



# **STATEMENT**

**of the**

**American Medical Association**

**to the**

**House Committee on Energy and Commerce  
Subcommittee on Health  
United States House of Representatives**

**RE: Telemedicine**

**May 1, 2014**

**Division of Legislative Counsel  
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The American Medical Association (AMA) appreciates the opportunity to provide our views on telemedicine to the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health. The interest in telemedicine (also often referred to as “connected health”) among state and federal regulators, lawmakers, physicians, allied health professionals, and telecommunication and technology companies has grown rapidly over a relatively short period of time. Current telecommunication technologies have been touted as: (1) ameliorating provider shortages; (2) increasing access to medical care while improving affordability for geographically remote and underserved populations; and, (3) reducing health care costs over time. It is widely expected that the broad-range of new technologies that support or enable medical practice will only continue to grow. There is increasing support among policymakers and early adopter physicians to modify or alter certain mechanisms that safeguard patient safety because they believe this will facilitate greater utilization of telecommunication technologies in healthcare. The AMA is in the process of conducting a comprehensive review of the foregoing considerations and the challenges to ensure that such telecommunication technologies are implemented in a manner that protects patient safety and promotes improved patient health outcomes. The diversity of telecommunication technologies, clinical practice settings, and medical specialties, along with the rapid rate of innovation, are factors that should be carefully weighed by policymakers.

In brief, there are broad considerations that the AMA urges policymakers to consider.

**Patient safety (consumer protection)**

The relationship of trust between the patient and physician has long been understood as foundational to ethical practice in medicine. AMA policy stresses that such relationships must be predicated on: open and honest communication between the physician and the patient, including disclosure of all information necessary for the patient to be an informed participant in his or her care; commitment of the physician to be an advocate for the patient

and for what is best for the patient, without regard to the physician's personal interests; provision by the physician of that care which is necessary and appropriate for the condition of the patient and neither more nor less; and avoidance of any conflict of interest or inappropriate relationships outside the therapeutic relationship.

**The AMA supports state-based medical licensure because it protects the interests of patients and the ability of states to enforce state medical practice laws.** Physicians must be licensed in the state where the patient receives services and the AMA opposes federal legislation that would preempt or waive licensure and medical practice laws for telemedicine encounters. State licensure is the mechanism by which medical practice laws are enforced, including minor consent laws and reproductive and end of life medical practice laws, for example. Without state-based licensure the state is unable to hold out-of-state providers accountable for the medical care they provide to patients located in the state. Furthermore, patients and other health care providers from other states who become involved in litigation would have significant burdens resolving conflicts of law as it would not be clear which applicable state laws of medical practice, standards of care, or medical liability apply. Currently, state medical boards are able to regulate physicians delivering telemedicine services in their state in much the same way state regulators provide oversight for a broad array of other professionals delivering services in their state—treating physician licensure differently would be a marked departure that is not justified when a broad array of providers already offer telemedicine services and are able to comply with state licensure requirements.

As an alternative to state-based licensure, national licensure would be costly, complicated, and time-consuming. We need look no further than programs set-up on a national scale in the recent past requiring physician and provider enrollment in Medicare. It could be years before such an infrastructure is designed and implemented and likely would be subject to legal challenges.

Instead, solutions that focus on modernizing current state licensure processes should be a priority. For example, at the same time that the AMA supports state-based licensure, AMA policy calls for modernization of the state licensure process since the current process in some states can be costly, slow, and paperwork-intensive, whether a physician wants a license in one state or ten. The AMA has urged the Federation of State Medical Boards (FSMB) and other major telemedicine stakeholder proponents to support funding to deploy new technologies that streamline, automate, and simplify the licensure processes. However, modernization of the infrastructure and processing of licensure applications is only one step to paving the way for telemedicine. The FSMB is already developing a model compact for interstate licensure, which is set-up to streamline the regulatory process and expand access to care without compromising patient protection under the current licensure scheme. The AMA continues to provide input on this effort and recognizes that the end goal is engage state medical boards and state medical associations in the development of this compact and to apply lessons learned from the nurse compact so that widespread adoption becomes a reality.

### **Promoting patient centered care and care coordination**

The AMA urges policymakers to promote telemedicine that will support care delivery that is patient centered, promotes care coordination, and facilitates team-based communication. We urge policymakers to support telemedicine that promotes interoperability of systems,

products, and platforms—or minimally portability of data. Telemedicine should be consistent with and serve as infrastructure for new value-based accountable care delivery models, and without data portability, new telemedicine models—particularly outpatient care—may further fragment care and create additional silos instead of building medical neighborhoods of collaboration. Promoting patient care coordination through medical home and accountable care models will become achievable where data portability and interoperability are promoted in the context of telemedicine. The foregoing is more likely where telemedicine technologies are used to extend the capacity and reach of physicians and health care practices and systems in the community where a patient resides. Alternatively, such care coordination and new delivery models will become more difficult to implement if new telemedicine platforms and options create barriers to engagement with a patient’s treating physicians, medical home team, and neighborhood.

As part of the AMA’s review of telemedicine technologies, we have had the opportunity to consider a number of innovative platforms—this review remains ongoing. The companies offering telemedicine platforms and technologies have approached the need for care coordination with the medical home and the medical team, and the need to construct technologies and policies that support patient centered care between traditional and new locations of care and members of the patient’s medical team with differing levels of importance. Currently, some new telecommunication vendors that use free-standing platforms to triage urgent care, for example, have relatively weak methods to support care coordination with a patient’s medical home where an established physician-patient relationship exists outside of the telemedicine platform offered. On the other hand, some vendors have developed models that emphasize partnerships with existing community providers to scale or extend the patient’s medical home’s reach utilizing telemedicine models. One vendor, for example, offers a variety of data sharing interfaces via the Health Insurance Portability and Accountability Act-compliant standards to allow the vendor to support information sharing with the patient’s medical home. Again, the AMA urges policymakers to promote telemedicine that will support care delivery that is patient centered, promotes care coordination, and facilitates team-based communication.

### **Evidence base and clinical standards of care**

Policymakers should also increase support for further development of research and evidence regarding the impact telemedicine has on quality and costs. There is a developing body of research on an array of telemedicine technologies and services, but the evidence base in some areas does not exist or is limited. As the technologies proliferate and the medical services that are covered expand, there will be increasing pressure to ensure that there is a clinical evidence base to support new applications, and that uses are safe and efficacious. Research has moved from demonstrating the technology works and is functional to evaluating the comparative effectiveness of services offered through telecommunication modalities as compared to in-person services.

Telemedicine is not a separate medical specialty. Standards of care for telemedicine services in some areas are well-established, but in many other areas remains a work in progress where a number of pace setting specialties have been very involved in developing relevant clinical practice guidelines. National medical specialty societies continue to develop clinical guidelines or position statements relating to telemedicine—these include the American College of Radiology, American Academy of Dermatology, American Psychiatric

Association, and Society of American Gastrointestinal and Endoscopic Surgeons, for example. The AMA is engaging both national specialty and state medical societies concerning practice guidelines as well as policies broadly governing telemedicine and expects more activity in this area.

While there is growing evidence that certain uses of telemedicine can improve care coordination and adherence, there is equally concerning indications that certain telemedicine prescribing practices in urgent care settings and where care is not coordinated with a medical home or compliant with practice guidelines may lead to public health threats. Specifically, the prescribing of antibiotics without appropriate diagnostic testing may further exacerbate the serious and growing problem of antibiotic resistance—a persistent and deepening public health threat.<sup>1</sup>

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We appreciate the Subcommittee’s critical role in reviewing telemedicine policy issues and look forward to working with the Health Subcommittee and Congress.

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<sup>1</sup> The Centers for Disease Control and Public Health (CDC) has reported over 2 million antibiotic resistant infections in the United States each year and at least 23,000 deaths. The most important factor contributing to antibiotic resistance is antibiotic use. The most common inappropriate use is for acute respiratory tract infections. Over half of all outpatient antibiotic uses are unnecessary. Shapiro, D. J., et al. (2013). *J Antimicrob Chemother* 69(1): 234-240; Antibiotic Resistance Threats in the United States, CDC, September 16, 2013. In addition, a JAMA study on eVisits concluded that 99 percent presenting through eVisit received antibiotic compared to 49 percent presenting in-person who received antibiotic. Mehrotra, A., et al. (2013). *JAMA Intern Med* 173(1): 72-74.