North Carolina Medical Board
Policy Committee Meeting
Wednesday, November 19, 2014

Committee Members: Mr. Arnold, Chairperson; Dr. Udekwu; Dr. B. Walker; Dr. Lietz and Ms. Meelheim
Staff: Todd Brosius and Wanda Long

1. Old Business:
    a. Position Statement Review
        i. Telemedicine
        Contact With Patients Before Prescribing

2. New Business:

    a. Hospice Request – Exception for Prescribing

    b. Position Statement Review
        i. Medical, Nursing, Pharmacy Boards: Joint Statement on Pain Management in End-of-Life Care

3. Position Statement Review tracking chart

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1. Old Business
    a. Position Statement Review
        i. Telemedicine
            Contact With Patients Before Prescribing

11/2013 Committee Discussion: Mr. Arnold reported on the developments by FSMB's SMART group regarding a telemedicine policy statement. The SMART group is seeking comments from licensing boards by December 6 and are hoping to have an approved version prior to the FSMB's annual meeting in April 2014. Dr. Udekwu discussed the need for the Board to give the FSMB direction regarding topics such as scope of practice and the need to have studies that demonstrate the effectiveness of telemedicine in particular instances. Dr. Udekwu commented on the pending legislation, the focuses on easing the licensing burden, reducing the need for face to face encounters. It was also noted that federal legislation is beginning to blur the jurisdictional boundaries regarding licensure requirements as they apply to telemedicine.

11/2013 Committee Recommendation: Request full Board to review the FSMB's draft of policy on telemedicine so that the Board can give targeted input by the December 6 deadline. Table consideration of Board's Position Statement until January meeting.

11/2013 Board Action: Approve the Committee Recommendation.

01/2014 Committee Discussion: Mr. Arnold updated the Committee regarding the upcoming steps and timeline for the FSMB's SMART group developing telemedicine guidelines. It was estimated that the FSMB may have guidelines in place sometime in April. The Committee agreed that it would be prudent to have the benefit of the FSMB's efforts before the Board took additional steps regarding its own position statement.

01/2014 Committee Recommendation: Table matter until FSMB guidelines have been approved.

01/2014 Board Action: Approve the Committee Recommendation.

03/2014 Committee Discussion: Mr. Arnold updated the Committee on the progress of the FSMB guidelines. They have received initial approval and will be up for final approval at the FSMB Annual meeting. It was also discussed that representatives of Blue Cross Blue Shield will present information to the Committee at its July 2014 meeting. Dr. Udekwu also indicated that two Board members would be attending the CTEL meeting.

03/2014 Committee Recommendation: Table issue until the July 2014 meeting.

03/2014 Board Action: Approve the Committee Recommendation.

05/2014 Committee Discussion: Ms. Apperson reported on the Telemedicine guidelines that were recently adopted by the FSMB.

05/2014 Committee Recommendation: Dr. Udekwu, Mr. Arnold and Ms. Apperson to begin reviewing the Board's current Telemedicine Position Statement and provide the Policy Committee their recommendations at the July Committee meeting.

05/2014 Board Action: Approve the Committee Recommendation.

07/2014 Committee Discussion: Representatives from Blue Cross Blue Shield (BCBS) presented information on two pilot studies they had completed, one potential study involving a large established group with quality metrics already in place and one potential research driven study in an urgent care setting. The BCBS representatives agreed to provide the Committee members with the 21 quality metrics used in the potential pilot program and 25 diagnoses that could be handled in an e-visit protocol.
Ms. Apperson reported that the Board will host a roundtable on August 20, 2014, for approximately a dozen invited participants. Additionally, there will be time allotted at the end of the meeting for the general public to provide comments.

07/2014 Committee Recommendation: Table this issue until the September 2014 Committee meeting to allow information from the August 20th roundtable to be presented.

07/2014 Board Action: Approve the Committee Recommendation.

09/2014 Committee Discussion: Dr. Henry DePhillips, Chief Medical Officer for Teladoc, Inc. spoke with the Committee regarding the companies structure and protocols regarding telemedicine, including the relative outcome and prescribing habits of telemedicine companies generally and Teladoc specifically. Ms. Apperson presented the proposed changes from the drafting committee to the Telemedicine and Contact with Patients before Prescribing Position Statements. Dr. Walker-McGill pointed out the distinction between the terms “evaluation’ and “examination.” The Committee made a few small changes to the work group’s draft of the Telemedicine position statement to address this distinction.

09/2014 Committee Recommendation: Amend the proposed changes to the Telemedicine position statement with regard to the Examination subsection. Present the proposed changes to the full Board for approval to publish for public comments.

09/2014 Board Action: Accept the Committee’s recommendation

TO: Policy Committee
FROM: Christina Apperson
DATE: November 6, 2014
RE: Revised Position Statements on Telemedicine

At the May Board Meeting, the Policy Committee tasked Dr. Pascal Udekwu (Policy Committee Chair), Mr. Michael Arnold (Public Member) and Christina Apperson (staff) with hosting a Roundtable on Telemedicine and updating the NCMB's position on telemedicine.

The Telemedicine Roundtable was held at the Board offices on August 20, 2014. Twelve Board members, over fifty health care professionals and telemedicine and insurance industry leaders and a member of the North Carolina Congressional delegation (Congresswoman Renee Elmers) attended.

The Telemedicine Drafting Work Group, which includes Dr. Udekwu, Mr. Arnold, Dr. Scott Kirby, Mr. Todd Brosius and Ms. Christina Apperson, presented proposed amendments to the Telemedicine and Contact with Patients before Prescribing Position Statements which were approved by the Board for release for public comment at the September meeting.

Changes to the position statements include the following:
*The expectation that telemedicine practitioners will engage in practice improvement and outcomes monitoring
*Clarification that telemedicine practitioners are held to the "standard of care" governing their practice specialty and there is no separate (or lower) standard of care for telemedicine practice
*Clarification that the physician-patient relationship need not be established through an in-person encounter so long as a physician may acquire the same or superior information through the use of technology and peripherals
*Additional burdens are placed on the practitioner to ensure he or she verifies identity and location of the patient and provides his or her identity, location and professional credentials to the patient
*A new section clarifies constraints on prescribing
*Telemedicine practitioners are held to the same professional standards concerning communication and transfer of health care records to the primary care physician or medical home
*Contact with patients prior to prescribing need not occur through an in-person encounter, so long as a practitioner has access to the same or superior information through telemedicine technology

Written public comments from stakeholders, interested parties and licensees accompany this memo. While generally strongly in favor of the changes, comments focus primarily in three areas:
*several noted that the word "evaluation" replaces "examination" in several instances and questioned whether the "evaluation" should replace "examination" in all instances
*conflicting opinions over whether the term "and peripherals" should be eliminated from the section that requires practitioners using telemedicine without an in-person evaluation to ensure they use adequate "technology and peripherals sufficient to provide an examination that is equal or superior to an in-person examination."
*a suggestion that when the in-person evaluation is not performed, the adequacy of the evaluation should be judged as "consistent with the standard of care for the condition presented" instead of the more explicit standard of "equal or superior to an in-person evaluation."

After reviewing the public comments, the Board is urged to adopt the revised Position Statements entitled “Telemedicine” and “Contact with Patients before Prescribing.”

Telemedicine

"Telemedicine" is the practice of medicine using electronic communication, information technology or other means between a licensee in one location and a patient in another location with or without an intervening health care provider.

The Board recognizes that technological advances have made it possible for licensees to provide medical care to patients who are separated by some geographical distance. As a result, telemedicine is a potentially useful tool that, if employed appropriately, can provide important benefits to patients, including: increased access to health care, expanded utilization ~~-~~of specialty expertise, rapid availability of patient records, and the reduced cost of patient care. Telemedicine providers are expected to adhere to current standards for practice improvement and monitoring of outcomes.

The Board cautions, however, that licensees practicing via telemedicine will be held to the same standard of care as licensees employing more traditional in-person medical care. A failure to conform to the appropriate standard of care, whether that care is rendered in-person or via telemedicine, may subject the licensee to potential discipline by this Board. It is the Board's position that there is not a separate standard of care applicable to telemedicine. Telemedicine providers will be evaluated according to the standard of care applicable to their area of specialty.

The Board provides the following considerations to its licensees as guidance in providing medical services via telemedicine:

Training of Staff — Staff involved in the telemedicine visit should be trained in the use of the telemedicine equipment and competent in its operation.

Evaluations and Examinations — Licensees using telemedicine technologies to provide care to patients located in North Carolina must provide an appropriate evaluation ~~examination~~ prior to diagnosing and/or treating the patient. However, this evaluation ~~examination~~ need not be in-person if the ~~technology is sufficient to provide the same information to the licensee as if the exam had been performed face-to-face.~~ licensee employs technology and peripherals sufficient to provide an examination that is equal or superior to an in-person examination.

Other examinations may also be considered appropriate if the licensee is at a distance from the patient, but a licensed health care professional is able to provide various physical findings that the licensee needs to complete an adequate assessment. On the other hand, a simple questionnaire without an appropriate examination may be a violation of law and/or subject the licensee to discipline by the Board.[1]

Licensee-Patient Relationship — ~~The licensee using telemedicine should have some means of verifying that the person seeking treatment is in fact who or she claims to be.~~The licensee using telemedicine should verify the identity and location of the patient and should inform the patient of the licensee's name, location and professional credentials. A diagnosis should be established through the use of accepted medical practices, i.e., a patient history, mental status examination, physical examination and appropriate diagnostic and laboratory testing. Licensees using telemedicine should also ensure the availability for appropriate follow-up care and maintain a complete medical record that is available to the patient and other treating health care providers.

Prescribing — Licensees are expected to practice in accordance with the Board's Position Statement "Contact with patients before prescribing." Licensees are cautioned that prescribing controlled substances for the treatment of pain via telemedicine is disfavored by the Board. Licensees prescribing controlled substances for other conditions should obey all relevant federal and state laws and are expected to participate in the Controlled Substances Reporting System.

Medical Records — The licensee treating a patient via telemedicine must maintain a complete record of the telemedicine patient's care according to prevailing medical record standards. The medical record serves to document the analysis and plan of an episode of care for future reference. It must reflect an appropriate examination of the patient's presenting symptoms, and relevant components of the electronic professional interaction must be documented as with any other encounter.

The licensee must maintain the record's confidentiality and disclose the records to the patient consistent with state and federal law. If the patient has a primary care provider and a telemedicine provider for the same ailment, then the primary care provider's medical record and the telemedicine provider's record constitute one complete patient record. Licensees practicing via telemedicine will be held to the same standards of professionalism concerning medical records transfer and communication with the primary care provider and medical home as those licensees practicing via traditional means.

Licensure — The practice of medicine is deemed to occur in the state in which the patient is located. Therefore, any licensee using telemedicine to regularly provide medical services to patients located in North Carolina should be licensed to practice medicine in North Carolina.[2] Licensees need not reside in North Carolina, as long as they have a valid, current North Carolina license.

North Carolina licensees intending to practice medicine via telemedicine technology to treat or diagnose patients outside of North Carolina should check with other state licensing boards. Most states require physicians to be licensed, and some have enacted limitations to telemedicine practice or require or offer a special registration. A directory of all U.S. medical boards may be accessed at the Federation of State Medical Boards Web site: http://www.fsmb.org/directory_smb.html.

(Adopted July 2010)

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[1] See also the Board's Position Statement entitled "Contact with Patients before Prescribing."

[2] N.C. Gen. Stat. § 90-18(c)(11) exempts from the requirement for licensure: "The practice of medicine or surgery by any nonregistered reputable physician or surgeon who comes into this State, either in person or by use of any electronic or other mediums, on an irregular basis, to consult with a resident registered physician or to consult with personnel at a medical school about educational or medical training. This proviso shall not apply to physicians resident in a neighboring state and regularly practicing in this State."

The Board also notes that the North Carolina General Statutes define the practice of medicine as including, "The performance of any act, within or without this State, described in this subdivision by use of any electronic or other means, including the Internet or telephone." N.C. Gen. Stat. § 90-1.1(5)

Contact with patients before prescribing

Created: Nov 1, 1999
Modified:
February 2001; November 2009, May 2013 Reviewed July 2010

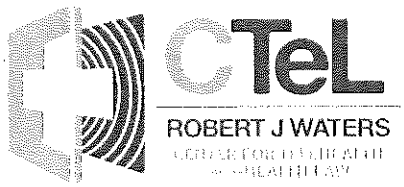
It is the position of the North Carolina Medical Board that prescribing drugs to an individual the prescriber has not examined to the extent necessary for an accurate diagnosis is inappropriate except as noted in the paragraphs below. Before prescribing a drug, a licensee should make an informed medical judgment based on the circumstances of the situation and on his or her training and experience. Ordinarily, this will require that the licensee perform an appropriate history and physical examination, make a diagnosis, and formulate a therapeutic plan, a part of which might be a prescription. This process must be documented appropriately.

Prescribing for a patient whom the licensee has not personally examined may be suitable under certain circumstances. These may include admission orders for a newly hospitalized patient, prescribing for a patient of another licensee for whom the prescriber is taking call, continuing medication on a short-term basis for a new patient prior to the patient's first appointment, an appropriate prescription in a telemedicine encounter where the threshold information to make an accurate diagnosis has been obtained, or prescribing an opiate antagonist to someone in a position to assist a person at risk of an opiate-related overdose. Established patients may not require a new history and physical examination for each new prescription, depending on good medical practice.

Prescribing for an individual whom the licensee has not met or personally examined may also be suitable when that individual is the partner of a patient whom the licensee is treating for gonorrhea or chlamydia. Partner management of patients with gonorrhea or chlamydia should include the following items:

- Signed prescriptions of oral antibiotics of the appropriate quantity and strength sufficient to provide curative treatment for each partner named by the infected patient. Notation on the prescription should include the statement: "Expedited partner therapy."
- Signed prescriptions to named partners should be accompanied by written material that states that clinical evaluation is desirable; that prescriptions for medication or related compounds to which the partner is allergic should not be accepted; and that lists common medication side effects and the appropriate response to them.
- Prescriptions and accompanying written material should be given to the licensee's patient for distribution to named partners.
- The licensee should keep appropriate documentation of partner management. Documentation should include the names of partners and a copy of the prescriptions issued or an equivalent statement.

It is the position of the Board that prescribing drugs to individuals the licensee has never met based solely on answers to a set of questions, as is common in Internet or toll-free telephone prescribing, is inappropriate and unprofessional.



November 1, 2014

Cheryl Walker-McGill, MD
President
North Carolina Medical Board
PO Box 20007
Raleigh, NC 27619-0007

Dear Dr. Walker-McGill:

The Robert J. Waters Center for Telehealth and e-Health Law (CTeL) appreciates the opportunity to comment on the proposed telemedicine guidelines being considered by the North Carolina Medical Board (Board).

CTeL was founded in 1995 as the pioneer non-profit organization providing research and policy guidance in telemedicine. We have long been involved in telemedicine's legal research and policy development, reflecting the 175 years of combined experience CTeL's board of directors have in the telemedicine field. We appreciate the Board's efforts to balance the need to ensure safe medical procedures with the changing landscape of telemedicine delivery models.

In January 2013, CTeL first provided state medical boards with recommendations on the establishment of the physician-patient relationship through telemedicine. We urged that states recognize that a physician-patient relationship can be established through telemedicine—with certain conditions.

Since that time, we have continued to refine our recommendations. We view any proposed telemedicine statutes or regulations through the lens of CTeL's safe telemedicine principles (attached). These principles include:

1. Telemedicine is a mechanism to deliver safe, effective healthcare.
2. Legally recognize an examination through telemedicine technology that provides the practitioner with information equal to or superior to an in-person examination.
3. A physician-patient relationship can only be established through an examination by tablet, phone app, or web camera if the examination 1) provides information equivalent to an in-person examination, 2) conforms to the standard of care expected of in-person care; and 3) if necessary, incorporates peripherals and diagnostic tests sufficient to provide an accurate diagnosis.
4. A physician-patient relationship cannot be established through an examination by telephone (audio-only), text message, or email.
5. "On call" language may not be used by a physician to prescribe for a patient never seen by the physician unless there is an established agreement between the patient's personal physician and covering physician, compliant with state law governing on call relationships between practitioners.

CTeL
ROBERT J WATERS

We believe a telemedicine encounter incorporating these principles can help ensure a safe medical encounter. After all, a safe medical encounter is a safe telemedicine encounter.

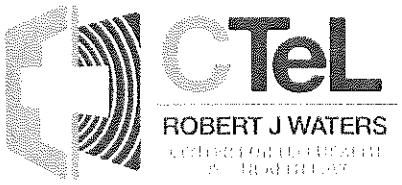
We applaud the Board for including language requiring the examination to 1) be equivalent or superior to an in-person examination; 2) conform to the standard of care; and 3) incorporate diagnostic tests and peripherals, if necessary.

We believe requiring diagnostic/laboratory tests and peripherals, if necessary to confirm the diagnosis, is critical in helping to ensure a safe medical encounter. To make certain that physicians understand the Board's expectations, these specific references should be included in any telemedicine policy statement where the Board expects an encounter that 1) is equal to or superior to an in-person examination and 2) conforms to the standard of care.

Regarding web-based examination, CTeL is routinely approached for a list of states that permit an "electronic examination" to establish the physician-patient relationship. Based on our conversations with the requestors, we are concerned that many delivery models and their physicians believe a mere visual "examination" of the patient complies with state laws and regulations. That is why we feel strongly that all state legal and regulatory language related to telemedicine must include reference to diagnostic tests and peripherals to confirm the diagnosis. For many "common" issues, we urge the Board to consider whether a safe medical encounter can be executed without these tools, and still meet the Board's requirement that the encounter mirror an in person encounter and conform to the standard of care.

CTeL would also like to note, that delivering medical care by telephone is not new or unique. Physicians have been providing medical care by telephone, since the telephone was invented. A telephone call diagnosing and treating a patient does not automatically make the encounter "telemedicine."

CTeL does not believe a first time encounter, over the telephone, can allow the physician to meet the requirements of equivalency to in-person examinations and conform to the standard of care. Business models using audio-only do not incorporate the use of diagnostic tools or peripherals, which we believe is necessary to keep with the medical standard of care provide and provide an accurate diagnosis. Except in statutorily recognized "on call" arrangements between the patient's physician and physician he/she designate to be on call, we do not believe an appropriate examination can be executed through audio-only.



The same concern would apply to conducting an "examination" through a web portal or email, with written-only information. We would urge the board to clearly state that audio-only examination, or a physician-patient exchange through email or a web portal, is not sufficient for a first time encounter. Absent this language, we believe the Board will be in a continual state of enforcement, examining audio-only and written encounters to determine whether the encounter is equivalent to an in-person examination and conforms to the standard of care.

Finally, we want to comment on the issue of enforcement. Enforcement of these standards will be critical to ensure that those practicing telemedicine in North Carolina are practicing safe medicine. Observers have noted that we have seen the current explosion of "telemedicine" models because of a general lack of enforcement at the state level. It will be critical for the Board to set clear and direct enforcement standards so that delivery models and their physicians know what is—and is not—permissible in North Carolina to ensure a safe medical encounter through telemedicine.

Again, thank you for allowing CTeL the opportunity to comment on the Board's proposed policy changes for telemedicine. We stand ready to answer any questions you might have or provide further information in this area. We believe specific guidelines, like those the Board is considering, coupled with aggressive enforcement, are critical to the future of telemedicine. We believe we are one bad encounter away from onerous regulations that would not discriminate between the various methods of the delivery of telemedicine. This is an outcome that none of us want.

Sincerely,

Greg Billings
Executive Director

PO Box 15850 Washington, DC 20003 Phone 202.499.6970 Fax 202.499.6971 www.ctel.org

Safe Telemedicine Principles

1. **Telemedicine is a mechanism to deliver safe, effective healthcare.**

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

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

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

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

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

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

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

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

The Robert J. Waters
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May, 2014

To the North Carolina Medial Board:

Carolinas HealthCare System (CHS) appreciates the opportunity to comment on the North Carolina Medical Board draft position statements on "Telemedicine" and "Contact with Patients before Prescribing." We have carefully reviewed proposed language and ask that you consider the following comments and concerns.

CHS applauds the Board's emphasis on its expectation that all care adhere to current treatment standards regardless of the method of delivery. CHS is committed to establishing protocols and monitoring the quality and effectiveness of all healthcare provided by CHS, whether that care is provided virtually or in the facility setting. The Board's recognition that "evaluation" is an appropriate term for care provided in a telemedicine environment, as the term "examination" has traditionally been associated with a facility visit is commendable. However, we would ask that the term "evaluation" is used consistently to replace "examination" throughout the Telemedicine position statement.

Moreover, we are concerned that the Board's recognition of the inherent differences between a telemedicine evaluation and an examination in a facility is undermined by recommended language which would require that a telemedicine evaluation provide an "examination that is equal or superior to an in-person examination. " This language could be interpreted to be at least as restrictive as existing language regarding telemedicine technology, which appears to set an expectation that the technology yield the "same information" as if the exam had been performed face to face. Through our communications with NCMB administration we have understood that the use of "same information" was meant to indicate the importance of having access to all of the information necessary to meet the standard of care. We fear that the proposed language will be interpreted as similarly inflexible and will stimulate additional questions and confusion regarding how to adhere to this expectation.

Given the Board's recognition of the importance of telemedicine to expand access to appropriate, cost effective health care we do not believe the Board's intention is to set parameters that if strictly interpreted would be impossible to meet in the virtual environment. Rather, we understand the Board's desire is to ensure that all evaluations provided with the use of telemedicine technology meet the same treatment expectations as exams conducted in a facility. In fact, the Board's proposed revised language regarding "Contact with patients before prescribing" more clearly reflects this intention by emphasizing the importance of accessing the information needed to make an accurate diagnosis. In order to add clarity and consistency, we propose the attached revisions to the language regarding telemedicine evaluations and examinations.

In addition, we would ask that the Board consider adding language acknowledging the importance of providers of telemedicine maintaining an infrastructure to follow up and allow patients, both new and

existing, every opportunity to receive comprehensive, quality health care. Coordinating access to referrals to meet additional treatment needs should be an expectation of all providers of virtual care. In addition, the Board should emphasize the importance of integrating care within an electronic medical record (EMR) to connect clinical providers across all points of care.

CHS truly appreciates the Board's diligent and thoughtful approach to evaluating the complexities of telemedicine and we look forward to final position statements that uphold the standards of the Board while recognizing the meaningful role that telemedicine will increasingly play in the provision of superior healthcare.

Sincerely,

Sanjeev K Gulati, MD FACC
Medical Director, Advanced Heart Failure/Mechanical Circulatory Support
Associate Professor of Internal Medicine at Carolinas HealthCare System
Research Associate Professor, College of Health and Human Services, University of North Carolina at Charlotte

[Enclosure]

Telemedicine

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The Board cautions, however, that licensees practicing via telemedicine will be held to the same standard of care as licensees employing more traditional in-person medical care. A failure to conform to the appropriate standard of care, whether that care is rendered in-person or via telemedicine, may subject the licensee to potential discipline by this Board. It is the Board's position that there is not a separate standard of care applicable to telemedicine. Telemedicine providers will be evaluated according to the standard of care applicable to their area of specialty.

The Board provides the following considerations to its licensees as guidance in providing medical services via telemedicine:

Training of Staff — Staff involved in the telemedicine visit should be trained in the use of the telemedicine equipment and competent in its operation.

Telemedicine Evaluations ~~and Examinations~~ — Licensees using telemedicine technologies to provide care to patients located in North Carolina must provide an appropriate evaluation ~~examination~~ prior to diagnosing and/or treating the patient. However, this evaluation ~~examination~~ need not be in-person if the ~~technology is sufficient to provide the same information to the licensee as if the exam had been performed face-to-face.~~ licensee employs technology ~~and peripherals~~ sufficient to accurately diagnose and treat the patient in adherence with the applicable standard of care.

Other evaluations ~~examinations~~ may also be considered appropriate if the licensee is at a distance from the patient, but a licensed health care professional is able to provide various physical findings that the licensee needs to complete an adequate assessment. On the other hand, a simple questionnaire without an appropriate evaluation ~~examination~~ may be a violation of law and/or subject the licensee to discipline by the Board.[1]

Licensee-Patient Relationship — ~~The licensee using telemedicine should have some means of verifying that the person seeking treatment is in fact who or she claims to be.~~ The licensee using telemedicine should verify the identity and location of the patient and should inform the patient of the licensee's name, location and professional credentials. A diagnosis should be established through the use of accepted medical practices, i.e., a patient history, mental status evaluation ~~examination~~, physical evaluation ~~examination~~ and appropriate diagnostic and

laboratory testing. Licensees using telemedicine should also ensure the availability for appropriate follow-up care and maintain a complete medical record that is available to the patient and other treating health care providers.

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The licensee must maintain the record's confidentiality and disclose the records to the patient consistent with state and federal law. If the patient has a primary care provider and a telemedicine provider for the same ailment, then the primary care provider's medical record and the telemedicine provider's record constitute one complete patient record. Licensees practicing via telemedicine will be held to the same standards of professionalism concerning medical records transfer and communication with the primary care provider and medical home as those licensees practicing via traditional means.

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(Adopted July 2010)

[1] See also the Board's Position Statement entitled "Contact with Patients before Prescribing."

[2] N.C. Gen. Stat. § 90-18(c)(11) exempts from the requirement for licensure: "The practice of medicine or surgery by any nonregistered reputable physician or surgeon who comes into this State, either in person or by use of any electronic or other mediums, on an irregular basis, to consult with a resident registered physician or to consult with personnel at a medical school about educational or medical training. This proviso shall not apply to physicians resident in a neighboring state and regularly practicing in this State."

The Board also notes that the North Carolina General Statutes define the practice of medicine as including, "The performance of any act, within or without this State, described in this subdivision by use of any electronic or other means, including the Internet or telephone." N.C. Gen. Stat. § 90-1.1(5)

Christina C. Apperson

From: Stevens, Jason D <jdstevens@novanthealth.org>
Sent: Tuesday, November 4, 2014 6:55 AM
To: Christina C. Apperson; Christina C. Apperson
Cc: Capps, Richard H
Subject: Telehealth - Novant Health comments
Attachments: Contact with Patients_Novant Health Comments.docx; Telemedicine Position Statement_Novant Health Comments.docx

Christina – thanks so much for allowing Novant Health to be part of the Board's forum on telehealth.

We have reviewed the proposed revisions that you sent to us, and have included some suggested additional revisions – which are marked up on the attached files. Please let me know if you would like to discuss or if you have any questions.

We look forward to hearing the results from the November meeting.

Best regards,
Jason

Jason D. Stevens
Assistant General Counsel
Novant Health, Inc.
P: 704-384-9454
F: 704-417-1649
E: jdstevens@novanthealth.org

Contact with patients before prescribing

Created: Nov 1, 1999
Modified:
February 2001; November 2009, May 2013 Reviewed July 2010

It is the position of the North Carolina Medical Board that prescribing drugs to an individual the prescriber has not examined to the extent necessary for an accurate diagnosis is inappropriate except as noted in the paragraphs below. Before prescribing a drug, a licensee should make an informed medical judgment based on the circumstances of the situation and on his or her training and experience. Ordinarily, this will require that the licensee perform an appropriate history and physical examination, make a diagnosis, and formulate a therapeutic plan, a part of which might be a prescription. This process must be documented appropriately.

Prescribing for a patient whom the licensee has not personally examined may be suitable under certain circumstances. These may include admission orders for a newly hospitalized patient, prescribing for a patient of another licensee for whom the prescriber is ~~taking call~~providing care coverage, continuing medication on a short-term basis for a new patient prior to the patient's first appointment, an appropriate prescription in a telemedicine encounter where the threshold information to make an accurate diagnosis has been obtained, or prescribing an opiate antagonist to someone in a position to assist a person at risk of an opiate-related overdose. Established patients may not require a new history and physical examination for each new prescription, depending on good medical practice.

Prescribing for an individual whom the licensee has not met or personally examined may also be suitable when that individual is the partner of a patient whom the licensee is treating for gonorrhea or chlamydia. Partner management of patients with gonorrhea or chlamydia should include the following items:

- Signed prescriptions of oral antibiotics of the appropriate quantity and strength sufficient to provide curative treatment for each partner named by the infected patient. Notation on the prescription should include the statement: "Expedited partner therapy."
- Signed prescriptions to named partners should be accompanied by written material that states that clinical evaluation is desirable; that prescriptions for medication or related compounds to which the partner is allergic should not be accepted; and that lists common medication side effects and the appropriate response to them.
- Prescriptions and accompanying written material should be given to the licensee's patient for distribution to named partners.
- The licensee should keep appropriate documentation of partner management. Documentation should include the names of partners and a copy of the prescriptions issued or an equivalent statement.

It is the position of the Board that prescribing drugs to individuals the licensee has never met based solely on answers to a set of questions, as is common in Internet or toll-free telephone prescribing, is inappropriate and unprofessional.

Telemedicine

"Telemedicine" is the practice of medicine using electronic communication, information technology or other means between a licensee in one location and a patient in another location with or without an intervening health care provider.

The Board recognizes that technological advances have made it possible for licensees to provide medical care to patients who are separated by some geographical distance. As a result, telemedicine is a potentially useful tool that, if employed appropriately, can provide important benefits to patients, including: increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and the reduced cost of patient care. Telemedicine providers are expected to adhere to current standards for practice improvement and monitoring of objective outcomes of patients who have had a telehealth visits.

The Board cautions, however, that licensees practicing via telemedicine will be held to the same standard of care as licensees employing more traditional in-person medical care. A failure to conform to the appropriate standard of care, whether that care is rendered in-person or via telemedicine, may subject the licensee to potential discipline by this Board. It is the Board's position that there is not a separate standard of care applicable to telemedicine. Telemedicine providers will be evaluated according to the standard of care applicable to their area of specialty.

The Board provides the following considerations to its licensees as guidance in providing medical services via telemedicine:

Training of Staff — Staff involved in the telemedicine visit should be trained in the use of the telemedicine equipment and competent in its operation.

Evaluations and Examinations — Licensees using telemedicine technologies to provide care to patients located in North Carolina must provide an appropriate evaluation ~~examination~~ prior to diagnosing and/or treating the patient. However, this evaluation ~~examination~~ need not be in-person ~~if the technology is sufficient to provide the same information to the licensee as if the exam had been performed face-to-face.a licensee employs t~~ as long as the licensee is able to provide appropriate care for the patient's acuity given the patient's clinical presentation, the provider's familiarity with the patient, and the provider's knowledge of the patient's past medical treatmenthistory ~~echnology and peripherals sufficient to provide an examination that is equal or superior to an in-person examination.~~

Other examinations may also be considered appropriate if the licensee is at a distance from the patient, but a licensed health care professional is able to provide various physical findings that the licensee needs to complete an adequate assessment. On the other hand, only a simple questionnaire without provider's familiarity with the patient and the provider's knowledge of the patient's past medical history, ~~completed by a non-licensed healthcare professional~~ without an appropriate evaluation ~~examination~~ may be a violation of law and/or subject the licensee to discipline by the Board.[1]

Licensee-Patient Relationship — ~~The licensee using telemedicine should have some means of verifying that the person seeking treatment is in fact who or she claims to be.~~The licensee using telemedicine should verify the identity and location of the patient and should inform the patient of the licensee's name, location and professional credentials. A diagnosis should be established through the use of accepted medical practices, i.e., a patient history, mental status

examination, physical examination and appropriate diagnostic and laboratory testing. Licensees using telemedicine should also ensure the availability for appropriate follow-up care and maintain a complete medical record that is available to the patient and other treating health care providers.

Prescribing — Licensees are expected to practice in accordance with the Board's Position Statement "Contact with patients before prescribing." Licensees are cautioned that prescribing controlled substances for the treatment of pain via telemedicine is disfavored by the Board. Licensees prescribing controlled substances for other conditions should obey all relevant federal and state laws and are expected to participate in the Controlled Substances Reporting System.

Medical Records — The licensee treating a patient via telemedicine must maintain a complete record of the telemedicine patient's care according to prevailing medical record standards. The medical record serves to document the analysis and plan of an episode of care for future reference. It must reflect an appropriate examination of the patient's presenting symptoms, and relevant components of the electronic professional interaction must be documented as with any other encounter.

The licensee must maintain the record's confidentiality and disclose the records to the patient consistent with state and federal law. If the patient has a primary care provider and a telemedicine provider for the same ailment, then the primary care provider's medical record and the telemedicine provider's record constitute one complete patient record. Licensees practicing via telemedicine will be held to the same standards of professionalism concerning medical records transfer and communication with the primary care provider and medical home as those licensees practicing via traditional means.

Licensure — The practice of medicine is deemed to occur in the state in which the patient is located. Therefore, any licensee using telemedicine to regularly provide medical services to patients located in North Carolina should be licensed to practice medicine in North Carolina.[2] Licensees need not reside in North Carolina, as long as they have a valid, current North Carolina license.

North Carolina licensees intending to practice medicine via telemedicine technology to treat or diagnose patients outside of North Carolina should check with other state licensing boards. Most states require physicians to be licensed, and some have enacted limitations to telemedicine practice or require or offer a special registration. A directory of all U.S. medical boards may be accessed at the Federation of State Medical Boards Web site: http://www.fsmb.org/directory_smb.html.

(Adopted July 2010)

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[1] See also the Board's Position Statement entitled "Contact with Patients before Prescribing."

[2] N.C. Gen. Stat. § 90-18(c)(11) exempts from the requirement for licensure: "The practice of medicine or surgery by any nonregistered reputable physician or surgeon who comes into this State, either in person or by use of any electronic or other mediums, on an irregular basis, to consult with a resident registered physician or to consult with personnel at a medical school about educational or medical training. This proviso shall not apply to physicians resident in a neighboring state and regularly practicing in this State."

The Board also notes that the North Carolina General Statutes define the practice of medicine as including, "The performance of any act, within or without this State, described in this subdivision by use of any electronic or other means, including the Internet or telephone." N.C. Gen. Stat. § 90-1.1(5)

Teladoc

October 20, 2014

Todd Brosius, Attorney
North Carolina Medical Board
1203 Front Street
Raleigh, NC 27609-7533

Dear Mr. Brosius:

With this letter, I would like to comment on the North Carolina Medical Board proposed rules on telemedicine.

As you know, Teladoc is the first and largest telemedicine provider in the United States. Founded in 2002, Teladoc provides patients with access to cost effective and transparent options for health care through its nationwide network of board-certified family physicians, pediatricians, emergency medicine physicians and internists, when they cannot get to their own PCP timely.

Teladoc physicians always review a patient's medical history prior to delivering services, and, with the consent of the patient, securely forward a copy of the consult to the patient's primary care physician. As a testament of its dedication to compliance with the appropriate standard of care, Teladoc has never had a medical malpractice claim filed against it or its physicians.

Due to Teladoc's extensive presence in the telemedicine community, Teladoc has a strong interest in the North Carolina Medical Board's ("Board") position statement entitled "Telemedicine", and in ensuring such health care services are provided in a safe manner that does not unduly obstruct the benefits that this unique model of health care delivery offers to patients, providers, and payors.

Teladoc appreciated the opportunity to participate in the Board's roundtable discussion on telemedicine and we believe the draft revisions to the position statement entitled "Telemedicine" are significant improvements. However, we are concerned that the revised position statement for "Telemedicine" does not provide the clear guidance physicians are seeking, and we would like to offer the following suggestions to improve the position statement prior to final approval by the Board:

Evaluations and Examinations

Under the heading "Evaluations and Examinations", the position statement allows for evaluations that are not in-person, provided the "...licensee employs technology and peripherals sufficient to provide an examination that is equal or superior to an in-person examination."

Teladoc 4100 Spring Valley, Ste 515 Dallas, TX 75244
(214) 302-5200 (972) 661-2312 www.teladoc.com

Teladoc

Recommendation 1.

Teladoc suggests revising the provision above as follows:

"However, this evaluation need not be in-person if the licensee employs technology ~~and peripherals~~ sufficient to provide an examination that is ~~equal or superior to an in-person examination.~~ consistent with the standard of care for the condition presented."

Rationale: Teladoc believes that standards governing the provision of telemedicine services should be focused on compliance with the standard of care rather than the type of equipment being utilized, and that the type of equipment necessary to perform a telemedicine evaluation consistent with the standard of care should be determined by the physician depending on the condition the patient presents.

The current language in the proposed position statement is subjective and unclear. Physicians seeking to comply with the position statement have no guidance on what the Board may consider "...peripherals sufficient to provide an examination that is equal or superior to an in-person examination" for the various medical conditions that may be presented. As such, physicians must proceed with uncertainty and at the risk of discipline by the Board.

The standard of care with which health care providers have a duty to comply is more consistent and more important, for patient safety, than the peripherals utilized. Primarily emphasizing the standard of care, rather than the peripherals, is more likely to ensure that electronic examinations are equivalent to personal examinations. The revision proposed above helps ensure patient safety by making the primary consideration consistency with the standard of care for the condition presented, and is a more objective requirement with which health care professionals have familiarity.

Recommendation 2.

Alternatively, if the Board believes the position statement should explicitly state that telemedicine examinations must be equal or superior to in-person examinations, Teladoc recommends the following modification:

"However, this evaluation need not be in-person if the licensee employs technology ~~and peripherals~~ sufficient to provide an examination that is equal or superior to an in-person examination."

Rationale: By referencing "technology and peripherals" the Board may be seen as requiring the use of peripherals during all examinations that are not conducted in-person. However, there are many instances when the use of "peripherals" may not be necessary. Mandating the use of "peripherals" when they are not necessary will lead to increased cost and time for an examination with no additional benefit to the patient. Again, Teladoc believes the physician should have the ability to determine if the use of "peripherals" is necessary to conduct

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Teladoc

an examination that is equal or superior to an in-person examination and that satisfies the standard of care.

Teladoc appreciates the opportunity to provide comments on this important position statement, and urges the Board to incorporate the recommendations herein prior to final approval of the revised position statement by the Board.

Sincerely,

Henry DePhillips, MD

Digitally signed by Henry DePhillips, MD
DN: cn=Henry DePhillips, MD, o=Teladoc, Inc., ou=Health Services, email=hdephillips@teladoc.com, c=US
Date: 2014.10.22 09:57:50 -04'00'

Henry DePhillips, M.D.
Chief Medical Officer
Teladoc, Inc.

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North Carolina Medical Society
Established 1849
Leadership in Medicine

November 5, 2014

Comments to the North Carolina Medical Board
RE: Revised telemedicine position statement

To whom it may concern,

The North Carolina Medical Society (NCMS) appreciates the opportunity to comment on the Medical Board's revised position statement regarding licensees' use of telemedicine. As the field of telemedicine is growing rapidly, it is important to address issues that may arise which would jeopardize patient safety and to provide clear guidance for licensees wishing to use telemedicine to provide healthcare services.

The NCMS believes that the prevailing standard of care must be maintained in all cases regardless of how that care is being provided, be it in-person or via telemedicine. The Board's revisions include statements qualifying how care provided via telemedicine must be "equal to, or superior to an in-person examination." The Board's proposed revised statement on Contact With Patients Before Prescribing also adds clarification that prescribing for a patient whom the licensee has not personally examined may be suitable when "an appropriate prescription in a telemedicine encounter where the threshold information to make an accurate diagnosis has been obtained."

We believe the threshold to meet in all cases should be the prevailing standard of care and the Board should authorize the delivery of services by any means which uphold that standard of care. As currently written, we believe the Board's revised statement has the potential to prevent healthcare providers from using telemedicine.

We urge the Board to revise its proposed statements to make this clarification as many organizations will look to telemedicine as a means to provide coordinated, high quality and efficient care, and to provide access to care where it may not otherwise be readily available.

We appreciate the opportunity to provide comments on this proposed rule. Should you have any questions, please contact Jennifer Gasperini, Director of Health Policy at 919-833-3836.

Sincerely,

Jennifer Gasperini
Director, Health Policy
NC Medical Society
919-833-3836

cc: Robert W. Seligson, Executive Vice President and CEO

Christina C. Apperson

From: Kofi Jones <Kofi.Jones@AmericanWell.com>
Sent: Wednesday, November 5, 2014 11:25 AM
To: Christina C. Apperson
Cc: Peter Antall, M.D.
Subject: RE: North Carolina Medical Board Telemedicine Policy Comments - Please Respond by Nov. 5
Attachments: Telemedicine Position Statement discussion draft - OLC-AW edits.docx

Christina –

Thank you for your ongoing work and commitment where telemedicine policy is concerned.
We have attached a version of the Boards "Telemedicine Position Statement discussion draft" with our recommended changes.

Please note, we have made only one edit, striking the words "and peripherals" in the Evaluations and Examinations portion of the statement (see below).

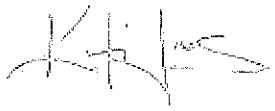
This recommendation would both support the concept that the standard of care should be the same regardless of whether the North Carolina-licensed provider is providing care in-person or via healthcare technologies, while still acknowledging that there are multiple and evolving technologies which may be appropriate during any given clinical encounter.

In addition, multiple specialties, from tele-stroke, to behavioral health, to hospice care, do not require *"peripherals"* to uphold the standard of care, and thus, could be significantly set back by the original language.

Evaluations and Examinations — Licensees using telemedicine technologies to provide care to patients located in North Carolina must provide an appropriate evaluation ~~examination~~ prior to diagnosing and/or treating the patient. However, this evaluation ~~examination~~ need not be in-person if the ~~technology is sufficient to provide the same information to the licensee as if the exam had been performed face-to-face.~~ licensee employs technology ~~and peripherals~~ sufficient to provide an examination that is equal or superior to an in-person examination.

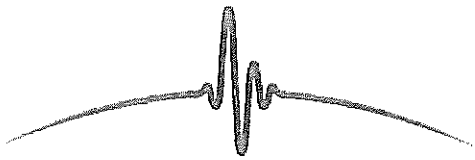
We had no additional input on the "Contact with Patients before Prescribing" document.

Thank you again for including us in your discussion. Please let us know if anything further is needed at this time.



Ms. Kofi Jones | Vice President of Public Affairs
American Well Systems | 75 State Street, 26th Floor | Boston, MA 02109
Office: 617.204.3506 Mobile: 857-210-7757 Fax: 617.428.4917
Kofi.Jones@AmericanWell.com

From: Christina C. Apperson [mailto:Christina.Apperson@NCMEDBOARD.ORG]
Sent: Tuesday, September 23, 2014 3:51 PM
To: Shilpa Shelton (shilpa.shelton@dm.duke.edu); Steve Keene (Skeene@ncmedsoc.org); David Sousa (David.Sousa@MMICNC.COM); Natasha.McKenzie@carolinashealthcare.org; 'Greg Billings' (Greg@CTeL.org); Kofi Jones; 'tseaman@teladoc.com'; mark.rumans@vidanthealth.com; jdstevens@novanthealth.org; susan.jackson@bcbsnc.com;



American Telemedicine Association
1100 Connecticut Avenue, NW, Suite 540, Washington, DC 20036-4146
202.223.3333 • Fax: 202.223.2787 • www.americantelemed.org

November 5, 2014

R. David Henderson
Executive Director
North Carolina Medical Board
1203 Front Street
Raleigh, NC 27609-7533

Reference: Proposed Amendments to "Telemedicine" Position Statement

Dear Mr. Henderson:

The American Telemedicine Association appreciates the opportunity to comment on the proposed changes to North Carolina Medical Board's ("the Board") official Position Statement entitled, "Telemedicine".

We recognize the need to implement mechanisms to assure that all health services that are delivered either in-person or via telemedicine are of the highest quality and provided in a safe manner. However, in reviewing the proposed regulations we note an area where changes in the Board's position would weaken this intent while facilitating unnecessary disruptions in service. This is noted below.

Telemedicine – Evaluations and Examinations

We appreciate that the Board has identified an opportunity to improve its policies which affect North Carolina licensed physicians using telemedicine. However, we find the parts of the proposed policy statement both overly prescriptive as well as conflicting and believe it will interfere with the intent of the Board to ensure safe and effective medical practice via telemedicine.

The Board continues to establish a separate and unequal standard for healthcare delivered in-person vs. via telemedicine -- with telemedicine held to higher and somewhat unattainable requirement. The revised position statement requires that licensees using telemedicine must provide an "evaluation" prior to diagnosing and/or treating a patient. However, the Board has no official statement or legal precedent requiring the same standard for in-person medical practice - physicians who provide medical services in-person (i.e. do not use telemedicine). We recommend that the board maintain a consistent position and uphold their opinion that "there is not a separate standard of care applicable to telemedicine." Therefore, such a requirement should apply to all licensees regardless of their method of providing care.

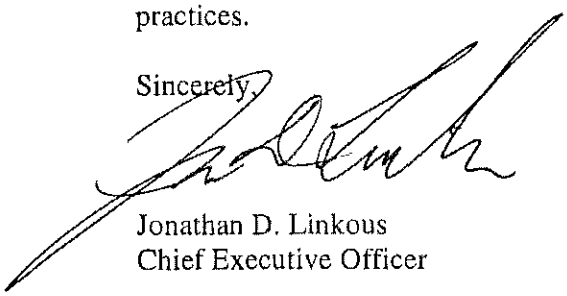
Further, the Board requires a licensee use "technology and peripherals sufficient to provide an examination that is equal or superior to an in-person examination." We suggest that such language should be consistent with in-person examinations and, instead of specifying technology or peripherals, rely on the medical judgment of the provider.

Finally, we recommend that the Board consistently use the term "evaluation(s)" in lieu of "examination (s)" throughout the position statement document in order to provide all NC licensees with clear and unambiguous professional guidance. Therefore, we recommend that the Board adopt the following further revision to the draft language under the section "Evaluations and Examinations":

> **Evaluations and Examinations** — Licensees ~~using telemedicine technologies to provide~~ providing care to patients located in North Carolina must provide an appropriate evaluation prior to diagnosing and/or treating the patient. However, this evaluation need not be in-person if the licensee employs means ~~technology and peripherals~~ sufficient to provide an evaluation ~~examination~~ that is equal or superior to an in-person evaluation ~~examination~~.
>
> Other ~~examinations~~ evaluations may also be considered appropriate if the licensee is at a distance from the patient, but a licensed health care professional is able to provide various physical findings that the licensee needs to complete an adequate assessment. On the other hand, a simple questionnaire without an appropriate ~~examination~~ evaluation may be a violation of law and/or subject the licensee to discipline by the Board.

In conclusion, we urge the Medical Board to propose consistent application among medical practices.

Sincerely,



Jonathan D. Linkous
Chief Executive Officer

NORTH CAROLINA
Psychiatric
Association

North Carolina Psychiatric Association
a District Branch of the American Psychiatric Association

4917 Waters Edge Drive, Suite 258
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www.ncpsychiatry.org

DATE: November 5, 2015

TO: Christina Apperson, NC Medical Board, Christina.Apperson@ncmedboard.org

RE: NC Psychiatric Association comments on NCMB's Telemedicine Position Statements

Thank you for the opportunity to provide feedback to the NC Medical Board's position statements on Telemedicine. The North Carolina Psychiatric Association (NCPA) is pleased to have been included in the Telemedicine Roundtable discussions.

Regarding the proposed changes to the NC Medical Board's position statements on Telemedicine, NCPA is supportive of the proposed changes to the language; however, we have concerns about the stated licensing requirements for doctors participating in telemedicine in North Carolina.

Currently, the Licensure section states:

> **Licensure** — The practice of medicine is deemed to occur in the state in which the patient is located. Therefore, any licensee using telemedicine to regularly provide medical services to patients located in North Carolina should be licensed to practice medicine in North Carolina.[2] Licensees need not reside in North Carolina, as long as they have a valid, current North Carolina license.

NCPA favors an approach that prioritizes in-state licensees practicing telemedicine, rather than out-of-state licensees. Clinical decision making for a patient requires real knowledge of the environment, services, and local care systems available to the patient. The state's current mental health system has been unstable for a decade. There is a skill set —and knowledge of the geography— that is somewhat important in making a decision to commit a patient or refer to another level of care.

Likewise, clear understanding of the statutes and local rules play an important part in clinical decision-making that might be hampered by someone out of state. North Carolina has a 2-exam commitment process, which is unlike most other states. North Carolina has outpatient involuntary commitment and psychiatric advance directives, all policies that are important for a clinician to know and consider in a telepsychiatric consultation.

With this in mind, NCPA encourages the NC Medical Board to closely monitor the availability of licensees who reside in North Carolina to practice telemedicine. Further, we encourage the development of policies that create an environment within North Carolina that attracts and retains psychiatric physicians.

Christina C. Apperson

From: [redacted]
Sent: Friday, October 10, 2014 3:45 PM
To: Christina C. Apperson
Subject: RE: Public Comment on NC Medical Board Telemedicine Position Statements -- Nov. 5

Follow Up Flag: Flag for follow up
Flag Status: Flagged

Dear Ms. Apperson,

I appreciate the opportunity to comment on the draft position statement. As a NP who has been tasked to preform Virtual Visits with patient who are associated with Carolinas Health Care System, CHS and a later to the public at large, via a cell phone, or personal computer; I have acquired some experience in this matter. First of all the position is spot on by defining what is telemedicine and stating its intended use.

CHS is marketing Virtual Care to the NC public stating---
You can participate in a Virtual Visit for a wide range of issues, including:

- Seasonal allergies
- Cold, cough, bronchitis and flu
- Sinus and upper respiratory infections
- Conjunctivitis/pink eye
- Skin conditions
- Lower back pain
- Urinary tract infections
- See http://www.carolinashealthcare.org/virtualvisit-faqs#1

Our training in terms of performing an examination or evaluation, is by observation, and asking the patient to participate by taking their own pulse, temp, ask for a pain scale, palpate their limp nodes or skin lesions, press on their back and or shine a light into their mouth. We are to listen for auditable wheezes, and or ask the patient to walk and or demonstrate range of motion. After reviewing the draft statements; I personally do not feel comfortable in making any diagnosis or write for prescriptions by using this type of an examination or evaluation as it, in my opinion is inferior or less than my in person office exam.

It is wise to publish that the use of telemedicine should be equal to or superior to an in person office visit, and please keep the word "peripherals", in the statement. I would only suggest that you provide some definition regarding what peripherals are.

Your draft position statements are in keeping with advances in technology and our ever changing society. My vote is to **more forward** with the draft statements.

Sincerely,

Christina C. Apperson

From: lunsford king <lunsfordking@gmail.com>
Sent: Tuesday, November 4, 2014 4:29 PM
To: Christina C. Apperson
Subject: comment on telemedicine

I am a psychiatrist from Wilmington and I have practiced in many practice settings, and unfortunately my experience with telemedicine was quite negative. I joined a group several years ago based in wilmington (ACT Medical Group) that focused on telemedicine. The telemedicine format seemed suited to a very fast clinical pace, but it made collateral history less accessible and coordination of care more challenging. It also limited my mental status exam. These issues alone were troubling, but it also appeared that telemedicine, at this company at least, involved a significantly higher percentage of benzodiazepine and psychostimulant prescriptions compared with the direct patient contact setting.

Sincerely, LR King, Jr. MD

Christina C. Apperson

From: mark kasari <kdnyfxr@gmail.com>
Sent: Tuesday, November 4, 2014 10:02 AM
To: Christina C. Apperson
Subject: Telemedicine

We welcome the North Carolina Medical Board's open dialogue on Telemedicine regulation. System related factors such as substandard processes, teamwork, and communication are primarily responsible for medical mishaps. Telemedicine has the potential to transform the practice of medicine, but has unresolved legal (medical malpractice liability and privacy protection), insurance reimbursement and ethical concerns. An example of such an innovative health technology is Tele-health. Tele-health has resulted in reduced hospital readmission rates and length of stay. These monitoring programs can improve care, but adopters should focus on the people rather than the technology. Telemedicine does not replace one's primary care physician, but is a convenient option for a patient residing in a rural area or when a patient's regular physician is unable to offer a timely appointment. The North Carolina Health Professions 2011 Data Book, a report on health care resources in North Carolina, showed that the number of physicians licensed by the NC Medical Board increased between 2010 and 2011. All but one county in North Carolina (Tyrell) had at least one physician reporting a primary practice location in that county. Only four counties had the fewest number of physicians and forty eight counties were seen to have an increase in the number of practicing physicians. North Carolina has many major regional hospitals, as well as an overall increasing number of physicians. For these reasons, among others, we feel that the utilization of a North Carolina licensed telemedicine physician residing outside of North Carolina is unnecessary.

Telemedicine is not a replacement for either an urgent care practice or an emergency room. Telemedicine is appropriate for the continuity of chronic medical issues and not for acute medical issues.

The North Carolina Medical Board should consider the following:

1) Telemedicine physicians should have an agreement with the patient's local health care provider. This will ensure continuity and accountability.

2) Telemedicine is the use of modern information technology as a means to deliver health care service in remote areas and to manage medical information. Its efficacy should be established and validated first as an intrastate method of patient care and only later considered for interstate use once potentially unresolved issues are addressed.

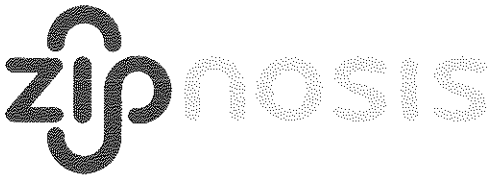
3) Lastly, Telemedicine should be narrowly defined to focus on chronic medical issues and not the acute medical problems.

Telemedicine has the potential to transform the practice of medicine, but it still has unresolved issues and unknown patient ramifications. We recommend that the NCMB tread cautiously and diligently seek educated outside input as it further defines the telemedicine scope of care.

Dr. Mark Kasari, MD

President 2014

Cumberland County Medical Society



Pascal O. Udekwu, MDDS, Pres.
North Carolina Medical Board
PO Box 20007
Raleigh, NC 27619-00078

Re: Proposed Telemedicine Standards

Dear Dr. Udekwu:

Please accept the following comments and suggestions for modifications of your board's proposed revisions to your telemedicine regulations.

My name is Rebecca Hafner-Fogarty. I am a primary care physician, the CMO of Zipnosis a telemedicine company headquartered in MN, and a member of the MN BMP where I chair the licensure committee. I do want to carefully and clearly state that I do not represent the MN BMP in this testimony.

However, because of my role as an experienced medical regulator, I believe that I have a unique understanding of the tension between our mission as medical regulators to protect the public, and the need for innovation in health care to improve access and decrease costs. As a clinician, I work hard to practice evidence based medicine. As a regulator, I strongly believe that our policy making decisions should be informed by the most current medical evidence. It is my personal belief that on-line care/telemedicine is the practice of medicine. Furthermore, I believe that a single standard of care should apply. With that in mind, I'd now like to make a couple of specific comments on your proposed standards.

First, congratulations on your thoughtful and thorough attempts to continue to articulate a standard for reputable telemedicine clinicians.

I would strongly encourage you to substitute another term for telemedicine. I believe that the term telemedicine too narrowly defines the current and evolving practices of mHealth/ virtual medicine. By using the term telemedicine, you may find yourself having to re-visit your standards in the very near future when patient administered technologies are combined with internet messaging between doctors and patients to provide medical care that does not involve real time video imaging.

I would suggest using that the term virtual medicine is a more broadly accurate term. In light of its wide acceptance, you may also wish to keep the term telemedicine, but define it more broadly to explicitly include current and emerging technologies that do not rely on real time video conferencing. I would like to specifically comment on the final three lines on the document, "Contact with patients before prescribing".

Having served on the MN BMP during the "bad old days" of rogue internet pharmacies, I understand the inclusion of the final sentence of this document. I would suggest adding an additional sentence for clarity: Adaptive interviews which may include the capture of relevant patient supplied photos or other data do not constitute questionnaires. I would agree that prescribing based solely on a "simple internet questionnaire" is inappropriate and unprofessional. However, making a decision to prescribe based on a structured history obtained through an adaptive interview for a condition where there is medical evidence supporting the safety and effectiveness of treatment decisions based on history alone, does not constitute defacto unprofessional conduct.

Unlike most conventional telemedicine companies, Zipnosis provides asynchronous(store and forward) internet triage and care for mild acute primary care conditions. Since 2011 we have safely provided triage or treatment for over 70,00 patients(over 10,00 in 2014). The vast majority of these patients are patients of our partner health systems. These innovative organizations use our sophisticated adaptive interview(NOT a "simple" on-line questionnaire) to efficiently and effectively collect a structured chief complaint and patient history(sometimes including patient supplied vital signs or photos where appropriate). This information is then reviewed by a physician(or NP or PA) who makes an assessment, and if appropriate a treatment plan. Patients with conditions not appropriate for virtual care are triaged to the next best point at care—either by the expert logic built into the interview, or by the clinician at the end of the interview. Where there is evidence to support the safety and effectiveness of treatment based on history alone clinicians are given the option to prescribe. The medical record of the virtual visit is transmitted and stored as part of the patient's EHR within the health system.
In this capacity Zipnosis provides both another way for clinicians to effectively and efficiently connect with existing patients, and equally important an entry point into the medical system for patients without a medical home. To equate this highly sophisticated virtual care encounter(and others still in development) with a simple internet questionnaire is grossly inaccurate. Yet, without the addition of the clarifying statement future boards may be tempted to do just that.

Thank you for the opportunity to comment on the proposed standards and congratulations on your fine work. I would be happy to answer any questions or supply any additional information that you might find helpful

Sincerely,

Rebecca J. Hafner-Fogarty, MD, MBA, FAAFP
CMO Zipnosis

Christina C. Apperson

From: Jim Poole <fstbraiin@gmail.com>
Sent: Wednesday, November 5, 2014 8:35 AM
To: Christina C. Apperson
Subject: Telemedicine changes

I wish to applaud the medical board in taking this seriously. Our office sees over 250 ADHD and mental health patients per week. As my pediatric client base "grows up", they go off to college, as I own Growing Child Pediatrics in Raleigh, seeing over 10,000 patients per MONTH and the largest medicaid provider in WAKE Co. I have been using Skype and Face Time to connect with them in schools around the country. This is a tremendously valuable program for them, as I have been able to make changes "on the fly" and assist them with their studies and ultimately their grades, keeping them in school. All the parents understand that I will be doing this, and I have had many parents call my office for me to "please SKYPE my child, they need help!!".

The other aspect is after making long term relationships as it relates to ADHD and learning, physicians are not well trained in this problem. My patients when they move to another town or into a rural area have not been able to connect with someone who has expertise in this area, and to that we SKYPE. They are excited and look forward to our continued connection.

On another note, I do feel that in the mental health arena, it is vital to make a personal contact first, unless there is a physician or certified mid-level provider at the site who can give the necessary insight into the problem, what is happening, and to read the body language and family situation. This would be if the telemed MD is prescribing medication from afar; as there is just too many aspects of mental health therapy for kids, adolescents, and young adults to just give controlled drugs by a computer screen.

My office has seen over 6,000 ADHD patients, many of which have co morbidity of depression, OCD, ODD, mood disorders, etc. Our success rate is the best of any I know in the country. We are 50% Medicaid, and we initially see patients making C/D/F grades in school, we take 76% to A/B honor roll!!! (that survey was just completed on our last 1,000 patients!!)

Thanks for looking into this, and would be happy to discuss further the issues and positives of this program.

Of MAJOR IMPORTANCE is to stress or make a statement to insurance / Medicaid to cover such a program financially as it will keep costs down and provide better care!

James M Poole, MD FAAP
Growing Child Pediatrics, LLC - 7 locations in Raleigh/Zeb/Knightdale/Wake Forest/Clayton
Fast Braiin, LLC Educational Centers-Raleigh/Clayton/Wake Forest/ Oxford,NC/Greenville,SC

my cell: 919-880-3679

Christina C. Apperson

From: dckeithbsmd@aol.com
Sent: Tuesday, November 4, 2014 4:02 PM
To: Christina C. Apperson
Subject: PT CONTACT PRIOR TO PRESCRIBING

After 33 years with an MD and various types of practice settings insofaras socioeconomnics of my patients as well as the level of sophistication of not only their medical needs but also their ability to understand me, I have the following insights to offer the NCMB:

Our success with getting connected to patients is in direct proportion to the time spent listening, in a quiet setting with no interuptions. This time is measured by quality, not quantity.

All patients need educated at every opportunity. Much of this can be directed through "screen time" or self-education but if not edited by knowlegdeable feedback they go away uncertain.

Our main gift to our patients is the improvement of their physical and mental lot in life by stretching ourselves to see what they seek and helping them attain that goal.

We have time constraints. Our own lot in life is suffering as more interference with our practice of medicine thins out our zeal and detracts from our self stature. Doctors no longer concentrate merely on our profession.

There may be a future shortage of care providers and/or lack of ability putting patient in the same room as the provider.

Patients need to be touched by our hands to leave the encounter satisfied and we need to touch them to be able to realize the full scope of their well being or lack thereof.

Telemedicine would be an injustice to both parties if carried out without attention to the above "truths", in my considered opinion, just as not investigating the use of telemedicine to counter current underservicing concerns would be dangerous to some people's health.

I will always be against prescribing medicines, investigational studies or therapeutics of any sort without patient contact by a warm body although there could be a team approach with the best mind afar and an agent in the room relaying the necessary info and performing the necessary evaluation..

2. New Business:
    a. Hospice Request – Exception for Prescribing

TO: Policy Committee

FROM: Dr. Kirby

DATE: November 3, 2014

RE: Hospice Request and Recommendation

Annette Kiser, MSN, RN, NE-BC, Director of Quality & Compliance, The Carolinas Center for Hospice & End of Life Care has requested the Board consider "an exception for hospice physicians to prescribe for patients they have not seen" when a hospice patient is referred to hospice "because [the patient] needs aggressive symptom management and wants to receive care outside the hospital setting". Ms. Kiser indicates it is not always feasible for the hospice physician to visit the patient prior to prescribing medications for symptom or pain management. The responsibility for ensuring medications are available often falls to the hospice physician. It is important to note that prior to the hospice physician prescribing medications an experienced hospice nurse will have made a visit to complete an assessment of the patient, their symptom management needs and their current medication profile. Ms. Kiser writes that failure provide for these needs may cause unnecessary suffering, and therefore requests the Board consider including language in the appropriate position statements to allow hospice physicians to prescribe appropriate medications under these circumstances and thus "give hospice physicians protection from unnecessary scrutiny".

I have incorporated portions of Ms. Kiser's suggestions in the relevant position statements as noted in red below. (Only the modified portion of the position statement is shown).

Contact with patients before prescribing

It is the position of the North Carolina Medical Board that prescribing drugs to an individual the prescriber has not personally examined is inappropriate except as noted in the paragraphs below. Before prescribing a drug, a licensee should make an informed medical judgment based on the circumstances of the situation and on his or her training and experience. Ordinarily, this will require that the licensee personally perform an appropriate history and physical examination, make a diagnosis, and formulate a therapeutic plan, a part of which might be a prescription. This process must be documented appropriately.

Prescribing for a patient whom the licensee has not personally examined may be suitable under certain circumstances. These may include admission orders for a newly hospitalized patient, medication orders or prescriptions, including pain management, from a hospice physician for a patient admitted to a certified hospice program, prescribing for a patient of another licensee for whom the prescriber is taking call, continuing medication on a short-term basis for a new patient prior to the patient's first appointment, or prescribing an opiate antagonist to someone in a position to assist a person at risk of an opiate-related overdose. Established patients may not require a new history and physical examination for each new prescription, depending on good medical practice.

End-of-life responsibilities and palliative care

It is the position of the North Carolina Medical Board that patients and their families should be assured of competent, timely, comprehensive palliative care at the end of their lives. Licensees should be knowledgeable regarding effective and compassionate pain relief, and patients and their families should be assured such relief will be provided. The Board recognizes there are times when a hospice patient needs medications to manage pain or other symptoms in an urgent situation. Under these circumstances a hospice physician who is an employee of, under contract with, or a volunteer with a Medicare-certified hospice may prescribe medications to a patient admitted to the hospice program who he has not seen when the needs of the patient dictate.

The following are documents submitted by Ms. Kiser for consideration by the Board:

Exception to Physician-Patient Relationship for Hospice Physicians Proposed by The Carolinas Center for Hospice & End of Life Care

Patients at the end of life deserve prompt and efficient management of pain and symptoms to ensure their quality of life is maintained in the best manner possible. Many patients are referred to hospice because they need aggressive symptom management and want to receive care outside the hospital setting. Failure to provide for these needs would cause unnecessary suffering and could lead to unwanted hospitalization.

The Board recognizes that there are times when a patient needs a prescription for medications to manage pain or other symptoms in an urgent situation. It is not always feasible for the hospice physician to visit the patient prior to prescribing these medications. Many attending physicians are reluctant to order, or are unfamiliar with, urgent pain and symptom management that occurs for hospice patients. Therefore, the responsibility for ensuring medications are available falls to the hospice physician. By virtue of the Medicare Conditions of Participation for Hospices, the hospice physician must meet the medical needs of the patient when the attending physician is unable to provide this care. Prior to the hospice physician prescribing medications, an experienced hospice nurse will have made a visit to complete an assessment of the patient, their symptom management needs and their current medication profile.

A proper professional relationship will be considered to exist between any licensed physician who is an employee of, under contract with, or a volunteer with a Medicare-certified hospice program and any patient admitted for services in the hospice program. The hospice physician can prescribe medications to a patient he has not seen when the needs of the patient dictate. The Board will consider this acceptable behavior.

Ronald J Crossno, MD CMD FAAFP FAAHPM
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V: 512.417.8497 F: 888.656.2446 E: rcrossno@earthlink.net

Jeff Seymore, MD

Medical Director, Hospice & Community Care 2275
India Hook Rd,

Rock Hill, SC 29732

By email: jeff@hospicecommunitycare.org

Re: Texas Experience with Hospice Medical Director Prescribing

Dear Dr. Seymore:

As we had discussed, I am writing this letter to explain our experience in Texas regarding the issue of Hospice Medical Directors (HMDs) prescribing for hospice patients who have not been physically examined by the HMD.

The issue is two-fold. The practical logistics of hospice care are such that hospice referrals often come with little notice to the agency or HMD. After-hours admissions often involve hospital discharges with acute care needs for the patient who wants to "go home to die." This means prescriptions for pain management are needed urgently or even emergently, before there is a chance for the HMD to see the patient. Likewise, changes to the patient's condition may necessitate additional changes to the medical regimen without an opportunity for the HMD to see the patient. In both these cases, referring physicians are often reluctant to or unfamiliar with urgent pain management that is performed in the home hospice setting, leaving this responsibility to the HMD, who is used to working with the rest of a trained interdisciplinary team who is evaluating the patient in person.

The second part of the issue is the assurance that the patient is properly identified, has a medically diagnosed condition consistent with a need for pain management, and that he/she understands the nature of the condition and benefits of treatment. Since these particulars are statutorily mandated by the rules under which hospices may admit patients, these concerns are automatically addressed upon hospice admission. Likewise, the hospice and HMD are by regulation, available twenty-four hours a day, seven days a week for problems, should they arise. In Texas, these particulars are the definition of a proper professional relationship between prescriber and patient.

The Texas Academy of Palliative Medicine (TAPM), with support from the Texas & New Mexico Hospice Organization and the Texas Partnership for End of Life Care, worked with the Texas State Board of Medical Examiners (now known as the Texas Medical Board) to update its rules regarding the definition of a proper professional relationship with a patient for purposes of prescribing medications. The amended rule reflecting these changes was originally published on April 23, 2004 in the ***Texas Register***.

The page documenting this from the current TMB rules is attached, with the entire rules available online at http://www.tmb.state.tx.us/idl/45407D14-79CD-93CE-1A70-192E86E93374. The section most pertinent to this discussion follows:

Texas Medical Board Rules

Chapter 190, Disciplinary Guidelines

Subchapter B.190.8. Violation Guidelines

When substantiated by credible evidence, the following acts, practices, and conduct are considered to be violations of the Act. The following shall not be considered an exhaustive or exclusive listing.

(1) Practice Inconsistent with Public Health and Welfare. Failure to practice in an acceptable professional manner consistent with public health and welfare within the meaning of the Act includes, but is not limited to:

(A) - (K) [Not pertinent]

(L) prescription of any dangerous drug or controlled substance without first establishing a proper professional relationship with the patient.

(i) A proper relationship, at a minimum requires:

(I) establishing that the person requesting the medications is in fact who the person claims to be;

(II) establishing a diagnosis through the use of acceptable medical practices such as patient history, mental status examination, physical examination, and appropriate diagnostic and laboratory testing. An online or telephonic evaluation by questionnaire is inadequate;

(III) discussing with the patient the diagnosis and evidence for it, the risks and benefits of various treatment options; and

(IV) ring the availability of the licensee or coverage of the patient for appropriate follow-up care.

(ii) A proper professional relationship is also considered to exist between a patient certified as having a terminal illness and who is enrolled in a hospice program, or another similar formal program which meets the requirements of subclauses (I) through (IV) of this clause, and the physician supporting the program. To have a terminal condition for the purposes of this rule, the patient must be certified as having a terminal illness under the requirements of 40 TAC 97.403 (relating to Standards Specific to Agencies Licensed to Provide Hospice Service) and 42 CFR 418.22.

I remain active with TAPM, and we have been monitoring for any reports of issues with these rules. With now ten years of experience, we have heard no reports of any problems. It was the statement of the then TMB Executive Medical Director, that failure of HMDs to be able to prescribe necessary medications, including controlled substances, for hospice patients would be a major public health concern in that any such restrictions would lead to needless suffering of terminally ill patients and/or would result in otherwise unnecessary hospitalizations that patients did not desire.

I would be happy to share any other information with you regarding our experience with this in Texas. Please let me know if I can help in any way.

Sincerely,

Ronald J Crossno, MD CMD FAAFP FAAHPM

§190.8. Violation Guidelines.

When substantiated by credible evidence, the following acts, practices, and conduct are considered to be violations of the Act. The follo\\ng shall not be considered an exhaustive or exclusive listing.

(1) Practice Inconsistent \\th Public Health and Welfare. Failure to practice in an acceptable professional manner consistent with public health and welfare within the meaning of the Act includes, but is not limited to:

(A) failure to treat a patient according to the generally accepted standard of care;

(B) negligence in performing medical servces;

(C) failure to use proper diligence in one's professional practice;

(D) failure to safeguard against potential complications;

(E) improper utilization review;

(F) failure to timely respond in person when on-call or when requested by emergency room or hospital staff;

(G) failure to disclose reasonably foreseeable side effects of a procedure or treatment;

(H) failure to disclose reasonable alternative treatments to a proposed procedure or treatment;

(1) failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, procedures, or autopsies as required under Chapter 49 of the Code of Criminal Procedure;

(J) termination of patient care without providing reasonable notice to the patient;

(K) prescription or administration of a drug in amanner that is not in compliance \\th Chapter 200 of this title (relating to Standards for Physicians Practicing Complementary and Alternative Medicine) or, that is either not approved by the Food and Drug Administration (FDA) for use in human beings or does not meet standards for off-label use, unless an exemption has othe™se been obtained from the FDA;

(L) prescription of any dangerous drug or controlled substance without first establishing a proper professional relationship with the patient.

(i) A proper relationship, at a lll1ll11llum requtres:

(I) establishing that the person requesting the medication is in fact who the person claims to be;

(II) establishing a diagnosis through the use of acceptable medical practices such as patient history, mental status examination, physical examination, and appropriate diagnostic and laboratory testing. An online or telephonic evaluation by questionnaire is inadequate;

(III) discussing \vith the patient the diagnosis and the evidence for it, the risks and benefits of various treatment options; and

(IV) ensuring the availability of the licensee or coverage of the patient for appropriate follow-up care.

(ii) A proper professional relationship is also considered to exist between a patient certified as having a terminal illness and who is enrolled in a hospice program, or another similar formal program which meets the requirements of subclauses (I) through (IV) of this clause, and the physician supporting the program To have a terminal condition for the purposes of this rule, the patient must be certified as having a terminal illness under the requirements of 40 TAC §97.403 (relating to Standards Specific to Agencies Licensed to Pro\de Hospice Service) and 42 CFR 418.22.

(III) Notwithstanding the pro\sions of this subparagraph, establishing a professional relationship is not required for:

(1) a physician to prescribe medications for sexually transmitted diseases for partners of the physician's established patient, if the physician determines that the patient may have been infected \\th a sexually transmitted disease; or

(II) a physician to prescribe medications to a patient's family members if the patient has an illness determined by the Centers for Disease Control and Prevention, the World Health Organization, or the Governor's office to be pandemic.

(M) inappropriate prescription of dangerous drugs or controlled substances to oneself, family members, or others in which there is a close personal relationship that would include the following:

(i) prescribing or administering dangerous drugs or controlled substances \\thout taking an adequate history, performing a proper physical examination, and creating and maintaining adequate records; and

(ii) prescribing controlled substances in the absence of immediate need. "Immediate need" shall be considered no more than 72 hours.

(N) providing on-call back-up by a person who is not licensed to practice medicine in this state or who does not have adequate training and experience.

2. New Business:

b. Position Statement Review

i. Medical, Nursing, Pharmacy Boards: Joint Statement on Pain Management in End-of-Life Care

CURRENT POSITION STATEMENT:

Joint Statement on Pain Management in End-of-Life Care

(Adopted by the North Carolina Medical, Nursing, and Pharmacy Boards)

Through dialogue with members of the healthcare community and consumers, a number of perceived regulatory barriers to adequate pain management in end-of-life care have been expressed to the Boards of Medicine, Nursing, and Pharmacy. The following statement attempts to address these misperceptions by outlining practice expectations for physicians and other health care professionals authorized to prescribe medications, as well as nurses and pharmacists involved in this aspect of end-of-life care. The statement is based on:

- the legal scope of practice for each of these licensed health professionals;
- professional collaboration and communication among health professionals providing palliative care; and
- a standard of care that assures on-going pain assessment, a therapeutic plan for pain management interventions; and evidence of adequate symptom management for the dying patient.

It is the position of all three Boards that patients and their families should be assured of competent, comprehensive palliative care at the end of their lives. Physicians, nurses and pharmacists should be knowledgeable regarding effective and compassionate pain relief, and patients and their families should be assured such relief will be provided.

Because of the overwhelming concern of patients about pain relief, the physician needs to give special attention to the effective assessment of pain. It is particularly important that the physician frankly but sensitively discuss with the patient and the family their concerns and choices at the end of life. As part of this discussion, the physician should make clear that, in some end of life care situations, there are inherent risks associated with effective pain relief. *The Medical Board will assume opioid use in such patients is appropriate if the responsible physician is familiar with and abides by acceptable medical guidelines regarding such use, is knowledgeable about effective and compassionate pain relief, and maintains an appropriate medical record that details a pain management plan.* Because the Board is aware of the inherent risks associated with effective pain relief in such situations, it will not interpret their occurrence as subject to discipline by the Board.

With regard to pharmacy practice, North Carolina has no quantity restrictions on dispensing controlled substances including those in Schedule II. This is significant when utilizing the federal rule that allows the partial filling of Schedule II prescriptions for up to 60 days. In these situations it would minimize expenses and unnecessary waste

of drugs if the prescriber would note on the prescription that the patient is terminally ill and specify the largest anticipated quantity that could be needed for the next two months. The pharmacist could then dispense smaller quantities of the prescription to meet the patient's needs up to the total quantity authorized. Government-approved labeling for dosage level and frequency can be useful as guidance for patient care. Health professionals may, on occasion, determine that higher levels are justified in specific cases. However, these occasions would be exceptions to general practice and would need to be properly documented to establish informed consent of the patient and family.

Federal and state rules also allow the fax transmittal of an original prescription for Schedule II drugs for hospice patients. If the prescriber notes the hospice status of the patient on the faxed document, it serves as the original. Pharmacy rules also allow the emergency refilling of prescriptions in Schedules III, IV, and V. While this does not apply to Schedule II drugs, it can be useful in situations where the patient is using drugs such as Vicodin for pain or Xanax for anxiety.

The nurse is often the health professional most involved in on-going pain assessment, implementing the prescribed pain management plan, evaluating the patient's response to such interventions and adjusting medication levels based on patient status. In order to achieve adequate pain management, the prescription must provide dosage ranges and frequency parameters within which the nurse may adjust (titrate) medication in order to achieve adequate pain control. Consistent with the licensee's scope of practice, the RN or LPN is accountable for implementing the pain management plan utilizing his/her knowledge base and documented assessment of the patient's needs. *The nurse has the authority to adjust medication levels within the dosage and frequency ranges stipulated by the prescriber and according to the agency's established protocols.* However, the nurse does not have the authority to change the medical pain management plan. When adequate pain management is not achieved under the currently prescribed treatment plan, the nurse is responsible for reporting such findings to the prescriber and documenting this communication. Only the physician or other health professional with authority to prescribe may change the medical pain management plan.

Communication and collaboration between members of the healthcare team, and the patient and family are essential in achieving adequate pain management in end-of-life care. Within this interdisciplinary framework for end of life care, effective pain management should include:

- thorough documentation of all aspects of the patient's assessment and care;
- a working diagnosis and therapeutic treatment plan including pharmacologic and non-pharmacologic interventions;
- regular and documented evaluation of response to the interventions and, as appropriate, revisions to the treatment plan;
- evidence of communication among care providers;
- education of the patient and family; and
- a clear understanding by the patient, the family and healthcare team of the treatment goals.

It is important to remind health professionals that licensing boards hold each licensee accountable for providing safe, effective care. Exercising this standard of care requires the application of knowledge, skills, as well as ethical principles focused on optimum patient care while taking all appropriate measures to relieve suffering. The healthcare team should give primary importance to the expressed desires of the patient tempered by the judgment and legal responsibilities of each licensed health professional as to what is in the patient's best interest.

(Adopted October 1999) (Amended January 2011)

3. Position Statement Review tracking chart:

1/2010 Committee Recommendation: (Loomis/Camnitz) Adopt a 4 year review schedule as presented. All reviews will be offered to the full Board for input. Additionally all reviews will be documented and will be reported to the full Board, even if no changes are made.

1/2010 Board Action: Adopt the recommendation of the Policy Committee.

POSITION STATEMENT	ADOPTED	SCHEDULED FOR REVIEW	LAST REVISED/ REVIEWED/ ADOPTED	REVISED/ REVIEWED	REVISED/ REVIEWED	REVISED/ REVIEWED	REVISED/ REVIEWED
Telemedicine	May-10	Nov-13	May-10				
Medical, Nursing, Pharmacy Boards: Joint Statement on Pain Management in End-of-Life Care	Oct-99	Nov-14	Jan-11	Oct-99			
HIV/HBV Infected Health Care Workers	Nov-92		Jan-11	Jan-05	May-96		
Writing of Prescriptions	May-91		Mar-11	Mar-05	Jul-02	Mar-02	May-96
Laser Surgery	Jul-99		Mar-11	Jul-05	Aug-02	Mar-02	Jan-00
Office-Based Procedures	Sep-00		May-11	Jan-03			
Sale of Goods From Physician Offices	Mar-01		May-11	Mar-06			
Competence and Reentry to the Active Practice of Medicine	Jul-06		Jul-11	Jul-06			
Prescribing Controlled Substances for Other Than Valid Medical or Therapeutic Purposes, with Particular Reference to Substances or Preparations with Anabolic Properties	May-98		Sept-11	Nov-05	Jan-01	Jul-98	
Referral Fees and Fee Splitting	Nov-93		Jan-12	Jul-06	May-96		
Self- Treatment and Treatment of Family Members and Others With Whom Significant Emotional Relationships Exist	May-91		Mar-12	Sep-05	Mar-02	May-00	May 96
Availability of Physicians to Their Patients	Jul-93		May-12	Nov-11	Jul-06	Oct-03	Jan-01
Sexual Exploitation of Patients	May-91		May-12	Sep-06	Jan-01	Apr-96	
Care of the Patient Undergoing Surgery or Other Invasive Procedure	Sep-91		Jul-12	Sep-06	Mar-01		
The Physician-Patient Relationship	Jul-95		Jul-12	Sep-06	Aug-03	Mar-02	Jan-00
The Retired Physician	Jan-97		Jul-12	Sep-06			
Physician Supervision of Other Licensed Health Care Practitioners	Jul-07		Sep-12	Jul-07			
Medical Testimony	Mar-08		Sep-12	Mar-08			
Advance Directives and Patient Autonomy	Jul-93		Nov-12	Mar-08	May-96		
End-of-Life Responsibilities and Palliative Care	Oct-99		Jan-13	Mar-08	May-07		
Drug Overdose Prevention	Sep-08		Mar-13	Sep-08			

Professional Use of Social Media	Mar-13		Mar-13				
The Treatment of Obesity	Oct-87		May-13	Nov-10	Jan-05	Mar-96	
Contact With Patients Before Prescribing	Nov-99		May-13	Jul-10	Feb-01		
Medical Record Documentation	May-94		May-13	May-09	May-96		
Retention of Medical Records	May-98		Jul-13	May-09			
Capital Punishment	Jan-07		Jul-13	Jul-09			
Professional Obligations pertaining to incompetence, impairment, and unethical conduct of healthcare providers	Nov-98		Sept-13	Mar-10	Nov-98		
Unethical Agreements in Complaint Settlements	Nov-93		Sept-13	Mar-10	May-96		
Guidelines for Avoiding Misunderstandings During Physical Examinations	May-91		Jan-14	Jul-10	Oct-02	Feb-01	Jan-01
Departures from or Closings of Medical	Jan-00		May-13	Jul-09	Aug-03		
Policy for the Use of Controlled Substances for the Treatment of Pain	Sep-96		May-14	Jan-13	Sep-08	Jul-05	
Access to Physician Records	Nov-93		May-14	Sep-10	Aug-03	Mar-02	Sep-97
Medical Supervisor-Trainee Relationship	Apr-04		Jul-14	Nov-10	Apr-04		
Advertising and Publicity	Nov-99		Aug-14	Nov-10	Sep-05	Mar-01	