

Memorandum of Understanding for PrEP Care Coordination

Between (AGENCY NAME) and
the UIHC/IDPH TelePrEP Service

I. Cooperative Agreement

This Memorandum of Understanding (MOU) is made and agreement entered into by and between the (AGENCY NAME), hereinafter referred to as (XX) and the University of Iowa Hospitals and Clinics (UIHC)/Iowa Department of Public Health (IDPH) TelePrEP service, hereinafter referred to as "TelePrEP."

The purpose of this MOU is for the (XX) and TelePrEP to enter into a collaborative partnership to provide TelePrEP support services consistent with current USPHS/CDC guidelines (<https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf>) utilizing resources supported by the Iowa Department of Public Health.

The respective responsibilities and obligations for (XX) and TelePrEP in their mutual desire and intent to exercise the collaborative partnership are as follows.

II. Responsibilities

A. Responsibilities of the (XX):

- a. (XX) maintains the ability to refer clients for PrEP Navigation Support and/or TelePrEP services via utilizing the IDPH PrEP Referral Form.
- b. (XX) will retain signed copies of patient release of information (ROI) forms allowing for the sharing of rapid testing, serology, and STD test results outlined in the release.
- c. When applicable, (XX) will perform rapid testing, serology, and STD testing services in accordance with IDPH programmatic standards utilizing IDPH provided rapid HIV test kits and the Tests of Public Health Significance Test Request Form.
- d. (XX) will fax client lab results to TelePrEP at **319-384-8060**
- e. In the event of a positive lab test result:
 - Syphilis, gonorrhea, chlamydia, Trichomoniasis: (XX) will conduct client notification, treatment, and/or partner services in accordance with (XX) policy and practice.
 - HIV, hepatitis B or C: (XX) will conduct client notification, treatment or referral, and/or partner services in accordance with (XX) policy and practice.

B. Responsibilities of TelePrEP:

1. TelePrEP will provide navigation services related to insurance, medication assistance, and linkage to a TelePrEP or community PrEP provider.
2. TelePrEP will provide a lab request form in the agreed upon manner (email, fax, etc) indicating which lab tests need to be obtained during the visit to (XX) and documenting the release of information (see attachment 1).
3. In the event of a positive lab test result, TelePrEP will work with (XX), as requested, to ensure treatment and/or referral, as indicated.

4. TelePrEP providers will maintain the responsibility of interpreting serum creatinine laboratory results, provide patient counseling when appropriate, and refer for care as needed.
5. TelePrEP will remind clients to get their labs drawn at each three-month interval, counsel patients to request 'TelePrEP lab appointment' when contacting (XX), and ensure monitoring occurs in accordance with USPHS/CDC guidelines.

III. Terms of Agreement

The term of this MOU is ongoing beginning on the date of signature, and may be amended by mutual agreement.

Termination of the MOU may occur with the mutual consent of both parties, upon receipt and acceptance of a thirty (30) day written notice, termination on an agreed- upon date may occur without penalty to either party.

IV. Payment for Services

(XX) agrees to provide the services listed above according to the corresponding rates listed below. This agreement acknowledges that clients will be informed that payment is due at the time services are rendered.

Charge	Rate

*Indicate here any availability of insurance or sliding fee scales.

V. Confidentiality

Both parties acknowledge that they are health care providers cooperating in providing treatment and prevention. This agreement contemplates exchange of protected health information (PHI) as identified in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and use of Electronic Health Records (EHR) as identified in the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH). Both parties agree and shall abide by the privacy and security regulations and requirements of both Acts.

VI. Contact Information

(XX) Contact Numbers:

To follow-up lab results:	
For lab questions:	

TelePrEP Contact Numbers:

Seth Owens	PrEP Navigator	319-930-9093 (cell)
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Kim Spading	PrEP Provider	319-930-9111 (cell)
Angie Hoth	PrEP Provider & TelePrEP Manager	319-930-9432 (cell)
TelePrEP	Main phone number	319-467-8777
TelePrEP fax		319-384-8060
TelePrEP email		teleprep@healthcare.uiowa.edu

VII. Signatures

The MOU shall be effective May 17, 2019 or as of the date executed by both parties to this agreement, whichever is earlier, and shall continue in effect until all responsibilities are discharged.

By: _____ Date: _____

By: _____ Date: _____

Title:

Agency:

By: _____ Date: _____

By: _____ Date: _____

Title: Angela Hoth PharmD MPH, TelePrEP Coordinator
Michael Ohl MD MSPH, TelePrEP Medical Director

Agency: UIHC Iowa TelePrEP Service
Dept. of Internal Medicine, Infectious Diseases
200 Hawkins Drive, SW34 GH
Iowa City, IA 52242

(Agency) TelePrEP Client Service Request

INDICATE AGENCY VISIT FEES ASSOCIATED WITH THIS VISIT IN THIS BOX

Date:		Referred By:	
Client Name:		Client DOB:	
Client Address:		Sex Assigned at Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Phone Number:		Language:	

Labs requested for this visit (Private Coverage):

Requests for these sets of labs indicate that the patient is insured and willing/able to utilize insurance to support these tests.

Serology:

- ☐ HIV Screen
- ☐ HCV Screen
- ☐ HBV Surface Antigen
- ☐ HBV Surface Antibody
- ☐ HBV IgG and IgM

- ☐ Serum Creatinine
- ☐ Syphilis TPPA
- ☐ Syphilis VDRL
- ☐ Pregnancy

STD GC/CT:

- ☐ Urine
- ☐ Oral
- ☐ Vaginal
- ☐ Rectal

Labs requested for this visit (IDPH SUPPORTED):

Requests for these sets of labs indicate that the patient is uninsured, underinsured, or insurance averse in accordance with the IDPH Tests of Public Health Significance definitions.

☐ Conventional HIV Screen☐ Rapid HIV Screen☐ PrEP Serology (TOPHS)☐ Initiation Panel☐ Monitoring Panel☐ STD Screening (gc/ct)☐ Urine☐ Oral☐ Vaginal☐ Rectal**Fee For Service Lab:** ☐ Pregnancy (\$_____)**Medical Director Signature:** _____

Michael Ohl, MD

**Please release all lab results to TelePrEP via fax
at 319-384-8060**

I, as the patient or patient's legal representative, authorize the Polk County Health Department to release and deliver confidential medical information in accordance to this authorization.

This release will be active beginning the date signed and last for 90 days thereafter.

This release covers all records related to the services requested above including information related to the following:

- ☒ AIDS-related information, diagnosis, & test results
- ☒ Sexually transmitted infection and/or disease screening, test results, and treatment
- ☒ Kidney function screening and test results
- ☒ Sexually transmitted infections and/or diseases

I SPECIFICALLY AUTHORIZE disclosure and redisclosure of this confidential information to the person or entity listed below:

University of Iowa Hospitals and Clinics
Iowa TelePrEP Clinic
Dr. Michael Ohl, Dr. Angie Hoth, Dr. Dena Dillon, Dr. Kim Spading
Fax #: 319-384-8060

Signature of patient or patient's legal representative: _____ Date: _____

Printed name and relationship of patient's legal representative: _____