LOS ANGELES COUNTY
COMMISSION ON HIV

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STANDARDS AND BEST PRACTICES COMMITTEE
Virtual Meeting

Tuesday, September 1, 2020

10:00AM-12:00PM (PST)

Agenda + Meeting Packet will be available on the Commission's website at:
http://hiv.lacounty.gov/Standards-and-Best-Practices-Committee

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LOS ANGELES COUNTY
COMMISSION ON HIV

AGENDA FOR THE **VIRTUAL** MEETING OF THE

STANDARDS AND BEST PRACTICES COMMITTEE

TUESDAY, SEPTEMBER 1, 2020, 10:00 AM – 12:00 PM

******WebEx Information for Non-Committee Members and Members of the Public Only******

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or Dial

1-415-655-0001

Access code: 145 810 5280

(213) 738-2816 / Fax (213) 637-4748
HIVComm@lachiv.org http://hiv.lacounty.gov

Standards and Best Practices (SBP) Committee Members			
Erika Davies *Co-Chair*	Kevin Stalter *Co-Chair*	Miguel Alvarez, *alternate*	Wendy Garland, MPH
Felipe Gonzalez	Grissel Granados, MSW	Thomas Green	David Lee, MSW, LCSW, MPH
Katja Nelson, MPP	Joshua Ray (Eduardo Martinez, *alternate*)	Justin Valero, MA	Amiya Wilson
Harold Glenn San Agustin, MD			
QUORUM: 7			

AGENDA POSTED: August 27, 2020

ATTENTION: Any person who seeks support or endorsement from the Commission on any official action may be subject to the provisions of Los Angeles County Code, Chapter 2.160 relating to lobbyists. Violation of the lobbyist ordinance may result in a fine and other penalties. For information, call (213) 974-1093.

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 72 hours notice before the meeting date. To arrange for these services, please contact the Commission Office at (213) 738-2816 or via email at HIVComm@lachiv.org.

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SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located in Metroplex Wilshire, one building west of the southwest corner of Wilshire and Normandie. Validated parking is available in the parking lot behind Metroplex, just south of Wilshire, on the west side of Normandie.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and

AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.

If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting. External stakeholders who would like to participate in the deliberation of discussion of an a posted agenda item, but who may only be able to attend for a short time during a limited window of opportunity, may call the Commission's Executive Director in advance of the meeting to see if the scheduled agenda order can be adjusted accordingly. Commission leadership and staff will make every effort to accommodate reasonable scheduling and timing requests - from members or other stakeholders - within the limitations and requirements of other possible constraints.

Call to Order, Introductions, Conflict of Interest Statements 10:00 AM – 10:03 AM

I. ADMINISTRATIVE MATTERS 10:03 AM – 10:07 AM

1. Approval of Agenda **MOTION #1**

2. Approval of Meeting Minutes **MOTION #2**

II. PUBLIC COMMENT 10:07 AM – 10:10 AM

3. Opportunity for members of the public to address the Commission on items of interest that are within the jurisdiction of the Commission

III. COMMITTEE NEW BUSINESS ITEMS 10:10 AM – 10:15 AM

4. Opportunity for Commission members to recommend new business items for the full body or a committee level discussion on non-agendized Matters not posted on the agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting, or matters requiring immediate action because of an emergency situation, or where the need to take action arose subsequent to the posting of the agenda.

IV. REPORTS

5. Executive Director/Staff Report 10:15 AM – 10:25 AM

6. Co-Chair Report 10:25 AM – 10:35 AM

7. Division of HIV & STD Programs (DHSP) Report 10:35 AM – 10:45 AM

V. DISCUSSION ITEMS

8. Childcare Services Standards Review 10:45 AM – 11:20 AM

9. Universal Standards of Care Review 11:20 AM – 11:45 AM

VI. NEXT STEPS 11:45 AM – 11:55 AM

10. Task/Assignments Recap

11. Agenda development for the next meeting

VI. ANNOUNCEMENTS 11:55 AM – 12:00 PM

12. Opportunity for members of the public and the committee to make announcements

VII. ADJOURNMENT 12:00 PM

13. Adjournment for the virtual meeting of September 1, 2020

PROPOSED MOTIONS	
MOTION #1	**Approve the Agenda Order, as presented or revised.**
MOTION #2	**Approve the Standards and Best Practices Committee minutes, as presented or revised.**

LOS ANGELES COUNTY
COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov • *VIRTUAL WEBEX MEETING*

Presence at virtual meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges and must verbally acknowledge their attendance in order to vote.
Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

August 4, 2020

Draft

MEMBERS PRESENT	MEMBERS PRESENT *(cont.)*	PUBLIC	COMM STAFF / CONSULTANTS
Erika Davies, *Co-Chair*	Harold Glenn San Agustin, MD	Sunnie Rose Berger	Cheryl Barrit, MPIA
Kevin Stalter, *Co-Chair*	Justin Valero, MA	Jennifer Gjurashaj	Jane Nachazel
Wendy Garland, MPH	Amiya Wilson	Meyerer Perez	
Felipe Gonzalez			**DHSP STAFF**
Grissel Granados, MSW	**MEMBERS ABSENT**		None
Thomas Green *(Alt to Péna)*	Miguel Alvarez *(Alt.)*		
David Lee, MSW, LCSW, MPH	Joshua Ray, RN/Eduardo Martinez		
Katja Nelson, MPP			

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.

CONTENTS OF COMMITTEE PACKET

1) **Cover Page**: Standards and Best Practices (SBP) Committee Virtual Meeting, *8/4/2020*
2) **Agenda**: Standards and Best Practices (SBP) Committee Meeting Agenda, *8/4/2020*
3) **Minutes**: Standards and Best Practices (SBP) Committee Meeting Minutes, *7/7/2020*
4) **Table**: 2020 Work Plan - Standards and Best Practices, *Updated 7/28/2020*
5) **Definitions**: Service Standards, Ryan White HIV/AIDS Programs
6) **Table**: Standards & Best Practices Committee, Psychosocial Support Services Standards, Reviewer/Public Comments, *2020*
7) **Standards**: Psychosocial Support Standards of Care, *Final Draft for SBP Approval, Motion 3, 8/4/2020*
8) **Standards**: Childcare Services Standards of Care, *DRAFT FOR SBP REVIEW, Updated 7/15/2020*
9) **Standards**: Ryan White Program Universal Standards of Care, *Commission Approved 9/12/2019*
10) **Standards Updates**: Universal Standards Updates, *As of PPC meeting 12/3/2019*

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST STATEMENTS: Mr. Stalter called the meeting to order at 10:06 am.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA
MOTION #1: Approve the Agenda Order, as presented ***(Passed by Consensus)***.

2. APPROVAL OF MEETING MINUTES
MOTION #2: Approve the 7/7/2020 Standards and Best Practices (SBP) Committee Meeting Minutes, as presented ***(Passed by Consensus)***.

II. PUBLIC COMMENT

3. OPPORTUNITY FOR PUBLIC TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION: There were no comments.

III. COMMITTEE NEW BUSINESS ITEMS

4. OPPORTUNITY FOR COMMISSIONERS TO RECOMMEND ITEMS FOR FUTURE AGENDAS, OR ITEMS REQUIRING IMMEDIATE ACTION DUE TO AN EMERGENCY, OR IF NEED FOR ACTION AROSE AFTER POSTING AGENDA

- § Mr. Stalter noted hearing a report on 8/3/2020 that telehealth appointments have grown from 1% to 43% of visits. This growth is bound to continue. He had also heard that co-payments were being waived by executive order going forward.
- § He felt this offered an opportunity to increase PrEP uptake and consistency. A common concern he hears in helping people access PrEP is the difficulty of four visits per year which may mean missing work. Supporting adherence by simplifying requirements to a laboratory test and telehealth visit would be helpful. He suggested adding it to a Standard of Care (SOC).
- § Ms. Barrit said update of the Universal SOC, including telehealth, was on the 2020 Work Plan. Review starts on this agenda.

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

- § Ms. Barrit noted the Health Resources and Services Administration (HRSA) document in the packet provides a definition of service standards, how and why they are used. It is helpful in developing SOCs meant to provide the minimum Part A SOCs.
- § The next full Commission on HIV Meeting has been rescheduled to 8/20/2020 in order not to pose a conflict for those who wish to attend the virtual 2020 National Ryan White Conference on HIV Care and Treatment on 8/11-14/2020.
- § Andrea Kim, PhD, MPH, Chief, HIV and STD Surveillance, will present at the 8/20/2020 Commission Meeting on the 2019 HIV Annual Surveillance Report recently released by DHSP.
- § Commission staff continue to serve as Disaster Services Workers (DSWs) in response to COVID-19. Sonja Wright, MS, Lac, was deployed full-time to do contact tracing for at least the next four months. Everyone is urged to respond if they receive a contact tracer call. Ms. Barrit's weekend DSW assignment with Project Room Key was extended to the end of September.
- Ü Add HRSA Service Standards summary to packets when developing SOCs.

6. CO-CHAIR REPORT: Mr. Stalter offered his best wishes to everybody and looked forward to when we can all be together again. Meanwhile, he hoped people had the opportunity for some safe human connection with those close to them.

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) REPORT

- § Ms. Garland did not attend in July as she participated in AIDS 2020: 23rd International AIDS Conference, 7/6-10/2020.
- § About 80% of DHSP staff remain re-assigned to COVID-19 activities. HIV and STD work is continuing as well as possible.
- § The HIV Surveillance Annual Report, 2019, was released in May or June. It was available on the DHSP website for review.
- § DHSP made several presentations to the Planning, Priorities and Allocations (PP&A) Committee earlier in the month.
- § One presentation summarized results from a May 2020 survey of contracted agencies to assess the impact of COVID-19 on operations, service access, and continuity. There is a strong emphasis on assessing capacity for and use of telehealth to improve DHSP understanding of where and how DHSP could help agencies provide services. The full report and PowerPoint are on the DHSP website. Ms. Barrit requested a summary of the PowerPoint which will also be posted when done.
- § Ms. Garland also presented to PP&A on the Year (YR) 29 Service Utilization Report and an initial YR 30 data Monitoring Report in development to offer a comparison with YR 29 to illuminate COVID-19 related utilization changes. Only the first quarter worth of data was available for the YR 30 Monitoring Report to date, but a monitoring dashboard was being developed. A summary of the YR 29 Utilization Report will be distributed to Commissioners for review.
- § DHSP was also reviewing the composition of current service delivery and added capacity to track a number of services being delivered by telehealth to better understand how that is helping to maintain service continuity. Meanwhile, DHSP is working to help agencies maintain face-to-face services for those clients who cannot connect via telehealth.
- § DHSP received Centers for Disease Control and Prevention (CDC) funding a couple of years ago for a Quality Improvement activity with contracted providers. The focus chosen was on strategies for Medical Care Coordination (MCC) providers to improve retention in care. A learning collaborative for MCC providers was planned for March 2020.
- § Instead, the focus was pivoted to telehealth resources, working with clients remotely, maintaining services, and engaging clients during the pandemic. Last week over 100 people participated in the second webinar related to that initiative. The presentation was recorded. It included resources and strategies to help engage clients on the phone or via video. DHSP will continue offering webinars monthly through October 2020.
- Ü Ms. Garland will forward a schedule to staff for distribution of the remaining MCC retention in care initiative webinars.

V. DISCUSSION ITEMS

8. PSYCHOSOCIAL SUPPORT SERVICES STANDARDS

- § Ms. Davies noted this SOC was opened for public comment from 7/13-31/2020. A summary of comments was in the packet.
- § Maribel Ulloa, Housing Opportunities for Persons With AIDS (HOPWA), recommended identifying HOPWA specifically for coordination and a two-way referral process. That was added on page 4.
- § Ms. Barrit reported staff also summarized comments by Rebecca Gitlin, PhD, Department of Mental Health (DMH), which centered on highlighting Trauma-Informed Care, measurable supervision for peer support staff, and case consultation for agencies using peer support and clinical or case management staff. Those comments were previously integrated.
- § Several people questioned the need to include a specific reference to HOPWA both in lieu of a more general reference and in consideration of possible duplication, e.g., with the Universal SOC. Ms. Barrit confirmed that linkage and referral to other Ryan White services and services outside the Ryan White system is a HRSA expectation and reflected in the Universal SOC.
- § The body also discussed whether to add the sentence on page 4, box 3, under Documentation, requiring two-way referral with non-funded programs and participation in case conferencing, as needed. Mr. Valero felt referrals could be beneficial, but wanted to ensure accountability. Ms. Garland noted contracts often include referrals, e.g., by requiring Memorandums Of Understanding (MOUs) with other providers to enable smooth referrals. DHSP monitors contracts. Such referrals tend to be "hub and spoke," not two-way. It may require a systemic revision of contracting language to ensure two-way referral.
- § There was general support for a referral process that can be monitored by DHSP. Mr. Lee felt less formal documentation than an MOU was preferable as it would be prohibitive to engage in the extensive MOU process for each potential service.
- § Referring to the top middle box, also for Staff Requirements on page 4, Mr. Gonzalez suggested changing "...and/or experienced consumer preferred," to "...and/or qualified PLWH preferred" to offer opportunities to more people. Mr. Valero agreed since the revision would open such positions to people like himself who are PLWH, but not Ryan White consumers. Mr. Lee, however, preferred existing language as he felt experience with the Ryan White system was valuable.
- § Ms. Davies felt it might be beneficial to offer providers the option by adding PLWH to consumers. For example, providers could find a consumer most helpful for a peer navigator, but identify a PLWH qualified to serve as a peer educator.
- § Mr. Stalter noted SOC language should be clear to agencies. With that lens, Ms. Granados preferred PLWH, but others valued the consumer experience. Ms. Barrit clarified that HRSA defines "consumer" as a PLWH who is using a Part A service.
- § On "qualified" versus the existing "experienced," Mr. Green found "qualified" nebulous. The body kept "experienced."
- Ü Table 1, Psychosocial Support Services SOC, Page 4, Staff Requirements, Standard Box 3: change "such as *HOPWA*," to "such as *medical care, housing, et cetera*."
- Ü Table 1, Psychosocial Support Services SOC, Page 4, Staff Requirements, Standard Box 1: change "...experienced consumer preferred," to "...experienced consumer */PLWH* preferred."

MOTION #3: Approve the Psychosocial Support Standards of Care, as revised, and move to the Executive Committee and full Commission on HIV for approval ***(Passed by Consensus)***.

9. CHILDCARE SERVICES STANDARDS REVIEW

- § As requested, Ms. Barrit consulted with the HRSA Project Officer on eligibility of "informal" child care. The Project Officer referred her to the Program Notification which functions as guidance. That allows informal child care but, consistent with overall HRSA guidance, does not allow direct payment to clients. She also reviewed booking services such as Nanny.com.
- § The main revision is addition of a section under Table 1, Childcare Services SOC, Page 2, Service Component, for Licensed-exempt Childcare. The Standard column addresses what is commonly referred to as informal childcare. It details three types of such care as: 1. a relative or person who cares for children of one other family besides their own; 2. agencies that offer limited childcare to clients; or, 3. online childcare booking services. Some of the third group offer gift cards which could potentially be used as a mechanism for DHSP or an agency to purchase such services for clients.
- § The Documentation column addresses: compliance with DHSP-required payment mechanism; liability concerns, especially to ensure understanding that online booking companies are not employment agencies so liability is between the babysitter and parent; and, documentation that cash payments do not go to clients or primary care givers and are for actual costs.
- § Background check resources and online/mobile apps were added in Appendix A. It includes a website for the Child Care Alliance Los Angeles. Los Angeles County (LAC) was working with the Alliance on a voucher-based childcare system for essential workers and low-income families funded by the Coronavirus Aid, Relief, and Economic Security (CARES) Act.
- § Other comments from the previous meeting by Mr. Ray and Mr. Gonzalez were also incorporated, as noted.

- § Ms. Davies asked whether agencies were being asked to ensure licensed-exempt childcare providers have had the noted trainings. She especially expressed concern about family members and, for online/mobile apps, availability of apps that have training in needs of children in families impacted by HIV. The latter may also impinge on confidentiality.
- § Mr. Gonzalez suggested revising "families impacted by HIV" to include other co-morbidities such as domestic violence as a means of diluting the risk of disclosure. Ms. Granados, speaking as a new mother and PLWH, just wanted someone to take care of her child well. Knowledge of her HIV status or other co-morbidities was not important to her.
- § She supported the addition of licensed-exempt childcare as most people eligible for these services likely prefer it. She agreed with concerns about requiring training. In addition, other than for an agency's in-house childcare, she felt requiring agencies to ensure provider training would likely be a barrier to agencies offering the service. She recommended distinguishing between childcare services provided in-house by an agency, which should require training, and the other forms of limited childcare listed for which training could simply be encouraged.
- § Regarding definitions, Ms. Barrit clarified that parents do not relinquish care of the child under child watch so parents need to remain on-site and available, e.g., to change a diaper. Childcare pertains to more formal supervision.
- Ü Table 1, Childcare Services SOC, Page 3, Training, Bullet 7: Delete, "Needs of children in families impacted by HIV."
- Ü Table 1, Childcare Services SOC, Page 3, Training: Since Universal SOC have training, waive most requirements except for, e.g., participation in First Aid/CPR, and fire and electrical safety, to offer more flexibility to agencies in meeting their needs.
- Ü Distinguish between in-house and the other licensed-exempt childcare services.
- Ü Add definitions of childcare and child watch.
- Ü Email subject matter expert suggestions to Ms. Barrit. They need not be HIV-specific. She planned to reach out to contacts at the LAC+USC Maternal Child and Adolescent Adult (MCA) Center and the University of California, Los Angeles (UCLA) Los Angeles Family AIDS Network (LAFAN). She hoped to collect additional feedback for review at the next meeting.

9-A. UNIVERSAL STANDARDS

- § Ms. Barrit noted this was last approved 9/12/2019. It reflects the key components expected for overall service standards and serves as the base of minimum expectations for all the other SOCs. For example, it addresses basic agency policies like for confidentiality and operational requirements such as a secure location for files.
- § The body notably addressed cultural competency during the last review and added national standards, but review is due.
- § There is no specific section on telemedicine. That could be integrated into existing sections or added separately.
- § Ms. Davies felt it would be simpler to add a separate section to address all aspects of the service, e.g., how to sign up new clients and document services under different circumstances such as for clients who may not have internet access.
- Ü Ms. Barrit has been collecting a telehealth best practices and lessons learned file. She will put together materials for review.
- Ü Agreed to use the broader "telehealth" term. "Telemedicine" refers to remote clinical services.
- Ü In an interview on 8/3/2020, Centers for Medicare and Medicaid Services (CMS) staff said CMS would release telehealth best practices shortly. Ms. Barrit will check its website. She will also contact Emily Ganz McKay for any suggestions.
- Ü Dr. San Agustin will try to attend and report back on at least one of the telehealth presentations at the 8/11-14/2020 National Ryan White Conference on HIV Care and Treatment.
- Ü The body will review the draft Universal SOC in preparation for next month's discussion.

VI. NEXT STEPS

10. TASK/ASSIGNMENTS RECAP: There was no additional discussion.

11. AGENDA DEVELOPMENT FOR NEXT MEETING:

- § The meeting will focus on development of the Childcare and Universal SOCs.
- Ü People may email additional topic suggestions to Ms. Barrit, if desired.

VII. ANNOUNCEMENTS

12. OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS: There were no announcements.

VIII. ADJOURNMENT

13. ADJOURNMENT: The meeting adjourned at 11:53 am.

2020 WORK PLAN – STANDARDS & BEST PRACTICES
UPDATED 8/25/2020

Purpose of Work Plan: To focus and prioritize key activities for Commission on HIV (COH) Committees and subgroups for 2019

Prioritization Criteria: Select activities that 1) represent the core functions of the COH and Committee; 2) advance the goals of the Comprehensive HIV Plan and Los Angeles County HIV/AIDS Strategy; and 3) align with COH staff and member capacities and time commitment.

TASK/ACTIVITY	DESCRIPTION/NOTES	TARGET START/ APPROVAL DATES	STATUS
Emergency Financial Assistance (EFA)	Update Standards of Care to align with PY29/multi-year allocations	November 2019/ ~~May~~ June 2020	In progress
Psychosocial Support Services	Update Standards of Care to align with PY29/multi-year allocations	November 2019/ ~~June~~ Aug 2020	In progress/COH on 9/10
Childcare Services	Update Standards of Care to align with PY29/multi-year allocations	~~March~~ Sept/Oct 2020	In Progress
Universal Standards of Care	Update Standards annually to ensure language and key points from meeting discussions on other standards are universally captured. Include telehealth.	~~May~~ August 2020	
Update Standards according to PP&A Committee recommendations	Update workplan in accordance with PP&A priorities and allocations for the upcoming year(s).	TBD	
Develop STD service standards	STD service standards are interwoven throughout the Prevention Standards. Consider expanding by aligning with LACHAS/CHP goals, BOS STD motion and DHSP STD grant application. Resources: HIV/STD Prevention Standards; Universal HIV/STD Prevention Standards; CA and National clinical guidelines; STD prevention recommendations by highly impacted populations; DHSP STD RFP; CA Syphilis Prevention Summit 2017 materials; DHSP STD surveillance data; 2019 SBP Work Plan.	TBD	
Increase SBP membership (ideally with people who provide or supervise direct service)	Review and update recruitment and retention plan developed by Operations Committee. Present community engagement toolkit developed by staff. Review sign-in sheets for SBP meetings and identify regular non-COH member attendees as possible individuals to recruit for committee-only membership. COH Co-Chair Priority.	Ongoing	COH staff is reviewing attendance and will adjust Committee assignments if necessary

LOS ANGELES COUNTY COMMISSION ON HIV

CHILDCARE SERVICES STANDARDS OF CARE

INTRODUCTION

Standards of Care for the Ryan White HIV/AIDS Part A Program outline the elements and expectations a service provider should follow when implementing a specific service category. The standards are written for providers for guidance on what services may be offered when developing their Ryan White Part A programs. The standards set the minimum level of care Ryan White funded agencies offer to clients, however, providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV developed the Childcare Services Standards of Care to establish the minimum standards of care necessary to ensure people living with HIV (PLWH) are able to receive quality childcare services when attending core medical and/or support services appointments and meetings. The development of the Standards includes guidance from service providers, people living with HIV, the Los Angeles County Department of Public Health, Division of HIV and STD Program (DHSP), and members of the Los Angeles County Commission on HIV, Standards & Best Practices Committee.

CHILDCARE SERVICES OVERVIEW

Childcare services are provided to children living in the household of people living with HIV (PLWH) for the purpose of enabling those clients to attend medical visits, related appointments, and/or Ryan White related meetings, groups, or training sessions. The goal of childcare services is to reduce barriers for clients in accessing, maintaining and adhering to primary health care and related support services.

The Health Resources Services Administration (HRSA) allows the following use of funds: a licensed or registered childcare provider to deliver intermittent care of informal childcare provided by a neighbor, family member or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services. The use of these funds under this service category should be limited and carefully monitored. Direct cash payments to clients are not permitted.

SERVICE REQUIREMENTS

All service providers receiving funds to provide childcare services are required to adhere to the following standards:

Table 1. CHILDCARE SERVICES STANDARDS OF CARE

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Licensed Facilities (i.e., childcare centers, family childcare homes)	Depending on agency capacity, DHSP guidance, and individual client needs, licensed and/or license-exempt childcare services may be provided on an intermittent basis to the children living in the household of PLWH who are Ryan White eligible clients for the purpose of enabling clients to attend medical visits, related appointments, and/or Ryan White HIV/AIDS Program (RWHAP) related meetings, groups, or training sessions. Agencies must be a licensed childcare provider in the State of California. Services must be delivered according to California State and local childcare licensing requirements which can be found on the California Department of Social Services, Community Care Licensing Division website.[1]	Documentation in the client's primary record must reflect the appointment and/or meeting/group/training session attended. A copy of valid California childcare license or proper certification.
Licensed-exempt Childcare	License-exempt childcare includes: 1) individuals who care for the children of a relative, or who care for the children of one other family in addition to their own children; 2) agencies that offer limited onsite childcare or child watch to their clients. These programs usually require that the parent or guardian remain on the premises and that they remove their children within a specified amount of time; and 3) online childcare booking service. Online or mobile app based childcare services that offer gift cards may be considered as an option for agencies	Where license-exempt childcare arrangements are obtained, subrecipient must ensure: a. Documentation of compliance with DHSP-required mechanism for handling payments for licenses-exempt childcare arrangements b. Appropriate liability release forms are obtained that protect the client, provider and the Ryan White program c. Documentation that no cash payments are being made to clients or primary care givers d. Documentation that payment is for actual costs of service.

[1] https://cdss.ca.gov/inforesources/child-care-licensing

	and clients. Agencies that opt to provide childcare through online or mobile app based childcare services are responsible for reading, understanding, explaining to the clients, and accepting the terms of service specified in the company website. Child watch is a non-licensed service provided onsite at a service provider's site during the duration of the client's appointment only. Parents are responsible for their children during child watch hours.	e. Providers must develop policies, procedures and signed agreements with clients for child watch services.
Recommended Training	Agencies are responsible for ensuring childcare providers and volunteers are trained appropriately for their responsibilities. Childcare staff encouraged to participate in trainings such as: · First aid/CPR · Fire and electrical safety · Child development · Waste disposal procedures · Child abuse · Domestic violence	Record of trainings on file at provider agency.
Language	Whenever possible, childcare should be delivered in the language most familiar to the child. If this is not possible, interpretation services must be available in cases of emergency.	Appropriate language noted in client or program file.
Confidentiality	Client confidentiality will be maintained at all times. HIV status will never be disclosed without written permission from a client.	Record of HIPAA and confidentiality before the start of service provision.
Service Promotion	Agencies coordinating childcare services with licensed and license-exempt providers are expected to promote the availability of childcare to potential clients as well as external partners.	Program flyers and emails documenting that childcare services was promoted to clients and HIV service providers. Offer of childcare services is noted in client case file.

	Agencies should attempt to disseminate information about the availability of childcare throughout all components of the continuum of HIV care, including meetings with internal agency staff and relaying information to external HIV medical and social services partners.	
	Agencies should inform clients of the details of the childcare services, including: • How far in advance the service must be scheduled • Whether the childcare is in-home or at the service site	Description of information shared with potential clients and partners and method of communication on file.
Referrals	Programs coordinating childcare services will provide referrals and information about other available resources to adults living with HIV who have the primary responsibility for the care of children. Special consideration should be given to helping clients find longer term or additional childcare options and resources.[2] Whenever appropriate, program staff will provide linked referrals demonstrating that clients, once referred, have accessed services. Staff are required to coordinate across Ryan White funded and non-funded programs to ensure clients' needs are met. Follow up with client in 30 days to track referrals related to care coordination.	Documentation of referral efforts will be maintained on file by coordinating agency. Description of staff efforts of coordinating across systems in client file (e.g. referrals to housing case management services, etc.). Documentation of follow up in client file.

[2] Los Angeles County Department of Public Health, Office for the Advancement of or Early Care and Education: https://childcare.lacounty.gov/resources-for-families-and-communities/

Appendix A: Examples of Childcare Resources

Trustline.org - TrustLine is a database of nannies and baby-sitters that have cleared criminal background checks in California. It's the only authorized screening program of in-home caregivers in the state with access to fingerprint records at the California Department of Justice and the FBI.

Childcareaware.org - works with more than 400 state and local Childcare Resource and Referral agencies nationwide.

Online or mobile app based childcare booking sites that offer gift cards:
Urbansitters.com
Nanno.com
Bambino.com

Child Care Alliance Los Angeles offers voucher-based services for low income families.
https://www.ccala.net/

YMCA of Greater Williamson County Members Responsibilities and Guidelines for Child Watch Page 11

FEDERATION OF STATE MEDICAL BOARDS

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup

Adopted as policy by the Federation of State Medical Boards in April 2014

INTRODUCTION

The Federation of State Medical Boards (FSMB) Chair, Jon V. Thomas, MD, MBA, appointed the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup to review the "Model Guidelines for the Appropriate Use of the Internet in Medical Practice" (HOD 2002)[1] and other existing FSMB policies on telemedicine and to offer recommendations to state medical and osteopathic boards (hereinafter referred to as "medical boards" and/or "boards") based on a thorough review of recent advances in technology and the appropriate balance between enabling access to care while ensuring patient safety. The Workgroup was charged with guiding the development of model guidelines for use by state medical boards in evaluating the appropriateness of care as related to the use of telemedicine, or the practice of medicine using electronic communication, information technology or other means, between a physician in one location and a patient in another location with or without an intervening health care provider.

This new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients[2] via telemedicine technologies. It is the intent of the SMART Workgroup to offer a model policy for use by state medical boards in order to remove regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while ensuring the public health and safety.

In developing the guidelines that follow, the Workgroup conducted a comprehensive review of telemedicine technologies currently in use and proposed/recommended standards of care, as well as identified and considered existing standards of care applicable to telemedicine developed and implemented by several state medical boards.

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[1] *The policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine supersedes the Model Guidelines for the Appropriate Use of the Internet in Medical Practice (HOD 2002).*

[2] *The policy does not apply to the use of telemedicine when solely providing consulting services to another physician who maintains the physician-patient relationship with the patient, the subject of the consultation.*

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Model Guidelines for State Medical Boards' Appropriate Regulation of Telemedicine

Section One. Preamble

The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine, which is the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location with or without an intervening healthcare provider.[3] However, state medical boards, in fulfilling their duty to protect the public, face complex regulatory challenges and patient safety concerns in adapting regulations and standards historically intended for the in-person provision of medical care to new delivery models involving telemedicine technologies, including but not limited to: 1) determining when a physician-patient relationship is established; 2) assuring privacy of patient data; 3) guaranteeing proper evaluation and treatment of the patient; and 4) limiting the prescribing and dispensing of certain medications.

The [Name of Board] recognizes that using telemedicine technologies in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these technologies can enhance medical care by facilitating communication with physicians and their patients or other health care providers, including prescribing medication, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice.[4]

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method in enabling Physician-to-Patient communications. For clarity, a physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not.[5]

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine technologies in the practice of medicine. The [Name of Board] is committed to assuring patient access to the convenience and benefits afforded by telemedicine technologies, while promoting the responsible practice of medicine by physicians.

It is the expectation of the Board that physicians who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;

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[3] *See Center for Telehealth and eHealth Law (Ctel), http://ctel.org/ (last visited Dec. 17, 2013).*

[4] *Id.*

[5] *See Cal. Bus. & Prof. Code § 2290.5(d).*

- Adhere to recognized ethical codes governing the medical profession;
- Properly supervise non-physician clinicians; and
- Protect patient confidentiality.

Section Two. Establishing the Physician-Patient Relationship

The health and well-being of patients depends upon a collaborative effort between the physician and patient.[6] The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient's health care. Although the Board recognizes that it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks assistance from a physician who may provide assistance. However, the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient.

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship. A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient. Where appropriate, a patient must be able to select an identified physician for telemedicine services and not be assigned to a physician at random.

Section Three. Definitions

For the purpose of these guidelines, the following definitions apply:

"Telemedicine" means the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient.[7]

"Telemedicine Technologies" means technologies and devices enabling secure electronic communications and information exchange between a licensee in one location and a patient in another location with or without an intervening healthcare provider.

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[6] *American Medical Association, Council on Ethical and Judicial Affairs, Fundamental Elements of the Patient-Physician Relationship (1990), available at http://www.ama-assn.org/resources/doc/code-medical-ethics/1001a.pdf.*

[7] *See Ctel.*

Section Four. Guidelines for the Appropriate Use of Telemedicine Technologies in Medical Practice

The [Name of Board] has adopted the following guidelines for physicians utilizing telemedicine technologies in the delivery of patient care, regardless of an existing physician-patient relationship prior to an encounter:

Licensure:
A physician must be licensed, or under the jurisdiction, of the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time telemedicine technologies are used. Physicians who treat or prescribe through online services sites are practicing medicine and must possess appropriate licensure in all jurisdictions where patients receive care.[8]

Establishment of a Physician-Patient Relationship:
Where an existing physician-patient relationship is not present, a physician must take appropriate steps to establish a physician-patient relationship consistent with the guidelines identified in Section Two, and, while each circumstance is unique, such physician-patient relationships may be established using telemedicine technologies provided the standard of care is met.

Evaluation and Treatment of the Patient:
A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:
Evidence documenting appropriate patient informed consent for the use of telemedicine technologies must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following terms:

- Identification of the patient, the physician and the physician's credentials;
- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, appointment scheduling, patient education, etc.);
- The patient agrees that the physician determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

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[8] *Federation of State Medical Boards, A Model Act to Regulate the Practice of Medicine Across State Lines (April 1996), available at http://www.fsmb.org/pdf/1996_grpol_telemedicine.pdf.*

Continuity of Care:
Patients should be able to seek, with relative ease, follow-up care or information from the physician [or physician's designee] who conducts an encounter using telemedicine technologies. Physicians solely providing services using telemedicine technologies with no existing physician-patient relationship prior to the encounter must make documentation of the encounter using telemedicine technologies easily available to the patient, and subject to the patient's consent, any identified care provider of the patient immediately after the encounter.

Referrals for Emergency Services:
An emergency plan is required and must be provided by the physician to the patient when the care provided using telemedicine technologies indicates that a referral to an acute care facility or ER for treatment is necessary for the safety of the patient. The emergency plan should include a formal, written protocol appropriate to the services being rendered via telemedicine technologies.

Medical Records:
The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies. Informed consents obtained in connection with an encounter involving telemedicine technologies should also be filed in the medical record. The patient record established during the use of telemedicine technologies must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records & Exchange of Information:
Physicians should meet or exceed applicable federal and state legal requirements of medical/health information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical retention rules. Physicians are referred to "Standards for Privacy of Individually Identifiable Health Information," issued by the Department of Health and Human Services (HHS).[9] Guidance documents are available on the HHS Office for Civil Rights Web site at: www.hhs.gov/ocr/hipaa.

Written policies and procedures should be maintained at the same standard as traditional face-to-face encounters for documentation, maintenance, and transmission of the records of the encounter using telemedicine technologies. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the physician addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Sufficient privacy and security measures must be in place and documented to assure confidentiality and integrity of patient-identifiable information. Transmissions, including patient e-mail, prescriptions, and laboratory

[9] *45 C.F.R. § 160, 164 (2000).*

results must be secure within existing technology (i.e. password protected, encrypted electronic prescriptions, or other reliable authentication techniques). All patient-physician e-mail, as well as other patient-related electronic communications, should be stored and filed in the patient's medical record, consistent with traditional record-keeping policies and procedures.

Disclosures and Functionality on Online Services Making Available Telemedicine Technologies:
Online services used by physicians providing medical services using telemedicine technologies should clearly disclose:

- Specific services provided;
- Contact information for physician;
- Licensure and qualifications of physician(s) and associated physicians;
- Fees for services and how payment is to be made;
- Financial interests, other than fees charged, in any information, products, or services provided by a physician;
- Appropriate uses and limitations of the site, including emergency health situations;
- Uses and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;
- To whom patient health information may be disclosed and for what purpose;
- Rights of patients with respect to patient health information; and
- Information collected and any passive tracking mechanisms utilized.

Online services used by physicians providing medical services using telemedicine technologies should provide patients a clear mechanism to:

- Access, supplement and amend patient-provided personal health information;
- Provide feedback regarding the site and the quality of information and services; and
- Register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s).

Online services must have accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity.

Advertising or promotion of goods or products from which the physician receives direct remuneration, benefits, or incentives (other than the fees for the medical care services) is prohibited. Notwithstanding, online services may provide links to general health information sites to enhance patient education; however, the physician should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, physicians should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of preferred relationships with any pharmacy is prohibited. Physicians shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit form that pharmacy.

Prescribing:
Telemedicine technologies, where prescribing may be contemplated, must implement measures to uphold patient safety in the absence of traditional physical examination. Such measures should guarantee that the identity of the patient and provider is clearly established and that detailed documentation for the clinical evaluation and resulting prescription is both enforced and independently kept. Measures to assure informed, accurate, and error prevention prescribing practices (e.g. integration with e-Prescription systems) are encouraged. To further assure patient safety in the absence of physical examination, telemedicine technologies should limit medication formularies to ones that are deemed safe by [Name of Board].

Prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters.

Section Five. Parity of Professional and Ethical Standards
Physicians are encouraged to comply with nationally recognized health online service standards and codes of ethics, such as those promulgated by the American Medical Association, American Osteopathic Association, Health Ethics Initiative 2000, Health on the Net and the American Accreditation HealthCare Commission (URAC). There should be parity of ethical and professional standards applied to all aspects of a physician's practice.
A physician's professional discretion as to the diagnoses, scope of care, or treatment should not be limited or influenced by non-clinical considerations of telemedicine technologies, and physician remuneration or treatment recommendations should not be materially based on the delivery of patient-desired outcomes (i.e. a prescription or referral) or the utilization of telemedicine technologies.

REFERENCES

American Accreditation HealthCare Commission. *Health Web Site Standards*. July 2001.

AMA. Council on Ethical and Judicial Affairs. *Code of Medical Ethics*. 2000-2001.

AMA. *Report of the Council on Medical Service*. Medical Care Online. 4-A-01 (June 2001).

College of Physicians and Surgeons of Alberta. *Policy Statement*. *Physician/Patient Relationships* (February 2000).

Colorado Board of Medical Examiners. *Policy Statement Concerning the Physician-Patient Relationship*.

The Department of Health and Human Services, HIPPA Standards for Privacy of Individually Identifiable Health Information. August 14, 2002.

FSMB. *A Model Act to Regulate the Practice of Medicine Across State Lines*. April 1996.

Health Ethics Initiative 2000. eHealth Code of Ethics. May 2000.

Health on the Net Foundation. *Code of Medical Conduct for Medical and Health Web Sites*. January 2000.

La. Admin. Code tit. 46, pt. XLV, § 7501-7521.

New York Board for Professional Medical Conduct. Statements on Telemedicine (draft document). October 2000.

North Carolina Medical Board. Position Statement. Documentation of the Physician-Patient Relationship. May 1, 1996.

Oklahoma Board of Medical Licensure. Policy on Internet Prescribing. November 2, 2000.

South Carolina Board of Medical Examiners. Policy Statement. Internet Prescribing. July 17, 2000.

Texas State Board of Medical Examiners. Internet Prescribing Policy. December 11, 1999.

Washington Board of Osteopathic Medicine and Surgery. Policy Statement. Prescribing Medication without Physician/Patient Relationship. June 2, 2000.

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LOS ANGELES COUNTY
COMMISSION ON HIV

RYAN WHITE PROGRAM

UNIVERSAL STANDARDS OF CARE

Commission Approved

September 12, 2019

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INTRODUCTION

Standards of Care outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. Standards of Care are available for each service category to set the minimum level of care Ryan White funded agencies should offer to clients.[1] The Standards are intended to help Ryan White Part A funded agencies meet the needs of their clients. Providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV developed the Universal Standards of Care to reflect current guidelines from federal and national agencies on HIV care and treatment, and to establish the minimum standards of care necessary to achieve optimal health among people living with HIV (PLWH), regardless of where services are received in the County. The development of the Standards includes guidance from service providers, consumers and members of the Los Angeles County Commission on HIV, Standards and Best Practices Committee.

UNIVERSAL STANDARDS OVERVIEW

The objectives of the Universal Standards are to ensure agencies:

- Provide services that are accessible and non-discriminatory to all people living with HIV in Los Angeles County with a focus on highly impacted populations
- Educate staff and clients on the importance of receiving care, treatment as prevention, and how people who are completely, durably suppressed will not sexually transmit HIV.
- Protect client rights and ensure quality of care
- Provide client-centered, age appropriate, culturally and linguistically competent care
- Provide high quality services through experienced and trained staff
- Meet federal, state, and county requirements regarding safety, sanitation, access, and public health.
- Guarantee client confidentiality, protect client autonomy, and ensure a fair process of addressing grievances
- Inform clients of services, establish eligibility, and collect information through an intake process
- Effectively assess client needs and encourage informed and active participation
- Address client needs through coordination of care and referrals to needed services

1. GENERAL AGENCY POLICIES

All agencies offering Ryan White services must have written policies that address client confidentiality, release of information, client grievance procedures, and eligibility. Agency policies and procedures facilitates service delivery as well as ensures safety and well-being of clients and staff.

[1] Appendix A: List of Ryan White Part A Service Categories

1.0 GENERAL AGENCY POLICIES	
Standard	**Documentation**
1.1 Agency develops or utilizes an existing client confidentiality policy in accordance with state and federal laws to assure protection of client HIV status, behavioral risk factors, and/or use of services.	1.1 Written client confidentiality policy on file.
1.2 Client determines what information of theirs can be released and with whom it can be shared.	1.2 Completed *Release of Information Form* on file including: • Name of agency/individual with whom information will be shared • Information to be shared • Duration of the release consent • Client signature For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), form must be HIPAA disclosure authorization compliant.
1.3 Agency develops or utilizes an existing grievance procedure to ensure clients have recourse if they feel they are being treated in an unfair manner or feel they are not receiving quality services.	1.3 Written grievance procedure on file that includes, at minimum: • Client process to file a grievance • Information on the Los Angeles County Department of Public Health, Division of HIV & STD Programs (DHSP) Grievance Line 1-800-260-8787. [2] Additional ways to file grievances can be found at http://publichealth.lacounty.gov/dhsp/QuestionServices.htm DHSP Grievance Line is posted in a visible location on site.

[2] http://publichealth.lacounty.gov/dhsp/QuestionServices.htm

Standard	Documentation
1.4 Agency provides eligibility requirements for services available upon request. Eligibility requirements must follow guidance from Division of HIV & STD Programs (DHSP) and HRSA under Policy Clarification Notice #16-02.[3]	1.4 Written eligibility requirements on file.
1.5 All client files are stored in a secure and confidential location, and electronic client files are protected from unauthorized use.	1.5 Client files must be locked and/or password protected with access provided only to appropriate personnel.
1.6 Agency maintains progress notes of all communication between provider and client.	1.6 Legible progress notes maintained in individual client files that include, at minimum: • Date of communication or service • Service(s) provided • Recommended referrals linking clients to needed services (See Section 7: Referrals and Case Closure)
1.7 Agency develops or utilizes an existing crisis management policy.	1.7 Written crisis management policy on file that includes, at minimum: • Mental health crises • Dangerous behavior by clients or staff
1.8 Agency develops a policy on utilization of Universal Precaution Procedures.[4] a. Staff members are trained in universal precautions.	1.8 Written policy or procedure on file. a. Documentation of staff training in personnel file.
1.9 Agency ensures compliance with Americans with Disabilities Act (ADA) criteria for programmatic accessibility (e.g. building and design accessibility, parking, etc.). For agencies with multiple sites, all sites must be in compliance.	1.9 ADA criteria on file at all sites.

[3] https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
[4] https://www.cdc.gov/niosh/topics/bbp/universal.html

Standard	Documentation
1.10 Agency complies with all applicable state and federal workplace and safety laws and regulations, including fire safety.	1.10 Signed confirmation of compliance with applicable regulations on file.

2. CLIENT RIGHTS AND RESPONSIBILITIES

A key component of HIV/AIDS service delivery is the historic and continued involvement of people living with HIV in the design and evaluation of services. The quality of care and quality of life for people living with HIV/AIDS is maximized when people living with HIV are active participants in their own health care decisions with their providers. This can be facilitated by ensuring that clients are aware of and understand the importance of their input in the development of HIV programming.

2.0 CLIENT RIGHTS AND RESPONSIBILITIES	
Standard	**Documentation**
2.1 Agency ensures services are available to any individual who meets the eligibility requirements for the specific service category.	2.1 Written eligibility requirements on file. Client utilization data made available to funder.
2.2 Agency includes input from people living with HIV/AIDS in the design and evaluation of services to ensure care is client-centered.	2.2 Written documentation of how input was received to inform service planning and evaluation in regular reports. Lists may include: • Consumer Advisory Board meetings • Participation of people living with HIV in HIV program committees or other planning bodies • Needs assessments • Satisfaction surveys • Focus groups

Standard	Documentation
2.3 Agency provides each client a copy of the *Patient & Client Bill of Rights*[5] document that informs them of the following: • Confidentiality policy • Expectations and responsibilities of the client when seeking services • Client right to file a grievance • Client right to receive no-cost interpreter services • Client right to access their file (if psychotherapy notes cannot be released per clinician guidance, agency should provide a summary to client within 30 days) • Reasons for which a client may be discharged from services and the process that occurs during involuntary discharge	2.3 *Patient & Client Bill of Rights* document is signed by client and kept on file.

3. STAFF REQUIREMENTS AND QUALIFICATIONS

Staff must be well qualified and, if necessary, hold all required licenses, registration, and/or degrees in accordance with applicable State and federal regulations as well as requirements of the Los Angeles County Department of Public Health, Division of HIV & STD Programs. At minimum, all staff will be able to provide timely, linguistically and culturally competent care to people living with HIV. Staff will complete orientation through their respective hiring agency, including a review of established programmatic guidelines, and supplemental trainings as required by the Los Angeles County Department of Public Health, Division of HIV and STD Programs.

3.0 STAFF REQUIREMENTS AND QUALIFICATIONS	
Standard	**Documentation**
3.1 Staff members meet the minimum qualifications for their job position and have the knowledge, skills, and ability to effectively fulfill their role and the communities served.	3.1 Staff resumes on file.

[5] Appendix B: Patient & Client Bill of Rights

Standard	Documentation
3.2 If a position requires licensed staff, staff must be licensed to provide services.	3.2 Copy of current license on file.
3.3 Staff will participate in trainings appropriate to their job description and program a. Required education on how a client achieving and maintaining an undetectable viral load for a minimum of six months will not sexually transmit HIV.	3.3 Documentation of completed trainings on file
3.4 New staff will participate in trainings to increase capacity for fulfilling the responsibilities of their position. a. Required completion of an agency-based orientation within 6 weeks of hire b. Training within 3 months of being hired appropriate to the job description. c. Additional trainings appropriate to the job description and Ryan White service category.	3.4 Documentation of completed trainings on file

4. CULTURAL AND LINGUISTIC COMPETENCE

Ryan White funded agencies must provide services that are culturally and linguistically competent based on the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. As noted in the CLAS Standards, ensuring culturally and linguistically appropriate services advances health equity, improves quality, and helps eliminate health care disparities by establishing a blueprint for health and health care organizations. For the purpose of these standards, culture is defined as the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics.[6] The standards below are adapted directly from the National CLAS Standards.

[6] National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice. Office of Minority Health, US Department of Health and Human Services. April 2013. https://www.thinkculturalhealth.hhs.gov/clas/standards

Agencies should also strive towards acknowledging implicit bias, how it plays a role in service delivery, and how it can be addressed and countered. Agencies must provide services that align with strategies to reduce implicit bias by the Institute for Healthcare Improvement.[7] For the purpose of the standards, implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control. Residing deep in the subconscious, these biases are different from known biases that individuals may choose to conceal for the purposes of social and/or political correctness.[8]

Cultural competence and acknowledging implicit bias relies on behaviors, attitudes, and policies that come together in a system, agency, or among individuals that reduces stigma and enables effective delivery of services. Linguistic competence is the ability to communicate effectively with clients, including those whose preferred language is not the same as the provider's, those who have low literacy skills, and/or those with disabilities. Cultural and linguistic competence is a goal toward which all service providers must aspire, but one that may never be completely achieved given the diversity of languages and cultures throughout our communities, and understanding that culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetime. However, agencies should ensure staff are involved in a continual process of learning, personal growth, and training that increases cultural and linguistic competence, addresses implicit bias, decreases stigma and enhances the ability to provide appropriate services to all individuals living with HIV/AIDS.

Federal and State language access laws require health care facilities that receive federal or state funding to provide competent interpretation services to limited English proficiency patients at no cost, to ensure equal and meaningful access to health care services.[9] Interpretation refers to verbal communication where speech is translated from a speaker to a receiver in a language that the receiver can understand. Translation refers to the conversion of written material from one language to another.

4.0 CULTURAL AND LINGUISTIC COMPETENCE	
Standard	**Documentation**
4.1 Recruit, promote, and support a culturally and linguistically diverse workforce that are responsive to the population served.	4.1 Documentation of how staff demographics reflect the demographics of clients served on file (e.g. race, gender identity, age, sexual orientation, etc.)

[7] http://www.ihi.org/communities/blogs/how-to-reduce-implicit-bias
[8] http://kirwaninstitute.osu.edu/research/understanding-implicit-bias/

[9] Title VI of the Civil Rights Act of 1964 and California's 1973 Dymally-Alatorre Bilingual Services Act

Standard	Documentation
4.2 Agency develops or utilizes existing culturally and linguistically appropriate policies and practices. a. Agency educates and trains workforce on culturally and linguistically appropriate practices on an ongoing basis.	4.2 Written policy and practices on file a. Documentation of completed trainings on file.
4.3 Provide resources onsite to facilitate communication for individuals who experience impairment due to a challenging medical condition or status (e.g. augmentative and alternative communication resources or auxiliary aids and services)	4.3 Resources on file b. Checklist of resources onsite that are available for client use. c. Type of accommodations provided documented in client file.
4.4 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	4.4 *Signed Patient & Client Bill of Rights* document on file that includes notice of right to obtain no-cost interpreter services.
4.5 Ensure the competence of individuals providing language assistance a. Use of untrained individuals and/or minors as interpreters should be avoided b. Ensure quality of language skills of self-reported bilingual staff who use their non-English language skills during client encounters	4.5 Staff resumes and language certifications, if available, on file.
4.6 Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area in clinic points of entry (e.g. registration desks, front desks, reception, waiting rooms, etc.) and areas where work with client is performed (e.g. clinic rooms, meeting rooms, etc.)	4.6 Materials and signage in a visible location and/or on file for reference.

5. INTAKE AND ELIGIBILITY

All clients who request or are referred to HIV services will participate in an intake process conducted by appropriately trained staff. The intake worker will review client rights and responsibilities, explain available services, the confidentiality and grievance policy, assess immediate service needs, and secure permission to release information.

5.0 INTAKE AND ELIGIBILITY	
Standard	**Documentation**
5.1 Intake process begins within 5 days of initial contact and is completed within 30 days of initial contact with client.	5.1 Completed intake on file that includes, at minimum: • Client's legal name, name if different than legal name, and pronouns • Address, phone, and email (if available). A signed affidavit declaring homelessness should be kept on file for clients without an address. • Preferred method of communication (e.g., phone, email, or mail) • Emergency contact information • Preferred language of communication • Enrollment in other HIV/AIDS services; • Primary reason and need for seeking services at agency If client chooses not to complete the intake within 30 days of initial contact, document attempts to contact client and mode of communication in client file.
5.2 Agency determines client eligibility	5.2 Documentation includes: • Los Angeles County resident • Income equal to or below the required Federal Poverty Level (FPL) as determined by Division of HIV & STD Programs • Verification of HIV positive status

6. REFERRALS AND CASE CLOSURE

A client case may be closed through a systematic process that includes case closure justification and a transition plan to other services or other provider agencies, if applicable. Agencies should maintain a list of resources available for the client for referral purposes. If the client does not agree with the reason for case closure, they should follow the grievance policy at the provider agency and/or be referred to the Department of Public Health, Division of HIV and STD Programs Grievance Line.

6.0 REFERRALS AND CASE CLOSURE	
Standard	**Documentation**
6.1. Agency will maintain a comprehensive list of providers for full spectrum HIV-related and other service referrals a. Staff will provide referrals to link clients to services based on assessments and reassessments	6.1 Identified resources for referrals at provider agency (e.g. lists on file, access to websites) a. Written documentation of recommended referrals in client file
6.2 If needed, staff will engage additional providers for specific support services (e.g. behavioral health, substance abuse, housing)	6.2 Agency establishes partnerships with agencies for referrals as needed. Memoranda of Understanding (MOU) on file.
6.3 For clients with missed appointments or pending case closure, staff will attempt to contact client. a. Cases may be closed if the client: • Relocates out of the service area • Is no longer eligible for the service • Discontinues the service • No longer needs the service • Puts the agency, service provider, or other clients at risk • Uses the service improperly or has not complied with the services agreement • Is deceased • Has had no direct agency contact, after repeated attempts, for a period of 12 months.	6.3 Attempts to contact client and mode of communication documented in file. a. Justification for case closure documented in client file

Standard	Documentation
6.4 Agency has a transition procedure in place that is implemented for clients leaving services to ensure a smooth transition for clients who no longer want or need services.	6.4 Completed transition summary in file, signed by client and supervisor (if possible). Summary should include reason for discharge; and a plan for transition to other services, if applicable, with confirmation of communication between referring and referral agencies, or between client and agency.
6.5 Agency develops or utilizes existing due process policy for involuntary discharge of clients from services; policy includes a series of verbal and written warnings before final notice and discharge.	6.5 Due process policy on file as part of transition, discharge, and case closure policy described in the *Patient & Client Bill of Rights* document. (Refer to Section 2).

ACKNOWLEDGEMENTS

The Los Angeles County Commission on HIV would like to thank the following people for their contributions to the development of the Universal Standards of Care.

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7. APPENDICES

APPENDIX A

RYAN WHITE PART A SERVICE CATEGORIES

Ryan White HIV/AIDS Program Part A provides assistance to jurisdictions that are most severely impacted by the HIV epidemic. Part A funds must be used to provide core medical and support services for people living with HIV.

Core medical services include the following categories:

- AIDS Drug Assistance Program
- AIDS pharmaceutical assistance
- Early intervention services
- Health insurance premium and cost sharing assistance for low-income individuals
- Home and community-based health services
- Home health care
- Hospice services
- Medical case management, including treatment-adherence services
- Medical nutrition therapy
- Mental health services
- Oral health
- Outpatient and ambulatory medical care
- Substance abuse outpatient care

Support services include the following categories:

- Case Management (Non-Medical)
- Childcare Services
- Emergency Financial Assistance
- Food Bank/Home Delivered Meals
- Health Education/Risk Reduction
- Housing Services
- Legal Services
- Linguistic Services
- Medical Transportation
- Outreach Services
- Psychosocial Support Services
- Referral
- Rehabilitation
- Respite Care
- Substance Abuse Residential
- Treatment Adherence Counseling

APPENDIX B

PEOPLE WITH HIV/AIDS BILL OF RIGHTS AND RESPONSIBILITIES

The purpose of this Patient and Client Bill of Rights is to help enable clients act on their own behalf and in partnership with their providers to obtain the best possible HIV/AIDS care and treatment. This Bill of Rights and Responsibilities comes from the hearts of people living with HIV/AIDS in the diverse communities of Los Angeles County. As someone newly entering or currently accessing care, treatment or support services for HIV/AIDS, you have the right to:

A. Respectful Treatment

1. Receive considerate, respectful, professional, confidential and timely care in a safe client-centered environment without bias.
2. Receive equal and unbiased care in accordance with federal and State laws.
3. Receive information about the qualifications of your providers, particularly about their experience managing and treating HIV/AIDS or related services.
4. Be informed of the names and work phone numbers of the physicians, nurses and other staff members responsible for your care.
5. Receive safe accommodations for protection of personal property while receiving care services.
6. Receive services that are culturally and linguistically appropriate, including having a full explanation of all services and treatment options provided clearly in your own language and dialect.
7. Look at your medical records and receive copies of them upon your request (reasonable agency policies including reasonable fee for photocopying may apply).
8. When special needs arise, extended visiting hours by family, partner, or friends during inpatient treatment, recognizing that there may be limits imposed for valid reasons by the hospital, hospice or other inpatient institution.

B. Competent, High-Quality Care

1. Have your care provided by competent, qualified professionals who follow HIV treatment standards as set forth by the Federal Public Health Service Guidelines, the Centers for Disease Control and Prevention (CDC), the California Department of Health Services, and the County of Los Angeles.
2. Have access to these professionals at convenient times and locations.
3. Receive appropriate referrals to other medical, mental health or other care services.

C. Make Treatment Decisions

1. Receive complete and up-to-date information in words you understand about your diagnosis, treatment options, medications (including common side effects and complications) and prognosis that can reasonably be expected.

2. Participate actively with your provider(s) in discussions about choices and options available for your treatment.
3. Make the final decision about which choice and option is best for you after you have been given all relevant information about these choices and the clear recommendation of your provider.
4. Refuse any and all treatments recommended and be told of the effect not taking the treatment may have on your health, be told of any other potential consequences of your refusal and be assured that you have the right to change your mind later.
5. Be informed about and afforded the opportunity to participate in any appropriate clinical research studies for which you are eligible.
6. Refuse to participate in research without prejudice or penalty of any sort.
7. Refuse any offered services or end participation in any program without bias or impact on your care.
8. Be informed of the procedures at the agency or institution for resolving misunderstandings, making complaints or filing grievances.
9. Receive a response to a complaint or grievance within 30 days of filing it.
10. Be informed of independent ombudsman or advocacy services outside the agency to help you resolve problems or grievances (see number at bottom of this form), including how to access a federal complaint center within the Center for Medicare and Medicaid Services (CMS).

D. Confidentiality and Privacy

1. Receive a copy of your agency's Notice of Privacy Policies and Procedures. (Your agency will ask you to acknowledge receipt of this document.)
2. Keep your HIV status confidential or anonymous with respect to HIV counseling and testing services. Have information explained to you about confidentiality policies and under what conditions, if any, information about HIV care services may be released.
3. Request restricted access to specific sections of your medical records.
4. Authorize or withdraw requests for your medical record from anyone else besides your health care providers and for billing purposes.
5. Question information in your medical chart and make a written request to change specific documented information. (Your physician has the right to accept or refuse your request with an explanation.)

E. Billing Information and Assistance

1. Receive complete information and explanation in advance of all charges that may be incurred for receiving care, treatment and services as well as payment policies of your provider.
2. Receive information on any programs to help you pay and assistance in accessing such assistance and any other benefits for which you may be eligible.

F. Patient/Client Responsibilities

In order to help your provider give you and other clients the care to which you are entitled, you also have the responsibility to:

1. Participate in the development and implementation of your individual treatment or service plan to the extent that you are able.
2. Provide your providers, to the best of your knowledge, accurate and complete information about your current and past health and illness, medications and other treatment and services you are receiving, since all of these may affect your care. Communicate promptly in the future any changes or new developments.
3. Communicate to your provider whenever you do not understand information you are given.
4. Follow the treatment plan you have agreed to and/or accepting the consequences of failing the recommended course of treatment or of using other treatments.
5. Keep your appointments and commitments at this agency or inform the agency promptly if you cannot do so.
6. Keep your provider or main contact informed about how to reach you confidentially by phone, mail or other means.
7. Follow the agency's rules and regulations concerning patient/client care and conduct.
8. Be considerate of your providers and fellow clients/patients and treat them with the respect you yourself expect.
9. Refrain from the use of profanity or abusive or hostile language; threats, violence or intimidations; carrying weapons of any sort; theft or vandalism; intoxication or use of illegal drugs; sexual harassment and misconduct.
10. Maintain the confidentiality of everyone else receiving care or services at the agency by never mentioning to anyone who you see here or casually speaking to other clients not already known to you if you see them elsewhere.

For More Help or Information

Your first step in getting more information or involving any complaints or grievances should be to speak with your provider or a designated client services representative or patient or treatment advocate at the agency. If this does not resolve any problem in a reasonable time span, or if serious concerns or issues that arise that you feel you need to speak about with someone outside the agency, you may call the number below for confidential, independent information and assistance.

For patient complaints/grievances call (800) 260-8787
8:00 am – 5:00 pm
Monday – Friday

Universal Standards Updates
As of PPC meeting 12/3/19

From Non-Medical Case Management Standards:

1. Under Staff Requirement and Qualifications

Given there are case management services funded outside of the Ryan White Part A program, staff are responsible for ensuring clients' needs are met through collaboration and coordination across Ryan White funded and non-funded programs.
**Consider adding Case Conferences section back to Universal Standards*

Standards Table:

Staff are required to coordinate across Ryan White funded and non-funded programs to ensure clients needs are met.	Documentation of staff efforts of coordinating across systems for the client on file (e.g. housing case management services, etc.).

2. Trainings

Case Managers and Case Manager Supervisors should have experience in or participate in trainings on:

- LGBTQ+/Transgender community
- HIV Navigation Services (HNS) provided by CDC (currently taken by MCC teams)

ELEVATION
HEALTH PARTNERS

ELEVATING HEALTH FOR ALL

Mission Possible HIV Quality Improvement Learning Collaborative for MCC Team

MCC Promising Practices in Telehealth Integration

Presented by: LAC DHSP and Elevation Health Partners

July 22, 2020 12:00 – 1:30 pm

Welcome

Becca Cohen, MD, MPH
Associate Medical Director
and HIV Clinical Specialist
LAC Department of Public Health Division
HIV and STD Programs (DHSP)
RCohen@ph.lacounty.gov

About Becca

Becca oversees efforts to improve viral suppression and retention in care among people living with HIV in LA County and works closely with DHSP's Program Support and Quality Improvement Unit to lead quality improvement efforts within the Ryan White Program. She sees patients for HIV treatment, PrEP, and transgender care at LA County's Correctional Health Services. She is committed to providing high-quality HIV care and prevention services for LA county residents of all genders and ensuring that health care providers and staff are trained so that gender inclusive and affirming care is provided in all health care settings.

Welcome

Wendy Garland, MPH

Chief of Research and Innovation

LAC Department of Public Health Division

HIV and STD Programs (DHSP)

WGarland@ph.lacounty.gov

About Wendy

Wendy is a Chief Epidemiologist and leads the Research and Evaluation Unit at DHSP. She oversees HIV and STD research, demonstration projects and evaluation of prevention and treatment services to reduce disparities in HIV and STD incidence and health outcomes and promote health equity among residents of LA County. She has nearly 20 years of experience in the field of HIV prevention, care and treatment and led the development of the Medical Care Coordination program.

Welcome

Natalie Martin, MBA, SHRM-SCP, TCI-CF
President and CEO
Elevation Health Partners
natalie@elevationhealthpartners.com

About Natalie

With over thirty years of experience, Natalie has spent the last 15 years assisting California's counties, communities, and health systems in clinical system redesign, practice transformation, and data sharing to deliver patient-centered, accountable, community care. Leading the team at Elevation Health Partners, Natalie works in close partnership with funding organizations, federal, state, and county government entities, and community organizations to identify needs and improve patient experience and health outcomes. Natalie works hand on in the field working shoulder-to-shoulder with healthcare and social services teams.

Welcome

Rachel Proud, MPH
Senior Managing Consultant
Elevation Health Partners
rachel@elevationhealthpartners.com

About Rachel

Rachel's expertise is in Practice Transformation, Patient Centered Medical Home (PCMH), Social Determinants of Health (SDoH), Coding for Quality, HEDIS/P4P, and she is currently building her knowledge and understanding of the health and social needs of PLWHA. Rachel serves on the Elevation Health leadership team to assist the firm with achieving client goals and objectives and is also the Legislative and Health Policy Subject Matter Expert for the firm.

Objectives

By the end of this webinar participants will:

- Share and learn promising practices in telehealth integration for MCC services
- Learn how MCC peers are prioritizing in-person services
- Increase understanding of patient preference in MCC service modalities
- Deepen understanding of disparities and equitable care related to telehealth HIV care
- Share input on evolving solutions for obtaining patient consent
- Gather promising practices for Elevation Health to document into a compilation for MCC teams

Reflection: What Matters

California Department of PublicHealth

COVID-19 Race and Ethnicity Data
July 19, 2020

All Cases and Deaths associated with COVID-19 by Race and Ethnicity

Race/Ethnicity	No. Cases	Percent Cases	No. Deaths	Percent Deaths	Percent CA population
Latino	140,066	55.7	3,373	44.8	38.9
White	44,276	17.6	2,308	30.7	36.6
Asian	14,368	5.7	997	13.2	15.4
African American	10,866	4.3	654	8.7	6.0
Multi-Race	1,887	0.7	41	0.5	2.2
American Indian or Alaska Native	566	0.2	25	0.3	0.5
Native Hawaiian and other Pacific Islander	1,512	0.6	41	0.5	0.3
Other	38,119	15.1	91	1.2	0.0
Total with data	251,660	100.0	7,530	100.0	100.0

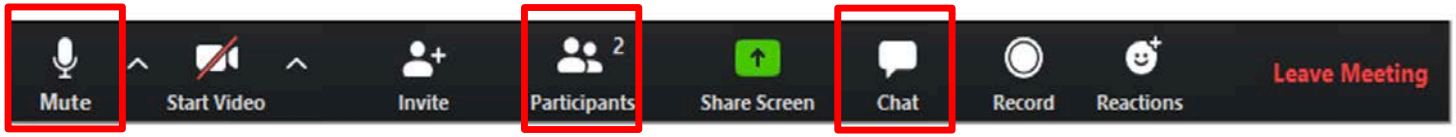
Cases: 391,538 total; 139,878 (36%) missing race/ethnicity
Deaths: 7,651 total; 121 (2%) missing race/ethnicity
***457 cases with missing age**
****Census data does not include 'other race' category**

Racism and Public Health Resources

- American Public Health Association – Racism and Health publications includes a webinar on Racism: The Ultimate Underlying Health Condition
- National Association for County and City Health Officials – Racially Driven Violence Against Black Americans Is a Public Health Issue
- The second installment of a Virtual Dialogue Series on societal inequities is coming up July 30th, 10-12 with a focus on Race & Health
  - Muntu Davis, M.D., M.P.H., Public Health Officer, Department of Public Health
  - Erika Flores Uribe, M.D., M.P.H, Director of Language Access and Inclusion
  - Curley Bonds, M.D., Chief Deputy, Clinical Operations, Department of Mental Health
  - Matthew Trujillo, Ph.D. Manager of Strategic Initiatives/The Advancement Project California
  - Georges C. Benjamin, M.D., Executive Director, American Public Health Association

Today's Webinar is Interactive!

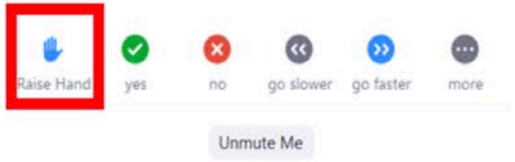
- We will use the chat feature to facilitate input during the webinar and follow up on GlassCubes
- We will use the raise hand feature to unmute your line so that you can share your insights with peers and ask questions. NOTE: you will need to agree to being unmuted so if you raise your hand, keep an eye out for the button pop up and select "unmute"
- Polls will pop up on our screen and results will be shared on the screen as well



1. This button will allow you to mute and unmute your mic. When the mic is muted a red line will be drawn diagonally through it. My mic is currently NOT muted above. The ^ symbol to the right of Mute will allow you to control your audio settings within a meeting. You can set your audio to the device you're using or sync it to your system audio.
2. The video button will start and stop your camera. If you do not want your camera to display, this button should look the same as above.
3. If you have permissions to invite, you will be able to invite other users to your meeting here.
4. View the participants in the meeting if you have permission.
5. Share your desktop or an individual application.
6. The chat button will allow you to open the in-meeting chat. You can send messages to one participant or the entire class. Please speak with your course staff to find out more about how Q&A will be handled in your individual section.
7. If you have permission to record the meeting you can do so here.
8. Click here to leave or end the video meeting

How do I raise my hand?

Raising you hand can be done by clicking "Participants" (button #4 above) in the in-meeting control bar and clicking the "Raise Hand" icon highlighted below:



After you have clicked the raise hand button, the hand icon will appear next to your name in the participants listing. Please wait patiently for your teacher to notice and call on you. Be ready to unmute yourself (button #1) and speak slowly and clearly.

Opportunity*

COVID-19, Telemedicine, and Patient Empowerment in HIV Care and Research

- Studies – based on in person visits - have found that high quality communication from providers (e.g., active listening, clear explanation) and a strong patient-provider relationship leads to improved patient engagement in HIV care and better ART adherence
- Stigma, mistrust, and mistreatment in medical care among PLWHA remain current issues
- Increase in telehealth solutions provides an opportunity to reinvent how providers and patients define connection, identify best practices, and provide training to providers at all levels
- These insights must be informed by the perspectives of PLWHA with complex histories and from historically marginalized groups
- Telehealth may offer new opportunities for hard to reach patients, those with transportation barriers, and those that express a preference for telehealth options
- An approach focused on patients' values and preferences provides an opportunity to empower PLWHA

*Mgbako O, Miller EH, Santoro AF, et al. COVID-19, Telemedicine, and Patient Empowerment in HIV Care and Research. AIDS Behav. 2020;24(7):1990-1993. doi:10.1007/s10461-020-02926-x

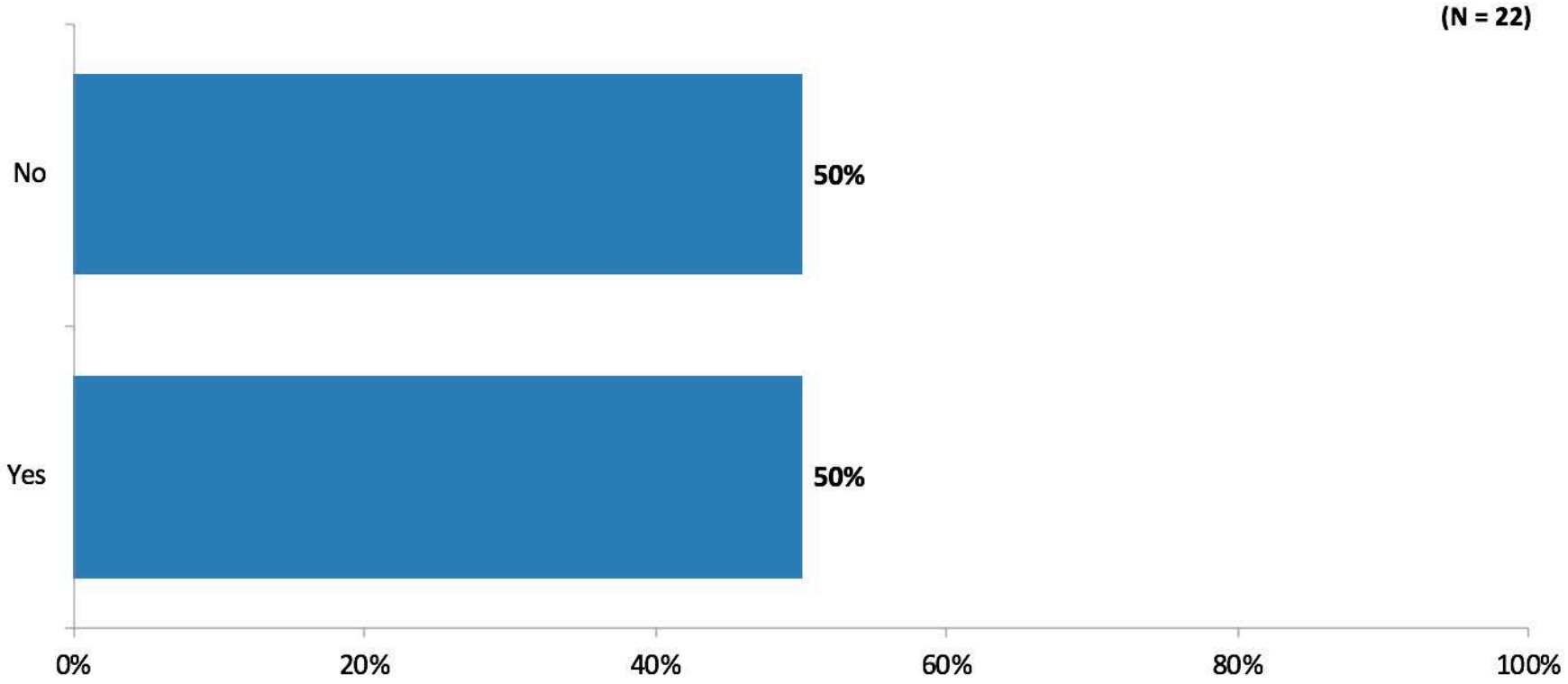
Telephone Utilization Proven in Additional Settings

- Social Work Maxim
  - Meet patients where they are
  - Literally true with telephonic engagement (at home)
- Telemental Health
- Collaborative Care Model

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4744872/
https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf

Prioritizing In Person MCC Services

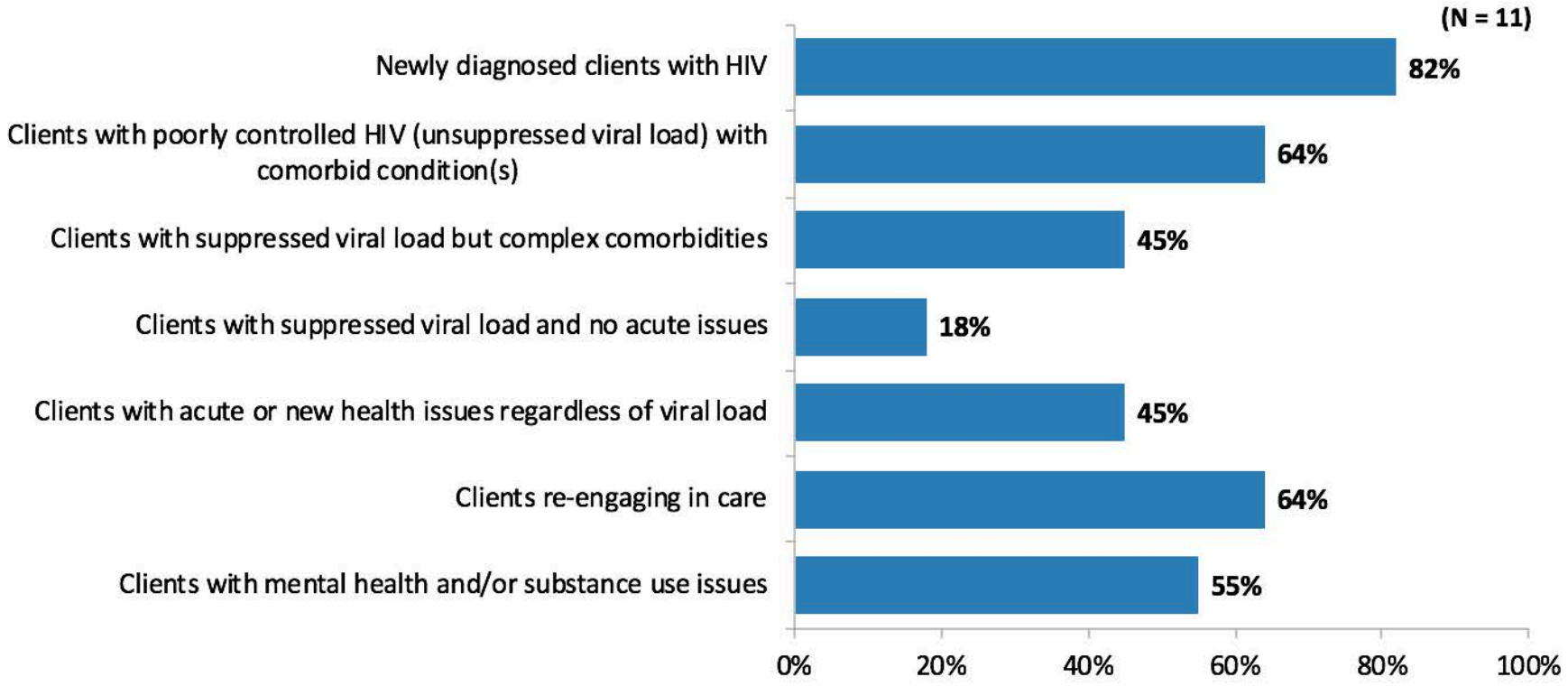
Are you prioritizing clients for in-person MCC services?



Source: MCC - COVID Provider Assessment 5-13-20

Prioritizing In Person MCC Services

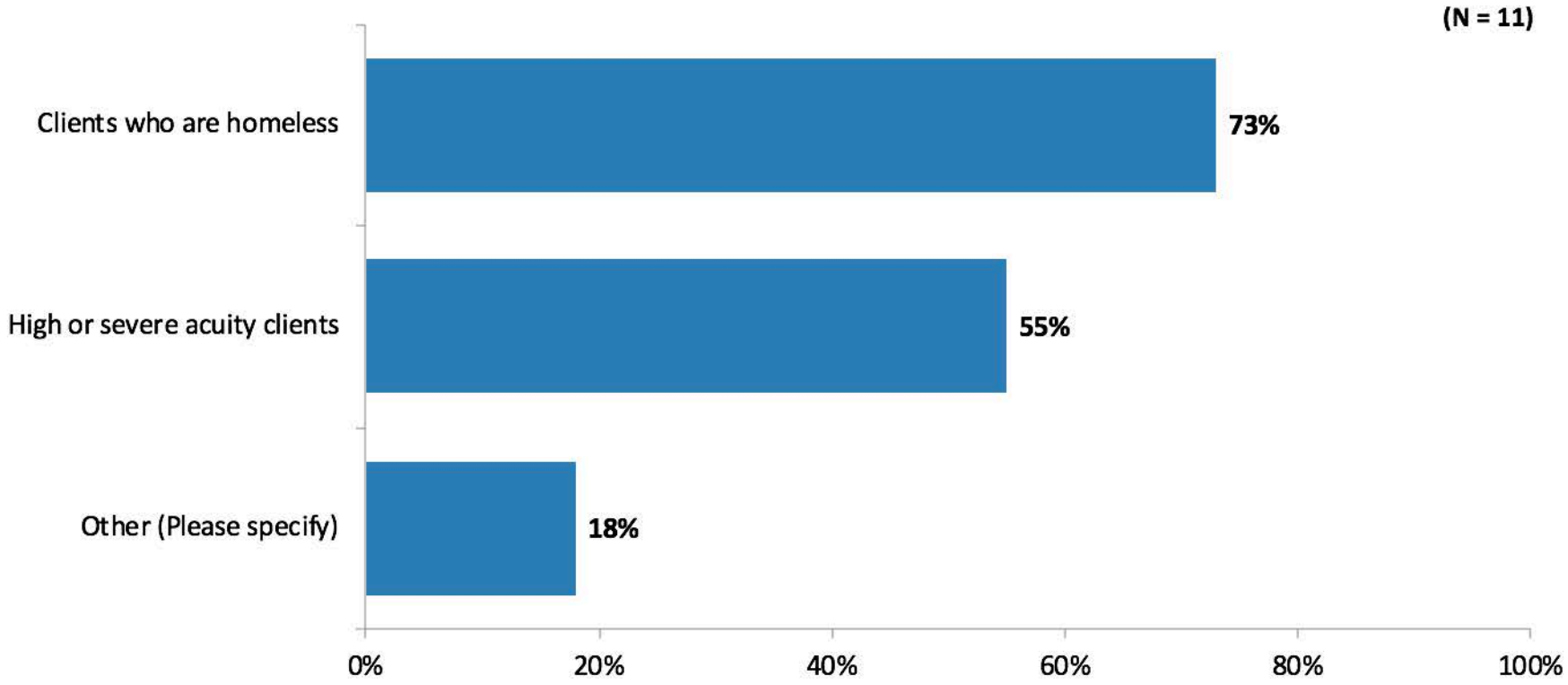
Which MCC clients are being prioritized? (Check all that apply.)



Source: MCC - COVID Provider Assessment 5-13-20

Prioritizing In Person MCC Services

Which MCC clients are being prioritized? (Check all that apply.) (Continued)



Source: MCC - COVID Provider Assessment 5-13-20

Additional Consideration for Prioritizing In Person MCC Services

In Person

- Initial visits/ assessment
- Rapport needs to be established; not comfortable meeting over the phone (very guarded)
- Newly diagnosed
- *New to clinic*
- *Identified through inpatient care (frequents the ER/hospital)*
- Comorbidities/ complexity
- When physical exam is important
- *Low health literacy*
- *Low technology literacy*
- *Limited access or without internet, adequate phone or computer-based technology*
- Homeless with limited to no access to a phone or computer
- Paperwork/documentation assistance required in person
- Need for lab testing, medical…

Telephone

- Transportation barriers
- Convenience (engaged in care) and willingness to speak on the phone
- Not engaged in care
- Rapport established (provider referral, warm hand off…)
- Missed/cancelled appointment
- Declined on-site appointment
- *Childcare barriers*
- Inconsistent attendance/scheduling conflicts
- *High no show rate*
- *High cancellation rate*
- Physical injury/limited mobility/chronic pain
- Reducing the risk of COVID-19 exposure to the patient

Hidden Barrier: Staff, Leadership, Clinician resistance

Issue	Solution
It's unfamiliar and uncomfortable	Training
A belief that it's not effective	Education
Difficult to build rapport with a new, unestablished patient who would prefer a face-to-face visit	Training

Discussion: Patient Perspectives

Use the "raise your hand" feature in Zoom and we will unmute you to join the discussion

Do you capture patient preference as a factor in prioritizing in-person MCC services?

TELEPHONE VISITS

Telephone Encounters Evidence

- Phone visits are shown to:
  - Increase access
  - Transcend barriers
  - Improve treatment outcomes
  - Provide early follow-up
  - Allow frequent contact
  - Improve routine symptom monitoring
  - Provide adherence support
  - Promote engagement
  - Support persistent outreach and flexibility
  - Provide treatment

https://aims.uw.edu/nyscc/training/sites/default/files/UsingthetelephoneinCollaborativeCare_1-31-19.pdf

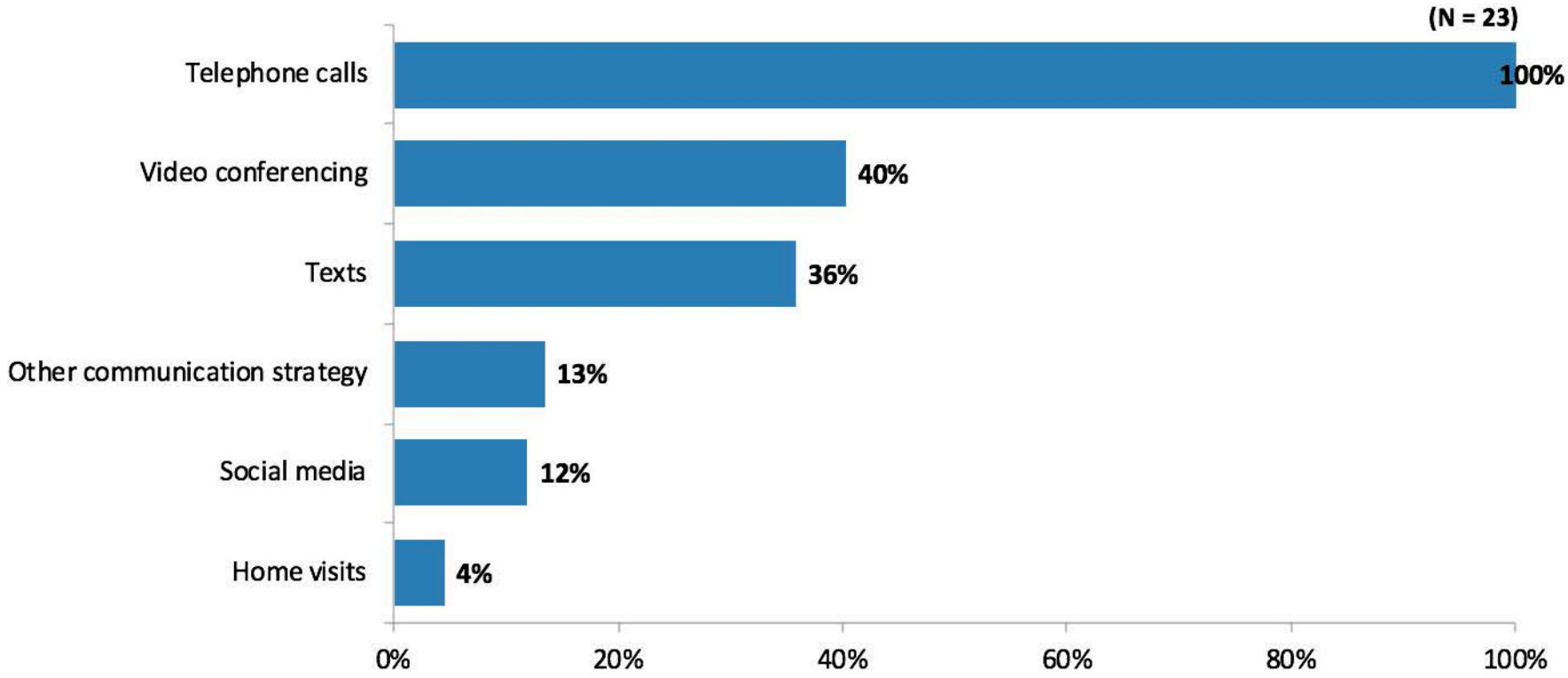
Patient Perspective

- Advantages
  - When honoring patient preference
  - Convenience
  - No transportation barriers
  - Decreased travel time/expenses
  - Avoiding stigmatizing clinic experiences
  - Minimization of COVID-19 infectious risk through close social contact
- Difficulties
  - Technology fear/ frustration
  - Connectivity disruptions
  - Environmental challenges (privacy, disruptions, noise)
  - Rapport/ trust
  - Emotional connection
  - Confidentiality
  - Increases disparities
- Unique to care team
  - Rapport/ trust skills
  - Achieving team care

"Go into Settings, Privacy, Activity Controls, Web Activity, Manage Activity, and deselect Giant Snake."

Agency Telephone Use - Communication

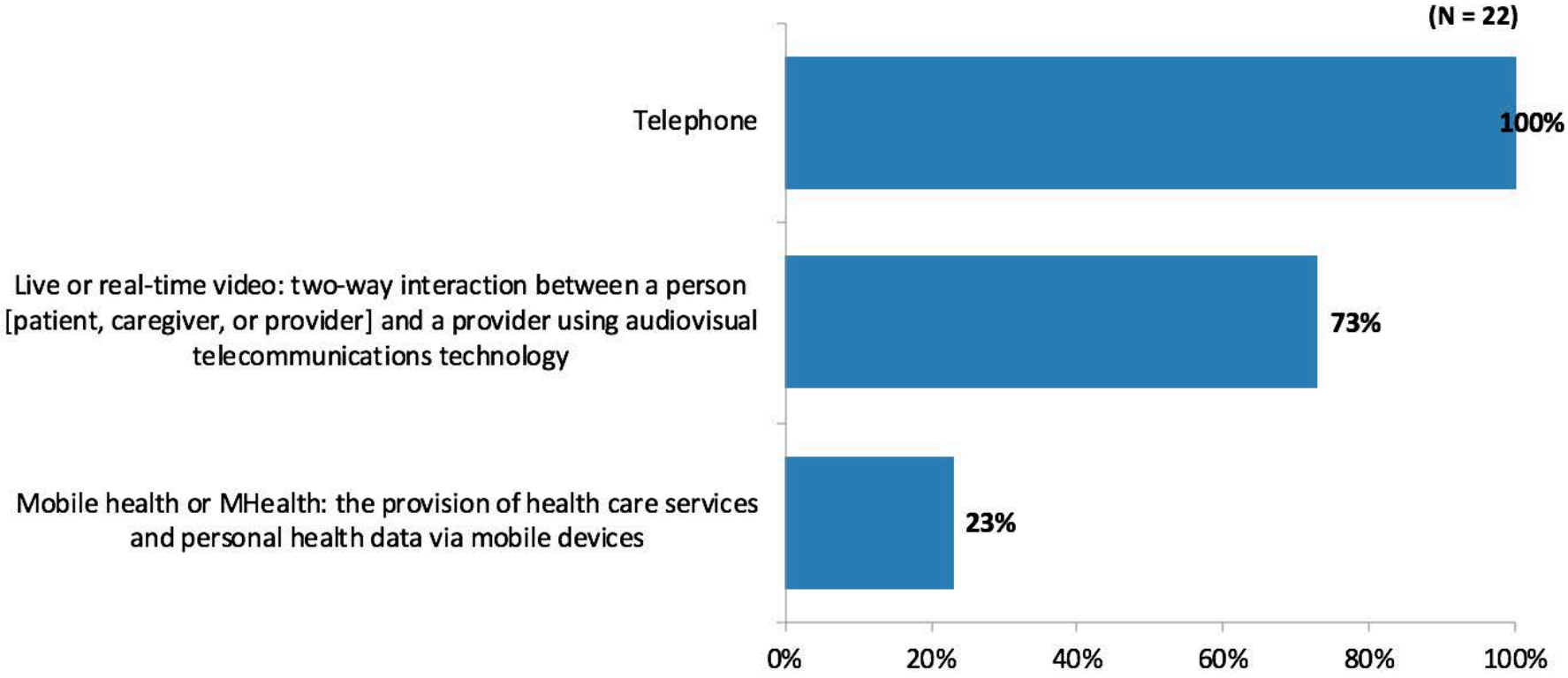
Please rank your three main current communication strategies in order of frequency:



Source: MCC - COVID Provider Assessment 5-13-20

Agency Telehealth Modalities

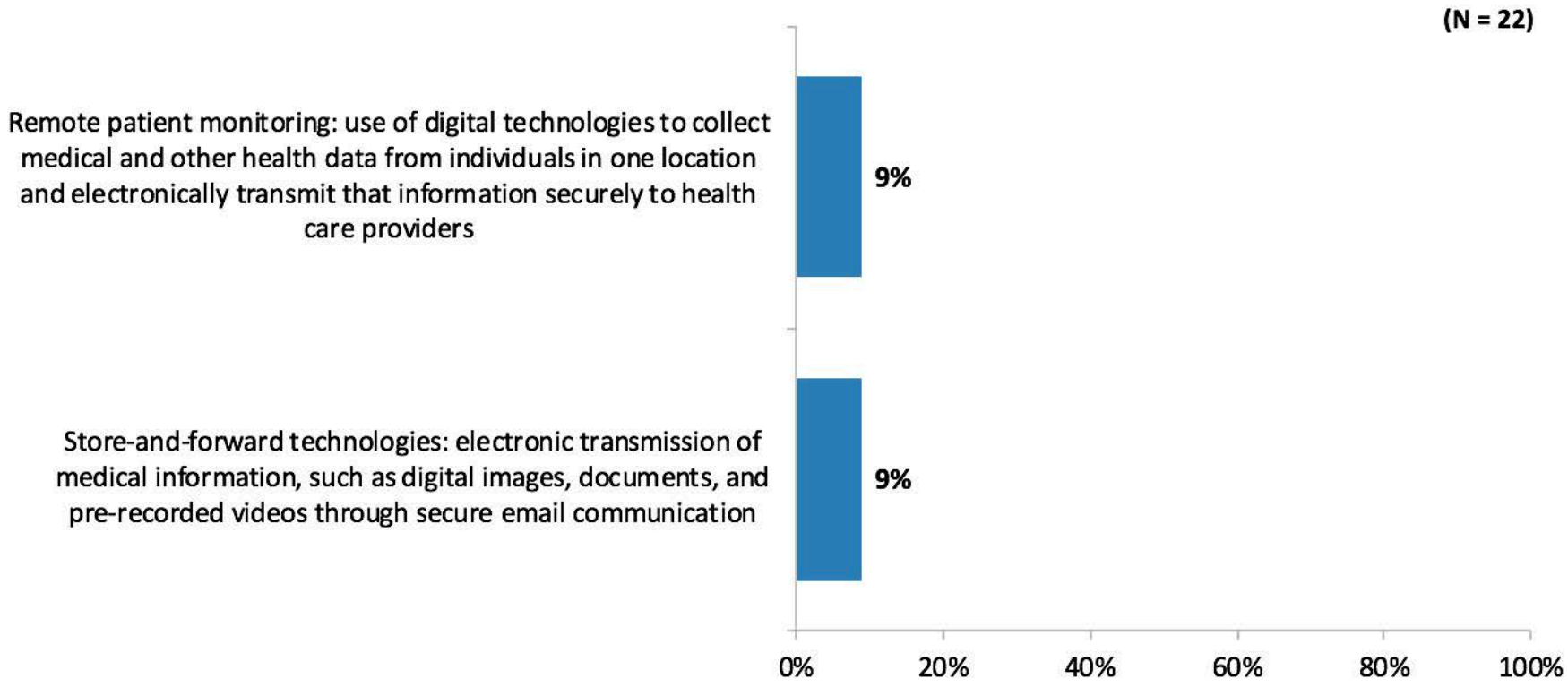
Which telehealth modalities does your agency currently use? (Check all that apply):



Source: MCC - COVID Provider Assessment 5-13-20

Agency Telehealth Modalities

Which telehealth modalities does your agency currently use? (Check all that apply): (Continued)



Source: MCC - COVID Provider Assessment 5-13-20

MCC Telephone Visits

- What is a telephone visit?
  - Documented as a telephone visit in CaseWatch
  - May result in a completed assessment, reassessment, brief intervention, care planning or linked referral
  - Takes the place of a face-to-face visit
  - Medically necessary and clinically appropriate for telephone communication (provider discretion)
  - Meets all procedural and technical components of an in-person visit (vs. follow up call)

Telephone Visit Scheduling Tips

As we go through this slide, please use the "chat" feature in Zoom to offer tips and solutions for organizing your day/ scheduling visits and we'll share these now

- Leave half or part of every day unstructured – or split the day half and half for telephone and in-person visits
- Alter days of the week of morning/ afternoon shifts to address patient needs
- Example: Schedule a series of morning phone visits, break for lunch and catch up charting from the morning and then 2 hours of calls in the afternoon with the end of the day as catch up for unexpected visits/calls
- Educate the patient at the time of scheduling about the telephone visit steps and any preparation they need to be aware of, such as being in a quiet space or how to log into the platform a few minutes beforehand

Telephone Visit Execution Tips

- Doing continuous calls plus CaseWatch and EHR documenting is difficult with a high number of telephone visits/hour
- Patients may sit in silence when staff are documenting the visit rather than listening/responding and too much silence on the phone can erode trust. Tips:
  - Tell the patient when you are documenting
  - If care team meetings are possible, assign a team member to take notes
- If you have background noise, acknowledge this noise and assure patients that call is still private and confidential
- Prepare staff and patients with a checklist (see attached examples)
- Train staff on successful telephone encounters
  - Scripts
  - Workflow
  - Engagement

Normalize Telephone Visits

- Discuss phone use with patient at initial contact
  - Emphasize frequent contact in beginning of treatment, as a key component of treatment outcomes
  - Address preference for scheduled sessions vs. as needed sessions
  - Patient preference, no clinician preference
- Explain purpose of phone appointments – as a treatment option, not just a back-up!
  - See how medications are working
  - Assess and monitor symptoms
  - Work on treatment goals
  - Check in between in-person visits

https://aims.uw.edu/nyscc/training/sites/default/files/UsingthetelephoneinCollaborativeCare_1-31-19.pdf

Telephone Visits: Measuring Success

- How will your agency measure success? How will we demonstrate the effectiveness of telephone and virtual modalities? Is there a business case for sustaining this approach in a post pandemic environment?
  - Total number of assessments/ interventions
  - Impact on MCC metrics
  - No show/ rescheduling rates
  - By patient preference
  - Patient satisfaction/engagement
  - Clinician and staff engagement

Empathy and Rapport on the Phone

- Rapport is developed by fostering a caring connection through the desire to understand and support
- A great deal of extra information is conveyed over the phone (vocal inflection, patterns of speech/thought, cadence)
- Research has shown that people can tell if you're smiling by the tone of your voice. Warmly express that you're happy to have the chance to talk with the patient today

Sample Call Outline

- All calls have a beginning – the opening, a middle, and an end – the closing
- Patient ASK is an important tool in phone conversation

Call 'Beginning' Tips

Opening

- Take a breath before you call the patient. For patients you know, reflect upon something you admire about them before initiating the call
- SMILE as you begin. Warmly express that you're happy to have the chance to talk with the patient today
- ASK patient if this is still a convenient time to talk
- Engage patient in agenda setting –ASK – Prioritize and negotiate what you'll address
- Communicate how much time you are planning for the call

Middle → Closing

Call 'Middle' Tips

Opening

Middle

- Acknowledge the pandemic: ask how the patient is coping with the COVID-19 pandemic
- Review care plan (Agenda Setting) from previous contact (check medication adherence and response, assess or provide brief, goal-oriented talk/ treatment intervention…)
- If performing risk assessment, review scores, share what you have learned and what it means for the patient
- Follow the same clinical guidelines you would with an in-person visit

Closing

Communication Tips

- **Elicit reactions to recommendations overtly.** Because you cannot see the patient's nonverbal reactions, regularly ask, "What do you think about that?"

- **Increase the frequency of empathic statements and use a warm tone of voice.** For example, you could say, "This sounds really tough. You sound sad." Patients are missing out on your nonverbal and facial expressions of care, so you need to convey these sentiments with your voice.

- **Mirror tone and language of patient.** Mirroring or repeating the language used by the patient. With upset patient, mirror a few tones lower.

- **Shorten your educational spiels**. Break up your explanations into short chunks. Repeat them if necessary. Elicit reactions and questions regularly.

- **Remember that the summary and teach-back are vital.** Be sure to assess the patient's understanding and buy-in of your co-created plan and elicit questions.

Call ‘Closing’ Tips

Opening → Middle →

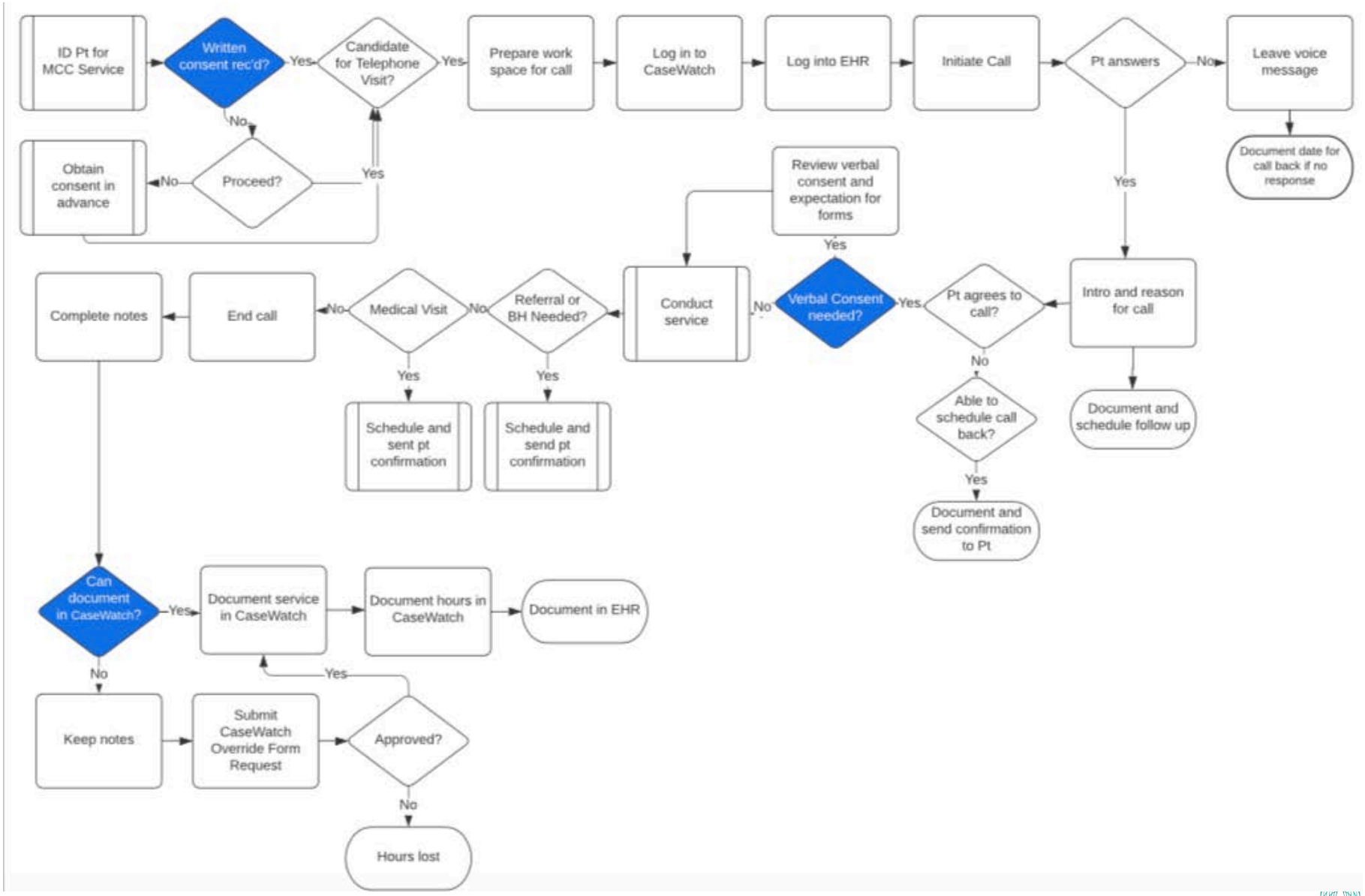
Closing

- ASK to schedule follow-up appointment, for agreement on next steps
- Share importance of next steps
- Set expectations for timing and nature of next contact
- ASK to confirm contact information, best day/ time to call…
- Share procedure for re-scheduling
- ASK and document patient preference for next appointment. “Based on what we discussed today, it is best if this next appointment is in-person at our x location. Do you have any concerns about an in-person visit at the x location?” [Address concerns] “Have I addressed your concerns about coming into the x location? Ok great. I’ll check in with you three days before the appointment to make sure you are still comfortable and if anything has changed, we’ll make a new plan together”

Video Tips

- Tips from telephone visits apply, plus…
  - Set up the camera at eye-level to ensure proper contact and test it in advance
  - Adjust the lighting to make sure you are clear in the camera and there isn't too much background light in the video
    - Face into the light. Minimize or avoid windows behind you. Keep the light bright and defuse. Use lamps and overhead light to make it as even as possible
    - Keep backgrounds simple
    - Note head space as you would for a photograph
  - Keep device stationary with no moving devices (e.g., ceiling fans) behind you that could cause video distortions
  - Dress appropriately as if you're in person at the office (wear ID badge, scrubs, physician coat)

Telephone Visit Workflow Example



Telephone Workflow Observations

- Most telephone visits happen on the spot with the first call to the patient (rarely a call to schedule a future appointment with a scheduled time)
- Decision process in place for meeting in-person at outset, policies and documentation still under development
  - Lab visits and need for medical care are prioritized use cases
- How much prep goes into the visit before the call – for staff or patient?
- Use of paper and post-it notes during call with most documentation (CaseWatch, EHR) after the call is over
- Modifications in service due to COVID-19
- Phone and technology may require additional steps, not documented
- MCC Consent
  - Prioritizing collection before the assessment, intervention, etc.
  - Cases of verbal consent– CaseWatch hours complexities
  - Collected with photo of ID via email with designated team member to check emails
  - Mailed with pre-paid return envelope
  - On demand consent promising to streamline workflow

Top Technology Needs of MCC Teams

- The following are the most critical tools for performing remote care/ telephone visits
  - CaseWatch access
  - EHR access
  - Telephone number cloaking tool (Konnect)
  - Voicemail access
  - Encrypted email (Virtru)
  - Calendar tool
  - Text messaging/ office chat
  - Excel for tracking effort
- Supply of "Obama" phones (for patients) were an initial concern
- Strong anecdotal case for telephonic visits: patients have greater access to phones than video
- Advantages of video visits in MCC care not established, work in progress?

Consent Updates

- Verbal consent is still permitted per HIPAA
- DHSP has extended eligibility requirements through August 30, 2020
- It remains important for team to do their best in collecting signed forms

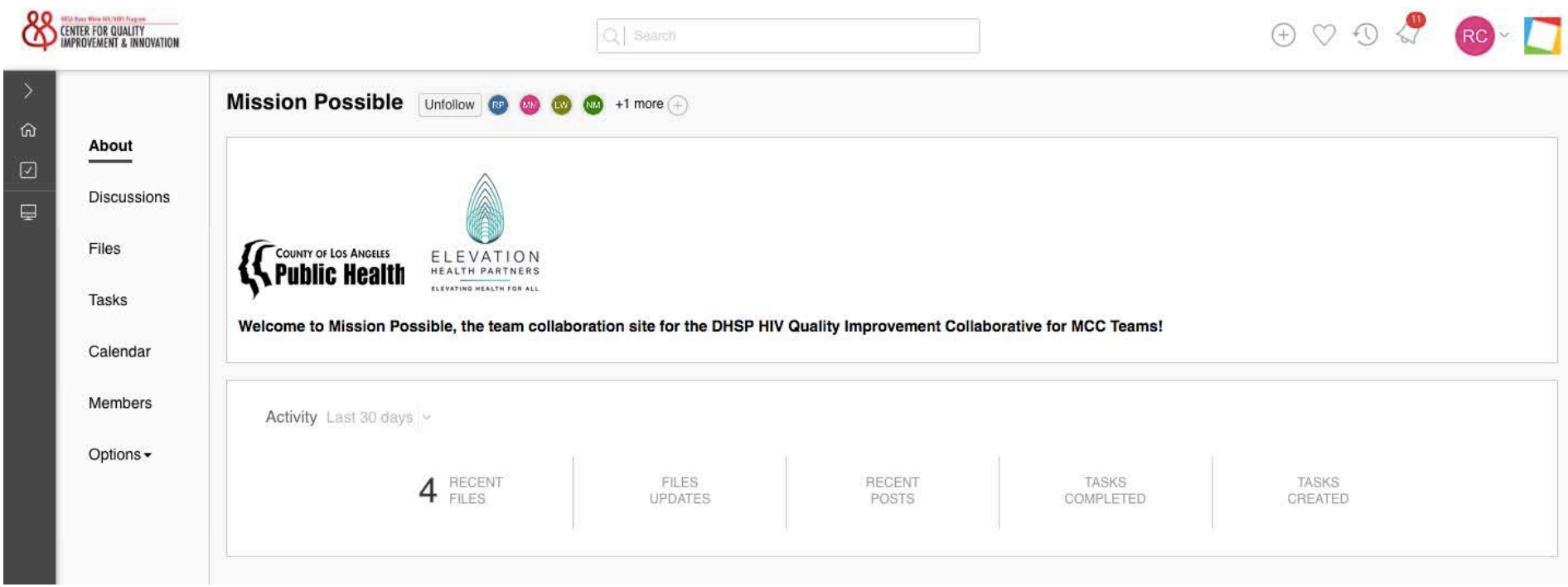
Poll: On demand and electronic consent could help to streamline MCC workflow considerably. What innovations have worked for your agency?

1. **Fillable PDF**
2. **DocuSign or similar**
3. **Enhanced Verbal consent (as with credit cards and banking)**
4. **Texting solutions**
5. **Encrypted email**
6. **Other**
7. **None suited to population**

GlassCubes Reminder

- GlassCubes: an online workspace where you can share files and have discussions
  - Hosted by the Center for Quality Improvement and Innovation (CQII)
  - MCC teams have all been sent invitations to join the workspace
  - If you have not received an email, check your spam or junk folder
  - If you're comfortable, you can post your email in the chat and Rachel will send you an invitation email
  - Goal is to provide a platform for ongoing dialogue and exchange of best practices

GlassCubes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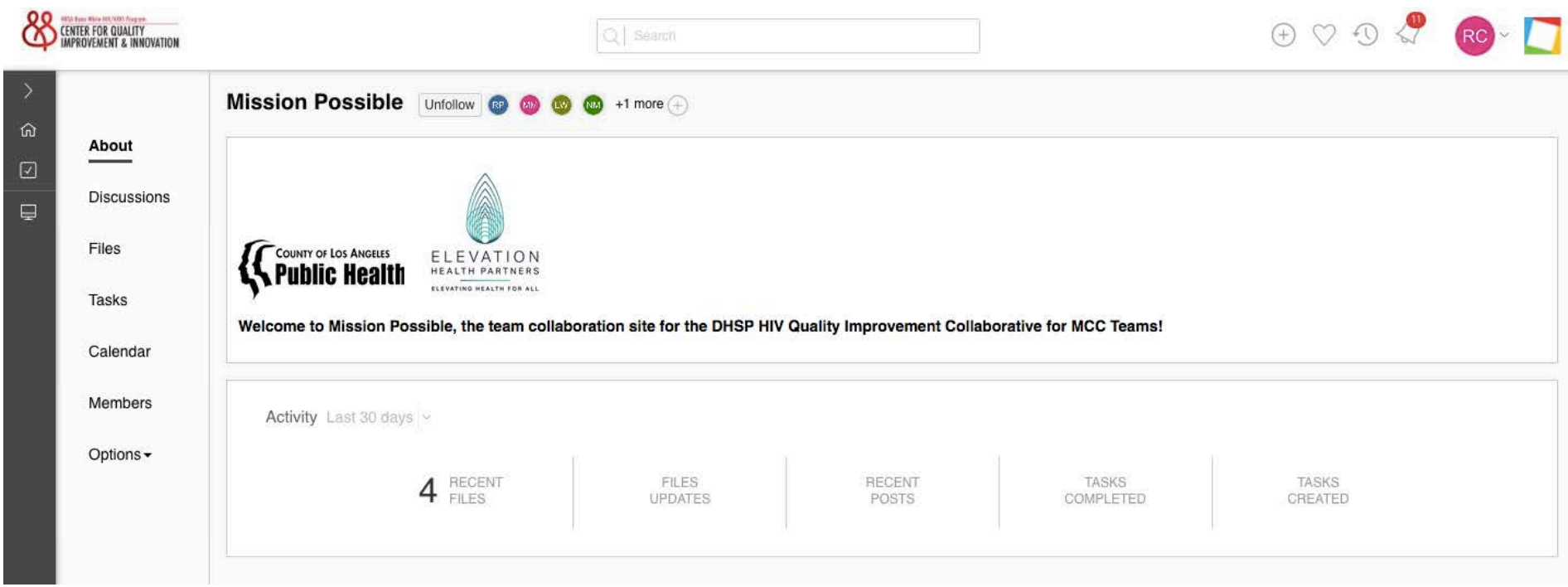
County of Los Angeles Public Health
ELEVATION HEALTH PARTNERS
ELEVATING HEALTH FOR ALL
Welcome to Mission Possible, the team collaboration site for the DHSP HIV Quality Improvement Collaborative for MCC Teams!
Activity
Last 30 days
4 RECENT FILES
FILES UPDATES
RECENT POSTS
TASKS COMPLETED
TASKS CREATED

GlassCubes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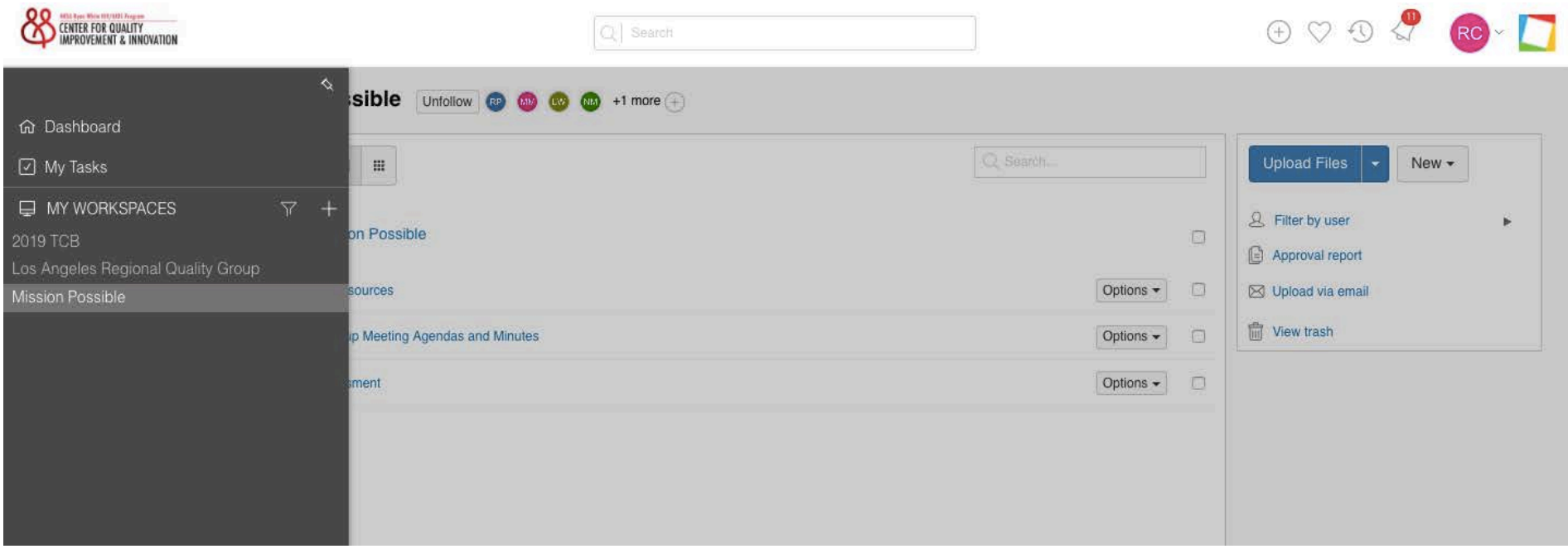
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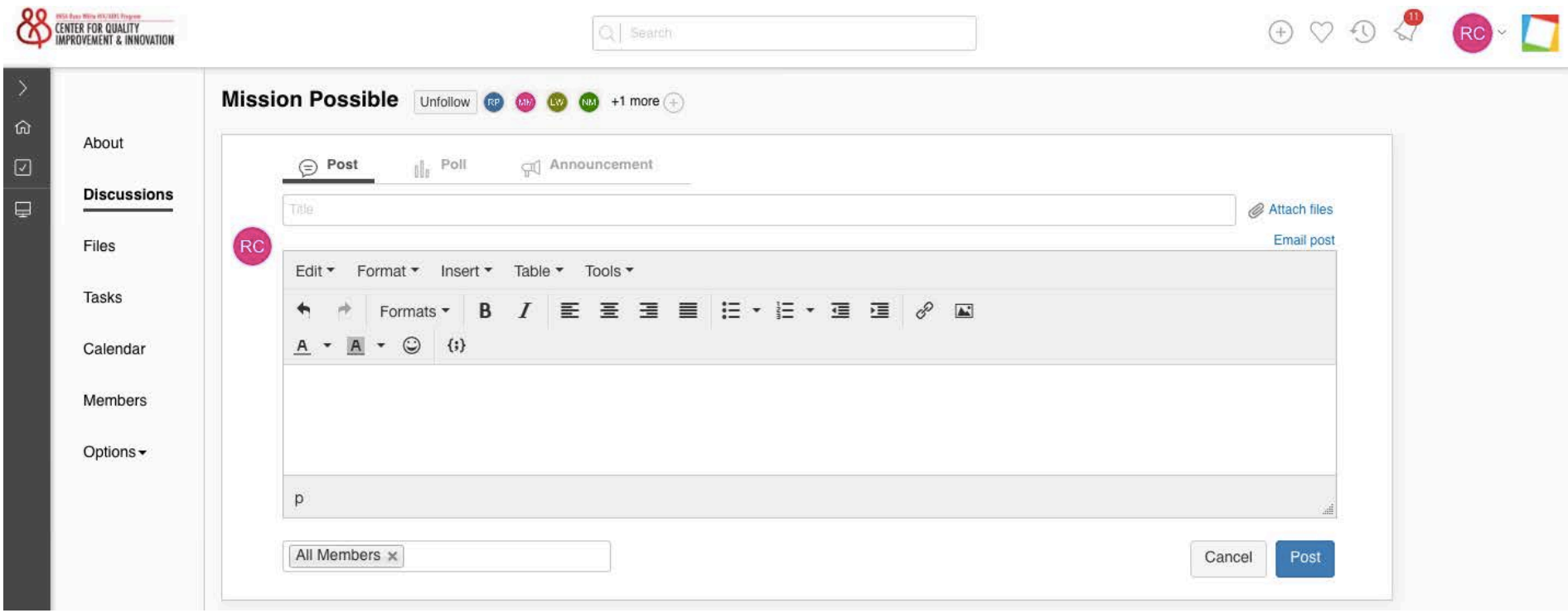
GlassCubes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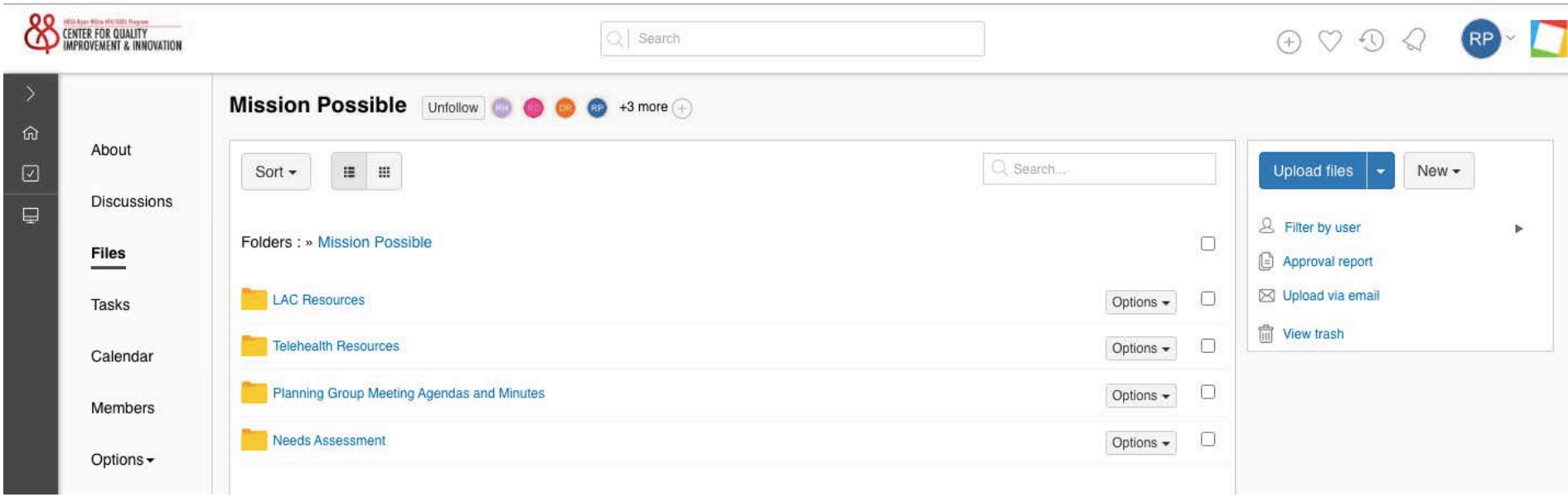
GlassCubes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Upload files
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Folders : » Mission Possible
Filter by user
Approval report
Upload via email
View trash
LAC Resources
Telehealth Resources
Planning Group Meeting Agendas and Minutes
Needs Assessment
Options

Inspiration from the Field

AIDS and Behavior
https://doi.org/10.1007/s10461-020-02926-x

NOTES FROM THE FIELD

COVID-19, Telemedicine, and Patient Empowerment in HIV Care and Research

Ofole Mgbako[1,2] · Emily H. Miller[1] · Anthony F. Santoro[2] · Robert H. Remien[2] · Noga Shalev[1] · Susan Olender[1] · Peter Gordon[1] · Magda E. Sobieszczyk[1]

Beyond the tragic loss of life, the COVID-19 pandemic has disrupted HIV care delivery throughout the U.S. To meet the needs of people living with HIV/AIDS (PLWHA) along the care continuum, health systems have expanded the use of telemedicine (e.g., video, telephone visits) to maintain HIV treatment adherence and care engagement. Despite some promising early results [1, 2], providers must consider the implications of telemedicine on the patient-provider relationship and the establishment of trust in ongoing care, particularly for the most vulnerable. An approach focused on patients' values and preferences provides an opportunity to empower PLWHA in this new paradigm of HIV care. As HIV primary care physicians and researchers working in New York City, we have grappled with the benefits and challenges of telemedicine as we seek continuity in our work during the COVID-19 pandemic.

The move toward telemedicine in HIV care has increased over the past decade [2, 3]. A recent study of 371 PLWHA found 57% of respondents were more likely to use telemedicine for their HIV care compared to in-person [4]. This sample was predominantly US-born, with a higher education level and perceived HIV-related stigma [4]. Broad acceptance of telemedicine may be true only in specific subgroups of PLWHA. Due to the notable health disparities in both the COVID-19 and HIV-1 pandemics, we believe it is important to work towards equitable models of HIV care [5]. In this paper, we present a patient case from our HIV clinic and explore the potential tradeoffs between patient-centered care and telemedicine.

View from the Clinic

A young African American woman with uncontrolled HIV and multiple comorbidities presented for a follow-up video visit appointment. The patient was unemployed and fearful of leaving her apartment due to risk of COVID-19 given her compromised immune status. During the visit, the patient seemed stressed by multiple difficulties that arose with the video visit interface, including many connectivity disruptions; as a result, her appointment was converted to a telephone visit. During the call she reported possible side effects from her complicated antiretroviral treatment (ART) regimen. She also required specialty care for her other medical conditions. Her provider scheduled an in-person visit in one month.

From the provider perspective, the patient had a complex HIV history and low health literacy, factors often associated with poor HIV-related outcomes. Balancing the need for routine bloodwork and supportive in-person services with the patient's reluctance to leave her apartment was challenging. The patient also seemed overwhelmed by the technology such that the telemedicine visit negatively influenced the provider's ability to build rapport.

A Patient-Centered Approach for PLWHA: Communication, Trust and the Human Touch

Despite COVID-19, clinicians must have a deep understanding of the most important aspects of the patient-provider relationship vital for positive outcomes along the HIV care continuum. Studies have found that high quality communication from providers (e.g. active listening, clear explanation)

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Published online: 21 May 2020

Springer

COVID-19, Telemedicine, and Patient Empowerment in HIV Care And Research

"This moment provides a unique opportunity to build a telemedicine model in HIV care that empowers patients. HIV providers should continually appraise their telemedicine programs through patient feedback, focus on increasing access among the most at-risk PLWHA, and consider provider education training on optimal communication to enhance trust and connection…PLWHA with higher medical complexity and who are socially vulnerable – as in our patient case – will continue to be the ones lost to care and excluded from research if the telemedicine system is not designed with them in mind."

Link:
https://www.researchgate.net/publication/341560882_COVID-19_Telemedicine_and_Patient_Empowerment_in_HIV_Care_and_Research

Mgbako O, Miller EH, Santoro AF, et al. COVID-19, Telemedicine, and Patient Empowerment in HIV Care and Research. AIDS Behav. 2020;24(7):1990-1993. doi:10.1007/s10461-020-02926-x

Register today for our next webinar!

- Topic: Patient Perspectives on MCC Telehealth Services
- When: Wednesday August 19th, 2020 12-1:30pm
- Register here: https://elevationhealthpartners.zoom.us/meeting/register/tJAlcOmhrDIuG90gIUTwD6d2yaMoZeBN-qdg
- We are looking for examples of patient perspectives to share during this session:
  - Patient stories
  - Patient participation in the webinar
  - Testimonials
- Please take a moment to indicate in the chat feature if you have a patient story to share
- Please contact us if you'd like to contribute by emailing Rachel Proud at rachel@elevationhealthpartners.com

Evaluation

- Immediately after this webinar you will receive an email with a Qualtrics survey link to complete an evaluation of this webinar from Rachel Proud.

Please provide your feedback so that we can ensure future Mission Possible webinars are best suited to your needs!

Questions and Discussion

Thank you!

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MCC Virtual Visit: Technical Tips for Success

Follow these tips to help your telephone or video visit go as smoothly as possible.

Environment:

- If you can, establish a regular, quiet and private space at your location that you can dedicate to virtual visits. Close doors and windows to high-traffic areas if you can.
- Ensure privacy of the patient can be maintained (HIPAA). If you live with family, a partner and/or roommate(s), you need to make sure the visit with the patient can't be overheard (clinically appropriate space, even when working remotely).
- Avoid background noise if you can. Consider deliveries, pets and activities of family. Develop a schedule or negotiate for quiet times if you can.
- Manage telephone and laptop battery life. If your space is not near an outlet, set a calendar event for charging devices rather than relying on memory.
- Don't eat or drink during the visit.

Video Considerations:

- Set up the camera at eye-level to ensure proper contact and test it in advance.
- Adjust the lighting to make sure you are clear in the camera and there isn't too much background light in the video.
    - Face into the light. Minimize or avoid windows behind you. Keep the light bright and defuse. Use lamps and overhead light to make it as even as possible.
    - Keep backgrounds simple.
    - Note head space as you would for a photograph
- Keep device stationary with no moving devices (e.g., ceiling fans) behind you that could cause video distortions.
- Dress appropriately as if you're in person at the office (wear ID badge, scrubs, physician coat)

Equipment

- High-speed internet and proper browser (i.e., Google Chrome) for documenting in CaseWatch
- Laptop or desktop computer for documenting the visit
- Plug in your computer to avoid low battery issues
- Phone to connect with the patient

- Headphones if available
- Establish protocols in case technology fails: Determine if an in-person visit is appropriate

Pre-Call Planning

- Give yourself 10 minutes before the call to get organized and check connections.
- Turn off web applications and all notifications on cell phones and laptops that can cause background noise or distractions during the telephone visit.
- Review the patient's chart before beginning the call to ensure you're prepared for the visit type (assessment, re-assessment or brief intervention) so you have the patient history available and on hand.
- Be exactly on time for outgoing calls and allow up to 10 minutes to continue to try the patient for the scheduled time if you do not reach the patient initially.
- For patients dialing in to a conference line or using telehealth technology, log in up to 5 minutes ahead so that you are waiting for the patient when they arrive on the line.
- If you anticipate a need for resources to share with the patient (provider, MCC team member, referral) have this information available in advance.

Call Opening

- Take a breath before you call the patient. For patients you know, reflect upon something you admire about them before initiating the call.
- SMILE as you begin. Introduce yourself and state your agency identification and remind the patient of your relationship.
- Check to see that both you and the patient can hear each other clearly and let the patient know it's ok to interrupt if they can't hear.
- ASK patient if this is still a convenient time to talk.
- ASK the patient their name and verify their identity with a question or two (DOB, phone, address). "I realize of course that I called you, but it is important to confirm that I have the right person so I would like to ask you two security questions. Is that ok?"
- Obtain verbal patient consent for the telephone visit (and document). "Before we begin, I would like to confirm with you that you agree to have this visit over the phone."
- Warmly express that you're happy to have the chance to talk with the patient today. "I am really happy that we are able to talk/ have your appointment today."
- Engage patient in agenda setting – ASK – prioritize and negotiate what you'll address on the call.
- Communicate how much time you are planning for the call. "I planned 30 minutes for our time today which means we will probably talk until about 12pm. Does that still work for you?"

Call Middle

- Acknowledge the elephant in the room: ask how the patient is coping with the COVID-19 pandemic.

- Review care plan (Agenda setting) from previous contact (check medication adherence and response, assess or provide brief, goal-oriented talk/ treatment intervention…)
- If performing a risk assessment, review scores, share what you have learned and what it means for the patient and check in with the patient. “What are your thoughts about what I just shared with you?”
- Follow the same clinical guidelines you would with an in-person visit.

Call Closing

- Set expectations for timing and nature of next contact (6 months, as needed…) but ASK to do so. “I’d like to plan some next steps with you that we can agree on together. Can I do that now?”
- Share the importance of next steps. “Staying engaged in care is important [give patient specific reason]…”
- ASK to confirm contact information, best day/ time to call…
- Share procedure for re-scheduling, if applicable.
- ASK and document patient preference for next contact. “Based on what we discussed today, it is best if this next appointment in person at our x location. Do you have any concerns about an in-person visit at the x location?” [Address concerns] “Have I addressed your concerns about coming into the x location? Ok great.”

Communication Tips

- **Elicit reactions to recommendations overtly.** Because you cannot see the patient’s nonverbal reactions, regularly ask, “What do you think about that?”
- **Increase the frequency of empathic statements and use a warm tone of voice.** For example, you could say, “This sounds really tough. You sound sad.” Patients are missing out on your nonverbal and facial expressions of care, so you need to convey these sentiments with your voice.
- **Mirror tone and language of patient.** Mirroring or repeating the language used by the patient. With upset patient, mirror a few tones lower.
- **Shorten your educational spiels**. Break up your explanations into short chunks. Repeat them if necessary. Elicit reactions and questions regularly.
- **Remember that the summary and teach-back are vital.** Be sure to assess the patient’s understanding and buy-in of your co-created plan and elicit questions.

TELEHEALTH CLINICAL GUIDELINES

fraserhealth
Better health. Best in health care.

Interior Health

northern health
the northern way of caring

Provincial Health Services Authority
Province-wide solutions. Better health.

UBC

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

VANCOUVER ISLAND health authority

Table of Contents

Introduction

1.1. Purpose

The purpose of this document is to provide generic Clinical Guidelines for the use of Telehealth in British Columbia (BC) Health Authorities (HAs). The guidelines are intended to:

- Be used in conjunction with all applicable organizational standards, protocols, and policies and procedures for care service provision.
- Are designed to guide staff, physicians, and clinical practitioners providing assessment, treatment, and consultative services via videoconferencing technologies.

The guidelines have been developed through a collaborative, consultative process amongst the BC Health Authorities. The 2003 National Initiative for Telehealth (NIFTE) Guidelines and Clinical Standards and Outcomes were used a measure for alignment.

It is recommended that organizations and individuals providing Telehealth services familiarize themselves with other NIFTE Guidelines (Human Resources, Organizational Readiness, Organizational Leadership, Technology and Equipment).

1.1. Background

The BC Ministry of Health (BC Ministry of Health, 2013) reports; Telehealth uses video conferencing and supporting technologies to put clients in touch with health professionals across distances. Telehealth is especially useful in remote areas where clients must travel long distances to meet their health care providers.

For client's telehealth:

- Reduces the travel burden
- Provides access to a wider range of specialist advice and services; and
- Can deliver faster, more efficient health care by using technology to remove the distance and time management barriers

Telehealth can also:

- Be used for general health promotion including continuing professional education that would otherwise be missed by professionals in distant locations
- Reduce CO2 emissions by reducing physicians and clients travel requirements
- Improve staff recruitment and retention in remote locations by reducing professional isolation, improving access to continuing professional development, and providing easier access to support

- Facilitate communications between professionals and improve team-based approaches to care between different health care providers around B.C.

The BC Health Authorities have worked together using telehealth to increase not only the reach of the provincial telehealth network, but also the scope, quality, and safety of the services offered using Telehealth technologies.

These guidelines are created and maintained current recent research and knowledge

Definitions

Client: A potential or actual recipient of Telehealth services

Provider: A healthcare professional offering Telehealth services

Telehealth: The use of communications and information technology to deliver health and health care services and information over large and small distances. Telehealth uses the transmission of voice, data, images, and information rather than moving clients, health provider, or educators. 1

Client Site: Client site is also referred to as: Request Site, Remote Site, Patient Site, Distant site, Participating Site, or Referring Site. This is the site of the client or local provider(s) receiving support from consulting clinicians.

Consulting Site: The site the consulting provider broadcasts from. Consulting site may also be referred to as Host Site, Originating Site, Physician Site, Provider Site, or Referral Site.

Clinical Telehealth Support: Physical client support may be required to:

- Assistance positioning the client
- undress and re-dress wounds
- Take the client's vital signs
- Or operate a wound camera or digital stethoscope
- Assist and report physical, neurological, or haptic testing

Appropriately trained health providers such as LPN's, RN's, physiotherapists, or care aides would be used to assist clients. Adjunct telehealth equipment such as exam cameras and stethoscopes need to be available at the request site to enable enhanced remote assessment.

Remote site assistants may also be needed to conduct follow-up activities such as scheduling subsequent appointments, documenting the encounter, document management, and client education and support as required.

1 Canada Health Infoway definition (2004) derived from Picot, J. (1998). Sector Competitiveness Frameworks Series: Telehealth Industry Part 1 –Overview and Prospects. Industry Canada: Industry Sector Health Industries.

Guidelines

1.2. Telehealth and Clinical Practice

Care standards for practice, such as evidence-based best practice, should be carried through to care delivered via telehealth. Whenever possible, health professionals will use existing applicable clinical best practice guidelines (BPGs) when providing care via telehealth.

Modifications may need to accommodate for the inability to physically examine a client or the need to have physical examination performed and translated by a remote site assistant.

1.3. Duty of Care

The duty of care for telehealth should follow the same principles as face-to-face care. For example:

- The responsible provider should give the client adequate, current, and ongoing care instructions
- If face-to-face appointments require the use of interpreters, the presence of family members or a care provider, or other aides those same supports should be arranged for telehealth appointments
- Consults to local providers: If second opinions or advice is being given by the consultant, the local clinician is ultimately responsible for the care they provide to the client
- If there is any doubt about roles and responsibilities, the consultant and local provider must reach an agreement before a telehealth consultation is provided

1.4. Program Suitability for Telehealth

The following need to be considered when undertaking a telehealth program:

- The ability to communication under a variety of conditions. If you are used to drawing pictures or rely on certain physical queues you may be limited
- Have an understanding of the scope of service being provided via Telehealth;
- Able to attend a short orientation to the technology, navigation, and telehealth environment
- Operational protocols and procedures such as scheduling, reserving rooms, timeliness
- Professional telemedicine guidelines
- The limitations of video conferencing technologies

The organization is responsible for training clinical users about the equipment and how to use it. Clinical telehealth users should endeavour to learn the basics of how to use video conferencing equipment and can seek refresher training or assistance as required [See Appendix A for BCTDC Guidelines for Point to Point Calls].

1.5. Ethics

Health care professionals involved in telehealth services need to ensure the client-provider relationship via telehealth:

- Maintains the integrity and value of the therapeutic and workplace relationships
- Upholds professional standards governing health and medical professions
- Meets the standards of quality and safety as for face-to-face services

Health care professionals must recognize when Telehealth approaches are not appropriate for the client's needs and be aware of any ethical risks to clients. Backup plans and safeguards should be developed to reduce risk. Risk reduction strategies include ensuring that clients are screened for appropriateness and duty of care is outlined in clinical workflows at the program level.

Health care professionals are required to follow the Health Authority's process and their Professional Practice Standards when addressing ethical concerns and issues that arise due to the use of Telehealth (e.g.) if the Telehealth service requires duties outside normal scope of practice.

1.6. Client Suitability Guidelines

Clinical programs should identify inclusion and exclusion criteria for perspective telehealth clients. The following list includes some factors that can influence suitability:

- Level of physical assessment required
- Availability of support at the client site
- Ability of the client to participate such as physical, mental, and cognitive barriers
- Distance between provider and client locations
- Dependency on local availability of associated imaging and lab tests
- Client desire to participate in a telehealth consultation
- Ability to schedule telehealth session within the timeframes for a service or program's standard of practice guidelines

1.7. Informed Consent

The clinical program is responsible for explaining what to expect, privacy and confidentiality measures in place, and the client's right to refuse care via telehealth. Telehealth service providers should provide materials such as telehealth posters and brochures to clients as needed.

- Clients must be informed that access to a face-to-face consultation is never denied if they opt out of or don't wish to receive care via telehealth.
- Documentation in the client record must reflect client notification and agreement to the service.

Written consent is only required by the provider site when:

- If written consent is normally required for face-to-face sessions
- Clients are asked to release requisite personal information from one organization to another
- Clients are asked to participate in research projects while in care, or
- Recording a Telehealth session is not typically performed as it may compromise the identity of a client; however, if the provider(s) involved in the videoconference have just reason for recording a clinical event, consent must be obtained.

1.8. Protecting Client Privacy and Confidentiality

Every clinical relationship is based on respect for privacy and confidentiality. Individuals accessing telehealth technology are entitled to expect their privacy to be guaranteed, including:

- Privacy of personal information
- Privacy of personal communications
- Privacy of consulting space

Clinical Telehealth service providers must be aware of and ensure compliance with relevant legislation and regulations designed to protect the confidentiality of patient-client information. Organizations and health professionals are encouraged to consult with legal counsel and relevant professional licensing/regulatory bodies when determining confidentiality policy.

For comprehensive information on protection of client privacy and confidentiality, individuals should refer to the *BC Freedom of Information and Protection of Privacy Act* and policies within their Health Authority.

Privacy Impact Assessments (PIA) and Risk Assessments are mitigating strategies recommended in the development phase of all Telehealth projects as per Health Authority standard.

Telehealth consultations take place over a confidential, technically secure connection. Data is protected and access limited to "those who need to know". This generally refers to the patient-client, provider(s), and other care providers such as family or invested local health providers. Technical support staff may be required to assist with technical difficulties. Technical support staff are employees of the Health Authority and have signed confidentiality agreements.

Backup plans such as having a phone consult, rescheduling the appointment for another time, or other alternative are important to have in place in the event a technical difficulty prevents an adequate telehealth consultation.

1.9. Client Identity

To ensure safe quality Telehealth services clients must be positively identified using best practices. Risk of misidentification and exposure to care and intervention not intended for the client is mitigated by adhering to regional standards for positive client identification prior to receiving care or intervention. Failure to correctly identify clients may result in a range of adverse events such as the client receiving information meant for a different person. Each clinical telehealth program will determine a means of identification to be used based on the type of service provided and population served. See policies within each Health Authority.

Ideally three identifiers should be used (when available) prior to the provision of any service or procedure. Examples include:

- Unique identifiers such as Personal Health Number (PHN)
- The client's legal name
- Date of Birth
- Client barcodes
- Double witnessing or a client wristband
- A client's room number is not to be used as an identifier.

1.10. Documentation and Client Records

1.10.1 Client Information required by Clinical Telehealth Program at provider site

The information required is determined by the individual Clinical Telehealth Program. This is generally the same as what's required for a face-to-face appointment and provided in advance of the Telehealth appointment or session.

1.10.2 Consultation Report

A report from the telehealth provider is documented and incorporated into the client record. Documentation timelines for telehealth consults are consistent with existing clinical processes for face-to-face consultations.

1.10.3 Client Information required by healthcare providers at client site

Information required by the client site is coordinated through the provider site and may consist of electronic and paper charts, diagnostic images and lab reports.

1.10.4 Clinical Telehealth Support Notes

Clinical documentation by clinical support staff who attend the client should be completed as determined during program development and recorded in the same timely manner face-to-face events are documented.

1.10.5 Responsibility for Records

The original client record is held with the Provider. Copies of the Telehealth consult report or note are shared with the referring physician or clinician as they would be for face-to-face consultations.

1.11. Quality Measurement

Telehealth encourages clinical telehealth programs to establish evaluation methods for their telehealth appointments. Appropriate categories for evaluation may include:

- **Access:** e.g.: number of client seen, number of clients who may not have previously had access to care
- **Quality** : Outcomes, client and provider satisfaction,
- **Productivity**: Improved productivity amongst clinical staff, multidisciplinary team meetings

Outcome indicators would be determined within the clinical telehealth program. The indicators will be used to identify successes and opportunities for improvement. Results will be shared with relevant stakeholders.

Standardized Telehealth Provider and Client satisfaction surveys have been created by the BC Telehealth Development Committee for general use across the province. Telehealth programs are welcome to implement a more specific survey at their discretion.

Sources Used

This document has been created, reviewed and amended by various groups and individuals as noted in the document control table in Section 6.0. The document authors would like to acknowledge that have considered and included information and/or passages from the following documents.

- Accreditation Canada, 2010. Telehealth Services Standards
- BC TeleThoracic Project Team, 2009. TH-5 Standard of Care Protocol
- BCCA Telehealth Committee, 2009. Telehealth Terminology
- Capital Health, Alberta, 2006. Telehealth Consent Policy
- College of Registered Nurses of BC, 2005. Telehealth Practice Standard
- Government of Western Australia, Telehealth Development Unit, 2003.Telehealth Policy and Guidelines for the Delivery of Clinical and Other Services
- National Initiative for Telehealth (NIFTE), 2003. National Initiative for Telehealth Framework of Guidelines. https://dspace.ucalgary.ca/bitstream/1880/42967/3/NIFTEguidelines2003eng.pdf

1.12. Additional Resources

The reviewers and authors of this document have conducted numerous literature reviews to inform this document. During the course of this research they have identified (below) resources that may be useful to organizations and/or individuals offering Telehealth services.

- Accreditation Canada, 2013. Telehealth Services Standard.
- RACGP, 2012. Implementation guidelines for video consultations in general practice (3rd Edition) http://www.racgp.org.au/your-practice/e-health/telehealth/gettingstarted/guidelines
- European Code of Practice for Telehealth Services 2014
- http://www.telehealthcode.eu/images/stories/telehea/pdf/TELESCOPE_2014_CODE_FINAL_PDF_-_RELEASE_29_OCT_2013.pdf
- American Telemedicine Association. ATA Standards & Guidelines (multiple domains). http://www.americantelemed.org/practice/standards/ata-standards-guidelines

Reviews and Document Control

This document has been [o rwill be] sent to the following listed below for their review and comment, and part of their role is to obtain feedback from key stakeholders in their organization.

Group	Member
BC TDC	Fraser Health Authority
	Interior Health Authority
	Northern Health Authority
	Provincial Health Authority Services
	Vancouver Coastal Health
	Vancouver Island Health Authority (Island Health)
	University of BC MedIT

1.13. Document Control

Date	Author	Version	Change Reference
Oct. 18, 2010	S. Wyatt	1.0	Outline & contents, including input from some IHA clinicians
Nov. 10, 2010	S. Wyatt	2.0	Update to outline & contents incorporating input from Oct. 21st BC TDC meeting & Nov. 4th working group meeting
Nov. 17, 2010	S. Wyatt	3.0	Update/revision of contents incorporating input from Nov 16th working group meeting
Nov. 26, 2010	S. Wyatt	3.1	Incorporated feedback from VIHA
Dec 2, 2010	S. Wyatt	3.2	Update/revision of partial contents incorporating input from Nov 29th working group meeting
Dec 14, 2010	S. Wyatt	4.0	Update/revision of contents incorporating input from Dec 9th working group meeting
Dec. 15, 2010	S. Wyatt	5.0	Revision of contents incorporating input from Dec 15th working group meeting
April 18, 2011	J. Henderson	6.0	Revision of contents incorporating input from BCTDC meeting
July 30, 2012	J. Henderson	7.0	Added BCTDC approved Telehealth definition
Oct. 23, 2012	J. Henderson	7.1	Added Appendix “BCTDC Guidelines for Point to Point Calls” Removed Ethics and Privacy/Confidentiality Health Authority Appendix placeholders
May 8, 2013	N. Gabor / J. Henderson	7.2a	Update/revision of partial contents incorporating input from Provincial Ethics committee members
October 21, 2013	J. Henderson	7.2b	Removed Appendix D – Provider Survey and associated references within the document
November 26, 2013	L. Caron	7.2c	Updated contents to disclose the origin of document contents and alignment with NIFTE Guidelines. Addition of Additional Resources Section.

Date	Author	Version	Change Reference
January 14, 2014	L.Caron	8.0	Reviewed with BCTDC Clinical Guidelines WG. Modified, accepted changes per Nov. 2013
September 2014	Mdeachma	9.0	Pagination, formatting, headers, footers, and appendices numbering updated

Appendix A. BCTDC Guidelines for Point to Point Calls

BCTDC Guidelines for Point to Point Calls

Telehealth - Enabling access and removing barriers to quality care

Recent changes to the Health Authority (HA) network infrastructure in British Columbia (BC) have altered the way in which video conferencing endpoints may connect with one another. These guidelines are intended to support HA Telehealth programs and ensure that point to point calls between the regions and other authorized organizations follow agreed upon principles to assure quality, safety and the protection of privacy for all participants.

These guidelines, created and adopted by the BC Telehealth Development Committee (BCTDC) address point to point calls involving video conference participants using a video conferencing endpoint which has been approved through the appropriate HA processes and which has a network address associated with the secure HA networks and the eHealth Network Gateway (eNG) used to securely link all six regional HAs. Calls connected through a bridge or facilitated through video conferencing system management software are not addressed within this document, nor are calls involving participants outside of the eNG / HA network.

SECTION 1 – Terminology and Definitions

Call Types

Point to Point (Direct) - **One video conference endpoint calls another directly (in scope of these guidelines).** Also, where video conferencing system management software – ex. Tandberg Management Suite (TMS) or Converged Management Application (CMA) - is used to schedule the direct connection of two endpoints, but without including any bridge (multipoint control unit or MCU) infrastructure (out of scope)

Point to Point (Bridged) - Two endpoints are connected through a bridge (a technology hardware component used to connect multiple video conference endpoints together in one conference) (out of scope)

Multi-point (Direct) - Multiple endpoints are called directly by one host endpoint using multi-point software on that device (out of scope)

Multi-point (Bridged) - Multiple endpoints are connected via a bridge (out of scope)

End Point Types

Current (HA approved, established and recognized (commissioned) facility-based video conferencing devices and enterprise-based video conferencing applications currently in use). The vast majority of video conferencing end point devices, applications and infrastructure in use within the HAs are manufactured by either Polycom or Cisco (Tandberg). A small number of Sony, Picture Tel and LifeSize units also exist which may be connected to the network. Current types include:

- Standards based, fixed room-based video conferencing unit
- Standards based mobile video conferencing unit (a clinical cart)
- Standards based desktop video conferencing units (ex. Cisco EX90, Polycom HDX 4000)
- Desktop computer (or laptop) software based video conferencing standard application (ex. Cisco MOVI)

Future (Exploratory applications which may currently be approved for test or pilot studies, or which may be considered for use at a later time). Future types may include:

- Computer (PC or laptop) based video enabled applications – MS Communicator; Lync

- Vidyo, cloud computing applications like Blue Jeans network, etc.
- Tablets, iPads, mobile phone applications, etc.

Video conferencing Application Types

- Clinical (patient to clinician; clinician to clinician(s))
- Educational (clinician to clinician; educator to staff; etc.)
- Administrative (general; finance; HR; interviews; performance reviews; etc.)

SECTION 2 – Basic Principles

The majority of direct point to point calls are for clinical sessions. There may be exceptions for some educational or administrative meetings. The following points outline common understanding and guidelines for point to point calls in a clinical setting where both end points are accessed within the eNG.

- It is recommended that prior to establishing a point to point call or series of calls, that both locations are apprised of the plan, how it is different from bridged calling, and then asked to confirm their approval
- Point to point calls involving a HA location must still be scheduled, so as to avoid any conflict with other use of the room or equipment. This also enables technical support staff to be aware of the call taking place and provides them with the information necessary for troubleshooting. NOTE – the exception to this would be any urgent or emergent established service, such as Telestroke.
- Where one of the locations is not physically within a Health Authority facility, the end point unit or application must be provided or approved by the Health Authority to meet the standards for security, privacy and quality. (Refer to BCTDC Provincial Telehealth Guidelines documents for more information)
- Where one of the locations is not physically within a HA facility, participants must make every effort to adhere to the Health Authority standards for maintaining the security and privacy of the session. For example, joining the call from a private room where no one who is not part of the session can see or hear any part of the conference. (Refer to BCTDC Provincial Telehealth Guidelines documents for more information)
- The providing site (where the clinician is) will initiate and disconnect the call, unless different arrangements are made prior to the appointment. Every effort must be made to ensure that the caller has the correct "dialling" information for the patient location.
    - Recommendation – dialling information is provided directly to the clinician each time via a confirmation form, which also provides information on how to access technical support
    - Recommendation – endpoint directories are maintained with information that is current and which clearly identifies each location
- There are two time zones in BC. Respecting these is critical.
    - Recommendation – a list of communities on Mountain Time is created and shared as a tool for education or for posting in clinical rooms.
    - Recommendation – endpoint directory is amended for communities on Mountain Time to identify these for the caller.
- All callers must adhere to scheduled start and end times for appointments (NO early calling or extended appointments). Failure to observe this may negatively impact other scheduled consultations, resulting in unnecessary calls for support, and may also result in a breach of privacy, should another meeting or consultation be in progress at that time.
- Endpoint units with multipoint software should not be used for clinical consultations or for meetings or conferences where confidential patient information is discussed, as other callers may inadvertently call in.
    - Recommendation – endpoints with multipoint software should be identified across the regions so that they can be easily identified and avoided for use in clinical situations.
- Performing pre-test of endpoints prior to session to ensure no connectivity issues are present

Appendix B. College of Physicians and Surgeons of BC Professional Standards and Guidelines - Telemedicine

College of Physicians and Surgeons of British Columbia

Professional Standards and Guidelines

Telemedicine

Preamble

This document is a standard of the Board of the College of Physicians and Surgeons of British Columbia.

According to the Federation of Medical Regulatory Authorities of Canada:

"Telemedicine is the provision of medical expertise for the purpose of diagnosis and patient care by means of telecommunications and information technology where the patient and the provider are separated by distance. Telemedicine may include, but is not limited to, the provision of pathology, medical imaging and patient consultative services."

College's Position

The role of the College is to regulate physicians, not technology, and to remind physicians that the use of technology does not alter the ethical, professional and legal requirements around the provision of appropriate medical care.

Physicians who are physically located in British Columbia must ensure that they are registered with this College, and should be aware that this College may address complaints relating to the provision of medical care in other jurisdictions.

Physicians in British Columbia should advise patients that accessing medical care from a physician who is not located/registered in this province may pose risks related to lack of appropriate medical licensure or training and that this College may not be able to assist them with complaints relating to inappropriate medical care.

Physicians should also be aware that practising medicine using only electronic communication or across different jurisdictions may affect their liability insurance and they should disclose such information to their liability insurer.

In providing medical care using telecommunications technologies, physicians are advised that they are responsible to:

- ensure that both the physician-site and the patient-site are using appropriate technology that complies with legal requirements regarding privacy and security and accreditation standards where required
- ensure that the physician's identity is known to the patient and the identity of the patient is confirmed at each consultation

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November 2013

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BC Ministry of Health. (2013). Telehealth. Retrieved 11 18, 2013, from eHealth: http://www.health.gov.bc.ca/ehealth/telehealth.html

BC Ministry of Health. (2013). Telehealth. Retrieved 11 18, 2013, from eHealth -safer, better, faster healthcare: http://www.health.gov.bc.ca/ehealth/telehealth.html