Innovation and Resilience: How Ryan White HIV/AIDS Program Recipients Leverage Telehealth during the COVID-19 Pandemic - 2021.

Background

On January 31, 2020, a public health emergency was declared in response to confirmed cases of coronavirus disease 2019 (COVID-19) in the United States.

The COVID-19 pandemic has greatly impacted the delivery of healthcare in the nation. Measures to control the spread of the virus have included social distancing, which significantly limits in-person interactions. As a result, demand for and use of telehealth has surged since the onset of the pandemic. To facilitate provision of care during the pandemic, several changes to telehealth laws, regulations, and policies at the Federal and state levels have been made. Healthcare systems, payers, and providers, including many Ryan White HIV/AIDS Program (RWHAP) recipients, have modified health care service delivery methods and have leveraged telehealth services to provide care for people with HIV.

As a result of the widespread use of telehealth services during the COVID-19 pandemic, and in recognition of the importance of timely delivery of pertinent technical assistance (TA) to recipients amidst the rapidly evolving COVID-19 pandemic, the Health Resources and Services Administration's (HRSA) HIV AIDS Bureau (HAB) established a Telehealth TA Workgroup.[1] Formed in July 2020, the workgroup was tasked with developing TA materials for RWHAP recipients on telehealth, specifically around best practices and lessons learned during the pandemic and to identify key features and approaches to augment and provide high quality comprehensive HIV care and treatment. The workgroup interviewed seven RWHAP Parts A, B, and C recipients to understand the strategies and impact of the implementation of telehealth services in their respective programs during the COVID-19 pandemic. Additionally, the workgroup compiled an inventory of Federal resources including legislation, regulations, and other provisions that may support implementation of telehealth services among RWHAP recipients. This document collates findings, lessons learned, and effective practices gleaned from the recipient interviews. It will serve as a TA resource for RWHAP recipients on key approaches to augment and provide high quality comprehensive HIV care and treatment via telehealth during and post-pandemic.

Process

The HAB Telehealth TA Workgroup, with the assistance of HAB program leadership and project officers from the RWHAP Parts A, B, and C, identified recipients in each Program Part that implemented telehealth services. Of the nine recipients contacted for interviews, seven[2] agreed to participate. Interview topics included the following: 1) How recipients leveraged updated telehealth laws, provisions, and flexibilities resulting from the COVID-19 pandemic; 2) Strategies

[1] The workgroup's members were Akil Pierre (HAB, Office of Program Support (OPS)), Sherrillyn Crooks (HAB, OPS), Jennifer Moore (HAB, OPS), and Lieutenant Commander Emeka Egwim (HAB, Division of Policy & Data (DPD)).
[2] The seven recipients were Arkansas Department of Health, Iowa Department of Public Health, Montgomery AIDS Outreach, Prism North Texas, Sun River Health, University of Pittsburgh Medical Center (UPMC) Presbyterian – Shadyside, and West Virginia University.

to ensure linkage to and retention in care; 3) Technology considerations and bridging the digital divide; 4) Informed consent for treatment; 5) Telehealth procedural workflows; 6) Documentation and third party billing, and; 7) Case examples of the successful application of telehealth with RWHAP clients. Interviews were conducted between October and December 2020. The workgroup also reached out to Federal partners including the Federal Office of Rural Health Policy (FORHP), the HRSA Office of Planning, Analysis and Evaluation (OPAE), and the Centers for Disease Control and Prevention (CDC), and reviewed key changes to telehealth regulations and policies from the Centers for Medicare & Medicaid Services (CMS).

Telehealth Laws, Regulations, and Provisions

There have been a number of legislative and regulatory changes[3,4,5] regarding telehealth in the states, including state Medicaid programs. In general, and pursuant to these authorities, the Centers for Medicare & Medicaid Services (CMS) issued waivers and flexibilities regarding telehealth services through the end of the public health emergency. CMS expanded the types of practitioners that may furnish telehealth services as well as the types of permitted telehealth services, among other provisions.[6] However, many of these statutory and regulatory provisions are tied to the continued declaration of a public health emergency, and thus will no longer be in effect once the declaration is no longer in effect, absent further statutory or regulatory changes.

In April 2021, the nonprofit National Telehealth Policy Resource Center of the Center for Connected Health Policy published a report[7] that outlines state-by-state telehealth laws and reimbursement policies.

Recipient Feedback

Q#1: How did RWHAP recipients leverage updated telehealth laws, regulations, and provisions that responded to the COVID-19 pandemic to improve retention in care, and reach historically hard-to-reach clients?

Marketing and messaging

Recipients resoundingly expressed the importance of marketing and messaging about the range of resources and modified approaches to care given the pandemic. In each case, recipients custom-tailored material for the audience – patients or providers – highlighting

[3] The Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020, Pub. L. 116-123. March 6, 2020

[4] The Families First Coronavirus Response Act (FFCRA), Pub. L. 116-133. March 18, 2020.

[5] The Coronavirus Aid, Relief, and Economic Security (CARES) Act, P.L. 116-136. March 27, 2020

[6] For more information regarding these waivers and flexibilities, please visit https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf (updated April 8, 2021). For services that can be provided through telehealth, and the duration, please visit https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

[7] Center for Connected Health Policy (CCHP). *State Telehealth Laws and Reimbursement Policies Report, Spring 2021*. April 2021. https://www.cchpca.org/resources/state-telehealth-laws-and-reimbursement-policies-report-spring-2021/

strategies to deliver care while curtailing the spread of the virus. For example, providers were notified of provisions available for reimbursement of telehealth. Clients on the other hand were provided a description of the array of telehealth services (management of diabetes, hypertension, mental/behavioral health, HIV care, etc.) available, as well as the ease of accessing these services while practicing social distancing. This material was disseminated via emails, phone calls, or printed handouts.

Coordination with local and state resources

Recipients found it was effective to coordinate with local and state resources in order to facilitate care for patients experiencing homelessness or unstable housing. Cell phones provided a means by which providers could coordinate and conduct telehealth appointments for unstably housed patients. While one recipient purchased cellphones for some clients using RWHAP funds, others did not use RWHAP funds for this type of client support. Instead, most worked with federal programs such as Housing Opportunities for Persons with AIDS (HOPWA) and leveraged the boots-on-the-ground expertise of case workers and social workers to secure transportation from homeless shelters to the clinics, housing, and cell phones for clients. Needs assessments were conducted to determine of how many clients had access to needed technology/infrastructure and how feasible it would be to collaborate with local resources to increase access for those in need.

Caring for clients across vast rural areas, or areas with internet voids

The digital divide often poses challenges for providing healthcare in rural areas. Pre-pandemic, many providers found value in implementing telehealth using a "direct-to consumer care" model[8] which they modified given the COVID-19 pandemic. With this model, using technology such as Bluetooth stethoscopes, nurses met with clients at collaborative satellite sites (e.g. Federal Qualified Health Centers (FQHCs) or state university hospital systems), and linked to a physician or nurse specialist at the home site. Modifications included limiting in-person visits and allowing patients to use their smart phones, tablets, laptops provided they could access the recipient's encrypted Health Insurance Portability and Privacy Act (HIPAA) compliant software. With this model, recipients mitigated challenges related to travel distance as well as the digital divide.

Safety measures consistent with social distancing

Recipients implemented social distancing protocols consistent with guidelines from the CDC as those from local and state health departments to minimize the spread of COVID-19. These included arranging for patients to obtain lab-work in their community rather than

[8] Per the U.S Department of Health and Human Services, a telehealth direct-to-consumer care model involves patients visiting their provider's office but obtain virtual care from another provider through a video consultation. Patients may also attend appointments virtually from their home, instead of at a clinic or formal health care setting. This type telehealth is also called direct-to-patient, direct-to-consumer, or on-demand care. It occurs when patients initiate an appointment and consult with a health care provider on their own device, on their own schedule. It can happen synchronously or asynchronously, depending on the goal of the appointment and the patient's needs.

in-person at the clinic, mailing patients' meds via their local pharmacies, authorizing 90-day refills, and providing at-home HIV and STI testing. Some recipients established drive-up telehealth services for clients with vehicles. With this model, which also bridges the digital divide, the client remains in the vehicle and is provided a tablet device on-site to access the telehealth platforms. In all cases, this reduced the number of patients in the waiting room, thereby reducing the risk of spreading COVID-19.

Rapport building

Strong patient-provider rapport is key to retention in care and achieving desirable clinical outcomes for people with HIV. To that end, one recipient decided to see clients new-to-care safely in-person. Consistent with the *Ending the HIV Epidemic in the U.S*[9] plan, with this approach a person with HIV could be seen in person within 48 hours of a positive diagnosis, counselled on their medical condition, including how to take their antiretroviral (ART) medication, and the importance of adhering to their treatment regimen. This helped establish and nurture effective patient-provider relationships while facilitating assessment of patients' overall wellbeing in order to link them to the support services they needed.

Digital literacy and patient-driven approaches to determining telehealth modalities

In general, recipients did not assume clients' aptitudes for technology. However, some found it helpful to develop rubrics with which providers could assess clients' relative comfort with technology. When third-party payers, including CMS, began reimbursing providers for telephonic telehealth services, providers made all visit options (in-person, telephonic only, and audio-visual) available, and most recipients noted the majority of clients opted for telephonic visits. This may have been due to the relative convenience, privacy, and familiarity with the modality when compared to video conferencing platforms, many of which were embedded in proprietary clinic patient management software systems. Most recipients provided quick tips and tech support to guide providers and clients through the process of accessing and navigating the telehealth platforms. These resources included, but were not limited to, staff trainings on the virtual platforms, utilizing IT helpdesk support to assist patients and providers with technical issues, and disseminating tip sheets with pictorial directions. For those clients who were experiencing homelessness or unstable housing, peer advocates were instrumental in checking in with clients, providing tech support, and scheduling. Recipients found it most effective to provide care using the modalities clients identified as most appropriate for themselves. Collectively, these approaches proved vital to the continuity of care during the pandemic.

Q#2: To what extent did changes to provisions at the state-level impact delivery of telehealth to clients out of state, as well as by providers licensed out-of-state? What range of services did recipients provide via telehealth?

[9] The U.S Department of Health and Human Services (HHS). *Ending the HIV Epidemic*. HHS, June 2021. https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview. Accessed September 9, 2021

Out-of-state care delivery and receipt

The pandemic has significantly impacted employment, childcare, remote learning, and telework flexibilities. The telehealth provisions have facilitated provision of care to clients who moved out-of-state to be with loved ones given the changes brought about by the pandemic. Likewise, recipients could retain the services of their providers that moved out of state as a result of the pandemic. Together, these proved valuable for clinics in healthcare professional shortage areas. While recipients did not experience notable increases in patients from out-of-state, recipients geographically close to state borders continued to care for existing clients from out-of-state as they normally did pre-pandemic. However, despite the cross-state flexibilities, in general, providers were not well versed in other states' regulatory guidelines, so there was hesitance to care for new patients from other states even when there were opportunities to do so.

Range of telehealth services

Delivering a relatively comprehensive range of services via telehealth during the pandemic has been key to continuity of care. Of note, behavioral health services, integrated mental health programs, and psychiatric care were most commonly mentioned as examples of services provided via telehealth by recipients interviewed. Other services provided via telehealth included: nutrition education; social work case management; substance abuse counselling; support groups; patient health questionnaires; pharmacist medication adherence consults; family nurse practitioner services; sexual health counseling; COVID-19-related housing assistance; food assistance; and AIDS education and training though local RWHAP Part F AIDS Education and Training Centers (AETC). One program also implemented a crisis intervention program to deliver support via telehealth to clients and providers experiencing anxiety due to the pandemic. Although some providers continued their own lab services, most enlisted the services of such vendors as LabCorp or Quest Diagnostics that could be accessed locally by clients without having to travel long distances. A number of recipients have also been exploring at-home testing for sexual transmitted infections. With this model, a patient is provided a kit with instructions on how to collect a sample and mail the test kit back to the lab. This model has been effective for pre-exposure prophylaxis (PrEP) testing, and patients who have HIV can be timely initiated on treatment.

Q#3: How did programs implement technology requirements to deliver care via telehealth?

Safeguarding patient privacy and security

Recipients prioritized patient privacy and security of information, and utilized various strategies to ensure these rights were valued and protected. These included partnering with information technology (IT) departments to guarantee HIPAA compliance across telehealth modalities, embedding telehealth portals in established electronic medical records (EMR) vetted as secure, as well as testing various software platforms for secure use.

Q #4 How did programs implement requirements to obtain appropriate informed consent for telehealth?

Seamless EMR and patient portal modules

Some recipients reported they obtained consent telephonically and documented patient responses in provider notes. Others obtained it seamlessly through modules embedded within EMRs or patient portals which required digital signatures. One recipient utilized a layered approach for obtaining consent. First, providers obtained consent via a telephonic intake process, and then again at the beginning of the actual virtual visit. The providers then documented patient responses in an attestation section of their notes. If patients were required to physically sign a form, they were asked to come into the clinic or the form was mailed to their homes with return to sender mail and postage.

Q#5: What policies, procedure manuals, or work flows were developed to provide telehealth?

Tailoring approaches to specific staff roles, clinic types, and patient needs

Clinic-level telehealth policies, procedure manuals, and workflows varied depending on the relative size of the organizations and specific roles of the personnel. Recipients found it important to have clear policies and procedures in order to mitigate risk, meet specific requirements of malpractice insurers, and ensure compliance with regulatory requirements. Organizations that had already established protocols and trained staff prior to the pandemic only needed minor modifications due to the pandemic. Organizations newly implementing telehealth during the pandemic needed to develop complete workflows.

Policies and workflows varied to meet the specific needs of the patient type (new or established), or the resources provided by, or available to the clinic. For one recipient, protocols were developed to track phones distributed to patients and ensure the phones were compatible with the proprietary patient portal. For another, new patient intake and initiation-of-care protocols differed from those for established patients. In this case, in-person visits were required for new patients in order to build the clinician/patient relationship, while established patients could opt for telehealth services for continued engagement. For all recipients interviewed, documentation requirements were critical for the development and establishment of policies, including providing attestation and consent documentation protocols. Policies also documented designated roles and procedures for the multidisciplinary and inter-professional team.

Q#6: How did recipients approach documentation and billing requirements or challenges?

Proactive Practice Management

All recipients interviewed reported that dynamic practice managers were essential in keeping abreast of evolving requirements which differed by third party payer type, as well as guidelines and regulations, and relaying important information to the clinicians. These practice managers were effective at ensuring clinicians understood the level and nature of

services, documentation requirements, and third party payer claim modifiers required for telehealth billing codes. With these resources in place, clinicians could fulfill the requirements with relative ease, while focusing on delivering care services via telehealth. Additionally, practice managers were instrumental in developing EMR templates and workflows that implemented the evolving guidelines, training providers, identifying inefficiencies, fine-tuning processes, retro-correcting errors, and contracting with payers.

Inclusion of telehealth in EMRs and billing considerations

Billing processes were facilitated by the inclusion of comprehensive record-keeping platforms and telehealth as a new visit type in EMRs. In one case, a recipient embedding a template that started with a clock to time the telehealth visit. As the pandemic progressed, third party payers periodically updated telehealth billing codes, documentation requirements, reimbursement rates, and methodologies (e.g. time-based versus service-based formulae). However, virtually all recipients reported that earlier in the pandemic, most third party payers' codes and rates were inadequate to account for the level of service being furnished via telehealth. As such, some recipients found it necessary to "warehouse" third party claims until such time when the codes and rates were updated, and there was more clarity on billing parameters and requirements. With the embedded records, staff could easily reconcile accounts retroactively and review notes in order to ensure accurate billing for procedures and telehealth services. This secured more adequate reimbursement, which in turn encouraged and sustained the provision of telehealth services.

Data and tech support services

Recipients noted that providers often sent billing codes that were not properly mapped in their CAREWare systems. It was important to have data support to work through these issues and ensure recipients could capture normal reports in the CAREWare system.

Q#7: Use case examples highlighting the application of telehealth to provide care for people with HIV during the COVID-19 PHE.

Interviewees provided a range of cases that support the added value of telehealth as a resource for providing quality care services during the pandemic. The examples highlight the following:

- Maintaining safety measures, including social distancing to reduce the risk of exposure for clients, providers, and staff;
- Providing counselling to households of RWHAP clients that tested positive for COVID-19, in order to manage anxiety and mitigate the risk of spreading within the household;
- Facilitating a higher level of engagement in the provision of substance use disorder counselling, mental health services, and related support service for RWHAP clients;
- Increasing appointment adherence rates, reengaging clients returning to care after prolonged loss to care (over 12 months), and initiating services for clients new-to-care;

- Overcoming lack of transportation as a barrier to access (in rural communities for example), as well as safeguarding the ability to provide care for those patients that had to relocate to be with family due to the impact of the pandemic (re: unemployment and income challenges).

Specific examples provided by the interviewees are as follows:

Example 1: Clients expressed support for telehealth as a convenient modality for providing care, and understood they needed to be compliant with rescreening schedules as a condition for continued access to telehealth services. Many with underlying conditions were concerned about the risk of COVID-19 exposure if they needed to visit a case manager on site to complete an application. The provision of telehealth appointments greatly decreased their exposure level and concerns.

Example 2: In one case, a patient who lives in rural part of the state was diagnosed with HIV for several years and had a substance use disorder (SUD). The patient's geographic location made it difficult to access a RWHAP funded clinic in urban part of the state. The recipient began providing telehealth services to this patient and within three months, already saw improvements in the client's adherence to SUD treatment, ART, and is encouraged that the client is now on track to achieving viral suppression. In another case, a client with pulmonary complications, multiple hospitalizations, and clinic visits recently began receiving video telehealth services, augmented by a nurse to physically draw labs. As a result of these services, there is a higher level of engagement with clinic staff, and this helps identify potential flare ups before symptoms become emergent. The client's condition is now controlled, and there is now a marked reduction in hospitalizations.

Example 3: This recipient observed fewer no-shows, and all recipients we interviewed reported the experiencing the same. The program recorded a no-show rate of 20% in January 2020, which fell to 14% in February 2020, and down to 13% by May 2020. Likewise, appointment adherence rates increased to 88% in April 2020 from 80% in January 2020. Additionally, in the second quarter of 2020, they marked their highest rate of increase in HIV patients returning to care after being absent from care for over 12 months. The recipient said "our ability to furnish care via telehealth was reassuring to clients concerned about the risk of exposure to COVID-19." These phenomena may be attributable to ease of access to care via telehealth and/or the increased health consciousness driven by frequent public health updates in the media given the pandemic.

Example 4: This recipient reported that telephonic conversations have provided greater insight into clients' problems. For example, one client "had hyperlipidemia but was hesitant about taking their statins." The telephonic visits enabled more forthcoming conversations with this client about their diet before labs are drawn and lifestyle habits.. "We have been able to get a higher level of detail in the information patients share via telehealth" the recipient said, adding that "there is a switch in the balance of time spent talking and listening to the patient, and there seems to be a better connection." With this

insight the clinic was able to counsel the client on how to normalize their diet and adjust the times at when certain labs are drawn relative to what the client has eaten. The recipient was certain this level of engagement would not have transpired in-person.

Example 5: This recipient reported on the value of delivering telehealth services while easing clients' anxiety during the pandemic and encouraging adherence to HIV antiretroviral medication. A few of their clients tested positive for COVID-19 during the pandemic, and the clinic provided them counseling and frequent check-ins while monitoring them for severity and disease progression via telehealth. "We were able to counsel them so that their families were safe in the same residence and helped ease overall anxiety," the recipient said in describing how they were able to be supportive and attentive to the needs of these households. In another case, a patient lived alone and their family was afraid to visit them. The client had frequent telehealth visits to monitor their condition, during which it was revealed the client was experiencing food insecurity because of an inability to access the grocery store. The case manager obtained groceries from a local pantry and delivered them to the patient's doorstep.

Example 6: This recipient provided examples that demonstrate the flexibility telehealth affords in determining how to most effectively engage their clients. In one case a client was new to the area, had been off of ART for a few months, and needed to get back in care. However, transportation was a barrier, and the client was experiencing difficulty securing rides from the town across the state-line to the hospital. The staff and providers were able to leverage telehealth to establish a rapport with the client, keep them engaged and motivated, and this facilitated the provision of HIV care to the client.

For this recipient, several established clients reside in-town. However given the changes in employment, as well as telework flexibilities brought about by the pandemic, many moved to be with family in other parts of the country. Leveraging telehealth, the recipient has kept clients engaged, conducted video visits, ordered labs, and mailed patients their medications. In another case, a 19 year old client was "going through many life challenges." Their feelings of being socially disconnected were further exacerbated by changes brought about by the pandemic. However, via telehealth, the recipient implemented check-in visits to assess the client, kept them engaged in care, and connected the client with mental health care services.

Example 7: "We have a pair of clients to whom we were able to provide phones. One was diagnosed with a reoccurrence of cancer. Via telehealth, we've been able to connect with and monitor this client to ensure they are in good care. It has really kept the client in good spirits."

Keys to Success Summary

Recipients may find the following approaches most helpful when considering implementing telehealth in their programs[10]:

- Identify provisions and flexibilities provided by legislative, regulatory, and policy changes at the Federal and state levels;
- Match individual clients' and clinic needs with specific telehealth provisions, flexibilities, services, and modalities by which those services are delivered;
- Avoid presumptions of the relative aptitude of clients and providers for technology. Allow clients to self-determine which modality best fits their needs, then provide the resources and support to effectuate delivery of care accordingly;
- Designate a telehealth champion (an in-practice leader to drive telehealth initiatives) to:
    - Keep abreast of legislative, regulatory and policy changes
    - Train providers and staff on their specific roles
    - Provide the technical team with updates to the EMR to incorporate telehealth documentation and billing requirements, and other changes
    - Outline telehealth workflows and procedural manuals
    - Develop quick-start, how-to pamphlets for clients, staff, and providers
- Collaborate with local and state resources to facilitate provision of care and support services. This includes, but is not limited to, local systems that transport patients to visits, state or local programs that provide shelter and food to those unstably housed, or Federal and state programs that provide cellphones to low income people;
- Invest in information technology support services to mitigate and resolve issues related to accessing and utilizing telehealth platforms;
- Document baseline and incremental changes in performance and effectiveness measures like medication adherence, rate of viral suppression, number of missed appointments, number of clients, cost, and level of engagement over time. The sustainability of telehealth as a mode of delivering care may be dependent on providers' ability to demonstrate cost effectiveness, while maintaining quality of care and moving clients towards desirable clinical outcomes, as supported by data;
- Network with other practices with similar client demographics and other circumstances like geographic factors, to exchange ideas, and best practices.

[10] While the feedback provided by the seven recipients are informative, findings based on their responses may not be applicable across all RWHAP recipients