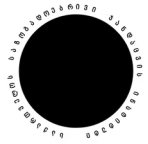

ASF TELEMEDICINE STANDARDS

Complete Reference — Base Standard + 1 Endorsement

Version 3.0 · 2026

Accréditation Sans Frontières · Paris, France · Geneva, Switzerland · Tbilisi, Georgia

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Foreword

This standard originates from a deliberate policy choice made in Georgia in 2014: to advocate for international healthcare accreditation rather than attempt to replace it. Working through the Public Health Institute of Georgia (PHIG, established 2011), its founders organized the country's first structured accreditation initiative — including expert missions by Joint Commission International — and carried this advocacy directly to Georgia's Ministry of Health over the following years.

That advocacy produced, in 2018, the first draft of a Georgian-adapted accreditation standard, and in 2020, the formal establishment of Accréditation Sans Frontières (ASF) as an international legal entity in Paris, alongside the ASF International Standards Council — the standing body responsible for developing and revising ASF's standards. The Council's methodology is directly informed by the World Health Organization's guideline development process, including WHO's use of the GRADE framework for weighing evidence certainty, adapted to the practical work of accreditation. ASF's founder has served since 2016 as a founding member of the UN Secretary-General's Independent Accountability Panel for Every Woman, Every Child, Every Adolescent, and ASF has been a member of the International Society for Quality in Health Care (ISQua) since 2023.

This advocacy also found regulatory validation in Georgian government policy requiring independent international accreditation of hospitals, formally implemented through Order №4/б (26 January 2023).

Consistent with the structure recognized across major international standards bodies, ASF's work spans four pillars: accreditation of organizations against its published standards, accreditation of the standards themselves through the International Standards Council's ongoing review, accreditation of the surveyors who conduct ASF's own assessments, and accreditation of the training that equips facilities and professionals to meet them, delivered through GMJ Academy. This standard has been developed and refined through consultation with practitioners across multiple continents, and every edition includes a Health & Migration endorsement grounded in WHO's Global Competency Standards for health workers serving refugees and migrants — a commitment ASF treats as non-negotiable. Consistent with ASF's founding principle of accreditation without borders, this standard is published in full and made freely available to any organization seeking to build accreditation capacity in its own country.

This, the third edition, is published in 2026. The ASF International Standards Council reviews and revises each standard on a three-year cycle.

About This Document

This is the ASF Telemedicine complete standard — seven mandatory base standards covering the full patient journey through any remote care service, from a single independent provider to a multi-provider telehealth platform, plus one built endorsement layering onto that base: Health & Migration. No endorsement is ever issued alone — it is only assessed after the base standard is genuinely met in full.

Every criterion follows the same two-page structure established across ASF's standards: an assessment page (a facility self-assessment table, and exactly what an ASF assessor will independently check) and a guidance page (why the standard exists, what good and failure look like, how to implement from zero).

Every criterion carries at least one reference. Numbered references are formal, individually verified Vancouver-style citations; where a criterion instead reflects genuine professional consensus without one attributable paper, that is stated honestly rather than assigned an invented citation.

Immediately after this page is the Facility Classification chapter — the same four-type model already established for ASF's Hospital standard, adapted for telemedicine services specifically: Crisis, Transitional, Small, or Standard.

Alignment With ISO 9001:2015

This standard's governance structure — Standard 7 — is deliberately built to reflect the core management principles of ISO 9001:2015, the international quality management system standard [7]. This is a statement of structural alignment, not a claim of certification: ISO 9001:2015 compliance is a formal status determined only through accredited external audit, which this document does not confer. The table below shows the mapping honestly, clause by clause.

ISO 9001:2015 CLAUSE	WHERE THIS STANDARD REFLECTS IT
Clause 4 — Context of the Organization	Not directly covered — outside this standard's patient-safety scope.
Clause 5 — Leadership	7.1 — Leadership Is Real and Accountable
Clause 6 — Planning	3.4 (Risk Register) and 7.8 (Quality Objectives Are Set, Specific, and Tracked)
Clause 7 — Support	4.2 (Credentials), 7.4 (Records), 7.6 (Scope of Practice)
Clause 8 — Operation	Standard 4 (Care & Treatment) in full
Clause 9 — Performance Evaluation	7.7 — Leadership Reviews Overall Performance at Planned Intervals
Clause 10 — Improvement	7.5 (Incident Reporting) and 7.9 (Continual Improvement Process)

Facility Classification — Which Type of Telemedicine Service Are You?

Four Facility Types, Not One

The same four-category model built for ASF's Hospital standard applies here, with one deliberate change: Small is anchored to a genuine, real-world unit for telemedicine — a single licensed provider. Unlike a hospital or a physical clinic, telemedicine can be, and very often is, delivered by exactly one provider working independently, since the technology itself removes many of the physical staffing constraints a building would otherwise impose.

Standard (ST)

A fully resourced, functioning telemedicine service — a full multi-provider platform, robust technical infrastructure, no adaptation needed.

Small (SM) — where staffing depth, not crisis or poverty, is the defining constraint

Exactly one licensed provider is the confirmed anchor. This is not a research threshold requiring external verification — it is the plain, real unit of independent telemedicine practice itself: a solo provider, otherwise stable, genuinely limited only by being one person doing what a larger platform would otherwise share.

Transitional (TR)

Real national resource or infrastructure limitation, no active conflict — the same World Bank-anchored logic used throughout ASF's standards.

Crisis (CR)

Active conflict or humanitarian emergency — overrides every other consideration, exactly as in the Hospital standard.

The Universal Floor

A small number of criteria apply in full, in every one of the four types, with no exceptions: genuine patient identity verification — a real, specific step this document exists to require, not something a physical clinic ever had to think about — real informed consent about what remote

care can and cannot do, dignity and non-discrimination, and a defined emergency escalation pathway that exists before it is ever needed, not improvised when it is.

Which Type of Telemedicine Service Are You?

Answer these questions in order, top to bottom. The moment you answer YES, stop — that is your answer. If you reach the end still answering NO, you are Standard.

WORK DOWN THIS LIST. STOP AT YOUR FIRST YES.			
1	**Is your country in an active war, armed conflict, or a declared humanitarian emergency right now?** *This means fighting, displacement, or a declared emergency is actually happening now — not that things are generally difficult.*	☐ **YES → CR CRISIS**	☐ NO → next question
2	**Does your national government struggle badly to fund healthcare, or is national power or medicine supply unreliable — even though there is no war or crisis?** *This is about your country as a whole, not just your own facility.*	☐ **YES → TR TRANSITIONAL**	☐ NO → next question
3	**Is your service staffed by exactly one licensed provider, and is that the main reason you cannot offer certain services — for example, coverage during your own absence, or care across multiple specialties or licensing jurisdictions at once?** *This applies even in a stable, well-funded country. A genuine solo provider, not a small team — the limit here is being one person, nothing else.*	☐ **YES → SM SMALL**	☐ NO → next question
If you answered NO to all three questions above: You are **STANDARD (ST)** — no crisis, no national constraint, and staffing depth is not holding you back.			

THIS IS ME
My type: ☐ **CR** ☐ **TR** ☐ **SM** ☐ **ST**

Example: A solo telehealth physician serving patients in rural Moldova — no active conflict, so NO to question 1. National healthcare funding is genuinely unreliable, so YES to question 2. Stop there. This service is TR.

Verified, not just accepted, on the assessor's visit. If reality is different from what you ticked, the classification is corrected on the spot.

Table of Contents

STANDARD 1

Technology Platform Reliability & Security

MANDATORY

5 criteria

	Standard 1.1 NON-NEGOTIABLE · *Standard 1: Technology Platform Reliability & Security* **A Signed, Executed Business Associate Agreement Genuinely Exists**	ASSESSMENT ASF-TM-STD1-v3.0
CR FULL	TR FULL	SM FULL	ST FULL

1.1
NON-NEGOTIABLE
L1

THE STANDARD

A Signed, Executed Business Associate Agreement Genuinely Exists

Every telemedicine platform and technology vendor handling patient information has a genuinely signed, executed Business Associate Agreement in place — not merely the availability of one, and not an assumption that selecting a healthcare-tier platform alone constitutes compliance.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a genuinely signed, executed Business Associate Agreement with every platform and vendor handling patient information?** *Real, executed agreement by both parties, not availability alone.* Doc: Executed BAA documentation	YES	PARTIAL	NO
2	**Was the agreement genuinely signed before any clinical session occurred, not after the fact?** *Real, prior execution, not a retroactive formality.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Does coverage genuinely extend to every vendor touching patient information — video, messaging, storage — not just the primary platform?** *Complete, genuine coverage across every relevant vendor, not the main platform alone.* Doc: Vendor BAA inventory	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *BAA execution review*	Reviews the actual signed agreement for genuine execution by both parties.
DOCUMENT *Timing review*	Reviews whether execution genuinely preceded clinical session use.
DOCUMENT *Vendor inventory review*	Reviews whether every vendor handling patient information has a genuine, executed agreement.

REFERENCES

[1] Every telehealth platform used for clinical sessions must provide a signed Business Associate Agreement, executed by both parties before any clinical sessions are conducted, distinct from the common misconception that selecting a healthcare-tier platform alone constitutes compliance.

Standard 1.1 · *Standard 1: Technology Platform Reliability & Security*

Guidance & Learning

GUIDANCE ASF-TM-STD1-v3.0

WHY THIS STANDARD EXISTS

Many providers genuinely believe that choosing a platform marketed as healthcare-appropriate is itself sufficient, but the agreement must actually be signed by both parties before any clinical session occurs — the real legal and practical protection exists only once execution has genuinely happened, not from the platform's marketing category alone.

The evidence: [1] Every telehealth platform used for clinical sessions must provide a signed Business Associate Agreement, executed by both parties before any clinical sessions are conducted, distinct from the common misconception that selecting a healthcare-tier platform alone constitutes compliance.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A genuinely signed, executed agreement exists for every relevant vendor.	✗ An agreement is available from the vendor but was never actually executed.
✓ Execution genuinely occurred before any clinical session.	✗ Sessions occurred before execution was genuinely completed.
✓ Coverage genuinely extends to every vendor touching patient information.	✗ Coverage is limited to the primary platform, missing other vendors handling patient information.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **The primary video platform has a genuine, executed agreement but a secondary messaging tool doesn't.**
Every vendor genuinely touching patient information carries the same real requirement.

2 **Agreements are executed but not periodically reconfirmed as still current and active.**
An agreement's real protective value depends on it remaining genuinely current, not assumed indefinitely valid.

3 **Execution happened but isn't documented in a way that's genuinely easy to verify later.**
Genuine, accessible documentation is what makes verification reliable when it's actually needed.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Inventory every vendor genuinely handling patient information across the full technology stack.

Week 2 Confirm genuine execution of agreements for every identified vendor.

Week 3 Address any vendor relationship lacking genuine, executed coverage.

Ongoing Periodically reconfirm agreements remain current and active.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual, signed agreement document, not a vendor's general compliance marketing.
A real, specific, signed document is the evidence of genuine execution, not assumed compliance.

Ask about coverage for a secondary tool, like messaging or file storage, not just the primary video platform.
This is where genuine coverage gaps most commonly hide.

E-LEARNING academy.gmj.ge/tm-std1-1-executed-baa — 30 min · complete before self-assessment

	Standard 1.2 **NON-NEGOTIABLE** · *Standard 1: Technology Platform Reliability & Security* **Encryption Meets Current Technical Standards, Not Assumed Adequate**	**ASSESSMENT** ASF-TM-STD1-v3.0
CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

1.2
NON-NEGOTIABLE
L1

THE STANDARD

Encryption Meets Current Technical Standards, Not Assumed Adequate

Video, audio, and data transmission genuinely meet current, specific encryption standards — end-to-end encryption for live sessions, strong transport encryption for signaling, encryption at rest for stored records — not assumed adequate from general platform reputation without genuine, specific verification.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is live session encryption genuinely end-to-end, specifically verified, not assumed from general platform reputation?** *Real, specific, verified encryption, not general trust in the platform's reputation.* Doc: Encryption specification documentation	YES	PARTIAL	NO
2	**Does signaling and API transmission genuinely meet current transport encryption standards?** *Specific, verified technical compliance, not a general assumption of security.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is data genuinely encrypted at rest for any stored records, not only during active transmission?** *Real, verified encryption for stored data specifically, not protection limited to live transmission alone.* Doc: Data-at-rest encryption verification	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Encryption specification review*	Reviews the platform's actual, documented encryption specifications against current standards.
DOCUMENT *Transport security review*	Reviews signaling and API transmission encryption for genuine, current compliance.
DOCUMENT *At-rest encryption review*	Reviews encryption verification for stored records specifically.

REFERENCES

[2] Telehealth security requires end-to-end encryption for real-time sessions, transport layer security of at least TLS 1.2 for signaling and APIs, and AES-256 encryption for data at rest, with these specific technical standards, not general platform reputation, constituting genuine compliance.

Standard 1.2 · *Standard 1: Technology Platform Reliability & Security*

Guidance & Learning

GUIDANCE ASF-TM-STD1-v3.0

WHY THIS STANDARD EXISTS

Encryption requirements are specific and technical, not a general assurance of "security," and a platform's real protective value depends on genuinely meeting these specific standards — a facility that hasn't actually verified this, relying instead on general platform trust, has no real way of knowing whether patient information is genuinely protected in transit and at rest.

The evidence: [2] Telehealth security requires end-to-end encryption for real-time sessions, transport layer security of at least TLS 1.2 for signaling and APIs, and AES-256 encryption for data at rest, with these specific technical standards, not general platform reputation, constituting genuine compliance.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Live session encryption is genuinely end-to-end and specifically verified.	✗ Encryption is assumed adequate from general platform reputation, not specifically verified.
✓ Transport encryption genuinely meets current standards.	✗ Transport security doesn't genuinely meet current standards.
✓ Data at rest is genuinely, verifiably encrypted.	✗ Stored data lacks genuine, verified encryption.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Live session encryption is genuinely verified but stored recording encryption hasn't been specifically checked.**
Every stage where patient information exists deserves the same genuine verification, not live transmission alone.

2 **Encryption specifications are documented but haven't been independently verified through actual testing.**
Documentation alone doesn't confirm genuine, real-world implementation without independent verification.

3 **Specifications meet current standards but haven't been reviewed since a relevant standard was updated.**
Encryption standards genuinely evolve, and compliance should track current, not historical, requirements.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current encryption specifications against genuine, current technical standards.

Week 2 Verify encryption for stored records specifically, not live transmission alone.

Week 3 Independently test or verify documented encryption claims.

Ongoing Review encryption compliance as technical standards evolve.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the platform's actual, specific encryption specification document, not a general security assurance.
A specific, real document reveals genuine, verifiable compliance, not assumed adequacy.

Ask specifically about encryption for stored session recordings, not just live transmission.
This is where genuine verification is most commonly incomplete.

E-LEARNING academy.gmj.ge/tm-std1-2-encryption-standards — 30 min · complete before self-assessment

	Standard 1.3 **NON-NEGOTIABLE** · *Standard 1: Technology Platform Reliability & Security* **Consumer-Grade Video Platforms Are Never Used for Clinical Sessions**	**ASSESSMENT** ASF-TM-STD1-v3.0
CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

1.3
NON-NEGOTIABLE
L1

THE STANDARD

Consumer-Grade Video Platforms Are Never Used for Clinical Sessions

Clinical telemedicine sessions never occur on consumer-grade video platforms — standard FaceTime, consumer Zoom, standard Google Meet, Skype — regardless of convenience or a provider's personal familiarity with these tools, since none genuinely offer the Business Associate Agreement this whole standard depends on.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are clinical sessions genuinely never conducted on consumer-grade video platforms lacking a Business Associate Agreement?** *A firm, absolute exclusion, not an occasional exception for convenience.* Doc: Approved platform list documentation	YES	PARTIAL	NO
2	**Are all providers specifically aware of which platforms are genuinely approved, not assuming familiar consumer tools are acceptable?** *Real, specific awareness across all providers, not an assumption of general understanding.* Doc: Provider platform training record	YES	PARTIAL	NO
3	**Is there a specific process preventing an ad hoc fallback to a consumer platform during a technical difficulty?** *A real, defined alternative, not defaulting to a familiar but non-compliant tool under pressure.* Doc: Technical difficulty fallback protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Approved platform documentation review*	Reviews the specific, documented list of genuinely approved platforms.
ASK *Provider awareness interview*	Asks a provider to confirm which platforms are genuinely approved for clinical use.
DOCUMENT *Fallback protocol review*	Reviews the defined fallback process preventing ad hoc consumer platform use during technical difficulty.

REFERENCES

[3] Consumer video platforms including standard FaceTime, consumer Zoom, standard Google Meet, and Skype are explicitly identified as non-compliant for clinical telehealth use because they do not offer Business Associate Agreements, with temporary pandemic-era enforcement waivers for such platforms having since expired.

Standard 1.3 · *Standard 1: Technology Platform Reliability & Security*

Guidance & Learning

GUIDANCE ASF-TM-STD1-v3.0

WHY THIS STANDARD EXISTS

Temporary allowances for consumer platforms during the COVID-19 public health emergency have genuinely expired, and consumer platforms don't offer Business Associate Agreements at all — meaning a session conducted on one of these platforms is fundamentally outside this whole document's security framework, regardless of how the actual conversation goes.

The evidence: [3] Consumer video platforms including standard FaceTime, consumer Zoom, standard Google Meet, and Skype are explicitly identified as non-compliant for clinical telehealth use because they do not offer Business Associate Agreements, with temporary pandemic-era enforcement waivers for such platforms having since expired.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Clinical sessions genuinely never occur on consumer-grade platforms.	✗ Consumer platforms are used occasionally for convenience or familiarity.
✓ All providers are specifically, confidently aware of approved platforms.	✗ Providers are uncertain which platforms are genuinely approved.
✓ A defined fallback process prevents ad hoc consumer platform use during difficulty.	✗ No defined fallback exists, risking ad hoc consumer platform use under pressure.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Awareness is strong among full-time providers but less consistent among occasional or covering providers.**
Every provider conducting a clinical session carries the same real responsibility for platform compliance.

2 **The approved platform list is documented but not proactively reinforced through periodic training.**
Documentation alone doesn't guarantee genuine, sustained awareness without periodic reinforcement.

3 **A fallback protocol exists but hasn't been specifically tested through a real technical difficulty scenario.**
An untested protocol may not hold up reliably under genuine, real-time pressure.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current platform use for any instance of consumer-grade platform reliance.

Week 2 Establish and document the specific, genuinely approved platform list.

Week 3 Train all providers, including covering or occasional staff, on approved platforms.

Ongoing Test the technical difficulty fallback protocol periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a provider directly whether they've ever used a consumer platform for convenience.
A direct question often surfaces informal practice a policy review wouldn't catch.

Ask what a provider would do if the approved platform failed mid-session.
A specific, confident answer reveals a genuine fallback process, not improvisation toward a familiar consumer tool.

E-LEARNING academy.gmj.ge/tm-std1-3-no-consumer-platforms — 30 min · complete before self-assessment

Standard 1.4 **NON-NEGOTIABLE** · *Standard 1: Technology Platform Reliability & Security*

Multi-Factor Authentication and Access Controls Are Genuinely Enforced

ASSESSMENT ASF-TM-STD1-v3.0

CR FULL	TR FULL	SM FULL	ST FULL

1.4
NON-NEGOTIABLE
L1

THE STANDARD

Multi-Factor Authentication and Access Controls Are Genuinely Enforced

Multi-factor authentication and role-based access controls are genuinely, consistently enforced for every provider accessing patient information — not optional, not bypassed for convenience, and not limited to some providers while others access the system through a single-factor login.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is multi-factor authentication genuinely, consistently enforced for every provider accessing patient information?** *Real, consistent enforcement across every provider, not optional or bypassed for some.* Doc: MFA enforcement record	YES	PARTIAL	NO
2	**Are role-based access controls genuinely limiting each provider's access to what their actual role requires?** *Real, specific role-based limitation, not broad access granted regardless of actual need.* Doc: Access control configuration documentation	YES	PARTIAL	NO
3	**Are session timeouts genuinely enforced, not disabled or extended indefinitely for convenience?** *Real, enforced timeout settings, not convenience overriding genuine security practice.* Doc: Session timeout configuration	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *MFA enforcement review*	Reviews configuration for genuine, consistent multi-factor authentication enforcement.
DOCUMENT *Access control review*	Reviews role-based access configuration for genuine, appropriate limitation.
DOCUMENT *Session timeout review*	Reviews session timeout configuration for genuine enforcement.

REFERENCES

[4] Administrative controls including role-based access controls, multi-factor authentication, and session timeouts are established as essential technical safeguards for telehealth systems handling sensitive health information, reflected in health data security frameworks recognized across many countries' privacy and data protection regulation.

Standard 1.4 · *Standard 1: Technology Platform Reliability & Security*

Guidance & Learning

GUIDANCE ASF-TM-STD1-v3.0

WHY THIS STANDARD EXISTS

A single compromised password provides real, complete access to patient information without a second, genuine authentication factor in place, and access controls that exist in policy but aren't actually, consistently enforced provide no more real protection than having no access controls at all.

The evidence: [4] Administrative controls including role-based access controls, multi-factor authentication, and session timeouts are established as essential technical safeguards for telehealth systems handling sensitive health information, reflected in health data security frameworks recognized across many countries' privacy and data protection regulation.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Multi-factor authentication is genuinely, consistently enforced for every provider.	✗ Multi-factor authentication is optional or inconsistently enforced.
✓ Role-based access controls genuinely limit access to actual role requirements.	✗ Access controls don't genuinely limit provider access based on actual role.
✓ Session timeouts are genuinely enforced, not disabled for convenience.	✗ Session timeouts are disabled or extended indefinitely.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **MFA is enforced for primary provider accounts but not for administrative or support staff accessing the same system.**
Every account genuinely accessing patient information carries the same real security requirement.

2 **Access controls exist but haven't been reviewed to confirm they genuinely match current provider roles.**
Role-based access needs genuine, periodic reconfirmation as roles and staffing change.

3 **Timeouts are enforced but set to an interval long enough to provide limited real protective value.**
A genuinely protective timeout interval balances real security against reasonable convenience, not convenience alone.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current authentication and access control configuration for genuine, consistent enforcement.

Week 2 Extend multi-factor authentication to every account accessing patient information.

Week 3 Reconfirm role-based access controls genuinely match current provider roles.

Ongoing Audit authentication and access control enforcement periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual current authentication configuration, not a general assurance of MFA use.
A specific, real configuration reveals genuine enforcement, not assumed compliance.

Ask an administrative staff member whether they use multi-factor authentication for their own access.
This reveals whether genuine enforcement extends beyond primary provider accounts.

E-LEARNING academy.gmj.ge/tm-std1-4-access-controls — 30 min · complete before self-assessment

Standard 1.5 **CORE** · *Standard 1: Technology Platform Reliability & Security*

Connection Failure During a Session Has a Defined, Practiced Recovery Process

ASSESSMENT ASF-TM-STD1-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

1.5
CORE
L1

THE STANDARD

Connection Failure During a Session Has a Defined, Practiced Recovery Process

A genuine, defined process exists for a connection failure during an active clinical session — a specific reconnection protocol, a defined alternative contact method — not improvised in the moment, with the patient left uncertain whether or how care will continue.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does a genuine, specific process exist for reconnecting after a connection failure during a session?** *A real, defined protocol, not improvisation in the moment.* Doc: Connection failure recovery protocol	YES	PARTIAL	NO
2	**Is there a defined alternative contact method the patient genuinely knows about in advance?** *Real, advance patient awareness of an alternative contact method, not left to guess during the disruption.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Has this recovery process genuinely been practiced or tested, not only described in policy?** *Real, tested practice, not a protocol that exists only on paper.* Doc: Recovery process testing record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Recovery protocol review*	Reviews the specific, defined connection failure recovery process.
ASK *Patient awareness interview*	Asks a patient whether they know what to do if a session connection fails.
DOCUMENT *Testing record review*	Reviews evidence the recovery process has genuinely been tested, not only described.

REFERENCES

[5] Security depends on the full system, not the software alone, establishing that operational resilience — including defined processes for technical failure during a clinical session — is a genuine component of telehealth platform reliability, distinct from encryption and access control alone.

Standard 1.5 · *Standard 1: Technology Platform Reliability & Security*

Guidance & Learning

GUIDANCE ASF-TM-STD1-v3.0

WHY THIS STANDARD EXISTS

A connection failure during a session is a genuine, foreseeable technical reality, and a patient left with a frozen or disconnected screen, uncertain whether to wait or how to reach their provider, experiences a real disruption to their care — a defined, practiced recovery process is what prevents a technical failure from also becoming a care continuity failure.

The evidence: [5] Security depends on the full system, not the software alone, establishing that operational resilience — including defined processes for technical failure during a clinical session — is a genuine component of telehealth platform reliability, distinct from encryption and access control alone.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A genuine, specific recovery process exists for connection failure.	✗ No specific process exists beyond general hope the connection will be restored.
✓ Patients are genuinely aware of an alternative contact method in advance.	✗ Patients have no advance awareness of an alternative contact method.
✓ The recovery process has genuinely been tested, not only described in policy.	✗ The process exists only in writing, never tested.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **A recovery process exists for provider-side awareness but isn't proactively communicated to patients in advance.**
A process patients don't know about provides limited real reassurance during an actual disruption.

2 **An alternative contact method exists but isn't consistently the same across different providers.**
Consistent, genuine patient awareness depends on a reliable, predictable alternative method.

3 **The process is described in policy but hasn't been genuinely tested against a real or simulated failure.**
An untested process may not function reliably when a genuine connection failure actually occurs.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current connection failure response for a genuine, specific defined process.

Week 2 Establish and communicate a consistent alternative contact method to patients in advance.

Week 3 Test the recovery process against a simulated connection failure.

Ongoing Confirm patient awareness of the recovery process periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a patient what they would do if their session connection failed mid-appointment.
A confident, specific answer reveals genuine, communicated awareness, not an assumed process.

Ask staff to describe the last time this recovery process was genuinely tested.
A specific, real example reveals genuine practice, not a protocol that exists only on paper.

E-LEARNING academy.gmj.ge/tm-std1-5-connection-recovery — 30 min · complete before self-assessment

STANDARD 2

Cross-Jurisdictional Licensure & Legal Compliance

MANDATORY

5 criteria

	Standard 2.1 **NON-NEGOTIABLE** · *Standard 2: Cross-Jurisdictional Licensure & Legal Compliance* **Provider Licensure Is Verified for the Patient's Actual Location**	**ASSESSMENT** ASF-TM-STD2-v3.0
CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

2.1
NON-NEGOTIABLE
L1

THE STANDARD

Provider Licensure Is Verified for the Patient's Actual Location

Every provider is genuinely licensed in the specific state or jurisdiction where the patient is actually located at the time of the visit — not where the provider is based, and not assumed sufficient because the provider holds a license somewhere.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is every provider genuinely licensed in the specific jurisdiction where the patient is actually located?** *Real, verified licensure matching the patient's actual location, not the provider's own.* Doc: Provider licensure verification by patient jurisdiction	YES	PARTIAL	NO
2	**Is this verification done for every individual visit, not assumed from a one-time check at provider onboarding?** *Real, per-visit verification, not a single historical check assumed to remain sufficient.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there a specific process preventing a visit from proceeding if the provider lacks jurisdiction-appropriate licensure?** *A real, enforced block, not a visit that proceeds regardless of a licensure gap.* Doc: Licensure gap prevention process	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Licensure verification review*	Reviews records confirming provider licensure matches patient location for a sample of visits.
DOCUMENT *Per-visit verification review*	Reviews whether verification genuinely happens per visit, not only at initial onboarding.
DOCUMENT *Prevention process review*	Reviews the specific process preventing a visit from proceeding without appropriate licensure.

REFERENCES

[6] The Interstate Medical Licensure Compact Commission establishes that the location of medical practice is the state where the patient is located, with all laws and regulations of the patient's state applying, distinct from the provider's own location or state of principal licensure.

Standard 2.1 · *Standard 2: Cross-Jurisdictional Licensure & Legal Compliance*

Guidance & Learning

GUIDANCE ASF-TM-STD2-v3.0

WHY THIS STANDARD EXISTS

The practice of medicine occurs where the patient is, not where the provider happens to be sitting, and this isn't a minor technicality — a provider seeing a patient in a jurisdiction where they aren't licensed is practicing outside their legal authority regardless of how the actual clinical care goes.

The evidence: [6] The Interstate Medical Licensure Compact Commission establishes that the location of medical practice is the state where the patient is located, with all laws and regulations of the patient's state applying, distinct from the provider's own location or state of principal licensure.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every provider is genuinely licensed for the patient's actual location.	✗ Providers rely on licensure in their own state, not the patient's actual location.
✓ Verification happens for every individual visit, not a one-time check.	✗ Verification happened once at onboarding, never reconfirmed per visit.
✓ A real, enforced process prevents a visit without appropriate licensure.	✗ Visits proceed regardless of an identified licensure gap.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Verification happens reliably for scheduled appointments but not consistently for urgent or same-day visits.**
Every visit, regardless of how it's scheduled, carries the same real legal requirement.

2 **The process relies on the patient self-reporting their location without independent confirmation.**
Genuine verification benefits from more than self-report alone, given how consequential a licensure gap actually is.

3 **Verification is strong for the primary state a provider expects but less rigorous for infrequent, unexpected patient locations.**
An infrequent location still carries the same real licensure requirement as a common one.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current licensure verification practice against genuine, per-visit, patient-location matching.

Week 2 Establish a systematic process confirming licensure before every visit proceeds.

Week 3 Build independent confirmation of patient location, not self-report alone.

Ongoing Audit licensure verification for infrequent or unexpected patient locations.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask how the service would specifically verify licensure for a patient calling from an unexpected state.
A specific, confident answer reveals genuine, systematic practice, not an assumption of general coverage.

Ask what happens if a visit is already underway when a location or licensure issue is identified.
A specific, real answer reveals whether the prevention process genuinely holds, not just exists in policy.

E-LEARNING academy.gmj.ge/tm-std2-1-patient-location-licensure — 30 min · complete before self-assessment

	Standard 2.2 **NON-NEGOTIABLE** · *Standard 2: Cross-Jurisdictional Licensure & Legal Compliance* **Patient Location at the Time of the Visit Is Specifically Documented**	**ASSESSMENT** ASF-TM-STD2-v3.0
CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

2.2
NON-NEGOTIABLE
L1

THE STANDARD

Patient Location at the Time of the Visit Is Specifically Documented

The patient's actual physical location at the time of each visit is specifically, genuinely documented — not assumed from an address on file, and not left undocumented entirely, given this location is what determines which laws and licensure requirements actually apply.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is the patient's actual location at the time of each visit specifically, genuinely documented?** *Real, current-visit documentation, not an assumption based on an address on file.* Doc: Visit-specific location documentation	YES	PARTIAL	NO
2	**Is the patient specifically asked to confirm their current location, not assumed unchanged from a prior visit?** *Real, active confirmation at each visit, not carried forward from previous documentation.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**When a patient's confirmed location differs from what's on file, does this trigger genuine, specific review?** *A real, active response to a location discrepancy, not proceeding without reconsidering licensure implications.* Doc: Location discrepancy review process	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Location documentation review*	Reviews visit records for genuine, specific, current location documentation.
OBSERVE *Confirmation practice observation*	Observes whether patients are specifically asked to confirm current location at each visit.
DOCUMENT *Discrepancy review process check*	Reviews the process for responding when confirmed location differs from what's on file.

REFERENCES

[7] Documenting the patient's specific location at the time of the telemedicine visit is established as essential practice, distinct from relying on an address on file, given that applicable law and licensure requirements are determined by the patient's actual location during the encounter.

Standard 2.2 · *Standard 2: Cross-Jurisdictional Licensure & Legal Compliance*

Guidance & Learning

GUIDANCE ASF-TM-STD2-v3.0

WHY THIS STANDARD EXISTS

A patient's location can genuinely change from what's on file — traveling, temporarily staying elsewhere — and since the applicable law depends specifically on where the patient actually is during the visit, not their home address, documentation that doesn't capture the real, current location leaves the entire licensure verification process built on a potentially inaccurate foundation.

The evidence: [7] Documenting the patient's specific location at the time of the telemedicine visit is established as essential practice, distinct from relying on an address on file, given that applicable law and licensure requirements are determined by the patient's actual location during the encounter.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Patient location is genuinely, specifically documented for every visit.	✗ Location documentation relies on an address on file, not confirmed for the actual visit.
✓ Patients are actively asked to confirm their current location, not assumed unchanged.	✗ Patients aren't specifically asked; location is assumed carried forward.
✓ A discrepancy in confirmed location triggers genuine, specific review.	✗ A location discrepancy doesn't trigger any real review or reconsideration.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Confirmation happens at the start of a new patient relationship but isn't repeated for established patients.**
An established patient's actual location can genuinely change just as a new patient's can.

2 **Location is documented but not specifically enough to confirm which state or jurisdiction actually applies.**
Genuine specificity is what makes the documentation actually useful for confirming licensure requirements.

3 **A discrepancy is noted but doesn't consistently trigger a genuine pause to reconsider licensure implications.**
A noted discrepancy without real, resulting reconsideration doesn't provide the protective value this documentation exists to ensure.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current location documentation practice for genuine, visit-specific accuracy.

Week 2 Establish active patient confirmation of current location at every visit.

Week 3 Build a genuine review process for identified location discrepancies.

Ongoing Audit location documentation specificity and confirmation consistency.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual location documentation for a specific, recent visit.
A real, specific record reveals genuine practice, not an assumption based on file address.

Ask what happens if a patient confirms they're currently in a different state than their address on file.
A specific, confident answer reveals a genuine review process, not passive documentation alone.

E-LEARNING academy.gmj.ge/tm-std2-2-location-documentation — 30 min · complete before self-assessment

	Standard 2.3 **NON-NEGOTIABLE** · *Standard 2: Cross-Jurisdictional Licensure & Legal Compliance* **Interstate Compact Membership Is Verified for the Specific Provider Type**	**ASSESSMENT** ASF-TM-STD2-v3.0
CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

2.3
NON-NEGOTIABLE
L1

THE STANDARD

Interstate Compact Membership Is Verified for the Specific Provider Type

Interstate licensure compact coverage is verified specifically for each provider's actual profession — physician, nurse, physician assistant, or other licensed role — not assumed to apply broadly across all provider types on the basis that one compact exists.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is compact coverage specifically verified for each provider's actual profession, not assumed to apply broadly?** *Real, profession-specific verification, not a general assumption covering all provider types.* Doc: Profession-specific compact verification	YES	PARTIAL	NO
2	**For a non-physician provider, is their own specific, relevant compact verified — not the physician compact assumed to cover them?** *Specific, correct compact verification matching the provider's actual profession.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is the current member-state list for each relevant compact genuinely, specifically checked, not assumed static?** *Real, current verification, not an assumption that compact membership hasn't changed.* Doc: Current member-state verification record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Profession-specific verification review*	Reviews compact verification records for genuine, profession-specific accuracy.
DOCUMENT *Non-physician provider review*	Reviews whether non-physician providers have their own correct, specific compact verified.
DOCUMENT *Current membership review*	Reviews whether member-state lists are genuinely, currently checked, not assumed static.

REFERENCES

[8] The Interstate Medical Licensure Compact covers physicians specifically and does not extend to nurses, physician assistants, or other allied health professionals, who require verification under their own distinct interstate compacts with separate membership states and requirements.

Standard 2.3 · *Standard 2: Cross-Jurisdictional Licensure & Legal Compliance*

Guidance & Learning

GUIDANCE ASF-TM-STD2-v3.0

WHY THIS STANDARD EXISTS

The Interstate Medical Licensure Compact covers physicians specifically and doesn't extend to nurses, physician assistants, or other allied health professionals, who have their own genuinely separate compacts with their own membership states and requirements — treating compact coverage as a general umbrella covering every provider type risks a genuine, real licensure gap for exactly the providers whose specific compact wasn't actually checked.

The evidence: [8] The Interstate Medical Licensure Compact covers physicians specifically and does not extend to nurses, physician assistants, or other allied health professionals, who require verification under their own distinct interstate compacts with separate membership states and requirements.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Compact coverage is genuinely verified specific to each provider's actual profession.	✗ Compact coverage is assumed to apply broadly across all provider types.
✓ Non-physician providers have their own correct, specific compact verified.	✗ Non-physician providers are assumed covered by the physician compact.
✓ Current member-state status is genuinely, specifically checked.	✗ Member-state status is assumed static, not currently verified.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Physician compact verification is thorough but nurse or physician assistant compact verification is less rigorous.**
Every provider type genuinely licensed under a distinct compact deserves the same specific, rigorous verification.

2 **Compact membership was verified at provider onboarding but hasn't been reconfirmed as membership can change over time.**
Compact membership genuinely can change, including states withdrawing, and verification should reflect current status.

3 **Verification happens for the provider's primary compact but not for a secondary licensure type the same provider also holds.**
Every licensure type a provider actually holds deserves the same current, specific verification.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current compact verification for genuine, profession-specific accuracy across all provider types.

Week 2 Establish specific verification processes for each distinct provider profession and compact.

Week 3 Confirm current member-state status for every relevant compact, not assumed static.

Ongoing Reverify compact membership periodically as states join or withdraw.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask how the service verifies compact coverage for a non-physician provider specifically.
A specific, confident answer reveals genuine, profession-specific practice, not an assumption of broad coverage.

Ask when compact membership status was last reconfirmed as current.
A specific, real answer reveals genuine, ongoing verification, not a one-time check assumed to remain valid.

E-LEARNING academy.gmj.ge/tm-std2-3-profession-specific-compact — 30 min · complete before self-assessment

Standard 2.4 **CORE** · *Standard 2: Cross-Jurisdictional Licensure & Legal Compliance*

A Genuine Process Exists for a Patient Who Relocates or Travels Mid-Treatment

ASSESSMENT ASF-TM-STD2-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

2.4
CORE
L1

THE STANDARD

A Genuine Process Exists for a Patient Who Relocates or Travels Mid-Treatment

When an established patient relocates or is traveling to a different jurisdiction, a genuine, defined process addresses the resulting licensure implications — not continuing care as though nothing changed, or abruptly discontinuing care without a real transition plan.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does a genuine, defined process address licensure implications when a patient relocates or travels?** *A real, specific process, not continuing regardless of the licensure gap or abruptly dropping care.* Doc: Relocation and travel process documentation	YES	PARTIAL	NO
2	**Are patients specifically asked to inform the provider of a genuine relocation or extended travel?** *Real, proactive patient communication, not assumed the provider will otherwise learn of a change.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**When a genuine licensure gap is identified, is there a real transition plan, not care simply ending abruptly?** *A genuine, structured transition, not the patient left without a real plan for continuing care.* Doc: Transition plan documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Relocation process review*	Reviews the specific, defined process for addressing patient relocation or travel.
ASK *Patient communication interview*	Asks staff how patients are prompted to report a genuine relocation or extended travel.
DOCUMENT *Transition plan review*	Reviews evidence of a genuine transition plan when a licensure gap is identified.

REFERENCES

[9] Genuine attention to changing licensure implications when a patient relocates or travels, distinct from continuing care regardless of resulting licensure gaps or abruptly discontinuing without transition, is established as necessary practice for telemedicine continuity of care.

Standard 2.4 · *Standard 2: Cross-Jurisdictional Licensure & Legal Compliance*

Guidance & Learning

GUIDANCE ASF-TM-STD2-v3.0

WHY THIS STANDARD EXISTS

A patient's relocation or travel genuinely changes which laws and licensure requirements apply to their ongoing care, and a service that doesn't have a real process for this — either continuing regardless of the licensure gap it creates, or simply dropping the patient — fails to genuinely address a situation that real patients, in an increasingly mobile population, will actually encounter.

The evidence: [9] Genuine attention to changing licensure implications when a patient relocates or travels, distinct from continuing care regardless of resulting licensure gaps or abruptly discontinuing without transition, is established as necessary practice for telemedicine continuity of care.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A genuine, defined process addresses relocation or travel licensure implications.	✗ Care continues regardless of a resulting licensure gap.
✓ Patients are proactively asked to report a genuine relocation or extended travel.	✗ No proactive process prompts patients to report relocation or travel.
✓ A real transition plan exists when a licensure gap is identified.	✗ Care ends abruptly without any real transition plan.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **The process addresses permanent relocation but not extended temporary travel to a different jurisdiction.**
Extended travel can create the same real licensure implications as permanent relocation.

2 **Patients are asked about relocation at intake but not proactively reminded to report it as an ongoing patient.**
A patient's situation can genuinely change well after their initial intake, and ongoing prompting reflects this reality.

3 **A transition plan exists but doesn't consistently include a specific, named alternative provider.**
A genuine transition needs a real, specific destination, not a plan that only ends the current relationship.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for genuine attention to patient relocation and travel.

Week 2 Establish proactive patient communication about reporting relocation or extended travel.

Week 3 Build a genuine transition plan process including specific alternative provider options.

Ongoing Confirm transition plans are genuinely offered when a licensure gap is identified.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real, recent example of a patient relocation and how it was actually handled.
A real, traced example reveals genuine practice, not policy language alone.

Ask how patients are reminded, as ongoing patients, to report a change in their location.
A specific, confident answer reveals genuine, ongoing attention, not a one-time intake question.

E-LEARNING academy.gmj.ge/tm-std2-4-relocation-process — 30 min · complete before self-assessment

Standard 2.5 **CORE** · *Standard 2: Cross-Jurisdictional Licensure & Legal Compliance*

Coordinated Disciplinary Risk From Compact Licensure Is Genuinely Understood

ASSESSMENT ASF-TM-STD2-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

2.5
CORE
L1

THE STANDARD

Coordinated Disciplinary Risk From Compact Licensure Is Genuinely Understood

Providers practicing under interstate compact licensure genuinely understand that disciplinary action in one member state can trigger coordinated notification and potential action across all member state boards — not treating a compact license as though each state's standing were entirely independent of the others.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Do providers practicing under compact licensure genuinely understand the coordinated disciplinary notification structure?** *Real, genuine understanding of this specific consequence, not an assumption each state's standing is independent.* Doc: Provider training on compact disciplinary structure	YES	PARTIAL	NO
2	**Is this understanding specifically confirmed, not assumed from general awareness that compacts exist?** *Real, confirmed understanding, not general familiarity with the concept of interstate compacts.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Does the service's own compliance culture reflect genuine awareness of this heightened, cross-state stake?** *Real, organizational awareness reflected in practice, not limited to individual provider knowledge alone.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Provider training review*	Reviews training records confirming providers are specifically educated on coordinated disciplinary risk.
ASK *Provider understanding interview*	Asks a provider to explain what happens if disciplinary action occurs in one compact member state.
ASK *Organizational awareness interview*	Asks service leadership how this heightened risk genuinely informs organizational compliance practice.

REFERENCES

[10] Under interstate medical licensure compact structures, if a participating state board takes disciplinary action against a provider's compact-facilitated license, all compact member boards are notified and authorized to take similar action, establishing coordinated disciplinary risk as a genuine, distinct consequence of compact licensure.

Standard 2.5 · *Standard 2: Cross-Jurisdictional Licensure & Legal Compliance*

Guidance & Learning

GUIDANCE ASF-TM-STD2-v3.0

WHY THIS STANDARD EXISTS

Compact licensure carries a genuine, real, and specific consequence beyond a single-state license: action against a provider's standing in one member state is shared with every other member board, which can affect the provider's ability to practice across multiple states simultaneously — a provider who doesn't genuinely understand this carries real, uninformed risk to their broader practice from an issue that might otherwise seem contained to one jurisdiction.

The evidence: [10] Under interstate medical licensure compact structures, if a participating state board takes disciplinary action against a provider's compact-facilitated license, all compact member boards are notified and authorized to take similar action, establishing coordinated disciplinary risk as a genuine, distinct consequence of compact licensure.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Providers genuinely understand the coordinated disciplinary notification structure.	✗ Providers treat each state's standing as entirely independent of the others.
✓ This understanding is specifically confirmed, not assumed from general familiarity.	✗ Understanding is assumed, never specifically confirmed.
✓ The service's compliance culture genuinely reflects awareness of this heightened stake.	✗ Organizational compliance practice doesn't reflect genuine awareness of coordinated risk.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Providers understand the general concept but not the specific practical implications for their own multi-state practice.**
Genuine understanding requires connecting the general concept to a provider's own real, practical situation.

2 **Training covers this at onboarding but isn't reinforced as compact structures and provider participation evolve.**
A provider's understanding benefits from genuine, periodic reinforcement, not a single initial explanation.

3 **Individual providers understand the risk but organizational compliance practice doesn't reflect it structurally.**
Genuine organizational reflection of this risk matters as much as individual provider awareness.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current provider understanding of coordinated disciplinary notification structure.

Week 2 Build specific training explaining this consequence and its practical implications.

Week 3 Confirm genuine provider understanding through direct discussion, not assumed awareness.

Ongoing Reinforce this understanding periodically as compact participation evolves.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a provider directly to explain what would happen if one state took disciplinary action against their compact license.
A specific, accurate answer reveals genuine understanding, not general familiarity with the concept.

Ask service leadership how this risk specifically informs their own compliance practices.
A specific, thoughtful answer reveals genuine organizational awareness, not individual provider knowledge alone.

E-LEARNING academy.gmj.ge/tm-std2-5-coordinated-disciplinary-risk — 30 min · complete before self-assessment

STANDARD 3

Remote Clinical Assessment & Limitations Recognition

MANDATORY

5 criteria

	Standard 3.1 **NON-NEGOTIABLE** · *Standard 3: Remote Clinical Assessment & Limitations Recognition* **Providers Recognize Which Presenting Concerns Genuinely Require In-Person Examination**	**ASSESSMENT** ASF-TM-STD3-v3.0
CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

3.1
NON-NEGOTIABLE
L1

THE STANDARD

Providers Recognize Which Presenting Concerns Genuinely Require In-Person Examination

Providers genuinely recognize when a presenting concern requires in-person, hands-on examination and refer accordingly — not proceeding with remote assessment for every concern regardless of whether it's actually the kind of presentation remote care can reliably address.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Do providers genuinely recognize which presenting concerns require in-person examination?** *Real, specific recognition, not remote assessment applied indiscriminately.* Doc: Provider training on remote assessment limitations	YES	PARTIAL	NO
2	**Is there specific, defined guidance identifying presentations that genuinely warrant in-person referral?** *A real, specific document, not left to individual judgment alone.* Doc: In-person referral guidance documentation	YES	PARTIAL	NO
3	**When such a presentation occurs, does the provider genuinely refer, not attempt remote assessment anyway?** *Real, consistent referral, not remote assessment attempted despite recognized limits.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Provider training review*	Reviews training records for genuine, specific coverage of condition-appropriate remote assessment limits.
DOCUMENT *Referral guidance review*	Reviews the specific, defined guidance identifying presentations warranting in-person referral.
DOCUMENT *Referral practice review*	Reviews records for genuine, consistent in-person referral when warranted.

REFERENCES

[11] A retrospective review of teledermatology consultations found 60.2 percent of patients had additional diagnoses identified only on in-person examination, including an additional malignant diagnosis in 8.4 percent of patients, establishing genuine, condition-specific limits to remote assessment that providers must actively recognize.

Standard 3.1 · *Standard 3: Remote Clinical Assessment & Limitations Recognition*

Guidance & Learning

GUIDANCE ASF-TM-STD3-v3.0

WHY THIS STANDARD EXISTS

Real diagnostic accuracy varies genuinely by condition and exam type — remote musculoskeletal assessment has shown good concordance with in-person exam, while teledermatology has been found to miss a genuine, real share of diagnoses, including malignant ones, that only surfaced on in-person examination — a provider who doesn't recognize this real, condition-specific difference risks proceeding remotely with exactly the presentations least suited to it.

The evidence: [11] A retrospective review of teledermatology consultations found 60.2 percent of patients had additional diagnoses identified only on in-person examination, including an additional malignant diagnosis in 8.4 percent of patients, establishing genuine, condition-specific limits to remote assessment that providers must actively recognize.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Providers genuinely recognize condition-specific limits to remote assessment. ✓ Specific, defined guidance identifies presentations warranting in-person referral. ✓ Providers genuinely refer, not attempt remote assessment despite recognized limitation.	✗ Remote assessment is attempted for every presentation regardless of genuine suitability. ✗ No specific guidance exists; recognition is left to individual judgment alone. ✗ Providers attempt remote assessment despite a presentation warranting in-person referral.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Guidance covers well-known high-risk presentations but not the full range of conditions with documented remote assessment limits.**
Genuine recognition should extend to the full, real range of documented limitations, not only the most obvious examples.

2 **Recognition is strong among experienced providers but less consistent among newer team members.**
Every provider conducting remote assessment carries the same real responsibility for recognizing genuine limits.

3 **Referral happens for the most severe presentations but less consistently for moderate ones with documented remote assessment gaps.**
Moderate presentations can still carry genuine, real risk of a missed finding without in-person examination.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current provider practice for genuine recognition of condition-specific remote assessment limits.

Week 2 Build specific, documented guidance identifying presentations warranting in-person referral.

Week 3 Train all providers, including newer staff, on this specific guidance.

Ongoing Audit referral practice against the defined guidance.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a provider to describe a specific presentation they would genuinely refer for in-person examination, not attempt remotely.
A specific, real example reveals genuine recognition, not general awareness of the concept.

Ask for a real example of a recent in-person referral and what specifically prompted it.
A real, traceable example reveals whether this recognition translates into genuine practice.

E-LEARNING academy.gmj.ge/tm-std3-1-in-person-referral-recognition — 30 min · complete before self-assessment

	Standard 3.2 **NON-NEGOTIABLE** · *Standard 3: Remote Clinical Assessment & Limitations Recognition* **The Same Standard of Care Applies Remotely as In-Person**	**ASSESSMENT** ASF-TM-STD3-v3.0

CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

3.2
NON-NEGOTIABLE
L1

THE STANDARD

The Same Standard of Care Applies Remotely as In-Person

Remote assessment genuinely meets the same standard of care a provider would apply in person — the same thoroughness, the same diligence in ordering appropriate tests, the same rigor in establishing a differential diagnosis — not a lowered bar accepted simply because the visit happens to be remote.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does remote assessment genuinely meet the same standard of care a provider would apply in person?** *Real, equivalent thoroughness and diligence, not a lowered bar for remote convenience.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Are diagnostic tests ordered with the same genuine diligence remotely as they would be in person?** *Real, consistent ordering practice, not testing skipped because the visit is remote.* Doc: Diagnostic test ordering record	YES	PARTIAL	NO
3	**Is a genuine differential diagnosis established for remote presentations, not skipped for convenience?** *Real, documented differential diagnosis practice, not an assumption remote visits require less rigor.* Doc: Differential diagnosis documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Assessment rigor observation*	Observes remote consultations for genuine thoroughness equivalent to in-person practice.
DOCUMENT *Test ordering review*	Reviews diagnostic test ordering patterns for genuine consistency with in-person practice.
DOCUMENT *Differential diagnosis review*	Reviews documentation for genuine differential diagnosis practice in remote encounters.

REFERENCES

[12] The standard of care remains the same whether a visit is conducted in person or remotely, with malpractice claims analysis identifying failure to order diagnostic testing, failure to assess continued symptoms, and failure to establish a differential diagnosis as leading contributors to diagnostic error in telehealth practice.

Standard 3.2 · *Standard 3: Remote Clinical Assessment & Limitations Recognition*

Guidance & Learning

GUIDANCE ASF-TM-STD3-v3.0

WHY THIS STANDARD EXISTS

The standard of care doesn't change because a visit is remote rather than in-person, and real malpractice claims analysis specifically identifies failure to order diagnostic testing, failure to address continued symptoms, and failure to establish a differential diagnosis as leading contributors to diagnostic error — none of which are unique to remote care, but all of which genuine, careful practice must guard against regardless of visit format.

The evidence: [12] The standard of care remains the same whether a visit is conducted in person or remotely, with malpractice claims analysis identifying failure to order diagnostic testing, failure to assess continued symptoms, and failure to establish a differential diagnosis as leading contributors to diagnostic error in telehealth practice.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Remote assessment genuinely meets the same standard of care as in-person practice.	✗ Remote assessment is conducted with less thoroughness than in-person practice.
✓ Diagnostic tests are ordered with the same genuine diligence remotely.	✗ Testing is skipped or delayed because the visit happens to be remote.
✓ A genuine differential diagnosis is established, not skipped for remote convenience.	✗ Differential diagnosis practice is abbreviated or skipped for remote presentations.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Rigor is generally equivalent but documentation of the differential diagnosis process is less thorough remotely.**
Documented rigor matters as much as the underlying clinical thinking, particularly for later review.

2 **Test ordering is consistent for common presentations but less rigorous for less familiar remote complaints.**
Every presentation deserves the same genuine diligence, not only the most common ones.

3 **Standard of care is generally maintained but providers report feeling less confident applying it under time-pressured remote scheduling.**
Genuine standard of care shouldn't erode under scheduling pressure, whether remote or in person.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current remote assessment practice for genuine equivalence to in-person standard of care.

Week 2 Reinforce diagnostic test ordering and differential diagnosis documentation standards for remote visits.

Week 3 Address any scheduling pressure that risks eroding genuine assessment rigor.

Ongoing Audit remote assessment quality against the same standard applied in-person.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a provider to describe how their remote assessment process compares to their in-person process for a similar complaint.
A specific, thoughtful answer reveals genuine equivalence, not an assumption of it.

Review documentation for a remote visit and an in-person visit for a similar presenting concern.
A real, direct comparison reveals whether genuine equivalent rigor actually holds.

E-LEARNING academy.gmj.ge/tm-std3-2-equivalent-standard-of-care — 30 min · complete before self-assessment

Standard 3.3 **NON-NEGOTIABLE** · *Standard 3: Remote Clinical Assessment & Limitations Recognition*

Uncertain or Complex Presentations Trigger Genuine Escalation, Not Extended Remote Attempts

ASSESSMENT ASF-TM-STD3-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

3.3
NON-NEGOTIABLE
L1

THE STANDARD

Uncertain or Complex Presentations Trigger Genuine Escalation, Not Extended Remote Attempts

When a presentation remains genuinely uncertain after remote assessment, the provider escalates to in-person evaluation or specialist referral — not continuing extended remote attempts to resolve uncertainty that hands-on examination could genuinely address more reliably.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does a genuinely uncertain presentation trigger escalation to in-person evaluation, not extended remote attempts to resolve it?** *Real, timely escalation, not continued remote assessment when uncertainty genuinely persists.* Doc: Escalation trigger documentation	YES	PARTIAL	NO
2	**Is there a specific, defined point at which genuine diagnostic uncertainty should prompt this escalation?** *A real, specific threshold, not left to indefinite continuation of remote assessment.* Doc: Escalation threshold guidance	YES	PARTIAL	NO
3	**Are new or genuinely complex concerns specifically flagged for a lower threshold toward in-person evaluation?** *Real, specific recognition that new or complex concerns warrant genuine caution, not treated identically to established, straightforward concerns.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Escalation trigger review*	Reviews records for genuine, timely escalation when diagnostic uncertainty persists.
DOCUMENT *Threshold guidance review*	Reviews the specific, defined threshold guiding when escalation should genuinely occur.
OBSERVE *New concern handling observation*	Observes whether new or complex concerns receive genuinely heightened caution toward in-person evaluation.

REFERENCES

[13] Clinicians and subject matter experts describe genuine challenges in managing diagnostic uncertainty via telemedicine due to the absence of hands-on examination, with few patients receiving a new diagnosis through telemedicine and many preferring in-person visits specifically for new or complex concerns.

Standard 3.3 · *Standard 3: Remote Clinical Assessment & Limitations Recognition*

Guidance & Learning

GUIDANCE ASF-TM-STD3-v3.0

WHY THIS STANDARD EXISTS

Real qualitative research on telemedicine's diagnostic process specifically identifies managing diagnostic uncertainty as a genuine, documented challenge, and few patients report receiving a genuinely new diagnosis through telemedicine, with many preferring in-person visits for new or complex concerns — this reflects a real, appropriate limit, not a failure of remote care, and providers should genuinely act on this limit rather than push past it.

The evidence: [13] Clinicians and subject matter experts describe genuine challenges in managing diagnostic uncertainty via telemedicine due to the absence of hands-on examination, with few patients receiving a new diagnosis through telemedicine and many preferring in-person visits specifically for new or complex concerns.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Genuine diagnostic uncertainty triggers timely escalation to in-person evaluation.	✗ Extended remote attempts continue despite genuine, persistent uncertainty.
✓ A specific, defined threshold guides when escalation should occur.	✗ No specific threshold exists; escalation is left to indefinite individual judgment.
✓ New or complex concerns receive genuinely heightened caution toward escalation.	✗ New or complex concerns are treated identically to established, straightforward ones.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Escalation happens reliably for acute presentations but less consistently for gradually worsening uncertain symptoms.**
Genuine uncertainty deserves the same escalation discipline regardless of whether it presents acutely or develops gradually.

2 **A general escalation principle is understood but the specific threshold varies meaningfully between providers.**
A specific, consistent threshold provides more reliable protection than principle alone, applied inconsistently.

3 **New concerns are treated with more caution but complex, longer-standing concerns don't receive the same heightened attention.**
Complexity itself, not only newness, is a genuine, real reason for heightened caution toward escalation.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current escalation practice for genuine, timely response to diagnostic uncertainty.

Week 2 Establish a specific, defined threshold guiding escalation decisions.

Week 3 Train providers on heightened caution for both new and genuinely complex concerns.

Ongoing Audit escalation timing against the defined threshold.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a provider to describe the specific point at which they'd escalate an uncertain remote presentation.
A specific, confident answer reveals genuine, consistent practice, not indefinite individual discretion.

Ask for a real, recent example of an escalation and what specifically prompted it.
A real, traceable example reveals whether escalation genuinely happens, not just exists as a stated principle.

E-LEARNING academy.gmj.ge/tm-std3-3-uncertainty-escalation — 30 min · complete before self-assessment

Standard 3.4 **NON-NEGOTIABLE** · *Standard 3: Remote Clinical Assessment & Limitations Recognition*

Providers Actively Compensate for the Absence of Hands-On Exam

ASSESSMENT ASF-TM-STD3-v3.0

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

3.4
NON-NEGOTIABLE
L1

THE STANDARD

Providers Actively Compensate for the Absence of Hands-On Exam

Providers actively, deliberately compensate for the absence of hands-on examination — through appropriate diagnostic testing, structured patient self-examination guidance, and genuinely scheduled follow-up — not proceeding as though the missing physical exam simply doesn't matter.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Do providers actively, deliberately compensate for missing hands-on exam through appropriate additional testing?** *Real, deliberate compensation, not proceeding as though the missing exam is inconsequential.* Doc: Compensatory testing documentation	YES	PARTIAL	NO
2	**Is structured guidance genuinely provided for patient self-examination, where relevant, not left to unguided patient description?** *Real, structured guidance for patient self-assessment, not vague, unguided self-report alone.* Doc: Patient self-examination guidance materials	YES	PARTIAL	NO
3	**Is follow-up genuinely, specifically scheduled to compensate for assessment limitations, not left open-ended?** *Real, specific scheduled follow-up, not a vague suggestion to return if symptoms persist.* Doc: Follow-up scheduling documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Compensatory testing review*	Reviews evidence of genuine, deliberate additional testing to compensate for missing exam.
DOCUMENT *Self-examination guidance review*	Reviews structured guidance materials provided for patient self-examination.
DOCUMENT *Follow-up scheduling review*	Reviews whether follow-up is genuinely, specifically scheduled, not left open-ended.

REFERENCES

[14] Clinicians describe relying more on additional diagnostic testing, structured patient self-reports, and scheduled in-person follow-up visits specifically to compensate for the absence of hands-on physical examination in telemedicine encounters, establishing active compensation as effective, documented practice.

Standard 3.4 · *Standard 3: Remote Clinical Assessment & Limitations Recognition*

Guidance & Learning

GUIDANCE ASF-TM-STD3-v3.0

WHY THIS STANDARD EXISTS

Real qualitative research on telemedicine's diagnostic process specifically found that clinicians who manage this limitation well describe relying more on additional testing, patient self-reports, and scheduled in-person follow-ups specifically to compensate for what remote assessment genuinely cannot capture — this is documented, effective adaptive practice, not simply accepting a diagnostic gap.

The evidence: [14] Clinicians describe relying more on additional diagnostic testing, structured patient self-reports, and scheduled in-person follow-up visits specifically to compensate for the absence of hands-on physical examination in telemedicine encounters, establishing active compensation as effective, documented practice.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Providers genuinely, deliberately order additional testing to compensate for missing exam.	✗ Providers proceed without additional compensation for the missing physical exam.
✓ Structured guidance genuinely supports patient self-examination where relevant.	✗ Patient self-report is unguided, without structured supporting materials.
✓ Follow-up is genuinely, specifically scheduled to compensate for assessment limitations.	✗ Follow-up is left open-ended, without a specific, scheduled compensatory check.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Compensatory testing happens for complex presentations but less consistently for moderate ones.**
Even a moderate presentation can genuinely benefit from compensation for the missing physical exam.

2 **Self-examination guidance exists for common presentations but isn't developed for less frequent complaint types.**
Every relevant presentation deserves genuine, structured guidance, not only the most common ones.

3 **Follow-up is scheduled but the specific timing isn't tailored to the actual clinical urgency of the presentation.**
Genuine compensation should reflect the real urgency of the specific concern, not a generic follow-up interval.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for genuine, active compensation for missing hands-on exam.

Week 2 Build structured patient self-examination guidance for common presentation types.

Week 3 Establish specific, clinically-appropriate follow-up scheduling practice.

Ongoing Audit compensatory practice for consistency across presentation types.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a provider how they specifically compensate for not being able to physically examine a patient.
A specific, thoughtful answer reveals genuine, deliberate practice, not an assumption remote care is equivalent without adaptation.

Ask to see actual structured self-examination guidance provided to a patient.
A real, specific document reveals genuine practice, not vague verbal instruction alone.

E-LEARNING academy.gmj.ge/tm-std3-4-active-compensation — 30 min · complete before self-assessment

Standard 3.5 **CORE** · *Standard 3: Remote Clinical Assessment & Limitations Recognition*

New, Undiagnosed Symptoms Receive Specific, Heightened Caution

ASSESSMENT ASF-TM-STD3-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

3.5
CORE
L1

THE STANDARD

New, Undiagnosed Symptoms Receive Specific, Heightened Caution

A genuinely new, undiagnosed symptom receives specific, heightened diagnostic caution — not treated with the same routine confidence a provider might reasonably apply to an established, previously diagnosed condition being managed remotely.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does a genuinely new, undiagnosed symptom receive specific, heightened diagnostic caution?** *Real, specific heightened caution, not routine confidence applied identically to established conditions.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Is there a specific, lower threshold for in-person referral or additional testing when a symptom is genuinely new?** *A real, specifically lower threshold for new symptoms, not the same threshold applied regardless of whether a condition is established or new.* Doc: New-symptom threshold guidance	YES	PARTIAL	NO
3	**Are patients genuinely offered the option of in-person evaluation for a new concern, not assumed to prefer remote continuation?** *Real, genuine option offered, not an assumption the patient prefers remote care regardless of the concern's novelty.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

OBSERVE *New-symptom caution observation*	Observes whether new, undiagnosed symptoms genuinely receive heightened diagnostic caution.
DOCUMENT *Threshold guidance review*	Reviews whether a specifically lower referral threshold exists for genuinely new symptoms.
ASK *Patient option interview*	Asks a patient whether they were genuinely offered in-person evaluation for a new concern.

REFERENCES

[15] Research on telemedicine's diagnostic process found few patients receive a genuinely new diagnosis through telemedicine, with patients themselves preferring in-person evaluation specifically for new concerns, establishing a genuine, documented distinction between remote management of known conditions and remote establishment of new diagnoses.

Standard 3.5 · *Standard 3: Remote Clinical Assessment & Limitations Recognition*

Guidance & Learning

GUIDANCE ASF-TM-STD3-v3.0

WHY THIS STANDARD EXISTS

Real research specifically found that few patients receive a genuinely new diagnosis through telemedicine, and many patients themselves prefer in-person evaluation for new concerns — reflecting a genuine, appropriate distinction between managing a known condition remotely, which telemedicine can do well, and establishing a brand-new diagnosis remotely, which carries genuinely different, real uncertainty.

The evidence: [15] Research on telemedicine's diagnostic process found few patients receive a genuinely new diagnosis through telemedicine, with patients themselves preferring in-person evaluation specifically for new concerns, establishing a genuine, documented distinction between remote management of known conditions and remote establishment of new diagnoses.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ New, undiagnosed symptoms genuinely receive heightened diagnostic caution.	✗ New symptoms are treated with the same routine confidence as established conditions.
✓ A specifically lower threshold guides referral or testing for new symptoms.	✗ No specifically lower threshold exists for new symptom presentations.
✓ Patients are genuinely offered in-person evaluation for new concerns.	✗ Patients aren't genuinely offered in-person evaluation, assumed to prefer remote continuation.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Heightened caution is applied for symptoms the provider recognises as potentially serious but not consistently for less alarming new symptoms.**
Genuine caution for new symptoms shouldn't depend solely on initial perceived severity, which can itself be uncertain remotely.

2 **A lower threshold exists conceptually but isn't consistently applied across different providers.**
Consistent application across the whole team is what gives this threshold genuine, reliable protective value.

3 **Patients are offered in-person evaluation when they raise a new concern but not proactively for one the provider identifies.**
The option should be genuinely offered regardless of who first identifies the new concern.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for genuine, heightened caution with new, undiagnosed symptoms.

Week 2 Establish a specific, consistently applied lower referral threshold for new symptoms.

Week 3 Train providers to proactively offer in-person evaluation for new concerns, regardless of who identifies them.

Ongoing Audit new-symptom handling for genuine, consistent heightened caution.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a provider how their approach genuinely differs for a new symptom versus an established, known condition.
A specific, thoughtful answer reveals genuine, real distinction in practice, not identical treatment regardless of novelty.

Ask a patient whether they were offered in-person evaluation when they raised a new concern.
A specific, real answer reveals whether the option is genuinely offered, not assumed unnecessary.

E-LEARNING academy.gmj.ge/tm-std3-5-new-symptom-caution — 30 min · complete before self-assessment

STANDARD 4

Emergency Escalation for the Remote Patient

MANDATORY

5 criteria

	Standard 4.1 **NON-NEGOTIABLE** · *Standard 4: Emergency Escalation for the Remote Patient* **Patient Location Is Confirmed at the Start of Every Session**	**ASSESSMENT** ASF-TM-STD4-v3.0

CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

4.1
NON-NEGOTIABLE
L1

THE STANDARD

Patient Location Is Confirmed at the Start of Every Session

The patient's actual, current location is genuinely confirmed at the start of every single session — not assumed from an intake record or a prior visit, given that a patient's real location on any given day can genuinely differ from what's on file, and this is exactly the information an emergency response would need most.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is the patient's actual, current location genuinely confirmed at the start of every single session?** *Real, active confirmation every session, not assumed from intake or a prior visit.* Doc: Session-start location confirmation record	YES	PARTIAL	NO
2	**Is this confirmation specific enough to guide an actual emergency response — not just a general city or region?** *Real, specific detail sufficient for genuine emergency dispatch, not a vague general area.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Does a location differing from what's on file trigger any specific, genuine documentation or awareness?** *Real, active awareness of a location change, not silently overwritten or ignored.* Doc: Location change documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Session-start confirmation observation*	Observes an actual session opening for genuine, specific location confirmation.
DOCUMENT *Confirmation specificity review*	Reviews documented location confirmations for genuine, actionable specificity.
DOCUMENT *Location change awareness review*	Reviews whether a location differing from file triggers genuine documentation.

REFERENCES

[16] Genuine confirmation of a client's physical location at the start of every single session, not reliance on intake records, is established as essential telehealth crisis protocol, because not knowing where a patient actually is can be the difference between emergency help arriving and not arriving.

Standard 4.1 · *Standard 4: Emergency Escalation for the Remote Patient*

Guidance & Learning

GUIDANCE ASF-TM-STD4-v3.0

WHY THIS STANDARD EXISTS

A real documented case shows precisely why this matters: a patient in genuine crisis was actually located many hours from her home on the day of the emergency, and the provider was only able to activate emergency services in the correct jurisdiction because current location had been genuinely established — had the provider relied on the address on file, that emergency response would have gone to the wrong place entirely.

The evidence: [16] Genuine confirmation of a client's physical location at the start of every single session, not reliance on intake records, is established as essential telehealth crisis protocol, because not knowing where a patient actually is can be the difference between emergency help arriving and not arriving.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Actual, current location is genuinely confirmed at the start of every session.	✗ Location is assumed from intake or a prior visit, not confirmed each session.
✓ Confirmation is specific enough to genuinely guide an emergency response.	✗ Confirmation is vague, insufficient for genuine emergency dispatch.
✓ A location change from what's on file triggers genuine documentation and awareness.	✗ A location change goes unnoticed or undocumented.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Confirmation happens reliably for new patients but lapses into assumption for established, long-term patients.**
An established patient's actual location can change just as genuinely as a new patient's, and deserves the same confirmation.

2 **Confirmation is verbal but not specifically documented in a way that's genuinely retrievable during an actual emergency.**
Documentation that's difficult to retrieve quickly doesn't provide real, usable protection in an actual crisis.

3 **Confirmation happens for scheduled visits but is inconsistent for urgent or same-day sessions.**
Every session, regardless of how it was scheduled, carries the same real emergency preparedness need.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current location confirmation practice for genuine consistency across all patients and session types.

Week 2 Establish a specific, mandatory location confirmation step at the start of every session.

Week 3 Build genuine documentation practice for location changes from what's on file.

Ongoing Audit confirmation consistency across established and new patients alike.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe an actual session opening to confirm location is genuinely, specifically confirmed.
Direct observation reveals genuine practice, not an assumption from stated policy.

Ask a long-term patient whether they're asked to confirm their location at the start of each session.
This tests whether the practice genuinely extends to established patients, not just new ones.

E-LEARNING academy.gmj.ge/tm-std4-1-session-location-confirmation — 30 min · complete before self-assessment

	Standard 4.2 **NON-NEGOTIABLE** · *Standard 4: Emergency Escalation for the Remote Patient* **A Specific, Tiered Emergency Activation Protocol Exists**	**ASSESSMENT** ASF-TM-STD4-v3.0

CR FULL	TR FULL	SM FULL	ST FULL

4.2
NON-NEGOTIABLE
L1

THE STANDARD

A Specific, Tiered Emergency Activation Protocol Exists

A specific, tiered protocol exists for activating emergency services — direct local activation where covered, a patient-reported local dispatch number where standard coverage doesn't reach, and a relay mechanism connecting the provider to local emergency services as a further alternative — not a single, undifferentiated assumption that dialing a standard emergency number will always work regardless of the patient's actual location.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does a specific, tiered protocol exist for activating emergency services across different location scenarios?** *A real, multi-tiered protocol, not a single method assumed to work everywhere.* Doc: Tiered emergency activation protocol documentation	YES	PARTIAL	NO
2	**Are providers genuinely trained on all tiers of this protocol, not only the most common, direct method?** *Real, complete training across every tier, not familiarity with the simplest scenario alone.* Doc: Provider protocol training record	YES	PARTIAL	NO
3	**Has this protocol genuinely been tested or rehearsed, not only described in written policy?** *Real, tested practice, not a protocol that exists only on paper.* Doc: Protocol testing record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Protocol documentation review*	Reviews the actual, specific, tiered emergency activation protocol.
DOCUMENT *Training completeness review*	Reviews training records for genuine coverage of all protocol tiers, not the simplest scenario alone.
DOCUMENT *Testing record review*	Reviews evidence the protocol has genuinely been tested or rehearsed.

REFERENCES

[17] A documented telehealth emergency management protocol establishes a three-tiered emergency activation process: direct local emergency service activation where standard coverage exists, a patient-reported local dispatch number where it doesn't, and an e911 relay center connecting the clinician to local emergency services as a further alternative.

Standard 4.2 · *Standard 4: Emergency Escalation for the Remote Patient*

Guidance & Learning

GUIDANCE ASF-TM-STD4-v3.0

WHY THIS STANDARD EXISTS

Not every location a patient might genuinely be in has the same standard emergency service coverage, and a provider who only knows one method for activating emergency services has no real plan for the situations where that method doesn't apply — a genuine, tiered protocol is what ensures emergency activation remains possible across the real range of locations a patient could actually be in.

The evidence: [17] A documented telehealth emergency management protocol establishes a three-tiered emergency activation process: direct local emergency service activation where standard coverage exists, a patient-reported local dispatch number where it doesn't, and an e911 relay center connecting the clinician to local emergency services as a further alternative.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, tiered protocol genuinely exists for varying location scenarios.	✗ Only a single emergency activation method is known, assumed to work everywhere.
✓ Providers are genuinely trained on all tiers, not just the most common method.	✗ Training covers only the most common, direct activation method.
✓ The protocol has genuinely been tested, not only described in policy.	✗ The protocol exists only in writing, never tested or rehearsed.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Providers know the direct activation method well but are less confident with the relay center alternative.**
Every tier deserves the same genuine provider confidence, since any tier might be the one actually needed.

2 **The protocol is documented but hasn't been updated to reflect current relay center contact information.**
An outdated contact detail can undermine the entire protocol's genuine, real functionality when actually needed.

3 **The protocol has been reviewed internally but never tested through an actual simulated emergency scenario.**
An untested protocol may not hold up reliably during a genuine, real-time emergency.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current emergency activation knowledge for genuine coverage of all protocol tiers.

Week 2 Establish or update the specific, tiered protocol with current contact information.

Week 3 Train all providers on every tier, not the most common scenario alone.

Ongoing Test the protocol periodically through simulated emergency scenarios.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a provider to walk through all three tiers of the emergency activation protocol, not just the simplest one.
A specific, complete answer reveals genuine, full training, not familiarity with one method alone.

Ask when the protocol was last genuinely tested through a simulated scenario.
A specific, real answer reveals genuine practice, not a protocol that exists only on paper.

E-LEARNING academy.gmj.ge/tm-std4-2-tiered-emergency-protocol — 30 min · complete before self-assessment

	Standard 4.3 NON-NEGOTIABLE · *Standard 4: Emergency Escalation for the Remote Patient* **The Provider Remains Connected Until Emergency Services Have Genuinely Taken Over Care**	ASSESSMENT ASF-TM-STD4-v3.0

CR FULL	TR FULL	SM FULL	ST FULL

4.3
NON-NEGOTIABLE
L1

THE STANDARD

The Provider Remains Connected Until Emergency Services Have Genuinely Taken Over Care

When emergency services are activated during a session, the provider genuinely stays connected with the patient until local emergency responders have arrived and care has actually been transferred — not disconnecting once the call for help has been made, leaving the patient alone in the interval before help physically arrives.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does the provider genuinely remain connected with the patient until emergency responders have actually arrived?** *Real, continuous connection through the full interval, not disconnecting once the call is made.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Is care genuinely, actively transferred to responders, not simply the session ending once they're present?** *Real, active handoff of relevant information to responders, not a passive disconnection.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is this expectation specifically, clearly trained, not left to individual provider judgment in the moment?** *Real, specific training on this expectation, not assumed instinctive behavior under crisis pressure.* Doc: Provider training on remaining connected	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
ASK *Provider practice interview*	Asks a provider to describe what they would do, and when they would disconnect, during an actual emergency activation.
DOCUMENT *Training review*	Reviews training records confirming providers are specifically trained to remain connected through handoff.
DOCUMENT *Real event review*	Reviews documentation from a genuine past emergency event, where available, for evidence of continued connection through handoff.

REFERENCES

[18] Established telehealth emergency management protocol specifically requires clinicians to remain connected on the session with the patient until local emergency services arrive on scene and care is genuinely transferred, only disconnecting once that handoff has actually occurred.

Standard 4.3 · *Standard 4: Emergency Escalation for the Remote Patient*

Guidance & Learning

GUIDANCE ASF-TM-STD4-v3.0

WHY THIS STANDARD EXISTS

The real gap between activating emergency services and responders actually arriving on scene is exactly when a patient in crisis is most vulnerable and most alone, and a provider who disconnects once the call is made abandons the patient during precisely this interval — remaining connected through genuine handoff is what makes emergency activation an actual continuation of care, not simply a referral out.

The evidence: [18] Established telehealth emergency management protocol specifically requires clinicians to remain connected on the session with the patient until local emergency services arrive on scene and care is genuinely transferred, only disconnecting once that handoff has actually occurred.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Providers genuinely remain connected until emergency responders have actually arrived.	✗ Providers disconnect once the emergency call is made, before responders arrive.
✓ Care is genuinely, actively transferred to responders, not a passive disconnection.	✗ The session ends without any genuine, active handoff to responders.
✓ This expectation is specifically, clearly trained, not left to individual judgment.	✗ No specific training establishes this expectation.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **The expectation is generally understood but the specific point of appropriate disconnection isn't clearly defined.**
A specific, clear definition of when handoff has genuinely occurred provides more reliable guidance than general understanding alone.

2 **Training addresses this for adult patients but hasn't specifically been extended to pediatric or otherwise vulnerable patient scenarios.**
Every patient population deserves the same genuine commitment to remaining connected through handoff.

3 **Providers report they would remain connected but this hasn't been specifically confirmed through a real or simulated event.**
Stated intention isn't the same as confirmed behavior under genuine, real-time pressure.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current provider understanding of remaining connected through emergency handoff.

Week 2 Establish specific, clear training on this expectation, including the defined point of appropriate disconnection.

Week 3 Extend training to cover the full range of relevant patient populations.

Ongoing Confirm this practice through review of real events or simulated scenarios.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a provider directly when they would consider it appropriate to disconnect during an emergency activation.
A specific, confident answer reveals genuine, trained understanding, not an assumption of instinctive good judgment.

Review documentation from a real past emergency event, where one exists, for evidence of continued connection.
A real, documented example reveals genuine practice, not a stated intention.

E-LEARNING academy.gmj.ge/tm-std4-3-remain-connected-through-handoff — 30 min · complete before self-assessment

	Standard 4.4 NON-NEGOTIABLE · *Standard 4: Emergency Escalation for the Remote Patient* **Emergency Contacts Are Genuinely Verified as Aware and Willing**	ASSESSMENT ASF-TM-STD4-v3.0
CR FULL	TR FULL	SM FULL	ST FULL

4.4
NON-NEGOTIABLE
L1

THE STANDARD

Emergency Contacts Are Genuinely Verified as Aware and Willing

A patient's designated emergency contact is genuinely verified as aware of and willing to serve in that role — not simply a name and number listed on an intake form without any actual confirmation that this person knows they've been named or agrees to it.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is the designated emergency contact genuinely verified as aware of and willing to serve in that role?** *Real, active verification, not a name listed without actual confirmation.* Doc: Emergency contact verification record	YES	PARTIAL	NO
2	**Does the patient have both a primary and secondary emergency contact, each genuinely verified?** *Real, verified coverage for both a primary and a genuine backup, not reliance on a single, unconfirmed contact.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is verification genuinely reconfirmed periodically, not assumed to remain accurate indefinitely?** *Real, periodic reconfirmation, not a one-time check assumed valid forever.* Doc: Periodic reconfirmation record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Verification record review*	Reviews evidence of genuine verification that emergency contacts are aware and willing.
DOCUMENT *Primary and secondary coverage review*	Reviews whether both a primary and secondary contact are genuinely designated and verified.
DOCUMENT *Reconfirmation schedule review*	Reviews whether verification is periodically reconfirmed, not treated as permanently valid.

REFERENCES

[19] Genuine designation of primary and secondary emergency contacts requires a verification step confirming the contact has been informed and is willing to serve in that role, distinct from a name and number recorded without active confirmation.

Standard 4.4 · *Standard 4: Emergency Escalation for the Remote Patient*

Guidance & Learning

GUIDANCE ASF-TM-STD4-v3.0

WHY THIS STANDARD EXISTS

An emergency contact who doesn't actually know they've been designated, or who wasn't genuinely asked whether they're willing, provides no real, reliable support in an actual crisis — the whole protective value of this designation depends on it reflecting a genuine, confirmed relationship, not an assumption based on a name the patient happened to write down.

The evidence: [19] Genuine designation of primary and secondary emergency contacts requires a verification step confirming the contact has been informed and is willing to serve in that role, distinct from a name and number recorded without active confirmation.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Emergency contacts are genuinely verified as aware and willing to serve.	✗ Contacts are listed without any genuine verification of awareness or willingness.
✓ Both a primary and secondary contact are designated and genuinely verified.	✗ Only a single, unconfirmed contact exists, with no verified backup.
✓ Verification is periodically reconfirmed, not assumed to remain accurate indefinitely.	✗ Verification, if it happened, was never reconfirmed and may be outdated.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Primary contacts are genuinely verified but secondary contacts are recorded without the same active confirmation.**
A secondary contact carries the same real, genuine importance as a backup, deserving the same verification.

2 **Verification happened at intake but hasn't been reconfirmed even as significant time has passed.**
A relationship or willingness can genuinely change over time, and periodic reconfirmation reflects this reality.

3 **Verification is documented as complete but the actual method of confirmation isn't specifically recorded.**
Specific documentation of how verification occurred provides more genuine assurance than a completed checkbox alone.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current emergency contact designation for genuine verification versus unconfirmed listing.

Week 2 Establish a specific, active verification process for both primary and secondary contacts.

Week 3 Build a periodic reconfirmation schedule.

Ongoing Audit emergency contact verification for continued accuracy.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the specific documentation of how a real emergency contact's willingness was actually confirmed.
A real, specific record reveals genuine verification, not an assumption based on a listed name.

Ask when emergency contact verification was last reconfirmed for a long-term patient.
A specific, real answer reveals genuine, ongoing practice, not a one-time check.

E-LEARNING academy.gmj.ge/tm-std4-4-emergency-contact-verification — 30 min · complete before self-assessment

Standard 4.5 **CORE** · *Standard 4: Emergency Escalation for the Remote Patient*

A Specific Threshold Exists for When Telehealth Is No Longer Clinically Appropriate

ASSESSMENT ASF-TM-STD4-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

4.5
CORE
L1

THE STANDARD

A Specific Threshold Exists for When Telehealth Is No Longer Clinically Appropriate

A specific, defined threshold exists for recognizing when telehealth is no longer clinically appropriate for a given patient's situation and a higher level of care must be facilitated — not continuing remote sessions indefinitely because no clear point was ever established for when this shift should genuinely occur.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does a specific, defined threshold exist for recognizing when telehealth is no longer clinically appropriate?** *A real, specific threshold, not an undefined, case-by-case judgment made in the moment.* Doc: Level-of-care threshold documentation	YES	PARTIAL	NO
2	**Are providers genuinely trained to recognize this threshold, not left to develop their own individual sense of it?** *Real, specific training on the defined threshold, not assumed clinical instinct alone.* Doc: Provider threshold training record	YES	PARTIAL	NO
3	**When this threshold is reached, is there a genuine, defined process for facilitating a higher level of care?** *A real, specific facilitation process, not the threshold being recognized without a clear next step.* Doc: Higher-level-of-care facilitation process	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Threshold documentation review*	Reviews the specific, defined threshold for when telehealth is no longer clinically appropriate.
DOCUMENT *Training review*	Reviews training records confirming providers are specifically trained to recognize this threshold.
DOCUMENT *Facilitation process review*	Reviews the defined process for facilitating a higher level of care once the threshold is reached.

REFERENCES

[20] Established telehealth crisis protocol specifically addresses when telehealth is no longer clinically appropriate and a higher level of care needs to be facilitated, establishing a defined threshold as necessary practice, distinct from indefinite continuation of remote sessions without a clear transition point.

Standard 4.5 · *Standard 4: Emergency Escalation for the Remote Patient*

Guidance & Learning

GUIDANCE ASF-TM-STD4-v3.0

WHY THIS STANDARD EXISTS

Some patient situations genuinely exceed what telehealth alone can safely manage, and without a specific, defined threshold for recognizing this, a provider may continue remote sessions well past the point where a higher level of care should have already been facilitated — a real, clear threshold is what prevents this drift from happening gradually and going unnoticed.

The evidence: [20] Established telehealth crisis protocol specifically addresses when telehealth is no longer clinically appropriate and a higher level of care needs to be facilitated, establishing a defined threshold as necessary practice, distinct from indefinite continuation of remote sessions without a clear transition point.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, defined threshold genuinely exists for this determination.	✗ No specific threshold exists; the determination is left to undefined, case-by-case judgment.
✓ Providers are specifically trained to recognize this threshold, not relying on individual instinct alone.	✗ Providers aren't specifically trained; recognition depends on individual instinct.
✓ A genuine, defined process facilitates a higher level of care once the threshold is reached.	✗ The threshold, if recognized, doesn't lead to any defined facilitation process.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **A general principle is understood but the specific, defined threshold criteria aren't documented.**
Documented, specific criteria provide more consistent, reliable recognition than general principle alone.

2 **The threshold is well understood for acute crisis situations but less clearly defined for gradually deteriorating ones.**
Gradual deterioration deserves the same genuine, defined threshold as acute presentations, since drift can be harder to notice.

3 **A facilitation process exists but doesn't specify a genuine, named pathway to the actual higher level of care.**
A real, named pathway is what makes facilitation actionable, not a process that ends at recognition alone.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for a genuine, defined threshold versus undefined case-by-case judgment.

Week 2 Establish specific, documented threshold criteria, including for gradual deterioration.

Week 3 Train providers on recognizing this threshold and the defined facilitation process.

Ongoing Review threshold application against real, recent cases for consistency.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a provider to describe the specific criteria that would tell them telehealth is no longer appropriate for a patient.
A specific, confident answer reveals genuine, defined understanding, not undefined individual judgment.

Ask for a real, recent example of a patient transitioned to a higher level of care and what specifically prompted it.
A real, traceable example reveals whether this threshold genuinely functions in practice.

E-LEARNING academy.gmj.ge/tm-std4-5-higher-level-of-care-threshold — 30 min · complete before self-assessment

STANDARD 5

Prescribing & Controlled Substance Management

MANDATORY

5 criteria

	Standard 5.1 NON-NEGOTIABLE · *Standard 5: Prescribing & Controlled Substance Management* **Controlled Substance Prescribing Genuinely Tracks Current National Regulatory Status**	ASSESSMENT ASF-TM-STD5-v3.0
CR FULL	TR FULL	SM FULL / ST FULL

5.1
NON-NEGOTIABLE
L1

THE STANDARD

Controlled Substance Prescribing Genuinely Tracks Current National Regulatory Status

Controlled substance prescribing practice genuinely reflects the current regulatory status in the relevant jurisdiction — not a fixed assumption based on a rule that was true previously, given that telemedicine prescribing rules for controlled substances remain genuinely evolving in many countries.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does the service genuinely know the current telemedicine prescribing requirements in this jurisdiction?** *Real, current knowledge, not a general assumption they remain fixed.* Doc: Current regulatory status documentation	YES	PARTIAL	NO
2	**Is there a specific process for monitoring and responding to a change in this regulatory status?** *A real, active monitoring process, not passive reliance on unchanged practice.* Doc: Regulatory monitoring process	YES	PARTIAL	NO
3	**Are providers genuinely aware that any current flexibility is provisional, not permanent?** *Real, accurate understanding, not an assumption of permanence.* Doc: Provider awareness of temporary status	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Current status review*	Reviews documentation confirming the service's specific, current knowledge of the current requirements' status.
DOCUMENT *Monitoring process review*	Reviews the specific process for monitoring and responding to regulatory status changes.
ASK *Provider awareness interview*	Asks a provider whether they understand the current prescribing flexibility as temporary, not permanent.

REFERENCES

[21] Telemedicine prescribing regulations for controlled substances remain an actively evolving area of law in numerous countries, with the underlying international framework under the Single Convention on Narcotic Drugs (1961, as amended) requiring national implementation that can itself change, making active tracking of current, jurisdiction-specific requirements a genuine, ongoing necessity.

Standard 5.1 · *Standard 5: Prescribing & Controlled Substance Management*

Guidance & Learning

GUIDANCE ASF-TM-STD5-v3.0

WHY THIS STANDARD EXISTS

Requirements for prescribing controlled substances via telemedicine — including whether an initial in-person evaluation is required — are genuinely still evolving in many countries, and a service that treats a current flexibility or exception as a permanent, settled rule risks continuing a prescribing practice that becomes genuinely non-compliant the moment the relevant regulation changes.

The evidence: [21] Telemedicine prescribing regulations for controlled substances remain an actively evolving area of law in numerous countries, with the underlying international framework under the Single Convention on Narcotic Drugs (1961, as amended) requiring national implementation that can itself change, making active tracking of current, jurisdiction-specific requirements a genuine, ongoing necessity.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The service genuinely knows the current, specific requirements in this jurisdiction.	✗ The service assumes current flexibility is a permanent, settled rule.
✓ A real, active monitoring process tracks regulatory status changes.	✗ No active monitoring process exists for regulatory status changes.
✓ Providers genuinely understand any current flexibility as provisional, not permanent.	✗ Providers are unaware this flexibility could lapse or change.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Leadership is aware of the current temporary status but this awareness hasn't been specifically communicated to prescribing providers.**
Every provider actually prescribing controlled substances needs the same genuine, current awareness.

2 **Monitoring happens informally but isn't assigned as a specific, accountable responsibility.**
A specific, accountable monitoring responsibility is more reliable than informal, diffuse awareness.

3 **The service tracks the current regulatory status but hasn't built a specific contingency plan for if a flexibility lapses without renewal.**
Genuine preparedness includes a real plan for the possibility of non-renewal, not only awareness of the current status.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Confirm the service's current, specific knowledge of the applicable requirements' status in this jurisdiction.

Week 2 Assign specific, accountable responsibility for monitoring regulatory status changes.

Week 3 Communicate current temporary status clearly to all prescribing providers.

Ongoing Build a contingency plan for a potential lapse in the temporary extension.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a provider directly what the current status of the relevant telemedicine prescribing flexibility is in this jurisdiction.
A specific, accurate answer reveals genuine, current awareness, not an assumption of permanence.

Ask who is specifically responsible for monitoring this regulatory status.
A specific, confident answer reveals a real, accountable process, not diffuse or assumed awareness.

E-LEARNING academy.gmj.ge/tm-std5-1-current-regulatory-status — 30 min · complete before self-assessment

Standard 5.2 **NON-NEGOTIABLE** · *Standard 5: Prescribing & Controlled Substance Management*

Every Controlled Substance Prescription Is Genuinely for a Legitimate Medical Purpose

ASSESSMENT ASF-TM-STD5-v3.0

CR FULL	TR FULL	SM FULL	ST FULL

5.2
NON-NEGOTIABLE
L1

THE STANDARD

Every Controlled Substance Prescription Is Genuinely for a Legitimate Medical Purpose

Every controlled substance prescription issued via telemedicine is genuinely, verifiably issued for a legitimate medical purpose by a provider acting within the usual course of professional practice — the same underlying requirement that applies whether the evaluation was conducted in person or remotely, not a standard that relaxes because the visit happened to be virtual.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is every controlled substance prescription genuinely, verifiably issued for documented medical necessity?** *Real, verifiable documentation, not a prescription lacking genuine clinical justification.* Doc: Prescription medical necessity documentation	YES	PARTIAL	NO
2	**Is this standard applied with the same rigor remotely as it would be in person?** *Real, equivalent rigor, not a relaxed standard for remote convenience.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there an active process for identifying a prescribing pattern suggesting inadequate verification?** *A real, active review process, not passive trust alone.* Doc: Prescribing pattern review process	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Medical necessity documentation review*	Reviews prescription records for genuine, specific documentation of legitimate medical purpose.
OBSERVE *Rigor equivalence observation*	Observes remote prescribing consultations for genuine rigor equivalent to in-person practice.
DOCUMENT *Pattern review process review*	Reviews the process for identifying prescribing patterns suggesting inadequate verification.

REFERENCES

[22] The Single Convention on Narcotic Drugs (1961, as amended), ratified by 186 countries, establishes that the production, distribution, and use of controlled substances must be limited exclusively to medical and scientific purposes, a principle applying identically whether a prescription is issued in person or via telemedicine.

Standard 5.2 · *Standard 5: Prescribing & Controlled Substance Management*

Guidance & Learning

GUIDANCE ASF-TM-STD5-v3.0

WHY THIS STANDARD EXISTS

This requirement traces to the foundational international drug control framework itself, not merely a national policy choice, and it applies identically to remote and in-person prescribing — meaning a service can't treat telemedicine's convenience as license to be less rigorous about verifying genuine medical necessity behind every controlled substance prescription it issues.

The evidence: [22] The Single Convention on Narcotic Drugs (1961, as amended), ratified by 186 countries, establishes that the production, distribution, and use of controlled substances must be limited exclusively to medical and scientific purposes, a principle applying identically whether a prescription is issued in person or via telemedicine.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every prescription has genuine, documented evidence of legitimate medical purpose.	✗ Prescriptions lack genuine, specific documentation of medical necessity.
✓ The same rigor applies to remote prescribing as would apply in person.	✗ Remote prescribing is treated with less rigor than in-person practice.
✓ A real, active process reviews prescribing patterns for potential concern.	✗ No process reviews prescribing patterns for potential inadequate verification.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Documentation is thorough for new prescriptions but less rigorous for ongoing refills of existing prescriptions.**
Genuine, continued medical necessity deserves the same documentation rigor at refill as at initial prescribing.

2 **Rigor is generally equivalent but providers report feeling more rushed during high-volume remote scheduling.**
Genuine rigor shouldn't erode under scheduling pressure, remote or in-person.

3 **A pattern review process exists but hasn't identified or addressed any real concern to date.**
An untested process, or the honest absence of findings, still deserves genuine confidence it would function if needed.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current prescription documentation for genuine, specific medical necessity evidence.

Week 2 Reinforce documentation standards for refills, not only initial prescriptions.

Week 3 Establish a genuine pattern review process for prescribing across the service.

Ongoing Address any scheduling pressure that risks eroding prescribing rigor.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual documented medical necessity for a specific, real controlled substance prescription.
A real, specific example reveals genuine documentation practice, not an assumption of adequacy.

Ask how the service would identify a concerning prescribing pattern if one existed.
A specific, confident answer reveals a genuine, real process, not passive trust alone.

E-LEARNING academy.gmj.ge/tm-std5-2-legitimate-medical-purpose — 30 min · complete before self-assessment

Standard 5.3 **NON-NEGOTIABLE** · *Standard 5: Prescribing & Controlled Substance Management*

Sub-National Controlled Substance Requirements Are Verified Alongside National Rules

ASSESSMENT ASF-TM-STD5-v3.0

CR FULL	TR FULL	SM ADAPTED	ST FULL

5.3
NON-NEGOTIABLE
L1

THE STANDARD

Sub-National Controlled Substance Requirements Are Verified Alongside National Rules

Sub-national or regional controlled substance prescribing requirements — where the relevant country has a federal, provincial, or similarly devolved governance structure — are genuinely verified alongside national-level rules, not assumed covered by national compliance alone, given some regions impose their own, additional requirements beyond what national law requires.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are sub-national requirements genuinely verified for each region, where such authority exists?** *Real, per-region verification, not an assumption national compliance alone is sufficient.* Doc: Sub-national requirement verification record	YES	PARTIAL	NO
2	**Is this verification genuinely current, reflecting each region's recent updates?** *Real, current verification, not outdated regional understanding.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**When a region's requirement is stricter than the national baseline, is the stricter standard actually followed?** *Real adherence to the more restrictive standard, not the more permissive one.* Doc: Restrictive-standard adherence documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Sub-national verification review*	Reviews documentation of genuine, specific regional-level requirement verification.
DOCUMENT *Currency review*	Reviews whether regional verification reflects current, recent regulatory updates.
DOCUMENT *Restrictive-standard adherence review*	Reviews evidence that the more restrictive applicable standard, regional or national, is genuinely followed.

REFERENCES

[23] In countries with federal, provincial, or similarly devolved governance structures, sub-national controlled substance telemedicine prescribing rules can apply independently of and in addition to national requirements, with some regions imposing distinct exceptions or conditions beyond the national baseline.

Standard 5.3 · *Standard 5: Prescribing & Controlled Substance Management*

Guidance & Learning

GUIDANCE ASF-TM-STD5-v3.0

WHY THIS STANDARD EXISTS

National-level flexibility doesn't override a region or province's own, separate requirements where such sub-national authority exists, and a service that only tracks national rules may be missing a genuine, additional regional requirement — like a specific region's own recent-in-person-evaluation exception criteria — that applies independently of whatever national flexibility is currently in effect.

The evidence: [23] In countries with federal, provincial, or similarly devolved governance structures, sub-national controlled substance telemedicine prescribing rules can apply independently of and in addition to national requirements, with some regions imposing distinct exceptions or conditions beyond the national baseline.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Sub-national requirements are genuinely, specifically verified for each relevant region.	✗ Only national requirements are tracked, with sub-national rules assumed covered.
✓ Verification is genuinely current, reflecting recent regional regulatory updates.	✗ Verification is outdated, missing recent regional regulatory changes.
✓ The more restrictive applicable standard is genuinely followed when regional and national rules differ.	✗ The more permissive national standard is followed even where a region imposes a stricter requirement.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Sub-national verification happens for regions with the highest patient volume but not for less frequent regions.**
Every region where a patient is genuinely located carries the same real requirement, regardless of patient volume.

2 **Verification was thorough at initial setup but hasn't been reconfirmed as regional regulations have since evolved.**
Regional requirements genuinely change, and verification should reflect current, not historical, regulation.

3 **Awareness of a stricter regional requirement exists but isn't consistently, practically applied in actual prescribing.**
Genuine awareness needs to translate into consistent, real practice, not remain theoretical.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for genuine sub-national verification alongside national compliance.

Week 2 Establish specific verification for every region where patients are genuinely located, where such regional authority exists.

Week 3 Build a process for identifying and applying the more restrictive standard where regional and national rules differ.

Ongoing Reconfirm sub-national requirements as regulations evolve.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask how the service verifies controlled substance requirements for a specific, less common patient region.
A specific, confident answer reveals genuine, comprehensive verification, not coverage limited to high-volume regions.

Ask for a real example of a regional requirement stricter than the national baseline and how it's actually applied.
A real, specific example reveals whether the more restrictive standard genuinely governs practice.

E-LEARNING academy.gmj.ge/tm-std5-3-subnational-requirements — 30 min · complete before self-assessment

Standard 5.4 **NON-NEGOTIABLE** · *Standard 5: Prescribing & Controlled Substance Management*

Prescribing Restricted Stimulants to Minors Follows Any Narrow Exception Precisely

ASSESSMENT ASF-TM-STD5-v3.0

CR FULL	TR FULL	SM ADAPTED	ST FULL

5.4
NON-NEGOTIABLE
L1

THE STANDARD

Prescribing Restricted Stimulants to Minors Follows Any Narrow Exception Precisely

Where a narrow exception exists in this jurisdiction permitting a restricted stimulant medication to be prescribed to a minor without a prior in-person evaluation, the service genuinely follows that exception's specific, actual conditions — such as real-time interactive audio-visual technology and prior written guardian consent — not treated as a general allowance applicable without these specific conditions genuinely met; where no such exception exists here, the standard in-person evaluation requirement applies without exception.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is real-time, interactive audio-visual technology genuinely used, not a lower-fidelity alternative?** *Real, specific technology meeting the exact requirement, not a lesser substitute.* Doc: Technology modality documentation	YES	PARTIAL	NO
2	**Is prior written parental or guardian consent genuinely obtained and documented?** *Real, prior, written consent, not verbal or after-the-fact agreement.* Doc: Written parental consent documentation	YES	PARTIAL	NO
3	**Is this exception applied only to the specific medication and population it actually covers?** *Genuine, narrow application, not extended beyond the exception's actual scope.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Technology modality review*	Reviews records confirming real-time, interactive audio-visual technology was genuinely used.
DOCUMENT *Written consent review*	Reviews documentation of genuine, prior written parental or guardian consent.
DOCUMENT *Scope adherence review*	Reviews whether this exception is applied only within its actual, narrow scope.

REFERENCES

[24] Some jurisdictions permit a narrow exception for prescribing certain restricted stimulant medications to minors using real-time, interactive audio-visual technology and prior written guardian consent, in place of the standard in-person evaluation requirement; where no such exception exists in a given jurisdiction, the standard requirement applies without exception.

Standard 5.4 · *Standard 5: Prescribing & Controlled Substance Management*

Guidance & Learning

GUIDANCE ASF-TM-STD5-v3.0

WHY THIS STANDARD EXISTS

Where this kind of exception exists at all, it's deliberately narrow and specific, applying only to a particular medication class, a particular patient population, and only when specific conditions are genuinely satisfied — treating it as a general allowance for prescribing to minors without meeting the exact requirements risks genuinely exceeding what a limited exception actually permits, and assuming such an exception exists where it doesn't is its own serious error.

The evidence: [24] Some jurisdictions permit a narrow exception for prescribing certain restricted stimulant medications to minors using real-time, interactive audio-visual technology and prior written guardian consent, in place of the standard in-person evaluation requirement; where no such exception exists in a given jurisdiction, the standard requirement applies without exception.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Real-time, interactive audio-visual technology is genuinely used for every such prescription.	✗ A lower-fidelity or asynchronous technology modality is used instead of real-time audio-visual.
✓ Prior written parental or guardian consent is genuinely obtained and documented.	✗ Consent is verbal, obtained after the fact, or not genuinely documented.
✓ The exception is applied only within its genuine, narrow scope.	✗ The exception is applied more broadly than its actual, narrow scope permits.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Consent is obtained but not consistently documented as specifically written and prior to the prescription.**
The exception's specific requirement is prior written consent, and documentation should genuinely reflect this exact standard.

2 **Technology modality is generally real-time but isn't specifically verified as meeting the interactive audio-visual requirement.**
Genuine verification of the specific technology standard matters as much as general real-time capability.

3 **The exception is correctly applied for restricted stimulants but staff aren't fully clear it doesn't extend to other medication classes.**
Clear, genuine understanding of this exception's exact scope prevents its accidental extension to prescriptions it doesn't actually cover.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for genuine adherence to this exception's specific requirements.

Week 2 Confirm technology modality and consent documentation specifically meet the exact exception standard.

Week 3 Train providers on the exception's genuine, narrow scope, not broader application.

Ongoing Audit compliance for every use of this specific exception.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual, written parental consent document for a real, recent case using this exception.
A real, specific document reveals genuine compliance, not an assumption consent was obtained appropriately.

Ask a provider to describe exactly which medications and patients this exception genuinely applies to.
A specific, accurate answer reveals genuine understanding of the exception's actual, narrow scope.

E-LEARNING academy.gmj.ge/tm-std5-4-minor-stimulant-exception — 30 min · complete before self-assessment

Standard 5.5 **CORE** · *Standard 5: Prescribing & Controlled Substance Management*

A Provider's Controlled Substance Prescribing Authorization Is Verified and Current

ASSESSMENT ASF-TM-STD5-v3.0

CR FULL	TR FULL	SM FULL	ST FULL

5.5
CORE
L1

THE STANDARD

A Provider's Controlled Substance Prescribing Authorization Is Verified and Current

Every prescribing provider's controlled substance prescribing authorization — issued by the relevant competent national authority — is genuinely verified as current and in good standing, not assumed valid from a historical check, and reconfirmed on a genuine, regular schedule rather than left unexamined until a problem surfaces.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is every prescribing provider's controlled substance authorization genuinely verified as current, not assumed from a historical check?** *Real, current verification, not reliance on a past check assumed to remain valid.* Doc: Prescribing authorization verification record	YES	PARTIAL	NO
2	**Is this verification genuinely reconfirmed on a regular schedule, not left unexamined indefinitely?** *Real, periodic reconfirmation, not a one-time check treated as permanently sufficient.* Doc: Periodic reconfirmation schedule	YES	PARTIAL	NO
3	**Is there a specific process preventing prescribing if an authorization issue is genuinely identified?** *A real, enforced block, not prescribing continuing despite a known authorization concern.* Doc: Authorization issue prevention process	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Verification record review*	Reviews evidence of genuine, current authorization verification for every prescriber.
DOCUMENT *Reconfirmation schedule review*	Reviews whether verification is genuinely, periodically reconfirmed.
DOCUMENT *Prevention process review*	Reviews the specific process preventing prescribing when a registration issue is identified.

REFERENCES

[25] Under the international framework established by the Single Convention on Narcotic Drugs, each country designates a competent national authority responsible for controlled substance prescribing authorization, with this authorization status forming the foundational basis for lawful prescribing, requiring genuine, periodic verification distinct from a one-time historical check assumed to remain accurate indefinitely.

Standard 5.5 · *Standard 5: Prescribing & Controlled Substance Management*

Guidance & Learning

GUIDANCE ASF-TM-STD5-v3.0

WHY THIS STANDARD EXISTS

A lapsed or restricted controlled substance prescribing authorization would mean a provider genuinely lacks the authority to prescribe controlled substances at all, and a service that doesn't actively, periodically verify this status has no real way of knowing whether every controlled substance prescription it's issuing is being issued by someone who's currently, genuinely authorized to do so.

The evidence: [25] Under the international framework established by the Single Convention on Narcotic Drugs, each country designates a competent national authority responsible for controlled substance prescribing authorization, with this authorization status forming the foundational basis for lawful prescribing, requiring genuine, periodic verification distinct from a one-time historical check assumed to remain accurate indefinitely.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every provider's authorization is genuinely, currently verified.	✗ Registration status is assumed valid from a past, historical check.
✓ Verification is genuinely reconfirmed on a regular, periodic schedule.	✗ Verification is never reconfirmed after initial onboarding.
✓ A real, enforced process prevents prescribing when a registration issue is identified.	✗ Prescribing continues despite an identified registration issue.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Verification happens for full-time prescribing providers but less consistently for occasional or covering providers.**
Every provider actually prescribing controlled substances carries the same real requirement for current, verified registration.

2 **Verification is reconfirmed periodically but the interval is long enough that a genuine lapse could go uncaught for a meaningful time.**
A genuinely protective interval catches a lapse before it affects a meaningful number of prescriptions.

3 **A prevention process exists but hasn't been specifically tested against a real, identified registration issue.**
An untested process may not reliably catch a genuine registration issue when one actually occurs.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current authorization verification practice for genuine currency and consistency.

Week 2 Establish a regular, periodic reconfirmation schedule covering all prescribing providers.

Week 3 Build a specific, enforced prevention process for identified registration issues.

Ongoing Extend verification consistently to occasional and covering providers.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual, current authorization verification for a specific prescribing provider.
A real, specific, current record reveals genuine verification, not an assumption of continued validity.

Ask what would happen if a provider's registration were found to have lapsed.
A specific, confident answer reveals a genuine, enforced prevention process.

E-LEARNING academy.gmj.ge/tm-std5-5-dea-registration-verification — 30 min · complete before self-assessment

STANDARD 6

Data Privacy & Patient Confidentiality

MANDATORY

5 criteria

	Standard 6.1 NON-NEGOTIABLE · *Standard 6: Data Privacy & Patient Confidentiality* **The Patient's Session Environment Is Actively Addressed**	ASSESSMENT ASF-TM-STD6-v3.0
CR FULL	TR FULL	SM FULL	ST FULL

6.1
NON-NEGOTIABLE
L1

THE STANDARD

The Patient's Session Environment Is Actively Addressed

The patient's session environment is genuinely, actively addressed at the start of care — specific guidance on finding a private location, practical suggestions when home isn't quiet or private — not simply assumed private because the patient is participating from their own device.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is the patient genuinely, proactively guided on finding a private location for their session, not left to figure this out alone?** *Real, active guidance, not an assumption the patient will independently find privacy.* Doc: Patient environment guidance materials	YES	PARTIAL	NO
2	**Are practical alternatives offered when a patient's home genuinely isn't private or quiet?** *Real, concrete alternative suggestions, not guidance limited to an assumed-available private home space.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is environment addressed specifically for sensitive topics, not treated as equally important for every visit type?** *Genuine, calibrated attention reflecting the real sensitivity of what will actually be discussed.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Guidance materials review*	Reviews actual patient-facing materials for genuine, specific environment guidance.
OBSERVE *Session opening observation*	Observes whether environment is genuinely addressed at the start of an actual session.
DOCUMENT *Sensitivity calibration review*	Reviews whether environment attention is genuinely calibrated to the sensitivity of the visit.

REFERENCES

[26] Official telehealth guidance specifically advises patients to find a private location for their session and provides concrete suggestions — a quiet room at home, a private space in a community setting, a parked car — reflecting that session environment privacy requires active guidance, not assumed adequacy from platform security alone.

Standard 6.1 · *Standard 6: Data Privacy & Patient Confidentiality*

Guidance & Learning

GUIDANCE ASF-TM-STD6-v3.0

WHY THIS STANDARD EXISTS

A patient joining from their own phone or laptop doesn't automatically mean they're somewhere private, and genuine, proactive guidance on finding a private location — not just technical platform security — is what actually protects a conversation about sensitive health information from being overheard by someone else in the room.

The evidence: [26] Official telehealth guidance specifically advises patients to find a private location for their session and provides concrete suggestions — a quiet room at home, a private space in a community setting, a parked car — reflecting that session environment privacy requires active guidance, not assumed adequacy from platform security alone.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Patients are genuinely, proactively guided on finding a private location.	✗ Environment privacy is assumed adequate without any active guidance.
✓ Concrete alternatives are offered when home isn't private or quiet.	✗ No alternatives are offered for patients without a private home space.
✓ Attention to environment is genuinely calibrated to visit sensitivity.	✗ Environment receives the same minimal attention regardless of topic sensitivity.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Guidance exists in intake materials but isn't reinforced verbally at the start of an actual session.**
Real, active reinforcement at the point of use is more reliable than guidance provided once and easily forgotten.

2 **Alternatives are suggested generally but not tailored to what's realistically available to a specific patient's circumstances.**
Genuine, practical guidance should reflect what's actually feasible for the individual patient, not a generic list.

3 **Environment is addressed for new patients but not consistently revisited for established, ongoing patients.**
An established patient's actual environment can change, and deserves the same genuine, ongoing attention.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current patient environment guidance for genuine specificity and practicality.

Week 2 Build concrete alternative suggestions for patients without a private home space.

Week 3 Reinforce environment guidance verbally at the start of sessions, not intake materials alone.

Ongoing Revisit environment guidance periodically for established patients.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a patient whether they were given any specific guidance on finding a private location.
A specific, real answer reveals genuine practice, not an assumption of adequate guidance.

Observe an actual session opening for genuine environment discussion.
Direct observation reveals whether this happens in practice, not just in intake documentation.

E-LEARNING academy.gmj.ge/tm-std6-1-session-environment — 30 min · complete before self-assessment

Standard 6.2 **NON-NEGOTIABLE** · *Standard 6: Data Privacy & Patient Confidentiality*

A Third Party Present But Unseen Is Genuinely Disclosed and Consented To

ASSESSMENT ASF-TM-STD6-v3.0

CR FULL	TR FULL	SM FULL	ST FULL

6.2
NON-NEGOTIABLE
L1

THE STANDARD

A Third Party Present But Unseen Is Genuinely Disclosed and Consented To

When someone other than the patient is present during a session — visible or not — this is genuinely disclosed, and specific consent is obtained before discussing sensitive information, particularly when the patient is in a public location where the conversation could be overheard.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are providers genuinely trained to actively ask whether anyone else is present, not assuming the patient is alone?** *Real, active inquiry, not an assumption based on who's visible on screen.* Doc: Provider training on third-party presence inquiry	YES	PARTIAL	NO
2	**Is specific consent genuinely obtained and documented before discussing sensitive information with a third party present?** *Real, documented consent, not proceeding without confirming the patient is comfortable being overheard.* Doc: Third-party presence consent documentation	YES	PARTIAL	NO
3	**When a patient is in a public location, does the provider genuinely address this before continuing with sensitive topics?** *Real, active address of the public-location risk, not proceeding as though the setting were private.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

OBSERVE *Third-party inquiry observation*	Observes an actual session opening for genuine, active inquiry about anyone else present.
DOCUMENT *Consent documentation review*	Reviews records for genuine, documented consent when a third party is present.
OBSERVE *Public location handling observation*	Observes how a provider genuinely addresses a patient joining from an apparently public location.

REFERENCES

[27] Established health privacy guidance specifically requires recorded consent before continuing a consultation when a translator, caregiver, or family member is present, or when the patient is in a public location where the conversation may be overheard, reflecting the genuine risk of an unseen third party during a telehealth session.

Standard 6.2 · *Standard 6: Data Privacy & Patient Confidentiality*

Guidance & Learning

GUIDANCE ASF-TM-STD6-v3.0

WHY THIS STANDARD EXISTS

A person present but out of camera view can hear everything discussed without the provider ever knowing they're there, and genuine disclosure and consent — not an assumption the patient is alone simply because no one else appears on screen — is what actually protects the patient's real control over who learns their sensitive health information.

The evidence: [27] Established health privacy guidance specifically requires recorded consent before continuing a consultation when a translator, caregiver, or family member is present, or when the patient is in a public location where the conversation may be overheard, reflecting the genuine risk of an unseen third party during a telehealth session.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Providers genuinely, actively ask whether anyone else is present.	✗ Providers assume the patient is alone based only on what's visible on screen.
✓ Specific, documented consent is genuinely obtained when a third party is present.	✗ Consent for third-party presence isn't genuinely obtained or documented.
✓ Public location risk is genuinely, actively addressed before continuing.	✗ A patient's apparently public location isn't addressed before continuing with sensitive topics.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Inquiry happens for new patients but isn't consistently repeated for established, ongoing patients.**
An established patient's actual circumstances at a given session can genuinely differ from prior visits.

2 **Consent is obtained verbally but not consistently documented in a genuinely retrievable way.**
Documented consent provides more reliable, real evidence than a verbal exchange alone.

3 **Public location risk is addressed when obviously apparent but not consistently for more ambiguous settings.**
Genuine attention to this risk shouldn't depend solely on how obviously public a setting appears.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for genuine inquiry about third-party presence at session start.

Week 2 Train providers to actively ask and document consent when a third party is present.

Week 3 Build specific guidance for addressing apparently public patient locations.

Ongoing Extend genuine, repeated inquiry to established, ongoing patients.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe an actual session opening for genuine inquiry about who else might be present.
Direct observation reveals whether this genuinely happens, not an assumption based on stated policy.

Ask to see documented consent for a real case where a third party was present.
A real, specific record reveals genuine practice, not policy language alone.

E-LEARNING academy.gmj.ge/tm-std6-2-third-party-disclosure — 30 min · complete before self-assessment

	Standard 6.3 NON-NEGOTIABLE · *Standard 6: Data Privacy & Patient Confidentiality* **Session Recording Follows a Clear, Specific Policy**	ASSESSMENT ASF-TM-STD6-v3.0
CR FULL	TR FULL	SM FULL	ST FULL

6.3
NON-NEGOTIABLE
L1

THE STANDARD

Session Recording Follows a Clear, Specific Policy

Session recording follows a clear, specific, documented policy — whether recording ever occurs, under what circumstances, where recordings are stored, and how long they're retained — not left ambiguous, given real, documented gaps in this area leave both providers and patients genuinely uncertain and uncomfortable.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does the service have a clear, specific, documented policy on whether and when sessions are recorded?** *A real, specific written policy, not ambiguity left for individual providers to navigate independently.* Doc: Session recording policy documentation	YES	PARTIAL	NO
2	**Does this policy genuinely address storage location and retention duration for any recordings that are made?** *Real, specific storage and retention detail, not a policy silent on what happens to a recording after the session.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Are patients genuinely, specifically informed whether their session is being recorded, before it happens?** *Real, prior, specific notification, not recording occurring without the patient's genuine knowledge.* Doc: Patient recording notification record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Policy documentation review*	Reviews the actual, specific, documented recording policy.
DOCUMENT *Storage and retention review*	Reviews whether the policy specifically addresses storage location and retention duration.
OBSERVE *Patient notification observation*	Observes whether patients are genuinely, specifically informed about recording before it occurs.

REFERENCES

[28] Practitioners often lack clear guidance on whether and how to record telehealth sessions, creating genuine ambiguity and discomfort for both provider and patient, establishing a clear, specific, documented recording policy as necessary to close this documented gap.

Standard 6.3 · *Standard 6: Data Privacy & Patient Confidentiality*

Guidance & Learning

GUIDANCE ASF-TM-STD6-v3.0

WHY THIS STANDARD EXISTS

Real research specifically found that practitioners often lack clear guidance on whether and how to record sessions, creating genuine ambiguity and discomfort for both provider and patient — a service that hasn't resolved this ambiguity with a clear, specific policy leaves a real gap exactly where clarity matters most, since a patient has a genuine right to know if they're being recorded.

The evidence: [28] Practitioners often lack clear guidance on whether and how to record telehealth sessions, creating genuine ambiguity and discomfort for both provider and patient, establishing a clear, specific, documented recording policy as necessary to close this documented gap.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A clear, specific, documented recording policy genuinely exists.	✗ No clear policy exists; practice is left to individual provider discretion.
✓ The policy specifically addresses storage location and retention duration.	✗ The policy is silent on storage location or retention duration.
✓ Patients are genuinely, specifically informed about recording before it happens.	✗ Recording occurs without the patient's genuine, prior knowledge.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **A policy exists for standard consultations but isn't specifically addressed for group or family sessions.**
Every session type deserves the same genuine policy clarity, not standard consultations alone.

2 **Storage location is specified but retention duration isn't clearly, specifically defined.**
Both elements genuinely matter to a patient's real understanding of what happens to their recorded information.

3 **Notification happens but isn't consistently documented as genuinely occurring before recording begins.**
Documentation of prior notification is what makes genuine compliance verifiable, not assumed from general practice.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current recording practice for genuine, specific policy clarity.

Week 2 Build a clear, documented policy addressing whether, when, storage, and retention.

Week 3 Establish consistent, documented patient notification before any recording.

Ongoing Extend policy clarity to all session types, not standard consultations alone.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual, written recording policy, not a general assurance recording is handled appropriately.
A specific, real document reveals genuine clarity, not assumed adequacy.

Ask a provider directly what the specific retention period is for a session recording.
A specific, confident answer reveals genuine, clear policy, not individual discretion.

E-LEARNING academy.gmj.ge/tm-std6-3-recording-policy — 30 min · complete before self-assessment

Standard 6.4 **NON-NEGOTIABLE** · *Standard 6: Data Privacy & Patient Confidentiality*

The Provider's Own Home Office Meets the Same Privacy Standard

ASSESSMENT ASF-TM-STD6-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

6.4
NON-NEGOTIABLE
L1

THE STANDARD

The Provider's Own Home Office Meets the Same Privacy Standard

A provider conducting sessions from a home office genuinely meets the same privacy and security standard as a clinical setting would — device encryption, a secure network, genuine physical privacy from others in the household — not treated as a lower-scrutiny environment simply because it's the provider's own home.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is the provider's device for conducting sessions genuinely encrypted, not assumed adequate without verification?** *Real, verified device encryption, not an assumption based on the device being personally owned and trusted.* Doc: Provider device encryption verification	YES	PARTIAL	NO
2	**Is the provider's home network genuinely secure, specifically verified, not assumed adequate?** *Real, verified network security, not an unexamined assumption about home network safety.* Doc: Home network security verification	YES	PARTIAL	NO
3	**Does the provider genuinely have physical privacy from others in the household during a session?** *Real, verified physical privacy, not an assumption based on having a designated home office space.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Device encryption review*	Reviews evidence of genuine, verified encryption for devices used to conduct sessions.
DOCUMENT *Network security review*	Reviews evidence of genuine, verified home network security.
ASK *Physical privacy interview*	Asks a provider to describe their actual physical privacy setup during sessions.

REFERENCES

[29] Many clinicians continue conducting sessions from home offices with unencrypted devices and storing session recordings in personal cloud storage, having never completed the compliance transition required since temporary pandemic-era enforcement discretion ended, establishing the provider's home office as a genuine, distinct privacy compliance layer separate from platform security.

Standard 6.4 · *Standard 6: Data Privacy & Patient Confidentiality*

Guidance & Learning

GUIDANCE ASF-TM-STD6-v3.0

WHY THIS STANDARD EXISTS

Real, documented findings show many clinicians never completed the transition required when temporary pandemic-era flexibility ended, continuing to use unencrypted devices and store recordings in personal cloud storage from home offices — the provider's home is a genuine, distinct compliance layer separate from the platform itself, and a service that only verifies platform security while overlooking the provider's actual working environment has a real, documented gap.

The evidence: [29] Many clinicians continue conducting sessions from home offices with unencrypted devices and storing session recordings in personal cloud storage, having never completed the compliance transition required since temporary pandemic-era enforcement discretion ended, establishing the provider's home office as a genuine, distinct privacy compliance layer separate from platform security.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Provider devices are genuinely, verifiably encrypted.	✗ Device encryption is assumed adequate without genuine verification.
✓ Home network security is genuinely, specifically verified.	✗ Home network security is unexamined, not specifically verified.
✓ Providers genuinely have real physical privacy during sessions.	✗ Physical privacy is assumed from a designated space without genuine confirmation.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Device encryption is verified for provider-issued equipment but not for personally owned devices also used for sessions.**
Every device genuinely used to access patient information deserves the same verification, regardless of ownership.

2 **Network security is addressed at initial setup but not periodically reconfirmed as home network configurations can change.**
A home network's real security can change over time, and periodic reconfirmation reflects this reality.

3 **Physical privacy is generally adequate but hasn't been specifically confirmed for providers sharing a household with others working or studying at home.**
A shared household is exactly where genuine physical privacy deserves specific, not assumed, confirmation.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current home office privacy and security for genuine verification versus assumed adequacy.

Week 2 Verify encryption for every device genuinely used to conduct sessions, regardless of ownership.

Week 3 Confirm home network security and genuine physical privacy for every provider.

Ongoing Periodically reconfirm home office security as configurations may change.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a provider to describe their actual home office setup, including device and network security.
A specific, confident answer reveals genuine attention, not an assumption of adequacy.

Ask specifically about physical privacy for a provider sharing a household with others.
This reveals whether genuine privacy has been confirmed, not assumed from a general home office description.

E-LEARNING academy.gmj.ge/tm-std6-4-home-office-security — 30 min · complete before self-assessment

Standard 6.5 **NON-NEGOTIABLE** · *Standard 6: Data Privacy & Patient Confidentiality*

Substance Use Disorder Records Follow the Heightened, Distinct Confidentiality Standard

ASSESSMENT ASF-TM-STD6-v3.0

CR FULL	TR FULL	SM ADAPTED	ST FULL

6.5
NON-NEGOTIABLE
L1

THE STANDARD

Substance Use Disorder Records Follow the Heightened, Distinct Confidentiality Standard

Records related to substance use disorder treatment genuinely follow the specific, heightened confidentiality standard that applies to them — requiring the patient's own written consent for disclosure — not treated identically to general health information under standard confidentiality practice.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Do substance use disorder records genuinely follow this distinct, heightened confidentiality standard?** *Real adherence to this distinct standard, not treated identically to general health information.* Doc: SUD-specific confidentiality protocol documentation	YES	PARTIAL	NO
2	**Is disclosure genuinely based on the patient's own specific written consent, not a general release?** *Real, specific written consent for this category, not a general release assumed sufficient.* Doc: Patient written consent for SUD record disclosure	YES	PARTIAL	NO
3	**Are staff specifically trained on this distinct standard, not assuming general health privacy training suffices?** *Real, specific training, not an assumption of general confidentiality knowledge.* Doc: Staff training on substance use disorder confidentiality standard	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *SUD protocol review*	Reviews evidence that substance use disorder records genuinely follow the distinct, heightened standard.
DOCUMENT *Written consent review*	Reviews documentation confirming disclosure is based on genuine, specific patient written consent.
DOCUMENT *Staff training review*	Reviews training records confirming staff are specifically educated on this distinct standard.

REFERENCES

[30] Multiple countries' health privacy frameworks specifically establish heightened confidentiality protections for substance use disorder or addiction treatment records, distinct from general health information privacy practice, often requiring the patient's own specific consent for disclosure.

Standard 6.5 · *Standard 6: Data Privacy & Patient Confidentiality*

Guidance & Learning

GUIDANCE ASF-TM-STD6-v3.0

WHY THIS STANDARD EXISTS

Substance use disorder treatment records are governed by a genuinely distinct, stricter federal confidentiality framework than general health information, specifically because unauthorized disclosure of this particular information can carry real, serious consequences for a patient beyond typical privacy harm — a service that applies only general confidentiality practice to these specific records falls short of what this distinct, real legal standard actually requires.

The evidence: [30] Multiple countries' health privacy frameworks specifically establish heightened confidentiality protections for substance use disorder or addiction treatment records, distinct from general health information privacy practice, often requiring the patient's own specific consent for disclosure.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Substance use disorder records genuinely follow the specific, heightened standard.	✗ These records are treated identically to general health information.
✓ Disclosure is genuinely based on the patient's own specific written consent.	✗ Disclosure relies on a general release, not specific written consent for this category.
✓ Staff are specifically trained on this distinct standard, not assuming general practice suffices.	✗ Staff aren't specifically trained; general health privacy knowledge is assumed sufficient.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **The distinct standard is understood by clinical staff but not consistently by administrative staff who may handle these records.**
Every staff member with access to these specific records deserves the same genuine understanding of this heightened standard.

2 **Written consent is obtained but doesn't specifically distinguish this category from general information release consent.**
Genuine compliance requires consent language specifically reflecting this distinct, heightened requirement.

3 **The standard is applied for direct SUD treatment records but not consistently for related information in a broader clinical note.**
Related information embedded elsewhere carries the same genuine sensitivity and deserves the same heightened standard.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current handling of substance use disorder records for genuine adherence to the distinct standard.

Week 2 Establish specific written consent language distinguishing this category from general release.

Week 3 Train all staff with potential record access, not clinical staff alone, on this heightened standard.

Ongoing Audit handling of related information within broader clinical notes for consistent application.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask an administrative staff member whether they're aware of the distinct standard for these specific records.
This reveals whether genuine understanding extends beyond clinical staff alone.

Ask to see the actual, specific written consent language used for this category of disclosure.
A real, specific document reveals genuine compliance, not an assumption general consent suffices.

E-LEARNING academy.gmj.ge/tm-std6-5-sud-confidentiality — 30 min · complete before self-assessment

STANDARD 7

Governance & Provider Credentialing

MANDATORY

5 criteria

	Standard 7.1 NON-NEGOTIABLE · *Standard 7: Governance & Provider Credentialing* **Malpractice Insurance Explicitly Covers Telemedicine**	ASSESSMENT ASF-TM-STD7-v3.0
CR FULL	TR FULL	SM FULL	ST FULL

7.1
NON-NEGOTIABLE
L1

THE STANDARD

Malpractice Insurance Explicitly Covers Telemedicine

Every provider's malpractice insurance explicitly, affirmatively states coverage for telemedicine practice — not assumed included in a standard policy that predates telemedicine becoming mainstream, given many such older policies contain explicit exclusions for virtual care absent a specific endorsement.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does every provider's malpractice policy explicitly, affirmatively state coverage for telemedicine practice?** *Real, affirmative confirmation in the policy itself, not an assumption based on a standard policy's silence.* Doc: Malpractice policy telemedicine endorsement documentation	YES	PARTIAL	NO
2	**Has this coverage been genuinely confirmed in writing with the insurance carrier, not assumed from a verbal assurance?** *Real, written confirmation, not a verbal representation alone.* Doc: Written carrier confirmation	YES	PARTIAL	NO
3	**Is this verification genuinely reconfirmed when a provider's policy renews or changes, not treated as a one-time check?** *Real, periodic reconfirmation, not verification assumed to remain valid indefinitely.* Doc: Renewal reconfirmation record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Policy endorsement review*	Reviews the actual policy documentation for genuine, affirmative telemedicine coverage.
DOCUMENT *Written confirmation review*	Reviews evidence of genuine, written carrier confirmation, not verbal assurance alone.
DOCUMENT *Renewal reconfirmation review*	Reviews whether coverage is genuinely reconfirmed at each policy renewal or change.

REFERENCES

[31] Many older malpractice insurance policies were drafted before telemedicine became mainstream and contain explicit exclusions for virtual care unless a formal endorsement is added, with coverage needing to be affirmatively stated in policy declarations or endorsements, since silence is not protection.

Standard 7.1 · *Standard 7: Governance & Provider Credentialing*

Guidance & Learning

GUIDANCE ASF-TM-STD7-v3.0

WHY THIS STANDARD EXISTS

Silence in a policy about telemedicine isn't protection — many older malpractice policies were drafted before virtual care became common and explicitly exclude it unless a formal endorsement is added, meaning a provider who's never specifically confirmed telemedicine coverage could discover, only after a claim arises, that they were never actually covered for the care they were delivering.

The evidence: [31] Many older malpractice insurance policies were drafted before telemedicine became mainstream and contain explicit exclusions for virtual care unless a formal endorsement is added, with coverage needing to be affirmatively stated in policy declarations or endorsements, since silence is not protection.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every policy explicitly, affirmatively states telemedicine coverage.	✗ Telemedicine coverage is assumed from a standard policy's silence on the matter.
✓ Coverage is genuinely confirmed in writing with the carrier.	✗ Confirmation, if any, is verbal, not documented in writing.
✓ Verification is genuinely reconfirmed at every renewal or policy change.	✗ Coverage was verified once and never reconfirmed at renewal.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Coverage is confirmed for the primary provider but not specifically verified for covering or contracted providers.**
Every provider delivering care under this service carries the same real requirement for confirmed coverage.

2 **Written confirmation exists but doesn't specifically reference telemedicine by name, leaving genuine ambiguity.**
Specific, explicit language addressing telemedicine directly is what actually resolves the real ambiguity this criterion exists to prevent.

3 **Verification happened at initial policy purchase but hasn't been reconfirmed through a subsequent renewal cycle.**
A subsequent renewal is exactly when coverage terms can genuinely change, and deserves the same reconfirmation.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current malpractice policies for genuine, explicit telemedicine coverage language.

Week 2 Obtain written confirmation from the carrier for any policy lacking explicit telemedicine language.

Week 3 Extend verification to all providers, including covering or contracted staff.

Ongoing Reconfirm coverage at every policy renewal or change.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual written confirmation of telemedicine coverage, not a general assurance of adequate insurance.
A real, specific document reveals genuine verification, not an assumption of coverage.

Ask when telemedicine coverage was last reconfirmed with the carrier.
A specific, real answer reveals genuine, ongoing practice, not a one-time historical check.

E-LEARNING academy.gmj.ge/tm-std7-1-explicit-telemedicine-coverage — 30 min · complete before self-assessment

	Standard 7.2 NON-NEGOTIABLE · *Standard 7: Governance & Provider Credentialing* **Malpractice Coverage Genuinely Follows the Patient's State**	ASSESSMENT ASF-TM-STD7-v3.0
CR FULL	TR FULL	SM FULL	ST FULL

7.2
NON-NEGOTIABLE
L1

THE STANDARD

Malpractice Coverage Genuinely Follows the Patient's State

Malpractice coverage genuinely, explicitly extends to every state where a patient is actually located during care — not assumed sufficient because a provider is licensed there through an interstate compact, given compact licensure and malpractice insurance are genuinely separate, unlinked requirements.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does malpractice coverage genuinely, explicitly extend to every state where patients are actually located?** *Real, specific, state-by-state confirmed coverage, not assumed from compact licensure alone.* Doc: State-specific coverage confirmation	YES	PARTIAL	NO
2	**Is coverage genuinely verified separately from licensure, not treated as automatically bundled together?** *Real, distinct verification of insurance coverage, not conflated with licensure compliance.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there a specific process for confirming coverage before a provider sees a patient in a genuinely new state?** *A real, proactive verification process, not discovering a coverage gap only after care has already been delivered.* Doc: New-state coverage verification process	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *State-specific coverage review*	Reviews evidence that malpractice coverage explicitly extends to every state where patients are actually located.
ASK *Licensure-insurance distinction interview*	Asks staff whether they understand licensure and insurance coverage as genuinely separate requirements.
DOCUMENT *New-state verification process review*	Reviews the process for confirming coverage before a provider sees a patient in a new state.

REFERENCES

[32] Interstate licensure compacts such as the Interstate Medical Licensure Compact facilitate multi-state licensure but do not inherently standardize malpractice insurance requirements, meaning providers must separately confirm their coverage explicitly extends to every state where they actually deliver care.

Standard 7.2 · *Standard 7: Governance & Provider Credentialing*

Guidance & Learning

GUIDANCE ASF-TM-STD7-v3.0

WHY THIS STANDARD EXISTS

Interstate licensure compacts streamline the ability to legally practice across state lines but do not standardize or guarantee malpractice insurance coverage in those same states — a provider could be genuinely, legally licensed to see a patient in a given state while simultaneously lacking any real insurance coverage for care delivered there, and coverage genuinely needs to follow the patient, not simply the provider's practice address.

The evidence: [32] Interstate licensure compacts such as the Interstate Medical Licensure Compact facilitate multi-state licensure but do not inherently standardize malpractice insurance requirements, meaning providers must separately confirm their coverage explicitly extends to every state where they actually deliver care.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Coverage genuinely, explicitly extends to every state where patients are actually located.	✗ Coverage is assumed sufficient based on compact licensure alone.
✓ Coverage is genuinely verified separately from licensure compliance.	✗ Insurance verification is conflated with licensure compliance, not separately confirmed.
✓ A proactive process confirms coverage before seeing a patient in a new state.	✗ Coverage gaps are discovered only after care has already been delivered in a new state.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Coverage is confirmed for the provider's most common patient states but not for less frequent ones.**
Every state where a patient is genuinely located carries the same real coverage requirement, regardless of frequency.

2 **Staff understand the general principle but haven't specifically verified it applies correctly to their own current coverage.**
General understanding needs to translate into genuine, specific verification of the provider's own actual policy.

3 **A new-state verification process exists but isn't consistently followed under scheduling pressure.**
A defined process needs consistent application even under pressure to provide genuine, reliable protection.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current coverage for genuine, explicit extension to every state where patients are actually located.

Week 2 Establish a proactive verification process before seeing a patient in a genuinely new state.

Week 3 Train staff on the genuine, distinct separation between licensure and insurance coverage.

Ongoing Audit coverage against actual patient location patterns.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask how the service would confirm malpractice coverage before a provider sees a patient in a state they haven't seen patients in before.
A specific, confident answer reveals a genuine, proactive process, not an assumption of automatic coverage.

Ask a provider directly whether they understand licensure and malpractice coverage as separate requirements.
A specific, accurate answer reveals genuine understanding, not conflation of the two.

E-LEARNING academy.gmj.ge/tm-std7-2-coverage-follows-patient — 30 min · complete before self-assessment

Standard 7.3 **CORE** · *Standard 7: Governance & Provider Credentialing*

Technology-Driven Operational Failures Are Specifically Covered

ASSESSMENT ASF-TM-STD7-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

7.3
CORE
L1

THE STANDARD

Technology-Driven Operational Failures Are Specifically Covered

Insurance coverage specifically addresses technology-driven operational failures — a failed video platform, corrupted data transmission, an algorithmic triage tool error contributing to patient harm — not assumed included within standard clinical malpractice coverage, given traditional malpractice policies often don't cover this genuinely distinct category of exposure.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does insurance coverage specifically address technology-driven operational failures?** *Real, specific confirmation, not an assumption it's automatically included.* Doc: Technology failure coverage confirmation	YES	PARTIAL	NO
2	**Has this coverage question been genuinely raised and confirmed with the carrier?** *Real, direct confirmation, not silence interpreted as inclusion.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Does the service understand which technology failure scenarios this coverage would and would not address?** *Real, specific understanding, not an assumption of broad protection.* Doc: Coverage scope understanding documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Technology coverage confirmation review*	Reviews evidence that technology-driven failure coverage was specifically confirmed, not assumed.
ASK *Carrier confirmation interview*	Asks staff whether this specific coverage question was genuinely raised with the insurance carrier.
DOCUMENT *Scope understanding review*	Reviews the service's documented understanding of what this coverage does and doesn't address.

REFERENCES

[33] When care delivery depends on digital platforms, software malfunctions including failed video platforms, corrupted data transmission, or algorithmic triage tool errors can contribute to patient harm, with traditional malpractice policies often not covering these technology-driven operational failures.

Standard 7.3 · *Standard 7: Governance & Provider Credentialing*

Guidance & Learning

GUIDANCE ASF-TM-STD7-v3.0

WHY THIS STANDARD EXISTS

When care delivery genuinely depends on digital platforms, a software malfunction can contribute to patient harm in ways a standard clinical malpractice policy — built around clinical judgment errors — was never actually designed to address, and a service that hasn't specifically confirmed this coverage exists has a real, distinct gap exactly where telemedicine's technology dependence creates its own genuine risk.

The evidence: [33] When care delivery depends on digital platforms, software malfunctions including failed video platforms, corrupted data transmission, or algorithmic triage tool errors can contribute to patient harm, with traditional malpractice policies often not covering these technology-driven operational failures.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Coverage for technology-driven operational failures is specifically confirmed, not assumed.	✗ Technology failure coverage is assumed included within standard clinical malpractice.
✓ This coverage question was genuinely raised and directly confirmed with the carrier.	✗ This specific question was never raised with the carrier; silence is treated as inclusion.
✓ The service understands the specific scope of what this coverage addresses.	✗ The service has no specific understanding of what technology-related coverage actually includes.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Coverage was discussed generally with the carrier but the specific scenarios named in this criterion weren't individually addressed.**
Genuine confirmation should specifically address concrete scenarios, not remain at a general, unspecific level.

2 **Coverage exists for platform failures but hasn't been specifically confirmed for algorithmic or automated triage tool errors.**
Every genuinely distinct technology exposure deserves the same specific confirmation, not only the most obvious one.

3 **Understanding of coverage scope exists at a leadership level but isn't communicated to providers who might need it in an actual claim.**
Providers facing an actual claim need this same genuine understanding, not knowledge confined to leadership alone.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current malpractice coverage for genuine confirmation of technology-driven failure protection.

Week 2 Raise this specific coverage question directly with the insurance carrier, addressing concrete scenarios.

Week 3 Document the service's specific understanding of coverage scope.

Ongoing Communicate this understanding to providers, not leadership alone.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask whether the specific question of technology failure coverage was ever directly raised with the carrier.
A specific, real answer reveals genuine confirmation, not an assumption based on general policy language.

Ask a provider whether they understand what would happen, insurance-wise, if a platform failure contributed to a patient harm event.
A specific, thoughtful answer reveals genuine, communicated understanding, not knowledge confined to leadership alone.

E-LEARNING academy.gmj.ge/tm-std7-3-technology-failure-coverage — 30 min · complete before self-assessment

	Standard 7.4 NON-NEGOTIABLE · *Standard 7: Governance & Provider Credentialing* **Provider Credentials Are Verified Directly, Not Accepted on Self-Report**	ASSESSMENT ASF-TM-STD7-v3.0

CR FULL	TR FULL	SM FULL	ST FULL

7.4
NON-NEGOTIABLE
L1

THE STANDARD

Provider Credentials Are Verified Directly, Not Accepted on Self-Report

Every remote provider's credentials — licensure, board certification, education — are verified directly with the issuing authority, not accepted based on the provider's own self-reported documentation, given the absence of a physical site visit that might otherwise surface an inconsistency makes this direct verification genuinely more important, not less.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are every provider's credentials genuinely verified directly with the issuing authority, not accepted on self-report?** *Real, direct verification, not trust in documentation the provider submitted themselves.* Doc: Direct credential verification record	YES	PARTIAL	NO
2	**Does this verification genuinely cover licensure, board certification, and education, not licensure alone?** *Complete, genuine verification across every relevant credential type, not a partial check.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is verification genuinely reconfirmed periodically, not treated as a one-time check at initial hire?** *Real, periodic reconfirmation, not verification assumed to remain valid indefinitely.* Doc: Periodic reconfirmation schedule	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Direct verification review*	Reviews evidence of genuine, direct verification with issuing authorities for every provider.
DOCUMENT *Credential completeness review*	Reviews whether verification genuinely covers licensure, certification, and education together.
DOCUMENT *Reconfirmation schedule review*	Reviews whether verification is genuinely, periodically reconfirmed.

REFERENCES

[34] Direct verification of provider credentials with the issuing licensing authority, distinct from acceptance of self-reported documentation, is established as necessary practice, carrying particular importance for remote-only practice arrangements that lack the informal verification opportunities a physical site provides.

Standard 7.4 · *Standard 7: Governance & Provider Credentialing*

Guidance & Learning

GUIDANCE ASF-TM-STD7-v3.0

WHY THIS STANDARD EXISTS

A telemedicine service typically has no physical site to visit, no in-person interview process that might otherwise reveal an inconsistency, and no colleague who's worked alongside the provider in a shared physical space — this absence of the informal verification opportunities a physical facility has almost by default means direct, formal credential verification carries genuinely more, not less, real weight.

The evidence: [34] Direct verification of provider credentials with the issuing licensing authority, distinct from acceptance of self-reported documentation, is established as necessary practice, carrying particular importance for remote-only practice arrangements that lack the informal verification opportunities a physical site provides.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every provider's credentials are genuinely, directly verified with issuing authorities.	✗ Credentials are accepted based on provider self-report without direct verification.
✓ Verification genuinely covers licensure, certification, and education together.	✗ Verification covers licensure alone, missing certification or education.
✓ Verification is genuinely, periodically reconfirmed, not a one-time check.	✗ Verification happened once at hire and was never reconfirmed.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Direct verification happens for licensure but board certification is accepted from self-submitted documentation.**
Every credential category carries the same real importance and deserves the same direct verification.

2 **Verification is thorough at initial onboarding but isn't reconfirmed as licenses and certifications approach renewal.**
A credential's real, current validity depends on genuine reconfirmation, not a historical check alone.

3 **Verification happens for full-time providers but is less rigorous for occasional or covering providers.**
Every provider actually delivering care carries the same real requirement for genuine, rigorous verification.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current credential verification for genuine, direct confirmation versus self-report acceptance.

Week 2 Establish direct verification with issuing authorities for licensure, certification, and education.

Week 3 Build a periodic reconfirmation schedule extending to all providers, including occasional staff.

Ongoing Audit verification records for continued currency.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask how the service would directly verify a specific provider's board certification, not licensure alone.
A specific, confident answer reveals genuine, complete verification, not licensure-only checking.

Ask when a specific provider's credentials were last reconfirmed.
A specific, real answer reveals genuine, ongoing practice, not a one-time historical check.

E-LEARNING academy.gmj.ge/tm-std7-4-direct-credential-verification — 30 min · complete before self-assessment

Standard 7.5 **CORE** · *Standard 7: Governance & Provider Credentialing*

A Genuine Coverage Plan Exists for a Solo Provider's Absence

ASSESSMENT ASF-TM-STD7-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

7.5
CORE
L1

THE STANDARD

A Genuine Coverage Plan Exists for a Solo Provider's Absence

For a service staffed by a single provider, a genuine, defined coverage arrangement exists for when that provider is unavailable — illness, leave, emergency — with a real, named alternative for patients needing care in that gap, not an assumption that patients will simply wait or seek care elsewhere on their own.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does a genuine, defined coverage arrangement exist for when a solo provider is unavailable?** *A real, specific arrangement, not an assumption that patients will manage without care.* Doc: Coverage arrangement documentation	YES	PARTIAL	NO
2	**Is there a real, named alternative provider or service patients can be directed to during a coverage gap?** *A specific, real alternative, not a vague suggestion to seek care elsewhere.* Doc: Named alternative provider documentation	YES	PARTIAL	NO
3	**Are patients genuinely informed of the coverage plan, not left to discover it only when they need it?** *Real, proactive patient awareness, not information they only encounter during an actual gap.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Coverage plan review*	Reviews the actual, defined coverage arrangement for when the sole provider is unavailable.
DOCUMENT *Alternative provider review*	Reviews the specific, named alternative provider or service patients would be directed to.
ASK *Patient awareness interview*	Asks a patient whether they know what to do if the service's provider were unavailable.

REFERENCES

[35] Defined coverage arrangements for a solo provider's unavailability, distinct from an assumed continuation of care without one, are established as necessary practice for genuine continuity in any single-provider care model, telemedicine included.

Standard 7.5 · *Standard 7: Governance & Provider Credentialing*

Guidance & Learning

GUIDANCE ASF-TM-STD7-v3.0

WHY THIS STANDARD EXISTS

Telemedicine's technology removes many of the physical staffing constraints a building would otherwise impose, making genuine solo practice a real, common model here — but this also means the same real, specific vulnerability applies as with any solo practice: without a defined coverage plan, every patient's continuity simply stops the moment the one provider is unavailable, at exactly the moment it might matter most.

The evidence: [35] Defined coverage arrangements for a solo provider's unavailability, distinct from an assumed continuation of care without one, are established as necessary practice for genuine continuity in any single-provider care model, telemedicine included.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A genuine, defined coverage arrangement exists and is real, not theoretical.	✗ No defined coverage arrangement exists beyond an assumption patients will manage.
✓ A specific, named alternative provider is identified for coverage gaps.	✗ No specific alternative is identified; patients are vaguely told to seek care elsewhere.
✓ Patients are genuinely, proactively aware of the coverage plan.	✗ Patients only learn about coverage gaps when they actually encounter one.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **A coverage plan exists for planned absences but not genuinely for sudden, unplanned unavailability.**
A genuine emergency doesn't announce itself in advance, and the plan needs to cover this reality too.

2 **An alternative provider is named but the relationship hasn't been recently reconfirmed as still active.**
A coverage relationship needs to remain genuinely active, not just historically established.

3 **The plan exists but patient awareness relies on them happening to ask, not proactive communication.**
Genuine, proactive awareness is more reliable than a plan patients only discover by chance.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current coverage arrangements for genuine readiness, including sudden, unplanned absence.

Week 2 Establish or reconfirm a specific, named alternative provider relationship.

Week 3 Build proactive patient communication about the coverage plan.

Ongoing Periodically reconfirm the coverage relationship remains genuinely active.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask what specifically would happen if the provider became suddenly, unexpectedly unavailable today.
A specific, confident answer reveals a genuine plan, not an assumption it would work out.

Ask a patient directly whether they know what to do if the provider were unavailable.
This tests genuine, proactive awareness, not an assumption patients would figure it out.

E-LEARNING academy.gmj.ge/tm-std7-5-solo-provider-coverage — 30 min · complete before self-assessment

Endorsements

What follows is an optional endorsement — an additional standard layered on top of the base seven, never issued alone. A service must genuinely pass Standards 1 through 7 before the endorsement below is assessed. "Telemedicine Service" alone means the base seven only. "Telemedicine Service + Health & Migration" means the base seven, verified first, plus the endorsement that follows.

STANDARD 8

Health & Migration

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

10 criteria

	Standard 8.1 **NON-NEGOTIABLE** · *Standard 8: Health & Migration* **People-Centred Care Adapted to Migration and Displacement Experience**	**ASSESSMENT** ASF-TM-STD8-v3.0
CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

8.1
NON-NEGOTIABLE
L1

THE STANDARD

People-Centred Care Adapted to Migration and Displacement Experience

Care is genuinely adapted to a patient's migration and displacement experience — including trauma-informed practice and awareness of legal-status barriers to access — not delivered identically regardless of that history, whether the visit occurs in a stable setting or through the far more variable circumstances telemedicine allows a displaced patient to connect from.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is care genuinely adapted to a patient's migration and displacement experience, not delivered identically regardless of history?** *Genuine adaptation, not a generic cultural-awareness statement.* Doc: Training record on migration-adapted care	YES	PARTIAL	NO
2	**Is trauma-informed practice genuinely applied, not just referenced as a principle?** *Actual practice adaptation, not an assumption of general sensitivity.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Are providers aware of legal-status barriers to access that may affect this specific patient?** *Specific awareness, not a general sense that barriers can exist.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
ASK *Migration-adapted care interview*	Asks providers how they adapt practice specifically for a patient's migration and displacement history.
OBSERVE *Trauma-informed practice observation*	Observes an actual consultation for genuine trauma-informed practice, not generic sensitivity.
DOCUMENT *Training content review*	Reviews training materials for specific coverage of migration-adapted, trauma-informed care.

REFERENCES

[36] WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.

Standard 8.1 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-TM-STD8-v3.0

WHY THIS STANDARD EXISTS

A refugee or migrant patient's health needs are shaped by what happened before they ever reached this consultation — in their country of origin, in transit, on arrival — and telemedicine's ability to reach a patient in genuinely difficult circumstances makes this context, if anything, more likely to be actively relevant to the specific visit at hand, not less.

The evidence: [36] WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Care is genuinely, visibly adapted to migration and displacement history.	✗ Care is delivered identically regardless of migration history.
✓ Trauma-informed practice is actually applied, not just referenced.	✗ Trauma-informed practice exists only as a stated principle, not applied practice.
✓ Providers demonstrate specific awareness of legal-status access barriers.	✗ Providers show no specific awareness of legal-status barriers.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Adaptation happens for patients who disclose their history but isn't proactively considered otherwise.**
Not every patient will volunteer this history unprompted, even when it is clinically relevant.

2 **Providers are aware of the principle but haven't received specific training on applying it remotely.**
General awareness doesn't reliably translate into genuine practice adaptation without specific training.

3 **Adaptation is strong for the first consultation but isn't sustained across ongoing remote follow-up.**
An ongoing relationship depends on this understanding genuinely persisting, not fading after the initial encounter.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for genuine adaptation to migration and displacement history.

Week 2 Train providers specifically on trauma-informed, migration-adapted practice.

Week 3 Build awareness of legal-status access barriers into standard practice.

Ongoing Revisit adaptation as the ongoing patient relationship develops.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a provider to describe a specific example of adapting care for a patient's migration history.
A real, specific example reveals genuine practice, not familiarity with the principle.

Ask about continuity of care support specifically for patients without stable documentation.
This is where genuine adaptation is most tested.

E-LEARNING academy.gmj.ge/tm-std8-1-migration-adapted-care — 30 min · complete before self-assessment

Standard 8.2 **NON-NEGOTIABLE** · *Standard 8: Health & Migration*

Digital Literacy and Device Access Barriers Are Actively Addressed

ASSESSMENT ASF-TM-STD8-v3.0

CR FULL	TR FULL	SM ADAPTED	ST FULL

8.2
NON-NEGOTIABLE
L1

THE STANDARD

Digital Literacy and Device Access Barriers Are Actively Addressed

Barriers to telemedicine access specific to displaced and migrant populations — limited device access, unreliable connectivity, lower digital literacy — are genuinely, actively addressed, not assumed absent simply because a patient has managed to connect for this particular visit.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are device and connectivity barriers specific to this population genuinely, actively assessed, not assumed absent?** *Real, active assessment, not an assumption a successful connection today means reliable access generally.* Doc: Access barrier assessment process	YES	PARTIAL	NO
2	**Is digital literacy support genuinely offered where needed, not assumed unnecessary?** *Real, offered support, not an assumption every patient can navigate the platform independently.* Doc: Digital literacy support materials	YES	PARTIAL	NO
3	**Is there a genuine alternative access method for a patient whose connectivity or device access is unreliable?** *A real, practical alternative, not care limited to those with reliable technology access.* Doc: Alternative access method documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Barrier assessment review*	Reviews the process for genuinely assessing device and connectivity barriers for this population.
DOCUMENT *Digital literacy support review*	Reviews materials or processes genuinely supporting patients with lower digital literacy.
DOCUMENT *Alternative access review*	Reviews the genuine alternative access method available for patients with unreliable technology access.

REFERENCES

[37] Systematic review of telemedicine for refugee populations identifies limited access to technology, unreliable internet connectivity, and insufficient digital literacy as key barriers hindering effective telemedicine use, requiring active strategies including affordable connectivity, digital literacy support, and multilingual platforms.

Standard 8.2 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-TM-STD8-v3.0

WHY THIS STANDARD EXISTS

Real research specifically identifies limited technology access, unreliable connectivity, and insufficient digital literacy as key, documented barriers for refugee populations using telemedicine, and a patient who managed to connect today doesn't necessarily have reliable access for their next visit — active, genuine attention to these barriers, not an assumption of adequacy from one successful connection, is what actually sustains real access over time.

The evidence: [37] Systematic review of telemedicine for refugee populations identifies limited access to technology, unreliable internet connectivity, and insufficient digital literacy as key barriers hindering effective telemedicine use, requiring active strategies including affordable connectivity, digital literacy support, and multilingual platforms.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Device and connectivity barriers are genuinely, actively assessed.	✗ Barriers are assumed absent because a patient managed to connect for this visit.
✓ Digital literacy support is genuinely offered where needed.	✗ No digital literacy support is offered; independent navigation is assumed.
✓ A real alternative access method exists for unreliable technology access.	✗ No alternative exists for patients with unreliable technology access.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Assessment happens at intake but isn't revisited as a patient's actual circumstances may change.**
A patient's access reliability can genuinely change, particularly for a population with real mobility.

2 **Digital literacy support exists in the dominant local language but not in the patient's own language.**
Genuine support needs to be usable in the language the patient actually understands.

3 **An alternative access method exists but isn't proactively offered, relying on the patient to request it.**
A patient who doesn't proactively receive this offer may not know to ask, and may quietly go without the access support they genuinely need.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for genuine assessment of device and connectivity barriers.

Week 2 Build digital literacy support materials in relevant languages.

Week 3 Establish and proactively offer a genuine alternative access method.

Ongoing Revisit access barrier assessment as patient circumstances change.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask how the service would identify a patient struggling with the platform who hasn't said so directly.
A specific, thoughtful answer reveals genuine, proactive attention, not reliance on the patient to report difficulty.

Ask what alternative exists for a patient whose smartphone or data access is genuinely unreliable.
A specific, real answer reveals a genuine alternative, not an assumption everyone has adequate access.

E-LEARNING academy.gmj.ge/tm-std8-2-digital-access-barriers — 30 min · complete before self-assessment

	Standard 8.3 NON-NEGOTIABLE · *Standard 8: Health & Migration* **Language and Communication Aids — Interpreters and Cultural Mediators**	ASSESSMENT ASF-TM-STD8-v3.0
CR FULL	TR FULL	SM ADAPTED	ST FULL

8.3
NON-NEGOTIABLE
L1

THE STANDARD

Language and Communication Aids — Interpreters and Cultural Mediators

Trained interpreters or cultural mediators are engaged for language-discordant remote consultations — never minor children, and only family members when genuinely no other option exists and the situation is not high-risk.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are trained interpreters or cultural mediators engaged for language-discordant remote consultations?** *Not ad hoc bilingual staff or family members as the default.* Doc: Interpreter engagement record	YES	PARTIAL	NO
2	**Is a minor ever used to facilitate interpretation for a family member?** *This should never happen — a specific, absolute rule, not a judgement call.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**When a family member interprets due to genuine unavailability of a trained interpreter, is this reserved for low-risk situations only?** *Not used for informed consent, complex diagnoses, or bad news — situations requiring professional language support.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Interpreter engagement review*	Reviews records for evidence of trained interpreter or cultural mediator engagement.
ASK *Minor-interpreter policy check*	Asks providers directly whether minors are ever used to interpret, and confirms understanding that this is never acceptable.
OBSERVE *High-risk situation check*	Checks whether family-member interpretation, where it occurs, is confined to genuinely low-risk situations.

REFERENCES

[38] WHO Competency Standard 3 explicitly states health workers have a responsibility not to engage minors to facilitate interpretation, given the associated significant risk, and identifies inaccuracy, information distortion, and compromised confidentiality as documented risks of family-member interpretation generally.

Standard 8.3 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-TM-STD8-v3.0

WHY THIS STANDARD EXISTS

Family members interpreting, especially minors, carries real, well-documented risks — inaccurate interpretation, withheld or distorted information, compromised confidentiality, and trauma to the family member themselves — and telemedicine's remote format doesn't reduce this real risk, since a family member is often the only other person genuinely present in the room regardless.

The evidence: [38] WHO Competency Standard 3 explicitly states health workers have a responsibility not to engage minors to facilitate interpretation, given the associated significant risk, and identifies inaccuracy, information distortion, and compromised confidentiality as documented risks of family-member interpretation generally.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Trained interpreters or cultural mediators are the default for language-discordant consultations.	✗ Ad hoc bilingual staff or family members are the default, with trained interpreters rarely engaged.
✓ Providers confirm, without hesitation, that minors are never used to interpret.	✗ A minor has been used to interpret, even occasionally.
✓ Family-member interpretation, when it happens, is reserved for genuinely low-risk situations only.	✗ Family members interpret for high-risk situations like informed consent or bad news.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Trained interpreters are engaged for scheduled consultations but not for urgent or same-day remote visits.**
Risk doesn't scale down proportionally with how urgent or unscheduled an interaction feels.

2 **The no-minors rule is understood by providers but not consistently reinforced with support staff scheduling sessions.**
A critical safeguard needs to be embedded across the whole team, not held only by the treating provider.

3 **Remote interpreter access exists but connection quality issues sometimes lead to reverting to a family member mid-session.**
A genuine backup for interpreter connection failure is what actually prevents reversion to an unqualified family member.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent language-discordant consultations for interpreter engagement patterns.

Week 2 Establish reliable remote interpreter access, tested for connection quality alongside the platform itself.

Week 3 Brief all staff on the firm exclusion of children as interpreters, without exception.

Ongoing Audit interpreter use records for consistency.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff directly whether a child has ever interpreted for a parent during a remote session.
A direct question often surfaces what a general policy question won't.

Ask what happens if the remote interpreter's own connection fails mid-session.
This reveals whether a genuine backup exists, not reversion to an unqualified family member.

E-LEARNING academy.gmj.ge/tm-std8-3-language-cultural-mediators — 30 min · complete before self-assessment

	Standard 8.4 **CORE** · *Standard 8: Health & Migration* **Genuine Agency Is Respected, Not Treated as a Passive Technology Recipient**	**ASSESSMENT** ASF-TM-STD8-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

8.4
CORE
L1

THE STANDARD

Genuine Agency Is Respected, Not Treated as a Passive Technology Recipient

Refugee and migrant patients are genuinely treated as having real agency and competence in using telemedicine technology — not designed for or spoken to as passive recipients presumed incapable, an assumption real research specifically warns against as its own documented harm.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are patients genuinely assessed as individuals for technology competence, not assumed uniformly incapable based on background?** *Real, individual assessment, not a blanket assumption applied to the whole population.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Does communication about technology use respect the patient's real agency, not speak to them as a passive recipient?** *Genuine, respectful communication, not language or tone presuming incapability.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Are staff specifically trained to recognise this documented risk of over-generalizing incapability to this population?** *Real, specific training on this documented concern, not an assumption good intentions alone prevent it.* Doc: Staff training on agency and stereotype avoidance	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Individual assessment observation*	Observes whether technology competence is genuinely assessed per patient, not assumed from population background.
OBSERVE *Communication tone observation*	Observes provider communication for genuine respect of patient agency, not a presumptive, simplified tone.
DOCUMENT *Staff training review*	Reviews training records for specific coverage of this documented stereotype risk.

REFERENCES

[39] Research on refugee telehealth implementation specifically cautions that health technologies should be designed to create space for refugees to practice and demonstrate genuine agency, rather than treating them as passive beneficiaries of the technology, a framing that itself perpetuates harmful assumptions about their capabilities.

Standard 8.4 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-TM-STD8-v3.0

WHY THIS STANDARD EXISTS

Real, documented barriers to telemedicine access for this population are genuine and worth actively addressing, but treating every patient in this population as uniformly lacking technological capability — rather than recognising genuine, real variation and individual competence — replicates exactly the stereotype researchers in this field have specifically identified as harmful, denying patients the chance to demonstrate and exercise their own real agency.

The evidence: [39] Research on refugee telehealth implementation specifically cautions that health technologies should be designed to create space for refugees to practice and demonstrate genuine agency, rather than treating them as passive beneficiaries of the technology, a framing that itself perpetuates harmful assumptions about their capabilities.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Technology competence is genuinely assessed per individual, not assumed from population background.	✗ All patients from this population are assumed uniformly incapable with technology.
✓ Communication genuinely respects patient agency, not a presumptive tone.	✗ Communication is presumptive or simplified based on the patient's background alone.
✓ Staff are specifically trained on this documented risk of over-generalizing incapability.	✗ No specific training addresses this documented stereotype risk.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Individual assessment happens for adult patients but assumptions persist more readily for older patients within this population.**
Age within this population doesn't determine genuine technology competence any more than population background does.

2 **Staff avoid overtly presumptive language but subtly simplify explanations more than the individual patient's demonstrated understanding warrants.**
Genuine respect for agency means calibrating explanation to the actual person, not a background-based default.

3 **Awareness of this concern exists informally but hasn't been specifically, formally trained.**
Informal awareness is less reliable than specific, formal training in genuinely preventing this documented pattern.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for genuine, individual assessment versus population-based assumption.

Week 2 Train staff specifically on this documented stereotype risk and how to avoid it.

Week 3 Build communication practices that calibrate to individual demonstrated competence.

Ongoing Audit communication tone for continued respect of patient agency.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe how a provider explains platform use to a patient from this population, if possible.
Direct observation reveals genuine, individually calibrated respect, not a presumptive default tone.

Ask staff whether they've received specific training on avoiding this documented stereotype.
A specific, confident answer reveals genuine awareness, not an assumption good intentions are sufficient.

E-LEARNING academy.gmj.ge/tm-std8-4-genuine-agency — 30 min · complete before self-assessment

Standard 8.5 **NON-NEGOTIABLE** · *Standard 8: Health & Migration*

Continuity Across Mobility Is Actively Supported Through Portable Records

ASSESSMENT ASF-TM-STD8-v3.0

CR FULL	TR FULL	SM ADAPTED	ST FULL

8.5
NON-NEGOTIABLE
L1

THE STANDARD

Continuity Across Mobility Is Actively Supported Through Portable Records

When a genuinely mobile or displaced patient's location changes, the service actively supports continuity through a portable, patient-accessible record — not treating each new location, or each new provider the patient might reach, as an entirely fresh start with no continuity from what came before.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the service provide a genuinely portable record, not one locked within a single system?** *A real, portable format the patient can carry forward, not accessible only here.* Doc: Portable record format documentation	YES	PARTIAL	NO
2	**Is the record genuinely updated close to a known relocation, not left outdated?** *Real, current information reflecting the patient's actual status, not a stale record.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Does the patient know how to access and use this record themselves?** *Real, patient-controlled access, not continued dependency on this service.* Doc: Patient record access instruction	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Portable record review*	Reviews whether patients genuinely receive a portable, accessible record format.
DOCUMENT *Record currency review*	Reviews whether the record is genuinely kept current, particularly near a known relocation.
ASK *Patient access interview*	Asks a patient whether they know how to access and use their own portable record.

REFERENCES

[40] Refugees experience genuine difficulty accessing their medical records and maintaining continuity of care due to mobility-related challenges, with the absence of standardized, interoperable procedures between health systems resulting in fragmented records, incomplete medical history, and documented medical errors.

Standard 8.5 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-TM-STD8-v3.0

WHY THIS STANDARD EXISTS

Real, documented research specifically identifies that refugees experience genuine difficulty accessing their own medical records because of mobility, and that fragmented, incompatible health records between different systems can result in incomplete medical history and real, documented medical errors — telemedicine's own reliance on Standard 2's principle that care follows the patient's actual location makes this fragmentation risk genuinely more, not less, acute for a population whose location itself is often unstable.

The evidence: [40] Refugees experience genuine difficulty accessing their medical records and maintaining continuity of care due to mobility-related challenges, with the absence of standardized, interoperable procedures between health systems resulting in fragmented records, incomplete medical history, and documented medical errors.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A genuinely portable, patient-accessible record format is actively provided.	✗ Records remain locked within this service's own system, not genuinely portable.
✓ The record is genuinely kept current, particularly near a known relocation.	✗ The record becomes outdated, not reflecting the patient's actual, recent status.
✓ Patients genuinely know how to access and use their own record independently.	✗ Patients remain dependent on requesting their own information from this service each time.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **A portable record format exists but isn't proactively offered unless the patient specifically requests it.**
A patient who doesn't know to ask shouldn't be less likely to receive genuine continuity support.

2 **The record is current at creation but isn't genuinely updated as the ongoing relationship continues.**
Continuity value depends on the record reflecting the patient's actual, current status, not only their status at one point in time.

3 **Patients are given the record but not specific instruction on how to actually use or share it with a future provider.**
A portable record a patient doesn't know how to use provides limited real continuity value.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current record practice for genuine portability versus system lock-in.

Week 2 Establish a standard, portable, patient-accessible record format, proactively offered.

Week 3 Build a process for keeping the record genuinely current, particularly near known relocations.

Ongoing Confirm patients understand how to access and use their own record independently.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a patient whether they have their own accessible copy of their health record, and whether they know how to use it.
A real, specific answer reveals genuine portability, not a record locked within the service's own system.

Ask how the record is updated when a patient reports an upcoming relocation.
A specific, confident answer reveals genuine, proactive practice, not passive record-keeping.

E-LEARNING academy.gmj.ge/tm-std8-5-portable-continuity-record — 30 min · complete before self-assessment

Standard 8.6 **CORE** · *Standard 8: Health & Migration*

Evidence-Informed Care for Refugee and Migrant Populations

ASSESSMENT ASF-TM-STD8-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

8.6
CORE
L1

THE STANDARD

Evidence-Informed Care for Refugee and Migrant Populations

Staff use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain — not applying general telemedicine guidelines uncritically to a population with documented, different health needs.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are staff aware of evidence-informed guidelines specific to refugee and migrant health where they exist?** *Specific, current awareness, not general clinical knowledge assumed to be sufficient.* Doc: Guideline awareness record	YES	PARTIAL	NO
2	**Do staff recognise where this population's health needs genuinely differ from the general population?** *Genuine, specific recognition, not an assumption that general guidelines always apply equally.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is practice adapted where population-specific evidence indicates a different approach is warranted?** *Actual practice adaptation, not awareness without application.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Guideline awareness review*	Reviews whether staff have access to and awareness of population-specific evidence-informed guidelines.
ASK *Population-difference interview*	Asks staff to describe a specific way this population's health needs differ from the general population.
OBSERVE *Practice adaptation check*	Checks whether practice genuinely reflects population-specific evidence where it exists.

REFERENCES

[41] WHO Competency Standard 7 requires health workers to use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain.

Standard 8.6 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-TM-STD8-v3.0

WHY THIS STANDARD EXISTS

Refugee and migrant health needs genuinely differ from the general population in ways that matter clinically, including documented, elevated risk of mental health disorders tied to trauma, displacement, and resettlement stress — care that ignores this and applies general guidelines uncritically can miss real, evidence-based adjustments this specific population needs.

The evidence: [41] WHO Competency Standard 7 requires health workers to use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff are aware of and use population-specific evidence-informed guidelines where they exist.	✗ General telemedicine guidelines are applied uncritically with no population-specific awareness.
✓ Staff can describe specific, genuine differences in this population's health needs.	✗ Staff cannot describe any specific way this population's needs differ.
✓ Practice is genuinely adapted where population-specific evidence indicates it should be.	✗ Awareness exists but doesn't translate into any actual practice adaptation.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Awareness exists for well-known differences but not for more specific or recent evidence.**
Evidence in this area continues to develop, and awareness needs to stay genuinely current.

2 **Guidelines are known but not consistently applied under time pressure.**
Consistent application under real conditions is what gives awareness genuine protective value.

3 **Evidence gaps are acknowledged but staff default to general population assumptions rather than flagging genuine uncertainty.**
Genuine engagement with real uncertainty is more protective than defaulting to an assumption that may not actually apply.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current awareness of population-specific evidence-informed guidelines.

Week 2 Establish access to current, relevant guidelines for staff.

Week 3 Train staff on specific, genuine population differences relevant to practice.

Ongoing Refresh awareness as evidence in this area develops.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff for a specific example of a practice adaptation based on population-specific evidence.
A real example reveals genuine application, not just familiarity with the concept.

Ask how staff would handle a genuine evidence gap for this population.
A thoughtful, honest answer reveals genuine engagement rather than a default assumption.

E-LEARNING academy.gmj.ge/tm-std8-6-evidence-informed-care — 30 min · complete before self-assessment

Standard 8.7 **NON-NEGOTIABLE** · *Standard 8: Health & Migration*

Staff Reflective Practice, Bias Awareness, and Self-Care in Migration Contexts

ASSESSMENT ASF-TM-STD8-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

8.7
NON-NEGOTIABLE
L1

THE STANDARD

Staff Reflective Practice, Bias Awareness, and Self-Care in Migration Contexts

Staff maintain active awareness of their own culture, beliefs, and potential biases through structured reflective practice, and the service actively fosters a supportive environment with genuine access to psychological support — not assumed self-awareness or an assumption that staff will manage vicarious trauma exposure on their own.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the service have a structured process for staff reflective practice regarding bias and cultural awareness?** *A defined process, not an assumption that staff will naturally self-reflect adequately.* Doc: Reflective practice process description	YES	PARTIAL	NO
2	**Does the service provide genuine, accessible psychological support and a real space to discuss difficult cases?** *Actual, used support and a real, regular opportunity, not a theoretical benefit or informal hope.* Doc: Psychological support access record	YES	PARTIAL	NO
3	**Can staff describe a specific instance of adapting their practice after recognising a bias, and do they recognise signs of vicarious trauma in themselves?** *Genuine, concrete examples, not general statements of good intentions or awareness.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Reflective practice process review*	Reviews the service's structured process, if any, for staff reflective practice on bias and cultural awareness.
DOCUMENT *Support access review*	Reviews what psychological support and debrief structure genuinely exist and whether they are actually used.
ASK *Staff example interview*	Asks a staff member for a specific instance of recognising and adapting for their own bias, and how they process the emotional weight of this work.

REFERENCES

[42] WHO Competency Standards 8 and 9 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to maintain structured awareness of their own biases and institutional discrimination's impact, and to engage in self-care within a supportive team environment addressing the wellbeing impacts of migration-context care.

Standard 8.7 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-TM-STD8-v3.0

WHY THIS STANDARD EXISTS

Unacknowledged bias shapes clinical judgement in ways that are genuinely hard to see from the inside, and staff providing this care are regularly exposed, secondhand, to accounts of trauma and displacement — both are real, documented occupational realities of this work, and both require structured, deliberate support rather than being left to individual capacity alone, remote practice included.

The evidence: [42] WHO Competency Standards 8 and 9 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to maintain structured awareness of their own biases and institutional discrimination's impact, and to engage in self-care within a supportive team environment addressing the wellbeing impacts of migration-context care.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A structured reflective practice process genuinely exists and is used, not just assumed.	✗ No structured reflective practice process exists beyond an assumption of individual self-awareness.
✓ Genuine, accessible psychological support exists and staff actually use it.	✗ Psychological support exists only nominally, with no evidence staff actually access it.
✓ Staff can describe specific, real examples of both bias adaptation and vicarious trauma awareness.	✗ Staff cannot describe any specific example of adapting practice or recognising vicarious trauma.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Reflective practice happens informally but is not structured into any genuine, regular process.**
Individual good practice does not reliably generalise without a defined, shared process.

2 **Support exists but is genuinely difficult to access given remote staff working independently across locations.**
A benefit's existence does not guarantee genuine, comfortable access to it, particularly for a dispersed remote team.

3 **Support exists for acute incidents but not for the cumulative emotional weight of this work over time.**
Cumulative emotional impact deserves the same genuine, structured support as any acute incident.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current training content and support access for genuine coverage of bias and staff wellbeing.

Week 2 Establish a structured reflective practice process feasible for a remote or dispersed team.

Week 3 Identify genuine, accessible psychological support options appropriate to remote practice.

Ongoing Revisit reflective practice and wellbeing periodically, using real case examples where appropriate.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a specific personal example, not a general statement of awareness.
A concrete instance distinguishes genuine reflective practice from familiarity with the concept.

Ask directly whether support has been used, not just whether it exists.
Genuine uptake, not nominal availability, is the real test.

E-LEARNING academy.gmj.ge/tm-std8-7-reflective-practice-and-self-care — 30 min · complete before self-assessment

Standard 8.8 **NON-NEGOTIABLE** · *Standard 8: Health & Migration*

Digital Privacy Concerns Specific to Displaced Populations Are Genuinely Addressed

ASSESSMENT ASF-TM-STD8-v3.0

CR FULL	TR FULL	SM ADAPTED	ST FULL

8.8
NON-NEGOTIABLE
L1

THE STANDARD

Digital Privacy Concerns Specific to Displaced Populations Are Genuinely Addressed

The service genuinely recognises and addresses the specific, heightened digital privacy concerns displaced populations face — including the real possibility that health-related digital data could be requested or analyzed by immigration or asylum authorities — not treating this population's privacy needs as identical to a general patient's under standard confidentiality practice.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does the service genuinely recognise this population's specific digital privacy concerns?** *Real, specific recognition, not general confidentiality practice assumed sufficient.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Is there honest communication about what genuinely is and isn't shared with any authority?** *Real, honest, specific communication, not a vague general assurance.* Doc: Patient privacy communication materials	YES	PARTIAL	NO
3	**Are staff specifically trained on this concern, not assuming general privacy training suffices?** *Real, specific training, not general health privacy training assumed sufficient.* Doc: Staff training on migration-specific privacy concerns	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
ASK *Recognition interview*	Asks staff whether they specifically recognise and address this population's distinct digital privacy concerns.
DOCUMENT *Patient communication review*	Reviews materials for genuine, specific, honest communication about data sharing with authorities.
DOCUMENT *Staff training review*	Reviews training records for specific coverage of this documented, distinct privacy concern.

REFERENCES

[43] Some governments have begun analyzing migrants' phone data as part of asylum adjudication processes, establishing genuine, documented grounds for displaced patients' distinct privacy concerns regarding digital health data, separate from general patient confidentiality practice.

Standard 8.8 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-TM-STD8-v3.0

WHY THIS STANDARD EXISTS

Real, documented cases show some governments analyzing migrants' phone data as part of asylum adjudication, and a patient carrying genuine, well-founded fear that health information could similarly be accessed or used against their immigration status faces a real, distinct privacy concern beyond ordinary confidentiality — a service that doesn't genuinely address this specific fear risks patients withholding health information out of caution, or avoiding care altogether.

The evidence: [43] Some governments have begun analyzing migrants' phone data as part of asylum adjudication processes, establishing genuine, documented grounds for displaced patients' distinct privacy concerns regarding digital health data, separate from general patient confidentiality practice.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The service genuinely recognises and addresses this population's distinct digital privacy concerns.	✗ This population's privacy needs are treated identically to general patients, with no specific recognition.
✓ Specific, honest communication clarifies what is and isn't shared with any authority.	✗ Communication offers only vague, general privacy assurance, not specific clarity.
✓ Staff are specifically trained on this documented, distinct concern.	✗ Staff rely on general privacy training, with no specific coverage of this distinct concern.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Recognition exists informally among some staff but isn't consistently, formally addressed across the whole team.**
Every staff member interacting with this population deserves the same genuine, formal understanding.

2 **Communication is honest but not proactively offered, relying on the patient to raise the concern themselves.**
A patient may not know to ask, and proactive communication reaches concerns that would otherwise go unaddressed.

3 **Training references data privacy generally but doesn't specifically name this population's documented, distinct concern.**
General privacy training doesn't reliably surface this specific, documented concern without being named directly.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for genuine recognition of this population's distinct digital privacy concerns.

Week 2 Build specific, honest, proactive patient communication addressing this concern directly.

Week 3 Train all staff specifically on this documented, distinct concern, not general privacy training alone.

Ongoing Revisit communication and training as the relevant regulatory landscape evolves.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff directly whether they've discussed this specific concern with patients from this population.
A specific, real answer reveals genuine recognition, not an assumption general privacy practice covers it.

Ask to see the actual, specific language used to communicate this to a patient.
A real, specific example reveals genuine, honest communication, not a vague general assurance.

E-LEARNING academy.gmj.ge/tm-std8-8-migration-specific-digital-privacy — 30 min · complete before self-assessment

Standard 8.9 **CORE** · *Standard 8: Health & Migration*

Legal Status Diversity Recognition

ASSESSMENT ASF-TM-STD8-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

8.9
CORE
L1

THE STANDARD

Legal Status Diversity Recognition

The service can name which legal status categories it actually serves — asylum seeker, recognised refugee, stateless person, and others — and demonstrates it doesn't apply a single, uniform assumption about access rights across all of them.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Can staff name the specific legal status categories this service actually serves?** *Specific, named categories, not a general sense that "migrants" are served.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Does the service avoid applying a single, uniform assumption about access rights across all statuses?** *Genuine differentiation, not treating all categories identically.* Doc: Status-specific access policy documentation	YES	PARTIAL	NO
3	**Is there a specific process for verifying which category applies when it's genuinely unclear?** *A real, defined process, not guesswork or assumption when status is ambiguous.* Doc: Status verification process	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
ASK *Status category awareness interview*	Asks staff to name the specific legal status categories this service actually serves.
DOCUMENT *Status-specific policy review*	Reviews documentation for genuine differentiation across status categories, not a uniform assumption.
DOCUMENT *Verification process review*	Reviews the process for verifying status when it's genuinely unclear.

REFERENCES

[44] WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.

Standard 8.9 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-TM-STD8-v3.0

WHY THIS STANDARD EXISTS

Asylum seeker, recognised refugee, and stateless person are not interchangeable categories — they carry genuinely different legal access rights in different countries, and treating them as one undifferentiated group risks either wrongly denying care someone is entitled to, or missing a specific vulnerability tied to a particular status.

The evidence: [44] WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff can name the specific legal status categories this service actually serves.	✗ Staff have only a general sense that "migrants" are served, without specific categories.
✓ Policy genuinely differentiates access considerations across status categories.	✗ A single, uniform assumption about access rights is applied regardless of status.
✓ A specific, defined process exists for verifying unclear status.	✗ No process exists for verifying status when it's genuinely unclear.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **Staff can name the most common category served but not less frequent ones the service still encounters.**
Even infrequent categories deserve genuine, specific awareness, not the risk of misapplied assumptions.

2 **Differentiation exists in one provider's own understanding but isn't shared with the wider team.**
Every staff member interacting with patients benefits from the same genuine understanding.

3 **A verification process exists but staff are inconsistently confident applying it.**
Consistent, confident application across the whole team is what makes this process genuinely reliable.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current staff awareness of the specific legal status categories actually served.

Week 2 Build specific, differentiated access guidance for each relevant status category.

Week 3 Establish a clear verification process for genuinely unclear status.

Ongoing Refresh staff awareness periodically, particularly for less frequently encountered categories.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff to name every specific legal status category the service has served recently.
Specificity reveals genuine, current awareness rather than a general assumption.

Ask what happens when a patient's specific status is genuinely unclear.
A confident, specific answer reveals a genuine process, not improvisation.

E-LEARNING academy.gmj.ge/tm-std8-9-legal-status-recognition — 30 min · complete before self-assessment

	Standard 8.10 NON-NEGOTIABLE · *Standard 8: Health & Migration* **Care Is Documented and Provided Regardless of Immigration or Legal Status**	ASSESSMENT ASF-TM-STD8-v3.0
CR FULL	TR FULL	SM FULL	ST FULL

8.10
NON-NEGOTIABLE
L1

THE STANDARD

Care Is Documented and Provided Regardless of Immigration or Legal Status

Care is provided and fully documented for every patient regardless of immigration or legal status, with no differential standard of care, documentation practice, or record-keeping applied based on status — not a lesser or informal standard applied to patients without documented status.

SERVICE SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is the same standard of care applied and documented the same way regardless of a patient's immigration or legal status?** *Genuinely equal treatment, not a lesser or informal standard for undocumented patients.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Are staff specifically trained that immigration status is never a reason to withhold or alter care or documentation?** *Specific, documented training, not assumed understanding.* Doc: Staff training record	YES	PARTIAL	NO
3	**Is patient information protected with the same confidentiality standard regardless of status, with no informal sharing of status-related information?** *The same confidentiality protection extended to every patient, without exception.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Care standard observation*	Observes whether care and documentation practice is genuinely consistent regardless of patient status.
DOCUMENT *Staff training review*	Reviews training records confirming staff understand immigration status is never a basis for differential care.
ASK *Confidentiality practice interview*	Asks staff how patient status information, where known, is protected.

REFERENCES

[45] Equal standard of care and documentation regardless of immigration or legal status, without differential record-keeping practice, is established practice in international guidance on healthcare access for migrant and refugee populations.

Standard 8.10 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-TM-STD8-v3.0

WHY THIS STANDARD EXISTS

A patient who fears that seeking remote care will expose their immigration status to consequences may delay or avoid care entirely, and any indication that this service applies a different standard based on status only reinforces that fear — genuine equal treatment, documented the same way for everyone, is what makes telemedicine genuinely accessible to this population.

The evidence: [45] Equal standard of care and documentation regardless of immigration or legal status, without differential record-keeping practice, is established practice in international guidance on healthcare access for migrant and refugee populations.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Care and documentation are genuinely consistent regardless of status.	✗ Care or documentation practice differs based on a patient's known or assumed status.
✓ Staff are specifically trained on this principle, not assumed to understand it.	✗ No specific training addresses this principle.
✓ Confidentiality protection is applied equally without exception.	✗ Status-related information is handled less carefully than other confidential information.

MOST COMMON REASONS SERVICES SCORE PARTIAL

1 **The principle is understood by treating providers but not consistently by administrative or scheduling staff.**
A patient's first interaction is often with administrative staff, where the same principle needs to hold.

2 **Care is consistent but documentation habits vary informally based on individual staff assumptions.**
Consistency needs to extend to documentation practice specifically, not only the clinical care itself.

3 **The principle is followed but has never been specifically, formally trained.**
Informal adherence is less reliable than specific, formal training, particularly as staff change over time.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for any differential treatment based on status.

Week 2 Establish specific staff training on this principle, covering all staff, not only clinical roles.

Week 3 Confirm documentation practice is genuinely consistent regardless of status.

Ongoing Reinforce training periodically, particularly for new staff.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask administrative or scheduling staff, not only providers, about this principle.
This reveals whether the principle genuinely extends beyond clinical staff.

Ask how patient status information, where it becomes known, is protected.
A specific, confident answer reveals genuine practice, not just a stated value.

E-LEARNING academy.gmj.ge/tm-std8-10-status-neutral-care — 30 min · complete before self-assessment

References

Numbered references below are formal citations, in Vancouver style, each individually verified against the original source before inclusion. The [N] marker on each criterion's Reference line and "The evidence" line corresponds to its number here.

1. Every telehealth platform used for clinical sessions must provide a signed Business Associate Agreement, executed by both parties before any clinical sessions are conducted, distinct from the common misconception that selecting a healthcare-tier platform alone constitutes compliance.

2. Telehealth security requires end-to-end encryption for real-time sessions, transport layer security of at least TLS 1.2 for signaling and APIs, and AES-256 encryption for data at rest, with these specific technical standards, not general platform reputation, constituting genuine compliance.

3. Consumer video platforms including standard FaceTime, consumer Zoom, standard Google Meet, and Skype are explicitly identified as non-compliant for clinical telehealth use because they do not offer Business Associate Agreements, with temporary pandemic-era enforcement waivers for such platforms having since expired.

4. Administrative controls including role-based access controls, multi-factor authentication, and session timeouts are established as essential technical safeguards for telehealth systems handling sensitive health information, reflected in health data security frameworks recognized across many countries' privacy and data protection regulation.

5. Security depends on the full system, not the software alone, establishing that operational resilience — including defined processes for technical failure during a clinical session — is a genuine component of telehealth platform reliability, distinct from encryption and access control alone.

6. The Interstate Medical Licensure Compact Commission establishes that the location of medical practice is the state where the patient is located, with all laws and regulations of the patient's state applying, distinct from the provider's own location or state of principal licensure.

7. Documenting the patient's specific location at the time of the telemedicine visit is established as essential practice, distinct from relying on an address on file, given that applicable law and licensure requirements are determined by the patient's actual location during the encounter.

8. The Interstate Medical Licensure Compact covers physicians specifically and does not extend to nurses, physician assistants, or other allied health professionals, who require verification under their own distinct interstate compacts with separate membership states and requirements.

9. Genuine attention to changing licensure implications when a patient relocates or travels, distinct from continuing care regardless of resulting licensure gaps or abruptly discontinuing without transition, is established as necessary practice for telemedicine continuity of care.

10. Under interstate medical licensure compact structures, if a participating state board takes disciplinary action against a provider's compact-facilitated license, all compact member boards are notified and authorized to take similar action, establishing coordinated disciplinary risk as a genuine, distinct consequence of compact licensure.

11. A retrospective review of teledermatology consultations found 60.2 percent of patients had additional diagnoses identified only on in-person examination, including an additional malignant diagnosis in 8.4 percent of patients, establishing genuine, condition-specific limits to remote assessment that providers must actively recognize.

12. The standard of care remains the same whether a visit is conducted in person or remotely, with malpractice claims analysis identifying failure to order diagnostic testing, failure to assess continued symptoms, and failure to establish a differential diagnosis as leading contributors to diagnostic error in telehealth practice.

13. Clinicians and subject matter experts describe genuine challenges in managing diagnostic uncertainty via telemedicine due to the absence of hands-on examination, with few patients receiving a new diagnosis through telemedicine and many preferring in-person visits specifically for new or complex concerns.

14. Clinicians describe relying more on additional diagnostic testing, structured patient self-reports, and scheduled in-person follow-up visits specifically to compensate for the absence of hands-on physical examination in telemedicine encounters, establishing active compensation as effective, documented practice.

15. Research on telemedicine's diagnostic process found few patients receive a genuinely new diagnosis through telemedicine, with patients themselves preferring in-person evaluation specifically for new concerns, establishing a genuine, documented distinction between remote management of known conditions and remote establishment of new diagnoses.

16. Genuine confirmation of a client's physical location at the start of every single session, not reliance on intake records, is established as essential telehealth crisis protocol, because not knowing where a patient actually is can be the difference between emergency help arriving and not arriving.

17. A documented telehealth emergency management protocol establishes a three-tiered emergency activation process: direct local emergency service activation where standard coverage exists, a patient-reported local dispatch number where it doesn't, and an e911 relay center connecting the clinician to local emergency services as a further alternative.

18. Established telehealth emergency management protocol specifically requires clinicians to remain connected on the session with the patient until local emergency services arrive on scene and care is genuinely transferred, only disconnecting once that handoff has actually occurred.

19. Genuine designation of primary and secondary emergency contacts requires a verification step confirming the contact has been informed and is willing to serve in that role, distinct from a name and number recorded without active confirmation.

20. Established telehealth crisis protocol specifically addresses when telehealth is no longer clinically appropriate and a higher level of care needs to be facilitated, establishing a defined threshold as necessary practice, distinct from indefinite continuation of remote sessions without a clear transition point.

21. Telemedicine prescribing regulations for controlled substances remain an actively evolving area of law in numerous countries, with the underlying international framework under the Single Convention on Narcotic Drugs (1961, as amended) requiring national implementation that can itself change, making active tracking of current, jurisdiction-specific requirements a genuine, ongoing necessity.

22. The Single Convention on Narcotic Drugs (1961, as amended), ratified by 186 countries, establishes that the production, distribution, and use of controlled substances must be limited exclusively to medical and scientific purposes, a principle applying identically whether a prescription is issued in person or via telemedicine.

23. In countries with federal, provincial, or similarly devolved governance structures, sub-national controlled substance telemedicine prescribing rules can apply independently of and in addition to national requirements, with some regions imposing distinct exceptions or conditions beyond the national baseline.

24. Some jurisdictions permit a narrow exception for prescribing certain restricted stimulant medications to minors using real-time, interactive audio-visual technology and prior written guardian consent, in place of the standard in-person evaluation requirement; where no such exception exists in a given jurisdiction, the standard requirement applies without exception.

25. Under the international framework established by the Single Convention on Narcotic Drugs, each country designates a competent national authority responsible for controlled substance prescribing authorization, with this authorization status forming the foundational basis for lawful prescribing, requiring genuine, periodic verification distinct from a one-time historical check assumed to remain accurate indefinitely.

26. Official telehealth guidance specifically advises patients to find a private location for their session and provides concrete suggestions — a quiet room at home, a private space in a community setting, a parked car — reflecting that session environment privacy requires active guidance, not assumed adequacy from platform security alone.

27. Established health privacy guidance specifically requires recorded consent before continuing a consultation when a translator, caregiver, or family member is present, or when the patient is in a public location where the conversation may be overheard, reflecting the genuine risk of an unseen third party during a telehealth session.

28. Practitioners often lack clear guidance on whether and how to record telehealth sessions, creating genuine ambiguity and discomfort for both provider and patient, establishing a clear, specific, documented recording policy as necessary to close this documented gap.

29. Many clinicians continue conducting sessions from home offices with unencrypted devices and storing session recordings in personal cloud storage, having never completed the compliance transition required since temporary pandemic-era enforcement discretion ended, establishing the provider's home office as a genuine, distinct privacy compliance layer separate from platform security.

30. Multiple countries' health privacy frameworks specifically establish heightened confidentiality protections for substance use disorder or addiction treatment records, distinct from general health information privacy practice, often requiring the patient's own specific consent for disclosure.

31. Many older malpractice insurance policies were drafted before telemedicine became mainstream and contain explicit exclusions for virtual care unless a formal endorsement is added, with coverage needing to be affirmatively stated in policy declarations or endorsements, since silence is not protection.

32. Interstate licensure compacts such as the Interstate Medical Licensure Compact facilitate multi-state licensure but do not inherently standardize malpractice insurance requirements, meaning providers must separately confirm their coverage explicitly extends to every state where they actually deliver care.

33. When care delivery depends on digital platforms, software malfunctions including failed video platforms, corrupted data transmission, or algorithmic triage tool errors can contribute to patient harm, with traditional malpractice policies often not covering these technology-driven operational failures.

34. Direct verification of provider credentials with the issuing licensing authority, distinct from acceptance of self-reported documentation, is established as necessary practice, carrying particular importance for remote-only practice arrangements that lack the informal verification opportunities a physical site provides.

35. Defined coverage arrangements for a solo provider's unavailability, distinct from an assumed continuation of care without one, are established as necessary practice for genuine continuity in any single-provider care model, telemedicine included.

36. WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.

37. Systematic review of telemedicine for refugee populations identifies limited access to technology, unreliable internet connectivity, and insufficient digital literacy as key barriers hindering effective telemedicine use, requiring active strategies including affordable connectivity, digital literacy support, and multilingual platforms.

38. WHO Competency Standard 3 explicitly states health workers have a responsibility not to engage minors to facilitate interpretation, given the associated significant risk, and identifies inaccuracy, information distortion, and compromised confidentiality as documented risks of family-member interpretation generally.

39. Research on refugee telehealth implementation specifically cautions that health technologies should be designed to create space for refugees to practice and demonstrate genuine agency, rather than treating them as passive beneficiaries of the technology, a framing that itself perpetuates harmful assumptions about their capabilities.

40. Refugees experience genuine difficulty accessing their medical records and maintaining continuity of care due to mobility-related challenges, with the absence of standardized, interoperable procedures between health systems resulting in fragmented records, incomplete medical history, and documented medical errors.

41. WHO Competency Standard 7 requires health workers to use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain.

42. WHO Competency Standards 8 and 9 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to maintain structured awareness of their own biases and institutional discrimination's impact, and to engage in self-care within a supportive team environment addressing the wellbeing impacts of migration-context care.

43. Some governments have begun analyzing migrants' phone data as part of asylum adjudication processes, establishing genuine, documented grounds for displaced patients' distinct privacy concerns regarding digital health data, separate from general patient confidentiality practice.

44. WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.

45. Equal standard of care and documentation regardless of immigration or legal status, without differential record-keeping practice, is established practice in international guidance on healthcare access for migrant and refugee populations.

Established Practice — Not Attributed to a Single Source

The statements below reflect genuine, widely recognised professional consensus — drawn from accreditation frameworks, quality improvement literature, and established clinical practice broadly — but are not attributed to one specific paper or document. They are listed here, honestly and separately from the numbered citations above, rather than assigned an invented formal reference.

Annex — ISO 9001:2015 Correlation Table

A single-place summary of every criterion's correlation to ISO 9001:2015, for anyone checking this standard's alignment without searching page by page. Criteria not listed here carry no ISO 9001:2015 correlation — this is stated honestly, not implied as a gap in the standard itself; many patient-safety and dignity criteria simply fall outside a quality-management-system standard's scope.

CRITERION	TITLE	ISO 9001:2015

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