State Telehealth Plan
Remote Patient Monitoring Subgroup
Electronic Meeting
September 3rd, 2020
1:00 p.m.

Topic/Subject	Discussion	Recommendation
I. Welcome	Ms. Wooten called the meeting to order at 1:00 p.m.	
II. Process	Ms. Wooten introduced the subgroups and leaders and reiterated the bill language.	
III. Presentation from Dr. William Harp **Workgroup Comments**	The 2020 General Assembly passed two bills that required the Board of Medicine to seek reciprocal licensing agreements with our contiguous states. Virginia has five contiguous states: NC, KY, TN, WV and MD. We also include D.C. There are eight boards of medicine because all have a medical board, but TN and WV also have osteopathic medical boards. The best thing to do is have the executives communicate with other executives in the contiguous states. A few months ago we asked them if reciprocity was something in which contiguous states were interested? Some states were not interested chiefly because their boards of medicine had just joined the Medical Licensure Compact, a complicated pathway. They do not want to add another pathway of reciprocity with the state of Virginia at this time. But DC and Maryland had some interest. The only requirements right now are an active license in a contiguous state and no reason for revocation of license. They indicated they wanted to include a criminal background check and five years of practice, among other things. The Virginia Board of Medicine requires a full license to practice in Virginia, as well as the other jurisdictions mentioned, with the exception of TN Osteo. Dr. Mishra asked Dr. Harp about the timeline with MD and DC.	

	Dr. Harp told the workgroup that MD may be able to work something out pretty quickly; not so with DC. Ms. Wooten introduced the question for the subgroup: Are there remote patient monitoring devices that need to be considered as part of the plan? What are the best practices? Dr. Mishra asked if the group was seeking out products. Dr. Mishra he indicated that when we talk about RPM, we are discussing a way that gathers physiological, psychological, or patient entered data. This affects monitoring and outcomes for the patient. Oximetry monitoring can be used for a variety of disease states. For COVID-19 patients, you can have that information and send the patient home. There is also a question of how long to monitor the patient. There is an afferent loop and an efferent loop. There can be many ways to collect data and communicate back w patient. It can be used for mental health and substance abuse disorders. Structured questionnaire may also be helpful. Dr. Mishra added that in terms of supervision of the provider, telehealth has force multiplied how we can take care of our patients. But it has created information silos. Home health care companies do not give their data to the physicians, so having some process for how the data is transferred to the primary care team is something for the subgroup to consider. How do we make sure this remains a patient centric process?	
IV. Public Comment Period	There was no public comment.	
V. Adjourn	Ms. Wooten discussed next steps and adjourned the meeting at 1:32 p.m.	

State Telehealth Plan
Criteria for Use Subgroup
Electronic Meeting
September 3rd, 2020
2:15 p.m.

Topic/Subject	Discussion	Recommendation
I. Welcome	Ms. Wooten called the meeting to order at 2:15 p.m.	
II. Process	Ms. Wooten introduced the subgroups and leaders and reiterated the bill language.	
III. Presentation from Dr. William Harp **Workgroup Comments**	Dr. Harp gave his presentation on Reciprocity. The 2020 General Assembly passed two bills that required the Board of Medicine to seek reciprocal licensing agreements with our contiguous states. Virginia has five contiguous states: NC, KY, TN, WV and MD. We also include D.C. There are eight boards of medicine because all have a medical board, but TN and WV also have osteopathic medical boards. The best thing to do is have the executives communicate with other executives in the contiguous states. A few months ago we asked them if reciprocity was something in which contiguous states were interested? Some states were not interested chiefly because their boards of medicine had just joined the Medical Licensure Compact, a complicated pathway. They do not want to add another pathway of reciprocity with the state of Virginia at this time. But DC and Maryland had some interest. The only requirements right now are an active license in a contiguous state and no reason for revocation of license. They indicated they wanted to include a criminal background check and five years of practice, among other things.	

	The Virginia Board of Medicine requires a full license to practice in Virginia Dave Nutter asked why Virginia does not the join the Compact. Dr. Harp indicated that in 2016, the Board made the decision not to sign onto the compact because there were issues that were still regarding licensing, fees, and other items. In lieu of joining the compact, the Board of Medicine decided to develop regulations for licensure by endorsement. This began in December of 2018. The finances of the compact were unclear when we voted in 2016 not to join; there were some statutory hurdles to the finances. The licensing fees and application fees had to go to the compact instead of the state. That was an awkward situation statutorily. For an applicant to join the compact, they would have to submit a $700 fee and pay a licensing fee for the state in which they were seeking licensure. Those fees ranged from $75-790. It is generally $400-500, while Virginia is $302. We figured this would be better for applicants, and also relieved us from hiring one or two more staff to issue letters of qualification. We could also meet or exceed the timeframe for expeditious licensing. It takes over fifty days for the compact for a license to be issues; for Virginia it takes under thirty days. We thought our model was a better model. Dave Nutter also asked how the licensure by endorsement has been going – how many people have participated in that program? Has this helped the border state areas like the far southwest? Dr. Harp told the subgroup he had no data about the bordering states. At this point there have likely been between 200-300. But the interstate compact has issued 11,000 through the compact, whereas there are roughly one million physicians in the United States. Ms. Wooten introduced the question for the workgroup: Are there specific guidelines that have been released during COVID-19 as it relates to telemedicine and telehealth that should be considered as part of the plan? What are the best practices? Ms. Allen said that during the pandemic that CMS has utilized authority to issue numerous blanket waivers for a variety of different facility types; some for telehealth	

	and some not. I have shared a copy of all the waivers that are out there. The waivers won't be there forever. We need to contemplate what the telehealth plan will look like and make allowances for the fact that there may be federal guidance that comes out and changes how healthcare is delivered. She added that it is a long document, however by looking at the blanket waivers, you can see where telehealth may not be permitted on the federal side. Ms. Evanko made a comment in the Medicaid originating site restriction was lifted which was very helpful. Jeffrey Feit agreed with the expansion of the originating site both by facility and by geography (the allowance to originate non-rural). As did Mark Mattingly. He commented that during the relaxation, HHS relaxed the HIPPA requirements for telehealth. Those will most likely come back after the state of emergency is lifted.	
IV. Public Comment Period	Michael Colman asked when the draft of the telehealth plan would be available. Ms. Wooten said the draft would be available in the Town Hall around late October.	
V. Adjourn	Ms. Wooten discussed next steps and adjourned the meeting at 2:51 p.m.	

State Telehealth Plan
Sustainability Subgroup
Electronic Meeting
September 3rd, 2020
3:30 p.m.

Topic/Subject	Discussion	Recommendation
I. Welcome	Ms. Anderson called the meeting to order at 3:30 p.m.	
II. Process	Ms. Anderson introduced the subgroups and leaders and reiterated the bill language.	
III. Workgroup Comments	Ms. Anderson asked the subgroup the question: Are there any other sustainable models nationwide that should be considered as a framework? Dr. Yee indicated that Minnesota and New Hampshire have done some new things as they operate outside of traditional billing. Beth O'Connor commented that Alaska has done a lot with telehealth and it may be worthwhile to look at them as well. Ms. O'Connor asked if we were considering considerations of broadband connectivity or lack thereof? Ms. Anderson responded, that we would be. Ms. O'Connor indicated that without broadband, there can be no telehealth. Dr. Yee asked isn't the First Net Initiative funded by the state? Ms. Anderson said she will check to see if it still is.	
IV. Public Comment Period	There was no public comment.	
V. Adjourn	Ms. Wooten discussed next steps and adjourned the meeting at 3:48 p.m.	