BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DEPARTMENT OF CONSUMER AFFAIRS • VETERINARY MEDICAL BOARD
1747 North Market Blvd., Suite 230, Sacramento, CA 95834-2987
P (916) 515-5520 | Toll-Free (866) 229-6849 | www.vmb.ca.gov

MEMORANDUM

DATE	January 25, 2021
TO	Multidisciplinary Advisory Committee (MDC)
FROM	Telemedicine Subcommittee (Subcommittee) Kristi Pawlowski, RVT, Chair Richard Sullivan, DVM
SUBJECT	**Agenda Item 6. Discussion and Potential Recommendation on Section 2032.1, Article 4, Division 20, Title 16 of the California Code of Regulations (CCR) Regarding Telemedicine and Time to Refill Prescriptions**

Background

In May 2020, the Board voted to request the Director of the Department of Consumer Affairs (DCA) issue a temporary waiver of California Code of Regulations (CCR),title 16, section 2032.1, subsection (b)(3), to the extent it requires a veterinarian to have communicated with the client a course of treatment appropriate to the circumstance in order to establish a veterinarian-client-patient relationship (VCPR).

The Board requested the waiver be effective for the duration of the current State of Emergency issued by Governor Gavin Newson on March 4, 2020, or until January 1, 2021, whichever date was earlier.

In addition, the Board voted to request a waiver of CCR, title 16, section 2032.1, subsection (c), to the extent it prohibits a veterinarian from prescribing a drug for a duration longer than one year from the date the veterinarian examined the animal and prescribed the drug. This temporary waiver was requested for issuance of prescriptions for a duration of no longer than 18 months from the date of last examination and prescription of the medication or until the Declaration of Emergency ends, whichever date was earlier.

Pursuant to Governor Newsom's Executive Order N-39-20, on June 4, 2020, the DCA Director issued an Order Waiving Restrictions on Telemedicine and Extending Time to Refill Prescriptions (June 4 Order), which contained two waivers regarding the VCPR.

Telemedicine Waiver

With respect to telemedicine restrictions related to the VCPR, the June 4 Order was extended on July 31, 2020, and extended again on September 17, 2020, so that the waiver was in effect through December 31, 2020.

In November 2020, the Board's Executive Committee requested the DCA Director extend the waivers for 60 days, allowing time for the Board to decide if it would like to further extend the waivers.

On December 15, 2020, the Director issued a new Order (December 15 Order) further extending the June 4 Order waiving, until February 28, 2021, specified telemedicine restrictions related to the VCPR.

Prescriptions

For prescription refills associated with the VCPR, the June 4 Order authorized prescription refills up to 18 months for refills based on an in-person examination of an animal patient last performed by a veterinarian between June 1, 2019 and August 1, 2019. On November 25, 2020, the Director withdrew and superseded that waiver and issued an order authorizing prescription refills up to 20 months for refills based on an in-person examination of the animal patient last performed by the veterinarian between June 1, 2019 and August 1, 2019.

On July 31, 2020, the Director issued an order authorizing prescription refills up to 18 months for prescriptions that may be not be refilled between August 2, 2020, and October 1, 2020, due to the one-year time limitation for refilling a prescription from the date the veterinarian last examined the animal patient and prescribed the drug.

On September 17, 2020, the Director issued an order authorizing prescription refills up to 18 months for prescriptions that may be not be refilled between October 2, 2020, and December 31, 2020, due to the one-year time limitation for refilling a prescription from the date the veterinarian last examined the animal patient and prescribed the drug.

The December 15 Order authorizes prescription refills up to 18 months for prescriptions that may be not be refilled between January 1, 2021, and February 28, 2021, due to the one-year time limitation for refilling a prescription from the date the veterinarian last examined the animal patient and prescribed the drug.

MDC Review

During the July 2020 Board meeting, the Board directed the MDC to evaluate the telemedicine waiver and determine whether it should be made permanent. MDC Chair, Kristi Pawlowski, RVT, joined Dr. Richard Sullivan to form this Subcommittee to research this matter further and help facilitate the MDC's collaborative discussions during the October 21, 2020 meeting.

During the October meeting, MDC members heard from stakeholders with differing perspectives regarding the benefits and concerns of providing veterinary care through telemedicine. The MDC members asked questions of the stakeholders and engaged in a collaborative discussion. No actions were taken during this meeting.

The MDC will continue its discussion on these matters during the January 27, 2020 MDC meeting. During that meeting, the Subcommittee will provide examples of what telemedicine services are and are not currently allowed under existing law (without the waivers) and what additional telemedicine services are allowed with the waivers. MDC

members will hear from the Executive Director of The College of Veterinarians of Ontario (CVO) about how they regulate telemedicine with the least restrictive requirements in North America. CVO's Professional Practice Standard and related Guide regarding telemedicine are attached for reference.

In addition, the MDC will hear from the American Association of Veterinary State Board's Virtual Veterinary Care panelist, Aaron Smiley, DVM, on how he utilizes telemedicine in his practice.

Subcommittee Recommendation
The Subcommittee acknowledges the need for clarity in the regulation and believes this is due to the lack of definitions for telehealth and telemedicine. The Subcommittee recommends the Board pursue rulemaking to clarify the difference between telehealth and telemedicine and provide education necessary for the profession to comply with the Veterinary Medicine Practice Act.

Action Requested

If the MDC seeks more information on defining telehealth and telemedicine prior to making a rulemaking recommendation to the Board, please consider directing the Subcommittee to research the issue further and present recommendations at a future MDC meeting.

After consideration of all the information provided and listening to the panelists and stakeholder, if the MDC determines the regulatory language requiring a VCPR to be established for each medical condition for the provision of telemedicine is necessary to protect consumers, please entertain the following motion: In order to adequately protect consumers and animal patients in the provision of veterinary telemedicine, the MDC recommends maintaining the existing VCPR condition specific language.

Attachments:
1. CVO's Professional Practice Standard, Telemedicine, Revised September 2018
2. CVO's Guide to the Professional Practice Standard, Telemedicine, Revised November 2017
3. CVO's Regulatory Sandbox Policy, June 2020
4. CVO's Notice to Licensed Members Relaxing Certain Regulations on Prescribing and Describing During Public Health Emergency, March 18, 2020
5. CVO's Telemedicine Survey Summary
6. CVO's PowerPoint Presentation to the VMB
7. "Assessment of Disparities in Digital Access Among Medicare Beneficiaries and Implications for Telemedicine," JAMA Internal Medicine, October 2020
8. Telehealth vs. Telemedicine definitions
9. CVMA Comments on Telemedicine Proposal, January 25, 2021

THE COLLEGE OF VETERINARIANS OF ONTARIO

PROFESSIONAL PRACTICE STANDARD

Telemedicine

Published: May 2016
Revised: March 2017; September 2018

Introduction[1]

Advancements in communication and information technology provide opportunities for new approaches to the delivery of veterinary medicine. As the broader world of telehealth continues to expand, the College recognizes the value of utilizing developments in technology to improve access to the provision of veterinary medicine, where appropriate, and supports innovations in the delivery of veterinary services.

In all circumstances, an individual practising veterinary medicine in Ontario must be licensed with the College of Veterinarians of Ontario. This standard should not be construed to alter the scope of practice of any veterinarian or authorize the delivery of veterinary medicine in a manner not otherwise authorized by legislation. This standard supports a consistent standard of care and scope of practice notwithstanding whether the tools of delivery are physically or virtually based. For clarity, a veterinarian using telemedicine technologies in the provision of veterinary services to a patient (whether existing or new) must take appropriate steps to establish the veterinarian-client-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not.

[1] Introduction adapted from the Federation of State Medical Boards' Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine

The College has developed this standard to educate licensed members as to the appropriate use of telemedicine technologies in the practice of veterinary medicine. The College is committed to assuring patient and client access to the convenience and benefits offered by telemedicine technologies, while promoting the responsible practice of veterinary medicine by veterinarians.

Definitions[2]

Telemedicine: Telemedicine is the provision of specific veterinary medical advice and veterinary treatment of an animal(s) based on the remote diagnosis of disease and injury by means of telecommunications technology where no physical examination of the animal(s) by the veterinarian takes place. It does not include consultation between veterinarians where colleagues in different physical locations consult remotely with each other or the provision of general, non-specific, advice.

Telehealth: Telehealth is the overarching term that encompasses all uses of technology geared to remotely deliver health information, education or care remotely. Telehealth includes a broad variety of technology and tactics to deliver virtual medicine, health and education services. Telehealth is not a specific service, but a collection of tools which allow veterinarians to enhance care and education delivery. Telehealth encompasses both telemedicine and general advice.

Practice Expectations

A veterinarian meets the Professional Practice Standard: Telemedicine when he/she:

1. Understands that a veterinarian-client-patient relationship is established via telemedicine meeting the same expectations as when the relationship is established in-person.

2. Understands that practising veterinary medicine via telemedicine is only permitted in the context of a valid veterinarian-client-patient relationship.

3. Understands that telemedicine is a method or mode of delivering veterinary medicine, rather than a new model of practice. Further, a veterinarian's existing legal and professional obligations are not altered when veterinary medicine is provided via telemedicine.

4. Employs sound professional judgment to determine whether using telemedicine is appropriate in particular circumstances each and every time he or she considers practising via telemedicine, and only provides advice via telemedicine to the extent that it is possible without a physical examination. In doing so, a veterinarian must consider whether practising via telemedicine will enable him or her to satisfy all relevant and applicable legal and professional obligations, and meet the expected standard of care in any specific case. He or she does not

[2] Working definitions taken from the benchmark created by the Innovation and Technology Advisory Group of the College of Veterinarians of Ontario

substitute telemedicine technology for a physical examination when a physical examination is necessary, and where he or she could not thereby make an appropriate diagnosis or create a treatment plan.

5. Accepts that he or she cannot prescribe drugs when practising via telemedicine alone, unless the veterinarian has recent and sufficient knowledge of the animal or group of animals by virtue of a history and inquiry and either physical examination of the animal(s) or groups of animals or medically appropriate and timely visits to the premises where the animal or group of animals is kept to reach at least a general or preliminary diagnosis.

6. Practises veterinary medicine via telemedicine only in association with an accredited facility.

7. Ensures that the client is aware of the veterinarian's location, licensure status and the privacy and security issues involved in accessing veterinary care via telemedicine.

8. Ensures that he or she safeguards a client's privacy when practising via telemedicine by taking appropriate precautions and confirming that the technology and physical setting being used by the veterinarian and client have adequate security protocols in place to ensure compliance with the veterinarian's legal and professional obligations to protect clients' privacy and confidentiality.

9. Ensures that the technology used with respect to practice via telemedicine is of sufficient and appropriate quality to ensure the accuracy of remote assessment.

10. Ensures that information that is collected when a veterinarian practises via telemedicine becomes a part of the medical record. Maintains all applicable aspects of record keeping, outlined in the College's regulations and standards.

Legislative Authority

Veterinarians Act, R.S.O. 1990
R.R.O. 1990, Reg. 1093: General (*Veterinarians Act*)

Other References

The following can be found on the College's website at www.cvo.org:

Guide to the Professional Practice Standard: Telemedicine
Professional Practice Standard: Medical Records
Guide to the Professional Practice Standard: Medical Records
Professional Practice Standard: The Veterinarian-Client-Patient Relationship
Guide to the Professional Practice Standard: The Veterinarian-Client-Patient Relationship

Professional Practice Standard: Delegation
Professional Practice Standard: Informed Client Consent
Guide to the Professional Practice Standard: Informed Client Consent

THE COLLEGE OF VETERINARIANS OF ONTARIO

GUIDE TO THE PROFESSIONAL PRACTICE STANDARD

Telemedicine

Published: May 2016
Revised: November 2017

Introduction

The College's Professional Practice Standard: Telemedicine establishes the expectations that are fundamental to practicing veterinary medicine electronically via telemedicine. Telemedicine is a method of delivering veterinary medicine using information and communication technologies, such as video chat, when the veterinarian and animal being treated are in different physical locations. Using a question and answer format, this Guide to the Professional Practice Standard addresses questions and offers suggestions on how to apply the Professional Practice Standard in situations that arise in veterinary practice.

Frequently Asked Questions About What Constitutes Telemedicine

What does practising via telemedicine mean?

Practising via telemedicine refers to delivering veterinary medicine at a distance using telecommunication technology. It is a *method* or *mode* of delivering veterinary medicine using information and communication technologies, such as video chat, when the veterinarian and animal being treated are in different physical locations. Practising via telemedicine does not alter a veterinarian's existing legal and professional obligations.

Does telemedicine include consultation between veterinarians?

The College's chosen definition of telemedicine does not include teleconsultation, in which colleagues in different physical locations consult remotely with each other. The reasoning is that, in cases of teleconsultation, professional obligations and responsibilities remain with the licensed member who is in an established veterinarian-client-patient relationship (VCPR)

What are the expectations of a veterinarian when utilizing telemedicine exclusively?

A veterinarian can practice exclusively via telemedicine from an accredited facility and can establish a VCPR via telemedicine. He or she must inform the client about the scope of services that are available via telemedicine; the services are limited due to the veterinarian's inability to perform a physical examination or prescribe drugs.

Where is the practice of telemedicine occurring when a veterinarian and an animal are not in the same location?

It is the policy of the College of Veterinarians of Ontario that professional services are rendered where the Ontario animal(s) is located. All veterinarians who are treating Ontario animal(s), groups of animals, or herd(s) must be licensed in Ontario. Veterinarians who treat Ontario animals, groups of animals, or herds without an Ontario licence are engaged in unauthorized practice.

What are some examples of the appropriate use of telemedicine?

- A family on vacation consults with their veterinarian with whom they have a VCPR about an issue related to their pet's diabetes that the veterinarian has been treating. The veterinarian determines that he or she can consult about the condition without a physical examination, because one was performed recently
- A family skypes with their veterinarian to confer about a follow-up question after a recent onsite appointment
- A veterinarian consults with a client in a remote region via e-mail, inclusive of digital photographs.
- A food producer consults a veterinarian via video chat about a potential skin condition in a herd

Frequently Asked Questions About Determining When Telemedicine is Appropriate

Does service to a remote area require a valid and pre-existing VCPR if a client cannot get to a veterinarian in time?

There are exceptions to the need to establish a VCPR prior to providing veterinary medicine, including situations where a veterinarian, acting reasonably and with evidence, determines that there is an emergency situation and that an animal or animals require(s) immediate veterinary services.

Frequently Asked Questions About Practising Via Telemedicine

Does a veterinarian have to work from an accredited facility to practice via telemedicine?

Yes. A veterinarian licensed in Ontario must work from an accredited facility to practice veterinary medicine. This is no different when practicing via telemedicine. The veterinarian can be the owner or an associate at an accredited hospital, mobile, or office that offers telemedicine services. Veterinarians do not have to be physically present at the accredited facility to provide telemedicine service, although they can be.

A veterinarian may also open a new practice that exclusively provides telemedicine

services. They would need to apply to the College to become accredited as an office.

How often should a veterinarian see an animal, group of animals, or herd in person when practising via telemedicine?

The appropriate timelines of visits will depend on the circumstances of a case and on the VCPR.

Can a veterinarian work with a third-party company that provides a software or web interface which offers virtual access to veterinary services?

Yes. Third-party companies may offer and provide services to veterinarians that facilitate public access to veterinary services. Veterinarians should ensure that third-party companies are allowing the public to choose their veterinarian and should not be involved in a system of steering. Veterinary service must be provided by veterinarians only and veterinarians must be affiliated with an accredited facility. A third party company is not an accredited facility.

How will clients know who is responding to a query via telemedicine?

A veterinarian should always clearly identify himself or herself and indicate his or her location and accredited facility name to the client as an assurance of the veterinarian's identity. He or she should indicate that this information is verifiable on the public register.

When should veterinarians respond to queries made via telemedicine?

Telemedicine is merely a mode of delivering veterinary medicine. Practising via telemedicine does not change a veterinarian's existing professional obligations to provide guidance to clients on what is necessary to provide safe, quality animal care.

Is it permissible to bill clients for services that are provided via telemedicine?

Veterinarians can bill for services provided via telemedicine when they feel that it would be appropriate to do so.

What are the medical record requirements when practising via telemedicine?

A veterinarian's existing legal and professional obligations are not altered when veterinary services are provided via telemedicine. This includes the requirement to keep accurate and complete medical records which should be kept at the accredited facility that the veterinarian is associated with. Veterinarians should adhere to the medical records requirements required by Regulation 1093 and College policy when providing veterinary medicine via telemedicine. A veterinarian should make a note that a service was provided via telemedicine if he or she also offers services in-person. Following a telemedicine encounter, the veterinarian should transfer medical records to a client's usual veterinarian, if applicable.

Legislative Authority

Veterinarians Act, R.S.O. 1990, c. V.3 and R.R.O. 1990, Reg. 1093: GENERAL

Other References

The following can be found on the College's website at www.cvo.org:

Professional Practice Standard: Telemedicine
Professional Practice Standard: Medical Records
Guide to the Professional Practice Standard: Medical Records
Professional Practice Standard: The Veterinarian-Client-Patient Relationship
Guide to the Professional Practice Standard: Veterinarian-Client-Patient Relationship
Professional Practice Standard: Delegation
Professional Practice Standard: Informed Client Consent
Guide to the Professional Practice Standard: Informed Client Consent

Policy	Regulatory Sandbox
Date Approved	June 2020
Date Revised	

Policy

The Regulatory Sandbox is a Council initiative which supports problem-solving through innovative strategy. It permits the exemption of certain regulatory requirements in order to test new products, services or ways of practising veterinary medicine on a time limited basis and with appropriate safeguards for public protection.

A Regulatory Sandbox permits the ability to safely assess the scope and nature of the regulatory implications of an innovative solution to an identified risk-based problem and determine what might be required, or not, to modernize the veterinary regulatory framework.

Definition

A Regulatory Sandbox is a tool designed to allow a regulator to relax specific legal and regulatory requirements to create a safe space to experiment with an innovative idea while mitigating any fallout from failure. It is particularly helpful in identifying where existing regulations hinder innovation and where amended rules might better manage public protection.

A Regulatory Sandbox is managed by the regulator, and it is the regulator that permits a project to happen outside normal rules, but within a strict protocol for the duration of the pilot project.

Overarching Principles

As innovation in the veterinary sector becomes essential to solving emerging issues in service delivery and public expectation, the College's Regulatory Sandbox allows ideas to be introduced for trial that require exemption from existing regulatory requirements while maintaining public protection.

All ideas approved to operate in the Sandbox remain subject to all applicable regulatory requirements and any conditions, terms or limitations approved by Council. Any exemption granted is on a time limited basis, with agreed-to milestones and risk management oversight. Every agreement is subject to regular reporting and the evaluation of outcomes.

Criteria for Sandbox Project Selection

The criteria to be used to determine approval of a Regulatory Sandbox project include:

1. Identification of a specific problem not able to be solved within existing regulatory parameters
2. Identification of specific regulatory barriers that prevent safe testing and trial

3. Demonstrated alignment with the College mandate, its Strategic Plan and the public interest
4. A clearly articulated innovation solution to the identified problem inclusive of critical success factors
5. An articulated risk mitigation plan ensuring animal and public safety
6. Identified key leadership
7. A detailed workplan for a time limited trial, including project milestones, reporting and evaluation intervals
8. Projected financial implications for the College

Procedure

1. Concepts believed suitable for a Regulatory Sandbox project will be introduced by the Registrar and receive a first critique by the Executive Committee.

2. A Sandbox project that meets all the criteria will be forwarded to Council for its approval.

3. Where the opportunity includes a product or service of a third party and where public disclosure prior to market release would risk potential intellectual property confidentiality breach, Council's debate and discussion will be held in camera utilizing its customary rules for such action.

4. Progress on all Sandbox projects will be regularly reported to Council as per an agreed-upon project workplan.

THE COLLEGE OF VETERINARIANS OF ONTARIO

Coronavirus:

URGENT NOTICE
from the College of Veterinarians of Ontario

March 18, 2020

College Temporarily Relaxes Certain Regulations on Prescribing and Dispensing During Public Health Emergency

As the need for physical distancing and other public health measures to curb the spread of COVID-19 exists, the challenges relating to regulations prohibiting prescribing via telemedicine alone have become clear. As a result, the College has made a decision to temporarily relax certain regulations relating to prescribing via telemedicine during the current public health emergency.

Prescribing and Dispensing Drugs Via Telemedicine Alone
The ability to prescribe drugs to an animal in Ontario is, and continues to be, restricted to licensed veterinarians in Ontario.

Under the College's existing rules and regulations, a veterinarian-client-patient relationship (VCPR) may be established via telemedicine alone.

Currently, College regulations and policy state that a licensed veterinarian may not prescribe drugs when practising via telemedicine alone, as they would not have recent and sufficient knowledge of the animal obtained by a physical examination.

The College has made the decision to not strictly enforce certain provisions of our regulation (section 33. (1) (b) of Regulation 1093) during the current public health emergency. Veterinarians may now, until otherwise directed, prescribe a non-controlled drug using telemedicine alone, in cases where they have not conducted an in-person examination of the animal(s), and where they deem this necessary and prudent in their professional judgment. In such a case, the assessment of the animal(s) would be conducted virtually where a veterinarian can gather sufficient information on the animal(s) via telemedicine to reach at least a general or preliminary diagnosis, and continue to maintain medical records.

Possible scenarios currently are:

- As is the case currently, a licensed veterinarian within an existing VCPR may prescribe drugs for a patient with a known condition via telemedicine alone where they have recent and sufficient knowledge.

- Now, within an existing VCPR, where the patient is being presented for a new condition via telemedicine, a veterinarian may prescribe a non-controlled drug using telemedicine alone.
- Now, when a new VCPR is established via telemedicine, a veterinarian may prescribe a non-controlled drug using telemedicine alone.

Dispensing Drugs for an Animal Pursuant to another Veterinarian's Prescription
In general, veterinarians do not act as dispensing pharmacies for each other and are not obligated to dispense drugs outside of a VCPR but during these uncertain times a client's regular veterinarian may not be available. There is a narrowly-defined exemption in the College's regulations, which is not changing, that allows a veterinarian to dispense a non-controlled drug pursuant to a prescription from another veterinarian who is licensed in Ontario (the prescribing veterinarian) when the following conditions are met:

(a) it is not reasonably possible for the client to obtain the drug from the prescribing veterinarian or a pharmacy;
(b) it is necessary in the interests of the animal to administer or dispense the drug without the delay that would be associated with returning to the prescribing veterinarian;
(c) the dispensing veterinarian makes a reasonable effort to discuss the matter with the prescribing member;
(d) the dispensing veterinarian conducts a sufficient assessment of the animal's circumstances, which may not require a physical examination in every case, to ascertain that it is unlikely that there has been a material change in the circumstances since the prescription was given;
(e) the quantity of the drug dispensed is no more than would reasonably enable the client to return to the prescribing veterinarian for future prescriptions or quantities of the drug; and
(f) the dispensing veterinarian makes a written record of the transaction.

Inter-Professional Collaboration
Both veterinarians and pharmacists are dispensing professions. In these challenging times, it is of the utmost importance to work collaboratively, inter-professionally, and responsibly to reduce unnecessary exposure to COVID-19 and assist where drugs may be in short supply. Veterinarians are encouraged to reach out to, and co-operate with, pharmacies for the purposes of dispensing, where this would allow for greater accessibility and less exposure to COVID-19.

Survey Sent to All Members in Private Practice (3857)

1165 Respones

30% Response Rate

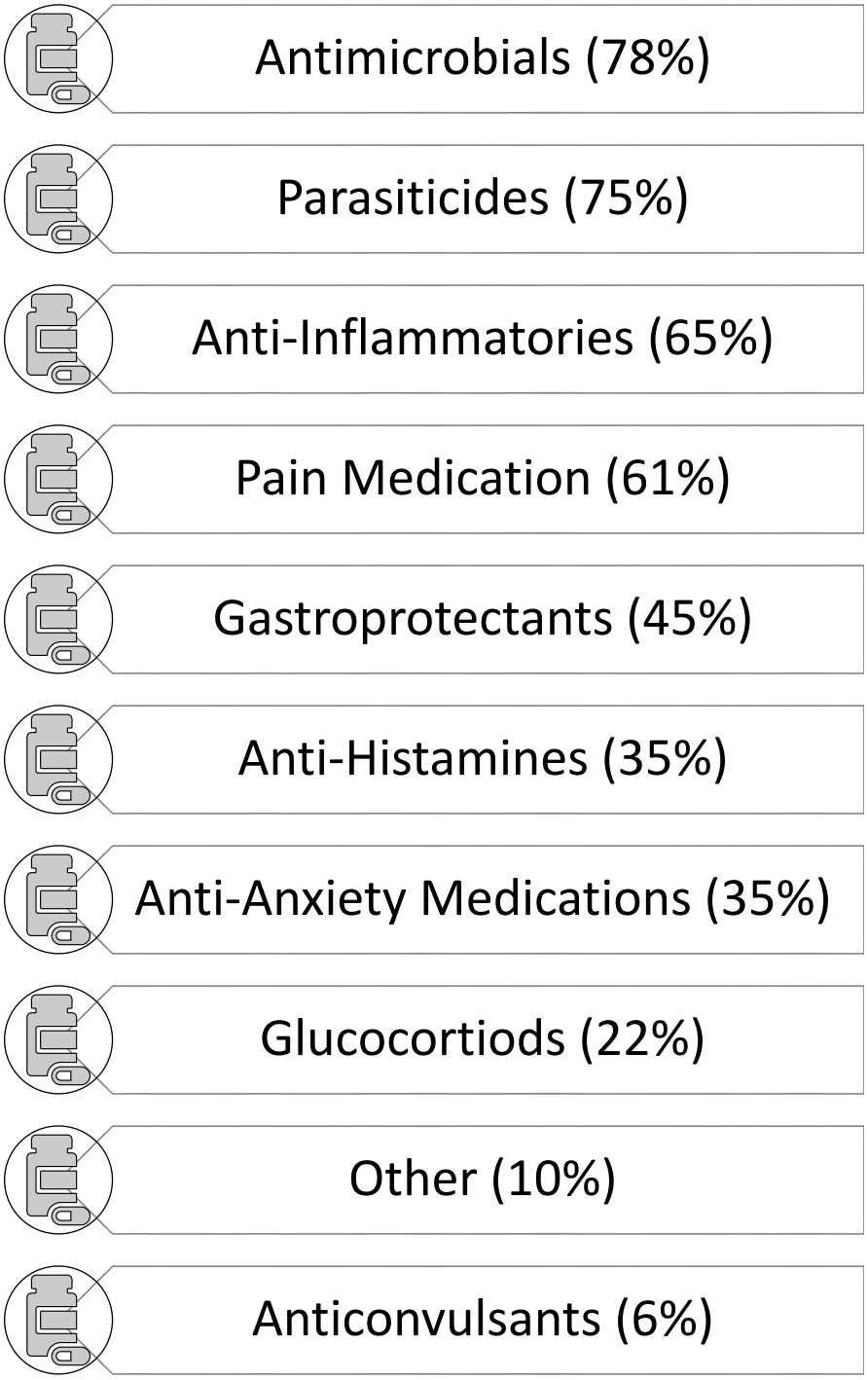
90% Aware of Temporary Allowance

72% Utilized Prescribing via Telemedicine Alone

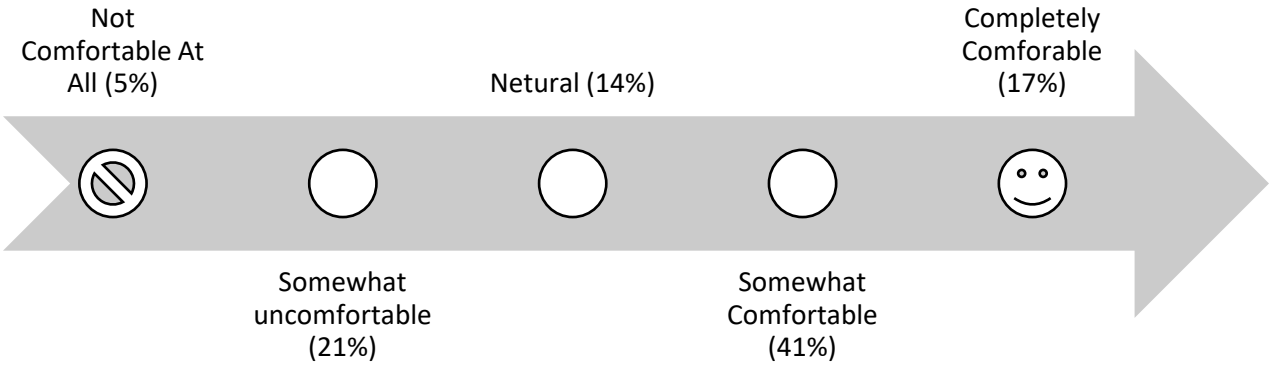
Reasons for Not Utilizing

1. Type of Practice Not Applicable
2. No Need
3. Prefer Physical Exam and/or Premise Visit
4. Not Currently Working

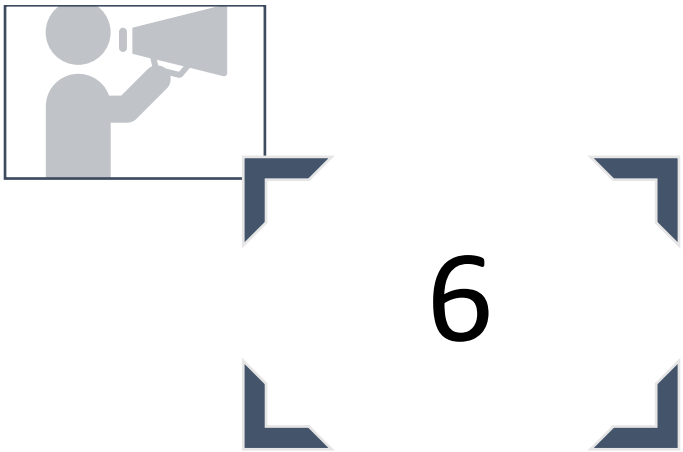
Types of Medications Prescribed



Level of Comfortable in Prescribing via Telemedicine Alone



How Strongly Do You Believe Prescribing Via Telemedicne Should Continue? (1-10)



Additional Comments Related to Prescribing via Telemedicine Alone

1. Prescribing via telemedicine alone should only be for certain types of prescriptions

2. Veterinarians should be allowed to use their professional judgement to determine when to prescribe via telemedicine alone

3. Telemedicine should not replace the need for a physical exam and/or premise visit

4. Clients provide incorrect or improper information that can lead to misdiagnosis

5. Prescribing via telemedicine alone better serves rural/remote/vulnerable clients and animals

6. Prescribing via telemedicine alone offers greater client access and/or affordability

7. Prescribing via telemedicine alone will require clear regulations/rules/guidelines

8. Prescribing via telemedicine alone should only be allowed during the pandemic

9. In support of continuing to allow prescribing via telemedicine alone

10. Concerns about drug misuse/antimicrobial stewardship

11. Allow for prescribing via telemedicine alone if a follow-up in-person physical exam and/or premise visit is required

12. Prescribing via telemedicine alone will discourage clients from bringing their animals in for an exam

Summary of Raw Data

Q1 - A veterinarian working from an accredited facility can establish a veterinarian-client-patient relationship ("VCPR") with a new client/patient via telemedicine alone. However, a veterinarian must have recent and sufficient knowledge of the animal(s) obtained through either a physical examination or premise visit to prescribe a drug. Are you aware that the College temporarily modified these rules in response to the Covid-19 pandemic? The modification permits prescribing of all non-controlled drugs and substances to a new client/patient via telemedicine within a VCPR but without requiring a physical examination or premise visit to obtain recent and sufficient knowledge.

- Answered: 1,162 Skipped: 3
- Yes: 1,043 (89.76%) No: 119 (10.24%)

Q2 – Have you utilized the ability to prescribe through telemedicine during the pandemic?

- Answered: 1,141 Skipped: 24
- Yes: 821 (71.95%) No: 320 (28.05%)
- Respondents who indicated "Yes" were directed to Q4
- Respondents who indicated "No" were directed to Q3

Q3 – Why not?

- Answered: 278 Skipped: 887
- Comments were reviewed for common themes. Top four themes presented in the infographic
- The survey ended for respondents after Q3

Q4 – What type of non-controlled drugs and/or substances have you prescribed to clients through telemedicine within a VCPR but without a physical examination or premise visit?

- Answered: 801 Skipped: 364
- Antimicrobials: 622 (77.65%) Anti-Inflammatories: 522 (65.17%) Anti-Anxiety Medications: 278 (34.71%) Antihistamines: 281 (35.08%) Glucocorticoids: 174 (21.72%) Pain Medications: 492 (61.42%) Anticonvulsants: 47 (5.87%) Parasiticides: 600 (74.91%) Gastroprotectants: 362 (45.19%) Other: 81 (10.11%)
- Other included: nutraceuticals, eye/ear drops, anti-emetics, anti-fungals, topicals, apoquel, supplements

Q5 – On a scale of 1-5, what is your comfort level to prescribe via telemedicine within a VCPR but without a physical examination or premise visit?

- Answered: 798 Skipped: 367
- Not comfortable at all: 40 (5.01%) Somewhat uncomfortable: 166 (20.80%) Neutral: 115 (14.41%) Somewhat comfortable: 340 (42.61%) Completely comfortable 137 (17.17%)

Q6 – On a scale of 1-10, how strongly do you believe that the College's Professional Practice Standard: Telemedicine should be altered to permanently allow prescribing through telemedicine within a VCPR but without a physical examination or premise visit?

- Answered: 790 Skipped: 375
- Total numbers: 5,403
- Average response: 6

Q7 – Do you have any other comments related to this topic?

- Answered: 328 Skipped: 837
- Comments were reviewed for common themes. Top twelve themes presented.

THE COLLEGE OF VETERINARIANS OF ONTARIO

THE EVOLUTION OF TELEMEDICINE IN ONTARIO, CANADA

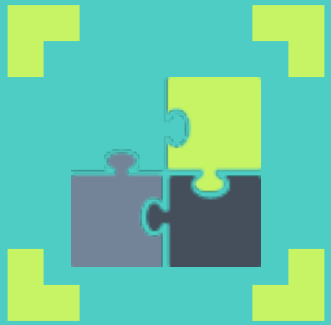
Jan Robinson
Registrar &
Chief Executive Officer
College of Veterinarians
of Ontario

January 2021

VETERINARY Context

Ontario

GOVERNANCE Context



STRATEGY 2017

2016 First Professional Practice STANDARD

INNOVATION and TECHNOLOGY Advisory Group

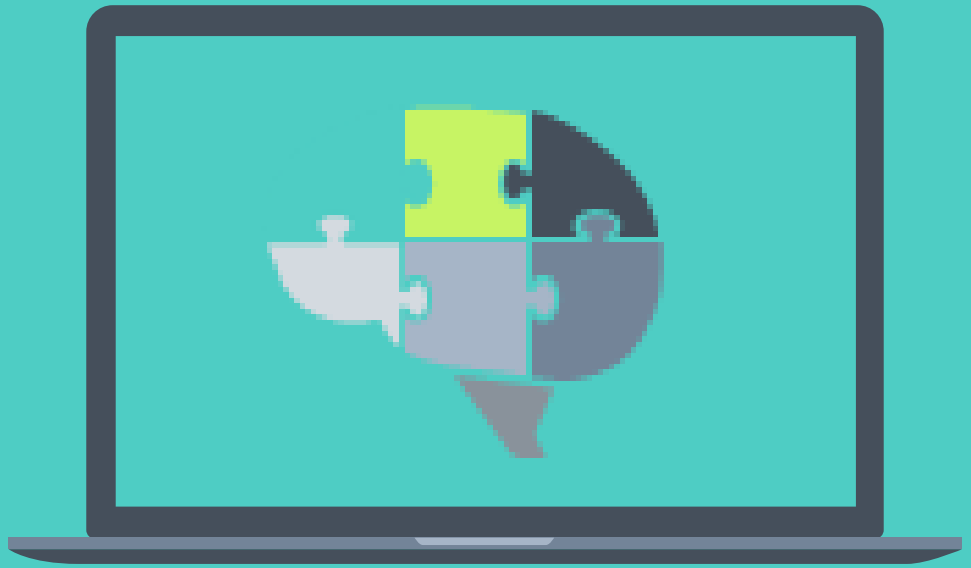
VCPR

Focus of changes in 2018

2018

First accredited FACILITY

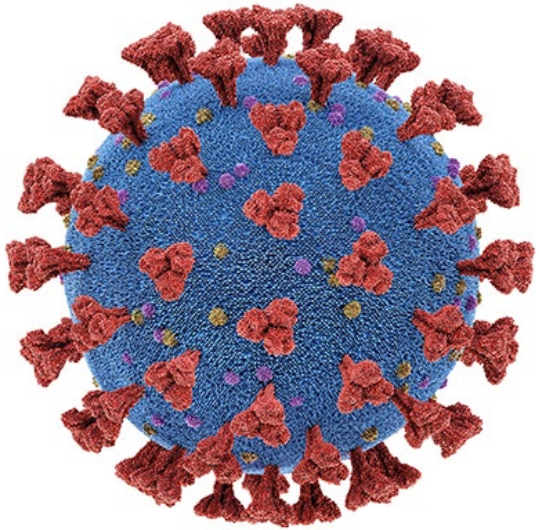
Discussions with INNOVATORS



DISCUSSIONS at the national level

ENFORCEMENT

COVID - 19 and prescribing



The future…

Questions

THE COLLEGE OF VETERINARIANS OF ONTARIO

Thanks!

Jan Robinson

Registrar & Chief Executive Officer
College of Veterinarians of Ontario
www.cvo.org
jrobinson@cvo.org

THE COLLEGE OF VETERINARIANS OF ONTARIO

quine from retail pharmacies, including an approximate additional 93 000 patients who received both hydroxychloroquine and azithromycin. First, evidence of efficacy in preventing or treating COVID-19 is limited. Treatment guidelines found insufficient clinical data to recommend for or against hydroxychloroquine or chloroquine use and recommend against combining either with azithromycin, except in clinical trials.[1] Second, because of reports of cardiac and other adverse events, the US Food and Drug Administration has cautioned against using hydroxychloroquine or chloroquine for COVID-19 outside of hospitalized settings or clinical trials.[5] If azithromycin is used with hydroxychloroquine or chloroquine, correcting electrolyte levels, completing electrocardiographic monitoring, and avoiding other QTc interval-prolonging drugs are recommended.[6] Third, sudden increases in demand for hydroxychloroquine and chloroquine limit availability for FDA-approved uses for rheumatoid arthritis, lupus, and malaria.[5] While some of the largest increases in hydroxychloroquine and chloroquine dispensing occurred in states with high COVID-19 case rates (eg, New Jersey, New York), other states with large increases in dispensing had moderate (eg, Florida) or low (eg, Hawaii) case rates.

These data do not include prescribing indication, so not all increased dispensing may be for COVID-19. It is unknown if patients immediately used or saved these medications. Finally, data were collected prior to release of many treatment guidelines and as state board of pharmacy dispensing regulations for hydroxychloroquine and chloroquine were evolving.[2]

As COVID-19 continues to spread, ongoing assessment of the use of potential therapies will be essential to inform safe and appropriate treatment, along with prompt adverse event reporting to FDA's MedWatch safety reporting program (https://www.fda.gov/safety/medwatch-fda-safety-information-and-adverse-event-reporting-program). State-specific data can help target efforts to improve prescribing.

Nadine Shehab, PharmD, MPH
Maribeth Lovegrove, MPH
Daniel S. Budnitz, MD, MPH

Author Affiliations: US Centers for Disease Control and Prevention COVID-19 Response Team, National Center for Emerging and Zoonotic Infectious Diseases, Division of Healthcare Quality Promotion, US Centers for Disease Control and Prevention, Atlanta, Georgia (Shehab, Lovegrove, Budnitz); Lantana Consulting Group, Atlanta, Georgia (Shehab).

Accepted for Publication: June 9, 2020.

Corresponding Author: Daniel S. Budnitz, MD, MPH, US Centers for Disease Control and Prevention COVID-19 Response Team, National Center for Emerging and Zoonotic Infectious Diseases, Division of Healthcare Quality Promotion, US Centers for Disease Control and Prevention, 1600 Clifton Rd NE, Mailstop V18-4, Atlanta, GA 30329 (dbudnitz@cdc.gov).

Published Online: July 6, 2020. doi:10.1001/jamainternmed.2020.2594

Author Contributions: Dr Budnitz had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.
Concept and design: Shehab, Budnitz.
Acquisition, analysis, or interpretation of data: All authors.
Drafting of the manuscript: Shehab.
Critical revision of the manuscript for important intellectual content: Lovegrove, Budnitz.
Statistical analysis: Lovegrove.
Supervision: Budnitz.

Conflict of Interest Disclosures: None reported.

Funding/Support: This study was funded by the US federal government.

Role of the Funder/Sponsor: Federal government employees had a role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Disclaimer: The findings and conclusion in this report are those of the authors and do not necessarily represent the official position of the US Centers for Disease Control and Prevention.

Additional Contributions: We thank Mathew Sapiano, PhD, Lantana Consulting Group, a contractor to the US Centers for Disease Control and Prevention, for assistance with data visualization and Andrew Geller, MD, Centers for Disease Control and Prevention, for review of the manuscript. No funding was received by Drs Sapiano and Geller.

1. National Institutes of Health. COVID-19 treatment guidelines. Published 2020. Accessed April 30, 2020. https://covid19treatmentguidelines.nih.gov/introduction/

2. American Medical Association. Joint statement on ordering, prescribing or dispensing COVID-19 medications. Published 2020. Accessed April 30, 2020. https://www.ama-assn.org/delivering-care/public-health/joint-statement-ordering-prescribing-or-dispensing-covid-19

3. Liu M, Caputi TL, Dredze M, Kesselheim AS, Ayers JW. Internet searches for unproven COVID-19 therapies in the United States. *JAMA Intern Med*. Published online April 29, 2020.. doi:10.1001/jamainternmed.2020.1764

4. US Centers for Disease Control and Prevention. 2019 Annual surveillance report of drug-related risks and outcomes—United States Surveillance Special Report. Published November 1, 2019. Accessed May 8, 2020. https://www.cdc.gov/drugoverdose/pdf/pubs/2019-cdc-drug-surveillance-report.pdf

5. US Food and Drug Administration. FDA drug safety communication: FDA cautions against use of hydroxychloroquine or chloroquine for COVID-19 outside of the hospital setting or a clinical trial due to risk of heart rhythm problems, does not affect FDA-approved uses for malaria, lupus, and rheumatoid arthritis. Published April 24, 2020. Accessed April 30, 2020. https://www.fda.gov/media/137250/download

6. Roden DM, Harrington RA, Poppas A, Russo AM. Considerations for drug interactions on QTc in exploratory COVID-19 (coronavirus disease 2019). *J Am Coll Cardiol*. Published online April, 2020. doi:10.1016/j.jacc.2020.04.016

HEALTH CARE POLICY AND LAW

Assessment of Disparities in Digital Access Among Medicare Beneficiaries and Implications for Telemedicine

In response to the coronavirus disease 2019 (COVID-19) pandemic, Medicare temporarily expanded its coverage of telemedicine to all beneficiaries, included visits in the patient's home, and began paying for audio-only visits at the same rate as video and in-person visits.[1,2] Previously, Medicare (with a few exceptions) limited telemedicine coverage to video visits for rural beneficiaries and required video visits to take place at a medical facility, such as a physician's office, rather than at a patient's home.[3]

Related article page 1389

Supplemental content

Access to technology at home and the ability to use technology may affect use of video or audio-only telemedicine visits by Medicare beneficiaries. Although evidence on the efficacy of video vs audio-only visits is lacking,[4] audio-only visits might be inadequate in some situations, such as when visual monitoring or diagnosis is important for care. We examined

Table. Limitations in Computer and Internet Access Among Community-Dwelling Medicare Beneficiaries in 2018[a]

Characteristic	Without desktop or laptop computer with high-speed internet[b]		Without smartphone with a data plan for wireless internet[c]		Without any digital access[d]	
	Proportion (95% CI), %	*P* value[e]	Proportion (95% CI), %	*P* value[e]	Proportion (95% CI), %	*P* value[e]
Among Medicare beneficiaries	41.4 (40.4-42.4)	NA	40.9 (40.0-41.8)	NA	26.3 (25.5-27.1)	NA
Sex						
Male	39.2 (38.1-40.2)	<.001	38.6 (37.6-39.7)	<.001	24.0 (23.2-24.9)	<.001
Female	43.3 (42.4-44.2)		42.8 (41.9-43.7)		28.1 (27.3-28.8)	
Age, y						
<64	46.8 (45.8-47.8)	<.001	35.2 (34.2-36.1)	<.001	24.4 (23.6-25.2)	<.001
65-69	33.5 (32.5-34.3)		29.8 (28.8-30.7)		17.1 (16.4-17.8)	
70-74	36.2 (35.1-37.3)		36.1 (35.0-37.2)		21.1 (20.3-22.0)	
75-59	42.0 (40.8-43.1)		46.1 (44.9-47.3)		28.6 (27.5-29.6)	
80-84	49.9 (48.7-51.1)		56.9 (55.6-58.1)		38.4 (37.2-39.6)	
≥85	59.1 (57.9-60.2)		66.5 (65.3-67.7)		50.0 (48.7-51.2)	
Race/ethnicity						
Non-Hispanic White	38.6 (37.4-39.8)	<.001	40.7 (39.7-41.7)	<.001	24.5 (23.6-25.3)	<.001
Non-Hispanic Black	56.3 (55.0-57.5)		47.9 (46.7-49.0)		37.3 (36.1-38.5)	
Hispanic	51.8 (50.7-53.0)		40.1 (38.9-41.2)		31.6 (30.5-32.7)	
Other	35.5 (33.4-37.5)		31.2 (29.3-33.1)		20.7 (18.9-22.6)	
Marital status						
Married	32.4 (31.4-33.5)	<.001	33.5 (32.5-34.5)	<.001	17.9 (17.2-18.7)	<.001
Widowed	54.3 (53.3-55.4)		54.5 (53.4-55.5)		40.6 (39.6-41.7)	
Divorced or separated	49.2 (48.1-50.3)		44.8 (43.8-45.8)		31.2 (30.3-32.2)	
Never married	51.7 (50.6-52.9)		47.6 (46.4-48.7)		34.3 (33.2-35.4)	
Educational attainment						
Less than high school	62.3 (61.2-63.4)	<.001	54.8 (53.6-56.1)	<.001	44.8 (43.7-46.0)	<.001
High school	49.9 (48.9-50.8)		50.1 (49.2-51.0)		34.2 (33.5-35.0)	
Some college or higher	30.3 (29.5-31.1)		31.4 (30.7-32.2)		16.1 (15.5-16.6)	

(continued)

disparities in digital access (ie, access at home to technology that enables video telemedicine visits) among Medicare beneficiaries by socioeconomic and demographic characteristics.

Methods | For this cross-sectional study, we analyzed public use respondent- and household-level data files from the 2018 American Community Survey (ACS; from January 1 2018, to December 31, 2018), a nationally representative survey of the US population. We selected respondents to the ACS who lived in the community (excluding those in nursing homes) and indicated that they were Medicare beneficiaries at the time of the survey. The University of Pittsburgh Institutional Review Board waived study review because this study used deidentified data and was determined to be non-human subjects research.

Among Medicare beneficiaries, we assessed the proportion who did not have (1) a desktop or laptop computer with a high-speed internet subscription, (2) a smartphone with a wireless data plan, or (3) either means of digital access. We examined how access limitations differed by, age, sex, race/ethnicity, marital status, educational level, language, income, enrollment in Medicaid, and disability status. We adjusted for person-level survey weights in the ACS to make our estimates representative of the national Medicare population. Analyses were performed using Stata, version 16 (StataCorp LLC). Reported *P* values were 2-sided and considered to be statistically significant at $P < .05$. The eAppendix in the Supplement provides more details about the methods.

Results | The study sample consisted of 638 830 surveyed individuals. When weighted, this sample represented 54 749 082 individuals in the community-dwelling Medicare population.

Overall, 41.4% (95% CI, 40.4%-42.4%) of Medicare beneficiaries lacked access to a desktop or laptop computer with a high-speed internet connection at home, and 40.9% (95% CI, 40.0%-41.8%) lacked a smartphone with a wireless data plan (**Table**). The proportion of beneficiaries without either form of digital access was 26.3% (95% CI, 25.5%-27.1%), and this proportion varied across demographic and socioeconomic groups. For example, a 50.1% (95% CI, 49.3%-50.9%) of beneficiaries with income of 100% below the federal poverty level lacked digital access compared with 11.5% (95% CI, 11.0%-11.9%) of those with income 400% or more above the federal poverty level ($P < .001$). The proportion of Medicare beneficiaries with digital access was lower among those who were 85 or older, were widowed, had a high school education or less, were Black or Hispanic, received Medicaid, or had a disability.

Discussion | Using data from 2018, we found that 26.3% of Medicare beneficiaries lacked digital access at home, making it unlikely that they could have telemedicine video visits with clinicians. The proportion of beneficiaries who lacked digital access was higher among those with low socioeconomic status, those 85 years or older, and in communities of color. Although Medicare's payment for audio-only visits at the same rate as video and in-person visits may be associated with im-

Table. Limitations in Computer and Internet Access Among Community-Dwelling Medicare Beneficiaries in 2018[a] (continued)

Characteristic	Without desktop or laptop computer with high-speed internet[b]		Without smartphone with a data plan for wireless internet[c]		Without any digital access[d]	
	Proportion (95% CI), %	*P* value[e]	Proportion (95% CI), %	*P* value[e]	Proportion (95% CI), %	*P* value[e]
Language spoken at home						
English	41.0 (39.9-42.1)	<.001	41.9 (40.9-42.8)	<.001	26.3 (25.4-27.1)	.01
Spanish	50.2 (49.0-51.4)		38.1 (37.0-39.2)		29.7 (28.6-30.9)	
Other	36.7 (35.5-37.9)		34.6 (33.3-35.9)		22.5 (21.3-23.6)	
Household income, % of FPL[f]						
<100	67.5 (66.7-68.2)	<.001	61.9 (61.1-62.7)	<.001	50.1 (49.3-50.9)	<.001
100 to <200	59.3 (58.5-60.1)		58.5 (57.5-59.4)		43.3 (42.4-44.2)	
200 to <300	44.1 (43.2-45.0)		45.5 (44.5-46.4)		27.9 (27.1-28.6)	
300 to <400	35.9 (34.9-36.8)		37.1 (36.2-38.0)		20.3 (19.6-21.0)	
≥400 FPL	25.0 (24.2-25.8)		24.5 (23.9-25.2)		11.5 (11.0-11.9)	
Enrolled in Medicaid						
Yes	54.4 (53.4-55.3)	<.001	47.3 (46.2-48.4)	<.001	36.1 (35.2-37.0)	<.001
No	38.5 (37.5-39.5)		39.5 (38.5-40.4)		24.0 (23.2-24.8)	
Has disability[g]						
Yes	48.9 (48.0-49.9)	<.001	48.1 (47.1-49.0)	<.001	33.6 (32.8-34.4)	<.001
No	36.9 (36.0-37.9)		36.7 (35.7-37.6)		21.8 (21.1-22.6)	

Abbreviations: FPL, federal poverty level; NA, not applicable.

[a] Analyses based on 638 830 observations in the 2018 American Community Survey. When weighted, this sample represented 54 749 082 individuals in the community-dwelling Medicare population.

[b] Medicare beneficiaries in households that did not have a desktop or laptop computer with high-speed internet provided via a cable, digital subscriber line, or fiber-optic connection. The eAppendix in the Supplement gives variable definitions.

[c] Medicare beneficiaries in households that did not have a smartphone or other mobile device with a data plan for wireless internet service. The eAppendix in the Supplement gives variable definitions.

[d] Medicare beneficiaries who not have access at home to either (1) a laptop or internet computer with a high-speed wireline internet connection or (2) a smartphone with a data plan for wireless internet service.

[e] *P* values are for differences between groups of Medicare beneficiaries categorized according to the demographic and socioeconomic variables shown and are adjusted for clustering within public use microdata areas.

[f] The FPL that applied to the individual's household size and state in 2018.

[g] Details of the assessment of disability status using the American Community Survey are given in the eAppendix in the Supplement.

proved access to care for those without digital access, the inability to have a video visit may be associated with increased disparities in access to care. Moreover, some Medicare beneficiaries are unable to use technology for video or even audio visits. Limitations of our study include the lack of data in the ACS on beneficiaries' ability to use technology or community-level broadband internet availability.

During the COVID-19 pandemic, federal telemedicine policy has focused on reimbursement and clinicians' capacity to deliver care remotely.[1] Our results underscore a need to address disparities in digital access among patients. Expanding programs such as Lifeline, a program of the Federal Communications Commission that provides reduced-cost phone or internet service to families with incomes 135% or more below the federal poverty level,[5] may help reduce disparities. However, Lifeline does not pay for devices, and patients may also need assistance using technology for video visits. Addressing these factors associated with digital access in populations with low socioeconomic status will be important as the use of telemedicine increases.

Eric T. Roberts, PhD
Ateev Mehrotra, MD, MPH

Author Affiliations: Department of Health Policy & Management, University of Pittsburgh Graduate School of Public Health, Pittsburgh, Pennsylvania (Roberts); Department of Health Care Policy, Harvard Medical School, Boston, Massachusetts (Mehrotra); Division of General Medicine and Primary Care, Beth Israel Deaconess Medical Center, Boston, Massachusetts (Mehrotra).

Corresponding Author: Eric T. Roberts, PhD, Department of Health Policy & Management, University of Pittsburgh Graduate School of Public Health, 130 DeSoto St, Rm A653, Pittsburgh, PA 15261 (eric.roberts@pitt.edu).

Published Online: August 3, 2020. doi:10.1001/jamainternmed.2020.2666

Author Contributions: Eric T. Roberts, PhD, had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.
Concept and design: Both authors.
Acquisition, analysis, or interpretation of data: Roberts.
Drafting of the manuscript: Roberts.
Critical revision of the manuscript for important intellectual content: Both authors.
Statistical analysis: Roberts.
Supervision: Mehrotra.

Conflict of Interest Disclosures: Dr Mehrotra reported receiving grants from the National Institutes of Health during the conduct of the study. No other disclosures were reported.

Funding/Support: This study was supported by grant K01HS026727 (Dr Roberts) from the Agency for Healthcare Research and Quality and grants 1R01MH112829 and 1R01DA048533 (Dr Mehrotra) from the National Institutes of Health.

Role of the Funder/Sponsor: The funding organizations had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Disclaimer: This content is solely the responsibility of the authors and does not necessarily represent the official views of the Agency for Healthcare Research and Quality or the National Institutes of Health.

1. CMS. Medicare telemedicine health care provider fact sheet. Updated March 17, 2020. Accessed April 14, 2020. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

2. Centers for Medicare & Medicaid Services. Trump Administration issues second round of sweeping changes to support U.S. healthcare system during COVID-19 pandemic. Published April 30, 2020. Accessed May 5, 2020. https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid

3. Mehrotra A, Huskamp HA, Souza J, et al. Rapid growth in mental health telemedicine use among rural Medicare beneficiaries, wide variation across states. *Health Aff (Millwood)*. 2017;36(5):909-917. doi:10.1377/hlthaff.2016.1461

4. Grigsby J, Sanders JH. Telemedicine: where it is and where it's going. *Ann Intern Med*. 1998;129(2):123-127. doi:10.7326/0003-4819-129-2-199807150-00012

5. Federal Communications Commission. Lifeline support for affordable communications. Updated August 17, 2016. Accessed May 5, 2020. https://www.fcc.gov/consumers/guides/lifeline-support-affordable-communications

HEALTH CARE POLICY AND LAW

Assessing Telemedicine Unreadiness Among Older Adults in the United States During the COVID-19 Pandemic

There has been a massive shift to telemedicine during the coronavirus disease 2019 (COVID-19) pandemic to protect medical personnel and patients, with the Department of Health and Human Services and others promoting video visits to reach patients at home.[1,2] Video visits require patients to have the knowledge and capacity to get online, operate and troubleshoot audiovisual equipment, and communicate without the cues available in person. Many older adults may be unable to do this because of disabilities or inexperience with technology. This study estimated how many older adults may be left behind in the United States in the migration to telemedicine.

Related article page 1386

Methods | We completed a cross-sectional study of community-dwelling adults (N = 4525) using 2018 data from the National Health and Aging Trends Study, which is nationally representative of Medicare beneficiaries aged 65 or older, to assess the prevalence of telemedicine unreadiness. The institutional review board of the University of California, San Francisco, deemed this study not to be human subjects research because the data are deidentified and publicly available. *Telemedicine* is defined as the use of communications technology to deliver health care to patients at a distance. Envisioning telemedicine as direct-to-patient video visits, we defined *unreadiness* as meeting any of the following criteria for disabilities or inexperience with technology: (1) difficulty hearing well enough to use a telephone (even with hearing aids), (2) problems speaking or making oneself understood, (3) possible or probable dementia, (4) difficulty seeing well enough to watch television or read a newspaper (even with glasses), (5) owning no internet-enabled devices or being unaware of how to use them, or (6) no use of email, texting, or internet in the past month. National prevalence was determined using analytic weights.[3]

If a family member or caregiver cannot facilitate physician visits, an alternative is telemedicine by telephone. We thus assessed telemedicine unreadiness under 4 scenarios: (1) video visits as described above; (2) video visits assuming patients who have social supports (defined as having a child in the household or at least 2 individuals in one's social network) are telemedicine ready; (3) telephone visits with disability criteria reduced to difficulty speaking, difficulty communicating, or dementia and with technology criteria reduced to absence of any telephone; and (4) telephone visits assuming patients with social supports are telemedicine ready.

We used multivariable logistic regression to assess the adjusted odds of not being ready for video visits by age, sex, race/ethnicity, rurality, marital status, educational level, income, and self-rated health.

Results | Of the 4525 adults included in this study, 1925 (43%) were men, 2600 (57%) were women, and the mean (SD) age was 79.6 (6.9) years. The cohort consisted of 3119 (69%) non-Hispanic White individuals, 952 (21%) non-Hispanic Black individuals, and 273 (6%) Hispanic individuals. An additional 181 individuals (4%) self-identified as non-Hispanic other, which consisted of persons who reported their race/ethnicity as American Indian, Asian, Native Hawaiian, Pacific Islander, other, do not know, or more than 1 race/ethnicity.

Table 1. National Prevalence of Telemedicine Unreadiness in US Adults Older Than 65 Years in 2018 by Mode of Telemedicine Visit[a]

Reason for unreadiness	No., millions (%)			
	Video visits	Video visits with social support[b]	Telephone visits	Telephone visits with social support[b]
Any unreadiness	13.0 (38)	10.8 (32)	6.7 (20)	5.5 (16)
Unreadiness owing to any inexperience with technology	10.1 (30)	8.3 (25)	0.3 (1)	0.2 (1)
Has no internet-enabled devices or does not know how to use them	1.9 (6)	1.5 (4)	NA	NA
Has not emailed, texted, or gone online in a month	8.2 (24)	6.8 (20)	NA	NA
Has no telephone (cell phone or other)	NA	NA	0.3 (1)	0.2 (1)
Unreadiness owing to any physical disability	6.8 (20)	5.5 (16)	6.6 (20)	5.4 (16)
Difficulty hearing	0.8 (2)	0.7 (2)	0.8 (2)	0.7 (2)
Difficulty communicating	2.1 (6)	1.6 (5)	2.1 (6)	1.6 (5)
Probable dementia	2.5 (7)	1.8 (5)	2.5 (7)	1.8 (5)
Possible dementia	2.3 (7)	1.9 (6)	2.3 (7)	1.9 (6)
Difficulty seeing	0.5 (1)	0.4 (1)	NA	NA

Abbreviation: NA, not applicable.

[a] Estimates used complete case analysis for missingness; the number of missing cases never exceeded 16 (<0.2% of sample) for any criterion.

[b] *With social support* assumes that older adults are telemedicine ready if they have a child in the household or 2 or more people in their social network.

TELEHEALTH vs TELEMEDICINE:

American Veterinary Medical Association Definitions:

Telehealth: Telehealth is the overarching term that encompasses all uses of technology geared to remotely deliver health information or education.

Telemedicine: Telemedicine is the use of medical information exchanged from one site to another via electronic communications regarding a patient's clinical health status. Telemedicine is a tool that may be utilized to augment the practice of veterinary medicine.

California Veterinary Medical Association Definitions:

Telehealth: Veterinary Telehealth means the use of electronic communications and information technologies, including synchronous interactions and asynchronous storage and forward transfers, to facilitate veterinary healthcare at a distance.

Centers for Disease Control Definitions:

Telehealth: Telehealth is "the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration." Often, telehealth is used interchangeably with the terms telemedicine or eHealth. Telehealth, however, is broader than these other terms.

Telemedicine: Telemedicine and eHealth are distinct areas within telehealth. Telemedicine is defined by the Federation of State Medical Boards as "the practice of medicine using electronic communication, information technology, or other means between a physician in one location, and a patient in another location, with or without an intervening health care provider." The World Health Organization defines *eHealth* as "the use of information and communication technologies (ICT) for health.

Telemedicine is the use of electronic information and telecommunication technology to get the health care you need while practicing social distancing. Contact your healthcare provider about the management of your health generally or about management of an existing health condition.

US Department of Health and Human Services Definition:

Telehealth: The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) defines telehealth as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, and public health and health administration. Technologies include videoconferencing, the internet, store- and-forward imaging, streaming media, and landline and wireless communications.

Telehealth services may be provided, for example, through audio, text messaging, or video communication technology, including videoconferencing software.

Texas Health Services Definitions:

Telehealth: "Telehealth service" means a health service, other than a *telemedicine* medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine: Telemedicine medical service means a health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.

Center for Connected Health Policy Definitions

Telehealth: (California) means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store-and-forward transfers.

American Telemedicine Association Definitions

Telemedicine: A mode of delivering healthcare services through the use of telecommunications technologies, including but not limited to asynchronous and synchronous technology, and remote patient monitoring technology, by a healthcare practitioner to a patient or a practitioner at a different physical location than the healthcare practitioner.

- *Asynchronous: (Store and forward) the exchange of information regarding a patient that does not occur in real time, including the secure collection and transmission of a patient's medical information, clinical data, clinical images, laboratory results, or a self-reported medical history*
- *Synchronous: the exchange of information regarding a patient occurring in real time*

CALIFORNIA® VETERINARY MEDICAL ASSOCIATION

1400 River Park Drive, Suite 100
Sacramento, CA 95815-4505
916-649-0599
fax 916-646-9156
staff@cvma.net
www.cvma.net

January 25, 2021

Jessica Sieferman
Executive Officer
California Veterinary Medical Board
1747 North Market Blvd., Suite 230
Sacramento, CA 95834

RE: Comments on Telemedicine Proposal

Dear Ms. Sieferman:

The California Veterinary Medical Association, representing over 7,800 veterinarians, registered veterinary technicians, and veterinary students, is opposed to a recent proposal to change the California Veterinary Medicine Practice Act to expand the use of telemedicine in California veterinary practice.

The CVMA was present for numerous discussions on this topic beginning in the early phases of the COVID-19 pandemic in 2020. At that time, veterinary practices faced unique circumstances which limited face-to-face veterinary appointments as part of an effort to comply with statewide mandates to control the spread of COVID-19. To accommodate this unplanned change to veterinary practice, a temporary waiver was put in place by the California Department of Consumer Affairs (DCA) at the request of the Veterinary Medical Board (VMB). Pursuant to that waiver, a veterinarian who has previously established a veterinarian-client-patient-relationship (VCPR) for a specific condition by performing a physical examination of the animal patient may utilize telemedicine to establish VCPRs for new conditions manifesting thereafter. The waiver thus enables the veterinarian to recommend a course of treatment and prescribe medication without physically examining the animal patient for the presumptive condition being treated. Additionally, the waiver extends the time period during which a veterinarian may provide prescriptions without repeating a physical examination of the animal patient.

Presently before the VMB is a request to make this temporary waiver permanent, and to expand its authorizations vis-à-vis the use of telemedicine relative to the creation and maintenance of the VCPR. The CVMA convened 83 veterinarians and registered veterinary technicians on January 22, 2021 to discuss this topic as part of the CVMA joint Board of Governors and House of Delegates meeting. Leaders from across the state, including those in

academia, research, public health, food animal, equine, and small animal private practice debated the topic in depth. After extensive thoughtful dialogue, the leaders voted to voice opposition to the proposal. The following provide rationale for the CVMA's position.

A. Telemedicine Used to Establish a VCPR Lowers the Quality of Veterinary Medical Service

Veterinarians are trained to form at least a preliminary diagnosis through both client communication and in-person physical examination of the animal patient. During a physical exam, the veterinarian gathers data from the animal patient by use of sight, sound, touch, smell, and through use of specialized instrumentation. Because telemedicine does not involve an in-person physical exam, it limits a veterinarian in gathering information about the animal patient. This limitation, and the inevitable guesswork produced thereby, will result in a greater frequency of error than when diagnosis and treatment are performed in concert with a physical exam. Put simply, the sole or primary use of telemedicine will produce inaccurate diagnoses and treatment plans, higher rates of unnecessary prescriptions, and delays in correct therapy. It can lead to prolonged patient suffering, greater expense and confusion for the client, and diminished trust in the veterinarian.

B. The "Condition-Specific "Component of the VCPR Should Be Maintained

The proposal before the VMB chiefly aims to secure the permanent removal of the "condition-specific" requirement from the VCPR. This would unequivocally be a step backward for the veterinary profession and the animals we serve. Each condition or disease process in an animal patient can vary widely in presentation. Indeed, it is no exaggeration to say that a veterinarian examining an animal patient in the past for a separate condition adds little to no value in making a new accurate diagnosis remotely. For example, if a veterinarian establishes a VCPR for an ear infection through a physical exam, that diagnosis and treatment does not contribute in any way to the accuracy of a telemedicine diagnosis for a forelimb lameness in the same animal. And, at the risk of stating the obvious, because animals are unable to verbally describe their physical state, the condition by condition, "hands-on" nature of the VCPR becomes all the more critical.

C. Telemedicine and the Judicious Use of Antibiotics

According to a 2020 survey conducted by The College of Veterinarians of Ontario (one of the only jurisdictions in North America in which a VCPR may be established via telemedicine), the most common type of medication prescribed through telemedicine is antibiotics. In California, a concerted effort is taking place to curb the inappropriate use of antibiotics in veterinary medicine, as part of a larger movement to combat antibiotic resistance. Using telemedicine to make a presumptive diagnosis for a patient without sufficient information works against this goal.

This is not a theoretical concern. In a recent continuing education seminar conducted by the CVMA on the judicious use of antibiotics in dermatologic cases, 230 veterinarian course attendees were shown photos of three skin conditions in canine case studies. Attendees were asked, based on what they saw, whether they thought that antibiotics were warranted in each

case. In all three instances, 78-86% of attendees indicated that they would prescribe antibiotics for treatment. However, n*one of the three skin conditions were bacterial in nature*, thus demonstrating why simply looking at a patient via telemedicine can result in misdiagnosis and misuse of antibiotics.

D. Telemedicine Does Not Help Underserved Populations

Some proponents of telemedicine presumptively conclude that the expansive use of telemedicine will assist in providing access to veterinary care, especially to low income populations. That is a tenuous assertion, at best. Those who, for economic or other reasons, have difficulty taking their animals to a veterinary practice will not be better served by veterinary telemedicine. Telemedicine only allows the veterinarian to make an educated guess based on limited information (when compared to a diagnosing pursuant to a physical examination of the animal patient). Thus, those who utilize telemedicine receive a lower quality of care than those who present their animal in-person to a veterinarian. Lower quality care is not an appropriate substitute for the level of care that California consumers have come to expect from the veterinary profession, and perpetuates the very disadvantages being observed in underserved populations. Furthermore, many people within the underserved communities for which greater "access" is sought do not possess adequate technology through which telemedicine may be effectively used.

Finally, implicit in the "access" argument is the assumption that the expansive use of telemedicine will result in a cost savings, thus economically benefiting underserved populations. This assumption is also unsupported. Diagnosis and treatment of animals—whether through in-person examinations or telemedicine—requires the devotion of clinical resources, prescription medications, and veterinary time. The more expansive use of telemedicine does not vitiate or reduce any of these items nor the costs associated with them; indeed, because of the inherently imprecise nature of telemedicine (discussed in Part A, *supra*), diagnosis and treatment through telemedicine can actually take longer (especially in cases where the owner is forced to conduct extensive positioning of the animal), and produce more time and cost.

E. Clients Are Not Trained to Assess or Interpret Clinical Symptoms and Behaviors

With further respect to the clinical morass that can be produced by the overreliance on telemedicine, we must note the obvious point that clients often mis-assess or misinterpret their animal's symptoms and behaviors. Animals, unlike people, instinctively hide their ailments and cannot speak to convey what they are feeling. Their behavioral cues are subtle, and require skilled observation to detect in many cases. Technology cannot currently duplicate the observations made during a veterinary physical exam. A client's description of events can augment the veterinarian's in-person examination of an animal, but cannot replace this exam in a virtual setting with reliable results. Clients rarely possess the animal handling or veterinary skills necessary to even obtain basic information from their animal and in many cases, are at risk of injury if they attempt to perform elements of a physical exam at the veterinarian's request.

F. Telemedicine is Largely Not Permitted in Other United States Jurisdictions

In November of 2020 the CVMA performed an extensive review of all veterinary telemedicine state laws in the United States). A memorandum synopsizing that review is attached hereto. As can be seen, the conclusion reached is that telemedicine is not widely permitted in veterinary medicine and in fact, only three states imply the possibility that telemedicine may be used for establishing a VCPR in the first instance. The review also clarifies that the American Veterinary Medical Association (AVMA) currently does not endorse telemedicine as a means to establish a VCPR and reinforces that the VCPR is condition-specific (41 states utilize the AVMA VCPR model language.) We encourage you to review the attached memorandum and recognize the incorrectness of any assertion suggesting that California is somehow unique or divergent in its formulation of the VCPR.

G. Expanding Prescription Refill Times Can Increase Risk to the Patient

With respect to the companion proposal to extend the term of prescription refills in absence of a physical recheck examination, such would be inconsistent with the maintenance of consumer and animal protection, and lower the quality of veterinary care. For many species of animals, one year represents a significant portion of a lifespan. Also, there are time periods in an animals' lives where their physiology changes substantially, For instance, dogs undergo dramatic physiologic changes in their early life, so that their aging is not "linear" like other species. It is in the animal's best interest, especially if it is on a medication, to be routinely examined by a veterinarian. A physical exam can reveal new diseases or ailments, such as an abdominal or bone mass, and laboratory tests can monitor a body's medication tolerance. Expanding prescription refill times will increase potential harm to animals since risks will go that much longer undetected.

H. The More Expansive Use of Telemedicine Impacts Compliance with Minimum Standards

Like all healing arts professionals, veterinarians are legally and ethically bound to comply with minimum practice standards in diagnosing and treating their patients. Those standards must be met in all instances, regardless of the modality through which treatment is being rendered. Consistent with that principle, VMB enforcement of minimum practice standards will not be relaxed in cases which telemedicine was utilized. Veterinarians utilizing telemedicine will be held to the same standard as those who are physically examining animal patients, and a veterinarian charged for negligence, incompetence, or unprofessional conduct will not be permitted by the VMB to find safe harbor based on the fact that treatment was rendered via telemedicine. In all instances, the law still requires the same quality and minimum standard of practice, regardless of a veterinarian's choice to forgo a physical examination.[1]

[1]Moreover, when it comes to VMB oversight, the significantly broadened use of telemedicine will likely create an additional strain on the VMB to ensure that virtual appointments and resources are being conducted/utilized at the same standards as their in-person counterparts.

I. The More Expansive Use of Telemedicine Will Put Undue Pressure on Veterinarians

If telemedicine is allowed for the establishment of a VCPR and the diagnosis of new conditions, veterinarians will be pressured to 1) incorporate telemedicine into their practices even though their skills and training are not conducive to its use, and 2) provide diagnoses and medications without being able to collect sufficient data to do so. This pushes veterinarians past a comfort limit and subjects all parties (veterinarian, client and patient) to unnecessary risk. In addition, veterinarian liability for injury to a client when the client is asked to perform components of a physical exam is a very real possibility. All of these confounding real-world factors increase the likelihood of a misdiagnosis using telemedicine.

J. Current Telemedicine Law is Widely Misunderstood

In speaking with many veterinarians around the state over a long period of time, the CVMA has observed that there are fundamental misunderstandings among licensees concerning California's VCPR regulation (Title 16, Cal. Code Regs. ["CCR16"], § 2032.1), and that many practitioners do not even realize that existing law contains a telemedicine provision in the first place.

In most cases in which veterinarians express a desire to utilize telemedicine, the law already permits what they wish to do. Examples include follow-up consultations, providing advice in an emergency situation, and providing medication refills in the absence of the originally prescribing veterinarian, which is actually allowed in a different section of the law (CCR16, § 2032.25.) Many veterinarians seem to misunderstand that a VCPR is condition-specific, and that the "one year" component of a VCPR only applies to prescribed and dispensed medications. Furthermore, Section 2032.1 allows for a VCRP to be established and maintained through "medically appropriate and timely visits to the premises where the animal is kept," which means that practitioners operating in the food animal, shelter animal, or population management context may establish a VCPR with a herd, flock, or similar animal group without the need for an animal-by-animal exam and relationship.

Given the relative lack of uniform understanding within the profession about the VCPR, its current authorizations, and the applicable law, the CVMA feels that educational materials about the VCPR and its telemedicine provisions would be of great benefit to the veterinary profession.

For the aforementioned reasons and others that will most certainly surface in concern for the welfare of our patients and those clients we serve, the CVMA respectfully requests that the VMB uphold California's VCPR regulation as currently written, and that any waivers in regard to this section be granted only in consideration of emergency events, such as the current pandemic. At the very least, the CVMA asks that no permanent expansion of telemedicine be made until the current COVID-related healthcare crisis is over, so that permanent rulemaking on this important issue may remain unfettered and uninfluenced by current healthcare exigencies.

Thank you very much for your time and consideration.

Sincerely,

Dirk B. Yelinek, DVM
President, California Veterinary Medical Association

_____
encl.

CVMA CALIFORNIA VETERINARY MEDICAL ASSOCIATION

MEMORANDUM

From: Dan Baxter

To: CVMA Directors

Date: November 16, 2020

Re: VCPR/Telemedicine: National Canvass

I. Introduction

This memorandum discusses the way in which the various states of the Union define the veterinarian-client-patient relationship (VCPR), and more specifically whether and how those respective definitions allow for the establishment or maintenance of a VCPR through "telemedicine." I prepare this memorandum on the heels of the recent October 2020 meetings of the California Veterinary Medical Board and its Multidisciplinary Committee, at which telemedicine proponents indicated that California is the only state—or one of very few states—whose legal framework does not specifically recognize telemedicine as a valid pathway through which a VCPR may be created or maintained. Also posited was the proposition that California is the only state—or one of very few states—that treats the VCPR as a condition-specific relationship.

While additional commentary regarding the various states' treatment of telemedicine is set forth below, the overall takeaway from my review is that the above-described pronouncements are inaccurate. Indeed, based on my review, only eleven states other than California actually address telemedicine in their respective statutory or regulatory frameworks. Of those, most permit the use of telemedicine in a limited manner, with only two states appearing to permit the exclusive use of telemedicine to initiate a VCPR. Moreover, since the vast majority of states follow the AVMA's lead relative to the definition of the VCPR, it is impossible to maintain that those states view the VCPR as anything other than condition-specific.

II. AVMA Treatment of the VCPR and Telemedicine

Because many states' treatment of the VCPR is wholly or partly drawn from definitions utilized by the AVMA, it is useful to set forth those definitions. According to the AVMA's Principles of Veterinary Medical Ethics (hereinafter, "the AVMA's Principles"), and as relevant to the issue at hand, a VCPR "can only exist when…"

> …the veterinarian has performed a timely physical examination of the patient(s) or is personally acquainted with the keeping and care of the patient(s) by virtue of medically appropriate and timely visits to the operation where the patient(s) is(are) managed.

The use of the terms "timely physical examination" and "personally acquainted…by virtue of…visits to the operation" is strongly indicative of the AVMA's view that the existence of the VCPR is condition-specific, and dependent on either (1) the personal laying of hands on the animal patient, or (2) "timely" physical visits to the "operation" at which the animal patient resides. This latter alternative is likely directed to situations where the animal at issue is part of a herd, flock, litter, or other large group of similarly-situated animals, such as those found in an agricultural, commercial, laboratory, or shelter setting.

The AVMA's Principles are silent with respect to telemedicine. Indeed, the Principles' only mention of telephonic or electronic interfacing comes in their definition of the practice of veterinary medicine, which is stated to include the "[r]endering of advice or recommendation by any means including telephonic and other electronic communications with regard to [diagnosis or treatment]." However, the AVMA does maintain a self-described telemedicine "policy" on its website. That policy states, *inter alia*, that "veterinary telemedicine should only be conducted within an existing (VCPR), with the exception for advice given in an emergency until that patient can be seen by a veterinarian," and further instructs that "[w]ithout a VCPR, any advice provided through electronic means should be general and not specific to a patient, diagnosis, or treatment." The policy also sets forth the AVMA's opposition to "remote consulting, including telemedicine, offered directly to the public when the intent is to diagnose and/or treat a patient in the absence of a VCPR."

Based on the above, I am comfortable concluding that one cannot use the AVMA's Principles—or other AVMA commentary—as a foothold for arguing that the VCPR may be created or materially maintained via telemedicine alone, or that the VCPR is *not* a condition-specific relationship that must be reestablished for each clinical course.

III. State Laws

A significant majority of United States jurisdictions follow the AVMA's definition of the VCPR, in whole or in substantial part. In that regard, the "timely physical examination" and "personally acquainted…by virtue of…visits to the operation" criteria set forth by the AVMA is used verbatim, or in substantially similar form, by 41 states, including California. An additional state, Hawaii, does not have specific statutory or regulatory language dealing with the VCPR, but expressly incorporates the AVMA's Principles in its statutory framework. Pennsylvania also does not explicitly reference the VCPR, but its brief definition of "under the veterinarian's care" indicates that "the veterinarian or one of the veterinarian's licensed associates has examined the animal or has made medically appropriate and timely visits to the premises where the animal is kept." Finally, while Tennessee's regulatory language departs somewhat from the AVMA's, Tennessee *expressly prohibits* the exclusive use of telemedicine in veterinary medicine: "The veterinary-client-patient relationship cannot be established or maintained solely by telephone or other means."

Of the remaining seven jurisdictions not accounted for above, four of them (Alaska, Delaware, the District of Columbia, Michigan) have no relevant laws currently on the books,[1] while the remaining three (Alabama, New Jersey, and South Dakota) follow language that materially differs from the AVMA's Principles. Of those three, only New Jersey and South Dakota's laws could legitimately be read to allow for a more magnanimous application (than directed by the AVMA) of telemedicine to establish or maintain a VCPR. In that vein, neither New Jersey nor South Dakota insist on a physical examination of—or similarly "personal" acquaintance with—the animal as an antecedent to the creation or continuance of the VCPR.[2]

Other than California, only 11 states address the issue of telemedicine in their statutory/regulatory structures. Those states are discussed alphabetically below.

1. Colorado

In addition to being one of the many states that generally follows the AVMA's Principles in defining the VCPR, Colorado also has the most extensive legal framework relative to telemedicine. While Colorado's regulations do not "allow the establishment of a [VCPR] solely by telephonic or other electronic means," the Colorado State Board of Veterinary Medicine issued a series of policies and guidelines in October of 2018, including several guidelines relative to the use of telemedicine.[3] While the guidelines are carefully drafted and stop short of serving as a panacea for telemedicine's application (in fact, they reiterate the need for a VCPR to be established consistent with the definition found in the AVMA's Principles), they do strongly suggest that once the VCPR has been *established*, the maintenance of that relationship may be continued entirely via telemedicine where the client provides informed consent to same. (See Veterinary Policies and Guidelines, Part III, pp. 23-24—https://drive.google.com/file/d/0B-K5DhxXxJZbeTF2SDJ1T3hza0U/view.) And, while these guidelines are not crystal clear (to be sure, they are heavily reliant on the veterinarian's duty to follow "generally accepted standards of practice"), I believe they can legitimately be read for the proposition that a VCPR in Colorado is *not* a condition-specific relationship, but one that may be initiated one time for an animal, with potential blanket application over all conditions going forward.

2. Georgia

Georgia's regulations have one line devoted to telemedicine, indicating that "[a] veterinarian/client/patient relationship cannot be established solely by telephone, computer or other electronic means." The pregnant negative of this prohibition is that the VCPR in Georgia may be *continued or maintained* solely via telemedicine. However, while Georgia—like California—has issued emergency rules modestly loosening telemedicine restrictions, it does not

[1] Per my communications with the AVMA's Director, State Advocacy Division (Ashley Morgan, DVM), there is currently a VCPR-related bill making its way through the Michigan legislature.
[2] Both states, in relevant part, simply require "sufficient knowledge" of the animal(s) at issue "to initiate at least a general or preliminary diagnosis" of the condition.
[3] Colorado and several other states' frameworks employ the word "telehealth" instead of "telemedicine."

appear to have offered any general guidance on the extent to which telemedicine may be utilized in the context of a VCPR.

3. Idaho

Idaho law on telemedicine is extremely terse, simply indicating that the practice of veterinary medicine includes that performed through "telephonic, electronic, or other means." However, on June 18, 2018, the Idaho Board of Veterinary Medicine adopted Policy No. 2018-2, which contains guidelines strongly suggesting that in certain circumstances, a VCPR may be both established and maintained via telemedicine:

> The veterinarian must employ sound professional judgment to determine whether using Telehealth is appropriate in particular circumstances each and every time animal care is provided and only provide medical advice or treatment via Telehealth to the extent that it is possible without a hands on examination. A veterinarian using Telehealth must take appropriate steps to obtain Informed Consent, establish the VCPR and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of Telehealth as a component of, or in lieu of, hands on medical care, while others are not.

After this and other language, Idaho's policy concludes with language mirroring the AVMA's Principles relative to prescriptions, indicating that prescriptions made via telemedicine modalities require "sufficient knowledge of the animal or group of animals by virtue of a history and inquiry and either physical examination or medically appropriate and timely visits to the premises where the animal or group of animals is kept."

In light of the above language, it appears that Idaho will allow for a VCPR to be maintained via telemedicine when (a) it is deemed clinically appropriate by the veterinarian and (b) informed consent is provided by the client. For a prescription to be issued, however, there appears to be a physical/locational component that can only be fulfilled by an in-person examination or personal visits to the place where the animal resides.

4. Illinois

Like Georgia, Illinois directs one line—albeit via statute rather than regulation—to telemedicine, indicating that a VCPR "does not mean a relationship solely based on telephonic or other electronic communications." Unfortunately, the Illinois Veterinary Licensing and Discipline Board does not appear to have offered any guidance that fleshes out whether and to what extent telemedicine can permissibly play a role in the creation or maintenance of the VCPR.

5. Iowa

Iowa is similar to Georgia and Illinois, offering a one-sentence regulatory prohibition stating that a valid VCPR "cannot be established by contact solely based on a telephonic or electronic communication." While the Iowa Board of Veterinary Medicine has temporarily suspended the enforcement of that prohibition for companion animals "until further notice" due to COVID-19, it has maintained the prohibition for livestock.

6. Mississippi

Mississippi's relevant statute is similar, stating that "a veterinarian-client-patient relationship cannot be established solely by telephonic or other electronic means." And, although Mississippi has—like Iowa—adopted a COVID-19 protocol allowing for the limited use of telemedicine, that protocol specifically does *not* permit the initiation of a VCPR via telemedicine modalities.

7. Oklahoma

An analysis of Oklahoma's veterinary telemedicine law/policy is essentially identical to that of Idaho. Oklahoma's relevant statute defines the practice of veterinary medicine to include telemedicine, and the Oklahoma Veterinary Board issued a position statement in 2018 with language very similar to the guidelines issued by the Idaho Board of Veterinary Medicine. Therefore, my conclusions relative to Oklahoma's treatment of the issue are the same as with respect to Idaho.

8. Tennessee

Tennessee's statutory language—referenced at the beginning of this section—is the most explicitly prohibitive of telemedicine utilization, indicating that "[t]he veterinary-client-patient relationship cannot be established ***or maintained*** solely by telephone or other electronic means." I have been unable to determine whether the Tennessee Board of Veterinary Medical Examiners has issued any temporary regulations or guidelines regarding the enforcement of this prohibition during the pendency of COVID-19.

9. Texas

Texas is another state whose relevant statute provides that a VCPR "may not be established solely by telephone or electronic means." The Texas Board of Veterinary Medical Examiners indicates on its website that Texas law "allow[s] for veterinarians to provide care via telemedicine to existing patients," but that "a veterinarian client patient relationship may not be established solely through telemedicine." The Board then states that because "[t]here is no written guidance on how often a veterinarian must see an animal to maintain the valid client-patient relationship," practitioners are "encourage[d]…to use their best judgment and use telemedicine and use telemedicine where they can to meet the needs of their clients and patients."

10. Utah

Utah's statute is identical to Texas's, and I have been unable to find any further governmental guidance regarding the application of the statute, either generally or with respect to practice in a COVID-19 environment. The only possibly-relevant authority I have located is a March 25, 2020 gubernatorial order that allows medical providers to render telemedicine services to patients when certain disclosure and consent requirements are fulfilled. (Veterinary medicine appears in Utah to be governed in part by more general healing arts-related directives, but it is unclear in this instance whether the March 25 order has any application to veterinary medicine.)

11. Virginia

Virginia's pertinent mention of telemedicine comes in its directives relative to controlled substance prescriptions, which cover both human healing arts and veterinary medicine. In its statutory framework, Virginia allows the prescription of enumerated controlled substances upon the establishment of "a bona fide practitioner-patient relationship by an examination through face-to-face interactive, two-way, real-time communications services or store-and-forward technologies," provided that various conditions attendant to the communications are met. I have found no guidance issued by the Virginia Board of Veterinary Medicine regarding the use of telemedicine, either in general or with respect to practice in a COVID environment.

IV. Conclusions/Takeaways

Based on my above-described review and findings, I have reached the following conclusions:

1. The AVMA's Principles and policies do not support the proposition that the VCPR may be initiated or materially maintained solely via telemedicine.

2. The AVMA's Principles and policies do not support the proposition that the VCPR is not condition-specific.

3. 41 of the 51 United States jurisdictions reviewed follow—either verbatim or in substantively similar terms—the AVMA's definition of the VCPR, including the alternate criteria of "timely physical examination" and "personal[] acquaint[ance]…by virtue of…visits to the operation." Two other states not counted among those 41 jurisdictions (Hawaii and Pennsylvania) are to the same effect.

4. Two states—New Jersey and South Dakota—define the VCPR in a manner in which it appears that neither a physical examination nor a similarly "personal" acquaintance with the animal patient is a condition precedent to the creation or continuance of the VCPR.

5. Only eleven states (not including California) explicitly address telemedicine in their respective statutory or regulatory frameworks. None of those states erect an

outright ban on veterinary telemedicine, and all of them appear to contemplate that telemedicine may be utilized—to at least some extent—in the context of an established VCPR. Out of those eleven states:

a. Two of them (Idaho and Oklahoma) appear to contemplate that a VCPR may be established *and* maintained via telemedicine modalities, even exclusively.

b. One state, Illinois, appears to permit telemedicine to be used to establish *and* maintain a VCPR, but not exclusively.

c. Six states—Colorado, Georgia, Iowa, Mississippi, Texas, and Utah—appear to permit the use of telemedicine (perhaps even exclusively, in certain circumstances) to maintain the VCPR, but telemedicine may not be the sole or exclusive means through which a VCPR is established.

d. One state, Tennessee, expressly prohibits the exclusive use of telemedicine to establish *or* maintain the VCPR.

e. One state, Virginia, appears to follow a general healing arts model under which prescriptions may possibly be issued via telemedicine.

6. Among the 11 states having telemedicine laws on the books, none of them explicitly address whether and to what extent the VCPR is seen as a condition-specific phenomenon, a once-and-for-all proposition, or something in between.

Accordingly, my overall conclusion is that the aforementioned pronouncements that (a) California is the only state (or one of few) that does not specifically allow for the expansive practice of telemedicine, or (b) California is an outlier in treating the VCPR as condition-specific, are incorrect.