

Telemedicine Standards

The complete ASF accreditation standard for telemedicine facilities. Every criterion is published in full — statement, classification, and the verification questions used by Monitors and supervisors. Free. No account required.

8 standards · 45 criteria · 34 non-negotiable · 11 core · 0 standard · Version 3.0



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How to read this page: Each standard groups related criteria. Each criterion has a classification — **Non-Negotiable** (all must be met; any single failure bars accreditation), **Core** ($\geq 85\%$ for accreditation, $\geq 70\%$ for certification), or **Standard** ($\geq 70\%$ for accreditation). The verification questions show what a Monitor checks. To test your facility against these criteria, use the free self-assessment tool.

STANDARD 1 · MANDATORY

Technology Platform Reliability & Security

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.

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

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.

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.
2. Does signaling and API transmission genuinely meet current transport encryption standards? — Specific, verified technical compliance, not a general assumption of security.
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.

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.

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.
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.
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.

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.

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

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.

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.
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.
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.

STANDARD 2 · MANDATORY

Cross-Jurisdictional Licensure & Legal Compliance

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.

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.

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.
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.

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.

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.
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.
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.

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.

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.
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.
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.

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.

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.
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.
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.

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.

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.
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.
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.

STANDARD 3 · MANDATORY

Remote Clinical Assessment & Limitations Recognition

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.

1. Do providers genuinely recognize which presenting concerns require in-person examination? — Real, specific recognition, not remote assessment applied indiscriminately.
2. Is there specific, defined guidance identifying presentations that genuinely warrant in-person referral? — A real, specific document, not left to individual judgment alone.
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.

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 — not a lowered bar accepted simply because the visit happens to be remote.

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.
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.
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.

3.3 Uncertain or Complex Presentations Trigger 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.

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.
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.
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.

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.

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.
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.
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.

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.

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

STANDARD 4 · MANDATORY

Emergency Escalation for the Remote Patient

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.

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.
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.
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.

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.

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.
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.
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.

4.3 The Provider Remains Connected Until 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.

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.
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.
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.

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.

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

4.5 A Specific Threshold Exists for When 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.

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.
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.
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.

STANDARD 5 · MANDATORY**Prescribing & Controlled Substance Management****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.

1. Does the service genuinely know the current telemedicine prescribing requirements in this jurisdiction? — Real, current knowledge, not a general assumption they remain fixed.
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.
3. Are providers genuinely aware that any current flexibility is provisional, not permanent? — Real, accurate understanding, not an assumption of permanence.

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.

1. Is every controlled substance prescription genuinely, verifiably issued for documented medical necessity? — Real, verifiable documentation, not a prescription lacking genuine clinical justification.
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.
3. Is there an active process for identifying a prescribing pattern suggesting inadequate verification? — A real, active review process, not passive trust alone.

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.

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

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.

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

5.5 A Provider's Controlled Substance 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.

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.
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.
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.

STANDARD 6 · MANDATORY

Data Privacy & Patient Confidentiality

6.1 The Patient's Session Environment Is Actively Addressed

Non-Negotiable

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

1. Is the patient genuinely, proactively guided on finding a private location for their session, not left to figure this out alone? — Real, active guidance, not an assumption the patient will independently find privacy.
2. Are practical alternatives offered when a patient's home genuinely isn't private or quiet? — Real, concrete alternative suggestions, not guidance limited to an assumed-available private home space.
3. Is environment addressed specifically for sensitive topics, not treated as equally important for every visit type? — Genuine, calibrated attention reflecting the real sensitivity of what will actually be discussed.

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

Non-Negotiable

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

1. Are providers genuinely trained to actively ask whether anyone else is present, not assuming the patient is alone? — Real, active inquiry, not an assumption based on who's visible on screen.
2. Is specific consent genuinely obtained and documented before discussing sensitive information with a third party present? — Real, documented consent, not proceeding without confirming the patient is comfortable being overheard.
3. When a patient is in a public location, does the provider genuinely address this before continuing with sensitive topics? — Real, active address of the public-location risk, not proceeding as though the setting were private.

6.3 Session Recording Follows a Clear, Specific Policy

Non-Negotiable

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

1. Does the service have a clear, specific, documented policy on whether and when sessions are recorded? — A real, specific written policy, not ambiguity left for individual providers to navigate independently.
2. Does this policy genuinely address storage location and retention duration for any recordings that are made? — Real, specific storage and retention detail, not a policy silent on what happens to a recording after the session.
3. Are patients genuinely, specifically informed whether their session is being recorded, before it happens? — Real, prior, specific notification, not recording occurring without the patient's genuine knowledge.

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

Non-Negotiable

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

1. Is the provider's device for conducting sessions genuinely encrypted, not assumed adequate without verification? — Real, verified device encryption, not an assumption based on the device being personally owned and trusted.
2. Is the provider's home network genuinely secure, specifically verified, not assumed adequate? — Real, verified network security, not an unexamined assumption about home network safety.
3. Does the provider genuinely have physical privacy from others in the household during a session? — Real, verified physical privacy, not an assumption based on having a designated home office space.

6.5 Substance Use Disorder Records Follow the Heightened, Distinct Confidentiality Standard

Non-Negotiable

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

1. Do substance use disorder records genuinely follow this distinct, heightened confidentiality standard? — Real adherence to this distinct standard, not treated identically to general health information.
2. Is disclosure genuinely based on the patient's own specific written consent, not a general release? — Real, specific written consent for this category, not a general release assumed sufficient.
3. Are staff specifically trained on this distinct standard, not assuming general health privacy training suffices? — Real, specific training, not an assumption of general confidentiality knowledge.

STANDARD 7 • MANDATORY

Governance & Provider Credentialing

7.1 Malpractice Insurance Explicitly Covers Telemedicine

Non-Negotiable

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

1. Does every provider's malpractice policy explicitly, affirmatively state coverage for telemedicine practice? — Real, affirmative confirmation in the policy itself, not an assumption based on a standard policy's silence.
2. Has this coverage been genuinely confirmed in writing with the insurance carrier, not assumed from a verbal assurance? — Real, written confirmation, not a verbal representation alone.
3. Is this verification genuinely reconfirmed when a provider's policy renews or changes, not treated as a one-time check? — Real, periodic reconfirmation, not verification assumed to remain valid indefinitely.

7.2 Malpractice Coverage Genuinely Follows the Patient's State

Non-Negotiable

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

1. Does malpractice coverage genuinely, explicitly extend to every state where patients are actually located? — Real, specific, state-by-state confirmed coverage, not assumed from compact licensure alone.
2. Is coverage genuinely verified separately from licensure, not treated as automatically bundled together? — Real, distinct verification of insurance coverage, not conflated with licensure compliance.
3. Is there a specific process for confirming coverage before a provider sees a patient in a genuinely new state? — A real, proactive verification process, not discovering a coverage gap only after care has already been delivered.

7.3 Technology-Driven Operational Failures Are Specifically Covered

Core

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

1. Does insurance coverage specifically address technology-driven operational failures? — Real, specific confirmation, not an assumption it's automatically included.
2. Has this coverage question been genuinely raised and confirmed with the carrier? — Real, direct confirmation, not silence interpreted as inclusion.
3. Does the service understand which technology failure scenarios this coverage would and would not address? — Real, specific understanding, not an assumption of broad protection.

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

Non-Negotiable

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

1. Are every provider's credentials genuinely verified directly with the issuing authority, not accepted on self-report? — Real, direct verification, not trust in documentation the provider submitted themselves.
2. Does this verification genuinely cover licensure, board certification, and education, not licensure alone? — Complete, genuine verification across every relevant credential type, not a partial check.
3. Is verification genuinely reconfirmed periodically, not treated as a one-time check at initial hire? — Real, periodic reconfirmation, not verification assumed to remain valid indefinitely.

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

Core

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

1. Does a genuine, defined coverage arrangement exist for when a solo provider is unavailable? — A real, specific arrangement, not an assumption that patients will manage without care.
2. Is there a real, named alternative provider or service patients can be directed to during a coverage gap? — A specific, real alternative, not a vague suggestion to seek care elsewhere.
3. Are patients genuinely informed of the coverage plan, not left to discover it only when they need it? — Real, proactive patient awareness, not information they only encounter during an actual gap.

STANDARD 8

Health & Migration

8.1 People-Centred Care Adapted to Migration and Displacement Experience

Non-Negotiable

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

1. Is care genuinely adapted to a patient's migration and displacement experience, not delivered identically regardless of history? — Genuine adaptation, not a generic cultural-awareness statement.
2. Is trauma-informed practice genuinely applied, not just referenced as a principle? — Actual practice adaptation, not an assumption of general sensitivity.
3. Are providers aware of legal-status barriers to access that may affect this specific patient? — Specific awareness, not a general sense that barriers can exist.

8.2 Digital Literacy and Device Access Barriers Are Actively Addressed

Non-Negotiable

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

1. Are device and connectivity barriers specific to this population genuinely, actively assessed, not assumed absent? — Real, active assessment, not an assumption a successful connection today means reliable access generally.
2. Is digital literacy support genuinely offered where needed, not assumed unnecessary? — Real, offered support, not an assumption every patient can navigate the platform independently.
3. Is there a genuine alternative access method for a patient whose connectivity or device access is unreliable? — A real, practical alternative, not care limited to those with reliable technology access.

8.3 Language and Communication Aids — Interpreters and Cultural Mediators

Non-Negotiable

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

1. Are trained interpreters or cultural mediators engaged for language-discordant remote consultations? — Not ad hoc bilingual staff or family members as the default.
2. Is a minor ever used to facilitate interpretation for a family member? — This should never happen — a specific, absolute rule, not a judgement call.

3. When a family member interprets due to genuine unavailability of a trained interpreter, is this reserved for low-risk situations only? — Not used for informed consent, complex diagnoses, or bad news — situations requiring professional language support.

8.4 Genuine Agency Is Respected, Not Treated as a Passive Technology Recipient

Core

Refugee and migrant patients are genuinely treated as having real agency and competence in using telemedicine technology — not designed for or spoken to as passive recipients presumed incapable, an assumption real research specifically warns against as its own documented harm.

1. Are patients genuinely assessed as individuals for technology competence, not assumed uniformly incapable based on background? — Real, individual assessment, not a blanket assumption applied to the whole population.
2. Does communication about technology use respect the patient's real agency, not speak to them as a passive recipient? — Genuine, respectful communication, not language or tone presuming incapability.
3. Are staff specifically trained to recognise this documented risk of over-generalizing incapability to this population? — Real, specific training on this documented concern, not an assumption good intentions alone prevent it.

8.5 Continuity Across Mobility Is Actively Supported Through Portable Records

Non-Negotiable

When a genuinely mobile or displaced patient's location changes, the service actively supports continuity through a portable, patient-accessible record — not treating each new location, or each new provider the patient might reach, as an entirely fresh start with no continuity from what came before.

1. Does the service provide a genuinely portable record, not one locked within a single system? — A real, portable format the patient can carry forward, not accessible only here.
2. Is the record genuinely updated close to a known relocation, not left outdated? — Real, current information reflecting the patient's actual status, not a stale record.
3. Does the patient know how to access and use this record themselves? — Real, patient-controlled access, not continued dependency on this service.

8.6 Evidence-Informed Care for Refugee and Migrant Populations

Core

Staff use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain — not applying general telemedicine guidelines uncritically to a population with documented, different health needs.

1. Are staff aware of evidence-informed guidelines specific to refugee and migrant health where they exist? — Specific, current awareness, not general clinical knowledge assumed to be sufficient.
2. Do staff recognise where this population's health needs genuinely differ from the general population? — Genuine, specific recognition, not an assumption that general guidelines always apply equally.
3. Is practice adapted where population-specific evidence indicates a different approach is warranted? — Actual practice adaptation, not awareness without application.

8.7 Staff Reflective Practice, Bias Awareness, and Self-Care in Migration Contexts

Non-Negotiable

Staff maintain active awareness of their own culture, beliefs, and potential biases through structured reflective practice, and the service actively fosters a supportive environment with genuine access to psychological support — not assumed self-awareness or an assumption that staff will manage vicarious trauma exposure on their own.

1. Does the service have a structured process for staff reflective practice regarding bias and cultural awareness? — A defined process, not an assumption that staff will naturally self-reflect adequately.
2. Does the service provide genuine, accessible psychological support and a real space to discuss difficult cases? — Actual, used support and a real, regular opportunity, not a theoretical benefit or informal hope.
3. Can staff describe a specific instance of adapting their practice after recognising a bias, and do they recognise signs of vicarious trauma in themselves? — Genuine, concrete examples, not general statements of good intentions or awareness.

8.8 Digital Privacy Concerns Specific to Displaced Populations Are Genuinely Addressed

Non-Negotiable

The service genuinely recognises and addresses the specific, heightened digital privacy concerns displaced populations face — including the real possibility that health-related digital data could be requested or analyzed by immigration or asylum authorities — not treating this population's privacy needs as identical to a general patient's under standard confidentiality practice.

1. Does the service genuinely recognise this population's specific digital privacy concerns? — Real, specific recognition, not general confidentiality practice assumed sufficient.
2. Is there honest communication about what genuinely is and isn't shared with any authority? — Real, honest, specific communication, not a vague general assurance.
3. Are staff specifically trained on this concern, not assuming general privacy training suffices? — Real, specific training, not general health privacy training assumed sufficient.

8.9 Legal Status Diversity Recognition

Core

The service can name which legal status categories it actually serves — asylum seeker, recognised refugee, stateless person, and others — and demonstrates it doesn't apply a single, uniform assumption about access rights across all of them.

1. Can staff name the specific legal status categories this service actually serves? — Specific, named categories, not a general sense that "migrants" are served.
2. Does the service avoid applying a single, uniform assumption about access rights across all statuses? — Genuine differentiation, not treating all categories identically.
3. Is there a specific process for verifying which category applies when it's genuinely unclear? — A real, defined process, not guesswork or assumption when status is ambiguous.

8.10 Care Is Documented and Provided Regardless of Immigration or Legal Status

Non-Negotiable

Care is provided and fully documented for every patient regardless of immigration or legal status, with no differential standard of care, documentation practice, or record-keeping applied based on status — not a lesser or informal standard applied to patients without documented status.

1. Is the same standard of care applied and documented the same way regardless of a patient's immigration or legal status? — Genuinely equal treatment, not a lesser or informal standard for undocumented patients.
2. Are staff specifically trained that immigration status is never a reason to withhold or alter care or documentation? — Specific, documented training, not assumed understanding.
3. Is patient information protected with the same confidentiality standard regardless of status, with no informal sharing of status-related information? — The same confidentiality protection extended to every patient, without exception.