

# MAKING CONNECTIONS

A GUIDE TO STARTING A RURAL HIV CARE TELEMEDICINE PROGRAM

OCTOBER 2017



PRESENTED BY

**AIDS**  
**United**

**MAO**

MEDICAL ADVOCACY AND OUTREACH

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AIDS United's mission is to end the AIDS epidemic in the United States. We fulfill our mission through strategic grantmaking, capacity building, policy/advocacy, technical assistance, and formative research. Learn more at [www.aidsunited.org](http://www.aidsunited.org)

Medical Advocacy and Outreach of Alabama provides community prevention education, quality services, and compassionate care to those living with and/or affected by HIV and related illnesses. Services include social services, medical treatment, including telemedicine, medication assistance, pharmacy services and consultations, behavioral health counseling, patient education, prevention education, HIV and hepatitis C testing, food bank services, and interpretation services for Spanish-speaking and deaf and hard-of-hearing clients. Go to <http://maoi.org/> for more information.



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# About AIDS United's Access to Care Initiative

The AIDS United Access to Care (A2C) initiative supported innovative, evidence-based, collaborative programs that connected thousands of low-income and marginalized people living with HIV to supportive services and health care. All funded projects within the A2C portfolio developed a team of organizations that collaborated to reduce barriers along the HIV care continuum, provided innovative solutions to longstanding access problems, and changed the way that systems operate in their communities.

The AIDS United Social Innovation Fund was inspired by the first ever United States National HIV/AIDS Strategy, which emphasized the necessity of public-private partnerships to help end the HIV epidemic. The Social Innovation Fund, a program of the Corporation for National and Community Service and 14 national private funders, supported 12 innovative, evidence-based, collaborative programs working in communities across the country to connect thousands of low-income and marginalized individuals living with HIV to care and support services.

Social Innovation Fund projects were supported by a rigorous national evaluation conducted by Johns Hopkins University. Grantees informed one another as well as other initiatives across the country, and their successes put them at the forefront of the innovative, evidence-based, collaborative care necessary to end the HIV epidemic in the United States. Learn more at: [www.aidsunited.org/Programs-0024-Grantmaking/Access-to-Care.aspx](http://www.aidsunited.org/Programs-0024-Grantmaking/Access-to-Care.aspx)

The Social Innovation Fund was inspired by the first ever U.S. National HIV/AIDS Strategy, which emphasized the necessity of public-private partnerships to help end the HIV epidemic.

# Table of Contents

- Why Telemedicine? ..... 1
  
- Overview of Medical Advocacy and Outreach of Alabama  
and the Alabama eHealth Program ..... 3
  
- Steps for Starting a Telemedicine Program ..... 7
  
- Considerations for Program Development ..... 12
  
- Appendix ..... 17

# Why Telemedicine?

“Telemedicine is helping to bring about social justice . . . because that’s one way of providing access so that health equity is regained.”

– Alabama eHealth Program Staff Member

Telemedicine holds great promise for providing HIV-specific and other care to some of the most underserved communities in the U.S., such as low-income people living with HIV in the rural south. The purpose of this guide is to provide practical information and tips for organizations interested in starting or building upon an existing telemedicine program.

This guide discusses telemedicine as an effective strategy for providing high-quality care across distances and provides practical “how-to” information by highlighting the experiences of Medical Advocacy and Outreach, an AIDS United Social Innovation Fund grantee, as they planned and implemented the Alabama eHealth program. This guide also includes downloadable forms, links to other resources, and information about how to request support or technical assistance to set up a telemedicine program in your community.



## A NOTE ABOUT LANGUAGE . . .

In this resource, the word **client** is used to describe people receiving services, including patients in medical settings.

## What the Background Research Says about Telemedicine

Existing research supports the use of telemedicine to provide high-quality HIV care. Most important, several studies exploring HIV care delivered through telemedicine found positive clinical results for clients. For example, one study that directly compared telemedicine to in-person HIV care found comparable clinical and psychosocial outcomes!<sup>1</sup>

Telemedicine also offers a cost-effective means to manage a large caseload, provide needed support services, and offer clinical consultation for HIV care providers in difficult-to-access geographies.

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<sup>1</sup>Based on draft manuscript by Kriti Jain, Johns Hopkins University.

## How Telemedicine Works

Telemedicine is a secure video chat environment between a client and a provider who are at different physical locations. The client visits a nearby clinic, staffed by a nurse, who uses telemedicine equipment to conduct an exam. Images and sounds (heartbeat, breath sounds, images of ear canals, etc.) are transmitted to a provider at a second location in real-time.

Throughout the encounter, the provider, nurse, and client communicate with each other through real-time encrypted audio and video. This allows clients to access the quality of care they deserve in the communities where they live.



# Overview of Medical Advocacy and Outreach of Alabama and the Alabama eHealth Program

## Medical Advocacy and Outreach History

Founded in 1987, Medical Advocacy and Outreach of Alabama (MAO) began as an all-volunteer force and transitioned to a full-service medical provider for people living with HIV in 1996. Since then, MAO clinic staff have traveled to rural areas throughout Alabama where HIV rates are highest to provide care where it is needed most. However, the travel burden on the providers took time away from clients served as the staff spent nearly half of their day traveling to and from rural clinic locations.

## The Birth of Alabama eHealth

In 2011, faced with the challenge of the rural setting, poverty-driven barriers to care, and an ever-increasing HIV/AIDS diagnosis rate, MAO sought a new means of providing care. Realizing that the barriers to care were preventing rural Alabamians from accessing the care they needed, MAO looked for innovative ways to bring quality care to underserved rural populations.

Thanks to a matching grant from AIDS United and the Corporation for National and Community Service's (CNCS's) Social Innovation Fund, MAO established Alabama's first telemedicine network serving people living with HIV in rural Alabama. Using high-speed internet, Bluetooth peripherals, high definition audio-video equipment, and partnerships with rural social services organizations, MAO created a network to bring primary HIV care to rural Alabama.

That same year, MAO opened its first telemedicine clinic in Selma, Alabama. Telemedicine allowed for a provider in Montgomery to treat a patient in Selma, via a real-time video conference with the help of an on-site nurse to facilitate on the client end of the encounter. Using high-definition cameras and video screens that meet privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), clinicians in urban settings can treat clients in rural clinics, providing real-time, direct-to-patient HIV primary care from a distance. Growing from one clinic and one provider location, MAO expanded its telemedicine network to cover 28 counties throughout rural Alabama. Today, MAO operates a telemedicine network consisting of two provider locations and 10 rural clinics.



Watch a video of a telemedicine encounter here.



## HIV Treatment and Stigma

Many people living with HIV cite stigma as a main barrier in accessing—or staying in—HIV care. By branding the telemedicine clinics as Alabama eHealth, MAO removed the stigma associated with HIV-specific clinics. Alabama eHealth is a neutral label, and clinics have been placed in partnering agencies that serve various specialties. It should be noted that HIV-focused organizations can address stigma in many ways, including placing care in more convenient locations to clients and offering ancillary services like mental health counseling, social services, and pharmacy consultations through telemedicine.

### **“They Think It’s Like Star Trek”: Alabama eHealth Clients Love Telemedicine!**

In the planning stages of the Alabama eHealth project, some Medical Advocacy and Outreach staff and providers were concerned that clients wouldn’t like receiving care through telemedicine. Much to their surprise, most clients were enthusiastic about telemedicine.

Even clients who didn’t immediately welcome telemedicine warmed up to it after experiencing it first-hand. According to one staff member, “some of the patients will start off wary of it but then tend to embrace it.” Staff observed widespread acceptance of telemedicine, even among clients who are older, are less familiar with technology, and have lower health literacy. Some providers even went so far as to describe a sense of wonder from clients, commenting that clients “are usually amazed . . . that somebody can hear their heartbeat 50 miles away.”<sup>2</sup>

In addition, clients’ privacy is always respected. No client-provider interactions are ever recorded, only transmitted securely between the provider and client site. Program staff described reassuring clients through their wariness: “We’ve had to reassure them that this isn’t out on Facebook and somebody can’t see you. This is a secure connection; your privacy is being respected.”

An unexpected benefit of telemedicine is that clients often appreciate being able to get a sense of providers’ personalities by seeing them in their own offices. Clients retain control of the interaction in terms of whether the interaction takes place through telemedicine or through an in-person appointment with the provider.

“In rural communities in the South, AIDS has got this huge ring of stigma around it. If a site was to be known as an AIDS clinic, we would lose patients.”

—Alabama eHealth  
Program Staff Member

“I think [patients] think it’s neat . . . like Star Trek.”

—Alabama eHealth  
Program Staff Member

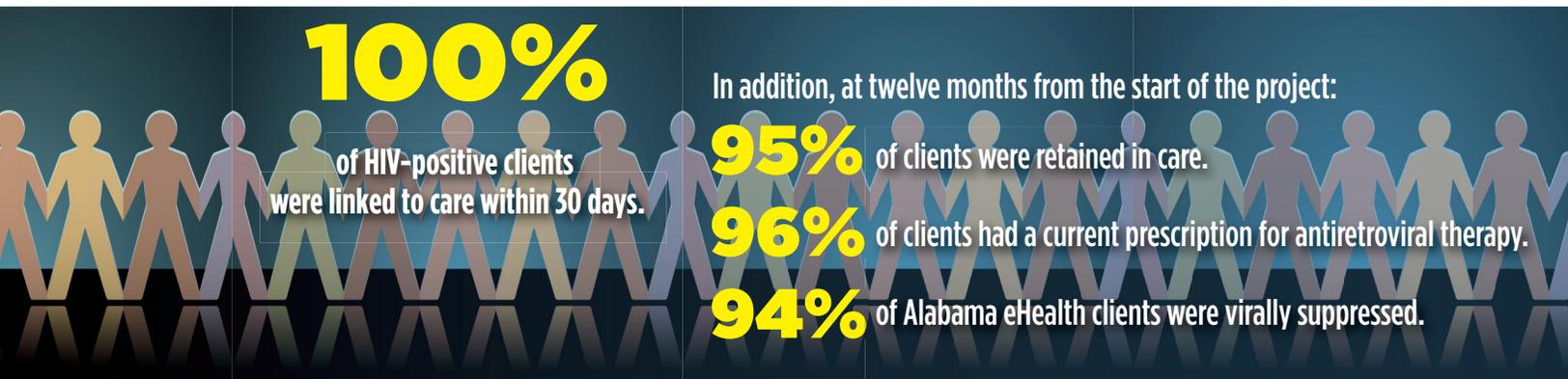
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<sup>2</sup> Malsby, C, et al. Social Innovation Fund Case Studies: Experiences with Linkage and Retention in HIV Care across Twelve Subgrantees and their Partners. Report submitted to the Corporation for National and Community Service, 2016.

## Evaluation of the Alabama eHealth Program

Like other AIDS United Social Innovation Fund projects, Alabama eHealth participated in a rigorous national evaluation conducted by the Bloomberg School of Public Health at Johns Hopkins University. Among other things, the national evaluation looked at client health outcomes and whether the program saved money in the long run.

### Client Health Outcomes

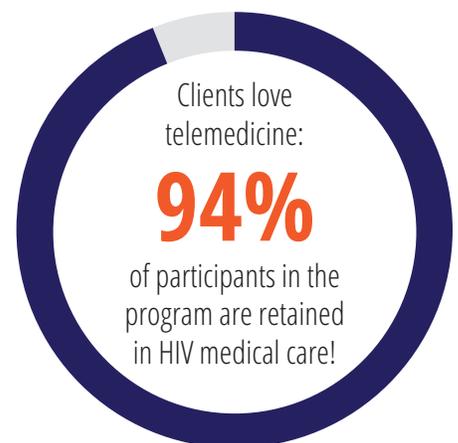


### Cost Savings

The evaluation found that the Alabama eHealth program is also cost-saving: For each dollar spent, the program saved \$1.44 in future medical costs.

### National Recognition

For innovative use of technology in HIV care, the Alabama eHealth project was named winner of the 2015 American Academy of HIV Medicine/Institute for Technology in Health Care HIV Practice Award. Additionally, the White House's national HIV strategy highlighted the Alabama eHealth model as a viable and cost-effective means of reaching rural people living with HIV. In 2015, Dr. Robert Bentley, the governor of Alabama, nominated MAO's CEO Michael Murphree to the state's health care task force, recognizing his expertise in meeting the needs of rural residents. Murphree has also been invited to participate in three rural health conferences at the White House, where he advocated for policies to bolster rural health care capabilities. Building on their AIDS United and CNCS Social Innovation Fund support, MAO staff have become nationally recognized experts in the delivery of HIV-specific care through telemedicine.



## Looking Forward

Building on their existing success, MAO plans to add four clinic locations in 2017. Having already expanded the range of services offered by telemedicine, MAO will expand services in 2017 to include diabetes management, hepatitis C specific care, substance abuse treatment, and counseling. Focusing on some of the poorest counties in their state, MAO will expand to some of the poorest areas in the nation. MAO believes that it is incumbent upon their organization, and the nation's health care infrastructure, to dissolve the barriers to care presented by rurality, poverty, stigma, and the profound lack of resources that affect our most vulnerable neighbors. They believe that technology is an effective tool for lowering these barriers.

"The Telemedicine option has been invaluable for our agency and the women, men, and youth we serve," explains Michael Murphree, CEO of MAO. "Without the technological help provided by our telemedicine equipment, our agency would not have the infrastructure to adequately reach our most rural people. Our state population is 50% rural/small town, and Alabama and the rest of the US must do a better job of serving those communities. Telehealth can help tremendously in moving the discussion of better medical, behavioral, and social service care from urban/suburban specific models to practical rural options."

# Steps for Starting a Telemedicine Program

The 10 steps described below provide a roadmap for planning and implementing a telemedicine program. Please note that some steps can be addressed concurrently and you may find it useful to move through the steps in a slightly different order.

Additional considerations for program development are discussed in the next section of this guide.



## Step 1: Conduct Pre-implementation Research

Before developing your telemedicine program in earnest, it is important to do background research. Questions to ask include:

- Is distance and/or transportation a significant barrier to accessing HIV care in your service area?
- Where in your service area are services most needed?
- What would it take to start using electronic medical records (EMR)?
- Which existing telemedicine programs could serve as a model for your program?
- How might expanding your service delivery area affect your relationships with other organizations in the area?
- What would it take to obtain minimal bandwidth necessary for telemedicine provision? (See “Considerations for Program Development” for detailed information about broadband requirements.)
- Can you obtain third-party reimbursement from insurance companies?



### HOW TO START A TELEMEDICINE PROGRAM:

1. Do your homework
2. Obtain funding
3. Convert to EMRs
4. Build and cultivate partnerships
5. Get connected
6. Hire and train staff
7. Get equipment
8. Train partners
9. Offer HIV care via telemedicine
10. Add more services



## Step 2: Obtain Seed Funding

Starting a telemedicine program requires a sizable upfront investment. Funding is needed for staff time, telemedicine equipment, and broadband connections. In MAO’s case, initial funding was secured through a grant from AIDS United and the Corporation for National and Community Service’s Social Innovation Fund. These start-up funds also supported a staff position devoted to information technology (IT) support, which was vital to the set-up and ongoing success of the program.

This groundwork led to later funding from the Alabama Department of Public Health through the Centers for Disease Control and Prevention for further expansion.

In addition to grant funding, programs may consider:

- Sharing costs with partnering organizations.
- Working with sites that have a large enough client base to cover costs via third-party reimbursements.



## Step 3: Change from Paper to Electronic Medical Records (EMR)

Establishing a multi-site telemedicine program is facilitated by use of web-based EMRs, allowing clinical staff to access each client’s information from multiple sites at once. Web-based EMRs allow traveling nurses at spoke sites, where the client accesses telemedicine services, and providers at hub sites to view the same information via computer.

It is worth noting that there are telemedicine “peripheral” devices, such as Bluetooth-enabled stethoscopes that can automatically enter data into an EMR (if the EMR will allow it). MAO is currently inputting this data manually; the stethoscope and digital scope camera have “store and forward” capability (they upload to a laptop for entry into EMR later).



### TELEMEDICINE TERMS

#### ***Distant or Hub Site:***

Provider location during a telemedicine encounter

#### ***Originating or Spoke Site:***

Rural clinic from which the patient accesses telemedicine services.



## Step 4: Develop Partnerships

Strong, well-defined partnerships are essential to the success of a telemedicine program. MAO partnered with several organizations serving people living with HIV: AIDS service organizations, primary care clinics, local departments of health, and other social service organizations. For example, at three Federally Qualified Health Centers (FQHCs), a nurse facilitates appointments between local clients and providers at hub sites.

Partnerships with social services agencies are also critical. For example, partner Selma Friends for Life schedules appointments for clients, arranges transportation, and addresses other structural

barriers keeping people living with HIV from care. Other social services agencies support people living with HIV through food pantries, substance use treatment, health education, and testing.

When establishing partnerships to support telemedicine services, it is crucial to:

- Establish a shared understanding through a formal memorandum of understanding (MOU).
- Communicate openly and regularly.
- Train staff at all partnering organizations on topics such as confidentiality, HIPAA, and stigma reduction.
- Confirm that all systems are in place to obtain third-party reimbursement from insurance companies.

## **5 Step 5: Obtain an Adequate Broadband Connection**

It may seem basic, but telemedicine requires high-speed internet at all locations served. In rural areas, this broadband infrastructure may not exist or may be prohibitively expensive. Minimum broadband requirements are discussed in more detail in the “Considerations for Program Development” chapter.

## **6 Step 6: Hire and Train Staff**

It is helpful to hire staff that are enthusiastic about—if not familiar with—technology and delivering great care through telemedicine. MAO found that most existing staff were eager and adapted easily, but some found it challenging. Providing thorough orientation and ongoing training on all aspects of the program and technology is essential. This is particularly important as new technology or workflows are augmented or improved. Staff buy-in is critical to the success of your telemedicine project.

## **7 Step 7: Obtain Telemedicine Equipment**

It is beyond the scope of this guide to provide a detailed discussion of telemedicine equipment. Shown below are “the basics” needed to provide telemedicine.

“It’s very, very hard to get the bandwidth that we need to run our telemedicine in [some] areas.”

—Alabama eHealth Program Staff Member

“In the beginning... we would spend 10 or 15 minutes trying to get the patient into the telemedicine office, get the equipment operable and so on and so forth. Now it just flows like clockwork.”

—Alabama eHealth Program Staff Member

### *For the Hub Site*

The main items to be used by the provider at the hub site are a telepresence system and monitor.

### *For the Spoke Site*

For each spoke (client) site, the following items are needed:

- A utility cart, which can be moved from room to room as necessary.
- A digital stethoscope.
- Electronic stethoscope software.
- A hand-held video system used for capturing images of the body.

In MAO's experience, it is a good idea to speak with multiple vendors before selecting one from which to purchase equipment. In discussions with potential vendors, it is useful to ask about service plans and ongoing support for equipment.



## **Step 8: Train Partners**

Training partners is an ongoing endeavor—not a one-time event. Training is recommended for all staff at partner sites, and may include the following depending on the specific job responsibilities of each staff person:

- Use of telemedicine equipment and software.
- Confidentiality and HIPAA.
- Scheduling procedures.
- Emergency protocols.
- Basic troubleshooting and how to contact IT support.
- Use of the electronic medical record (EMR), if applicable.

## 9 Step 9: Offer HIV Medical Care via Telemedicine

Once the first eight steps have been completed, it is time to start offering medical care through telemedicine!

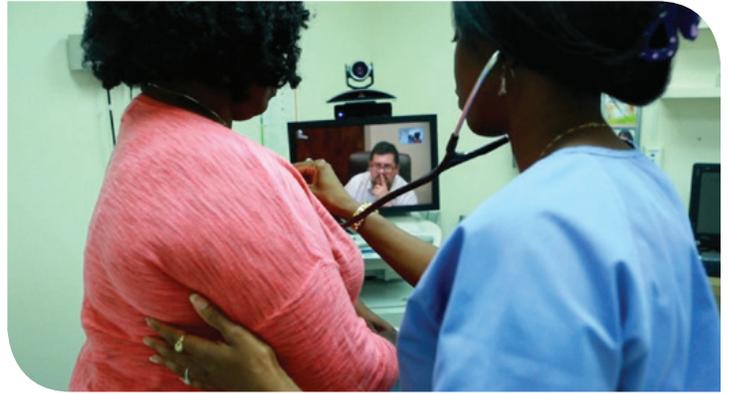
## 10 Step 10: Offer Additional Services via Telemedicine

While this toolkit was made specifically as a guide for developing an HIV-specific telemedicine program, the same equipment and process can be used to offer a wide array of services to the clients and communities you serve. MAO currently provides mental health care, social work and case management services, clinical pharmacy consultations, pre-exposure prophylaxis (PrEP) related care, and hepatitis C care via telemedicine. In most cases, these services were seamlessly integrated into the existing telemedicine care infrastructure.

In some cases, new protocols were needed because remotely located clinicians needed different things from the nurse facilitators. These changes were particularly important for mental health counseling. Specifically, since counselors are not on location with clients, they rely on in-person staff in case clients become angry, violent, or actively suicidal.

In addition, it is worth noting that higher display resolution may be needed for psychosocial support encounters to accurately see and interpret a client's facial expressions or other nonverbal cues. Likewise, the service provider may need to practice "projecting" gestures and facial expressions more so than in a face-to-face encounter.

In addition, the MAO team uses telemedicine equipment for staff meetings across the Alabama eHealth program's multiple locations. Being able to see distant colleagues helps build communication and maintain relationships.



# Considerations for Program Development

## Scheduling and Service-Delivery Models

There are multiple possibilities for partnering with remote sites for telemedicine service delivery. MAO uses three service delivery models:

- Primary care Federally Qualified Health Center (FQHC) clinics—FQHCs loan MAO space; MAO pays for the telemedicine cart and broadband. Clients are seen by a nurse in the telehealth suite on a designated day.
- County health departments—County health departments pay for equipment and broadband. MAO sends a nurse once a month. Telemedicine clients are seen in exam rooms, with appointments interspersed with non-telehealth patients.
- Family practice residency program—A full-time nurse sees clients in a dedicated telemedicine suite. MAO pays for the telemedicine equipment and broadband.

MAO found it helpful to begin small with their program, which they launched first at the family practice residency program.

## Legal Considerations

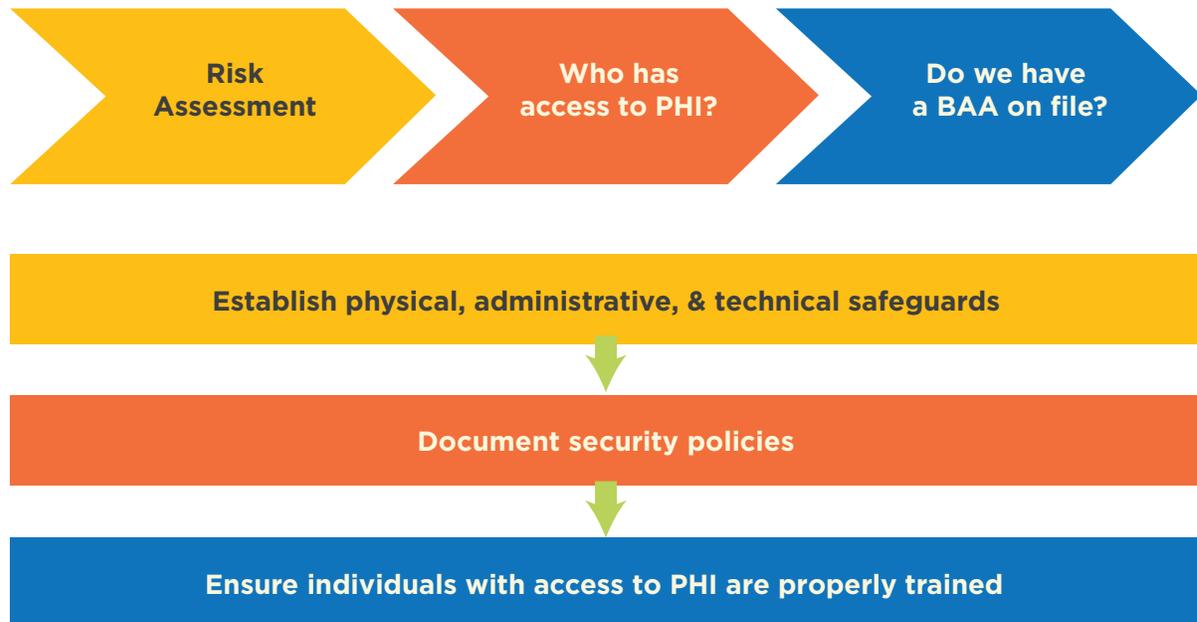
The information in this guide does not constitute legal advice. Organizations are encouraged to seek legal counsel when planning telemedicine programs.

### ***Health Insurance Portability and Accountability Act of 1996 (HIPAA) Compliance***

To protect personal health information (PHI) when offering telemedicine services, organizations must consider HIPAA compliance in the same way they would with in-person care. The following areas of HIPAA compliance are essential for telemedicine programs:

- Business Associates—A “business associate” is a person or entity outside the covered entity’s workforce that performs certain functions or activities that involve the use or disclosure of protected health information. In telemedicine, this would include the remote client care sites. Telemedicine providers must have a business associate agreement (BAA) with collaborating partners at each client/remote site.
- Internet Security—Programs can maximize security by using encrypted connections, as discussed in the next section; by having BAAs in place with all IT providers; and by using common-sense security precautions (e.g., closing medical records before walking away from computers, keeping passwords in a secure location, setting up computer screens to lock out after a few minutes of non-use, etc.).

It is recommended that programs conduct a risk assessment, as shown in the diagram below.



For more information about telemedicine and HIPAA compliance, go to:

[www.telehealthresourcecenter.org/sites/main/files/file-attachments/hipaa\\_for\\_trcs\\_2014\\_0.pdf](http://www.telehealthresourcecenter.org/sites/main/files/file-attachments/hipaa_for_trcs_2014_0.pdf)

### ***Anti-Kickback Statute***

In short, the anti-kickback statute states that providers cannot pay for referrals. This statute is designed to protect clients and federal health care programs from fraud and abuse by inhibiting the use of money to influence health care decisions. “Safe harbor exemptions” allow for telemedicine providers to pay rent to a remote location, so long as it is within fair market value and not contingent upon referrals. Any exchange of money should be outlined in the MOU between the two partnering agencies.

For more information about how the anti-kickback statute applies to telemedicine, see:

[www.telehealthresourcecenter.org/toolbox-module/federal-fraud-and-abuse-anti-kickback-statute](http://www.telehealthresourcecenter.org/toolbox-module/federal-fraud-and-abuse-anti-kickback-statute)

### ***Sherman Anti-Trust Act***

The Sherman Anti-Trust Act promotes competitive behavior in order to prevent monopolies. Telemedicine providers are at risk of being challenged because they often provide services otherwise not available in rural areas where they operate. A monopoly is not automatically a violation. Providers are encouraged to document the lack of competition in the area prior to their telemedicine presence in order to avoid and refute challenges.

For additional information about the Sherman Anti-Trust Act, go to: [www.telehealthresourcecenter.org/toolbox-module/antitrust](http://www.telehealthresourcecenter.org/toolbox-module/antitrust)

## State Telehealth Rules and Medicaid Program Policies

Telehealth rules vary by state. See <http://bit.ly/2s50s5p> for detailed information.

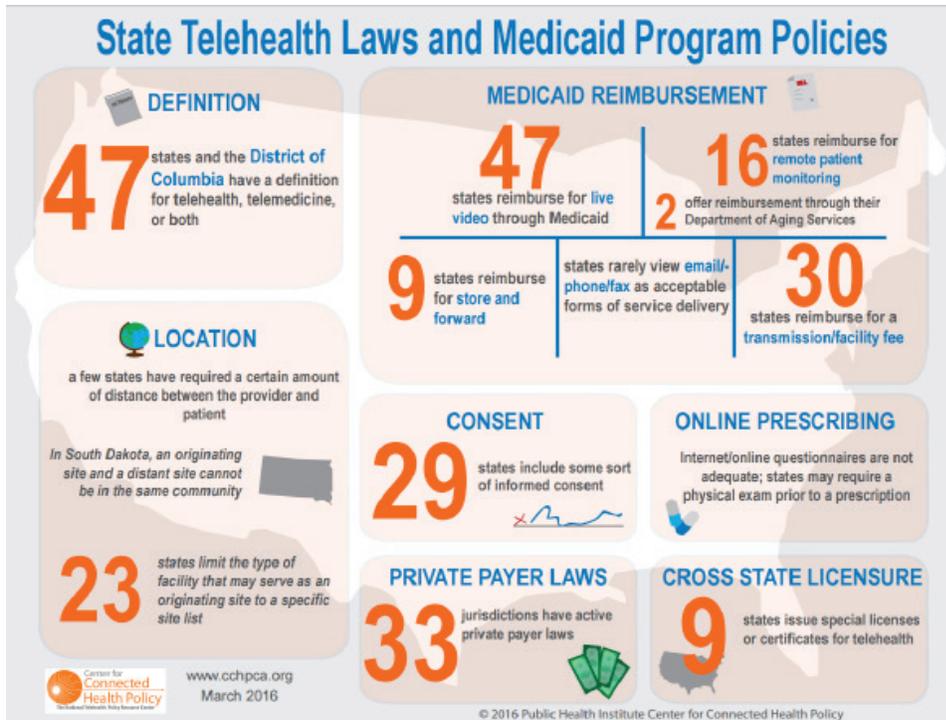


Image reprinted with permission from the Public Health Institute Center for Connected Health Policy

## Barriers and Facilitators to Telemedicine Program Planning and Implementation

Organizations contemplating a telemedicine program can benefit from MAO's experiences planning, implementing, continuously improving, and evaluating their program. Summarized below are potential barriers and facilitators to consider in planning a new program.

### **Potential Barriers**

The biggest barriers in MAO's experience were broadband availability and sufficiency, staff difficulty becoming comfortable with telemedicine equipment, and adapting to new workflows.

### **Facilitators**

Based on MAO's experience, these tips can help facilitate the development of a telemedicine program:

- Cultivate nurse and frontline provider champions. "Early adopters" can be invaluable in helping other staff and providers buy in to telemedicine.
- Hire dedicated IT staff—and have their cell phone numbers on hand.
- Build upon existing collaborations.
- Consider branding telemedicine services without including HIV or AIDS. For example, MAO uses the name "Alabama eHealth" on all their signage, forms, etc., to reduce HIV-associated stigma.
- It is critical that staff practice running a telemedicine appointment, until it becomes second nature. Being fluid in your actions will put your clients at ease.

## Technology: The Who, What, Where, When, and How

### **Staffing**

Working with the technology requirements of a telemedicine program is a full-time job. Based on MAO's experience, it is highly recommended that programs planning to start a telemedicine program hire an information technology (IT) specialist who will be dedicated to the program. The IT specialist doesn't necessarily need prior telemedicine experience; however, they need to be committed to becoming a specialist in telemedicine equipment and the associated technological requirements.

***In fact, the rest of this "Technology" section is intended for readers with some IT knowledge. Readers without much IT background may wish to skip to the next section and work with an IT specialist to plan for technology needs.***

## **Bandwidth Requirements**

Access to adequate, affordable bandwidth can be a challenge, particularly in rural areas. Therefore, finding out about available and planned bandwidth in a program's service area must be the priority when planning a new telemedicine project or location.

These are the *minimum* bandwidth requirements for telemedicine services:

- 500 Kbps in each of the downlink and uplink directions is the minimum bandwidth required for telemedicine. Such services should provide a minimum of 640 x 480 resolution at 30 frames per second. Depending on the services provided, higher bandwidth speeds may be needed.
- Different technologies provide different video quality results at the same bandwidth. Each endpoint should use bandwidth sufficient to provide at least the minimum required resolution during normal operation.
- Security settings must also be considered when deciding on bandwidth allocation.



MAO's staff provide technical assistance and consultation on all aspects of telemedicine, including IT issues. Contact information can be found in "Additional Telemedicine Resources" in the Appendix of this guide.

## **Security and Encryption**

- An AES 128-bit encryption key is considered very strong and suitable to withstand most attacks.
- The U.S. Government requires 192 or 256-bit AES encryption keys for highly sensitive data; AES is the U.S. government standard for data encryption.
- An encryption algorithm key length indicates its strength measured in bits.

Most of the time data breaches don't happen when encryption is hacked; they happen due to human error. As noted above, it is crucial to use common-sense computer security precautions, such as closing medical records before walking away from computers, keeping passwords in a secure location, and setting up computer screens to lock out after a few minutes of non-use.

# Appendix

This appendix contains the following items for use in your program:

- Telemedicine Recipient Consent Form
- Additional Telemedicine Resources
- Technical Assistance

## Telemedicine Recipient Consent Form

I (name) \_\_\_\_\_ agree to participate in this medical visit through telemedicine equipment/services. I understand that my provider, (provider name) \_\_\_\_\_ is seeing me today, from (facility address) \_\_\_\_\_.

I understand that, through telemedicine services, my visit with the provider will occur through special technology. I consent to the use of this technology during my visit. This consent is valid for this visit as well as any follow-up visits, additional treatment services provided by mental health, pharmacy, and/or case management staff, or administrative services that I may need.

I have the authority to revoke this consent, as I see fit, as long as I do so in a clear, signed statement. My provider or my provider's coworkers shall file this consent form in my medical record, and I am entitled to a copy, free of charge, whenever I request.

I understand that:

1. I can decline telemedicine services at any time without affecting my right to future care or treatment, and any program benefits, to which I ordinarily have been entitled;
2. I may have to travel to see a health care provider, in person, if I decline telemedicine services;
3. The same confidentiality rules that apply to in-person medical treatment, also apply to my telemedicine visit(s);
4. I have the right, as provided by law, to access all medical information gathered during my telemedicine visit(s);
5. Any information/data gathered during my telemedicine visit(s), regarding my private health information, cannot be shared with any third party, except as allowed by HIPAA, without my separate, prior written consent;
6. I will be informed of all individuals involved in my telemedicine visit, and have the right to decline any non-provider staff from participating; I understand that exercising this right will not affect my care during my telemedicine visit;
7. In case of an urgent situation, I will have access to an appropriately trained employee or third party provider, in person, immediately following my telemedicine visit. If an employee or third party-provider is unavailable, I will be informed of this fact prior to undertaking my telemedicine visit;
8. I may contact the health care provider responsible for my telemedicine visit, at xxx-xxx-xxxx for any questions related to the telemedicine services that I receive.

\*\*\*I HAVE READ THIS DOCUMENT CAREFULLY, AND MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION\*\*\*

\_\_\_\_\_  
SIGNATURE OF PATIENT OR PARENT / LEGAL GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PERSON OBTAINING CONSENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
FACILITY AT WHICH CONSENT IS OBTAINED

## Additional Telemedicine Resources

- American Telemedicine Association: [www.americantelemed.org/](http://www.americantelemed.org/)

The American Telemedicine Association (ATA) is an international resource and advocate promoting the use of advanced remote medical technologies. ATA and its diverse membership works to fully integrate telemedicine into transformed health care systems to improve quality, equity, and affordability of health care throughout the world. Resources include practice guidelines.

- Health Resources and Services Administration's Office for Advancement of Telehealth: [www.hrsa.gov/ruralhealth/telehealth/](http://www.hrsa.gov/ruralhealth/telehealth/)

The Office for the Advancement of Telehealth (OAT) in the Federal Office of Rural Health Policy (FORHP) promotes the use of telehealth technologies for health care delivery, education, and health information services. In addition, OAT provides telehealth grants.

- Telehealth Resource Centers: [www.telehealthresourcecenter.org/](http://www.telehealthresourcecenter.org/)

Telehealth Resource Centers (TRCs) have been established to provide assistance, education, and information to organizations and individuals who are actively providing or interested in providing medical care at a distance. Their charter from the Office for Advancement of Telehealth is to assist in expanding the availability of health care to underserved populations. And because they are federally funded, the assistance they provide is generally free of charge. Topics include how-to, legal and regulatory issues, reimbursement, credentialing, and licensing.

## Technical Assistance



### Technical Assistance from AIDS United

## Getting to zero

The AIDS United Getting to Zero initiative provides no-cost capacity building assistance to CBOs across the country as they work to evaluate and grow their telemedicine programs. Email [cba@aidsunited.org](mailto:cba@aidsunited.org) to find out more!



### Technical Assistance from MAO

MAO provides technical assistance through our **Direct Practice Telehealth Resource Center (DPTRC)**. MAO supports organizations with all aspects of their Telehealth program, from concept all the way to fruition. DPTRC staff help with

- project planning,
- grant sourcing,
- IT infrastructure enhancements,
- vendor contacts,
- clinic flow,
- billing questions, and
- project implementation.

We provide on-site services as well as continuing support through conference calls, support calls, and emails.

To request Technical Assistance, please email KC Vick or Alexandria Andersen at [KVick@maoi.org](mailto:KVick@maoi.org) or [Aandersen@maoi.org](mailto:Aandersen@maoi.org). Visit [www.maoi.org](http://www.maoi.org) to learn more.



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