State Telehealth Plan
Remote Patient Monitoring Subgroup
Electronic Meeting
August 6th, 2020
1:00p.m.

Topic/Subject	Discussion	Recommendation
I. Welcome	Ms. Wooten called the meeting to order at 1:08p.m.	
II. Process	Ms. Wooten introduced the subgroups and leaders and reiterated the bill language.	
III. Workgroup Member Comments	Dr. Rheuban brought up the fact the COVID-19 remote patient monitoring is only available for certain patients. Best practices and broad utilization should be included in thoughts about the plan. Ms. Schriver indicated her agency struggled with some individuals not knowing how to use certain applications, so public education might be an option to consider. Mr. Berg indicated he did not know all the technologies that would be involved. He asked about who would be conducting or facilitating these types of services. He did not know of many organizations or EMS agencies that would be onboard with this unless they had specifically created some sort of related program, unless there was a monetary incentive. Is there a bullet list or document that shares what is involved for this type of process? Ms. Wooten asked Mr. Berg if he wanted to include this type of process document in the plan. Mr. Berg indicated he wanted to know the expectation for the plan, and what pieces were needed to make this work in order for him to offer better information. Mr. Perkins responded that the point of the discussion is to decide how to make things work and get from point A to Z. The idea is that the subgroups will answer these types of questions together. Mr. Berg asked if the programs that already exist already have a “playlist” of the items required and said it could be helpful to start with those.	

	Mr. Perkins indicated they have discussed things like that, but going forward the subgroup would be discussing best practices and determining what will work for certain counties. Dr. Haider brought up the standard operability platforms such as the one fire uses. It may help in this subgroup and the others. Is using a statewide platform something we should think about or not? Fire is a way to get data easily from a variety of applications. He asked the subgroup how to best inject that data into EMRs to get better service? Maybe the state can promote use of that technology to do more remote monitoring. Ms. Schriver followed up on the previous comments and asked if this was intended to be a state wide state run remote monitoring, or an effort to encourage other clinicians to *offer* remote monitoring. What is the goal for this group? Ms. Wooten responded it is to have the expertise of this work group, and then develop and formulate a plan. It is to be able to pull together what we need to do for remote patient monitoring, identify best practices and place it into a plan. Ms. Schriver asked for the Medicaid population, if we could examine the at risk population. Dr. Lindbeck said the direction to go would be to provide a framework to allow many different users to achieve different goals using different platforms rather than trying to develop a statewide standard. A standard may not meet everyone's needs and may even limit what folks are able to do rather than being inclusive. For example, the First Net system provides bandwidth and priority to first responders. On the data side, it would not be hard for those at EMS agencies to add mobile health and telehealth consults to the usual data requirements on their platform.	

	Dr. Rheuban echoed what Dr. Lindbeck said and agreed with Ms. Schriver and indicated she would like to include the list of remote patient monitoring conditions provided by VHHA. Dr. Haider indicated he supported the high risk population comment. Which policies and financial approaches promote those things? Ms. Solenski mentioned she agreed w a previous comment about high risk population. She encouraged that the subgroup should think about a multidisciplinary approach. Home monitoring and physical therapists as well as pharmacists all at the same time is a helpful approach to the patient. Being able to track and collect data throughout the state and be able to lead and give feedback about what is working and what isn't. A partnership with Matrix and VDH working side by side would be very helpful. Dr. Pratt mentioned that veterans and their families as well as those with mental health risks are at high risk.	
IV. Public Comment Period	Mr. Gray mentioned that the practical application of remote monitoring in the market place is on a contractual basis. This determines who is eligible, how the data is tracked, and why/how it is done. In some cases remote patient monitoring may not be possible, and there are lots of different payers. Coordination is important. Ms. Hale (a member of the subgroup) indicated that in her evaluation process of certain projects, working in a community coalition working with Riverside Health System, high risk patients can have access to coaches who are involved in chronic condition management. Implementation of Remote Patient Monitoring will be valuable for high risk patients.	
V. Adjourn	Ms. Wooten adjourned the meeting at 1:51p.m.	

State Telehealth Plan
Criteria for Use Subgroup
Electronic Meeting
August 6th, 2020
2:15 p.m.

Topic/Subject	Discussion	Recommendation
I. Welcome	Ms. Wooten called the meeting to order at 2:15pm	
II. Process	Ms. Wooten explained the housekeeping rules and everyone introduced themselves via the chat box. She reiterated HB1332 to the subgroup. Mr. Perkins explained the workgroup question: "What will we need to do to be nimble enough to leverage all existing and potential emerging telehealth technologies?"	
III. Workgroup Member Comments	Dr. Summar indicated that he has been in telehealth for some time. From a technology standpoint, broadband access has been the biggest barrier. Dr. Bachireddy indicated that on the Virginia Medicaid side, he has been doing telehealth care since March. During the crisis, payers have opened up telehealth from "not much" in Virginia to "a lot". That has been helpful and appropriate. Without much evidence for what does and does not work, the payers have expanded. He asked the workgroup to imagine how we would act after the crisis. How will we learn and move forward with what does and does not work with telehealth? During COVID, it is important to balance risks. Still, there has been something lost in terms of quality of care. What do we have to be more thoughtful about? What are we paying for? Dr. Summar indicated that there was improved access because there was more flexibility around appointments with the use of telehealth. The "forced experiment" over the last few months has helped give insight. Dr. Mattingly said the rapid adoption people had for telehealth during the crisis, especially during the behavioral health realm, has been impressive. People were more than willing to learn and wanted to stay connected. There has been a significant increase in telehealth utilization.	

	Mr. Colman said the telehealth effort should direct patients into telehealth if they agree. It has been a journey attempting to educate certain individuals. Ms. Baker indicated that previously, the payment sites often had to be office or clinic locations. As Dr. Summar reported, we have seen that using the clients' home as site locations, quicker and more appropriate services are able to be provided and the barrier of transportation has been eliminated. Ms. Evanko said we should take into consideration all different kinds of professions. She represents the behavioral health professions and they should be regarded as well as other professions that are "off the beaten path". Dr. Summar indicated there are some things that must be done face to face, but he saw huge benefit using telehealth for his patients. Ms. Amir said some people may not have access or be comfortable with the telehealth platforms. This might create a burden but if there are streamlined processes that might be helpful. Dr. Summar asked if clinicians saw an uptick or downtick in expenses. Dr. Mattingly said that overall, we saw a downtick in claims coming through. There was a significant downtick in March because elective procedures were cancelled. But it has rebounded now. Dr. Chethan said that acute care went down over the next few months. There is a lag on the claims, by 2-3 months, but they are seeing as of May that the expenses are slowly coming up. There will be a learning curve – some of the folks among professions will need to learn new skills. What does using telehealth well mean? We will have to educate all of Virginia. The physician side of healthcare is a self-policing and self-regulating profession. Hopefully they will continue to do that so that the level of quality in telehealth will continue to rise.	

	Ms. Brimm brought up issues of access for people with disabilities. Telehealth by phone or computer should be equally accessible for each community, as well as for people who do not speak English as their first language. Different methods should be accessible to clinicians as well. People with disabilities should not automatically be deemed as unable to use telehealth. Marshall Summar said that he found that for some patients with disabilities, telehealth made appointments more accessible. Translation services also worked almost a little bit smoother because the translator was brought more into the conversation. Ms. Brimm said that was gratifying to hear. But she mentioned that we should still program into the plan a plan for accessibility so that we do not have to wonder whether they have what they need. Ms. Baker said that a concern might be the kind of platforms used. One of the platforms only allowed one client and one provider at a time. There had to be a way to include the interpreter while ensuring HIPAA compliance. Both provider and client should know how to use it. Use of phones with video capability has been helpful.	
IV. Public Comment Period	There was no public comment.	
V. Adjourn	Mr. Perkins indicated the draft will be posted on the Virginia Regulatory Town Hall for public comment. Mr. Perkins adjourned the meeting at 2:57p.m.	

State Telehealth Plan
Sustainability Subgroup
Electronic Meeting
August 6th, 2020
3:30p.m.

Topic/Subject	Discussion	Recommendation
I. Welcome	Mr. Perkins called the meeting to order at 3:35p.m.	
II. Process	Mr. Perkins introduced the subgroups leaders, reviewed the provisions of HB1332, and explained the charge and the question for the subgroup.	
III. Workgroup Member Comments	Mr. Colman said there is a huge benefit that the patient would be able to talk to a clinician over the phone and then leave. However, the EMS provider would still have to spend some amount of time and resources driving over and driving back. Even so, a lot of the low acuity complaints would be avoided when telehealth is implemented. Dr. Martin indicated a huge increase in mental health issues, and telehealth has been important in treating those issues. 30-45 minutes spent doing a mental health visit is still taking resources, but it is important to create a plan for sustainability. Dr. Schriver contributed that in order for us to be nimble with telehealth, we must look at other alternative payment models so that the state providers can share in cost savings. If more interactions are virtual that might create more savings and they might be shared. In some communities, there is issue with band width and video visits cannot be supported on some devices. It would be helpful to partner with EMS providers and use triage software to avoid unnecessary dispatching of EMS vehicles. Then, we can best utilize and optimize our telehealth capabilities. Mr. Perkins informed the group that the governor is working on making broadband accessible for the commonwealth. Mr. Barber asked the group to consider the health equity of this plan. VCU health helps to serve low income populations in Virginia who will certainly need access to broadband.	

	Mr. Berg pointed out that Mr. Barber's point is valid, and the school systems right now are attempting to work out virtual education. Even in the urban areas, there are issues with technologies and bandwidth. It may be helpful to look at how schools are overcoming this problem. He cautioned against tapping into existing programs to move this forward. We maybe should not use existed funded programs as the catalyst… We should inspire deeper thoughts on how to pay for this. One option might be insurance, but since not everyone has insurance it might be the commonwealth citizens paying for it. Ms. Dolan brought up the comprehensive approach to telehealth sustainability and the challenges already experienced. They already have the technology but as a hospital and looking at the technical side, a problem that could arise might be the covering of costs associated with billing and providers such as physical therapists. Dr. Mattingly said he worked with Virginia Premier on the payer side and said it might be helpful to break down into two different areas: Triage and information when patients reach out to their doctors either telephonically or audio visually. It may help to think about it differently. Dr. Lindbeck said that the Medical Center said they were interested in reaching out and establishing relationships with existing patients via some sort of telehealth technology. There was no mechanism or history of reaching out to undefined EMS patients. Dr. Adekoya advised the subgroup to ensure we have the existing infrastructure moving forward to support telehealth. Dr. Pratt said she appreciates everybody taking part in the groups. Dr. Rheuban said the broad deployment of telehealth has been impressive thus far.	
IV. Public Comment Period	There was no public comment. Mr. Perkins reviewed the next steps including that the plan will be posted on the Virginia Town Hall for public comment.	

V. Adjourn	Dr. Perkins adjourned the meeting at 4:06p.m.	