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Secretary, Agency for Health Care Administration

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State Surgeon General & Secretary, Department of Health

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Sunshine Health

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Baptist Health South Florida

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Care Angel

Kim Landry, MD
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William Manzie
Memorial Healthcare

Elizabeth Miller, CRNP
WellCare

Steven Selznick, DO
Selznick Consulting, CFP Physicians Group

Mike Smith
Florida State University, College of Medicine

Matthew Stanton
Cleveland Clinic

Monica Stynchula
REUNIONCare

Sarvam Terkonda, MD
Mayo Clinic

Agenda
June 20, 2017
9:00am – 4:00pm

Location: Wellcare
8328 N. Florida Avenue
Tampa, FL 32604


9:00 – 9:05 Welcome & Introductions, Roll Call, Review & Approval of May Minutes
Chair Senior

9:05 – 9:10 Welcome Wellcare
Ken Burdick, CEO

9:10 – 9:40 Baycare – Publix Collaboration
Greg Hindahl, MD

9:40 – 10:10 Triple Care
David Chess, MD

10:10 – 10:20 Break

10:20 – 11:20 Panel Discussion: Tallahassee Memorial Healthcare Nemours
Lauren Faison
Shayan Vyas, MD

11:20 – 11:35 Public Comments
Chair Senior

11:35 – 12:35 Lunch Break

12:35 – 2:00 Member Discussion
Council Members

2:00 – 2:15 Break

2:15 – 3:45 Member Discussion & Next Steps
Council Members

3:45 – 4:00 Wrap Up & Closing
Chair Senior

Meeting Materials and Information will be available at: www.AHCA.myflorida.com/Telehealth
Additional comments and information may also be sent to: Telehealth@ahca.myflorida.com
BayCare and Telehealth: Today and Tomorrow

Greg Hindahl, MD, FAAFP, VP & CMIO
BayCare Health System
Presentation to Florida Telehealth Advisory Council
June 20, 2017
BayCare By The Numbers

- 25,600 Team Members
- 3,491 Beds
- 845,288 Home Health Visits
- 59,761 Outpatient Surgeries
- 592,487 ER Visits
- 13 Imaging Facilities
- 158,909 Discharges
- $266.8 Million Community Benefit
- 14 Hospitals
- 340 Locations In 4 Counties
- 4 Ambulatory Surgery Centers
- 10 Urgent Care Centers
- 406 BayCare Medical Group (BMG) Physicians
- 5,400 Physicians
BayCare’s Care Continuum

Community-Based Care
- Wellness Centers (3)
- Home Care Offices (20)
- Physician Practice Locations (154)
- Employed Physicians (500+)

Post Acute Care
- Skilled Nursing Facilities (2)
- Outpatient Rehab Facilities (17)
- Inpatient Acute Care Rehab Locations (2)

Acute Care
- LTAC Hospital (1)
- Behavioral Health Hospital (2)
- Acute Care Hospitals (14)
- Free-Standing ER (1)
- Urgent Care (14)
- Ambulatory Surgery Centers (4)

Revised March 2015
Why Telehealth?

Benefits

- Helps us solve some very difficult operational and clinical challenges
- It’s the right thing to do for our patients and families despite limited or no reimbursement
  - Improved Access
  - Improved experience/convenience for patients and their families
- Reduce hospital readmissions from both homecare and skilled nursing facilities
BayCare Investment in TeleHealth

- **Invested to date:** $21.5 million
  - $20.5 million for eICU/TeleSNF
  - $1 million for other telehealth initiatives
- **Projected annual spend:** $8.6 million
- **Medicaid Reimbursement to date:** $27,400
  - For limited pediatric behavioral health services
Improving Access for Non-Emergent Care

BayCare Anywhere

- Provides 24/7/365 coverage for patients for minor illness and conditions
- 30% of the patients seen by BayCare physicians, which includes 2 pediatricians
- Ratings for both satisfaction with the provider and satisfaction with the experience 4.9/5.0 for the 1,600+ visits since go live last July
Improving Access for Non-Emergent Care

BayCare Anywhere

- All patients called by our TeleMedicine Care Manager
- The visit encounter summary placed in the patient’s chart in Cerner
- Urgent care visits within 24 hours are discounted by the cost of the telemedicine visit
- BayCare Team Members and their families can access telemedicine visits for $10 copay
Improving Access to Specialists

• eICU
• TelePsych
• TeleEndocrinology
• TeleStroke
• Wound Care

• Helping improve outcomes and reduce complications
• Limited or no reimbursement for this care
Improving Access to Specialists: Future Use Cases

- Post-Transcatheter Aortic Valve Replacement (TAVR) follow up
- Improving care for patients with abnormal mammograms
Reducing Readmissions

• **TeleSNF**
  - Live with 12 SNFs, plan for 16 by end of 2017
  - Have prevented over 120 readmissions since program’s go-live in August 2016

• **Home Monitoring Program**
  - Live at all of our acute care hospitals for our discharged COPD and CHF patients who are at medium and high risk for readmission
BayCare + Publix: Expanding Access to Care

• BayCare, Publix announce partnership on March 17
  -Largest non-profit health care system plus largest private company in Tampa Bay

• Extends health care options in our communities
  -Pinellas, Hillsborough, Polk and Pasco Counties
Focus on Telehealth

• Telehealth is major component of partnership
• New health care options for patients
• Plans for ‘telehealth rooms’ for private encounters
What Does it Mean for Patients?

• Enhanced Telehealth Encounters
  - Private telehealth rooms for patients
  - BayCare Medical Group physicians and American Well’s Online Care Group provide care
  - Diagnostic devices add clinical capabilities beyond traditional telehealth encounters
  - Enables minor tests, such as flu and strep
What Will it Look Like?

A vision of where we’re headed

Rendering of Private Telehealth Room, Kiosk with medical equipment
More Plans for Telehealth at Publix

- **Monitor Critical Patient Groups**
  - Publix FDA-approved higi stations provide convenient mechanism to collect a patient’s vitals, providing medically-reliable data for care related to hypertension and congestive heart failure

- **Integrate Patient Information**
  - After visit summary, other information added to patient’s medical record
Telehealth Use Case Wish List

• Follow-up care capability for patients to see primary care physicians and specialists
• Physician to physician consultations with patient and family present
• Expanded access for Behavioral Health
• TelePharmacy for discharged patients who are not home care patients
• Care transition visits by a physician ‘transitionist’
Our Policy Recommendations

• From our experience, lack of reimbursement by health plans is the single largest barrier to expanded use of telehealth.

• This Council’s recommendations must address reimbursement.
Florida’s Telehealth Legislative Framework should include…

• **Coverage Parity**
  – Health plans must provide coverage for health care services appropriately provided via telehealth to the same extent that the services would be covered if they were provided through an in-person visit, consistent with standard billing practices.

• **Reimbursement Parity**
  – Health plans must reimburse health care services provided via telehealth at the same rate as an in-person visit, consistent with standard billing practices.
Questions?
**Greg Hindahl, MD, FAAFP**

Dr. Hindahl currently serves as BayCare Health Systems VP & Chief Medical Information Officer (CMIO). He has held this position for five years. As the CMIO Dr. Hindahl provides administrative oversight for BayCare in the following areas: Inpatient and Ambulatory Cerner EMR; IS support for clinical users in our hospitals and employed physician offices; IS Training and Education Team; Meaningful Use; Physician Portal; Dragon Voice Recognition for Physicians, Cerner PowerChart Touch for inpatient and ambulatory. He is currently the clinical executive in charge of developing BayCare’s Telemedicine Vision and Strategy.

Prior to working for BayCare, Dr. Hindahl served for four and a half years as the CMIO for Deaconess Health System in Evansville, Indiana. There he provided physician leadership for Deaconess’s Implementation of Epic’s Inpatient and Ambulatory EMR and helped them reach HIMSS Level 7 for all of their hospitals. Dr. Hindahl received his medical degree from Indiana University in 1983. He completed his Family Medicine Residency in 1986 and has been Board Certified in Family Medicine since 1986. He practiced Family Medicine and Emergency Medicine for 22 years. He also served as a Family Medicine Residency Director for 12 years in the Deaconess Hospital Family Medicine Residency Program in Evansville. He led 7 different teams of physicians, nurses, pharmacists, students and residents on medical mission trips to impoverished areas of rural Jamaica while at Deaconess.
TripleCare

treating through telemedicine™
The Challenge

Building a Safe Place for Advanced Medical Care
Overview

• The Challenge: Keeping nursing home residents out of the hospital when they don’t need to be there.

• The TripleCare Solution: Highly-trained physicians who provide excellent patient care to nursing home residents at the bedside via telemedicine.

• TripleCare Results: Treated over 80% of nursing home patients and residents in place, reduced re-hospitalization rates and increased revenue based on census maintenance or growth.
Key Skilled Nursing Facility Challenges

- Much sicker patients
- Lower reimbursement
- Staff turnover
- Smaller pool of patients (hospital census is down)
- Increased regulatory oversight and compliance pressure
- Clinical outcomes matter a lot – STAR ratings and $ penalties
- Families and patients have increased expectations
The TripleCare Solution
An Example of How TripleCare Works

http://6abc.com/health/high-tech-healthcare-helps-eliminate-unnecessary-hospital-visits/1416091/
TripleCare Mission, Goals and Experience

• Founded in 2011

• Mission is to provide excellent, respectful, thoughtful medical care to patients on site

• Goal is to transform nursing facilities from a Nursing - Social Model to a Medical Model
  – Catalyzing a Clinical and Financial Paradigm shift
  – Integrating with facility clinical/payor staff

• We are the most experienced providers of after-hours telemedicine care in nursing facilities in the country.
  – Operating in 11 states and having cared for over 13,000 patients.
Our TripleCare Clinical Practice

• Access to face-to-face bedside care from a team of physicians

• 113 hours of coverage/week at times when bedside physician care is rarely available (nights, weekends, holidays)

• Improve clinical outcomes, enhance care, and differentiate facility
Our Physician Group

• Highly-curated team of dedicated expert physicians - not a loose affiliate network
• Board certified internists, geriatricians, hospitalists and family practitioners
• All licensed to do business in the state where patients reside
• Covered by industry-standard malpractice umbrella and individual policies
• Each customer has a custom physician network – nurses will develop relationships with their practitioner group
• TripleCare physicians are trained that the nurse is their customer – service is as important as clinical care
• Specially trained on Advanced Care Directives
How TripleCare Works

1. The nurse calls TripleCare and connects directly to a physician.
2. The physician connects to the telemedicine unit, examines the patient with the nurse and treats in place when possible.
3. Full notes and orders are faxed securely to the nurse to update the patient’s record.
4. The physician communicates with the attending on the episode and the treatment plan.
TripleCare’s Telemedicine Unit

- Video camera, monitor, and speakers mounted on a traditional medical cart
- 20x zoom camera
- Digital stethoscope (Transducer volume and frequency is physician-controlled while wireless headset allows nurse to participate in exam)
- No button operation - Always on and self-monitoring
- Pillow speaker and privacy phone
- 6-8 hour battery life (no room plug in required)
Common TripleCare Patient Episodes

• Chief complaints
  – Shortness of breath
  – Fever
  – Change in mental status
  – GI symptoms
  – Chest pain
  – Falls with injuries
  – Behavior changes

• Common diagnoses
  – CHF
  – Pneumonia
  – COPD
  – Hypovolemia/hypotension
  – Urosepsis
The Attending Community

- Very positive reception
- Four key questions
  - Billing
  - Involvement
  - Malpractice
  - Quality
- “Rest Assured” campaign
TripleCare Difference - Dedicated Bedside Care

- 113 hours availability on demand plus National Holidays
- Physicians dedicated to working for TripleCare (can’t be clinically or socially involved in other activity)
- Each Facility has a expert group of physicians who provide consistent care, rotate weekly – no “hand offs”
- No answering service – immediate connection to the TripleCare Physician, no delay in care or “call backs”
- Physicians experienced in caring for acutely ill medically complex patients in SNF
- Physicians communicate directly with patients, families and attendings
- True clinical integration. Phone based sign out and sign ins with NPs and attendings
- Advanced Care Planning conversations at times of clinical transitions
- State of the Art Technology – made simple, no buttons or sign ins--just wheel the unit into the room.
TripleCare Results
Results

• Treat in place over 80% of the time when called
• Reduction of hospital admissions and readmissions
• Elevation of nursing skills and morale, decreasing turnover and improving job satisfaction
• Improvement of clinical outcomes helps brand facility to key stakeholders (hospitals, ACOs, managed care)
• Increased attractiveness to community and referring physicians
• Positive reception by the attending physician community
• Clients are seen as innovators and safe providers of care
• High patient and family satisfaction
Case Studies
## Artman RTH Rates 2014-2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>17%</td>
</tr>
<tr>
<td>2015</td>
<td>12%</td>
</tr>
<tr>
<td>2016</td>
<td>12%</td>
</tr>
</tbody>
</table>

*TripleCare Service Active*
Paul’s Run RTH Rates 2014-2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>24%</td>
</tr>
<tr>
<td>2015</td>
<td>15%</td>
</tr>
<tr>
<td>2016</td>
<td>11%</td>
</tr>
</tbody>
</table>

TripleCare Service Active
Artman – 7 Days Post-TripleCare Intervention

82% Sustained Impact

7-Day Follow Up after Our Initial Episode of Care

65 patients stayed on site

12 patients Hospitalized or died in the following 7 days
AristaCare at Norwood Hospitalization and ED Visit – CMS Data

2015 – Before Full Implementation of TripleCare
7/2015 through 6/2016 – After TripleCare

2015

- Hospitalization: 20.1
- ED Visit: 6.86

7/2015 - 6/30/2016

- Hospitalization: 16
- ED Visit: 7.4
Cobble Hill Hospitalization and ED Visit - CMS Data

2015 – Before TripleCare
7/2015 through 6/2016 – After TripleCare

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospitalization</th>
<th>ED Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>21.98</td>
<td>8.66</td>
</tr>
<tr>
<td>7/2015 - 6/30/2016</td>
<td>16.5</td>
<td>6.1</td>
</tr>
</tbody>
</table>

Proprietary & Confidential | www.triple.care
Cobble Hill Hospital Admissions

Hospitalizations per Year Before and After TripleCare

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014-2015</td>
<td>490</td>
</tr>
<tr>
<td>2015-2016</td>
<td>402</td>
</tr>
</tbody>
</table>

18% decrease
(No other significant changes made in care delivery)
Cobble Hill - Samuels Foundation - Findings

- TripleCare services were provided for one full year starting March 1, 2015 and extending to February 29, 2016

- During that period a total of 402 transfers occurred compared to 490 during the prior year, representing an **18% reduction in total transfers**

- TripleCare physicians were contacted by Cobble Hill staff as the “physician on call” on a total of 313 residents because of changes in the residents’ medical conditions

- 91 avoided hospitalizations (third party confirmed)
Cobble Hill – Payor Financial Impact

<table>
<thead>
<tr>
<th>Avoided Hospital Admission Savings</th>
<th>91 avoided x $15,000/hospitalization = $1,365,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoided Ambulance Costs</td>
<td>91 avoided x $1,200/hospitalization = $109,200</td>
</tr>
<tr>
<td>Avoided Medicare Skilled Days at CHHC</td>
<td>16 Medicaid/11 Medicare pts avoided skilled = $75,840</td>
</tr>
<tr>
<td><strong>TOTAL SAVINGS</strong></td>
<td><strong>$1,550,040</strong></td>
</tr>
<tr>
<td>ISNP Cost Savings</td>
<td><strong>$500,000</strong></td>
</tr>
</tbody>
</table>
Liberty Lutheran

- Two nursing facilities with a total of 181 SNF beds, 60 post acute beds
- TripleCare treated 263 of 294 (89%) of cases in place
- TripleCare saved Lutheran approximately $280K by avoiding hospitalizations
- Nurses felt increasingly self-confident and satisfied with TripleCare’s services.
- Net Revenues after TripleCare and variable costs = $106,760

<table>
<thead>
<tr>
<th>Quarterly Historical Payor Mix</th>
<th>Breakdown of 100 Patients</th>
<th>Average Daily Rate</th>
<th>Average Days Lost to Hospitalization</th>
<th>Revenue Retained per 100 TripleCare Saves</th>
</tr>
</thead>
<tbody>
<tr>
<td>37% Private</td>
<td>37</td>
<td>$393</td>
<td>7.5</td>
<td>$109,057</td>
</tr>
<tr>
<td>15% Managed Care</td>
<td>15</td>
<td>$373</td>
<td>7.5</td>
<td>$41,962</td>
</tr>
<tr>
<td>22% Medicare</td>
<td>22</td>
<td>$542</td>
<td>7.5</td>
<td>$89,430</td>
</tr>
<tr>
<td>26% Medicaid</td>
<td>26</td>
<td>$205</td>
<td>7.5</td>
<td>$39,975</td>
</tr>
<tr>
<td>100% Total</td>
<td>100</td>
<td></td>
<td></td>
<td>$280,425</td>
</tr>
</tbody>
</table>
Thank You
Expanding Care Through TeleHealth
June 20, 2017
Tallahassee Memorial HealthCare
Facts & Figures

- 772 Beds
- Serving 17 Counties
- Partnerships with:
  - UF Health
  - Wolfson Children’s Hospital
  - Doctors’ Memorial Hospital
  - Weems Memorial Hospital
- Acute Care Hospital
- Psychiatric Hospital
- Multi-Specialty Care Centers
- Inpatients: 29,586
- Outpatients: 133,046
- Emergency Care: 122,100
- Births per year: 3,800
- Surgeries per year: 16,400
- Employees: 4,586
- Physicians on medical staff: 558
- Employed Physicians: 175+
- Not-for-profit
- 31 physician practices
- 3 Residency Programs

Not-for-profit Hospital

Your Hospital for Life
Mission & Vision of TMH

- **Mission**
  - Transforming care.
  - Advancing health.
  - Improving lives.

- **Vision**
  - Leading our community to be the healthiest in the nation.
TMH Telehealth Goals

*Increase patient access to primary and specialty care.*

- Neurology
- Orthopedic Follow-Ups
- Wound Care
- Mental Health
- Dermatology
TMH Telehealth Goals

**Promote Successful Transitions in Care**

- Post-Acute Facilities
- High Risk Follow-Ups
- Nurse to Nurse Hand-Offs
- Transfers
TMH Telehealth Goals

*Increase Efficiencies Within the Regional Health System*

- Transportation Costs
- Duplication in Tests/Labs
- Patient Wait Times
- Physician Time
- Cost of Care
TMH Telehealth Goals

*Reduce readmissions and unnecessary visits to the emergency room*

- Telehealth Monitoring
- Post-Acute Visits
- Outpatient Availability
- Increased Communication
TMH Telehealth Goals

Improve health and overall quality of life for patients

Delivering care when and where it is needed at a lower cost.
Challenges/Opportunities

1. Set technology parameters
2. Uniform Reimbursement
3. Resource Center
4. Online Training Resources
5. Marketing/Education
Shaping The Future.

Shayan Vyas, MD, FAAP
Pediatric Intensivist, Medical Director, Telehealth Assoc Prof., UCF
One of the Nation’s Leading Pediatric Health Systems

OUR LOCATIONS

86 CARE LOCATIONS IN COMMUNITIES ACROSS 6 STATES

Children’s Health System
Leveraging Technology
Deliver high-quality pediatric care to children at a distance through the use of our simple telemedicine platforms.

- Increase access to pediatric expertise across states
- Improve care and outcomes
- Improve value to partners – assist in keeping care local
- Reducing cost
64% of parents surveyed have used or plan to use telemedicine within the next year for their child.

98% of parents who have tried an online doctor visit for their child said it was better or the same as an in-person visit.
CareConnect is our comprehensive telehealth program, we have completed over 3,400 visits since inception in late 2014 (not including store/forward).

- Clinician-to-clinician
- Clinician-to-family
- On-demand
- Store/Forward
Clinician-to-Clinician

- ERs
- Hospitals
- Critical Care Transport Team
- Cruise ships
- Schools
Clinician-to-Family

- Nemours & non-Nemours PCPs
- Nemours’ clinics
- Schools
- Direct-to-consumer (DTC) on demand
- DTC - scheduled visits
24/7 On-demand Urgent Care Visits

- Board certified Nemours employed Pediatricians
- 5 States (FL, MD, DE, PA, NJ) (Ga – Q3/Q4)
- Records sent to Patient + PCP
- 97% patient satisfaction
- Real-time eligibility with Payers including Medicaid plans
Nemours committed to significant expansion of Telemedicine to improve access to care.
Clinician-to-Family (Specialties)

We are providing telemedicine in the following specialties across Nemours service area (300+ clinicians trained)

- Allergy
- Cardiology
- Dermatology
- Endocrinology
- ER Post-discharge care
- Gastroenterology
- Genetics
- Headache Clinic
- Infectious disease
- Maternal Fetal Medicine
- Nephrology
- Neurology
- Neurosurgery
- Nutrition
- Orthopedics
- Palliative care
- Perinatology
- Phenylketonuria (PKU)
- Post hospitalization care
- Psychiatry
- Psychology
- Pulmonology
- Rheumatology
- Speech Therapy
- Sports Medicine
- Surgery Follow-up
- Transition of Care
- Urology
- Weight Management
Parents are most willing to use telehealth services for common childhood ailments, including:

- **58%** Cold and Flu
- **51%** Pink Eye
- **48%** Rash
- **41%** Well-Child Visits

68% of CareConnect users said they avoided a trip to the emergency department as a result of their online visit.
Helping parents with practical guidance in plain language

*Preventative, acute and chronic issues*

- Simple instructions
- Informative illustrations
- Distributed by clinicians via the EHR
- Created exclusively for pediatrics
Store and Forward Telemedicine

- Radiology
- Echo/EKG
- EEG
Quality & Clinical Protocols

- Starting a pediatric telemedicine program
- Recruiting and educating/training providers
- 1 ½ years of DTC experience
- Provider to provider experience
- Quality and safety of telemedicine
- Unique use cases and deployment strategy
EMR Integration for Specialty Care

- Bi-directional flow between EMR & platform
- All scheduling conducted from EMR
- Phase 2
Nemours CareConnect has been recognized for the following awards:

- 2016 Innovation of the Year
- Top Apps to Know 2015 & 2016
- 2017 Achievement Award
Near Future...
TytoCare Pilots
Remote Monitoring

Spirometer
Projected Number of Office Visits, 2015 - 2025

Social forces, including the mobility of the nuclear family, the aging of populations, and the rapid adoption of technology are expected to expand the use of telemedicine visits.
Thank you.

Questions?

svyas@Nemours.org

407-694-2070 M
Telehealth Barriers Discussion

The Council categorized areas of identifiable or perceived obstacles for the expansion of telehealth into seven specific areas at the May meeting. Under each of the main categories, the Council also identified subcategories. The Council had more in-depth discussion on a telehealth definition and technology at its April and May meetings. In order to facilitate the discussion regarding the report content three action items are provided for consideration.

1. **Action Needed:**
   - Determine if any other categories or subcategories need to be added (see next page)

**Options:**

a. Accept current major categories  
b. Modify current major categories  
c. Move forward with current major categories and modify if determined necessary at future meeting

2. **Action Needed:**
   - Determine if the Council would like to recommend legislative language as part of the report

**Options:**

a. Agree to develop legislative language as an attachment to the report  
b. Agree to provide conceptual recommendations only in the report  
c. Make a determination on this at a future meeting of the Council

3. **Action Needed:**
   - Determine how the Council would like to proceed with developing report language

**Options:**

a. Members develop recommendation language for specific categories and provide to staff for compilation and review and input by entire Council  
b. Members develop recommendation language for each category and provide to staff for compilation and review and input by entire Council  
c. Members provide input for each category verbally at meetings and staff compile for review and input
Barrier Categories

- Definition of Telehealth
- Technology
  - Equipment Costs
  - Patient Access to Technology
  - Interoperability
- Health Practitioner Issues
  - Direct to Consumer Models
  - Out of State Licensure and Consultations
  - Collaboration of Care Teams
- Patient/Consumer Protection
  - Cross state licensure (conditional practice and/or licensure compacts)
  - Practitioner standard of care (PT, OT, Pharmacy, Mental Health, etc)
  - Consent
  - Patient Expectations vs. Services Offered
  - On-line Prescribing
- Insurance Coverage and Reimbursement
  - Reimbursement for specific modalities (live video, store & forward, remote monitoring)
  - Payment Parity
  - Public Payer – specifically support changes to Medicare requirements & add in other modalities to Medicaid fee for service language
  - Site Transmission Fees – permitted or not
  - Location of Services – originating rite requirements
- Education
  - Medical School Training
  - Promote Continuing Education
  - Outreach
Sample Report Outline

Executive Summary

*Pending completion of the rest of the report*

Background

Chapter 2016-240, Laws of Florida created the Telehealth Advisory Council (Council) to make recommendations to the Governor and the Legislature. The law designates the Secretary of Agency for Health Care Administration (Agency) as the Council Chair, and designates the State Surgeon General (or designee) as a member. The Agency’s Secretary and the Surgeon General appointed 13 Council members representing specific stakeholder groups. The Council’s charge was to review survey and research findings, and to employ that information to inform recommendations to increase the use and accessibility of services provided via telehealth. The Council’s review also includes the identification of barriers to implementing or accessing services provided via telehealth.

The law directed the Agency to compile survey, research findings, and submit a report of findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The Agency submitted the report on December 31, 2016 to meet the requirements of Chapter 2016-240; and represents the collaborative efforts across Agency, Department of Health, and Office of Insurance Regulation.

This report presents the recommendation of the Council based on Florida survey results, research findings, and public testimony. Research review and testimony demonstrates a clear benefit for at risk and vulnerable populations. The Council identifies barriers attributed to hindering the growth of telehealth in Florida and provides recommendations to reduce or eliminate the barriers, when necessary.

*Add in testimonies...public health, pediatric care, behavioral health, dental programs, speech pathology/audiology...etc.*

The Council categorized areas with identifiable obstacles for the expansion of telehealth into seven specific areas: definition of telehealth/telemedicine, technology, health practitioner issues, patient/consumer protection, insurance coverage and reimbursement, and education.

Telehealth Definition

Stakeholders expressed the need for a clear definition of telehealth. Providers indicated the need for a definition so it is clear the use of technological modalities is a viable way to treat patients within their scope of practice. *(cite)* Health plans noted the need for clarity in the allowable use of technology for reimbursement purposes. *(cite)*
The American Telemedicine Association uses the terms telemedicine and telehealth interchangeably. (cite) Other entities use the term telemedicine as a specific reference to the practice of medicine and telehealth as an encompassing term inclusive of the broader scope of health care.

There are several definitions for “telemedicine” in Florida regulations. (cite) These definitions include the broader scope language associated with the term telehealth. In order to provide clarity the Council recommends that a definition of telehealth be included in statutes. Rules referencing telemedicine can be technical modified, if needed.

**Recommended Definition**

*Telehealth means the mode of delivering health care and public health services through, synchronous and asynchronous, information and communication technology by a Florida license practitioner, within the scope of their practice, who is located at a site other than the site where a recipient is located.*

**Technology**

There are three overarching concerns related to technology identified as barriers to implementing and expanding the use of telehealth for treating patients: access to technology, interoperability, and equipment costs.

**Equipment costs**

Florida providers specifically identified the cost of equipment needed to treat patients using telehealth as a barrier. The growing telehealth market and continually innovative technological developments, however, are indicative of price point reductions. Further research and stakeholder input suggests the availability of technology at varying price points. (cite) There are also federal grant funding programs available to implement telehealth programs. (cite) Provide examples of funding programs

**Access to Technology**

A concern from a national prospective is the connectivity to broadband and the accessibility to computers/mobile devices. Florida has been very successful in implementing broadband connections throughout the state. *Add in statistic on broadband here.*

The accessibility of virtual care can be provide via mobile devices. The number of individuals currently using mobile devices for internet connectivity is (number here). Those individuals qualifying for government assistance programs qualify for mobile phone assistance. *Medicaid Quality to provide additional information and statistics from Lifeline.*

**Interoperability**

One area of concern is the lack of interoperability between technology vendors. *Florida HIE provides opportunities for interoperability.*
Recommended Action
Support technological initiatives already in place.

Health Care Practitioner
- Direct to Consumer models
- Out of state consultations
- Collaboration of team

Patient/Consumer Protection
- Cross state licensure (conditional practice and/or licensure compacts)
- Patient expectations vs. services offered
- Practitioner standard of care (PT, OT, Pharmacy, mental health)
- Consent
- On-line Prescribing
  - In person examination required first
  - Who is eligible
  - Types of drugs

Coverage & Reimbursement
- Reimbursement for certain modalities (live video, store and forward, remote patient monitoring)
- Payment Parity – parity of service payment, conditioned to terms of policies
- Public Payer – regulations – Medicare similar to Medicaid language, Add Modalities to Medicaid language
- Site Transmission – permitted or not
- Location of Services – originating site requirements

Education
- Medical School training
- Promote Continuing Education

Summary
Telehealth Definition Discussion

The Council identified the need to recommend the inclusion of a definition for telehealth in Florida Statutes. The Council identified two main options at the May meeting. The feedback provided by members is included in the materials.

Action Needed:

A determination on which telehealth definition is most appropriate for Florida.

Options:

1) Vote on the currently proposed definitions
2) Delay vote to allow more time for thought and input on other proposed definitions
<table>
<thead>
<tr>
<th>Council Members</th>
<th>Definition #1</th>
<th>Definition #2</th>
<th>Other Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Justin</td>
<td>Telehealth means the mode of delivering health care and public health services through, synchronous and asynchronous, information and communication technology by a Florida license practitioner, under their scope of practice, who is located at a site other then the site where a recipient is located.</td>
<td>Telehealth means the delivery of health care and public health services through telecommunications from a licensed provider to a patient who is at a remote location.</td>
<td>Telehealth is the delivery of health care services by licensed health care professionals using information and communication technologies for the exchange of valid information or diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities.</td>
</tr>
<tr>
<td>Philip</td>
<td>Celeste</td>
<td>&quot;Telehealth&quot; is defined as a mode of delivering health care and public health services, through synchronous and asynchronous information and communication technology, by a Florida licensed practitioner, <strong>within the</strong> scope of his/her practice, who is located at a site other than the site where a recipient is located.</td>
<td></td>
</tr>
<tr>
<td>Ernest</td>
<td>Bertha</td>
<td>#1 modifications - Telehealth is defined as a mode of delivering health care and public health services, through synchronous and asynchronous information and communication technology, by a Florida licensed practitioner, <strong>within the</strong> scope of his/her practice, who is located at a site other than the site where a recipient is located.</td>
<td></td>
</tr>
<tr>
<td>Anne</td>
<td>Burdick</td>
<td>#2 modifications - Telehealth means the delivery of health care and public health services through telecommunications from a licensed provider to a patient who is at a different location.</td>
<td></td>
</tr>
<tr>
<td>Leslee</td>
<td>Gross</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Darren</td>
<td>Hay</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Kim</td>
<td>Landry</td>
<td>#2 modifications - Telehealth means the delivery of health care and public health services through telecommunications from a licensed provider to a patient who is at a different location</td>
<td></td>
</tr>
<tr>
<td>William</td>
<td>Manzie</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elizabeth</td>
<td>Miller</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steven</td>
<td>Selznick</td>
<td>#1 modifications - “Telehealth” means the mode of delivering health care and public health services, <strong>including, but not limited to</strong>, patient assessment, diagnosis, consultation and treatment, through synchronous and asynchronous information and communication technology by a Florida licensed practitioner, under their scope of practice, who is located at a site other than the site where a recipient is located.</td>
<td></td>
</tr>
<tr>
<td>Mike</td>
<td>Smith</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Matthew</td>
<td>Stanton</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Monica</td>
<td>Stynchula</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Sarvam</td>
<td>Terkonda</td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>
Reference Materials

- 2017 Telehealth Benchmark Survey
- Article on Benchmark Survey
- Article on Indiana Telehealth & Prescribing Regulations submitted by Dr. Burdick
- New Jersey Legislation submitted by Mr. Smith
- Teledentistry Whitepaper submitted by Douglas Manning, DMD
During December 2016 and January 2017, REACH Health conducted the 2017 U.S. Telemedicine Industry Benchmark Survey among healthcare executives, physicians, nurses and other professionals throughout the United States. Four hundred and thirty-six (436) individuals participated in this survey, a 12% increase from the 2016 survey. Participants provided input related to their priorities, objectives and challenges, telemedicine program models and management structures, clinical specialties, service lines and settings of care, and their telemedicine platforms. This third annual report examines the survey results, including detailed findings such as the telemedicine program attributes that are most highly correlated with success. Customers of REACH Health comprised 4% of total survey participation.
Summary of Findings

Teledicine continues to evolve from a specialty offering to a mainstream service. Nearly half of hospital and IDN respondents who began their telemedicine programs/initiatives with a departmental approach are transitioning to an enterprise approach.

For the second year in a row, patient-oriented objectives including improving patient outcomes, improving patient convenience and increasing patient engagement and satisfaction occupy the top three positions as the most common objectives for telemedicine programs.

In addition to patient oriented objectives, reducing cost of care ranks consistently high across objectives and ROI contributors.

Similar to 2016 findings, issues stemming from reimbursement and EMR systems pose the top impediments to telemedicine, accounting for six of the top seven challenges.

Reimbursement, both government and private, poses the primary obstacle to success. Even when effective mitigation of challenges is taken into account, reimbursement continues to present the most formidable obstacles.

Persistent challenges related to EMR systems were also widely noted in the survey. These include the lack of integration between telemedicine and EMR systems and lack of native telemedicine capabilities in EMR systems. Also noted were challenges posed by the use of multiple EMR systems in heterogeneous telemedicine networks.

Maturity of telemedicine programs varies widely among both service lines and settings of care. In general, settings requiring highly specialized treatment continue to be more mature than those requiring generalized treatment.

Regardless of maturity, all settings and specialties studied exhibit strong activity in terms of planning and preparation for telemedicine programs.

A variety of program attributes were tested in the study and correlated with program success. Some, such as the priority of the telemedicine program as ranked among other hospital priorities, exhibit a predictably strong correlation with success. Others, such as executive support, exhibit only a slight correlation to program success.

Telemedicine platform features were rated based on their value to an organization. Three of the top six platform features are related to telemedicine data: clinical documentation, ability to send documentation to/from the EMR, and ability to analyze consult data. All of these were rated as critical or valuable by nearly 80% of respondents.

Supporting metrics for these and other key findings are examined in further detail in the subsequent Results Section.
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![Image](image.png)
Survey Results

Telemedicine as a Priority

Telemedicine continues to mature and evolve, due in part to a growing population of aging and unhealthy individuals, coupled with an increasing shortage of specialist physicians. Slightly more than half of survey participants noted telemedicine as a top priority or high priority.

![Priority of telemedicine in your organization](image)

Interestingly, this represents a slight decrease in priority ranking from the 2016 survey. This is seen as a sign of continuing evolution and maturation of telemedicine, moving from ad-hoc project status to a mainstream service for many providers. This shift in priority could also be related to uncertainty regarding the future of the Affordable Care Act (ACA) and potential changes to Medicare and Medicaid funding.
In fact, survey respondents were asked how they expect the potential overhaul, replacement, or repeal of the ACA to impact their telemedicine programs. The responses indicate quite a bit of uncertainty with “Can’t Predict” accounting for 26 to 47 percent of the responses to the various potential impacts (see chart below). However, answers also suggest an overall positive outlook, with only a small percentage of participants indicating they expected a decrease in the various areas. Note that the survey was completed before specific legislative changes were proposed in February and March of 2017.

![ACAREPLACE/REPEAL IMPACT](chart)

**Telemedicine Objectives**

Respondents were asked to rate their telemedicine program priorities. We expanded “Improving financial return” in 2016 to two options: “reducing cost of care” and “increasing revenue” in 2017.

From most common to least common, telemedicine program objectives can be categorized as follows:

1. Patient oriented - access, convenience, satisfaction and outcomes
2. Improving leverage and efficiency of limited physician resources
3. Reducing readmissions and cost of care
4. Improving image in the local community
5. Improving financial performance
6. Reducing EMS bypass.
Patient-oriented objectives top the list as most common objectives for telemedicine programs, continuing the patient-oriented trend of past years. Improving patient outcomes, increasing patient engagement and improving patient convenience occupy the top three positions as the most common objectives for telemedicine programs again in 2017.

There is an emphasis on better leveraging specialists with almost two-thirds of respondents ranking these a top or high priority.
Success Factors

Survey participants were also asked to rate their success in achieving objectives:

![Success with Objectives chart]

- Providing remote or rural patients with access to specialists: 65% Highly Successful, 33% Moderately Successful, 2% Unsuccessful
- Providing 24x7 access to specialists (filling gaps in local coverage): 56% Highly Successful, 36% Moderately Successful, 8% Unsuccessful
- Improving patient convenience: Objective #3 55% Highly Successful, 42% Moderately Successful, 3% Unsuccessful
- Improving patient outcomes: Objective #1 52% Highly Successful, 47% Moderately Successful, 1% Unsuccessful
- Increasing patient engagement and satisfaction: Objective #2 48% Highly Successful, 51% Moderately Successful, 1% Unsuccessful
- Improving leverage of limited physician resources: 47% Highly Successful, 46% Moderately Successful, 7% Unsuccessful
- Providing access to new specialties: 44% Highly Successful, 52% Moderately Successful, 4% Unsuccessful
- Improving specialist efficiency: 37% Highly Successful, 53% Moderately Successful, 10% Unsuccessful
- Improving image in the local community: 36% Highly Successful, 59% Moderately Successful, 5% Unsuccessful
- Reducing cost of care delivery: 26% Highly Successful, 60% Moderately Successful, 13% Unsuccessful
- Reducing EMS bypass: 22% Highly Successful, 58% Moderately Successful, 20% Unsuccessful
- Increasing revenue: 21% Highly Successful, 55% Moderately Successful, 24% Unsuccessful
- Reducing hospital readmissions: 18% Highly Successful, 72% Moderately Successful, 10% Unsuccessful
- Supporting research or clinical trials: 18% Highly Successful, 59% Moderately Successful, 24% Unsuccessful
- Reducing ED overcrowding: 14% Highly Successful, 64% Moderately Successful, 22% Unsuccessful
- Capturing market share from competitive health systems: 13% Highly Successful, 64% Moderately Successful, 23% Unsuccessful
In addition to assessing success with objectives, a variety of organizational and telemedicine program attributes were tested in the study and correlated with success of the top three objectives:

1. Improving patient outcomes
2. Increasing patient engagement and satisfaction
3. Improving patient convenience.

Some attributes exhibit a strong correlation with the success of these three objectives, while others exhibit an unexpectedly low correlation to success.

Not surprisingly, the priority of the telemedicine program, as ranked among other provider priorities, exhibits a strong correlation with success.

Telemedicine programs ranked as a top priority are 56% more likely (57% vs. 32%), to be highly successful than those ranked as a low priority.
One of the keys to success, suggested by many telemedicine program experts, is the designation of a full-time, dedicated program coordinator or manager. The survey results from both 2015 and 2016 showed measurable support for this anecdotal observation and again in the 2017 results.

**Key Takeaway**
Telemedicine programs with a dedicated program coordinator or manager are 20% more likely to be highly successful than those with a program manager or coordinator that spends less than half of their time focused on the program.

**Correlation with Success: Dedication of Program Manager**

<table>
<thead>
<tr>
<th>Dedication of Program Manager</th>
<th>Highly Successful</th>
<th>Moderately Successful</th>
<th>Unsuccessful</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% Dedicated Program Manager</td>
<td>62%</td>
<td>38%</td>
<td></td>
</tr>
<tr>
<td>Less than 50% Dedicated Program Manager</td>
<td>50%</td>
<td>48%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Note: This data is filtered for hospitals and IDNs only to allow for a more accurate year over year comparison.

**Key Takeaway**
The role (administrative vs. clinical) of the person with primary responsibility for the telemedicine program has only a nominal impact on success.
### Telemedicine Program Challenges

Survey participants identified and ranked their challenges in terms of those that remain unaddressed, partially addressed, fully addressed or not a challenge.

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Unaddressed</th>
<th>Partially Addressed</th>
<th>Fully Addressed</th>
<th>Not a Challenge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare reimbursement</td>
<td>39%</td>
<td>41%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Inadequate Telemedicine parity laws</td>
<td>38%</td>
<td>42%</td>
<td>11%</td>
<td>9%</td>
</tr>
<tr>
<td>Medicaid reimbursement</td>
<td>36%</td>
<td>40%</td>
<td>16%</td>
<td>8%</td>
</tr>
<tr>
<td>Private payor reimbursement</td>
<td>34%</td>
<td>48%</td>
<td>9%</td>
<td>8%</td>
</tr>
<tr>
<td>Lack of common EHR/EMR in hub &amp; spoke hospitals</td>
<td>34%</td>
<td>37%</td>
<td>9%</td>
<td>20%</td>
</tr>
<tr>
<td>Lack of integration with current EHR / EMR</td>
<td>33%</td>
<td>38%</td>
<td>13%</td>
<td>16%</td>
</tr>
<tr>
<td>Determining ROI</td>
<td>31%</td>
<td>49%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Lack of native capabilities in EHR / EMR</td>
<td>30%</td>
<td>39%</td>
<td>11%</td>
<td>20%</td>
</tr>
<tr>
<td>Physician compensation</td>
<td>28%</td>
<td>40%</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>Potential regulatory liability</td>
<td>25%</td>
<td>41%</td>
<td>16%</td>
<td>18%</td>
</tr>
<tr>
<td>Potential malpractice liability</td>
<td>25%</td>
<td>31%</td>
<td>23%</td>
<td>21%</td>
</tr>
<tr>
<td>Staff turnover</td>
<td>25%</td>
<td>33%</td>
<td>6%</td>
<td>37%</td>
</tr>
<tr>
<td>Physician credentialing and/or licensing</td>
<td>22%</td>
<td>40%</td>
<td>26%</td>
<td>12%</td>
</tr>
<tr>
<td>Lack of adequate specialist physician coverage</td>
<td>21%</td>
<td>51%</td>
<td>14%</td>
<td>15%</td>
</tr>
<tr>
<td>Lack of funding</td>
<td>20%</td>
<td>47%</td>
<td>10%</td>
<td>23%</td>
</tr>
<tr>
<td>Spoke/partner recruiting</td>
<td>20%</td>
<td>39%</td>
<td>16%</td>
<td>25%</td>
</tr>
<tr>
<td>Cost of supporting technology</td>
<td>20%</td>
<td>48%</td>
<td>19%</td>
<td>14%</td>
</tr>
<tr>
<td>Physician acceptance</td>
<td>17%</td>
<td>54%</td>
<td>20%</td>
<td>9%</td>
</tr>
<tr>
<td>Patient acceptance</td>
<td>13%</td>
<td>39%</td>
<td>27%</td>
<td>21%</td>
</tr>
<tr>
<td>Lack of executive support</td>
<td>13%</td>
<td>29%</td>
<td>22%</td>
<td>36%</td>
</tr>
</tbody>
</table>
Reimbursement, both government and private, continues to create the most significant obstacles to success, accounting for the top four unaddressed challenges to telemedicine.

Challenges related to EMR systems also create significant obstacles to success, accounting for three of the next four unaddressed challenges.

In spite of the ongoing challenges related to reimbursement and EMR systems, healthcare providers continue to actively plan, implement and expand telemedicine programs. See “Telemedicine Program Maturity and Status” below.

Determining ROI continues to be elusive for many organizations even though 73% of respondents identified reducing cost of care as one of their Top or High priorities for telemedicine.

Physician compensation remains relatively high on the list of challenges, possibly related to parity law challenges, noted as one of the greatest challenges to telemedicine programs.

Amidst other telemedicine challenges faced by healthcare providers, patient acceptance continues to be consistently ranked as one of the least challenging.

An increasing percentage of respondents continue to identify EMR challenges as unaddressed, than do respondents who identify those challenges as fully addressed.

**EMR Challenges**

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Unaddressed</th>
<th>Partially Addressed</th>
<th>Fully Addressed</th>
<th>Not a Challenge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of common EHR / EMR in hub and spoke hospitals</td>
<td>34%</td>
<td>37%</td>
<td>9%</td>
<td>20%</td>
</tr>
<tr>
<td>Lack of integration with current EHR / EMR</td>
<td>33%</td>
<td>38%</td>
<td>13%</td>
<td>16%</td>
</tr>
<tr>
<td>Lack of native capabilities in EHR / EMR</td>
<td>30%</td>
<td>39%</td>
<td>11%</td>
<td>20%</td>
</tr>
</tbody>
</table>

**Key Takeaways**

EMR challenges continue to plague providers with the percentage that fall into partially addressed or unaddressed rising from 2016 to 2017.

EMR challenges were identified as unaddressed by more than two times the number of respondents who indicated they have been fully addressed.
Both executive support and the adequacy of funding were also tested for correlations with success of the top three objectives:

1. Improving patient outcomes
2. Increasing patient engagement and satisfaction
3. Improving patient convenience.

**Key Takeaway**

While executive support and the adequacy of funding can both be correlated with program success, both seem to have only a slight impact.
Telemedicine Program ROI Contributors

Survey participants provided insight into their key contributors to return on investment (ROI) for their telemedicine programs.

### Primary contributors to ROI

<table>
<thead>
<tr>
<th>Contribution</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved patient satisfaction</td>
<td>48%</td>
</tr>
<tr>
<td>Keeping patients within our healthcare system</td>
<td>46%</td>
</tr>
<tr>
<td>Private payor reimbursement</td>
<td>41%</td>
</tr>
<tr>
<td>Medicare reimbursement</td>
<td>37%</td>
</tr>
<tr>
<td>Medicaid reimbursement</td>
<td>32%</td>
</tr>
<tr>
<td>Reduced cost of care</td>
<td>30%</td>
</tr>
<tr>
<td>Improved reputation</td>
<td>28%</td>
</tr>
<tr>
<td>Greater productivity from physicians &amp; nurses</td>
<td>27%</td>
</tr>
<tr>
<td>Reduced transportation expenses</td>
<td>27%</td>
</tr>
<tr>
<td>Increased referrals</td>
<td>26%</td>
</tr>
<tr>
<td>Reduced readmissions</td>
<td>18%</td>
</tr>
<tr>
<td>Shorter stays</td>
<td>17%</td>
</tr>
<tr>
<td>Increased post-acute patient follow-up care</td>
<td>15%</td>
</tr>
<tr>
<td>Reduced ED overcrowding</td>
<td>11%</td>
</tr>
<tr>
<td>Increased fee for service payments</td>
<td>7%</td>
</tr>
<tr>
<td>Reduced EMS bypass</td>
<td>7%</td>
</tr>
<tr>
<td>Other (please explain)</td>
<td>7%</td>
</tr>
</tbody>
</table>

### Key Takeaways

- In 2015, “Improved Reputation” topped the list. In both 2016 and 2017, “Improved Patient Satisfaction” was most commonly noted as a contributor to ROI.
- Based on ad-hoc responses in the 2016 survey, “Keeping patients within our healthcare system” was added to the answer options for 2017 and came in at number two.

Other ROI contributors noted by survey participants included:

- “Providing immediate consultative access in life threatening conditions, thus reducing time to definitive care and improving outcomes”
- “Keeping patients closer to home and their support systems”
Telemedicine Program Maturity and Status

Settings of Care

As noted in previous years, the maturity of telemedicine programs varies widely among settings of care. In general, settings requiring highly specialized treatment are more mature than those most often requiring more generalized treatment. The exceptions are E-Visits and General Practice Physicians, both of which have grown rapidly during the last three years.

![Maturity by Settings of Care](image)

With a deeper look at the status of telemedicine programs, responses indicate that regardless of maturity, activity remains high in terms of implementation and planning across all care settings.
**Key Takeaways**

- All care settings, regardless of maturity, continue to show strong growth with competition for patients, improved patient experience and outcomes on the rise.

- The Acute Care and Clinic settings continue to mature. Both exhibit a small drop in respondents in the Planning phase compared to 2016.

- Active E-visit programs grew by 40% in 2017, and General Practice also saw strong growth as well.
Medical Specialties and Service Lines

The maturity of telemedicine programs also varies widely across specialties and service lines.

Key Takeaways

- Similar to settings of care, in general, service lines requiring access to specialists, especially those in increasingly short supply, are maturing more rapidly than the more generalized service lines. By 2020, the Association of American Medical Colleges estimates shortages of 45,000 primary care physicians and 46,000 surgeons and specialists.

- Note that only four service lines—Stroke, Neurology, Radiology and Burn—have fewer telemedicine implementations during the last three years than prior years.
A closer look at the status of telemedicine programs across service lines also indicates a pattern similar to the settings of care analysis.

**Key Takeaways**

- Similar to settings of care, activity remains strong in terms of planning and preparation for all service lines studied.
- Seven service lines (Stroke, Behavioral Health, Neurology, Radiology, Pediatrics, Emergency Medicine, and Burn) are maturing. All exhibit a lower percentage of respondents in the Implementing or Planning phase than in the Active phase.
Enterprise Approach to Telemedicine

As the telemedicine industry continues to mature, there is an increasing trend toward an enterprise approach to telemedicine, with health systems moving more rapidly in this direction compared to standalone hospitals. This trend is illustrated in the responses to organizations’ current approach to telemedicine, with over one-third of respondents already taking an enterprise approach.

The data also indicates a notable shift from a departmental approach to an enterprise approach – 45% of telemedicine programs that began with a departmental approach are now shifting to an enterprise approach.
Telemedicine Program Management

Degree of Focus

The designation of a full-time dedicated program manager has been correlated to a more successful telemedicine program in past years. The survey results indicate that over one-third of the participating organizations now have a dedicated program manager. This is consistent with the 2016 results.

Key Takeaway

Recognition of the importance of a dedicated full-time telemedicine program manager or coordinator is increasing across all settings of care. This is likely due to the high correlation with program success, as noted in 2016 and 2015.
Accountability for Success

Survey participants were asked to indicate the orientation (clinical or administrative) of the person primarily held accountable for the success of their telemedicine program. Administrative (non-clinical) managers accounted for almost half of responses.

The “Other” option accounted for 17% of participant responses and included a wide range of replies. Numerous answers indicated the telemedicine program is managed via a team. Examples included:

- “Shared between Corporate and Physician” or “Shared between Physician and Administrative”
- “Multi-disciplinary team and administration”
- “Lead by a physician, but day to day management handled by a project manager”.

Physician Coverage Models

Survey participants provided insight into their use of third-party physician services to supplement their staff or fully support their telemedicine programs.
Key Takeaway

Overall, all specialties are primarily dependent on internal staff or affiliated physicians for telemedicine physician coverage. Behavioral Health is the only specialty that falls below a 60:40 ratio of internal to third-party physician staffing. These results are consistent with prior years studied (2015 & 2016).
As noted above, Behavioral Health is the only specialty which falls below a 60:40 staffing ratio. In fact, as illustrated in the chart below, Behavioral Health is steadily shifting the mix toward third-party physician coverage.

### Behavioral Health Physician Coverage Year Over Year

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Entirely by On-Staff/Affiliated Physicians</td>
<td>66%</td>
<td>58%</td>
<td>56%</td>
</tr>
<tr>
<td>Mix of On-Staff &amp; 3rd Party PSO</td>
<td>20%</td>
<td>28%</td>
<td>28%</td>
</tr>
<tr>
<td>Entirely Supported by 3rd Party PSO</td>
<td>14%</td>
<td>14%</td>
<td>16%</td>
</tr>
</tbody>
</table>

**Note:** this data is filtered for hospitals and IDNs only to allow for a more accurate year over year comparison.

### Telemedicine Program Assets

Telemedicine programs are a compilation of assets, each of which are important. This year respondents were asked to rate some of these assets based on their importance relative to program success.

### Asset Importance Relative to Program Success

<table>
<thead>
<tr>
<th>Asset</th>
<th>Highly Important</th>
<th>Somewhat Important</th>
<th>Not Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician coverage services provided by our on-staff or affiliated physicians</td>
<td>79%</td>
<td>17%</td>
<td>4%</td>
</tr>
<tr>
<td>Our Telemedicine technology (platform)</td>
<td>71%</td>
<td>25%</td>
<td>4%</td>
</tr>
<tr>
<td>Reporting and analytics based on telemedicine program performance metrics</td>
<td>69%</td>
<td>26%</td>
<td>5%</td>
</tr>
<tr>
<td>Third-party physician coverage services</td>
<td>28%</td>
<td>35%</td>
<td>37%</td>
</tr>
</tbody>
</table>

To reduce potential skewing of the responses by organizations that either completely outsource physician coverage or only use in-house doctors, the data was filtered to analyze only organizations that use both in-house physicians and outsourced coverage. As illustrated in the following chart, even when filtered for a more balanced sample, the responses remain similar.
Key Takeaways

- Telemedicine technology, reporting and analytics and in-house physicians are viewed as highly important to the success of telemedicine programs.
- Outsourced physician coverage services are less frequently cited as important to success.

Telemedicine Platforms

Over half of participants indicated their telemedicine platform was primarily purchased or licensed from a vendor.
Key Takeaway

In general, larger organizations are more likely than smaller organizations to build systems internally. However, the survey results indicated that with telemedicine solutions, the mix of “Build vs. Buy” is highly consistent across the spectrum of organizational sizes, with large organizations only slightly more likely to assemble their telemedicine platforms internally.

Use of EMR Systems

Two-thirds of the survey participants indicated their telemedicine solution is a stand-alone system, not integrated with their EMR system. Only 10% indicated their EMR system serves as their telemedicine system.

EHR/EMR System and Telemedicine Platform

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our telemedicine platform is a stand-alone solution, not integrated with our EHR/EMR system.</td>
<td>56%</td>
</tr>
<tr>
<td>Our telemedicine platform is a stand-alone solution, integrated with our EHR/EMR system.</td>
<td>22%</td>
</tr>
<tr>
<td>Our telemedicine platform is our EHR/EMR system.</td>
<td>10%</td>
</tr>
<tr>
<td>Other (please explain)</td>
<td>8%</td>
</tr>
</tbody>
</table>

Key Takeaway

The majority dependence on standalone telemedicine platforms is likely a reflection of the EMR Challenges noted on page 11.
### Telemedicine Platform Features

We asked participants which features of their telemedicine platform were most valuable to their organization.

#### Value of Telemedicine Platform Features

<table>
<thead>
<tr>
<th>Feature</th>
<th>Critical or Valuable</th>
<th>Nice-to-Have</th>
<th>Neutral</th>
<th>Of Limited Value or Not Valuable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Audio &amp; Video for live patient engagement</td>
<td>94%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Ability to produce clinical documentation from each consultation</td>
<td>84%</td>
<td>7%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Support for standard devices, such as laptops and tablets as clinical endpoints</td>
<td>83%</td>
<td>10%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Ability to send clinical documentation to/from your EMR</td>
<td>83%</td>
<td>9%</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>Ability for clinicians to communicate through HIPPA-compliant messaging</td>
<td>79%</td>
<td>14%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Ability to analyze telemedicine consult data to assess and improve performance</td>
<td>79%</td>
<td>15%</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>Ability for remote specialists and bedside-clinicians to collaborate in consultations</td>
<td>77%</td>
<td>15%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Ability to access patient history directly from the telemedicine system</td>
<td>74%</td>
<td>17%</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>Ability to access PACS images (such as CT Scans) directly from the telemedicine system</td>
<td>73%</td>
<td>11%</td>
<td>5%</td>
<td>11%</td>
</tr>
<tr>
<td>Browser-based system with no software to install or maintain</td>
<td>73%</td>
<td>16%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>Ability to access lab and test results directly from the telemedicine system</td>
<td>70%</td>
<td>18%</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>Support for peripheral devices such as stethoscopes, otoscopes, etc.</td>
<td>63%</td>
<td>17%</td>
<td>7%</td>
<td>13%</td>
</tr>
<tr>
<td>Store-and-Forward capabilities / Asynchronous</td>
<td>62%</td>
<td>18%</td>
<td>8%</td>
<td>13%</td>
</tr>
<tr>
<td>Physician scheduling</td>
<td>61%</td>
<td>17%</td>
<td>9%</td>
<td>13%</td>
</tr>
<tr>
<td>Specialized workflow and documentation for each specialty (separate from your EMR)</td>
<td>56%</td>
<td>17%</td>
<td>9%</td>
<td>17%</td>
</tr>
<tr>
<td>Ability to configure the telemedicine display to accommodate individual clinician preferences</td>
<td>52%</td>
<td>33%</td>
<td>9%</td>
<td>6%</td>
</tr>
<tr>
<td>Ability for remote specialists to drive telemedicine robots around the hospital</td>
<td>21%</td>
<td>23%</td>
<td>18%</td>
<td>37%</td>
</tr>
</tbody>
</table>
Audio/Video was cited most often as critical/valuable. This is unsurprising, as live A/V is often required for reimbursement and is critical in a wide array of examinations and clinical protocols across specialties.

Three of the top six platform features are related to telemedicine data: clinical documentation, ability to send documentation to/from the EMR, and ability to analyze consult data. All of these were rated as critical or valuable by almost 80% of respondents.

Participant Demographics

Organization Types

Survey participants represented a broad mix of healthcare organizations. More than half were from teaching hospitals or systems, with just over a quarter from non-teaching hospitals or systems and slightly over 10% from physician practices.
Organization Sizes

Organizations represented by the survey participants covered a broad range of revenues, clustered at both the high and low ends of the spectrum. Around a third (31%) have revenues of $1B or greater, with just under half (48%) at the low end of the scale with under $50M in revenues.

![Organization Revenue Pie Chart]

Telemedicine Program Models

The organizations represented in the survey that are focused on provider-to-provider telemedicine have more active than planned telemedicine programs. Those focused on direct-to-consumer telemedicine indicate a mix of planned and active programs. This correlates with the earlier finding that the higher acuity settings requiring highly specialized treatment are more mature than lower acuity settings requiring generalized treatment.

Survey participation was weighted to providers offering telemedicine services to healthcare providers (Hubs) followed by those providing direct-to-remote patients via E-Visits, and those who receive telemedicine services (spokes). Next were those offering Home Health and Remote Monitoring, followed by those who provide direct-to-remote patient via Kiosks.
Telemedicine Programs Geographic Scope

Consistent with previous survey results, slightly over 70% of the survey participants operate telemedicine programs within the boundaries of a single state. This is not surprising considering the challenges of multi-state physician licensing as well as the variations in state-specific regulations and Medicaid reimbursement. Less than a quarter operate multi-state or nation-wide programs. Only five (5) percent operate international programs.
Conclusion

The third annual REACH Health telemedicine industry survey examined responses from 436 healthcare professionals. They provided input pertaining to their priorities, objectives and challenges, telemedicine program models and management structures, service lines and settings of care, and telemedicine platforms. Analysis of this information exposed numerous findings such as the challenges that have been most widely mitigated and those that continue to pose obstacles, as well as identifying telemedicine program attributes that are highly correlated to success. Responses were also compared to our previous year’s findings to better understand trends and changes in telemedicine.

REACH Health thanks the survey participants for their valued input. Survey participants are invited to contact REACH Health at General.Inquiries@reachhealth.com to request a copy of their individual responses that can be used for benchmark comparisons with the summarized results.

About REACH Health

REACH Health is the leading enterprise telemedicine software company, providing solutions for multiple specialties and settings of care, all supported on one common software platform. Designed by hands-on physicians and expert software engineers, these solutions are recognized for fostering collaboration between bedside clinicians and remote specialists through shared clinical workflows. These solutions are also highly configurable, enabling physicians to tailor each consultation based on personal preferences and the information specific to their medical specialty.

REACH Health pioneered one of the nation’s first telesstroke programs and continues to be the innovation leader, delivering groundbreaking advancements in telemedicine and telehealth. Today, many of the nation’s most successful telemedicine programs rely on REACH to achieve measurable improvements in their clinical, operational and financial performance. For more information, visit reachhealth.com.
Survey: 20 unaddressed challenges to telemedicine programs


Reimbursement from Medicare and inadequate telehealth parity laws are the biggest challenges to telemedicine programs that have not been addressed, according to the 2017 U.S. Telemedicine Industry Benchmark Survey from Reach Health, a telemedicine software company.

The survey includes responses from 436 physicians, executives, nurses and other healthcare professionals throughout the United States. Responses were collected between December 2016 and January 2017.

Here are 20 top unaddressed challenges to telemedicine programs, according to survey respondents:

1. Medicare reimbursement: 39 percent
2. Inadequate telemedicine parity laws: 38 percent
3. Medicaid reimbursement: 36 percent
4. Private payer reimbursement: 34 percent
5. Lack of common EHR/EMR in "hub and spoke" model hospitals: 34 percent
6. Lack of integration with current EHR/EMR: 33 percent
7. Determining return-on-investment: 31 percent
8. Lack of native capabilities in EHR/EMR: 30 percent
9. Physician compensation: 28 percent
10. Potential regulatory liability: 25 percent
11. Potential malpractice liability: 25 percent
12. Staff turnover: 25 percent
13. Physician credentialing and/or licensing: 22 percent
14. Lack of adequate specialist physician coverage: 21 percent
15. Lack of funding: 20 percent
16. Partner recruiting: 20 percent
17. Cost of supporting technology: 20 percent
18. Physician acceptance: 17 percent
19. Patient acceptance: 13 percent
20. Lack of executive support: 13 percent

Note: Respondents could pick more than one unaddressed challenge.
Indiana Reverses Course on Telemedicine Prescribing and Controlled Substances Laws
By Nathaniel Lacktman*

Indiana has taken another step towards expanding the meaningful use of telemedicine in connection with clinical services and prescribing. HB 1337, signed by Governor Eric Holcomb and effective July 1, 2017, will allow providers to prescribe controlled substances via telemedicine without an in-person examination, albeit with some notable limitations and restrictions. The law reverses Indiana’s 2016 telehealth law that prevented providers from prescribing controlled substances via telehealth technologies.

Prescribing Drugs via Telemedicine

Under the new law an Indiana provider may prescribe non-controlled substances via telemedicine, without an in-person exam, if the following conditions are met:

- The provider has satisfied the applicable standard of care in the treatment of the patient.
The issuance of the prescription by the provider is within the provider’s scope of practice and certification.

- The prescription is not for a controlled substance.
- The prescription is not for an abortion inducing drug.
- The prescription is not for an ophthalmic device, including: (1) glasses; (2) contact lenses; or (3) low vision devices.

Prescribing Controlled Substances via Telemedicine

Under the new law an Indiana provider may prescribe controlled substances via telemedicine, without an in-person exam, if the prescriber satisfies the conditions outlined above and the following conditions are met:

- The prescription is not for an opioid, unless the opioid is a partial antagonist that is used to treat or manage opioid dependence.
- The prescriber maintains a valid controlled substance registration.
- The prescriber meets the conditions set forth in the federal Ryan Haight Act.
- The patient has been examined in-person by a licensed Indiana health care provider and the licensed health care provider has established a treatment plan to assist the prescriber in the diagnosis of the patient.
- The prescriber has reviewed and approved that treatment plan and is prescribing for the patient pursuant to that treatment plan.
- The prescriber complies with Indiana’s INSPECT prescription drug monitoring program.
- The prescription for a controlled substance is prescribed and dispensed in accordance with Indiana Code 35-48-7.

While Indiana’s new law removes its prior blanket ban on telemedicine prescribing of controlled substances, it still requires the patient to undergo an in-person exam conducted by an Indiana health care provider, although not necessarily by the prescriber herself. This renders Indiana law more restrictive than many states, and even more restrictive than the federal Ryan Haight Act. The new law follows a growing trend among states to amend and eliminate prior statutory prohibitions on telemedicine prescribing of controlled substances. Michigan, for example, recently enacted a law to eliminate its previous ban, and now allows health professionals to prescribe controlled substances via telemedicine without an in-person examination.
This is encouraging news for providers using telemedicine in their practice, as controlled substances are an important and clinically significant component of certain specialties, including telepsychiatry, endocrinology, and hospitalists/emergency medicine.

Telemedicine prescribers should continue to be mindful of prescribing requirements under federal laws, as remote prescribing of controlled substances is governed by the Ryan Haight Act. Providers must understand and navigate many intersecting state and federal laws on telemedicine, medical practice, fraud and abuse, and controlled substances.

*We would like to thank Nathaniel M. Lacktman (Foley & Lardner LLP, Tampa, FL) for authoring this alert. We also would like to thank the Health Information and Technology Practice Group leadership for sharing this alert with the Academic Medical Centers and Teaching Hospitals; Business Law and Governance; Hospitals and Health Systems; Medical Staff, Credentialing, and Peer Review; Physician Organizations; and Regulation, Accreditation, and Payment Practice Groups.

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ASSEMBLY, No. 1464

STATE OF NEW JERSEY

217th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2016 SESSION

Sponsored by:
Assemblywoman PAMELA R. LAMPITT
District 6 (Burlington and Camden)
Assemblyman CRAIG J. COUGHLIN
District 19 (Middlesex)
Assemblyman HERB CONAWAY, JR.
District 7 (Burlington)
Assemblywoman VALERIE VAINIERI HUTTLE
District 37 (Bergen)
Assemblyman JOSEPH A. LAGANA
District 38 (Bergen and Passaic)
Assemblyman RAJ MUKHERJI
District 33 (Hudson)

Co-Sponsored by:
Assemblymen Singleton, Benson, Assemblywoman N.Munoz, Assemblyman Zwicker, Assemblywomen Jimenez, Pinkin, McKnight and Assemblyman Johnson

SYNOPSIS

Authorizes health care practitioners to provide health care services through telemedicine.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.

(Sponsorship Updated As Of: 3/7/2017)
A1464 LAMPITT, COUGHLIN
2

AN ACT authorizing the provision of health care services through
telemedicine, supplementing and amending various parts of the

BE IT ENACTED by the Senate and General Assembly of the State
of New Jersey:

1. (New section) a. Unless specifically prohibited or limited
by federal or State law, a health care practitioner may remotely
provide health care services to a patient in the State, and a bona fide
relationship between health care practitioner and patient may be
established, through the use of telemedicine.

b. A health care practitioner who provides a health care service
to a patient through the use of telemedicine shall be subject to the
same standards of care and rules of practice as are applicable to
traditional in-person practice, and the use of telemedicine shall not
alter or diminish any existing duty or responsibility of the health
care practitioner, or any assistant thereof, including, but not limited
to, any duty or responsibility related to recordkeeping, or the
maintenance of patient confidentiality. Any health care practitioner
who engages in telemedicine in a manner that does not comply with
the ordinary standards of care or rules of practice applicable to in-
person practice, shall be subject to discipline by the respective
licensing board, as provided by law.

c. A health care practitioner is authorized to engage in
consultations with an out-of-state peer professional, including, but
not limited to, a sub-specialist, using electronic or other means, and
shall not be required to obtain an additional license or separate
authorization in order to do so.

d. Notwithstanding any other provision of law to the contrary,
and in order to facilitate the increased use of telemedicine as
authorized by this section, when a health care practitioner proposes
to engage in telemedicine with patients in a hospital, the governing
body of the hospital, as necessary and appropriate, shall verify and
approve the credentials of, and grant telemedicine practice
privileges to, such practitioner, based solely upon the
recommendations of the hospital’s medical staff, which
recommendations have been derived from information provided by
the originating site employer.

e. In accordance with the “Administrative Procedure Act,”
P.L.1968, c.410 (C.52:14B-1 et seq.), the State boards or other
entities that, pursuant to Title 45 of the Revised Statutes, are
responsible for the licensure of health care practitioners in the State,
shall each adopt rules and regulations that are applicable to the
health care practitioners under their respective jurisdictions, as may
be necessary to clarify that such practitioners, when engaged in

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is
not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.
telemedicine, will be subject to the same rules of practice and standards of care as are applicable to health care practitioners who are engaged in the provision of health care services to patients through the use of traditional in-person means or methods. Such rules and regulations may require an applicant for an initial or renewed practice license to provide proof of their successful completion of training in the effective use of technology and the maintenance of records and patient confidentiality when engaging in telemedicine.

f. As used in this section:

“Health care practitioner” means an individual who provides a health care service to a patient in the State, and includes, but is not limited to, a physician, nurse practitioner, psychologist, psychiatrist, psychoanalyst, licensed clinical social worker, physician assistant, or any other health care professional acting within the scope of a valid license or certification issued pursuant to Title 45 of the Revised Statutes.

“Health care service” means any health-related service, including, but not limited to, diagnosis, testing, or treatment of physical or mental human disease or dysfunction; consultation related to such diagnosis, testing, or treatment; and any other service which is rendered for the purpose of determining the status of, or maintaining or restoring, an individual’s physical or mental health, and for which a license or certification is required, as a pre-condition to the rendering thereof, pursuant to Title 45 of the Revised Statutes.

“Originating site employer” means the person or entity that employs a health care practitioner at the site where the practitioner originates and renders services, through the use of telemedicine, to a patient who is located at a remote site.

“Telemedicine” means the delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the gap between the health care practitioner who is located at one site, and a patient who is located at a different, remote site, either with or without the assistance of an intervening health care provider, and which typically involves the provision of health care services through the application of secure, two-way videoconferencing or store-and-forward technology that is designed to replicate the traditional in-person encounter and interaction between health care practitioner and patient by allowing for interactive, real-time visual and auditory communication, and the electronic transmission of images, diagnostics, and medical records. “Telemedicine” does not include the use of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.

2. (New section) The Board of Medical Examiners shall evaluate the Telemedicine Licensure Compact currently being
promoted by the Federation of State Medical Boards, and shall
determine what State actions and legislation are necessary to allow
the State to participate in the compact. Within 180 days after the
effective date of P.L. , c. (pending before the
Legislature as this bill), the board shall submit a report to the
Governor, and, pursuant to section 2 of P.L.1991, c.164 (C.52:14-
19.1), to the Legislature, containing its findings on the matter, and
providing recommendations for legislation or other State action that
may be necessary to implement the Telemedicine Licensure
Compact in this State.

3. (New section) a. Unless specifically prohibited or limited
by federal or State law, health care services that are delivered to a
patient through the use of telemedicine shall be covered, under the
State Medicaid and NJ FamilyCare programs, to the same extent
that such services would be covered if they were delivered through
traditional in-person means or methods. In-person contact between
a health care practitioner and a patient shall not be required as a
condition of provider reimbursement under the Medicaid or NJ
FamilyCare programs for: (1) health care services that are
delivered through the use of telemedicine, so long as the use of
telemedicine in the particular case is not medically contraindicated,
and the services would otherwise be eligible for reimbursement
under such programs if delivered in person; and (2) professional
fees and facility fees associated with the delivery of health care
services through the use of telemedicine, as authorized by section 1
of P.L. , c. (pending before the Legislature as this
bill), so long as the fees would otherwise be eligible for
reimbursement under such programs in the case of in-person service
delivery. Health care services delivered through telemedicine shall
be reimbursed at a rate that is equal to the reimbursement rate
provided for in-person services.

b. Unless expressly required by federal or State law, the
Commissioner of Human Services shall not establish any siting or
location restrictions on a patient or health care practitioner as a
condition of reimbursement under the Medicaid or NJ FamilyCare
programs, and shall authorize reimbursement for health care
services that are provided through telemedicine, as required by this
section, even if the patient is located in his or her own home or in
another non-medical facility at the time of the patient’s receipt of
such services.

c. The Commissioner of Human Services, in consultation with
the Commissioner of Children and Families, shall apply for such
State plan amendments or waivers as may be necessary to
implement the provisions of this section, and shall secure federal
financial participation for State expenditures under the federal
Medicaid program and Children’s Health Insurance Program.
d. The Commissioner of Human Services, in consultation with the Commissioner of Children and Families, shall adopt rules and regulations, pursuant to the “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et seq.), as may be necessary to implement the provisions of this section.

e. As used in this section:

“Health care practitioner” means an individual who provides a health care service to a patient in the State, and includes, but is not limited to, a physician, nurse practitioner, psychologist, psychiatrist, psychoanalyst, licensed clinical social worker, physician assistant, or any other health care professional acting within the scope of a valid license or certification issued pursuant to Title 45 of the Revised Statutes.

“Health care service” means any health-related service, including, but not limited to, diagnosis, testing, or treatment of physical or mental human disease or dysfunction; consultation related to such diagnosis, testing, or treatment; and any other service which is rendered for the purpose of determining the status of, or maintaining or restoring, an individual’s physical or mental health, and for which a license or certification is required, as a pre-condition to the rendering thereof, pursuant to Title 45 of the Revised Statutes.

“Medicaid” means the Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

“NJ FamilyCare” means the NJ FamilyCare Program established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.).

“Telemedicine” means the same as that term is defined by section 1 of P.L. , c. (C. ) (pending before the Legislature as this bill).

4. (New section) a. Unless specifically prohibited or limited by federal or State law, any carrier that offers a managed care plan in this State shall provide coverage for health care services that are delivered to a covered person through the use of telemedicine, to the same extent that the services would be covered if they were delivered through in-person means or methods. In-person contact between a health care practitioner and a patient shall not be required as a condition of carrier reimbursement under a managed care plan for: (1) covered services that are delivered through the use of telemedicine, so long as the use of telemedicine in the particular case is not medically contraindicated, and the services would otherwise be eligible for reimbursement if delivered in person; and (2) professional fees and facility fees associated with the delivery of covered services through the use of telemedicine, so long as the fees would otherwise be eligible for reimbursement in the case of in-person service delivery. Covered services delivered through the use of telemedicine shall be reimbursed at a rate that is equal to the reimbursement rate provided for in-person services.
b. Unless expressly required by federal or State law, a carrier shall not establish any siting or location restrictions on a patient or health care practitioner as a condition of reimbursement under a managed care plan, and shall authorize reimbursement for health care services that are delivered through telemedicine, as required by this section, even if the patient is located in his or her own home or in another non-medical facility at the time of the patient’s receipt of such services.

c. A carrier may:
   (1) charge a deductible, co-payment, or coinsurance for a covered service delivered through telemedicine, so long as it does not exceed the deductible, co-payment, or coinsurance applicable to such service when delivered in person;
   (2) limit coverage to services that are delivered by health care providers in the health benefits plan’s network; and
   (3) require originating site health care providers to document the reasons the services are being delivered through the use of telemedicine rather than in person.

d. Nothing in this section shall be construed to:
   (1) prohibit a carrier from providing coverage for only those health care services that are medically necessary, subject to the terms and conditions of the covered person’s health benefits plan; or
   (2) require a carrier to reimburse a remote site health care provider if the remote site health care provider has insufficient information to render an opinion.

e. As used in this section:
   “Carrier” means the same as that term is defined by section 2 of P.L.1997, c.192 (C.26:2S-2).
   “Covered person” means the same as that term is defined by section 2 of P.L.1997, c.192 (C.26:2S-2).
   “Covered service” means the same as that term is defined by section 2 of P.L.1997, c.192 (C.26:2S-2).
   “Health care practitioner” means an individual who provides a health care service to a patient in the State, and includes, but is not limited to, a physician, nurse practitioner, psychologist, psychiatrist, psychoanalyst, licensed clinical social worker, physician assistant, or any other health care professional acting within the scope of a valid license or certification issued pursuant to Title 45 of the Revised Statutes.
   “Health care provider” means the same as that term is defined by section 2 of P.L.1997, c.192 (C.26:2S-2).
   “Managed care plan” means the same as that term is defined by section 2 of P.L.1997, c.192 (C.26:2S-2).
   “Originating site” means the site at which a health care practitioner originates and renders services, through the use of telemedicine, to a patient who is located at a remote site.
“Remote site” means the distant site at which a patient receives health care services that are being rendered thereto, through the use of telemedicine, by a health care practitioner located at an originating site.

“Telemedicine” means the same as that term is defined by section 1 of P.L. , c. (C. ) (pending before the Legislature as this bill).

5. (New section) a. The State Health Benefits Commission shall ensure that every contract purchased thereby, which provides hospital and medical expense benefits, also provides coverage for health care services that are delivered to a covered person through the use of telemedicine, to the same extent that the services would be covered if they were delivered through in-person means or methods. In-person contact between a health care practitioner and a patient shall not be required as a condition of carrier reimbursement under a health benefits contract for: (1) health care services that are delivered through the use of telemedicine, so long as the use of telemedicine in the particular case is not medically contraindicated, and the services would otherwise be eligible for reimbursement if delivered in person; and (2) professional fees and facility fees associated with the delivery of health care services through the use of telemedicine, so long as the fees would otherwise be eligible for reimbursement in the case of in-person service delivery. A contract purchased by the State Health Benefits Commission shall provide for the reimbursement of health care services delivered through the use of telemedicine at a rate that is equal to the reimbursement rate provided for in-person services.

b. Unless expressly required by federal or State law, a health benefits contract purchased by the State Health Benefits Commission shall not establish any siting or location restrictions on a patient or health care practitioner as a condition of reimbursement thereunder, and shall authorize reimbursement for health care services that are delivered through telemedicine, as required by this section, even if the patient is located in his or her own home or in another non-medical facility at the time of the patient’s receipt of such services.

c. A contract purchased by the State Health Benefits Commission may:

(1) provide for a deductible, co-payment, or coinsurance for a health care service delivered through telemedicine, so long as it does not exceed the deductible, co-payment, or coinsurance applicable to such service when delivered in person;

(2) limit coverage to services that are delivered by health care providers in the health benefits plan’s network; and

(3) require originating site health care providers to document the reasons the services are being delivered through the use of telemedicine rather than in person.
d. Nothing in this section shall be construed to:

   (1) prohibit the State Health Benefits Commission from purchasing a contract that provides coverage for only those health care services that are medically necessary, subject to the terms and conditions of the covered person’s health benefits plan; or

   (2) require the contract purchased by the State Health Benefits Commission to provide for the reimbursement of a remote site health care provider if the remote site health care provider has insufficient information to render an opinion.

e. As used in this section:

   “Health care practitioner” means an individual who provides a health care service to a patient in the State, and includes, but is not limited to, a physician, nurse practitioner, psychologist, psychiatrist, psychoanalyst, licensed clinical social worker, physician assistant, or any other health care professional acting within the scope of a valid license or certification issued pursuant to Title 45 of the Revised Statutes.

   “Health care provider” means and includes a health care practitioner, and a hospital or other health care facility licensed pursuant to Title 26 of the Revised Statutes.

   “Health care service” means any health-related service, including, but not limited to, diagnosis, testing, or treatment of physical or mental human disease or dysfunction; consultation related to such diagnosis, testing, or treatment; and any other service which is rendered for the purpose of determining the status of, or maintaining or restoring, an individual’s physical or mental health, and for which a license or certification is required, as a precondition to the rendering thereof, pursuant to Title 45 of the Revised Statutes.

   “Originating site” means the site at which a health care practitioner originates and renders health care services, through the use of telemedicine, to a patient who is located at a remote site.

   “Remote site” means the distant site at which a patient receives health care services that are being rendered thereto, through the use of telemedicine, by a health care practitioner who is located at an originating site.

   “Telemedicine” means the same as that term is defined by section 1 of P.L.  , c.  (C. ) (pending before the Legislature as this bill).

6. (New section) a. The School Employees’ Health Benefits Commission shall ensure that every contract purchased thereby, which provides hospital and medical expense benefits, also provides coverage for health care services that are delivered to a covered person through the use of telemedicine, to the same extent that the services would be covered if they were provided through in-person means or methods. In-person contact between a health care practitioner and a patient shall not be required as a condition of
reimbursement under such a contract for: (1) health care services that are delivered through the use of telemedicine, so long as the use of telemedicine in the particular case is not medically contraindicated, and the services would otherwise be eligible for reimbursement if delivered in person; and (2) professional fees and facility fees associated with the delivery of health care services through the use of telemedicine, so long as the fees would otherwise be eligible for reimbursement in the case of in-person service delivery. A contract purchased by the School Employees’ Health Benefits Commission shall provide for the reimbursement of health care services delivered through the use of telemedicine at a rate that is equal to the reimbursement rate provided for in-person services.

b. Unless expressly required by federal or State law, a health benefits contract purchased by the School Employees’ Health Benefits Commission shall not establish any siting or location restrictions on a patient or health care practitioner as a condition of reimbursement thereunder, and shall authorize reimbursement for health care services that are delivered through telemedicine, as required by this section, even if the patient is located in his or her own home or in another non-medical facility at the time of the patient’s receipt of such services.

c. A contract purchased by the School Employees’ Health Benefits Commission may:

(1) provide for a deductible, co-payment, or coinsurance for a health care service delivered through telemedicine, so long as it does not exceed the deductible, co-payment, or coinsurance applicable to such service when delivered in person;

(2) limit coverage to services that are delivered by health care providers in the health benefits plan’s network; and

(3) require originating site health care providers to document the reasons the services are being delivered through the use of telemedicine rather than in person.

d. Nothing in this section shall be construed to:

(1) prohibit the School Employees’ Health Benefits Commission from purchasing a contract that provides coverage for only those health care services that are medically necessary, subject to the terms and conditions of the covered person’s health benefits plan;

or

(2) require the contract purchased by the School Employees’ Health Benefits Commission to provide for the reimbursement of a remote site health care provider if the remote site health care provider has insufficient information to render an opinion.

e. As used in this section:

“Health care practitioner” means an individual who provides a health care service to a patient in the State, and includes, but is not limited to, a physician, nurse practitioner, psychologist, psychiatrist, psychoanalyst, licensed clinical social worker, physician assistant, or any other health care professional acting
within the scope of a valid license or certification issued pursuant to Title 45 of the Revised Statutes.

“Health care provider” means and includes a health care practitioner, and a hospital or other health care facility licensed pursuant to Title 26 of the Revised Statutes.

“Health care service” means any health-related service, including, but not limited to, diagnosis, testing, or treatment of physical or mental human disease or dysfunction; consultation related to such diagnosis, testing, or treatment; and any other service which is rendered for the purpose of determining the status of, or maintaining or restoring, an individual’s physical or mental health, and for which a license or certification is required, as a pre-condition to the rendering thereof, pursuant to Title 45 of the Revised Statutes.

“Originating site” means the site at which a health care practitioner originates and renders health care services, through the use of telemedicine, to a patient who is located at a remote site.

“Remote site” means the distant site at which a patient receives health care services that are being rendered thereto, through the use of telemedicine, by a health care practitioner who is located at an originating site.

“Telemedicine” means the same as that term is defined by section 1 of P.L. , c. (C. ) (pending before the Legislature as this bill).

7. Section 5 of P.L.1987, c.116 (C.30:4-27.5) is amended to read as follows:

5. a. The commissioner shall adopt rules and regulations , pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) , regarding a screening service and its staff [that] , as may be necessary to effectuate the following purposes and procedures:

   [a. A] (1) Except when mental health screening services are provided remotely, through the use of telemedicine, a screening service shall serve as the facility in the public mental health care treatment system wherein a person believed to be in need of involuntary commitment to outpatient treatment, a short-term care facility, a psychiatric facility , or a special psychiatric hospital [undergoes] will undergo an assessment to determine what mental health services are appropriate for the person and where those services may be most appropriately provided in the least restrictive environment.

   The screening service may provide emergency and consensual treatment to the person receiving the assessment , and may transport the person or detain the person up to 24 hours for the purposes of providing the treatment and conducting the assessment.

   [b. ] (2) When a person is assessed by a mental health screener , either directly, through traditional in-person means or methods, or
remotely, through the use of telemedicine, and the mental health
treatment seems necessary, the screener shall provide, on a
screening document prescribed by the division, information
regarding the person's history and available alternative facilities and
services that are deemed inappropriate for the person. When
appropriate and available, and as permitted by law, the screener
shall make reasonable efforts to gather information from the
person's family or significant others for the purposes of preparing
the screening document. If a psychiatrist, in consideration of this
document and in conjunction with the psychiatrist's own complete
assessment, concludes that the person is in need of commitment to
treatment, the psychiatrist shall complete the screening certificate.
The screening certificate shall be completed by a psychiatrist except
in those circumstances where the division's contract with the
screening service provides that another physician may complete the
certificate.

Upon completion of the screening certificate, screening service
staff shall determine, in consultation with the psychiatrist or another
physician, as appropriate, the least restrictive environment for the
appropriate treatment to which the person shall be assigned or
admitted, taking into account the person's prior history of
hospitalization and treatment and the person's current mental health
condition. Screening service staff shall designate:

1. **[(1)] (a)** inpatient treatment for the person if he is immediately
or imminently dangerous, or if outpatient treatment is deemed
inadequate to render the person unlikely to be dangerous to self,
others, or property within the reasonably foreseeable future; and

2. **[(2)] (b)** outpatient treatment for the person when outpatient
treatment is deemed sufficient to render the person unlikely to be
dangerous to self, others, or property within the reasonably
foreseeable future.

If the screening service staff determines that the person is in
need of involuntary commitment to outpatient treatment, the
screening service staff shall consult with an outpatient treatment
provider to arrange, if possible, for an appropriate interim plan of
outpatient treatment in accordance with section 9 of P.L.2009,
c.112 (C.30:4-27.8a).

If a person has been admitted three times or has been an inpatient
for 60 days at a short-term care facility during the preceding 12
months, consideration shall be given to not placing the person in a
short-term care facility.

The person shall be admitted to the appropriate facility or
assigned to the appropriate outpatient treatment provider, as
appropriate for treatment, as soon as possible. Screening service
staff are authorized to coordinate the initiation of outpatient
treatment, or to transport [the person] or arrange for
transportation of the person to the appropriate facility.
[c.] (3) If the mental health screener determines that the
person is not in need of assignment or commitment to an outpatient
treatment provider, or admission or commitment to a short-term
care facility, psychiatric facility, or special psychiatric hospital, the
screener shall refer the person to an appropriate community mental
health or social services agency or appropriate professional or
inpatient care in a psychiatric unit of a general hospital.

[d.] (4) A mental health screener shall make a screening
outreach visit, or shall conduct a mental health screening through
the use of telemedicine, if the screener determines, based on
clinically relevant information provided by an individual with
personal knowledge of the person subject to screening, that the
person may need involuntary commitment to treatment and the
person is unwilling or unable to come to the screening service for
an assessment.

e.] (5) If the mental health screener determines that there is reasonable cause to believe
that the person is in need of involuntary commitment to
treatment, the screener shall so certify the need on a form prepared
by the division.

b. The rules and regulations adopted pursuant to this section
shall authorize the initiation and completion of mental health
screening through the use of telemedicine, subject only to the
existing rules and regulations that are applicable to in-person
mental health screening processes. A mental health screener shall
not be required to obtain a separate license or authorization in order
to engage in telemedicine for mental health screening purposes, and
shall not be required to request and obtain a waiver from existing
rules, as provided in N.J.A.C.10:31-11.1 et seq., prior to engaging
in the mental health screening process by means of telemedicine.

(c) As used in this section, “telemedicine” means the same as
that term is defined by section 1 of P.L. , c. (C.) (pending
before the Legislature as this bill).

(cf: P.L.2009, c.112, s.5)

8. Section 5 of P.L.1939, c.115 (C.45:9-5.1) is amended to read
as follows:

5. [Within the meaning of this chapter (45:9-1 et seq.), except]\n
a. Except as [herein] may be otherwise expressly provided by
law, [and except for the purposes of the exemptions hereinafter
contained in sections 45:9-14.1 to 45:9-14.10, inclusive, the phrase
"the practice of medicine or surgery" and the phrase "the practice of
medicine and surgery" shall include] as used in Chapter 9 of Title
45 of the Revised Statutes:

"Board" means the Board of Medical Examiners established
pursuant to R.S.45:9-1.
“Medical practice license” means a board-issued license that authorizes the holder thereof to engage in the practice of medicine with patients in this State, and includes a license that is issued to an in-State applicant, following an examination thereof, as provided by R.S.45:9-6, and a reciprocal license that is issued to an out-of-State applicant, without an examination thereof, as provided by R.S.45:9-13.

“Physician” means a person who possesses a current and valid license to engage in the practice of medicine.

“Practice of medicine” means the practice of any branch of medicine [and/or] or surgery, including, but not limited to, the practice of osteopathy, as defined by section 17 of P.L.1939, c.115 (C.45:9-14.3), and any method of the diagnosis or treatment of any human ailment, disease, pain, injury, deformity, or mental or physical condition [, and the term "physician and surgeon" or "physician or surgeon" shall be deemed to include practitioners in any branch of medicine and/or surgery or method of treatment of human ailment, disease, pain, injury, deformity, mental or physical condition. Within the meaning of this act, except as herein otherwise specifically provided, and except for the purposes of the exemptions hereinafter contained in sections 45:9-14.1 to 45:9-14.10, inclusive, the practice of medicine and/or surgery shall be deemed to include, inter alia, the practice of osteopathy, and nothing herein contained shall be construed to exempt the holder of a license issued under or validated by the provisions contained in sections 45:9-14.1 to 45:9-14.10, inclusive, from the operation of the provisions contained in section 45:9-16 of this Title. A professional using any means or method, including, but not limited to, telemedicine. “Practice of medicine” does not include the practice of healing through spiritual, religious, or mental means alone, such as through prayer, provided that no material medicine is prescribed or used, and no physical manipulation or material means are employed, for healing purposes.

“Professional school or college shall be taken to mean a medical school or college [, or any other school or college having purposes similar to a medical school or college [, provided, however, that as to any applicant for a license under the provisions of this chapter who, prior to October first, one thousand nine hundred and thirty-five, matriculated in such a school or college, a professional school or college shall, for the purposes of the provisions contained in sections 45:9-14.1 to 45:9-14.10, inclusive, from the operation of the provisions contained in section 45:9-16 of this Title, which, except as otherwise provided, such school or college shall be has been approved by the board.
“Telemedicine” means the same as that term is defined by section 1 of P.L. , c. (C. ) (pending before the Legislature as this bill).

b. Notwithstanding any other law, rule, or regulation to the contrary:

(1) Whenever, in any law, rule, or regulation, reference is made to “a physician or surgeon,” “a physician and surgeon,” “a person licensed to practice medicine or surgery,” “a person licensed to practice medicine and surgery,” “a physician licensed to practice medicine or surgery,” or “a physician licensed to practice medicine and surgery,” the same shall be deemed to mean a “physician,” as defined by subsection a. of this section.

(2) Whenever, in any law, rule, or regulation, reference is made to the “practice of medicine or surgery” or the “practice of medicine and surgery,” the same shall be deemed to mean the “practice of medicine,” as defined by subsection a. of this section.

(3) Whenever, in any law, rule, or regulation, reference is made to a “license to practice medicine or surgery” or a “license to practice medicine and surgery,” the same shall be deemed to mean a “medical practice license,” as defined by subsection a. of this section.

(4) Whenever, in any law, rule, or regulation, reference is made to a “permit to practice medicine or surgery” or a “permit to practice medicine and surgery,” the same shall be deemed to mean a permit or certificate of registration that is issued, pursuant to section 12 of P.L.1989, c.300 (C.45:9-19.12), to a person who is engaging in the practice of medicine while in training.

(cf: P.L.1953, c.233, s.2)

9. R.S.45:9-6 is amended to read as follows:

45:9-6. [All persons commencing the ] a. (1) No person shall engage in the unauthorized practice of medicine [or surgery] in this State. Any person who proposes to commence the practice of medicine with any patient in the State shall first apply to the board for a license [so ] to do so, in accordance with the provisions of subsection b. of this section, or the provisions of R.S.45:9-13, as appropriate.

(2) A person shall be regarded as engaging in the unauthorized practice of medicine in this State if the person, despite not being licensed under this section or R.S.45:9-13: (a) holds himself or herself out to the public as being able to diagnose, treat, issue prescriptions for, or engage in physical operations to address, any human ailment, disease, pain, injury, deformity, or mental or physical condition, whether through the use of traditional in-person means or methods, or through telemedicine; (b) holds himself or herself out to the public as being able to diagnose or treat any human ailment, disease, pain, injury, deformity, or mental or physical condition through the use of quasi-medical processes, such
as faithcurism, faith healing, mind healing, laying on of hands, or similar non-traditional healing systems; or (c) actively engages in any of the activities described in subparagraphs (a) and (b) of this paragraph.

(3) Except as otherwise provided by section 3 of P.L.1989, c.153 (C.45:9-41.19), or by any other law, the association of a person’s name with a medical abbreviation or designation, such as “doctor,” “physician,” “surgeon,” “Dr.,” “M.D.,” “M.B.,” “professor of medicine,” “professor of surgery,” or any other title intended or designed to identify the person as a physician, shall constitute evidence of the person’s engagement in the practice of medicine. [The board shall, except]

b. Except as [herein] otherwise provided by R.S.45:9-13, the board shall examine all [qualified] applicants for [such] a medical practice license. Every license applicant shall present to the board secretary [of the board], at least 20 days before [the commencement of] the examination at which [he desires] the applicant wishes to be examined, a written application for admission to the examination on a form provided by the board, together with satisfactory proof that [he] the applicant is more than 21 years of age, is of good moral character, and is either a citizen of the United States or has declared his intention to become [such] a U.S. citizen. [He] The applicant shall also present to the board with a certificate [of] from the Commissioner of Education of this State showing that [he], before entering a professional school or college, had [the applicant has] obtained an academic education consisting of a [4 years'] four year course of study in an approved public or private high school, or [the] an equivalent [thereof] course of study, prior to commencing training at a professional school or college, and shall additionally submit to the board, any other information and proofs required by R.S.45:9-7 and R.S.45:9-8.

c. Any license issued to an applicant [prior to becoming] who is not yet a citizen of the United States shall be treated as a temporary license and shall be subject to the provisions of [Revised Statutes 45:9-14] R.S.45:9-14.

(cf: P.L.1968, c.16, s.1)

10. Section 1 of P.L.1971, c.236 (C.45:9-6.1) is amended to read as follows:

1. a. All [persons who are licensed to practice medicine and surgery] physicians engaging in the practice of medicine with patients in this State shall be required [on or before July 1] biennially [to register on] a form prescribed by the board and furnished by the executive director [of the board] thereof, and to pay a biennial registration fee to be determined by the board. Upon
receipt of a physician’s biennial registration form and fee payment, the board shall provide the physician with a biennial certificate of registration, which confirms the physician’s compliance with this section.

b. The license of any physician who fails to procure a biennial certificate of registration, pursuant to subsection a. of this section, shall be automatically suspended on July 1. It shall be the duty of the executive director of the board on June 1 of each year, to send a written notice to the last known address of each physician practicing in the State whose license is expiring that year, regardless of whether the physician is a State resident or not, reminding the physician that the biennial registration fee is due on or before July 1, and that the physician’s license to practice in this State will be suspended if the fee is not paid and the certificate procured by July 1 of that year.

c. Any person whose medical practice license has been suspended under this section may have their license reinstated by the payment of all past due annual registration fees and, in addition thereto, a fee to be determined by the board to cover cost of reinstatement.

d. Any physician who desires to retire from the practice of medicine and surgery, and refrain, during the period of retirement, from practicing under the terms of their medical practice license, may, upon application to the executive director of the board, be registered biennially as a retired physician, without the payment of the registration fee required by subsection a. of this section, as a retired physician. The certificate of registration issued to a retired physician shall state, among other things, that the holder has been licensed to practice in New Jersey, but, during the period of retirement, shall not so practice. The holder of such a certificate of registration as a retired licensee shall be entitled to resume the practice of medicine at any time; provided that the retired physician first obtains, from the executive director, a biennial certificate of registration for practicing physicians, as herein before provided in subsection a. of this section. Any person who holds a certificate of registration as a retired physician shall, during the period of such retirement, be regarded as an unlicensed person, and any such person who commences or continues the practice of medicine under the terms of their medical practice license, without first having obtained a biennial certificate of registration authorizing the physician to
resume such practice, shall be liable to the penalties prescribed by
R.S.45:9-22.

g. If an applicant for reinstatement of licensure has not engaged
in the practice of medicine in any jurisdiction for a period of more
than five years, or the board's review of the reinstatement
application establishes a basis for concluding that there may be
clinical deficiencies in need of remediation, [before reinstatement]
the board may require the applicant [prior to reinstatement, to
submit to, and successfully pass, an examination or [an] skills
assessment [of skills]. If that examination or skills assessment
identifies clinical deficiencies or educational needs, the board may
require the [licensee] applicant, as a condition of reinstatement of
licensure, to take and successfully complete any educational
training, or to submit to any supervision, monitoring, or limitations
[, as] that the board determines are necessary to assure that the
[licensee practices] applicant, once reinstated, will practice with
reasonable skill and safety.

f. The license to practice medicine [and surgery of], which is
held by any person who fails to procure [any] a biennial certificate
of registration [, or in lieu thereof a biennial certificate of
registration] either as a practicing physician or a retired [licensee]
physician, shall, at the time and in the manner required by this act
[shall] be automatically suspended. Any person whose license
[shall have been] is automatically suspended shall, during the
period of such suspension, be regarded as an unlicensed person [, and [in case he shall continue or engage in] any such person who
commences or continues the practice of medicine under the terms of
[his] the medical practice license during such period [, shall be
liable to the penalties prescribed by R.S.45:9-22. [Any person to
whom a certificate of registration as a retired licensee shall have
been issued who shall continue or engage in practice under the
terms of his license without first having obtained a certificate of
registration authorizing him to resume such practice, shall be liable
to the penalties prescribed by R.S.45:9-22 for practicing without a
license. It shall be the duty of each such licensee holding]

g. Each physician who holds a biennial certificate of
registration [to practice medicine and surgery in this State] that has
been issued under this section, whether a State resident or not, [to]
shall notify the executive director of the board [, in writing, of any
change in [his] the physician’s office address or [his] employment
within ten days after such change [shall have] has taken place.

h. This section shall not be construed so as to render
inoperative the provisions of R.S.45:9-17.
(cf: P.L.2001, c.307, s.5)

11. R.S.45:9-7 is amended to read as follows:
45:9-7. Except as otherwise provided in this chapter [9 of Title 45 of the Revised Statutes] and in addition to any other requirements provided thereby, every applicant for admission to an examination for a medical practice license [to practice medicine and surgery] shall [also] present proof acceptable to the board demonstrating that, in addition [to], and subsequent to [], obtaining the preliminary education specified in R.S.45:9-6, and prior to commencing [his] study in a professional school or college, [he] the applicant had completed a satisfactory course of study in a college or school of arts and science accredited by an agency recognized by the board, the duration of [such] which course [to have been] was at least two years in length, [during which period he had earned no] and resulted in the accrual of not less than 60 course-hour credits, [which credits include one three-credit course including three credits each in chemistry, physics, and biology.]

An applicant whose premedical education does not meet the requirements set forth in this section may, at the discretion of the board, be permitted to remediate the substantive deficiencies in a manner determined by rules adopted by the board, and be deemed eligible for licensure. The board may waive the educational requirements of this section for any applicant who demonstrates that he has attained the substantial equivalent of these requirements through his post-secondary education, competency, accomplishments, and achievements in the practice of medicine [and surgery].

(cf: P.L.1993, c.145, s.1)

12. R.S.45:9-8 is amended to read as follows:

45:9-8. a. Except as otherwise provided in [R.S.45:9-1 et seq.] this chapter, and in addition to any other requirements provided thereby, every applicant for admission to [licensure by] an examination [to] for a medical practice [medicine and surgery] license shall [, in addition to the requirements set forth in R.S.45:9-1 et seq.]:

[a.] (1) Prove to the board that the applicant has received (a) a diploma from some legally incorporated professional school or college of the United States, Canada, or other foreign country, which school or college, in the opinion of the board, was in good standing at the time of the issuance of the diploma, or (b) a license conferring the full right to practice all of the branches of medicine and surgery in some foreign country; [and]

(2) [Shall further prove] Prove to the board that, prior to the receipt of such diploma or license, as aforesaid, the applicant had studied not less than [4] four full school years, including four satisfactory courses of lectures of at least eight months each, either...
consecutively or in four different calendar years, in some legally
incorporated and registered American or foreign professional school
or schools, college or colleges in good standing in the opinion of
the board, which courses shall have included a thorough and
satisfactory course of instruction in medicine and surgery; and

(b. (1) The) (3) (a) If the applicant [if he has] graduated
from a professional school or college [after July 1, 1916 and]
before July 1, 2003, [shall further] prove to the board that, [after
receiving such] following graduation and receipt of a diploma or
license, [the applicant has completed [as] at least a one-year
internship acceptable to the board [for at least one year] in a
hospital approved [by the board] thereby, or in lieu thereof [he],
has completed one year of post-graduate work acceptable to the
board in a school or hospital approved by the board, unless
required by regulation to complete additional post-graduate work;
or

[(2) The] (b) If the applicant [if he has] graduated from a
professional school or college after July 1, 2003, [shall
further] prove to the board that, [after receiving his] following
graduation and receipt of a diploma, [he] the applicant has
completed and received academic credit for at least two years of
post-graduate training in an accredited program and has signed a
contract for a third year of post-graduate training in an accredited
program, and, moreover, that at least two years of that training are
in the same field or would, when considered together, be credited
toward the criteria for certification by a single specialty board
recognized by the American Board of Medical Specialties [or], the
American Osteopathic Association or another certification entity
[with] having comparable standards [that] and which is
acceptable to the board.

[c. ] b. If an applicant for licensure has not engaged in practice
for a period of more than five years, or the board's review of the
application establishes a basis for concluding that there may be
clinical deficiencies in need of remediation, the board may require
the applicant to submit to, and successfully pass, an examination or
an assessment of skills. If that examination or assessment identifies
clinical deficiencies or educational needs, the board may require an
applicant, as a condition of licensure, to take and successfully
complete any educational training, or to submit to any supervision,
monitoring or limitations, as the board determines are necessary to
assure that the applicant will practice with reasonable skill and
safety.

(cf: P.L.2001, c.307, s.6)

13. R.S.45:9-13 is amended to read as follows:

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45:9-13. [Any] a. (1) Whenever an applicant for a medical practice license to practice medicine and surgery, upon proving that the applicant has been examined and licensed by the examining and licensing board of another State, or by the National Board of Medical Examiners, or by certificates of has received a certificate from the National Board of Examiners for Osteopathic Physicians and Surgeons, the board shall issue a reciprocal medical practice license to the applicant, without conducting an examination as required by R.S.45:9-6, provided that the criteria identified in section 3 of P.L.2013, c.182 (C.45:1-7.5) are deemed to have been satisfied.

(2) If a person applies for reciprocal medical practice licensure, pursuant to subsection a. of this section, and the board finds that the criteria in section 3 of P.L.2013, c.182 (C.45:1-7.5) are not satisfied, the board may still elect, in its discretion, to issue a reciprocal medical practice license to such applicant, without further examination upon payment to the treasurer of the board of a license fee of $150.00; and

b. For the purposes of this section, any questions related to the academic requirements of other States shall be determined by the Commissioner of Education of this State.

c. The board is authorized to impose a licensing fee of $150 in association with the issuance of a reciprocal medical practice license under this section.

(45:9-15) 14. R.S.45:9-15 is amended to read as follows:

45:9-15. [All examinations] Any examination that is provided in association with the issuance or reinstatement of a medical practice license shall be written in the English language, and, except as otherwise provided in the exemptions contained in this chapter [(45:9-1, et seq.), the questions] shall include such questions as can be answered in common by all schools of practice. The examinations shall test applicants in the following subjects: Pharmacology and therapeutics; obstetrics and gynecology; diagnosis, including diseases of the skin, nose and throat; surgery, including surgical anatomy and diseases of the eye, ear and genito-urinary organs; anatomy; physiology; chemistry; histology; pathology; bacteriology; hygiene; medical jurisprudence; and such
other subjects as the board may decide. If any applicant has completed a course of four full school years of study in, and has been regularly graduated from, a school of homeopathy or eclecticism, the member or members of the board of those schools, respectively, shall examine such applicant in the pharmacology and therapeutics of the school from which such applicant has been so graduated. All examinations shall be both scientific and practical, and of sufficient severity to test the candidate’s fitness to engage in the practice of medicine [and surgery]. If the applicant passes the examination [is satisfactory], the board shall issue or reinstate, as appropriate, a medical practice license entitling the applicant to engage in the practice of medicine [and/or surgery] with patients in this State. [Said] The application and examination papers shall be retained in the files of the board for a period of five years, and shall be prima facie evidence of all matters therein contained. All licenses shall be signed by the president and secretary of the board and attested by the seal thereof. All licenses granted under the exemptions contained in this chapter [(45:9-1, et seq.)] shall bear indication of the [school of] practice area in which the licensee is limited to practice, by virtue of [said] the license [to practice].

(cf: P.L.1939, c.115, s.25)

15. R.S.45:9-19 is amended to read as follows:

45:9-19. The clerk of every court wherein [any person licensed to practice medicine and surgery in this state] a physician is convicted of a crime shall [make] submit a written report thereof [in writing] to the board, upon blanks provided [by the board] thereby. The report shall state the name and address of the person so convicted, the date thereof, the nature of the crime of which [he] the person was convicted, and the sentence imposed by the court. (cf: R.S.45:9-19)

16. Section 12 of P.L.1989, c.300 (C.45:9-19.12) is amended to read as follows:

12. The State Board of Medical Examiners shall, by regulation, provide for the issuance of permits to, or the registration of, persons engaging in either the practice of medicine [or surgery] or the practice of podiatric medicine while in training, and shall establish the scope of permissible practice by [these] such persons, within the context of an accredited graduate medical education program conducted at a hospital licensed by the Department of Health. [A] The holder of a permit [holder] or certificate of registration issued pursuant to this section shall be [permitted] authorized to engage in practice outside the context of a graduate medical education program [for additional remuneration], only if that practice [is]:
a. [Approved] is approved by the director of the graduate medical education program in which the permit holder is participating; and

b. [With respect to any practice] (1) when conducted at or through a health care facility licensed by the Department of Health, is supervised by a plenary licensee who shall either remain on the premises of the health care facility or be available through electronic communications; or

c. With respect to any practice] (2) when conducted outside of a health care facility licensed by the Department of Health, is supervised by a plenary licensee who shall remain on the premises.

(cf: P.L.2012, c.17, s.409)

17. Section 16 of P.L.1989, c.300 (C.45:9-19.14) is amended to read as follows:

16. A physician or podiatrist whose federal or State privilege to purchase, dispense or prescribe controlled substances has been revoked, suspended, or otherwise limited shall not be permitted to administer, dispense, or prescribe controlled substances in a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), a health maintenance organization operating pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.), or a telemedicine situation, unless [the administration] such action has been approved by the State Board of Medical Examiners. The board may condition its approval on the physician's or podiatrist's participation in a licensed health care practitioner treatment program recognized by the board.

(cf: P.L.1989, c.300, s.16)

18. Section 25 of P.L.1989, c.300 (C.45:9-19.15) is amended to read as follows:

25. a. The State Board of Medical Examiners shall increase the licensing fee of physicians and podiatrists in an amount sufficient to fund the costs of establishing and operating the Medical Practitioner Review Panel and the position of medical director, established pursuant to P.L.1989, c.300 (C.45:9-19.4 et al.).

b. The board shall establish a reduced licensing fee for physicians and podiatrists who are 65 years of age or older and who have no affiliation status with a licensed health care facility or a health maintenance organization.

c. The board shall charge the following licensing fees to a physician whose professional practice is limited to providing patient care exclusively without compensation or the expectation or promise of compensation and in a facility or through a program conducted under the supervision of a physician licensed by and in good standing with the State: $150 for the license application fee; $125 each for the initial and biennial registration fees, respectively; and $100 for the endorsement fee.
Nothing in this subsection, except for the licensing fee, shall be construed to exempt any person from, or abrogate any provision in Title 45 of the Revised Statutes [or] any other [Title] law applicable to the practice of medicine [or surgery and] [or any regulations adopted pursuant thereto, including, but not limited to, requirements for licensure or coverage by medical malpractice liability insurance. (cf: P.L.2001, c.410, s.1)

19. Section 1 of P.L.2005, c.257 (C.45:9-19.16a) is amended to read as follows:

1. Notwithstanding the provisions of section 8 of P.L.1978, c.73 (C.45:1-21) or any other law to the contrary, in any case in which the board receives documentation demonstrating that a physician’s authority to engage in the practice of medicine [and surgery is] has been revoked by another state or by an out-of-State agency or authority, or is currently subject to a final or interim order of active suspension or other bar to clinical practice, which has been imposed by any other state, agency or authority such State or entity, the State Board of Medical Examiners board shall immediately suspend the physician’s medical practice license when the action of the other state, agency, or authority is grounded on facts that demonstrate that the physician’s continued practice would endanger or pose a risk to the public health or safety pending a determination of findings by the board. Otherwise, when such an action of another state, or out-of-State agency or authority is grounded on facts which would provide a basis for disciplinary sanction in this State [for reasons] consistent with section 8 of P.L.1978, c.73 (C.45:1-21), for actions or inactions involving gross or repeated negligence, fraud or other professional misconduct adversely affecting the public health, safety or welfare, the board may immediately suspend the physician’s license, pending a determination of findings by the board. The documentation from the other state, or from the out-of-state agency or authority, shall be a part of the record and shall establish conclusively the facts upon which the board rests its determination in any disciplinary proceeding or action undertaken pursuant to this section. The State Board of Medical Examiners board shall provide written notification to the physician whose license is suspended pursuant to the requirements of this section. The Board] and shall provide the physician with an opportunity to submit relevant evidence in mitigation or, for good cause shown, an opportunity for oral argument, but only as to the discipline imposed by this State. Relevant evidence in mitigation [or oral argument] may be submitted to the board or a committee to which it is has that has been delegated the authority to hear argument and make a recommendation.
recommendations to the board. A final determination as to
discipline shall be made within 60 days [of] after the date [of
mailing or personal service of the notice] on which the written
notification is mailed to or served on the physician in accordance
with this section.
(cf: P.L.2005, c.257, s.1)

20. R.S.45:9-21 is amended to read as follows:

45:9-21. The prohibitory provisions of Article II of this
chapter, which relate to medical practice licensure and the practice
of medicine in this State, shall not apply to the following:

a. A person who is commissioned [surgeon or physician of] by
the regular United States Army, Navy, or Marine hospital service to
engage in the practice of medicine while so commissioned, and
who engages in such practice while actively engaged in the
performance of his official duties. This exemption shall not apply
to reserve officers of the United States Army, Navy or Marine
Corps, or to any officer of the National Guard of any state or of the
United States;

b. A [lawfully qualified] physician [or surgeon of] from
another state [taking] who temporarily takes charge [temporarily,
on written permission of the board,] of the practice of a [lawfully
qualified] physician [or surgeon of] in this State during [his] the
latter physician’s temporary absence from the State [, upon written
request to the board for permission so to do. Before such
permission is granted by the board and before any person may enter
upon such practice he must submit], provided that: (1) the out-of-
State physician receives written permission from the board to do so,
following submission of a written request and $50 fee thereto; (2)
the out-of-State physician has submitted proof to the board showing
that [he] the physician can fulfill the requirements [demanded in
the other sections] of this article relating to applicants for
[admission] medical practice licensure by examination or
[indorsement from another state. Such permission may be granted]
applicants for reciprocal medical practice licensure; and (3) the
temporary placement will last for a total period of not less than two
weeks, nor more than four months [upon payment of a fee of $50.
The board] or, in [its] the discretion [may extend such
permission for further] of the board, for additional periods of two
weeks to four months, but [not to exceed in the] in no case, for a
period that exceeds an aggregate of one year;

c. A physician [or surgeon of] located in another state of the
United States [and] who is duly authorized under the laws thereof
to engage in the practice of medicine [or surgery] therein, [if] so
long as such [practitioner] physician does not [open an office or
place for] **engage in** the practice of [his profession] medicine, including telemedicine, with patients in this State;

d. A person [while actually] **who is actively** serving as a member of the resident medical staff of any legally incorporated charitable or municipal hospital or asylum approved by the board [.

Hereafter] , except that such exemption [of any such resident physician] shall not apply with respect to any [individual after he shall have] person who has served as a resident physician for a total period of five years;

e. The practice of dentistry by any legally qualified and registered dentist;

f. The ministration to, or treatment or healing of, the sick or suffering by [prayer or] spiritual, religious, or mental means alone, including through the use of prayer, whether gratuitously or for compensation, [and without] , provided that such ministration, treatment, or healing does not involve the use of any [drug material remedy] drugs or medicine, physical manipulation, or material means of healing;

g. The practice of optometry by any legally qualified and registered optometrist;

h. The practice of podiatric medicine by any legally licensed podiatrist;

i. The practice of pharmacy by a legally licensed and registered pharmacist of this State, [but] except that this [exception] exemption shall not be extended to give [to said] a licensed pharmacist the right and authority to carry on the business of a dispensary, unless the dispensary [shall be] is in charge of a [legally licensed and registered] physician [and surgeon] of this State;

j. [A person claiming the right to practice medicine and surgery in this State who has been practicing therein since before July 4, 1890, if said right or title was obtained upon a duly registered diploma, of which the holder and applicant was the lawful possessor, issued by a legally chartered medical institution which, in the opinion of the board, was in good standing at the time the diploma was issued:] (deleted by amendment, P.L. , c. (pending before the Legislature as this bill).c. )

k. A professional nurse, [or] a registered physical therapist, or a masseur, while operating in each particular case under the specific direction of a [regularly licensed] physician [or surgeon. This] in this State, except that this exemption shall not apply to such assistants of persons who are licensed as osteopaths, chiropractors, optometrists, or other practitioners holding limited licenses;

l. A person [while giving] who engages in the provision of aid, assistance or relief in an emergency or accident [cases]
situation, either under the direction of a physician, or pending the
arrival of, or transport of the patient to, a [regularly licensed]
physician, or surgeon or under the direction thereof];
m. The operation of a bio-analytical laboratory by a licensed
bio-analytical laboratory director, or by any person working under
the direct and constant supervision of a licensed bio-analytical
laboratory director;
n. Any [employee of a State or county institution holding]
person who holds the degree of M.D. or D.O., and is regularly
employed, on a [salary] salaried basis, on [its] the medical staff
of a State or county agency or institution, or as a member of the
teaching or scientific staff of a State agency, [may apply] and who,
following application to [the State Board of Medical Examiners of
New Jersey], and [may], in the discretion of [said], the board,
[be] is granted an exemption from the provisions of this chapter;
provided [said employee] that such person continues to be
employed as a member of the medical staff of a State agency or
county institution, or as a member of the teaching or scientific staff
of a State agency, and does not [conduct any type of] engage in
the private [medical] practice of medicine;
o. The practice of chiropractic by any legally licensed
chiropractor; or
p. The practice of a physician assistant in compliance with the
(cf: P.L.2005, c.259, s.16)

21. R.S.45:9-22 is amended to read as follows:
45:9-22. a. Any person [commencing or continuing] who
commences or continues the practice of medicine [and surgery] in
this State without first having obtained a medical practice license,
as provided in [this chapter or any supplement thereto] R.S.45:9-6
or R.S.45:9-13, or without having obtained a certificate of biennial
registration, as provided in section 1 of P.L.1971, c.236 (C.45:9-
6.1), or in any other manner that is contrary to [any of] the
provisions of this chapter [or any supplement thereto], or who
[practices] commences or continues the practice of medicine [and
surgery] under a false or assumed name, or [falsely impersonates]
while impersonating another practitioner of a like or different name
[.], or who buys, sells, or fraudulently obtains a medical practice
license, any record or registration pertaining thereto, or a diploma
[as a doctor of medicine and surgery or any branch thereof, or
method of treatment of human ailment, disease, pain, injury,
deformity, mental or physical condition] indicating that the person
has successfully completed training at a professional school or
college in the practice of medicine; [or a license to practice
medicine and surgery, record or registration pertaining to the same,
or] ; and any person, company, or association who [shall employ
for a stated salary or otherwise,] employs an unlicensed person, on
a paid or unpaid basis, in a job that entails the practice of medicine,
or [aid or assist] who aids or assists any such person [not regularly
licensed to practice medicine and surgery in this State, to] in the
practice of medicine [and surgery therein] with patients in the
State, or who violates any of the provisions of Article II of this
chapter [or any supplement thereto], shall be liable to a penalty of
[two hundred dollars ($200.00), for the first offense] $200.

b. Every person [practicing] engaged in the practice of
medicine [and surgery] under a firm name, and every person
[practicing] engaged in the practice of medicine [and surgery or]
as an employee of another, shall cause [his] the person's name to
be conspicuously displayed and kept in a conspicuous place at the
entrance of the place where such practice [shall be] is conducted [, and any]. Any person who [shall neglect to cause his name to be
displayed as herein required,] fails to comply with this requirement
shall be liable to a penalty of [one hundred dollars ($100.00)] $100.

The penalties provided for by this section shall be sued for and
recovered in a summary manner, by and in the name of the [State Board of Medical Examiners of New Jersey] board. [in a summary manner,] pursuant to ["the penalty enforcement law"
(N.J.S.2A:58-1 et seq.)] the “Penalty Enforcement Law of 1999,”
P.L.1999, c.274 (C.2A:58-10 et seq.) [and the Rules Governing the
Courts of the State of New Jersey]. [Process] The Superior Court
and the municipal court shall have jurisdiction to enforce the
provisions of the “Penalty Enforcement Law of 1999” in connection
with this section, and process shall be either in the nature of a summons or warrant.

(cf: P.L.1989, c.153, s.21)

22. Section 1 of P.L.1975, c.297 (C.45:9-22.1) is amended to
read as follows:

1. No physician and no professional service corporation
engaged in the practice of medicine [and surgery] in this State shall
charge a patient an extra fee for services rendered in completing a
medical claim form in connection with a health insurance policy.
Any person violating the provisions of this act section shall be
subject to a fine of [[$100.00] $100 for each offense.

Such penalty shall be [collected and enforced by summary
proceedings pursuant to "the penalty enforcement law"
(N.J.S.2A:58-1 et seq.)] sued for and recovered in a summary
manner, by and in the name of the board, pursuant to the “Penalty
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The Superior Court and the municipal court shall have jurisdiction within its territory of such proceedings. Process to enforce the provisions of the “Penalty Enforcement Law of 1999” in connection with this section, and process shall be either in the nature of a summons or warrant [and shall issue in the name of the State, upon the complaint of the State Board of Medical Examiners].

(cf: P.L.1991, c.91, s.453)

23. Section 1 of P.L.1997, c.249 (C.45:9-22.19) is amended to read as follows.

1. a. A physician may prescribe, dispense, or administer a medication or drug, including a controlled or non-controlled substance, to a patient in this State, provided that:

(1) the physician has first engaged in a face-to-face examination of the patient, either directly, through traditional in-person means or methods, or remotely, through the use of telemedicine, as defined in section 1 of P.L. , c. (C. ) (pending before the Legislature as this bill), in a manner that conforms to the accepted standards of care and rules of practice; and

(2) the prescription, dispensation, or administration of the medication or drug is done in compliance with any laws, rules, or regulations, including, but not limited to, the provisions of subsection b. and c. of this section, which are applicable to the particular substance being prescribed, dispensed, or administered.

b. A physician licensed pursuant to chapter 9 of Title 45 of the Revised Statutes may prescribe a Schedule II controlled dangerous substance for a patient in any quantity which does not exceed a 30-day supply, as defined by regulations adopted by the State Board of Medical Examiners board, in consultation with the Department of Health and Senior Services. The, provided that the physician shall document the diagnosis and the medical need for the prescription in the patient's medical record, in accordance with guidelines established by the State Board of Medical Examiners board.

b. A physician may issue multiple prescriptions authorizing a patient to receive a total of up to a 90-day supply of a Schedule II controlled dangerous substance, provided that the following conditions are met:

(1) each separate prescription is issued for a legitimate medical purpose by the physician acting in the usual course of professional practice;

(2) the physician provides written instructions on each prescription, other than the first prescription if it is to be filled immediately, indicating the earliest date on which a pharmacy may fill each prescription;
(3) the physician determines that providing the patient with multiple prescriptions in this manner does not create an undue risk of diversion or abuse; and
(4) the physician complies with all other applicable State and federal laws and regulations.
(cf: P.L.2009, c.165, s.1)

24. Section 3 of P.L.2003, c.96 (C.45:9-22.23) is amended to read as follows:
   a. The following information shall be included in each profile of a physician, podiatrist or optometrist, as applicable:
      (1) Name of all professional schools or colleges attended by the physician or podiatrist, or optometry schools attended by the optometrist, as the case may be, and the dates of graduation;
      (2) Graduate medical or optometry education, including all internships, residencies and fellowships;
      (3) Year first licensed;
      (4) Year first licensed in New Jersey;
      (5) Location or locations of the practitioner’s office practice site or sites, if any, and an indication as to whether the practitioner is available to provide health care services remotely, through the use of telemedicine;
      (6) A description of any criminal convictions for crimes of the first, second, third or fourth degree within the most recent 10 years. For the purposes of this paragraph, a person shall be deemed to be convicted of a crime if the individual pleaded guilty or was found or adjudged guilty by a court of competent jurisdiction. The description of criminal convictions shall not include any convictions that have been expunged. The following statement shall be included with the information about criminal convictions: "Information provided in this section may not be comprehensive. Courts in New Jersey are required by law to provide information about criminal convictions to the State Board of Medical Examiners (or the New Jersey State Board of Optometrists).";
      (7) A description of any final board disciplinary actions within the most recent 10 years, except that any such disciplinary action that is being appealed shall be identified;
      (8) A description of any final disciplinary actions by appropriate licensing boards in other states within the most recent 10 years, except that any such disciplinary action that is being appealed shall be identified. The following statement shall be included with the information about disciplinary actions in other states: "Information provided in this section may not be comprehensive. The State Board of Medical Examiners (or the New Jersey State Board of Optometrists) receives information about disciplinary actions in
other states from physicians (or optometrists) themselves and outside sources.”;

(9) In the case of physicians and podiatrists, a description of the circumstances surrounding: (a) any revocation or involuntary restriction of the practitioner’s privileges at a health care facility by the governing body or another official thereof, which has been imposed, in accordance with rules of procedural due process, for reasons related to the practitioner’s competence or misconduct, or impairment (taken by a health care facility's governing body or any other official of the health care facility after procedural due process has been afforded); (b) the practitioner’s resignation from, or nonrenewal of medical staff membership at, a health care facility for reasons related to the practitioner’s competence or misconduct, or impairment; or (c) the restriction of the practitioner’s privileges at a health care facility (taken in lieu of, or in as settlement of, a pending disciplinary case related to the practitioner’s competence or misconduct, or impairment. Only those cases that have occurred within the most recent 10 years and that were reported by the health care facility pursuant to section 2 of P.L.2005, c.83 (C.26:2H-12.2b) shall be included in the profile; and

(10) All medical malpractice court judgments and all medical malpractice arbitration awards reported to the applicable board, in which a payment has been awarded to the complaining party during the most recent five years, and all settlements of medical malpractice claims reported to the board, in which a payment is made to the complaining party within the most recent five years, as follows:

(a) Pending medical malpractice claims shall not be included in the profile, and information on pending medical malpractice claims shall not be disclosed to the public;

(b) A medical malpractice judgment that is being appealed shall be so identified;

(c) The context in which the payment of a medical malpractice claim occurs shall be identified by categorizing the number of judgments, arbitration awards, and settlements against the [physician, podiatrist or optometrist] practitioner into three graduated categories: average, above average, and below average [number of judgments, arbitration awards and settlements]. These groupings shall be arrived at by [comparing] determining the number of [an individual physician's, podiatrist's or optometrist's] medical malpractice judgments, arbitration awards, and settlements [to] associated with the particular practitioner, and comparing these values with the experience of other [physicians, podiatrists, or optometrists] practitioners within the same [speciality] specialty. In addition to any information provided by a physician,
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podiatrist or optometrist, an insurer or insurance association
authorized to issue medical malpractice liability insurance in the
State shall, at the request of the division, provide data and
information necessary to effectuate this subparagraph; and

(d) The following statement shall be included with the
information concerning medical malpractice judgments, arbitration
awards and settlements: "Settlement of a claim and, in particular,
the dollar amount of the settlement may occur for a variety of
reasons, which do not necessarily reflect negatively on the
professional competence or conduct of the physician (or podiatrist
or optometrist). A payment in settlement of a medical malpractice
action or claim should not be construed as creating a presumption
that medical malpractice has occurred."

b. If requested by a physician, podiatrist or optometrist, the
following information shall be included in the practitioner’s profile:

(1) Names of the hospitals where the physician, podiatrist or
optometrist has practice privileges;

(2) Appointments of the physician or podiatrist to medical
professional school or college faculties, or of the optometrist to
optometry school faculties, within the most recent 10 years;

(3) Information regarding any board certification granted by a
specialty board or other certifying entity recognized by the
American Board of Medical Specialties, the American Osteopathic
Association or the American Board of Podiatric Medicine, or by
any other national professional organization that has been
demonstrated to have comparable standards;

(4) Information regarding any translating services that may be
available at the practitioner’s office practice site or sites, as applicable, or
locations, any translating services that may be available to a patient
who is receiving health care services remotely, through the use of
telemedicine, and any languages other than English that are
spoken by the physician, podiatrist or optometrist;

(5) Information regarding whether the physician, podiatrist or
optometrist participates in the Medicaid program or
accepts assignments under the Medicare program;

(6) Information regarding the medical insurance plans in which
the physician, podiatrist or optometrist is a participating provider;

(7) Information concerning the hours during which the
physician, podiatrist or optometrist conducts his practice, and the hours during
which the practitioner is available to engage in remote practice,
(8) Information concerning the accessibility of the practitioner’s office practice [site or sites] locations [ , as applicable. ] to persons with disabilities.

The following disclaimer shall be included with the information supplied by the [physician, podiatrist or optometrist] practitioner pursuant to this subsection: "This information has been provided by the physician (or podiatrist or optometrist) but has not been independently verified by the State Board of Medical Examiners (or the New Jersey State Board of Optometrists) or the Division of Consumer Affairs."

If the [physician, podiatrist or optometrist] practitioner includes information regarding medical insurance plans in which the practitioner is a participating provider, the following disclaimer shall be included with that information: "This information may be subject to change. Contact your health benefits plan to verify if the physician (or podiatrist or optometrist) currently participates in the plan."

c. Before a profile is made available to the public, each [physician, podiatrist or optometrist] practitioner shall be provided with a copy of [his] their respective profile. The [physician, podiatrist or optometrist] practitioner shall be given 30 calendar days to correct a factual inaccuracy that may appear in the profile and [so] advise the Division of Consumer Affairs [ , or its designated agent , thereof]; however, upon receipt of a written request that the division or its designated agent deems reasonable, the [physician, podiatrist or optometrist] practitioner may be granted an extension of up to 15 calendar days to correct a factual inaccuracy and [so] advise the division or its designated agent.

d. If new information or a change in existing information is received by the division concerning a [physician, podiatrist or optometrist] practitioner, the [physician, podiatrist or optometrist] practitioner shall be provided with a copy of the proposed profile revision [ , and shall be given 30 calendar days to correct a factual inaccuracy and [to] return the corrected information to the division or its designated agent.

e. The profile and any revisions thereto shall not be made available to the public until after the review period provided for in this section has lapsed.

(cf: P.L.2005, c.83, s.18)

25. Section 1 of P.L.1975, c.240 (C.45:9-27.5) is amended to read as follows:

1. As used in [this act] P.L.1975, c.240 (C.45:9-27.5 et seq.):

a. ["Physician or surgeon"] “Physician” means a person [licensed or permitted] who possesses a current and valid license or
permit, which authorizes the person to engage in the practice of
medicine [or surgery] with patients in this State.

b. "Contingent fee arrangement" means an agreement for
medical services of one or more physicians [or surgeons],
including any associated or forwarding medical practitioners, under
which compensation is in whole or in part is contingent upon the
successful accomplishment or disposition of the legal claim to
which such medical services are related.

(cf: P.L.1975, c. 240, s.1)

26. Section 2 of P.L.1975, c.240 (C.45:9-27.6) is amended to
read as follows:

2. Any physician [or surgeon] who renders treatment which
[he] the physician knows or reasonably should know is or will be
related to, or is or will be the basis of, a legal claim for workmen's
compensation or damages in negligence shall provide [his] the
patient with a true, accurate, and itemized copy of the bill for
treatment rendered. Such physician [or surgeon should] shall
certify and attest by his signature on all originals and copies of such
bills to the actuality and accuracy of the examinations and
treatments rendered and the amounts charged for them.

(cf: P.L.1975, c.240, s.2)

27. Section 4 of P.L.1975, c.240 (C.45:9-27.8)

4. In any matter where medical services rendered to a client
form any part of the basis of a legal claim for damages or
workmen's compensation, a physician [or surgeon] shall not
contract for, charge, or collect a contingent fee.

(cf: P.L.1975, c.240, s.4)

28. Section 4 of P.L.1991, c.378 (C.45:9-27.13) is amended to
read as follows:

4. a. The board shall issue a license as a physician assistant to
an applicant who has fulfilled the following requirements:

(1) Is at least 18 years of age;

(2) Is of good moral character;

(3) Has successfully completed an approved program; and

(4) Has passed the national certifying examination administered
by the National Commission on Certification of Physician
Assistants, or its successor.

b. In addition to the requirements of subsection a. of this
section, an applicant for renewal of a license as a physician
assistant shall:

(1) Execute and submit a sworn statement made on a form
provided by the board that neither the license for which renewal is
sought nor any similar license or other authority issued by another
jurisdiction has been revoked, suspended or not renewed; and
(2) Present satisfactory evidence that any continuing education requirements have been completed as required by this act.

c. [The] Whenever an applicant for a license under this section submits evidence to the board showing that the applicant has been examined and licensed as a physician assistant by the examining and licensing board of another state of the United States, the board shall issue a reciprocal practice license to the applicant based on such evidence, and in lieu of the examination required by paragraph (4) of subsection a. of this section, provided that the criteria identified in section 3 of P.L.2013, c.182 (C.45:1-7.5) are deemed to have been satisfied. If the board determines that the criteria in section 3 of P.L.2013, c.182 (C.45:1-7.5) are not satisfied, the board, in consultation with the committee, may [accept] still elect, in its discretion, to issue a reciprocal license to the applicant, in lieu of the examination required by paragraph (4) of subsection a. of this section, provided that the applicant submits proof showing that [an] the applicant [for licensure] holds a current license in [a] another state which has standards substantially equivalent to those of this State.

d. The board shall issue a temporary license to an applicant who meets the requirements of paragraphs (1), (2) and (3) of subsection a. of this section and who is either waiting to take the first scheduled examination following completion of an approved program, or is awaiting the results of the examination. The temporary license shall expire upon the applicant's receipt of notification of failure to pass the examination.

(cf: P.L.1993, c.337, s.1)

29. Section 6 of P.L.1991, c.378 (C.45:9-27.15) is amended to read as follows:

6. a. A physician assistant may practice in all medical care settings, including, but not limited to, a physician's office, a health care facility, an institution, a veterans' home, or a private home, or may practice through the use of telemedicine, as defined by section 1 of P.L. , c. (C. ) (pending before the Legislature as this bill), provided that:

(1) the physician assistant is under the direct supervision of a physician [pursuant to], as provided by section 9 of [this act] P.L.1991, c.378 (C.45:9-27.18);

(2) the practice of the physician assistant is limited to those procedures authorized under section 7 of [this act] P.L.1991, c.378 (C.45:9-27.16);

(3) an appropriate notice of employment has been filed with the board pursuant to subsection b. of section 5 of [this act] P.L.1991, c.378 (C.45:9-27.14);
(4) the supervising physician or physician assistant advises the patient at the time that services are rendered that they are to be performed by the physician assistant;
(5) the physician assistant conspicuously wears an identification tag using the term "physician assistant" whenever acting in that capacity; and
(6) any entry by a physician assistant in a clinical record is appropriately signed and followed by the designation, "PA-C."

b. Any physician assistant who practices in violation of any of the conditions specified in subsection a. of this section shall be deemed to have engaged in professional misconduct in violation of subsection f. of section 8 of P.L.1978, c.73 (C.45:1-21).

(cf: P.L.1992, c.102, s.4)

30. Section 1 of P.L.1947, c.262 (C.45:11-23) is amended to read as follows:
1. a. As used in [this act] P.L.1947, c.262 (C.45:11-23 et seq.):
   “Board” means the New Jersey Board of Nursing created by [this act] section 2 of P.L.1947, c.262 (C.45:11-24).
   [b. The practice of nursing as a registered professional nurse is defined as diagnosing and treating human]
   "Collaborating physician" means a person who is licensed to practice medicine, pursuant to chapter 9 of Title 45 of the Revised Statutes, and who agrees to work with an advanced practice nurse.
   “Homemaker-home health aide” means a person employed with a home care services agency who performs nursing regimens or tasks that have been delegated thereto, pursuant to the authority of a registered professional nurse.
   “Home care services agency” means and includes any agency, facility, or other entity that is engaged in the business of procuring or offering to procure employment for homemaker-home health aides in exchange for a direct or indirect fee, and includes home health agencies, assisted living residences, comprehensive personal care homes, assisted living programs, or alternate family care sponsor agencies licensed by the Department of Health pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.); and health care service firms or nonprofit homemaker-home health aide agencies regulated by the Division of Consumer Affairs and the Attorney General, pursuant to the respective provisions of P.L.1989, c.331 (C.34:8-43 et seq.), P.L.2002, c.126 (C.34:8-45.1 et seq.), and P.L.1960, c.39 (C.56:8-1 et seq.).
“Licensed practical nurse” means a person who is licensed, pursuant to R.S.45:11-27, to engage in the practice of practical nursing.

“Practical nursing” means nursing practice that involves the performance of tasks and responsibilities within the framework of casefinding, the reinforcement of the patient and family teaching program through health teaching and health counseling, and the provision of supportive and restorative care, all under the direction of a registered professional nurse or a licensed or otherwise legally authorized physician or dentist.

“Professional nursing” means nursing practice that involves the identification of, and discrimination between, physical and psychosocial patient responses, including the signs, symptoms, and processes that denote a patient’s health need or reaction to actual or potential physical or emotional health problems, and the selection and implementation of therapeutic measures essential to the effective management of such patient responses, through such services as the use of casefinding, health teaching, health counseling, and provision of supportive or restorative patient care supportive to or restorative of life and well-being, and executing the execution of medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist, using any authorized means or methods, including telemedicine, as defined by section 1 of P.L.1947, c.262 (C.45:11-23 et seq.) (pending before the Legislature as this bill). [Diagnosing in the context of nursing practice means the identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen within the scope of practice of the registered professional nurse. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen. Human responses means those signs, symptoms, and processes which denote the individual’s health need or reaction to an actual or potential health problem. The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. The]

“Registered professional nurse” means a person who is licensed, pursuant to R.S.45:11-26, to engage in the practice of professional nursing.

b. As used in P.L.1947, c.262 (C.45:11-23 et seq.), the terms "nursing," "professional nursing," and "practical nursing" [as used in this act] shall not be construed to include:
(1) nursing performed, in the prescribed course of study or training, by students who are enrolled in a school of nursing accredited or approved by the board, performed in the prescribed course of study and training, nor

(2) nursing performed by a graduate of a school identified in paragraph (1) of this subsection, in hospitals, institutions and agencies, a hospital, institution, or agency approved by the board for this purpose, by graduates of such schools pending, during the period of time that the graduate is awaiting the results of the first licensing examination scheduled by the board following the graduate’s completion of a course of study and the attaining of the age qualification for examination, or thereafter, with the approval of the board, in the case of each individual pending, during such extended period of time that the graduate is awaiting the results of any subsequent examinations; nor shall any of said terms be construed to include

(3) nursing performed by a nurse who is qualified under the laws of another state or country, for a period not exceeding 12 months, or, if approved by the board, for a longer period of time, in hospitals, institutions or agencies by a nurse legally qualified under the laws of another state or country, a hospital, institution, or agency in this State, pending the nurse’s receipt of results of an application for licensing under this act, if provided that such nurse does not represent or hold himself or herself out to the public as a nurse who is licensed to practice in this State; nor shall any of said terms be construed to include the practice of

(4) nursing in this State performed by any legally qualified nurse of another state whose engagement made outside of this State requires such nurse to accompany and care for the patient while in this State during the period of such engagement, not to exceed six months in this State, if provided that such nurse does not represent or hold himself or herself out to the public as a nurse who is licensed to practice in this State; nor shall any of said terms be construed to include

(5) nursing performed by employees or officers of the United States Government or any agency or service thereof while in the discharge of their official duties; nor shall any of said terms be construed to include

(6) services performed by nurses aides, attendants, orderlies and ward helpers in hospitals, institutions and agencies, or by technicians, physiotherapists, or medical secretaries; and such duties performed by said persons aforementioned shall not be subject to rules or regulations which the board may prescribe
concerning nursing; nor shall any of said terms be construed to include:

(7) first aid nursing assistance, or gratuitous care provided by friends or members of the family of a sick or infirm person; or

(8) incidental care of the sick by a person employed primarily as a domestic or housekeeper, notwithstanding that the occasion for such employment may be sickness, if such incidental care does not constitute professional nursing and the person engaging in such care does not claim or purport to be a licensed nurse; and

(9) services rendered in accordance with the practice of the religious tenets of any well-recognized church or denomination which subscribes to the art of healing by prayer. A person who is otherwise qualified shall not be denied licensure as a professional nurse or practical nurse by reason of the circumstances that such person is in religious life and has taken a vow of poverty.

c. "Homemaker-home health aide" means a person who is employed by a home care services agency and who is performing delegated nursing regimens or nursing tasks delegated through the authority of a duly licensed registered professional nurse. "Home care services agency" means home health agencies, assisted living residences, comprehensive personal care homes, assisted living programs or alternate family care sponsor agencies licensed by the Department of Health and Senior Services pursuant to P.L.1971, c.136 (C.26:2H-1 et al.), nonprofit homemaker-home health aide agencies, and health care service firms regulated by the Director of the Division of Consumer Affairs in the Department of Law and Public Safety and the Attorney General pursuant to P.L.1989, c.331 (C.34:8-43 et seq.) and P.L.1960, c.39 (C.56:8-1 et seq.), respectively, which are engaged in the business of procuring or offering to procure employment for homemaker-home health aides, where a fee may be exacted, charged or received directly or indirectly for procuring or offering to procure that employment.


e. "Collaborating physician" means a person licensed to practice medicine and surgery pursuant to chapter 9 of Title 45 of the Revised Statutes who agrees to work with an advanced practice nurse.

c. Nothing in this act shall confer the authority to be deemed to provide a person who is licensed to practice nursing with the authority to practice another health profession.
unless the person first obtains the appropriate license therefor, pursuant to Title 45 of the Revised Statutes. (cf: P.L.2004, c.122, s.1)

31. Section 4 of P.L.1947, c.262 (C.45:11-26) is amended to read as follows:

4. a. Qualifications of applicants. An applicant for a license to practice professional nursing shall submit evidence to the board in such form as the board may prescribe showing that (1) the applicant: (1) has attained his or her eighteenth birthday, (2) is of good moral character, is not a habitual user of drugs and has never been convicted or has not pleaded nolo contendere, non vult contendere or non vult to an indictment, information or complaint alleging a violation of any Federal or State law relating to narcotic drugs; (3) holds a diploma from an accredited 4-year high school or the equivalent thereof as determined by the New Jersey State Department of Education; and (4) has completed a course of professional nursing study in an accredited school of professional nursing as defined by the board and holds a diploma therefrom.

Notwithstanding anything herein contained, any person who possesses the educational and school of professional nursing qualifications for registration required by the law of this State at the time of his or her graduation from an accredited school of professional nursing shall be deemed to possess the qualifications identified in paragraphs (3) and (4) prescribed hereinabove in this subsection.

Notwithstanding anything herein contained, any person who possesses the qualifications identified in paragraphs (1) and (2) of this subsection, and who has graduated from a school of professional nursing, which need not be an accredited school, shall be deemed to have qualifications identified in paragraphs (3) and (4) of this subsection, but only upon complying with such reasonable requirements as to high school and school of nursing studies and training as the board may prescribe; and provided further, that such person shall make a complete application in the form and manner prescribed by the board within one year from the effective date of this act P.L.1947, c.262 (C.45:11-23 et seq.), and shall satisfactorily complete such application in the form and manner prescribed by the board within two years after the filing of the application, which examinations shall be limited to the subject matters in the curriculum required by the board at the time of the applicant's graduation, as provided for in subsection b. hereof, within 2 years after the date of the filing of such application of this section.
b. License.

(1) By examination. The applicant shall be required to pass a written examination in such subjects as the board may determine, which examination may be supplemented by an oral or practical examination, or both. Upon successfully passing such examinations the applicant shall be licensed by the board to practice professional nursing.

(2) By indorsement without examination. Whenever an applicant submits evidence to the board showing that the applicant has been examined and licensed as a registered or professional nurse by the examining and licensing board of another state of the United States, the board shall issue a reciprocal practice license to the applicant, by indorsement, and without conducting a written examination thereof, provided that the criteria identified in section 3 of P.L.2013, c.182 (C.45:1-7.5) are deemed to have been satisfied. If the board determines that these statutory criteria are not satisfied, the board may still elect, in its discretion, to issue a reciprocal professional nursing license to an applicant who has been duly licensed or registered as a registered or professional nurse by examination or by original waiver, under the laws of another State, territory, or possession of the United States, or the District of Columbia, or any foreign country, if, in the opinion of the board, the applicant has the qualifications required by section 22 of this act P.L.1947, c.262 (C.45:11-23 et seq.) for the licensing of professional nurses, or possesses equivalent qualifications.

c. Fees. An applicant for a license by examination shall pay to the board at the time of application a fee of $25.00 $25, and, at the time of each application for re-examination, a fee of $20.00 $20. An applicant for a reciprocal license without examination shall pay to the board at the time of application a fee of $15.00 $15.

d. Nurses registered under a previous law. Any person who, as of the effective date of this act P.L.1947, c.262 (C.45:11-23 et seq.), holds a subsisting certificate of registration as a registered nurse, which was issued pursuant to the provisions of the act repealed by section 22 of this act P.L.1947, c.262 (C.45:11-23 et seq.), shall be deemed to be licensed as a professional nurse under this act P.L.1947, c.262 (C.45:11-23 et seq.) during the calendar year in which this act shall take effect. Any person who heretofore held a certificate of registration under such act as aforesaid shall be entitled to a renewal of such license as provided for professional nurses who are licensed originally under this act pursuant to P.L.1947, c.262 (C.45:11-23 et seq.).
e. Title and abbreviations used by licensee. Any person who holds a license to practice professional nursing, which has been issued under this section, shall during the effective period of such license be entitled to use the title "Registered Nurse" and the abbreviation "R.N." The effective period of a license or a renewal thereof shall commence on the date of issuance and shall terminate at the end of the calendar year in which it is issued, and shall not include any period of suspension ordered by the board as hereinafter provided.

(cf: P.L.1966, c.186, s.2)

32. Section 5 of P.L.1947, c.262 (C.45:11-27) is amended to read as follows:

5. a. Qualifications of applicants. An applicant for a license to practice practical nursing shall submit evidence to the board in such form as the board may prescribe, showing that the applicant: (1) has attained his or her eighteenth birthday; (2) is of good moral character, is not an habitual user of drugs, and has never been convicted or has not pleaded nolo contendere, non vult contendere or non vult to an indictment, information, or complaint alleging a violation of any Federal or State law relating to narcotic drugs; (3) has completed two years of high school or the equivalent thereof, as determined by the New Jersey State Department of Education; (4) has completed a course of study in a school of practical nursing approved by the board and holds a diploma either therefrom, or holds a diploma from a school of practical nursing operated by a board of education in this State; and (5) is certified by the Department of Education as having completed the number of hours of instruction in the subjects and curriculum prescribed by the board and an approved course of affiliation, or has equivalent qualifications as determined by the board.

b. License.

(1) By examination. The applicant shall be required to pass a written examination in such subjects as the board may determine, which examination may be supplemented by an oral or practical examination, or both. Upon successfully passing such examinations, the applicant shall be licensed by the board to practice practical nursing.

(2) By indorsement without examination. Whenever an applicant submits evidence to the board showing that the applicant has been examined and licensed as a practical nurse, or as a person entitled to perform similar services under a different title, by the examining and licensing board of another state of the United States, the board shall issue a reciprocal practice license to the applicant, by indorsement, and without conducting an examination thereof, provided that the criteria identified in section 3 of P.L.2013,
c.182 (C.45:1-7.5) are deemed to have been satisfied. If the board determines that these statutory criteria are not satisfied, the board [shall] may still elect, in its discretion, to issue a reciprocal practical nursing license [to practice practical nursing] without examination to any applicant who has been duly licensed as a practical nurse or as a person who is entitled to perform similar services under a different title, either by [practical nurse] examination or by original waiver under the laws of another State, territory, or possession of the United States, or the District of Columbia, if, in the opinion of the board, the applicant has the qualifications required by [this act] P.L.1947, c.262 (C.45:11-23 et seq.) for the licensing of practical nurses, or possesses equivalent qualifications.

(3) Waiver. If application therefor is made, upon a form prescribed by the board, on or before September 1, 1958, the board shall issue a license to practice practical nursing to an applicant who submits evidence to the board [evidence] in such form as the board may prescribe, showing that the applicant has the qualifications identified in paragraphs (1) and (2) [provided in] of subsection ["a"] a. of this section, and had, within [5] five years prior to application, at least [2] two years of satisfactory experience in practical nursing, at least [1] one year of which shall have been performed in this State, except in cases of nursing performed in an agency or service of the Federal Government; provided, however, that except in cases of such nursing performed in an agency or service of the Federal Government, such applicant is indorsed under oath by [2] two physicians who are duly licensed to practice medicine [and surgery] in New Jersey, and who have personal knowledge of the applicant's qualifications and satisfactory performance of practical nursing, and by [2] two persons who have employed the applicant.

c. Fees. An applicant for license by examination shall pay to the board, at the time of application, a fee of [$20.00] $20, and at the time of each application for re-examination, a fee of [$10.00] $10. At the time of application an applicant for a reciprocal license without examination, or for a license by waiver, shall pay to the board, at the time of application, a fee of [$10.00], and an applicant for license by waiver shall pay to the board a fee of [$10.00] $10.

d. Title used by licensee. Any person who holds a license to practice practical nursing, which has been issued under this [act] section, shall, during the effective period of such license, be entitled to practice practical nursing and to use the title "Licensed Practical Nurse" and the abbreviation "L.P.N." The effective period of a license or a renewal thereof shall commence on the date of issuance and shall terminate at the end of the calendar year in

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which it is issued, and shall not include any period of suspension
ordered by the board as hereinafter provided.

(cf: P.L.1966, c.186, s.3)

33. Section 8 of P.L.1991, c.377 (C.45:11-47) is amended to
read as follows:

8. a. The New Jersey Board of Nursing may issue a certification
as an advanced practice nurse to an applicant who fulfills the
following requirements:

(1) Is at least 18 years of age;
(2) Is of good moral character;
(3) Is a registered professional nurse;
(4) Has successfully completed an educational program,
including pharmacology, approved by the board; and
(5) Has passed a written examination approved by the board.

b. In addition to the requirements of subsection a. of this
section, an applicant for renewal of a certification as an advanced
practice nurse shall present satisfactory evidence that, in the period
since the certification was issued or last renewed, all continuing
education requirements have been completed as required by
regulations adopted by the board.

c. [The] Notwithstanding the provisions of paragraph (5) of
subsection a. of this section to the contrary, whenever an applicant
submits evidence to the board showing that the applicant has been
examined and licensed or certified as an advanced practice nurse, or
as a person entitled to perform similar services under a different
title, by the examining and licensing or certification board of
another state of the United States, the board shall certify the
applicant as an advanced practice nurse, by indorsement, and
without conducting an examination thereof, provided that the
criteria identified in section 3 of P.L.2013, c.182 (C.45:1-7.5) are
deemed to have been satisfied. If the board determines that these
statutory criteria are not satisfied, the board may [accept, in lieu of
the] still elect, in its discretion, to certify the applicant as an
advanced practice nurse, by indorsement, and without requiring the
applicant to undergo the written examination required by paragraph
(5) of subsection a. of this section, provided that the applicant
submits proof showing that [an] the applicant [for certification]
holds a current license or certification as an advanced practice
nurse, or as a person entitled to perform similar services under a
different title, in a state which has standards substantially
equivalent to those of this State.

(cf: P.L.1999, c.85, s.6)

34. Section 10 of P.L.1991, c.377 (C.45:11-49) is amended to
read as follows:

10. a. In addition to all other tasks which a registered
professional nurse may, by law, perform, an advanced practice
nurse may manage preventive care services, and diagnose and manage deviations from wellness and long-term illnesses, consistent with the needs of the patient and within the scope of practice of the advanced practice nurse, by:

(1) initiating laboratory and other diagnostic tests;
(2) prescribing or ordering medications and devices, as authorized by subsections b. and c. of this section; and
(3) prescribing or ordering treatments, including referrals to other licensed health care professionals, and performing specific procedures in accordance with the provisions of this subsection.

b. An advanced practice nurse may order medications and devices in the inpatient setting, subject to the following conditions:
(1) the collaborating physician and advanced practice nurse shall address in the joint protocols whether prior consultation with the collaborating physician is required to initiate an order for a controlled dangerous substance;
(2) the order is written in accordance with standing orders or joint protocols developed in agreement between a collaborating physician and the advanced practice nurse, or pursuant to the specific direction of a physician;
(3) the advanced practice nurse authorizes the order by signing [his] the nurse's own name, printing the nurse's name and certification number, and printing the collaborating physician's name;
(4) the physician is present or readily available through electronic communications;
(5) the charts and records of the patients treated by the advanced practice nurse are reviewed by the collaborating physician and the advanced practice nurse within the period of time specified by rule adopted by the Commissioner of Health and Senior Services pursuant to section 13 of P.L.1991, c.377 (C.45:11-52);
(6) the joint protocols developed by the collaborating physician and the advanced practice nurse are reviewed, updated and signed at least annually by both parties; and
(7) the advanced practice nurse has completed six contact hours of continuing professional education in pharmacology related to controlled substances, including pharmacologic therapy and addiction prevention and management, in accordance with regulations adopted by the New Jersey Board of Nursing. The six contact hours shall be in addition to New Jersey Board of Nursing pharmacology education requirements for advanced practice nurses related to initial certification and recertification of an advanced practice nurse as set forth in N.J.A.C.13:37-7.2 and 13:37-7.5.

c. An advanced practice nurse may prescribe medications and devices in [all] any other medically appropriate [settings] setting, or while engaging in telemedicine, as defined by section 1 of P.L. , c. (C. ) (pending before the Legislature as this bill), subject to the following conditions:
(1) the collaborating physician and advanced practice nurse shall address in the joint protocols whether prior consultation with the collaborating physician is required to initiate a prescription for a controlled dangerous substance;
(2) the prescription is written in accordance with standing orders or joint protocols developed in agreement between a collaborating physician and the advanced practice nurse, or pursuant to the specific direction of a physician;
(3) the advanced practice nurse writes the prescription on a New Jersey Prescription Blank pursuant to P.L.2003, c.280 (C.45:14-40 et seq.), signs [his] the nurse’s name to the prescription and prints [his] the nurse’s name and certification number;
(4) the prescription is dated and includes the name of the patient and the name, address, and telephone number of the collaborating physician;
(5) the physician is present or readily available through electronic communications;
(6) the charts and records of the patients treated by the advanced practice nurse are periodically reviewed by the collaborating physician and the advanced practice nurse;
(7) the joint protocols developed by the collaborating physician and the advanced practice nurse are reviewed, updated and signed at least annually by both parties; and
(8) the advanced practice nurse has completed six contact hours of continuing professional education in pharmacology related to controlled substances, including pharmacologic therapy and addiction prevention and management, in accordance with regulations adopted by the New Jersey Board of Nursing. The six contact hours shall be in addition to New Jersey Board of Nursing pharmacology education requirements for advanced practice nurses related to initial certification and recertification of an advanced practice nurse as set forth in N.J.A.C.13:37-7.2 and 13:37-7.5.

d. The joint protocols employed pursuant to subsections b. and c. of this section shall conform with standards adopted by the Director of the Division of Consumer Affairs pursuant to section 12 of P.L.1991, c.377 (C.45:11-51) or section 10 of P.L.1999, c.85 (C.45:11-49.2), as applicable.

e. (Deleted by amendment, P.L.2004, c.122.)
(cf: P.L.2004, c.122, s.2)
"Board" means the State Board of Psychological Examiners established pursuant to section 9 of P.L.1966, c.282 (C.45:14B-9).

"Licensed practicing psychologist" means an individual to whom a license has been issued pursuant to the provisions of this act, which license is in force and not suspended or revoked as of the particular time in question.

The "practice" of psychology means the rendering of professional psychological services for a fee, monetary or otherwise, to an individual or group of individuals, whether in the general public or in public or private organizations, by any authorized means or method, including telemedicine, as defined by section 1 of P.L., c. (C. ) (pending before the Legislature as this bill) [either public or private, for a fee, monetary or otherwise].

"Professional psychological services" means the application of psychological principles and procedures in the assessment, counseling, or psychotherapy of individuals for the purposes of promoting the optimal development of their potential or ameliorating their personality disturbances and maladjustments as manifested in personal and interpersonal situations. [Within the meaning of this act, professional psychological services] "Professional psychological services" does not include the application for a fee, monetary or otherwise, of psychological principles and procedures for purposes other than those described in this section.

"Board" means the State Board of Psychological Examiners acting as such under the provisions of this act.

"Recognized educational institution" means any educational institution [which] that is a [2-year] two-year junior college or [one which] that grants the Bachelor's, Master's, [and] or Doctor's degrees[, or any one or more thereof], and which is recognized by the New Jersey State Board of Education or by any accrediting body acceptable to the State Board of Psychological Examiners. (cf: P.L.1966, c.282, s.2)

Section 14 of P.L.1966, c.282 (C.45:14B-14) is amended to read as follows:

14. Each person desiring to obtain a license as a practicing psychologist shall make application therefor to the board upon such form and in such manner as the board shall prescribe and shall furnish evidence satisfactory to the board showing that [he] the applicant:

(a) Is at least 21 years of age;

(b) Is of good moral character;
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[(c)] c. Is not engaged in any practice or conduct which would
be a ground for refusing to issue, suspending, or revoking a license
issued pursuant to [this act] P.L.1966, c. 282 (C.45:14B-1 et seq.);
and
[(d)] d. Qualifies for reciprocal licensing by an examination
of credentials or, as provided by section 20 of P.L.1966,
c.282 (C.45:14B-20), or for admission to an assembled licensure
examination to be conducted by the board pursuant to section 18
(cf: P.L.1966, c.282, s.14)

37. Section 20 of P.L.1966, c.282 (C.45:14B-20) is amended to
read as follows:

20. [The] Whenever an applicant for a license under P.L.1966,
c.282 (C.45:14B-1 et seq.) submits evidence to the board showing
that the applicant has been examined and licensed by the examining
and licensing board of another state of the United States, the board
shall issue a reciprocal practice license to the applicant, without
conducting a written examination thereof, provided that the criteria
identified in section 3 of P.L.2013, c.182 (C.45:1-7.5) are deemed
to have been satisfied. If the board determines that these statutory
criteria are not satisfied, the board may still elect, in its discretion,
to issue a reciprocal practice license by an examination of
credentials, without prior examination, to any applicant who
presents evidence that [he] the applicant; [(a)] is licensed or
certified as a psychologist in another State [with], which has
licensure or certification requirements [for said license or
certificate] that are substantially similar to this State, such that the
board is of the opinion that [said] the applicant is competent to
engage in the practice of psychology in this State; or [(b)] holds a
diploma from a nationally recognized psychological board or
agency.
(cf: P.L.1966, c.282, s.20)

38. Section 3 of P.L.2000, c.57 (C.45:14BB-3) is amended to
read as follows:

3. As used in [this act] P.L.2000, c.57 (C.45:14BB-1 et seq.):
"Advisory committee" means the Certified Psychoanalysts
Advisory Committee established pursuant to section 4 of [this act]
"Director" means the Director of the Division of Consumer
Affairs in the Department of Law and Public Safety; or his
designee.
"National psychoanalytic association" means a national
professional organization of psychoanalysts that conducts on-site
visits of psychoanalytic institutes applying for association membership.

"Psychoanalytic services" means therapeutic services [that] which are based on an understanding of the unconscious and how unconscious processes affect the human mind as a whole, including actions, thoughts, perceptions and emotions, and which are delivered to a patient by a State certified psychoanalyst through any appropriate means or method, including, but not limited to, telemedicine.

"State certified psychoanalyst" means an individual who has met the eligibility requirements contained in section 6 of [this act] P.L.2000, c.57 (C.45:14BB-6) and holds a current, valid certificate of State certification.

(cf: P.L.2000, c.57, s.3)

39. Section 10 of P.L.2000, c.57 (C.45:14BB-10) is amended to read as follows:

10. a. Notwithstanding the provisions of section 6 of P.L.2000, c.57 (C.45:14BB-6) to the contrary, whenever an applicant for certification under P.L.2000, c.57 (C.45:14BB-1 et seq.) submits evidence to the director showing that the applicant has been examined and licensed or certified as a psychoanalyst by the examining and licensing board of another state of the United States, the director shall certify the applicant as a State certified psychoanalyst, by indorsement, and without conducting an examination thereof, provided that the criteria identified in section 3 of P.L.2013, c.182 (C.45:1-7.5) are deemed to have been satisfied. If the director determines that these statutory criteria are not satisfied, the director may still elect, in his or her discretion, to certify the applicant as a State certified psychoanalyst, by endorsement, and without requiring the applicant to undergo the examination required by subsection e. of section 6 of P.L.2000, c.57 (C.45:14BB-6), provided that the conditions described in section b. of this section are satisfied.

b. The director may waive the education, experience and examination requirements for State certification [pursuant to this act] that are provided by P.L.2000, c.57 (C.45:14BB-1 et seq.), and may issue a State certification [by endorsement] to any applicant who holds a current license, registration or certificate to practice psychoanalysis issued by the agency of another state or country which, in the opinion of the director, has requirements for licensure, registration or certification that are equivalent to, or higher than [those required to be certified pursuant to this act] the requirements provided by P.L.2000, c.57 (C.45:14BB-1 et seq.).

(cf: P.L.2000, c.57, s.10)
40. Section 3 of P.L.1991, c.134 (C.45:15BB-3) is amended to read as follows:

3. As used in this act P.L.1991, c.134 (C.45:15BB-1 et seq.):
   "Board" means the State Board of Social Work Examiners, established in section 10 of this act P.L.1991, c.134 (C.45:15BB-10).

   "Certified social worker" means a person who holds a current, valid certificate issued pursuant to subsection c. of section 6 or subsection c. of section 8 of this act P.L.1991, c.134 (C.45:15BB-6 or C.45:15BB-8).

   "Clinical social work" means the professional application of social work methods and values in the assessment and psychotherapeutic counseling of individuals, families, or groups. Clinical social work services shall include using any authorized means or method, including telemedicine, as defined by section 1 of P.L., c. (C.) (pending before the Legislature as this bill).

   The practice of clinical social work includes, but shall not be limited to: assessment; psychotherapy; client-centered advocacy; and consultation.

   "Director" means the Director of the Division of Consumer Affairs.

   "Licensed clinical social worker" means a person who holds a current, valid license issued pursuant to subsection a. of section 6 or subsection a. or d. of section 8 of this act P.L.1991, c.134 (C.45:15BB-6 or C.45:15BB-8).

   "Licensed social worker" means a person who holds a current, valid license issued pursuant to subsection b. of section 6 or subsection b. of section 8 of this act P.L.1991, c.134 (C.45:15BB-6 or C.45:15BB-8).

   "Psychotherapeutic counseling" means the ongoing interaction between a social worker and an individual, family, or group for the purpose of helping to resolve symptoms of mental disorder, psychosocial stress, relationship problems, or difficulties in coping with the social environment, through the practice of psychotherapy.

   "Social work" means the activity directed at enhancing, protecting, or restoring a person's capacity for social functioning, whether impaired by physical, environmental, or emotional factors. The practice of social work shall include, but shall not be limited to: policy and administration; clinical social work; social work counseling; planning and community organization; social work education; and research.

   "Social work counseling" means the professional application of social work methods and values in advising and providing guidance to individuals, families, or groups for the purpose of enhancing, protecting, or restoring the capacity for coping with the social environment, exclusive of the practice of psychotherapy.
"Supervision" means the direct review of a supervisee for the purpose of teaching, training, administration, accountability, or clinical review by a supervisor in the same area of specialized practice.

(cf: P.L.1995, c.66, s.1)

41. Section 7 of P.L.1991, c.134 (C.45:15BB-7) is amended to read as follows:

7. [An] Notwithstanding the provisions of section 6 of P.L.1991, c.134 (C.45:15BB-6) to the contrary, whenever an applicant for licensure under P.L.1991, c.134 (C.45:15BB-1 et seq.) submits evidence to the board showing that the applicant has been examined and licensed by the examining and licensing board of another state of the United States, the board shall issue a reciprocal practice license to the applicant, without conducting a written examination thereof, provided that the criteria identified in section 3 of P.L.2013, c.182 (C.45:1-7.5) are deemed to have been satisfied. If the board determines that these statutory criteria are not satisfied, the board may [be exempted] still elect, in its discretion, to issue a reciprocal practice license to the applicant, and thereby exempt the applicant from the [requirement of] provisions of P.L.1991, c.134 (C.45:15BB-1 et seq.) requiring the taking and passing of any licensure examination [provided for in this act if] provided that the applicant [satisfies the board that the applicant] is licensed or registered under the laws of a state, territory, or jurisdiction of the United States, which, in the opinion of the board, imposes substantially the same educational and experiential requirements as this [act] State, and the applicant, pursuant to the laws of [the] such state, territory, or jurisdiction, has taken and passed an examination similar to that from which exemption is sought.

(cf: P.L.1991, c.134, s.7)

42. The following sections of law are repealed:
   R.S.45:9-18; and

43. This act shall take effect immediately, and sections 4, 5, and 6 of this act shall apply to contracts that are entered into on or after the effective date hereof.

STATEMENT

This bill would authorize health care practitioners in the State – including physicians, nurse practitioners, psychologists, psychiatrists, psychoanalysts, licensed clinical social workers, physician assistants, and any other health care professional acting...
within the scope of a valid license or certification issued pursuant to
Title 45 of the Revised Statutes – to deliver health care services,
and establish a practitioner/patient relationship, through the use of
telemedicine. This authorization would extend to mental health
screeners, who, as specified by the bill, would be allowed to engage
in mental health screening procedures through telemedicine without
necessitating a waiver from existing rules.

“Telemedicine” is defined by the bill to mean the delivery of a
health care service using electronic communications, information
technology, or other electronic or technological means to bridge the
gap between the health care practitioner who is located at one site,
and a patient who is located at a different, remote site, either with or
without the assistance of an intervening health care provider, and
which typically involves the provision of health care services
through the application of secure, two-way videoconferencing or
store-and-forward technology that is designed to replicate the
traditional in-person encounter and interaction between health care
practitioner and patient by allowing for interactive, real-time visual
and auditory communication, and the electronic transmission of
images, diagnostics, and medical records. “Telemedicine” would
not include the use of audio-only telephone conversation, electronic
mail, instant messaging, phone text, or facsimile transmission.

Pursuant to the bill’s provisions, the delivery of health care
services through the use of telemedicine would be subject to the
same standards of care and rules of practice as are applicable to
traditional in-person practice, and the use of telemedicine would not
reduce or eliminate any existing duty or responsibility of the health
care practitioner, or any assistant thereof, including any duty or
responsibility related to recordkeeping or the maintenance of patient
confidentiality. Any health care practitioner who engages in
telemedicine without complying with the ordinary standards of care
or rules of practice applicable to in-person practice would be
subject to discipline by the respective licensing board, as provided
by law.

The bill would authorize an out-of-State health care practitioner
to engage in telemedicine with patients in this State, but only
pursuant to a reciprocal medical practice (or other appropriate
practice) license. Existing law at N.J.S.A.45:1-7.5 – which was
enacted in 2013 and became effective on July 1, 2014 – already
provides that a reciprocal license must be granted to any out-of-
State health care practitioner, upon application therefor, if: (1) the
other state has substantially equivalent requirements for licensure,
registration, or certification; (2) the applicant has practiced in the
profession within the five-year period preceding application; (3) the
respective New Jersey State board receives documentation showing
that the applicant’s out-of-State license is in good standing, and that
the applicant has no conviction for a disqualifying offense; and (4)
an agent in this State is designated for service of process if the non-
resident applicant does not have an office in this State. Consistent
with the provisions of N.J.S.A.45:1-7.5, this bill would amend the
individual practice laws pertaining to the reciprocal licensure (or
licensure by indorsement) of physicians, nurse practitioners, social
workers, psychologists, psychoanalysts, and physician assistants –
which, in most cases, currently provide only for discretionary
reciprocal licensure – in order to clarify that a reciprocal license:
(1) must be granted if the conditions established by N.J.S.A.45:1-
7.5 are satisfied; and (2) may still be granted, in the discretion of
the respective licensing board, in cases where those statutory
conditions are not satisfied.

In addition to clarifying the existing State law that pertains to the
reciprocal licensing of health care practitioners, the bill would also
require the Board of Medical Examiners to evaluate the interstate
Telemedicine Licensure Compact that is currently being promoted
by the Federation of State Medical Boards, and which, if adopted,
would establish a universally-accepted and more simplistic system
of reciprocal licensing for physicians. Within 180 days after the
bill’s effective date, the board would be required to submit to the
Governor and Legislature, a report of its findings on the matter, and
recommendations for legislation or other State action necessary to
implement the compact in this State.

In order to facilitate the use of telemedicine in this State, and
except when contrary to federal or State law, the bill would prohibit
the State Medicaid and NJ FamilyCare programs, as well as any
private health benefits plan – including those provided by private
carriers, and those contained in contracts purchased by the State
Health Benefits Commission and the School Employees’ Health
Benefits Commission – from requiring in-person contact between a
health care practitioner and a patient, or from establishing any siting
or location restrictions on a health care practitioner or a patient, as a
condition of reimbursement under the respective program or plan.
The bill would further require such programs and plans to provide
coverage and reimbursement for: (1) health care services that are
delivered through telemedicine, to the same extent, and at the same
reimbursement rate, that such services are covered and reimbursed
when provided in-person (so long as the use of telemedicine is not
medically contraindicated), and (2) any professional or facility fees
that may be associated with the delivery of covered services
through telemedicine, so long as such fees would otherwise be
eligible for coverage or reimbursement in the case of in-person
service delivery.

Finally, the bill would specify that a health care practitioner may
engage in consultations with out-of-State peer professionals,
including, but not limited to, a sub-specialist, using electronic or
other means, without obtaining a separate license or authorization
therefor.
In addition to the substantive changes described above, the bill would incorporate a number of technical and stylistic changes to the existing laws that govern the practice of various types of health care practitioners, as is necessary to both accomplish the bill’s purposes and enhance clarity and readability in these areas. In particular, the bill would:

(1) redefine various statutory terms and revise various statutory provisions that are used to delineate the scope of practice for various health care practitioners, in order to expressly include telemedicine as an acceptable means or method of practice and service delivery;

(2) update language contained in relevant sections of Title 45 of the Revised Statutes, in order to reflect the changes that have been made by the bill;

(3) ensure that the laws being amended by the bill contain modern language, avoid the use of archaic or redundant terminology, use language consistently from section to section, and conform to modern tenets of statutory drafting (including, for instance, the tenet that provides for the alphabetization of definitional terms);

(4) consolidate two existing sections of law (R.S.45:9-18 and R.S.45:9-18.1) that are used to help define both the “practice of medicine” and the unauthorized practice thereof, but which are presently allocated separately from other similar provisions of law, and incorporate these provisions into a more logical and cohesive statutory location – in particular, into the existing statutory definitions and sections of law that outline the parameters of acceptable medical practice;

(5) repeal the existing sections of law being consolidated; and

(6) eliminate certain provisions of law which are applicable to a class of people who are no longer practicing (specifically, persons who matriculated in college prior to 1935 and persons who were practicing medicine before July 4, 1890).
Teledentistry as a Method to Improve Oral Health Access in Florida
Prepared by Douglas T. Manning DMD, JD, MPH
in conjunction with the
Florida State Oral Health Improvement Plan (SOHIP)

INTRODUCTION

The 2000 Surgeon General’s Report, *Oral Health in America: A Report of the Surgeon General*, called for “action to promote access to oral healthcare for all Americans, especially the disadvantaged and minority children found to be at greatest risk for severe medical complications resulting from minimal oral care and treatment”. Many of these disadvantaged populations and minority children reside in areas that lack access to oral health care and subspecialty services. Telehealth can be an effective way to improve access to care and ease of care. In theory, when data rather than clients are moved, health resources can extend their reach. Implementation of a telehealth system can increase access to prevention and educational health care services, can improve access to primary care services, can widen the reach of specialty care, and can expand the chance for utilization of medical education and training by health care professionals and community members. Telehealth brings services to clients rather than clients to services. In an effort to address improving access to oral health care for Florida’s disadvantaged populations, the Florida Department of Health has instigated a study of the logistics, costs, and policy concerns involved in implementing a teledentistry program. This white paper will discuss the equipment and technology required to set up a teledentistry program in Florida Department of Health facilities. The paper will study two proposed situations: a fixed-based remote unit and a mobile-based remote unit each of which utilize dental hygienists who will link to a fixed-based hub unit with a dentist on site. The teledentistry technology linking a remote-based dental hygienist to an off-site dentist will increase access by expanding the capability of dentists to examine patients who cannot otherwise access or easily access a Department of Health or other organization or private dental facility. The Department of Health envisions using teledentistry for two distinct purposes: 1) to provide isolated populations with examination, consultation, and referral services for both basic and specialized oral healthcare; and 2) to fulfill the general supervision requirement of the Florida Statutes (Section 466.023 (2) (b) Dental hygienists; scope of practice and Section 466.003 (10) Definitions – “General Supervision”) and the Florida Administrative Code (F.A.C.) (Rule 64B5-16.001 (6)) so that a remote-based dental hygienist may position and expose dental x-ray film or sensors; apply American Dental Association or Food and Drug Association approved topical fluorides (which would include fluoride varnishes); use appropriate instruments to preassess and chart suspected findings of the oral cavity; take or record patient’s blood pressure rate, pulse rate, respiratory rate, case history, and oral temperature; perform prophylactic cleanings; applying dental sealants; provide oral hygiene instruction; and provide oral health education without a dentist needing to be physically present.

BACKGROUND

*Telehealth Defined*
Just as communication technology and uses of electronic information have developed over the years, the terms to describe health care services at a distance, such as “telehealth”, “e-health”, and “telemedicine”, have also evolved. Currently, “telehealth” and “e-health” are generally used as umbrella terms. These describe all the possible variations of health care services using telecommunications. “Telemedicine” has come to describe the direct provision or support of clinical care at a distance through the use of electronic communication and information technologies. Terms such as “telepathology”, “teleradiology” and “teledentistry” have evolved to describe the application of telehealth to those particular medical specialties. Thus, “teledentistry” has come to mean the use of electronic information and telecommunications technologies to support long-distance clinical oral health care, patient and professional health-related education, public health, and health administration.

Two other terms need clarification as they are sometimes used interchangeably in telehealth—“encounter” versus “consultation”. Both describe provider actions concerning a patient, but they each have distinct and different meanings. A “consultation” is a provider to provider discussion of a patient’s diagnosis, treatment, or condition. Usually the patient’s primary care provider seeks input from another general provider or specialist located at a distant site. Here, the care of the patient remains the responsibility of the patient’s primary care provider. Conversely, an “encounter” is an event where a provider has contact with a patient. The provider can be located at either the originating or distant site. In such situations, the care of the patient becomes the responsibility of any provider that has direct contact with the patient.

Two different types of data transmission and technology make up most telehealth applications—“store and forward” and “two-way interactive” or “real time”. Store and forward technology is used to transfer digital data (e.g. still images, video, radiographs, CT scans, MRIs, EKGs, etc.) that is captured and stored in one location than forwarded or transferred to another location. Two-way interactive technology allows a person at a remote or distant site to see or hear in real time images or sound occurring at an originating site. In most health care applications, whether utilizing store and forward or two-way interactive technology, clarity and detail of the data are the most important issues. Speed of data transfer and the compatibility, interoperability, scalability, accessibility, and reliability of the technology are also significant.

**History**

In its simplest form, telehealth has been around for decades. The familiar use of the telephone for consultations between patients and clinicians and the use of radios to link emergency medical personnel to medical centers have been commonplace in health care for this and most of the last century. However, in the last 30 years, clinicians, health services researchers, and others have been investigating the use of advanced telecommunications and computer technologies to improve health care.

The National Aeronautics and Space Administration (NASA) played an important role in the early development of telemedicine. Beginning in the 1960’s and continuing through the
1980’s, NASA provided much of the technology and funding for early telemedicine demonstration projects. Early telemedicine projects focused upon populations in remote areas such as mountainous locales, island nations, open plains, and arctic regions where specialists and even primary care providers were scarce. Most of these early telemedicine projects, while improving access, failed to survive the end of grant funding as telecommunications costs were high and the technologies were new, unfamiliar, and difficult to use and maintain. Moreover, most early (and many new) telehealth projects failed because of a lack of an initial needs assessment and business plan. Over the past decade the technologies that provide health care services at a distance have improved dramatically. They have become more commonplace and user-friendly. Moreover, competition and the Federal Communication Commission’s (FCC) Rural Health Care Support Mechanism including the Universal Service Fund have transpired to bring the costs of telecommunication services down. Telemedicine projects continue to serve isolated populations. The concept of isolated populations has expanded from not only those populations located in geographically remote localities, to include isolated populations located in urban settings, correctional facilities and home health settings. The majority of the early and even later projects have used telemedicine for education, research, triage/evaluation/referral, and specialty consultation services. One of the first teledentistry projects, the Department of Defense through the United States Armed Forces’ Total Dental Access (TDA) project, focused on three applications: continuing dental education, dentist-laboratory communications, and referral and consultation patient care services. In general, clinical applications involving direct patient care have not been compatible with telemedicine services. However, certain fields such as mental health services (telemental health) and the advent of new robotic technology (telesurgery) offer the opportunity for clinical applications. Today, telehealth systems can be found in hospitals, clinics, private offices, nursing homes, rehabilitation facilities, homes, assisted living facilities, schools, prisons and health departments. As technology continues to evolve, telemedicine applications will continue to expand.

**Services**

Telehealth encompasses a broad array of medical health services. Telemedicine has a variety of applications in patient care, education, research, administration, and public health.

*Medical education* provides distance learning primary or continuing education services to health professionals located in remote locations.

*Consumer medical and health information* includes the use of the internet or other electronic media for consumers to obtain specialized health information, on-line discussion groups, or peer-to-peer support.

*Health care research* permits health care researchers to become linked to other health care researchers despite geographical separation.

*Management and administration services* allow key health centers to oversee satellite or remote sites.
Specialist referral/consultation services typically involve a specialist assisting a general practitioner in rendering a diagnosis. These services can involve a specialist interacting with a patient “live” or in “real time” or involve a specialist reviewing a patient’s records without the patient being present via store and forward technology.14

Home health care or remote patient monitoring uses medical devices attached to a patient that collect and send patient data to a remote monitoring station for interpretation.6, 14

Supervision of direct care services allows a doctor (or dentist) to provide statutory supervision of a health care auxiliary (e.g. nurse, physician assistant, dental hygienist) who then can provide direct patient care at a site remote from that of the supervising doctor.11

Direct patient care allows a remote health care provider to provide direct patient care through interactive conversation, observation, or even new robotic technology.11 Examination, diagnosis, treatment planning, prescription writing, mental health services including individual and group therapy, and robotic surgery are all possible.11

These services utilize a wide range of technology including telephone lines, cable, fiber optics, wireless technology, and even satellites to transmit data over a variety of networks.4, 6, 8, 11, 12, 14, 15 Networks can be public or private. Public networks are shared while private networks are dedicated for a specific use and for a specific organization.8, 14, 15 Hub and spoke networks link large health care facilities with outlying or satellite offices.14, 15 Point-to-point connections use private networks to link sites in one organization or company.14, 15 Primary or specialty care to home connects primary care providers, specialists, or home health auxiliaries with patients over for interactive clinical examinations, consultations, and limited treatment.15 Home to monitoring center links connect home health care monitoring devices to call centers.14, 15 And web-based or e-health patient services sites utilize the internet to provide direct consumer outreach and information services.16

Telemedicine

Telemedicine, simply put, is the clinical application of providing care at a distance.8 A variety of medical specialties now utilize telemedicine in one form or another. Teleradiology, telepathology, and telepharmacy were some of the earliest telemedicine specialties and continue to be the most common applications of telemedicine today. Radiographs, CT scans, MRIs pathology slides, and scripts are easily sent from one location to another for diagnostic interpretation usually utilizing store and forward technology. Many medical specialties, including dermatology, oncology, internal medicine, obstetrics and gynecology, and neurology have found telemedicine technology to be conducive for consultative services.6

Interactive technology occurs when face to face, live consultations, diagnosis or treatment is necessary. Telemental health, teledermatology, telemergency care all utilize interactive, real time technology.4
Telecardiology, telehome care, and telemedicine in correctional facilities utilize both store and forward and real time technology to monitor patient’s vital signs. Stethoscopes, blood pressure cuffs, and heart monitors can all be hooked up to computers that send information in real time or stored and forwarded at a later time for evaluation.

Telesurgery is a new field that utilizes exotic technologies like robotics that allow surgeons to operate on a patients at a distant location.

For more information on telemedicine projects with specific applications using nurses or paramedics at distant sites, see: Space Technology Applied to Rural Papago Advanced Health Care (STARPAHC). 1972-75. (paramedics) and see Massachusetts General Hospital/Logan International Airport Medical Station. 1967 (nurses).

**Teledentistry**

Teledentistry is a relatively new adjunct in the modern trend of telemedicine. Teledentistry is a combination of telecommunications and dentistry which involves the exchange of clinical information and images over remote distances. Most teledentistry programs to date have focused upon distance management and administration of remote facilities, learning and continuing education, and consultation and referral services rather than supervision of auxiliaries or direct patient care. Most teledentistry programs are associated with a dental or medical school. Some of these are worthy of examining briefly. The following list of programs is not exhaustive as smaller programs and programs outside the United States may exist, but are not as well publicized. One last note, there are a number of internet dental consulting firms which offer teledental specialty consulting for a fee. Two examples of these are the Jordan Dental Center based in Amman, Jordan (http://www.jordan-dental.com/index.html) and Dental Consults based in England (http://www.dental-consults.com/index.html). Mention of these services is for educational purposes only and does not serve as an endorsement of either.

The Department of Defense initiated the “Total Dental Access” project in 1994. The Total Dental Access project focused on three areas of dentistry: patient care including referrals to specialists and consultations; continuing education; and dental-laboratory communications. The project utilized multiple transfer technologies including image file transfers by modem, image file transfers by satellite, ISDN-based (Integrated Services Digital Network) technology, POTS-based (Plain Old Telephone Service) technology, and web-based technology. An analysis of the Teledentistry project concluded that teledentistry demonstrated was cost-effective within 6 months to a year of initiation and that teledentistry improved access and quality of care by facilitating better and timely information to the dentists which improved decision making and produced better communication between the dentists and their patients. For more on the Total Dental Access project, see: http://www.amia.org/pubs/symposia/D005388.PDF#search='department%20of%20defense%20teledentistry'

Marquette University School of Dentistry initiated the Marquette University Dental Telehealth and Education Link in 2003. The project aimed to create a network linking Marquette and other health systems with dental sites in remote areas where access to care is problematic. The project
utilized both store and forward and interactive technology for the purposes of primary care, consultation, education, and public awareness programs. The Wisconsin Advanced Telecommunications Foundation (WATF) was the major funding agency on this project, but the Milwaukee Area Health Education Center and Wisconsin Geriatric Education Center also were sponsors. For more on the Marquette University Dental Telehealth and Education Link see: http://www.dental.mu.edu/teledent/index.html.  

In 2003 the Childrens Hospital Los Angeles Teledentistry Program began a store and forward teledentistry program. Initially this program was run in association with the University of Southern California School of Dentistry (USCSD) Mobile Dental Clinic (see below). This ongoing program provides enhanced dental treatment to children in rural, remote, underserved areas of California. For more on the Childrens Hospital of Los Angeles Teledentistry Program see: http://www.childrenshospitalla.org/body.cfm?id=781.  

The USCSD mobile clinic was the first non-military dental clinic in the United States to utilize digital imaging and the Internet to diagnose and treatment plan patients in remote locations. The Harold McAlister Charitable Foundation and The California Wellness Foundation (TCWF) grant funded this project. While the mobile clinics continue to operate they no longer utilize teledentistry at this time. For more on the USCSD Mobile Dental Clinic see: http://www.usc.edu/hsc/dental/update/january03/community_01.htm and see http://www.usc.edu/hsc/dental/community/mobile_clinic.htm.  

In 2004, the State of Minnesota Department of Health in conjunction with the University of Minnesota School of Dentistry and the Hibbing Community College Dental Clinic sponsored a Teledentistry Project. The project continues to utilize direct videoconferencing to create a telecommunication network linking the University of Minnesota School of Dentistry’s specialists with dentists and dental students in sites in remote rural areas where access to care is problematic. For more on the University of Minnesota School of Dentistry’s Teledentistry Project see: http://www.dentistry.umn.edu/patients/tx_options/specialty_clinics/Teledentistry.html#whatsteledentistry.  

The University of Rochester Medical Center’s Eastman Dental Center in association with Aetna insurance established the Teledentistry in Childcare Project in 2005. This project helps inner city families easily access the oral health treatment they need for their children in childcare. The project’s goal is to develop a new strategy for the prevention and early detection of early childhood caries (ECC). The project utilizes a computer and camera which allow dentists to examine and interact with a child in real-time. For more on the Teledentistry in Childcare Project see: http://www.urmc.rochester.edu/pr/news/story.cfm?id=784.  

In the summer of 2005, the University of Washington School of Dentistry’s Pediatric Dentistry residency program began a videoconferencing project based at a remote site at the Farm Workers Clinic in Yakima Valley. The project entails both a distance learning educational component, using both store and forward and live videoconferencing capabilities, and a clinical consultation component, which allows live video consultations chairside. The project utilizes an intra-oral camera in Yakima linked to the videoconferencing system in Seattle via the internet. For more
on Washington University’s Pediatric Dentistry residency program at Yakima Valley Farm Workers Clinic see, http://www.dental.washington.edu/pedo/news/summer2005.pdf.\textsuperscript{26, 27}

The University of Tennessee’s Mid-South Telehealth Consortium (MSTC) in collaboration with the Tennessee Department of Health initiated a Mobile Healthcare Telehealth Project in 2002. The Department of Health and Human Services through the USDA: Rural Utilities Service and NTIA: Technology Opportunities Program with matching contributions from program partners funded the project. The mobile healthcare telehealth project provided mobile access to a variety of dental and ophthalmology services previously unavailable in the rural communities of central and western Tennessee. The dental outreach program provides school-aged children with access to dental screenings, cleanings, education, and the application of dental sealants through a unique partnership between hygienists from the TN Department of Health and dentists at UTHSC College of Dentistry. For more on the MSTC mobile healthcare telehealth project see: http://webster.utmem.edu/telemedicine/projects.html.\textsuperscript{28}

Recently, the University of Florida College of Dentistry (UFCD) received a grant from the Department of Health and Human Services, Health Resources and Services Administration (HRSA), Office for Advancement of Telehealth (OAT). The purpose of the project is to enhance UFCD’s Statewide Network for Community Oral Health and improve access to oral health care for Florida residents. The project has 3 primary goals: to expand and evaluate video-conferencing (VC) capabilities from the University of Florida Gainesville campus to health facilities located throughout the state; to develop and evaluate web-based educational materials for dental students, dental residents, faculty and practitioners; and to develop and evaluate clinical consultation services including the use of digital radiography for the efficient exchange of diagnostic information across clinical locations. The project will utilize both store and forward and two-way interactive technologies. The grant period runs from September 1, 2004 through February 28, 2006. For more on UFCD’s Teledentistry project see: http://www.dental.ufl.edu/Offices/Teledentistry/Default.htm.\textsuperscript{17}

Since 2003, the Apple Tree/Head Start Teledentistry Model\textsuperscript{29, 30} has provided expanded access to oral health by providing mobile, teledental oral health care services in the Minneapolis, Minnesota area. Dental hygienists utilize store and forward technology (generally, utilizing portable, digital dental equipment (e.g. intraoral camera) and a laptop) to deliver oral health care services at five Head Start programs with federal funding. Hygienists provide on-site educational, diagnostic, and preventative services at Head Start facilities so that an off-site “collaborating” dentist can review findings and make the diagnosis needed to schedule invasive treatment. The legislatively approved “collaborative agreements” allow for dental hygienists to provide limited oral health care services (e.g. medical history, digital images, screening, cleanings, and oral hygiene education, but not fluoride treatments or sealants) off-site, without “direct” supervision of a dentist. For more on Apple Tree Dental see: http://www.appletreedental.org/AppleTreeInstitute/InstituteProjects/ClinicalInnovations.aspx.\textsuperscript{29}

The U.S. Department of Health and Human Services Indian Health Service also utilizes teledentistry to provide oral health care to American Indians and Alaskan Natives in various states around the country. However, there is little documented information regarding these
programs. For more on the Indian Health Service Division of Oral Health see: http://www.ihs.gov/MedicalPrograms/Dental/index.cfm.

TELEHEALTH TECHNOLOGY

There are many approaches, equipment, and technologies available to develop a telehealth network. There is no standard model or right or wrong design. The decision of which approach, equipment, and technology to use will depend on many factors: cost, availability of telecommunication services, and the type of health care services that the telehealth program wishes to deliver all will play a significant role in designing the network. These factors will play a primary role in the decision of whether to use store and forward technology, two-way interactive technology, or some combination of both. One note, in the last decade, the technologies which provide healthcare services at a distance have improved dramatically and have significantly dropped in price and probably will continue to do so.

For a more detailed account and an explanation of telehealth technology, network design, and specific telecommunication technology characteristics see Chapter 13, Telehealth Technology, section II – Networks; and section III – Network Equipment in the Office for the Advancement of Telehealth’s Telemedicine Technical Assistance Documents: A Guide to Getting Started in Telemedicine.

Telecommunication Technologies

There is a wide-variety of telecommunications technologies available which can go into the design of a telehealth network. In fact, the technologies are constantly changing. Before designing any network a needs assessment that will determine the type of data transmission and technology required for the network must be accomplished. Factors such as how fast the data needs to be reviewed by the distant site, whether real time communication is necessary, and to what degree is quality and definition important will determine the choice between transmitting data via store and forward technology, two-way interactive technology, or some combination of both. Broadband video telehealth technologies and networks are more complex than store and forward or technologies using plain old telephone service. Information technology staff, telecommunications staff, as well as the telehealth staff should all have input in the decisions regarding specific technologies and products that are used in the development of the network. A team approach is most effective and valuable. The following sections will attempt to explain the different telecommunications available for the design of a telehealth network. Some basic terminology and concepts need explanation first.

Definitions

“Broadband” - refers to telecommunication in which a wide band of frequencies is available to transmit information. Because a wide band of frequencies is available, information can be multiplexed and sent on many different frequencies or channels within the band concurrently, allowing more information to be transmitted in a given amount of time (much as more lanes on a highway allow more cars to travel on it at the same time).
“Bandwidth” - is a primary factor governing the performance of a network. Bandwidth is the rate that data flows over the network. It is a measure of capacity rather than speed. Bandwidth is proportional to the complexity of the data for a given level of system performance. Bandwidth serves as a practical limit to the size, cost, and capability of the telehealth service. Providers of telecommunication technologies can deliver bandwidth on a variety of physical and transmission medium such as: twisted wire pairs or optical fiber strung on telephone poles or buried as cables beneath the surface; or radio waves or satellite transmissions which are completely wireless. Although standard phone lines can support certain telemedicine applications, frequently higher bandwidth technologies are necessary.

“Latency” - is another measure of the performance of a network. Together, latency and bandwidth define the speed and capacity of a network. Latency is the time it takes a piece of transmitted data to be received at its destination. It is measured in milliseconds. Video conferencing becomes unusable with latency greater than 300 milliseconds. High latency degrades the performance of even the largest capacity networks. Variations in latency create “jitter” – data packets reach the destination with different delays. Jitter can seriously affect the quality of streaming audio and/or video.

“Quality of Service” (QoS) – refers to the probability of data succeeding in passing between two points in a network. QoS is a guaranteed throughput level – that an amount of data will be transferred from one place to another in a specific amount of time. QoS is of particular concern for the continuous transmission of high-bandwidth video and multimedia information such as video conferencing. Availability of service 24/7, continuous adequate bandwidth levels (vs. average bandwidth level), delay or latency (transmission capability), jitter or latency variation, and transmission loss are all measures of QoS. A defined or guaranteed QoS may be required for certain types of network traffic. Generally, QoS can be guaranteed by over provisioning a network so that all data get a QoS sufficient to support QoS-sensitive applications or network customers and providers can enter into contractual agreements which specify the ability of a network to give guaranteed performance/throughput/latency bounds usually by prioritising traffic.

“Videoconference” – A videoconference is a live connection between people located in separate facilities for the purpose of communication. The connection can be site to site or multisite. At its simplest, videoconferencing provides transmission of static images and text between two locations. At its most sophisticated, it provides transmission of full-motion video images and high-quality audio between multiple locations. Videoconferencing is not limited to a single telecommunications technology. Videoconferencing requires a computer with videoconferencing software and an internet connection. Most videoconferencing calls require at least 384 Kbps of bandwidth to function with adequate speed and quality.

**Characteristics**

There are five basic technical factors that should be considered when looking at purchasing any telehealth technology.
'Compatibility” - newer versions of telehealth technologies should be compatible with earlier versions of similar technologies, decreasing the likelihood of rapid product obsolescence.\textsuperscript{8, 41}

“Interoperability” - technologies should meet the Health Resources and Services Administration, Office for the Advancement of Telehealth (OAT) recommended guidelines and standards so that developing telehealth networks can interface together; creating a national infrastructure that can share information.\textsuperscript{8, 41}

“Scalability” – the telehealth technology should be capable of migrating into expanded capabilities without total replacement.\textsuperscript{8, 41} Additionally, features and functions should be available as options rather than impacting the base cost of the technology.\textsuperscript{8, 41}

“Accessibility” - the level of access to the vendor's in terms of sales, timely delivery, and equipment maintenance.\textsuperscript{8, 41}

“Reliability” - that the network and equipment will work as intended, that the end user can consistently use the equipment for its intended purpose without operational error, and that the technologies can be reliably serviced with minimum downtime.\textsuperscript{8, 41}

\textit{Networks}

A network is a connection of related items, no matter what is being connected together.\textsuperscript{8} In telehealth, a network using wires, hubs, switches, and routers creates a computer network.\textsuperscript{8} There are two basic types of computer networks.

“Local Area Networks” of “LAN”\textsuperscript{8, 35} – A LAN is also known as an Intranet. A LAN connects computers in a building or in an organization together so they are able to communicate with each other and other computer based equipment such as printers, servers, and routers.

“Wide Area Networks” or “WAN”\textsuperscript{8, 35} - A WAN, or Internet, connects LANs to other LANs so they can communicate. This network is accomplished using wired or wireless telecommunication connections and a device known as a router.

“Private Networks”\textsuperscript{8} – are designed for the use of a specific organization or company. The networks can use dedicated connections that are always on and ready for use (tends to be more expensive), or they can use dial-up services that connect certain network devices on demand (tends to be less expensive). Telecommunications provider may guarantee such factors as constant bandwidth of the WAN connection and QoS. Guaranteed bandwidth means that the capabilities of the WAN connection will not change. QoS on the other hand allows certain types of data over a network connection to have priority over other types of data in an effort to guarantee a certain level of connection quality.

“Public Networks”\textsuperscript{8} - is a WAN connection which a number of other people share with little or no guarantee of QoS. The telecommunications carrier cannot guarantee the speed and quality of the data transmissions. One person on the connection could possibly interfere with the information someone else may be trying to send or receive since it is all on the same connection.
“Virtual Private Network” or “VPN” is a network that uses a public telecommunication infrastructure, such as the Internet, to provide remote offices or individual users with secure access to their organization's network. A virtual private network can be contrasted with an expensive system of owned or leased lines that can only be used by one organization. Shared networks are not secure unless the use of encryption software or hardware is used to ensure privacy.

**Telecommunication services**

Telecommunication services may be supplied via phone service – wired or wireless - or cable service. The costs vary greatly from service to service, from state to state, and between phone companies. Listed below are the most common types of telecommunications services utilized in telehealth.

**Media**

The physical material used to link computers together is called the media. The most common forms of media are telephone lines, twisted-pair cable, coaxial (coax) cable, and fiber-optic cable. Others include infrared light, radio waves, and additional wireless communication equipment.

“Telephone Lines” - Telephone lines, although not designed for computer networking, are the most common method of linking remote computers to computer networks. The advantages of telephone lines are that they are widely available, no special network cables need be installed, range is unlimited, and (unless one is dialing long distance) they are inexpensive to use. The disadvantage of telephone lines is that they transfer data very slowly. Due to line noise, wire properties, and power constraints, most modem connections are limited to 33 Kbps or less. This slow transfer speed keeps them from being commonly used for computer networks.

“Twisted Pair Cable” - Twisted-pair cables are used for most Ethernet LANs. Twisted-pair cable can transmit information at varying rates of speed, depending on their type. There are five types, the most commonly used being CAT3 and CAT5. CAT3 can handle speeds up to 10 Mbps and CAT5 can transmit data at speeds of up to 100 Mbps.

“Coaxial Cable” – Coaxial networking cable is very similar to that used for cable TV connections. Coaxial cable is a high bandwidth carrier with the ability to transmit data, voice, and video.

“Fiber Optics” – is a high-bandwidth transmission technology that uses light rather than electricity to transmit digital audio, video, and data signals. This system permits high capacity transmission at extreme speeds with very low error rates as optical fiber is immune to electrical interference. Data transfer speeds from 100 Mbps to 2 Gbps are possible. Fiber optic lines are the next generation of carrier and are currently being deployed to replace coaxial cable and wire pair carriers.
“Wireless Media”⁴³, ⁴⁸ - There are a variety of wireless network media, each of which uses a different transmission protocol. Typically, a wireless network uses infrared light or radio transmissions to distribute data.

**Wired Services**

“Plain Old Telephone Service” or “POTS”⁸, ⁴³, ⁴⁹ - is analog service used for most home telephone connections and dial-up Internet connections.⁸, ³⁵, ⁴¹ Although POTS lines are provisioned for 64 Kbps of bandwidth, connections are rarely above 33 Kbps and in most cases never above 45 Kbps.⁸, ⁴¹ POTS lines utilize twisted-pair cable. A POTS connection can work for store and forward telehealth and it can support POTS based video connections to reach areas where broadband is not available.⁸

“Digital Subscriber Line” or “DSL”⁸, ³⁵, ⁴³, ⁴⁹ – uses existing phone lines and is a type of broadband connection with a constant connection. It can provide up to 1.5 Mbs of bandwidth, but speeds are dependent on distance. DSL lines utilize twisted-pair cable. However, the speed and availability of DSL is limited by the customer's distance from the local telephone switch.

“Integrated Services Digital Network” or “ISDN”⁸, ³⁵, ⁴¹, ⁴³ – is a common dial-up transmission path for videoconferencing that uses existing phone networks.⁸, ⁴¹ There are two kinds BRI and PRI. BRI is an ISDN interface that provides 128 Kbps of bandwidth, while PRI is an ISDN interface standard that operates using 23, 64 Kbps channels and one 64 Kbps data channel.⁸, ³⁴, ⁴¹ BRI lines utilize twisted-pair cable. PRI lines utilize twisted-pair or coaxial cable. ISDN services are generally switchable (e.g. can be dialed like a phone and used on demand).⁸, ⁴¹ Thus, they are not dedicated.⁴¹ Per minute charges accumulate at some contracted rate and then are billed to the site placing the call.⁸ A device known as a “inverse multiplexor” can combine multiple ISDN inputs into aggregate signal of 384 Kbps that is needed for videoconferencing.⁸, ⁴¹

“T-1” – is a digital carrier capable of transmitting 1.544 Mbps of electronic information.⁸, ³⁴, ³⁵, ⁴¹ T-1 is the general term for a digital carrier available for high-value voice, data, or compressed video traffic.⁸ T1 services can be provisioned to use various communication protocols (e.g., Frame Relay, ATM, etc.).⁸ Telehealth users typically purchase T-1 as a leased phone line that is dedicated from point to point.⁴¹ T-1 lines utilize twisted-pair or coaxial cable.

“T-3” – is a digital carrier which multiplexes multiple T-1 lines.¹⁰, ³⁵ A T3 line is comprised of 28 T1 lines. This coupling allows for transmission speeds of electronic information up to 45 Mbps.¹⁰, ³⁴ T-3 lines utilize optical fiber cable.

**Wireless Services**

“Cellular Phone Service”³⁵, ⁵⁰ - Cellular telephone is wireless voice and data communications that uses short-wave analog or digital cellular radio transmission. The subscriber has a wireless connection from a mobile telephone to a nearby transmitter. The transmitter's span of coverage is called a cell. As a user moves around, the user's phone signal is picked up by the nearest antenna and then forwarded to a base station that connects to the wired network. It requires cell transmitters for coverage; otherwise there will be blind or dead spots.
“Wi-Fi” sometimes known as “wireless fidelity” is a wireless protocol where wireless users can connect to the wired network via local wireless access points or hotspots. Wi-Fi uses radio waves (rather than telephone cable) to connect to the Internet. Unlike cellular phone service, Wi-Fi offerings can connect to only one access point at a time. Once the customer is out of range of a "hotspot", the connection will drop, and the customer will need to re-connect to the Internet via another hotspot. A disadvantage of Wi-Fi is that the network connections are not secure, thus, encryption and privacy are issues.

“Satellite” - Satellite telecommunication is one particular example of a wireless communication system. Satellite telecommunication as a whole has distinct advantages and disadvantages compared to terrestrial data connections. Satellite telecommunication can extend service into areas of sparse population, harsh climatic conditions and rugged terrain where it is uneconomic or impractical to extend the terrestrial network. Moreover, satellite telecommunication is able to deliver data to any number of end points for the same cost — the multicasting model (vs. point to point) and it is also insensitive to time, distance and location.

Satellite telecommunication systems utilize human-made satellites, which are highly specialized wireless receiver/transmitters that act as radio wave relay stations and require the following earth-based equipment: the antenna (often a dish which will vary in size to match the particular service for which they are designed) and the associated equipment (receiver/decoder, transmitter which usually are packaged as part of the modem). The dish/antenna can fixed with coordinates set to one position (e.g. fixed to the side of a building); fixed with coordinates that need to be set for each new location and position (e.g. fixed to a mobile van – utilizing an auto-acquire feature); or portable with coordinates that need to be set for each new location and position (e.g. a briefcase style dish).

The most common telecommunication satellites are in a geostationary orbit. In this orbit, satellites do not appear to move in relation to the earth. Thus, an earth-based dish/antenna only need acquire the satellite once to have continuous communication. In orbits closer to the earth (medium-earth orbit or low-earth orbit) the satellite appears to travel around the earth, thus creating the need for the earth-based dish/antenna to track the satellite or satellites.

A satellite telecommunications system with satellite return works in the following basic manner: the earth-based satellite dish/antenna acquires a satellite; it uses the Indoor Transmit Unit (ITU) to send data up to the satellite; and the satellite in turn sends the data to a terrestrial-based Network Operations Center (NOC). The NOC forwards the request to the Internet, where the data is routed to its final destination. Data returning from the Internet is routed to the NOC, where it is sent up to the satellite. The satellite relays the data to the specified satellite dish/antenna where, the satellite telecommunications system's Indoor Receive Unit (IRU) receives and decodes the high-speed data, then presents the data to the user.

Bandwidth, latency, security, and the ability to acquire a satellite are the main problems associated with satellite telecommunication service. Depending on service plan, bandwidth can run up to a maximum of 1.0 Mbps upload and 2.5 Mbps download. The issue with bandwidth is whether 384 Mbps (the bandwidth needed for diagnostic quality videoconferencing) can be
guaranteed. Small transmission delays do occur, but these are normally in the millisecond time frame, thus, not an issue in teledentistry. While security of data transmitted via radio waves can be a problem, most systems come with encryption to overcome this issue. Trees, tall buildings, and rain can affect service by blocking the dish/antenna’s sightline to the satellite. However, newer systems, like the Broadband Global Area Network (BGAN) system, eliminate most weather related transmission issues.

HughesNet is the main provider of satellite telecommunication service in North America.\textsuperscript{54}

**Technical Standards**

“DICOM” or “Digital Imaging and Communication in Medicine”\textsuperscript{34, 35, 55, 56} – is the industry standard for communications transfers of digital images and other medical information between computers. The DICOM Standards Committee exists to create and maintain international standards for communication of biomedical diagnostic and therapeutic information in disciplines that use digital images and associated data. The goals of DICOM are to achieve compatibility and to improve workflow efficiency between imaging systems and other information systems in healthcare environments worldwide. DICOM standards can be accessed at: [http://medical.nema.org/](http://medical.nema.org/).

To help insure that different manufactures CODEC equipment can work together, there are a set of videoconferencing standards in place.\textsuperscript{8} The most common standards for videoconferencing are the International Telecommunication Union Telecommunication Standardization Sector (ITU-T) standards - H.323 and H.320.\textsuperscript{8} The H.323 standard is used for videoconferencing on IP networks and H.320 is the standard used for ISDN networks.\textsuperscript{8} These standards are further broken down into protocol standards for data transport over networks; video protocols; audio protocols; far end camera control; and file transfer.\textsuperscript{8} It is important to know what standard protocols the network videoconferencing equipment uses so that people outside of an organization’s network can communicate with that network.\textsuperscript{8} Some examples of standard protocols that video conferencing equipment can use are: Video: H.261, H.263, H.264; Audio: G.711, G.722; Camera control: H.281; and Data transfer: T.120.\textsuperscript{8}

**Network Equipment**

“CODEC”\textsuperscript{34, 35} – is an acronym for coder-decoder. This is a videoconferencing device that converts analog video and audio signals to digital video and audio code and vice versa. CODECs typically compress the digital code to conserve bandwidth on a telecommunications path. CODECs usually come with software that will encrypt data transmissions.

“Router”\textsuperscript{34, 35} – is a network device that routes network data transmissions between a transmitter (sender) and a receiver. Routers are typically software-controlled and can be programmed to provide the least expensive, fastest or least busy of available routes.

“Switch”\textsuperscript{34, 35} – is an electrical device that selects the path of a video transmission. Switches are used to control network traffic by directing traffic on specific ports to specific destinations.
**Room Design**

When choosing a room for videoconferencing the following characteristics are important in order to allow the participants to be well seen and heard. The ideal telehealth room should be a quiet room. The walls should be solid blue or gray in color and have some sort of cloth, padding or sound panels on them to absorb some sound. Fluorescent lighting should be in the room with the bulbs being 3200 to 4700 Kelvin degrees in temperature. Lighting should cover the top and front of conference participants and should be adequate for the room’s size. Windows, if any, should be covered with room darkening cloth curtains. Any tables in the room should be dark in color, non-glass top, and cloth covered if possible. For a more detailed account and an explanation of these room design characteristics see Chapter 13, Telehealth Technology, section V, Room Evaluation in the Office for the Advancement of Telehealth’s *Telemedicine Technical Assistance Documents: A Guide to Getting Started in Telemedicine*.

**Funding/Subsidy Programs**

There are a number of Federal government and foundation resources available for telehealth funding. A good starting point for information on telehealth grants and funding are: the Telemedicine Information Exchange (TIE) (http://tie.telemed.org/); the Office for the Advancement of Telehealth (OAT) (http://telehealth.hrsa.gov/) of the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB); the American Telehealth Association (ATA) (http://www.atmeda.org/); and the Foundation Center (http://fdncenter.org). The following organizations and programs are a sampling of telehealth funding sources that may be applicable to a teledentistry project.

**United States Department of Agriculture (USDA) Rural Development**

USDA Rural Development administers a number of rural utilities programs to enhance telecommunications services in rural areas through the Rural Utilities Service (RUS).

**Distance Learning and Telemedicine (DLT) Program** is charged with bringing electronic educational resources to rural schools and improving health care delivery in rural America. It is specifically designed to meet the educational and health care needs of rural America through the use of advanced telecommunications technologies. The DLT program administers $20 million in grants with minimum grants of $50,000 and maximum grants of $500,000.

**Rural Development Broadband Loan and Loan Guarantee Program** provides loans and loan guarantees to fund the cost of construction, improvement, or acquisition of facilities and equipment for the provision of broadband service in eligible rural. The Programs’ goal is to ensure that rural consumers enjoy the same quality and range of telecommunications services that are available in urban and suburban communities.

**Rural Development Community Connect Grant Program** is designed to provide financial assistance in the form of grants to eligible applicants that will provide currently un-served areas, on a "community-oriented connectivity" basis, with broadband transmission service that fosters economic growth and delivers enhanced education, health care, and public safety services. This
all-encompassing connectivity concept will give small, rural communities a chance to benefit from the advanced technologies that are necessary to foster economic growth, provide quality education and health care opportunities, and increase and enhance public safety efforts.

*The Universal Service Administration (USAC)*\(^6^2\)

*Rural Health Care Program Universal Service Fund*\(^6^3\) is a support program authorized by Congress and designed by the Federal Communications Commission (FCC) to provide reduced rates to rural health care providers (HCPs) for telecommunications services and Internet access charges related to the use of telemedicine & tele-health. Support is available for telecommunications services and monthly Internet access charges (only the monthly ISP charge is eligible for support) used for the provision of health care. However, equipment charges are not eligible for support.

*Health Resources and Services Administration (HRSA), Office for the Advancement of Telehealth (OAT)*\(^5^7\)

*Telehealth Network Grant Program (TNGP)*\(^5^7, \text{ } 6^4\) helps communities build the human, technical, and financial capacity to develop sustainable telehealth programs and networks. Grants may be used to develop telehealth network projects in rural areas, in medically underserved areas, in frontier communities, and for medically underserved populations, to (a) expand access to, coordinate, and improve the quality of health care services; (b) improve and expand the training of health care providers; and (c) expand and improve the quality of health information available to health care providers, and patients and their families. Awards will be made for up to three years.

*National Telecommunications and Information Administration (NTIA)*\(^6^5\)

The *Technology Opportunities Program (TOP)*\(^6^6\) supported demonstrations of new telecommunications and information technologies to provide education, health care, or public information in the public and non-profit sectors. However, as of 2004, matching grant funds are no longer available under TOP.

**Teledental Equipment**

Teledentistry sites require some or all of the following basic equipment. The exact equipment required will depend on the nature of the site being outfitted. Hub sites will be different from remote sites – hub sites will only require videoconferencing equipment, whereas remote sites will require digital dental diagnostic equipment along with videoconferencing equipment. Moreover, mobile sites may require different transmission equipment than fixed sites (e.g. satellite dishes and modems). The equipment listed does not include telecommunication service equipment (e.g. routers, switches, T-1 lines, etc.). The nature of the telecommunication equipment will depend on the type of telecommunication service utilized by each site. Further, the teledental equipment does not include the equipment or supplies needed to outfit a traditional dental unit with traditional dental (which will be necessary in the remote sites). One other note,
there are a variety of manufacturers and models. Thus, there are a variety of choices for each individual piece of equipment.

**Videoconferencing System**

The videoconferencing system should include: a CODEC unit with a pan tilt video camera, monitor (preferably one that can split screen or comes as two monitor units), mobile cart with shelf for laptop computer or keyboard, back-up battery, input and output connections, and have the ability to encrypt and unencrypt data. Tandberg and Polycom are the leaders in this industry.

**Extraoral Digital Camera**

Extraoral cameras are good for face, smile, arch, and anterior teeth images. There are 3 types of digital cameras: point and shoot, professional, and modified point and shoots. Point and shoot are typically off-the-shelf and can take good portrait photo images, but have limited close-up and intraoral capabilities. Professional level SLR cameras are top of the line single lens reflex camera bodies that allow for the addition of an assortment of lens and flash attachments. While these can take the most accurate images, they are the most difficult to manage. Modified point and shoots are off-the-shelf cameras that have been modified for dentistry. These cameras have added hardware (e.g. macro lens and flashes) to improve the macro capability of the camera and the ability of the flash to disperse or expose correctly under macro conditions.

Extraoral cameras should be able to capture color and have sufficient image resolution capacity. Extraoral cameras should include: at least 4 megapixel resolution, be capable of faster shutter speeds, have through the lens viewing (SLR) or an LCD monitor (for direct viewing for accurate, repeatable framing alignment), manual focus macro lens (at least 3x optical zoom), dual point lighting (e.g. ring flash or flash diffuser to distribute light evenly – standard flashes create washout), glass lens rather than plastic, manual focus and f-stop (aperture-size) settings (for consistent, repeatable results), a video-out port to download to a monitor and/or a USB hub to download to a computer, and selectable compression/resolution levels for final imaging. Moreover, the camera system should include mirrors and retractors (an occlusal mirror, a buccal No. 1 mirror, and universal retractors), and computer dental software that supports viewing the images, storing the images, and editing the images.

**Intraoral Wand Digital Camera**

Intraoral wand cameras are good for diagnostic purposes because of the high intensity light they utilize and the magnification they can produce. They are good for individual teeth, for hard to reach areas and where light is difficult (posterior areas), and are excellent for locating early white spot lesions. Intraoral wand cameras can take still images or video. Intraoral wand cameras should be lightweight (to reduce operator fatigue), have focus-free optics, integrate seamlessly with other dental digital software packages, utilize LED lighting (rather than fragile fiber-optic or fan cooled lighting sources), and they should come with USB or firewire interfaces (for direct connectivity to a computer)

**Digital Radiographic Equipment**
There are 3 ways to obtain digitized radiographs: 1) converting traditional film radiographs to digital (digitized) images via a scanner – the digitized images are then transferred to and viewed on a computer; 2) using phosphor plate technology – a radiograph is taken using a phosphor plate (instead of film) to store the image, the plate is then scanned by a laser to produce an image which can be viewed on a computer; and 3) using sensor or direct digital technology – radiographs are taken using digital sensors – the image is immediately shown on a computer screen. The scanner and phosphor plate technologies are slower, but less expensive. The sensor technology is real time.

**Laser Caries Detection Device (KaVo DIAGNOdent)**

The DIAGNOdent uses laser technology to detect and quantify hidden or sub-surface caries by measuring laser fluorescence within the tooth structure. The DIAGNOdent is designed to be an adjunct to the traditional oral examination in the detection of occlusal decay. However, the DIAGNOdent is limited in that it will only detect caries in pit and fissure lesions - it will not detect interproximal decay or decay around or under existing restorations. Moreover, while the DIAGNOdent has high sensitivity (% correctly diagnoses cariously involved sites), it does not have as high a specificity (% correctly diagnoses healthy sites). This results in too many false positives and the restoration of healthy teeth.

**Computer**

Every teledentistry site, whether a remote or hub site, must be equipped with a computer. The computer can be either a laptop or desktop computer. No matter the type or brand of computer it must have the following minimum requirements: CPU Speed: 2.8 GHz Pentium 4; Operating System: Windows 2000 Service Pack 4 or Windows XP Service Pack 1 w/Microsoft knowledge base KB822603 update; System RAM: 1 KB; Hard Drive: 80 GB; CD-ROM Drive: 48x; Video Display Adapter: 64 MB RAM; and USB Port: Must be USB 2.0.

**Regulations**

**State Dental Practice Act, Statutes, and Rules**

The Department of Health envisions using teledentistry for two distinct purposes: 1) to provide isolated populations with examination, consultation, and referral services for both basic and specialized oral healthcare; and 2) to fulfill the general supervision requirement of the Florida Statutes (Section 466.023 (2) (b) Dental hygienists; scope of practice and Section 466.003 (10) Definitions – “General Supervision”2 and the Florida Administrative Code (F.A.C.) (Rule 64B5-16.001 (6)) so that a remote-based dental hygienist may position and expose dental x-ray film or sensors; apply American Dental Association or Food and Drug Association approved topical fluorides (which would include fluoride varnishes); use appropriate instruments to preassess and chart suspected findings of the oral cavity; take or record patient’s blood pressure rate, pulse rate, respiratory rate, case history, and oral temperature; perform prophylactic cleanings; provide oral hygiene instruction; and provide oral health education without a dentist needing to be physically present. The Florida Statutes (F.S.) and the F.A.C. do not directly address teledentistry.
However, both the statutes and rules read together may support the Department of Health’s need for teledentistry, but in a limited fashion.

**Teledental Exam**

Section 466.024 (3) F.S. requires that “[a]ll remedial tasks shall be performed under the direct, indirect, or general supervision, of a dentist, as determined by rule of the board . . .” Rule 64B5-16.001 (6), F.A.C. states that “[g]eneral supervision requires that a licensed dentist examine the patient, diagnose a condition to be treated, authorize the procedure to be performed. Whether a dentist may utilize teledentistry to examine a patient, diagnose a condition to be treated, and authorize procedures that a dental hygienist may perform and thus, satisfy the general supervision requirement is not addressed in either the Florida Statutes or F.A.C.

**Supervision**

Section 466.003 (10) F.S. defines “general supervision” as “supervision whereby a dentist authorizes the procedures which are being carried out but need not be present when the authorized procedures are being performed. The authorized procedures may also be performed at a place other than the dentist’s usual place of practice. . . .” Rule 64B5-16.001 (6), F.A.C., which also defines “general supervision”, is silent as to whether a dentist must be present or not. In contrast, Rules 64B5-16.001 (4 & 5), F.A.C. which define “direct supervision” and indirect supervision”, respectively, both have language requiring the dentist “be on the premises” while the delegated remedial tasks are being performed by a dental hygienist.

Section 466.023 (1) F.S. states that “[a] dentist may only delegate remedial tasks [to be performed by a dental hygienist] so defined by law or rule of the board.” Section 466.023 (1) F.S. and section 466.024 F.S. and Rules 64B5-16.006 (3) (c) & (h) & 4 (c) and 64B5-16.007 (3 & 4) F.A.C. describe which tasks are remedial and delegable and determine which tasks shall be performed under direct, indirect, or general supervision of a dentist. Accordingly, dental hygienists may under general supervision apply American Dental Association or Food and Drug Association approved topical fluorides (which would include fluoride varnishes); use appropriate instruments to preassess and chart suspected findings of the oral cavity; take or record patient’s blood pressure rate, pulse rate, respiratory rate, case history, and oral temperature; perform prophylactic cleanings; position and expose dental x-ray film or sensors; and provide oral hygiene instruction; and provide oral health education without supervision.

However, Rule 64B5-16.006 (2) (h) F.A.C. states that the following remedial tasks – “[a]pplying sealants” - may be performed by a dental hygienist only under indirect supervision. Indirect supervision requires that the dentist be on the premises. See, section 466.003 (9) F.S. and Rule 64B5-16.001 (5) F.A.C. This is in contrast to section 466.023 (2) (b) F.S. which allows dental hygienists to perform their duties “in public health programs and institutions of the Department of Children and Family Services, Department of Health, and Department of Juvenile Justice under the general supervision of a licensed dentist.” (emphasis added). Whether this means a dental hygienist may apply sealants under general supervision in a DOH facility as the teledentistry project desires is unclear.
**Privacy and Security**[^8][^76]

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA, Public Law 104-191). HIPAA gives guidance on most privacy and security issues in health care. HIPAA seeks to streamline electronic medical record systems while protecting patients, improving health care efficiency, and reducing fraud and abuse. HIPAA’s privacy rule deems that any “individually identifiable health information” in any form or medium is to be “protected health information”. This information includes, but is not limited to: name and address; date of birth; social security number; payment history; account number; and name and address of the health care provider and/or health plan. HIPAA’s privacy rule applies to health plans, health care clearinghouses, and health care providers that transmit “protected health information” in any form or medium, including electronic, paper, and oral.

Telehealth encounters and consultations by their nature are transmissions of health information. Protected health information can potentially be sent anywhere in the world in a matter of seconds. HIPAA requires that health care providers protect this individually identifiable health information. Thus, telehealth systems should have security measures such as encryption and dedicated lines where possible designed into the system. Moreover, HIPAA requires that health care providers obtain consent prior to using or disclosing protected health information to carry out treatment, payment or other health care operations. Thus, before a teledental encounter or consultation takes place, the patient must be made aware of and give his or her consent to the fact that teledentistry involves the electronic transmission of his or her protected health information.

**Reimbursement**[^8][^77-80]

The ability of providers to bill and collect fees for health care services provided via telehealth is a large issue for sustaining a telehealth program. Reimbursement for telehealth services is limited. Reimbursement for teledental services is almost non-existent. The primary health care insurers, Medicare, Medicaid, and private insurance each have different positions regarding reimbursement for telehealth services.

The Center for Medicare and Medicaid Services (CMS) administers the Medicare and Medicaid programs in the United States. CMS recognizes telemedicine not as a discrete medical procedure, but rather as a method for delivering care. As such, the Medicare program, permits reimbursement for telehealth in rural health professional shortage areas (HPSAs) in three areas: remote patient face-to-face services seen via live video conferencing; non face-to-face services that can be conducted either through live video conferencing or via store and forward telecommunication services; and for home telehealth services. Medicare, however, has very limited dental coverage and thus, does not reimburse for teledental services.

Conversely, the Medicaid program, which covers dental services for qualified children, pregnant mothers and some adults, allows each state to determine whether they will reimburse for telehealth and thus, teledental services. Therefore, Medicaid reimbursement for telehealth services varies from state to state. In 2003, 34 states had some reimbursement for telehealth services. Florida’s Medicaid program does not reimburse for telehealth or teledental services.
Medicaid reimbursement for teledental services can be accomplished in one of a number of ways. State mandates, where either State legislatures or state regulatory agencies, such as the Florida’s Office of Insurance Regulation, can enact rules or statutes that mandate reimbursement of teledental services. Or negotiations with the state agency responsible for Medicaid programs, such as Florida’s Agency for Health Care Administration, to persuade the Medicaid program to reimburse for teledental services. One approach here can be to obtain a program waiver or propose a short term pilot program.

Like Medicaid, reimbursement through private commercial insurers varies from state to state and even region to region within individual states. As of 2003, private insurance reimbursement for teledental services was also limited. Only 29 states had some private insurers who would reimburse for telehealth procedures. Five states, Louisiana, California, Oklahoma, Texas, and Kentucky, have passed legislation mandating private payer reimbursement of telemedicine services. Florida is one of the 21 states that have no private insurers who covered telehealth services.

**Liability**

Liability or medical malpractice exposure will attach to any health care practitioner who actively participates in the treatment of a patient. Liability will attach irregardless of whether the health care practitioner participates in person or via an interactive telehealth link or via store and forward technology and irregardless of whether his or her participation is regarded as a direct patient encounter or a consultation. Any provider should inquire as to whether his or her existing malpractice policy, covers procedures performed utilizing telehealth technology. However, for this DOH teledentistry pilot program, health care practitioners are probably protected against liability under the State’s sovereign immunity policy.

**Storage of Medical Records**

Health care practitioners in the electronic era must consider a variety of legal, ethical and clinical issues in deciding how to keep their medical records. Since teledentistry involves the electronic transmission of health care data, issues regarding whether to record and store this data are relevant. The prevailing thought is that any data that is recorded must be made part of the patient’s permanent record. Thus, still photos, digital radiographs, and paper or electronic medical histories must be saved and stored. However, any data that is not recorded, such as live interactive videoconferencing transmissions, need not be recorded or stored.

**Conclusion**

Teledentistry is not a separate dental specialty. Teledentistry does not create new oral health care services. It simply provides an alternative method to deliver existing services. Currently, teledental technologies have not yet become an integral part of mainstream oral health care. The reasons are many including: reimbursement; regulatory and legal sanction; privacy and security; compatibility and interoperability of technology across systems; sustainability; and acceptance of teledentistry by patients and providers alike. Yet despite these barriers, the technology currently
exists to provide teledental specialty consultation and referral services, distance learning educational services, and limited teledental clinical preventative services. It is not far fetched to imagine that in the near future teledentistry will be just another way to access an oral health care provider. This is especially encouraging for isolated populations who may have difficulty accessing the oral health care system due to distance, ability to travel, or lack of oral health care providers in their area.

2. Florida Statutes; Title XXXII Regulation of Professions and Occupations; Chapter 466 Dentistry, Dental Hygiene, and Dental Laboratories; 2005.
3. Florida Administrative Code; Chapter 64B-16 Remedial Tasks Delegable to Dental Hygienists and Dental Assistants. 64B5-16; 2000.


16. Regulation of Professions and Occupations; Dentistry, Dental Hygiene, and Dental Laboratories. Title XXXII; 2005.


