Virginia Department of Health
Division of Disease Prevention
HIV Care Services
Method to Deliver Services: Medical Telemedicine
This component could be added to each of the service categories later.

Telemedicine Services Standards

Description:
The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) defines Telehealth as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.[i]

The Virginia Department of Health (VDH) encourages and provide continue support for the advancement of Telemedicine/Telehealth, its applications, and its greater relevance to Virginia health service delivery. **Medical Telemedicine** is seen as a tool in medical practice, not a separate form of medicine or health service. Telemedicine is the practice of medicine using technology to deliver care at a distance. For example, a physician in one location uses a telecommunications infrastructure to deliver care to a patient at another location. **Telehealth** is not a telephone conversation, email/instant messaging conversation, or fax; it typically involves the application of videoconferencing or store-and-forward technology to provide or support health care delivery.

The **standard of care** is the same whether service delivery to the patient is in-person, through Telehealth or other methods of electronically enabled health care.

Program Guidance:
All service provision will comply with the HHS Guidelines and the Commonwealth of VDH Service Standards for people living with HIV, including the following:

1.0 Intake and Eligibility *National Monitoring Standards: Eligibility determination process requiring documentation in patient medical records of low-income status and eligibility based on a specified percent of the Federal Poverty Level (FPL), proof of an individual's HIV-positive status, residency, and determination and documentation of patient eligibility every six months.[ii] Documentation that Medical Telemedicine Services funds are used only to support eligible activities, including enabling eligible individuals to access HIV-related health and support services. The need for Medical Telemedicine Services should be identified and documented in the client's HIV service plan.*
HRSA, the funder for Ryan White HIV services, prohibits continued HIV services, including medications to clients who are not recertified for eligibility of services by their specified date; therefore, if a client has not completed their annual certification or

recertification at six months they are not eligible for Ryan White services.[iii]	
Standard	**Measure**
Referral	
1.1) Referral for Medical Telemedicine Services by a Ryan White Part B provider is documented prior to initiation of the service.	1.1) Documentation of referral for Medical Telemedicine Services is present in the client's record, signed and dated.
Eligibility	
1.2) The client's eligibility for Ryan White Part B services is determined.	1.2) Documentation of the client's eligibility is present in the client's record.
1.3) To be eligible for this service applicants must: a) Be diagnosed with HIV b) Live in Virginia c) Have an individual or family income at or below 500% of FPL d) Ryan White Part B is the payer of last resort and other funding sources must be vigorously pursued. Providers are responsible to ensure that clients are screened and deemed ineligible for other payer sources covered by Federal or State programs such as Medicare, Medicaid, all other forms of insurance or third party payers such as private and commercial insurance plans, and other payers. e) Provide recertification every six months with proof of income, changes in insurance coverage, or any changes in residency f) **Client eligibility ensures Part B services are used as the payer of last resort**. Client must agree to participate in the insurance option client is eligible and that best meets the client's medical needs regardless of preference. *Note:* The Part B Program is the payer of last resort. This is interpreted as "funds received will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made" by another payment source.[iv]	1.3) Documentation is present in files that verifies: a) Client is diagnosed with HIV b) Client lives in Virginia c) Client meets income guidelines d) Client Medicaid status (gap of services) e) Recertification for continued eligibility for Part B services every six months f) Client agrees to participate in insurance option that best meets their medical needs and for which the client is eligible.

Apply through the VDH Central Office or through agency's eligibility services.	
Intake	
1.4) Eligibility screening and intake to be completed within 15 days of initial contact with client.	1.4) Documentation of intake and eligibility screening in record signed and dated.
Recertification	
1.5) Client must be recertified every six months to continue to receive Ryan White Medical Telemedicine Services. There is no grace period.	1.5) Documentation of recertification of the client's eligibility every six months is present in the client's record.
2.0 Key Services Components and Activities (including assessment and service plan) *National Monitoring Standards: Medical Telemedicine Services are used only to enable an eligible individual to access HIV-related health and support services.*[v]	
Standard	Measure
Documentation	
2.1) Track consent to use Medical Telemedicine for HIV-related treatment.	2.1) Documentation that client was given option of Medical Telemedicine in client's record.
2.2) Medical Telemedicine Services provided are used to enable an individual to access HIV-related health and support services. The Medical Telemedicine Services should be available for the benefit of all people located in rural, remote and in accessible places.	2.2) Documentation of purpose for all Medical Telemedicine Services provided (e.g., Medical Telemedicine to and what type of medical or support services) in client's record.
2.3) Provision of all Medical Telemedicine Services is documented by type of services, date of service and purpose.	2.3) Documentation of Medical Telemedicine Services provided in client's records signed and dated.
2.4) Track and document referral sources in the client record.	2.4) Is there documentation of referral in the client record?
2.5) Provide cancellation policy to client including inclement weather, breakdowns, etc.	2.5) Is there documentation that clients are aware of cancellations, inclement weather, breakdowns?
2.6) Arrange Medical Telemedicine Services for those with acute medical needs.	2.6) Is there documentation that services were arranged for those Medical Telemedicine needs?
2.7) Scope of the standards covers Medical Telemedicine related equipment, practices and technologies used by health care facility participating in this service and includes standards for electronic transmission, software and hardware. [vi] [vii] [viii] Technical standards for different systems of a facility's Medical Telemedicine may include:	2.7) Standards and guidelines cover Medical Telemedicine Infrastructure, connectivity, Data Interchange and Exchange along with Minimum Data sets and security.

• Data standards; • Data exchange; • Messaging standards; • Medical image capture; • Storage and transmission standards; • IT infrastructure; • Technical standards for interconnectivity; interoperability and process guidelines	
2.8) In addition to technical standards, clinical protocols and guidelines are needed. Clinical protocols for Medical Telemedicine practice include [ix]: • Preliminary scheduling procedures • Actual consultation procedures and Medical Telemedicine (such as telecommunications transmission specifications)	2.8) Policies and procedures documentation is present in files that verifies the listed elements.
2.9) Identify the mechanisms for protecting the privacy & confidentiality of individuals' health data.	2.9) Policies and procedures documentation is present in files that verifies the listed elements.
2.10) Develop a security measures that must be built-in or addressed in any Medical Telemedicine application system: • Who can have access to individuals' health information? • What kind of security technology is used for the above authentication, such as password, fingerprint and smart card? • What kind of encryption is used for storing medical data? • What kind of encryption is used for transmitting medical information? • How will lost or stolen equipment be handled?	2.10) Security elements in place to address requirements including storage security, network security, data encryption, audit trails etc.
2.11) Developed networks should be reliable and secured to ensure user confidence, system and data integrity, and robust system operation.	2.11) Documentation is in place that networks are reliable and secured.
Note: It is essential to know the local conditions of a particular Medical Telemedicine provider (using different systems) especially in the rural areas when applying certain standards.	
Assessment/Service Plan/Provision of Services	
2.12) An initial assessment documenting services needed that will use Medical Telemedicine must	2.12) Documentation of need for services that use Medical Telemedicine in client's

be completed prior to initiation of service.	record signed and dated.
2.13) Within fifteen (15) business days after the initial assessment a service plan will be developed and agreed upon by the client and provider outlining service goals, objectives, and interventions. This should include client identified needs as well as plans for continuity of primary medical care and support services, clients are assessed for: History of accessing primary care and other services and barriers to access, particularly Medical Telemedicine barriers. Staff explains to the client during the first encounter what services are available at the agency based on the client's identified needs.	2.13) Documentation of service plan in client's record signed and dated. Clients' needs and service plan are reviewed and revised a minimum of every six months.
2.14) Clients will be notified of Medical Telemedicine cancellations in a timely manner. Alternative Medical Telemedicine Services will be provided as available.	2.14) Documentation of cancellation and referral to alternative Medical Telemedicine source in client's record signed and dated.
2.15) Medical Telemedicine agency will be notified by client and/or provider of Medical Telemedicine cancellations and changes in scheduling as they occur.	2.15) Documentation of changes and cancellations in client's record signed and dated.
2.16) <u>Direct Medical Telemedicine – Providers of Medical Telemedicine Services</u> Direct Medical Telemedicine Providers deliver non-emergency Medical Telemedicine Services that enable an eligible client to access or be retained in core medical and support services. Clients are provided with information on Medical Telemedicine Services and instructions on how to access the services. General Medical Telemedicine procedures: • Agency must allow clients to confirm core or support service appointments at least 48 hours in advance • Agency provides clients with information on Medical Telemedicine limitations, clients' responsibilities for accessing and receiving Medical Telemedicine, and the agency's role and responsibilities for	2.16) A signed statement from client consenting to Medical Telemedicine Services and agreeing to safe and proper conduct in the use of Medical Telemedicine Services is on file. Documentation of client orientation to direct Medical Telemedicine Services in client's record.

providing Medical Telemedicine Services • Clients initiate and coordinate their own services with Medical Telemedicine providers following client orientation to the agencies Medical Telemedicine policies, procedures and client guidelines • Advocates (e.g. case manager) for the client may assist clients in accessing Medical Telemedicine Services if needed • All clients will be screened for other Medical Telemedicine resources (e.g., Medicaid-eligible clients) • Accommodations are provided for related/affected individuals and/or caregivers as necessary for the benefit of the client • Client consent to Medical Telemedicine Services is on file in the client record. Consent includes the consequences of violating the agreement, e.g., such as removal, suspension and/or possible termination of Medical Telemedicine Services • Clients and Ryan White/State Services providers are notified of service delays and changes in appointments or schedules as they occur.	
2.18) Documentation of each Medical Telemedicine transaction includes: a) Client eligibility b) Type of Medical Telemedicine Service used to meet client's need	2.18) Documentation of each Medical Telemedicine Services in client's record signed and dated.
Transition and Discharge	
2.19) Client discharged when Medical Telemedicine Services are no longer needed, goals have been met, upon death or due to safety issues (*see 2.13*). <u>Prior to discharge</u>: Reasons for discharge and options for other service provision should be discussed with client. Whenever possible, discussion should occur face-to-face. If not possible, provider should attempt to talk with client via phone. If verbal contact is not	2.19) Documentation of discharge plan and summary in client's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable. Is there documentation that the client was notified of their removal to receive Medical Telemedicine Services in writing?

possible, a certified letter must be sent to client's last known address. If client is not present to sign for the letter, it must be returned to the provider. Documentation: Client's record must include: a) Date services start b) Special client needs c) Services needed/actions taken, if applicable d) Date of discharge e) Reason(s) for discharge f) Referrals made at time of discharge, if applicable. Transfer: If client transfers to another location, agency or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If client moves to another area, transferring agency will make referral for needed services in the new location. Unable to Locate: If client cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. A certified letter must be mailed to the client's last known mailing address within five business days after the last attempt to notify the client. The letter will state that the case will be closed within 30 days from the date on the letter if an appointment with the provider is not made. Withdrawal from Service: If client reports that services are no longer needed or decides to no longer participate in the Service Plan, client may withdraw from services. Because clients may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure reasons for withdrawal are understood, or identify factors interfering with the client's ability to fully participate if services are still needed. If other issues are identified that cannot	

be managed by the agency clients should be referred to appropriate agencies. Administrative Discharge: Clients who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a client for this reason, the case must be reviewed by leadership according to that agency's policies. Clients who are discharged for administrative reasons must be provided written notification of and reason for the discharge, and must be notified of possible alternative resources. A certified letter that notes the reason for discharge and includes alternative resources must be mailed to the client's last known mailing address within five business days after the date of discharge, and a copy must be filed in the client's chart. If a client is removed from Medical Telemedicine Services due to falsifying the existence of a medical appointment in order to access service, is there documentation of the client being removed?	
Case Closure	
2.20) Case will be closed if client: a) Has met the service goals; b) Decides to transfer to another agency; c) Needs are more appropriately addressed in other programs; d) Moves out of state; e) Fails to provide updated documentation of eligibility status thus, no longer eligible for services; f) Fails to maintain contact with the medical Telemedicine staff for a period of three months despite three documented attempts to contact client; g) Can no longer be located; h) Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan; i) Exhibits pattern of abuse as defined by	2.20) Documentation of case closure in client's record with clear rationale for closure.

agency's policy. j) Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program; or k) Is deceased.	
3.0 Client Rights and Responsibilities *National Monitoring Standards: Provision of Part B funded HIV primary medical care and support services, to the maximum extent, without regard to either: the ability of the individual to pay for such services, or the current or past health conditions of the individuals served.*[x]	
Standard	Measure
3.1) Services are available and accessible to any individual who meets program eligibility requirements. All providers shall be in compliance with all applicable Federal, State, and local anti-discrimination laws and regulations, including but not limited to the Americans with Disabilities Act. All providers shall adopt a non-discrimination policy prohibiting the refusal of rendering services on the basis of fact or perception of race, color, creed, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, domestic partner status, marital status, height, weight, disability, or HIV/AIDS diagnosis. Each provider shall make available to clients a process for requesting interpretation services, including American Sign Language.	3.1) Written eligibility requirements and non-discrimination policy on file.
3.2) Client's Rights and Responsibilities policy exists which requires each Client to sign & date a form indicating they has been offered: a) Explanation of the policy, and b) Copy of *Client's Rights and Responsibilities* and to communicate client's understanding of the policy	3.2) Written policy on file.
3.3) Explanation of *Client's Rights and Responsibilities* is provided to each client. Client rights include: • Be treated with respect, dignity, consideration, and compassion;	3.3) Current *Client's Rights and Responsibilities* form signed and dated by client and located in client's record.

• Receive services free of discrimination; • Be informed about services and options available. • Participate in creating a plan of services; • Reach an agreement about the frequency of contact the client will have either in person or over the phone. • File a grievance about services received or denied; • Not be subjected to physical, sexual, verbal and/or emotional abuse or threats; • Voluntary withdraw from the program; • Have all records be treated confidentially; Have information released only when: • A written release of information is signed; • A medical emergency exists; • There is an immediate danger to the client or others; • There is possible child or elder abuse; or • Ordered by a court of law. Client responsibilities include: • Treat other clients and staff with respect and courtesy; • Protect the confidentiality of other clients; • Participate in creating a plan of service; • Let the agency know any concerns or changes in needs; • Make and keep appointments, or when possible; phone to cancel or change an appointment time; • Stay in contact with the agency by informing the agency of change in address and phone number, responding to phone calls and mail • Avoid subjecting the agency's staff to physical, sexual, verbal and/or emotional abuse or threats.	
4.0 Grievance Process	
Standard	Measure
4.1) Grievance policy exists which requires each	4.1) Written grievance procedure on file,

client to sign & date indicating they has been offered: a) Explanation of the policy, and b) Copy of *Grievance Procedure* c) Communication of client's understanding of the policy Policy shall describe the process for resolving client grievances, including identification of whom to contact and applicable timelines. Policy shall be available in languages and formats (e.g. for persons with disabilities) appropriate to populations served.	available in languages and formats appropriate to populations served.
4.2) Explanation of *Grievance Procedure* is provided to each client. Clients may file a grievance if their request for services is denied or if they have any complaint or concern about the services received.	4.2) Current *Grievance Procedure* form signed and dated by client and located in client's record.
4.3) Grievance process shall be fair and expeditious for resolution of client grievances.	4.3) Documentation of client grievances, status and resolution.
4.4) Review the grievance policy yearly with client's signature.	4.4) Current *Client's Rights and Responsibilities* form signed and dated by client and located in client's record.
5.0 Personnel Qualifications (including licensure)	
Standard	Measure
5.1) Direct Medical Telemedicine Agency staff and volunteers providing Medical Telemedicine through direct Medical Telemedicine must maintain appropriate liability, licenses, and trainings:	5.1) Documentation of training completed in personnel file at agency providing Medical Telemedicine Services.
5.2) Staff Supervision a) Each agency must have and implement a written plan for supervision of all staff b) Supervisors must review monthly Medical Telemedicine logs for completeness, compliance with these standards, and quality and timeliness of service delivery c) Staff must be evaluated at least annually by their supervisor according to written agency policy on performance appraisals	5.2) Documentation of completed staff supervision plan at agencies providing Medical Telemedicine Services. Documentation of monthly Medical Telemedicine log at agencies providing Medical Telemedicine Services. Documentation of annual staff performance evaluations.
6.0 Cultural and Linguistic Competency	

Standard	Measure
6.1) Health services are culturally and linguistically competent, client-guided and community based. At a minimum, provider's documentation should include: a) Experience with providing services to the diverse ethnic, linguistic, sexual or cultural populations targeted; b) Capacity of staff, including volunteers and Board, to design, provide and evaluate culturally and linguistically appropriate services; c) List of cultural competency trainings completed by staff.	6.1) Documentation of cultural and linguistic competence as reported in annual Cultural and Linguistic Competency Report.
6.2) Easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area shall be available.[xi]	6.2) Culturally and linguistically appropriate materials and signage accessible.
7.0 Privacy and Confidentiality (including securing records)	
Standard	Measure
7.1) Client confidentiality policy exists which include: a) Release of information requirements, and b) Health Insurance Portability and Accountability Act.	7.1) Written client confidentiality policy on file at provider agency.
7.2) Client's consent for release of information is determined.	7.2) Current *Release of Information Form* signed and dated by client and provider representative and located in client's record. Each release form indicates who may receive the client's information and has an expiration of not more than 12 months from date of signature.
7.3) Each client file is stored in a secure location. Electronic client records are protected from unauthorized use.	7.3) Files stored in locked file or cabinet with access limited to only appropriate personnel. Electronic files are secure with password protection and access is limited to appropriate personnel.
7.4) Annual submission of *Verification of Receipt of Assurance of Key Requirements* document by all staff that handle client identifying information.	7.4) Documentation of signed *Verification of Receipt of Assurance of Key Requirement* forms.

[i] https://www.hrsa.gov/rural-health/telehealth/index.html
[ii] HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards for Part A and B Grantees: Universal (April, 2013)
[iii] HRSA/HAB Ryan White HIV/AIDS Program Services: Clarifications on Ryan White Program Eligibility Determinations and Recertification Requirements Policy Clarification Notice #13-02
[iv] HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards—Program Part B (April, 2013), p.38.
[v] HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards—Program Part B (April, 2013), p.38
[vi] Health Level 7, version 2.3
[vii] Health Level 7, version 2.4
[viii] Digital Imaging and Communications in Medicine, version 3.0
[ix] Clinical Document Architecture, Health Level 7, version 2.0
[x] National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. Available at: https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf