



**Scott Walker,**  
**Governor**  
**Dave Ross, Secretary**

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**MEDICAL EXAMINING BOARD**  
**Room 121A, 1400 East Washington Avenue, Madison**  
**Contact: Tom Ryan (608) 266-2112**  
**February 17, 2016**

*The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Board.*

**AGENDA**

**8:00 A.M.**

**OPEN SESSION – CALL TO ORDER – ROLL CALL**

**A) Adoption of Agenda (1-5)**

**B) Minutes of January 20, 2016 – Review and Approval (6-14)**

**C) Administrative Updates**

- 1) Department and Staff Updates
- 2) Board Members – Term Expiration Dates
  - a) Mary Jo Capodice – 07/01/2018
  - b) Greg Collins – 07/01/2016
  - c) Rodney Erickson – 07/01/2015 (Appointed for Second Term)
  - d) Suresh Misra – 07/01/2015
  - e) Carolyn Ogland Vukich – 07/01/2017
  - f) Michael Phillips – 07/01/2017
  - g) David Roelke – 07/01/2017
  - h) Kenneth Simons – 07/01/2018
  - i) Sridhar Vasudevan – 07/01/2016
  - j) Timothy Westlake – 07/01/2016
  - k) Russel Yale – 07/01/2016
  - l) Robert Zondag – 07/01/2018
  - m) Bradley Kudick – Effective 07/01/2016 (Public Member)**
- 3) Introductions, Announcements and Recognition
- 4) Wis. Stat. s 15.085 (3)(b) – Affiliated Credentialing Boards' Biannual Meeting with the Medical Examining Board to Consider Matters of Joint Interest
- 5) Informational Items

**D) Elections, Appointments, Reappointments, Confirmations, and Committee, Panel and Liaison Appointments (15-17)**

- 1) Reappointment
  - a) Council on Physicians Assistants
    - 1) Jeremiah Barrett – Reappointment until 7/1/2016 (First Term 7/18/2012-7/1/2015)

- E) Legislative/Administrative Rule Matters (18-75)**
  - 1) Review and Respond to Clearinghouse Report and Public Hearing Comments Concerning Clearinghouse Rule 15-087 Relating to Telemedicine
  - 2) Update on Pending Legislation and Possible and Pending Rulemaking Projects
  
- F) Legislative Report (18-75)**
  - 1) Update on Senate Bill 568 and Assembly Bill 726 Relating to Board and Council Reorganization and Various Other Changes
  - 2) Update on Senate Bill 698 Relating to Duties and Powers of DSPTS
  - 3) Update on Assembly Bill 768 Relating to the Diagnosis and Treatment of Lyme Disease
  - 4) Update on Assembly Bill 852 Relating to Informed Consent for Performance of Certain Elective Procedures Prior to the Full Gestational Term of a Fetus and Other Provisions
  - 5) Senate Bill 268/Assembly Bill 364 – Prescriber PDMP Reporting
  - 6) Senate Bill 269/Assembly Bill 365 – Law Enforcement PDMP Reporting
  - 7) Senate Bill 271/Assembly Bill 367 – Methadone Reporting
  - 8) Senate Bill 272/Assembly Bill 366 – Pain Clinic Certification
  - 9) Assembly Bill 659/Senate Bill 522 – Opioid Treatment Programs
  - 10) Assembly Bill 660/Senate Bill 520 – Medical Examining Board Authority
  - 11) Assembly Bill 866/Senate Bill 709 – Prescription Refills
  
- G) Wis. Stat. § 448.14 Annual Report Requirement/Medical Examining Board – Calendar Year 2015 – Board Review for Approval (76-77)**
  
- H) Wisconsin State Coalition for Prescription Drug Abuse Reduction – Report from Timothy Westlake (78-81)**
  
- I) Interstate Medical Licensure Compact Commission – Report from Wisconsin’s Commissioners**
  
- J) Federation of State Medical Boards (FSMB) Matters (82-83)**
  - 1) FSMB 2016 House of Delegates and Annual Meeting – April 28-30, 2016 – San Diego, California – Consider Attendance
  
- K) Screening Panel Report**
  
- L) Newsletter Matters**
  
- M) Informational Items (84-116)**
  - 1) Sex and Gender Based Health: Integration of Evidence into Medical Education and Clinical Care
  
- N) Items Added After Preparation of Agenda**
  - 1) Introductions, Announcements and Recognition
  - 2) Administrative Updates
  - 3) Elections, Appointments, Reappointments, Confirmations, and Committee, Panel and Liaison Appointments
  - 4) Education and Examination Matters
  - 5) Credentialing Matters
  - 6) Practice Matters
  - 7) Future Agenda Items
  - 8) Legislation/Administrative Rule Matters
  - 9) Liaison Report(s)
  - 10) Newsletter Matters
  - 11) Annual Report Matters

- 12) Informational Item(s)
- 13) Disciplinary Matters
- 14) Presentations of Petition(s) for Summary Suspension
- 15) Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
- 16) Presentation of Proposed Decisions
- 17) Presentation of Interim Order(s)
- 18) Petitions for Re-Hearing
- 19) Petitions for Assessments
- 20) Petitions to Vacate Order(s)
- 21) Petitions for Designation of Hearing Examiner
- 22) Requests for Disciplinary Proceeding Presentations
- 23) Motions
- 24) Petitions
- 25) Appearances from Requests Received or Renewed
- 26) Speaking Engagement(s), Travel, or Public Relation Request(s), and Reports

O) Future Agenda Items

P) Public Comments

**CONVENE TO CLOSED SESSION to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02 (8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.).**

**Q) Request for Waiver of 24 Months of ACGME/AOA Approved Post Graduate Training**

- 1) Olusola Adedipe (**117-240**)

**R) Deliberation on Division of Legal Services and Compliance (DLSC) Matters**

- 1) Monitoring
- 2) **Complaints**
  - a) 15 MED 278 – Michael H. Malek, M.D. (**241-243**)
- 3) **Administrative Warnings**
  - a) 13 MED 501 – R.S. (**244-245**)
  - b) 14 MED 580 – D.H. (**246-247**)
  - c) 15 MED 052 – S.A.H. (**248-250**)
  - d) 15 MED 344 – R.S.S. (**251-252**)
- 4) **Proposed Stipulations, Final Decisions and Orders**
  - a) 13 MED 187 – Vance A. Masci, M.D. (**253-258**)
  - b) 13 MED 492 and 15 MED 310 – Nosheen Hasan, M.D. (**259-266**)
  - c) 14 MED 251 – Waleed S. Najeeb, M.D. (**267-273**)
  - d) 14 MED 274 – Leonardo Aponte, M.D. (**274-282**)
  - e) 14 MED 383 – Jonathan Hayward, P.A. (**283-288**)
  - f) 14 MED 559 – James R. Feltes, M.D. (**289-295**)
  - g) 15 MED 186 – Jeremias B. Vinluan, M.D. (**296-303**)
- 5) **Case Closings**
  - a) 14 MED 060 (**304-310**)
  - b) 14 MED 220 (**311-318**)
  - c) 14 MED 530 (**319-330**)
  - d) 14 MED 601 (**330-333**)

- e) 15 MED 030 **(334-338)**
- f) 15 MED 053 **(339-345)**
- g) 15 MED 083 **(346-348)**
- h) 15 MED 084 **(349-351)**
- i) 15 MED 086 **(352-354)**
- j) 15 MED 087 **(355-357)**
- k) 15 MED 088 **(358-360)**
- l) 15 MED 089 **(361-363)**
- m) 15 MED 090 **(364-366)**
- n) 15 MED 091 **(367-369)**
- o) 15 MED 092 **(370-372)**
- p) 15 MED 104 **(373-384)**
- q) 15 MED 161 **(385-395)**
- r) 15 MED 212 **(396-398)**
- s) 15 MED 244 **(399-411)**
- t) 15 MED 288 **(412-417)**
- u) 15 MED 308 **(418-420)**

**S) Open Cases**

**T) Consulting With Legal Counsel**

**U) PLANNED PARENTHOOD OF WISCONSIN, INC., et al., Plaintiffs-appellees, v. BRAD D. SCHIMEL, Attorney General of Wisconsin, et al., Defendants-Appellants – Consulting with Amber Cardenas, Board Legal Counsel (421-422)**

**V) Deliberation of Items Added After Preparation of the Agenda**

- 1) Education and Examination Matters
- 2) Credentialing Matters
- 3) Disciplinary Matters
- 4) Monitoring Matters
- 5) Professional Assistance Procedure (PAP) Matters
- 6) Petition(s) for Summary Suspensions
- 7) Proposed Stipulations, Final Decisions and Orders
- 8) Administrative Warnings
- 9) Proposed Decisions
- 10) Matters Relating to Costs
- 11) Complaints
- 12) Case Closings
- 13) Case Status Report
- 14) Petition(s) for Extension of Time
- 15) Proposed Interim Orders
- 16) Petitions for Assessments and Evaluations
- 17) Petitions to Vacate Orders
- 18) Remedial Education Cases
- 19) Motions
- 20) Petitions for Re-Hearing
- 21) Appearances from Requests Received or Renewed

**RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION**

- W) Open Session Items Noticed Above not Completed in the Initial Open Session
- X) Vote on Items Considered or Deliberated Upon in Closed Session, if Voting is Appropriate
- Y) Delegation of Ratification of Examination Results and Ratification of Licenses and Certificates
- Z) **Board Member Training Presentation**

**ADJOURNMENT**

**ORAL INTERVIEW OF CANDIDATE(S) FOR LICENSURE**

**ROOM 124D/E**

**11:15 A.M., OR IMMEDIATELY FOLLOWING THE FULL BOARD MEETING**

**CLOSED SESSION** – Reviewing Applications and Conducting Oral Interviews of One (1) Candidate  
for Licensure – Dr. Simons & Dr. Yale

**NEXT MEETING DATE MARCH 16, 2016**

**MEDICAL EXAMINING BOARD  
MEETING MINUTES  
January 20, 2016**

**PRESENT:** Mary Jo Capodice, D.O.; Greg Collins; Rodney Erickson, M.D.; Carolyn Ogland Vukich, M.D.(*via GoToMeeting*); Michael Phillips, M.D.; David Roelke, M.D.; Kenneth Simons, M.D.; Sridhar Vasudevan, M.D.; Timothy Westlake, M.D.; Robert Zondag

**EXCUSED:** Russell Yale, M.D., Suresh Misra, M.D.

**STAFF:** Tom Ryan, Executive Director; Nifty Lynn Dio, Bureau Assistant; and other Department staff

**CALL TO ORDER**

Kenneth Simons, Chair, called the meeting to order at 8:00 a.m. A quorum of ten (10) members was confirmed.

**ADOPTION OF AGENDA**

**Amendments to the Agenda:**

- *Removed: TELECONFERENCE/VIRTUAL MEETING and updated year to 2016 from header*
- *Added: Additional material for Item T.1 Application Review*
- *Removed: Report from Speaking Engagements*
- *Added: Item G.8: Senate Bill 568 replaced pages 37-38 to include link*
- *Added: Item U.3.d: 15 MED 262 – Proposed Stipulation, Final Decision and Order*
- *Removed: Item U.4.h: 15 MED 278 – Case Closing*
- *Removing: Item R: Review of WARN00000416 DLSC Case # 13 MED 308*

**MOTION:** Mary Jo Capodice moved, seconded by Michael Phillips, to adopt the agenda as amended. Motion carried unanimously.

**MINUTES OF DECEMBER 16, 2015 – REVIEW AND APPROVAL**

**Amendments to the Minutes:**

- *Amendment: Michael Phillips attended in person*

**MOTION:** Sridhar Vasudevan moved, seconded by Robert Zondag, to approve the minutes of December 16, 2015 as amended. Motion carried unanimously.

**ELECTIONS, APPOINTMENTS, REAPPOINTMENTS, CONFIRMATIONS, AND  
COMMITTEE, PANEL AND LIAISON APPOINTMENTS**

**BOARD CHAIR**

**NOMINATION:** Sridhar Vasudevan nominated Kenneth Simons for the Office of Board Chair.

Tom Ryan called for nominations three (3) times.

Kenneth Simons was elected as Chair by unanimous consent.

**VICE CHAIR**

**NOMINATION:** David Roelke nominated Timothy Westlake for the Office of Vice Chair.

Tom Ryan called for nominations three (3) times.

Timothy Westlake was elected as Vice Chair by unanimous consent.

**SECRETARY**

**NOMINATION:** Sridhar Vasudevan nominated Mary Jo Capodice for the Office of Secretary.

Tom Ryan called for nominations three (3) times.

Mary Jo Capodice was elected as Secretary by unanimous consent.

<b>2016 ELECTION RESULTS</b>	
<b>Board Chair</b>	Kenneth Simons
<b>Vice Chair</b>	Timothy Westlake
<b>Secretary</b>	Mary Jo Capodice

**LIAISON APPOINTMENTS**

<b>2016 LIAISON APPOINTMENTS</b>	
<b>Professional Assistance Procedure (PAP) Liaison</b>	<b>Mary Jo Capodice</b> Alternate – <b>Michael Phillips</b>
<b>Office of Education and Examinations Liaison</b>	<b>Timothy Westlake</b> Alternate – <b>David Roelke</b>
<b>Website Liaison</b>	<b>Robert Zondag</b> Alternate – <b>Greg Collins</b>
<b>Credentialing Liaison(s)</b>	<b>David Roelke, Rodney Erickson</b> Alternate – <b>Russell Yale, Carolyn Ogland Vukich</b>
<b>Legislative Liaison</b>	<b>Timothy Westlake, Kenneth Simons, Greg Collins</b>
<b>Maintenance of Licensure Liaisons</b>	<b>Rodney Erickson, Carolyn Ogland Vukich</b> Alternate – <b>Mary Jo Capodice</b>
<b>Newsletter Liaison</b>	<b>Kenneth Simons</b> Alternate – <b>Robert Zondag</b>
<b>Monitoring Liaison</b>	<b>Mary Jo Capodice</b> Alternate – <b>Sridhar Vasudevan</b>
<b>Continuing Education Liaison</b>	<b>Rodney Erickson</b> Alternate – <b>David Roelke</b>
<b>Administrative Rules Liaison</b>	<b>Russell Yale</b> Alternate – <b>David Roelke</b>

<b>Prescription Drug Monitoring Program Liaison</b>	<b>Timothy Westlake</b> Alternate – <b>Sridhar Vasudevan</b>
<b>Travel Liaison</b>	<b>Greg Collins</b> Alternate – <b>Kenneth Simons</b>
<b>Controlled Substances Committee</b>	<b>Mary Jo Capodice, Rodney Erickson, Carolyn Ogland Vukich, Sridhar Vasudevan, Timothy Westlake</b>
<b>Appointed to Controlled Substances Board as per Wis. Stats. §15.405(5g) (MED)</b>	<b>Timothy Westlake</b>

**MOTION:** Sridhar Vasudevan moved, seconded by Michael Phillips, to affirm the Chair’s appointment of liaisons for 2016. Motion carried unanimously.

### **DELEGATION MOTIONS**

#### *Delegated Authority for Urgent Matters*

**MOTION:** Robert Zondag moved, seconded by David Roelke, that, in order to facilitate the completion of assignments between meetings, the Board delegates its authority by order of succession to the Chair, highest ranking officer, or longest serving member of the Board, to appoint liaisons to the Department to act in urgent matters, make appointments to vacant liaison, panel and committee positions, and to act when knowledge or experience in the profession is required to carry out the duties of the Board in accordance with the law. Motion carried unanimously.

#### *Council Delegation Motion*

**MOTION:** Robert Zondag moved, seconded by Carolyn Ogland Vukich, to delegate to the Board’s Councils and/or it’s liaisons the authority to review applications and conduct examinations of candidates for licensure and to make recommendations regarding the licensure of applicants based upon the application reviews and examinations. Recommended credential denials should be considered by the Medical Examining Board. This delegation motion is not intended to be exhaustive of the Councils’ advisory authority. Motion carried unanimously.

#### *Delegated Authority for Application Denial Reviews*

**MOTION:** Robert Zondag moved, seconded by Timothy Westlake, that the Board counsel or another department attorney is formally authorized to serve as the Board’s designee for purposes of Wis. Admin Code § SPS 1.08(1). Motion carried unanimously.

#### *Document Signature Delegation*

**MOTION:** Robert Zondag moved, seconded by Rodney Erickson, to delegate authority to the Chair or chief presiding officer, or longest serving member of the Board, by order of succession, to sign documents on behalf of the Board. In order to carry out

duties of the Board, the Chair, chief presiding officer, or longest serving member of the Board, has the ability to delegate this signature authority for purposes of facilitating the completion of assignments during or between meetings. The Chair, chief presiding officer, or longest serving member of the Board delegates the authority to Executive Director or designee to sign the name of any Board member on documents as necessary and appropriate. Motion carried unanimously.

### ***Credentialing Authority Delegations***

**MOTION:** Robert Zondag moved, seconded by Mary Jo Capodice, to delegate authority to the Credentialing Liaisons to address all issues related to credentialing matters except potential denial decisions should be referred to the full Board for final determination. Motion carried unanimously.

**MOTION:** David Roelke moved, seconded by Robert Zondag, to delegate credentialing authority to DSPS for those submitted applications that meet the criteria of Rule and Statute and thereby would not need further Board or Board liaison review. Motion carried unanimously.

### ***Monitoring Delegations***

**MOTION:** Sridhar Vasudevan moved, seconded by Greg Collins, to affirm the Chair's appointment of Mary Jo Capodice as the Monitoring Liaison, and Sridhar Vasudevan as the alternate, to adopt the 'Roles and Authorities Delegated to the Monitoring Liaison and Department Monitor; document as presented. Motion carried unanimously.

## **LEGISLATIVE/ADMINISTRATIVE RULE MATTERS**

### **Emergency/Permanent Scope for Med 13 Relating to Prescribing CME**

**MOTION:** Sridhar Vasudevan moved, seconded by Timothy Westlake, to approve the Scope Statement for an emergency and permanent rule on Med 13 relating to Continuing Medical Education for Prescribing Opioids for submission to the Governor's Office and publication, and to authorize the Chair to approve the scope for implementation no less than 10 days after publication. Motion carried unanimously.

**MOTION:** David Roelke moved, seconded by Greg Collins, to delegate to the legislative liaisons the ability to work with the legislature and other interested parties on a realignment of the reporting period for the 30 credit continuing professional development requirement. Motion carried unanimously.

## **REPORT FROM OPIOID PRESCRIBING COMMITTEE – RELATING TO A PROPOSED PAIN MANAGEMENT CONTINUING MEDICAL EDUCATION REQUIREMENT**

**MOTION:** Sridhar Vasudevan moved, seconded by David Roelke, to authorize Timothy Westlake or his designee from the Board to participate in the Wisconsin Health Systems Prescription Drug Abuse Reduction Coalition. Motion carried unanimously.

## CLOSED SESSION

**MOTION:** Robert Zondag moved, seconded by Sridhar Vasudevan, to convene to Closed Session to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02 (8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.). The Chair read the language of the motion aloud for the record. The vote of each member was ascertained by voice vote. Roll Call Vote: Mary Jo Capodice – yes; Greg Collins – yes; Rodney Erickson – yes; Carolyn Ogland Vukich – yes; Michael Phillips – yes; David Roelke – yes; Kenneth Simons – yes; Sridhar Vasudevan – yes; Timothy Westlake – yes; and Robert Zondag – yes. Motion carried unanimously.

The Board convened into Closed Session at 10:54 a.m.

## RECONVENE TO OPEN SESSION

**MOTION:** Sridhar Vasudevan moved, seconded by Carolyn Ogland Vukich, to reconvene in Open Session at 11:59 a.m. Motion carried unanimously.

## VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION

**MOTION:** David Roelke moved, seconded by Greg Collins, to affirm all motions made and votes taken in Closed Session. Motion carried unanimously.

## MONITORING MATTERS

### Jose Araujo, M.D. – Requesting Full License

**MOTION:** Sridhar Vasudevan moved, seconded by David Roelke, to grant the request of Jose Araujo, M.D. for removal of limitations from license. Motion carried.

### Mazin Ellias, M.D. – Requesting Full License

**MOTION:** Timothy Westlake moved, seconded by Michael Phillips, to grant the request of Mazin Ellias, M.D. for removal of limitations from license. Motion carried unanimously.

*(Sridhar Vasudevan recused himself and left the room for deliberation and voting in the matter concerning Mazin Ellias, M.D.)*

## APPEARANCE – APPLICATION REVIEW – FIDELIS IKEGWUONU

**MOTION:** Timothy Westlake moved, seconded by Michael Phillips, to deny Fidelis Ikegwonu's petition for approval by the Board to retake Step 2 of the USMLE pursuant to Wis. Admin. Code § Med 1.08. **Reason for Denial:** Fidelis Ikegwonu failed to present evidence satisfactory to the Board of further professional training or education. Fidelis Ikegwonu has not shown successful completion of an LCME or AOA accredited Medical School as required in Board

orders dated 11/24/14 and 02/02/15. The Board will not consider any further petitions in this regard prior to 02/01/2017. Motion carried unanimously.

**REQUEST FOR WAIVER OF 24 MONTHS OF ACGME/AOA APPROVED POST GRADUATE TRAINING**

**Nikolaos Chatzizacharias**

**MOTION:** Michael Phillips moved, seconded by David Roelke, to find that the training and education of Nikolaos Chatzizacharias is substantially equivalent to the requirements set forth in Wis. Stat. § 448.05(2)(b). Motion carried.

*(Kenneth Simons recused himself and left the room for deliberation and voting in the matter concerning Nikolaos Chatzizacharias.)*

**DELIBERATION ON DIVISION OF LEGAL SERVICES AND COMPLIANCE (DLSC) MATTERS**

**Complaints**

***14 MED 473 – Victor Ruiz, M.D.***

**MOTION:** Robert Zondag moved, seconded by Rodney Erickson, to find probable cause to believe that Victor Ruiz, M.D., DLSC case number 14 MED 473, has committed unprofessional conduct, and therefore to issue the Complaint and hold a hearing on such conduct pursuant to Wis. Stat. § 448.02(3)(b). Motion carried.

*(Kenneth Simons recused himself and left the room for deliberation and voting in the matter concerning Victor Ruiz, DLSC case number 14 MED 473.)*

***14 MED 607 – Paul Awa, M.D.***

**MOTION:** Michael Phillips moved, seconded by David Roelke, to find probable cause to believe that Paul Awa, M.D., DLSC case number 14 MED 607, has committed unprofessional conduct, and therefore to issue the Complaint and hold a hearing on such conduct pursuant to Wis. Stat. § 448.02(3)(b). Motion carried.

*(Greg Collins recused himself and left the room for deliberation and voting in the matter concerning Paul Awa, DLSC case number 14 MED 607.)*

**Administrative Warnings**

***15 MED 286 – J.M.P.***

**MOTION:** Timothy Westlake moved, seconded by Robert Zondag, to issue an Administrative Warning in the matter of DLSC case number 15 MED 286 – J.M.P. Motion carried unanimously.

***15 MED 335 – S.R.***

**MOTION:** Mary Jo Capodice moved, seconded by Michael Phillips, to issue an Administrative Warning in the matter of DLSC case number 15 MED 335 – S.R. Motion carried.

*(Kenneth Simons recused himself and left the room for deliberation and voting in the matter concerning S.R., DLSC case number 15 MED 335.)*

***15 MED 383 – M.A.S.***

**MOTION:** Robert Zondag moved, seconded by David Roelke, to issue an Administrative Warning in the matter of DLSC case number 15 MED 383 – M.A.S. Motion carried unanimously.

**Proposed Stipulations, Final Decisions and Orders**

***13 MED 367 – Gregg M. Gaylord, M.D.***

**MOTION:** Mary Jo Capodice moved, seconded by Robert Zondag, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Gregg M. Gaylord, M.D., DLSC case number 13 MED 367. Motion carried.

*(Sridhar Vasudevan recused himself and left the room for deliberation and voting in the matter concerning Gregg M. Gaylord, M.D., DLSC case number 13 MED 367.)*

***14 MED 120 – Eleazar M. Kadile, M.D.***

**MOTION:** Greg Collins moved, seconded by Michael Phillips, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Eleazar M. Kadile, M.D., DLSC case number 14 MED 120. Motion carried unanimously.

***14 MED 454 – Michael D. O'Reilly, M.D.***

**MOTION:** Michael Phillips moved, seconded by Timothy Westlake, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Michael D. O'Reilly, M.D., DLSC case number 14 MED 454. Motion carried unanimously.

***15 MED 262 – Wilton C. Calderon, M.D.***

**MOTION:** Sridhar Vasudevan moved, seconded by David Roelke, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Wilton C. Calderon, M.D., DLSC case number 15 MED 262. Motion carried unanimously.

***15 MED 277 – Andrew J. Weddle, D.O.***

**MOTION:** Greg Collins moved, seconded by Michael Phillips, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against

Andrew J. Weddle, D.L., DLSC case number 15 MED 277. Motion carried unanimously.

## Case Closings

### **CASE CLOSING(S)**

**MOTION:** Greg Collins moved, seconded by David Roelke, to close the following cases according to the recommendations by the Division of Legal Services and Compliance:

1. 13 MED 469 – S.H.I. *Prosecutorial Discretion (P5-Flag)*
2. 14 MED 246 – J.L.P. *Prosecutorial Discretion (P3)*
3. 15 MED 144 – K.D.D. *No Violation*
4. 15 MED 154 – K.S.C. *Prosecutorial Discretion (P4)*
5. 15 MED 183 – V.C. *No Violation*
6. 15 MED 252 – B.S.H. *Prosecutorial Discretion (P3)*
7. 15 MED 356 – M.S. *No Violation*

Motion carried unanimously.

### *15 MED 052*

**MOTION:** Rodney Erickson moved, seconded by Sridhar Vasudevan, to table DLSC case number 15 MED 052 against S.A.H. Motion carried unanimously.

### **PROPOSED FINAL DECISIONS AND ORDERS**

#### **Jonathan G. Peterson, M.D., Respondent**

**MOTION:** David Roelke moved, seconded by Michael Phillips, to adopt the Findings of Fact, Conclusions of Law, and Proposed Decision and Order in the matter of disciplinary proceedings against Jonathan G. Peterson, M.D., Respondent – DHA case number SPS-14-0092/DLSC case number 14 MED 029. Motion carried unanimously.

#### **Roger A. Pellmann, M.D., Respondent**

**MOTION:** David Roelke moved, seconded by Robert Zondag, to adopt the Findings of Fact, Conclusions of Law, and Proposed Decision and Order in the matter of disciplinary proceedings against Roger A. Pellmann, M.D., Respondent – DHA case number SPS-15-0057/DLSC case number 15 MED 025. Motion carried unanimously.

### **DELEGATION OF RATIFICATION OF EXAMINATION RESULTS AND RATIFICATION OF LICENSES AND CERTIFICATES**

**MOTION:** Robert Zondag moved, seconded by Mary Jo Capodice, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

### **ADJOURNMENT**

**MOTION:** Sridhar Vasudevan moved, seconded by Carolyn Ogland Vukich, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 12:02 p.m.

DRAFT

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Kimberly Wood, Program Assistant Supervisor-Advanced		<b>2) Date When Request Submitted:</b>  2/1/2016  Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting									
<b>3) Name of Board, Committee, Council, Sections:</b>  Medical Examining Board											
<b>4) Meeting Date:</b>  2/17/2016	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b>  Medical Examining Board – Council Member Appointment Matters 1) Council on Physician Assistants a. Reappointments i. Jeremiah Barrett									
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>  N/A									
<b>10) Describe the issue and action that should be addressed:</b>  The Board should determine how best to proceed with the reappointment of Jeremiah Barrett to the Council on Physician Assistants.  a. Reappointments ii. Jeremiah Barrett – Reappointment until 7/1/2019 (First term 7/18/2012 – 7/1/2015) 1. Motion Language: to reappoint Jeremiah Barrett to the Council on Physician Assistants as an Educator Member for a term to expire on July 1, 2019.											
<b>11) Authorization</b>  <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; border-bottom: 1px solid black;"><b><i>Kimberly Wood</i></b></td> <td style="width: 30%; border-bottom: 1px solid black; text-align: right;"><b><i>2/1/2016</i></b></td> </tr> <tr> <td style="font-size: small;">Signature of person making this request</td> <td style="font-size: small; text-align: right;">Date</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Supervisor (if required)</td> <td style="border-bottom: 1px solid black; text-align: right;">Date</td> </tr> <tr> <td colspan="2" style="border-bottom: 1px solid black;">Executive Director signature (indicates approval to add post agenda deadline item to agenda)    Date</td> </tr> </table>				<b><i>Kimberly Wood</i></b>	<b><i>2/1/2016</i></b>	Signature of person making this request	Date	Supervisor (if required)	Date	Executive Director signature (indicates approval to add post agenda deadline item to agenda)    Date	
<b><i>Kimberly Wood</i></b>	<b><i>2/1/2016</i></b>										
Signature of person making this request	Date										
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<b>Directions for including supporting documents:</b> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.											

## Jeremiah L. Barrett, MPAS, PA-C



### EDUCATION

1998-2001 Masters Physician Assistant Studies, Marquette University, Cum Laude

1993-1998 Bachelor of Science Biology, Indiana University

### TEACHING/LECTURES

-2010 – Current *Adjunct Faculty*, Marquette University Aurora Health Care Post Graduate Physician Assistant Emergency Medicine Program Lecturer

-2010 – Current *Clinical Assistant Professor*, Department of Physician Assistant Studies, Marquette University

- Course Director and Instructor – Introduction to Clinical Medicine, Clinical Medicine II, Clinical Decision-Making I&II. Develop syllabi, objectives, lecture content, assessment, and student advising

- Instructor – Introduction to Medical History and Physical Examination, Emergency Medicine and Clinical Decision-Making III

-2004 – 2010 *Adjunct Clinical Professor*, Department of Physician Assistant Studies, Marquette University

- Lecturer, Endocrine and Surgery Section of Clinical Medicine courses (2004-2010)

- Preceptor for Physician Assistant students interested in Endocrinology (2002-2010)

-2002 – 2010 *Clinical Preceptor*, Department of Physician Assistant Studies, University of Wisconsin

- Preceptor for Physician Assistant students interested in Endocrinology (2002-2010)

-2005 Lecturer, Continuing Medical Education Resources

- Teach Review Course for Physician Assistant National Certifying / Recertifying Examination

- Lecture topic Endocrinology

### CLINICAL EXPERIENCE

-2008 – Current *Physician Assistant*, Department of Endocrinology, Medical College of Wisconsin, Milwaukee, Wisconsin.

- Inpatient and outpatient endocrinology consultation service

-2002 – 2008 *Physician Assistant*, Midwest Endocrinology, St. Luke's Medical Center, Milwaukee, Wisconsin.

Inpatient and outpatient endocrinology consultation service

-2001 – 2002 *Physician Assistant*, Cardiology, Beloit Clinic, Beloit, Wisconsin.

Inpatient and outpatient cardiology consultation service

## **PROFESSIONAL AFFILIATIONS**

American Academy of Physician Assistants. Fellow member since 2001.

Alternate Wisconsin member to the House of Delegates in 2010 and student member of the House of Delegates in 2000.

Wisconsin Academy of Physician Assistants. Member since 1998.

Christian Medical and Dental Association. Member since 2000.

## **PROFESSIONAL LICENSURE AND CERTIFICATIONS**

Wisconsin Physician Assistant License. 10/2001 to present.

Certified by the National Commission on Certification of Physician Assistants, 10/2001. Recertified in 2007 and 2013.

Basic Life Support for Healthcare Providers certification-expires 11/2016.

## **COMMITTEES / SERVICE**

-Member, Didactic Curriculum Committee

-Member, Progress and Promotion Committee

-Member, Admissions Committee

-Liaison to the Milwaukee Public Health Department

## **REFERENCES**

Available upon request

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:  <b>Dale Kleven</b> <b>Administrative Rules Coordinator</b>		2) Date When Request Submitted:  <b>2/5/16</b>  Items will be considered late if submitted after 12:00 p.m. on the deadline date: ▪ 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections:  <b>Medical Examining Board</b>			
4) Meeting Date:  <b>2/17/16</b>	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? <b>Legislation and Rule Matters – Discussion and Consideration</b> <b>1. Review and Respond to Clearinghouse Report and Public Hearing Comments Concerning Clearinghouse Rule 15-087 Relating to Telemedicine</b> <b>2. Update on Senate Bill 568 and Assembly Bill 726 Relating to Board and Council Reorganization and Various Other Changes</b> <b>3. Update on Senate Bill 698 Relating to Duties and Powers of DSPS</b> <b>4. Update on Assembly Bill 768 Relating to the Diagnosis and Treatment of Lyme Disease</b> <b>5. Update on Assembly Bill 852 Relating to Informed Consent for Performance of Certain Elective Procedures Prior to the Full Gestational Term of a Fetus and Other Provisions</b> <b>6. Update on Pending Legislation and Possible and Pending Rulemaking Projects</b>	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both		8) Is an appearance before the Board being scheduled?  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:
10) Describe the issue and action that should be addressed:  2. Senate Bill 568: <a href="http://docs.legis.wisconsin.gov/2015/proposals/reg/sen/bill/sb568">http://docs.legis.wisconsin.gov/2015/proposals/reg/sen/bill/sb568</a> Assembly Bill 726: <a href="http://docs.legis.wisconsin.gov/2015/proposals/reg/asm/bill/ab726">http://docs.legis.wisconsin.gov/2015/proposals/reg/asm/bill/ab726</a>  3. Senate Bill 698: <a href="http://docs.legis.wisconsin.gov/2015/proposals/reg/sen/bill/sb698">http://docs.legis.wisconsin.gov/2015/proposals/reg/sen/bill/sb698</a>  4. Assembly Bill 768: <a href="http://docs.legis.wisconsin.gov/2015/proposals/reg/asm/bill/ab768">http://docs.legis.wisconsin.gov/2015/proposals/reg/asm/bill/ab768</a>  5. Assembly Bill 852: <a href="http://docs.legis.wisconsin.gov/2015/proposals/reg/asm/bill/ab852">http://docs.legis.wisconsin.gov/2015/proposals/reg/asm/bill/ab852</a>			
11) <i><b>Dale Kleven</b></i> Signature of person making this request		Authorization  <i><b>February 5, 2016</b></i> Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)    Date			
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**Note:** Bold, underline, italics, and highlighting below have been retained from the comments as submitted and were not added in the preparation of this document

## **Med 24.02 - Definitions**

### **Froedtert**

The definitions outlined in Med 24.02 and the technology and equipment specifications in Med 24.17 warrant further consideration. Taken together, these sections appear to both limit the use of a telephone and to set a new precedent. Telephonic consults have been safely used for years, including in the practices exempted in Med 24.21. Simplicity and a single standard of care should apply and telephonic care should be addressed and permitted in the definitions in Med 24.02. The requirements in Med 24.17 should be reconsidered.

## **Med 24.02 (1)**

### **AthenaWerx**

**Comment:** The definition of asynchronous per the American Telemedicine Association, the world's leading industry and public policy organization dedicated to the use of virtual care, defines asynchronous store-and-forward as "the store and forward transmission of medical images and/or clinical data from one site to another. The data transfer takes place over a period of time. The transmission typically does not take place simultaneously. This is the opposite of synchronous or real-time interaction."<sup>1</sup> No other definition from any other source identifies an 'originating site' as a requirement for store-and-forward telemedicine. In fact, the proposed document from the Medical Examining Board does not include a definition of 'originating site.'

**RECOMMENDATION:** It is recommended that the Medical Examining Board adopt ATA's definition of store-and-forward asynchronous as this definition has been vetted by industry experts and reflects the true nature of asynchronous care delivery.

## **Med 24.02 (4)**

### **WMS**

Should the definition of "Licensee" mean a physician licensed by the Board? Or does the MEB intend the rules to apply to the other professions currently under the MEB's purview?

## **Med 24.02 (5)**

### **AthenaWerx**

**Comments:** Again, the American Telemedicine Association defines Telemedicine as "the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status. Telemedicine includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools, and other forms of telecommunications technology." The Board's definition does not reflect current definitions by ATA, the World Health Organization, the Agency for Research in Health Quality,

nor the Institute of Medicine. Teleradiology and telepathology have never been considered telemedicine with respect to rules promulgated by a medical board. In fact, teleradiology has been used since 1968 and became mainstream in the mid 1980s. No consideration was made to develop specific rules to regulate the practice of teleradiology and subsequently, telepathology. The movement of images between patient sites and interpreting clinician sites has not been considered 'telemedicine' for the purposes of regulating practice. The Board's inclusion of telepathology and teleradiology in the proposed rules will have significant effect on the ability of the practitioner to provide services to many areas of the state where radiologist and pathologists are not available. The impact is explained later in the comments.

Email consultations are becoming more prevalent as health plans, providers, and patients recognize that many conditions can be treated through email messaging. Kaiser Permanente and Group Health from the West Coast are some of the first health plans to pay for email consultations between established patients and their providers. After 600,000 email consultations, Kaiser concluded that email consultations help improve patient care and outcomes.<sup>2</sup>

In addition, the definition of telemedicine by the Board contradicts the existing Wisconsin State Medicaid definition and the definition in WI Act 30. The Board should not develop an additional definition which causes confusion between the agencies at the state level as well as for licensees who are trying to follow WI public policy.

**RECOMMENDATIONS:** It is recommended that the Board strike telepathology and teleradiology from the definition for the purposes of applying subsequent rule making in Chapter Med 24, and that the Board recognize email consultations as a part of the definition of telemedicine.

### **CCA**

Retail clinics in other states utilize a variety of telemedicine technologies, which may or may not include interactive audio visual tools, peripheral devices, or asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services. In order to give retail clinics the flexibility to choose the best, most cost effective model for their clinic sites and patient population, CCA requests clarification as to what telemedicine models would fall under Med 24.02 (5)'s definition, i.e., models of telemedicine that rely on peripherals and do not include all of the technologies listed in the definition.

### **WAPA**

Telemedicine is a delivery practice that should be overseen by the Board and this is encapsulated effectively in the provision of proposed 24.02(5) defining telemedicine as the practice of medicine and involving interactions between patients and licensees. We believe this approach of vesting oversight of telemedicine in the Board, and delineating its practice to the Board's licensees will provide the safest and best route for the integration of telemedicine in Wisconsin.

## WMS

We heard several comments about the last sentence of this section defining "Telemedicine," with some uncertain of the MEB's intent for laying out specific exclusions in the definition.

## Zipnosis

Zipnosis would recommend changing lines 2 and 3 to read: " .....interactive audio-visual or asynchronous store and forward...."

## **Med 24.02 (6)**

### AthenaWerx

**Comments:** The definition of telemedicine technologies by the Board also includes electronic health records, picture archival systems (PACs), and other HIT systems used to transmit patient health information including adt transmission of insurance and discharge information. It is assumed that the Board does not want to include electronic health records in the definition of telemedicine.

**Recommendations:** It is recommended that the Board not attempt to define telemedicine technologies which are in an ever evolving state due to innovation. Recommended language could include "telemedicine technologies are used to transmit patient data, physiologic parameters, and/or live video interaction and must be secure and support state and federal requirements for privacy and confidentiality."

## **Med 24.03 – Practice Guidelines**

### Froedtert

The proposed rule could be simplified by eliminating sections that address content addressed elsewhere in the administrative code or statutes. Since Med 10 has already established standards related to unprofessional conduct, the section could be removed.

## WHA

WHA has areas of concern regarding most of Med 24 as it is at times duplicative and/or contradictory of existing rules (e.g., Med 10, 17, 21) and at other times creates a higher standard of practice for the use of telemedicine than traditional in-person medicine. For example, Med 24.03, Practice Guidelines state that a physician, "...shall utilize evidence-based telemedicine practice guidelines and standards of practice, to the degree they are available, to ensure patient safety, quality of care, and positive outcomes." When compared to existing rule, Med 10.03 (2) (b), a standard established as unprofessional conduct includes "departing from or failing to conform to the standard of minimally competent medical practice which creates an unacceptable risk of harm to a patient or the public whether or not the act or omission resulted in actual harm to any person..." This language in Med 10 is similar language to the proposed Med 24.03, but different. Med 10 appears to cover the same concerns of Med 24.03, and is at

best, redundant, and at worse confusing. This additional complexity that it places on our physician providers in Wisconsin is a relevant concern.

### **WMS**

The requirement that a physician "shall" use available practice guidelines could be stricter than the MEB intends -it appears to be stricter than any requirements currently in place for non-telemedicine health care. Guidelines are also not "standards of practice", which the rule draft seems to equate. This is a section where perhaps a narrower use of "technology practice guidelines" may be appropriate?

### **Zipnosis**

This provision actually has the effect of imposing a higher standard of care on telemedicine than on medicine in general. For this reason, Zipnosis would recommend removing it.

## **Med 24.04 – Wisconsin Medical License Required**

### **AthenaWerx**

In lieu of the recent passage of the Interstate Licensure Compact by Wisconsin, this section should be revised to state that “a physician who uses telemedicine....must have a valid WI license either through reciprocity (Compact) or as a fully licensed physician with Wisconsin as the primary state of residence.”

### **Froedtert**

The proposed rule could be simplified by eliminating sections that address content addressed elsewhere in the administrative code or statutes. Since Med 10 has already established standards related to unprofessional conduct, the section could be removed.

### **WAPA**

In proposed Med 24.04 the language speaks only to physicians needing to be licensed in Wisconsin. It is WAPA's position that PAs delivering telemedicine services in Wisconsin should be Wisconsin licensees as well, and that each reference to physician should also specifically state PAs as licensed providers.

### **WMS**

Society council members generally support this section, as it is rooted in patient protection and MEB oversight.

## **Med 24.05 – Standards of Care and Professional Ethics**

### **AthenaWerx**

**Comments:** Med 24.05 is a paragraph that sets the foundation for virtual care practice in Wisconsin. No other extensive or complicated rules are required. In fact, Illinois' state Medical

Board has issued no additional rules other than those regulatory requirements for medical licensees in the state of Illinois. There is no separate regulatory requirements for practicing via telemedicine other than the Board's rules for medical practice in the state of Wisconsin.

**Recommendations:** Much of these rules should be stricken as unnecessary and duplicative, which ultimately will cause confusion in interpretation by physicians working in or interested in working in Wisconsin virtually.

### WMS

Society council members generally support this section, as it is rooted in patient protection and MEB oversight.

### **Med 24.06 – Scope of Practice**

#### AthenaWerx

Again, Med 24.06 is unnecessary and duplicative of Board current rules that state that licensees must practice within their scope and according to the education, training, experience, ability, licensure, and certification. This section is duplicative and should be stricken.

### WMS

Society council members generally support this section, as it is rooted in patient protection and MEB oversight.

### **Med 24.07 – Identification of Patient and Physician**

#### AthenaWerx

**Comments:** When patients are seen in-person, little is done in many organizations to ensure that the patient is who they say they are. No picture ID is required to be seen for in-person care. At a minimum, the patient is asked their name and birthday, and no other information is requested unless some suspicion has arisen as to the patient's intentions or identity. In the thousands of health care interactions that occur every day in Wisconsin, only a handful of encounters require picture identification. This section again will create confusion on the part of users of telemedicine who now will 'think' there is a different requirement than for in-person care for the identification of the patient.

In-person care procedures do not provide for the identification of, licensure status of, certification and credential of health care providers who treat patients. There is no basis for requiring health care organizations develop a separate method to allow patients to access this information when services are delivered via telemedicine. A quick internet search by patients provides all the information, and most likely more, than what could be provided by an organization using telemedicine.

**Recommendations:** Section Med 24.07 should be stricken as unnecessary.

## Froedtert

The proposed rule could be simplified by eliminating sections that address content addressed elsewhere in the administrative code or statutes. Since Med 10 has already established standards related to unprofessional conduct, the section could be removed.

## WMS

The Society believes that a physician properly identifying a patient is critical, but is concerned with language requiring that "the patient has the ability to verify" various aspects of "all health care" professionals providing care via telemedicine. One real world example we heard is *apropos* to the potential confusion over this language: what of the incapacitated nursing home patient who receives geriatric psychiatric care via telehealth? That patient may literally lack the ability to "verify" information about a remote physician.

## **Med 24.08 – Physician-Patient Relationship**

### Froedtert

Physician patient relationships and practices related to medical history and diagnosis are part of the standard of care; this standard should apply regardless of setting. The proposed rule could be simplified by assuming a single standard of care regardless of care setting and eliminating the section.

### HealthPartners

We support the current proposed language that is being considered and we are especially supportive of including the following provisions:

- ***Med 24.08 Physician-patient relationship***

***A valid physician-patient relationship may be established through any of the following:***

***[ . . . ](3) Telemedicine, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.***

We agree that a practitioner-patient relationship can be established through a telemedicine encounter where the standard of care does not require an in-person encounter.

## WMS

The first sentence in this section raises some questions, not the least of which is if the scope statement for this rule proposal allows the MEB to establish a new definition of the physician-patient relationship that applies beyond telemedicine. It may be more appropriate to include only the second sentence and the first two subsections for this area, knowing that sections MED 24.04, 24.05 and 24.06 exist to protect the patient.

## Zipnosis

Zipnosis agrees that it is important to explicitly state that the physician patient relationship may be established via telemedicine. However, for clarity we would recommend deleting the last line of Med 24.08 (3).

## **Med 24.09 – Medical History and Physical Examination**

### AthenaWerx

**Comments:** The beginning of Med 24.09 states “a licensee shall perform a medical interview and physical examination for each patient.” Further in the section, the language states that a licensee “who uses telemedicine shall interview the patient to collect the relevant medical history and perform a physical examination, when medically necessary...” This section contradicts itself and is unclear. The beginning states all licensee must conduct a physical exam. Behavioral health providers do not conduct physical exams. Are these providers required to conduct a physical exam when using telemedicine? In the latter section, is the physical exam only performed when medically necessary or both the interview and physical exam?

If this section is intended to prevent on-line pharmacies from prescribing and dispensing medications as the result of a completion of a form, this situation is covered clearly by the federal Ryan Haight Act of 2008. No other stipulations are necessary in Med 24.

**Recommendations:** The above-mentioned section is misleading and confusing and needs clarification or reference to Ryan Haight and nothing else.

### Froedtert

Physician patient relationships and practices related to medical history and diagnosis are part of the standard of care; this standard should apply regardless of setting. The proposed rule could be simplified by assuming a single standard of care regardless of care setting and eliminating the section.

### HealthPartners

We support the current proposed language that is being considered and we are especially supportive of including the following provisions:

- ***Med 24.09 Medical history and physical examination***

***An Internet questionnaire that is a static set of questions provided to the patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview, does not constitute an acceptable medical interview and physical examination for the provision of treatment, including issuance of prescriptions, electronically or otherwise, by a licensee.*** We support your making the important distinction between a simple static online questionnaire, and the complex adaptive online interviews that are now possible.

## WMS

This section provides much specificity in certain areas which may already be covered under the general expectations required under MED 24.03 and/or MED 24.05. The Internet questionnaire issue overall probably deserves more discussion after determining what is already in use in Wisconsin and whether the care provided from those services is problematic.

## Zipnosis

Zipnosis would recommend that line 2 be changed to read: "... a medical interview and physical examination **sufficient to establish an informed diagnosis....**". This change would conform this part of the section to language in the rest of the section.

## **Med 24.10 – Nonphysician Health Care Providers**

### CCA

Section Med 24.10 labeled Nonphysician health care providers states, "If a licensee who uses telemedicine relies upon **or delegates** the provision of telemedicine services to a nonphysician health care provider, the licensee shall ensure that all of the following are met:

- (1) Systems are in place to ensure that the nonphysician health care provider is qualified and trained to provide that service within the scope of the nonphysician health care provider's practice.
- (2) The licensee is available in person or electronically to consult with the nonphysician health care provider, particularly in the case of injury or an emergency."

Wisconsin's retail clinics are primarily staffed by nurse practitioners. Wisconsin law requires that nurse practitioners and other advanced practice nurses who prescribe medications practice in collaboration with a physician. According to Wisconsin regulation N-8.10, "Advanced practice nurse prescribers **shall work in a collaborative relationship with a physician.**" Nurse practitioners are not required to have aspects of their practice delegated to them by physicians. The use of the term "delegates" in Med 24.10 could present a potential conflict with the existing Board of Nursing regulation governing nurse practitioner practice. Additionally, subsection (2) of Med 24.10 requires that a licensee to be available in person or electronically to consult with the nonphysician health care provider, particularly in the case of injury or an emergency. This language could again conflict with Board of Nursing regulation N-8.10, which only mandates that nurse practitioners and physicians be "in each other's presence **when necessary**, to deliver health care services within the scope of the practitioner's professional expertise." For the Medical Examining Board to specify situations in which in-person or electronic consultation must occur may be interpreted as going above and beyond the Board of Nursing regulation.

In order to prevent any potential confusion, CCA requests that the following clarifying language be added to Med 24.10:

**Nothing in this section is intended to restrict or interfere with the provision of telemedicine services by an advanced registered nurse practitioner, physician assistant or other licensed**

**practitioner with whom the licensee has a supervisory or collaborative relationship, as long as that practitioner is acting within their existing scope of practice as prescribed by state law.**

Adding this language will prevent any perceived conflict and ensure that the patients of nurse practitioners and physician assistants experience the full benefits of telemedicine.

### **WAPA**

WAPA appreciates the recognition in proposed Med 24.10 that PAs, when acting as delegates of physicians, have a recognized role in the delivery of telemedicine. When arising in this context, special attention will need to be directed to the concept embodied in proposed Med 24.10(2) (licensee availability to any non-physician) and its interplay with Med 8.10(2), which currently establishes the parameters for supervising physician consultation. As the practice of medicine grows, the utilization of PAs will play a key role in delivering care to the people of WI. It is of utmost importance that the proposed telemedicine rules are written in such a manner to allow for flexibility for modernization of the PA Med chapter 8 rules in the future. Again, WAPA appreciates the Board's interest in this topic and welcomes the opportunity to provide any assistance it can to the Board.

### **WMS**

This section is possibly already covered under MED 24.05.

## **Med 24.11 – Informed Consent**

### **AthenaWerx**

The Board's requirement for informed consent sets back Wisconsin 20 years and is unnecessary and uninformed. There are no national standards and no documented scientific evidence to support the requirement for informed consent. Informed consent is used in health situations where risk is involved, such as interventional procedures, experimental treatments or medications, or investigation situations such as treatments or the use of devices. Telemedicine has been used in the United States since 1954 and is one of the most studied of all health care modalities, with little evidence to support that there is risk associated with the use of telemedicine. Case law substantiates missed diagnosis in the areas of teleradiology but not in interactive video visits between a patient and provider. In fact, case law has developed when patients were not offered telemedicine when available and the patient had a bad outcome. Informed consent would be difficult to obtain by the specialist and would essentially create such a significant barrier that the deployment of telemedicine strategies throughout the state would come to a halt. Telemedicine provides access to needed care for remote and disparate populations and requiring informed consent for traditional care is far-fetched and unrealistic. There is nothing risky or experimental about telemedicine. Wisconsin health care systems have been using telemedicine for over 20 years without informed consent and there is no documented cases where patients have been harmed as a result of getting care via telemedicine. In fact, scientific evidence proves that diagnostic accuracy and patient satisfaction is higher when telemedicine is used than in-person care.

**Recommendations:** It is strongly recommended that the Board strike the entire section of Med 24.11 and any requirement for informed consent.

### **Froedtert**

An informed consent standard has been previously established in Med 18. The section could be eliminated to simplify the proposed rule and set a single standard for informed consent.

### **WMS**

This section is possibly already covered under MED 24.05.

## **Med 24.12 – Coordination of Care**

### **AthenaWerx**

**Comments:** Med 24.12 requires a licensee using telemedicine to know information about the patient and the patient’s community that is not required for in-person care. To require a licensee who is using telemedicine to know the primary care resources, which practices use the medical home model, and to require a licensee to provide a copy of the record to the patient’s medical home or treating physician violates the patient’s privacy. When a patient is referred by primary care to a specialist for in-person care, the specialist is not required to know the community resources of the patient’s locale. If the patient does not want a copy of the record to go back to the treating physician (medical home) such as behavioral health treatments, this section 24.12 now requires all licensees using telemedicine to send a copy of the record back to the medical home provider despite the patient’s wishes. Again, the Board has created a double standard that elevates a telemedicine encounter artificially above the requirements for in-person care. There are no reasons to put additional requirements or restrictions of the provision of care via telemedicine that are not present when care is delivered in-person. Twenty-years experience with telemedicine in the state of Wisconsin has not produced any problems with coordination of care that are not already present in a health care system that is fractured, and does not have a common platform on which to share information between providers.

**Recommendations:** This section should be stricken as it will be impossible for licensees to carry out as this section constitutes additional requirements that are not required for in-person care.

### **Teladoc**

We submit the following recommendations to the draft rule:

A licensee who uses telemedicine shall, when medically appropriate, identify the medical home or treating physician(s) for the patient, when available, where in-person services can be delivered in coordination with the telemedicine services. The licensee shall provide a copy of the medical record to the patient’s medical home or treating physician(s), with the patient’s consent.

HIPPA requires that we obtain patient consent in order to send the medical record. We encourage the patient to grant that permission, but in some cases they may not. We support

the intent and agree that records should be made available to the medical home or primary care physician to promote continuity of care but federal law will not allow us to comply with Med 24.12 without patient consent.

### **WHA**

Med 24.12 and Med 24.13 bring to light certain areas of concern. WHA does not support the rule as written; specifically that the licensee is responsible for assuring that appropriate and adequate follow up care occur (24.13) and the coordination of that care (24.12), but rather, that providers of care via telemedicine should assure that all records associated with that care are easily and readily accessible by the patient at the completion of that care, as well as in the future when the details of that care might be needed by another care provider (and as authorized by the patient). These are issues of medical records sharing and information retrieval, that are perhaps best addressed elsewhere in existing statute (e.g. WI Statute, Ch. 146.83) and do not constitute an issue large enough to promulgate an entire new rule (Med 24).

### **WMS**

The Society believes this section is properly patient-centered.

### **Zipnosis**

Zipnosis would recommend striking the last sentence of this section as it has the effect of imposing a higher standard of care on telemedicine than on medicine in general. As a telemedicine company that licenses our platform only to health systems and integrates telemedicine visits into health system EHRs, Zipnosis has made a strong commitment to supporting continuity of care. In an ideal world all patients would have access to telemedicine offered by their own health system/medical home. And all telemedicine encounters would be integrated into patients' comprehensive medical records. However in today's mobile society patients may not have a medical home or may seek care outside of a medical home setting. Requiring a telemedicine provider to send a copy of the telemedicine encounter could create a nearly impossible burden for the provider.

### **Med 24.13 – Follow-Up Care**

#### **AthenaWerx**

**Comments:** Med 24.13 again puts additional restrictions and requirements on licensees that use telemedicine that are not required for in-person care. No licensee in the state of Wisconsin is required to know local resources of patient locales for the purposes of follow-up care. If a patient travels from Ladysmith, Wisconsin, to Madison, Wisconsin, for the purposes of specialty care, the Madison based licensee is not required to know the resources available in Ladysmith. If the patient needs additional follow-up, the specialist either does the follow-up themselves, or refers the patient back to primary care. If the patient does not have a primary care provider in Ladysmith, the specialist is not required to find a primary care provider for the patient. It is unreasonable for the Board to require a telemedicine licensee to know local resources. No

health care provider is responsible for ensuring that patients receive follow-up. Why is this a stipulation for licensees who use telemedicine.

**Recommendations:** The provisions of Med 24.13 are unnecessary and unreasonable and must be removed.

### **WHA**

Med 24.12 and Med 24.13 bring to light certain areas of concern. WHA does not support the rule as written; specifically that the licensee is responsible for assuring that appropriate and adequate follow up care occur (24.13) and the coordination of that care (24.12), but rather, that providers of care via telemedicine should assure that all records associated with that care are easily and readily accessible by the patient at the completion of that care, as well as in the future when the details of that care might be needed by another care provider (and as authorized by the patient). These are issues of medical records sharing and information retrieval, that are perhaps best addressed elsewhere in existing statute (e.g. WI Statute, Ch. 146.83) and do not constitute an issue large enough to promulgate an entire new rule (Med 24).

### **WMS**

This section is possibly already covered under MED 24.05.

### **Med 24.14 – Emergency Services**

#### **WMS**

This section is possibly already covered under MED 24.05.

### **Med 24.15 – Medical Records**

#### **AthenaWerx**

**Comments:** Although not a barrier, stating separate requirements for sharing patient health records with the patient and providing patient access to records is a duplication of other state and federal requirements for patient health information and is unnecessary to be reiterated in this regulatory document. Meaningful use requires a summary of the visit to be available to the patient. A summary of each telemedicine encounter is included in the visit summary required by Meaningful Use and therefore, is a duplicate regulatory requirement in this section.

#### **Froedtert**

The proposed rule could be simplified by eliminating sections that address content addressed elsewhere in the administrative code or statutes. Since Med 10 has already established standards related to unprofessional conduct, the section could be removed.

## WMS

There are questions whether this section establishes stricter standards for telemedicine than in non- telemedicine care, and if so whether that is appropriate. Does the broader coordination of care requirement in proposed MED 24.12 satisfy the intent of this proposed section, which is quite detailed?

## **Med 24.16 – Privacy and Security**

### AthenaWerx

**Comments:** There are no additional requirements for policies and procedures that govern Privacy and Security for telemedicine encounters than those requirements stipulated in HIPAA, the Security Rules, and HITECH. To outline this set of requirements by the Board for telemedicine encounters is duplicative of existing requirements. The national standards set by the American Telemedicine Association already cover extensively the requirements for adhering to existing privacy and security standards. HIPAA does not require a policy on hours of operation.

**Recommendations:** This section is duplicative of existing state and federal requirements and should be stricken or minimized to say ‘existing state and federal requirements for patient privacy and security shall be followed for telemedicine encounters.’

### Froedtert

HIPAA regulations address technical violations and provide penalties; the section could be removed to simplify the proposed rule.

## WMS

Does the MEB intend that physicians ensure that privacy is maintained only per HIPAA? Or does the MEB intend that a physician comply with all federal and state medical privacy laws?

## **Med 24.17 – Technology and Equipment**

### Froedtert

Wisconsin has not generally regulated the type of technology used by physicians. The definitions outlined in Med 24.02 and the technology and equipment specifications in Med 24.17 warrant further consideration. Taken together, these sections appear to both limit the use of a telephone and to set a new precedent. Telephonic consults have been safely used for years, including in the practices exempted in Med 24.21. Simplicity and a single standard of care should apply and telephonic care should be addressed and permitted in the definitions in Med 24.02. The requirements in Med 24.17 should be reconsidered.

## WMS

Does the MEB intend that physicians ensure that privacy is maintained only per HIPAA? Or does the MEB intend that a physician comply with all federal and state medical privacy laws?

## **Med 24.18 – Disclosure and Functionality of Telemedicine Services**

### **AthenaWerx**

**Comments:** It is very difficult to understand the reasoning behind any of the requirements in Med 24.18. None of these requirements are in place for in-person care. During an in-person encounter, no licensee is required to provide contact information for the licensee, identity, licensure, certification (these typically hang on an office wall), credentials, limitation of services that can be provided, fees, cost-sharing, payment, financial interests other than fees charged, or information collected and passive tracking mechanisms utilized. This section is totally unnecessary and frankly, cannot be accomplished within the context of a visit or encounter between a patient and provider. There is no risk, scientifically grounded, or public policy reason that many of these requirements need to be in place for a telemedicine encounter when these requirements are not in place for in-person visits. If the Board intends to quash the use of telemedicine in the state of Wisconsin, this section certainly will achieve that outcome for the Board.

**Recommendations:** Remove entire section Med 24.18.

### **WMS**

There are concerns that this section could be too onerous for compliance with every telemedicine encounter; perhaps the information "shall be available to the patient upon request" rather than a blanket requirement that a physician "shall disclose". It should also be noted that some of the required disclosures could cause confusion; for example, MED 24.18 (4) requires disclosure of drug or services limitations, but no such limitations currently appear elsewhere in proposed MED 24.

## **Med 24.19 – Patient Access and Feedback**

### **AthenaWerx**

**Comments:** There are no state or federal requirements that mandate licensees allow patient to supplement or amend patient-provider personal health information. To do so would require patient access to all and any electronic or paper health records. With only 25 percent of patients using patient portals, this additional requirement for telemedicine providers over in-person care is unsubstantiated and does not add any value to the health care encounter, clinical outcomes, or patient satisfaction. The section simply adds more barriers to the use of telemedicine.

Health care systems all have patient rights and responsibilities policies that include the ability and mechanism for filing a complaint with the organization's patient liaison, patient security officer, or patient legal team. To my knowledge, no organization in Wisconsin provides each patient who is seen in person, the mechanism to file a complaint with the Wisconsin Medical Examination Board.

**Recommendations:** This requirement is unreasonable for telemedicine encounters and should be stricken.

## WMS

The Society believes this section is properly patient-centered.

### **Med 24.20 – Financial Interests**

#### CCA

The last portion of Med 24.20 states, **“The maintenance of a preferred relationship with any pharmacy is prohibited. Licensees shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit from the pharmacy.”** The majority of Wisconsin’s retail clinics are co-located with a pharmacy. These clinics already have internal policies in place to protect against providers receiving unlawful consideration or benefit from the pharmacy. Every clinic also complies with applicable state and federal laws prohibiting unlawful payments, remunerations, kickbacks, bribes and rebates. Finally, all CCA’s member clinics respect patient pharmacy freedom-of-choice.

Accordingly, CCA requests clarification as to the intent of the highlighted portion of Med 24.20. The language of the proposed rule could be simplified by stating, “licensees shall comply with all federal and state laws and regulations governing the issuance of prescriptions and protecting the right of patients to have prescriptions filled at the pharmacy of their choice.”

#### WMS

This section is possibly already covered under MED 24.05.

### **Med 24.21 – Circumstances Where the Standard of Care May Not Require a Licensee to Personally Interview or Examine a Patient**

#### AthenaWerx

**Comments:** In 40 years of being a licensed health care professional, I have never encountered a clinician who would prescribe a medication for a patient that the clinician has not seen or may be in the process of scheduling an appointment (Med 24.21(1)). To allow such practice raises grave concern and create a lax approach to the prescribing and dispensing of medications that certainly must be unintended by the Board. Such allowances would constitute disregard for the patient – physician relationship and the safe practice of medicine. Did the Board really intent to allow such practice?

Although many of the situations listed above constitute current standards of practice, each of these situations can be enhanced through the use of telemedicine, and perhaps should support the use of telemedicine.

**Recommendations:** Med 24. 21 (1) should be stricken as there is no situation in which a licensee should prescribe a medication for a patient that has not been evaluated properly.

## HealthPartners

There is also one area in the draft policy where we would like to suggest the addition of a clarifying exception. Although phone calls and emails are excluded from the definition of “telemedicine” under the proposed rule, these are modes of communication commonly used with established patients. Sometimes this occurs when a patient calls the physician with a question after an in-person visit, or emails the physician requesting a prescription refill. Or, it could be a scheduled phone or “e-visit” encounter. It would be helpful if the rule could make clear that it is not the intention of the Board to limit or disrupt these common practices with regard to established patients, provided of course, that the services are provided by a licensee and in accordance with applicable standards of care and professional ethics. For example, an additional exception could be added to Med 24.21, as follows:

- ***Med 24.21 Circumstances where the standard of care may not require a licensee to personally interview or examine a patient.***

***Under the following circumstances, whether or not such circumstances involve the use of telemedicine, a licensee may treat a patient who has not been personally interviewed, examined and diagnosed by the licensee:***

***[. . . ] (10) Situations in which the licensee has previously established a valid physician-patient relationship through an in-person encounter, and telephone or electronic messaging is being used by the licensee to provide additional services to the patient that are in accordance with the same standards of care and professional ethics as a licensee using a traditional in-person encounter with a patient.***

## WMS

Similar to the scope question in MED 24.08, does this section go beyond telemedicine?

## **Med 24.22 – Prescribing Based Solely on an Internet Request, Internet Questionnaire or a Telephonic Evaluation-Prohibited**

### AthenaWerx

**Comments:** The language in Med 24.22 prohibits an on-call licensee, who has not personally evaluated a patient, who has access to the patient’s full electronic health record, and who has received a call from the patient based on the organization’s comprehensive triage system, from writing a prescription for a patient. Again, certainly the Board did not intend this consequence of the language in 24.22. The federal Ryan Haight Act of 2008 covers internet prescribing and any attempt by the Board to add language to effect prohibiting internet prescribing only confuses the situation. Rules for internet prescribing should be under the purview of the Wisconsin Pharmacy Examining Board and not the Medical Board.

**Recommendations:** Recommendations are to strike this section as it is duplicative of other state and federal statutes and regulatory language and prevents legitimate access to prescriptions for patients accessing care through triage systems of their own organizations.

## HealthPartners

We support the current proposed language that is being considered and we are especially supportive of including the following provisions:

***Med. 24.22 Prescribing based solely on an Internet request, Internet questionnaire or a telephonic evaluation—prohibited.***

***Prescribing to a patient based solely on an Internet request or Internet questionnaire such as a static questionnaire provided to a patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview, is prohibited.***

We support your making the important distinction between a simple static online questionnaire, and the complex adaptive online interviews that are now possible.

## WMS

Similar to the concern raised for proposed sec. MED 24.09, the Internet questionnaire issue overall probably warrants further MEB discussion to determine if problems exist under current experience in this area.



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Anthem Blue Cross and Blue Shield in Wisconsin  
Delta Dental of Wisconsin, Inc.  
Humana, Inc.  
MHS Health Wisconsin.  
Molina Healthcare of Wisconsin  
UnitedHealthcare of Wisconsin  
WEA Insurance Corporation  
WPS Health Insurance

January 19, 2016

Ms. Katie Vieira  
Administrative Rules Coordinator,  
Division of Policy Development  
Department of Safety and Professional Services  
1400 East Washington Avenue  
Madison, WI 53708-8935

**Subject: Support for Creation of Chapter 24, relating to telemedicine**

Dear Ms. Vieira,

The Alliance of Health Insurers (AHI) AHI member companies represent about two-thirds of the Wisconsin health insurance market. Collectively, AHI member companies employ over 15,450 people in Wisconsin and maintain business offices located throughout the state. Its member companies provide health care coverage to roughly 2.3 million residents or approximately 68% of the total population enrolled in large group, small group, or individual commercial market plans. In addition, AHI member companies provide managed care services to approximately 421,700 participants in Wisconsin's BadgerCare and SSI MA programs or roughly 60% of the population enrolled in those MA programs under managed care.

AHI commends the Wisconsin Medical Examining Board for considering and drafting the proposed permanent rule regarding telemedicine regulation, Chapter Med 24. AHI members have concluded the rule strikes an appropriate balance between promoting health care innovation and properly ensuring patient safety. AHI supports the rule as drafted.

AHI member companies have considered the proposed permanent rule and have concluded its implementation will:

- improve patient access to quality care through implementation of innovative technologies,
- appropriately considers patient safety, and
- appropriately and adequately defines telemedicine.

In particular, we are pleased the proposed permanent rule permits establishment of a physician-patient via the use of telemedicine and does not require an in-person visit to do so.

Wisconsin patients have access to effective and affordable health care. Telehealth is a means to improve upon the high-quality health care system we already enjoy, particularly by improving patient access, regardless of distance and mobility.

Sincerely yours,

R.J. Pirlot  
Executive Director

**DATE:** January 12, 2016

**TO:** Katie Vieira, Administrative Rules Coordinator  
Department of Safety and Professional Services  
Division of Policy Development  
1400 East Washington Avenue, P.O. Box 8366  
Madison Wisconsin 53708-8935

**FROM:** Nina M Antoniotti, RN, MBA, PhD  
AthenaWerx Telemedicine Transformation  
1282 County Road S, Edgar Wisconsin 54426

**RE: WISCONSIN MEDICAL EXAMINING BOARD  
PUBLIC HEARING ON CHAPTER MED 24: TELEMEDICINE**

**The following comments are submitted in response to the Notice of Hearing, January 20, 2016, regarding the establishment of a permanent rule to create Chapter Med 24 relating to telemedicine.**

Chapter Med 24 seeks to establish rules relating to the practice of telemedicine by physicians in the state of Wisconsin. Wisconsin health care professionals have been using virtual care technologies to provide access to specialty care services since the early 1990's and large scale uses of telemedicine have been in existence since 2000, 15 years. Wisconsin Medicaid has been a leader in the nation in establishing comprehensive payment policies in 2003, 2005, and 2006, over a decade ago. My role in establishing formal telemedicine in the state of Wisconsin has taken many avenues – as Director of TeleHealth at Marshfield Clinic for 17 years; as an advisor to the state of Wisconsin in establishing Medicaid payment models as well as certification for behavioral health programs using TeleHealth; consulting with many other health organizations in establishing Telehealth programs including Gunderson Lutheran, Ministry Health Care, University of Wisconsin, Medical College of Wisconsin, Wisconsin Hospital Association, Wisconsin Dental Association, health care based telepharmacy locations; many small health care practices, non-profit organizations, public health departments, and community based mental health centers. I have also been instrumental in starting the first telepharmacy sites in Wisconsin which led to legislation allowing pharmacists to dispense a medication outside of a licensed pharmacy, allowing thousands of rural patients without access to community-based pharmacies, to receive their medications in a timely manner.

In addition, I have held positions in the American Telemedicine Association as a past Board member, past Chair and current member of the Clinical Standards and Guidelines Committee, past Chair and current member of the Business and Finance SIG of ATA, the past Vice President for the Center for Telemedicine and e-Health Law (Washington D.C.), and have authored numerous clinical standards and guidelines for the practice of telemedicine including core standards, behavioral health including asynchronous care, teledermatology, primary and urgent care, tele-ICU, telepathology, wound care, and telerehabilitation, including others.

The following comments are respectfully submitted based on my 20 years-experience in providing virtual care (telemedicine) in the state of Wisconsin, for consideration:

**Med 24.02 Definitions.**

**Under this section, the definition in “(1) Asynchronous store-and-forward transmission means the collection of patient’s relevant health information and the subsequent transmission of the data from the originating site to a health care provider at a distant site without the presence of the patient.”**

**Comment:** The definition of asynchronous per the American Telemedicine Association, the world’s leading industry and public policy organization dedicated to the use of virtual care, defines asynchronous store-and-forward as “the store and forward transmission of medical images and/or clinical data from one site to another. The data transfer takes place over a period of time. The transmission typically does not take place simultaneously. This is the opposite of synchronous or real-time interaction.”<sup>1</sup> No other definition from any other source identifies an ‘originating site’ as a requirement for store-and-forward telemedicine. In fact, the proposed document from the Medical Examining Board does not include a definition of ‘originating site.’

**RECOMMENDATION:** It is recommended that the Medical Examining Board adopt ATA’s definition of store-and-forward asynchronous as this definition has been vetted by industry experts and reflects the true nature of asynchronous care delivery.

**Definition of Telemedicine (5)**

**“Telemedicine” means the practice of medicine using electronic audio-visual communications and information technologies or other means, including interactive audio with asynchronous store-and-forward transmission, between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine includes asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services, including teleradiology and telepathology. Telemedicine shall not include the provision of medical services only through an audio-only telephone, e-mail messages, facsimile transmissions, or U.S. mail or other parcel service, or any combination thereof.**

**Comments:** Again, the American Telemedicine Association defines Telemedicine as “the use of medical information exchanged from one site to another via electronic communications to improve a patient’s clinical health status. Telemedicine includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools, and other forms of telecommunications technology.” The Board’s definition does not reflect current definitions by ATA, the World Health Organization, the Agency for Research in Health Quality, nor the Institute of Medicine. Teleradiology and telepathology have never been considered telemedicine with respect to rules promulgated by a medical board. In fact, teleradiology has been used since 1968 and became mainstream in the mid 1980s. No consideration was made

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<sup>1</sup> American Telemedicine Association. 2016. [www.americantelemed.org](http://www.americantelemed.org). accessed 1-10-2016. Washington D.C.

to develop specific rules to regulate the practice of teleradiology and subsequently, telepathology. The movement of images between patient sites and interpreting clinician sites has not been considered 'telemedicine' for the purposes of regulating practice. The Boards inclusion of telepathology and teleradiology in the proposed rules will have significant effect on the ability of the practitioner to provide services to many areas of the state where radiologist and pathologists are not available. The impact is explained later in the comments.

Email consultations are becoming more prevalent as health plans, providers, and patients recognize that many conditions can be treated through email messaging. Kaiser Permanente and Group Health from the West Coast are some of the first health plans to pay for email consultations between established patients and their providers. After 600,000 email consultations, Kaiser concluded that email consultations help improve patient care and outcomes.<sup>2</sup>

In addition, the definition of telemedicine by the Board contradicts the existing Wisconsin State Medicaid definition and the definition in WI Act 30. The Board should not develop an additional definition which causes confusion between the agencies at the state level as well as for licensees who are trying to follow WI public policy.

**Recommendations:** It is recommended that the Board strike telepathology and teleradiology from the definition for the purposes of applying subsequent rule making in Chapter Med 24, and that the Board recognize email consultations as a part of the definition of telemedicine.

#### **Definition of Telemedicine Technologies (6)**

**["Telemedicine technologies" means technologies and devices enabling secure electronic communications and information exchanges between a licensee in one location and a patient in another location with or without an intervening health care provider.]**

**Comments:** The definition of telemedicine technologies by the Board also includes electronic health records, picture archival systems (PACs), and other HIT systems used to transmit patient health information including adt transmission of insurance and discharge information. It is assumed that the Board does not want to include electronic health records in the definition of telemedicine.

**Recommendations:** It is recommended that the Board not attempt to define telemedicine technologies which are in an ever evolving state due to innovation. Recommended language could include 'telemedicine technologies are used to transmit patient data, physiologic parameters, and/or live video interaction and must be secure and support state and federal requirements for privacy and confidentiality.'

#### **Med 24.04 Wisconsin Medical License Required**

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<sup>2</sup> Baer D. 2011. Patient-physician email communication: the Kaiser Permanente experience. J Oncol Pract. Jul; 7(4)., 230-233.

In lieu of the recent passage of the Interstate Licensure Compact by Wisconsin, this section should be revised to state that “a physician who uses telemedicine....must have a valid WI license either through reciprocity (Compact) or as a fully licensed physician with Wisconsin as the primary state of residence.”

**Med 24.05 Standards of care and professional ethics. A licensee who uses telemedicine shall be held to the same standards of care and professional ethics as a licensee using traditional in-person encounters with patients. Failure to conform to the appropriate standards of care or professional ethics while using telemedicine may be a violation of the laws and rules governing the practice of medicine and may subject the licensee to potential discipline by the board.**

**Comments:** Med 24.05 is a paragraph that sets the foundation for virtual care practice in Wisconsin. No other extensive or complicated rules are required. In fact, Illinois’ state Medical Board has issued no additional rules other than those regulatory requirements for medical licensees in the state of Illinois. There is no separate regulatory requirements for practicing via telemedicine other than the Board’s rules for medical practice in the state of Wisconsin.

**Recommendations:** Much of these rules should be stricken as unnecessary and duplicative, which ultimately will cause confusion in interpretation by physicians working in or interested in working in Wisconsin virtually.

**Med 24.06 Scope of practice. A licensee who uses telemedicine shall ensure that the services provided are consistent with the licensee’s scope of practice, including the licensee’s education, training, experience, ability, licensure, and certification.**

Again, Med 24.06 is unnecessary and duplicative of Board current rules that state that licensees must practice within their scope and according to the education, training, experience, ability, licensure, and certification. This section is duplicative and should be stricken.

**Med 24.07 Identification of patient and physician. A licensee who uses telemedicine shall verify the identity of the patient and ensure that the patient has the ability to verify the identity, licensure status, certification, and credentials of all health care providers who provide telemedicine services prior to the provision of care.**

**Comments:** When patients are seen in-person, little is done in many organizations to ensure that the patient is who they say they are. No picture ID is required to be seen for in-person care. At a minimum, the patient is asked their name and birthday, and no other information is requested unless some suspicion has arisen as to the patient’s intentions or identity. In the thousands of health care interactions that occur every day in Wisconsin, only a handful of encounters require picture identification. This section again will create confusion on the part of users of telemedicine who now will ‘think’ there is a different requirement than for in-person care for the identification of the patient.

In-person care procedures do not provide for the identification of, licensure status of, certification and credential of health care providers who treat patients. There is no basis for requiring health care organizations develop a separate method to allow patients to access this information when services are delivered via telemedicine. A quick internet search by patients provides all the information, and most likely more, than what could be provided by an organization using telemedicine.

**Recommendations:** Section Med 24.07 should be stricken as unnecessary.

**Med 24.09 Medical history and physical examination.** A licensee shall perform a medical interview and physical examination for each patient. The medical interview and physical examination may not be in-person if the technology utilized in a telemedicine encounter is sufficient to establish an informed diagnosis as though the medical interview and physical examination had been performed in-person. Prior to providing treatment, including issuing prescriptions, electronically or otherwise, a licensee who uses telemedicine shall interview the patient to collect the relevant medical history and perform a physical examination, when medically necessary, sufficient for the diagnosis and treatment of the patient. An Internet questionnaire that is a static set of questions provided to the patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview, does not constitute an acceptable medical interview and physical examination for the provision of treatment, including issuance of prescriptions, electronically or otherwise, by a licensee.

**Comments:** The beginning of Med 24.09 states “a licensee shall perform a medical interview and physical examination for each patient.” Further in the section, the language states that a licensee “who uses telemedicine shall interview the patient to collect the relevant medical history and perform a physical examination, when medically necessary...” This section contradicts itself and is unclear. The beginning states all licensee must conduct a physical exam. Behavioral health providers do not conduct physical exams. Are these providers required to conduct a physical exam when using telemedicine? In the latter section, is the physical exam only performed when medically necessary or both the interview and physical exam?

If this section is intended to prevent on-line pharmacies from prescribing and dispensing medications as the result of a completion of a form, this situation is covered clearly by the federal Ryan Haight Act of 2008. No other stipulations are necessary in Med 24.

**Recommendations:** The above-mentioned section is misleading and confusing and needs clarification or reference to Ryan Haight and nothing else.

**Med 24.11 Informed Consent.** In accordance with ch. Med 18, a licensee who uses telemedicine shall ensure that the patient provides appropriate informed consent for the medical services provided, including consent for the use of telemedicine to diagnose and treat the patient, and that such informed consent is timely documented in the patient’s medical record.

The Board's requirement for informed consent sets back Wisconsin 20 years and is unnecessary and uninformed. There are no national standards and no documented scientific evidence to support the requirement for informed consent. Informed consent is used in health situations where risk is involved, such as interventional procedures, experimental treatments or medications, or investigation situations such as treatments or the use of devices. Telemedicine has been used in the United States since 1954 and is one of the most studied of all health care modalities, with little evidence to support that there is risk associated with the use of telemedicine. Case law substantiates missed diagnosis in the areas of teleradiology but not in interactive video visits between a patient and provider. In fact, case law has developed when patients were not offered telemedicine when available and the patient had a bad outcome. Informed consent would be difficult to obtain by the specialist and would essentially create such a significant barrier that the deployment of telemedicine strategies throughout the state would come to a halt. Telemedicine provides access to needed care for remote and disparate populations and requiring informed consent for traditional care is far-fetched and unrealistic. There is nothing risky or experimental about telemedicine. Wisconsin health care systems have been using telemedicine for over 20 years without informed consent and there is no documented cases where patients have been harmed as a result of getting care via telemedicine. In fact, scientific evidence proves that diagnostic accuracy and patient satisfaction is higher when telemedicine is used than in-person care.

**Recommendations:** It is strongly recommended that the Board strike the entire section of Med 24.11 and any requirement for informed consent.

**Med 24.12 Coordination of care. A licensee who uses telemedicine shall, when medically appropriate, identify the medical home or treating physicians for the patient, when available, where in-person services can be delivered in coordination with the telemedicine services. The licensee shall provide a copy of the medical record to the patient's medical home or treating physicians.**

**Comments:** Med 24.12 requires a licensee using telemedicine to know information about the patient and the patient's community that is not required for in-person care. To require a licensee who is using telemedicine to know the primary care resources, which practices use the medical home model, and to require a licensee to provide a copy of the record to the patient's medical home or treating physician violates the patient's privacy. When a patient is referred by primary care to a specialist for in-person care, the specialist is not required to know the community resources of the patient's locale. If the patient does not want a copy of the record to go back to the treating physician (medical home) such as behavioral health treatments, this section 24.12 now requires all licensees using telemedicine to send a copy of the record back to the medical home provider despite the patient's wishes. Again, the Board has created a double standard that elevates a telemedicine encounter artificially above the requirements for in-person care. There are no reasons to put additional requirements or restrictions of the provision of care via telemedicine that are not present when care is delivered in-person. Twenty-years experience with telemedicine in the state of Wisconsin has not produced any

problems with coordination of care that are not already present in a health care system that is fractured, and does not have a common platform on which to share information between providers.

**Recommendations:** This section should be stricken as it will be impossible for licensees to carry out as this section constitutes additional requirements that are not required for in-person care.

**Med 24.13 Follow-up care. A licensee who uses telemedicine shall have access to, or adequate knowledge of, the nature and availability of local medical resources to provide appropriate follow-up care to the patient following a telemedicine encounter.**

**Comments:** Med 24.13 again puts additional restrictions and requirements on licensees that use telemedicine that are not required for in-person care. No licensee in the state of Wisconsin is required to know local resources of patient locales for the purposes of follow-up care. If a patient travels from Ladysmith, Wisconsin, to Madison, Wisconsin, for the purposes of specialty care, the Madison based licensee is not required to know the resources available in Ladysmith. If the patient needs additional follow-up, the specialist either does the follow-up themselves, or refers the patient back to primary care. If the patient does not have a primary care provider in Ladysmith, the specialist is not required to find a primary care provider for the patient. It is unreasonable for the Board to require a telemedicine licensee to know local resources. No health care provider is responsible for ensuring that patients receive follow-up. Why is this a stipulation for licensees who use telemedicine.

**Recommendations:** The provisions of Med 24.13 are unnecessary and unreasonable and must be removed.

**Med 24.15 Medical records. A licensee who uses telemedicine shall ensure that complete, accurate and timely medical records are maintained for the patient in accordance with ch. Med 21, including all patient-related electronic communications, records of past care, physician-patient communications, laboratory and test results, evaluations and consultations, prescriptions, and instructions obtained or produced in connection with the use of telemedicine technologies. The licensee shall note in the patient's record when telemedicine is used to provide diagnosis and treatment. The licensee shall ensure that the patient or another licensee designated by the patient has timely access to all information obtained during the telemedicine encounter. The licensee shall ensure that the patient receives, upon request, a summary of each telemedicine encounter in a timely manner.**

**Comments:** Although not a barrier, stating separate requirements for sharing patient health records with the patient and providing patient access to records is a duplication of other state and federal requirements for patient health information and is unnecessary to be reiterated in this regulatory document. Meaningful use requires a summary of the visit to be available to the patient. A summary of each telemedicine encounter is included in the visit summary required by Meaningful Use and therefore, is a duplicate regulatory requirement in this section.

**Med 24.16 Privacy and security.** A licensee who uses telemedicine shall ensure that all telemedicine encounters comply with the privacy and security measures of the Health Insurance Portability and Accountability Act to ensure that all patient communications and records are secure and remain confidential. Written protocols shall be established by the licensee meet all of the following:

(1) Written protocols shall address all of the following:

(a) Privacy.

(b) Health care personnel who will process messages.

(c) Hours of operation.

(d) Types of transactions that will be permitted electronically.

(e) Required patient information to be included in the communication, including patient name, identification number and type of transaction.

(f) Archiving and retrieval.

(g) Quality oversight mechanisms.

(2) The written protocols should be periodically evaluated for currency and should be maintained in an accessible and readily available manner for review. The written protocols shall include sufficient privacy and security measures to ensure the confidentiality and integrity of patient-identifiable information, including password protection, encryption or other reliable authentication techniques.

**Comments:** There are no additional requirements for policies and procedures that govern Privacy and Security for telemedicine encounters than those requirements stipulated in HIPAA, the Security Rules, and HITECH. To outline this set of requirements by the Board for telemedicine encounters is duplicative of existing requirements. The national standards set by the American Telemedicine Association already cover extensively the requirements for adhering to existing privacy and security standards. HIPAA does not require a policy on hours of operation.

**Recommendations:** This section is duplicative of existing state and federal requirements and should be stricken or minimized to say 'existing state and federal requirements for patient privacy and security shall be followed for telemedicine encounters.'

**Med 24.18 Disclosure and functionality of telemedicine services.** A licensee who uses telemedicine shall disclose all of the following information to the patient:

(1) Types of services provided.

(2) Contact information for the licensee.

(3) Identity, licensure, certification, credentials, and qualifications of all health care providers who are providing the telemedicine services.

(4) Limitations in the drugs and services that can be provided via telemedicine.

(5) Fees for services, cost-sharing responsibilities, and how payment is to be made, if these differ from an in-person encounter.

(6) Financial interests, other than fees charged, in any information, products, or services provided by the licensee.

**(7) Appropriate uses and limitations of the technologies, including in emergency situations.**

**(8) Uses of and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies.**

**(9) To whom patient health information may be disclosed and for what purpose.**

**(10) Rights of patients with respect to patient health information.**

**(11) Information collected and passive tracking mechanisms utilized.**

**Comments:** It is very difficult to understand the reasoning behind any of the requirements in Med 24.18. None of these requirements are in place for in-person care. During an in-person encounter, no licensee is required to provide contact information for the licensee, identity, licensure, certification (these typically hang on an office wall), credentials, limitation of services that can be provided, fees, cost-sharing, payment, financial interests other than fees charged, or information collected and passive tracking mechanisms utilized. This section is totally unnecessary and frankly, cannot be accomplished within the context of a visit or encounter between a patient and provider. There is no risk, scientifically grounded, or public policy reason that many of these requirements need to be in place for a telemedicine encounter when these requirements are not in-place for in-person visits. If the Board intends to quash the use of telemedicine in the state of Wisconsin, this section certainly will achieve that outcome for the Board.

**Recommendations:** Remove entire section Med 24.18.

**Med 24.19 Patient access and feedback. A licensee who uses telemedicine shall ensure that the patient has easy access to a mechanism for the following purposes:**

**(1) To access, supplement and amend patient-provided personal health information.**

**(2) To provide feedback regarding the quality of the telemedicine services provided.**

**Comments:** There are no state or federal requirements that mandate licensees allow patient to supplement or amend patient-provider personal health information. To do so would require patient access to all and any electronic or paper health records. With only 25 percent of patients using patient portals, this additional requirement for telemedicine providers over in-person care is unsubstantiated and does not add any value to the health care encounter, clinical outcomes, or patient satisfaction. The section simply adds more barriers to the use of telemedicine.

Health care systems all have patient rights and responsibilities policies that include the ability and mechanism for filing a complaint with the organization's patient liaison, patient security officer, or patient legal team. To my knowledge, no organization in Wisconsin provides each patient who is seen in person, the mechanism to file a complaint with the Wisconsin Medical Examination Board.

**Recommendations:** This requirement is unreasonable for telemedicine encounters and should be stricken.

**Med 24.21** Circumstances where the standard of care may not require a licensee to personally interview or examine a patient. Under the following circumstances, whether or not such circumstances involve the use of telemedicine, a licensee may treat a patient who has not been personally interviewed, examined and diagnosed by the licensee:

(1) Situations in which the licensee prescribes medications on a short-term basis for a new patient and has scheduled or is in the process of scheduling an appointment to personally examine the patient.

(2) For institutional settings, including writing initial admission orders for a newly hospitalized patient.

(3) Call situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient.

(4) Cross-coverage situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient.

(5) Situations in which the patient has been examined in person by an advanced registered nurse practitioner or a physician assistant or other licensed practitioner with whom the licensee has a supervisory or collaborative relationship.

(6) Emergency situations in which the life or health of the patient is in imminent danger.

(7) Emergency situations that constitute an immediate threat to the public health including, but not limited to, empiric treatment or prophylaxis to prevent or control an infectious disease outbreak.

(8) Situations in which the licensee has diagnosed a sexually transmitted disease in a patient and the licensee prescribes or dispenses antibiotics to the patient's named sexual partners for the treatment of the sexually transmitted disease as recommended by the U.S. Centers for Disease Control and Prevention.

(9) For licensed or certified nursing facilities, residential care facilities, intermediate care facilities, assisted living facilities and hospice settings.

**Comments:** In 40 years of being a licensed health care professional, I have never encountered a clinician who would prescribe a medication for a patient that the clinician has not seen or may be in the process of scheduling an appointment (Med 24.21(1)). To allow such practice raises grave concern and create a lax approach to the prescribing and dispensing of medications that certainly must be unintended by the Board. Such allowances would constitute disregard for the patient – physician relationship and the safe practice of medicine. Did the Board really intent to allow such practice?

Although many of the situations listed above constitute current standards of practice, each of these situations can be enhanced through the use of telemedicine, and perhaps should support the use of telemedicine.

**Recommendations:** Med 24. 21 (1) should be stricken as there is no situation in which a licensee should prescribe a medication for a patient that has not been evaluated properly.

**Med 24.22 Prescribing based solely on an Internet request, Internet questionnaire or a telephonic evaluation—prohibited. Prescribing to a patient based solely on an Internet request or Internet questionnaire such as a static questionnaire provided to a patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview, is prohibited. Absent a valid physician-patient relationship, a licensee’s prescribing to a patient based solely on a telephonic evaluation is prohibited.**

**Comments:** The language in Med 24.22 prohibits an on-call licensee, who has not personally evaluated a patient, who has access to the patient’s full electronic health record, and who has received a call from the patient based on the organization’s comprehensive triage system, from writing a prescription for a patient. Again, certainly the Board did not intend this consequence of the language in 24.22. The federal Ryan Haight Act of 2008 covers internet prescribing and any attempt by the Board to add language to effect prohibiting internet prescribing only confuses the situation. Rules for internet prescribing should be under the purview of the Wisconsin Pharmacy Examining Board and not the Medical Board.

**Recommendations:** Recommendations are to strike this section as it is duplicative of other state and federal statutes and regulatory language and prevents legitimate access to prescriptions for patients accessing care through triage systems of their own organizations.



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January 18, 2016

Katie Vieira, Administrative Rules Coordinator,  
Department of Safety and Professional Services, Division of Policy Development, 1400 East  
Washington Avenue, P.O. Box 8366,  
Madison, WI 53708-8935

**Re: Comments to the Wisconsin Medical Examining Board's proposed order to create  
chapter Med 24 relating to telemedicine**

Dear Ms. Vieira,

The Convenient Care Association ("CCA"), on behalf of its members, appreciates the opportunity to offer comments to the Wisconsin Medical Examining Board's proposed order to create to create chapter Med 24 relating to telemedicine. The CCA was founded in 2006 to provide a unified voice for the retail-based convenient care industry. Convenient care clinics, often referred to as "retail clinics," are healthcare facilities located inside retail locations, such as pharmacies and grocery stores. The industry is currently made up of more than 2,000 retail clinics across more than 40 states and Washington D.C. Our members have collectively provided more than 35 million patient visits, and over 90 percent of patients are satisfied with clinic services.<sup>1</sup> Retail clinics offer high-quality, low-cost, and accessible healthcare. The care is provided by nurse practitioners and physician assistants, and encompasses basic primary care, preventive and wellness services, and some chronic disease monitoring and treatment. All members of the CCA are either certified or accredited by national organizations, such as The Joint Commission and the Accreditation Association for Ambulatory Health Care. Research on the industry has documented time and again that retail clinics deliver high-quality, cost-effective care and adhere to evidence-based practice guidelines. The CCA represents more than 99 percent of all retail clinics currently in operation across the country.

Retail clinic services, which are convenient and affordable, help increase access to care and prevent complications that often result in costly emergency room admissions. A major study sponsored by the RAND Corporation and published in the *Annals of Internal Medicine* found that care at convenient care clinics was equivalent in quality to other settings and 40 to 80 percent less costly.<sup>2</sup>

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<sup>1</sup> Convenient Care Association, <http://ccaclinics.org/about-us/about-cca>.

<sup>2</sup> Comparing Costs and Quality of Care at Retail Clinics with that of Other Medical Settings for Three Common Illnesses, *Annals of Internal Medicine*, August 2009.

There are currently 35 retail clinics serving thousands of patients across Wisconsin. Each clinic records approximately 20-40 patient encounters per day. The CCA fully supports the utilization of telemedicine as a means of expanding access to high quality, care for patients in Wisconsin and throughout the nation. The use of telemedicine among retail clinics in other states is growing rapidly and we applaud the Wisconsin Medical Examining Board's effort to establish the proposed telemedicine rule. In addition to increasing access, telemedicine has the potential to make care more efficient and cost effective for Wisconsin's patients, as well as lower costs for the state. However, CCA requests that the Medical Examining Board provide some additional clarification that will facilitate the adoption of telemedicine in Wisconsin's retail clinics and ensure that retail clinic providers and patients can take full advantage of the technology.

CCA's three main points of concern regarding Med 24 relate to the use of telemedicine by non-physician providers, the proposed financial interest language, and what type of telemedicine technology is required under the Medical Examining Board's telemedicine definition. Each of these concerns is explained in greater detail below.

**I. The Use of Telemedicine by Non-Physician Providers** – Section Med 24.10 labeled Nonphysician health care providers states, "If a licensee who uses telemedicine relies upon **or delegates** the provision of telemedicine services to a nonphysician health care provider, the licensee shall ensure that all of the following are met:

(1) Systems are in place to ensure that the nonphysician health care provider is qualified and trained to provide that service within the scope of the nonphysician health care provider's practice.

(2) The licensee is available in person or electronically to consult with the nonphysician health care provider, particularly in the case of injury or an emergency."

Wisconsin's retail clinics are primarily staffed by nurse practitioners. Wisconsin law requires that nurse practitioners and other advanced practice nurses who prescribe medications practice in collaboration with a physician. According to Wisconsin regulation N-8.10, "Advanced practice nurse prescribers **shall work in a collaborative relationship with a physician.**<sup>3</sup>" Nurse practitioners are not required to have aspects of their practice delegated to them by physicians. The use of the term "delegates" in Med 24.10 could present a potential conflict with the existing Board of Nursing regulation governing nurse practitioner practice. Additionally, subsection (2) of Med 24.10 requires that a licensee to be available in person or electronically to consult with the nonphysician health care provider, particularly in the case of injury or an emergency. This language could again conflict with Board of Nursing regulation N-8.10, which only mandates that

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<sup>3</sup> The full language of subsection (7) of Wisconsin regulation N-8.10 says, "Advanced practice nurse prescribers shall work in a collaborative relationship with a physician. The collaborative relationship is a process in which an advanced practice nurse prescriber is working with a physician, in each other's presence when necessary, to deliver health care services within the scope of the practitioner's professional expertise. The advanced practice nurse prescriber and the physician must document this relationship.

nurse practitioners and physicians be “in each other’s presence **when necessary**, to deliver health care services within the scope of the practitioner’s professional expertise.”<sup>4</sup> For the Medical Examining Board to specify situations in which in-person or electronic consultation must occur may be interpreted as going above and beyond the Board of Nursing regulation.

In order to prevent any potential confusion, CCA requests that the following clarifying language be added to Med 24.10.

**Nothing in this section is intended to restrict or interfere with the provision of telemedicine services by an advanced registered nurse practitioner, physician assistant or other licensed practitioner with whom the licensee has a supervisory or collaborative relationship, as long as that practitioner is acting within their existing scope of practice as prescribed by state law.**

Adding this language will prevent any perceived conflict and ensure that the patients of nurse practitioners and physician assistants experience the full benefits of telemedicine.

**II. Financial Interest** – The last portion of Med 24.20 states, “**The maintenance of a preferred relationship with any pharmacy is prohibited. Licensees shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit from the pharmacy.**” The majority of Wisconsin’s retail clinics are co-located with a pharmacy. These clinics already have internal policies in place to protect against providers receiving unlawful consideration or benefit from the pharmacy. Every clinic also complies with applicable state and federal laws prohibiting unlawful payments, remunerations, kickbacks, bribes and rebates. Finally, all CCA’s member clinics respect patient pharmacy freedom-of-choice.

Accordingly, CCA requests clarification as to the intent of the highlighted portion of Med 24.20. The language of the proposed rule could be simplified by stating, “licensees shall comply with all federal and state laws and regulations governing the issuance of prescriptions and protecting the right of patients to have prescriptions filled at the pharmacy of their choice.”

**III. Definition of Telemedicine** – Med 24.02 (5) defines telemedicine as, “the practice of medicine using electronic audio-visual communications and information technologies or other means, including interactive audio with asynchronous store-and-forward transmission, between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine includes asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services, including teleradiology and telepathology. Telemedicine shall not include the provision of medical services only through an audio-only telephone, e-mail messages, facsimile transmissions, or U.S. mail or other parcel service, or any combination thereof.”

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<sup>4</sup> See above Wisconsin regulation N-8.10

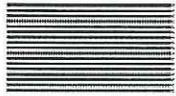
Retail clinics in other states utilize a variety of telemedicine technologies, which may or may not include interactive audio visual tools, peripheral devices, or asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services. In order to give retail clinics the flexibility to choose the best, most cost effective model for their clinic sites and patient population, CCA requests clarification as to what telemedicine models would fall under Med 24.02 (5)'s definition, i.e., models of telemedicine that rely on peripherals and do not include all of the technologies listed in the definition.

On behalf of CCA and its members, I appreciate the opportunity to submit comments on the proposed telemedicine order/rule. If you have any questions as to how the rule may impact Wisconsin's retail clinics, please do not hesitate to contact me at (215) 731-7140 or [tine@ccaclinics.org](mailto:tine@ccaclinics.org).

Sincerely,



Tine Hansen-Turton  
Executive Director, Convenient Care Association



## **ERIC** The ERISA Industry Committee

*The Only National Association Advocating Solely for the Employee Benefit and Compensation Interests of America's Largest Employers*  
1400 L Street, NW, Suite 350, Washington, DC 20005 • (202) 789-1400 • [www.eric.org](http://www.eric.org)

*Annette Guarisco Fildes, President & CEO*

January 14, 2016

Katie Vieira  
Administrative Rules Coordinator  
Department of Safety and Professional Services  
Division of Policy Development  
1400 East Washington Avenue  
P.O. Box 8366  
Madison, WI 53708-8935

*Sent via electronic mail to [Kathleen.Vieira@wisconsin.gov](mailto:Kathleen.Vieira@wisconsin.gov).*

Dear Ms. Vieira,

We are pleased that the Wisconsin Medical Examining Board (Board) has issued proposed regulations that recognize the potential benefits of telemedicine and welcome the opportunity to share our support for leveraging telemedicine to increase access to healthcare. On behalf of The ERISA Industry Committee (ERIC), we want to thank you for thoughtfully developing your regulations to maximize the benefits of telemedicine, and to express large employers' interests on this issue.

As the only national trade association advocating solely for the employee benefit and compensation interests of America's largest employers, ERIC speaks in one voice for large employers on public policy issues relating to employee benefits. Our members have workers in every state across the country, including many Wisconsinites.

ERIC's members are committed to, and known for, providing high-quality, affordable health care to millions of workers and their families. ERIC has a strong interest in proposals that affect its members' ability to deliver cost-effective benefits. ERIC's members devote considerable time and resources to their benefit plan design, balancing the provision of high-quality, affordable health care with the need to contain costs for these programs.

Our members need consistent telemedicine policies around the country so that their workers and their families can enjoy the same company benefits regardless of the state in which they live or work. It is imperative that funds to pay benefits are maximized and not diverted to administrative and compliance burdens stemming from a myriad of disparate and potentially conflicting state rules and regulations.

In addition to improved access to health care, employers support telemedicine for these reasons:

- **Accessibility. Flexibility. Without barriers.** Telemedicine gives employees and their families access to health care 24 hours a day, seven days a week, whether at home, in transit, or at work, without regard to standard office hours and proximity to a health care provider.
- **Benefits for rural, urban, and working families.** Telemedicine has long been seen as a means for providing access to care for rural populations. Urban underserved populations, retirees, the elderly, disabled employees, and those with language barriers, chronic conditions, or transportation barriers also stand to benefit from increased access to care, as well as working parents and others struggling to balance work and family demands.

- **Increased workforce satisfaction.** The response from employees who have used telemedicine services is very positive. Employees want to minimize the time spent attending to their health needs, or that of loved ones, and appreciate the opportunity to reach a health care professional at times and locations that are convenient to them. They like the service and want it to continue.
- **Connection to workplace clinics, rural health centers and employer wellness initiatives.** Telemedicine services can complement employer workplace clinics as well as rural health centers. Telemedicine also supports wellness initiatives that employers offer to further employee health and wellbeing.
- **Cost-effective care.** Employees, retirees, and their families need access to health care that they can utilize because it is provided at an affordable, cost-effective rate.

ERIC respects and supports the Board's duty to protect the public and consider patient safety while developing telemedicine policies. ERIC agrees with the Board that the standard of care and professional ethics governing in-person visits should apply in the same manner to telemedicine visits. We also appreciate the Board's position that telemedicine may be used to establish a physician-patient relationship when the standard of care does not require an in-person visit.

To achieve a balanced regulatory environment for telemedicine, ERIC encourages the Board, to the extent permitted by law, to:

- ADOPT technology-neutral requirements, permitting use of different types of technology platforms that are designed for telemedicine;
- ADOPT licensing policies that facilitate inter-state practice so providers, located in or out of the state, who deliver high-quality care, can serve patients located in Wisconsin;
- AVOID restrictions that require patients to visit specific locations (e.g., "originating sites") in order to access telemedicine services;
- AVOID imposing additional requirements on providers that offer telemedicine services that are not imposed on in-person visits; and
- CONSIDER the needs of patients to have better access to care that can be provided via telemedicine, either through a telemedicine visit or remote monitoring of health conditions.

Thank you for considering large employers' interests as you finalize your telemedicine regulations. ERIC is pleased to represent large employers with the goal of ensuring telemedicine benefits are accessible for millions of workers, retirees, and their families. We welcome additional questions and opportunities to contribute to your rulemaking process.

Sincerely,



Annette Guarisco Fildes  
President & CEO

# Froedtert Health

To: Wisconsin State Medical Examining Board  
Kenneth Simons, MD, Chair

From: Jonathon Truwit, MD  
Enterprise Chief Medical Officer

Date: January 20, 2016

Re: Public Hearing on CR 15-087, Creating Med 24 Related to Telemedicine

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I am writing on behalf of the Froedtert Health system, which includes three hospitals and twenty-five health center locations in Southeast Wisconsin. I want to thank you for the opportunity to provide comments on the creation of administrative rules relating to telemedicine.

Advancements in technology and new and novel applications of emerging technologies have created opportunities to enhance access and improve the quality of health care. Through technology, a unique opportunity to “meet patients where they are” exists. By leveraging technology we can bridge geographic distances, expand capacity in the face of physician workforce shortages and deliver safe and convenient care to patients. Telemedicine facilitates consults between providers, remote monitoring and direct patient care through virtual visits. The pace of change in this area almost certainly means that telemedicine applications will continue to develop and emerge in ways we have not yet imagined.

Telemedicine is a vehicle for the provision of medical care, and it would seem that the regulatory standards and physician expectations previously articulated by the Board should apply as uniformly as possible. Telemedicine regulations should be crafted in a manner that is sufficiently flexible to accommodate continued evolution in technology.

Wisconsin has not generally regulated the type of technology used by physicians. The definitions outlined in Med 24.02 and the technology and equipment specifications in Med 24.17 warrant further consideration. Taken together, these sections appear to both limit the use of a telephone and to set a new precedent. Telephonic consults have been safely used for years, including in the practices exempted in Med 24.21. Simplicity and a single standard of care should apply and telephonic care should be addressed and permitted in the definitions in Med 24.02. The requirements in Med 24.17 should be reconsidered.

The proposed rule could be simplified by eliminating sections that address content addressed elsewhere in the administrative code or statutes. Since Med 10 has already established standards related to unprofessional conduct, the following sections could be removed:

- Med 24.03 - Practice Guidelines.
- Med 24.04 - Requirement of Wisconsin License.
- Med 24.07 - Identification of Physician.
- Med 24.15 - Medical Records.

Physician patient relationships and practices related to medical history and diagnosis are part of the standard of care; this standard should apply regardless of setting. The proposed rule could be simplified by assuming a single standard of care regardless of care setting and eliminating the following sections:

- Med 24.08 - Physician Patient Relationship
- Med 24.09 - Medical History and Diagnosis

An informed consent standard has been previously established in Med 18. The following section could be eliminated to simplify the proposed rule and set a single standard for informed consent:

- Med 24.11 – Informed Consent sets a different standard.

Finally, HIPAA regulations address technical violations and provide penalties; the following section could be removed to simplify the proposed rule:

- Med 24.16 – Privacy and Security

Again, I appreciate the Board's work in this area and the opportunity to share these comments. If you have questions about this or other issues, please feel free to contact me via email at [Jonathon.Truwit@froedtert.com](mailto:Jonathon.Truwit@froedtert.com).

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January 19, 2016

Katie Vieira  
Administrative Rules Coordinator  
Department of Safety and Professional Services  
Division of Policy Development  
1400 East Washington Avenue  
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Madison, WI 53708-8935

Submitted electronically to Kathleen.Vieira@wisconsin.gov

Re: Chapter Med 24 Telemedicine

Dear Ms. Vieira:

We would like to thank you and the Wisconsin Medical Examining Board for your work on rules relating to telemedicine. We are grateful for the opportunity to provide input and are supportive of the current language that the Board is considering. We have only one substantive addition that we would like to recommend.

### **I. Background on Hospital and Clinic Telemedicine**

HealthPartners is a non-profit healthcare system, which provides health care services through a large integrated health system that includes more than 1,700 physicians, seven hospitals, 55 primary care clinics, 22 urgent care locations and numerous specialty practices in Minnesota and western Wisconsin.

We currently provide services via telemedicine through our hospitals and clinics and are working to expand the services we offer to improve access to care in rural areas. Some of the telemedicine services we provide include:

- **E-visits**  
HealthPartners offers E-visits for certain types of care and for managing ongoing health issues. E-visits allow providers and established patients to conduct a web-based exchange of non-urgent clinical information over a secure encrypted web site as an alternative to an in-person visit.
- **teleNeurology**  
We currently provide teleNeurology services through the Regions Hospital Comprehensive Stroke Center. Time is critical to achieving the best outcomes for individuals suffering from a stroke and thanks to telemedicine, patients no longer need to be at Regions to receive a consult from one of our Neurologists. Precious minutes can be saved by extending our Neurologists reach beyond the walls of the hospital and across state lines.

*Our mission is to improve health and well-being in partnership with our members, patients and community.*

## **II. Background on virtuwell**

In 2010, HealthPartners launched virtuwell, a 24/7 telemedicine clinic for about 50 common conditions like bladder infection, sinus infection or pink eye. virtuwell's online diagnosis and treatment services are currently available to residents in Wisconsin, Arizona, California, Colorado, Connecticut, Iowa, Michigan, Minnesota, New York, North Dakota, Pennsylvania, and Virginia.

At virtuwell, we ask patients the same questions you'd expect from a doctor's office visit, except we do it through an online adaptive interview process. As patients pace themselves through relevant presenting symptoms and medical history questions, virtuwell leverages sophisticated evidenced-based clinical algorithms to make sure all the right questions are asked. Then the interview is reviewed by a board-certified nurse practitioner, who double checks allergies and medications, initiates a phone call as appropriate, writes a diagnosis and treatment plan and sends electronic prescriptions, if indicated, to the patient's pharmacy of choice. If a patient's answers show that she needs to be seen in person, we tell her to see her primary doctor and do not charge for the advice. We also follow up with every patient to make sure they're getting better. And, patients may contact virtuwell with any follow up questions for which there is never an additional charge.

We would be happy to provide additional information or answer any questions you have about virtuwell.

## **III. Proposed Policies**

We support the current proposed language that is being considered and we are especially supportive of including the following provisions:

- ***Med 24.08 Physician-patient relationship***

***A valid physician-patient relationship may be established through any of the following:***

***[. . . ](3) Telemedicine, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.*** We agree that a practitioner-patient relationship can be established through a telemedicine encounter where the standard of care does not require an in-person encounter.

- ***Med 24.09 Medical history and physical examination***

***An Internet questionnaire that is a static set of questions provided to the patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview, does not constitute an acceptable medical interview and physical examination for the provision of treatment, including issuance of prescriptions, electronically or otherwise, by a licensee.***

***Med. 24.22 Prescribing based solely on an Internet request, Internet questionnaire or a telephonic evaluation—prohibited.***

***Prescribing to a patient based solely on an Internet request or Internet questionnaire such as a static questionnaire provided to a patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview, is prohibited.***

We support your making the important distinction between a simple static online questionnaire, and the complex adaptive online interviews that are now possible.

There is also one area in the draft policy where we would like to suggest the addition of a clarifying exception. Although phone calls and emails are excluded from the definition of "telemedicine" under the proposed rule, these are modes of communication commonly used with established patients. Sometimes this occurs when a patient calls the physician with a question after an in-person visit, or emails the physician requesting a prescription refill. Or, it could be a scheduled phone or "e-visit" encounter. It would be helpful if the rule could make clear that it is not the intention of the Board to limit or disrupt these common practices with regard to established patients, provided of course, that the services are provided by a licensee and in accordance with applicable standards of care and professional ethics. For example, an additional exception could be added to Med 24.21, as follows:

- ***Med 24.21 Circumstances where the standard of care may not require a licensee to personally interview or examine a patient.***

***Under the following circumstances, whether or not such circumstances involve the use of telemedicine, a licensee may treat a patient who has not been personally interviewed, examined and diagnosed by the licensee:***

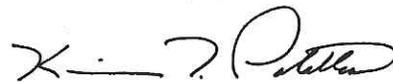
***[ . . . ] (10) Situations in which the licensee has previously established a valid physician-patient relationship through an in-person encounter, and telephone or electronic messaging is being used by the licensee to provide additional services to the patient that are in accordance with the same standards of care and professional ethics as a licensee using a traditional in-person encounter with a patient.***

Thank you again for the opportunity to provide input on the proposed telemedicine rules. If you have any additional questions or if we can be of assistance in any other way, please contact Kevin Palattao, Vice President of Clinic Patient Care Systems at Kevin.J.Palattao@HealthPartners.com, 952-883-5348.

Sincerely,



Andrew Zinkel, MD  
Associate Medical Director



Kevin Palattao  
VP Clinic Patient Care Systems



Bret Haake, MD  
VP Medical Affairs, CMO Regions



## TELADOC

January 5, 2016

Katie Vieira  
Administrative Rules Coordinator  
Department of Safety and Professional Services  
Division of Policy Development  
1400 East Washington Avenue Room 151  
Madison, WI 53708-8935  
Via email: [Kathleen.Vieira@wisconsin.gov](mailto:Kathleen.Vieira@wisconsin.gov)

Re: Proposed Rules Relating to Telemedicine Services

Dear Ms. Vieira:

Teladoc appreciates this opportunity to comment on the Wisconsin Department of Safety and Professional Services proposed rules relating to Telemedicine Services. Telemedicine is dynamic and evolving. Teladoc respects the role of the Department in considering the appropriate rules and clinical practice guidelines that are designed to be protective of public health and maintain high-quality care for patients while permissive of new technological innovations.

As you may know, Teladoc is the nation's first and largest telehealth platform, delivering on-demand healthcare anytime, anywhere, via mobile devices, a web based portal, video and interactive audio. We connect our enrollees with our network of more than 2,650 board-certified physicians and mental health providers with an average of 20 years of physician experience. These physicians treat a wide range of conditions such as upper respiratory infection, urinary tract infection, influenza and sinusitis. More than 12.6 million enrollees now benefit from access to Teladoc 24 hours a day, seven days a week, 365 days a year.

Teladoc has established more than 100 proprietary, evidence-based clinical guidelines specifically designed for telehealth. In addition, we are the first and only telehealth company that has received certification by the NCQA, an independent, not-for-profit, healthcare-oriented organization founded in 1990, dedicated to improving healthcare quality and verifying adherence to national standards of excellence in the provision of healthcare, and we have implemented the highest credentialing requirements, ensuring quality interactions and reliable resolutions.

After more than a decade of service and over 1 million telehealth visits, Teladoc has yet to be subject to a single malpractice claim.

### Teladoc telehealth delivery model

Teladoc provides telemedicine services via web-based interactive audio-video visits or interactive audio using asynchronous store and forward technology. While the choice is with the patient, the physician will use their professional discretion as to the modality that is appropriate. Teladoc physicians only treat minor, non-emergent, non-recurring medical issues with short-term prescriptions of common medications as may be appropriate to the diagnosis and standard of care. Teladoc physicians, where



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appropriate, advise the patient regarding whether that patient should seek an in-person consultation with a physician or go to an emergency room. The Teladoc physician may also refer the patient back to his or her primary care physician when appropriate.

Teladoc's services are only provided to patients through their employer, health-insurance company, state Medicaid plan or hospital system and are not open to the direct-to-consumer market. Only patients who have been appropriately validated through the Teladoc system may make appointments for a telehealth visit with Teladoc physicians.

Prior to a telehealth visit, the patient is required to complete a thorough medical history, including an overview of his or her care, allergies, medications, lab tests, family history, and the name of the patient's primary care physician if he/she has one. The patient is then placed in the queue to receive a telehealth visit. There is less than 10 minutes median physician response time. A Teladoc physician licensed in the state where the patient is located must access the patient's medical history/electronic health record and review it prior to being given the patient's contact information to initiate the telehealth visit. The physician verifies the patient's identity, makes appropriate documentation in the patient's medical record, acquires the patient consent to diagnose and treat, establishes a diagnosis, and recommends treatment (where appropriate), all in accordance with the appropriate standard of care.

During a telehealth visit, an array of medical technology is available to appropriately address the patient's concerns. This includes the ability to have a secure videoconference as well as upload medical images and files in real time. The Teladoc electronic platform also allows for easy follow-up contact by the patient or physician at any point, and Teladoc physicians are authorized with patient consent to communicate with the patient's primary care physician whenever necessary or appropriate to ensure continuity of care. The patient's electronic health record ("EHR") is updated after each consultation, is easily accessible to the patient on an ongoing basis, and will be provided to the patient's physicians (including the primary care physician) with the patient's permission.

Significantly, Teladoc physicians do not prescribe DEA-controlled substances, non-therapeutic drugs, lifestyle drugs and certain other drugs which may be harmful because of their potential for abuse.

For emergencies, patients are told to immediately visit their local emergency room, call 911 or our physicians will make the call for the patient.

### Wisconsin proposed rule Chapter Med 24

Teladoc applauds the Department's recognition that telemedicine is a valuable tool that uses technology and innovation to improve access to quality healthcare to the citizens of Wisconsin. As the Department contemplates good public policy that removes barriers to access, it is important to note that the standard of care should be the same for telemedicine as it is for traditional in-person medicine. The physician should use their professional judgement as to whether a telemedicine visit is appropriate and what technology is needed in order to establish a valid physician-patient relationship. Using the standard of care requirement, Teladoc commends the Department for its use "technology neutral" language. As we know, technology innovations move at light speed and it's impossible to contemplate what will be available in the next five years or more.



**TELADOC**

Accordingly, we submit the following recommendations to the draft rule:

**Med 24.12 Coordination of Care.** A licensee who uses telemedicine shall, when medically appropriate, identify the medical home or treating physician(s) for the patient, when available, where in-person services can be delivered in coordination with the telemedicine services. The licensee shall provide a copy of the medical record to the patient's medical home or treating physician(s), with the patient's consent.

HIPPA requires that we obtain patient consent in order to send the medical record. We encourage the patient to grant that permission, but in some cases they may not. We support the intent and agree that records should be made available to the medical home or primary care physician to promote continuity of care but federal law will not allow us to comply with Med 24.12 without patient consent.

Thank you again for this opportunity to comment and for your kind consideration.

Sincerely,

Claudia Duck Tucker  
Vice President, Government Affairs  
Teladoc

cc: Henry DePhillips, MD, Chief Medical Officer, Teladoc  
Adam Vandervoort, Chief Legal Officer, Teladoc

January 20, 2016

**To:** Kenneth Simons, MD, Chair  
Members, Wisconsin Medical Examining Board

**From:** Christine Longoria, MPAS, PA-C  
President, Wisconsin Academy of Physician Assistants

**RE:** Clearinghouse Rule 15-087

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The Wisconsin Academy of Physician Assistants, (WAPA), appreciates the opportunity to submit the following brief comments on Clearinghouse Rule 15-087 Relating to Telemedicine. For over forty years, WAPA has represented the interests of PAs with respect to legislation and other initiatives impacting the care they are licensed to deliver.

It is the impression of WAPA that telemedicine is, and will continue to be, a growing field of medicine and important for the delivery of healthcare in WI and nationwide. WAPA recognizes telemedicine is a model still in relative infancy. Moreover, WAPA is aware of numerous organizations utilizing PAs in a manner that would fall within the definition of telemedicine. Accordingly, WAPA's interest is to continue to advocate for the full utilization of PAs in all healthcare settings.

It is also the sense of WAPA that the proposed rule is likely to undergo various iterations as different stakeholders make their interests known. Accordingly, WAPA does not intend, at this time, to address the many specifics of the proposed rule. Rather it seeks to make general comments to allow the Board to understand its perspective as this rule works its way through the enactment process.

Because society still has much to learn about the best approach to telemedicine, WAPA believes first and foremost this is a delivery practice that should be overseen by the Board as it deals squarely with medical practices. Telemedicine is a delivery practice that should be overseen by the Board and this is encapsulated effectively in the provision of proposed 24.02(5) defining telemedicine as the practice of medicine and involving interactions between patients and licensees. We believe this approach of vesting oversight of telemedicine in the Board, and delineating its practice to the Board's licensees will provide the safest and best route for the integration of telemedicine in Wisconsin.

We do note that throughout the proposed rule, the Board has put forth language consistently referencing licensees and their role in providing telemedicine with one exception. In proposed Med 24.04 the language speaks only to physicians needing to be licensed in Wisconsin. It is WAPA's position that PAs delivering telemedicine services in Wisconsin should be Wisconsin licensees as well, and that each reference to physician should also specifically state PAs as licensed providers.

Additionally, WAPA appreciates the recognition in proposed Med 24.10 that PAs, when acting as delegates of physicians, have a recognized role in the delivery of telemedicine. When arising in this context, special attention will need to be directed to the concept embodied in proposed Med 24.10(2) (licensee availability to any non-physician) and its interplay with Med 8.10(2), which currently establishes the parameters for supervising physician consultation. As the practice of medicine grows, the utilization of PAs will play a key role in delivering care to the people of WI. It is of utmost importance that the proposed telemedicine rules are written in such a manner to allow for flexibility for modernization of the PA Med chapter 8 rules in the future. Again, WAPA appreciates the Board's interest in this topic and welcomes the opportunity to provide any assistance it can to the Board.

# WISCONSIN HOSPITAL ASSOCIATION, INC.



January 19, 2016

Kenneth Simons, MD  
Chair, Medical Examining Board of Wisconsin  
Department of Safety and Professional Services  
1400 East Washington Avenue, Room 112  
Madison, WI 53703

RE: Chapter Med 24, rule relating to telemedicine

Dear Dr. Simons and members of the Wisconsin Medical Examining Board,

The Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on the Wisconsin Medical Examining Board's (MEB) proposed Med 24 telemedicine rule. Telemedicine plays an important role in the delivery of high quality, high value health care in many of Wisconsin's hospitals.

WHA members include 129 small, mid and large-sized hospitals. We have hospitals in every part of the state—from very rural locations to the larger urban centers such as Madison and Milwaukee. 58 of those hospitals are critical access hospitals (CAHs). In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans hospitals among our members. Many of our members are integrated delivery organizations and are working to innovatively improve health, increase value and better serve our communities and the role that telemedicine serves in these endeavors is an important matter for WHA and its member hospitals.

Many of our hospitals are actively engaged in the use of telemedicine as a part of their health care delivery models. Many others are considering offering telemedicine services in the near future.

Examples of current telemedicine in Wisconsin hospitals includes:

- Store and forward consultation
- Live, interactive consultation
- Tele-psychiatry
- Tele-ICU
- Tele-radiology
- E-visits and other direct to consumer platforms
- Tele-neurology for treatment of possible acute stroke
- Urban to rural telemedicine networks

## History of Telemedicine

These examples are from our smallest, rural hospitals to our large urban medical centers. These interventions supported by a telemedicine platform include everything from acute primary care to emergent medical needs. It should be noted that the use of telemedicine in Wisconsin is not new, and in fact has been in use for more than 25 years; especially noteworthy is the widespread use of

teleradiology. As new technologies enable even greater and broader use of this tool, increased awareness of telemedicine has resulted, but the use of this tool is not new.

Although much of other early telemedicine applications arose out of concerns about the limited access of remote populations to a variety of health services, urban uses also appeared fairly early. And since Wisconsin is a state that has both large areas of the state classified as rural as well as urban and suburban centers, telemedicine is an important component in addressing challenges associated across populations. Evidence-based research suggests that the use of telemedicine is an important supplement to quality screening, diagnosis, and treatment of patients. Additionally, telemedicine adds value to the ever changing care payment and service delivery systems while at the same time not reducing the quality or safety of the care being delivered.

### **Concerns or Problems Associated with Telemedicine**

Even though telemedicine has such a long standing history within the practice of medicine, WHA has found no significant areas of concern, or problems specific to telemedicine. Extensive feedback from WHA members, key stakeholders, and even the Wisconsin Medical Examining Board did not identify for WHA any issues with telemedicine that additional rules or regulatory oversight would address. Additionally, WHA members have not identified any areas of concern, lack of clarity, or confusion around telemedicine that could be interpreted as reason for new rules and/or regulations.

### **Is Telemedicine a Form of Medical Practice or a Delivery Tool?**

Telemedicine is a tool used in the delivery of medicine and is not a separate clinical specialty; it is not a different type of medical practice, and does not broadly require a distinct and different set of regulatory guidelines or rules. Telemedicine is simply the provision of health care services to a patient from a health care provider who is at a site other than where the patient is located using telecommunications technology. When physicians use telemedicine in a clinical encounter, they are simply augmenting the sound clinical judgement that has been developed as a result of their clinical training and education. Performing a relevant patient assessment, obtaining medically necessary clinical histories, and providing culturally competent patient education are all components of the standard medical practice with or without telemedicine. In discussions with key stakeholders, WHA has surmised that potential practice issues that have been identified are issues of medical practice in general, and not specifically as a result of that medicine being delivered in a telemedicine platform. Therefore it would appear that existing medical practice rules and related statutes provide sufficient oversight of all medicine, including that which is delivered via a telemedicine platform.

WHA has areas of concern regarding most of Med 24 as it is at times duplicative and/or contradictory of existing rules (e.g., Med 10, 17, 21) and at other times creates a higher standard of practice for the use of telemedicine than traditional in-person medicine. For example, Med 24.03, Practice Guidelines state that a physician, "...shall utilize evidence-based telemedicine practice guidelines and standards of practice, to the degree they are available, to ensure patient safety, quality of care, and positive outcomes." When compared to existing rule, Med 10.03 (2) (b), a standard established as unprofessional conduct includes "departing from or failing to conform to the standard of minimally competent medical practice which creates an unacceptable risk of harm to a patient or the public whether or not the act or omission resulted in actual harm to any person..." This language in Med 10 is similar language to the proposed Med 24.03, but different. Med 10 appears to cover the same concerns of Med 24.03, and is at best, redundant, and at worse confusing. This additional complexity that it places on our physician providers in Wisconsin is a relevant concern.

Also, Governor Walker has been clear in his support of reducing and streamlining regulatory processes. Executive Order 50, the efficiencies experienced with physician licensing by joining the Interstate Medical Licensure Compact, and 2013 Act 236 are all examples of steps Governor Walker and the legislature have taken to reduce regulatory burden on Wisconsin physicians and other health care providers. Additionally, this increased regulatory complexity could decrease the provision of care via telemedicine and a similar reduction in patient's choosing telemedicine as an option in which to receive their care. All of this could have very direct impact on access, quality, and value of the medical care being delivered in Wisconsin.

### **Material Differences Between Traditional Medical Practice and That Which is Delivered via a Telemedicine Platform**

In examining the Med 24 rule draft, WHA has identified two areas that have the potential for needing more clarification and direction. Both of these areas are associated with the telemedicine activity that occurs with an e-visit. Specifically, an e-visit is defined as an evaluation and management service provided by a physician or other qualified health professional to a patient using a web-based or similar electronic-based communication network for a single patient encounter. The patient may or may not have a medical home, an established primary care provider, or a referring physician. Med 24.12 and Med 24.13 bring to light certain areas of concern. WHA does not support the rule as written; specifically that the licensee is responsible for assuring that appropriate and adequate follow up care occur (24.13) and the coordination of that care (24.12), but rather, that providers of care via telemedicine should assure that all records associated with that care are easily and readily accessible by the patient at the completion of that care, as well as in the future when the details of that care might be needed by another care provider (and as authorized by the patient). These are issues of medical records sharing and information retrieval, that are perhaps best addressed elsewhere in existing statute (e.g. WI Statute, Ch. 146.83) and do not constitute an issue large enough to promulgate an entire new rule (Med 24).

### **Telemedicine versus Telehealth**

WHA is concerned that the promulgation of rules by the MEB associated with telemedicine could cause confusion for other users of telehealth, such as advanced practice nurses, pharmacists, and dentists. All of these care providers utilize telehealth and if in the future direction is warranted regarding telehealth, the approach to more narrowly define it within medical practice could again add additional complexity to the already complex health care regulatory landscape.

### **Future Direction and Recommendations**

WHA recommends that before Wisconsin embarks on any promulgation of rules or regulatory approaches to telehealth/telemedicine, significant discussions occur between governing boards, state agencies, policymakers and most importantly the actual providers utilizing the tool (and the hospitals and health care systems that support these providers). The Wisconsin MEB as well as other stakeholders might model this process on that which was used by the Iowa medical board. In their press release dated June 3, 2015, the Iowa Board of Medicine stated, "there are many stakeholders in the rule...the rule-making process started...after a Board subcommittee spent several months reviewing national policies, laws and rules and meeting with representatives of Iowa physician and hospital organizations, medical educators, and regulatory officials to identify precepts for a rule".

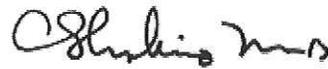
Whereas the regulatory and practice environment of Iowa is different from Wisconsin, the process of multi stakeholder involvement in first determining what need there might be for rules and regulations in Wisconsin is a process WHA strongly supports. And again, as mentioned earlier in this document, WHA has not heard from any member, legislator, or from the MEB that there are any pressing or urgent needs related to telemedicine that need to be addressed. Therefore, WHA recommends that this rule does not move forward and instead supports engaging in initial discussions with the MEB, legislators, and other key stakeholders to first determine if any need actually exists for additional or amended rules. This process would build upon the extensive interaction WHA has already had with our member stakeholders and providers.

Once again, thank you for the opportunity to comment on the MEB's proposed Med 24 rule. Please contact Steven Rush at 608-274-1820 or [srush@wha.org](mailto:srush@wha.org) with any questions.

Sincerely,



Eric Borgerding, President and CEO  
Wisconsin Hospital Association



Charles Shabino, MD, Chief Medical Officer  
Wisconsin Hospital Association



Mark, LePage, CMO  
Marshfield Clinic Health System



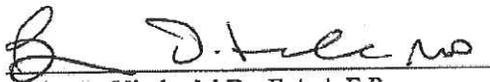
John Olson, CMO  
Lakeview Medical Center



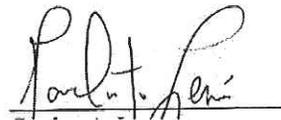
Ken Johnson MD, chief medical officer for HSHS  
eastern Wisconsin



David P. Mortimer, MDiv, Director, Innovation  
Institute, Hospital Sisters Health System



Blaise P. Vitale, M.D., F.A.A.F.P, Chief of Staff  
Burnett Medical Center



Gordon A. Lewis, CEO  
Burnett Medical Center



William Brazeau, Virtual Care System Director for  
Ministry Health Care



Christopher J. Decker  
Executive Vice President / Chief Executive Officer  
Pharmacy Society of Wisconsin

Lois Wenzlow, Director of Health Information Technology, Rural WI Health Cooperative

Steven Rush, PhD, RN, Vice President, Workforce and Clinical Practice, Wisconsin Hospital Association

Peter Roloff, MD, Interim Chief Medical Officer Chief Medical Information Officer – ambulatory system, Ministry Health Care

Peter D. Newcomer, MD, MMM Chief Ambulatory Medical Officer, UW Health

Andy Anderson, MD, MBA – Chief Medical Officer - System and Executive Vice President, Aurora Health Care, Inc.

John Almquist MD FHM Director Hospitalist Services-Ministry Medical Group

Thomas B. Brazelton, MD, MPH UW Health

David R. Rushlow, M.D. Chief Medical Officer Mayo Clinic Health System – Southwest WI

/Richard J. Shimp/

Richard J. Shimp, MD, Chief Medical Officer, Columbia-St. Mary's Hospital System



# Wisconsin Medical Society

Your Doctor. Your Health.

TO: Wisconsin Medical Examining Board  
Kenneth B. Simons, MD, Chair

FROM: Mark Grapentine, JD  
Senior Vice President - Government and Legal Affairs

DATE: January 20, 2016

RE: Comments on Clearinghouse Rule 15-087 - Telemedicine

On behalf of more than 12,500 members statewide, the Wisconsin Medical Society appreciates this opportunity to share our comments related to Clearinghouse Rule 15-087 relating to telemedicine.

Two of the Society's strategic policy councils, the Council on Health Care Delivery, Access and Financing and the Council on Legislation, reviewed the rule proposal. Different sections of the rule engendered varied reactions – some sections appear generally appropriate, others may warrant further Medical Examining Board (MEB) review to fully appreciate possible effects on physician regulation.

The Society's membership appreciates the MEB's foresight in recognizing that telehealth is a growing element of providing health care and that rules in telemedicine can be helpful in protecting the public while providing clarity for appropriate telemedicine practice. The Society believes that regulation in this area could benefit by initially focusing more on regulation of telemedicine as a tool rather than on how an individual physician uses those tools.

The following is feedback discussed by our councils on the proposed rule; sections are grouped together when comments are similar:

**MED 24.02(4) Definitions**

Should the definition of "Licensee" mean a physician licensed by the Board? Or does the MEB intend the rules to apply to the other professions currently under the MEB's purview?

**MED 24.02(5) Definitions**

We heard several comments about the last sentence of this section defining "Telemedicine," with some uncertain of the MEB's intent for laying out specific exclusions in the definition.

**MED 24.03 Practice guidelines**

The requirement that a physician "shall" use available practice guidelines could be stricter than the MEB intends – it appears to be stricter than any requirements currently in place for non-telemedicine health care. Guidelines are also not "standards of practice", which the rule draft seems to equate. This is a section where perhaps a narrower use of "technology practice guidelines" may be appropriate?

**MED 24.04 Wisconsin medical license required**

**MED 24.05 Standards of care and professional ethics**

**MED 24.06 Scope of practice**

Society council members generally support these sections, as they are rooted in patient protection and MEB oversight.

**MED 24.07 Identification of patient and physician**

The Society believes that a physician properly identifying a patient is critical, but is concerned with language requiring that “the patient has the ability to verify” various aspects of “all health care” professionals providing care via telemedicine. One real world example we heard is *apropos* to the potential confusion over this language: what of the incapacitated nursing home patient who receives geriatric psychiatric care via telehealth? That patient may literally lack the ability to “verify” information about a remote physician.

**MED 24.08 Physician-patient relationship**

The first sentence in this section raises some questions, not the least of which is if the scope statement for this rule proposal allows the MEB to establish a new definition of the physician-patient relationship that applies beyond telemedicine. It may be more appropriate to include only the second sentence and the first two subsections for this area, knowing that sections MED 24.04, 24.05 and 24.06 exist to protect the patient.

**MED 24.09 Medical history and physical examination**

This section provides much specificity in certain areas which may already be covered under the general expectations required under MED 24.03 and/or MED 24.05. The Internet questionnaire issue overall probably deserves more discussion after determining what is already in use in Wisconsin and whether the care provided from those services is problematic.

**MED 24.10 Nonphysician health care providers**

**MED 24.11 Informed consent**

**MED 24.13 Follow-up care**

**MED 24.14 Emergency services**

**MED 24.20 Financial Interests**

These sections are possibly already covered under MED 24.05.

**MED 24.12 Coordination of care**

**MED 24.19 Patient access and feedback**

The Society believes these sections are properly patient-centered.

**MED 24.15 Medical records**

There are questions whether this section establishes stricter standards for telemedicine than in non-telemedicine care, and if so whether that is appropriate. Does the broader coordination of care requirement in proposed MED 24.12 satisfy the intent of this proposed section, which is quite detailed?

**MED 24.16 Privacy and security**

**MED 24.17 Technology and equipment**

Does the MEB intend that physicians ensure that privacy is maintained only per HIPAA? Or does the MEB intend that a physician comply with all federal and state medical privacy laws?

**MED 24.18 Disclosure and functionality of telemedicine services**

There are concerns that this section could be too onerous for compliance with every telemedicine encounter; perhaps the information “shall be available to the patient upon request” rather than a blanket requirement that a physician “shall disclose”. It should also be noted that some of the required disclosures could cause confusion; for example, MED 24.18 (4) requires disclosure of drug or services limitations, but no such limitations currently appear elsewhere in proposed MED 24.

**MED 24.21 Circumstances where the standard of care may not require a licensee . . .**

Similar to the scope question in MED 24.08 above, does this section go beyond telemedicine?

**MED 24.22 Prescribing based solely on an Internet request, Internet questionnaire . . .**

Similar to the concern raised above for proposed sec. MED 24.09, the Internet questionnaire issue overall probably warrants further MEB discussion to determine if problems exist under current experience in this area.

Thank you again for this opportunity to share the Society’s thoughts on CR 15-087. We look forward to working the MEB on this and other important efforts.

Tom Ryan, Executive Director  
Ken Simons, MD Board Chair  
Wisconsin Medical Examining Board  
Wi Dept. of Safety and Professional Services  
1400E. Washington Ave  
PO Box 8366

Dear Dr. Simons and Mr. Ryan:

Thank you for the opportunity to provide comment on your proposed telemedicine rule changes. As a practicing primary care physician, an physician executive of a telemedicine company, and an experienced medical regulator( MN BMP), I believe that I comment from a unique vantage point. I have a deep understanding of the important role and mission of state medical boards in public protection.

I'd like to first offer some general comments.

Telemedicine is the practice of medicine. As such it should not be held to a higher or lower standard of care than any other way of providing medical care.

In general state medical boards do not have particular expertise in technology regulation. Attempts to regulate the technology will result in a recurrent cycle of rule revisions as you try to play "catch up" to the rapidly evolving technology. Where state medical boards do have both mission and expertise is in the regulation of medical professional. This should rightly be the focus of any state medical board telemedicine policy.

I'd also like to offer some comments on specific sections of the proposed rule.

24.02 Definitions(5). Zipnosis would recommend changing lines 2 and 3 to read:  
" .....interactive audio-visual or asynchronous store and forward...."

24.03 Practice guidelines. This provision actually has the effect of imposing a higher standard of care on telemedicine than on medicine in general. For this reason, Zipnosis would recommend removing it.

24.08 Physician-patient relationship(3). Zipnosis agrees that it is important to explicitly state that the physician patient relationship may be established via telemedicine. However, for clarity we would recommend deleting the last line.

24.09 Medical history and physical examination. Zipnosis would recommend that line 2 be changed to read: ".... a medical interview and physical examination sufficient to establish and informed diagnosis....". This change would conform this part of the section to language in the rest of the section.

24.12 Coordination of care. Zipnosis would recommend striking the last sentence of this section as it has the effect of imposing a higher standard of care on telemedicine than on medicine in general. As a telemedicine company that licenses our platform only to health systems and integrates telemedicine visits into health system EHRs, Zipnosis has made a strong commitment to supporting continuity of care. In an ideal world all patients would have access to telemedicine offered by their own health system/medical home. And all telemedicine encounters would be integrated into patients' comprehensive medical records. However in today's mobile society patients may not have a medical home or may seek care outside of a medical home setting. Requiring a telemedicine provider to send a copy of the telemedicine encounter could create a nearly impossible burden for the provider.

Thanks again for this opportunity to comment, and for the thought and work that the Wisconsin Medical Examining Board has put into crafting these revisions.

Best regards

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



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## WISCONSIN LEGISLATIVE COUNCIL RULES CLEARINGHOUSE

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**Scott Grosz**  
*Clearinghouse Director*

**Terry C. Anderson**  
*Legislative Council Director*

**Margit Kelley**  
*Clearinghouse Assistant Director*

**Jessica Karls-Ruplinger**  
*Legislative Council Deputy Director*

### CLEARINGHOUSE RULE 15-087

#### Comments

**[NOTE: All citations to “Manual” in the comments below are to the Administrative Rules Procedures Manual, prepared by the Legislative Reference Bureau and the Legislative Council Staff, dated December 2014.]**

#### **2. Form, Style and Placement in Administrative Code**

a. The introductory clause should be phrased as a complete sentence, i.e. “The Medical Examining Board proposes an order to create chapter Med 24 relating to telemedicine.”. [s. 1.02 (1), Manual.]

b. In s. Med 24.02 (5), the phrase “shall not include” should be revised to read “does not include”.

c. In s. Med 24.09, the agency should revise the use of the phrase “may not be in-person”. Generally, the phrase “may not” is used to prohibit an action. [s. 1.01 (2), Manual.] However, that does not appear to be the agency’s intended result. Rather, it appears that the agency wishes to authorize the performance of a physical examination via telemedicine, under certain circumstances.

d. In s. Med 24.16 (2), the agency should select “shall” or “may” rather than “should”. [s. 1.01 (2), Manual.]

e. In s. Med 24.21 (2) and (9), would clarity be improved if the agency placed the phrase “treatments provided in” after “For”? Additionally, the agency should delete “but not limited to” after “including” in s. Med 24.21 (7). [s. 1.01 (9) (f), Manual.] More generally, given its applicability “whether or not the circumstances involve the use of telemedicine”, should the content of s. Med 24.21 be included in a chapter titled “Telemedicine”?

f. The agency should insert a comma after “questionnaire” and delete “a” after “or” in s. Med 24.22 (title). Additionally, it appears the content of s. Med 24.22 duplicates a portion of the content of s. Med. 24.09.

**5. Clarity, Grammar, Punctuation and Use of Plain Language**

a. In s. Med 24.10 (2), the agency should clarify its expectation regarding the meaning of “available”. Should the agency specify a standard for response time?

b. In s. Med 24.12, to improve clarity, the agency could add a phrase such as “for the telemedicine encounter” after “medical record”.

c. In s. Med 24.16 (intro.), should “that” precede “meet” in the last sentence?

d. In s. Med 24.19 (intro.), how does the agency intend to determine whether patient access is “easy”?

e. In s. Med 24.20, could the agency identify the state and federal laws that prohibit financial interest in advertised or promoted goods or products?

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:  2/4/2016	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> <li>▪ 10 work days before the meeting for Medical Board</li> <li>▪ 14 work days before the meeting for all others</li> </ul>	
3) Name of Board, Committee, Council, Sections:  Medical Examining Board			
4) Meeting Date:  2/17/2016	5) Attachments: x Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page?  Wis. Stat. § 448.14 Annual Report Requirement/Medical Examining Board – Calendar Year 2015 – Board Review for Approval	
7) Place Item in: x Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing?  No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  This report is required by statute. Once the Board approves, it will be filed with the legislature.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	



**State of Wisconsin**  
**DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES**  
**CORRESPONDENCE / MEMORANDUM**

**DATE:** January 28, 2016

**TO:** Tom Ryan, Executive Director, DPD  
Al Rohmeyer, Administrator, DLSC

**FROM:** Janie Brischke, Program Policy Analyst Adv, DLSC

**SUBJECT:** Response to Wis. Stat. § 448.14 Annual Report Requirement/Medical Examining Board – Calendar Year 2015

This memo is provided pursuant to the annual report requirement set forth in Wis. Stat. § 448.14.

**Wis. Stat. § 448.14 Annual report.** Annually, no later than March 1, the board shall submit to the chief clerk of each house of the legislature for distribution to the appropriate standing committees under s. [13.172 \(3\)](#) a report that identifies the average length of time to process a disciplinary case against a physician during the preceding year and the number of disciplinary cases involving physicians pending before the board on December 31 of the preceding year.

The information provided assumes the following:

*“Disciplinary case” is defined as a complaint against a physician that was received in the Division of Legal Services and Compliance (DLSC), screened by the Medical Examining Board Screening Panel and opened for investigation.*

**Question 1 - Average length of time to process a disciplinary case against a physician during the preceding year.**

From January 1, 2015 – December 31, 2015, the average length of time to process cases under the purview of the Medical Examining Board:

1. Respondents closed with Formal Orders: 10.6 months
2. Respondents closed without Formal Orders after investigation: 9.3 months.

**Question 2 – Number of disciplinary cases involving physicians pending before the board on December 31, 2015: 162**

## Wisconsin State Coalition for Prescription Drug Abuse Reduction (revised name) January 29, 2016 Meeting Highlights

### Meeting Attendees

Tim Westlake, MD-Chair; Brad Schimel, AG; Jennifer Malcore; Michael McNett, MD; Steve Kulick, MD; Bruce Weiss, MD; Laura Wiggins, MD; Mark Grapentine; Johnny Koremenos; Anna Legreid Dopp, PharmD; Jeremy Levin; Nancy Nankivil; Mark Paget; Steve Rush; Kathy Schmitz

### Meeting Agenda

- 1) Tim Westlake, MD, and member of the Medical Examining Board, provided opening remarks regarding the intended mission of the coalition. The mission, as currently drafted, is to optimize Wisconsin health care assets to best position the health systems and providers in battling the prescription drug epidemic. Dr. Westlake, Attorney General Brad Schimel and State Representative John Nygren have been spearheading the state's efforts on this important public health/health care issue over the last several years. Attendee introductions were conducted and the meeting agenda was reviewed.
- 2) Mark Grapentine, Senior Vice President of Government Relations and Legislative Affairs for the Wisconsin Medical Society provided a high level summary on the HOPE legislation to level set the group for the meeting discussion.
- 3) The key areas for discussion included: What are the priority needs/issues? What assets/resources do we have to address them? Who else do we need to engage? The following provides highlights of the discussion by main topic area.

#### Provider/Physician Education

- Medical Examining Board establishes "floor" for educational requirements
- Best practice guidelines and continuing (medical) education coordinated across professions creating a united front/standard
- Inter professional education among/between physicians, pharmacist, nursing, optometrist, dentists supported by state associations
- Wisconsin approved content that is standardized, credible, evidence-based, free from commercial support or bias is important
- Informed consent-as best practice for providers-to discuss risks, benefits and alternatives to prescription drugs with patients should be considered
- Crating/centralizing common prescription protocol
- State associations serve as accreditor and repository for professional education for their constituency
- Medication Assisted Treatment education and certification critical for physicians and other clinicians to address capacity; needs health care system support
- Clinical documentation for improvement and evaluation purposes is relevant

#### Provider/Physician Access

- Wisconsin does not have current capacity among psychiatrists and behavior health providers, including AODA counselors, to rapidly and effectively address issue
- Overall workforce-supply and demand projections- need evaluation and action (psychiatry, primary care, behavioral health and AODA); capacity to care for unintended consequences is critical
- Teleconsulting needs exploration and support

- Training programs to increase certified behavioral health professionals is also needed
- Health care system engagement to centralize management of treatment within their system or to coordinate resources across geographies may be beneficial
- Primary care providers educated and incentivized by systems to complete MAT training; social and behavioral health structures to follow
- Engage Department of Corrections -use of MAT for inmates and those released
- Leverage About Health and Integrated Health Network-as two major players for health care system access—for clinical leadership; work with Rural Wisconsin Health Cooperative and Federally Qualified Health Centers for rural and underserved access (Care Program in Richland Center)
- Engage NPs and PAs and Pharmacists to administer MATs

#### **Data and Technology**

- Interoperability and integration of the PDMP with electronic health record system
- Optimization in care delivery through a state wide registry
- Optimize data acquisitions and transfers; engage possible data sources from payers and law enforcement; need nursing home, long term care, methadone center data
- Pharmacists can provide medication adherence and prescribing pattern data
- Need data regarding where there are treatment beds in rural and urban areas and other types of analysis

#### **Payer and Employer Engagement**

- Agree on a common benefit plan/policy/formulary/preauthorization processes
- Align payment/reimbursement that support right processes and care (Pay for Performance programs)
- Review third party payer reimbursement for “fraud” issues
- payers adopt best practice for pay for performance such as PDMP use, decreased opioid use in low back injury
- NO payment for “resort treatment centers”; concern of niche businesses/ services that take advantage of patient population and epidemic
- Track Medical Liability—people suing over overdose deaths and injuries
- Track other insurers, like automobile, for unintended law suits resulting from legislation

#### **Patient/Community Expectations**

- Support and expand Dose of Reality campaign-public education
- Create Coalition messaging through public service announcements, op eds, etc
- Develop scripted messaging and materials for physicians and their teams’ for use with patients on alternative therapies to opioids
- Leverage Measurement to incent physicians and systems to improve processes and outcomes
- Document a ROI for stakeholders-health care systems, law enforcement, education, government- to engage in reducing prescription drug abuse -like Methadone clinic in Illinois referred to by Dr. McNett

#### **Legislation/Attorney General**

- Allow delegates, assigned by a physician, to access the PDMP to support care delivery

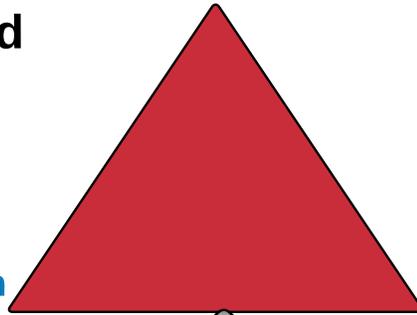
- Provide funding toward a strategy to increase behavior health/AODA counseling structures within the health care systems; support tele-consulting
  - Naloxone—standing order legislation
  - AG working on getting down cost of Naloxone through rebates and grants
  - National Association of AG to impact VA involvement; Engage veterans administration
  - Influence DEA to increase MAT options and decrease opioid prescribing
  - Align with federal legislation or contiguous states, including education requirements
- 4) Funding-The group discussed funding opportunities through granting organizations, including the Foundations of health care systems/stakeholders. The coalition could have a role in organizing grant funding (“Pay IT Forward” program)
- 5) Other entities/organizations-The group identified the following for possible participation in the coalition:
- Health Care Systems
  - Nurses
  - Veterinarians
  - Wisconsin Health Plan Association
  - Medicaid/Employee Trust Fund
  - Wisconsin Employer Coalitions in Madison and Milwaukee
  - Wisconsin Society of Addictive Medicine
  - Tribal Health
  - DEA
- 6) Next Steps
- ✓ Provide a meeting summary to participating entities/organizations (Nankivil)
  - ✓ Consider and reach out to additional entities/organization that may add to the mission of the coalition for their interest/involvement (Westlake)
  - ✓ Establish a spring date for a meeting of the Chief Medical Officers (and other relevant clinical leadership) of our Wisconsin provider health care systems. The purpose of the meeting would be to identify barriers and best practices in clinical care related to opioid prescribing (Westlake)

# Wisconsin State Coalition for Prescription Drug Abuse Reduction

REGULATORY  
BOARDS-  
MEB/BON/DEB/OEB

## Coalition Structure and Collaborative Impact Model

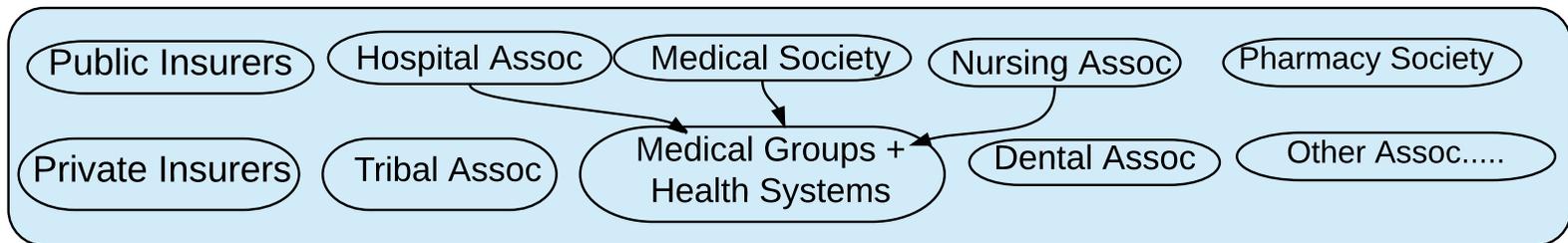
Rep Nygren  
Legislature



Attorney General  
Schimel

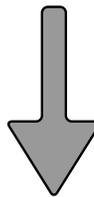


Associations



These Groups Bring-

- 1) Constituencies
- 2) Competencies
- 3) Resources



To Engage, Impact and Guide



**Mission: Optimize Wisconsin's health care assts to best position the providers, medical groups, and hospital systems in battling the prescription drug epidemic**

## MEMORANDUM

DATE: December 1, 2015

TO: **Presidents/Chairs and Executive Directors  
Member Medical and Osteopathic Boards**

FROM: Deanne Dooley  
Meetings and Travel Associate

RE: **Scholarship Program for the  
FSMB 2016 House of Delegates and Annual Meeting**

---

Preparations are underway for FSMB's Annual Meeting to be held April 28 – April 30, 2016, at the Manchester Grand Hyatt in San Diego, CA.

Reimbursement up to \$1,800 in travel expenses will be provided for each member board's president/chair attending as the voting delegate at the FSMB's House of Delegates Meeting on Saturday, April 30, 2016. If the president/chair is unable to participate, an alternate member of the medical board may be selected by the president/chair to attend as the designated voting delegate. **Please see the attached letter from the FSMB's Chair and President/CEO stressing the importance of the role of the voting delegate.**

The FSMB will also reimburse the executive director of each member board up to \$1,800 for expenses incurred in relation to his/her attendance at the Annual Meeting. In the event the executive director cannot participate, the president/chair may select another senior staff person to attend in the executive director's place.

Reimbursement for the voting delegate and the executive director will be made in accordance with the attached guidelines. Please complete the attached Scholarship Response Form identifying your board's scholarship recipients. **The deadline for returning the response form is February 1, 2016.** Upon receipt of the form, scholarship information and travel policies will be sent to the recipients.

**Annual membership dues for member boards must be paid in full in order for both the voting delegate and the executive director to take advantage of the scholarship opportunity.** A draft agenda for the 2016 Annual Meeting will be posted on the FSMB's website at [www.fsmb.org](http://www.fsmb.org). Should you have any questions, you may reach me at 817-868-4086.

December 1, 2015

Dear Colleagues:

Preparations are underway for FSMB's 2016 Annual Meeting scheduled for April 28-30 in San Diego, California. The FSMB's House of Delegates (HOD) business meeting is held on the last day of the Annual Meeting. FSMB member board participation at the HOD meeting is extremely important because it is the boards' unique opportunity to gain greater insight into the FSMB's work and to contribute to the organization's policymaking process. The role of the voting delegate in that process is especially important because the delegate represents his/her state medical board on matters of significance to the board and elects FSMB Fellows to assist in carrying out the FSMB's work.

In anticipation of the HOD business meeting, we ask that you consider which of your board members will be best suited to serve as your voting delegate. In order for the voting delegate to serve in a truly representative capacity, the delegate is asked to fulfill a number of responsibilities.

Before the HOD meeting, the voting delegate is asked to:

- Become familiar with the structure, purpose and history of the FSMB HOD as well as FSMB's policymaking and election processes
- Attend meetings of the state medical board the delegate represents to gain early information on statewide and national issues to be addressed at the HOD meeting
- Review all pre-meeting materials
- **Listen to a pre-recorded Voting Delegate Webinar to be distributed to the voting delegates no later than March 18, and participate, if necessary, in a follow-up Q&A teleconference on March 29 at either 3:00-3:30 pm CT or 6:30-7:00 pm CT to answer any questions the delegate may have**
- **Attend the Candidates Forum and Reference Committee meeting(s) at the Annual Meeting and provide Reference Committee testimony as necessary**
- Network with colleagues at the Annual Meeting for additional information and perspectives on issues

During the HOD meeting, the voting delegate is asked to:

- Follow the meeting rules as outlined by the Rules Committee
- Represent the position of the delegate's board during discussions as necessary
- Vote at the time requested

Following the meeting, the voting delegate is asked to:

- Report the results of the HOD meeting to the delegate's board
- Remain current on statewide and national issues affecting medical regulation in preparation for the next HOD meeting

As you can see, the role of the voting delegate should not be taken lightly. We therefore encourage you to give careful consideration in the selection of the individual who will be your representative at our 2016 meeting.

Sincerely,

J. Daniel Gifford, MD, FACP  
Chair

Humayun J. Chaudhry, DO, MACP, MACOI  
President and CEO

# Sex and Gender Based Health: Integration of Evidence into Medical Education and Clinical Care

**Marjorie R. Jenkins MD MEHP FACP**

Professor of Medicine

Associate Dean for Women in Science

Rush Endowed Chair for Excellence in Research

Director and Chief Science Officer, Laura W. Bush Institute for Women's Health



# Definitions

**Sex:** refers to biological differences, chromosomes, hormonal profiles, internal and external sex organs

**Gender:** the characteristics that a society or culture delineates as masculine or feminine



# Definitions

**Sex and Gender Specific Medicine (SGSM)**  
applies the science of biological, environmental, and social influences on health, and takes the **whole person** into consideration.

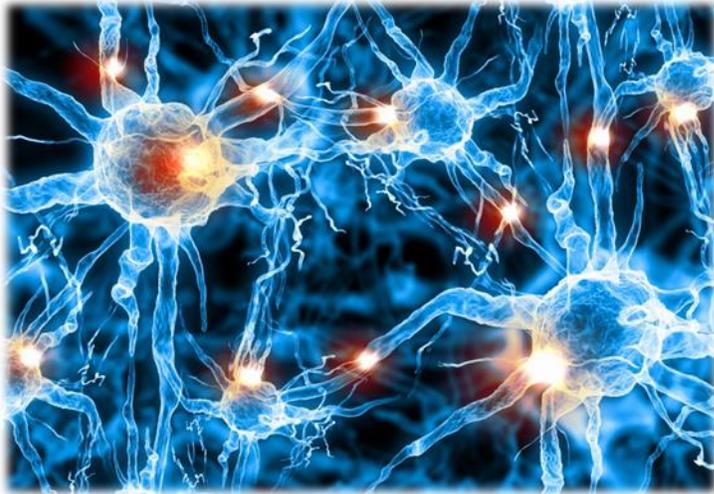


# “...Does Sex Matter?”

“There are multiple, ubiquitous differences in the basic cellular biochemistry of males and females that can affect an individual’s health.”  
**Institute of Medicine Report, 2001**



# From the Beginning: Sex and Cells



**Cellular differences :“every cell has a sex”**

“Hematopoietic stem cells (the progenitor cells of the blood system) divide significantly faster in females than males, driven by the female hormone estrogen.”

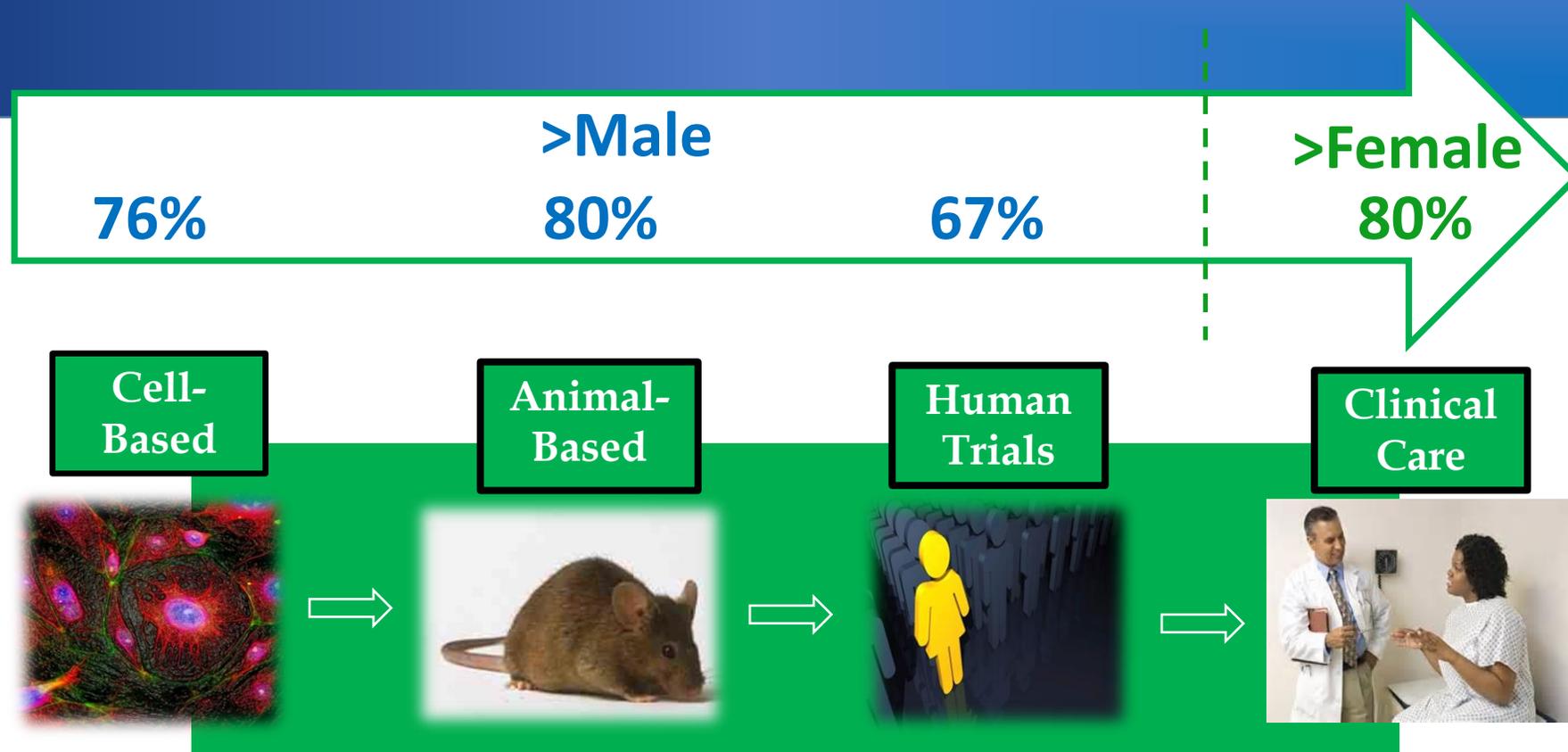
*Nature* (2014)

# Myth

**Basic Science & Clinical Research**  
Is generalizable to the global  
population.



# Reality: Bias in the Research Pipeline



# Reality

## Basic Science & Clinical Research

Research is generalizable to those who best represent the population studied.



# Sex and Gender in Research

## **Basic Science & Clinical Research**

Integrating sex and gender into research platforms changes the way research is carried out and ultimately to whom and how the research findings can be applied.



# Sex and Gender in Clinical Practice

## Clinical Practice

Sex and Gender Based Medicine (SGBM) helps practitioners provide patient-centered care.



# Sex and Gender in Physical Fitness

Washington Post  
February 25, 2014

## Fit but unequal

Take two highly trained, Olympic-caliber athletes: one man, one woman. Here are some biological differences that affect their performance:

**Muscle**  
Tobacco and other hormones give him a greater percentage of lean muscle, particularly in his upper body. Some research indicates that even his individual muscle fibers are larger. Because more muscle means more power, men's top performances in jumping and sprinting sports and especially weightlifting and throwing events greatly exceed women's.

**Heart**  
The man's heart, because of its larger size, can send more blood per beat to working muscles than his can. His blood also contains more oxygen-carrying hemoglobin. Together, his ability to take in and use oxygen — also called aerobic capacity, or VO2 max — is typically 15 to 25 percent greater than hers. That helps him to greater performance in endurance events.

**Fat**  
Her total body fat is 10% of her weight; his is half that. Her body needs more "essential fat" just to keep all systems running smoothly. "Storage" increases the fat storage. (These are in the white.) Regular people's healthy body-fat ranges are roughly 10 to 15% for women and 10 to 15% for men. Her extra fat is useful, but doesn't boost performance, so he is stronger pound for pound.

**Body composition for elite athletes (pounds)**

Sex	Body Composition	Weight
Male	72% Muscle	172
Female	81% Muscle	124

Body composition for elite athletes (pounds):\*

**Knees**  
Her wider pelvis means her femurs meet her tibiae at a greater angle. The tighter this "Q angle," the more stress is put on the knee joints. This is one reason female soccer players, for example, are five to six times as susceptible to knee injuries as male players are. Strength training, if it targets hamstring and rotator muscles, can reduce the risk.

**Flexibility**  
Thanks to anatomical differences, some of her joints have a greater range of motion, giving her the edge in gymnastics and figure skating. Hormones may also play a part in making joints more lax.

**Other differences:**  
The O ring is made for one quest: one muscle in part of the thigh.  
His O ring is made for one quest: one muscle in part of the thigh.  
Director's cut: Bodyfat.  
She can generate the power to get that extra bit of speed in her stride.  
She can generate the power to get that extra bit of speed in her stride.

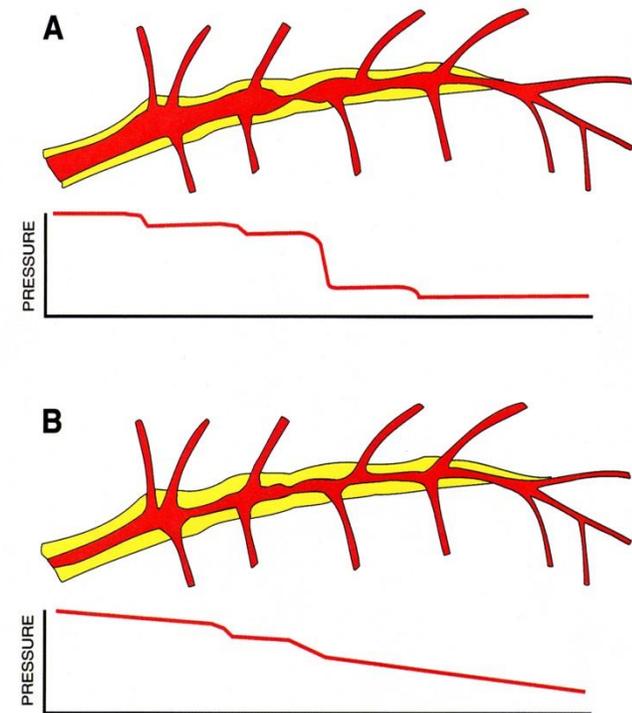
\*Source: Data on 10 elite male and 10 elite female athletes collected by the American College of Sports Medicine. "Comparing 20 elite male and female Olympic athletes: differences in performance and body composition." *Journal of Applied Physiology*, 2008. "Gender differences in strength and muscle fiber characteristics." by A.C. M. de Vries, et al., *Medicine & Science in Sports & Exercise*, 2008. American Academy of Orthopedic Surgeons. American Heart Association.

# Sex and Gender in Disease

## Pathophysiologic Differences

WISE (Women's Ischemic Syndrome Evaluation) study identified differences in coronary artery plaque and thrombosis formation.

- **Women** – coronary thrombosis from endothelial erosion
- **Men** – coronary thrombosis from plaque disruption



A schematic of mixed segmental and diffuse narrowings and associated pressure drops along the length of the artery at maximum flow. (A) Predominant, more severe single segmental stenoses with less diffuse narrowing, suitable for angioplasty or bypass surgery. (B) Predominantly diffuse disease or multiple stenoses with less segmental narrowing, not appropriate for angioplasty or bypass surgery. Reprinted with permission from Gould KL. Coronary artery stenosis and reversing atherosclerosis, 2nd ed. London: Arnold Publishing, 1999.

Burke et al, *Circulation* (1998)

Merz et al, *J of WH* (2010)

# Sex and Gender in Screening & Outcomes

## **Severity**

Men are twice as likely as women to die after an osteoporotic hip fracture.

## **Bias in Diagnosis**

Men are much less likely to receive screening for osteoporosis



# Sex and Gender in Treatment Outcomes

**Drug Safety:** Between 1997 and 2007 8 out of 10 FDA discontinued medications, women experienced the majority of toxic effects, including death. There is a known sex difference related to drug-induced QT prolongation and drug induced QT prolongation leading to fatal arrhythmias more often in women.



# The Benefits of Sex and Gender Specific Medicine



# Future Clinicians: Sex and Gender Matters

Programs that incorporate Sex and Gender Medicine into their curricula will:

- Attract talented students
- Better prepare students for clinical practice



# The Business of Medicine: Sex and Gender Matters

- Women make 80% of the healthcare decisions for themselves and their families.
- Physicians who integrate sex and gender based medicine into their clinical care will have a marketing advantage and potential for greater patient satisfaction among these decision makers.



# Knowledge Saves Lives

“Research discoveries alone do not save lives until they are integrated into patient care by an informed clinician.”

– *Marjorie Jenkins, MD*



# The Issue

**When disease processes are different...  
shouldn't the clinical approach be  
different?**

**When side effects are more likely...  
shouldn't alternative treatment choices  
be considered?**

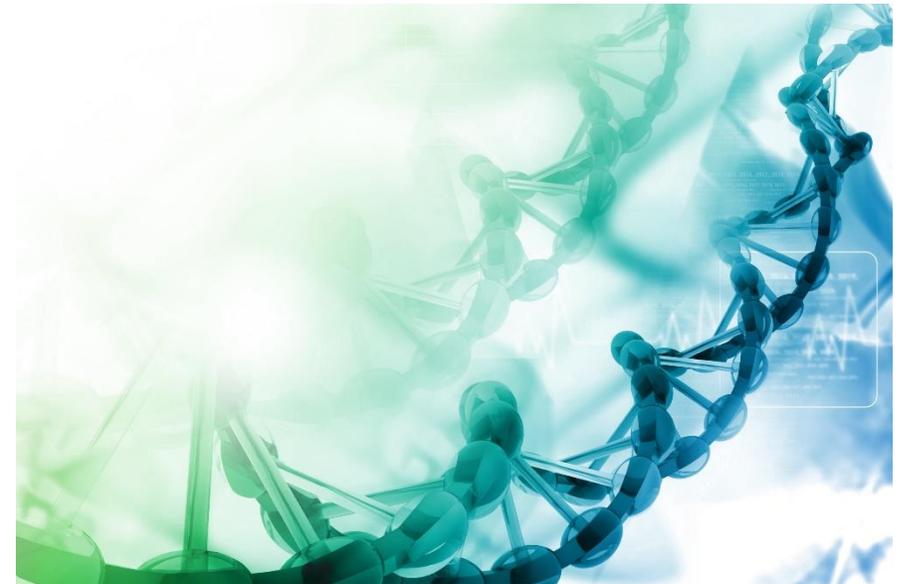
# Call to Action

If ignoring sex and gender difference in clinical care leads to patients being under-diagnosed, under-treated or experiencing undue side effects....**isn't it time for change?**

# NIH is Changing

In **2015**, the NIH released a notice outlining the expectation that sex as a biological variable will be factored into research designs, analyses, and reporting in vertebrate animal and human studies.

This requirement begins with **2016 applications**.



# Student Expectations are Changing

In 2014, 1191 US medical students completed an online survey focused on their knowledge, attitudes and awareness of sex and gender medicine. 1097 students representing 153 medical institutions responded as follows:

- 85.5% were aware that sex and gender differences in medicine exist
- 96.0% indicated that knowledge of sex and gender differences improved one's ability to manage patients
- 94.4% indicated that medical education should include teaching about sex and gender differences

# Medical Student Education is Changing

## **XXXY** | Sex and Gender MEDICAL EDUCATION SUMMIT *A Roadmap for Curricular Innovation*



October 18-19, 2015 | Mayo Clinic | Rochester, MN

The Sex and Gender Medical Education Summit is the first of its kind, a national collaboration dedicated to engaging educational thought leaders in creating a roadmap to integrate sex- and gender-based evidence into medical and interprofessional education.

You will be able to participate in creating guidelines for student competencies in sex- and gender-based medicine (SGBM), be the first to see results of a national medical student survey, review the alignment of LCME and ACGME standards with SGBM and much more!

**For more information visit [sgbmeducationsummit.com](http://sgbmeducationsummit.com)**

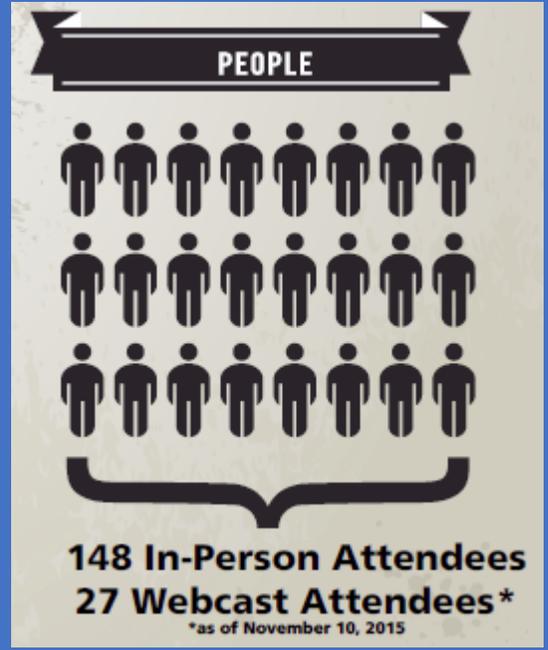
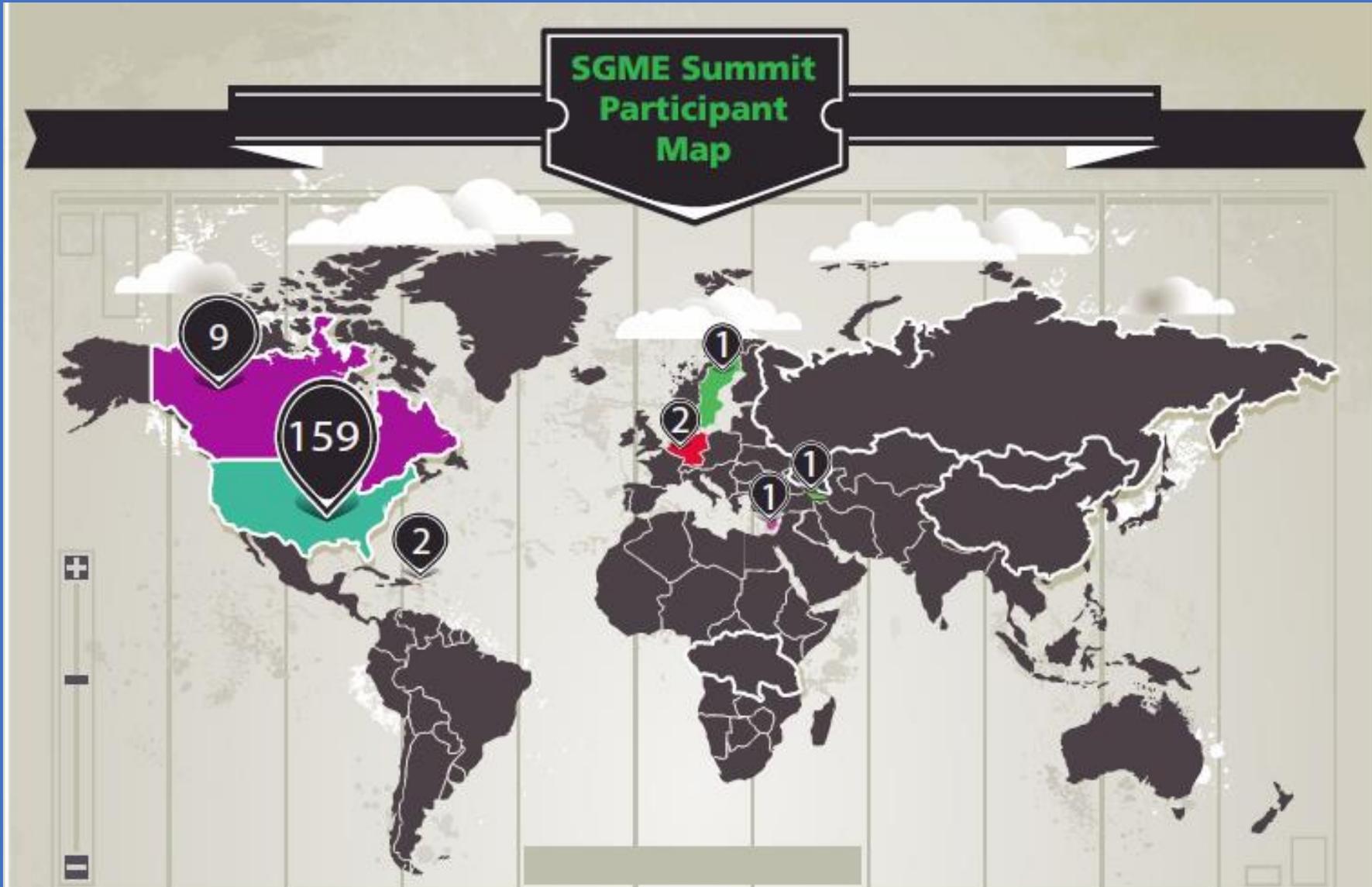


*with Sex and Gender Women's Health Collaborative*

[www.sgbmeducationsummit.org](http://www.sgbmeducationsummit.org)

# US Sex and Gender Medical Education Summit

October 18-19 2016, Mayo Clinic Rochester MN



# Health Professionals Views are Changing

SGME Summit Participants' Survey Results: An Overview

The FDA should consider recommending dosages based on the sex of the patient

Strongly Agree

Pre-test: 27%

Post-test: 66%

Sex and gender based medicine is a fundamental aspect of precision medicine

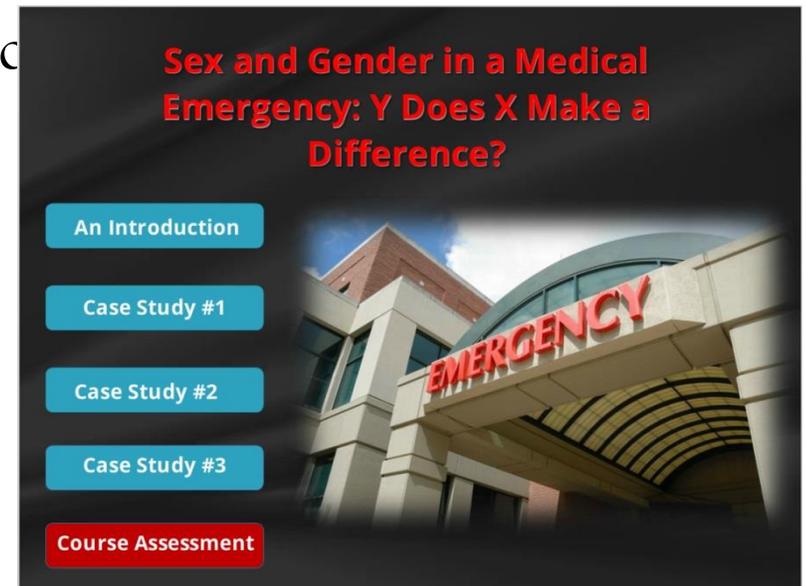
Strongly Agree

Pre-test: 40%

Post-test: 81%

# Continuing Medical Education is Changing

- Y Does X Make A Difference [www.laurabushinstitute.org](http://www.laurabushinstitute.org)
- First CME Sex and Gender Certificate Program for Clinicians
- Listing within a Sex and Gender National Practitioner Registry
- Participating CME Authors
  - Brown Univ
  - Harvard
  - Johns Hopkins
  - Northwestern
  - TTUHSC
  - UC San Diego
  - Vanderbilt



# Clinical Care is Changing

It wasn't until 2007 that we had a large scale study of aspirin for prevention of heart attacks and strokes in women.

Over the past decade multiple gender-specific national clinical guidelines for prevention of stroke and heart attack prevention have been published.



# Treatment Recommendations are Changing

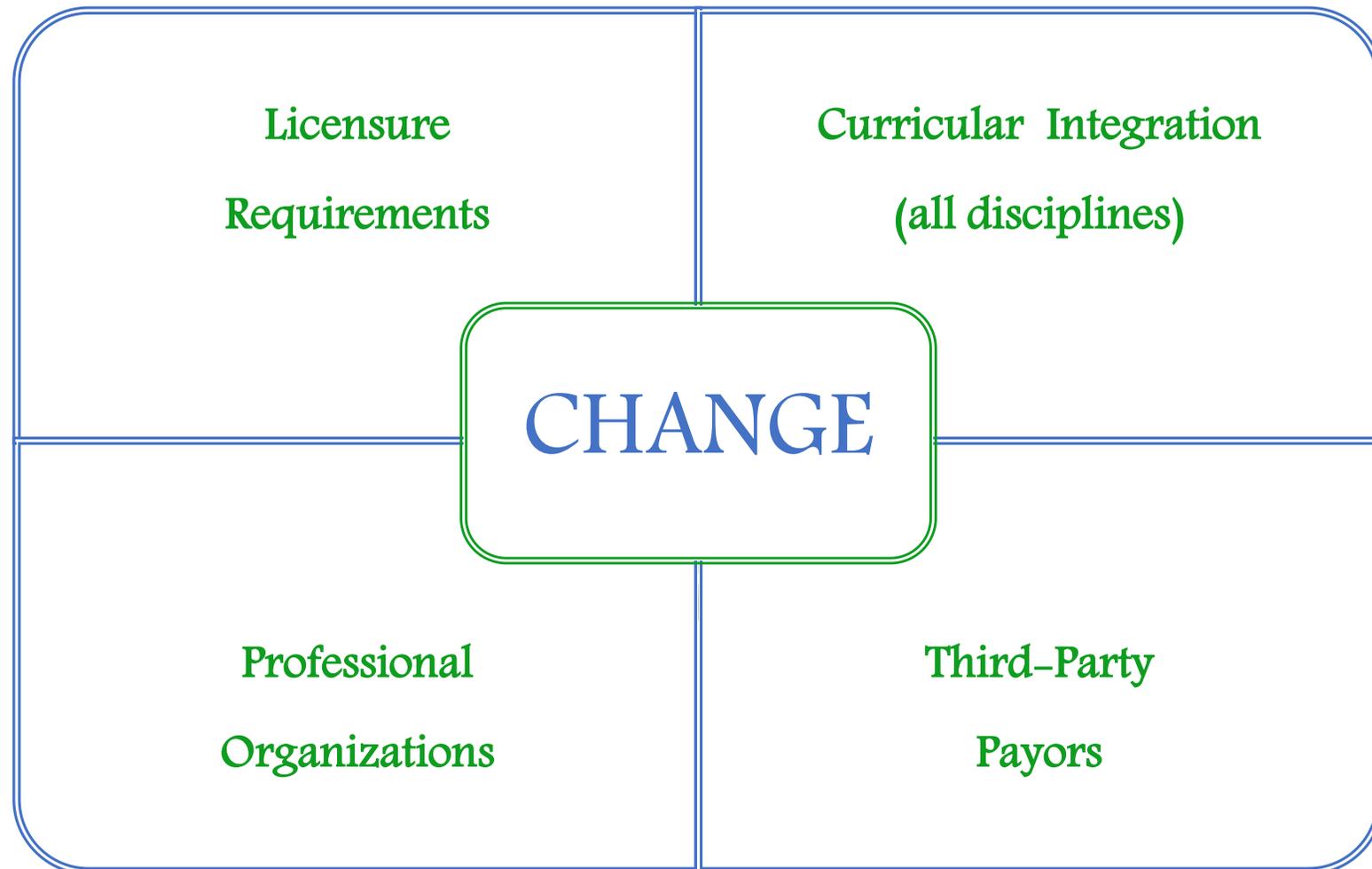
**February 2014**

First wide-spread sex-specific dosing recommendation issued by the US Food and Drug Administration.

Zolpidem (Ambien®) maximum dosing recommendation was cut in half (10mg to 5mg) after reports of morning impairment, including accidents and deaths. The majority of these events were in women.



# Achieving Comprehensive Change



# Personalized Care: Sex and Gender Matters

The practice of **one-sex medicine** is no longer an option.

Without the inclusion of sex and gender, **personalized medicine is unachievable.**



# Not Knowing The Difference Doesn't Mean There Is No Difference



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# Questions or Interest? Contact

Dr. Marjorie Jenkins  
[marjorie.jenkins@ttuhsc.edu](mailto:marjorie.jenkins@ttuhsc.edu)