Telehealth: Are you at risk?

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"In a health care milieu of cost containment, early discharge, and fewer home health resources, telemedicine (TM) technology can facilitate the work of home health nurses, advanced practice nurses (APNs), and in-hospital areas." The pressures to contain health care, including the early discharge of patients, combined with the closing of many home health care agencies, create higher demands for home health care at a time when such care is rapidly becoming less available. Telemedicine may help to close the gap between demand and availability of home health care services. It may also provide opportunities for the work of community health nurses and advanced practice nurses at reduced cost.

Telehealth is defined as the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education by using interactive audio, video, and data telecommunications. As early as the 1900's, military physicians used electrocardiograms to treat soldiers in combat areas. Currently, modern telecommunications technology is used extensively to provide health care at a distance by telehealth specialists practicing in emergency departments, correctional institutions, rural medical clinics, and military facilities. Telecommunications modalities used in telehealth include telephone, facsimile, cellular phones, video phones, computers, teleconferencing, video conferencing, and interactive television.

Teleconsulting
Teleconsulting is the practice of nurse consultation over distance using telecommunications technology. Teleconsulting encompasses a wide variety of activities including simple acts such as faxing medical records to more complex activities such as teaching via satellite to distant campuses, and delivering nursing care from off-site to patients' homes through the use of cameras and computer technologies. Perhaps, the most common use of teleconsulting is by managed care organizations that use "nurse triage" systems with centralized phone banks as a means to reduce unnecessary use of emergency rooms and walk-in clinics.

Nurses take calls from thousands of beneficiaries, and in some cases from states in which the nurses' licenses may not extend. They assess the patient's condition and determine the type of intervention needed. Decisions are made regarding immediate treatment, scheduling of appointments, and home management alternatives.

Telephone triage by a nurse, whether for an HMO or in a private office practice, does carry significant risk. The nurse's primary responsibility in telephone triage is (1) to determine the patient's appropriate level of care based on the chief complaint, history and presenting symptoms, and (2) to provide appropriate advice based on the patient's assessed needs. This advice may range from referral to an emergency room to provision of self-care treatment options and patient education. Telephone triage only provides advice and not a medical diagnosis. Besides adequate training, nurses performing telephone triage should have written clinical and telephone management guidelines available to guide them in the decision making process.

There are triage software systems with algorithmic capabilities that assist the nurse in determining the appropriate advice. However, triage software should not be considered a substitute for the nurse's clinical judgment and experience.

While the above telehealth nursing actions may be appropriate and legal in the state in which the nurses are licensed, they may violate the nursing licensure law of the states in which the clients reside. If a health care professional does not obtain a license to practice in a state but provides health care in that state, whether acting personally or through electronic means, she may face civil and criminal penalties, sanctions, and invalidate her malpractice insurance. Even though both state and federal governments significantly regulate health care, there are currently very few regulations published clarifying the legalities of telehealth.

This article is a brief historical perspective of the evolution of telehealth, barriers to implementation, and current solutions being proposed to regulate telehealth practice. It includes related liability issues, case reviews and some recommendations to help limit risk.

Historical Background

The United States Constitution reserves to states the right to establish laws in areas not assigned to the federal government. As early as the 1800's, states have used this authority to enact laws to regulate health care providers to help protect their citizens from unsafe or incompetent practitioners. Regulatory boards were established to develop standards, educational requirements, criteria for entry into the profession, and discipline non-complying licenses.

The current model for state-by-state licensure, however, does not permit telehealth practice across state lines. The model requires health care providers to be licensed in each state in which they practice. Nurses who practice in more than one state must have multiple licenses. Multiple licensure can be expensive and impractical for nurses who practice teleconsulting and computer consultation involving patients from many numerous states. Consequently, nurses may not seek licensure in additional states, which means that they are not complying with existing licensure laws and state practice acts.

Telehealth's exponential growth has propelled boards of nursing and medicine to explore multistate licensing and regulations. Additional incentive to develop multistate licensing occurred in March 1997, when Senate Bill 2171 was introduced into Congress to provide reimbursement for telehealth services under the Medicare program. In addition, the Bill directed the Secretary of Health and Human Services to conduct a study on telehealth licensure issues, barriers to practice, and federal remedies to eliminate barriers to interstate telehealth practice. More recently, the passage of the Telehealth Improvement Act of 1999 accentuated federal interest in reducing licensure barriers to the implementation of telehealth practice.

Federal regulation of telehealth practice under the supremacy clause of the 10th amendment to the Constitution would effectively over ride state authority in this area.

Licensing, Credentialing, and Standards of Practice

Licensing, credentialing, and practice standards are major barriers to the implementation of telehealth practice because regulations vary from state to state. In an effort to provide solutions in these areas, the Board of Nurse Examiners and the National Council of State Boards of Nursing are working together. They are considering the Nurse Multistate Licensure Agreement, a recognition model as one means to reduce licensure barriers. Multistate licensure is a system of licensure in which a single license allows a nurse to practice in more than one state. The Model allows practice, whether physical or electronic, across state lines through the nurse being licensed in a state that has adopted the interstate model.

The National Council of State Boards of Nursing is also considering the Interstate Compact on Nurse Licensure as a means to reduce licensure barriers to the implementation of telehealth practice. The Interstate Compact is an agreement between two or more states to coordinate activities associated with nurse licensure. The Compact allows for "mutual recognition" of nursing licensure among party states that agree to the compact. Nurses licensed in one party state are authorized to practice in all party states. Licensure is granted by the nurse's state of residence, regardless of the state(s) in which the nurse actually practices. A Coordinated Licensure Information System (CLIS), administered by a non-profit organization composed of state nurse licensure boards, will collect, store and make available information on nurses and applicants.

To view information on the current status of the State Compact Bill, the text of the bill, the status of bills introduced in different states in order to enact the Compact, click on http://www.ncsbn.org/public/regulation/mutual_recognition.htm

The following states have enacted legislation to implement the interstate nurse license compact: Arizona, Arkansas, Delaware, Idaho, Iowa, Maine, Maryland, Mississippi, Nebraska, North Carolina, North Dakota, South Dakota, Texas, Utah, and Wisconsin. The rest of the states have introduced legislation regarding the compact.

It may take years, however, before either of the above models is accepted and established. In the interim, telehealth providers may help reduce their liability exposure by determining whether an exemption, endorsement or a full license is required to practice within each state's jurisdiction by contacting the health department's nurse licensure authority. In addition, they should comply with each state's laws and state board recommendations governing the practice of telehealth. Lastly, they should become familiar with and apply both community and national standards of telehealth practice.
Patient Confidentiality/Record Keeping

Laws regarding emancipation, privacy, access to medical information, and rules regarding what specific information the provider must give before local informed consent requirements are met differ from one jurisdiction to another. In addition, computer-based medical records are not error-free and potentially allow for unique mistakes and security concerns. Also, the risk of losing data and invasion of privacy is greater when using the Internet for transmitting medical records. Telehealth provider's may reduce their liability risk by becoming knowledgeable and adhere to both applicable state laws and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards that regulate patient confidentiality, medical liability, security measures and medical record retention. They should inform patients of the hazardous nature of the Internet, as well as, ensure that security procedures for medical records and computers are maintained.

Case Law

A difficult issue for a court to resolve in a medical malpractice case involving patient injuries resulting from telehealth practice is which state's laws and regulations to apply in a multi-state treatment scenario. A court may have appropriate jurisdiction over a defendant health care provider usually resolves this issue by applying its state's choice of law procedures. Generally, this means that a court with appropriate jurisdiction in a case where the patient and health care provider are located in two different states is the state court where the patient lives and the health care provider is shown to be doing business in that state. The usual procedure for that court to apply its choice of law where a conflict of which laws to apply arises as in this case.

The laws of the state having the greatest interest in the medical malpractice claim are applied. This is usually where the injury has occurred, which, in most cases of telehealth, will be where the patient lives is and calling from. If courts allow cases to proceed under the laws of the patients' states, the state health care providers may lose any protective or advantageous measures under their own state laws.

In the past, merely receiving and providing simple consultations by telephone could not create a provider-patient relationship. Current case law, however, suggests that the more involvement a health care provider has with a patient's actual treatment or diagnosis, the more likely a provider-patient relationship can be implied. In Shannon v. McNulty, an obstetrical patient contacted the HMO's nurse call line on three consecutive days complaining of irregular and increasing abdominal and back pain. For the first two calls, a triage nurse instructed the patient to contact her primary obstetrician. The patient's third call was directed to an orthopedist who advised the patient to go to the emergency room of a nearby hospital. Upon arrival at the hospital, the patient was evaluated by the orthopedist and by a staff member from an obstetrical unit. Subsequently, she was admitted to the hospital. Later that evening, the patient delivered a premature 1 1/2 pound infant who died after two days. The patient sued the HMO and the obstetrician for failure to diagnose and treat her preterm labor that resulted in the death of her infant. The case was removed to the lower court for a new trial.

A non-resident defendant health care provider may be legally subject to the jurisdiction of a court pursuant to the state's long-arm statute and "minimum contacts" theory. A long-arm statute is one enacted by a state that gives the state's courts jurisdiction over any person or corporation doing business in that state. However, there must be some minimum contacts by the nonresident defendant within the state by some purposeful act through which the nonresident defendant avails himself of the benefits and protections of the laws of that state. Under the "fair warning" inquiry, the court had to determine whether the defendants purposely availed themselves of their privilege of conducting activities inside the state so as to invoke the benefits and protection of the state's laws. In this case, the only contact the defendants had with Illinois was a clerical worker's mailing of the plaintiff's mammogram report to her personal physicians in Illinois. The plaintiff, subsequently, learned she had cancer that had not been previously diagnosed. The plaintiff filed suit in Illinois against the Florida physicians who moved to quash, that is to void, the summons and to dismiss her complaint for lack of personal jurisdiction. Pursuant to Illinois' long-arm statute and prior rulings from the U.S. Supreme Court, the physician-defendants could be subject to the jurisdiction of the Illinois state court if they were found to have established "minimum contacts" within the state and if they had "fair warning" of the possibility of being sued there. Under the "minimum contacts" inquiry, the court had to determine:

1. whether the state was a reasonable forum for the litigation and
2. whether the lawsuit arose out of or was related to the defendants' contact with the forum state.

Under the "fair warning" inquiry, the court had to determine whether the defendants purposely availed themselves of the privilege of conducting activities inside the state so as to invoke the benefits and protection of the state's laws. In this case, the only contact the defendants had with Illinois was a clerical worker's mailing of the plaintiff's mammogram report to her personal physicians in Illinois. In fact, there was no evidence the physicians even knew the plaintiff resided or was being treated in Illinois.

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In another case, the court ruled the Texas physician had to respond to the malpractice suit in Kansas. As a result, the court ruled the Texas physician had to respond to the malpractice suit in Kansas.

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Providing telehealth consults can be fraught with potential liability issues. Currently, there are few regulations published clarifying the legalities of practicing across state and international boundaries. In the interim, civil and criminal penalties can be assessed against health care providers who do not comply with the unique laws of each state. In addition, practicing in a state without a valid license can invalidate one’s professional malpractice coverage making one personally liable for damage awards if sued.

Some malpractice insurance carriers and states may view telehealth as atypical practice. Consequently, premium rates may be increased and additional types of insurance may be required. Therefore, health care providers should determine from their malpractice carrier what type of insurance is needed in each state of practice, and inform malpractice insurance carriers of their telehealth activities, especially if multi-state, to ensure that their specific practices are covered.

Health insurance laws are also different in each state. Many states do not require insurance carriers to pay for telehealth services. However, California and Louisiana are two exceptions.\(^{27}\) Telehealth providers should determine whether telehealth is covered under the health insurance law of each state of practice and the individual health insurance plans of patient’s within their health care system, and inform patients of their insurance benefits and payment liabilities. An ongoing relationship should be developed with a qualified attorney and a risk manager to ensure ongoing legal compliance and to address quality improvement issues.

References

2. Supra note 1.
10. See e.g. KAN. STAT. ANN. 65-2803 (1997).
11. See Dent v. West Virginia, 129 U.S. 114 (1888) which upheld state medical licensing requirements.
12. U.S. Constitution; 10th Amendment.
13. Supra note 4.
14. Supra note 4.
15. Supra note 4.
17. Supra note 10.
20. See NEV. REV. STAT. ANN. Ch 129 (Miche 1993) and TEX. FAM. CODE ANN. 35.001 (West 1996).