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## Telehealth Centers of Excellence

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# Utilization of Telehealth to Provide Healthcare for People Experiencing Homelessness



#### PURPOSE

The purpose of this toolkit is to guide healthcare teams and community-based organizations in the use of telehealth to provide healthcare to people experiencing homelessness.

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## Abbreviations

|             |                                                                                   |             |                                  |
|-------------|-----------------------------------------------------------------------------------|-------------|----------------------------------|
| <b>AP</b>   | Attending Physician                                                               | <b>PEH</b>  | People Experiencing Homelessness |
| <b>CBO</b>  | Community-Based Organization                                                      | <b>POC</b>  | Point of Care                    |
| <b>CBOM</b> | Community-Based Organization Member                                               | <b>RP</b>   | Resident Physician               |
| <b>EHR</b>  | Electronic Health Record                                                          | <b>RPMT</b> | Remote Patient Monitoring Team   |
| <b>HT</b>   | Healthcare Team                                                                   | <b>SV</b>   | Student Volunteer                |
| <b>PR</b>   | Provider (resident physician, attending physician, or advanced practice provider) |             |                                  |



# Introduction

People experiencing homelessness (PEH) encounter barriers to healthcare, increasing their vulnerability to illness, hospitalization, and death. Telehealth can improve access to healthcare particularly in this population by mitigating barriers such as transportation, cost, and the stigma associated with the healthcare environment.

While many PEH have access to cell phones, inconsistencies in smart phone technology, internet connectivity, and phone turnover pose challenges with traditional telehealth delivery. Collaboration with community-based organizations (CBOs) can enhance the success of telehealth use for providing healthcare to PEH.

## A. Potential benefits

### 1. Convenience for unhoused patients

- + Care provided where patients are residing, passing through, or otherwise receiving social services, reducing transportation barriers
- + Visit times may be more flexible and during more favorable hours
- + Asynchronous modalities may be completed at any time

### 2. Convenience for providers

- + Without needing to be on-site, visits are easier to fit into provider workflow and allow care at multiple locations during a single session
  - > This is particularly important when camps where PEH stay and CBOs are geographically dispersed
- + Asynchronous modalities may be completed at any time

### 3. Reduced stigma, enhanced trust

- + Care delivered where patients are residing, passing through, or otherwise receiving social services, as well as removed from the often stigmatizing healthcare environments, sets the stage for an improved patient-provider relationship

### 4. Multidisciplinary care

- + Use of telehealth allows access to various healthcare providers with ease such as primary and specialty care, behavioral health, and pharmacy consultation
- + Simultaneously addressing social needs can improve overall patient outcomes

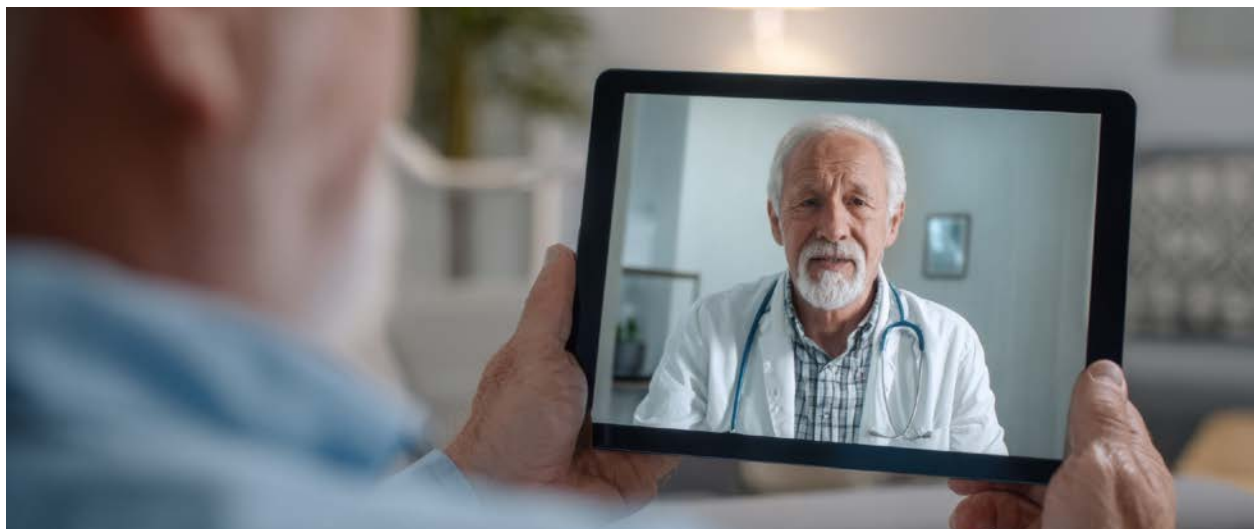


## B. Audience for this toolkit

- + Healthcare teams involved with care for PEH including but not limited to academic medical centers, Emergency Medical Services (EMS), Federally Qualified Healthcare Centers (FQHCs), free clinics, street medicine programs, mobile healthcare units
- + CBOs directly serving PEH including but not limited to shelters, social resource centers
- + CBOs indirectly serving PEH including but not limited to libraries, religious organizations

## C. How to use this toolkit

The purpose of this toolkit is to guide healthcare teams and CBOs in the use of telehealth to provide healthcare to PEH. This includes use of synchronous and asynchronous modalities that often engage team members in addition to the healthcare provider and patient (learners, CBOMs). Traditional patient/provider telehealth may also be incorporated into your program using established workflows. We provide workflows that are intended to be customizable for a variety of team compositions, technology types, and patient preferences. Programs may be based at a CBO and/or involve street medicine outreach. Your program may choose to use one or a combination of these care delivery methods. While selecting and adapting these workflows to your program's needs, it is essential to have open, frequent communication among all team members and partners and to engage the PEH to whom care is being provided to ensure acceptability and successful outcomes.



## D. Important considerations

The following are considerations that apply in general when providing healthcare to PEH, including special considerations for telehealth.

### 1. Building rapport and trust

- + Relationship building with unhoused communities and individual patients should be the keystone of any telehealth program for PEH
- + Individuals on-site with patients should offer care packages regardless of engagement with medical services including food, hygiene kits, and seasonal items (blankets, sunscreen, bug spray)
- + Assess receptivity to telehealth modalities prior to implementation and provide ample education
- + Assess and address social needs in addition to medical needs in-person or via telehealth
- + Maintain a regular cadence for providing care at CBO and street-based locations so your team is a reliable source of care

### 2. Device selection and technology

- + For most modalities, a variety of devices may be appropriate, including desktop and laptop computers, tablets, and cellular phones
- + In some cases, personal devices may be used, but optimal technology should be provided by your team and offered whenever possible

- + Having a mobile camera-enabled device (tablet, phone) can help with some physical exam aspects
- + HIPAA compliance must be established for telehealth visit platforms and team communication
- + Be aware of broadband access when providing care in rural or remote locations

### 3. Healthcare provider scope of care and reimbursement

- + Medical services provided should be commensurate with the training level and specialty of your healthcare provider
- + Depending on state laws for required levels of oversight, models presented in this toolkit can include Advanced Practice Providers and multidisciplinary learners
- + Consider the payor mix of your patient population and coverage for telehealth when determining whether services will be billed or supported by another funding source
- + All models presented in this toolkit can be adapted for use in treatment of substance use disorder if state laws allow

## 4. Obtaining vital signs and pertinent physical exam

- + Obtain equipment for vital signs that is easy to operate and reliable for non-medical team members
- + Test equipment before going to street-based locations
- + Train medical learners and non-medical team members to obtain vital signs and perform basic physical exam maneuvers (demonstrating swelling, joint range of motion, etc.)

## 5. Diagnostic workup

### Point of Care Testing (POCT)

- + Consider skill set and comfort level of team members that will be on-site with patients and types of specimens needed for various POCT (venipuncture versus fingerstick blood samples)
- + Consider resources and training for team members on POCT modalities to maximize available services
- + Consider adequacy of environment for obtaining samples (bathroom for urine/stool samples, private area for self swabs)
- + Assess need for CLIA Waiver and other state regulatory requirements

### Laboratory Testing

- + Collaborate with local clinics and laboratory facilities
- + Consider feasibility of obtaining samples for delivery to laboratory facility
- + Be familiar with scheduling practices of collaborating facilities (walk-in versus pre-scheduled)
- + Develop workflow to facilitate scheduling and transportation for laboratory testing when needed
- + Identify patient follow up preferences for review of laboratory test results

### Radiology Services

- + Collaborate with local radiology facilities
- + Be familiar with scheduling practices of collaborating facilities (walk-in versus pre-scheduled)
- + Develop workflow to facilitate scheduling and transportation for radiologic studies when needed
- + Identify patient follow up preferences for review of imaging results

## 6. Treatment

### Medications

- + Utilize low cost and/or over-the-counter options when possible
- + Collaborate with local pharmacies to optimize prescription pricing
- + Minimize transportation barriers for both one-time and chronically prescribed medications
  - > Pharmacy can deliver medication to CBO
  - > Outreach team can deliver medication to patient
- + Facilitate enrollment in patient assistance programs
- + Carry common over-the-counter medications for distribution

### Wound Care

- + Portable camera-enabled devices are helpful for wound assessment
- + Build capacity for wound care among on-site team members, as wounds are frequently encountered in care of PEH
- + Consider compact, portable wound care kits for street medicine outreach including supplies to leave with patients for self-care as needed

### Referrals

- + Assess telehealth capacity of specialists to whom you refer
- + Create a workflow to facilitate appointments with specialists that considers communication preferences of patients with regard to appointment reminders and visit completion
  - > Consider providing technology for telehealth visits outside of your program
- + Identify common specialty referrals and build relationships to specialists that consider barriers to care and practice in accessible locations
- + Communicate directly with consultants regarding social and medical complexity of patients

## 7. Preventive healthcare

- + Consider that evidence suggests that preventive care is important, often a priority for PEH, and can often be addressed with telehealth
- + Offer age-appropriate preventive care, including screenings and preventive healthcare counseling even when addressing acute healthcare concerns
- + Assess risk status for conditions for which screening exists, including non-communicable diseases (diabetes, hypertension, hyperlipidemia), communicable diseases (sexually transmitted infections, HIV, Hepatitis C, tuberculosis) and cancers (lung, colon, breast, prostate), as PEH are often higher risk than the general population for many medical conditions
  - > Consider POCT or specimen collection by on-site team (self swab for STI/HPV, POC A1C, HIV, and Hepatitis C tests)
- + Participate in shared decision making with patients when choosing to screen and when selecting screening modality
  - > Consider risk assessment, available screening tests and what they entail, and expectations for next steps with positive screening results (colonoscopy preparation with limited bathroom access, mailing address for Cologuard)
- + Create workflows for cancer screening based on capacity of on-site team and local resources
- + Offer recommended immunizations and have them available to administer by on-site team members or partner with pharmacies, clinics or health departments to provide
- + Offer HIV pre-exposure prophylaxis (PrEP) for qualifying patients
- + Provide screening for mental health conditions such as depression, anxiety, and PTSD using validated screeners when systems are in place to address positive screens
  - > Consider secure online screening that can be administered by the on-site team and viewed by the remote provider at time of visit
- + Provide screening for social determinant of health risks (food insecurity, transportation), intimate partner violence, and falls when systems are in place to address positive screens
  - > Consider secure online screening that can be administered by the on-site team and viewed by the remote provider at time of visit
- + Assess desire for contraception and/or prevention of sexually transmitted infections
  - > Engage in shared decision making with patients regarding preferred contraception method taking into consideration limitations of telehealth with regard to Long Acting Reversible Contraception (LARC)

*List continued on next page...*

- Have on-site team members provide or direct patient to complete POC pregnancy testing
- On-site team member may offer free condoms and emergency contraception
- Be familiar with local resources for free or low-cost contraception

## 8. Patient follow up

- + Develop workflow for patients to be seen in-person, if needed, based on acuity (ED, clinic for in person visit same day, future in-person follow up)
- + Ascertain the best way to contact patients for follow up (phone, in-person where they reside or frequently pass through, via CBO)
- + Assess and help mitigate transportation limitations for obtaining recommended follow up testing, treatment, and referrals
- + Develop workflow to communicate results of laboratory testing and imaging studies to patients
- + Coordinate with ER and hospital teams to assist with transitional care management and follow up as possible after a hospital discharge or ER evaluation

## 9. Quality control

- + Conduct patient and provider surveys, focus groups, and/or interviews at regular intervals to assess satisfaction
- + Perform chart review to assess patient needs and quality of care
- + Consider comparisons to in-person care and care of housed individuals to assess equity



# Needs and Capacity Assessment

Prior to and during care delivery, it is essential to assess patient and community needs, as well as healthcare resources to best identify opportunities for telehealth care for PEH in your area. Following initiation of services, clinical growth, or changes in personnel or patient population, it is helpful to revisit this evaluation.

The needs and capacity assessment can be a formal assessment with structured evaluations or a more informal evaluation through conversations with partners. Often this can be a multi-stage process with a focus on different aspects of care at different times (pediatric care services, cancer screening services, substance use disorder treatment). The inclusion of all stakeholders in this process including PEH, learners, CBOMs, and healthcare teams provides the greatest opportunity for high quality care and successful collaboration. Some components to consider in the needs and capacity assessment for each stakeholder are included below.

## Patients

- + Obtaining input and perspectives from PEH early on and throughout development is essential for program success.
- + Assess healthcare needs and wants (preventive care, acute and chronic disease management).
- + Determine optimal timing for telehealth based on usual sleep/wake times, work schedules, and times that social services are accessed.
- + Determine optimal location for telehealth services based on patient preferences (CBO or street medicine).
- + Assess transportation access with regard to obtaining follow up services and visits (personal vehicles, locations accessible by foot, public transportation).
- + Gauge trust and comfort level with healthcare in general and telehealth in particular. Different telehealth modalities may be considered when constructing program elements and on an individual basis.
- + Ask about communication preferences with regard to results and follow up care including technology access (phone access, email, via CBOs)

## Members of the healthcare team

- + Identification of healthcare team members willing and able to participate is important in planning for the use of telehealth modalities.
- + Determine the availability of healthcare team members with regard to timing and location in order to plan for direct care services, teleprecepting, asynchronous telehealth services, or video visits.
- + Clarify the composition of the healthcare team with regard to licensing and level of training in order to plan for appropriate supervision.
  - > Telehealth delivery models may be adapted based on state legislation for advance practice providers and supervision requirements.
- + Identify knowledge and previous experience with telehealth and opportunities to improve skills.
- + Evaluate skills and training of the healthcare team to identify scope of practice (potential for pediatric care, procedural skills).
- + Identify opportunities for collaboration in a multi-disciplinary care team to provide the greatest capacity for comprehensive care and to expand the scope of practice (teledermatology, asynchronous wound care consultations, pharmacy collaboration).

## Community partners

- + Community partners offer a unique perspective on the needs of the unhoused population and opportunities to improve healthcare services.
- + Elicit perspectives from multiple community partners, including those that will be directly involved in your program but also others that have experience providing services to PEH.
- + Develop a detailed catalogue of the specific services provided by various community partners to maximize the breadth of services offered to patients.
  - > Assess the desired level of involvement with your program.
- + Identify technology used by community partners and preferences with regard to communication and data collection.
- + Evaluate comfort and skills related to technology, telehealth, and various healthcare activities of CBOMs who will be directly involved with your program to identify feasibility of various care modalities, as well as opportunities for training.

## Technology

- + Identifying access to technology by PEH. The healthcare team and CBOs can assist with identifying telehealth modalities and workflows that are the best fit for your program.
- + Technology access may vary based on location of care. There may be improved connectivity at a community site as compared with street medicine outreach locations. Telehealth modalities have the capacity to adapt to the access at a particular location.
- + Community partners may have access to different devices for telehealth services (cell phone, tablet, computer) and should inform the patient intake processes.

## Coordination of care

- + Delivery of telehealth to PEH requires coordination of care between the healthcare team and CBOs.
- + Ensure a detailed informed consent process that specifies all team members (on-site and remote) and describes information sharing for coordination of care.
- + Identify opportunities for CBOs to assist patients in follow up care (obtaining medication, transportation to follow up appointments, cost of testing, coordination of childcare).
  - > Similarly, healthcare teams should look for opportunities to support their CBO partners.
- + Assess access to information sharing platforms that may be mutual between healthcare teams and CBOs.
  - > If limitations exist, investigate opportunities that allow necessary communication, but protect patient privacy.
- + Identify resources to assist patients with obtaining health insurances to improve access to care.

# Telehealth Visit Workflows

## A. Asynchronous

### I. E-visits

Electronic visits (E-visits) allow asynchronous, bi-directional communication between patients and providers through a secure online platform. Electronic questionnaires that ask key elements of a patient's history based on the chief complaint are reviewed remotely and asynchronously by a provider who is then able to develop a treatment plan without direct patient interaction.

E-visits can be completed by patients any time they are able to access the online platform, and providers may review and respond within a pre-defined timeframe (usually 24–48 hours) offering maximum flexibility and convenience for both patients and providers. E-visits can be completed by the patient individually based on connectivity and technology literacy, be offered by a CBOM at street-based locations, or be offered on devices based at CBOs, and this transportability makes them ideal for a transient population. E-visits are only appropriate for a limited number of conditions, and questionnaires must include 'red flags' that prompt in-person evaluation. When offered as a care modality for the unhoused, it is essential to have a concrete follow-up plan for receipt of results and treatments that is articulated in the e-visit, as well as specified opportunities for synchronous visits if needed.



## Examples of Amenable Conditions

- + Upper respiratory infection
- + Seasonal allergies
- + Urinary symptoms
- + Sexually transmitted infections
- + Rash \*recommend camera access for photos
- + Smoking cessation
- + Medication refills

## Suggested Partners

- + May be completed by patient alone
- + CBO for connectivity and possible assistance with completion (reading, language interpretation, technology utilization)

## Considerations

- + Platform HIPAA compliance (Electronic Health Record/Patient Portal, REDCap)
- + Patient preferred language
- + Patient reading literacy
- + Patient technology literacy
- + Established E-visit algorithms may need to be adapted to include conditions commonly seen in the unhoused population or variations on commonly seen conditions
- + E-visit must include preferred contact method for patient for results and treatments and what to expect regarding follow up timing

## Possible Variations

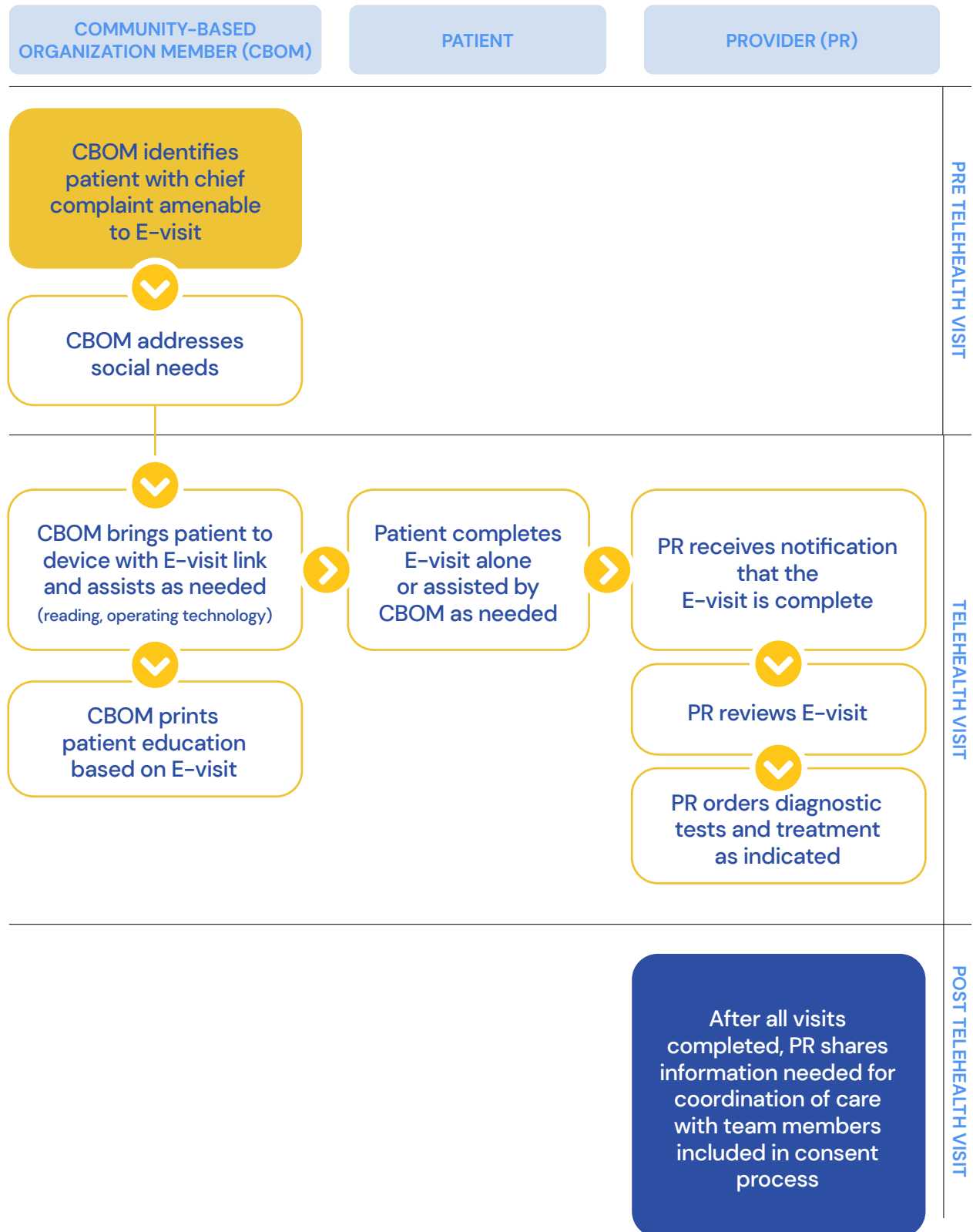
- + Patient completes E-visit via patient portal in EHR
- + Patient sent link to E-visit platform and completes on personal device
- + CBOM brings device with link to patient where they are staying

## Pediatric Considerations

- + Use in pediatric patients not well established but could be considered based on patient population



## Unhoused E-visit Workflow



## II. Remote Patient Monitoring

Remote Patient Monitoring (RPM) allows asynchronous monitoring of health parameters between a patient and their healthcare team where patients can obtain readings at a location remote to the clinic or care delivery site.

Patients are provided with an appropriate health monitoring device (automatic sphygmomanometer, glucometer) and a bluetooth hub for transmission of health data to an accepting platform. Healthcare team members can then review and respond based on the resulting health parameter. Algorithms should be developed for the process of monitoring and managing any resulting health parameters prior to initiation an RPM program. This should include standardized response protocols for any green (in an appropriate range), yellow (warning), or red flag (requires urgent/emergent in person assessment). Additionally, preferred methods of communication should be solicited for follow up on these protocols in particular in PEH.

### Examples of amenable conditions

- + Hypertension
- + Diabetes
- + COVID-19

### Suggested partners

- + May be completed by patient alone
- + Nurses for initial triage of RPM values
- + CBO for connectivity and possible assistance with completion (reading, language interpretation, technology utilization)

### Considerations

- + Technology required
  - > Appropriate RPM platform
  - > Bluetooth health monitoring device

- > Bluetooth transmission hub with access to outlet
- > Access to communication about health monitoring results

- + Platform HIPAA compliance (Electronic Health Record/Patient Portal, REDCap)
- + Patient technology literacy
- + Follow up (Activation must include preferred contact method for patient and what to expect regarding follow up)
- + Access to outlet for transmission at time of monitoring required which may include power sources in motor vehicles
- + Patient selection important when considering communication, availability of a consistent storage location, and capacity for follow up communication based on resulting values

## Possible variations

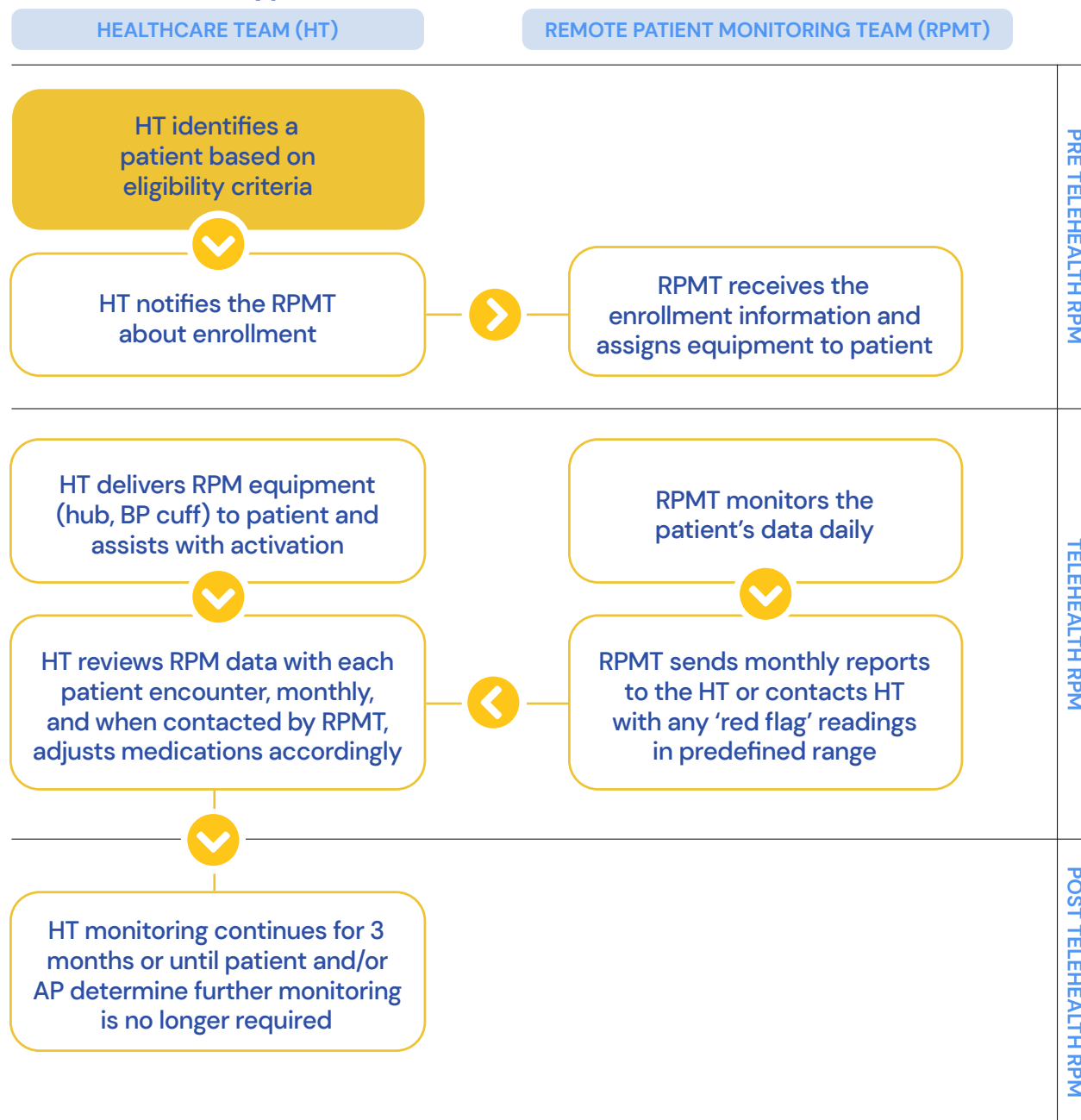
- + Patient completes RPM at community site
- + CBOM brings device with link to patient where they are staying

## Pediatric considerations

- + Use in pediatric patients not well established

\*This workflow is specific to hypertension and can be adapted for other amenable conditions

## Unhoused RPM Hypertension Workflow



## B. Synchronous

### I. Video Visit Direct to Patient

This model involves a remote healthcare provider which can include an attending physician, resident physician, or APP depending on local regulations and available supervision.

Patients are located at their preferred site (where they reside, place of work, CBO) for the video visit. The healthcare provider provides direct patient care delivered over a video platform including facilitating visit initiation, care delivery, and subsequent coordination of care. This is the most common delivery method for telehealth and can be applied to care delivery for PEH when the chief complaint does not require an in-person physical exam. This visit workflow offers flexibility both regarding location and timing as the healthcare provider is not required to be on site and offers opportunity for both on the fly visits as needed, as well as planned follow up visits.

#### Suggested partners

- + CBO to provide social services and facilitate appropriate follow up care

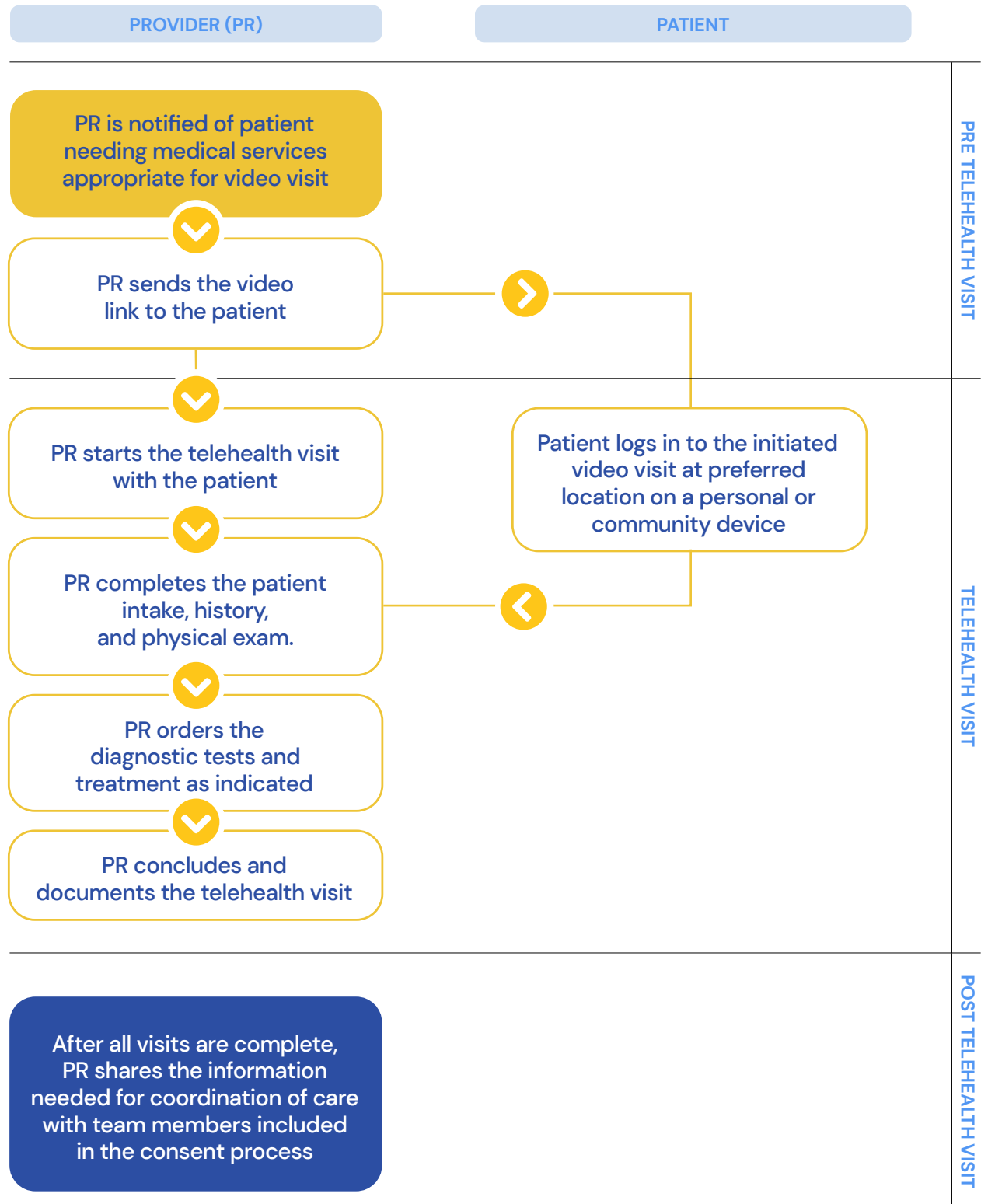
#### General considerations

- + Patient selection for visits may be limited by individuals with greater technology access
- + Patients should select a site for visit where appropriate privacy of health information can be maintained
- + For 'on the fly' visits providers may have designated timeslots when they are available for video visits of which patients can be made aware
- + Can alternate in-person and video visits depending on health condition to improve access to care in between in person visits

#### Pediatric considerations

- + Provider should be licensed to see children
- + Depending on age, children usually need assistance from an adult to facilitate the visit
- + May be used augment recommended health maintenance services in a medical home

## Unhoused Direct Video Visit Workflow



## II. Video Visit at a Community-Based Organization using Telepresenters

This model involves a remote healthcare provider with telepresenters located in-person with patients at a CBO.

In this workflow, the CBOM identifies a patient requiring medical services and utilizes the telepresenter to assist in patient intake, physical exam, and coordination of follow up care. Telepresenters may be volunteers, CBOMs, or learners and expanded care delivery is possible using a remote healthcare provider. Involving learners enhances educational opportunities through potential for multidisciplinary student engagement (medical, nursing, pharmacy) and may allow CBOMs to focus on client social needs as opposed to assisting with medical visits.

### Suggested partners

- + Academic medical institution to provide telepresenters (pre-professional students)
- + CBO to provide clinical space and social services, possibly telepresenters in absence of learners

### General considerations

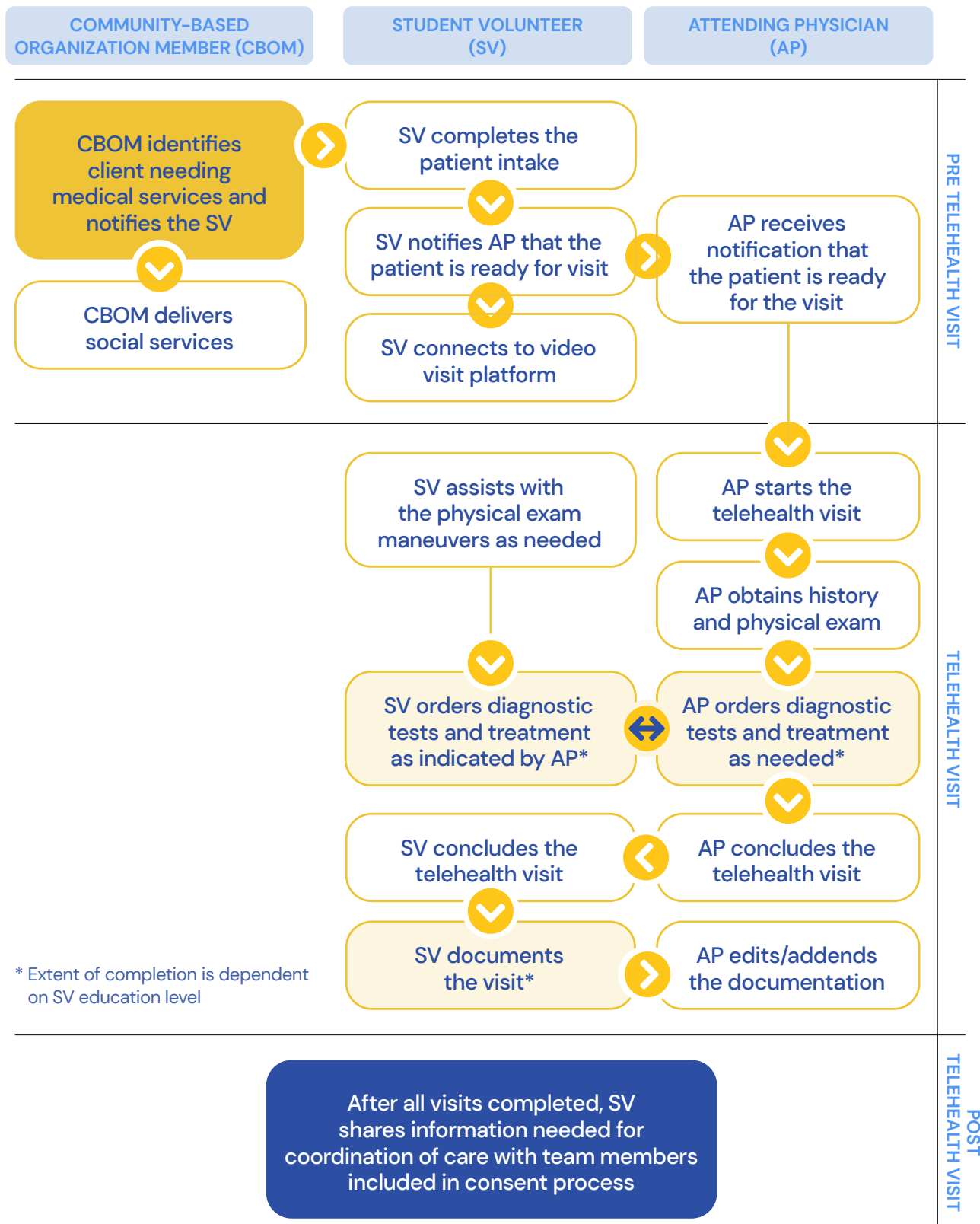
- + Pre-developed protocols and training for communication between telepresenters and healthcare providers improves care delivery
- + Telepresenters may be trained to assist with physical exam maneuvers (assessing swelling, musculoskeletal maneuvers)
  - > Consider connecting a remote web-enabled stethoscope, ophthalmoscope, otoscope, dermatoscope, etc.
- + In addition to providing training materials, new telepresenters may benefit from initially working with a more experienced telepresenter to learn how to navigate the intake process and any point of care testing
- + Establish secure communication pathways between providers and telepresenters as EHR access may vary between telepresenters based on training and role

### Pediatric considerations

- + Remote provider should be licensed to see children
- + Pediatric patients benefit from using these visits to augment recommended health maintenance services in a medical home

## Unhoused Video Visit with Telepresenter at CBO Workflow

This example uses a student volunteer but can be adapted for other types.



### III. Teleprecepting at a Community-Based Organization

This model involves a remote attending physician or APP and a graduate level medical learner that requires oversight (resident physician, APP student) on-site with the patient at a designated clinical space housed in a CBO.

The intention is for the visit to be primarily with an on-site graduate level medical learner, but for the remote supervising provider to be able to provide support and oversight via telephone or video as needed. The example provided involves a common structure at academic institutions including both undergraduate and graduate level learners, as well as CBOMs to provide social services. Remote oversight enhances autonomy for learners while being less demanding for preceptors. Delivering care to patients in a space where they are able to address social needs outside of the traditional healthcare environment enhances trust and reduces stigma.

#### Suggested partners

- + CBO to provide clinical space and social services
- + Academic medical institution (resident physicians, APP students, undergraduate health professional students)

#### General considerations

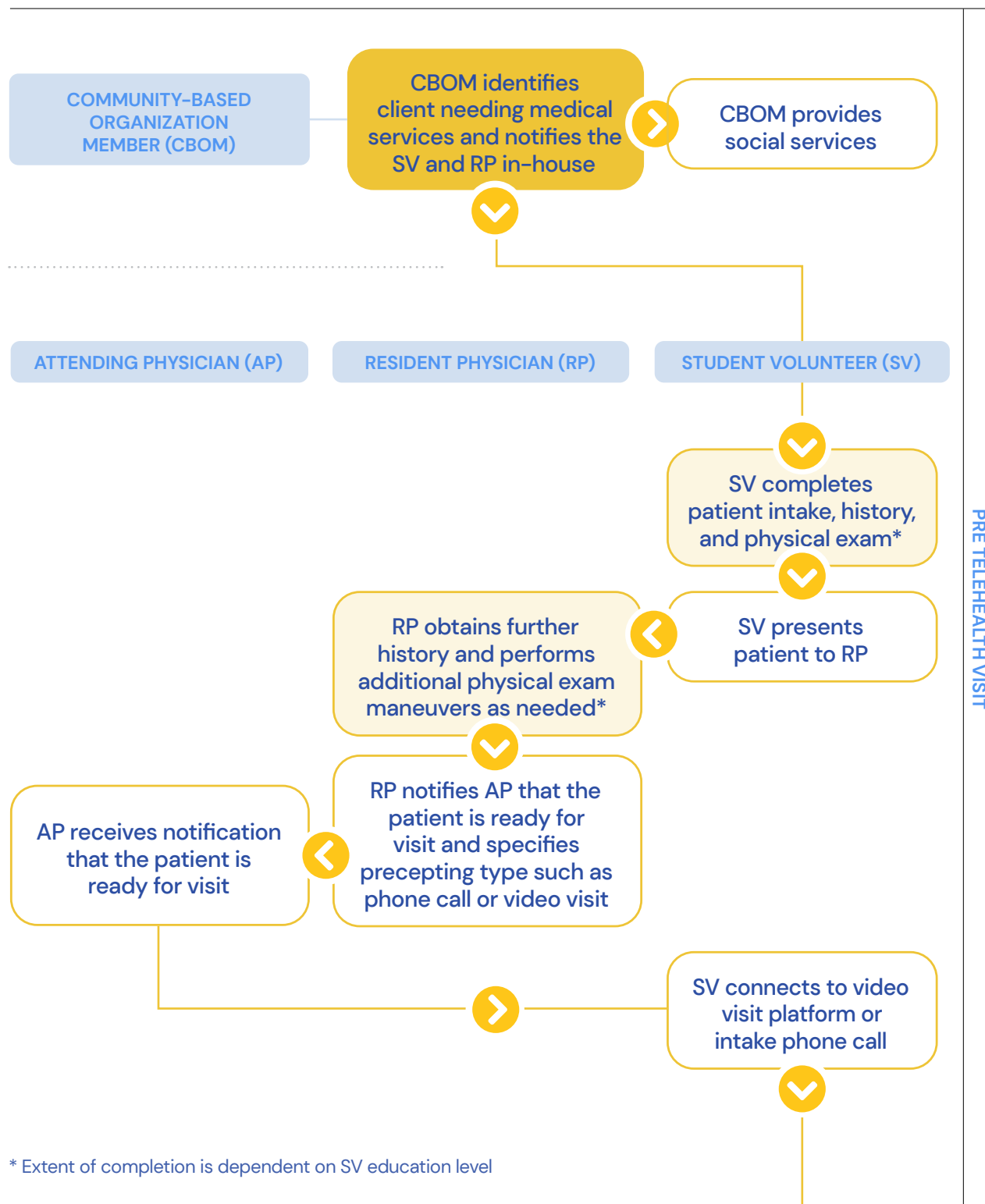
- + Precepting should be done in 'real time' when possible given challenges with patient transience and contact in case of plan change
- + Can be alternating in-person and teleprecepting depending on trainee comfort level and level of training
- + Consider local regulations when determining need for on-site supervision based on learner type

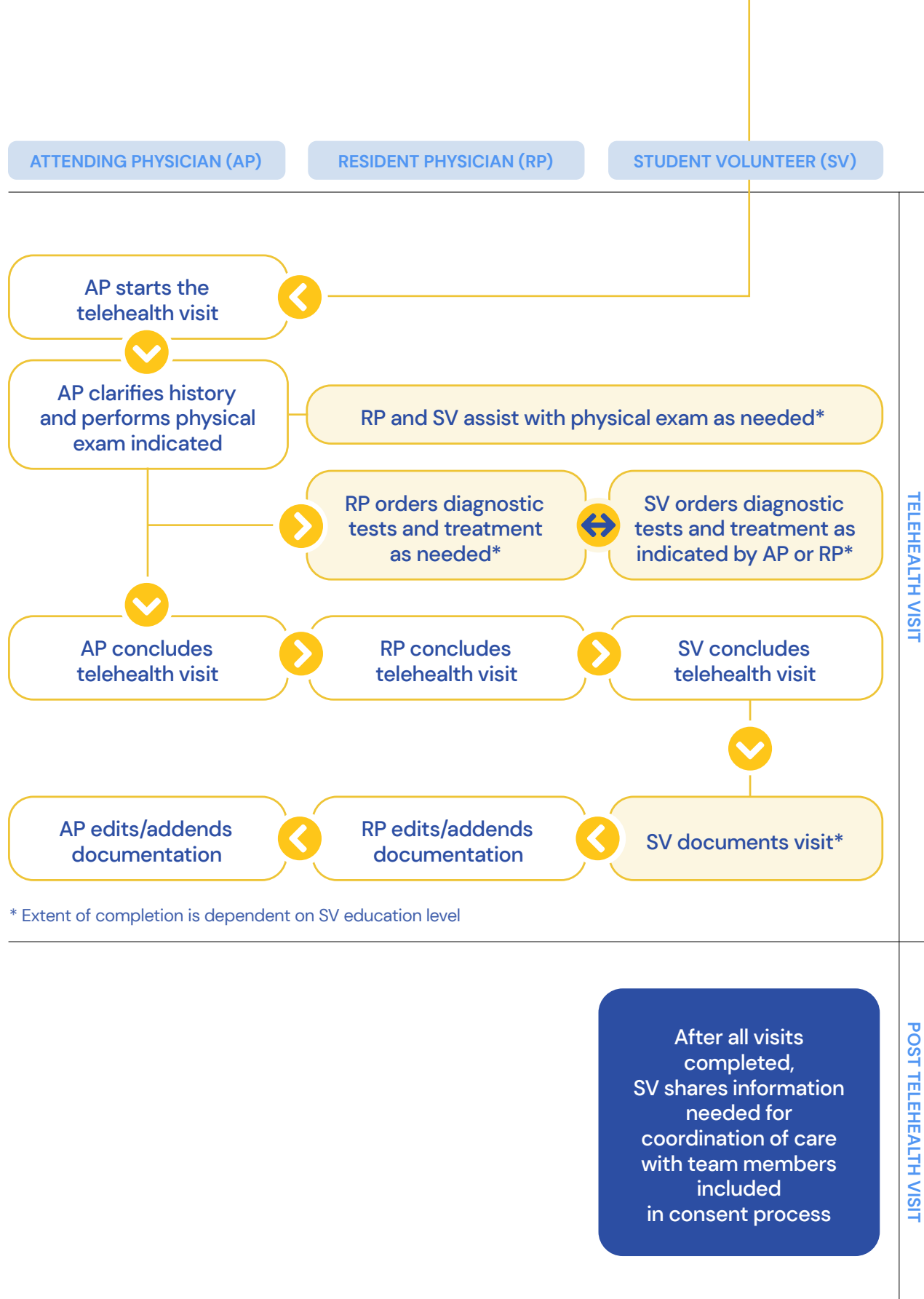
#### Pediatric considerations

- + Teleprecepting provider should be licensed to see children

## Unhoused Teleprecepting at CBO Workflow

This example uses resident physicians and medical students but can be adapted.





## IV. Teleprecepting Street Medicine

This model involves a remote attending physician or APP and a graduate level medical learner that requires oversight (resident physician, APP student) on-site with the patient at a street-based location, often where the patient is staying.

The intention is for the visit to be primarily with on-site graduate level medical learner but for the remote provider to be able to provide support and oversight via telephone or video as needed. The example provided is a common structure at academic institutions including both undergraduate and graduate level learners, as well as CBOMs to provide social services. Remote oversight enhances autonomy for learners while being less demanding for preceptors. Delivering care to patients where they reside and outside of the traditional healthcare environment enhances trust and reduces stigma.

### Suggested partners

- + CBO to provide clinical space and social services
- + Academic medical institution (resident physicians, pre-professional students)

### General Considerations

- + Consider deferring genitourinary, breast or other exams that may warrant additional privacy
- + Consider portable equipment available (otoscope, ophthalmoscope, ultrasound, EKG)
- + Offering food, hygiene kits, seasonal items, etc., regardless of engagement with medical care can help to build rapport
- + Consider patient privacy with regard to history and physical exam, let patient guide preferred location and environment

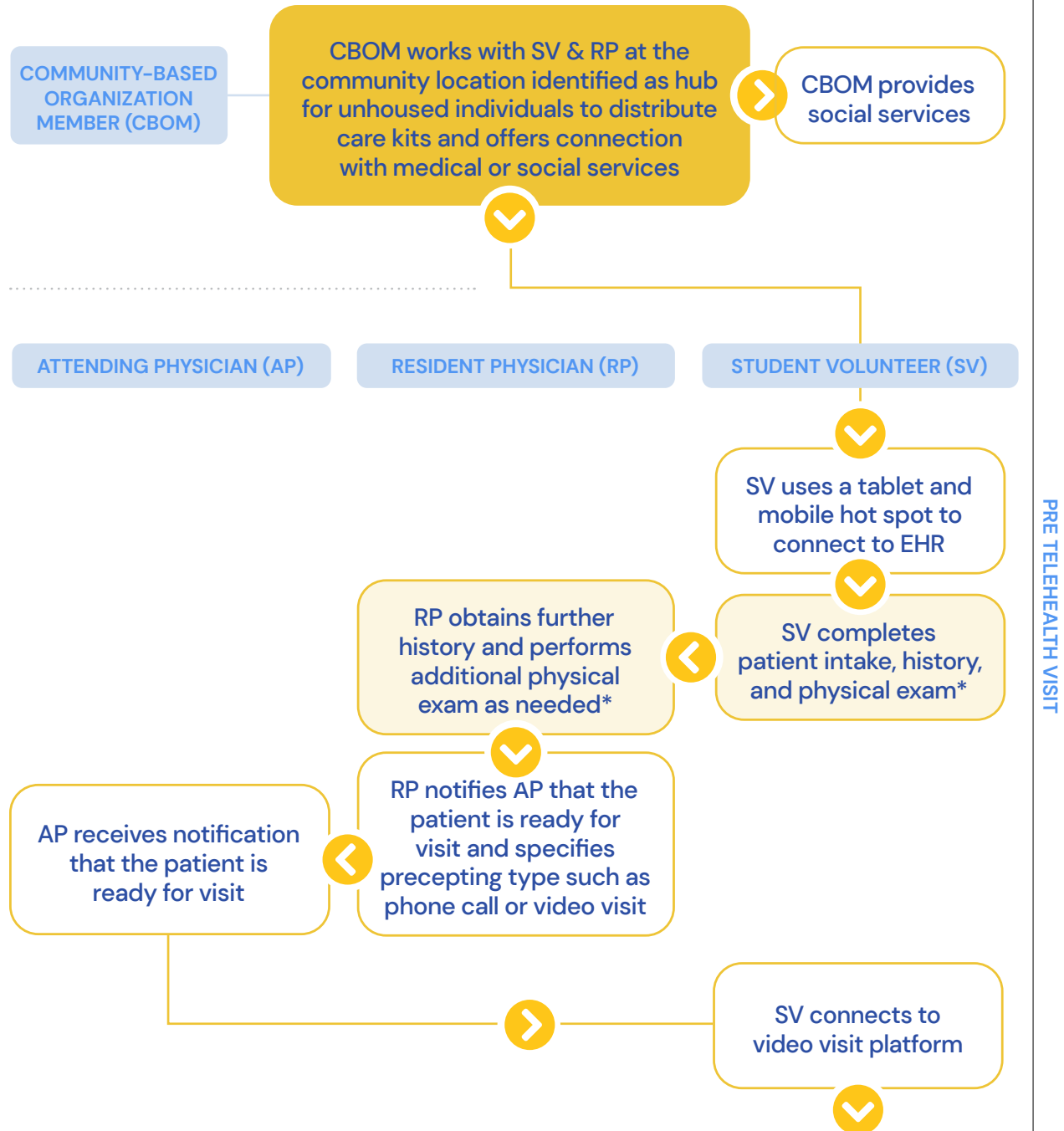
- + Precepting should be done in 'real time' when possible given challenges with patient transience and contact in case of plan change
- + Can be alternating in-person and video depending on trainee comfort level and level of training
- + Consider local regulations when determining need for on-site supervision based on learner type

### Pediatric Considerations

- + Precepting provider should be licensed to see children
- + Special consideration should be taken with regard to privacy and safety for children seen at street-based locations
- + Pediatric patients benefit from using these visits to augment recommended health maintenance services in a medical home

## Unhoused Teleprecepting Street Medicine Workflow

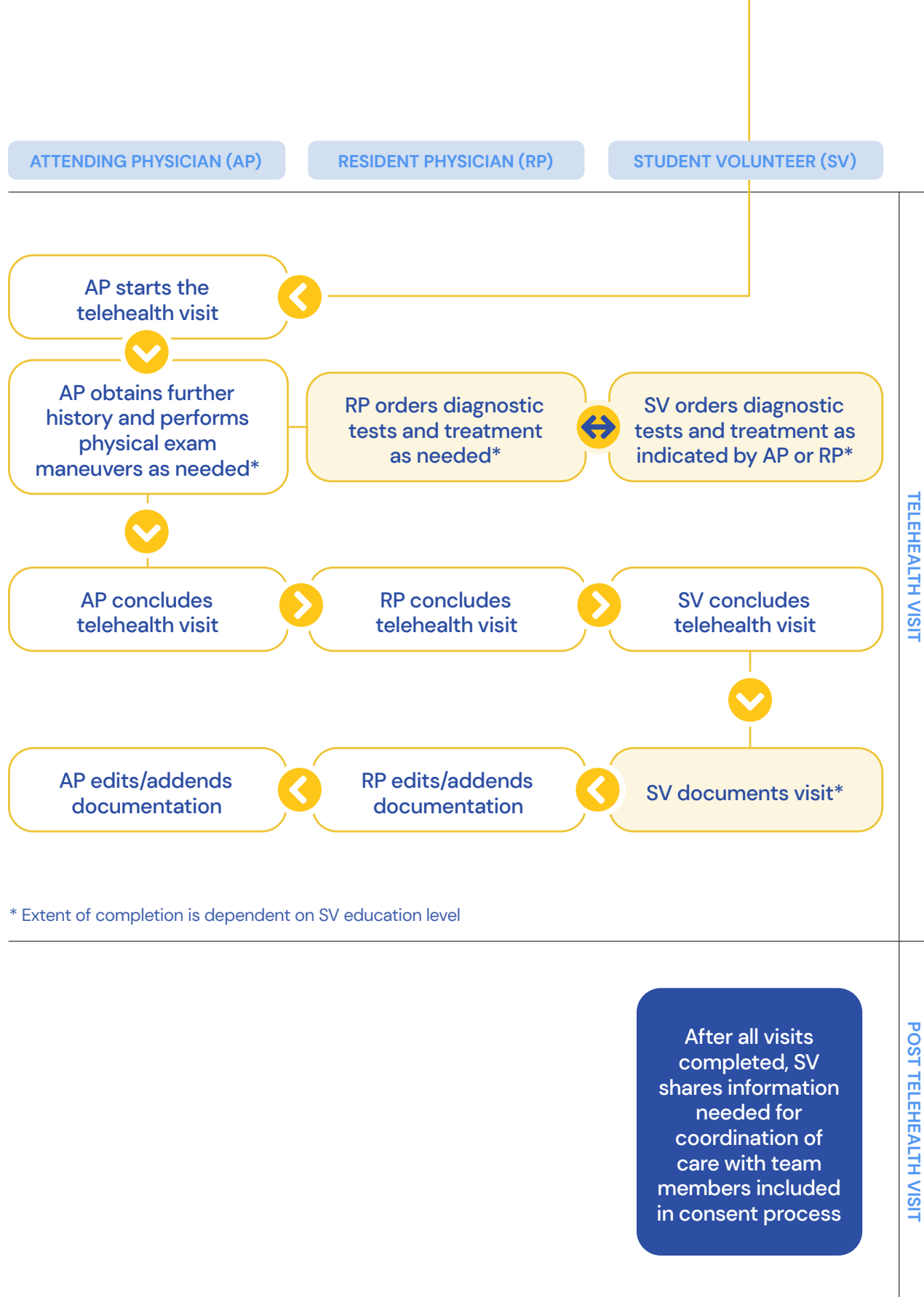
This example uses resident physicians and medical students but can be adapted.



PRE TELEHEALTH VISIT

\* Extent of completion is dependent on SV education level





\* Extent of completion is dependent on SV education level



## V. Video Visit Street Medicine via Community-Based Organization Outreach Worker

This model involved a CBOM with little to no medical knowledge facilitating telehealth with a patient at a street-based location.

This can be done 'on the fly' or scheduled ahead of time and requires the outreach worker do patient intake via a secure online platform that the physician can review prior to the visit. Ideally the outreach worker provides the technology for the visit, but a patient's personal device may be used if preferred. Outreach workers may simply facilitate the connection for the visit or assist during the visit by taking vital signs, assisting in physical exam maneuvers, providing wound care etc. commensurate with the skill set of the CBOM and based on comfort level of the CBOM and the patient.

### Suggested partners

- + CBO to provide at least one outreach worker

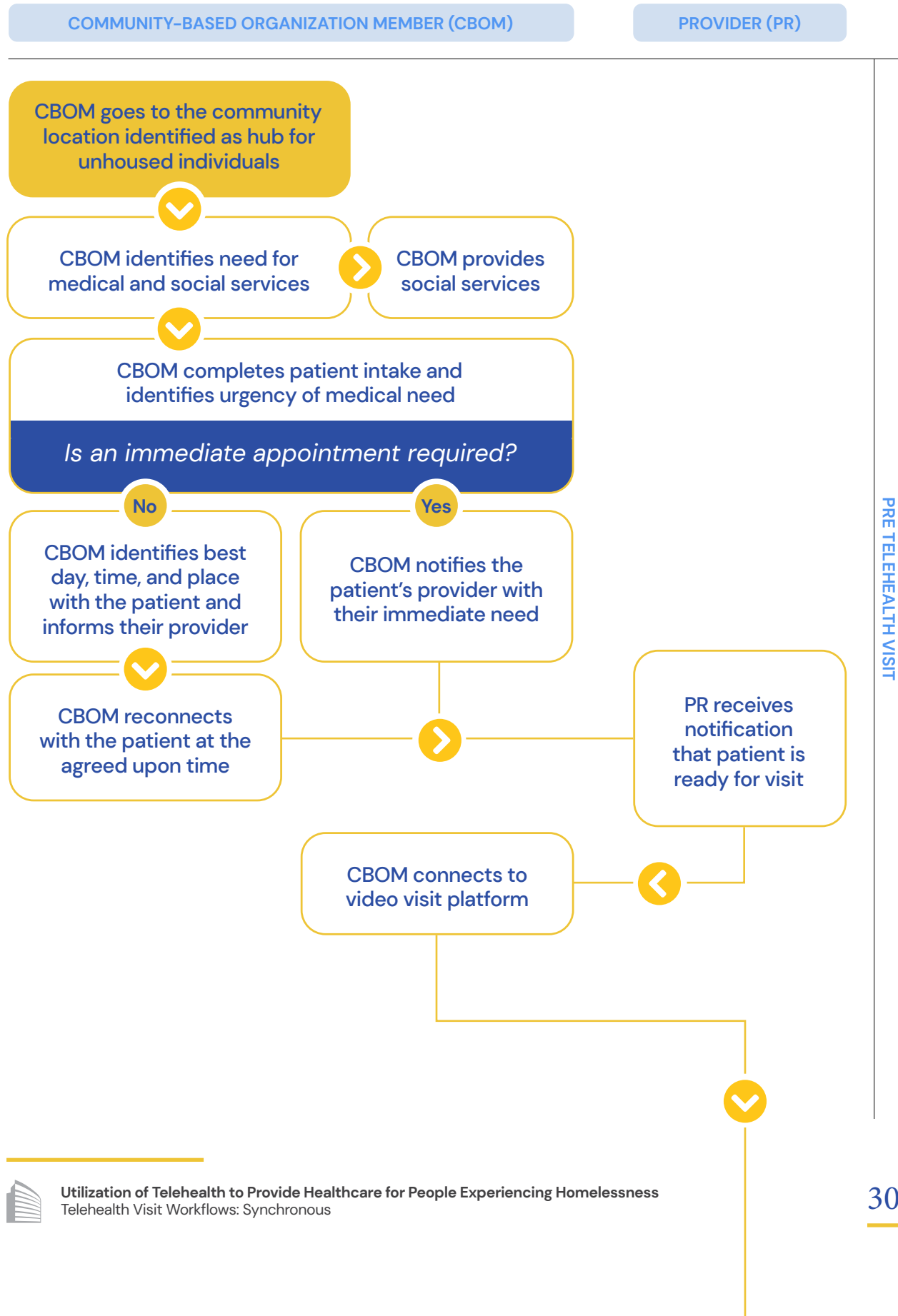
### General Considerations

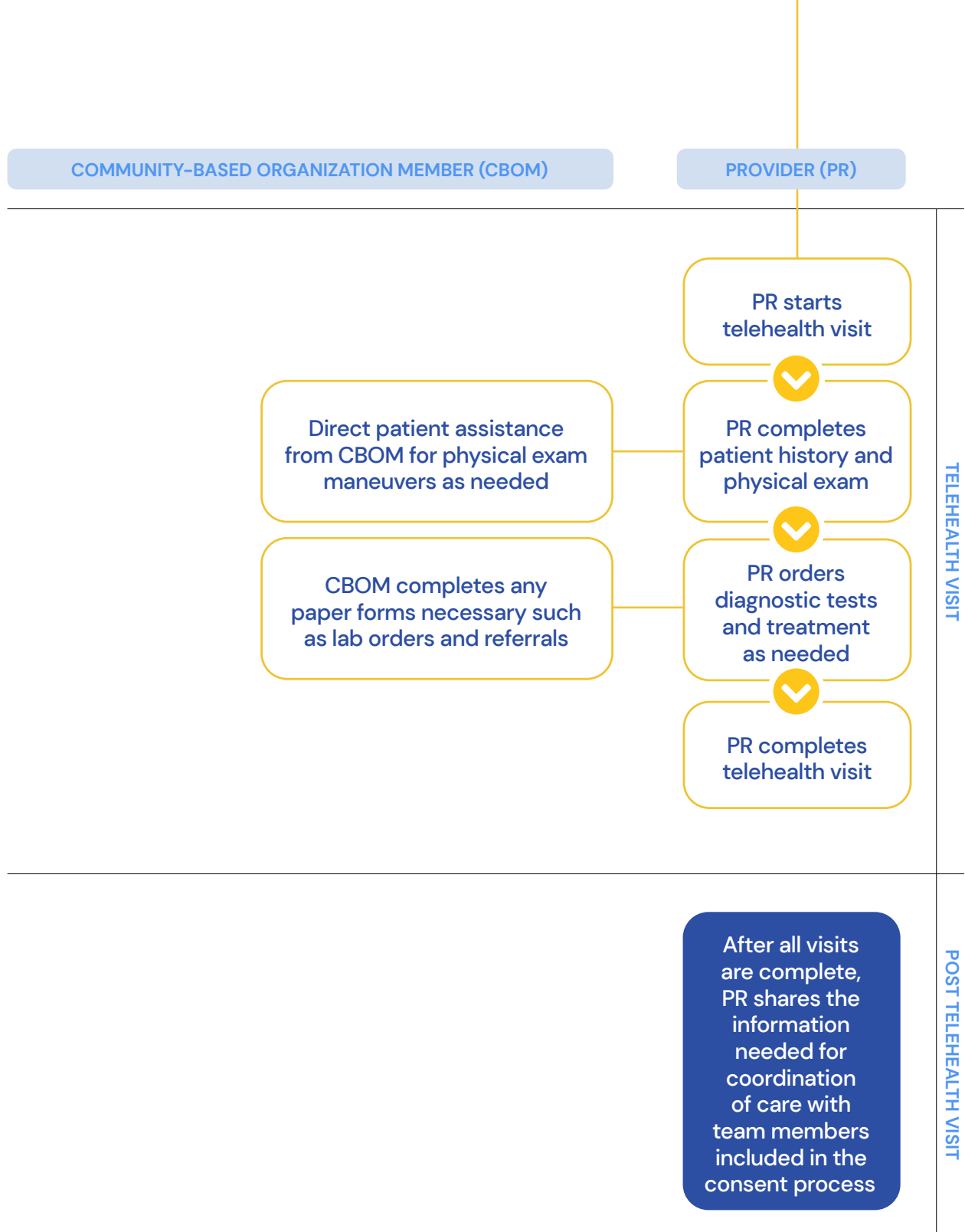
- + Technology literacy of outreach worker
- + Secure online intake process on a platform which both the CBOM and PR can access
- + Patient privacy (with regard to outreach worker and other proximal individuals)

### Pediatric Considerations

- + Provider should be licensed to see children
- + Assess need for guardian presence during visit based on age and chief complaint
- + Pediatric patients benefit from using these visits to augment recommended health maintenance services in a medical home

## Unhoused Video Visit Street Medicine via CBOM Workflow





# Telehealth Centers of Excellence

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