't know--

21 THE CHAIR: I'm just thinking out loud.

22 DR. REMLEY: Yeah. I think it's a
23 great question. Because I don't know what
24 section--it's not under the Department of
25 Health section of the Code. I don't know

1 whether this refers to all licensed
2 professionals in the state or
3 licensing--you all know more about that
4 than I do in terms of who's licensed and--

5 THE CHAIR: I'm trying to understand if
6 what a chiropractor does or what a
7 podiatrist does, can any of that be done by
8 telemedicine? I don't know the answer to
9 that.

10 DR. RHEUBAN: I think it could very
11 easily be done video-based.

12 DR. REMLEY: This just says health care
13 provider. So I don't know what--

14 THE CHAIR: Do you use nurse
15 practitioners that will provide--

16 MS. WIBBERLY: Yes. We see nurse
17 managed health clinics in other states. I
18 don't know if there are some in Virginia.
19 I suspect there may be. But I personally
20 would not limit--if they're practicing
21 within the scope of their license, I would
22 not limit how they would do that. Again
23 it's a tool, not a specific service.

24 THE CHAIR: Did you have something?
25 Doctor Choudhary, do you use midlevel?

1 DR. CHOUDHARY: Well, the practices
2 where I work it's all psychiatrists and--

3 THE CHAIR: I'm sorry. Do you use any
4 clinical--I forgot the--midlevel clinical
5 health--

6 DR. CHOUDHARY: When I was working for
7 one organization they had a licensed QMHP
8 or LMHP to--they actually support, and they
9 didn't necessarily substitute for a
10 psychiatrist or--

11 MS. DOUGLAS: Just one thing this
12 raises and that's significant to the Board
13 of Medicine in looking at this issue, there
14 are implications for all professionals.
15 You know, I'm hoping that we certainly look
16 at that by profession because everyone has
17 folks that are licensed in telemedicine.
18 Some way to make sure it's (inaudible).

19 THE CHAIR: Doctor Broadnax.

20 MS. BROADNAX: As far as our practice,
21 we use physician assistants. Psychologists
22 are allowed to use telemedicine if the
23 person--we're looking at some of the other
24 services that aren't covered under Medicare
25 right now like speech therapists,

1 occupational therapy. Many see children
2 who need those services. They could very
3 easily have those concessions through
4 telemedicine, but right now those services
5 aren't reimbursed for telemedicine.

6 So I agree that it shouldn't be so
7 restrictive as long as the person is
8 practicing within their scope of practice.
9 But if the intent is to increase access, I
10 think some of those ancillary services also
11 need to be--

12 THE CHAIR: Do you use them as initial
13 evaluation or as--

14 MS. BROADNAX: You can. Absolutely.

15 THE CHAIR: Just like you'd use them in
16 the office?

17 MS. BROADNAX: They can.

18 THE CHAIR: How about Teladoc? Are you
19 using midlevel?

20 DR. DEPHILLIPS: Currently all board
21 certified physicians only, although we're
22 expanding up the whole network which is all
23 levels--psychiatrists, licensed clinical
24 social workers, etcetera--for telemedicine.

25 THE CHAIR: Any thoughts on midlevel

1 providers, Mr. Billings?

2 MR. BILLINGS: As long as they're in
3 their scope of practice.

4 THE CHAIR: Any questions for the
5 board?

6 MS. JURAN: Just a point. It seems
7 that we keep using the term telemedicine in
8 speaking with a lot of other licensing
9 categories of health care providers. I'm
10 not sure whether telemedicine in that
11 context is the appropriate term. I think
12 it's telehealth. Someone else more in the
13 know on that might--

14 THE CHAIR: You're probably right.

15 That's all I have on the agenda unless
16 anybody--

17 MR. BILLINGS: One piece of information
18 to add on the copy that was made about the
19 federal Reinhite Act. There are provisions
20 recognizing the Reinhite Act passed in
21 2006, 2008. I was just at the front end of
22 my telemedicine career, so I can only
23 imagine where telemedicine in psychiatry
24 was at that point as it is now.

25 It was a past attempt to tighten up

1 sort of interstate pharmacy activity at the
2 federal level. I would guess that it was
3 quickly or it is reasonably unworkable now
4 in today's telepsychiatry.

5 There are provisions in there that do
6 allow the examination to be done from afar,
7 but they are very restrictive examinations.
8 The patient has to be at a certain facility
9 and there has to be some other criteria. So
10 there is statute language that does allow
11 telemedicine prescribing through that.

12 The point that I was making earlier
13 that the statute says that encounter has to
14 also be compliant with state law. So if for
15 example Virginia doesn't recognize
16 telemedicine encounter as a video encounter,
17 which I think 30 states specifically don't
18 recognize--either they're silent or don't
19 recognize it--then my reading of it would be
20 that they're not compliant with federal law
21 because they're not compliant with state
22 law.

23 I would suspect that there are
24 prescribings going on and the states
25 probably not knowing. So I think you want

1 mechanism where we have some sort of
2 training offered to telepresenters just
3 because that's the medium they use.

4 I think my bias is towards the clinical
5 telemedicine, formal types of telemedicine
6 encounters. So I'm very interested to learn
7 about some of these other services that are
8 offered as well.

9 I'm concerned about out-of-state
10 providers treating patients that come to our
11 medical center. I think that's something
12 that we need to look at very carefully in
13 terms of who's actually having this
14 interaction with the patient.

15 I guess my biggest concern is the
16 security surrounding all these new
17 technologies as well, because I can assure
18 you when we do telemedicine at VCU we're
19 using secure encrypted equipment that meets
20 the federal compliance and information
21 security requirements using a third party
22 vendor for protected health information.
23 I'm kind of leary about how that information
24 is stored and who uses it, who has access to
25 it. So I think everyone needs to take that

1 to really drill down with the DEA issue as
2 you think through should you get into
3 the--they're not an easy agency to deal
4 with.

5 THE CHAIR: I have to say this has been
6 very helpful for us, not just for the
7 board, but for everybody here. What I
8 would like to do is go around and give
9 everybody a minute or so to say what they
10 want in closing statements that the board
11 might need to hear or want to hear and then
12 we'll get out early.

13 So Doctor Broadnax, you want to say
14 something? You have your two minutes and
15 then--actually, you can have three. We'll
16 take one from Doctor DePhillips.

17 DR. DEPHILLIPS: Justifiably so.

18 MS. BROADNAX: Thank you for the
19 opportunity to participate today. I think
20 that in terms of some of the things that
21 you all are considering, particularly the
22 licensing or the training of providers, I
23 agree with Doctor Wibberly in that you
24 don't want to be limited in the area, but I
25 do think there should be some sort of

1 into consideration. Thank you.

2 THE CHAIR: Doctor DePhillips.

3 DR. DEPHILLIPS: A couple quick final
4 points. I'll really take only a minute.

5 Number one is I would encourage the
6 board to consider telemedicine as an
7 extension of the practice of medicine. We
8 talked earlier about diagnoses that might be
9 excluded from telemedicine. So for example
10 chest pain, active bleeding, open fracture,
11 those types of things clearly are not
12 appropriate to telemedicine. But the board
13 hasn't found a need to regulate physicians
14 in private offices from treating their own
15 patients with those diagnoses over the phone
16 because nobody does it. In telemedicine
17 it's not done. So I just would encourage
18 the group to think along those lines.

19 Number two, I'd give really thoughtful
20 consideration as to potentially excluding
21 use of the telephone, especially for primary
22 care telemedicine. The data between the
23 Rand study and Harvard Medical School study,
24 the access and the availability and the low
25 barrier to entry of allowing consumers to

1 use the phone for a common, uncomplicated
 2 medical condition. The access has been so
 3 well documented in rural areas and poor
 4 areas. The cost savings were huge,
 5 especially by giving the folks in remote
 6 areas an option besides going to the
 7 emergency room or in a car and going
 8 somewhere. And the documentation is also
 9 very clear that patient safety can be
 10 preserved if the right guardrails and
 11 boundaries are put in place.

12 So I would encourage the group to
 13 consider those things.

14 MS. RUSSEK: From a patient point of
 15 view I'm in favor of it, and I expect the
 16 board to protect me. I seriously do
 17 believe that the practitioner who is
 18 engaging in telemedicine should be able to
 19 have judgment as to whether or not they can
 20 treat someone via telemedicine. Again I
 21 wouldn't hesitate to utilize it in my own
 22 personal life.

23 MR. BILLINGS: I appreciate very much
 24 the opportunity to come down here today.
 25 I've already spoken enough so I'll let you

1 in place already and have for the last
 2 several years. That's something we
 3 support. We certainly are a facility that
 4 allows connection between those local
 5 communities and the UVAs and the VCUs of
 6 the world for some of the telemedicines
 7 taking place right now. So we have an
 8 asset there.

9 We want to make sure that we use it and
 10 we meet the needs of the patients that we
 11 care for directly. But then think about
 12 what we can do to support communities
 13 working in that, you know, again insuring
 14 it's good quality of care that, you know,
 15 that meets their needs, no different than if
 16 they were being seen face-to-face in a
 17 university or academic medical center or
 18 private practice office.

19 DR. RHEUBAN: I'll leave you with 14.5
 20 million miles of driving avoided through
 21 UVA's telemedicine program and equally so
 22 through VCU and how important that is for
 23 patients. I'd urge us not to throw up too
 24 many barriers to the delivery of quality
 25 health care through telemedicine. As it

1 have the big job ahead of you to try and
 2 thread the needle in terms of diagnosing
 3 patients and protect them. And given the
 4 fact I have northern Virginia at rush hour,
 5 I'm going to pass anything further.

6 THE CHAIR: You and I have the same--

7 MR. BILLINGS: I'll see you there.

8 MS. BOWLES: Thank you very much for
 9 allowing me to be involved in this
 10 discussion. I'm interested in making sure
 11 that telemedicine continues to be able to
 12 be used in rural situations. That's
 13 particularly important in various areas of
 14 Virginia more than we even realize. And
 15 also to reiterate that to take into
 16 consideration the midlevels and other
 17 providers that can participate and have in
 18 rural areas and made a big difference.

19 THE CHAIR: Mr. Trump, do you want to
 20 say anything in closing?

21 DR. TRUMP: I had a chance to say a
 22 couple things earlier, but the other is,
 23 you know, our local health departments
 24 around the state, most of the facilities,
 25 actually do have secured videoconferencing

1 stands right now even our UVA stroke
 2 neurologists who want to work with
 3 Specialists On Call, it's one year before
 4 they can be credentialed and privileged to
 5 do those services because of there's so
 6 many regulatory challenges.

7 So I urge you to consider the practice
 8 of safe telemedicine that allows access to
 9 care for all Virginians. Thank you.

10 THE CHAIR: Now the prudent Virginia
 11 physician.

12 DR. REMLEY: As a payor, we welcome the
 13 opportunity to learn with everyone as we go
 14 along. We're all about trying to get
 15 people the right care at the right time at
 16 an efficient price. So determining how
 17 that works.

18 One thing I think we didn't talk about
 19 today, we're blessed we have Karen Rheuban.
 20 We've got UVA that's been doing telemedicine
 21 longer than most around the country. We've
 22 got VCU. We've got Kathy Wiberly. We've
 23 got Edie working with both.

24 You know, we've got a lot of
 25 information and a lot of history. And if

1 there's anything I'd encourage the board to
2 think about how the board could encourage
3 the ability to do the research to be able to
4 quantify what's happening, to be able to see
5 what best practices are.

6 Because as Karen talked about,
7 specialties aside, if you're going to start
8 to look at that, this happens to be one of
9 the times where Virginia is sort of on the
10 cutting edge. And so it is important and
11 really good to have an article from Herbert,
12 but it's also really nice to say and here's
13 the experience in our state and how it's
14 working to share amongst ourselves. As
15 clinicians, to feel good about it, but also
16 to be able to justify to payors.

17 You know, the biggest payor in the
18 state is Medicaid. So, you know, how we
19 justify to them. You know, those types of
20 things I think to think about how we can
21 quantify what we're doing and develop best
22 practices and for research and documentation
23 is huge.

24 THE CHAIR: Doctor Hood.

25 DR. HOOD: I don't have anything

1 acceptable level is better than no level.
2 And I think what we need to do is try to
3 restrict unacceptable practice. So good
4 clinical care is good clinical care. It's
5 safe medicine. That should be our standard
6 irrelevant of technology that's being used.

7 THE CHAIR: Ms. Juran.

8 MS. JURAN: I just want to thank you
9 for including the Board of Pharmacy in this
10 discussion. If we can assist further, we
11 would be happy to.

12 THE CHAIR: Doctor Choudhary.

13 DR. CHOUDHARY: Thank you very much for
14 inviting me here. I think I'm just going
15 to reiterate I think preserving the
16 standard of care is going to be the most
17 important thing. While access is just as
18 clearly as important, I think we need to
19 make sure that telemedicine is something
20 that's a quality product.

21 THE CHAIR: Ms. Douglas.

22 MS. DOUGLAS: I thank you for inviting
23 me to the continued conversation about
24 this. The Board of Nursing has not
25 officially looked at this issue, but on a

1 further to add beyond the thoroughly
2 enlightening discussion we've already had.
3 I would like to thank the board for not
4 only giving me this opportunity, but
5 everyone here to share their thoughts and
6 ideas. I think it's a wonderful forum, and
7 I hope it will be lead to great things and
8 expanding care for all Virginians.

9 And I look forward to participating in
10 this further should you guys have any
11 questions, circle back on any issues,
12 especially in regard to pediatrics
13 specifically. Feel free to chat with me if
14 I can be of any further service.

15 MS. WIBBERLY: I don't have a whole lot
16 more to add other than, you know, just to
17 urge you to not put barriers, artificial
18 barriers, to that access of care. I think
19 access is a critical piece for our state
20 and our country. And to echo something
21 that Doctor Remley said, there's excellent
22 care and there's acceptable care. And I
23 think that telemedicine in terms of access
24 to care, if we bring access to someone who
25 does not have access right now, that

1 national level with national and state
2 Board of Nursing certainly this
3 discussion--our RNs and LPNs are involved
4 to provide care by telenursing on a regular
5 basis.

6 I guess what strikes me having heard,
7 you know, all of this is the same issue
8 with--the same issues with telemedicine are
9 the same issues we have looking at personal
10 care. You know, quality encounter, the
11 safety is appropriate for that, you know,
12 that individual.

13 Then there is the other piece of
14 authorization to practice, both Virginia
15 licensees, authorization to perhaps provide
16 telemedicine care to folks outside of
17 Virginia and people outside of Virginia
18 trying to provide telehealth services to
19 individuals in the Commonwealth. So that's
20 certainly a piece of the discussion.

21 The challenge as you know too well is
22 that you're looking at apples and oranges in
23 terms of quality and type of, you know, care
24 that's delivered around the map. I think
25 defining some terms if there is any further

1 formal discussion is going to be really
2 significant because I think just hearing
3 around the table today people are saying the
4 same thing, using a term, and it's meaning
5 two different things to them as they use
6 that term and that--if you're not clear what
7 the definition is.

8 DR. HENOCHOWICZ: So thank you very
9 much for allowing me to participate. The
10 main issue with respect to the ACP with
11 respect to primary care with respect to
12 patient safety and quality is that we not
13 allow a diminished quality of care by
14 having initial evaluations be allowed--not
15 be done in person. We feel that especially
16 in primary care that's very important.

17 With respect to telemedicine I think
18 and we think this is very exciting. There
19 are a lot of wonderful things that are going
20 on and will go on and they are fully
21 supportive of that and fully supportive of
22 having midlevel providers participate and
23 having telemedicine be a part of medical
24 practice, certainly within the context of
25 primary care, which after all is the way we

1 If you have additional information for
2 us, please let the board staff have it and
3 we--it will be distributed to us and made
4 available to other members of the panel.
5 And so our next step will be for the board
6 to meet and process this information and
7 then present a document to the full board
8 and to meet and present the document to the
9 full board. And so you will all be party to
10 that.

11 I thank you very much. Those traveling
12 be careful.

13 (Meeting concluded at 1:55 p.m.)
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25

1 all want medicine to be set up.

2 I mean it's--we have had a lot of
3 discussion in the last few years looking
4 for--with organized medicine. We feel there
5 is a shortage of internal medicine doctors,
6 shortage of primary care. I don't think
7 circumventing primary care and internal
8 medicine is the way to go as far as managing
9 this issue. I think internal medicine needs
10 to be part of the answer.

11 And I think directed consumer care is
12 something that's very troublesome, we find
13 troublesome. But we don't find telemedicine
14 troublesome at all, nor do we think it's
15 something that doesn't have promise for our
16 patients.

17 THE CHAIR: Again I just--no. Public
18 comment is over.

19 I would like to thank everybody. I'm
20 mindful of the time it takes to do this and
21 commitment it takes. I appreciate it. I
22 know this is a day out of a busy life for
23 you, and we appreciate your coming down. I
24 really thank all of the panel members for
25 participating.

1 CERTIFICATE
2

3 State of Virginia)
4 County of Amelia)

5 I, Holly M. Bush, do hereby certify that
6 the foregoing pages constitute a full and accurate
7 transcript, to the best of my ability, into English
8 text from the computer notes.

9 Witness my hand this 23rd day of
10 October, 2014.

11
12
13 _____
14 Holly M. Bush

15 My commission expires
16 December 31, 2014
17 Notary Registration No. 257683
18
19
20
21
22
23
24
25

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