BIG IDEAS

**ENDING THE HIV EPIDEMIC —
SUPPORTING ALL PEOPLE WITH HIV AND REDUCING NEW TRANSMISSIONS**

INTEGRATING TELEHEALTH INTO HIV SERVICES SYSTEMS CAN HELP TO SUSTAIN IMPROVED OUTCOMES

THE USE OF TELEHEALTH FOR DELIVERING HIV PREVENTION AND CARE SERVICES has been catapulted forward by the COVID-19 pandemic. Even though telehealth services have existed for many years,[1] the COVID-19 crisis response, which caused the closure or partial closure of many clinical settings and community-based organizations, forced HIV providers to quickly adapt to using telehealth services as a stopgap until regular clinical operations could resume.[2,3,4] Telehealth requires upfront investments in technology, an understanding of the regulatory environment, and adaptations to the service and billing models to be a viable option. Further, the Digital Divide, wherein groups of people such as low-income people, people in rural areas, people of color and other disadvantaged groups have less access to technology, impacts not only individuals, but also HIV services providers who have far fewer technical, financial, and other resources to adapt to technological change. Until there was a crisis forcing change, there were many barriers to widespread adoption of telehealth. While the actions taken in an emergency have spurred the use of telehealth, they may not be sustainable or align with personal preferences for ongoing care. There is a need for HIV telehealth services delivery to evolve from a crisis response to an integrated component of sustainable, high-quality care delivery. Our collective challenge now is to apply lessons learned over the past few months to craft a new vision for how to use the variety of telehealth services most effectively.

POLICY ACTION IS NEEDED TO SUPPORT TELEHEALTH SUSTAINABILITY

Telehealth services are welcome additions to HIV prevention and care programs. To maximize their benefits, attention is needed to:

GIVE CLIENTS MORE CONTROL over where, when, and how to access services, and give providers more flexibility in responding to patients in ways that lessen the demands of a full patient panel.

FOCUS ON PROMOTING EQUITY and intervening to address the Digital Divide and other barriers for individuals and organizations.

CREATE NEW OPPORTUNITIES for shared learning so that HIV providers and clinics can learn best practices and avoid common pitfalls.

INVEST IN RESEARCH to develop and evaluate innovative approaches for using telehealth technology.

TELEHEALTH SERVICES use electronic information and telecommunication technologies to support long-distance primary, behavioral, and specialty health care, along with patient and professional health education, public health, and health administration.

TELEMEDICINE is a category of telehealth services that involves two-way, real-time interactive communication for clinical care.

COVID-19 HAS SPURRED GREATER ADOPTION OF TELEHEALTH

Past health crises have produced local repercussions, but the COVID-19 pandemic is practically unprecedented in living memory for its rapid escalation around the globe and the immediate and widespread shutdown of much economic activity. The financial stress on individuals and families, HIV non-profit organizations, and health systems is immense, and this exacerbates the physical stress and fear associated with responding to the emergence and rapid transmission of COVID-19. In just a couple of weeks, most in-person HIV clinical services at non-hospital-based clinical sites were suspended, and even where operations resumed, there has been reduced capacity and new barriers, such as fewer options for drop-in visits. Telehealth services are regulated through various laws and programs both at the federal and state levels. Congress removed some of the pre-existing barriers to using telehealth services,[5] and the Administration exercised its discretion to relax enforcement of certain rules during the public health emergency (described in more detail later in this brief), although many of these changes are temporary and do not fully address all issues that have constrained the adoption of telehealth. Indeed, there is significant concern among HIV providers and others that after the COVID-19 emergency is over, certain key flexibilities could be discontinued, and this could interrupt continuity of care, reduce health outcomes, or lead some individuals to fall out of care completely.

POTENTIAL BENEFITS OF TELEHEALTH SERVICES

Telehealth has the potential to overcome several persistent barriers to engagement in care. While not an exhaustive list, potential benefits include:

- **Could overcome transportation barriers:** In both rural and urban areas, lack of access to transportation can limit access to health care. Telehealth can reduce the necessity for in-person visits.

- **Could give flexibility over when to access services:** Telehealth can give people more options for when they engage in care. Communicating via a patient portal or scheduling services can be done at any time, even outside of clinic hours. It also can prevent people from needing to arrange childcare or take time off from work for a short provider visit.

- **Could reduce stigma:** Telehealth can offer opportunities to improve access to LGBTQ+ health services or avoid microaggressions or other stigmatizing encounters that may happen at a clinic visit.

- **Could increase privacy:** For some people, accessing services from their own home is a way to avoid inadvertent disclosures, such as seeing friends in a waiting room or having conversations overheard.

- **Could strengthen engagement:** Provider phone calls and text messages can increase engagement for some by demonstrating that providers are invested in their ongoing engagement in care.

POTENTIAL DRAWBACKS OF TELEHEALTH SERVICES

Telehealth services can create new and different challenges for providers and clients alike if not appropriately addressed. Some of these challenges include:

- **Could increase inequities:** The US has a large Digital Divide in which low-income people (often racial and ethnic minorities) and persons in non-urban areas have less access to technology. Further, differences in comfort with and preferences for technology can exacerbate inequities among groups.

- **Could challenge staff and clinic capacity:** Adopting telehealth services can be expensive and disruptive to a clinic's workflow and can increase staff burden.

- **Could reduce access to supportive services:** The medical visit may underpin access to a variety of other services. People who do not come into a clinic may have less access to food and nutrition services that require being in person to access.

- **Could raise privacy concerns:** Some people with shared living arrangements may have limited options for private communications with a provider. Using telehealth services could increase the risk of inadvertent disclosure.

- **Could weaken the patient-provider relationship:** The loss of regular in-person visits could weaken the bond and lead to reduced communication and less satisfactory interactions.

MAO OF ALABAMA OFFERS A MODEL FOR RURAL ACCESS TO HIV SERVICES

Medical Advocacy and Outreach (MAO) of Alabama has been an early adopter of HIV telemedicine services. MAO launched its Alabama eHealth program in 2011 to better serve a low-income rural population spread across several counties.

MAO'S eHEALTH MODEL

eHealth is a telemedicine program that uses a secure video chat between a client and a provider at different locations. The client visits a nearby clinic, staffed by a nurse, who uses telemedicine equipment to conduct an exam. Images and sounds (i.e. heartbeats, breath sounds, images of ear canals, etc.) are transmitted to an MAO provider in real-time. eHealth currently operates out of 3 provider locations and 11 clinics, serving 28 counties.

eHEALTH OUTCOMES

In 2019, about 13% of MAO's clients with HIV received clinical care via telemedicine. The telemedicine retention rate roughly matched in-person clinic patients (80.5% vs. 80.3%), and viral suppression was slightly higher for telemedicine patients (90.2% vs. 88.4%).

MAO'S 10 STEPS TO STARTING A TELEMEDICINE PROGRAM

1. **Do your homework**
2. **Obtain funding**
3. **Convert to electronic medical records**
4. **Build and cultivate community partnerships**
5. **Obtain an adequate broadband connection**
6. **Hire and train staff**
7. **Obtain telemedicine equipment**
8. **Train staff at partner sites**
9. **Offer HIV medical care via telemedicine**
10. **Offer additional services via telemedicine**

SOURCES: (1) *Making Connections: A Guide to Starting a Rural HIV Care Telemedicine Program.* AIDS United and Medical Advocacy and Outreach (MAO). October 2017. (2) Personal communication, Michael Murphree, CEO, MAO, July 2020.

FROM CRISIS RESPONSE TO AN INTEGRAL PART OF HIV SERVICES DELIVERY

HIV providers have adopted telehealth models in the COVID-19 response that, while offering insights, may not be how they would choose to use telehealth in the future. Four critical policy questions are:

1. WHAT DO CONSUMERS AND PROVIDERS WANT FROM TELEHEALTH?

It is hard to definitively assert what consumers or providers want with respect to telehealth services because there is so much diversity in preferences, as well as inequities in experience with and access to technology that supports telehealth services. Nonetheless, many consumers and providers seem open to the incorporation of telehealth services into how they receive or deliver services, as long as it is easy and offers new choices without eliminating traditional approaches to in-person services and direct contact between patients and providers.

An emerging body of research shows that telehealth services can be used to increase engagement in care,[6] can lead to increased viral suppression,[7] and can increase satisfaction with the care experience. During the COVID-19 crisis, for example, many individuals reported that they greatly appreciated calls from their providers as it made them feel cared for when they were feeling isolated at home.[8] At the same time, consumers do not want to be forced to use telehealth services, especially if this would threaten their ability to occasionally see their provider in person. Similarly, while many providers report that telehealth is easy to use and an acceptable alternative, the sudden shift to telehealth services has required a steep mental shift for providers who have been accustomed to seeing and interacting with patients in person.[9] Patients and providers often cherish the intimacy of in-person visits and seem to be seeking opportunities to avail themselves of the flexibility of telehealth services on their terms, while retaining the option for in-person care.[10]

DIFFERENTIATING WHICH SERVICES ARE MOST AMENABLE TO TELEHEALTH

As HIV programs gain experience with telehealth services, emerging patterns offer guidance for the future:

Greater acceptance for established patients: Establishing trust is critical to the patient-provider relationship, and this is enhanced by face-to-face contact, including the capacity for human touch such as a warm handshake. Most providers believe that the first patient encounter, especially for patients just learning of their HIV status, should be done in person. Many providers have reported success, however, with remote PrEP initiation. Once a relationship is established, providers and patients often express that this relationship can be maintained when some visits are conducted via telehealth.

Client demographics/personal preferences: Individual preferences vary, but some groups are typically more comfortable with technology and remote communication. Experienced telehealth providers often recommend both enhanced supports to enable all patients to access telehealth, as well as acceptance that not all people will choose telehealth services.

Type of telehealth intervention: Telehealth services include different technologies, such as phone calls, text messages, and person-to-person videoconferences. They are used to schedule appointments, deliver laboratory results, provide adherence support, conduct follow-up visits, and provide mental health and physical health diagnosis visits. Many clinics recommend starting with the lowest technology approaches and evolving over time to more extensive uses.

Type of service: Some services are easier to deliver via telehealth than others. In responding to COVID-19, a large health center, Family Health Centers of San Diego, reported that roughly 90% of its mental health patient visits were being conducted via telehealth, whereas only 57% of adult medicine visits, 20% of physical therapy visits, and 8% of substance abuse treatment visits were being conducted via telehealth. Howard Brown, a health center in Chicago, reported that it started sending home HIV and STI screening kits, and home prevention kits (condoms, lube, and information). Staff at Howard Brown deliver primary care, PrEP navigation, ADAP navigation, support groups, and case management via video conference, and they send prescriptions by mail.

POLICY RECOMMENDATION: Give clients more control over where, when, and how to access services, and give providers more flexibility in responding to patients in ways that lessen the demands of a full patient panel

Personal preferences and comfort with technology vary. Therefore, a goal for telehealth policy could be to give clients greater options for when and how to use telehealth services without mandating them, and to give providers more flexibility with their time allocation. Options such as online appointment scheduling and phone or text appointment and refill reminders or adherence support messages are relatively easy to introduce in an optional manner. An advantage of telehealth medical visits could be to reduce time and expenses associated with traveling to a clinic. Therefore, clinics (informed by research) may seek to establish minimal standards for in-person visits and offer clients the option to replace some or all other appointments with telehealth visits. This may be especially valuable for routine screenings, such as the quarterly HIV and STI screenings that are typically part of a pre-exposure prophylaxis (PrEP) regimen. Research has shown that individuals can successfully collect samples and may prefer to do so at home.[11] Provider time is often overscheduled, and an advantage of telehealth is that it could give providers more flexibility on when to respond to patient queries. For example, they could designate specific days for providing telehealth to reduce overscheduling and improve clinic flow. Flexibility also could facilitate greater task shifting.

2. HOW CAN TELEHEALTH REDUCE HEALTH DISPARITIES?

Many innovations, at least initially, broaden rather than reduce health disparities. Inequitable access to resources frequently means that not all people have the same access to new technology. Careful attention is needed to identify and address barriers to uptake of telehealth services.

POLICY RECOMMENDATION: Focus on promoting equity and intervening to address the Digital Divide and other barriers for individuals and organizations

Most, but not all, people have access to smartphones, but not all people have reliable access to high-quality broadband internet service, which is needed to take advantage of some higher-level telehealth services, such as high-definition video calls.[12] For clients who lack phones or broadband access, clinics should establish programs for providing needed technology and purchasing data plans to facilitate access. As with MAO's model (see text box on previous page), clinics also may consider partnering with community-based organizations to serve as a site for clients to access telehealth visits. Although these sites are not at a client's home, they may be more accessible

REGULATION AND PAYMENT DEMAND CONTINUING POLICY REFORMS

Differing practice types (e.g. clinics, private practices, community-based organizations) and variable federal and state regulatory and financing systems create challenges for both regulating telehealth services and spurring its use. These challenges elude simple solutions:

RATIONALIZING AND ALIGNING REGULATORY REGIMES

HIV providers often serve clients with Medicare, Medicaid, self-insured health plans (sometimes called ERISA plans), and fully-insured health plans. Each is regulated differently. Whereas Medicare and self-insured plans are regulated by the federal government, Medicaid and fully-insured health plans are regulated by both the federal and state governments. In response to COVID-19, federal efforts to facilitate the use of telehealth services focused on loosening restrictions in Medicare, including allowing beneficiaries from any geographic area to access services from their homes. The Department of Health and Human Services (HHS) waived enforcement of the Health Insurance Portability and Accountability Act (HIPAA) to allow commonly used communications platforms (i.e. Zoom, Skype, and Facebook) to be used for telemedicine visits even if they are not fully HIPAA compliant. The Drug Enforcement Administration (DEA) loosened e-prescribing requirements for controlled substances. States expanded Medicaid's use of telehealth and relaxed restrictions on provider licensing, online prescribing, and written consent.

Going forward, many of these flexibilities will expire when the public health emergency ends, and broad support may not exist for simply extending all of them. The absence of enforcement for HIPAA-compliance may be justified as a crisis response, for example, but brings a heightened risk for data theft and the inappropriate disclosure of protected health information. Further, overlapping regulations create inconsistencies and gaps in protections. Resolving these issues will require broad stakeholder engagement and significant policy dialogue.

REVENUE MODELS TO FOSTER TELEHEALTH ADOPTION

Telehealth services encompass many activities ranging from full patient visits (involving ordering and evaluating laboratory results, performing diagnostics, and querying and counseling patients, which requires not only time, but other resources) to less intensive, but necessary services, such as phone consultations and text message adherence supports. What is the appropriate reimbursement for each of these services? Clients may not understand that a provider should be paid for responding to emails, yet if a provider is doing this for 100 patients, this requires substantial time. If such activities are bundled into a capitated rate, does the rate account for shifts in the delivery of in-person or telehealth services? Are financial incentives structured to strengthen engagement in care or only to reduce spending? Do financial incentives foster consumer choice over how they receive services? The complexity of these issues and competing policy solutions is daunting.

One particular area of policy debate is whether telehealth services should be required to be covered and also whether they should be reimbursed at parity with in-person services. The Brookings Institution and the John Locke Foundation found that 13 states have no private payer telemedicine laws, 7 mandate partial coverage of telemedicine specifying which services must be covered, 19 states mandate full coverage parity where coverage is the same for in-person and telemedicine services, and 11 states mandate full coverage and payment parity. Many payers paid for telemedicine services at parity with in-person services during the COVID-19 pandemic, but there is an unresolved debate over whether parity should be required beyond the current crisis. Providers strongly believe parity is essential to telehealth's sustainability and worry about lost revenue without parity, but payers and policymakers often assert that actual costs for telemedicine services are lower and wish to deploy telehealth services to lower costs.

HIV SOLUTIONS CAN ENHANCE REFORMS

As these issues are debated, HIV community stakeholders need to support the ongoing viability of critical prevention and care programs. The Ryan White HIV/AIDS Program, including through its Special Projects of National Significance (SPNS) and AIDS Education and Training Center (AETC) Programs, along with other relevant agencies and community partners, has a critical role to play in advancing this dialogue.

SOURCES: (1) Weigel G, et al. *Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond*. Kaiser Family Foundation. May 11, 2020. (2) Waiver or Modification of Requirements Under Section 1135 of the Social Security Act. U.S. Department of Health and Human Services. March 13, 2020. (3) *Medicare Telemedicine Health Care Provider Fact Sheet*. Centers for Medicare and Medicaid Services. March 17, 2020. (4) Turner Lee N, et al. *Removing Regulatory Barriers to Telehealth Before and After COVID-19*. Brookings Institution and John Locke Foundation. May 2020. (5) Abelson R. "Is telemedicine here to stay? *The New York Times*. August 3, 2020.

SELF-COLLECTED LAB TESTING IS AN IMPORTANT INNOVATION

Whether it is for HIV or other sexually transmitted infections (STIs), the ability to conduct screenings outside of the traditional clinic setting (i.e. in the home or other alternative venues) and have these services covered by insurance has the potential to improve access to care and contribute to the sustained use of telehealth services.

Do individuals want the option of at-home sample collection? Researchers are studying this question as it relates to HIV testing, PrEP services, and STI screenings. A pilot study of PrEP@Home found that 87% of respondents (48 of 55) would likely use PrEP@Home in place of their next clinical visit and 40% (22 of 55) indicated that they would be more likely to remain on PrEP if PrEP@Home was available.

Is self-collected sampling accepted as reliable? Home-based sample collection has been shown to be safe and has been validated to ensure accuracy consistent with traditional lab testing. The Food and Drug Administration regulation of home-based testing and the requirements of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) enacted high standards for laboratories analyzing samples collected in the home, and this has impeded the willingness of some payers to cover these tests. A limited number of commercial labs currently perform the full suite of tests, but the interest and capacity of these labs are growing and insurers are increasingly willing to cover these tests. In response to COVID-19, the Centers for Disease Control and Prevention issued guidance encouraging HIV non-clinic-based testing and also encouraging quarterly HIV and STI screening by home sample collection when in-person visits are not possible for persons on a PrEP regimen.

What are the potential advantages of home self-collection? The flexibility afforded by self-collecting lab specimens without traveling to a clinic or scheduling an appointment, along with the enhanced privacy of collecting samples at home, is believed to be a tool for increasing timely HIV and STI testing. Furthermore, the option of collecting specimens at home serves to overcome stigma-related avoidance of clinical settings for some individuals. Finally, many individuals do not have access to a proximate, welcoming clinic or provider offering PrEP services; ensuring continued access to PrEP medications and testing services for these persons is therefore essential to persistence. As more people initiate PrEP regimens, researchers are evaluating this as an effective strategy to facilitate fidelity to the PrEP regimen.

SOURCES: (1) Seigler AJ, et al. Developing and assessing the feasibility of a home-based preexposure prophylaxis monitoring and support program. *Clin Infect Dis.* 2019;68(3):501-504. (2) National Coalition of STD Directors. *At-home Self-Collection Lab Testing for Sexually Transmitted Infections*. Updated May 20, 2020. www.ncsddc.org/wp-content/uploads/2020/06/NCSD-TA-Brief-Home-STI-Testing-Care-FAQ-v5.20.2020.pdf. (3) HIV Self Testing Guidance. Center for Disease Control and Prevention website. April 28, 2020. www.cdc.gov/nchhstp/dear_colleague/2020/dcl-042820-HIV-self-testing-guidance.html. (4) Dear Colleague. Centers for Disease Control and Prevention website. May 15, 2020. www.cdc.gov/hiv/policies/dear-colleague/dcl/051520.html. (5) State Specific Tele-PrEP Services. NASTAD website. www.nastad.org/maps/state-specific-tele-prep-services. (6) State Specific Self-Testing Services. NASTAD website. https://www.nastad.org/maps/state-specific-self-testing-services.

than a clinic location and may be a place where clients feel more comfortable. Various groups may have different training needs or require a variety of supports in adopting new technology, so planning for this should be built into telehealth programs. While clinics should respect individual preferences, programs should assume that all groups, including seniors, persons with limited English proficiency, and persons in rural areas, will want to access telehealth services with adequate supports. Clinics also should recognize that undocumented persons and other groups may have a heightened need for privacy, which may call for more intentional approaches for establishing trust with patients.

3. WHAT SUPPORTS ARE NEEDED FOR CLINICS AND PRACTICES TO ADOPT TELEHEALTH?

The COVID-19 pandemic has forced clinics and providers to adapt. While their nimbleness is admirable, it seemed that nearly everyone was starting from scratch and had to learn the same lessons along the way.

POLICY RECOMMENDATION: Create new opportunities for shared learning so that HIV providers and clinics can learn best practices and avoid common pitfalls

Federal and state programs have a number of resources for supporting telehealth services,[13,14] but more resources are needed. Many stakeholders have asked for new tools, such as a common playbook

for introducing telehealth into a clinic, and new opportunities for shared learning that could include webinars, chat groups, and best practices reports.[15] Introducing telehealth into a clinic will likely require additional provider training, development of standard operating procedures and protocols, updates to electronic health records, and staff to provide technical support to patients and providers.

4. DO WE KNOW ENOUGH TO USE TELEHEALTH TO IMPROVE ENGAGEMENT IN CARE?

The broader health system has a lot of work to do to integrate telehealth services, including grappling with how to create new practice and reimbursement models that pay for all telehealth services delivered and give providers appropriate incentives to embrace telehealth, while demonstrating that telehealth services can be cost-effective. Further, there is more to be learned about which services are most useful and desired by which patient populations.

POLICY RECOMMENDATION: Invest in research to develop and evaluate innovative approaches for using telehealth technology

HIV and other researchers are beginning to provide insights that often demonstrate a willingness to use telehealth services and indicate common preferences among patient populations.[16,17] Continued investment in research is needed to establish best practices around in-person visit frequency, differentiated care models that allocate more time and resources to a subset of persons with greater barriers to care, and cost-effective approaches to telehealth services.

THE TIME IS NOW

Introducing telehealth services into HIV prevention and care programs is an important opportunity to improve outcomes and increase client and provider satisfaction. Moving from an emergency response to one that strengthens the financial viability of HIV programs, better supports the HIV workforce, and meets the needs of clients, however, will not be easy and will require informed policy action. Let's keep moving forward.

ENDNOTES

1   Wilkes AL, et al. Expanding HIV telemedicine in urban communities: Innovative approach for improving client retention and access. Oral presentation at: 2018 National Ryan White Conference on HIV Care and Treatment; December 14, 2018; Washington, DC. https://targethiv.org/sites/default/files/supporting-files/11087_Wilkes_508.pdf.

2   Rogers BG, et al. Development of telemedicine infrastructure at an LGBTQ+ clinic to support HIV prevention and care in response to COVID-19, Providence, RI [published online ahead of print April 29, 2020]. *AIDS Behav.* doi: 10.1007/s10461-020-02895-1.

3   Personal communication, David Munar, CEO, Howard Brown Health, July 2020.

4   Personal communication, Christian B. Ramers, MD, MPH, Family Health Centers of San Diego, July 2020.

5   Coronavirus Aid, Relief, and Economic Security Act (CARES Act), P.L. 116-136, enacted March 27, 2020.

6   Health Resources and Services Administration. *HRSA's Ryan White HIV/AIDS Program: Expanding HIV Care Through Telehealth*. October 2019. https://hab.hrsa.gov/sites/default/files/hab/Publications/careactionnewsletter/telehealth.pdf.

7   Ohl ME, et al. Impact of availability of telehealth programs on documented HIV viral suppression: A cluster-randomized program evaluation in the Veterans Health Administration. *Open Forum Infect Dis.* 2019;6(6):ofz206.

8   Heath S. How cold calling revealed COVID-19 social determinants of health. *PatientEngagementHIT*. June 9, 2020. https://patientengagementhit.com/news/how-cold-calling-revealed-covid-19-social-determinants-of-health.

9   Dandachi D, et al. It is time to include telehealth in our measure of patient retention in HIV care. *AIDS Behav.* 2020;24(9):2463-2465.

10 Mgbako O, et al. COVID-19, telemedicine, and patient empowerment in HIV care and research [published online ahead of print May 21, 2020]. *AIDS Behav.* doi: 10.1007/s10461-020-02926-x.

11 National Coalition of STD Directors. *At-home Self-collection Lab Testing for Sexually Transmitted Infections*. Updated May 20, 2020. www.ncsddc.org/wp-content/uploads/2020/06/NCSD-TA-Brief-Home-STI-Testing-Care-FAQ-v5.20.2020.pdf.

12 Bauman K. More than two-thirds access internet on mobile devices. United States Census Bureau website. August 8, 2018. www.census.gov/library/stories/2018/08/internet-access.html.

13 Telehealth Programs. Health Resources and Services Administration website. https://www.hrsa.gov/rural-health/telehealth.

14 Health Resources and Services Administration. *HRSA's Ryan White HIV/AIDS Program: Expanding HIV Care Through Telehealth*. October 2019. https://hab.hrsa.gov/sites/default/files/hab/Publications/careactionnewsletter/telehealth.pdf.

15 See, for example, Telemedicine Hack: A 10-week learning community to accelerate telemedicine implementation for ambulatory providers. Project Echo/University of New Mexico website. https://echo.unm.edu/covid-19/sessions/telemedicine-hack.

16 Seigler AJ, et al. Developing and assessing the feasibility of a home-based preexposure prophylaxies monitoring and support program. *Clin Infect Dis.* 2019;68(3):501-504.

17 Wong KYK, et al. Telemedicine: A solution to disparities in human immunodeficiency virus prevention and pre-exposure prophylaxis uptake, and a framework to scalability and equity. *Mhealth.* 2020;6:21.