Telemedicine Services Standards

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02:
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.

The Virginia Department of Health (VDH) encourages and provides continued 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 Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

1.0 Intake and Eligibility
As outlined in HRSA HAB Policy Clarification Notice 21-02 Clarifications on Ryan White Program Client Eligibility Determinations and Recertification Requirements, people are eligible to receive RWHAP services when they meet each of the following factors:

1. **HIV Status:** A documented diagnosis of HIV. (Note: People who do not have an HIV diagnosis are eligible to receive certain services as outlined in HRSA HAB PCN 16-02
2. **Low- Income:** The RWHAP recipient defines low-income. Low-income may be determined based on percent of Federal Poverty Level (FPL), which can be measured in several ways (e.g., Modified Adjusted Gross Income, Adjusted Gross Income, Individual Annual Gross Income, and Household Annual Gross Income).

3. **Residency:** The RWHAP recipient defines its residency criteria, within its service area. Note: Immigration status is irrelevant for the purposes of eligibility for RWHAP services. RWHAP recipients or subrecipients should not share immigration status with immigration enforcement agencies.	
Standard	**Measure**
Referral	
1.1) Documentation of referral for Medical Telemedicine Services by a Ryan White Part B provider 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. To be eligible for this service applicants must: a) Have an HIV diagnosis (one time only) b) Live in Virginia c) Have an individual or family income at or below 500% of the Federal Poverty Level (FPL) d) Be 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 that provide the service they are seeking. • Client Access Reviews (CARs) - refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility. • Provide continuation of eligibility every 24 months with proof of income, changes in insurance coverage, or any changes in residency • Client eligibility ensures the use of Part B services as the payer of last resort while vigorously pursuing other funding sources**.** Client must agree to participate in the insurance option that the client is eligible for and that best	1.2) Documentation of the client's eligibility is present in the client's record that verifies: a) Client is diagnosed with HIV b) Client lives in Virginia c) Client meets income guidelines d) Client Medicaid status verified (gap of services) • Ongoing CARS and complete Continuation Eligibility Determination every 24 months • Client agrees to participate in insurance option that best meets their medical needs and for which the client is eligible.

meets the client's medical needs regardless of preference. Submission of eligibility assessments should be through the VDH PROVIDE data system.	
Intake	
1.3) Eligibility screening and intake to be completed within 15 days of initial contact with client.	1.3) Documentation of intake and eligibility screening in record signed and dated.
Client Access Reviews/Continuation of Eligibility	
1.4) Client Access Reviews (CARs) refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility and continuation of eligibility conducted every 24 months to continue to receive Ryan White services. There is no grace period.	1.4) Documentation of CARS and continuation of eligibility is present in the client's record.
2.0 Key Services Components and Activities	
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) Document provision of all Medical Telemedicine Services 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) Documentation of referral in the client record
2.5) Provide cancellation policy to client including inclement weather, breakdowns, etc.	2.5) Documentation that clients are aware of cancellations, inclement weather, breakdowns

2.6) Arrange Medical Telemedicine Services for those with acute medical needs.	2.6) 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. Technical standards for different systems of a facility's Medical Telemedicine may include: • Data standards; • Data exchange; • Messaging standards; • Medical image capture; • Storage and transmission standards; • IT infrastructure; • Technical standards for interconnectivity; interoperability and process guidelines	2.7) Standards and guidelines cover Medical Telemedicine Infrastructure, connectivity, Data Interchange and Exchange along with Minimum Data sets and security.
2.8) In addition to technical standards, clinical protocols and guidelines are needed. Clinical protocols for Medical Telemedicine practice include: • 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 security measures that must be built-in or addressed in any Medical Telemedicine application system:	2.10) Security elements in place to address requirements including storage security, network security, data encryption, audit trails etc.

• 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?	
2.11) 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.
Assessment/Service Plan/Provision of Services	
2.12) Complete an initial assessment documenting services needed that will use Medical Telemedicine prior to initiation of service.	2.12) Documentation of need for services that use Medical Telemedicine in client's 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) Direct Medical Telemedicine – Providers of Medical Telemedicine Services • 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 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	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.

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 2.20*) <u>Prior to discharge</u>: Conduct discussion with client over reasons for discharge and options for other service provisions. 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 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. **Exception: If the client has noted during the*	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. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*

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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.	Discharge summary and other records send with the patient.
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. The three attempts should start no later than three months prior to the due date. 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 case closure within 30 days from the date on the letter if no appointment is schedule with the provider.	Document attempts made.
**Exception: If the client has noted during the intake or at any other time to the subrecipient staff that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*	

Withdrawal from Service: If client reports no longer needing services 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 understanding reasons for withdrawal, or if client still needs services identify factors interfering with the client's ability to fully participate. If other issues are identified that cannot be managed by the agency clients should be referred to appropriate agencies. Administrative Discharge: Discharge clients who engage in behavior that abuses the safety or violates the confidentiality of others. Prior to discharging a client for this reason, agency leadership according to that agency's policies must review the case. Provide clients discharged for administrative reasons written notification of and reason for the discharge and notify 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. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*	
Case Closure	
2.20) Case will be closed if client: a) Has met the service goals; b) No longer meets eligibility criteria; c) Decides to transfer to another agency;	2.20) Documentation of case closure in client's record with clear rationale for closure.

d) Needs are more appropriately addressed in other programs; e) Moves out of state; f) Fails to provide updated documentation of eligibility status thus, no longer eligible for services; g) Fails to maintain contact with the agency staff for a period of three months despite three (3) documented attempts to contact client; h) Can no longer be located; i) Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan; j) Exhibits pattern of abuse as defined by agency's policy. k) 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 l) Is deceased.	
3.0 <u>Client Rights and Responsibilities</u>	
Standard	**Measure**
3.1) Services are available and accessible to any individual who meets program eligibility requirements. Each provider shall assist clients with conducting Ryan White Part B eligibility, regardless of whether they receive other Part B services at your agency. All providers shall comply 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 any service on the basis of fact or perception of race, color,	3.1) Written eligibility requirements and non-discrimination policy on file.

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.	
3.2) Each agency should have a Client's Rights and Responsibilities policy, 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) Provide explanation of *Client's Rights and Responsibilities* to each client. Client rights include: • Be treated with respect, dignity, consideration, and compassion; • 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;	3.3) Current *Client's Rights and Responsibilities* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the rights and responsibilities.

• 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; respond to phone calls and mail and • 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 client to sign & date indicating they has been offered: a) explanation of the policy, b) copy of *Grievance Procedure* and 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.	4.1) Written grievance procedure on file, available in languages and formats appropriate to populations served.

4.2) Provide explanation of *Grievance Procedure* to each client. Clients may file a grievance if denied their request for services, 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. If client unable to sign, progress note should include documentation the client has received a copy of the grievance procedure.
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 *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the client's grievance procedure.
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.	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.
8.0 Quality Management	
Standard	**Measure**
8.1) Measure and report client health outcomes using Medical Nutrition Therapy services measures approved by VDH.	8.1) Performance measurement data on the following indicators: • Percentage of people living with HIV and receiving Medical Nutrition Therapy services, regardless of age, who will have at least two care markers in a 12-month period that are at least 3 months apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date). • Percentage of people enrolled in RW Part B-funded Program living with HIV and receiving Medical Nutrition Therapy services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

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