USCA HRSA Track: Better Rural HIV Care Through Data and Technology

Pamela Klein, MSPH, PhD

Health Scientist
Program and Clinical Evaluation & Technical Assistance
Division of Policy and Data
HIV/AIDS Bureau
Health Resources and Services Administration

United States Conference on AIDS
September 10, 2015

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Overview

- **Rural America and Health Care**
- **HIV in Rural America**
- **Ryan White HIV/AIDS Program in Rural America**
- **Barriers to Delivering High Quality HIV Care**
- **Today's Workshop Agenda**

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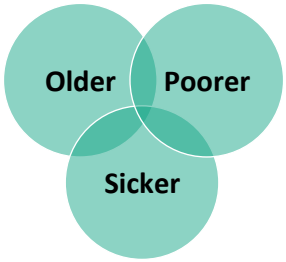
Who Are Rural Americans?

- 17% of Americans live in non-metropolitan, or rural, areas
- Compared to urban counterparts, residents of rural counties are more likely to be



- Life expectancy decreases as level of rurality increases

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Health Care in Rural America

- Smaller supply of health care providers per capita, especially for medical specialists and dentists
- Non-physician practitioners play an important role
- Residents live further away from health care resources
- Dependence on small rural hospitals that may lack highly-skilled facilities

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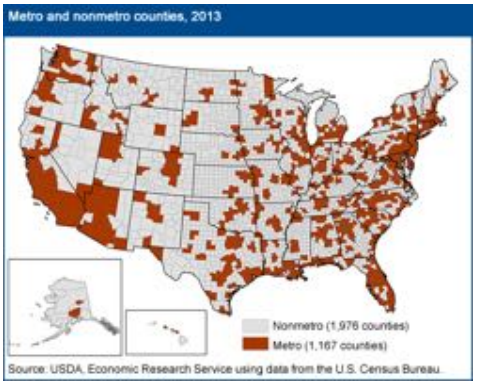
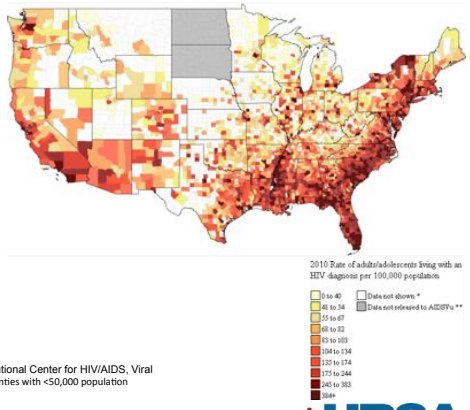
Photo Source: http://cokergroupreport.com/

How Does Rural America Intersect with the HIV Epidemic?



Adults and Adolescents Living with HIV by County, 2010



Data Sources: USDA Economic Research Service; Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Division of HIV/AIDS Prevention. Non-metro areas defined as counties with <50,000 population

* Data are not shown to protect privacy. ** State health department requested not to release data.

Note. Data include persons with a diagnosis of HIV infection, regardless of the stage of disease at diagnosis, and have been statistically adjusted to account for reporting delays and missing risk-factor information, but not for incomplete reporting.

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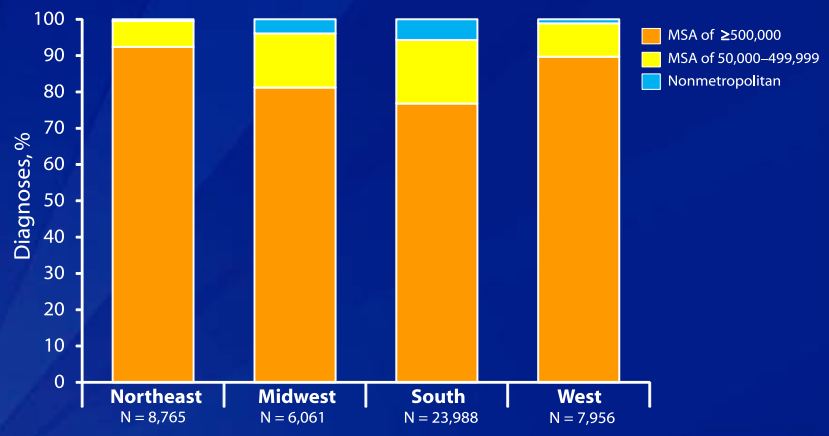
Diagnoses of HIV Infection among Adults and Adolescents, by Region and Population of Area of Residence, 2013—United States



Note. Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. All displayed data have been statistically adjusted to account for reporting delays, but not for incomplete reporting. Data exclude persons whose county of residence is unknown.

Source: CDC. HIV Surveillance in Urban and Nonurban Areas (through 2013). Slide Set.

CDC

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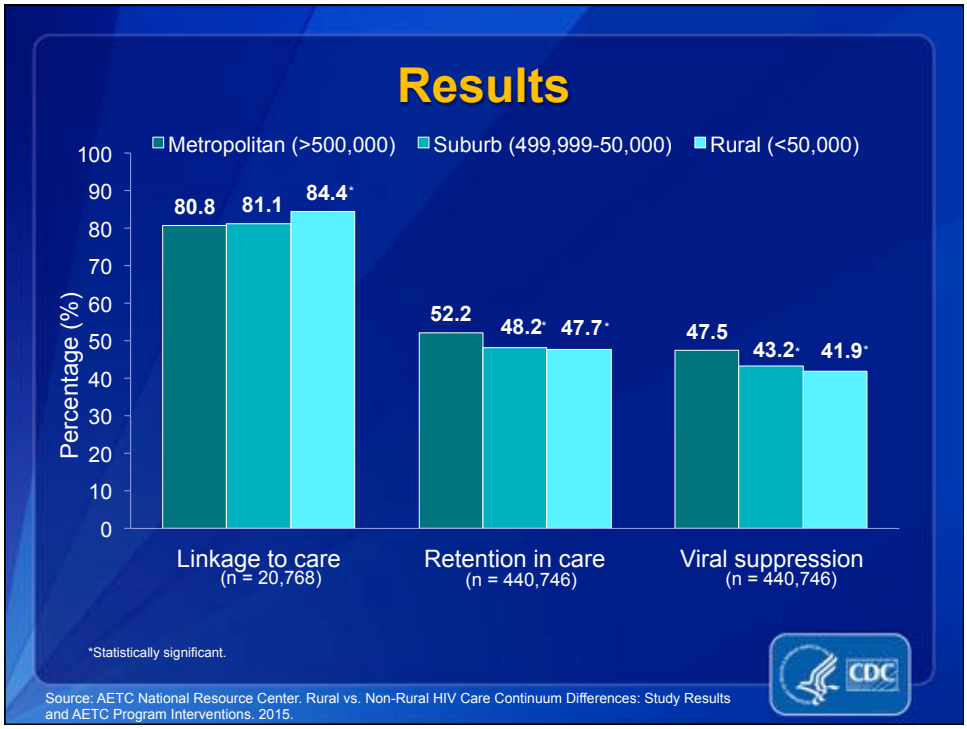

Ryan White HIV/AIDS Program Overview

- **Part A (Cities)**
- **Part B (States and Territories)**
  - ADAP – AIDS Drug Assistance Program
- **Part C (Community-based Organizations)**
  - Early Intervention Services and Capacity Development
- **Part D (Women, Infants, Children and Youth)**
- **Part F (Other Programs)**
  - AIDS Education and Training Centers (AETCs)
  - Special Projects of National Significance (SPNS)
  - Dental Programs
  - Minority AIDS Initiative (MAI)

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Who We Serve

Ryan White HIV/AIDS Program	**Served half a million (524,675) people** 2013
Care Engagement	~**2 out 3** people living with HIV (PLWH) engaged in medical care served by RWHAP
Demographics	47% Black/African American 23% Hispanic (2013) **~90%** living at/below 200% Federal Poverty Level (2013)

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Ryan White HIV/AIDS Program and Health Care

- RWHAP supports a **dynamic and complex system of care**; it is not an insurance program for discrete services
- The **need for an HIV care system for low-income PLWH remains** until the outcomes on the HIV care continuum are addressed and there is a cure

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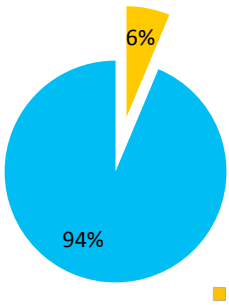
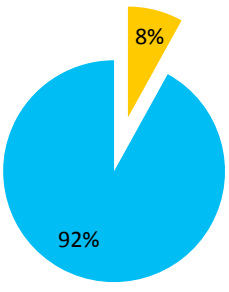
Ryan White HIV/AIDS Program Providers in Rural Zip Codes, 2013

All Ryan White HIV/AIDS Program (RWHAP) Providers [N=1788]



Outpatient Ambulatory Medical Care (OAMC) RWHAP Providers [N=846]



Rural Urban

Source: 2013 Ryan White Services Report
Rural Classification based on zip-code Rural-Urban Commuting Areas (RUCAs) with RUCA 1-3 = urban and RUCA 4-10 = rural

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Ryan White HIV/AIDS Program Providers in Rural America, 2013

Among the 500,638 RWHAP clients

Visited Only Rural Providers	Visited Only Urban Providers	Visited Rural & Urban Providers
2.1% (n = 10,278)	97.1% (n = 486,346)	0.8% (n = 4,014)

Among the 4,101 clients who visited a combination of RWHAP providers in rural and urban zip codes:

- 82.9% of them visited an urban-located provider for OAMC visits and a rural-located provider for other services

Source: 2013 Ryan White Services Report
Rural Classification based on zip-code Rural-Urban Commuting Areas (RUCAs) with RUCA 1-3 = urban and RUCA 4-10 = rural

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Rural Barriers to HIV Care Delivery

- **Difficult to develop economically viable service delivery programs in rural communities**
  - Low population density
  - Lower HIV prevalence than urban areas
- **Need to identify new methods to enhance the availability of quality medical and supportive care for rural people living with HIV**

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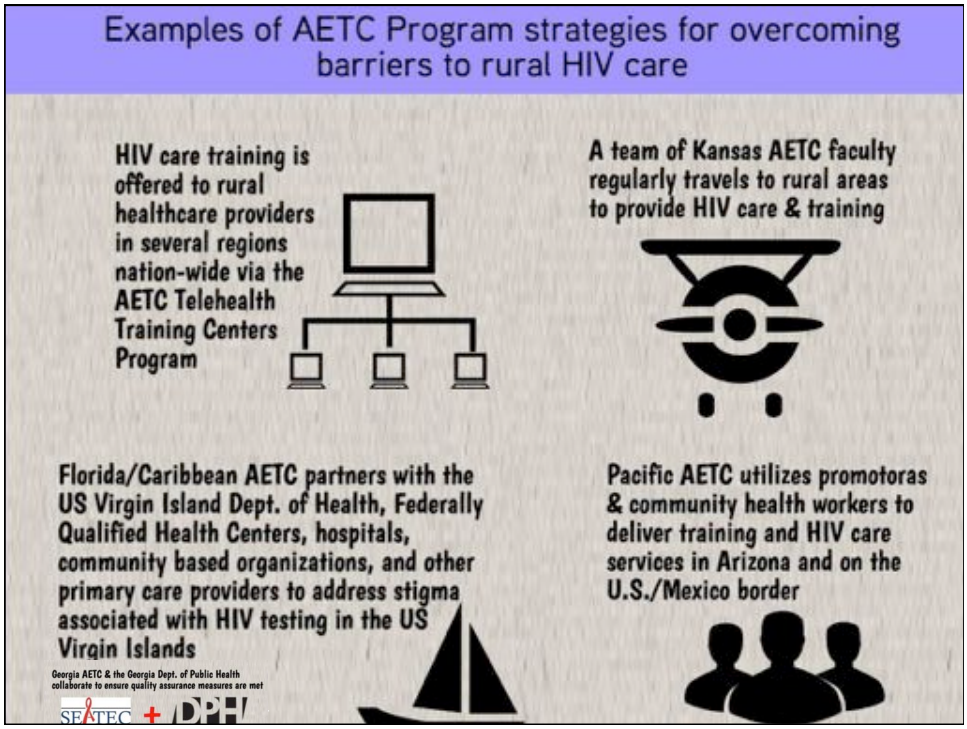
Ryan White CARE Act 25th Anniversary

HRSA Ryan White & Global HIV/AIDS Programs

Ryan White CARE Act 25th Anniversary

"Moving Forward with CARE: Building on 25 Years of Passion, Purpose, and Excellence"

HRSA Ryan White & Global HIV/AIDS Programs



Presenters

HIV/HCV Outbreak in Indiana: A Case Study
Susan Robilotto
HRSA HIV/AIDS Bureau

Data Driven Programming
Cyndee Burton
Matthew 25 AIDS Services

Building Capacity Through Innovative Technology
Natalia Martinez-Paz
NW AIDS Education and Training Center

HIV Care in Rural Alaska
Terri Bramel, Lisa Rea, and Laura Riley
Alaska Native Tribal Health Consortium

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Additional Resources

- **HRSA HIV/AIDS Bureau - http://hab.hrsa.gov/**
- **HRSA HIV/AIDS Bureau Data Resources - http://hab.hrsa.gov/data/index.html**
- **HRSA Federal Office of Rural Health Policy - http://www.hrsa.gov/ruralhealth/**
- **TARGET Center - https://careacttarget.org/**
- **AETC National Resource Center - http://www.aidsetc.org/**
  - Telehealth Training Centers Program
  - AETC National Resource Center – Rural Health Committee

HRSA Ryan White & Global HIV/AIDS Programs

Contact Information

Pamela Klein
HRSA HIV/AIDS Bureau
301-443-5545
pklein@hrsa.gov

HRSA Ryan White & Global HIV/AIDS Programs

HIV/ HCV Outbreak in Indiana: A case study in barriers to HIV care in rural United States

Susan Robilotto, D.O.
Clinical Consultant/Medical Officer
U.S. Department of Health and Human Services
Health Resources and Services Administration
HIV/ AIDS Bureau
Division of Metropolitan HIV/AIDS Programs
Division of State HIV/AIDS Program

September 10, 2015

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25 Years Ryan White HIV/AIDS Program
Moving Forward with CARE: Building on 25 Years of Passion, Purpose, and Excellence

Content

- Overview of the HIV/HCV outbreak in Indiana
- Highlight the barriers to delivering HIV care in rural settings
- Actions taken to overcome barriers

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25 Years Ryan White HIV/AIDS Program
Moving Forward with CARE: Building on 25 Years of Passion, Purpose, and Excellence

Learning Objectives

- Identify barriers to accessing and engaging in HIV care in rural areas
- Assess rural health care infrastructure in order to begin addressing barriers

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Indiana HIV Outbreak: Timeline

- **December 2014:** Significant increase in diagnoses of HIV occurring in region (Scott County) previously reporting <5 HIV diagnoses annually
- **February 25, 2015:** Indiana state health officials announce HIV outbreak in southeastern Indiana (Scott County): 26 confirmed and 4 preliminary HIV positive cases. Most are linked to injection of the prescription opioid, Opana
- **March 16, 2015:** CDC develops response team, which arrives in Austin, IN on March 23, 2015

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Indiana HIV Outbreak: Timeline

- **March 26, 2015:** Governor declares public health emergency in Scott County
- **March 31, 2015:** Community Outreach Center/One-Stop Shop opens in Austin, IN
- **April 4, 2015:** First syringe needle exchange program in Indiana opens in Scott County. It operates out of the Community Outreach Center/ One-Stop Shop
- **April 2015:** Counts of new HIV and Hepatitis C cases continue to rise as the community works with local, state, and federal partners to get at-risk community members tested

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Indiana HIV Outbreak: Timeline

- **May 2015:** New cases begin to decrease and retesting efforts ramp up for high-risk individuals previously identified as negative
- **May 5, 2015:** Governor signs legislation allowing needle exchange programs to be established at the local level
- **May 25, 2015:** Governor's Public Health Emergency order expires
- **June 25, 2015:** Community Outreach Center/One-Stop Shop closes
- **Early July 2015:** One-Stop Shop reopened in new location and is co-located with the Syringe Exchange Program

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Ongoing HIV Care

- 497 named contacts
- 174 confirmed HIV cases linked to the outbreak
- Hepatitis C co-infection rate is greater than 85%
- Injection drug use was driving factor in this outbreak
- Many of the People Who Inject Drugs (PWID) are involved in the corrections system

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Addressing Barriers to HIV Care

Lack of access to care:

- Care coordination to assist in establishing health care coverage
- State establishing presumptive eligibility for Medicaid coverage
- Co-locating services to facilitate enrollment

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Addressing Barriers to HIV Care

Lack of providers:

- Indiana University physicians brought in to help
- Local primary care physician receiving training and support on HIV care and treatment
- Potential of Public Health Service Corp medical providers
- Telehealth assistance
- Jail clinic established

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Addressing Barriers to HIV Care

Lack of transportation:

- Engagement of local community to assist
- Medicaid transportation
- One-Stop Shop moved to location accessible by walking

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Addressing Barriers to HIV Care

Stigma:

- Co-locating of services
- Local community education
- Community events

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Lessons Learned

- Establishing communication and collaboration between local, state and federal stakeholders is critical
- Efforts need to fit the community
- Other complicating issues need to be addressed in order to establish HIV care

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Learn More/Additional Resources

CDC MMWR, May 1, 2015/ 64 (16)

http://1.usa.gov/1hjloxB

Indiana State Department of Health

HIV Outbreak webpage

http://www.in.gov/isdh/26649.htm

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Contact

Susan Robilotto, D.O.
Clinical Consultant/Medical Officer, HRSA/HAB
301-443-6554
srobilotto@hrsa.gov

HRSA Ryan White & Global HIV/AIDS Programs

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Matthew 25 AIDS Services

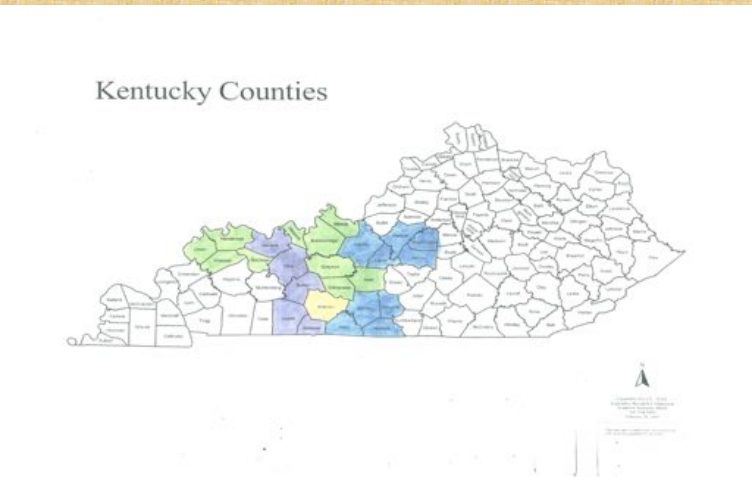
A Rural Experience: Data Driven Programming

Matthew 25 Timeline

- 1996 started as a church parish nurse program
- 1999 separated and became 501c3
- 2000 HRSA Planning Grant
- 2001 HRSA Ryan White EIS Part C award
- 2005 Kentucky Ryan White Part B award
- 2012 HRSA Ryan White EIS Part D award
- 2012 Initiated 340b programs

A Rural Experience: Data Driven Programming

The Kentucky Area



Comprehensive Picture

The devil is in the details!

Not everything that counts can be counted and not everything than can be counted counts.

Albert Einstein

A LITTLE DATA FROM HERE, A LITTLE DATA FROM THERE!

Different Folks
Different Strokes

Matthew 25 Henderson Location

- 202 patients
- 72% White, 12% A-A, 6% Asian, 8% Hispanic, 1% Burmese and 1%Bi-racial
- Females
- More Rural

Henderson Location

- 2 days
- Space
- HIV Testing
- On site Care Coordination
- Food pantry
- Transportation

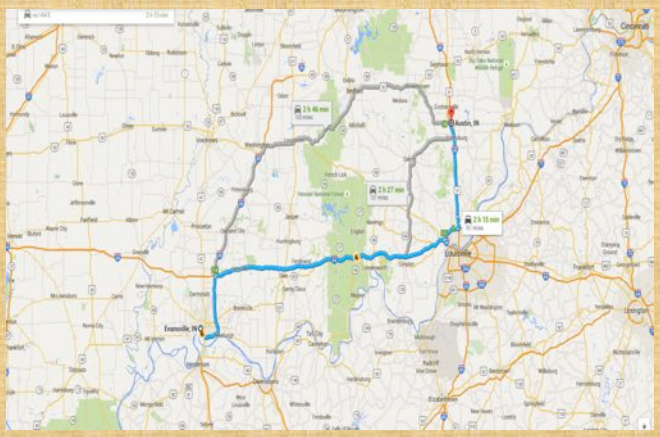
Matthew 25 Evansville Location

- 112 patients
- 69% White, 25% A-A, 3% Hispanic, 2% Bi-racial, and American Indian
- Homeless/Substance Use
- Low Income
- No On-site Care Coordination

Evansville Location

- Requires more time and resources
- Collaboration with other organizations
- 140 miles from the Indiana OUTBREAK

OUTBREAK IN AUSTIN, INDIANA



Matthew 25 Owensboro location

- 121 patients
- 72% White, 8% A-A, 2% Asian, 8% Hispanic, 10% Burmese and 2%Bi-racial
- Immigration Center
- 2 hours drive from Bowling Green

Owensboro Location

- Must have phone interpretation services
- Lunch
- Share space with another FQHC
- Have to have a traffic controller!

WORKING TOGETHER

Matthew 25 Community Bridge

Lessons Learned

- Clean data
- IT Security and HIPAA
- Know we are all in this together
- You get better with time!

Cyndee Burton, R.N., HCE, Administrator
270-826-0200
cburton@matthew25clinic.org

NORTHWEST AIDS EDUCATION AND TRAINING CENTER

Building Capacity in Rural HIV Care Through Innovative Technology

Natalia Martínez Paz, MPA, MA
Program Manager, NW AETC ECHO
University of Washington

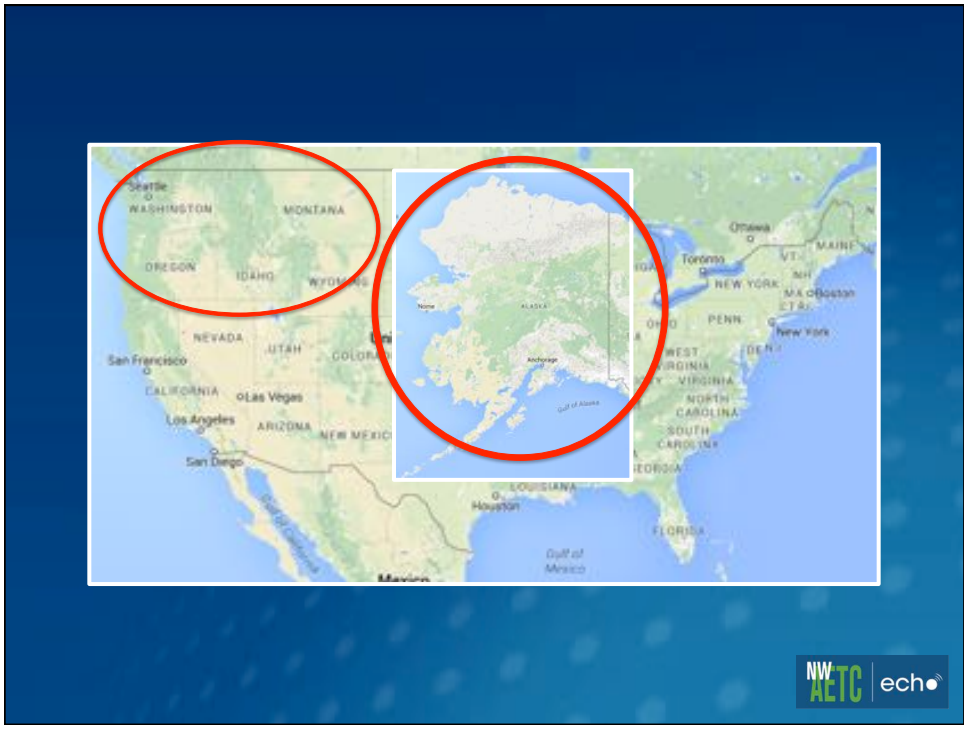
Presentation prepared by: Natalia Martínez Paz, MPA, MA & Brian Wood, MD

This presentation is intended for educational use only, and does not in any way constitute medical consultation or advice related to any specific patient.

Agenda

- Challenges in specialty care in the Pacific Northwest
- Extension for Community Health Outcomes (ECHO) model
- Continual innovation to build on past successes

The Problem



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The Theory

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Why provide specialty training?

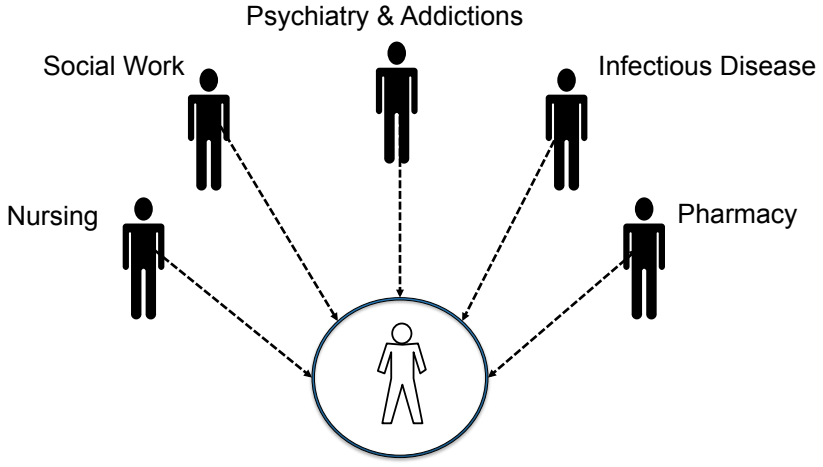
1. People need access to specialty care for their complex health conditions.

2. There aren't enough specialists to treat everyone who needs care, especially in rural and underserved communities.

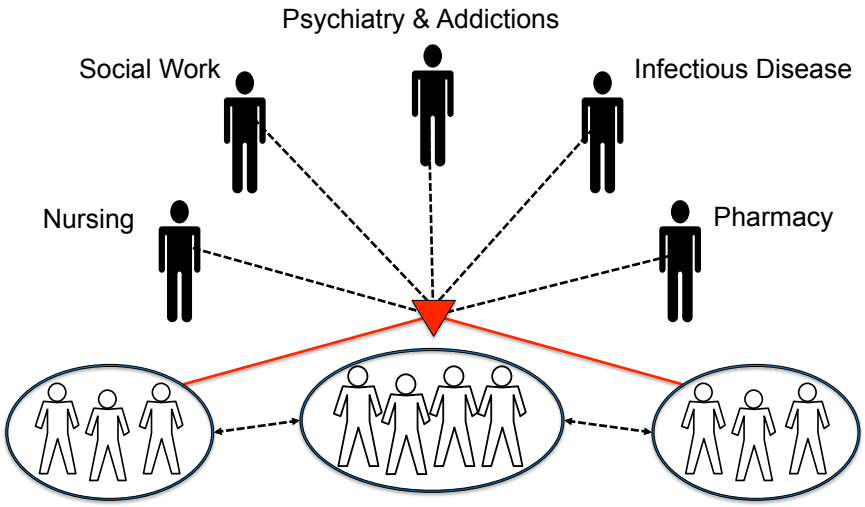
3. ECHO trains primary care clinicians to provide specialty care services. This means more people can get the care they need.

4. Patients get the right care, in the right place, at the right time. This improves outcomes and reduces costs.

Shifts Away From 1-1



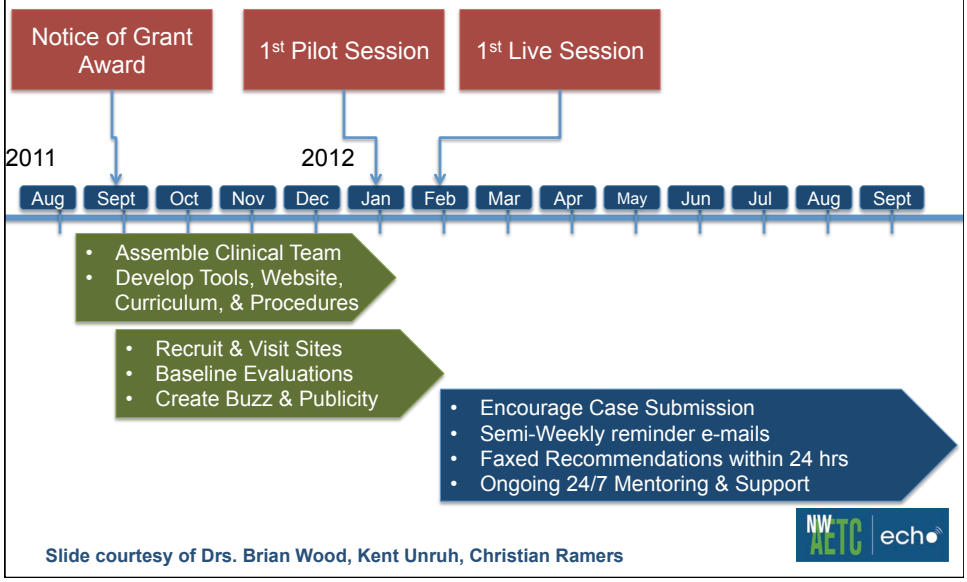
Knowledge Network



Peer Network
Interactive Learning Environment

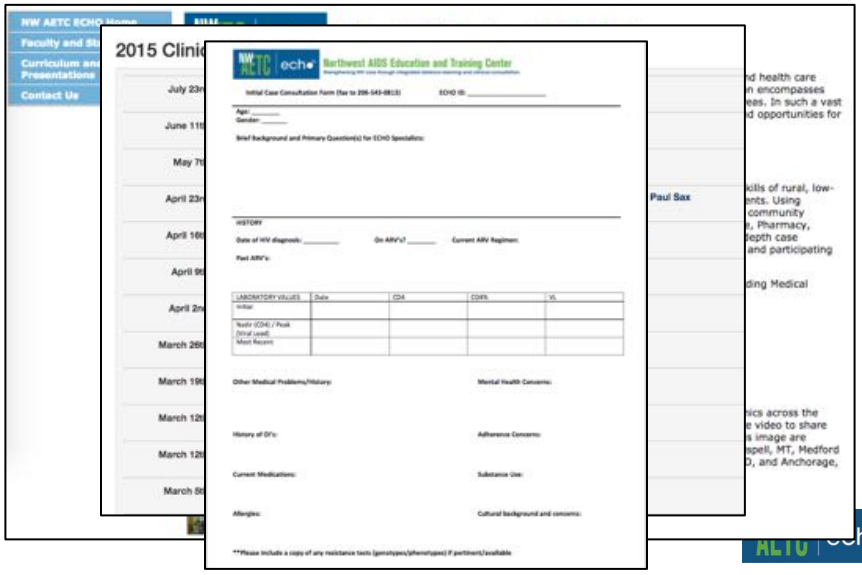
Building Blocks

NW AETC ECHO Timeline



Slide courtesy of Drs. Brian Wood, Kent Unruh, Christian Ramers

Policies, Procedures, Curriculum



MORE Policies, Procedures, Curriculum

SITE RECRUITEMENT

Importance of Site Visits

Goal: Build Relationships with Participants

The importance of the face-to-face visit

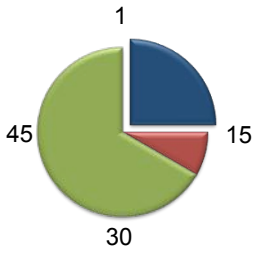
Assess clinic workflow and technology

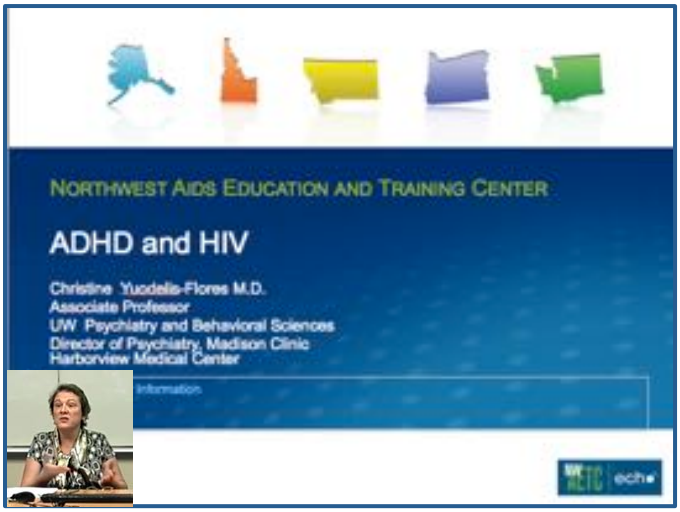
Meeting administrators helps to encourage buy-in

Technology Doesn't Make the Program.
Relationships Make the Program.

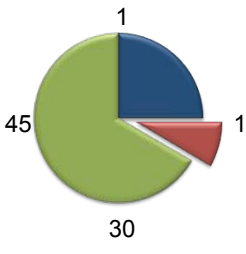
NW AETC ECHO

Clinical Update





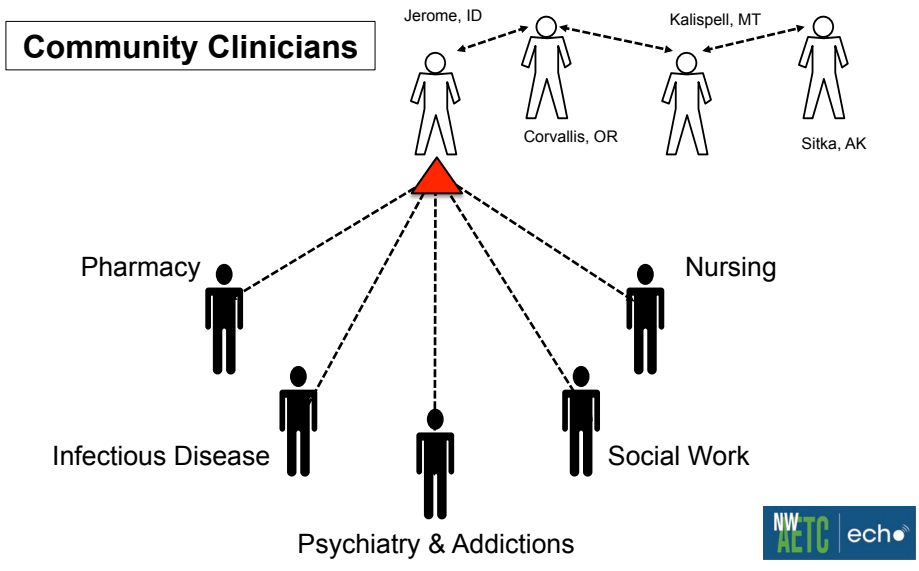
Discussion



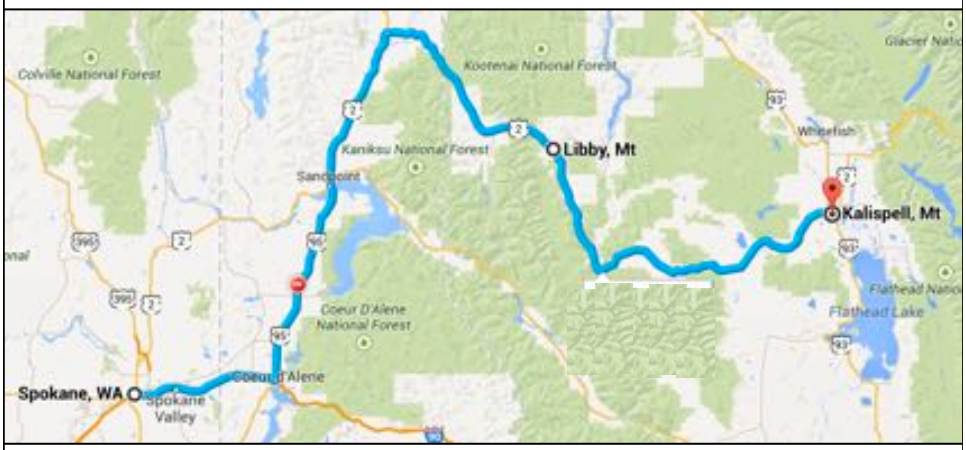
- Spokane, WA
- Eugene, OR
- Springfield, OR
- Pocatello, ID
- Vancouver, WA
- Medford, OR
- Corvallis, OR
- Bozeman, MT
- Missoula, MT
- Vancouver, WA
- Anchorage, AK
- Boise, ID

Case Presentations

Horizontal Knowledge Transfer

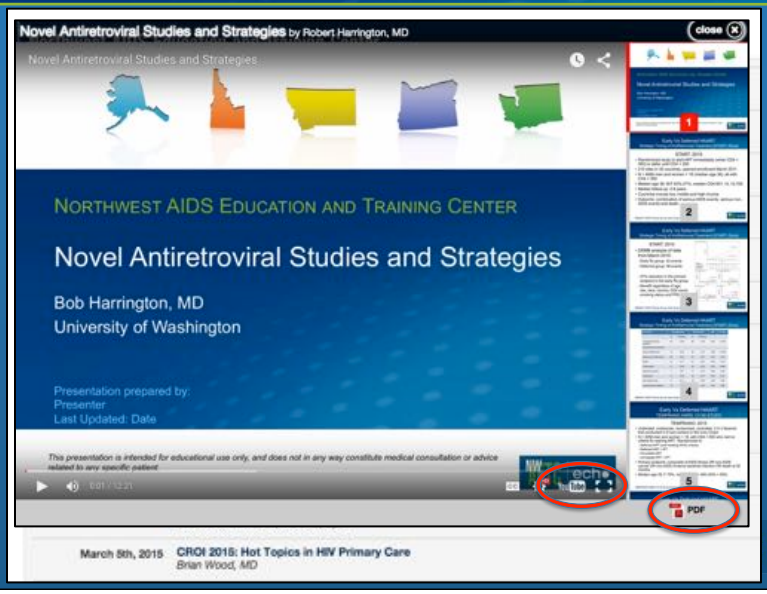


Fostering Peer-to-Peer Network & Support System Across Region

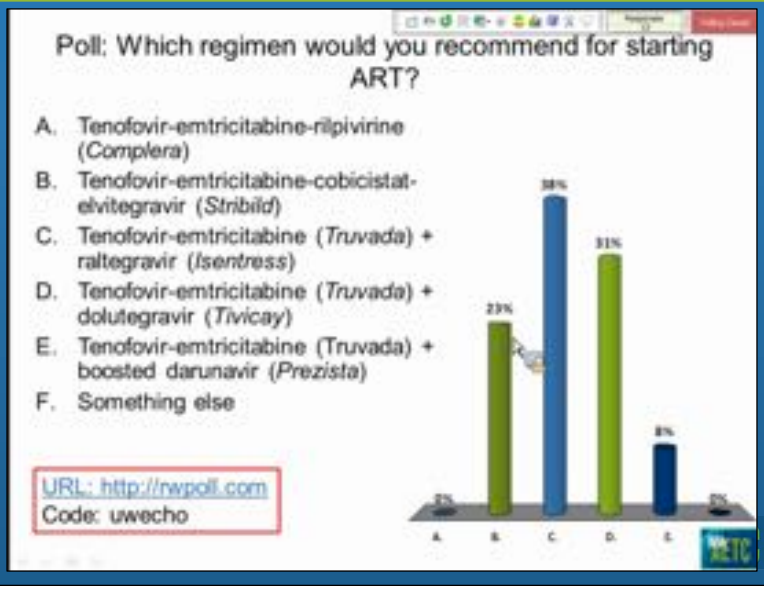


Integrating Innovation

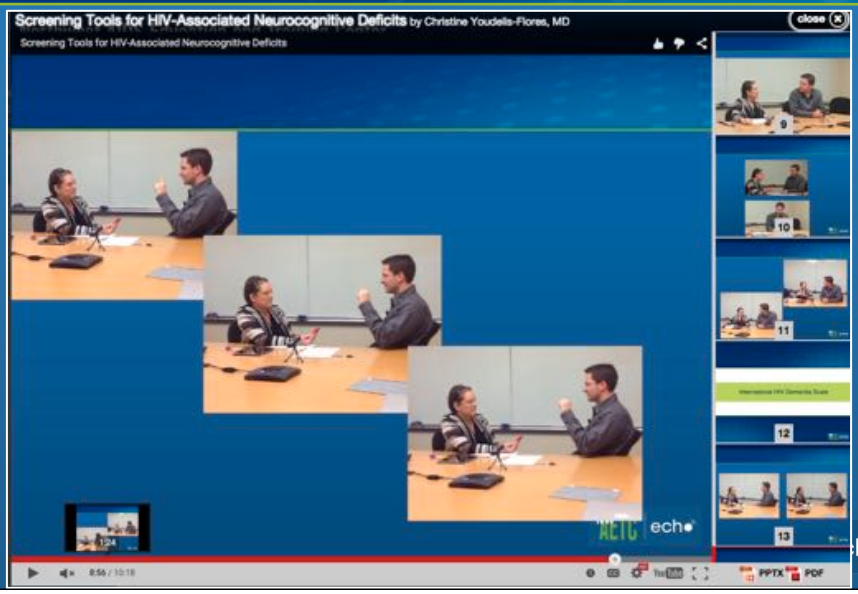
All Clinical Updates Made Freely Available on Web
Goal: Establish Channel for HIV Knowledge



Interactive Polling

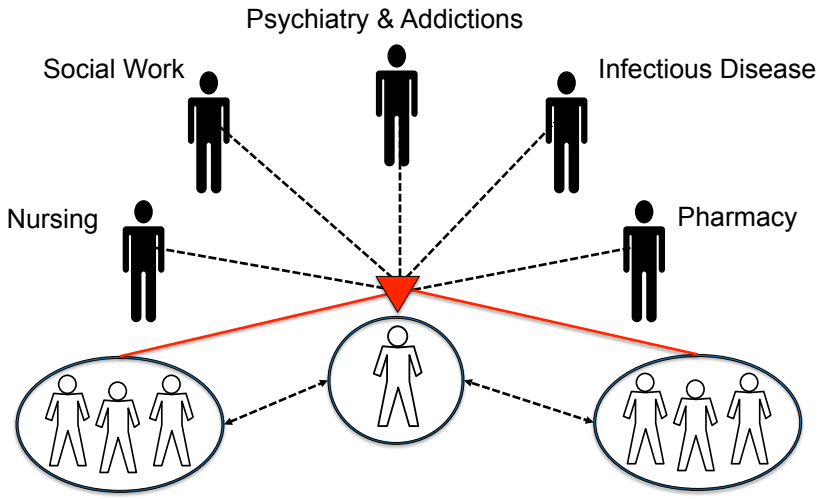


Interactive Presentations



Lessons Learned

Professional Isolation



Natalia Martínez Paz
www.nwaetcecho.org
nmp@uw.edu

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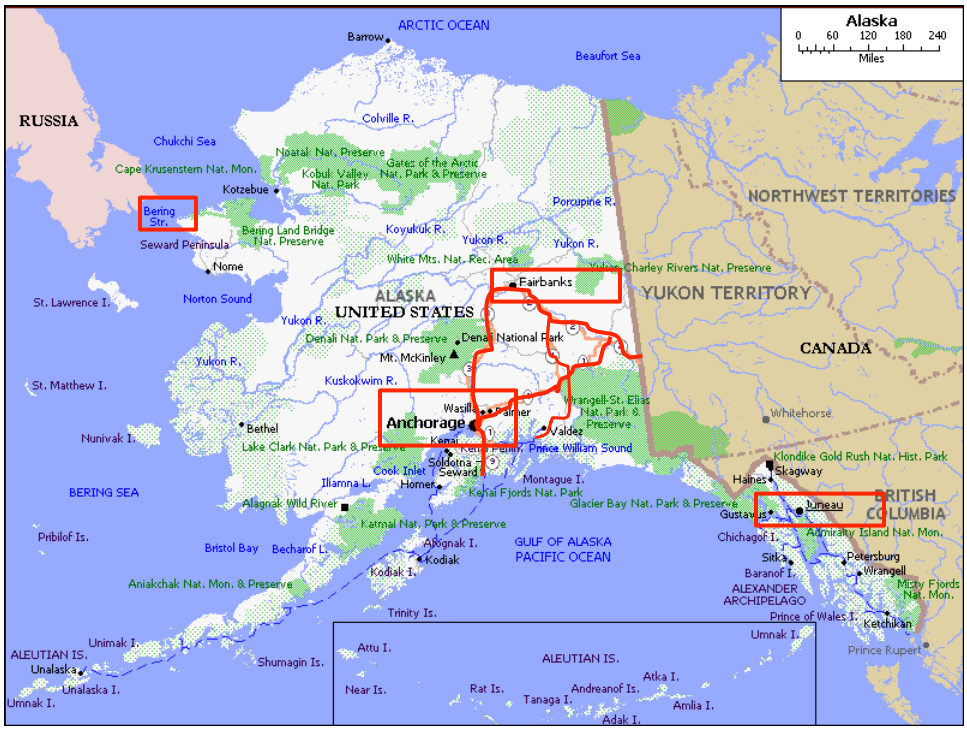
HIV Care in Rural Alaska: Addressing the Challenges Through Ryan White Part C HIV/AIDS Services

Terri Bramel, PA-C, AAHIVMS, Part C Project Director
Lisa Rea, RN, ACRN, Case Manager
Laura Riley, Program Director

Alaska Native Tribal Health Consortium

Challenges to HIV Care Delivery

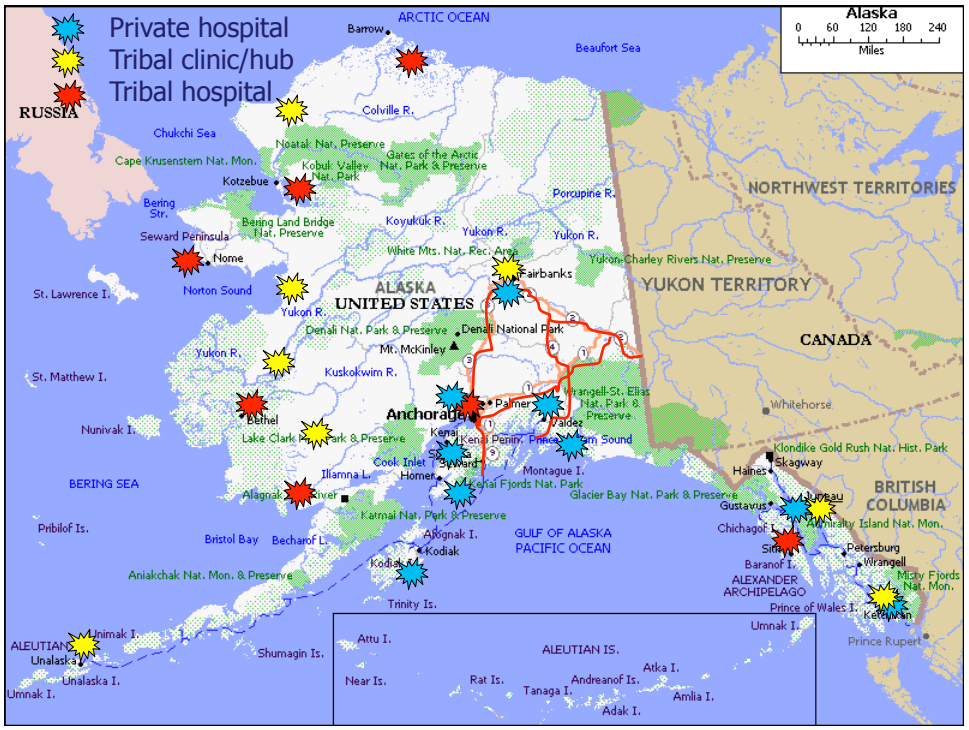
- Geographic
- Cultural
- Complex infrastructure for care delivery
- Stigma magnified in small communities

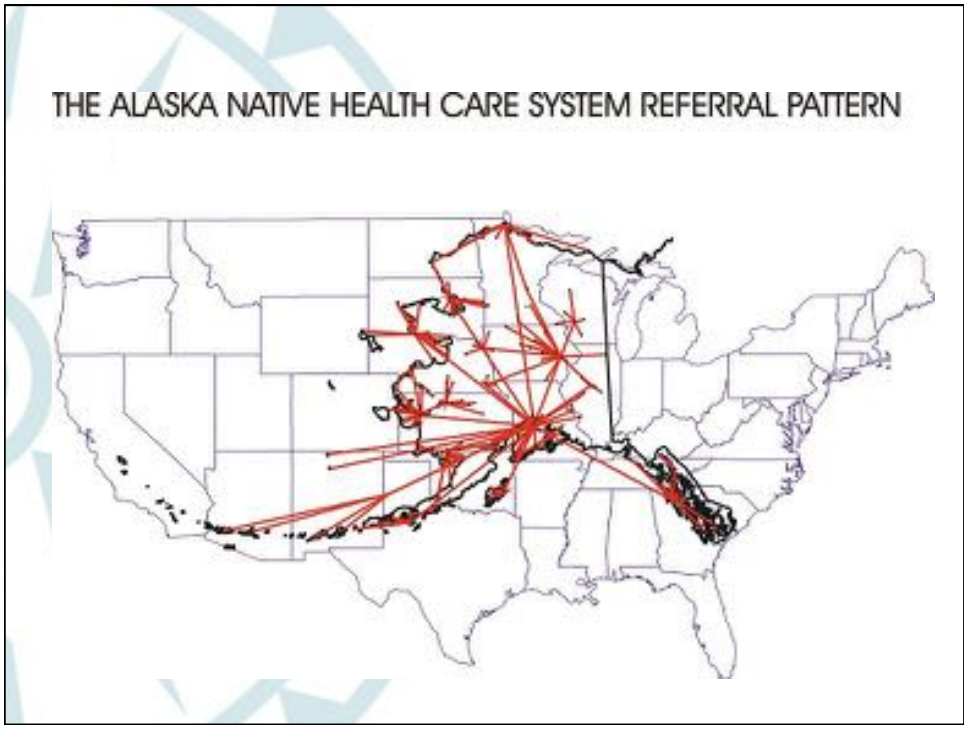


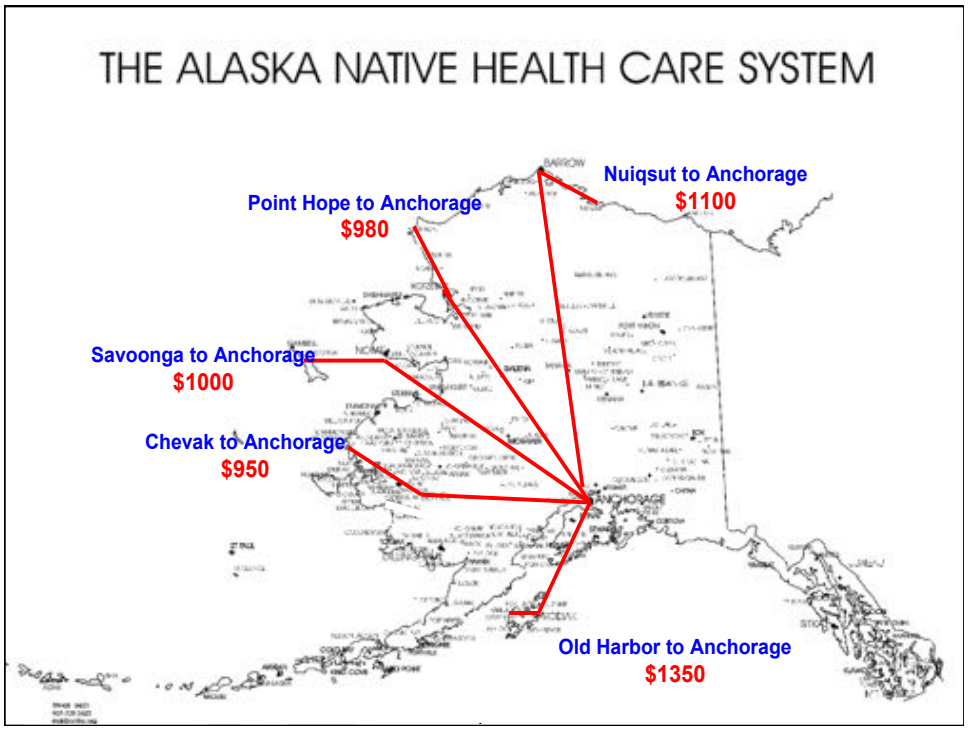
Alaska

200 of 336 communities accessible *only* by airplane or boat


Alaska Native Peoples and Languages
Iñupiaq
Gwich'in
Siberian Yupik
Koyukon
Hän
Tanana
Tanacross
Holikachuk
Deg Hit'an
Upper Kuskokwim
Upper Tanana
Ahtna
Central Yup'ik
Tanaina
Eyak
Tlingit
Tsimshian
Haida
Alutiiq
Aleut
229 Federally recognized Tribes
ANAI 15-18% of population

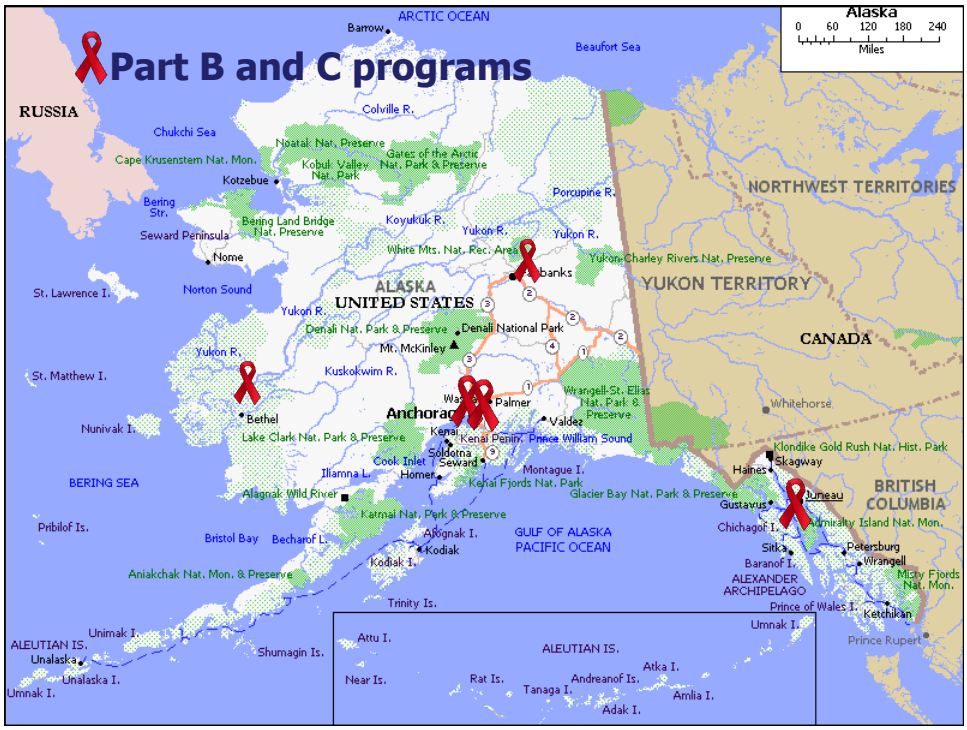

Private hospital
Tribal clinic/hub
Tribal hospital
ARCTIC OCEAN
Barrow
Beaufort Sea
RUSSIA
Chukchi Sea
Colville R.
Noatak Nat. Preserve
Gates of the Arctic Nat. Park & Preserve
Cape Krusenstern Nat. Mon.
Kobuk Valley Nat. Park
Kotzebue
Bering Str.
Seward Peninsula
Bering Land Bridge Nat. Preserve
Koyukuk R.
Yukon R.
Porcupine R.
NORTHWEST TERRITORIES
Nome
White Mts. Nat. Rec. Area
Fairbanks
Yukon-Charley Rivers Nat. Preserve
YUKON TERRITORY
St. Lawrence I.
Norton Sound
ALASKA
UNITED STATES
Denali Nat. Park & Preserve
Denali National Park
CANADA
Mt. McKinley
St. Matthew I.
Kuskokwim R.
Wrangell-St. Elias Nat. Park & Preserve
Whitehorse
Anchorage
Palmer
Valdez
Nunivak I.
Bethel
Lake Clark Nat. Park & Preserve
Kenai Peninsula
Prince William Sound
Klondike Gold Rush Nat. Hist. Park
Skagway
Haines
Cook Inlet
Homer
Montague I.
BERING SEA
Iliamna L.
Kenai Fjords Nat. Park
Glacier Bay Nat. Park & Preserve
BRITISH COLUMBIA
Juneau
Gustavus
Katmai Nat. Park & Preserve
Pribilof Is.
Bristol Bay
Becharof L.
Afognak I.
GULF OF ALASKA
PACIFIC OCEAN
Admiralty Island Nat. Mon.
Chichagof I.
Petersburg
Wrangell
Baranof I.
Misty Fjords Nat. Mon.
Aniakchak Nat. Mon. & Preserve
Trinity Is.
ALEXANDER ARCHIPELAGO
Prince of Wales I.
Ketchikan
Umnak I.
Prince Rupert
ALEUTIAN
Unimak I.
Unalaska
Attu I.
ALEUTIAN IS.
Shumagin Is.
Atka I.
Near Is.
Rat Is.
Andreanof Is.
Tanaga I.
Amlia I.
Adak I.
Unalaska I.
Umnak I.


THE ALASKA NATIVE HEALTH CARE SYSTEM REFERRAL PATTERN


THE ALASKA NATIVE HEALTH CARE SYSTEM
Nuiqsut to Anchorage
$1100
Point Hope to Anchorage
$980
Savoonga to Anchorage
$1000
Chevak to Anchorage
$950
Old Harbor to Anchorage
$1350

Ryan White HIV/AIDS Services In Alaska

- Part C
  - Anchorage Neighborhood Health Center
  - Alaska Native Tribal Health Consortium
- Part B- State of Alaska
  - Alaskan AIDS Assistance Association 4 A's
  - Interior AIDS Association IAA



Geographic Challenges to HIV Care Delivery

- Patients must travel to hubs (hospital) to get HIV labs
- Provider in village 1-2 times/year
- Meds get shipped by mail
  - Sometimes weather delay
  - Sometimes sitting at airport
  - Sometimes hub pharmacy out of stock- low volume use of HAART

Challenges to HIV Care Delivery

- Complex infrastructure for care delivery
  - Collaboration with local providers
    - Tribal health
    - Private
    - Part C
    - Community Health Centers
    - Military and VA
  - High rural provider turnover

Addressing the Challenges

HIV Care Team

- Medical Providers
  - MD, PA
  - Alliance with primary care provider
- Case managers/nurses/social workers/Part B
  - Central
  - Remote
- Pharmacist
  - Some clinic time, reviews meds and refills, available for consult
- Anyone else we can enlist- medical assistants, family, community health aides, public health nurses

Case Management

- Case managers in hubsites and in Anchorage
- Familiar with local community
- Easily accessible (comparatively)

Intensive Case Management

- Review all charts quarterly and identify care needs.
- **CAREWare reports**
- Calls to patient to schedule appointments, reminder calls for clinic.

Intensive Case Management

- Meet with Part B case managers monthly
  - Track patients moving in and out of DOC and rural areas
- Help coordinate other appointments and transportation

Intensive Case Management

- Develop relationships with patients- attending medical appointments, learning about each patient individually
- Develop relationships with providers – consulting, provide trainings on HIV and STIs

Intensive Case Management

- Pharmacies (ADAP)
- State Epidemiology/ DIS- linkage to care

Outreach

- Field clinics to hub sites.
  - Providers travel to hubsites, pts some in from surrounding areas for clinical visits and labs.
  - f/u can be done over the phone or by telemedicine

Skills for Providing HIV Care to Patients in Rural Alaska

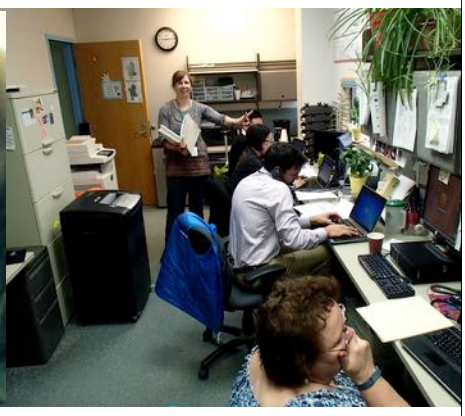
- Flexibility
  - Labs may not always happen right on time, appointments are delayed by travel and weather, patients may change their mind at last minute about anything
  - Clinic space in field clinics may not be ideal, make do with what you have or are given

Skills for Providing HIV care to Patients in Rural Alaska

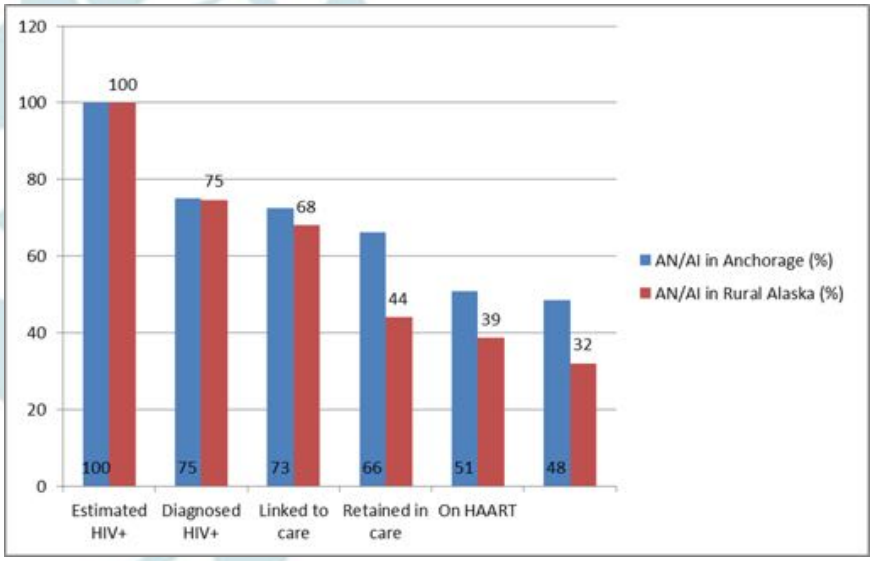
Planning

- plan that meds will be delayed – encourage and help patients have a "stash" in anticipation of this
- Field clinics take a lot of coordination between providers, local clinics and the patients- can be a challenge to find the "best time" for everyone

Anticipate the worst but hope and plan for the best!



2013 Continuum of Care
Rural vs. Urban



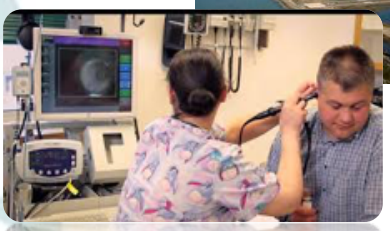
Telemedicine in Alaska

Providing medical care without boundaries

What is Telemedicine?

Telemedicine is the delivery of health-related services and information via telecommunications technologies

Examples of telemedicine?



Store and Forward:

Relating data in which messages are routed to one or more intermediate stations where they may be stored before being forwarded to their destinations. HIPAA compliant email with integrated peripherals!

Live Delivery Video Teleconferencing:

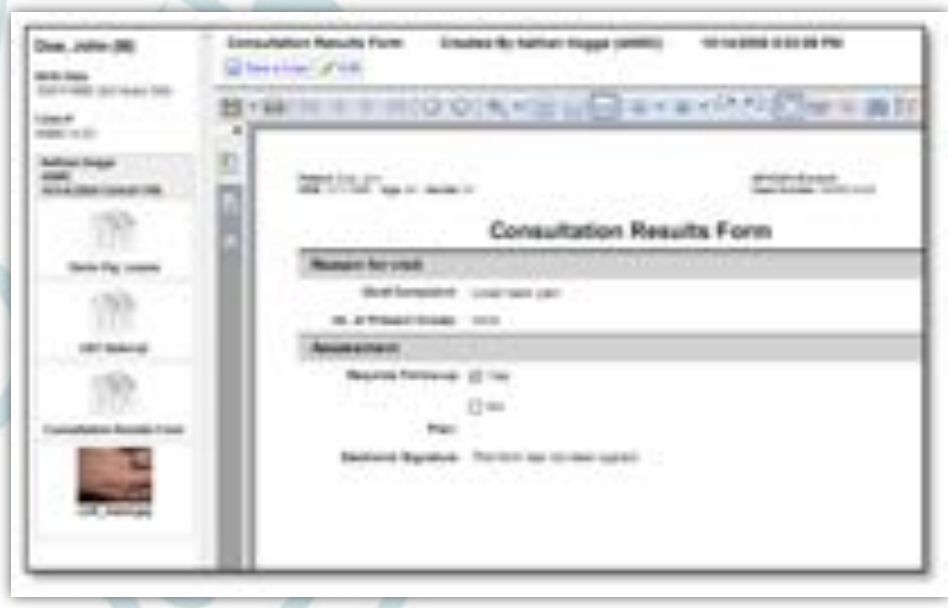
Specialty Care providers give care to patients in home/village settings

Why is telemedicine important to Alaska/rural areas?

- Lack of HIV experienced and specialty providers in the rural areas
- Patients health prevents travel
- Inconvenience for the patient to travel
- Expense to travel patients in
- In Alaska travel expense to Anchorage could exceed $1000 airfare PLUS lodging and food

What do telemedicine solutions look like?

What do telemedicine solutions look like?



What do telemedicine solutions look like?

How do I start a telemedicine program?

- Identify gaps in service
- Review YOUR state's laws regarding telemedicine http://www.telehealthresourcecenter.org/
- Research a program similar to your needs
- Review existing policies and procedures at your organization
- Assemble core team of providers, case managers, nurses, administration and IT to create standards
- Assess tech options for privacy, reliability, ease of use and affordability
- Develop an appointment process for reimbursement and billing
- Create a patient/provider panel for feedback and quality assurance

Thank You!

tlbramel@anthc.org
ldrea@anthc.org
lkriley@anthc.org

(907) 729-2907

http://afhcan.org/
http://www.anthc.org/index.cfm

- Special Thanks to Dr. Elizabeth Saltonstall, Medical Director/ Cat Herder