Practice Guidance for Emergency Telehealth and Acute Unscheduled Care Telehealth

ACEP Emergency Telehealth Section Policy Guidelines Task Force
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Part One: Vision & Definition

Telehealth Section Vision:

The purpose of this document is to provide guidance from the Emergency Telehealth Section to which any/all emergency telehealth encounters should meet in order to help maximize quality, safety, effectiveness, reliability, value, satisfaction, service and consistency to the patient and/or patient guardian while allowing for appropriate safety and protection to the telehealth emergency physician, non-emergency physician, physician assistant or nurse practitioner.

Emergency Telehealth Definition (as December 11, 2019 by Telehealth Section)

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Emergency telehealth is remotely caring for acute illness, injury and acute exacerbations of chronic diseases, including the initial evaluation, diagnosis, treatment, and prevention, coordination of care, disposition, and public health impact of any patient requiring expeditious care irrespective of any prior relationship. Emergency physicians are uniquely qualified to leverage acute care medical decision making via telehealth, unscheduled or scheduled, to provide medical care across the spectrum of conditions and severity.

The ACEP Telehealth Section believes the context for the definition of the emergency telehealth currently includes the following (08/25/20):

- An emergency physician or non-emergency physician's training, expertise, capabilities, capacity, certification, and credentialing dictate the quality and range of services offered through telehealth.
- Emergency telehealth may be utilized by or in consultation with a board-certified/eligible emergency physician.

- Emergency physicians (EP), non-emergency physicians (NEP), physician assistants (PA), nurse practitioners (NP) and others should use a variety of technologies safely, effectively, and within existing regulatory, quality, and confidentiality frameworks to deliver emergency medical care and address access to care, infection prevention, care efficiency, diagnostic interpretations, clinical interventions, monitoring, and transitions of care.
- Emergency telehealth may be conducted in a variety of settings that include, but are not limited to urban and rural hospital and freestanding emergency departments (EDs), acute care settings, urgent care clinics, observation medicine units, correctional care facilities, out of hospital settings, including the home, skilled nursing facilities, rehabilitation centers, during medical transport, emergency medical services at the scene of illness or injury or in the community, at disaster sites, as well as austere environments such as maritime, aviation, space, and military uses in and out of theatre, in work/employer setting or other settings that are conducive to telehealth encounters.
- Emergency physicians use evidence-based medicine and guidelines to effectively deliver emergency telehealth. Emergency telehealth emergency physicians, NEPs, PAs and NPs should participate in research and rigorous quality improvement to build and expand the base of evidence regarding emergency telehealth.
- The ACEP Emergency Telehealth Section believes that the prudent layperson standard, defined in the Balanced Budget Act (BBA) of 1997, applies to EMTALA *mandated* care regardless if care is delivered in person or through emergency telemedicine and that both in person and emergency telemedicine may be used to satisfy EMTALA screening obligations as dictated by local hospital/medical staff policies.
- Any PA or NP providing emergency telehealth care should be supervised by an emergency physician as determined appropriate by the EP responsible for and providing the supervision and/or collaboration.

*Telehealth refers to real time audio and visual telecommunications when involving patient interviews, exams, management and treatment of a patient by an EP, NEP, PA or NP. With rare exception, telehealth requires both audio and visual to qualify as telehealth.

Part Two: Location-Based Emergency Telehealth Practice Guidance & Goals

There are primarily two methods of classifying Emergency Telehealth.

A) Location of the Patient

1. Within an Emergency Department

2. Outside of the Emergency Department
3. Hybrid of the two listed.
    a. Pre-ED or Pre-Hospital care of a patient that transition to an ED patient
        i. Tele-EMS telehealth patient
            a. Patients cared for in the field but transition to the ED
            b. Patients directed to a non ED care setting (clinic, psychiatric facility, Urgent care
            c. Patients that can be managed with a televisit or subsequent referral and don't require EMS transport
        ii. Direct to consumer telehealth that transitions to an ED patient
        iii. Others
    b. An ED patient that is later a non ED patient
        i. An ED patient that requires a transfer and has Tele-EMS care during transport to the next ED or facility i.e. inter-facility transfer including intra-health system transfers and inter-health system transfers
        ii. An ED patient that is discharged home but receives follow up care by telehealth
        iii. Others

B) Location of the EP, NEP, PA or NP treating the Patient

1. At the same location where the patient is located (Originating or "Patient" Site)
    a. This can include EPs, NEPs, PAs and NPs that are at the same facility but not necessarily in the ED with the patient i.e. separate rooms, or nearby, in the main ED treatment area, in a nearby office, another part of the same building etc.
    b. While some may consider the EP, NEP, PA and NP to be at the Originating Site so long as they are affiliated with the same medical or healthcare organization as the one where the patient is located, this is NOT the intention of this Guidance Paper. If the EP, NEP, PA and/or NP is located at a separate location than the patient and could not be at the patient's bedside within a reasonable amount of time, i.e. within the same building and could be at bedside within a few minutes, that EP, NEP, PA or NP would be considered to be at a Distant Site and not the Originating Site (If the EP, NEP, PA or NP is on campus a mile away or on campus of the same healthcare facility located miles away, it is not the intention that this would qualify as being at the originating site)
2. Not at the same location as the patient being treated (Distant or "Remote" Site)
    a. Anywhere that is not at the same site as the patient and not able to be physically at patient's bedside within a short time i.e. minutes. This would include but not limited to the hospital, ED, office, home, etc.
3. Hybrid of the two listed.
    a. Care is provided by a distant site EP, NEP, PA or NP and then later by an originating site EP, NEP, PA or NP

b. Care is provided by an originating site EP, NEP, PA or NP and later by a distant site EP, NEP, PA or NP
c. Care is alternated between onsite and offsite EPs and/or NEPs, PAs, and NPs.

The simplest way to think of emergency telehealth encounters is based on the location of the patient.

1) **Emergency Department Originating Site Emergency Telehealth**. Telehealth encounters in the emergency department, by consulting specialists (including emergency specialists i.e. emergency physicians) with patients (Originating Site Services-OSS Telehealth or "Patient" Site.) These encounters include but are not limited to the following:
   A) Tele-Triage when the emergency physician, NEP, PA or NP is located in the same facility as the patient*
      1. Tele-Screening, i.e. on-site tents, when the EP, NEP, PA or NP are at same site as the patient.
      2. Tele-ePPE when emergency physician, NEP, PA or NP are at the same facility as the patient and being used to spare PPE.
   B) Tele-Residency when the resident physician and attending physician are located within the same facility.
   C) Tele-Emergency (Tele-EM) when the EP, NEP, PA or NP is located in the same facility as the patient. Some do not consider this telehealth for billing purposes (CMS 2020)
      1. Tele-ePPE conservation. EP, NEP, PA or NP are at the same location as patient but care for patient without being at bedside.
      2. Tele-efficiency. Certain EPs, NEPs, PAs or NPs are designated to care for patients via Telehealth while other EPs, NEPs, PAs or NPs are designated to see patients at bedside for complex evaluations or required procedures.
2) **Non-Emergency Department Originating Site Emergency Telehealth.** Emergency Telehealth encounters in which emergency physicians treat patients located outside of the ED directly via telehealth (Distant Site Services-DSS Telehealth or "Remote" Site Telehealth). It is the purpose of this paper to provide general guidance regarding these two types of telehealth encounters. The following are some of the examples of Telehealth that includes a patient located at the "Originating Site" and the Telehealth EP, NEP, PA or NP located at a "Distant Site" but is not exclusive and it is anticipated this list will grow with time:
   A) Tele-Screening, i.e. on-site tents, when EP, NEP, PA or NP are at different "facilities, sites, or locations" as the patient
   B) Tele-ePPE when EP, NEP, PA or NP are at a different location from the patient (not in ED, i.e. nursing home, patient's home, etc.) and being used to spare PPE.
   C) Tele-EMS when the EP, NEP, PA or NP use audiovisual, electronic transmission and digital care to assess and provide pre-hospital medical direction to pre-hospital personnel for treatment of patients prior to arrival to medical facility. This includes

viewing rhythm strips, EKGs, injuries and wounds, wounds, burns, disaster setting, vehicle patient was driving or a passenger in, etc. For patients who refuse EMS transport to the emergency department, Tele-EMS can be a valuable tool to allow the emergency physician, NEP, PA or NP to evaluate and perform a virtual assessment/exam of the patient. The patient can then be offered the risk and benefits of transport to allow patients to make an informed decision regarding his or her refusal. Tele-EMS could help identify a life-threatening concern and communicate this to the patient, thus providing information to the patient that could help persuade them to seek potentially life-saving treatment when the patient may have otherwise refused transport or treatment. If the patient is capable of making medical-related decisions on whether to accept or refuse treatment, the patient can refuse transport or treatment. As long as patient will allow it, the patient should still be given care instructions and follow-up instructions that include language that states: should the patient change his or her mind, they should call 911, proceed to the ER or seek immediate care.

D) Tele-Paramedic
    1. Mobile Integrated Health Care
    2. Community Paramedicine
    3. Tele-presenter / Tele-facilitator
E) Tele-Disaster
    1. Hurricane
    2. Flood
    3. Tornado
    4. Chemical Spill
    5. Fire
    6. Radioactive
    7. Infectious Outbreak
    8. Man-made disaster vs. natural vs. hybrid
    9. Other
F) Maritime Setting
G) Aeronautical setting
H) Tele-Transfer / Hospital Transfer/Command Center
I) Tele-Military / Tele-Combat
J) Tele-Immigration (Immigration holding facilities)
K) Tele-Humanitarian (Refugee camps)
L) Tele-Events {Car racing sites, tractor pulls, concerts (indoor or outdoor), etc.}
M) Wilderness Setting
N) Tele-Hospice (Hospice Setting)
O) Nursing Home Setting, Assisted Living Facilities,
P) Critical Care
Q) Shelter (Homeless, Women's, etc.)

R) Schools
S) Work Setting / Businesses
T) Correctional Facilities

This paper will attempt to provide these guidelines in the following format:

I) General practice guidance applicable to all emergency telehealth and acute unscheduled care interactions.
II) Guidance specific to specialist telehealth consultations in the emergency department (Originating Site Services Telehealth) i.e. EP at Patient Site
III) Guidance specific to emergency physicians who are treating patients via telemedicine (Distant Site Services Telehealth) i.e. EP at Remote Site (a.k.a. Distant Site)

Telehealth Section Goals:

PHASE 1: Establish Guidance for all telehealth encounters
PHASE 2: Identify settings for telehealth
PHASE 3: Identify clinical presenting conditions

PHASE I:

1) Establish guidance for all telehealth encounters to address operational issues including identification matters of both the patient and the emergency physician, NEP, PA and/or NP, recommended disclosures, privacy issues, emergency and escalation plans should equipment/connection failures occur, follow-up expectations, contingencies for emergencies, medical records access, and other matters related to creating a successful telehealth visit.
    a. Emergency physicians, NEPs, PAs and NPs must meet federal and state requirements to provide telehealth services

    b. Obtain the name of the patient (and guardians if applicable), date of birth, contact information, i.e. current physical address, phone number and e-mail address, and emergency contacts of the patient and means to contact emergency contacts, i.e. telephone numbers, e-mail address, physical address. If already obtained previously, the EP, NEP, PA or NP should confirm or verify the patient and emergency contact information.

    c. Obtain and document consent for the encounter; consent may be verbal, electronic or written but should comply with applicable laws. Consent is implied by the patient agreeing to participate or when patient is unable to give consent, i.e. when patient is unable to expressly consent for what is believed to be

medical reasons and when medical care is believed to be in the patient's best interest. Obtain consent to record the telehealth encounter, receive and/or store photographs, if that is part of the protocol or practice of, or determined to be indicated by the EP, NEP, PA or NP.

d. Consent should be in writing if reasonably possible. If not in writing, it should be clearly documented in the chart that consent was received. In situations in which a guardian or Power of Attorney (POA), ward of the state, etc. calls in on behalf of the patient, the EP, NEP, PA or NP and his/her team will make a good faith attempt to positively identify who the healthcare POA is and obtain a copy of the written POA, confirm the present location of the patient and the state in which the POA was created, if known, as long as it does not interfere with proper care or pose a risk or danger to the patient by doing so.

e. The EP, NEP, PA and/or NP should inform the patient, guardian and/or responsible party that he/she will make every reasonable precaution to safeguard the patient's privacy and confidentiality within the laws of the state that the patient is located (realizing that certain things, if suspected must be reported in certain states, i.e. abuse, imminent suicide risk, danger to others).

f. Establish a patient-physician relationship, (This is assumed with item c) that meets criteria with applicable federal, state or local laws/requirements.

g. The emergency physician, NEP, PA or NP must inform the patient of their right to decline care, terminate the encounter at any time and ability for patient or guardians to ask questions if they do not understand anything or want an explanation regarding treatment, care or anything related to the telehealth encounter.

h. Provide the name and location of the telehealth EP/NEP/PA/NP, or organizational point of contact, to the patient, guardian or clinical surrogate with the patient, i.e. "Hello, my name is Dr. John Doe, I am a medical doctor board certified in emergency medicine and practice from my home office in Baltimore, Maryland."

i. If the medical professional is not a physician, this must be clearly communicated and the non-physician must verify and document in the chart that patient or guardian understands that the clinician is not a physician. If the platform or service has a "list of EPs, NEPs, PAs or NPs" from which the patient can choose to have a telehealth encounter with before connecting, the "platform" or service that shows the list must clearly communicate whether the person is a physician

or non-physician and what the board specialty and status of that individual is. If the person providing the care is a PhD and identifies themselves as a "doctor," they must clearly explain they are not a medical doctor. I.e. a nurse practitioner with a doctorate in nursing would clearly communicate they are not a medical doctor, MD or DO but instead have a doctorate in nursing to avoid any confusion in the telehealth medical setting.

j. The patient should have a means to contact the EP, NEP, PA or NP who provides the service during the telehealth encounter to the patient, i.e. mailing or email address, telephone number of the EP, NEP, PA, NP or entity that they are working for where the patient received care.

k. The specialty of the physician providing the care must be clearly communicated. The board status of the physician (boarded or not and by what board) should be clearly stated. If the person providing the care is a PA or NP this should be clearly stated electronically or verbally to the patient or guardian of the patient.

l. Provide instructions on how and where to receive follow up care and emergency care. Specific instructions should be given regarding what primary care or specialty physician, non-physician provider, medical practice, clinic or telehealth visit to follow up with and the time interval for follow up or subsequent visits. If the patient's condition worsens, provide criteria for immediate follow up (call 911 or immediately go to ER). While there are present attempts to create safe harbors and exclusions in the Anti Kickback and Stark physician anti-self-referral statutes, these exclusions and safe harbors have not yet been enacted; therefore, telehealth EPs, NEPs, PAs and NPs should refer the patient for the most appropriate follow up in the most appropriate time frame, and make every effort possible to avoid, or avoid even the appearance of, referring the patient to an entity in which the EP, NEP, PA or NP has a financial benefit or a referral in which the EP, NEP, PA or NP receives a benefit or financial incentive.

m. The telehealth emergency physician, NEP, PA and NP should have an escalation protocol to follow in the event of connection or equipment failure, and have a method or policy for emergency response for addressing immediate life threatening conditions i.e. collapse, suicide ideation, imminent deterioration, etc.

n. How to obtain copies of and access to medical records and/or have medical records transmitted to another physician, PA or NP.

o. Privacy of individually identifiable healthcare records must be maintained and patient should be informed of privacy policy and/or protection.

p. An appropriate medical record of the encounter needs to be created and maintained as required based on established laws, regulations and appropriateness of encounter or based on what is customary in the practice of the emergency physician, NEP, PA or NP providing the care. This should be created by the emergency physician, NEP, PA or NP on hospital or non-hospital provided medical records or charting system.

    Medical Records typically should include at a minimum the following:

    1. Medical Records should be generated in an appropriate format consistent with an acceptable standard of care for an office-based or emergency department patient encounter.
    2. A complaint-specific History and Physical Exam (PE) should be documented as is appropriate, based upon the technology appropriate and available to the EP, NEP, PA or NP for any particular patient complaint(s).
    3. Documentation of assessment, plan, impression, discharge instructions, prescriptions and follow-up care should be included.
    4. Medical Records should be stored in a secure manner and be available for review or transfer to patient or secondary provider.

q. Prescriptions should be documented in the discharge plan and/or medical record.

r. Conduct an appropriate, real time examination to provide the Telehealth EP, NEP, PA and/or NP sufficient clinical information in order for them to practice at an acceptable level of skill and safety. The EP, NEP, PA or NP exam and practice of medicine during any emergency telehealth encounter should meet, or exceed, the standard of care of an emergency or acute unscheduled encounter when reasonably possible under most ordinary conditions (exceptions may occur under extraordinary circumstances such as disasters, public health emergencies, etc.). If any circumstances prevent the EP, NEP, PA or NP from meeting the standard of care during the telehealth encounter for whatever reason, the EP, NEP, PA or NP should immediately arrange for, or direct the patient or originating personnel to, transport of the patient to the ED, or other appropriate facility, so that the standard of care can be met.

    1. Establish a diagnosis through use of acceptable medical practices via appropriate history taking, physical examination, using peripherals if necessary including but not limited to a camera, voice transmission, an otoscope, a stethoscope, an ophthalmoscope, remote vital signs,

oximeter, ECG and /or any combination of the above or other device or tool as necessary. If unable to reach a diagnosis or exclude significant risks with reasonable certainty with the information and equipment available, refer the patient for further evaluation and/or testing within an appropriate time frame, i.e. immediately by calling 911 or directing patient to proceed to ED or next day/week follow up with a specific physician, clinic, facility, etc.

2. Discuss the diagnosis with the patient
3. Discuss treatment recommendations/options with patient (guardians or clinical surrogate if applicable) along with risks and benefits.
4. When applicable and originating site personnel capable and authorized, initiate treatment, i.e. IV fluids, medications, immobilization, burn or wound care, etc.

s. Ethics. Anyone involved in a telehealth encounter, whether emergency physician, NEP, PA, NP, company, hospital, communication provider, etc., should practice and behave in an ethical manner. Consideration and efforts should be made to apply telehealth in a manner to minimize disparities between patients regardless of a patient's insurance status, race, national origin, age, religion, political affiliation, home address (or lack of), or socioeconomic status. When in doubt, use good judgment and common sense to do what is best for the patient under the circumstances present.

PHASE II:

2) Identify various settings in which Telehealth can occur and make modifications to the above that make them more appropriate/suitable for those settings.
    a. Emergency Department
        1. Same facility
            a) Tele-Triage
            b) Tele-Residency
            c) Tele-EM for efficiency and ePPE, expertise, supervision
            d) Other
        2. Distant facility
            a) Tele-Triage
            b) Tele-Residency
            c) Tele-EM (expertise/supervision for others)
            d) Other
    b. Hospital setting
    c. Acute care settings
    d. Home setting, i.e. patient's home

e. Pre-hospital EMS
f. Disaster setting
    1. Hurricane
    2. Flood
    3. Tornado
    4. Chemical spill
    5. Fire
    6. Radioactive
    7. Infectious outbreak
    8. Man-made disaster vs. natural vs. hybrid
g. Maritime setting
h. Aeronautical setting
i. Medical System Transfer Command Center (Tele-Transfer)
j. Events (local and distant)
k. Wilderness
l. Hospice setting
m. Nursing Home, Assisted living
n. Critical Care
o. Shelter
p. Schools
q. Businesses
r. Correctional facilities
s. Military
t. Refugee camps
u. Immigration holding facilities
v. Other

PHASE III:

3) Identify specific clinical presenting conditions
    a. Most common complaints
        1. Cough
        2. Congestion
        3. Sore throat
        4. Other complaints that may lead to URI diagnosis
        5. Eye pain/redness
        6. Ear pain
        7. Breathing problems/short of breath/asthma flare up
        8. Dental pain
        9. Rash-, zoster, bites, impetigo, fungal, warts, cellulitis, parasites
        10. Headache
        11. Back pain

12. Chest pain
13. Psych-anxiety, insomnia, depression
14. Peds- croup, bronchiolitis, UTI, URI, fever
15. Abdominal pain, diarrhea, vomiting
16. Infectious-fever, Lyme, Zika, influenza, dysuria, travel health, yellow fever
17. Medication refill
18. OB/Gyn related c/o- hyperemesis, vaginitis, urinary incontinence, UTI
19. Tobacco cessation
20. Musculoskeletal
21. Diabetic hypoglycemia
22. Medication-assisted treatment (MAT), substance abuse
23. Other

b. Organ system approach
    1. Neurologic
    2. Cardiovascular
    3. Pulmonary
    4. Gastrointestinal
    5. Genitourinary
    6. Musculoskeletal
    7. Endocrine
    8. Immune/Lymphatic
    9. Integumentary

c. Age based
    1. Infant
    2. Child
    3. Adolescent
    4. Young adult
    5. Adult
    6. Elderly
    7. Geriatric

d. Gender or “Condition” based
    1. Male
    2. Female
        aa. Pre-puberty
        bb. Puberty/menopausal
        cc. Pregnancy
        dd. Post-menopausal
    3. Transgender
    4. Immunocompromised
    5. Cancer
    6. Hospice

Part Three: Practice Guidance, Specialist Telehealth in the Emergency Department & Future Direction of Emergency Telehealth & Acute Unscheduled Care

I) General Practice Guidance Applicable for all Emergency Telehealth & Acute Unscheduled Care Telehealth Encounters

Background and principles: As a general principle, all rules regarding general issues in emergency telehealth such as qualifications of physicians, consent, patient privacy, access to medical records and related issues should reflect the same rules and guidelines concerning non-telehealth physician-patient interactions. Additionally, some additional considerations must apply to the unique nature of the telehealth encounter. Therefore, this task force recommends the following rules and guidance:

1) Credentialing: Physicians practicing telehealth at any particular institution must be credentialed to physically practice medicine at that institution and/or have telemedicine privileges. Telemedicine credentialing should be based upon similar criteria as that for physicians credentialing for traditional privileges. In some scenarios, credentialing by proxy may be a reasonable option.

2) Board certification/board eligibility: ACEP believes that physicians who begin the practice of emergency medicine in the 21st century must have completed an accredited emergency medicine residency training program and be board certified, or eligible for certification, by the American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM).

3) Licensing: At the present time in the United States, it is generally accepted that physicians providing telehealth care must be licensed in the state that the patient is physically located at the time of the encounter. ACEP's Emergency Telehealth Section supports a national licensing standard that would allow physicians to practice in all 50 states and all US territories which would ease the burden qualified and willing EPs and NEPs face in order to provide telehealth services. Such a licensing standard would increase access to specialty care and help provide emergency telehealth services from board-certified physicians to residents of rural areas and other underserved communities that currently are unable to receive such services in a timely manner, if at all.

4) Privacy, confidentiality, portability of medical records:
    a. Telehealth interactions have the same requirements for privacy and confidentiality of the encounters themselves and of medical records generated

by these encounters as do traditional medical encounters per local, state and federal regulations.

b. Telehealth interactions raise additional confidentiality risk in terms of cybersecurity breaches of telehealth interactions and their records. All telehealth programs must include adequate point-to-point encryption of real-time data transmission and mechanisms to protect patient confidentiality of electronic medical records per local, state and federal regulations at the time of the encounter. Telehealth entities (hospitals, private companies) are responsible for maintaining anti-virus software, privacy of patient health information, the security of electronic devices used in telehealth and the employees or contractors they employ or contract with to provide services and must report a lost or stolen device or any breach of privacy or other kind as required by law or industry guidelines.
c. Business Associate Agreements (BAAs) should be made and in place prior to providing telehealth encounters. Waivers can be made under extraordinary circumstances, i.e. public health emergencies (PHE) such as the COVID-19 declared PHE. Covered health care entities that seek additional privacy protections for telehealth while using video communication products should provide such services through technology vendors that meet federal, state and/or local privacy requirements i.e. HIPAA and will enter into BAAs in connection with the provision of their video communication products.

5) Telehealth informed consent
It is recommended that the EP, NEP, PA and NP familiarize themselves with the informed consent standards and procedures of the facility or entity (hospital or non-hospital, company) for whom they provide telehealth services to assure that consent has been obtained prior to their involvement or to obtain consent themselves from the patient or guardian at the initiation of the telehealth encounter/visit. For example, when patients are registered at a hospital and consent to care, remote consultations are typically part of the consent form. If the physician is unclear or uncertain if the patient has provided consent or the patient is unclear about consent for the telehealth encounter, we recommend obtaining consent from the patient and/or guardian.

6) Support of research of clinical telehealth, and use of the “reasonable application” standard:
    a. At the present time, there is sparse research as to the correlation of telehealth encounters vs. traditional encounters.
    b. For this reason, the Telehealth Section strongly emphasizes the need for research and quality assurance efforts to validate the clinical accuracy, safety and efficacy of emergency telehealth encounters.
    c. Clinical practice within the telehealth format should, whenever possible, be based upon accepted practice in traditional encounters and validated in telehealth practice or trials using a telehealth format.

d. Until such validated research results are available and best practices can be established on verifiable clinical telehealth data and studies, clinical encounters via telehealth should be based upon a "reasonable application standard", meaning that it is "reasonable" to extrapolate evidence-based practices in traditional medicine to practice in a telehealth format.
e. Best for the patient standard. Another logical method would be for the EP, NEP, PA or NP to apply a high standard of ethics and use his or her knowledge and expertise in emergency medicine, known information, best medical judgment and common sense to do what is best for the patient.

7) When making remote medical decisions, we recommend EPs, NEPs, PAs and NPs use whatever technology or equipment that is necessary and available to them to reach an accurate diagnosis, or exclude significant risk, with a high degree of certainty and recommend an appropriate treatment plan. The technology or equipment must at least meet any minimum requirements that may exist in federal, state or local law/requirements. In DC it is required to have frame rate of 30 frames per second and latency less than 300ms. If the EP, NEP, PA or NP is unable to provide what he or she believes to be an appropriate evaluation and care due to the lack of technology, equipment or adequate testing, it is recommended that the EP, NEP, PA or NP refer or arrange for, as clinically appropriate, the transport of the patient to a higher level of care, i.e. hospital emergency department, so that the patient can receive the appropriate evaluation, testing, care and treatment that may be necessary as would be done in a traditional in-person visit.

8) There are inherent limitations to evaluation of patients using a telehealth platform. When utilizing telehealth and digital health technologies, providers should be expected to either obtain sufficient information to make a treatment plan or an actionable next step for the patient. In the absence of sufficient information, as is consistent with the standard of care of all other health delivery mechanisms, a referral for an in-person evaluation and/or further testing to obtain further information should be taken.

9) We recommend EPs, NEPs, PAs and NPs clearly document any limitations present during the telehealth encounter, how any limitations impacted the medical decision making and what was done to assure that the patient received appropriate care, i.e. 911 called to location, referred to ER immediately, scheduled to see orthopedist following day, etc.

II) <u>Practice Guidance Specific to Specialist Telehealth Consultations in the Emergency Department:</u>

It is anticipated that there will be additional telehealth consultation services for emergency departments in the future and additional need and demand for emergency physicians outside of the traditional bricks and mortar emergency

departments. As in our general recommendations and guidance for telehealth services, the ACEP Emergency Telehealth Section acknowledges that telehealth consultations by specialists should reflect best practices by emergency physicians and specialists in the emergency department. If best practices are not yet established for any particular telehealth specialty, until there are, it is reasonable to expect that any specialist providing telehealth services will apply the standard of care that is applicable to his or her specialty at said time when telehealth care is provided as would be done in the traditional practice (non-telehealth) of that specialty. In addition, some unique aspects of the telehealth interaction are considered in our recommendations:

1) As a general rule, all patients in the emergency department should be evaluated by an emergency physician. This includes patients who have telehealth consultations by specialists. For all patients in the ED, the EP is the attending physician and has final say over the care and management of the patient unless care is explicitly transferred to the consultant, i.e. for admission or ED-based transfer.

2) There must be clear designation of responsibility for maintenance and engagement of telehealth equipment for specialty consultations. This responsibility lies with the facility or entity i.e. hospital

3) Specialists are required to document their consultations similarly to in-person encounters. It is recommended that specialists do so in real time particularly with time-sensitive matters, i.e. tele-stroke, tele-radiology, tele-trauma, tele-surgery, tele-orthopedics, etc.

4) Emergency physicians and specialists providing telehealth consultations for emergency department patients should be able to interact as much as possible as if the specialist was physically in the emergency department.

5) There should be someone qualified and designated as a telehealth exam facilitator or presenter at bedside where the patient is located to assist the emergency physician, NEP, PA or NP with the emergency telehealth encounter/visit, i.e. Telehealth Presenter.

6) Informed Consent:
    a. Specialist evaluation: As a general rule, consent to interact with a specialist consultant is the same as with a specialist consultant in the ED—for evaluation itself there is implied consent by submitting to the examination and written consent is not needed. In addition, the emergency doctrine applies, I.e. a patient having an acute CVA stroke

does not need written consent to be seen by a neurologist either in person or via a telehealth encounter.

b. Need for written consent for treatment via a telehealth encounter should make medical and legal sense and be consistent with the need for consent in a traditional interaction. For example, the need for written consent from a patient or healthcare POA for TPA for acute CVA should be the same if the neurologist were physically present, this includes obtaining written consent or not obtaining written consent based upon the emergency doctrine.

c. For imaging studies read by tele-radiologists with medical staff radiologist over-reads, patients and families should be informed that the results are a preliminary reading by a tele-radiologist, and that a medical staff radiologist will re-read the film within 24 hours, and that the patient will be contacted if any new findings. Any tele-radiology reading must be provided to the EP, NEP, PA or NP caring for the patient in real time and in written form (even if hand written and faxed or electronic form that cannot be altered) for safety and other reasons particularly when time is of the essence, i.e. CVA

d. Transmission of photos of patients should take place on a secure platform that complies with applicable laws and all efforts should be made to eliminate or minimize any identifying characteristics. A Business Associate Agreement (BAA) should be in place with the platform provider and the emergency physician, NEP, PA, NP or whomever will be using the platform transmitting private information. Direct to consumer platforms already have this functionality. If the photo has to be taken and sent with the EP's, NEP's, PA's or NP's personal phone, it should be done with a secure app. If not possible, images should be erased from the phone as soon as possible. Prior consent to take and transmit a photo should be obtained from the patient. If under emergency circumstances, clinical circumstances and judgment dictate deviation from a secure or compliant transmission, documentation of such and patient or guardian consent in writing is recommended.

III-Future Directions

This guidance is a first step and was based on expert consensus because the ACEP Emergency Telehealth Section was not aware of, or able to find, established, generally accepted best practices, standards, guidelines or guidance when reviewing the literature. We believe, expect and hope that this guidance will undoubtedly need to be broadened and updated in the future.

This guidance will serve as a foundation on which future work can be built and further the ethical practice of quality emergency medicine and acute unscheduled care using telehealth. As emergency telehealth and acute unscheduled care expands into arenas we predict and arenas that may not yet be envisioned, as more research is done and best practices are established, guidelines and standards can be introduced and added to this work. Various areas that will need to be addressed include:

1) Guidance, guidelines and standards for emergency and acute unscheduled care telehealth for patients outside of the walls of brick and mortar emergency departments.
2) Guidance, guidelines and standards for the use, expectations and documentation of telehealth peripherals including but not limited to monitors, EKGs, pulse oximetry, electronic stethoscopes, otoscopes, ophthalmoscopes and cameras, remote ultrasound, point of care (POC) testing, etc.
3) Guidance, guidelines and standards for emergency telehealth and acute unscheduled care regarding electronic health records (EHRs) and operation space, how they must be modified and changed to properly capture the telehealth encounter.
4) Guidance, guidelines and standards for emergency and acute unscheduled care telehealth regarding proper coding, billing and reimbursement specific to telehealth. All services that are provided should be billed and reimbursed with parity to the in-person equivalent.
5) Universal, or a national, licensing mechanism needs to be developed and expedited to minimize impedance of emergency and acute unscheduled care telehealth to maximize access to, and options for, patients and the public.
    a. Currently, any EP or NEP must check with the state medical board in the state in which he or she plans on treating patients before doing so to ensure compliance with state licensing laws.
        1. States may require a full medical license, a telemedicine license, a license in a neighboring state or federal agency, or no licensing at all depending on the circumstances.
        2. The Federation of State Medical Boards is a resource that provides helpful information but is not the ultimate authority; the medical licensing board in the state is.
    b. There is an Interstate Medical Licensure Compact that includes twenty-seven (27) states (plus Guam) as of August 2020.
        1. 24 states serve as States of Primary License (SPL) and issuing licenses
        2. 3 are non-SPL states that issue licenses.
        3. These states include: Alabama, Arizona, Colorado, Georgia, Guam, Idaho, Illinois, Iowa, Kansas, Maine, Maryland, Michigan,

Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, North Dakota, Oklahoma, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.

c. For more information go to Interstate Medical Licensure Compact website at **https://www.imlcc.org/**