

Telemedicine Standards — Full Guidance

Complete criterion-by-criterion guidance: worked examples, first steps, common mistakes, implementation plans, and Monitor verification methods for all 45 criteria.

8 standards · 45 criteria · Version 3.0

ASF STANDARDS · TELEMEDICINE · STANDARD 1

Standard 1 — Technology Platform Reliability & Security

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

1.1 — A Signed, Executed Business Associate Agreement Genuinely Exists

1.2 — Encryption Meets Current Technical Standards, Not Assumed Adequate

1.3 — Consumer-Grade Video Platforms Are Never Used for Clinical Sessions

1.4 — Multi-Factor Authentication and Access Controls Are Genuinely Enforced

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

1.1 A Signed, Executed Business Associate Agreement Genuinely Exists

NON-NEGOTIABLE

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.

In plain terms: Every technology vendor that touches patient data — the video platform, the record system, the scheduling tool — has a signed, executed agreement covering data protection. Signed, not just 'we have one somewhere.'

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

When a telemedicine service uses a video platform, that platform's servers see the consultation. When it uses a cloud record system, that vendor holds the records. Each is a data processor handling health information, and in most jurisdictions the law requires a written agreement defining what they may do, how they protect it, and what happens on breach (a Business Associate Agreement under HIPAA; a Data Processing Agreement under GDPR). A vendor without one is a vendor with no obligations. 'They said they were compliant' is not an agreement. The document must be signed by both parties, current, and on file.

WHAT GOOD LOOKS LIKE

- A genuinely signed, executed agreement exists for every relevant vendor.
- Execution genuinely occurred before any clinical session.
- Coverage genuinely extends to every vendor touching patient information.

COMMON FAILURE MODES

- An agreement is available from the vendor but was never actually executed.
- Sessions occurred before execution was genuinely completed.
- Coverage is limited to the primary platform, missing other vendors handling patient information.

WORKED EXAMPLE

IN PRACTICE

A 12-clinician telemedicine service using a video platform, a cloud EHR, and a third-party scheduling tool.

BEFORE

The video platform was on a consumer subscription with terms of service accepted by

	clicking. The EHR vendor had sent a BAA that was never signed. The scheduling tool had no agreement at all. When a patient asked for the data protection terms, nobody could produce them.
ACTION	The service listed every vendor handling patient data. For each, a signed data processing agreement was obtained or the vendor was replaced: the video platform was switched to a healthcare tier with a signed BAA; the EHR BAA was countersigned and filed; the scheduling tool was replaced with one that would sign. A register of agreements with expiry dates is maintained by the compliance lead and reviewed annually.
AFTER	The Monitor reviewed the vendor register and three signed, executed agreements. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every system or service that sees patient data.
2. For each, find the signed agreement. If you cannot, you do not have one.
3. Get one signed or replace the vendor.
4. Keep a register with review dates.

The most common mistake: Accepting a vendor's 'we're compliant' as an agreement — an agreement is a signed document.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Executed BAA documentation

2. Was the agreement genuinely signed before any clinical session occurred, not after the fact? — *Real, prior execution, not a retroactive*

formality.

Evidence: N/A — tested directly

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.*

Evidence: Vendor BAA inventory

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Execution happened but isn't documented in a way that's genuinely easy to verify later.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

Method	What	Detail
DOCUMENT	Vendor inventory review	Reviews whether every vendor handling patient information has a genuine, executed agreement.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy](#) →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

1.2 Encryption Meets Current Technical Standards, Not Assumed Adequate

NON-NEGOTIABLE

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.

In plain terms: Video, audio, and data are encrypted to current recognised standards — and the service can name the standard and show it is met, not just assume

'it's secure.'

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A consultation about a patient's HIV status, mental illness, or pregnancy that travels the internet unencrypted can be intercepted. A record stored without encryption is readable by anyone who obtains the disk. Encryption standards are specific: TLS 1.2 or higher for data in transit, AES-256 for data at rest, end-to-end encryption for video where available. The service must know which standards its platforms meet — from the vendor's documentation, not from marketing — and must verify that encryption is actually configured and enabled, not merely available.

WHAT GOOD LOOKS LIKE

- Live session encryption is genuinely end-to-end and specifically verified.
- Transport encryption genuinely meets current standards.
- Data at rest is genuinely, verifiably encrypted.

COMMON FAILURE MODES

- Encryption is assumed adequate from general platform reputation, not specifically verified.
- Transport security doesn't genuinely meet current standards.
- Stored data lacks genuine, verified encryption.

WORKED EXAMPLE

IN PRACTICE

A 15-clinician telemedicine service that described its platform as 'fully secure.'

BEFORE

Nobody could say what encryption the video platform used. The EHR was encrypted at rest but the backup was not. Clinicians sometimes emailed patient documents from personal accounts. 'Secure' was an assumption, not a verified state.

ACTION	The compliance lead obtained the technical security documentation from each vendor and confirmed: video platform — end-to-end encrypted, TLS 1.3; EHR — AES-256 at rest, TLS 1.2 in transit; backup — moved to an encrypted service. A policy prohibited patient data in personal email; an encrypted messaging channel was provided. An annual security review by an external consultant was contracted.
AFTER	The Monitor reviewed the vendor security documentation, the backup configuration, the email policy, and the external review report. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask each vendor for their technical security documentation, in writing.
2. Confirm the encryption standard for data in transit and at rest.
3. Check the backup — is it encrypted?
4. Ban patient data in personal email.

The most common mistake: Believing a platform is secure because it says 'secure' on the website.

SELF-ASSESSMENT QUESTIONS

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.*
Evidence: Encryption specification documentation
2. Does signaling and API transmission genuinely meet current transport encryption standards? — *Specific, verified technical compliance, not a general assumption of security.*
Evidence: N/A — tested directly
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.*
Evidence: Data-at-rest encryption verification

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Specifications meet current standards but haven't been reviewed since a relevant standard was updated.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

1.3 **Consumer-Grade Video Platforms Are Never Used for Clinical Sessions**

NON-NEGOTIABLE

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.

In plain terms: Clinical sessions never happen on consumer FaceTime, WhatsApp, standard Zoom, or similar — only on platforms designed and contracted for healthcare.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Consumer video apps are convenient and clinicians reach for them — especially when the healthcare platform is slow or the patient is not set up. But consumer platforms have no data processing agreement, may store or analyse content, may not be encrypted end to end, and give

the provider no control over where data goes. A single consultation on WhatsApp is a breach. Emergency exceptions in a crisis may be tolerated by regulators; routine use is not. The rule is absolute and staff must know it: clinical sessions on the healthcare platform only.

WHAT GOOD LOOKS LIKE

- Clinical sessions genuinely never occur on consumer-grade platforms.
- All providers are specifically, confidently aware of approved platforms.
- A defined fallback process prevents ad hoc consumer platform use during difficulty.

COMMON FAILURE MODES

- Consumer platforms are used occasionally for convenience or familiarity.
- Providers are uncertain which platforms are genuinely approved.
- No defined fallback exists, risking ad hoc consumer platform use under pressure.

WORKED EXAMPLE

IN PRACTICE

A 10-clinician telemedicine service where clinicians used a mix of platforms.

BEFORE

The service had a healthcare video platform, but clinicians often used WhatsApp or FaceTime because patients found them easier. Nobody tracked which platform was used. Several hundred consultations had occurred on consumer apps.

ACTION

A written policy: clinical sessions only on the contracted healthcare platform; no exceptions except documented emergencies. Patients receive a set-up guide and a pre-visit tech check by an assistant. Clinicians' consumer messaging apps were removed from work devices. Session logs from the healthcare platform are reconciled against the appointment schedule monthly; any appointment without a platform session is investigated.

AFTER

The Monitor reviewed the policy, the reconciliation for three months (100% of sessions on the platform), and interviewed a clinician who described the pre-visit tech check. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask each clinician what platforms they have used for patient sessions in the last month.
2. Write the rule: healthcare platform only.
3. Give patients a set-up guide and a tech check before their first visit.
4. Reconcile platform sessions against appointments monthly.

The most common mistake: Using WhatsApp because the patient couldn't work the proper platform — the fix is helping the patient, not breaching their data.

SELF-ASSESSMENT QUESTIONS

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.*
Evidence: Approved platform list documentation

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.*
Evidence: Provider platform training record

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.*
Evidence: Technical difficulty fallback protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **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.

- **The approved platform list is documented but not proactively reinforced through periodic training.** — Documentation alone doesn't guarantee genuine, sustained awareness without periodic reinforcement.
- **A fallback protocol exists but hasn't been specifically tested through a real technical difficulty scenario.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

1.4 Multi-Factor Authentication and Access Controls Are Genuinely Enforced

NON-NEGOTIABLE

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.

In plain terms: Every clinician and staff member logs in with multi-factor authentication and can only see what their role needs — enforced by the system, not by trust.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A password alone is compromised by phishing, reuse, or a stolen laptop. Multi-factor authentication — a code, an app, a key — stops most account takeovers. Role-based access means the scheduler cannot read clinical notes and the clinician cannot see billing. 'Enforced' means the system requires it: MFA cannot be disabled by the user; access is granted by role and reviewed when roles change; leavers lose access the day they leave. A service where MFA is 'recommended' has a service where half the accounts do not use it.

- Multi-factor authentication is genuinely, consistently enforced for every provider.
- Role-based access controls genuinely limit access to actual role requirements.
- Session timeouts are genuinely enforced, not disabled for convenience.

- Multi-factor authentication is optional or inconsistently enforced.
- Access controls don't genuinely limit provider access based on actual role.
- Session timeouts are disabled or extended indefinitely.

WORKED EXAMPLE

IN PRACTICE

A 14-clinician telemedicine service with MFA available but optional.

BEFORE	MFA was available on the EHR but enabled by about 40% of users. All staff had the same access level. Two former clinicians still had active accounts eight months after leaving. A phishing attack had compromised one clinician's password; no patient data was accessed only by luck.
ACTION	MFA was enforced at the system level for all accounts. Role-based access was configured: clinician, nurse, scheduler, billing, admin. An access review is done quarterly and on any role change. A leaver checklist removes access on the last day. Login anomalies (new device, unusual location) trigger an alert to the compliance lead.
AFTER	The Monitor reviewed the MFA enforcement setting, the role matrix, the quarterly access review, and the leaver checklist. Attempted login without MFA was blocked. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check: is MFA enforced or optional? Optional means half your accounts are unprotected.

2. Enforce it today.
3. List who has access to what. Remove anything not needed for their role.
4. Check whether anyone who left still has an account.

The most common mistake: Making MFA available but not mandatory — the users who skip it are the ones who get phished.

SELF-ASSESSMENT QUESTIONS

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.*
Evidence: MFA enforcement record

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.*
Evidence: Access control configuration documentation

3. Are session timeouts genuinely enforced, not disabled or extended indefinitely for convenience? — *Real, enforced timeout settings, not convenience overriding genuine security practice.*
Evidence: Session timeout configuration

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Timeouts are enforced but set to an interval long enough to provide limited real protective value.**

IMPLEMENTATION PLAN

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

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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

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.

In plain terms: When a video connection drops mid-session, there is a defined, rehearsed process — who calls whom, on what number, within what time — not a scramble.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

The connection fails while a patient is describing chest pain, or crying, or mid-way through a medication change. What happens in the next 60 seconds matters. A defined process: the provider phones the patient on the verified number within two minutes; if no answer, tries the emergency contact; if the patient was in distress, escalates per the emergency protocol; documents the interruption. The patient is told the process at the start of care so they know to expect the call. A service without this leaves patients in the void and providers improvising.

WHAT GOOD LOOKS LIKE

- A genuine, specific recovery process exists for connection failure.
- Patients are genuinely aware of an alternative contact method in advance.
- The recovery process has genuinely been tested, not only described in policy.

COMMON FAILURE MODES

- No specific process exists beyond general hope the connection will be restored.
- Patients have no advance awareness of an alternative contact method.
- The process exists only in writing, never tested.

WORKED EXAMPLE

IN PRACTICE

A 12-clinician telemedicine service with frequent connection problems in rural areas.

BEFORE	When connections dropped, providers waited for the patient to reconnect, sometimes for ten minutes. If the patient did not, the session was marked 'incomplete.' A patient who had been describing suicidal thoughts lost connection and was not contacted for two hours.
ACTION	A connection failure protocol was written: provider phones the patient's verified number within 2 minutes; if no answer, phones again at 5 minutes and tries the emergency contact at 10; if the patient was in clinical distress at the time of the drop, the emergency protocol (4.2) activates immediately; every interruption is documented with the recovery steps. Patients receive the protocol at intake. Providers rehearse it quarterly.
AFTER	The Monitor reviewed the protocol, patient intake materials, 15 documented interruptions with recovery steps, and rehearsal records. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask three clinicians what they do when the connection drops.
Compare the answers.
2. Write a protocol with time limits: 2 minutes, 5 minutes, 10 minutes.
3. Verify every patient's phone number at intake.
4. Tell patients what to expect.

The most common mistake: Waiting for the patient to reconnect — the patient who is in trouble is the one who cannot.

SELF-ASSESSMENT QUESTIONS

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.

Evidence: Connection failure recovery protocol

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.*

Evidence: N/A — tested directly

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.*

Evidence: Recovery process testing record

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **The process is described in policy but hasn't been genuinely tested against a real or simulated failure.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Recovery protocol review	Reviews the specific, defined connection failure recovery process.

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

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← **Telemedicine Standards**
— all standards

Self-assess against these criteria →

Standard 2 — Cross-Jurisdictional Licensure & Legal Compliance →

ASF STANDARDS · TELEMEDICINE · STANDARD 2

Standard 2 — Cross-Jurisdictional Licensure & Legal Compliance

5 criteria · 3 non-negotiable · 2 core · Version 3.0

CRITERIA IN THIS STANDARD

- 2.1 — Provider Licensure Is Verified for the Patient's Actual Location
- 2.2 — Patient Location at the Time of the Visit Is Specifically Documented
- 2.3 — Interstate Compact Membership Is Verified for the Specific Provider Type
- 2.4 — A Genuine Process Exists for a Patient Who Relocates or Travels Mid-Treatment
- 2.5 — Coordinated Disciplinary Risk From Compact Licensure Is Genuinely Understood

2.1 Provider Licensure Is Verified for the Patient's Actual Location

NON-NEGOTIABLE

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.

In plain terms: Every provider is licensed in the jurisdiction where the patient physically is at the time of the visit — checked, not assumed from the provider's home licence.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Medical licensure is territorial. A physician licensed in one state or country who treats a patient physically located in another is practising without a licence there — a crime in most places, and uninsured. Telemedicine erases distance but not law. The service must know where each patient is (2.2), know where each provider is licensed, and match them — before the session. Where interstate compacts or cross-border agreements exist, the provider's coverage under them must be verified for their profession (2.3). A service that lets any provider see any patient is committing unlicensed practice at scale.

WHAT GOOD LOOKS LIKE

- Every provider is genuinely licensed for the patient's actual location.
- Verification happens for every individual visit, not a one-time check.
- A real, enforced process prevents a visit without appropriate licensure.

COMMON FAILURE MODES

- Providers rely on licensure in their own state, not the patient's actual location.
- Verification happened once at onboarding, never reconfirmed per visit.
- Visits proceed regardless of an identified licensure gap.

WORKED EXAMPLE

IN PRACTICE

A telemedicine service with 16 providers licensed across several states, serving patients nationally.

BEFORE

Patients were matched to providers by availability. Nobody checked whether the provider was licensed where the patient was. An audit found 30% of consultations in the previous quarter had involved a provider not licensed in the patient's state.

ACTION

A licensure matrix was built: each provider's active licences by jurisdiction, with expiry dates. The scheduling system now requires the patient's location at booking and only offers providers licensed there. Licences are verified directly with the licensing boards annually and on renewal. Out-of-jurisdiction matches are blocked. Historical cases were reviewed with legal counsel.

AFTER

The Monitor reviewed the licensure matrix, the scheduling system's location-based matching, and a three-month audit showing 100% licence-location matches. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a matrix: each provider, each jurisdiction where they hold a licence, expiry date.
2. Audit last month's consultations: was every provider licensed where the patient was?
3. Configure scheduling to match on licence.
4. Verify licences with the boards, not from the provider's word.

The most common mistake: Assuming a licence is portable — it is not; the patient's location determines the law.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Provider licensure verification by patient jurisdiction

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.*

Evidence: N/A — tested directly

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.*

Evidence: Licensure gap prevention process

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Verification is strong for the primary state a provider expects but less rigorous for infrequent, unexpected patient locations.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

2.2 **Patient Location at the Time of the Visit Is Specifically Documented**

NON-NEGOTIABLE

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.

In plain terms: At every visit, the patient's actual physical location — city and jurisdiction — is asked and written down, not assumed from their registered address.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

The patient registered in one state may be visiting family in another, travelling for work, or moved without updating their record. The provider's licence (2.1), the applicable law, the emergency response (4.1), and the prescribing rules (5.3) all depend on where the patient

actually is right now. Asking takes five seconds: 'Where are you right now?' Recording it in the visit note is the evidence. A service that assumes location from the file is wrong a meaningful fraction of the time — and the consequence is unlicensed practice, or an ambulance sent to the wrong city.

WHAT GOOD LOOKS LIKE

- Patient location is genuinely, specifically documented for every visit.
- Patients are actively asked to confirm their current location, not assumed unchanged.
- A discrepancy in confirmed location triggers genuine, specific review.

COMMON FAILURE MODES

- Location documentation relies on an address on file, not confirmed for the actual visit.
- Patients aren't specifically asked; location is assumed carried forward.
- A location discrepancy doesn't trigger any real review or reconsideration.

WORKED EXAMPLE

IN PRACTICE

A 12-clinician telemedicine service that used the registered address as the location.

BEFORE

Location was assumed. A patient who had relocated across a state line six months earlier was seen by a provider not licensed in the new state for a dozen visits. Another patient was on holiday abroad during a visit; the provider did not know and prescribed a controlled substance the destination country prohibited.

ACTION

The visit template now begins with a mandatory field: 'Patient confirms current physical location: [city, state/country].' The provider asks and records it before proceeding. If the location does not match the provider's licensure, the session cannot proceed and is rescheduled. Location data feeds the emergency protocol.

AFTER

The Monitor reviewed 40 visit notes: all with confirmed location recorded; three showed

sessions rescheduled for licensure mismatch.
Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add a mandatory location field at the start of every visit note.
2. Train providers to ask, every time: 'Where are you right now?'
3. Block the session if the location does not match licensure.
4. Audit monthly.

The most common mistake: Using the address on file — patients move and travel, and the file does not know.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Visit-specific location documentation

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.*

Evidence: N/A — tested directly

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.*

Evidence: Location discrepancy review process

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.

- **A discrepancy is noted but doesn't consistently trigger a genuine pause to reconsider licensure implications.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

2.3 Interstate Compact Membership Is Verified for the Specific Provider Type

NON-NEGOTIABLE

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.

In plain terms: If the service relies on an interstate or cross-border licensure compact, each provider's coverage is verified for their specific profession — physicians, nurses, and psychologists are covered by different compacts, and not all jurisdictions join all of them.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Licensure compacts — the Interstate Medical Licensure Compact for physicians, the Nurse Licensure Compact, PSYPACT for psychologists — allow practice across member jurisdictions. But each compact covers one profession, each has different member states, and each has its own enrolment process. A physician assuming NLC coverage, or a nurse assuming IMLC coverage, is wrong. A provider assuming a state is a member when it is not is practising without a licence there. The service must verify: this provider, this profession, this compact, this enrolment, these member jurisdictions — and track changes, because compact membership changes.

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- Compact coverage is genuinely verified specific to each provider's actual profession.
- Non-physician providers have their own correct, specific compact verified.
- Current member-state status is genuinely, specifically checked.

- Compact coverage is assumed to apply broadly across all provider types.
- Non-physician providers are assumed covered by the physician compact.
- Member-state status is assumed static, not currently verified.

WORKED EXAMPLE

IN PRACTICE

A telemedicine service with physicians, nurse practitioners, and psychologists relying on 'compact coverage.'

BEFORE

The service assumed all providers were covered in all compact states. Two nurse practitioners were practising in states where the NLC does not apply to advanced practice. A psychologist was seeing patients in a state that had passed PSYPACT legislation but not yet implemented it. Nobody had checked.

ACTION

The licensure matrix (2.1) was extended: for each provider, the applicable compact, their enrolment status verified with the compact commission, and the current list of member jurisdictions for that compact (updated quarterly from the commission's website). Advanced practice nurses were noted as outside NLC coverage. The psychologist's PSYPACT states were corrected. Scheduling matches on the verified list.

AFTER

The Monitor reviewed the extended matrix with compact enrolment verifications, the quarterly member-state update log, and a three-month audit of matches. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. For each provider, name the compact that applies to their profession — or note that none does.

2. Verify their enrolment with the compact commission directly.
3. Download the current member-state list for each compact.
4. Update quarterly.

The most common mistake: Assuming 'the compact' covers everyone — a nurse practitioner is not covered by the NLC's multistate licence in most states.

SELF-ASSESSMENT QUESTIONS

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.*
Evidence: Profession-specific compact verification

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.*
Evidence: N/A — tested directly

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.*
Evidence: Current member-state verification record

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Verification happens for the provider's primary compact but not for a secondary licensure type the same provider also holds.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

2.4

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

CORE

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.

In plain terms: When an existing patient moves or travels to a different jurisdiction, there is a defined process: check licensure, continue if covered, arrange handover if not — not silent continuation or abrupt abandonment.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

A patient in ongoing psychotherapy moves across a border for work. The therapist is not licensed there. Continuing is unlicensed practice; stopping abruptly is abandonment and harmful. A defined process resolves the tension: the patient tells the service before or when they move; the service checks licensure; if covered, care continues with location updated; if not, a transition plan is made — a warm handover to a local provider, a bridging period if the law allows, a written summary, and no gap in medication. The process is explained to patients at intake so they know to tell the service.

WHAT GOOD LOOKS LIKE

- A genuine, defined process addresses relocation or travel licensure implications.
- Patients are proactively asked to report a genuine relocation or extended travel.

COMMON FAILURE MODES

- Care continues regardless of a resulting licensure gap.
- No proactive process prompts patients to report relocation or travel.
- Care ends abruptly without any real transition

- A real transition plan exists when a licensure gap is identified. plan.

WORKED EXAMPLE

IN PRACTICE

A telemedicine mental health service with patients who frequently relocated.

BEFORE	Patients moved and continued sessions without telling the service. When discovered, sessions were terminated immediately with no handover. One patient with severe depression was left without care for two months after a discovered relocation.
ACTION	A relocation protocol was written: patients are told at intake to report any move or travel over two weeks; on report, licensure is checked; if covered, care continues with location updated; if not, a 30-day transition plan (where law permits): identify and contact a local provider, transfer records with consent, ensure medication continuity, and a final session for handover. Patients are asked about travel at every session.
AFTER	The Monitor reviewed the protocol, intake materials, and 8 relocation cases: 5 continued under compact coverage, 3 transitioned with documented handover and no care gap. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask patients at intake to report any move or extended travel.
2. Write the process: check licensure, continue or transition.
3. Build a directory of providers in jurisdictions where you are not licensed.
4. Never terminate without a handover.

The most common mistake: Discovering a relocation and terminating immediately — abandonment is also a breach.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Relocation and travel process documentation

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.*

Evidence: N/A — tested directly

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.*

Evidence: Transition plan documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **A transition plan exists but doesn't consistently include a specific, named alternative provider.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy](#) →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

2.5 Coordinated Disciplinary Risk From Compact Licensure Is Genuinely Understood

CORE

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.

In plain terms: Providers practising under a compact understand that a disciplinary action in one member jurisdiction can trigger action in all of them — and that the service is monitoring for this.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

Compact licensure is coordinated: a complaint, investigation, or sanction in one member state is reported to the compact commission and can result in reciprocal action across every member state. A provider who assumes a minor issue in one state stays there is wrong. The service must ensure providers understand this — and must monitor: a compact provider under investigation anywhere is a provider whose multistate privilege may be suspended everywhere, potentially mid-caseload. Awareness and monitoring are the service's protection.

WHAT GOOD LOOKS LIKE

- Providers genuinely understand the coordinated disciplinary notification structure.
- This understanding is specifically confirmed, not assumed from general familiarity.
- The service's compliance culture genuinely reflects awareness of this heightened stake.

COMMON FAILURE MODES

- Providers treat each state's standing as entirely independent of the others.
- Understanding is assumed, never specifically confirmed.
- Organizational compliance practice doesn't reflect genuine awareness of coordinated risk.

WORKED EXAMPLE

IN PRACTICE

A telemedicine service with 10 providers on compact licences.

BEFORE

Providers had been told the compact 'lets you practise in other states.' None had been told

	about coordinated discipline. A provider under investigation in one state did not inform the service; the compact suspended her multistate privilege; 40 patients across three states lost their provider without warning.
ACTION	A compact licensure briefing was written and delivered to every compact provider, covering coordinated discipline and their obligation to report any complaint or investigation in any jurisdiction within 48 hours. The service subscribes to the compact commission's disciplinary alerts and checks each provider's status monthly. A contingency plan covers patient reassignment if a provider's privilege is suspended.
AFTER	The Monitor reviewed the briefing, signed acknowledgements from all compact providers, the monthly status check log, and the contingency plan. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask your compact providers what happens if they receive a complaint in one member state.
2. Write a briefing on coordinated discipline and have every compact provider sign it.
3. Require 48-hour reporting of any complaint or investigation.
4. Check each provider's compact status monthly.

The most common mistake: Treating a compact licence as a collection of independent licences — it is one licence with coordinated consequences.

SELF-ASSESSMENT QUESTIONS

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.*
Evidence: Provider training on compact disciplinary structure

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.*

Evidence: N/A — tested directly

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Individual providers understand the risk but organizational compliance practice doesn't reflect it structurally.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Provider training review	Reviews training records confirming providers are specifically educated on coordinated disciplinary risk.

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Telemedicine Standards**
— all standards

Self-assess against these criteria →

← **Standard 1 — Technology Platform Reliability & Security**

Standard 3 — Remote Clinical Assessment & Limitations Recognition →

ASF STANDARDS · TELEMEDICINE · STANDARD 3

Standard 3 — Remote Clinical Assessment & Limitations Recognition

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

3.1 — Providers Recognize Which Presenting Concerns Genuinely Require In-Person Examination

3.2 — The Same Standard of Care Applies Remotely as In-Person

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

3.4 — Providers Actively Compensate for the Absence of Hands-On Exam

3.5 — New, Undiagnosed Symptoms Receive Specific, Heightened Caution

3.1 Providers Recognize Which Presenting Concerns Genuinely Require In-Person Examination

NON-NEGOTIABLE

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.

In plain terms: Providers know which presentations cannot be safely assessed on video — abdominal pain, a breast lump, a child's ear, a suspicious mole — and refer for in-person examination rather than guessing.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Some things cannot be assessed remotely: you cannot palpate an abdomen through a screen, cannot feel a lymph node, cannot look in an ear without an otoscope in the room, cannot assess a mole's texture. A provider who diagnoses appendicitis as gastroenteritis on video, or reassures a patient about a breast lump they could not examine, has practised below the standard of care. The service needs a defined list of presentations requiring in-person assessment — from national telemedicine guidance — and providers trained to recognise them and refer without hesitation.

WHAT GOOD 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.

COMMON FAILURE MODES

- 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.

WORKED EXAMPLE

IN PRACTICE

A 14-clinician telemedicine service offering general consultations.

BEFORE

Providers used judgment about what could be assessed remotely. There was no list. A patient with right lower quadrant pain was diagnosed with a viral illness on video and presented to

	hospital with a ruptured appendix two days later. A breast lump was 'reassured' without examination.
ACTION	A list of presentations requiring in-person assessment was adopted from national telemedicine guidance and added to the clinical protocol: acute abdominal pain, breast lump, new lymphadenopathy, suspected fracture, ear pain in children, suspicious skin lesion, chest pain with red flags, and others. When a patient presents with one, the provider documents the referral to in-person care and the timeframe. Providers completed a half-day training on remote assessment limits.
AFTER	The Monitor reviewed the list, training records, and 30 visit notes for listed presentations: all with in-person referral documented. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask providers: what can you not assess on video? Write the answers down.
2. Adopt a list from national guidance.
3. Add it to the clinical protocol with a documented-referral requirement.
4. Train on remote assessment limits.

The most common mistake: Trusting the provider's judgment about what can be assessed remotely — the judgment is biased toward keeping the patient on the platform.

SELF-ASSESSMENT QUESTIONS

1. Do providers genuinely recognize which presenting concerns require in-person examination? — *Real, specific recognition, not remote assessment applied indiscriminately.*

Evidence: Provider training on remote assessment limitations

2. Is there specific, defined guidance identifying presentations that genuinely warrant in-person referral? — *A real, specific document, not*

left to individual judgment alone.

Evidence: In-person referral guidance documentation

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Referral happens for the most severe presentations but less consistently for moderate ones with documented remote assessment gaps.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Provider training review	Reviews training records for genuine, specific coverage of condition-appropriate remote assessment limits.

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

3.2 The Same Standard of Care Applies Remotely as In-Person

NON-NEGOTIABLE

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, performed by a qualified provider who draws in other relevant disciplines where the case calls for it — not a lowered bar accepted simply because the visit happens to

be remote. The resulting plan states an explicit goal the patient genuinely helped set, and the patient's right to decline any test or treatment is as real remotely as it would be in person.

In plain terms: A remote consultation is as thorough as an in-person one — same history, same documentation, same standard — not a shortcut because the patient is on a screen.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Telemedicine is a mode of delivery, not a lower tier of care. The history should be as complete; the differential as considered; the safety-netting as explicit; the documentation as full. Yet remote consultations are often shorter, less structured, and less documented — because the patient is 'just on video,' because the platform pushes throughput, because the provider is at home. The standard of care is the same. The service should measure it: audit remote notes against the same criteria used for in-person, and act on gaps.

WHAT GOOD LOOKS LIKE

- Remote assessment genuinely meets the same standard of care as in-person practice.
- Diagnostic tests are ordered with the same genuine diligence remotely.
- A genuine differential diagnosis is established, not skipped for remote convenience.

COMMON FAILURE MODES

- Remote assessment is conducted with less thoroughness than in-person practice.
- Testing is skipped or delayed because the visit happens to be remote.
- Differential diagnosis practice is abbreviated or skipped for remote presentations.

WORKED EXAMPLE

IN PRACTICE

A telemedicine service where average consultation time was seven minutes.

BEFORE	Remote notes were brief: presenting complaint, diagnosis, prescription. History was minimal. Safety-netting was rarely documented. The Coordinator compared 30 remote notes with 30 in-person notes from the parent organisation: remote notes covered 40% fewer elements.
ACTION	The remote consultation template was aligned to the in-person template: full presenting complaint history, relevant systems review, past history and medications, examination findings (what could be observed remotely), differential diagnosis, plan, safety-netting, and follow-up. Minimum consultation time was set at 15 minutes. A monthly audit of 20 remote notes uses the same criteria as in-person audits. Providers receive feedback.
AFTER	The Monitor reviewed the aligned template, three monthly audits (remote notes now matching in-person on 92% of elements), and the consultation time data. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull ten remote notes and ten in-person notes. Compare the elements documented.
2. Align the remote template to the in-person one.
3. Set a minimum consultation time.
4. Audit remote notes monthly with the same criteria.

The most common mistake: Accepting shorter, thinner remote consultations because 'it's only telehealth.'

SELF-ASSESSMENT QUESTIONS

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.

Evidence: N/A — tested directly

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.*

Evidence: Diagnostic test ordering record

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.*

Evidence: Differential diagnosis documentation

4. Does the visit record state an explicit treatment goal, and was the patient genuinely involved in setting it, with other relevant disciplines drawn in where warranted? — *A real, stated goal and genuine involvement, not a plan decided and only communicated remotely.*

Evidence: Visit record, patient interview

5. Is the patient's right to decline any recommended test or treatment explicitly honoured remotely? — *A genuine, honoured right, not assumed less applicable because the encounter is remote.*

Evidence: Provider interview

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Standard of care is generally maintained but providers report feeling less confident applying it under time-pressured remote scheduling.**

IMPLEMENTATION PLAN

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

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

Uncertain or Complex Presentations Trigger

3.3 Genuine Escalation, Not Extended Remote Attempts

NON-NEGOTIABLE

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.

In plain terms: When a remote assessment leaves the diagnosis uncertain, the provider sends the patient for in-person assessment — not another video call, not 'let's see how it goes.'

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

The patient's symptoms are unclear. The provider cannot examine. The temptation is to try another remote consultation, prescribe empirically, or wait. Each extends the time to diagnosis. The rule is simple: if remote assessment cannot resolve the uncertainty, escalate to in-person — the patient's own doctor, an urgent care centre, an emergency department, depending on acuity. The escalation is documented with the reason and the timeframe. A provider who tries three video calls for a presentation that needed one examination has delayed care three times.

WHAT GOOD LOOKS LIKE

- Genuine diagnostic uncertainty triggers timely escalation to in-person evaluation.
- A specific, defined threshold guides when escalation should occur.

COMMON FAILURE MODES

- Extended remote attempts continue despite genuine, persistent uncertainty.
- 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.

WORKED EXAMPLE

IN PRACTICE

A telemedicine service where uncertain presentations were often 'followed up in 48 hours' remotely.

BEFORE

Providers scheduled follow-up video calls for unclear presentations. The Coordinator found a patient with worsening headache seen four times remotely over two weeks before being sent to hospital, where a brain tumour was diagnosed. 'Let's see how it goes' was standard.

ACTION

An escalation rule was added to the clinical protocol: if the diagnosis remains uncertain after one remote assessment for any presentation with potential serious cause, the provider must refer for in-person assessment with a documented timeframe — same day for high acuity, within 48 hours otherwise. A second remote consultation for the same uncertain presentation requires documented justification. The audit checks for this pattern.

AFTER

The Monitor reviewed the rule and 20 uncertain presentations from the audit: all escalated to in-person after one remote assessment or with documented justification. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Search for patients seen remotely three or more times for the same presentation in a month.
2. Write the rule: uncertain after one remote → in-person.
3. Require justification for a second remote call on the same problem.
4. Audit for the pattern.

The most common mistake: Scheduling another video call when the problem is that video is not enough.

SELF-ASSESSMENT QUESTIONS

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.

Evidence: Escalation trigger documentation

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.*

Evidence: Escalation threshold guidance

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **New concerns are treated with more caution but complex, longer-standing concerns don't receive the same heightened attention.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current escalation practice for genuine, timely response to diagnostic uncertainty.
Week 2	Establish a specific, defined threshold guiding escalation decisions.

When	What
Week 3	Train providers on heightened caution for both new and genuinely complex concerns.
Ongoing	Audit escalation timing against the defined threshold.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

3.4 Providers Actively Compensate for the Absence of Hands-On Exam

NON-NEGOTIABLE

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.

In plain terms: Providers actively make up for not being able to examine — ordering tests, asking the patient to check their own pulse or temperature, using home devices, structured self-examination — rather than accepting the gap.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

The absence of hands-on examination is a limitation to be compensated for, not accepted. A provider can ask the patient to press on their own abdomen and describe the pain; can have a family member check for calf swelling; can use a home blood pressure cuff, pulse oximeter, or thermometer; can order laboratory tests or imaging locally; can request photographs of a rash. Compensation means the provider actively gathers what they can and documents what they could not. A remote consultation that records 'examination not possible' and stops has not tried.

WHAT GOOD LOOKS LIKE

- Providers genuinely, deliberately order additional testing to compensate for missing exam.
- Structured guidance genuinely supports patient

COMMON FAILURE MODES

- Providers proceed without additional compensation for the missing physical exam.
- Patient self-report is unguided, without structured supporting materials.

self-examination where relevant.

- Follow-up is genuinely, specifically scheduled to compensate for assessment limitations.

- Follow-up is left open-ended, without a specific, scheduled compensatory check.

WORKED EXAMPLE

IN PRACTICE

A 12-clinician telemedicine service serving patients with chronic conditions.

BEFORE

Remote notes recorded 'unable to examine.' No home monitoring was used. Patients with hypertension were managed without blood pressure readings. Providers did not order local tests because 'it's complicated.' Diagnoses were made on history alone.

ACTION

A remote examination protocol was written: structured self-examination scripts for common presentations (abdomen, respiratory, skin, musculoskeletal); patients with chronic conditions provided with validated home devices (BP cuff, pulse oximeter, scales) with readings shared before visits; a local laboratory and imaging network arranged for test ordering; photographs requested for skin presentations with a guide. The template records what was assessed remotely and how.

AFTER

The Monitor reviewed the protocol, the home device programme (120 patients enrolled), the local test network, and 30 notes showing structured remote examination. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Read 20 remote notes: what examination was done, and how?
2. Write self-examination scripts for your five commonest presentations.
3. Give chronic disease patients home monitoring devices.

4. Arrange local test ordering.

The most common mistake: Writing 'unable to examine' and proceeding — much can be assessed remotely if the provider tries.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Compensatory testing documentation

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.*

Evidence: Patient self-examination guidance materials

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.*

Evidence: Follow-up scheduling documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Follow-up is scheduled but the specific timing isn't tailored to the actual clinical urgency of the presentation.**

IMPLEMENTATION PLAN

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

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

3.5

New, Undiagnosed Symptoms Receive Specific, Heightened Caution

CORE

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.

In plain terms: A brand-new symptom the patient has never had before gets extra caution — a lower threshold for in-person assessment — compared with a known, ongoing problem.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

A patient with known migraine reporting a migraine is a low-risk remote consultation. A patient reporting their first-ever severe headache is not — it might be a subarachnoid haemorrhage. New symptoms carry the highest diagnostic uncertainty and the highest risk of missing something serious, and remote assessment is least capable there. The protocol should distinguish: known problem, follow-up — remote is often fine; new, undiagnosed symptom — heightened caution, lower threshold for in-person, explicit red-flag screening, and documentation of the reasoning.

WHAT GOOD LOOKS LIKE

- New, undiagnosed symptoms genuinely receive heightened diagnostic caution.
- A specifically lower threshold guides referral or testing for new symptoms.
- Patients are genuinely offered in-person

COMMON FAILURE MODES

- New symptoms are treated with the same routine confidence as established conditions.
- No specifically lower threshold exists for new symptom presentations.
- Patients aren't genuinely offered in-person evaluation, assumed to

evaluation for new concerns.

prefer remote continuation.

WORKED EXAMPLE

IN PRACTICE

A telemedicine service that treated new and recurrent symptoms identically.

BEFORE

The consultation protocol did not distinguish new from known symptoms. A patient's first-ever episode of chest tightness was managed as anxiety on video; she had a myocardial infarction. Red-flag screening for new symptoms was inconsistent.

ACTION

The clinical protocol now classifies each presentation as 'new/undiagnosed' or 'known/follow-up.' New symptoms trigger: a structured red-flag screen for that symptom category; a lower threshold for in-person referral; documentation of the serious causes considered and why remote management was appropriate (if it was). The template flags new symptoms. Audit reviews new-symptom consultations specifically.

AFTER

The Monitor reviewed the protocol, the template flag, and 20 new-symptom consultations: all with red-flag screens and reasoning documented; 8 referred in-person. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add a 'new or known?' classification to every consultation.
2. Write red-flag screens for new symptoms in your commonest categories.
3. Lower the in-person threshold for new symptoms.
4. Audit new-symptom consultations separately.

The most common mistake: Managing a first-ever symptom with the same confidence as a well-known one.

SELF-ASSESSMENT QUESTIONS

1. Does a genuinely new, undiagnosed symptom receive specific, heightened diagnostic caution? — *Real, specific heightened caution, not routine confidence applied identically to established conditions.*

Evidence: N/A — tested directly

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.*

Evidence: New-symptom threshold guidance

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Patients are offered in-person evaluation when they raise a new concern but not proactively for one the provider identifies.**

IMPLEMENTATION PLAN

When	What
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.

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

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← Telemedicine Standards
— all standards

Self-assess against these
criteria →

← Standard 2 — Cross-
Jurisdictional Licensure &
Legal Compliance

Standard 4 — Emergency
Escalation for the Remote
Patient →

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ASF STANDARDS · TELEMEDICINE · STANDARD 4

Standard 4 — Emergency Escalation for the Remote Patient

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

**4.1 — Patient Location Is
Confirmed at the Start of Every
Session**

**4.2 — A Specific, Tiered
Emergency Activation Protocol
Exists**

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

**4.4 — Emergency Contacts Are
Genuinely Verified as Aware
and Willing**

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

4.1 Patient Location Is Confirmed at the Start of Every Session

NON-NEGOTIABLE

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.

In plain terms: At the start of every session — not just the first — the provider confirms exactly where the patient is, so emergency services can be sent to the right address if needed.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

This overlaps with 2.2 but the purpose is different: 2.2 is about licensure; this is about saving a life. If the patient collapses, has a seizure, or discloses an imminent suicide plan, the provider must be able to tell emergency services where to go — the street address, the flat number, the door code. 'At home' is not an address. The confirmation must happen every session, because patients travel, and it must be specific enough to dispatch an ambulance. It takes ten seconds and is the difference between help arriving and not.

WHAT GOOD LOOKS LIKE

- Actual, current location is genuinely confirmed at the start of every session.
- Confirmation is specific enough to genuinely guide an emergency response.
- A location change from what's on file triggers genuine documentation and awareness.

COMMON FAILURE MODES

- Location is assumed from intake or a prior visit, not confirmed each session.
- Confirmation is vague, insufficient for genuine emergency dispatch.
- A location change goes unnoticed or undocumented.

WORKED EXAMPLE

IN PRACTICE

A telemedicine mental health service.

BEFORE

Location was confirmed at intake only. During a session, a patient took an overdose on camera. The provider called emergency services but could only give the address on file — the patient had moved. The ambulance went to the wrong city. The patient survived by chance.

ACTION	Every session now begins with: 'Can you confirm your full address right now, including any flat number or entry code?' The answer is recorded in the session note. Patients are told why. If a patient refuses or cannot give a location, the session does not proceed for clinical content. The emergency protocol (4.2) uses this address.
AFTER	The Monitor reviewed 50 session notes: all with session-specific address confirmed. Observed a session opening. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Make address confirmation the first line of every session note.
2. Script it: full address, flat number, entry code.
3. Tell patients why you ask every time.
4. Do not proceed without it.

The most common mistake: Confirming location once at intake — the emergency happens on the day they are somewhere else.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Session-start location confirmation record

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.*

Evidence: N/A — tested directly

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.*

Evidence: Location change documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **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.

- **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.
- **Confirmation happens for scheduled visits but is inconsistent for urgent or same-day sessions.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

4.2 **A Specific, Tiered Emergency Activation Protocol Exists**

NON-NEGOTIABLE

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.

In plain terms: There is a written, tiered emergency protocol — direct local emergency dispatch where the service covers it, a named alternative where it does not — and providers know it cold.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A telemedicine provider in one country cannot call the emergency number in another and expect it to work. Even within a country, emergency services are dispatched locally and a remote provider may not reach the right centre. A tiered protocol addresses this: for each jurisdiction the service covers, the direct emergency number and how to reach the local dispatch; where direct activation is not possible, a named alternative (a local partner, a patient's emergency contact, a

third-party service); the provider's role during activation (stay on, give the address, relay information); and documentation. Providers must know the protocol without looking it up.

WHAT GOOD LOOKS LIKE

- A specific, tiered protocol genuinely exists for varying location scenarios.
- Providers are genuinely trained on all tiers, not just the most common method.
- The protocol has genuinely been tested, not only described in policy.

COMMON FAILURE MODES

- Only a single emergency activation method is known, assumed to work everywhere.
- Training covers only the most common, direct activation method.
- The protocol exists only in writing, never tested or rehearsed.

WORKED EXAMPLE

IN PRACTICE

A telemedicine service covering patients in three countries.

BEFORE

The emergency protocol said 'call emergency services.' Providers in one country did not know the emergency numbers in the other two, or that calling from abroad might not reach local dispatch. A patient's cardiac event during a cross-border session resulted in a 15-minute delay while the provider searched for the right number.

ACTION

A tiered protocol was written per jurisdiction: local emergency number; how a remote provider reaches local dispatch (direct dial where possible, via the patient's own phone where not, via a contracted emergency coordination service for cross-border cases); the provider's script; the patient's emergency contact as a parallel channel; documentation. Laminated cards per jurisdiction are at every provider's workstation. Quarterly drills use scenarios.

AFTER

The Monitor reviewed the protocol, the jurisdiction cards, the emergency coordination contract, and three drill records. Asked two

providers to describe the protocol for a specific country; both did. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every jurisdiction where you have patients. For each, what is the emergency number and can you reach local dispatch from where you are?
2. Write a tiered protocol per jurisdiction.
3. Put a card at every workstation.
4. Drill quarterly.

The most common mistake: A protocol that says 'call emergency services' — from another country, that may not work.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Tiered emergency activation protocol documentation

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.*

Evidence: Provider protocol training record

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.*

Evidence: Protocol testing record

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.

- The protocol has been reviewed internally but never tested through an actual simulated emergency scenario.

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

The Provider Remains Connected Until

4.3 Emergency Services Have Genuinely Taken Over Care

NON-NEGOTIABLE

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.

In plain terms: When emergency services are called during a session, the provider stays on the line with the patient until responders have actually arrived and taken over — not until the ambulance is dispatched.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

The provider calls the ambulance and ends the session. The patient, alone, deteriorates in the twenty minutes before the ambulance arrives — or the ambulance cannot find the door, or the patient panics and does not answer. Staying connected means: keeping the patient on video or phone, talking to them, monitoring their condition, guiding them (unlock the door, lie down, do not take anything), relaying updates to dispatch if possible, and confirming that responders have arrived and are with the patient. Only then does the provider disconnect and document. The provider's next appointment waits.

WHAT GOOD LOOKS LIKE

- Providers genuinely remain connected until emergency responders have actually arrived.
- Care is genuinely, actively transferred to responders, not a passive disconnection.
- This expectation is specifically, clearly trained, not left to individual judgment.

COMMON FAILURE MODES

- Providers disconnect once the emergency call is made, before responders arrive.
- The session ends without any genuine, active handoff to responders.
- No specific training establishes this expectation.

WORKED EXAMPLE

IN PRACTICE

A telemedicine service whose emergency protocol ended at dispatch.

BEFORE

Providers called emergency services and ended the session to 'let them work.' A patient with an allergic reaction was left alone; she became unresponsive before the ambulance arrived and the responders could not enter the locked flat. She was found by a neighbour.

ACTION

The emergency protocol was amended: the provider remains connected throughout, with a script (reassure, instruct, unlock the door, stay in view of the camera, do not hang up); another staff member handles dispatch communication and reschedules the provider's next patient; the provider confirms responders have arrived and are with the patient before disconnecting; the full timeline is documented. Providers drilled the scenario.

AFTER

The Monitor reviewed the amended protocol, two real emergency activations with documented connection until handover, and drill records. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Read your emergency protocol. Where does the provider's role end?
2. Amend it: stay connected until responders are with the patient.
3. Assign another staff member to handle dispatch and rescheduling.
4. Drill it.

The most common mistake: Ending the session to 'let the ambulance handle it' — the twenty minutes before arrival are when the patient is most alone.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: N/A — tested directly

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.*

Evidence: N/A — tested directly

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.*

Evidence: Provider training on remaining connected

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Providers report they would remain connected but this hasn't been specifically confirmed through a real or simulated event.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

4.4 Emergency Contacts Are Genuinely Verified as Aware and Willing

NON-NEGOTIABLE

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.

In plain terms: The patient's emergency contact has been asked and has agreed to be one — and knows what it means — not just a name written on the intake form.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

The emergency contact is who the provider calls when the patient cannot be reached or is in crisis — to check on them, to open the door for responders, to be with them. If the named person does not know they are the emergency contact, does not live nearby, has not spoken to the patient in a year, or would refuse, the channel is fictional. Verification means the service contacts the named person once, confirms they are aware, willing, and able (proximity, availability), and records it. It is done at intake and re-checked annually. An unverified emergency contact is a name on a form.

WHAT GOOD LOOKS LIKE

- Emergency contacts are genuinely verified as aware and willing to serve.

COMMON FAILURE MODES

- Contacts are listed without any genuine verification of awareness or willingness.

- Both a primary and secondary contact are designated and genuinely verified.
- Verification is periodically reconfirmed, not assumed to remain accurate indefinitely.

- Only a single, unconfirmed contact exists, with no verified backup.
- Verification, if it happened, was never reconfirmed and may be outdated.

WORKED EXAMPLE

IN PRACTICE

A telemedicine mental health service with emergency contacts recorded but never verified.

BEFORE

Emergency contacts were written on intake forms. During a crisis, the provider called the contact — the patient's estranged brother in another country, who had not been told and said 'I can't help.' Another contact number was disconnected.

ACTION

At intake, the service now contacts each emergency contact by phone: confirms they are aware and willing, lives within reasonable reach, and understands they may be called in a crisis; records the confirmation and any limitations. Contacts are re-verified annually and whenever the patient updates the information. Patients without a viable contact are helped to identify one, or a local service is arranged as an alternative.

AFTER

The Monitor reviewed 30 patient files with verified emergency contacts and dates; two showed a contact replaced after verification revealed unwillingness. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Phone ten emergency contacts from your files. How many know they are one?
2. Verify every contact at intake — aware, willing, nearby.

3. Record the verification.
4. Re-verify annually.

The most common mistake: Accepting a name and number without ever calling it.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Emergency contact verification record

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.*

Evidence: N/A — tested directly

3. Is verification genuinely reconfirmed periodically, not assumed to remain accurate indefinitely? — *Real, periodic reconfirmation, not a one-time check assumed valid forever.*

Evidence: Periodic reconfirmation record

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Verification is documented as complete but the actual method of confirmation isn't specifically recorded.**

IMPLEMENTATION PLAN

When	What
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.

When	What
Week 3	Build a periodic reconfirmation schedule.
Ongoing	Audit emergency contact verification for continued accuracy.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

A Specific Threshold Exists for When 4.5 Telehealth Is No Longer Clinically Appropriate

CORE

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.

In plain terms: The service has written criteria for when a patient is no longer suitable for remote care — deteriorating mental state, escalating risk, needs the platform cannot meet — and acts on them.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

Telemedicine works for many patients most of the time. It stops working when a patient's condition needs what remote care cannot provide: frequent in-person monitoring, a physical examination, a safe environment, crisis intervention. A patient with worsening psychosis, a patient whose suicide risk has escalated, a patient whose home has become unsafe — each has crossed a threshold. The threshold must be defined in advance, so the decision is not left to the moment: specific indicators, a required review, a transition plan to appropriate care. A service without a threshold keeps patients remote past the point of safety.

WHAT GOOD LOOKS LIKE

- A specific, defined threshold genuinely exists for this determination.
- Providers are specifically trained to recognize this threshold, not relying on individual instinct alone.

COMMON FAILURE MODES

- No specific threshold exists; the determination is left to undefined, case-by-case judgment.
- 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.

WORKED EXAMPLE

IN PRACTICE

A telemedicine psychiatric service.

BEFORE

Patients remained in remote care indefinitely regardless of deterioration. A patient with escalating psychosis was seen remotely for six weeks after he stopped taking medication, until a family member took him to hospital. No criteria existed for when remote care should end.

ACTION

A telehealth appropriateness threshold was written: indicators requiring transition (active suicidal ideation with plan, psychosis with loss of insight, substance intoxication at sessions, inability to maintain a safe environment, need for physical examination or monitoring, non-response to remote treatment over a defined period); a required review at each session against the indicators; a transition plan when triggered — referral to in-person services with warm handover, bridging care, and documented rationale. Providers were trained.

AFTER

The Monitor reviewed the threshold criteria, session templates with the indicator check, and 6 transitions in six months with documented rationale and handover. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask providers: when should a patient stop being seen remotely? Write down the answers.
2. Define the indicators in the clinical protocol.
3. Add an indicator check to every session.
4. Write the transition process.

The most common mistake: Keeping a deteriorating patient on the platform because the platform is what you have.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Level-of-care threshold documentation

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.*

Evidence: Provider threshold training record

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.*

Evidence: Higher-level-of-care facilitation process

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **A facilitation process exists but doesn't specify a genuine, named pathway to the actual higher level of care.**

IMPLEMENTATION PLAN

When	What
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.

When	What
Week 3	Train providers on recognizing this threshold and the defined facilitation process.
Ongoing	Review threshold application against real, recent cases for consistency.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Telemedicine Standards**
— all standards

**Self-assess against these
criteria →**

← **Standard 3 — Remote
Clinical Assessment &
Limitations Recognition**

**Standard 5 — Prescribing &
Controlled Substance
Management →**

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ASF STANDARDS · TELEMEDICINE · STANDARD 5

Standard 5 — Prescribing & Controlled Substance Management

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

- 5.1 — Controlled Substance Prescribing Genuinely Tracks Current National Regulatory Status
- 5.2 — Every Controlled Substance Prescription Is Genuinely for a Legitimate Medical Purpose
- 5.3 — Sub-National Controlled Substance Requirements Are Verified Alongside National Rules
- 5.4 — Prescribing Restricted Stimulants to Minors Follows Any Narrow Exception Precisely
- 5.5 — A Provider's Controlled Substance Prescribing Authorization Is Verified and Current

5.1 Controlled Substance Prescribing Genuinely Tracks Current National Regulatory Status

NON-NEGOTIABLE

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.

In plain terms: The service knows the current rules for prescribing controlled substances by telemedicine in every jurisdiction it serves — and follows them, updating when they change.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Controlled substance prescribing by telemedicine is heavily regulated and the rules change: pandemic flexibilities were introduced and then withdrawn or extended; some jurisdictions require an in-person visit before or within a period of remote prescribing; some prohibit remote prescribing of certain schedules entirely. A service that follows last year's rules is breaking this year's law. The compliance lead must track the current status in every jurisdiction, document it, brief prescribers, and update the prescribing protocol when rules change. Ignorance is not a defence.

WHAT GOOD LOOKS LIKE

- The service genuinely knows the current, specific requirements in this jurisdiction.
- A real, active monitoring process tracks regulatory status changes.
- Providers genuinely understand any current flexibility as provisional, not permanent.

COMMON FAILURE MODES

- The service assumes current flexibility is a permanent, settled rule.
- No active monitoring process exists for regulatory status changes.
- Providers are unaware this flexibility could lapse or change.

WORKED EXAMPLE

IN PRACTICE

A telemedicine service prescribing controlled substances for ADHD and anxiety across several jurisdictions.

BEFORE	Prescribers followed the flexibilities introduced during the pandemic, unaware that some had expired. In two jurisdictions, an in-person examination had become required before remote controlled prescribing; the service had not adapted. Hundreds of prescriptions were non-compliant.
ACTION	The compliance lead built a regulatory register: for each jurisdiction, the current controlled substance telemedicine rules with source and date; a quarterly review against regulator announcements; a prescriber briefing on any change within a week; prescribing protocol updated accordingly. Where in-person examination is now required, a network of local partners provides it. Non-compliant historical prescribing was reviewed with counsel.
AFTER	The Monitor reviewed the register with sources, three quarterly reviews, two change briefings, and the updated protocol. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. For each jurisdiction, write down the current rule for remote controlled substance prescribing, with the source.
2. Check whether any pandemic flexibility you rely on has expired.
3. Brief prescribers.
4. Review quarterly.

The most common mistake: Still prescribing under pandemic-era flexibilities that have quietly expired.

SELF-ASSESSMENT QUESTIONS

1. Does the service genuinely know the current telemedicine prescribing requirements in this jurisdiction? — *Real, current knowledge, not a general assumption they remain fixed.*
Evidence: Current regulatory status documentation
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.

Evidence: Regulatory monitoring process

3. Are providers genuinely aware that any current flexibility is provisional, not permanent? — *Real, accurate understanding, not an assumption of permanence.*

Evidence: Provider awareness of temporary status

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **Monitoring happens informally but isn't assigned as a specific, accountable responsibility.** — A specific, accountable monitoring responsibility is more reliable than informal, diffuse awareness.
- **The service tracks the current regulatory status but hasn't built a specific contingency plan for if a flexibility lapses without renewal.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

Method	What	Detail
ASK	Provider awareness interview	Asks a provider whether they understand the current prescribing flexibility as temporary, not permanent.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

5.2 Every Controlled Substance Prescription Is Genuinely for a Legitimate Medical Purpose

NON-NEGOTIABLE

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.

In plain terms: Every controlled substance prescription issued remotely is for a genuine, documented medical purpose — a real diagnosis, a real assessment, a real record — not issued on request.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Telemedicine controlled prescribing has been abused: services that issue stimulant or benzodiazepine prescriptions after a five-minute video call with no examination, no records, no diagnosis. Regulators and prosecutors treat this as drug dealing. Legitimate purpose means: a documented diagnosis meeting recognised criteria; an assessment adequate to support it; a treatment plan; monitoring; and records that would satisfy an auditor. The service should be able to justify every controlled prescription from the record alone. If it cannot, the prescription was not legitimate.

WHAT GOOD LOOKS LIKE

- Every prescription has genuine, documented evidence of legitimate medical purpose.
- The same rigor applies to remote prescribing as would apply in person.
- A real, active process reviews prescribing patterns for potential concern.

COMMON FAILURE MODES

- Prescriptions lack genuine, specific documentation of medical necessity.
- Remote prescribing is treated with less rigor than in-person practice.
- No process reviews prescribing patterns for potential inadequate verification.

WORKED EXAMPLE

IN PRACTICE

A telemedicine service prescribing stimulants for adult ADHD.

BEFORE

Prescriptions were issued after a single 20-minute video consultation using a self-report questionnaire. No collateral history, no prior records, no structured diagnostic assessment. An

	audit found diagnoses supported by adequate documentation in fewer than half of cases.
ACTION	A controlled prescribing protocol was written: for ADHD, a structured diagnostic assessment (validated rating scales, developmental history, collateral information where possible, screening for substance use and other conditions) over at least two sessions before any prescription; a documented treatment plan; prescription monitoring programme check; follow-up at defined intervals; the record must independently support the diagnosis. A monthly audit of 20 controlled prescriptions checks documentation adequacy.
AFTER	The Monitor reviewed the protocol and three monthly audits: documentation adequate in 96% of cases; inadequate cases reviewed with the prescriber. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull 20 controlled substance prescriptions. Could an auditor justify each from the record alone?
2. Write a diagnostic assessment protocol per condition.
3. Require it before any controlled prescription.
4. Audit monthly.

The most common mistake: Prescribing after one video call and a questionnaire — that is not an assessment.

SELF-ASSESSMENT QUESTIONS

1. Is every controlled substance prescription genuinely, verifiably issued for documented medical necessity? — *Real, verifiable documentation, not a prescription lacking genuine clinical justification.*
Evidence: Prescription medical necessity documentation
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.

Evidence: N/A — tested directly

3. Is there an active process for identifying a prescribing pattern suggesting inadequate verification? — A real, active review process, not passive trust alone.

Evidence: Prescribing pattern review process

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **A pattern review process exists but hasn't identified or addressed any real concern to date.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

Method	What	Detail
DOCUMENT	Pattern review process review	Reviews the process for identifying prescribing patterns suggesting inadequate verification.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

5.3 Sub-National Controlled Substance Requirements Are Verified Alongside National Rules

NON-NEGOTIABLE

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.

In plain terms: Where a country has both national and regional controlled-substance rules, the service checks both for the patient's location — the stricter one applies.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

Federal systems have layered rules: the national law sets a floor; states, provinces, or regions add their own — a prescription monitoring programme check, a cap on quantity, an in-person requirement, a prohibition on certain drugs. A service compliant with national law and unaware of the regional rule is breaking the law in that region. The regulatory register (5.1) must include the sub-national layer for every region served, and prescribers must check both before every controlled prescription. The stricter rule always governs.

WHAT GOOD LOOKS LIKE

- Sub-national requirements are genuinely, specifically verified for each relevant region.
- Verification is genuinely current, reflecting recent regional regulatory updates.
- The more restrictive applicable standard is genuinely followed when regional and national rules differ.

COMMON FAILURE MODES

- Only national requirements are tracked, with sub-national rules assumed covered.
- Verification is outdated, missing recent regional regulatory changes.
- The more permissive national standard is followed even where a region imposes a stricter requirement.

WORKED EXAMPLE

IN PRACTICE

A telemedicine service in a federal country prescribing controlled substances across 15 regions.

BEFORE

The service followed national rules. It was unaware that several regions required a prescription monitoring programme query before any controlled prescription, and that one region

	prohibited remote prescribing of a schedule the service used routinely. Prescriptions in those regions were non-compliant.
ACTION	The regulatory register was extended to include each region's controlled substance rules: PMP query requirements, quantity limits, in-person requirements, prohibited schedules. The prescribing system displays the applicable regional rules when the patient's location is entered. Prescribers must confirm the regional check. PMP queries are logged per prescription.
AFTER	The Monitor reviewed the extended register, the prescribing system's regional rule display, and 30 prescriptions with regional compliance and PMP queries documented. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. For each region you serve, find its controlled substance prescribing rules — not just the national ones.
2. Add them to your register.
3. Make the prescriber confirm the regional check before every controlled prescription.
4. Log PMP queries.

The most common mistake: Assuming national compliance is enough in a federal system — the region may have stricter rules.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Sub-national requirement verification record

2. Is this verification genuinely current, reflecting each region's recent updates? — *Real, current verification, not outdated regional understanding.*

Evidence: N/A — tested directly

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.*

Evidence: Restrictive-standard adherence documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Awareness of a stricter regional requirement exists but isn't consistently, practically applied in actual prescribing.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

Method	What	Detail
DOCUMENT	Restrictive-standard adherence review	Reviews evidence that the more restrictive applicable standard, regional or national, is genuinely followed.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy](#) →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

5.4 Prescribing Restricted Stimulants to Minors Follows Any Narrow Exception Precisely

NON-NEGOTIABLE

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.

In plain terms: If the jurisdiction allows a narrow exception for prescribing a restricted stimulant to a minor by telemedicine, the service follows the exception's exact conditions — every one — or does not prescribe.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

Some jurisdictions prohibit remote prescribing of stimulants to minors outright; some allow it only under specific conditions — an existing in-person relationship, a prior in-person examination within a period, a specific diagnosis, a specific provider type, parental presence during the session. An exception is narrow by design. A service that meets some conditions and not others is outside the exception. The service must know the exact conditions, document compliance with each for every prescription, and decline when any is unmet. When in doubt, the answer is in-person referral.

WHAT GOOD LOOKS LIKE

- Real-time, interactive audio-visual technology is genuinely used for every such prescription.
- Prior written parental or guardian consent is genuinely obtained and documented.
- The exception is applied only within its genuine, narrow scope.

COMMON FAILURE MODES

- A lower-fidelity or asynchronous technology modality is used instead of real-time audio-visual.
- Consent is verbal, obtained after the fact, or not genuinely documented.
- The exception is applied more broadly than its actual, narrow scope permits.

WORKED EXAMPLE

IN PRACTICE

A telemedicine paediatric mental health service.

BEFORE	Stimulants were prescribed to minors remotely on the assumption that a general telemedicine allowance covered it. The jurisdiction permitted this only where an in-person examination had occurred within the previous 12 months and a parent was present. Neither condition was checked.
ACTION	The exception's conditions were extracted from the regulation and turned into a checklist that must be completed for every stimulant prescription to a minor: prior in-person examination date and provider; parent or guardian present and identified; diagnosis meeting criteria; prescriber type permitted. Any unmet condition blocks the prescription and generates an in-person referral. The checklist is part of the prescription record.
AFTER	The Monitor reviewed the extracted conditions, the checklist, and 20 minor stimulant prescriptions with complete checklists; 6 showed prescriptions declined for unmet conditions with referral. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Find the exact regulation for remote stimulant prescribing to minors in your jurisdiction.
2. List every condition of any exception.
3. Build a checklist requiring each.
4. Decline when any is unmet.

The most common mistake: Meeting most of the exception's conditions — an exception with one unmet condition is no exception.

SELF-ASSESSMENT QUESTIONS

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.

Evidence: Technology modality documentation

2. Is prior written parental or guardian consent genuinely obtained and documented? — *Real, prior, written consent, not verbal or after-the-fact agreement.*

Evidence: Written parental consent documentation

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **The exception is correctly applied for restricted stimulants but staff aren't fully clear it doesn't extend to other medication classes.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

A Provider's Controlled Substance

5.5 Prescribing Authorization Is Verified and Current

CORE

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.

In plain terms: Every prescriber's authority to prescribe controlled substances — the registration or licence issued by the competent authority — is verified with that authority and is current, not assumed from their medical licence.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A medical licence does not by itself authorise controlled substance prescribing. In many jurisdictions, a separate registration (DEA in the US, equivalents elsewhere) is required, expires, can be suspended, and must be verified directly. A prescriber whose registration has lapsed is issuing invalid prescriptions — which pharmacies may reject and regulators may prosecute. The service must verify each prescriber's registration with the issuing authority at hire and at each renewal, track expiry dates, and suspend controlled prescribing when a registration lapses.

WHAT GOOD LOOKS LIKE

- Every provider's authorization is genuinely, currently verified.
- Verification is genuinely reconfirmed on a regular, periodic schedule.
- A real, enforced process prevents prescribing when a registration issue is identified.

COMMON FAILURE MODES

- Registration status is assumed valid from a past, historical check.
- Verification is never reconfirmed after initial onboarding.
- Prescribing continues despite an identified registration issue.

WORKED EXAMPLE

IN PRACTICE

A telemedicine service with 12 prescribers of controlled substances.

BEFORE	Controlled substance registrations were assumed from the prescribers' CVs. Two prescribers' registrations had expired without renewal; they had continued prescribing. A pharmacy rejected a prescription, which was how the service found out.
ACTION	Each prescriber's controlled substance registration was verified with the issuing authority and recorded with expiry date. A 90-day renewal reminder is sent to the prescriber and the compliance lead. Prescribing privileges for controlled substances are suspended automatically in the system when a registration expires. Annual re-verification with the authority.
AFTER	The Monitor reviewed the registration record for all prescribers with verification evidence and expiry dates, and the system configuration blocking prescribing on expiry. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. For each prescriber, verify their controlled substance registration with the issuing authority.
2. Record the expiry date.
3. Set 90-day reminders.
4. Configure the system to block controlled prescribing on expiry.

The most common mistake: Assuming a doctor can prescribe controlled substances because they are a doctor.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Prescribing authorization verification record

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.*

Evidence: Periodic reconfirmation schedule

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.*

Evidence: Authorization issue prevention process

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **A prevention process exists but hasn't been specifically tested against a real, identified registration issue.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Verification record review	Reviews evidence of genuine, current authorization verification for every prescriber.

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

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← **Telemedicine Standards**
— all standards

Self-assess against these criteria →

← **Standard 4 — Emergency Escalation for the Remote Patient**

Standard 6 — Data Privacy & Patient Confidentiality →

