North Carolina Medical Board
Best Practices Committee
September 2012

Committee members: Ms. Pamela Blizzard, Chair; Janice E. Huff, MD and Ms. Thelma Lennon

1. Old Business
    a. Teleconference with Gerilyn McGaughran, Marketing & Communications Director, CPEP

2. New Business
    a. Discussion of Draft Report of Best Practices Committee

Report of the Best Practices Committee
September, 2012

During the September 23-24, 2011 North Carolina Medical Board Retreat, the Board referred several agenda items to the Best Practices Committee for further research and discussion. This report provides a synopsis of the Committee's work the ensuing year on those items.

The Best Practices Committee, which met during every meeting of the full Board, includes Pamela Blizzard (Chair), Janice Huff, MD and Ms. Thelma Lennon. First the Committee was tasked with further study and discussion of the topic of telemedicine. Second the Committee was tasked with monitoring the progress of The Center for Personalized Education for Physicians (CPEP) in its feasibility study for expansion into North Carolina and, where appropriate, providing introductions to interested parties who might assist in those efforts.

Telemedicine

During the Retreat, Lisa Robin, Chief Advocacy Officer of the FSMB, briefed the Board on the history of federal legislation and FSMB advocacy efforts on the issue of telemedicine. Dr. Scott Kirby, MD, NCMB Medical Director, briefed the Board on the types and frequency of disciplinary issues involving inappropriate or unsafe telemedicine practice. After extensive discussion of whether additional telemedicine policy is needed the Board deferred the matter to the Best Practices Committee. Assisted by Dr. Kirby, the Best Practices Committee settled upon criteria for potential speakers to provide further education. It was decided that in order to avoid the appearance of a special relationship, solicited speakers could not be North Carolina licensees, entrepreneurs or insurers sponsoring telemedicine programs in the state.

<u>Ms. Paula Guy, RN, CEO of Georgia Partnership for Telehealth</u>

In May 2012 the Committee held a teleconference meeting with Paula Guy, RN, CEO of the Georgia Partnership for Telehealth (GPT). GPT came into existence because Georgia Insurance Commissioner Oxendine negotiated investment in Georgia rural health infrastructure as a condition of approval for the merger between Anthem and Wellpoint Insurance Companies. Oxendine secured $100 million over 20 years in rural capital bonds and $11.5 million over 3 years in the Georgia Telemedicine Program. This investment resulted in one of the premiere state networks in the nation that has stretched beyond its borders into Florida, Alabama

and South Carolina. There are over 300 locations in nursing homes, jails, school clinics, medical clinics, ER's and trauma centers. There were 40,000 clinical encounters last year, a number expected to double in the coming year. Approximately 200 physicians of all specialties participate.

GPT credentials physicians to participate. A primary care physician will refer a patient to a telehealth site and choose several specialists. Specialists block their available times for consultation. At the host site, a specially trained mid-level professional must accompany the patient and oversee the technical component of the visit. Consulting physicians at the other end are even authorized to participate with their iPad's, when clinically appropriate, through an encrypted, secure line. For certain specialties, adapted equipment exists that can take biological studies of the patient, such as specialty stethoscopes, with results appearing to the remote physician.

The system relies on T1 lines (funded by a universal service fund) that are networked into a hub residing in a rural Georgia hospital. Reimbursement by insurers is mandated by state law. Physicians and clinic sites pay a monthly subscription fee to participate.

Dr. Jean Rawlings Sumner, MD, Medical Director of the Georgia Composite Medical Board

In July the committee hosted a teleconference with Dr. Jean Rawlings Sumner, past President and current Medical Director of the Georgia Composite Medical Board. The Georgia Composite Medical Board published updated rules governing telemedicine practice but rejected the notion of a special telemedicine license just as it rejects national licensure. Georgia believes the standard of care for telemedicine is the same as that for health care provided through traditional means but that certain specialties such as psychiatry; ENT, cardiology, and radiology lend themselves more readily to telemedicine than others, such as general surgery. The Georgia Board does not believe that "Skyping & prescribing" or internet prescribing is appropriate telemedicine. Any physician treating Georgia patients via telemedicine must be licensed in Georgia and specialty consultations must be initiated by a Georgia-licensed provider. Midlevel practitioners who practice telemedicine may only be overseen by physicians who practice telemedicine. Dr. Sumner recounted sentinel disciplinary cases for the Georgia Board.

Dr. Sumner described the elements of an appropriate telemedicine exam, which include an in-person history and physical and a licensed health care professional in attendance at both telemedicine sites. A physician must provide clear information concerning their credentials and specialty training to the patient. A clinician should create a thorough medical record, stopping to document (by photo or otherwise) significant clinical findings. In the case of the specialist consultation, the specialist should promptly provide a copy of the medical record to the primary care physician. Prescriptions (should they be necessary) should be issued electronically. A physician should have printed information available at the end of the encounter for the patient concerning follow-up care, how to contact the physician if necessary, and a list of resources close to the patient (such as the ER) should the patient need to be seen in person. A telemedicine physician would have the same responsibility to encourage patient compliance as any other physician.

Conclusion & Recommendations

The Committee recognizes the rapid evolution of this complex topic and remains mindful of the enthusiasm of entrepreneurs and federal regulators alike to hasten its widespread adoption, to reap the benefits of anticipated cost savings and increased access to specialty care by those disadvantaged by geography. Nonetheless, the NCMB's raison d'être is to ensure patient safety. With these occasionally competing considerations in mind, the Committee makes the following recommendations in regard to telemedicine:

1. The NCMB should maintain its current Position Statement on Telemedicine. The current statement provides an adequate framework to allow the development of quality telemedicine standards of practice without unduly impinging upon technological innovation;
2. Recognizing that telemedicine is an issue that reaches beyond state – and even national – borders, the NCMB should support the FSMB's efforts to develop coherent patient-centered federal policy in accordance with the principles articulated in the FSMB's *Balancing Access, Safety and Quality in a New Era of Telemedicine*;
3. The NCMB should discuss promulgation of rules similar to those recently adopted by the Georgia Composite Board;
4. The NCMB should discuss the advisability of identifying business practices it deems patently unsuitable and formulating an appropriate strategy for responding; and
5. The Office of the Medical Director should continue reviewing telemedicine cases with its current philosophy; namely, that telemedicine is a modality to deliver quality health care, not a separate specialty subject to different or potentially inferior standards of care due to current technological limits.

CPEP-East

During its 2011 Board Retreat this Board considered concerns articulated by participants in physician assessment and education programs that the cost associated with travel and the inconvenience of a remote delivery site made participation needlessly difficult, expensive and time-consuming. Independent research confirmed that there are no similar programs of commensurate quality and/or longevity available nearby, nor is there any appetite among the state's own facilities and practitioners to begin such a program. Recognizing the benefit that a local CPEP office could bring to its own licensees and those in surrounding states, the Board voted to support CPEP in those efforts in such a way that would not cast the Board's arms' length relationship with CPEP into question. At the Retreat the Board directed the Best Practices Committee to assist CPEP in its feasibility study, while remaining mindful of the Board's obligation to remain impartial among various vendors of similar services.

Board staff participated in several conference calls with CPEP staff to identify key North Carolina stakeholders and potential funding sources. Board staff then telephoned several stakeholders to describe the Board's experience with CPEP, educate them on CPEP's business model and encouraged those individuals to meet with CPEP staff to learn more. To date, CPEP staff have visited North Carolina twice and received contributions from several interested parties.

Conclusion & Recommendations

The Committee notes that CPEP staff has made impressive progress in one year's time toward opening a CPEP-East office in North Carolina. The Committee makes the following recommendations in regard to CPEP-East:

1. Direct staff to continue to monitor and assist, as appropriate, CPEP's efforts to open a North Carolina office.
2. Direct staff to remain objective relative to the merits of CPEP versus other similar programs.
3. Direct staff to communicate that CPEP will not be the sole provider of services utilized by NCMB and volumes and patterns of referrals to CPEP will not change significantly in the event a North Carolina office opens.