



Telemedicine Implementation at a Midwestern HIV Clinic: Strategy and Year One Outcomes

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Disclosures

- None



Objectives

- To review implementation science strategies of telehealth services at the UNMC HIV clinic
- To describe year 1 clinic outcomes

UNMC HIV Team #ADHERENCE2022



- UNMC HIV clinic developed in 1985
- Ryan White funded C and D
- Four adult physicians, 2 pediatric
- Three nurse practitioners
- Pharmacists & pharmacy technician
- Five ID fellows
- Two nurse case managers and 2 medical assistants
- One front desk receptionist
- Client service team/case management
- Part C & D coordinator
- Phlebotomist/laboratory technician
- Administrative and support staff
- Clinical trials staff
- Psychiatry and dermatology on site
- Mental Health practitioner (recruiting)





Demographic Factors	PWH at the SCC (N=1128)
Age	
Median [Min, Max]	48.0 [3.00, 85.0]
Gender	
Cisgender Female	260 (23.0%)
Cisgender Male	849 (75.3%)
Transgender	19 (1.7%)
Race	
Black or African American	344 (30.5%)
White or Caucasian	696 (61.7%)
Ethnicity	
Hispanic or Latino	180 (16.0%)
Not Hispanic or Latino	946 (83.9%)
FPL	
<100%	372 (33.0%)
Insurance	
Medicaid	122 (10.8%)
Medicare	202 (17.9%)
Private	646 (57.3%)
Uninsured	152 (13.5%)
Housing Status	
Stable/permanent	1043 (92.5%)



Phase 1: Transformation

- Identified a need to transform our delivery of care model in order to ensure retention in care (RIC) for people with HIV (PWH) during pandemic
- There was a system-wide movement to offer telemedicine visits to patients in ambulatory clinics
 - Training materials disseminated regarding billing, E/M coding
 - Uniform statements to support billing (rationale for telemed visit)
 - Visit templates
- Interim Guidance for COVID-19 and PWH also supported modification of the standard every 6 month visit and lab check during time of pandemic



Needs Assessment: Barriers and Resolution

Patient level Barrier

- 50% of patients do not have MyChart or technology
- Patients were calling to cancel appointments
- Patients using mass transit
- Patients out of medications
- Fear and anxiety regarding COVID-19 in HIV

Resolution

- Utilize telephone evaluation instead of video telehealth
- Switch to telephone instead of cancelling
- Utilize taxi cab
- Provide 90 day supply
- COVID-19 education as part of telehealth, COVID-19 hotline



Needs Assessment: Barriers and Resolution


Clinic level barrier

- Space including waiting and exam rooms, and offices
- COVID-19 screening process
- PPE and NP swab collection
- Variation in providers criteria of who needs to be seen in person
- Staff concerns regarding COVID-19

Resolution

- Reducing the number of patients and staff in clinic
- Adapted organization's process
- Organizational training team
- Developed a procedure manual for staff and providers
- Weekly meetings to provide updates and discuss concerns

Developed criteria
for telehealth vs.
office visits
(algorithms)

2022 
Staff training on
telehealth tools and
shortcuts
(smartphrase)

Implementation Strategy

1. Assess for readiness and identify barriers and facilitators
2. Prepare clinic operations champions
3. Organize clinician implementation meetings
4. All staff training

Just-In-Time
training on
COVID-19 test
collection

Developed
criteria for
rescheduling
patients

Changed physical clinic set-up
to accommodate patients seen
in clinic (walk-ins, those not
eligible for telehealth)

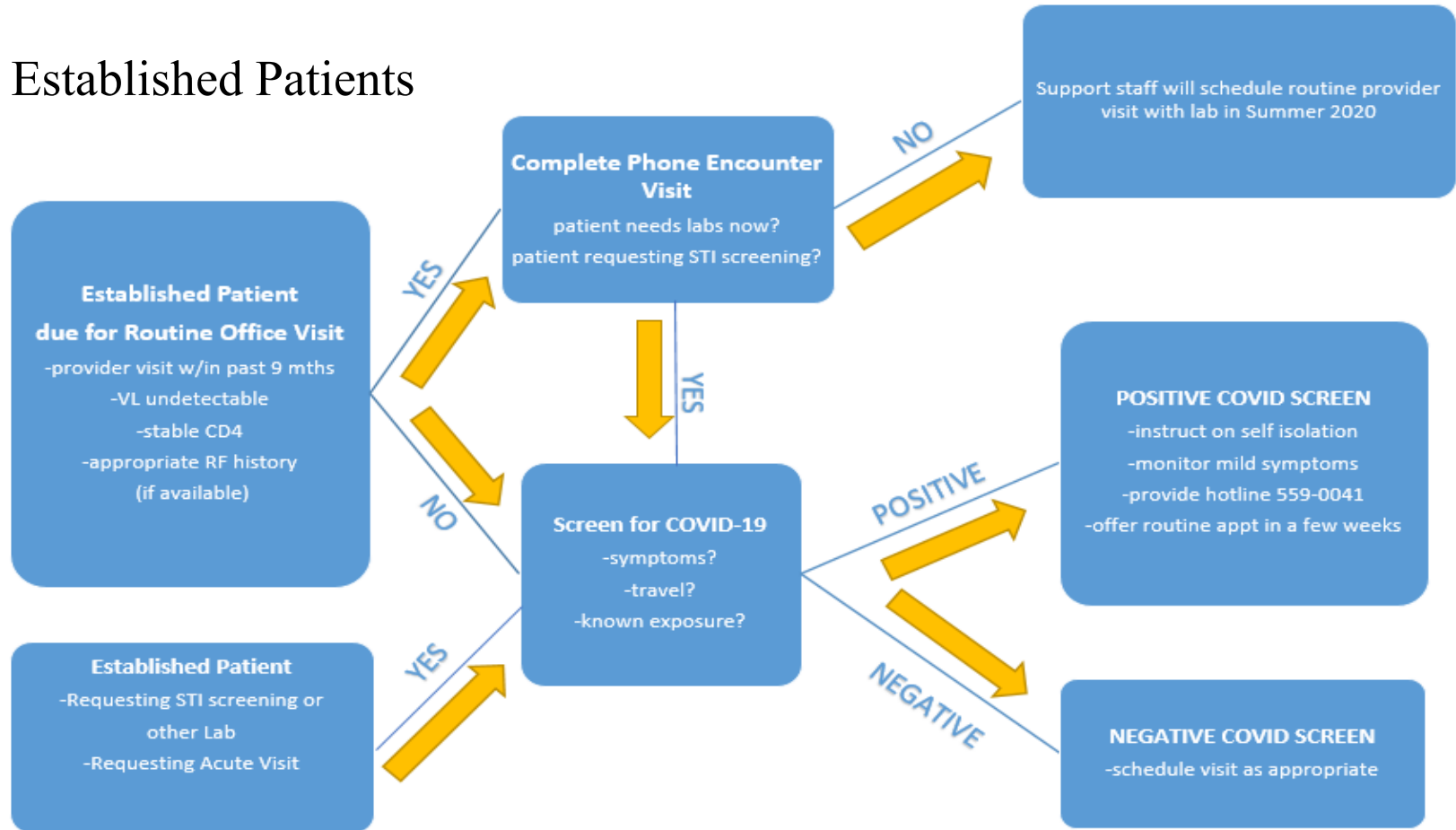
Just-In-Time training on
personal protective
equipment (PPE)



METHODS

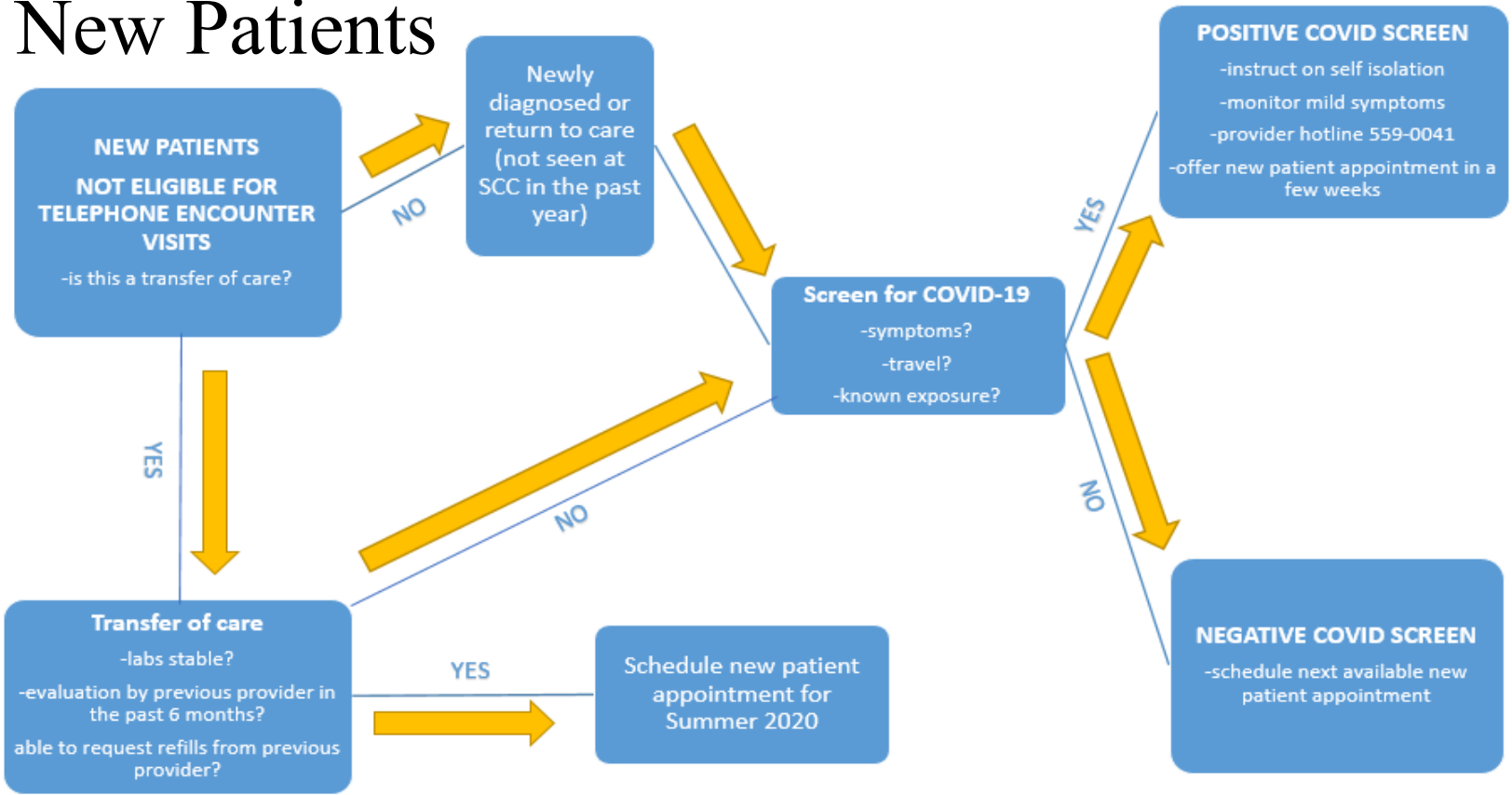
- We continuously updated an algorithm on patient eligibility and monitored outcome through chart reviews between may 1, 2020 to April 30, 2021.
- We collected patient demographics, clinical, and federal poverty level (FPL) information.
- We examined baseline and post-intervention clinic rates of
 - Viral load suppression (VLS, defined as HIV RNA < 200 copies per mL),
 - Medical visit frequency (MVF, defined as percentage of patients who had one visit in each 6 months of the preceding 24 months with at least 60 days between visits)
 - Lost to care (LOC, no follow up within 12 months period).

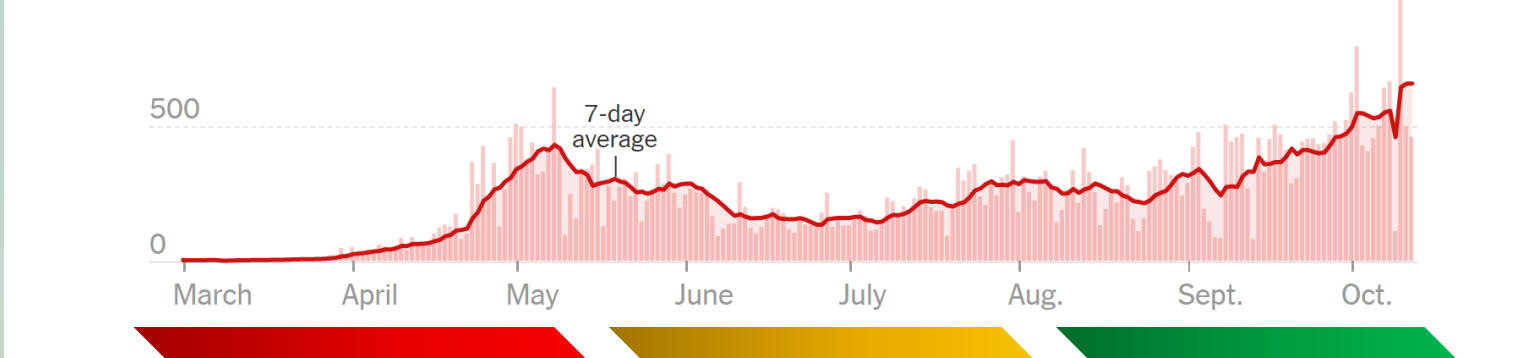
Established Patients





New Patients





Transformation

- Needs assessment
- Team planning meetings
- Developing tools and protocols



Refinement

- Monitoring outcomes
- Adjusting protocols
- Preparing for re-opening



Recovery

- Sustainability of telehealth
- Establishing new clinic flow
- Preparing for next phase



RESULTS

- We conducted a total of 2298 ambulatory medical visits; 1642 were in person and 656 (29%) were telemedicine visits.
- Out of those, 2177 were follow up visits (649, 30% telemedicine).
- There was no difference of telemedicine utilization based on race (28% in African Americans vs. 32% in Whites); ethnicity (30% in Hispanic vs. 30% in Hon-Hispanic); gender (24% in females vs. 30% in males); or FPL (28% in FPL < 200% vs. 31% in FPL >200%).
- By the end of April 2021, overall clinic VLS rate was 94%, MVF was 48%, and there were 40 patients LOC compared to 92%, 49%, and 43 patients in April 2020, respectively.



CONCLUSIONS

- Telemedicine was a safe alternative to routine in-person HIV care during the COVID-19 pandemic. We observed similar rates of utilization across demographic and FPL status. Applying selection criteria, viral suppression and retention in care rates were not adversely impacted by shift to telemedicine modality.



Questions

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