

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

Building the Plane While Flying It

Case Studies on COVID-19, Telehealth, and
Health Care for the Homeless Centers



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Introduction

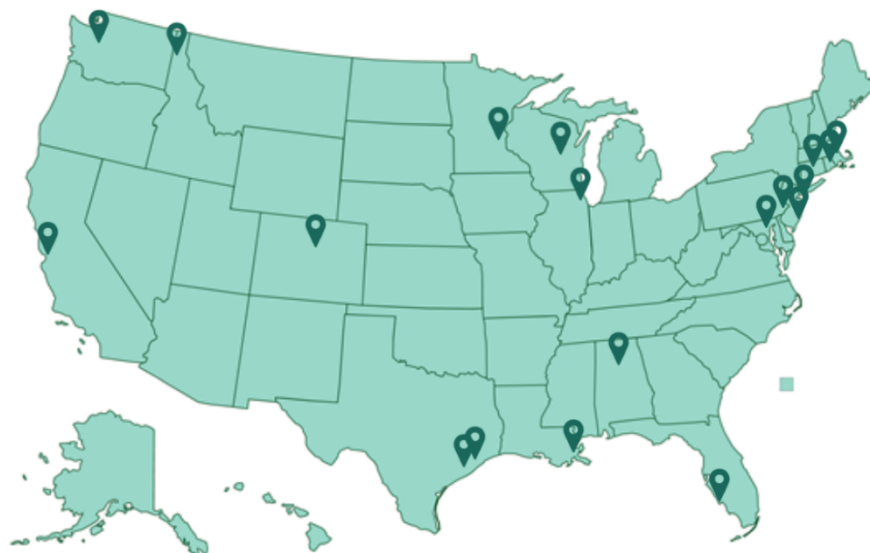
“Building the plane while flying it” is an increasingly familiar expression that captures the risk, uncertainty, and excitement that accompanies learning and developing as one goes. Many Health Care for the Homeless (HCH) health centers embodied this metaphor during the onset of the COVID-19 pandemic as they explored safer modalities to deliver care to people experiencing homelessness.

Although some HCH health centers used telehealth before the pandemic to provide care to people experiencing homelessness, it was largely considered an alternative care delivery system that often entailed years of careful planning and implementation. The onset of the pandemic, however, meant that telehealth was suddenly the safest way to deliver most care. Virtual care strategies that previously had years left before implementation needed to be actualized in a matter of days, in some cases within 24 hours.

Thanks to the innovation and drive of HCH teams, virtual care like telebehavioral health, telemedicine, teledermatology, and teledentistry is now being provided in a range of modalities, including telephonic sessions (audio-only), text messaging exchanges, and video conferencing sessions.

The National Health Care for the Homeless Council conducted telephone interviews in June 2020 with experts representing 17 of these HCH health centers across the United States. The goal of this document is to share these centers' stories and their **successes, challenges, lessons learned**, and **future strategies for virtual care**. Readers can find these four elements in each case study's section.

Locations of HCH centers and consumers interviewed



How to Use This Document

The response to the pandemic required by each organization and individual interviewed here was specific to their geographic location, organization type, and funding streams among other considerations, and as such, the details of each case study are included for readers to use as needed. Information like the description of the organization, the number of patients served, and the point of contact is located in the sidebar of each case study.

Despite the specificity of each story, some themes did emerge during the interview process that may be critical for telehealth policy and best practices going forward:

- **It is possible to engage patients experiencing homelessness in telehealth services.** Many interviewees warned against the misconception that patients experiencing homelessness are unwilling or unable to engage in virtual care. In many cases, transitioning to virtual care resulted in fewer missed appointments and increased engagement in behavioral healthcare.
- **Telephonic care is common but access to phones and internet is still lacking,** making video conferencing and agency-wide adoption of telehealth services difficult to implement.
- **Future telehealth use is often dependent on reimbursement policy and funding streams.** Although most health centers are currently receiving reimbursement for telephonic care, there is uncertainty about how long it will last and payment parity.

Overall, HCH health centers have tailored telehealth services to patients with different cognitive and physical abilities, vulnerabilities to the coronavirus, living conditions, consistencies in participation, and other social determinants of health. People living in a wide range of shelters or lack thereof are receiving patient-centered health care with the assistance of health center staff and community partners.

As organizations think more strategically and creatively to make these technology services more available, HCH health centers continue to lead the way in using powerful technology to deliver health care to the most marginalized people in our communities.

Acknowledgments

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Case Studies

Consumer Experience #1: Joanne G, Boston MA



The National Consumer Advisory Board (NCAB) is a committee of people who have experienced homelessness and been clients of Health Care for the Homeless health centers across the country, and who are involved in the governance of those HCH health centers. NCAB is a standing committee of the National Health Care for the Homeless Council, and NCAB's elected chairperson sits on the Council's Board of Directors.

Joanne is a member of the National Health Care for the Homeless Council's National Consumer Advisory Board (NCAB), a member of Boston Health Care for the Homeless Program's (BHCHP) Board of Directors and has received services from BHCHP for more than 10 years. COVID-19 has significantly impacted every way Joanne receives health services, as well as how BHCHP's leadership meets and determines its response to the crisis. Drawing on her experience as a consumer, consumer advocate, and health center board member, Joanne shared her thoughts and recommendations on telehealth.

Joanne did not have any prior experience with telehealth before the pandemic. This changed quickly, when both BHCHP and her other external health service providers at Boston Medical Center swiftly transitioned to telehealth. She feels lucky that she already had access to the telephone and computer technology she needed to make video appointments possible. However, there has been no single audiovisual platform used by her several different providers. Some have used Zoom, Google Hangout, or voice-only phone calls. In her experience, there has been little to no training on using the technology, which has posed a significant challenge.

Joanne has not been able to see certain specialists, due to the necessity of physical check-ins and procedures (e.g., for podiatry). She has also had limited success in sending digital photos of physical symptoms for physician feedback.

Joanne shared that, in this time of crisis and unprecedented health care changes, psychiatry has been not only the most important service to access, but the service most suited to remote communication. Though she acknowledged it's not the same as an in-person appointment, she is grateful for the opportunity to express her needs, hear a familiar voice, and get necessary prescriptions filled.

Successes

- "There are lots of heroes down there," Joanne said of BHCHP staff. BHCHP has been flexible and creative in their response to COVID-19. Staff of BHCHP have made widespread accommodations for patients, despite an already challenging limitation of resources.
- The use of telehealth at BHCHP has prevented layoffs or furloughs of health center staff. Health care workers, like Joanne's providers, are able to work from home, despite service closures.

- For Joanne, who considers herself a visual person, Zoom and video chatting have been instrumental in effectively connecting with service providers. This is especially important on days where the isolation and fear brought on by the virus feel overwhelming.
- The transition of psychiatry to telehealth has been particularly successful for Joanne. She feels welcome to express herself and communicate her needs from a distance, and she continues to receive her prescriptions. She is able to have all medications delivered to her door to limit her risk of exposure to the virus.

“I’m looking forward to when we can do face-to-face appointments again. I’m all about impressions. Without them, depression can set in easily.”

Challenges

- Transitioning to telehealth has been a major challenge for Joanne and others feeling isolated in self-quarantine. Joanne would never have chosen to participate in telehealth if it wasn't for the pandemic. This is a frightening time for her, and the lack of interaction with familiar health care workers only makes this time more challenging.
- Joanne shared that adapting to new technology has been a challenge for her. Without a standardized telehealth platform or formalized training on using audiovisual software, appointments become overwhelming and distracting.
- Joanne feels lucky to have access to a cellphone, a cellphone plan, and Internet. However, she fears that those patients without telephone or Internet access are left with severely limited options for safely accessing health care during this time.
- While some appointments are conducted visually over Zoom, there are some physicians that are limited to telephone-only capabilities. These audio-only appointments leave out the nonverbal cues, which are critical in how she communicates attitudes and comfortability regarding health service planning.

Recommendations for Physicians Providing Services in Telemedicine

“The key is making sure [patients] feel in control. They are the ones who should be making decisions.”

- Allow more space than ever for patient input. With the new distance between provider and patient, there is more possibility of service providers taking control without patient input.
- It is more important than ever to be very intentional with communication, and not to rush through the appointment. Communication over telehealth is challenging because there are limited nonverbal cues. Take the time to be clear in all types of communication about health.
- Be patient and recognize every patient as an individual. Every patient is different and will react to telehealth differently. People sometimes need to be encouraged to speak thoughts and feelings—this is only amplified by communicating remotely.

Moving Forward, Living with COVID-19

Joanne is looking forward to the day it is safe to have face-to-face appointments and that telehealth is no longer a necessity. Though she acknowledges how helpful telehealth might be for some consumers post-pandemic, telehealth is not something she desires to continue unless necessary. Even so, with so much uncertainty surrounding COVID-19, it is hard to imagine this technology not being the standard of health care for the foreseeable future. That is a terrifying thought for Joanne and others who are at high

risk for virus complications. For now, telehealth remains the best-case scenario, in that Joanne is able to touch base with her physicians, meet with the “heroes” at BHCHP, and receive her prescriptions from a distance.

“Four months ago, our lives changed and now it’s scary to even go out the door. I like to talk with people, so being distant has been a challenge... The important thing now is leading with compassion. Every patient is different and will react to telehealth differently. Like me, sometimes I need to have things pulled out of me. People need different things.”

Consumer Experience #2: Charlotte G, Houston TX



The National Consumer Advisory Board (NCAB) is a committee of people who have experienced homelessness and been clients of Health Care for the Homeless health centers across the country, and who are involved in the governance of those HCH health centers. NCAB is a standing committee of the National Health Care for the Homeless Council, and NCAB’s elected chairperson sits on the Council’s Board of Directors.

Charlotte is a member of the National Health Care for the Homeless Council’s National Consumer Advisory Board (NCAB), chair of Health Care for the Homeless Houston’s (HHH) Consumer Advisory Board (CAB), and a longtime patient of HHH. COVID-19 has reshaped how HHH and other health systems in Houston, TX, reach patients that are experiencing homelessness and housing instability.

Charlotte shared her perspective as an advocate and a patient on accessing, participating in, and adapting to this new age of telemedicine. Though she had limited experience with telephonic health services prior to the pandemic, there is no doubt that these services have been forced into the mainstream and normalized across different types of medicine. Her insights highlight a recent experience with telebehavioral health services amid the COVID-19 pandemic.

Prior to March 2020, Charlotte participated in some telehealth services which were marked by communication difficulties and general discomfort. However, with the onset of COVID-19 and the months that followed, “a lot of the kinks have been worked out.” At HHH and her other external clinics, audio-only appointments have taken the place of office visits. Her psychiatry appointments, as well as pain clinic appointments, have been conducted exclusively over the cellphone. HHH did not fully close its doors but has prioritized clinic access to those needing acute care only.

As the pandemic evolves, more chronic care patients and primary care patients will eventually have access to in-person care. Until then, telehealth is proving instrumental in engaging patients. Charlotte admitted that telehealth is daunting and can be difficult to transition to for some individuals. A lot of responsibility is placed on health center

staff to provide a comfortable and manageable space for telephonic health care interaction. “[HHH has] a very caring and engaging staff, so it may not be all that traumatic for our individual clients to go to telehealth...I’m sure that people are making adjustments and understanding this new climate. [Patients are] receiving attention and care to the highest of ability in this time.” As a patient, her personal transition to telehealth was made simpler by the fact she had a cellphone and a service plan prior to the pandemic.

Successes

- Telehealth has been a successful temporary avenue of accessing behavioral health appointments and maintaining the support Charlotte desires to stay healthy while social distancing.
- The shift to telehealth has been extremely beneficial in terms of numbers of individuals accessing care. The capacity to serve clients remotely has increased significantly and missed appointment rates have decreased.
- Though the pandemic forced HHH toward telemedicine, their plan to focus in-clinic care on acute care only has mitigated challenges in shifting services so rapidly. Limiting clinic access while using telehealth has also allowed for clinic space to be used for COVID-19 testing.
- From Charlotte’s perspective, HHH has shown strength and compassion in their pandemic response and shift to telemedicine. Though confusion and trauma could have dominated this transition, she shared that she and her peers are receiving attention and care to the “highest of ability in this time.” HHH’s staff is working overtime to ensure the pandemic does not cause people to fall through the cracks or lose connection to health care.

Challenges

- Those that do not have phone access are automatically not able to participate in telehealth. While the clinic can prioritize in-person visits for acute care, this leaves some chronic care patients with limited access to their recurring appointments.
- Especially regarding telephonic behavioral health appointments, there is a whole crucial visual

“Homelessness was the most traumatic experience in my life. I didn’t have any choices. So [regarding telehealth] I’m very aware that it is not my first choice.”

component missing. In the past, if Charlotte began feeling acute psychiatric symptoms, she could rely on her physician to engage her based on presentation and behavior. With virtual appointments, especially audio-only appointments, non-verbal cues are challenging to pick up on.

- Charlotte shared that, though HHH has been successful in its swift reaction to COVID, changes in telehealth have not been without resistance. Often the voices of people experiencing homelessness and housing instability are ignored, and decisions about their own health care do not include their input. Even though it is necessary, a forced transition to telehealth without a say in the matter can be retraumatizing.
- Similarly, people who experience homelessness are familiar with the feeling of being dismissed by social services and health care workers. “Telehealth is kind of impersonal and challenging to show [as a physician] that you’re really interested or engaged. Over the phone, I can’t really form an opinion. Sometimes that face-to-face interaction does so much more. I want to tell you are invested in my care.”

- Especially in the heat of Houston’s summer, appointments can be an opportunity for patients experiencing homelessness to access air conditioning, cold water, and snacks. Without this component, Charlotte fears appointments could become something no longer seen as essential.

Recommendations for Physicians Providing Services in Telemedicine

- No matter the type of appointment, telehealth interactions should always begin with a semblance of a wellness check. Let the patient share how they are doing—if there is an issue, there needs to be space to share. Try to eliminate any apprehension about participating. This is critical for providing comprehensive care over the phone.
- This pandemic has caused health services to evolve, affecting consumers more than providers. Taking more time and intentionality with patients who might find telehealth challenging can prevent traumatization and eventual lapse in care.
- It is just as important as ever to seek consumer input on the delivery of telemedicine, in terms of the individual and organization. Surveying the needs and desires of the people you serve is essential to determine who is a good candidate for telehealth post-pandemic, and what needs to change in broader service delivery.

“There needs to be a plan for reducing trauma for everyone. This can happen by using intentionality in telehealth.”

Moving Forward, Living with COVID-19

Charlotte knows that telehealth is the “future of medicine” and will continue to take a prominent role in delivery of health care. Especially considering the increased cases of COVID-19 in her region, she describes telehealth as a “new normal” and a new standard for communicating with health care professionals. As chair of HHH’s CAB, she brings her valuable experience as a consumer to inform not only the decisions regarding telehealth, but also reopening and broad responses to the pandemic.

“When I was first referred to HHH, they asked me what I needed. I used to say, ‘Everything.’ Sometimes you need to be taught to express your needs... I would say, ‘The task is too big,’ and just shut down. But my case manager started setting up appointments, which I would eventually respond to. Once I asked her, ‘Why didn’t you give up on me?’ She said, ‘Because you kept coming back.’ That’s what is most important in telehealth—don’t give up on people.”

HCH Case Study #1: Alabama Regional Medical Services (ARMS), Birmingham



Alabama Regional Medical Services (ARMS), formerly Birmingham Health Care, is a health center serving the greater Birmingham area since 1985. ARMS is a medical organization with a patient-centered philosophy that drives primary care excellence and provides comprehensive, team-based, coordinated, and accessible health care focused on quality and safety. ARMS is breaking down barriers by being a Primary Care Medical Home (PCMH) to people who are underserved, uninsured, under-insured, low-income, and experiencing homelessness in the community.

In 2019, the HCH health program served 9,039 patients in 26,310 visits.

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Prior to the COVID-19 pandemic, Alabama Regional Medical Services (ARMS) did not use telehealth to engage patients experiencing homelessness. In response to the onset of the pandemic, however, all in-person clinic appointments were cancelled and ARMS quickly began transitioning to virtual care in an effort to maintain contact with patients.

During the week of March 16, 2020, ARMS temporarily closed two sites. The leadership team met daily and developed plans to balance minimizing risk of exposure to the virus with providing quality care. Staff divided into two teams and alternated working on-site for one week and remotely the next. In-person visits were limited to emergency or walk-in services for patients.

After staff changes were made, ARMS informed shelters and substance use treatment partners about the transition to virtual care and asked them if they would collect vitals for patients using available equipment (e.g. a thermometer, scale, blood pressure monitor, computer for appointments, etc.). All shelters approached agreed to accommodate these requests. The medical assistant trained key shelter staff on telehealth basics.

By March 23, 2020, ARMS selected Doxy.me as the telephonic platform; entered templates, electronic medical record (EMR) provider notes, and consent forms into MicroMD; and developed related operating guides for staff. Shortly after, a team of psychiatrists conducted a pilot of telebehavioral health services and presented the results to leadership. On Monday, March 27, 2020, ARMS moved forward with telebehavioral health plans and within two weeks began offering both video and audio virtual care to patients in partner shelters.

ARMS contacted established patients first to both ensure they were comfortable transitioning to virtual care and refine telehealth protocols before opening the process to new patients. All previously cancelled appointments were rescheduled. Four staff were assigned to telehealth services for unhoused patients (one for primary care, two for behavioral health, one for scheduling). Current protocols include a pre-appointment briefing for the patient on how to use the system, including their provider's unique "waiting room" number and unique doxy.me website address. Once the patient is in the room, the provider may begin the visit. If a provider is delayed, the patient is notified by staff and may stay in the waiting room until the provider is available.

Successes

- Telephonic care has been executed successfully and clients were open to the transition.
- Alabama added new flexibility for reimbursing telephonic visits.
- Most SUD patients showed increased engagement with telehealth compared to in-person services. Providers report *more* people are participating in the virtual SUD aftercare group than had previously in the in-person meetings. Some group members have expressed the desire to keep the group virtual.

Challenges

- Reimbursement rates for telephonic care remain very low despite successful negotiations with third-party payers (e.g. Medicare, Medicaid) to increase rates.
- Primary care engagement has significantly decreased in the transition to virtual care.
- Engagement from students at the school-based clinic has decreased in the transition to virtual care. This may be due to a lack of telehealth-appropriate technology.
- Providers prefer video conferencing to audio-only but many patients do not have a data plan or smartphone with video capabilities. ARMS was not able to provide data plans

Lessons Learned and Recommendations

- Do not make assumptions about the willingness of clients to transition to telehealth. Often it is the staff that is reluctant to try something new, not the client.
- Telephonic care does involve extra work for both providers and administrative staff (e.g. obtaining client contact information, learning the steps for correct billing, coding).

Future Strategies for Virtual Care

ARMS has now used telehealth for three months but its future use depends on uncertain funding sources. For example, ARMS is currently using the free version of Doxy.me but might upgrade services with telehealth-specific funds in future budgets.

As ARMS reopens, some patients who need lab work or COVID-19 testing are transitioning back to in-person visits. Telehealth is still being used to engage patients living in shelters due to increased flexibility in shelter rules on coming-and-going. Shelters for men have typically been more flexible than shelters for women. Many shelters require residents to visit the clinic for COVID-19 testing to maintain residency.

Most providers are conducting some in-person visits, with one provider remaining fully assigned to telehealth appointments. Telehealth has made a difference in how ARMS delivers health care and they report they will likely retain some portion of it for immunocompromised individuals, but the extent they offer telehealth to other patients depends on reimbursement rates and other payment concerns since "it is hard to collect from those who are self-pay and the visit is virtual" (Amy Sparks, Director of Homeless/Behavioral Health Services).

"I discovered telehealth is not bad. On a personal note, I wasn't too sold on the idea. But I tried it, conducting many patient visits using the phone myself and even utilized it with my own doctor for a personal office visit. This experience has made me realize that you can get the same amount of service through telehealth as you can face to face."

Amy Sparks
Director of Homeless/Behavioral
Health Services.

HCH Case Study #2: AtlantiCare Health Services, Atlantic City, NJ



AtlantiCare Health Services Health Care for the Homeless Program is a Federally Qualified Health Center (FQHC) that provides primary health care, substance use, mental health, and outreach services within a case management framework for people experiencing homelessness in Atlantic County.

The health center has fully implemented the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards). These standards focus on improving health care quality and advancing health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities.

In 2019, AtlantiCare served 8,450 patients in 36,690 visits.

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AtlantiCare staff had been discussing piloting telephonic virtual care for several months, but on March 26, 2020, the reality of a rapidly spreading pandemic prompted them to act quickly.

In compliance with state orders, most staff were sent home to shelter in place but AtlantiCare continued to offer limited in-person appointments. On March 27, 2020, three telephonic sessions were piloted and soon after, staff began telephonic services to assist the community with timely care during the pandemic.

During the first month, staff sampled several different mobile options before deciding on a final system.

Using telephonic services, patients were able to talk with a board-certified provider about diagnosis, treatment, and medication needs. Providers conducted 200 telephonic visits by March 30, 2020 by emailing a link to patients who could talk with them via computer or phone. Patients needing further care were directed to the health center.

With in-person visits limited, patients without phones or available minutes were able to come to the clinic and use the phone for their telephonic visits. Patients were screened and their temperatures checked at the front door before entering the health center. Although this worked well, the practice was discontinued in early June when the clinic started providing more in-person visits.

"I decided that I didn't want to close the building under any circumstances because I knew people needed health care. No matter what happened, my motto was 'keep the lights on.'"

Sandy Festa
Executive Director- AtlantiCare
Health Services- FQHC

Successes

- Decreased no-shows among patients with telephonic appointments.
- Increased provider productivity, increased patient satisfaction, increased provider satisfaction, and maintenance of number of patients served.
- Remote assessment of COVID-19 symptoms was made available.
- Increased continuity of care for patients with chronic illnesses.
- Increased social support for patients by providers related to COVID-19.

Challenges

- On-the-job training difficult due to one-day timeline for implementation.
- Limited patient access to phones and internet connectivity.
- Some skepticism from providers that patients experiencing homelessness would engage in telephonic care.
- Reimbursement rates for telephonic visits are expected to be lowered.

Lessons Learned and Recommendations

- Telephonic care has proven to be a useful mechanism to connect unstably housed people who are experiencing symptoms of COVID-19 or other illnesses with a provider.
- Training is needed to implement virtual care using audio only. With things moving very quickly, ongoing training is not only needed, but necessary. For immediate implementation, there needs to be ongoing technical assistance and the sharing of information on promising practices.

Future Strategies for Virtual Care

AtlantiCare plans to maintain 30% of all visits virtually, specifically for medication refills, sick calls, provider-rendered patient education, behavioral health counseling, and psychiatry. They will continue telephonic visits and will begin InTouch Solo Health, a software platform built to provide real-time care, by the end of July.

CALLEN-LORDE

Callen-Lorde Community Health Center has been a leader and advocate, providing sensitive, quality health care to lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities in New York for over 50 years. Callen-Lorde is known to patients and providers alike as the provider of choice for culturally sensitive LGBTQ health care. Services are targeted to reach underserved members of the community and marginalized LGBTQ homeless youth and adults from across New York City, while remaining welcoming to all underserved and low-income residents of the service area.

In 2019, Callen-Lorde served approximately 17,000 patients in 110,000 visits.

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The pandemic accelerated Callen-Lorde's preexisting plans to roll out telehealth for patients. At first only behavioral health services were transitioned to telehealth (first telephonic only, then later video conferencing) over a two-week period because many providers were working remotely and technology capabilities were inconsistent.

Video conferencing was implemented for general care in mid-April. Patients with limited internet or phone access were provided a private room at clinic locations where they could engage in a video session with their provider.

In response to provider and patient feedback, guidance on how to use the telehealth video conferencing system and where to go for in-person services was provided to patients by medical assistants prior to the appointment. This arrangement resulted in an increased case load for providers since they were able to be more efficient during appointments.

Staff were initially trained by the IT team remotely but now have both virtual and in-person training options to promote social distancing.

Successes

- Callen-Lorde engaged their Community Advisory Board (CAB) throughout the process. The CAB piloted the videoconferencing features and provided feedback before the organization made the service available to all patients.
- Telebehavioral health video conferencing has been particularly successful in maintaining patient retention.
- A patient-centric model of care has been maintained throughout the transition to telehealth. This includes in-person visits that are both walk-in and schedulable, video, and telephonic visits.

Challenges

- Quickly providing home offices for 50 clinicians was financially and logistically difficult.
- Reimbursement rates differ between service delivery modalities and is uncertain going forward.
- Some visits are difficult to conduct virtually. For example, patients who are HIV positive and see their provider quarterly often have a list of conditions to review with the medical provider which has been difficult via video. It is also hard to do vital signs or finger sticks for patients with diabetes virtually.

Lessons Learned and Recommendations

- Develop a stronger population health model for pandemic response that takes into account social determinants of health such as food insecurity; could potentially include a “pandemic readiness survey.”
- Create a team early on to provide administrative and IT support to doctors and social workers.
- Ensure staff well-being. Callen-Lorde found success in creating an occupational health department that included both medical leadership and clinicians who were available to staff 24/7. Quarantined staff received a phone call every day, sometimes multiple times a day depending on their acuity, to ensure they were receiving appropriate medical care. The occupational health team also created a Zoom calendar run by volunteer community partners that included activities such as yoga, guided meditation, and a lunchtime support group.

Future Strategies for Virtual Care

Callen-Lorde is committed to continuing telehealth throughout the pandemic. Approximately half of services are anticipated to be provided virtually, but the organization will continually reassess based on staff and patient feedback in an effort to improve efficiency.

Currently, patients decide their level of telehealth engagement, but Callen-Lorde is considering implementing protocols that require one in-person visit every six months for certain diagnosis types. There are valid concerns around prescribing hypertensive medications for a patient without measuring their blood pressure first. One potential solution allows patients to choose virtual care for six months and then schedule an in-person visit afterwards if a medical need arises. Most of Callen-Lorde's providers have said they would like to provide approximately 60% of their care virtually and 40% in person going forward to both decrease commutes and meet increased caseloads.

“At the beginning, we certainly used the regular methods that we have for patient communications such as text messaging and our patient portal, our website, as well as social media. However, I remember working in the clinic very early in April, maybe the first week of April, one of our Bronx patients came as a walk-in to another location. They said, ‘What is going on? Why is the Bronx location closed? I had an appointment today. There was a sign on the door that this location was open.’

They had no idea COVID was happening or what COVID was. This is a Bronx resident that was homeless, they had no cellphone, had no access to local news, and genuinely did not understand why the city was shutting down around them. It really opened my eyes to the ways in which our typical communication allows so many patients to fall through the cracks. It really hit home to me.

When I talk about patient communications, I always bring up this woman that came in because I think it's a really important reminder that the ways in which all of us digest information isn't universal. There are people that aren't able to access the knowledge around even safety. I think part of that is why I felt it's really important that we do maintain onsite access in these instances. We have done a lot of planning around a possible second wave of COVID. In that planning, as I've always really maintained, it's important that we keep some minimum access for those that aren't able to access care remotely and aren't able to get the communications that we typically send out.”

Anthony Fortenberry
Chief Nursing Officer

HCH Case Study #4: Colorado Coalition for the Homeless, Denver CO



The Colorado Coalition for the Homeless (CCH) began delivering health care services in downtown Denver in 1985 to meet the unique medical needs of people experiencing homelessness.

Over the years, CCH expanded and now provides services at the Stout Street Health Center, a state-of-the-art Federally Qualified Health Center that opened in 2014 and at satellite health centers and shelter based clinics. There, CCH responds to the specialized health needs of adults and children experiencing or at risk of homelessness. CCH offers medical and behavioral health care, substance use disorder treatment, dental, vision, pharmacy, and case management services at multiple locations to reduce as many barriers as possible for patients each year.

In 2019, HCH program served 15,204 patients in over 117,000 visits.

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Colorado Coalition for the Homeless (CCH) Program had been providing telepsychiatry and telebehavioral health for several years prior to the COVID-19 pandemic to patients receiving services at a satellite clinic four hours from the main health centers in Metro Denver. In 2019, the organization participated in the [Prime Health Challenge](#) and partnered with Care on Location, a safety net organization in Denver that provided tech mentoring. Through this partnership, CCH expanded their virtual care to include telemedicine and is now one of few organizations in the nation piloting Care on Location's telemedicine backpack equipment program which provides virtual care at encampments, on street corners, and in permanent supportive housing (PSH) units.

In March 2020, approximately half of CCH's behavioral health team started working remotely from home and offering virtual care. Due to the flexibility in the regulations and reimbursement policies, with the State of Colorado allowing reimbursement for telephonic visits, virtual care was expanded to the audio modality. Since expanding telephonic care, this has been the primary way CCH has conducted their patient encounters.

CCH owns and operates 19 PSH buildings, and they recognize patients living in PSH need substantial behavioral health and primary care support. At the beginning of transitioning to telehealth, CCH purchased cellphones with a six-month service plan and distributed them to patients with the greatest need.

CCH staff are actively evaluating the efficacy of telehealth. Currently, approximately 52% of telehealth visits are conducted by video or by phone.

Successes

- The greatest success has been the widespread, efficient use of telephonic care, for both behavioral health and primary care.
- CCH has been successful in transitioning patients who did not need in-person visits to virtual care.
- Generally, both staff and clients have been surprised by the efficacy of telephonic care. Using this modality has eased the burden and effort of patients coming to the health center.

Challenges

- Not all providers had experience conducting billable telehealth sessions prior to the pandemic and telephonic settings, some expressed difficulty providing behavioral healthcare to patients without seeing them.

Telehealth regulations, including how to code and document patient encounters, has been difficult to understand. The State of Colorado requires patient consent to receive telehealth services separate from the regular health consent form. The limitations of the telehealth encounter must be explained to the patient, informing them that they are not required to seek care via telehealth. There are different state-by-state rules around consent for telehealth services and keeping abreast of the documentation and consent requirements can be challenging.

Lessons Learned and Recommendations

- Engage in technical assistance with an organization that has experience implementing telehealth.
- Don't reinvent the wheel. There are organizations in the community health world and Primary Care Associations that have expertise, particularly in the area of telebehavioral health, and can help.
- Be wary of companies advertising telehealth software and hardware. Providing virtual care—specifically telephonic health—can be done with a basic phone line and is not difficult. Remain openminded about what modalities can enhance different types of virtual visits.
- Telephonic care is particularly helpful for behavioral health services. Although, primary care visits proved more difficult to transition, many tasks can be done remotely to increase efficiency and safety.

Future Strategies for Virtual Care

Although telehealth may not be the best way to care for some patients, HCH health centers, CCH included, is dedicated to patient-centered, high-quality healthcare and will continue to offer different modalities of care to patients.

“We started doing telephonic care very early in the pandemic, even before we knew if we would get reimbursement for it; we actually used to use the phrase that we were building the plane while it was crashing, it really felt more like that. But it's gotten better, with us developing our own routine, but it was pretty hectic those first few weeks. I think we just worked and figured it all out. This is what we do at the Coalition.”

Andrew Grimm
COVID-19 Response Incident Commander
Vice President of Integrated Health Services

HCH Case Study #5: Community Health Center, Inc., Wherever You Are – Health Care for the Homeless Program, Middletown CT



“Wherever You Are” (WYA) is a Health Care for the Homeless team that goes where clients are located in New Britain, Meriden, Middletown, and Wallingford in three key location types: homeless shelters, domestic violence shelters, and street locations. By bringing care providers to soup kitchens, shelters, and the streets, the WYA staff makes every effort to reach and treat people without housing in these communities. The Health Care for the Homeless Program also aims to provide its clients with respectful, comprehensive, individualized treatments that will be accessible and affordable, thereby helping to reduce health care disparities among people experiencing homelessness and improve quality of care.

In 2019, the HCH program served 1,323 patients in 3,166 visits.

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Community Health Center, Inc., the largest health center network in Connecticut, operates 15 brick-and-mortar health centers and 190 school-based health centers across the state, serving 150,000 patients a year. Eight sites, located in shelters, food banks, or domestic violence shelters, form the “Wherever You Are” (WYA) Health Care for the Homeless program. As shelter-in-place orders were issued and shelters closed, Medicaid telehealth reimbursement regulations became more flexible and WYA quickly converted services using Zoom.

Zoom licenses were purchased for all staff, including providers, nurses, community health workers (CHWs), and the home visiting team. Each staff member was given their own Zoom room with waiting rooms to provide one-on-one care and maintain patient confidentiality. Training videos on how to use Zoom were recorded and could be viewed by staff at any time. Two members of the IT department were available at all times to assist with technical issues.

WYA simplified the scheduling process by funneling all scheduling inquiries through a single staff member. Patients were given clear, jargon-free guides on how to use the technology during their visit. For example, to reduce confusion regarding the type of visit, WYA staff changed the reminder message to “This is a telephone appointment. Do not come to the clinic. Click on this link to access the scheduled appointment.” Clear, low-literacy-level messages were not only provided during the scheduled visit, but also on the website and in email messages. Approximately 99% of WYA patients used audio-only for care.

WYA was so efficient in initiating and implementing virtual care that other health care agencies in Connecticut reached out to them for guidance and additional service provision.

Successes

- The transition to telephonic care was fairly seamless.
- Patient response has been positive, with some patients indicating they are getting more time with their provider.
- Patient retention rates have remained high.

Challenges

- Telehealth group meetings are difficult. Groups have been an important part of the care WYA offers, facilitating 12 substance use disorders support groups throughout the state. Patients are now requesting one-on-one behavioral health virtual visits. These requests are currently accommodated with school-based nurses assisting with care, but eventually one-on-one requests will not be possible when the nurses return to work.

- Many patients do not have access to personal phones and use friends' phones. It is very common for one person with a phone in the shelter to lend the phone to several other residents. Some shelter residents have government-provided phones with limited minutes and technical capabilities. WYA is exploring funding options to provide shelters with a cellphone that may be loaned to patients to engage in virtual care.
- Substance Use Disorder care is difficult to provide via telehealth.
- The percentage of patients with insurance is low and budget concerns come up as a result.

Lessons Learned and Recommendations

- Staff should use telehealth platforms on a consistent basis, rather than just when faced with a crisis. Staff and patients need to become familiar with the processes and always be prepared in the case of a resurgence of the virus or another crisis. Resources and technology need to be in place and staff trained and prepared to deliver continuously good care under any circumstance.
- The assumption was made that patients experiencing homelessness did not have the technology to engage in telehealth. However, approximately 50% of patients experiencing homelessness did have technology, which is similar to the general health center population. The percentage of patients experiencing homelessness facing challenges accessing phones is equal to the percentage of the general health center population also facing challenges accessing phones.
- Rather than starting from scratch, remember resources may already be available. Other organizations such as the National HCH Council or other HCH health centers are often willing to share their resources.

Future Strategies for Virtual Care

Currently, WYA and Community Health Center, Inc., staff are meeting weekly to discuss their telehealth plans and are not moving quickly to begin in-person care. The organization has continued to maintain a "core team," consisting of one provider, one nurse, and one medical assistant at each of their 15 brick-and-mortar health centers, providing care to patients seeking emergency, acute care, or those uncomfortable using the phone.

This practice will continue, with 40% of the patient population receiving in-person care, and approximately 60% of patients receiving telephonic care. The organization is planning to use COVID-19 funds to build and strengthen the infrastructure of the organization. Ryan White funds will also be used to ensure every eligible Ryan White patient has a phone in the case a crisis occurs again.

There is also potential for WYA to set up "technology hubs" at shelters across the state that would allow individuals without technology or phones to access private both audio and video virtual visits within the shelter. These hubs would facilitate access to appointments in a safe environment, with technology to make the appointment process seamless and less burdensome for patients. A printer would also be at the hub to allow the remote provider the ability to print materials for patient education as needed, as well as orders for lab tests.

HARRIS HEALTH SYSTEM

The Healthcare for the Homeless Program (HCHP) provides dental care and a variety of preventive and primary health care services to people experiencing homelessness through eight shelter-based clinics. Mobile health and dental van units provide additional services through a street outreach service delivery model. Harris Health System and HCHP use an integrated electronic medical record system, allowing off-site medical providers and team members to have instant access to progress notes, test results, referrals, and messaging.

In 2019, HCHP served 10,836 patients in 31,515 encounter visits.

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Prior to the COVID-19 pandemic, the Harris Health System—Health Care for the Homeless Program (HCHP) was not using telehealth to engage patients living in shelters or on the street. Although telebehavioral health was utilized by some patients in the larger care system, it had not extended to specifically serve those experiencing homelessness. In response to the pandemic, HCHP quickly extended telephonic care to patients experiencing homelessness at eight local shelters.

In March 2020, HCHP Medical Director Dr. Yasmeen Quadri began implementing virtual care for patients experiencing homelessness by spending a full day providing telephonic care to patients. During this time, Dr. Quadri learned how to use the system, document, and code visits. To obtain buy-in from staff, the vision of expanding virtual care using telephonic services was shared with the nurse manager and administrative director. Within 24 hours of learning the telephonic process, a protocol was developed to implement a pilot with one provider at one shelter site.

One week after the pilot, telephonic health services were expanded to the other seven shelters. In order to conduct calls, each shelter provides a minimally furnished room with a phone, one chair, one desk, one sheet of paper and pen. Two days prior to the virtual visit, patients are called to confirm their appointment, and an informed consent is obtained. At the time of the appointment, the patient receives a mask before entering the room, the visit is conducted, and the room is sanitized by shelter staff after each visit. The majority of telephonic visits are for medication refills, follow-up, and lab or imaging results. All patients receive health counseling during each visit. Currently due to the continuous threat of the virus, 50% of patients are engaged telephonically and 50% of HCHP patients receive in-person care. Patients with comorbidities such as mental illness, diabetes, hypertension, asthma, or COPD are seen in person.

Successes

- Harris Health System HCHP uses Doximity Dialer, a mobile application that allows the provider to call patients using their cellphone, while displaying a phone number selected by the provider on the patient's caller ID to maintain privacy if the provider is using their personal phone. This has proven to be very successful, because most patients will not answer blocked number calls.
- There is mutual cooperation between patient and health care provider. Patients see the providers going above and beyond to ensure they get the care they need and are responding positively.
- Patient retention rates have increased, especially for those struggling with substance abuse disorder.

Challenges

- Decreased caseloads.
- Outreach workers have encountered individuals who do not understand what is occurring and need education regarding the virus. Some are afraid, while others say that they are not concerned about the virus, stating they face challenges daily.
- Many patients do not have phones or available minutes; therefore, telehealth services, both audio and visual, do not work for these patients.

Lessons Learned and Recommendations

- Telehealth can be easy to implement.
- Use a train-the-trainer model to implement. Two providers were trained, who then trained other providers. This helped disseminate the virtual workflow, protocol, and procedures quickly.
- Identify a champion. It is important to have someone in the organization who is willing to be the first to either implement a change or pilot an idea. Start small, then expand.
- Collaborate with local disaster management organizations, including expert public health officials.
- Build and maintain trusting relationships with shelter staff and patients.
- Understand the patient's perspective. Listen to the patient, identify what their needs are, and acknowledge that providers may not know everything.
- Find ways to support people in isolation and quarantine. Experiencing homelessness is a traumatic experience, and being alone in isolation can be overwhelming, especially if someone has a mental illness. The ability to show compassion, a willingness to listen, and being trauma informed are skills necessary to serve this population.

Future Strategies for Virtual Care

HCHP will continue following the guidance from the Centers for Disease Control and Prevention, and the state-recommended social distancing, wearing masks, and ongoing COVID-19 screening and testing of patients. Staff will continue to provide face-to-face care in the clinic to one-third of patients, use telehealth video capabilities to engage another third of patients, and continue to use telephonic (audio only) services for the last third of patients.

Health Resources and Services Administration (HRSA) COVID-19 funding was used to purchase tablets and phones to make street outreach efforts more robust.

"I believe organizations need to understand that homeless health care is very different. Those trained in caring for people experiencing homelessness understand that patients who are homeless are different and need a specific kind of health care delivery using motivational interviewing and trauma-informed care. Housing and available quarantine facilities are part of Health Care for the Homeless. When emergency care policies are made, they are made for the entire organization, and it is imperative to have a homeless health care expert on the panel. At HCHP, telehealth was aggressively implemented as the thought was, 'They don't have phones and they can't participate in telehealth; it just isn't going to work.' But it is working, and the patients involved in telephonic care are loving it!"

Yasmeen Quadri, MD
Medical Director

HCH Case Study #7: HCH Network of King County, Seattle WA



The Health Care for the Homeless Network (HCHN) is a community project of Public Health Seattle and King County. Through a combination of direct and subcontract services, individuals experiencing homelessness can access care at shelters and other homeless programs, community health centers and public health programs including primary care, mobile medical, dental clinics, TB and STD clinics, maternal support services, school-based health and family planning programs as well as contracted community agencies providing medical, behavioral health and enabling services.

HCHN served 21,723 patients in 2019 in 114,726 visits.

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King County was one of the first areas in the United States to be impacted by the coronavirus. Prior to onset of the COVID-19 pandemic, HCHN had been providing primarily telebehavioral health services.

Protocols were developed for audio visits to ensure staff were familiar with the process since almost 60% of the visits were telephonic at one point.

Front desk and the nursing staff are informed regarding the recommended type of services that should be provided in-person. Patients who are considered high risk for developing complications should they contract COVID-19 are offered a virtual visit unless they have a condition that requires an in-person clinic visit such as wound care or if a test is needed to monitor an uncontrolled medical condition. Staff nurses use Skype for virtual visits and some providers use the clinic's landlines also, but they also have access to Skype.

Clinic staff inform patients on to how to participate in virtual care visits. Sometimes patients forget the time of their appointment and may call at a time that they are not scheduled. Health center staff do their best to accommodate those patients and adjust when needed.

Now that HCHN has the process for telephonic visits solidly in place, they are expanding their type of visits to offer telemedicine using video. Training was provided on how to code and bill for telemedicine and how to schedule the visit in the electronic medical records (EMR) by specific visit type. They worked with their EMR vendor and technology department to get ready to offer video services.

Successes

- HCHN was quick to transition to virtual care. Health center leadership started seeking advice regarding the best way to serve patients while keeping them safe, then moved quickly to alternative visits.
- Patients report increased satisfaction with telehealth compared to in-person care.
- Proactive outreach to patients with contact information was found important and successful.

Challenges

- Some patients have government-issued free phones and minutes but have difficulties using them because they misplace their phones, their phone is stolen, or they do not have a reliable place to charge their phone. These have been the main challenges encountered. Forty-four free phones were donated that included prepaid data services and minutes. Staff started giving them out to patients and this has helped. HCHN is looking for ways to keep these phones active and for patients

to keep getting them and have them available. Staff are also trying to figure out how to direct patients to charging stations, including a solar charging station, where patients may go to recharge their phones. This is a communitywide effort with many partners who are invested in finding solutions to help patients.

Lessons Learned and Recommendations

- Assess the population to understand their willingness to engage in telehealth and how to design virtual services in a way that is acceptable and accessible for them.
- Train staff on detailed protocols.
- Develop a communication strategy. Establish a workgroup to develop methods so staff can communicate better. This also ensures that people are knowledgeable about what changes are being implemented and what is expected of them. It allows them to explain to patients the purpose for the changes being made.
- Continue to explore and look for ways to improve engaging patients through technology. There are patients who are good with technology and can play an advisory role.
- Staff should be encouraged to explore and implement changes.
- Get to know the patients. Patients know if they are being well cared for. Many people experiencing homelessness may benefit by seeing their provider; they like to show the provider what is going on with them. Patients need to feel a connection to their care team, and this can be done by providing virtual care using video features.
- Offer a variety of options to patients and think about the future. No one knows what the winter will bring.
- Sometimes it is best not to wait for everything to fall into place. At some point a decision must be made to move forward and do what is best for patients even while waiting to see if reimbursement is available for telephonic care. That level of support and willingness to take a risk is key if one wants to be successful.

Future Strategies for Virtual Care

HCHN has decided to expand beyond telephonic care and add video conferencing. In late June, HCHN implemented telemedicine and has now finished a “dress rehearsal,” piloting the video modality and completing 10 visits using staff. Two dry runs were held to ensure everything was working correctly, including having workflows ready. Staff who participated were able to provide firsthand feedback about how the system may work better, how the workload makes more sense.

HCHN has worked very closely with their compliance officer and vendor to do the risk assessment to make sure the patient’s privacy complies with regulations. After implementing telemedicine in primary care, they will expand to other programs, such as family planning, behavioral health, and prenatal support services.

“We moved really quickly from in-person visits to phone visits, now telemedicine. Who knows what we are going to implement next? It’s all about trying to serve our patients the best way that we can. We did not anticipate that the stay-at-home order would result in the closure of many places where our homeless clients were able to charge their phones and to shelter themselves. These places were gone.”

Francisco Arias-Reyes
Primary Care Program Manager

HCH Case Study #8: Health Care for the Homeless Program, Baltimore MD



The mission of Healthcare for the Homeless in Baltimore is to prevent and end homelessness for vulnerable individuals and families by providing quality, integrated health care and promoting access to affordable and sustainable incomes through direct service, advocacy, and community engagement.

The agency provides comprehensive primary care, dental, behavioral health – including mental health and addiction services, psychiatry, outreach, HIV testing and treatment, occupational therapy, case management, peer recovery services, convalescent care, health education and other support groups, benefits assistance, and referrals to specialty care.

In 2019, they served nearly 10,000 clients.

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It was the middle of March when the leadership of Health Care for the Homeless in Baltimore realized it was no longer safe for clients to ride the bus, to be out in public, or come to the health center to receive health services due to the COVID-19 pandemic. All departments transitioned to telephonic care, including behavioral health, medical, and case management, and “dived right in” setting up to conduct visits telephonically. Staff called clients with appointments instructing them not to come to the clinic for their appointment and to wait for a phone call from health center staff to conduct the visit over the phone.

The agency's largest health center never closed and continued to provide services. Two smaller full-service sites in the metropolitan area, as well as the Mobile Clinic, medical outreach and all dental clinics were closed, with providers from those sites being reassigned to work at the main location. During the first week of transitioning to telephonic care, approximately half of the client encounters. By the fourth week of initiating virtual care, approximately 75% of all visits were being conducted by telehealth, with 99% of these visits using the modality of audio-only.

Staff rotated shifts to keep the number of people in the building to a bare minimum. Additional server capacity was immediately freed up so that the majority of client care and business operations could be conducted off-site. Equipment such as laptops were provided to enable staff to access the electronic health record (EHR) and other necessary business systems remotely. Staff used desk phones and agency provided or personal cellphones to engage clients, taking the proper precautions to maintain the privacy of personal phone numbers.

Successes

- The no-show rate decreased and patients are easier to contact.
- Expanded participation in the buprenorphine program. The number of patients who have followed up with their appointments has doubled since the transition to telehealth.
- Telehealth has enabled consistent and high-quality care for patients diagnosed with COVID-19.
- The transition to hotel rooms as shelter to mitigate the spread of

COVID-19 has been successfully integrated with primary care visits.

Challenges

- Learning a new skill is always challenging but doing it fast is even more challenging. Transition to virtual care in response to COVID-19 began before a process could be developed.
- New billing regulations are temporary, including Medicaid/Medicare reimbursement for telephonic care.

- Financial stability is difficult when reimbursement policies are inconsistent and temporary for telehealth services. BHCHP found that telehealth can increase the quality of care for patients experiencing homelessness, but these services also need to be financially viable for HCH programs.

Lessons Learned and Recommendations

- Many people experiencing homelessness are willing to engage in telehealth services, contrary to popular belief. Telehealth even eliminates some barriers to care that exist for in-person visits.
- Change is possible in a short time frame.
- Telehealth has several advantages to traditional in-person care, including decreasing the no-show rate by eliminating the transportation barrier.

Future Strategies for Virtual Care

As the pandemic continues, Baltimore leadership has recognized that creating new patterns following periods of quick inventiveness and flexibility is imperative. A “new normal” is more challenging to create and requires new structure and lots of communication and engagement.

Health Care for the Homeless in Baltimore will continue using telephonic care, as long as it is appropriate to address clients’ health care and safety needs. The extent to which audio-only care will be used will partially depend on reimbursement. The agency is also looking to pilot video telehealth in partnership with a local shelter as a potential new model of care.

“Not all of our patients have a phone. We worry a lot about the patients that we’re missing because they don’t have access to a phone. For our patients, their phone may not be functional 24 hours a day, seven days a week. I had a patient who couldn’t take his pills for a couple of days and it just happened that the days his phone was going to be off were one of those days when our appointment was supposed to be, so he needed some flexibility there. We haven’t done a lot with video, but a lot of our patients don’t have access to the technology needed to do video telehealth.”

Adrienne Trustman, MD
Chief Medical Officer

HCH Case Study #9: Heartland Alliance, Chicago IL

HEARTLAND ALLIANCE

Heartland Health Outreach, Inc., (HHO), the health care partner of Heartland Alliance, is a community health organization dedicated to improving the health and well-being of Chicago's most vulnerable populations, including people experiencing homelessness. HHO provides comprehensive, integrated services, including primary, oral, and behavioral health care; care coordination; and health education and prevention services. Services are provided through its main health center in the Uptown community, its satellite clinic on the west side of Chicago, and through medical outreach services at more than 50 overnight and transitional shelters and drop-in centers throughout Chicago.

In 2019, HHO served 10,057 patients in 99,239 visits.

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Prior to February 2020, HHO had many conversations about virtual care, but had not moved past the discussions. In February 2020, the Governor of Illinois closed schools and businesses in the state, which reignited a massive telehealth initiative at HHO.

HHO moved to provide telehealth quickly, following the early decision that the health center would remain open to treat patients. Staff were trained on telehealth by a contractor that provides interpretative services to Heartland Alliance patients whose primary language is not English. The familiarity of the trainers with the Zoom platform made the training an easy undertaking.

During a one-time meeting for Heartland Alliance providers, Zoom codes were issued and work schedules changed to accommodate one-week shifts. One half of the staff were scheduled to provide onsite in-person care at the health center, and the other half of the staff provided virtual care from home. A pilot was conducted using Zoom's video feature for psychiatric care.

Patients were alerted to changes in the offering of services through phone calls, notices at shelters, and case managers alerting patients by word of mouth. In-person visits at the clinic were reserved for patients who were unable to be engaged through telehealth, with adjustments that included limiting the number of patients scheduled, a provider available during hours the clinic was open, and shortened operating hours.

As the COVID-19 pandemic continued, staff were affected at various shelters in the Chicago area. Shelter staff became ill or unable to work or stopped reporting to work for fear of contracting the virus. With shelters experiencing a shortage in personnel, HHO staff stepped in and began caring for people in various shelters. As more shelters experienced staff shortages, calls for assistance increased, and HHO currently provides care in two dozen shelters throughout the city.

“HCH staff go into situation—we don't walk away. Whatever is needed we do it, even when it's a horrible situation.”

Case management played and continues to play an important role during this time, especially for patients with chronic diseases, such as diabetes, hypertension, tuberculosis, and HIV. Tablets were purchased for case managers to help engage patients in care. Case managers

continue to be 100% offsite, serving as care coordinators to assist patients in setting up appointments and finding resources, including food and medications. Case managers also help facilitate medication adherence by setting up video to watch patients take medications as prescribed. Currently, about 50% of patients are engaged through audio or video features of the Zoom platform.

Successes

- The telehealth training led by the interpreters was helpful and enabled a successful start.
- Telehealth works well for some people. Those who would previously not look the provider in the eye have been able to engage better in telehealth.
- Collaborating with other cooperative agencies, including other health centers, shelters, universities, and hospitals, has been recognized by the city and has been encouraged to continue.
- Housing is health. Patients in hotels used as alternative care sites are doing well. Stable living conditions also helps engage patients in telehealth.
- People with substance use disorders are doing better and seem to open up more on the phone than in person.

Challenges

- Access to phones and internet is limited for many people experiencing homelessness.
- Privacy is difficult to ensure when patients often must attend visits in a shelter, on the street, or in other crowded situations.
- Telehealth is challenging for some providers who like to be in the room with patients and move around.
- Telehealth documentation—including correct billing and management codes—is difficult to learn.
- Reimbursement is limited and changes depending on the service delivery modality.

Lessons Learned and Recommendations

- People are afraid. It is important to help alleviate that fear and show tenderness.
- Establish good relationships with shelter staff and realize shelter staff are not health care providers. They are not equipped to care for sick people. Not everyone is clear on how to use Personal Protective Equipment (PPE), so training should include shelter personnel.
- Recognize it takes time to build trusting relationships with new patients, especially via telehealth.
- Language barriers to care for non-English speakers requires the use of an interpreter which can result in longer appointments. Schedule accordingly.

Future Strategies for Virtual Care

HHO staff are having ongoing conversations to decide what parts of telehealth will continue. Currently, not all telehealth offered is through the Zoom platform. It has been decided that virtual care will be offered as long as possible, or at least until September 2020, with telebehavioral health visits scheduled until the end of the year. Some patients will be seen in person at the clinic, with more patients receiving virtual care in the shelter than in the clinic.

“Even if you don’t like telehealth or you do like it, you can’t do it all the time; we need to find a balance and make sure the balance tilts toward the patient. We must continue to be trauma- informed, and continue patient-first, patient-centered, patient-forward care. We must ask the question, ‘*Is the patient really engaged in this method?*’ It is important to make that determination. The option of how to access care is the patient’s decision. It is not something I, as a provider, get to decide or choose for them.”

Mary Tornabene
Family Nurse Practitioner

HCH Case Study #10: Hennepin County HCH Program, Minneapolis MN



The Hennepin County Health Care for the Homeless (HCH) Program is housed within Hennepin County Human Services and Public Health Department. Hennepin County HCH provides treatment including medications, coordinates health care services, provides substance use disorder and mental health services, provides health education, and coordinates access to health and social services in the community. Any homeless adult or child is eligible. This includes those living outside or on the street, in shelter or transitional housing, those doubled up with friends or relatives, or those who have been homeless within the past year.

In 2019, HCH Program served 4,031 patients in 12,542 visits.

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Hennepin Health Care for the Homeless (HCH) is a Federally Qualified Health Center (FQHC), operating nine different clinic sites across the county and providing mobile outreach. Prior to the COVID-19 pandemic, Hennepin telehealth was limited to medication refills and clients unable to conduct their clinic appointment in person.

Since the pandemic, the HCH program has reduced the number of sites, in order to free staff to respond to other needs created by the COVID-19 crisis, including relocating over 500 adults over 60 and medically vulnerable patients into six hotels dispersed throughout the Twin Cities Metro area.

A centralized phone line that included weekend and evening hours was established to triage patient needs. Patients receive guidance and support related to COVID-19 including testing and hotel relocation in the case of a positive diagnosis.

Hennepin HCH program uses a walk-in model of care, and the additional phone lines established are for each operational health center. The phone number is posted outside of each clinic and is used by patients with most living in shelters. Patients may call the line using their own phone or a phone made available by staff at the shelter/drop-in center. Depending on their symptoms, patients are seen either in-person at a clinic or by phone via a telehealth encounter. A variety of physical, behavioral and social services are provided to people living in the hotels via telephonic care. iPads have been distributed to select hotels, and with the assistance from social service staff, a small number of patients are receiving virtual care using the video modality. To minimize staff in the clinic spaces, all mental health services are being delivered via telehealth.

Successes

- The structure of being embedded in a Public Health Department as well as being an affiliate of the local safety-net hospital enables the HCH program to combine creating their own structures with collaborating with other partners in the public health clinical departments in Hennepin County.
- Workflows were reconfigured quickly to ensure the safety, efficacy, and quality of care for patients.
- The outreach team has been especially innovative in remaining connected to patients.
- Both audio and video telehealth services are provided to patients now.

Challenges

- Access to phones and internet remains a challenge for patients experiencing homelessness despite efforts by the HCH program to provide some ipads and phones.
- The program is relatively small and must think carefully about how to reorganize to meet patient needs, including maintaining the five “closed door clinics “and the outreach team supporting encampments and several hotels.
- Comprehensive care is difficult to provide with dramatically increased caseloads.

Lessons Learned and Recommendations

- Use a triage line to communicate effectively and quickly with patients.
- Hennepin Health Care for the Homeless program has remained open during the COVID-19 crisis. The larger Hennepin healthcare system has been delayed in some respects due to the dynamics occurring in Minneapolis, therefore, it has been difficult to assess how well some patients are doing by phone. The entire community is still in the crisis response mode. Staff have been thinking most carefully about our state's Medicaid, telehealth reimbursement, and working with the organization's billing and coding department to file for specific telephonic charges based on the length of time spent providing telephonic virtual care to patients.

“I think that it's been inspiring to see people come together across organizational barriers

in order to really creatively meet the needs of our patients and a community in crisis. I've really been inspired to see and learn and hear how much new stuff was happening in so many different directions. I think we often talk about innovation in healthcare but struggled to actually make those real changes. It's been really inspiring to see how much change can happen and how much in a very short time spurred on by the crisis. I'm hopeful that we're going to come out the other end of this with a clarified understanding about how to reach people, how to stay in touch with people, how often telehealth might be a more appropriate supportive approach to connecting with the patients than making them come all the way for an in-person visit.”

Kate Diaz Vickery, MD, MSc
Primary care provider, Hennepin County Health Care for the Homeless

HCH Case Study #11: Heritage Health, Coeur d' Alene ID



Heritage Health offers services to people experiencing homelessness in Kootenai County and the surrounding areas through an integrated Health Care for the Homeless and Community Health Center program using outreach and case management. Health services are offered rotating between seven churches, food banks, and shelters through a mobile unit. Heritage Health offers care in at least one site per day through the mobile clinic, and a walk-in clinic in stationary sites, as well as a street medicine program. Patients can either access walk-in services, make an appointment, or they can access services through the mobile unit.

2019 Patient visits for the Street Medicine program only: 1491 total encounters, 471 unique patients.

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Heritage Health has four main health clinics a street medicine team highlighted here. The street medicine team was not using virtual care prior to the onset of the COVID-19 pandemic to engage patients experiencing homelessness.

As the COVID-19 pandemic spread across the nation, the north portion of Idaho seemed to have a delayed impact from the virus, and it was toward the end of March that Heritage Health began preparing to transition to telephonic care. They quickly set up the telehealth platform Doxy.me and reduced in-person visits. IT staff conducted telehealth platform trainings for all staff.

The other clinics within the Heritage Health system transitioned to providing approximately 80% of visits virtually and 20% in-person. However, the Health Care for the Homeless program chose to transition approximately 5% of their population to audio-only, offering virtual service to patients at the Street Medicine Program at the Union Gospel Mission and the Women's and Children's Center in Coeur d'Alene. The use of telemedicine was possible for this population because they had access to a computer and smartphone provided to them by the center staff. Some of the patients engaged in their virtual care visits used video and audio for the telemedicine visits, while others used audio only.

Heritage Health communicated the operations changes through call, text, and social media campaigns. A central appointment line was already established that enabled patients to call one number for either in-person or virtual appointments.

Patients received instructions on how to use the telehealth platform chosen for the virtual visit when the patient's access coordinator called to confirm the appointment. The type of visit provided, in-person or virtual, was determined by the patient's comfort level, reported symptoms, and medical needs.

Successes

- Telehealth enabled patients to receive care safely.
- Reimbursement for telehealth visits was offered at a similar rate to in-person visits.
- Telehealth eliminated the transportation barrier to care for some patients.

Challenges

- Access to phones and internet is lacking, especially in rural areas.
- Balancing the safety of telehealth regarding the pandemic with the need for in-person visits to assess symptoms has been challenging.

Lessons Learned and Recommendations

- Recognize the value of telehealth and the relative ease of implementation.
- Connect patients to specialty providers through a telehealth platform if possible.
- Educate patients about expectations around telehealth visits.
- Establish a central hub that has either a borrowable laptop or smartphone that patients may access, or provide free Wi-Fi so patients may use their smartphones, if they have one.

Future Strategies for Virtual Care

It is not clear what the next steps will be to expand offering virtual care to other patients experiencing homelessness beyond the 5%. Staff are ambivalent regarding the need to push to expand telemedicine as beneficial for their patients. The preference is to engage patients face to face while maintaining social distancing and sanitation protocols. The thought is it is better for the patients both physically, socially, and emotionally to be engaged through in-person visits.

“I had children in clinic on Monday and a couple of patients complained of a cough and one was a patient that had a history of asthma and asthma attacks and so they weren’t going to let her in clinic. From a medical professional viewpoint I feel that a child with a history of asthma should have a face to face visit to accurately diagnose and treat. The danger with a telehealth visit (in this case), is the assumption of COVID-19 and under treatment.”

“Another patient called, and they put him on the schedule for a telephonic visit, also for a cough and shortness of breath. When I called him, it really sounded like he was having a congestive heart failure (CHF) exacerbation and he needed to go to the hospital. This was just a telephone, so I couldn’t even look at this man, to determine if he have swelling in his ankles. What does it look like? Is it worse than normal? Even with video, I could at least see that, but then again, listening to his lungs would help me determine if he had CHF or something else. That’s not possible to do over the phone or through telemedicine at all.”

Heather King
Family Nurse Practitioner

HCH Case Study #12: Partnership Community Health Center, Appleton WI



For over 20 years, Partnership Community Health Center (PCHC) has provided primary medical, dental and behavioral health care in Appleton, Oshkosh, and Waupaca Wisconsin. Care is complemented by multilingual health insurance enrollment and outreach to vulnerable populations. This approach is a cornerstone of our patient growth and financial stability.

The satellite clinic at COTS offers integrated primary care and behavioral health services to those living onsite as well as other vulnerable members of the community 2 days per week.

As of December 31, 2019, the COTS clinic has completed 3,490 patient visits for 593 individual patients.

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“Bringing Healthcare Home” is a unique collaboration between Partnership Community Health Center (PCHC) and COTS, a transitional homeless shelter in Appleton, WI. PCHC runs a satellite clinic out of the shelter to address barriers to healthcare as a root cause of poverty. PCHC uses a trauma-informed approach to build trusting relationships with both patients and community organizations. As a result, when the COVID-19 pandemic hit, the health center was well-positioned to support patients as well as their community.

Prior to the pandemic, PCHC had plans to implement telehealth but pushed up the timeline once in-person care was rendered unsafe by the pandemic. PCHC now offers telemedicine, telebehavioral health, and virtual insurance enrollment services. Staff worked quickly to develop workflows, standards, and procedures needed for all providers to deliver telemedicine via Zoom. The IT Team conducted training on the basics of telehealth appointments. The dental site only offered emergency services for a period of time early in the pandemic, but has since returned to offering all services in person.

The satellite clinic at COTS is currently closed for renovations to better accommodate social distancing guidelines for patients and staff. The Health Advocate at PCHC has been working with community partners and following up with patients via phone to ensure that patients normally seen at the COTS site continue to receive care during the renovations.

PCHC established a patient-texting platform for group messaging using Care Message to alert patients, including those seen at the COTS clinic, about changes happening within the health center. Mass mailings of postcards and flyers regarding the changes in health services were disseminated to all shelters, community partners, and patients, regardless of phone access. Appropriate informational and educational materials were developed in English and Spanish and distributed to patients describing the meaning of “virtual visits,” where to call for an appointment, and how to use Zoom.

Currently, many of the patients normally seen at the COTS location don’t have easy access to Zoom appointments, so their appointments are scheduled telephonically instead. Telephonic services are offered to any PCHC patient for whom technology or internet access poses a barrier.

Successes

- The implementation of virtual care has been speedy, intentional, and thoughtful.
- Transportation is no longer a barrier to care for many. Patients who have not accessed health care for months are now engaged and receiving care virtually via phone or Zoom.
- No-show appointments have decreased, with approximately 11% of patients not keeping the virtual appointments compared to the usual 18%-20% of no-show in-person appointments.

Challenges

- Skepticism regarding the feasibility of balancing the need for in-person visits with the transition to virtual care.
- Reimbursement policy is uncertain.
- Patients sometimes have limited access to privacy to conduct appointments.
- Telehealth cannot be provided for all care.
- Since access to phones and internet access is limited, understaffed shelters are relied on to keep in touch with some patients.

Lessons Learned and Recommendations

- Strengthening and redefining relationships with community partners is important.
- Relationships and networks must be established and nurtured. Because orders and instructions change frequently in a crisis, it is important to have dependable networks to help disseminate information to patients and to the community.
- Use an improvement cycle such as Plan, Do, Study, Act (PDSA) to provide continual quality improvement efforts.
- Remain patient-centered.

Future Strategies for Virtual Care

Telehealth will remain part of PCHC operations beyond the pandemic. PCHC is also working with the local Salvation Army office to set up a health assessment table that will allow clients to request services from PCHC without an outreach worker being physically present. Salvation Army clients will place a completed paper assessment in a locked box, and someone from PCHC will follow up with them via phone for scheduling. If the health assessment table produces positive results, PCHC plans to expand these services to other community partner locations.

“It is important to remember the patient is the driver of care. They decide where care should start and what the provider should focus on. I developed a short patient-centered assessment for all new patients to ask important questions such as: ‘Do you have questions about health insurance?’ ‘Do you have medical bills you need help with?’ And, ‘Do you have a doctor who can fill your medications?’ I really try hard to establish long-lasting relationships with my patients. With the pandemic, I worry I’ll lose connections and momentum by not being onsite at shelters to personally connect with patients and shelter staff. It’s important to me to make sure my patients don’t feel abandoned.”

Amber Price
Health Advocate

HCH Case Study #13: Pathways Clinic of Project H.O.M.E., Philadelphia PA



Pathways Clinic serves people with complex physical and behavioral health needs. Many of the people served have serious, chronic, and untreated medical issues that have been neglected for years and require significant health, care coordination.

Pathways Clinic houses people directly from the street, without precondition. They address their underlying issues around mental health, substance misuse, medical care, income and education to help integrate and welcome them back into the community. They provide furniture to people moving out of homelessness through their furniture bank.

In 2019, the HCH program served 5,089 patients in 24,938 visits.

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Pathways Clinic of Project H.O.M.E. Healthcare Services (PHHS) is an integrated care, interagency clinic between PHHS and Pathways to Housing. Pathways offers care to transient populations experiencing street homelessness at three satellite sites, and health care to formerly homeless individuals being housed at an onsite clinic at the Pathways site. They also conduct home visits and provide Permanent Supportive Housing.

During the second week of March following the City of Philadelphia's model, Pathways staff began planning the transition to telehealth. Several adjustments were made in their medical practices, including suspending their suboxone clinic and discontinuing in-person individual appointments. Two main concerns were how to implement safer practices to protect high-risk and most vulnerable patients and how to engage patients without phones in telehealth.

Participants were divided into three tiers, Tier 1 included participants who were the most at risk for dying within the next year and needed to be seen weekly. Before the city shut down with a shelter-in-place order, Pathways staff moved quickly to reach this high-risk group. Case managers increased outreach and delivery field efforts, including delivering Tracfones to help patients in Tier 1 access telephonic care and connect with health care services. Participants in Tier 2 included those with a fair number of health problems but were not determined to be at high risk of mortality within the next year. Participants grouped in Tier 3 included individuals who were low risk for mortality, fairly self-sufficient, with minor health care needs, but required care such as the monitoring of medications. Limited in-person medical care services remained available for emergency appointments only with a provider, administrative assistant, medical assistant, and one nurse available to provide care.

Successes

- Increased coordination with community partners.
- Outreach efforts increased, with case workers completing 100 text and phone calls daily.
- Many participants are already tech savvy, sometimes more so than providers.

Challenges

- Insurance and reimbursement changes were challenging to understand.
- Some acute and chronic conditions need closer monitoring and fare better with in-person visits; for example, wound care, antibiotic monitoring to ensure the patient is taking the medication correctly, or respiratory conditions may be harder to manage with telemedicine.

- The distribution of phones to high-risk participants was often unsuccessful since many phones were lost, stolen, broken, borrowed by other participants, or lent to friends.

Lessons Learned and Recommendations

- Participants are resilient. They cope with the pandemic and the trauma of unstable housing.
- Organizations must be creative and innovative in how to meet the needs of people experiencing homelessness. Communication is key, with the need to keep people in the loop, be aware of what is occurring day to day, and ensure that everyone is on the same page.
- Learning is ongoing. There is a continual need to adapt and incorporate new ideas to make virtual care more accessible to patients and continue to find acceptable ways to deliver quality care.
- Recognize the limitations that people experiencing homelessness have regarding telehealth. For example, when engaging participants through telephonic care, timeliness is important since putting patients on hold uses up their limited phone minutes.

Future Strategies for Virtual Care

Pathways to Housing will continue providing virtual care as long as it is needed by the participants. They will also continue the increased effort in communicating between partners.

HCH Case Study #14: Pinellas County HCH, Clearwater FL



The Pinellas County Health Care for the Homeless (HCH) program provides medical services, otherwise known as primary care, which includes treatment of illness and injury, as well as preventive care, education, limited prescription coverage and referrals for lab work, specialty care, dental assistance, behavioral-mental health assistance, and substance use treatment. Pinellas County residents without homes can receive basic health care in two primary locations, Bayside Health Clinic and Mobile Medical Unit. In 2016, the Pinellas County HCH program became a Patient-Centered Medical Home.

In 2019, HCH program served 2,952 patients in 25,036 visits.

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In 2018, Pinellas County secured technical assistance support from the National Health Care for the Homeless Council and the Southeastern Telehealth Resource Center to explore improved telehealth integration for the target population, with a focus on behavioral health services. During the site visit and subsequent interactions with the Resource Center, the county learned a great deal about new technologies and offerings for telehealth and virtual care that had not yet been explored. While the health center leadership was supportive of the opportunities, more groundwork was needed before moving forward.

In 2020, however, as "Safer at Home" orders were issued, Pinellas County in person visits were limited to urgent care appointments only, with all previously scheduled visits transitioned to telehealth or rescheduled for a later date. All dental visits were suspended except for emergency, relief-of-pain procedures.

Successes

- The HCH program staff has taken its first steps in implementing telehealth by upgrading its electronic medical record (EMR) and identifying and addressing the multiple layers and factors associated with virtual care. This includes examining legal issues, risk factors, and security questions associated with being part of a government agency and health care direct service provider.
- The HCH program's behavioral health providers have seamlessly made the shift to telebehavioral health during the pandemic by providing virtual video and telephone-based intakes, outpatient therapy appointments, group sessions, and case management services.

Challenges

- Some providers faced a learning curve regarding new workflow policies and technology upgrades.
- Access to phones and internet access is lacking, particularly in rural areas.
- Maintaining equipment at partner sites has been difficult.

Lessons Learned and Recommendations

- As a county government, the IT department is not as familiar with the health care needs and outcomes of the health center. It is very important to work closely early on and communicate the technological functions and tasks needed to accomplish stated goals and measures. Allow for an extended timeline with the vendors as they may not be familiar with the nuances of working with government entities.

- Reliable technical connectivity during a virtual care visit is essential. Spotty or non-existent technology jeopardizes trust and consistency in care. Broadband disparities and lack of infrastructure in the county must be addressed.
- A preassessment is needed before implementing telehealth to identify both barriers and solutions.

Future Strategies for Virtual Care

While the Bayside Health Clinic never closed, the on-site services remained limited and restricted to call-ahead policies to promote social distancing and limit the number of face-to-face interactions that put staff and patients at risk. These limitations sparked a renewed interest by the health center to explore and implement virtual care opportunities. Funding provided by Congress to address COVID-19 enabled the health center to plan a phased approach to virtual services.

- **Phase I: Electronic Medical Record Enhancements to Enable Virtual Visit Appointments.** The health center engaged with its EMR vendor, NextGen, to upgrade its software to enable virtual visits. Once upgraded, the health center will be able to schedule and conduct primary care visits with patients who have smartphone or Internet-based computer hardware.
- **Phase II: Virtual Rooms for Technology-Restricted Patients.** Recognizing people experiencing homelessness have limited access to smartphones or Internet-based computer hardware, the county is seeking to establish “virtual rooms” at key partner locations across the county that would shorten the distance and limit social interaction for the patients, while enabling patients to obtain ongoing medical care. The rooms would be similar to a library offering computers for public use, but the rooms would be HIPAA compliant with the appropriate camera/microphone technology needed.
- **Phase III: Medically Enhanced Virtual Rooms.** Where appropriate and with the additional staff assistance, the virtual rooms would include medical equipment to provide basic primary care diagnostic tools for obtaining blood pressure readings, and or camera- enabled otoscopes/stethoscopes.

HCH Case Study #15: Crossroads HCH Program, Providence RI



Providence Community Health Centers has been operating for 52 years, serving over 50,000 patients at six large health centers and two smaller health centers, offering OB-GYN, pediatrics, internal medicine, and family medicine. A school-based clinic runs during the school year.

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The process of transitioning patients to virtual care began with the providers working remotely shortly after Safe-at-Home orders were issued. All support staff, medical assistants, nurses, and health center director came to the clinic every day. The director of community relations led the efforts to alert the community through public service announcements and commercials by working with different agencies and churches. All patients were called to alert them to the change in health care services.

To implement the telephonic visit, the patient was called the day prior to the scheduled visit and the following message given: "Because of COVID, we are doing all visits by phone. The provider is going to call you at your appointment time. Be ready. Is this the best number for them to call you?"

Skype was one method chosen to engage patients, as well as Doximity available for providers using their personal cellphone to maintain privacy of personal numbers. Training on how to use telehealth was not offered, but handouts with instructions on how to initiate three-way calling, request an interpreter, or transfer a call from the clinic to the provider were made available.

Communication was important, and Crossroads staff did a virtual huddle every morning reviewing the schedule for the day. They tried several different procedures to identify the best system to implement the virtual visits. The provider called the patient with Skype and could alert staff via Skype if assistance was needed.

Patients that did not have a phone were given the opportunity to come into the health center, go into an exam room, and use the phone so the provider could do their visits.

Successes

- Telephonic care has been implemented successfully.
- The no-show rate has decreased while engagement increased.
- Behavioral health services, including the medication-assisted treatment program, are also being administered virtually and are busier than before.
- Patients appear to have adjusted to the telephonic visits well, stating that they are getting the care needed.

Challenges

- Coordination between remote staff and on-site staff is difficult.
- Although integrated health care was an important practice at Crossroads before the pandemic, it is no longer being implemented due to the staff coordination it requires.
- Some health measures are difficult to monitor virtually, limiting the ability to adjust medication.
- Access to phones and internet is lacking.

Lessons Learned and Recommendations

- It is important to be flexible, innovative, and have patience. At the beginning, telehealth guidance changed constantly and it was difficult to stay up to date.
- Collaborate with other homeless service providers. Rhode Island is small with great connections, a homeless services coalition, and a robust Continuum of Care (CoC).

Future Strategies for Virtual Care

Crossroads is planning to reopen the clinic slowly. Over the next three months, in-person visits will begin by scheduling in 20-minute blocks to encourage social distancing and crowd control; the desire is to not have patients sitting in the waiting room or in line at the registration desk. The provider will be coming into the clinic two days a week. The focus will be on chronic care, including diabetes, hypertension, people needing A1Cs checked, and immunizations updated. The future for using telehealth is hard to predict, but Crossroads anticipates it will continue a hybrid model between in-person visits and virtual care.

“The success of engaging patients experiencing homelessness through virtual care is probably not something we would have projected, or other people outside of these walls would have been like, ‘Oh, well, they don't have phones,’ or ‘They don't have minutes,’ or ‘How are you going to get in touch with them?’ I have to say, at least from the beginning of the stay-at-home order, I knew they were all wherever they were supposed to be; at their apartment, or with family, or wherever. There wasn't really anywhere to go. They shouldn't have been going anywhere. We just figured that was why the compliance with keeping their appointments was so much better.

Now that we don't have the stay-at-home order, they're still answering the phone. Sometimes they might be in the grocery store, on the bus. Maybe not the most appropriate place to be having a conversation with the provider, but they're still answering. The compliance has been much better. I think we will keep some form of telehealth; after all, isn't it better to see somebody virtually four times a year and take good care of them? Then why not do it that way, versus scheduling them four times and they only show up one time?”

Deborah Burbank, RN
Health Center Director

HCH Case Study #16: New Orleans Health Department, New Orleans LA



The New Orleans Health Department Health Care for the Homeless program was established as a Federally Qualified Health Center in 1988 to provide accessible and comprehensive care in the greater New Orleans area. HCH's mission is to improve the overall health and well-being of the city's individuals experiencing homelessness. Their vision is to build a healthy community through equitable social and environmental conditions. Their values are founded on the premise that all human beings have a right to access basic health care and is guided by the principles that all patients are treated with respect, dignity, quality, cultural competence, and are empowered to take an active role in the health care they receive.

In 2019, the HCH program served approximately 4,000 patients.

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Operating under the New Orleans Health Department, the Health Care for the Homeless (HCH) program operates three primary care clinics serving adults experiencing homelessness, as well as those who are uninsured or undocumented, and one dental location serving both adults and adolescents. Starting in March, the program's administrative and case management team began to take steps toward virtual care. Within two weeks, the HCH program staff were ready to offer both in-person and virtual health care to patients experiencing homelessness.

At the onset of the COVID-19 pandemic, HCH staff communicated with partners about the need for residents to quarantine and that provisions would be made for them to continue to have access to care at the clinic or telephonically. To reduce the risk of COVID-19, the number of face-to-face encounters were reduced at the health center. Providers' appointment schedules were divided in two, with face-to-face visits being offered in the morning, and telehealth in the afternoon. The staff felt it was important to continue onsite care due to the chronic diseases and comorbidities prevalent in homeless populations. When calling for appointments, patients were given the opportunity to select what type of visit they preferred.

Because there was a mandated order to shelter in place, face-to-face appointments were limited and reserved for new patients, patients requiring lab work, those with dermatologic issues, or patients with chronic illnesses such as diabetes, asthma, or hypertension needing chronic care management.

Afternoons were dedicated to telephonic visits only. Established patients needing prescription refills or follow-up appointments were scheduled for this type of visit. The scheduler would call the patient to begin the encounter; the provider would complete the assessment and indicate if any follow-up was needed; and all information was documented in the electronic medical record (EMR). For patients without phones, an exam room at the clinic was designated where patients could receive telephonic care. Approximately 25-30% of active patients were engaged in virtual care using either personal phones or the clinic's exam room phone.

Successes

- Staff were trained successfully using the Oregon Clinical Health Information Network (OCHIN) library for training material, while the nurse manager participated in webinars provided by OCHIN and Louisiana Primary Care Association (LPCA). OCHIN and LPCA-HCCN were proactive in sending telehealth training and guidance.

- The HCH program collaborated with Franklin and Associates to provide virtual care to people experiencing homelessness who were housed in a hotel. This initiative was sponsored by the State of Louisiana and UNITY and identified hotels to shelter unhoused folks during the pandemic. This seems to be working well, and HCH staff have provided this type of service at a second hotel.

Challenges

- Access to phones is limited but somewhat mitigated by dedicated outreach teams.
- At times, internet connection can cause outreach delays due to location and there is an increase of people using the internet during the pandemic.
- Some patients are resistant to receive services, as they do not feel it's an immediate need since focusing on the pandemic.
- Telehealth billing and reimbursement has also been a challenge due to the immediate transition in healthcare.

Lessons Learned and Recommendations

- Recognize and acknowledge the commitment of staff. In many instances, staff are shouldering several responsibilities and duties. It is vital for staff to know they are appreciated.
- Continually update policies and procedures to stay compliant with the recommendations from the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), Joint Commission, and the state.
- More outreach is needed and must be conducted in a safe manner to connect with people in the community who are unable to access primary care.

Future Strategies for Virtual Care

The HCH administrative and case management team are working towards providing telehealth in the future for patients who are displaced in the community and in local shelters. As long as patients are displaced, there will still be efforts made to connect patients through virtual care. The percentage of patients engaged through this method will depend on state reopening phases and city mandates that will guide the number of people or patients that may leave shelters and receive in-person care. Currently, 25-30% of visits are being provided virtually. This may gradually decrease by 5%-10%, depending on the restrictions, the need, and the demand for telehealth services.

“We have been very successful implementing telephonic care. Our administrative and case management leadership team came together, discussed barriers, appropriate measures, what things we needed to change, goals, establishing onsite and offsite telehealth services, community engagement, and meeting the health care needs of patients during the pandemic. I believe all of these goals have been accomplished.”

Rachelle B. Miles, RN
Clinical Nurse Manager, Health Care for the Homeless

HCH Case Study #17: Valley Homeless Healthcare Program, San Jose CA



Valley Homeless Healthcare Program (VHHP) provides healthcare services to people experiencing homelessness in Santa Clara County. VHHP provides care to over 7,000 people every year with services to meet the needs of the community. VHHP's clinic locations include 10 fixed sites and three Mobile Health Centers that serve many locations throughout Santa Clara County. VHHP also serves specific communities with unique healthcare needs through their Medical Respite Program, Gender Clinic, Saludos Migrant Farmworker Clinic, Backpack Homeless Healthcare Program and Teen Van. VHHP also links people to additional healthcare services within the greater Santa Clara Valley Medical Center system.

In 2019 HCH program served 7,220 patients in 42,271 visits

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The Valley Homeless Healthcare Program (VHHP) providers had discussed telehealth before, but as the pandemic hit their area, they transitioned patients to telehealth within a week and limited in-person appointments in an effort to ensure safe, quality care.

The degree of transition to telehealth varied among programs. For example, the Hope Clinic, a clinic for people in Permanent Supportive Housing, moved quickly to 100% virtual care, but two main access points where people drop in—the Homeless Shelter Clinic and another fixed clinic site called the Alexian Clinic—as well as key mobile sites, remained open. Patients are redirected to telehealth services if possible at clinics. With additional support, VHHP has been able to get more iPads at each open clinic site so that patients requesting mental health counseling can talk to a provider remotely.

VHHP has grown during the pandemic to manage and deliver health care 100% virtually to nearly 2,000 people considered high risk for COVID-19 who have been relocated to motels and other socially distant congregate settings. One of the motels being managed through telephonic care is a "COVID-19-positive" motel for those discharged from the hospital without another place to stay.

When individuals are relocated to the motel, HCH staff are given their phone number and the motel room number. This enables them to reach people through the motel numbers that they normally would have missed through cellphones. Physicians, nurse practitioners, nursing staff, mental health staff, pharmacists, social workers, and retirees have assisted VHHP in delivering telephonic care to this large population housed through the motel program.

Successes

- VHHP had great support from the larger county government and City of San Jose, including loaning staff to help provide care to people being sheltered throughout the county in motels.
- The fact that everyone switched gears quickly to meet the new demands during COVID, even though the whole team was not available on site, is incredible.
- Video visits were being reimbursed at a higher rate than phone visits, but now there is parity in reimbursement for both types of visits.
- VHHP was successful in being able to reach the majority of those nearly 2,000 people by phone to meet their medical needs.

Challenges

- Access to phones and internet is lacking.
- Recovery for the medication-assisted treatment program is difficult to assess virtually. Patients have felt less supported when the support is not in-person.
- Switching between telehealth and in-person care can be difficult for providers.
- Lack of a Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant video platform that allows for shared medical appointments (group visits) so that patients can still in engage in peer support treatment for substance use disorders.
- Lack of a unified, automated database system that is HIPAA compliant, able to sync with the medical record, and accurately lists and tracks patient information, including motel location, room number, entry date in the motel, exit date from the motel, telephone number, case manager, and healthcare provider.

Lessons Learned and Recommendations

- Meet patients where they are and engage them in health care on their terms.
- Recognize the ability to manage more patients using virtual care than first imagined.
- Do not schedule a clinician to switch from telehealth to in-person visits in the same day.
- Create a “telehealth team.” There is a learning curve to implement telehealth platforms.
- Lack of access to necessary technology should be considered a health care disparity.

Future Strategies for Virtual Care

Moving forward, VHHP is considering a hybrid model of maintaining some telehealth presence and opening more health care sites for in-person appointments. Currently VHHP is offering audio only for virtual visits but efforts are being made to expand the telehealth services to video. The electronic medical record (EMR) team is currently evaluating different security platforms, ensuring that any expanded telehealth offering will be HIPAA compliant. Individual assessments of patients who should continue with 100% virtual care includes those who meet a set of criteria that determines whether they can be in motels. This includes individuals that are 65 and above or 60 and above with a number of medical conditions.

“To bring this telehealth program on, we had to pull in providers that were not typically Valley Homeless Healthcare Program providers. They were doctors that maybe worked for the county but because their clinic had closed, we were able to take them on loan and the same with the nursing staff, as well. We have the number of people on loan to us for this telehealth program, and we also pulled some doctors out of retirement as well. You don't have to provide office space because they can do it from home. We developed a complex tracking system to follow names and placements, next needed provider call, nursing wellness check frequency, medication delivery, mental health and social work referrals.

“I'm sure you probably have been hearing this around the country, *but it was like building the airplane while it was flying*. However, everyone has been just willing to pitch in every single way. I think we've come to realize that actually there are some patients that are better served by telehealth. Some were very thankful, really embraced it, and really appreciated it. Yet, we need to be cognizant that there were also a significant segment of individuals we were not successful in reaching, and so there is still much work to be done to make sure that nobody falls through the cracks.”

Cheryl J. Ho, MD
Motel Tele-Health Medical Director, VHHP



March 20, 2020

Dear ARMS Partners:

In the presence of the current coronavirus pandemic, Alabama Regional Medical Services (ARMS) is taking measures to limit the spread of this novel virus in our community. Accordingly, we have begun telemedicine visits. Please call the clinic to schedule a telemedicine appointment through the front desk and they will make an appointment with a provider. They will also inform you of any paperwork that is needed. The paperwork can be submitted via fax.

Prescriptions will be delivered to your facility once a day as follow:

- 1). A designated representative from each facility will sign a form for prescription to be delivered by ARMS courier. This signature serves as confirmation that ALL prescription(s) listed on the form were received by the facility, confirmation that the patient will receive his/her prescription(s), and the patient had no questions or concerns regarding the prescription(s).
- 2). It is the responsibility of each facility representative to make sure the prescription(s) listed on their facility's form are the prescription(s) being delivered by the courier before signing for the prescription(s).
- 3). Once the delivery form is signed by each facility's representative, ARMS Rapid Care Pharmacy Metro and ARMS Rapid Care Pharmacy Northern are no longer responsible for the prescription(s). This includes but not limited to missing medication, stolen medication, wrong medication, etc....

If you have any questions please reach out to us at (205) 407-6900 Metro Clinic.

Sincerely,

Dr. Yocunda Clayton, Medical Director
(205) 422-0857, mobile

Amy Sparks, Director of Behavioral Health/Homeless Services
(205)368-9025, mobile

Nannette Allen, Chief Operation Officer
(205) 215-5058, mobile

Telemedicine Setup

1. **UNTIL APRIL 16th ONLY – MEDICARE** New patients can be seen via telephone or telehealth. **MEDICAID must be established patients.** Use your clinical judgement for identifying patients who should be seen face to face instead of via video
2. Face to face visits will still be possible and necessary for some patients – either because they prefer or they have a need to be seen face to face
3. Telemedicine visits would be scheduled ahead of time and would not be done “on the fly” if at all possible. This allows the front desk to go through normal scheduling procedures including verification of insurance and determination of paperwork required for us to see patient. If the patient is an uninsured patient, they will be notified that they can opt for telemedicine instead of face to face visit but they would be responsible for the whole fee including the \$85 fee. If they want to be able to apply for sliding fee or have their sliding fee renewed for the year, they will need to have an in person visit. Patients would be notified their copayments would still be due and will be billed.
 - a. When scheduling a visit for the patient, the front desk would say, “Due to the coronavirus outbreak we are attempting to modify how we see patients by rescheduling non-urgent visits and also offering telehealth – which is a video visit with your provider. Would you like to schedule your visit face to face or as a video visit?”
 - b. If the patient says they would like face to face instead, the request will be reviewed by the provider to determine when to schedule the patient.
 - c. If the patient says they would like to proceed with a video visit, the front desk will put an appointment on the schedule with the provider with appointment type **VIDEO TELEHEALTH** or **VIDEO TELEHEALTH MCD** and would then go ahead and verify the patient’s insurance and demographic information – including a valid email address.
 - d. Then the front desk will say, “Please be looking for an email invitation from your provider to use for the video visit. Use it to sign in at the time of your scheduled visit”
4. The Front desk staff will notify the MA for the provider of any telehealth visits they setup as same day.
5. Each morning the MA will review the schedule and will send out the appointment invitation via Doxy.me to the email of the patient. This email contains instructions for the patient on best way to use the system.
6. MAs and providers must use a computer to sign in to Doxy.me on the computer – not a mobile device to send the invitations. Phone can be used for the actual visit but invitations should be sent from the computer.
7. You CANNOT pull up the Doxy.me site from inside your Remote Desktop session (where you access EMR) – it must be done on your regular desktop
8. You should utilize CHROME not Internet Explorer
9. The first time the provider uses Doxy.me for a video encounter, they will have to allow access to the camera – a prompt should pop up
10. The provider would remain signed in to Doxy.me and check frequently for their patients checking in
11. The MA should contact the patient prior to the visit to ask the triage questions and depression screening for the patient.
12. The provider would start the visit after the patient checks in on Doxy.me. If the patient cannot get the technology to work or has trouble, the MA or provider will attempt to assist them. If the patient cannot navigate this visit type, the provider will determine if the patient needs a face to face visit or can do a telephone encounter.
13. The **VIDEO TELEHEALTH** or **VIDEO TELEHEALTH MCD** template should be used to document the visit afterwards. It provides the consent language and appropriate procedure codes. You **MUST CHOOSE THE APPROPRIATE VISIT LEVEL CODE ON THE PLAN PAGE. It will have the correct modifiers.**
14. AFTER THE VISIT, THE MA will notify Front desk that the visit took place and the time for check in and check out
15. Moving forward, the Medicaid telehealth consent will be included in all front desk packets and yearly packets so we can get written consent for the patient when they do come in face to face

Consent for Telehealth
(Example)

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that my health care provider wishes me to engage in a telehealth consultation and I am in agreement that this will benefit me.
4. I understand there may be technical obstacles which may terminate the ability to perform the service.
5. I agree I will be in a location that enables me to complete with consideration for my privacy and the connection whether via telephone or appropriate internet platform.
6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
7. I have had the alternatives to a telehealth consultation explained to me, and in choosing to participate in a telehealth consultation.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Client signature

Date

Staff signature

Date

WORK FROM HOME TELEHEALTH SERVICES

Telehealth services from a staff member's home may occur only in special emergency situations and with approval from the Alabama Department of Mental Health. When providing telehealth services from home the following procedures must be followed:

1. Qualified staff member must ensure that telehealth services occur in a private room in their home and away from distractions and interruptions. Patient confidentiality must always be maintained. No telehealth services shall be conducted in a public space.
2. Staff must ensure that there is a valid consent for telehealth services from the patient prior to providing telehealth services.
3. Only qualified staff members with the required equipment will be able to provide telehealth services (i.e., computer, telephone, Zoom connection).
4. Staff must verify the patient identification prior to conducting the session. Staff must also provide their identification to the patient prior to conducting the session.
5. Staff must have access to the patient's record. Staff shall not allow any unauthorized access by others in the client's record. When not in use of the client's record the record should not be accessible to others.
6. Staff must document both the start and end times utilizing the patient's individual service log. Staff member should note that the service was administered via telehealth services in the space provided for the patient's signature.
7. The qualified staff member will document the telehealth services in the patient's health record. The progress note should clearly indicate that the session occurred via telehealth.
8. Staff must ensure that all patient data is secured and the agency's HIPPA policies and procedures are followed:
 - a. There is to be no recording or sharing of patient data with unauthorized persons.
 - b. All documents containing protected health information, including counseling session notes and counseling logs, must be secured and returned to the program site as quickly as possible.
 - c. No documents containing patient information shall be placed in a trash can or left accessible and visible to others.
 - d. Patient phone number shall not be stored in any staff personal devices.
9. All work product completed outside of the electronic health record system must be returned to the program promptly upon the staff's return.
10. Staff shall only contact patients from home for telehealth services and for no other purpose.

1. Telehealth services must be provided through two-way audio-visual technology. Providing telehealth services through the phone, email, or fax alone is not allowed, unless approved by the state or Medicaid/insurance provider.
2. Staff shall be trained and able to properly operate all video conferencing equipment to ensure safe and competent operation of the equipment.
3. The site must obtain written consent from the patient prior to engaging in telehealth services.
4. Documentation of the patient's consent must be kept in the patient's medical record.
5. Staff at the site shall secure a private room for the clinical encounter. During the encounter doors of the private room must remain closed to ensure privacy.
6. Staff shall ensure that everyone involved in the clinical encounter, including the client, are made aware of everyone who is in each room, to include those persons off camera.
7. Recording of the telehealth session is strictly prohibited.
8. The authorized staff member shall have access to the patient's record and any additional pertinent patient documentation prior to and during the clinical encounter.
9. The staff member will verify the patient identification prior to conducting telehealth services.
10. The qualified staff member will document the telehealth visits in the patient's health record. The progress note should clearly indicate that the session occurred via telehealth via zoom, telephone call (additional communication approaches listed below in the communication approaches).
11. The staff member will document both the start and end times of in the patient's individual service log. Staff member should note that the service was administered via telehealth services in the space provided for the patient's signature.

PRIVACY POLICIES

When treating a patient via telecommunication, providers must verify the patient's identity at the start of each session, be aware of the patient's specific location during the session, and other persons in the vicinity.

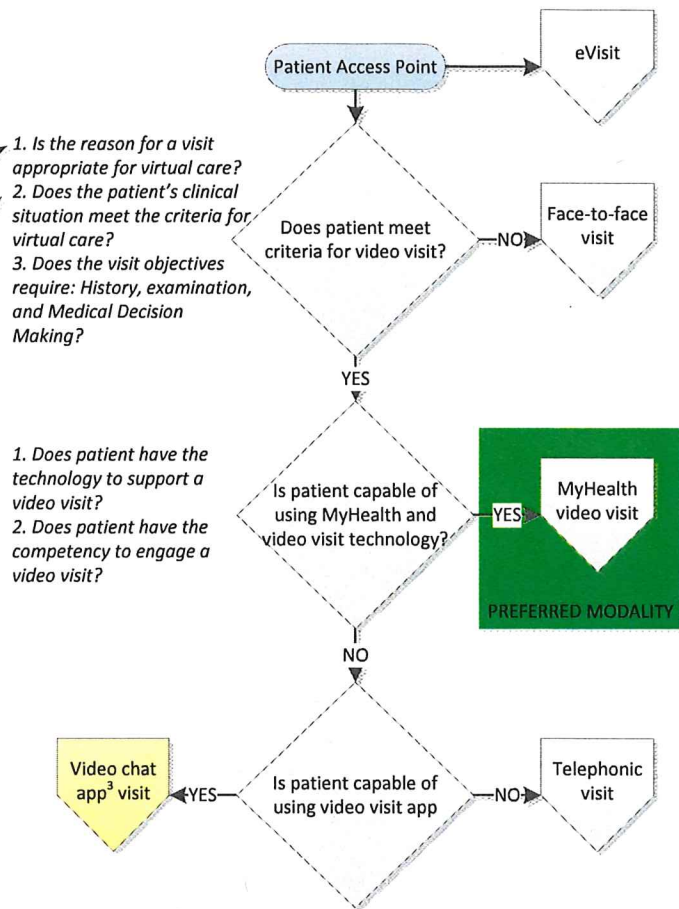
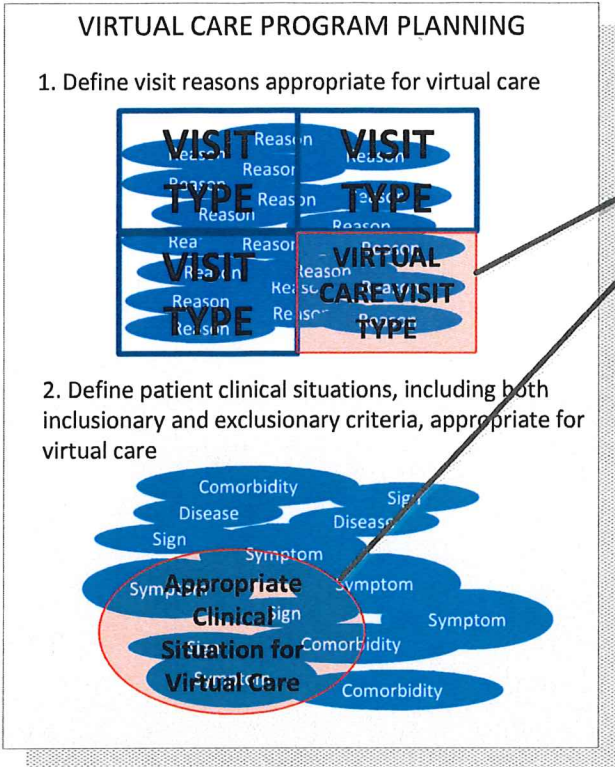
In emergency situations, when HIPAA guidelines are waived, covered entities & service providers should continue to implement reasonable safeguards to protect patient information against intentional or unintentional impermissible uses and disclosures to the furthest extent possible. This includes providers maintaining their work environment free of distractions, noise, other patients, visitors, etc. during patient communications, where possible.

COMMUNICATION APPROACHES

Unlike In-person or video enabled services, telephonic connections do not allow for physical observation of your patient, their environment or any signs of intoxication. It is essential that providers are attentive

to patient verbal cues such as cadence of speech, tone, volume, inflection and background sounds. Listen for meaning, not solely word content. If patients are unable to see the provider, maintaining an upbeat, professional tone and using overt verbal acknowledgement instead of what would normally be conveyed through body language (facial expressions, head nods, etc.) is important to convey warmth, empathy and understanding. Providers should utilize open ended communication and regularly prompt the patient to verbally confirm their feelings or concerns.

Harris Health Virtual Care Program Workflow and Requirements



VIRTUAL CARE REQUIREMENTS	Video Visit	Video Chat App	eVisit (email)	Telephonic Visit	Phone Encounter
MyHealth Account?	Yes	No	Yes	No	No
Appointment Required? ¹	Yes	Yes	No	Yes	No
Translator required if other language?	Yes	Yes	Yes	Yes	Yes
Consent for Tx, etc. required?	Yes	Yes	Yes	Yes	No
Two-factor identification?	Yes	Yes	Yes	Yes	Yes
Epic documentation of encounter	Yes	Yes	Yes	Yes	Yes
Full E/M visit documentation ²	Yes	Yes	Yes	Yes	No
Is Billable?	Yes	Yes	Yes	Yes	No
Has RVUs?	Yes	Yes	Yes	Yes	No

³ Temporarily Authorized (when other HIPPA-compliant modalities are unavailable)	NOT Authorized
*Must advise patient: Potentially introduce privacy risks *Enable all encryption and privacy modes when using ✓Apple FaceTime, ✓Facebook Messenger video chat, ✓Google Hangouts video, & ✓Skype	✗Facebook Live, ✗Twitch, ✗TikTok, & ✗other similar video applications that are public facing

¹Scheduled Virtual Care Benefits

1. Coordinates the time availability between patient and provider
2. May enhance translator readiness, if needed
3. Improves preparation of patient for encounter (e.g. instructions by registration staff to have equipment)
4. Ensures compliance elements (e.g. consent) is completed prior to visit (e.g. registration staff)
5. May be integrated in a provider's existing template and practice
6. Creates a billable encounter with full E/M documentation to enhance patient monitoring and follow-up

Residents may perform virtual care if appropriately supervised as required in the Medical Staff Bylaws (with similar documentation flow as face-to-face E/M visit)

²DOCUMENTATION REQUIREMENTS FOR VIRTUAL CARE

- Documentation in the EMR must occur within 48 hours.
- The visit encounter must be closed within fourteen (14) days.
- **Content Required:**
 - Chief complaint;
 - Diagnosis;
 - Level of service; and
 - Other documentation (also needed for professional billing):
 - History (and include type: problem focused, expanded problem focused, detailed, or comprehensive);
 - Visual/audio only examination performed and review of systems (and include type: problem focused, expanded problem focused, detailed, or comprehensive); and
 - Medical Decision Making (and include type: straightforward, low complexity, moderate complexity, or high) and include any change in therapy; ordered test and procedures; ordered consultations; planned follow up and education provided.

Community Health Services

401 Fifth Avenue, Suite 1000
Seattle, WA 98104-1818

206-263-8414 Fax 206-205-6236
TTY Relay: 711

www.kingcounty.gov/health

CLINICAL GUIDELINES FOR PRIMARY CARE

Telemedicine/MyChart Virtual Visit Guidelines

I. Purpose/Expected Outcome:

1. To provide telemedicine clinical diagnostics and treatments services to patients.

II. Policy

2.1 Billing: Billing for services must be in compliance with State and federal laws as well as in accordance with any third party payer's requirements.

2.2 Confidentiality/Privacy:

- i Be aware of your surroundings and others who may be able to see or overhear PHI being exchanged. You want to avoid inadvertent disclosures to others who have no business need to see or overhear the PHI.
- ii Conduct telemedicine sessions in private spaces when possible.
- iii Do not have telemedicine sessions in public spaces, if working in the field or outside the office.
- iv If you cannot conduct telemedicine sessions in a private space then use other measures such as a. Turing screens, or using privacy screens.
- v Lowering your voice,
- vi De-identifying information as you speak, and
- vii Any other similar precautions that fit the situation
- viii Do not share, write, or post your password on your computer or anywhere others could access.
- ix Totally close out of your telecommuting session when it is over.

2.3 Liability Coverage: King County is self-insured. Telemedicine visits are covered under our malpractice insurance.

2.4 Patient Consents: Patient Consents are required documentation and should be signed prior to conducting the visit. Epic-OCHIN MyChart Virtual Visits automatically has the patient read and sign consents as part of e-check in process.

2.5 Medical Record Documentation: Providers must document all telemedicine services provided during the visit.

- i Select same LOS as they would if the visit was in-person
- ii Select same program area as they would if the visit was in-person
- iii Use .kingvideovisit (if audio & video telemedicine visit)
- iv Provider does not need to update the place of service to be the place where the patient is (like they do in phone visits)

CLINICAL GUIDELINES FOR PRIMARY CARE

III. Procedure:

3.1 Scheduling Visits: Front Desk/Scheduling Staff will use “MyChart Virtual Visit” as visit type

3.2 Care Team: Will follow pre-charting and rooming process for this visit type

3.3 Provider: Will conduct visit and keep integrity of the medical record

DRAFT - Pending approval

Telemedicine Visit Checklist – Draft 07-17-2020

CHECKLIST		
<input type="checkbox"/>	Pre-visit planning was completed	
<input type="checkbox"/>	Review patient questionnaires' folder in your inbasket	
<input type="checkbox"/>	Correct Visit Type (MyChart Virtual Visit)	
<input type="checkbox"/>	Camera is connected and working	
<input type="checkbox"/>	Sound is enable and working	
<input type="checkbox"/>	Visit is arrived	
<input type="checkbox"/>	Patient Checked-in	
<input type="checkbox"/>	Interpreter is added to call (if needed)	
<input type="checkbox"/>	Open Zoom – check video and sound quality	Can you hear/see me okay?
<input type="checkbox"/>	Review patient forms with patient as needed	
<input type="checkbox"/>	Follow rooming process (except Vital signs unless self-reported)	
<input type="checkbox"/>	Confirm pharmacy	
<input type="checkbox"/>	Place the patient in the waiting room	
<input type="checkbox"/>	Secure session	
PROVIDER		
<input type="checkbox"/>	Open Zoom – check video and sound quality	Can you hear/see me okay?
<input type="checkbox"/>	Conduct Visit and document	
<input type="checkbox"/>	Follow web side manners	
<input type="checkbox"/>	Close and bill visit	