VHA Office of Health Informatics: Connected Care/Telehealth Services

Home Telehealth Operations Manual

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We wish to acknowledge the many contributions of the subject matter experts who have provided their technical expertise in order to make this manual possible.

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Document Version History

Responsible Office

The development and maintenance of this document is the responsibility of the Veterans Health Administration (VHA), Office of Health Informatics: Connected Care/Telehealth. Proposed changes to this document should be submitted to Catherine.Buck@va.gov.

Document Revision	Effective Date	Page	Description
1	April 2011		Initial Document Redevelopment
2	December 2011		Bi-annual Review of Manual
3	April 2012		Bi-annual Review of Manual
4	December 2012		Bi-annual Review of Manual
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6	April –June 2016		Annual Review of Manual
7	January 2017		Newly Revised Major Version
8	April 2017		Quarterly Update
		6	Patient Participation 70% requirement at least over 90 days
		12	Employee Education System link not hyperlinked
		15	Co-morbidities for DMPs and category of care for Weight Management
		23	Adding provider reviewing data for Home Telehealth: The Basics education requirement
		26	Patient Participation 70% requirement at least over 90 days
		29	Returned Merchandise Authorization Process
		33	Home Telehealth Reporting of IT issues
		34	HEALTH PROMOTION/DISEASE PREVENTION & standalone prevention DMPs; Weight Management co-morbid & category of care
		35	VA Provider vs VA PCP
		36	

Document Revision	Effective Date	Page	Description
		37	Closing CCHT consults to be in compliance with Directive 1232: Consult Processes & Procedures; CHOICE Program
		38	Clarifying co-signing vs additional signer
		39	Recommendations for reducing duplication of efforts for assessment documentation requirements for Home Telehealth and specialty programs like TeleMOVE, Homeless Veterans & SCI
		40	Monitoring note and partial response
		41	Periodic Evaluation Note and provider additional signer
		64	Patient Participation 70% requirement at least over 90 days; clarification for 30 minutes of monitoring
		A-1	Add vetted Home Telehealth Mental Health User Guide to list of attachments
			Add vetted Pain Management Toolkit to list of attachments
9	December 2017	4	Minor spelling correction
		13&31	Adjusted content to reflect Home Telehealth video terminology
		28	Care Coordinators will conduct on going chart reviews as part of their routine case management and process of care for evaluation of Veterans current needs, Veterans Equitable Resource Allocation status, and changes that may have occurred.
		34	Return Merchandise Authorization (RMA) changed to reflect new Home Telehealth Equipment Contract
		38-39	New DMP Process changes as communicated via National Alert Email
		38	Content addition on reviewing daily alerts
		41	

Document Revision	Effective Date	Page	Description
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			Updated content for the Initial Assessment & Treatment Plan Note
		44	Enrollment Agreement is now required to support documentation of Veteran's rights & responsibilities for Home Telehealth Program
		45	Updated content for Continuum of Care Form Note
		46	Updated content for Technology Education & Intervention Notes
		49	Updated content for Periodic Evaluation Note-changed from between 3-6 months to every 6 months
		49-50	Change in section title from Telephone Encounter & Office Encounter to Home Telehealth Note. New content added
		53	Added content related to Re-enrollment and new note templates with clinic reminders
		55	Deletion of Patient Self-management courses
		63-64	Changes in encounter section to reflect release of new national note titles and templates
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Document Revision	Effective Date	Page	Description
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		2	Provided new background information in Introduction to Home Telehealth
		3	Updated goals in Definition of Home Telehealth
		6	Added fifth category of care, updated existing categories of care
		10	Added resources to help determine feasibility and sustainability of programs
		15	Updated Collaboration with MOVE! to clarify use of categories of care and co/tri-morbid DMPs
		21	Added clarification about Program Support staff requirements for visits to Veterans' homes
		22	Added note about forthcoming decentralization of Preceptor Programs
		26	Updated Home Telehealth Process of Care image and description
		27	Added sections for Enrollment of Veterans into Home Telehealth
		29	Updated Discharge section and added Patient Participation section
		30	Updated list of Technologies approved for use
		34	Added guidance for use of Home Telehealth Tech Education, updated RMA procedures
		37	Clarified TeleMOVE exception to standard DMP requirements

Document Revision	Effective Date	Page	Description
		38	Provided updated list of Standardized DMPs
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		43	Reorganized Consult Guidance section to flow better
		48	Revised guidance for Discharge notes
		52	Added section for Civilian Health and Medical Program
		53	Updated Conditions of Participation section
		60	Added Policy section with guidance on Privacy and Managing VA-Issued Technology When Geographically Relocate
11	July 2019	17	Added a reference to VHA Directive 1108.13
		22	Updated decentralization to refer to both VISN and local levels
		23	Updated training terminology
		27	Clarified that meeting Veteran needs includes caregiver needs
		37	Clarified who is responsible for reviewing vendor-developed DMPs
		39	Clarified use of Co-morbid and Tri-morbid DMPs
		45	Updated frequency of caregiver burden assessments
		52	Clarified that CHAMPVA patients are currently not eligible for Home Telehealth enrollment
		58	Clarified timeframes for reviewing Veteran data

1. Purpose, Development Process and Audience

1.1 Purpose

The purpose of the Home Telehealth (HT) Operations Manual is to provide standard operational guidance and resources to implement, operate, monitor and sustain quality, safe and effective Home Telehealth care in the Veterans Health Administration (VHA). This manual will describe the prerequisites and critical success factors for providing these services within the framework of VHA strategic plans for Telehealth. The content and tools therein serve as a resource for quality improvements, as well as to expand the delivery of non-urgent care via Home Telehealth and ensure the efficiency, quality and sustainability of these services.

The Home Telehealth Operations Manual will assist Veterans Affairs (VA) staff to integrate the practices and procedures used in VHA Home Telehealth programs for the benefit of Veterans, caregivers, families and practitioners. This integration of practices and procedures applies to both establishing a new Home Telehealth program and operational standards for an existing Home Telehealth program. This manual references and links to all Office of Health Informatics: Connected Care/Telehealth programs including clinic based telehealth.

The Home Telehealth Operations Manual is meant to complement existing VHA clinic and administrative directives and guidelines. It provides sufficient detail for the intended audience to gain an understanding of the complex components of developing and managing Home Telehealth programs. The Operations Manual also contains links to additional training, tools, and resources that will compliment other national, VISN and local requirements ensuring competency and the ability to successfully plan, deploy and manage Home Telehealth programs.

1.2 Development Process

Telehealth leaders from the 18 VISNs comprised the development committee for this Operations Manual with oversight and leadership from the Telehealth Training Team within the Office of Health Informatics: Connected Care/Telehealth program office. Content was developed with the underlying goal of providing the greatest amount of relevant information to ensure safe and high-quality services to Veterans. Final reviews were completed by key staff within the Office of Health Informatics: Connected Care/Telehealth prior to approval and publication.

1.3 Audience

Although much of the content of this Operations Manual may be pertinent to Home Telehealth operations outside of VHA, this document is a resource developed solely for internal VHA Home Telehealth programs. The intended audience is VISN Telehealth

leadership, Facility Telehealth Coordinators, Lead Care Coordinators, Care Coordinators and administrative/technical staff, Telehealth practitioners and VHA staff that provide management and/or support to Home Telehealth Programs.

2. Home Telehealth: Introduction and History

2.1 Introduction to Home Telehealth

The nation's largest health care system, the Department of Veterans Affairs' (VA's) Veterans Health Administration (VHA), uses a wide variety of communication and information technologies to ensure excellence in the health care delivered to our nation's Veterans. The mission of Telehealth Services is to utilize health informatics, disease management, care/case management, and Telehealth technologies to facilitate access to care and improve the health of Veterans with the intent to provide the right care in the right place at the right time. New information technologies continue to revolutionize health care and VA has been recognized by the Institute of Medicine as a leader in using these technologies to improve the quality of health care delivery. VA's application of three areas of technology -- health informatics, telehealth, and disease management -- enables VA to coordinate the care of Veterans by extending and enhancing current care and case management activities and has become mission critical to the future direction of VA care to Veterans.

The term "Home Telehealth" applies to the use of telecommunication technologies to provide clinic care and promote patient self-management as an adjunct to traditional face-to-face health care. Health Information is exchanged from the Veteran's home or other location to the VA care setting, thus alleviating the constraints of time and distance. The Home Telehealth Operations Manual focuses on care that primarily occurs between the Veteran in his or her place of residence and a VA Non-Institutional Care setting. Home Telehealth also occurs in other settings and, with the addition of mobile technologies such as Interactive Voice Response systems and "Browser" or web-enabled technologies, Home Telehealth can take place almost anywhere a Veteran chooses.

2.2 Definition of Home Telehealth

In VA, Home Telehealth is defined as a program into which Veterans are enrolled that applies care and case management principles to coordinate care using health informatics, disease management, and technologies such as in-home and mobile remote patient monitoring, messaging and/or video technologies. The best candidates for these programs and activities are Veterans who are in post-acute care settings, high-risk Veterans with chronic disease or Veterans at risk for institutional long-term care. The goal of Home Telehealth is to improve clinical outcomes and access to care while reducing complications, hospitalizations, and clinic or emergency room visits for:

- Veterans in post-acute care settings;

- High-risk Veterans with chronic disease;
- Veterans at risk for institutional long-term care; and
- Veterans that would benefit from additional health promotion and disease prevention activities.

Home Telehealth provides non-urgent/non-emergent care and case management that also includes tracking and trending vital signs and other biometric data and symptoms.
The essence of Home Telehealth as implemented in VHA involves the ongoing assessment, monitoring, patient education and case management of Veterans in their place of residence and provides the appropriate information to Patient-Aligned Care Teams and the healthcare system to enable timely care. Use of Home Telehealth has the potential to reduce clinical complications and the use of healthcare resources that health complications may consume.

The use of technology is only one aspect of Home Telehealth and a core component of the Home Telehealth model which includes active care and case management. Case management paired with technology increases patient satisfaction, improves outcomes and enhances management of chronic disease through collaboration between the Veteran, the Home Telehealth clinician (Care Coordinator), and the Veteran's health care team using an interdisciplinary approach.

It is important to note that Care Coordinators (licensed clinical professionals that can make clinical assessments within their scopes of practice) combine the use of Home Telehealth technologies with the ongoing assessment, monitoring and case management of Veterans which allows providers and the healthcare system to have appropriate information to enable timely care. Home Telehealth is not intended to replace or duplicate other care management or case management activities. Rather, the use of disease management and health informatics technologies in Home Telehealth enhances and extends current VA care management and case management activities into non-VA settings and Veterans' homes for those not otherwise provided case management services. It is important these technologies are applied in a safe, effective, and cost-effective manner. The interdisciplinary and standardized approach taken by VA's Home Telehealth program means it can be applied across a variety of services and Veteran circumstances where combining services will enhance care to Veterans but not duplicate care.

2.3 The Home Telehealth Model

Systematically implementing Home Telehealth throughout the continuum of care has been a major undertaking for VHA, and has resulted in evidence of positive clinical outcomes and cost effectiveness such as:

- Increased access to health care
- Improved access to primary and specialty care
- Alternatives to long-term institutional care
- Decreased Veteran travel

- Improved clinical outcomes
- Improved Veteran and provider satisfaction
- Making Veterans' homes the preferred place of care when appropriate

The changing incidence and prevalence of chronic diseases has influenced VHA's choice in placing its continued strategic emphasis in expanding the existing Home Telehealth model. A cornerstone of the Home Telehealth model is the adoption of the principles of Wagner's Chronic Care Model[1].

2.3.1 The Wagner Chronic Care Model

The Wagner Chronic Care Model identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. There are evidence-based change concepts under each element, and in combination they foster productive interactions between informed patients who take an active part in their care and clinicians who have the resources and expertise to assist them.
The Wagner Chronic Care Model can be applied to a variety of chronic illnesses, health care settings and target populations. The bottom line is to heal their patients, have more satisfied providers and provide cost savings.

In 2003, five additional themes were incorporated into the Wagner Chronic Care Model:

- Patient safety (in Health System);
- Cultural competency (in Delivery System Design);
- Care coordination (in Health System and Clinical Information Systems);
- Community policies (in Community Resources and Policies); and
- Case management (in Delivery System Design).

When the Home Telehealth Model was developed in 2003, the Wagner Chronic Care Model was used as a foundation for identifying Veterans who would most benefit from services. Home Telehealth staff play a fundamental role in coordinating care, educating patients, building self-management skills and applying care and case management strategies to effectively monitor and intervene for the Veteran's well-being. These areas are integrated into the Home Telehealth process of care and in education and training required to provide services. These roles and responsibilities have focused on helping Veterans with chronic diseases become more actively involved in their health care decisions and Care Coordinators advocating as change agents for them.

2.3.2 Tenets of the Home Telehealth Model

The Model for Home Telehealth was developed based on the following principles:

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[1] 1E.H. Wagner, "Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness?" Effective Clinical Practice 1, no. 1 (1998): 2–4.)

- Making the Veteran's home and local community the preferred place of care when appropriate
- Focusing on Veterans with the highest patterns of utilization
- Providing case management for Non-Institutional Care Veteran patients and their caregivers
- Promoting improved Veteran patient self-management and knowledge of chronic disease states
- Providing patient education and health coaching to promote healthy behaviors
- Providing patient navigation support and advocacy throughout the healthcare system to meet health needs (e.g., for chronic disease management)

The Home Telehealth program utilizes a seamless interdisciplinary approach with an expectation that its Care Coordinators will coordinate care across all settings, episodes of illness and at the appropriate level of care within their scopes of practice. Home Telehealth is designed to help maximize function and independence while also recognizing an individual's right to self-determination. The fundamental components of Home Telehealth are as follows:

- Screening
- Assessment
- Care planning
- Intervention
- Evaluation

Upon enrollment in the Home Telehealth program, all patients are given instructions on how to reach a health care professional (e.g., nurse line) after normal work hours or for an emergency at any time during the day. Based on their judgement when symptoms are being experienced, Veterans are to continue to seek emergency medical assistance using their community resources (e.g., Emergency Room, 911) as they did prior to enrollment in Home Telehealth. Home Telehealth is not a program that provides care and case management 24 hours per day, 7 days per week.

In general, Home Telehealth programs operate on a Monday through Friday work week, during routine business hours. Data transmitted to and from patients using Home Telehealth technologies over a weekend or holiday is reviewed by Care Coordinators on the next standard workday. In addition, the model for Home Telehealth does not require or expect that data will be reviewed immediately as it is received during normal work hours; Care Coordinators will review data at various times during the day and this may result in data not being reviewed on the day it was electronically received.

2.3.3 Patient Populations and Categories of Care

The Home Telehealth program focuses on enrolling Veterans with chronic diseases such as, but not limited to: diabetes, hypertension, heart failure, post-traumatic stress disorder, depression, spinal cord injury, traumatic brain injury, chronic respiratory disease and other vulnerable populations.

In 2007, Office of Health Informatics: Connected Care/Telehealth developed four categories of care in which Veterans enrolled in Home Telehealth are placed. All patients must be placed in the appropriate Category of Care based on a formal assessment of individual patient health status. On March 12, 2018, a fifth category of care was released, Non-Institutional Care Low Responder. Until that time, Veterans not responding regularly were placed in the Health Promotion and Disease Prevention Category of Care due to the daily response requirement for Veteran Equitable Resource Allocation (VERA) reimbursement. During the panel size calculator study, data showed that Veterans who met the Non-Institutional Category of Care but did not meet the daily response requirement required the same amount of case management workload as Non-Institutional Care Veterans who were responding daily. Therefore, to appropriately capture that workload without impacting VERA reimbursement, the Non-Institutional Care Low Responder (NICLR) Category of Care was developed. The five categories of care and their explanations are below:

- **Non-institutional Care:** Must meet Non-Institutional Care criteria based on the administration of the Continuum of Care Form. To meet Non-Institutional Care requirements a Veteran must have one of the following:
    - Deficits in three or more Activities of Daily Living (ADL); or
    - One or more behavioral/cognitive deficits; or
    - Expected life limit of less than six months.
  - If the Veteran does not meet the Non-Institutional Care requirements above, then they can also be categorized as Non-Institutional Care by:
    - Having two or more ADL deficits; and
    - Meeting two of the following requirements:
      - Having three or more Instrumental Activities of Daily Living (IADL) deficits; or
      - Being age 75 or older; or
      - Living alone in the community; or
      - Having 12 or more clinic stops in the past 12 months.
  - If assigned a health promotion DMP such as Weight Management, it must be a co-morbid DMP. If any clinical needs fall outside a Care Coordinator's scope of practice (i.e., Registered Dieticians or Social Workers), collaboration with an RN Care Coordinator must occur to ensure all aspects of that Veteran's co-morbid needs are appropriately managed.

- **Non-Institutional Care Low Responder (NICLR)**
  - Must meet the same criteria for Non-Institutional Care described above.
  - Has been enrolled in Home Telehealth for at least three months (to properly assess and address regular participation).
  - Does not meet the patient participation guidelines of 70% response over three consecutive months.
  - Veterans assigned NICLR are included in any quality indicators or performance measures that focus on Non-Institutional Care.

    - Veterans assigned NICLR are not included in Veteran Equitable Resource Allocation reimbursement at this time.

- **Chronic Care Management**
    - Does not meet Non-Institutional Care criteria but must meet both below criteria for Chronic Care Management based on administration of the Continuum of Care Forum:
        - Diagnosis of one or more chronic illnesses amenable to Home Telehealth; and
        - Requires on-going intensive case management, monitoring and intervention.

- **Acute Care Management**
    - Patient has short-term clinic needs such as, but not limited to: post-operative care, transition management or post-hospital care (enrollment<= 6 months).

- **Health Promotion/Disease Prevention**
    - Primary need is for health promotion, disease prevention, and self-management education in maintaining healthy behaviors.
    - Is unable to answer at least 70% of the time through the technology for at least 90 days and cannot be qualified as NICLR since they do not meet the Non-Institutional Care requirements on the Continuum of Care Form.

2.4 History of VA Home Telehealth

Connected Care/Telehealth Services, within the VHA Office of Health Informatics and Analytics was established in July 2003 to support the development of new models of care in VA using leading edge health information technologies to address the pressing health needs of Veterans. Connected Care/Telehealth Services' mission and vision is to improve quality, convenience, and access to care for Veteran patients with the use of health informatics, telehealth, and disease management technologies that enhance and extend care and case management.

Connected Care/Telehealth Services is responsible for Telehealth implementation throughout VA in addressing clinical, technical and business issues whenever required to ensure telehealth programs are safe, useful, cost-effective and sustainable to meet the needs of Veteran patients. Connected Care/Telehealth Services supports the use of information and telehealth technologies to integrate the management of patients across the continuum of care and ensure patients receive the appropriate level of care when and where they need it. Collaborations necessary to support this work include the following:

- Working with other services in Connected Care/Telehealth Services to incorporate Telehealth and disease management technologies into routine practice.
- Working alongside or embedded within Patient Aligned Care Teams and other VA programs, clinicians, educators and patient groups to assist patients in easy access

to relevant data about their own health status, to enable them to actively participate in self-managing their care. An example is participating with other constituents in VHA in the continued development of MyHealtheVet.

- Collaboration with Office of Information Technology (OI&T) to support safe and secure technology.
- Collaboration with Patient Care Services and Connected Care/Telehealth Services to provide innovation and secure technology.
- Working with the Denver Logistics Center (DLC) to ensure timely purchase, patient assignment, delivery, retrieval and refurbishment of technology.
- Linking with other VA programs, clinicians, educators and external caregiver groups to understand the needs of caregivers in the context of telehealth and engaging in activities to support informal caregivers and volunteers and how they need to be considered in the planning and delivery of Connected Care/Telehealth Services. Making the home the preferred place of care maintains the caregiver in a pivotal position in the care delivery process. Connected Care/Telehealth Services, in partnership with others, supports the desire of Veteran patients to achieve the following experience from their interactions with VHA: "no decision about me is made without me."

2.5 Telehealth Organization and Infrastructure

The importance of organization and infrastructure at both VISN and VAMC (Station/Site) levels, in the development and operation of telehealth programming, cannot be over emphasized. Because telehealth involves such a large number and variety of organizational entities within these different levels of the organization, high degrees of coordination and oversight are necessary. An effective communication plan is essential.

Telehealth must be a continuum including clinic-based, home and mobile patient settings, as well as synchronous and asynchronous modalities of clinical service delivery.

2.5.1 VISN and Station-Level Infrastructure and Oversight of Home Telehealth

The VISN level infrastructure begins with a Telehealth Program Manager who has the responsibility and authority to guide, govern, strategically plan, deploy and operate telehealth programs. In some cases, a VISN-level Home Telehealth Program Manager is appointed to provide this oversight as Home Telehealth is one part of the telehealth continuum and must be integrated into an overall telehealth organizational matrix. Station level infrastructure may include the Facility Telehealth Coordinator overseeing all Connected Care/Telehealth Services staff within the local setting, including Clinical Video Telehealth (CVT), Home Telehealth and Store-and-Forward Telehealth. Alternatively, station level infrastructure may include a Home Telehealth Lead that oversees the Home Telehealth program and works collaboratively with the Facility Telehealth Coordinator.

2.5.2 National-Level Infrastructure and Oversight

Connected Care/Telehealth Services provides guidance and support for Home Telehealth Programs through its national Home Telehealth Lead and Clinic Nurse Analyst, National Development and Telehealth Training Teams, as well as its Data Analyst and Contracting Representative. In addition, the Quality Team provides support and guidance in the oversight of program responsibilities in providing Home Telehealth Services through the Conditions of Participation which can be found under the Condition of Participation category on the Telehealth SharePoint.

3. Planning and Expanding Home Telehealth Programs

Developing a business plan is essential to implementing new programs or expanding existing Home Telehealth services and this plan involves numerous steps. A methodological approach is recommended to ensure that critical elements are not overlooked, which could seriously impact overall program success. Successful Home Telehealth programs integrate technology and case management with clinical program needs. The primary components of planning for integrated Home Telehealth programs are:

- A thorough needs assessment, which includes basic infrastructure such as staffing, equipment, space and unmet clinic needs.
- A strong business case which includes an analysis of the return on investment and plan for sustainability, which are essential foundational elements for Home Telehealth program development. This is discussed in detail in Chapter 4.
- A plan for integrating Home Telehealth services across the Continuum of Care.

4. Business Case Development

A business case analysis addresses, at a high level, the business needs that the program seeks to address. It includes the reasons for the program, the expected business benefits, the options considered (with reasons for rejecting or carrying forward each option), and the budget which presents the expected costs of the program. It should also include a Gap analysis, which is a well-established technique for determining what direction an organization should go to move from their current state to their future "ideal" state and the expected risks.

Factors to consider when developing the business case for Home Telehealth:

- Costs associated with equipment, labor and space
- Capital investment, expenses and overhead
- Start-up and ongoing sustainability
- Bed Days of Care reduction costs
- Funding allocations received based on workload that is generated by the program, such as the VERA. The VERA is based on enrollments in Non-Institutional Care and Chronic Care Management categories of care.

Things to consider when developing the budget proposal:

- Perform a needs assessment for Home Telehealth Services at VISN and/or facility level
- Identify necessary resources (e.g. telehealth equipment, staffing, furniture, etc.)
- Gather supporting data reflective of the needs. For example: waiting times, travel costs, underserved populations, etc.
- Estimate cost of resources and set the budget request
- Develop a proposal that describes the needs, goals, strategies, investment, evaluation and expected outcomes
- Document the telehealth program investment payback period and successful sustainability of the Home Telehealth program

The following resources may be helpful to provide guidance regarding feasibility and sustainability of a program:

- National Telehealth Training Team
- VISN Telehealth Program Managers
- VISN Leads Council
- VHA Telehealth Intranet site

4.1 Needs Assessment

Strategic planning provides a structure to guide in developing or expanding a Home Telehealth program and identifies the goals and objectives. In order to develop the strategic plan, one needs to complete a needs assessment. The needs assessment is an important part of the business case and is constructed from the following:

- Numbers of patients that have health needs that can be treated via Home Telehealth
- Costs of providing care via Home Telehealth as compared to traditional methods

Given the on-going demand for primary and specialty care services in VHA and the mandate to improve access to services, especially at geographically remote sites, it is likely that the need for Home Telehealth will continue. A major component of the needs assessment will be the process for identification and enrollment of high-risk, high-cost patient populations most likely to benefit from Home Telehealth.

The needs assessment identifies the goals and objectives of the program as well as resources and activities needed to achieve the plan. It is also used to provide information such as the targeted population, business perspectives and metrics for performance evaluation. A needs assessment is also a systematic method of identifying the unmet needs of the population and making changes that will benefit from an intervention.

The Telehealth Program Manager needs to determine the patient population as well as the specific fields of relevance for analyses. Useful data includes:

- Patient data (e.g., utilization outcomes, quality outcomes, clinical outcomes)

- Documented problems in meeting the needs of a group of patients (such as distance and travel barriers, no-shows, medical problems, weather problems, etc.)
- Available resources
- Workload and capacity
- Special needs populations
- Provider data (e.g., utilization data, satisfaction data, clinical data)
- How will Home Telehealth fill the gap from one service to another
- Avoiding a duplication of services

The criteria in the needs assessment appraisal must include the following:

- Access to the targeted population: What specialty population(s) will be served with Home Telehealth?
- Expected outcomes from both the clinical and business perspectives (i.e., accomplishments using Home Telehealth)
- Performance measures: What performance measures will Home Telehealth assist?
- Space and resources available: Is there appropriate space to expand Home Telehealth?
- Staffing needs: What clinic and other staff will be necessary to expand Home Telehealth?
- Capacity and workload: How many patients could be enrolled in Home Telehealth based on the resources available?
- Technical considerations: What types of Home Telehealth technologies will best serve the identified population? What are the associated costs of that equipment or service?

Information received from the needs assessment will help support a productive clinical strategic plan to expand Home Telehealth.

The following are key elements that should be included when developing the strategic plan:

- The plan should focus on the "Who, What, Where, When and How" of both clinical and business aspects of the Home Telehealth program.
- Roles and responsibilities of the team should be well-defined for a successful implementation.
- Action items and deadlines should be clearly stated.

It is important to develop specific strategies and targets to guide Home Telehealth program development. The next step in developing the plan is execution and deployment. Information obtained from the needs assessment should guide the plan.

4.2 Home Telehealth Enrollment Goals and Panel Size

As part of the process for determining the types of patients that will be enrolled, a decision for panel sizes should be made. Panel sizes for full time, dedicated Care Coordinators should be dependent on the Care Coordinator's scope of responsibilities, scope of practice, and the complexity of care and intensity of service needs for the patients in the panel (case mix).

Historically, panel sizes in the Home Telehealth program have a Veterans Equitable Resource Allocation (VERA) of approximately 100-110 patients per Care Coordinator, but since 2014, panel sizes average 80-100. In 2014, Telehealth Services chartered a national Panel Size Workgroup to do a thorough analysis of appropriate panel size. Membership included a VISN Program Lead, Lead Care Coordinators, Care Coordinators and Master Preceptors. This group implemented a multi-site, multi-VISN time study to determine current panel sizes, what non-clinic tasks were being provided by Care Coordinators and the availability of program support staff. The group also looked at a number of factors (via the multi-VISN time study) that impacted Care Coordinators' workload including: staff coverage, use of over-time, comp time or non-compensated time; numbers of vendors and peripherals being used; administrative duties, Leads and Master Preceptor duties. From the results of the time study, the group developed a "Panel Size Calculator." Use of this tool, which is highly recommended by the Connected Care/Telehealth Services, will help leadership and Home Telehealth program staff determine what is safe and effective for their individual panel size based on these and other unique factors. The use of the Panel Size Calculator tool is not mandatory; however, if programs choose not to use it, they must have some other rationale in place to justify current/target panel sizes for all Home Telehealth staff.

4.3 Space Planning for Home Telehealth

The square footage needed for a Home Telehealth program office will vary depending on the number of staff and the types of services being provided. Basic planning for space should include an office that provides privacy for both audio and video interactions. These include face-to-face encounters and those that occur over the telephone.

If multiple Home Telehealth staff members are conducting enrollment visits within the same space, privacy considerations need to be addressed to ensure Health Insurance Portability and Accountability Act compliance. Use of headsets by Care Coordinators as well as white noise technologies are recommended. If video equipment is being used, privacy of conversations and images must also be addressed within the planned space.

All Home Telehealth programs should be in consultation with site safety staff to ensure office furniture is placed in such a manner to ensure maximum staff safety and accommodate patients with disabilities. There should be consideration of the installation of panic buttons for staff use in case there is a patient crisis.

Telework may be a viable option to resolve space issues because Home Telehealth does not require daily face-to-face contact. In this consideration, it is recommended there be staff on-site available during working hours to manage walk in visits by patients ensuring the

"Right Care at the Right Place at the Right Time". Telework has been successfully implemented as an option for Home Telehealth in several VISNs. For more information regarding VHA Telework, including Talent Management System (TMS) training for supervisors and supervisees, see Employee Education Service.

4.4 Deploying and Managing Home Telehealth Programs

There are several factors that should be considered when utilizing Home Telehealth services; such as whether to expand existing Home Telehealth programs, establish a new one, or create a combination thereof which will meet the needs of the patient population(s) to be served. Once the implementation or expansion plan has been developed and agreed to by all stakeholders, the VISN Telehealth Program Manager or Home Telehealth program manager can collaborate with stakeholders to determine how to take the necessary steps for successful implementation. A key consideration for how best to implement Home Telehealth is how to ensure integration with other services so that the care coordination provided by the Home Telehealth program can be most effective and efficient for all members of the healthcare team; most importantly, the patient. Home Telehealth is a very flexible program and its integration within the healthcare system can take place with many variations and via multiple mechanisms. Even with its flexibility, this integration for Home Telehealth will fall into two categories:

- **Option 1 Program:** A widespread, broad service, organizationally separate from any one primary or specialty care service/clinic, providing care and case management to patients with multiple chronic conditions who are receiving care anywhere across the VA healthcare continuum with outreach to non-VA health care settings. For example, the "Rural Home Telehealth Program" located within a VA Medical Center in Florida that reports directly to the Chief of Staff.
- **Option 2 Program:** A specialized service, organizationally aligned ('embedded') within an existing service or clinic, focusing care and case management to a limited subset of patients or special populations cared for by that service/clinic, with outreach to other VA and non-VA health care settings for those same patients. For example, a Mental Health Home Telehealth Program embedded in the Mental Health Outpatient Clinic.

In either case, it is important that the Home Telehealth program collaborate with the healthcare teams it will be working with closely prior to implementation to gain agreement for how care will be coordinated, how communication will occur and what, if any, clinic protocols are approved for standardized plans of care and/or clinic interventions. The next several sections describe some of the more frequent options employed for integrating Home Telehealth programs.

4.4.1 Integrating Home Telehealth with Other Services

Home Telehealth requires a collaborative and interdisciplinary team process across the continuum of care; this collaboration takes place regardless of how the Home Telehealth program is aligned organizationally.

Home Telehealth has been successfully affiliated with Patient-Aligned Care Teams, Health Promotion programs (e.g., MOVE!), Home-Based Primary Care, and Mental Health. Effective communication by the Home Telehealth program staff with the health care team must happen regularly and whenever there is a significant change in the health status of the Veteran.

The goal of VHA's Home Telehealth model is to integrate longitudinal, remote patient monitoring and case management with the face-to-face care provided by each patient's interdisciplinary team to optimize transitions between inpatient and outpatient care, facilitate specialty care, and optimize patient education and incorporate services such as Patient Aligned Care Teams, Home Based Primary Care, Mental Health Services and many others. Collaborating with the interdisciplinary team helps to facilitate seamless care management, incorporate population management, support flexibility across healthcare settings and encourages the Veteran to be a primary partner in the team through self-management skill building.

Home Telehealth team members should perform the following tasks:

- Become visible to interdisciplinary team members. Create opportunities for frequent formal and informal interactions.
- Collaborate with Patient Aligned Care Teams in the development of patient specific goals and plans of care.
- Share their expertise in care coordination and case management through team huddles, implementation meetings, grand rounds and other meetings.
- Maintain documentation on the patient. Focus communication activities on the provider and the RN Care Managers in the interdisciplinary team. Formally share outcome data and performance improvement approaches with the team.
- Collaborate with the team to develop/utilize disease specific treatment/intervention protocols to increase quality and efficiency in providing care.
- Use feedback as an essential tool for continued success.

When making the decision to develop or expand an existing program, it is imperative to review the needs assessment and decide which organizational alignment would best meet the needs of the Veterans. It is important to remember that integration can and should occur regardless of the selected alignment. Much collaboration has resulted in population-specific Disease Management Protocols (DMPs). These DMPs resulted in the need for Home Telehealth implementation supplements such as for TeleMOVE!, Mild Traumatic Brain Injury, and Spinal Cord Injury DMPs.

4.4.1.1 Integration with Patient Aligned Care Teams

VHA implemented the Patient Aligned Care Teams model as an approach to providing comprehensive primary care for adults. Patient Aligned Care Teams is a health care model that facilitates partnerships between individual patients and their personal providers and the patient's family and/or caregiver.

VHA's principles of Patient Aligned Care Teams are as follows:

- Veteran or patient-centric care
- On-going relationship with provider
- Physician directed medical practice
- Whole person orientation
- Coordinated care across the health system
- Quality and safety
- Enhanced access to care

The goal of VHA's Patient Aligned Care Teams model is to integrate coordination of care which optimizes transitions between inpatient and outpatient care, facilitates specialty care interfaces, incorporates supportive services such as Home Telehealth and Home Based Primary Care, includes seamless care management, incorporates population management, supports flexibility across healthcare settings and encourages the Veteran to be a primary partner in the team through self-management skill building.

Home Telehealth Care Coordinators have the skill set to leverage the use of case management, health informatics, telehealth technologies and disease management strategies to coordinate care of Veterans with high risk, high cost and/or high utilization patterns. Home Telehealth focuses on improving patient self-management skills to assist with improving VERA for all patient outcomes. Because of these, Home Telehealth has been an excellent partner for Patient Aligned Care Teams.

4.4.1.2 Collaboration with MOVE!

Connected Care/Telehealth Services and the VHA National Center for Health Prevention and Promotion worked together and deployed a Weight Management (TeleMOVE!) DMP in 2010. A national kick-off helped disseminate information and educate staff about this collaboration. An implementation guide was developed and is located at the end of this section under Resources. This single DMP is a Health Promotion/Disease Prevention Category of Care DMP and has created very healthy and energetic networking with Nutrition and Food Service partners. Beginning In 2017, Weight Management DMP may be combined with other VA or vendor DMPs to make a co-morbid or tri-morbid DMP. The stand-alone VHA Weight Management DMP is still considered a Health Promotion/Disease Prevention DMP. However, when combined with other VA or vendor DMPs, the Veteran may be classified as Health Promotion/Disease Prevention, Chronic Care Management or Non-Institutional Care as appropriate through screening with the Continuum of Care Form. Any Weight Management Veteran on a co-morbid or tri-morbid DMP must have thorough documentation that all aspects of care are managed appropriately by the Care Coordinators working within their scope of practice. For those reasons, Care Coordinators who are Registered Dieticians or Social Workers should be collaborating with RN Care Coordinators.

4.4.1.3 Integration with Home Based Primary Care

Some Home Telehealth programs are embedded within the Home Based Primary Care program where Home Telehealth is used to lengthen the time between home visits. Home Telehealth is a great tool to assist with the daily care management of the Home Based Primary Care Veteran with complex needs that require both program initiatives.

Home Telehealth is also used to help meet the in-home needs, as appropriate, of those Veterans that live outside the distance restrictions established by the Home Based Primary Care program, thus offering services to Veterans that cannot be managed by the Home Based Primary Care program.

4.4.1.4 Integration with Mental Health

Home Telehealth is also often integrated within the Mental Health Service line. There are Home Telehealth programs that have designated Mental Health Care Coordinators, as well as some programs that manage mental health patients within their chronic medical populations and work collaboratively with Mental Health Care Coordinators and medical providers and programs. Positive outcomes have been demonstrated in the Mental Health population as Home Telehealth provides case management for the Veteran's mental health condition plus their other chronic medical conditions.

Although programs have been enrolling patients with a variety of mental illnesses, VHA developed and released nationally a Substance Use Disorder Disease Management Protocol in 2010. The Home Telehealth Program Care Coordinator helps the Veteran transition from an intensive in-patient or out-patient Substance Abuse Program to successfully experience sobriety beyond their intensive program.

In addition, Mental Health DMPs such as Depression, Post Traumatic Stress Disorder, Psychosis and Bipolar Disorder have been nationally developed and released to meet the needs of Veterans with these chronic mental health issues. These DMPs all include information for the Veteran's Crisis Line (1-800-273-8255) so Veterans have that information readily available if needed.

4.4.2 Home Telehealth Collaboration Agreements

Facility-developed written service agreements such as Home Telehealth collaboration agreements or Care Coordination agreements have been used in VHA for many years to define the expectations of care coordination and hand-offs between services. Development of such agreements between Patient Aligned Care Teams (and/or specialty care teams) and Home Telehealth programs are highly encouraged, especially for new Home Telehealth programs to clearly define the expectations of care coordination. The purpose of such an agreement is to formalize the trust-based relationship between Patient Aligned Care Teams or specialty teams and Home Telehealth and to ensure that timely, high quality, comprehensive, coordinated and patient-centric care is provided to each Veteran in a safe, effective and efficient manner. The agreement should be reviewed and updated at regular intervals (e.g., such as every two years) and as needed when there are any significant changes. The agreement should clarify clinical, business and technical details of the care and communication methods between Home Telehealth and Patient Aligned Care Teams or specialty care teams.

A local agreement between Patient Aligned Care Teams or specialty care teams and Home Telehealth defines how they will work together to accomplish care management without duplication of services for the patient. Topics for inclusion in the agreement include:

- Referral methods
- Frequency and types of routine communication (e.g., using Computerized Patient Record System notes with the "identify additional signer" function and/or secure messaging)
- How changes in care plans will be coordinated and communicated
- Explanation of what types of diagnoses and conditions the Home Telehealth program is best equipped to manage, including the available DMPs
- Protocols - Which program/staff will act as "first contact" for patient issues and how follow-up is communicated to the team
- The process for ensuring smooth patient hand-off at the time the patient is discharged from Home Telehealth and other areas of mutual concern

Such agreements may also identify aggregate clinical indicators of mutual interest that will be utilized in ongoing performance improvement activities by Home Telehealth. Examples of these activities might include inpatient admissions and emergency room visits in the past year, aggregate Hemoglobin A1C data both pre- and post- enrollment for patients with Diabetes, and aggregate blood pressure data both pre- and post- enrollment for patients with Hypertension.

4.4.3 Clinical Protocols

One example of the collaboration tools that are sometimes utilized in Home Telehealth programs are Nurse (Advanced Practice Nurse [APN] or RN)-driven protocols. Such protocols are written as standardized plans of care or order sets that provide detailed descriptions of steps to be taken by the Advanced Practice Nurse/RN to deliver elements of evidence-based care to selected groups of patients (e.g., diabetic patients or patients with chronic heart failure or Chronic Obstructive Pulmonary Disease). Use of such protocols may further define the role of the RN and allow for practice 'at the top of their license', thus providing for more consistent and effective approaches to assist patients in achieving desired outcomes. In some cases, those same protocols might be utilized both by RN Care Coordinators in Home Telehealth and the Patient Aligned Care Teams RN Care Managers so that the same evidence-based approaches are utilized by both groups of RNs and with the same types of patients. Use of such protocols requires that the RN be skilled in care and case management and Home Telehealth processes and communications, both verbally and in Computerized Patient Record System documentation notes. It requires well-developed communication strategies with the patient's providers and a trust-based relationship with those providers as well as other members of the team. The development, approval, and use of such protocols need to follow local policy requirements.

See VHA Directive 1108.13: Provision and Use of Nursing Medication Management Protocols In Outpatient Team-Based Practice Settings for information on acceptable medication management protocols for RNs.

4.4.4 Human Resources, Key Positions, Roles and Responsibilities

Human factors involved in the care of the Veteran must be considered when creating Home Telehealth programs. A major challenge in the implementation and sustainability of Home Telehealth programs is collaborating with a large number of individuals, varying procedures and protocols, different work styles, biases and new technologies. It is the human factors, such as the personal connection, relationship and trust built with their Care Coordinator that matter most in the Veteran's experience with Home Telehealth. Beyond the technology, it is the people involved that contribute greatly toward a successful Home Telehealth experience.

One of the critical predictors of a successful and sustainable Home Telehealth program is adequate, appropriate and competent staff. Home Telehealth involves a range of processes that enable innovative new technologies to be used in the delivery of care and case management. The "Key Positions" below are provided to help identify the appropriate team members by illustrating how Human Resources and accreditation requirements should be approached when implementing a Home Telehealth program. Further detail is provided for each position.

Key Positions in Home Telehealth:

- Care Coordinator
- Lead Care Coordinator
- Facility Telehealth Coordinator
- Home Telehealth Support Staff
- Home Telehealth Master Preceptor
- Home Telehealth Preceptor
- Home Telehealth Clinic Champion
- VISN Home Telehealth Program Manager

4.5 Care Coordinators

Care Coordinators are case managers that are specialized, highly-skilled and have specific training and competency in the use of disease management, healthcare informatics and Home Telehealth technologies with complex Veteran patients. Care Coordinators are typically Registered Nurses or Licensed Clinic Care Social Workers who have the requisite training and scope of practice for this role. Care Coordinators emphasize collaboration and engage in processes that assess, advocate, plan, implement, coordinate, monitor, and evaluate health care options and services so that they meet the needs of the individual patient. Other professional staff members such as dietitians, physical or occupational therapists, pharmacists, physicians, etc. may serve as ancillary (paired with a nurse) Care Coordinators within their scope of practice. These role requirements are the same for all Home Telehealth programs. In programs that serve patients in the Health Promotion/Disease Prevention categories of care (such as TeleMOVE!, tobacco cessation, etc.) the Care Coordinator may be a Registered Dietitian or Social Worker who must collaborate with RNs for care that may be outside their scope of practice. Licensed Practical

Nurses or other professional staff members do not have the necessary skills to function as a Care Coordinator. The role requires significant assessment skills and duties required outside their scope of practice. There are however, many duties that the Licensed Practical Nurses can support in Home Telehealth. The resource, LPN FAQs, explains the Licensed Practical Nurses duties in detail.

Responsibilities of Care Coordinators may include:

- Provide initial and ongoing comprehensive assessment to include a review of systems which establish a comprehensive plan of care. The Care Coordinator through the treatment plan assesses, identifies, analyzes and prioritizes problems, interventions and appropriate measurable goals (i.e., Simple, Measurable, Achievable, Realistic, Time-oriented (SMART) goals). The treatment plan is an extension of the Veteran's primary care plan and is completed in collaboration with Patient Aligned Care Teams, Home Based Primary Care, Mental Health and other specialty care services as appropriate for each Veteran enrolled in the program.
- Triage and assess all data received from Home Telehealth patients such as vital signs, reported symptoms and question responses. The Care Coordinator will review all patient responses each work day and contact patients with high risk responses and trends, significant changes in condition or changes in other specific data elements received as clinically appropriate.
- Identify and intervene for potential exacerbations or complications to facilitate timely care in clinic, Emergency Response/urgent care, or care in the community.
- Provide appropriate interventions such as medication management, case management and patient education.
- Complete protocol-based interventions (as needed).
- Triage incoming calls and concerns of patients/families, resolve those within scope of practice and route others to interdisciplinary team staff or other services as indicated.
- Provide communication and data exchange with community-based providers when there is co-managed care.
- Provide interdisciplinary consultation and interventions such as with Home Based Primary Care and other non-institutional care programs and venues, mental health, social work, pharmacy, nutrition, etc.
- Identify patients' knowledge, health factors, skills and behaviors that support self-management and identify gaps within.
- Provide health care coaching, patient education and psychosocial support.
- Document and communicate with Patient Aligned Care Teams members regarding changes in status; progress to goals; patterns or trends of data; symptoms or findings of concern and need for provider assessment and/or interventions.
- Facilitate, document and communicate treatment changes to the Veterans as directed by providers. In addition, provide follow up evaluation of the Veteran after changes are implemented.

- Provide support and guidance and review changes in medications, goals and the treatment plan to Veterans during and after transitions in care such as following a hospital discharge, etc.
- Assess and analyze outcome indicators, develop action plans for both individual Veteran patients and aggregate populations to enable continuous performance improvement.

4.6 Lead Care Coordinators

Lead Care Coordinators have all the same competencies and training as Care Coordinators, but in addition, they perform administrative or supervisory duties as well (as listed below). Lead Care Coordinators may be Registered Nurses, Nurse Practitioners, Licensed Clinic Social Workers or other professional staff members (such as dietitians, physical or occupational therapists, pharmacists, etc.).

Responsibilities of a Lead Care Coordinator may include:

- Serve as local, VISN, and national contacts for specific types of communications related to Home Telehealth.
- Direct or indirect supervisory component in reviewing and evaluating the work performance of other Home Telehealth employees, making assignments such as coverage for patients in the event of absenteeism, ensuring staff competency and performing peer review.
- Provide guidance by establishing and maintaining positive teamwork among Home Telehealth staff.
- Responsible for ensuring continuity of care during emergency or disaster events.
- Responsible for developing a "Performance Improvement" culture which includes: collecting, analyzing and reporting on performance improvement measures, providing leadership to staff for continuous performance improvement initiatives and developing appropriate and effective performance improvement plans.
- Participate in local, network or national committees and task forces.
- Serve as point of contact for the Home Telehealth Conditions of Participation which includes: maintaining compliance, addressing deficiencies and ensuring the Home Telehealth program meets Conditions of Participation.
- Responsible for a Home Telehealth presence in the local facility or clinic through promotion and awareness-raising activities and develop key collaborations and outreach in local settings.
- Ensure new staff are oriented to all business, clinical and technical program processes.
- Monitor and ensure documentation of training completion dates for all Home Telehealth staff.
- Identification of preceptor-caliber staff and support of the preceptor role.

4.7 Facility Telehealth Coordinator

The VAMC-level Facility Telehealth Coordinator (FTC) is a key player for success. This position is usually but not always responsible for the operation of all telehealth programs within the facility. The FTC may be responsible for the overall planning, coordination, implementation and evaluation of clinical applications of all telehealth programs, (Home Telehealth, Clinical Video Telehealth, Store-and-Forward Telehealth) based on facility needs. If appropriate, the FTC must have a good understanding of the Home Telehealth program and must work collaboratively with both the VISN-level Telehealth Program Manager and the Home Telehealth Lead to optimize the Home Telehealth program at the facility.

4.8 Home Telehealth Support Staff

Staff under this heading might include: Program Support Assistants; Telehealth Clinical Technicians; Licensed Practical Nurses; Health Technician; or Medical Support Assistants. This role is vital as it may be the first contact patients and families have with the Home Telehealth program. It is recommended that for every three Care Coordinators in a program, there should be at least one full-time support role (3 Care Coordinators: 1 Support Staff).

Responsibilities of Support Staff may include the following:

- Being the first contact patients have with the program
- Troubleshooting and maintaining telehealth equipment
- Helping with enrollment, disenrollment and troubleshooting non-responding activities on telehealth equipment and documenting these as appropriate.
- Data entry, telephone answering, tracking, supply processing, etc.
- Preparing data reports such as outcomes and patient satisfaction and other miscellaneous reports
- Other administrative duties as assigned

(Note: If Program Support staff (not clinic staff) go into Veterans' homes to install or troubleshoot equipment depending on local or VISN guidance, programs should have in place polices and/or procedures to address Veteran and staff safety. Should a patient incident or emergency occur, support staff should be prepared to get the proper help and notify designated Home Telehealth staff as soon as possible.)

4.9 Home Telehealth Master Preceptor

The Home Telehealth Master Preceptor Program, along with VISN Telehealth staff, develops a team of experts to facilitate training and competency efforts within each VISN to promote personal and professional development. This program is fundamental to assisting with the preparation of competent Home Telehealth field staff in meeting Veteran healthcare needs. As previously stated in VHA's strategic plan, "Employees are the foundation of the Department of Veterans Affairs and are the key to its success." The Master Preceptor role supports the local, VISN and national level mission and vision for

Home Telehealth. Individuals eligible for this role might include: VISN or Home Telehealth Leads, Facility Telehealth Coordinators, Lead Care Coordinators or Care Coordinators. Currently all Home Telehealth Master Preceptor programs are being decentralized to the VISN and local levels through a National Workgroup Process.

4.10 Home Telehealth Preceptor

This role, previously known as Support Preceptors, helps in the preparation of fully trained Home Telehealth field support staff in meeting Veteran healthcare needs. These staff provide a vital service in the day-to-day operations of the Home Telehealth program. This program supports the on-going mission and vision of the local, VISN and national levels. Individuals eligible for this role might include: PSAs, Medical Support Assistants, Licensed Practical Nurses, Health Technicians or Telehealth Clinical Technicians. Currently all Home Telehealth Preceptor programs are being decentralized to the local level through a National Workgroup Process.

4.11 Home Telehealth Clinical Champion

The Clinical Champion is a clinical practitioner that strongly supports the implementation or expansion of a Home Telehealth program and is interested in promoting Home Telehealth among peer providers.

Characteristics of the Clinical Champion include:

- Serves as an "expert" in understanding the benefits of Home Telehealth services
- Serves as a role model and strong supporter of Home Telehealth Services; encourages and motivates others to refer to Home Telehealth programs
- Works around barriers and assists with resistance to change that may occur with any new program implementation

4.12 VISN Home Telehealth Program Manager

The VISN Home Telehealth Program is an administrative role that has clear oversight for the Home Telehealth program within their VISN. They strongly support the implementation or expansion of a Home Telehealth program and are interested in promoting Home Telehealth. They are the primary conduit for bidirectional communication from Office of Health Informatics: Connected Care/Telehealth Services to their Telehealth practice communities.

5. Staff Education, Training and Competency

Training and competency are the cornerstones of a successful Home Telehealth program. Superior interpersonal and comprehensive case management skills are required of all Home Telehealth staff.

To achieve these skills everyone involved in Home Telehealth will have formal training and skill assessment that includes clinical, business and technical elements. The VHA's National Telehealth Training Team provides a training plan of 'critical' and 'elective' training offerings. The training plan is located on the Connected Care/Telehealth Services website.

Performance support (any tool, material, process, or system that an organization can put in place to help its employees accomplish their job in an efficient and effective manner) and competency evaluation are managed primarily at the point of performance through the local supervisory chain of command. The needs of Veterans and staff drive the focus of competency for all staff involved in the delivery of Home Telehealth services. It is at the discretion of the VISN and local leads and supervisors to determine other training offerings that may be required for all Home Telehealth staff. In addition, all VISN/local standard clinical training and annual competency requirements apply to Home Telehealth staff.

Clinical, technical and business elements need to be assessed and analyzed using data collection, as well as the design of business operations to ensure that processes are in place to enable effective, efficient and sustainable Home Telehealth programs. A process must be put into place to ensure information on performance improvement and clinical outcomes related to Home Telehealth programs are shared and disseminated with both facility and VISN Quality Management and leadership. Currently all Home Telehealth competency processes are being decentralized to the VISN and local levels through a National Workgroup Process.

6. Orientation

Each new staff member must meet the minimum requirements for providing Home Telehealth services before beginning to care for Veterans in the Home Telehealth program. These requirements can be found within the Home Telehealth Training Plan. There is a national orientation program entitled "Navigating Your ABCs" provided monthly and 'just-in-time' by the Telehealth Training Team. The Home Telehealth Mental Health Guide provides a Mental Health orientation tool for staff use. Home Telehealth staff are also required to complete the annual skills assessment when appropriate and provided by The National Telehealth Training Team each fiscal year. An on-line course located on the Talent Management System, entitled "Home Telehealth: The Basics" was developed to meet the requirements for Home Telehealth coverage staff, non-Home Telehealth supervisors, clinicians/providers reviewing data over the technology platforms and to help Patient Aligned Care Teams RN Care Managers understand Home Telehealth.

6.1 National Telehealth Training Team

Connected Care/Telehealth Services operates an integrated National Telehealth Training Team devoted to providing training and performance support for the three telehealth areas: Clinical Video Telehealth, Home Telehealth and Store-and-Forward Telehealth. In

most instances, these training opportunities are primarily offered virtually to allow for convenient access for VA staff nationally.

The National Telehealth Training Team provides staff and administrators with requested and required training tools and performance support. The team provides training and serves as a resource for Home Telehealth programs. In addition, team staff provide support to ensure case management skills are developed so that Home Telehealth staff provide safe, high-quality care as directed through the Conditions of Participation, an internal accreditation process (refer to Section 11 titled Workload Capture and Data Management for more detailed information). Established in 2004, the National Telehealth Training Team continues to update and add learning opportunities in a variety of modalities:

- Web Based Courses
- "My Telehealth Learning Portal"
- Live Videoconference training and consultation
- Live Meeting Forum Training (Skype, Adobe Connect)
- Just in Time Training
- Videos
- Mentoring/Coaching programs
- Communities of Practice/collaborative learning groups and discussion boards
- Home Telehealth Electronic or Printed Resources

7. Home Telehealth Clinical Pathway and Care Coordination Process

Home Telehealth is a program that provides Veteran-centric care delivery, starting with a comprehensive assessment that leads to the development of patient-centric goals and a treatment plan that includes patient education, medication management and collaboration with other services and community resources. Home Telehealth is a program that supports Veterans across the healthcare continuum through:

- Daily monitoring and assessment of the Veteran's progress toward health goals
- Ensuring Veterans have meaningful choices
- Making the Veteran's residence the preferred site of care
- Supporting the Veteran's caregivers
- Enabling the timely provision of services and interventions
- Using evidence-based care guidelines to develop services
- The routine measurement and analysis of patient care outcomes and performance improvement

It is critical that Home Telehealth staff, most importantly Care Coordinators, understand that they are coordinating Veteran care and as such, they are expected to be an advocate

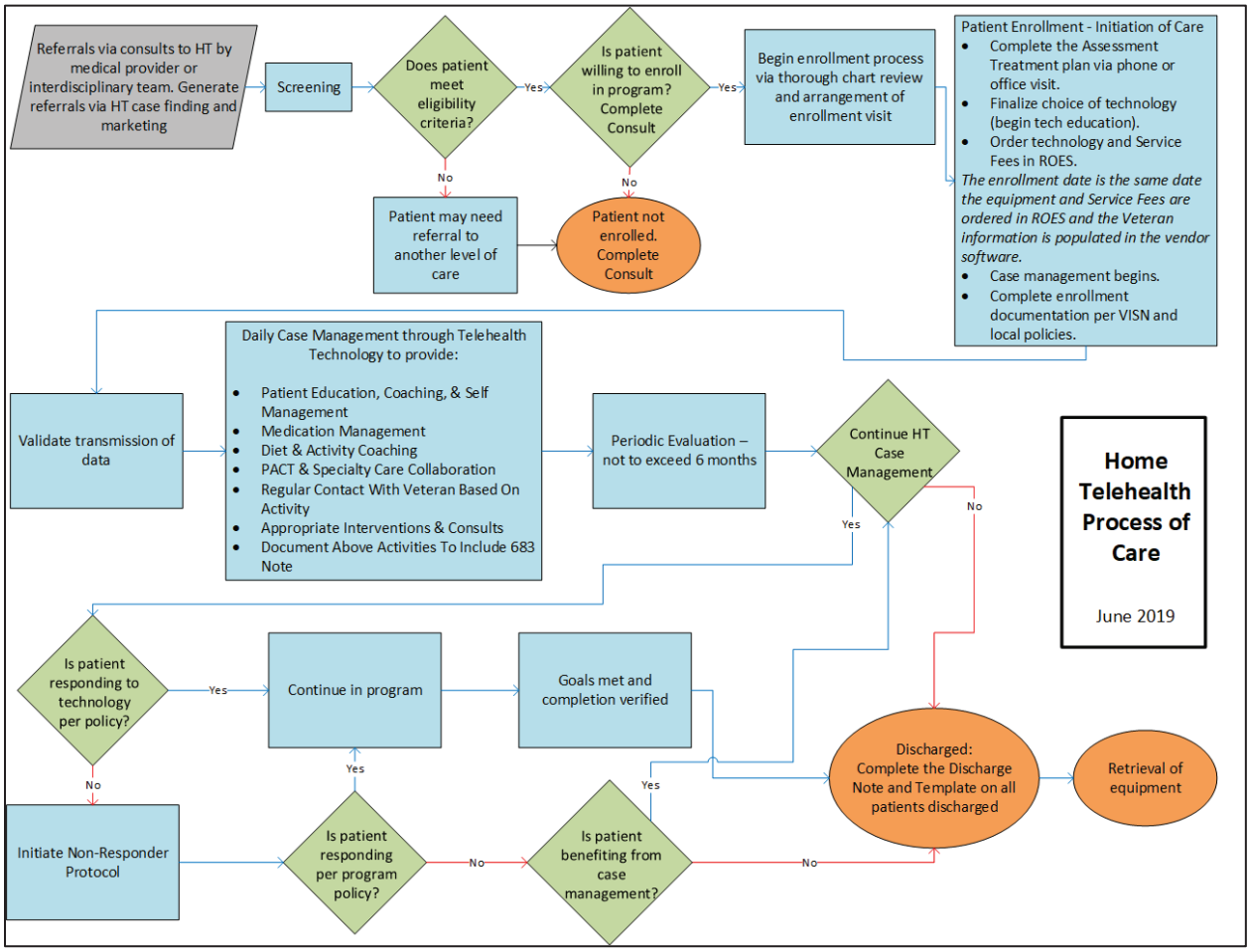
for the Veterans across the VA and non-VA healthcare continuum. Home Telehealth is not simply a "remote monitoring program" and is not intended to be implemented as a silo within the VA healthcare system. Care Coordinators look at the Veteran holistically; and they are in an optimum position to coordinate care across Service Lines and assist with transitions between both inpatient and outpatient settings. Understanding the expectations of care that this role provides can be best described through the clinical processes within the Home Telehealth model and the related Computerized Patient Record System medical record documentation standards (Section 10: Documentation Standards).

The fundamental Home Telehealth Care Coordination process and communication flow is illustrated in Figure 2 below and can be summarized into the following phases:

- Screening and Identifying Appropriate Veterans
- Enrollment into the Home Telehealth program including assessment and developing a plan of care
- Ongoing care coordination, case management and monitoring
- Disenrollment/transition to other services

This section provides further detail of key components of the Home Telehealth process of care – technology and disease management protocols (DMPs) – that need to be understood in order to fully comprehend the Home Telehealth clinic pathway, including the standards and processes of care, which are fully described in Section 10: Documentation Standards.

Figure 1: Home Telehealth Clinic Pathway Diagram



The following sections briefly describe the essential elements within the Home Telehealth Clinic Pathway. Detailed information on Home Telehealth notes and templates are provided within section 10: Documentation Standards. Some of these elements may vary slightly depending on local policy.

7.1 Screening and Identifying Appropriate Veterans

There are many case finding methodologies and data sources that staff can use to identify appropriate Veterans for enrollment. Some data sources include local data warehouse information where populations can be searched by clinic diagnosis, cost and other variables. The VHA Support Service Center (VSSC) provides Patient Aligned Care Teams data through the Compass of Measures where populations can also be identified by diagnosis and clinical need. Emergency Room visits and hospital discharges are also key in identifying appropriate Veterans for enrollment. Finally, it may be as simple as meeting with local Patient Aligned Care Teams to receive appropriate referrals for the program.

Another data source to identify potential Non-Intuitional Care patients for Home Telehealth enrollment is the Care Assessment Need Score (CAN) report. In February 2016, a new column was added to the report labeled "Consider for Home Telehealth Non-Institutional Care" which flags Veterans meeting identifying criteria for potential Non-Institutional Care enrollment. The training regarding this report is available via the Telehealth website under the training resources for Home Telehealth Care Coordinators.

All Veterans are eligible for program enrollment; however, not all may be suitable through assessment of enrollment criteria. A key concept to consider when screening Veterans for enrollment is that the Veteran must agree to actively participate in the Home Telehealth program. Active participation means that the patient understands and is willing to meet program expectations for participation which includes using their assigned Home Telehealth technology to submit responses to DMPs and input measurements for vital signs and other biometric data. The expectation is to provide this information daily, with some exceptions based on clinical goals for enrollment and non-routine events that may prevent them from doing so (e.g., vacation/travel, hospitalization, etc.). Not all Veterans are willing to do this and therefore they may not be suitable candidates for enrollment. Assessing the Veteran's readiness for change during the screening process is one way to determine if the Veteran will benefit from the program and should be enrolled.

Current VHA priorities are not only access to care and Veteran choice, but also Suicide Prevention. Home Telehealth plays a key role in identifying those at risk for suicide and other mental health issues. All Veterans enrolled in Home Telehealth are screened for acute and on-going Mental Health issues and care needs. Interventions and referrals are to be made as appropriate to meet the needs of the Veteran (including any caregiver needs).

7.2 Enrollment of Appropriate Veterans into the Home Telehealth Program Including Assessment and Developing a Plan of Care

Once screening has occurred and the Veteran agrees to participate, the decision is made for a Veteran to be enrolled in Home Telehealth. To begin, a formal enrollment visit is usually arranged. Visits can be in the office or by phone. As noted in the documentation section of this manual, the Care Coordinator, along with the Veteran and caregiver, discusses and completes a comprehensive assessment, develops the plan of care, and discusses program operations and processes. It is important for the Care Coordinator to have frequent contact with the Veteran during the early phase of their enrollment to establish rapport. It also helps to ensure full program participation. Having frequent contact early, instead of waiting for abnormal data, allows the Care Coordinator to better know the Veteran, and adjust alert parameters for appropriate flagging and interventions.

7.2.1 Enrollment Dates

The official enrollment date of a Veteran in a Home Telehealth program is the date "Service Fees" and "Equipment" are ordered in Remote Order Entry System (ROES).

In ROES, ordering of Service Fees is called "Service Enrollment" and is the "Enrollment Date". The date of billing begins with the ordering of Service Fees.

The official start date is also the date entered for enrollment in the Vendor Web site. This allows for a consistent date for billing and census, and also allows the vendor help desk to support Veterans with set up if needed, especially after hours or on weekends.

In order to be enrolled, the assessment of the Veteran must be completed prior to placing the order for equipment and service fees in ROES. The assessment may be done during an encounter prior to the order date or during the same day as the order date, but the encounter cannot be done after the order date.

The assessment documentation may be completed after the encounter is entered in CPRS depending on local policies and procedures as an addendum or historical entry. When completing the assessment treatment plan "template", the enrollment date entered should match the date on which Service Fees and Equipment were ordered.

7.3 Ongoing Care Coordination - Case Management and Monitoring

One of the foundational components of Home Telehealth is to provide ongoing, longitudinal monitoring and assessment. Ongoing monitoring and assessment are essential elements of daily case management of enrolled Veterans. Monitoring and assessments include analyzing all of the Veteran's daily responses to DMP questions and other health-related data and determining if timely intervention is required by the Care Coordinator using clinical judgement within their scope of practice.

The Care Coordinator must follow agreed communication protocols or Standard Operating Procedures as appropriate for their worksite for any responses and data that are not within expected parameters to ensure appropriate team members are alerted to changes in health status and can assist with timely interventions and adjustments to care plans. If any interventions are indicated, the Veteran is contacted by phone. At this time, the data is validated with the Veteran; further assessment and analysis is done, and then communicated to appropriate healthcare providers. Education is provided which covers a variety of things including, but not limited to, any medication management and adjustment in collaboration with the provider. Referrals to other services may also be part of the intervention provided. All of these elements must be documented in the Veteran's Electronic Medical Record. Further follow up and reassessment, along with other case management activities with the Veteran and/or others, may be required after the intervention and must also be documented. Care Coordinators will conduct on-going chart reviews as part of their routine case management and process of care for evaluation of Veterans' current needs, overall status, and changes that may have occurred.

Ongoing assessment occurs with each submission by the patient and can include multiple other interactions. For example, Veterans are provided a phone number to reach their assigned Care Coordinator during normal work hours and they may call to report or ask for

assistance with health concerns that are not routinely assessed via their DMP. Also, Veterans may stop in for a scheduled or unscheduled visit with their Care Coordinator when they come to the VA medical center for a visit with one of their other healthcare team members. Each interaction between a Veteran and the Care Coordinator is an opportunity for assessment and/or teaching to occur.

Sometimes Veterans may not participate as expected. This requires communication and follow up to review with the Veteran the benefits of participation and the goals of care. National guidance recommends that contact should be attempted when a Veteran has not participated in utilizing their assigned technology as clinically indicated for more than three consecutive days. It is important to communicate with the Veteran timely to try to re-engage the Veteran in full participation in the Home Telehealth program regularly to ensure their well-being and safety.

7.4 Discharge/Transition to Other Services

Consideration for discharge from the Home Telehealth program (other than a definitive discharge at time of a patient's death) include the following which are all dependent on each Veteran's unique situation and best judgement of the Care Coordinator:

- Patient is admitted to a nursing home setting as a long-term or permanent placement
- Veteran or Caregiver no longer desires participation in the program
- Patient has permanently relocated outside of VA catchment area
- Patient has not participated at least 70% over a 90-day period – and is not appropriate for placement in the Health Promotion/Disease Prevention or Non-Institutional Care Low Response Categories of Care. This decision to keep Veterans enrolled in Health Promotion/Disease Prevention or Non-Institutional Care Low Respondent should be well documented in the Veteran's medical record
- Patient has been a non-responder for 30 days or more (considering specific patient situation)
- Patient has achieved goals/transition to another program may be appropriate

The summary of care and recommendations for further intervention will be incorporated into the patient's medical record in the discharge note. In addition, disenrollment from VistA, the Remote Order Entry System and the vendor website should occur and a monthly monitor note (683) should be completed if appropriate.

7.5 Patient Participation

On enrollment, all HT Veterans should be informed that daily response is expected to ensure success with the program. Connected Care/Telehealth Services expects that Home Telehealth programs achieve a minimum 70% response rate consistently from each patient on their assigned technology. A patient who does not respond at least 70% of the time over a consecutive three-month period must be categorized as Health Promotion Disease

Prevention (HPDP), NICLR (if meets NIC criteria) or disenrolled from the program. Although select individual patients may not be expected to achieve a 70% response rate, there must be clear documentation in the EMR of the reason(s) an alternate plan of care is being utilized and listing specific benefit(s) the patient derives from the alternative plan. These patients must be categorized as HPDP or NICLR if they are retained in the HT program.

7.5.1 Home Telehealth Technology

VHA has implemented Home Telehealth using a standardized approach to include the implementation of Home Telehealth technologies. VHA has established secure environments for the acquisition, storage and transmission of patient data associated with Home Telehealth from Home Telehealth vendors under VA contract. This includes secure, bi-directional messaging as part of these platforms. All telehealth technology passes rigorous VA IT and security standards prior to availability on VA contracts. This ensures the secure transmission of patient sensitive data behind VA firewalls. Only these commercial off-the-shelf technologies that are accessible under the national Home Telehealth contract can be used in VA Home Telehealth programs. These technologies connect to servers behind the VA firewall and are supported by the appropriate vendors for the purposes of downloading and uploading health data so that Home Telehealth staff can monitor patients' conditions and health data on an ongoing basis.

A bi-directional Health Level 7 (HL7) International messaging of patient data insures accurate transfer of patient demographic data to vendor websites. After further testing and evaluation, this system will also facilitate the secure transfer of patient biometric data in vendor websites to the permanent patient recorded in Computerized Patient Record System VistA web HL7 provides a comprehensive framework and related standards for the electronic health information that supports clinical practice in hospital systems.

8. Home Telehealth Technology Platforms-VA Approved

Home Telehealth Technology platforms are those commercial off-the-shelf technologies that are accessible under a national contract. Only these technology platforms can be used in Department of Veterans Affairs (VA) Home Telehealth programs. These technologies are placed in patients' homes or are used through a patient's own mobile device, are connected to servers behind the VA firewall, and are supported by the appropriate vendors to provide health data so that Home Telehealth staff can monitor patients' conditions and health data on an ongoing basis.

The following are the primary Home Telehealth technologies approved for use in VA:

- **Hub Device**: Per the Home Telehealth contract, the hub device at a minimum transmits through a landline connection to provide a set of questions and answers as well as education and self-management skill building opportunities for a Disease Management Protocol. Patient responses are sent to staff and are then risk stratified

for timely intervention in the vendor website. Data from the hub device can be transmitted through the phone line (Plain Old Telephone Service) or cellular modem (either integrated in the hub device or a separate modem attached to the hub device). A vendor-provided tablet that connects via landline or cellular, is also considered a hub device.

- **Interactive Voice Response Technology**: Interactive Voice Response Technology provides a messaging service using DMPs that are accessed from a land telephone line or cell phone. The Veteran can use his or her voice or touch the keypad on the phone to generate answers to questions about his or her health for submission back to his or her VA Care Coordinator. The mode of transmission could either be by Plain Old Telephone Service or by the patient's own cellular phone service. This device can call the Veteran if the Veteran has not responded by a certain time each day and can support those who may forget to complete a session. Biometric measurements can be entered either manually or via peripherals with Bluetooth connection, depending on the vendor used.
- **Internet Browser / Mobile App Technology**: Browser / Mobile App is the latest addition to the Home Telehealth technology portfolio that provides greater flexibility for delivery of patient care. This technology allows patients to securely receive and transmit DMPs via any internet-enabled device such as a smart phone, tablet, laptop, or home PC via login to a secure vendor website. The device could be either a Veteran-owned device or a vendor/VA provided device. The access to the internet browser technology could occur either through a saved internet website or a downloaded mobile application on either the Veteran or vendor device.
- **Video**: Video is a Home Telehealth device or platform that uses both audio and visual components, which may include peripheral devices such as stethoscopes and other vital sign monitoring devices. See the Video Technology Use in Home Telehealth for more information on video.
- **Home Telehealth Peripheral Devices**: Home Telehealth peripheral devices are used in conjunction with the Home Telehealth technologies, based on clinic application. Peripherals on contract include: blood pressure monitors, heart rate monitors, weight scales, stethoscopes, blood glucose meters or cable adaptors, pulse oximeters, spirometers, thermometers, and pedometers. Peripheral devices connect by a cable to the hub device, are integrated within the hub device itself (such as a blood pressure monitor) or may connect wirelessly via Bluetooth for uploading vital signs and other biometric data. Home Telehealth staff, as part of the comprehensive assessment of each patient, determine the appropriate type of peripheral device, based on specific patient need. For example, patients with difficult manual dexterity may require a tethered or integrated device.
- **Cellular modems**: Cellular modems are considered a mode of transmission. These can be integrated in the home messaging device or a separate, tethered modem. They provide secure transmission to and from the units in instances where Plain Old Telephone Service transmission is not available or reliable. Cellular modems are not the same as Interactive Voice Response (which uses the patient's own cellular plan or phone service). Cellular modems allow full DMP content to be delivered to and

from the patient via the Home Telehealth technology securely to the vendors' website.

8.1 Telehealth Technology Ordering, Inventory and Support

There are specific vendors for Home Telehealth technologies under a national contract. Information on vendors and related technical content is available on the Connected Care/Telehealth Services website.

Multiple Home Telehealth systems/technologies are available as outlined above and therefore, the Home Telehealth program has choices to make regarding which ones will be best for their staff and the patients they serve.

Some very important considerations for planning and process:

- The larger system issues, including connectivity and bandwidth needs should be considered and addressed especially if using telemonitors.
- Ongoing technical training and technical support are primary variables.
- Inclusion of Office of Information and Technology, Prosthetics and Biomedical programs/staff are essential for successful technology deployment and management.

8.2 Denver Logistics Center

In FY 2010, VHA Prosthetics and Sensory Aids Service proposed to Connected Care/Telehealth Services that a program be undertaken to provide a national Home Telehealth equipment management system through the Denver Logistics Center. The Denver Logistic Center has been providing logistics for VA since 1953. This transition to a centralized process at the Denver Logistics Center was completed in June 2012.

The Denver Logistics Center is the supplying organization for all Home Telehealth technologies, providing distribution services and contracting support to Connected Care/Telehealth Services and Prosthetics and Sensory Aides Service with respect to the VHA Home Telehealth Program. The Denver Logistics Center provides logistics support for: purchasing and distribution, database management, IT, customers and vendor payment. This support includes, but is not limited to, the following for Home Telehealth programs nationally:

- Acquires, receives, stores, accounts for, ships and pays invoices for Telehealth devices and services identified by the National Program Office for Connected Care/Telehealth Services
- Orders, tracks and pays invoices for all licensing and/or service fees
- Provides information on orders placed and assigned for Home Telehealth
- Installs batteries and sets the date and time in the devices before they are sent to the Veteran

- Maintains a centralized database of all registered devices by serial number, Veteran name and current location of device/deployment status
- Maintains a centralized database of licenses
- Receives Telehealth devices that are returned by the Veteran
- Refurbishes or disposes of returned devices as indicated by device condition
- Tests each device for operability and data removal prior to postal delivery to the Veteran
- Manages the payment of vendor services

In most cases, if a Home Telehealth device is assigned to the Veteran, it is sent directly to the patient. In specific situations, programs may order equipment to be shipped to the facility for a limited amount of station stock.

Home Telehealth technology is ordered from the Denver Logistics Center through the Remote Order Entry System. All Telehealth staff may order Telehealth services and equipment via Remote Order Entry System including:

- VISN Telehealth Program Managers
- Facility Telehealth Coordinators
- Telehealth Clinic Technicians
- Home Telehealth Care Coordinators
- Home Telehealth Leads
- Licensed Practical Nurses
- Home Telehealth Program Support Assistants
- Any future Telehealth Services roles

All staff who place orders in Remote Order Entry System must first complete the required Remote Order Entry System training provided by Telehealth Services. VISN Program Managers and Facility Leads are responsible for ensuring that the required training is completed.

As detailed in the Remote Order Entry System training, any non-clinician ordering in Remote Order Entry System will be ordering based on the clinician's directions.

All sites should be able to demonstrate that for any Remote Order Entry System order, the person entering the order has completed the required Remote Order Entry System training and any orders entered by non-clinicians were at the direction of and communicated by the clinician. These two elements will be part of the ongoing Conditions of Participation reviews.

Staff need to conduct monthly audits of the ROES Report to ensure equipment and fees are accurate and current.

8.3 Matching Technologies to Clinic Need

An effective tool to help match the appropriate technology to the right Veteran is the Home Telehealth Technology Grid. The Technology Grid organizes the various technologies and their functions, costs, availability of national DMPs, and the technical needs of the specific clinical application. It also addresses the clinical, sensory, and functional aspects needed to use the technology successfully to help staff evaluate and select appropriate technologies and systems. The Technology Grid can be accessed from the Telehealth Services website under the Home Telehealth program section.

8.4 Technology Support, Maintenance, Infection Control, Service and Repair

The maintenance of telehealth technology involves collaboration between numerous entities: The Denver and Logistics Center, Prosthetics and Sensory Aids Service (PSAS), Office of Information Technology, the National Center for Patient Safety, and the respective Home Telehealth vendors under contract with VA to provide Home Telehealth technology and service, Home Telehealth staff, and VHA Office of Health Informatics: Connected Care/Telehealth Services.

It is required that all participating clinic and support staff have fundamental knowledge related to Home Telehealth technologies and systems. VHA National Telehealth Training Team offers numerous materials for this purpose as well as related support documents for use in the field. In addition, each vendor is responsible for providing training on its operating systems. Most vendors have regional trainers to meet the training needs of the technology.

For all patients assigned a new messaging device (including patients receiving a replacement unit), Home Telehealth staff need to provide appropriate education and training and validate the correct unit has been assigned to the correct patient. The following steps must be completed:

- Instruct patient to call when they receive their unit.
- Instruct the patient to immediately send data.
- That data transmission is verified by the Home Telehealth staff on the vendor desktop. If support staff confirms, the Care Coordinator will still review vital signs as per normal daily review.

The validation steps above should be documented in the patient's medical record. This can be done as an addendum to the Tech Education Note.

For new patients and when issuing new or replacement equipment, use the national note title and template "HT Tech Education" when explaining/educating/training Veterans or family members on the technology. Troubleshooting equipment can be added as an addendum to a "HT Tech Education" note or it can be a free-standing note. The template itself does not have to be used if documentation is for troubleshooting but the note title must be used.

Return Merchandise Authorization (RMA):

1. With the implementation of the 2017 Home Telehealth contract the Connected Care/Telehealth Services no longer restricts customer service communications between the vendor and any Home Telehealth patients. Home Telehealth vendors are now able to receive phone calls directly from Veterans or caregivers and make calls in response to Veterans' or caregivers' queries in reference to technology troubleshooting issues, such as re-setting passwords. Home Telehealth staff should still troubleshoot technology issues with Veterans who call the Home Telehealth program and if unable to resolve, can connect the Veteran with the appropriate vendor help desk. Home Telehealth staff will not be assisting Veterans with password resets due to privacy requirements. Resets will be done with the specific vendor.
2. Because of the change in customer service policy, all vendors will have standard protocols in place for the vendor customer service representative to direct urgent Veteran calls to the appropriate resources. These resources could include the Care Coordinator, VA Telephone Care Services, and the Veterans Crisis Line, depending on the specific situation and according to the protocols established. For devices determined to be defective after trouble-shooting with the Care Coordinator, the Veteran, and the vendor:

    - The vendor determines what items fall under warranty and assigns an RMA number.
    - Home Telehealth staff orders a retrieval kit and a replacement device for the Veteran.
        - The RMA'd device must be unauthorized.
        - The DLC will automatically authorize the replacement device.
        - If the technology type has been changed, verify accuracy of service fees.
    - Vendor notifies DLCtelehealthsupport@va.gov mail group of the RMA (this is the first notice to the DLC of the RMA).
    - Once the device returns to the DLC and is processed, a credit will be applied to the site.

For defective devices outside of warranty please email: DLCtelehealthsupport@va.gov.

Reporting of IT issues:

Examples of IT issues include: VistA integration delays or error messages that prevent patient activation or inactivation, patient identity errors, inability to access vendor websites, delays in vendor websites, and patient reports of vendor technology issues such as transmission delays or inability to receive or transmit data.

Steps:

1. If it is a specific vendor issue, contact the vendor help desk (including VistA issues).
2. Report to the local Information Resource Management or Clinic Applications Coordinator (varies by site).

3. Report to Information Resources Manager or Clinic Applications Coordinator that it is a Home Telehealth issue and if appropriate, affects patient care.
4. Report the issue to the National Service Desk following directions below:
    - Call National Service Desk at 888-326-6780 to report an Incident or request a Service Request. The following information will be required when communicating with the Service Desk personnel to complete the Incident Report:
        - Application Name: Home Telehealth
        - Vendor Name if applicable
        - End-User Requesting Support: (Name; Phone Number; Email Address)
        - Description of Request (Outage, Request for IT Support):
    - For Incidents:
        - Affected number of end users: Number of patients impacted?
        - Location of the end-users: Is patient care impacted?
        - Time the outage occurred: Are critical business functions impacted?
    - Duration of the outage: Has the contingency plan been activated?
    - A ticket will be generated and the person requesting the service will receive an email with the ticket information. A Subject Matter Expert will be assigned to triage the Incident and resolve the problem.
5. If you do not receive a response within 24 hours, please contact the national Home Telehealth Lead or Contract Representative.

Infection Control: The Denver Logistics Center is responsible for infection control procedures and data sanitization related to retrieved equipment. If a Veteran returns equipment to Home Telehealth staff at the VA, then the staff should follow local policies and procedures for the proper handling and return of equipment as it relates to storage and infection control.

8.5 Technology User Group

Each VISN has at least one representative on the national Home Telehealth Technology User Group. This group meets monthly and is led by the national Home Telehealth Lead and Clinic Nurse Analyst. The purpose of this group is to provide a communication process throughout all levels of Home Telehealth - local, VISN and national - to discuss technology issues, concerns, and needs. Each VISN Technology User Group representative is a critical communication link in this process. All staff should be aware of who their VISN Technology User Group representative is and report any concerns to them. In addition, each VISN Technology User Group representative should play an active role in VISN wide communication of issues discussed on the national Technology User Group call back to their VISN colleagues. This could occur as part of a standing agenda item for any routine VISN-wide Home Telehealth meetings. Often, the Technology User Group call is a source for

determining new issues that impacts the program at large and works to resolve those with the vendors and others as appropriate.

9. Disease Management Protocols (DMPs)

Home Telehealth technologies are used to support the fundamental components of care coordination and case management. There are multiple technologies for which VA has national contracts and they offer different capabilities and functionalities that enable the Care Coordinator to select the best technology based on the needs of the individual patient. The one functionality that all Home Telehealth technologies have in common is that they provide Disease Management Protocols.

A Disease Management Protocol (DMP) is a series of questions, answers, responses, education and information that are derived from routine clinical practice meant to replicate aspects of face-to-face assessments. The DMPs also include the capture of biometric data as assigned by the Care Coordinator based on individual patient need. The application of this clinical content is provided within the DMP and is based upon assessment of scientific evidence and clinical appropriateness by an expert group within VA. These DMPs are sent to the Veterans enrolled in Home Telehealth via an assigned Home Telehealth technology or service for daily responses that are transmitted back to the Home Telehealth Care Coordinator for review and intervention as needed. The assignment of a DMP links the Veteran's dataset to the national data collection service whereby outcomes data can be retrieved and analyzed.

As of fiscal year 2016, Connected Care/Telehealth Services is no longer developing its own national VHA standardized DMPs (described below). Instead, Connected Care/Telehealth Services will continue to annually review current VHA content to ensure national clinical guidelines are met and to address any other changes put forward by field staff. In addition, Connected Care/Telehealth Services through the National Telehealth Quality and Training Division will review new vendor DMPs to ensure VA standardized core content is included and clinical guidelines are adhered to. If a vendor-developed DMP is chosen, the VISN in which the vendor-developed DMP is used will be responsible for ensuring that the vendor-developed DMP meets the specific needs for their population.

In the past, if a VHA DMP title existed for a specific disease or condition, Care Coordinators were required to use the VHA version instead of any vendor-created version for the same disease or condition. This has changed with the implementation of the 2017 Home Telehealth contract. Care Coordinators may choose to use any DMP either VHA or vendor-developed, that in their clinical judgement best meets the needs of their patient. The only exception to this rule is the VHA Weight Management (TeleMOVE) DMP.

Even if a vendor has a weight management version available, Care Coordinators are not permitted to use any other version except the VHA-developed one. This was a request from the national subject matter experts for the MOVE! Program.

If a vendor-developed DMP is chosen, the VISN in which the vendor-developed DMP is used will be responsible for ensuring that the vendor-developed DMP meets national clinic practice guidelines. More information on these guidelines can be found at VA/DoD Clinic Practice Guidelines on the VA Intranet. The VHA has core content and is safe for use with patients. VISNs should continue to use the current process they have in place for approving DMP use and content.

In the past, VHA has not had co-morbid or tri-morbid DMP versions. Past approved practice was for Care Coordinators not to combine VHA DMPs together or combine VHA DMPs with vendor-developed DMPs. With the implementation of the 2017 Home Telehealth contract, Care Coordinators may choose to combine VHA vendor-developed DMPs into co-morbid or tri-morbid DMPs that in their clinical judgement best meet the needs of their patient. This includes VHA Weight Management (but not vendor weight management versions) and Tobacco Cessation DMPs. In addition, these DMPs could now be classified as Non-Institutional Care or Chronic Care Management (depending on the Continuum of Care Form Assessment) as long as the Veteran is assigned a co-morbid or tri-morbid DMP. If these types of DMP combinations are chosen, the VISN in which the combination DMPs are used, is responsible for ensuring that the combination DMP meets national clinic guidelines, has VHA core content, does not have duplicate content and is safe for use with patients. VISNs should continue to use the current process they have in place for approving DMP use and content.

VHA Standardized DMPs: This term refers to those DMPs that Connected Care/Telehealth Services and designated Subject Matter Experts developed to ensure the quality and safety of the content of DMPs that are provided to Veterans across all applicable vendor technology platforms. Currently these include:

- Heart Failure
- Chronic Obstructive Pulmonary Disease
- Depression
- Hypertension
- Diabetes
- Weight Management
- Chronic Kidney Disease
- Dementia
- Hepatitis C Cirrhosis
- Multiple Sclerosis
- Palliative Care
- Post-Traumatic Stress Disorder
- Substance Use Disorder
- Tobacco Cessation
- Stable and Able - (Homeless)
- Bipolar Disorder
- Psychosis

A current listing of available VHA DMPs and annual review dates is available on the HT Technology Grid.

Vendor Developed DMPs: These DMPs have been developed by the vendor. If a VISN or local site desires to utilize a vendor-developed DMP that has not been nationally standardized by VHA or approved under the national contract (See Core DMPs above), they must seek this authorization through their VISN Chief Medical Officer or designee before they may be utilized. All funding for this request will be managed by the requesting VISN or site and all changes to the DMP that may or may not affect national clinical guidelines are the responsibility of the VISN.

Co-morbid and Tri-morbid DMPs: The VHA Standardized DMPs are all focused on a single disease state. Vendors may offer their own co-morbid combinations. In addition, there is also the opportunity to combine VA DMPs together. For example, Weight Management may now be made a co-morbid by combining it with any other VA or vendor DMP. However, these combinations must be reviewed before use to ensure it meets the needs of their local patient population.

9.1 Disease Management Protocol Processes

9.1.1 Annual Review Process

VHA DMPs will be reviewed annually by Subject Matter Experts groups and the National Telehealth Training Team for changes in clinical practice guidelines and reported issues from the Home Telehealth community. Currently four to five DMPs are reviewed per quarter.

Care Coordinators send issues or requests for revisions to the DMP to the National Telehealth Training Team for review to determine if concerns are safety or non-safety issues. Non-safety issues or revisions will be addressed at the next annual review unless the Home Telehealth Team determines the issue needs to be changed sooner. Care Coordinators will be instructed to initiate a Quality Improvement Request for any issues reported to the National Telehealth Training Team that are determined to be safety issues. Vendors have seven days from the Quality Improvement Request submission date to resolve safety issues.

The Home Telehealth community is also notified of the national release of any new VHA DMPs through a VA national alert. All released DMPs are posted on the Connected Care/Telehealth Services web page.

The Home Telehealth community is notified of revisions to DMPs for the annual review through a VA national alert. Any comments are to be directed to the National Telehealth Training Team.

9.1.2 DMP Versioning

There is a specific, required nomenclature for all DMPs so that the DMP data sent from each of the vendors to Connected Care/Telehealth Services is uniform and provides for accurate

capture of these DMP assignments in the Home Telehealth data reports. All VHA DMPs that are annually reviewed will receive the next numeric designation once approved. For example, TeleMOVE! Version 2.0 is reviewed in 2016 and once approved the version becomes 3.0.

9.1.3 Setting alert parameters

Alert parameters must be set for each biometric data element monitored. The Home Telehealth alert parameters are individualized according to the Veteran's current health status and must be set so that the Care Coordinator is alerted when there is a change in the Veterans health status. Until those parameters are set, vendors are required to have default parameters in place based on clinical practice guidelines. Alert parameters should be meaningful and specific to each Veteran. Alert parameters that are not set or are set incorrectly may result in unnecessary daily red alerts.

When correctly set, alert parameters will help to improve time and efficiency in case management. For example; if a Veteran is enrolled into a hypertension DMP with a baseline blood pressure of 170/90 and he or she is starting new blood pressure medications, the high parameter should not be set at 130/80. This would result in the Care Coordinator receiving daily red alerts. The high parameter should be set above the patient's baseline (171-175/91-95) to ensure that the blood pressure is not trending upward. As the patient responds to the new medication, the high parameter can be adjusted down as the patient's blood pressure comes down. By doing this, the parameters will encourage more efficient case management of the individual's health status. Alert parameters within the DMP are not to be confused with clinical targets or goals. These are usually set by the provider in his or her discussion with the Veteran and are individualized. For example; a Veteran may come from Provider A with a blood pressure systolic target goal of 120 and a diastolic target goal of 75. But his or her actual blood pressure is consistently running 169/90. Parameters should not be set at 120/75. Set the high alert parameters above 169/90 to ensure the Veteran does not trend upward; set low alert parameters below 120/75 in case the Veteran goes too low. The Care Coordinator uses their clinical judgement for each individual Veteran's situation to determine the most effective alert parameter settings.

9.1.4 Data Review

Each Care Coordinator completes a daily review of data sent by patients on the vendor's web viewer. Based on clinical significance, and after communication with the Veteran to validate the data and analysis, the Care Coordinator extracts the clinically relevant information and data for inclusion into the appropriate CPRS note. Any data pasted into the note must be annotated with the source as per VA requirements.

As appropriate, the Care Coordinator notifies members of the patient's healthcare team via CPRS alerting to the content of the note which may require review, further assessment or intervention.

All alerts, especially red (high) and yellow (medium) should be reviewed daily. Reviewing yellow alerts can inform the Care Coordinator of impending problems and identify patterns

of risk for individual patients. All local program policy procedures regarding alert reviews should be followed.

10. Documentation Standards

As with any healthcare visit, intervention or encounter, the clinical documentation of the event is very important. Connected Care/Telehealth Services developed a comprehensive, user friendly and accurate delivery model for documentation in the Computerized Patient Record System (CPRS) for use by all Home Telehealth staff. It is vitally important to have documentation standardized for appropriate delivery of care to Veterans, effective communications with other healthcare providers, ability to pull accurate data and ease of chart reviewing for quality management and other purposes.

10.1 Documentation of Case Management Activities

Case management is the cornerstone of the Home Telehealth program. Thorough chart reviews on a regular basis and daily monitoring of data is only a portion of the overall management of care. There is a primary focus on enhancing patient self-management, education on the disease specific elements of care and oversight of health-related behaviors that are associated with positive patient outcomes. The Home Telehealth care coordination and case management process begins at identification of appropriate patients and ends at discharge and transition from the program.

The fundamental components of documenting Home Telehealth case management activities are as follows:

- Screening
- Comprehensive assessment and review of systems
- Identification and analysis of problems
- Goal setting
- Care planning and intervention
- Evaluation/Reassessment

The following documentation is completed:

- **Consult Screening**
- **On Admission:**
    - Assessment and Treatment Plan
    - Education Note (Technology Education)
    - Continuum of Care Form (CCF) & Category of Care determination
    - Caregiver Assessment (if appropriate) – this could be done several days after enrollment to meet the availability of the caregiver
- **On a Regular Basis:**
    - Monthly Monitoring note
    - Periodic Reassessment (no more than a maximum of 6 months, but can be less as determined by VISN policy)

- CCF every 6 months per VERA requirements for Non-Institutional Care (NIC), Non-Institutional Care Low Responder (NICLR) & Chronic Care Management (CCM) patients and for significant changes in condition for all patients. In addition, a CCF needs to be completed before a patient is placed from NIC to NICLR or NICLR to NIC to ensure the patient still meets NIC criteria
- Caregiver burden assessments at least every 6 months as part of the Periodic Reassessment

- **As Needed:**
  - Intervention Note - Used only for a need to intervene due to a DMP/ biometric data alert in need of reconciliation. If used to document an unsuccessful attempt to contact the Veteran, it must be coded historical for the encounter.
  - Home Telehealth Note - for miscellaneous activity not already covered by any other note. This note can also be used to document unsuccessful attempts to contact the Veteran (coded historical for encounter).

10.2 The Home Telehealth Consult Referral

The consult referral sources can be varied depending on the site and VISN. Home Telehealth staff may have the opportunity/authority to enter their own consults (in collaboration with the MD, NP or PA provider) for Veteran enrollment into the Home Telehealth program. There must be a MD, NP, or PA provider name associated with the Home Telehealth Program Consult. These individuals may or may not be the primary care provider, but enrollment is appropriate as long as there is a VA provider that will be following the Veteran while he or she is enrolled in the Home Telehealth Program. It is important to remember when a consult is entered into the Veteran's Electronic Medical Record (EMR) it must be addressed within a specified time frame per local policy. That does not mean that the Veteran must be enrolled into the Home Telehealth program within that timeframe; it means that the consult has been addressed and is either closed with a plan for disposition or is left open for future follow-up (depending on local policy). Use of an Electronic Waitlist (EWL) should follow national guidance as operationalized at the local facility. It is a requirement that all patients enrolled in the Home Telehealth program have a consult, even those that have been recently discharged (within 30 days) and are being re-enrolled. Directive 1232 Consult Processes and Procedures (released in 2017) specifically addresses the length of time all consults must be reviewed within. The Office of Health Informatics: Connected Care/Telehealth Services does not provide national guidance related to this; local and VISN policies should be followed. If Home Telehealth staff have concerns about the local or VISN timelines, and if timelines are of concern then a waiver should be pursued at the local or VISN level.

10.2.1 Completing the Screening

Once a consult is received for enrollment in Home Telehealth, the Care Coordinator reviews the patient's EMR to ensure they meet program criteria and makes the initial contact with the patient to evaluate further suitability for program services. Best practices indicate

Veterans are more likely to consent to Home Telehealth enrollment when they have participated in decision making on the need for program services prior to the consult placement. This screening is then documented in the EMR and the consult is completed and closed, regardless of whether the Veteran does or does not meet criteria for enrollment into the Home Telehealth program. It will suffice to close the consult with the screening note and final disposition of the Veteran such as "The Veteran verbally agrees to participate in the Home Telehealth program", "An appointment was set up for enrollment two weeks from today", "The Veteran has declined enrollment", or "The Veteran does not meet criteria for enrollment."

During the screening process, many elements are considered. One of the most important elements is the Veteran or caregiver's willingness to fully participate in the program (i.e. commitment to providing daily responses or at other, routine intervals per the agreed plan of care).

10.2.2 Content Within the Consult

It is helpful if the Care Coordinator understands the overall healthcare goals that the provider wants to achieve in partnership with the Veteran. Collaborating with the Patient-Aligned Care Team (PACT) to establish these goals upfront when the Veteran is enrolled is important to help drive and map out care delivery.

A Home Telehealth collaboration agreement or other guidance document may be used to help define roles and responsibilities of all staff and the communication that must occur between Telehealth staff and the PACT or specialty team.

Although the need for a written consent no longer exists, the verbal consent must be documented in CPRS within the Initial Assessment and Treatment Plan Note. The "Patient Enrollment Agreement" replaces the previously required written informed consent, as per policy in the VA Informed Consent Handbook. This document should be provided to the Veteran with the initial enrollment packet. In addition to outlining the Veterans' responsibilities, the Patient Enrollment Agreement includes the following elements:

- This required document helps the patient be fully informed of the risks and benefits of Home Telehealth and procedures.
- The patient must give verbal permission as consent at the time of enrollment for Home Telehealth service prior to the initiation of the Home Telehealth program.
- The Enrollment Agreement documents that Veteran patients enrolled in the Home Telehealth programs formally accept their role, agree to specific rights and undertake to perform required responsibilities that are necessary to ensure the care they receive is safe, appropriate and cost-effective.
- Veterans are informed that they have the right to refuse Home Telehealth services without negating their right to future healthcare.

10.3 Assessment Treatment Plan and Technology Education Notes

The initial assessment and review of systems may be performed over the phone or in person for a thorough review of the Veteran Electronic Medical Record (EMR). This is a comprehensive holistic case management assessment and review of systems which includes the identification of specific problems, a comprehensive medication review, and inclusion of goals targeting the development of a Home Telehealth treatment plan. The assessment treatment plan serves as an extension of the Veteran's overall treatment plan. The review of systems is not to be confused with a physical assessment of the patient. It is expected that the initial assessment and reassessment drill down on any complications that arise from their medical conditions. It is important for the Care Coordinator to remember if they are working with Veterans over the phone, that they need to develop a picture of the Veteran by asking very pertinent questions.

For specialties like Nutrition Services or Homeless Veterans who have their own specific assessment documentation requirements, a reference to those notes should be placed within the Home Telehealth Assessment & Treatment template. The Initial Evaluation and Treatment Plan note should show a signed "Receipt Acknowledged" as an additional signature by the primary care provider or referring provider and any other care providers in the EMR. Including the provider and other appropriate clinicians as additional signers identifies the collaborative relationship between these individuals and the Home Telehealth Program. This relationship is a requirement not only for the Conditions of Participation but for the Joint Commission as well.

The Home Telehealth treatment plan needs to be specific to the Veteran and include interventions that the Care Coordinator will provide to help the Veteran achieve their health care goals. The goals of care are established with the Veteran, the provider and the Care Coordinator. The goals for our Veterans need to be Simple and Specific, Measurable, Achievable and Attainable, Relevant, Realistic and Time framed (SMART).

The treatment plan is then regularly readdressed at least every 6 months (unless otherwise designated to be done earlier by local policy). In some cases, where there are significant changes in the Veteran's condition, a reassessment and update to the plan of care will need to occur before the 6-month deadline. Changes can be documented via an addendum if clinically indicated or according to VISN and local guidance. All documentation by the Care Coordinator is based upon the individual's scope of practice (i.e. RN, RD or SW).

Self-management skill building is a fundamental component of the Home Telehealth program. The DMP assigned to the Veteran focuses on educating and building upon the Veteran's understanding of his or her disease process while developing the self-management skill set necessary to manage the disease process from within the Veteran's home. The Care Coordinator reinforces this information as well as provides additional patient education within their scope of practice via phone contact and written materials as needed to enhance the patient's self-efficiency. It is expected that Care Coordinators be familiar with the content in the Disease Management Protocol and use DMPs in a clinical manner to reinforce Veteran education and self-management. Some DMPs have formal

training which is required before the Care Coordinator can use them. When this is the case, it is identified on the Training Plan.

Technology assessment and selection are also part of the initial evaluation. It is important to select the right Home Telehealth technology for the Veteran to use during his or her enrollment. There are many elements to consider when making this selection with the Veteran such as user ability, cost, connection type and clinical/safety needs. It is helpful to review the Technology Grid which defines critical elements of each Home Telehealth technology, so a thoughtful selection can be made. In addition, the Care Coordinator will need to determine when to use a cabled or wireless connected peripheral device. When the Veteran is not using cabled or wireless connected peripheral devices, the Veteran may self-report his or her biometric data.

Other components of the initial assessment documentation for enrollment in the Home Telehealth program are the Continuum of Care Forum, the Caregiver Burden Assessment, and the Tech Education. These notes must be completed prior to the 683 Note (Monthly Monitor Note, as separate notes, or can be included in the documentation for the overall Evaluation and Treatment Plan). They are listed as separate notes below.

10.3.1 Continuum of Care Form (CCF)

The CCF was developed from the Geriatric Evaluation and Assessment Tool used in Long-term Care. The CCF, like its predecessor, assesses a patient's functional status and needs to identify the appropriate Category of Care for Home Telehealth services and the potential need for referral to other non-institutional or long-term care programs. The Category of Care is directly linked to Veterans Equitable Resource Allocation (VERA) funding, especially for Non-Institutional Care (NIC) and Chronic Care Management (CCM) classified Veterans. Veterans classified as NICLR do not currently receive VERA allocation.

The CCF is completed upon enrollment for all Home Telehealth patients and can be documented in the evaluation treatment plan or completed separately. The CCF is then updated every six months for all Non-Institutional Care (NIC) patients as well as Chronic Care Management (CCM) Categories of Care. The CCF must be updated anytime there is a significant change in health status or when a Veteran is changed from NIC to NICLR or vise-versa. Any CCM or NIC categorized Veterans who are assigned to Health Promotion Disease Prevention (HPDP) and do not respond to their technology at least 70% of the time within a 90-day period, still require a Category of Care reassessment via the CCF at least every six months. Response statistics are made available via the vendor technology.

10.3.2 Caregiver Burden Assessment

The Caregiver Burden Assessment can be pulled into the evaluation treatment plan or used separately and should be completed when there is an identified home caregiver (non-professional) for the Veteran. The Caregiver Burden Assessment tool utilizes the Zarit Burden Scale short questionnaire to help identify the caregiver's level of perceived stress and strain. This allows for further identification of available assistance and resources that may be utilized to assist the caregiver and, in doing so, assist the Veteran. This assessment

may be utilized at any point in the process of care in addition to the initial assessment process. There is an electronic note title and template to document the assessment. It is vitally important that the Care Coordinator regularly assess the caregiver's risk for burden as well as support or services extended. After the initial assessment, using the Zarit Burden scale itself is optional, an assessment is not.

10.3.3 Technology Education Note

The Veteran and or his/her caregiver are assessed by the Care Coordinator to determine which technology best meets the Veteran's needs. The Home Telehealth Technology Grid should be used to determine appropriate technology related to functional, cognitive, environmental and financially sound considerations. The Home Telehealth staff then educates the Veteran and/or caregiver on the technology installed or implemented. Program Support staff can assist with equipment issues with oversite from a Care Coordinator. Care Coordinators assess the Veteran's/caregiver's competency in utilizing the technology via the appropriate note title and template guidance. This note and template guidance is to be used upon initial enrollment or as needed to document any technological changes. Troubleshooting technology is to be documented with either the "Home Telehealth Note" or the "Home Telehealth Tech Education Note". The template is not necessary and can be cancelled allowing for free text documentation. The "Tech Education" clinic is to be set-up with stop codes 674/685 which are Non-count. Care Coordinators providing troubleshooting for technology issues in addition to providing clinical care or an assessment during the same encounter can use the "Home Telehealth Note" instead of the "Tech Education Note" to get workload credit.

10.4 Ongoing Documentation

10.4.1 Intervention Note

Central to the Care Coordinator's role is reviewing the daily information submitted by Veterans on their panel, including vital sign measurements, symptom response, and Veteran's answers to health-related questions. The Care Coordinator, using clinical judgement and following their scope of practice, may contact the patient to verify the responses and complete an assessment to address the Veteran's care needs, provide case management, patient education and develop an appropriate plan of care. A Home Telehealth intervention with a patient should occur whenever there are findings from the data submitted by a Veteran that are outside of established parameters or otherwise concerning to the Care Coordinator that require direct communication with the Veteran/caregiver to further assess and resolve those concerns. There must be contact and clinical discussions or assessments with the Veteran or caregiver for this note to be an encounter note. If a Care Coordinator is unable to connect with the Veteran or caregiver, then the note is not considered an encounter. Programs have the option to use the Intervention Note to document unsuccessful attempts to reach the Veteran or caregiver but then the note must be marked historical. The other option is to use the Home Telehealth Note which would also need to be marked historical. The Care Coordinator should continue attempts to reach the Veteran. Once the Veteran is reached, the Intervention Note

and template should be used to complete the encounter. Not all interventions require a Primary Care Physician(PCP) notification or signature. However, the PCP should be notified of significant findings or the need for further assessment or action based upon the clinical judgement and within the scope of practice of the Care Coordinator.

10.4.2 Monthly Monitoring Note

Due to the associated, underlying stop code assigned to the Monthly Monitoring note, this note is often referred to as the "683" note. The Monthly Monitoring note identifies workload activity related to technology monitoring and data review over the course of one month. Optimally, every Veteran enrolled in the Home Telehealth program should have one Monthly Monitoring (683) note for every month if appropriate, (the CPT (Current Procedural Terminology) 99091, remote monitoring, uses "30 minutes" in the code description) that responds through the technology and are monitored by the Home Telehealth Care Coordinator. The initial 683 note can only be done after the Assessment and Treatment plan is completed. In addition, this note should always come after a successful transmission of data from the patient through the technology interface. In the event that the Veteran is partially responding (meaning they have submitted vital signs but no question responses or vice versa) or did not respond for part of the month to the DMP, the Care Coordinator must determine if this note should be ethically completed and entered into CPRS. The overall assessment of participation should include an evaluation of the number of days the Veteran has partially responded during the month. Having multiple non-responder notes does not take the place of actual care. It is advised that this note be completed near the end of the month to ensure that the note accurately reflects the months' workload activity. A 683 note would not be used if there is no transmission of data for the month covered. This note is not intended to be sent to the primary care provider for review. Local policy may require the diagnosis to be in the text of this note. Check with your local Health Information and Management Service (HIMS) staff. This note is not intended to function as a clinical note, but rather is an accounting (workload capture) of the daily monitoring by the Care Coordinator.

10.4.3 Periodic Evaluation Note

The Periodic Evaluation note is a reassessment of the Veteran completed at regular intervals and as needed based on local policy. The minimum requirement is every six months. This review must include direct input from the Veterans and/or caregiver either via phone or office visit.

The Periodic Evaluation Note contains:

- A Review of Systems section
- Comprehensive medication management
- Analysis of ongoing and new problems
- Summary of biometric data from the vendor website
- Review of SMART goals and interventions
- Review of the Veteran's progress to goals
- Summary and evaluation

- New goals and interventions as appropriate
- Further recommendations

Just like the Initial Assessment and Treatment Plan, the Periodic Evaluation Note should show a "Receipt Acknowledged" as an additional signer by the primary care provider (or referring provider if not the primary care provider) and any other appropriate care providers in the EMR. This is to demonstrate the on-going collaborative relationship with the Home Telehealth Program.

The Periodic Evaluation includes the following:

- An analysis of data and responses which includes Care Coordinator's professional assessment (within their scope of practice and collaboration with other team members as needed) of progress towards goals.
- Reviewing and revising problems, goals and treatment plans, patients, and alerts for phone calls to the VA phone advice line or Telecare.
- Further recommendations to provider/team.

10.4.4 Home Telehealth Note

The Home Telehealth note is used for other case management interactions, patient education, hospital discharge follow-up, non-responder follow-up and interventions not related to alerts received from technology. Care Coordinators may use the Home Telehealth Note title to address issues that arise from either the patient walking in, calling the Home Telehealth staff, or the staff calling the patient directly. If this note is used for administrative purposes, it must be marked historical.

10.4.5 Discharge Note

The Veteran may remain in the Home Telehealth program if the program is providing benefit for the Veteran and, if in the absence of the program's services, there is or would be significant risk of decompensation. These benefits should be documented in the EMR as part of the periodic reassessment. If there is no benefit for the patient remaining in the program, then disenrollment should occur and if appropriate, the Veteran may be transitioned to other clinical programs such as Home-Based Primary Care (HBPC). The Discharge Template removes all clinical reminders from the Veterans record, so a Discharge Note Template can be entered on all who are discharged. If there is no contact with the Veteran and/or caregiver this note would marked historical.

Possible reasons for disenrollment are discussed in section 7.4: Discharge/Transition to Other Services.

10.4.6 Re-Enrollment

For any re-enrollments, a new initial Assessment and Treatment plan, the Continuum of Care Form and the Caregiver Assessment must all be completed. This is necessary to ensure that associated clinical reminders built into the templates will function as planned. An addendum to prior enrollment notes after an "official discharge" (a discharge that was

completed using the templates) will not trigger any of the clinical reminders on the re-enrollment.

11. Workload Capture and Data Management

11.1 Coding and Workload Credit

It is vitally important to have accurate workload capture to evaluate programs for: clinical outcomes, success towards meeting performance targets, and data necessary for receiving funding related to initiatives and/or the VERA process. The VERA model funds patient care in VHA. Complex care allocations under VERA for those patients in the Non-Institutional Care or CCM categories of care is directly tied to accurate coding and workload capture for daily monitoring using the 683 stop code. This can provide a significant source of revenue for VISNs enabling them not only to sustain Home Telehealth programs but to expand and grow these with additional staffing resources.

Home Telehealth has two different components of data entry: 1) Encounter workload that is entered via VistA or CPRS and transmitted to the National Data Repositories and 2) Non-workload data, such as demographic and clinical data, which is entered via Home Telehealth vendor websites by Home Telehealth staff. The vendors send weekly census reports which contain several different data elements. Data from these two sources is used to produce a variety of reports.

Selection of the appropriate Disease Management Protocol (DMP) title is critical to ensure outcomes data capture. DMP titles must be ones that are recognizable in the data system. For example, there are several DMP titles that are used for monitoring patients with Diabetes. The Home Telehealth data system has a list of DMP titles that are recognized as providing clinic content for the management of Diabetes.

If a DMP title is entered that is new and not present in the list of recognizable DMP titles, these patients' data will be excluded in several different areas and reports. Some vendors allow free text for a DMP title. Utilizing this option may create titles not recognized in the Home Telehealth data bases. Vendors may develop and offer new DMPs that have titles that are not recognized in our system. For an updated list of approved national released DMPs, please check the Technology Grid Algorithm on the Home Telehealth Technology page of the Connected Care/Telehealth Services website.

The Home Telehealth Vendor Cube on the VSSC website has a report called 'Unknown DMPs'. Care Coordinators can use this report to see if they have any Veterans on their panel with an unknown DMP.

11.2 Completing the Encounter Information

Encounters occur in the outpatient setting and are captured via Patient Care Encounter (PCE) software. An encounter is a professional contact between a patient and a health care

provider vested with responsibility for diagnosing, evaluating and treating the patient's condition. Contact can include face-to-face interactions or those accomplished via tele-technology.

A telephone contact between a health care provider and a patient is only considered an encounter if the telephone contact is documented and that documentation includes the appropriate elements of a face-to-face encounter; history and clinical decision-making. Telephone encounters must be associated with a clinic, that is assigned one of the DSS Identifier telephone codes and are to be designated as count clinics. Notes in CPRS that do not meet the criteria for an encounter should be made as historical notes.

When clinicians document encounters, they go into CPRS and choose the correct clinic location/clinic title and then choose a note title name. Clinic locations and note titles are two separate things. Sometimes a clinic location is note title specific and other times a clinic location will have multiple note titles associated with it. As of July 2017, National Note Titles and Templates were launched. It is the expectation that all programs will use the National Note Titles and Templates according to the training provided by the National Telehealth Training Team and in accordance to the course located in TMS. Any changes to templates will be made at the National level.

At the end of all the national templates, staff can choose "Type of encounter" i.e. Home, Office, or Phone. The templates complete the "Phone" encounter in CPRS via the template, this feature is optional. The "Home" and "Office" encounters are completed as usual.

It is vitally important that the clinician select the correct clinic location name for the activity they are documenting. The clinic location name has underlying DSS stop codes that are not visible to the clinician completing the CPRS documentation. These DSS codes are used throughout VHA for multiple reports and analyses, not just within Home Telehealth. Examples include: DSS cost reports, outpatient workload reports and funding via VERA.

In FY 2010, VHA undertook a national initiative to 'clean up' clinic location names. In coordination and support of this effort, Connected Care/Telehealth Services developed a crosswalk to standardize the core Home Telehealth clinic location and titles. The crosswalk assists in the selection of the correct core clinic location title for the Home Telehealth activity that is documented. Each facility should be able to provide a current and complete list of their Home Telehealth clinic location titles and the activity that is to be captured in that clinic location.

Facilities may have additional clinic location titles if they are an Option 2 program. It is important that Care Coordinators have access to this list to assure they are selecting the correct clinic location. Specific clinic locations/titles need to be set up prior to implementation of the Home Telehealth program.

The monthly note is known as the 'Home Telehealth Monthly Monitor' or "Summary of Episode" Note. This is sometimes referred to as the 683, the DSS primary stop code. The 683 note is not intended for use as a clinic summary note. Optimally it is entered monthly

starting with the month of enrollment and ending with the month of discharge. In the event the Veteran is not able/or is not responding, or partially responding to the DMP, the Care Coordinator must determine if this note should be completed for that month as the note documents response to technology and data monitoring for the month.

There are different Home Telehealth DSS stop code coding schemes that are applied to the Option 1 and Option 2 organizational structures. The DSS Identifiers/Stop Codes for Home Telehealth (may be notated in DSS as CCHT) are to be utilized only by approved Home Telehealth programs appropriately designated by Connected Care/Telehealth Services. Within a facility there may be both Option 1 and Option 2 Workgroups or departments.

- **Option 1**: A Workgroup or department with staff specifically assigned to care coordination roles is an Option 1 Home Telehealth program. This option utilizes a Home Telehealth Service Unit/Clinic structure. DSS will set up a specific Department or Production Unit that will capture only Home Telehealth costs and workload.
- **Option 2:** An existing Workgroup or department such as Primary Care or Geriatrics who elect to integrate Home Telehealth activities into that existing department is an Option 2 program. Staff will incorporate Home Telehealth activities in addition to other activities in these programs. DSS will send the workload from their Home Telehealth activities to the existing Department or Production Unit that they are organizationally aligned with (e.g., Primary Care, Geriatrics, etc.). These areas must use their own program DSS clinic stop code combined with the use of the stop codes designated for Home Telehealth.

When expanding Home Telehealth programs, it is important to set up clinics prior to the commencement of Home Telehealth activities. When staff are added to Home Telehealth programs that previously worked in other areas, it is important that they receive training regarding the use of the appropriate clinic locations for Home Telehealth. Staff should not use their prior clinic locations for documentation. This is a common error resulting in lost Home Telehealth workload in expanding programs. It is recommended that staff have a printed copy of the facility clinic location/clinic titles and the corresponding Home Telehealth activities that are documented in these clinics.

11.3 Veterans Equitable Resource Allocation (VERA) for Home Telehealth

In FY 2010, two new VERA patient classifications were added for Home Telehealth (notated as CCHT in VERA literature). There are two VERA Classifications for Home Telehealth enrolled Veterans. One is for patients enrolled in the Chronic Care Management (CCM) Category of Care, and the other classification is for the Non-Institutional Care Category of Care. Detailed specifics of the VERA Patient Classification Criteria last updated in 2018, can be found in the VERA Patient Classification Manual website.

Data validation is essential in assuring that qualified workload is captured for performance targets, outcomes evaluation and VERA capture. Various reports are available to assist the

field in tracking progress towards meeting targets and identifying coding and workload capture errors. To access data on VERA, select the Allocation Resource Center (ARC).

11.4 Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) – Non-Coverage for Remote Monitoring

CHAMPVA is a cost sharing program, secondary payer to most health insurance plans including, but not limited to, Medicare, commercial plans, and other private health insurance. CHAMPVA has limited authority to provide reimbursement for telehealth services. CHAMPVA coverage of telehealth is limited to services which must be performed between a provider and patient utilizing interactive telecommunication systems using real-time audio and video communication. For that reason, transmission of vital sign data and symptom response information from a beneficiary's home is not considered a reimbursable covered CHAMPVA benefit. Therefore, CHAMPVA patients currently are not eligible for enrollment in Home Telehealth.

Title 38 United States Code (U.S.C.) 1781, *Medical care for survivors and dependents of certain veterans*, is the authority which allows CHAMPVA to provide medical care in the same or similar manner and subject to the same or similar limitations as medical care furnished to certain dependents and survivors of members of the Armed Forces under chapter 55 of Title 10 (TRICARE).

Title 38 Code of Federal Regulations (CFR) 17.272, *Benefit limitations/exclusions,* provides the authority for CHAMPVA to reimburse limited telehealth services.

Additionally, VHA Handbook 1601D.05, *Civilian Health and Medical Program of the Department of Veterans Affairs*, outlines the scope of CHAMPVA's authority.

Other Federal payers' (e.g., Medicare and TRICARE) authority to provide the reimbursement of telehealth is also limited to those services that utilize audio/video technology to provide clinic consultations and office visits. Reimbursement for the transmission of vital sign and symptom response data is not considered a reimbursable covered Medicare or TRICARE benefit.

To allow for these services, legislation and/or regulation would be required providing the authority for federal payers to reimburse home telehealth remote monitoring services as a benefit.

12. Quality Management

12.1 Conditions of Participation

The Connected Care/Telehealth Services Quality Program is based on a model of continuous quality improvement that includes all Telehealth and Connected Health programs. Key components of the quality management process include the following:

- Evaluating and monitoring process and performance data (i.e., performance management).
- Setting and utilizing benchmarks and analyzing data.
- Critically reviewing program implementation planning strategies.
- Standardizing foundational operations.
- Identifying and encouraging the application of strong and leading practices nationwide.
- Driving safe, Veteran-centric care using Telehealth and Connected Health programs.

A strong focus on achieving, sustaining and advancing clinical, business and technology outcomes through quality management initiatives will facilitate Veterans' access to care, including those Veterans in rural and highly rural areas, as well as an optimal utilization of VHA's resources. In addition, this focus on quality management has been very successful in achieving both internal and external accreditation.

The Connected Care Quality Management Program has incorporated these important quality concepts into a set of elements/standards called the Conditions of Participation (COP). These COP elements/standards are utilized to review implementation and ongoing operations for all VISN/Facility Telehealth programs. The five major COP elements are Executive Leadership, Staff, Veteran Centric Care, Business Acumen, and Technology. Each of these elements contains a general standard and several criteria describing the specific components of each standard. Specific evidence or requirements are listed under each standard to help Telehealth staff understand the expectation of performance to demonstrate adherence to the criteria and meeting the standard. More information is available in the COP Standards document.

The Conditions of Participation (COP) includes a quality review process, which includes the use of all Connected Care/Telehealth Services and Connected Health COP standards. In this review process, the Connected Care/Telehealth Services and Connected Health Quality Team has developed a National Quality Data Scorecard (NQDS) that contains essential data measures that are linked to Quality domains and the COP elements, standards and criteria. Each VISN is represented within the NQDS and program performance is measured by established benchmarks, for which VISNs are scored on a quarterly basis. Threshold levels for each data element within the NQDS Scorecard will be updated as needed based on review by the NQDS Review Team (four VISN Telehealth Program Managers check and validate the data within the NQDS). A Connected Care/Telehealth Services and Connected Health Standard Operating Procedure (SOP) has been developed which provides further details regarding the Connected Care/Telehealth Services and Connected Health Quality Management/COP/performance improvement process. See the National Quality Data Scorecard and corresponding National Quality Data Scorecard SOP for more information.

12.1.1 External Accreditation

The Joint Commission and other external accrediting bodies may review some or all components of Home Telehealth programs in the course of their surveys, using their usual review processes. Home Telehealth programs are surveyed by The Joint Commission where they are organizationally aligned. Home Telehealth patients might be identified during a typical tracer activity during a survey of any type. Tracer Methodology, as utilized by The Joint Commission is a system that involves surveyors actually 'tracing' a patient from their entry to care through the continuum of care to ensure adequate communication and safety measures necessary for quality outcomes are in place. This Joint Commission tracer activity may lead to review of any aspect of the Home Telehealth program including, but not limited to: privacy/confidentiality, infection control practices, clinical documentation, orientation/training/competency, performance improvement, etc. However, there are no separate or focused reviews of Telehealth programs and there are no separate Joint Commission standards for Home Telehealth.

12.2 Process and Performance Improvement

The goal of process and performance improvement is to achieve VHA's mission of providing excellent care and service through High Reliability Organizations. This requires everyone to embrace performance improvement. Leadership must develop and guide staff in creating quality management processes and a performance improvement culture. Telehealth Service leaders want all staff to understand that discovering and analyzing ways to deliver care and services better and more efficiently to Veterans is a critical element of continued program sustainment and success.

The idea of improving product and service delivery has a long history. Some process improvement models have endured because of their proven success. However, not all of these methods employ the same approach or involve the same steps. One successful approach endorsed by VHA is the Lean model.

VHA has made tremendous efforts to promote systematic, practical process and performance improvement using these approaches. It has been noted in literature that programs following a systematic process greatly increase their chances for successful systems redesign and performance improvement. The COPs require that each VISN identify, require and monitor core quality and performance indicators for all Home Telehealth programs. These indicators might be designed for a variety of clinic, business or technology areas related to Home Telehealth including, but not limited to, aspects of utilization, access, clinic outcomes, cost, quality of life, functional status and patient or provider satisfaction.

Whenever possible, indicators should be collected from data that are electronically available for review and tracking. Utilizing data from the performance improvement process, each program should communicate program experiences to program staff and others as appropriate, identifying opportunities for improvement and developing action plans, as necessary, to assure continuous program improvement. Utilization of the same

indicators across similar Home Telehealth programs with a VISN would provide the ability to compare and benchmark results. Use of a VISN-level score card for reporting of performance data and outcomes is highly recommended.

Suggested topics for continuous performance improvement initiatives include:

- **Clinical**
  - Specific clinic outcome and process measures for the patient population served by the program (such as HgA1c, blood pressure, weight, LDL, medication adherence, non-response and partial response rates, depression scores, pain scores, numbers of heart failure or COPD exacerbations, etc.).
  - Equivalency of outcomes achieved for care using Home Telehealth as compared to standard face-to-face care.
- **Business**
  - Census, average Daily Census, Category of Care.
  - Track and trend penetration by unique patients and rurality, number of encounters.
  - Tracking of the number and type of clinic utilizing Home Telehealth.
  - Improved access to care.
  - Impact on time to next appointment for new, established patients.
  - Changes in no-show, cancellation, unscheduled visit rates.
  - Utilization parameters such as admissions, length of stay, ER visits, primary care visits.
  - Return on investment.
  - Using National data baselines compare and contrast your program and then propose ideas to meet or exceed national average.
  - Technical Problems with equipment, software, vendor, etc.
  - Quality Improvement Request Tracking (Integrated Home Telehealth Application).
  - Closing the loop – Process and Performance Improvement.

Once data is collected, the data must be aggregated and analyzed. Various statistical evaluations can be used from very simple to complex analysis to determine significance and outliers. Once outliers have been identified then a plan of action must be developed. The plan of action must incorporate these elements to be successful:

- Setting a target and/or specific goal.
- Creating steps or action items to be completed.
- Identifying who will complete each item.
- Identifying a time frame for completion of each action item.
- Re-evaluating the target/goal to determine the effectiveness of the action items
- Changing action items, target /goals or completion to sustain the change.

12.3 Documentation/Process of Care Documentation Audit

Peer review is defined as a "continuous, systematic, and critical reflection by a number of care providers, on their colleagues' performance, using structured procedures, with the aim of achieving continuous improvement of the quality of care." This definition is consistent with recent views on continuous quality improvement which see quality assurance and audit as methods of continuous learning and asks practitioners to be open to evaluation and comments on performance.

Care Coordinator peer review general information:

- Can be undertaken by one or more colleagues for any given period.
- Is conducted on a variety of subjects in a planned and structured way.
- Sets criteria for data collection and evaluation of each other's work, this process includes exchange of experiences, developing guidelines, solving problems in practice, and making specific arrangements for achieving changes to improve the quality of care.
- Encourages collaboration with respect between peers through their evaluation and support.
- Provides evidence of areas in need of performance improvement.

Please refer to the *Resources* section for a sample Documentation Review Tool that could be used for this level of peer review documentation.

12.4 Quality Improvement Report (QIR) Process.

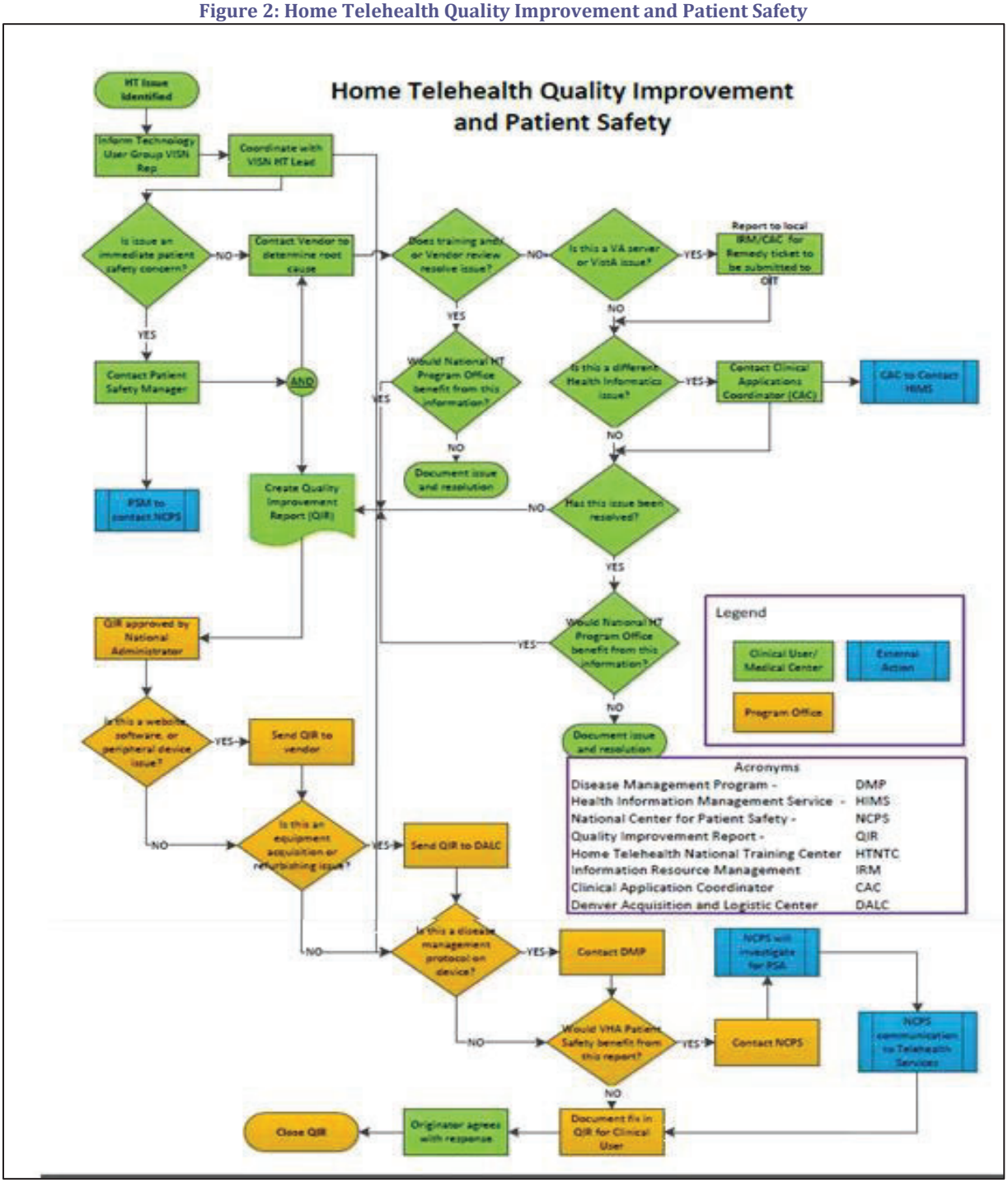
For situations with vendor or technology performance or patient safety issues, a Quality Improvement Report (QIR) is completed by the local Home Telehealth staff. The QIR includes information about the vendor involved and specific details regarding the issue.

The QIR is submitted through the Integrated Home Telehealth Application (IHTA). Once the QIR is submitted, an email alert is sent to the National QIR administrator, who then reviews and approves if appropriate. Approving the QIR then sends it to the appropriate vendor. The vendor must respond within 7 days after receiving and indicate plans for correction. The IHTA is fully automated and the Home Telehealth staff can review the history and progress of Home Telehealth vendor issues via a centralized database.

All QIRs are also reviewed for potential patient safety issues and urgent action. Any identified patient safety issues are to be reported locally according to site and VISN policies. In addition, the national Home Telehealth Lead communicates urgent patient safety issues to the National Center for Patient Safety (NCPS). A thorough review process is followed to determine if a national Patient Safety alert issued by NPCS is warranted. Connected Care/Telehealth Services continues to collaborate with NCPS, the vendor and any other appropriate parties throughout the resolution of the patient safety issue.

More detailed training regarding QIRs and the IHTA process is included in the Talent Management System (TMS) course "Home Telehealth Quality Improvement Reports".

Figure 2: Home Telehealth Quality Improvement and Patient Safety



13. Risk Management

The Home Telehealth program is not an emergent or urgent care program. Veteran data is not reviewed in "real time" and is not expected to be reviewed over a weekend or holidays. For example, a Care Coordinator may have finished a review of all patient data at 3:00pm. If a patient transmitted data at 3:30 pm, it may not be reviewed until the following business day. It is designed to provide case management and chronic disease management. The following are some important patient safety considerations for planning and operating Home Telehealth Programs and should be communicated to patients:

- Emergency procedures should be thoroughly documented and locally available. All Home Telehealth staff should be familiar with local procedures including those for Mental Health.
- In preparation for the need of emergency care, Home Telehealth staff should educate patients upon enrollment on disaster planning and to contact 911 or other local emergency services and to not use the Home Telehealth program as an emergency service provider. Staff should also inform patients that VA does not guarantee payment for non-VA Emergency care and to contact an eligibility specialist for details for emergent care coverage.

Each Network has a policy or procedure document that establishes guidelines for Continuity of Operations (COOP) for emergency management of Home Telehealth patients and staff within their VISN in the event of interruptions to service from natural or man-made disasters. A common oversight is the need to assist the Veteran in developing a disaster preparedness plan suitable for the Veterans propensity for natural disasters based on their location.

As part of this process, the following risk stratification methodology is used:

Level 1 (High Priority): Needs immediate evaluation

- Veteran is on life support, oxygen or ventilator-dependent.
- Veteran lives alone with cognitive impairment, psychological diagnosis with possibility of decompensation related to disaster and/or unable to access resources.
- Veteran with caregiver that is low functioning, cognitively impaired and cannot access resources.
- Veteran is dependent for assistance with medication management and/or unable to self-administer insulin or is unstable on coumadin.
- Interruption of health services would severely impact Veteran's ability to meet basic physiological and safety needs.

Level 2 (Moderate Priority): Needs to be evaluated within 3-7 days

- Veteran can manage for 3-7 days without Home Telehealth intervention.
- Veteran is unable to carry out medical plan of care independently for more than 3-7 days.

- Phone call required if Veteran is dependent on Home Telehealth for medication refills.

Level 3 (Low Priority): Can go 7-14 days without Home Telehealth intervention
- Veteran has physical, emotional and local resources and can access these.
- Veteran has a caregiver that is not cognitively or physically impaired.
- Veteran has friends or family able to assist with accessing resources.

(Note: All Veterans who are oxygen dependent or need C-pap are to be classified level 1, although they may have support to assist with resources, in times of a disaster this support may have changed.)

In addition, a COOP has been established at the national program office and includes routine testing at the two server locations (Austin, TX, and Hines, IL) so that there is always the ability to switch from one server to the other as needed. As programs have been implemented and grown within individual VISNs, national guidance from Connected Care/Telehealth Services has been included in individual VISN COOP arrangements.

A back up plan should be in place to ensure patient care is not jeopardized in the event of equipment failure. It is important that the VISN Program Manager for Home Telehealth and all facility Lead Care Coordinators follow national recommendations to offer appropriate interventions for patients.

14. Information Outreach

As a basic principle, information outreach is about means of communication. Information outreach strategies, though varied, are all aimed at convincing people to use particular products or services. Home Telehealth program leadership should plan their information outreach strategies and performance to keep their stakeholders aware of the value of Home Telehealth to Veterans.
Development of partnerships is a fundamental strength and challenge of the Home Telehealth program. By its nature, Home Telehealth can reduce workload and stretch limited health care resources, thus potentially increasing the need for collaborations within VA health care entities. Additionally, through cooperative efforts with local Veteran organizations the program can be promoted to potential Veterans in need of service. One significant advantage of Home Telehealth is the potential for improving access to care while unburdening the workload of Patient Aligned Care Teams' staff.

VA partners for consideration:

- **Healthcare partners**
    - Patient Aligned Care Teams
    - Local specialists (e.g., Cardiology, Neurology, etc.)
    - Mental Health & Social Work Leadership

- Diabetic Educators
- Operations Enduring Freedom/Operations Iraqi Freedom Program Managers
- Suicide Prevention Coordinators
- Women Veteran Program Managers (WVPM)
- Caregiver Support

- **Veteran Service Organizations and other partners**
  - American Legion
  - Veterans of Foreign Wars
  - Disabled American Veterans
  - State and local Veterans agencies and organizations
  - Local VSO (Veterans Service Officer)
  - Local Voluntary Service staff
  - Local social services offices/public health office
  - Local charitable organizations
  - National Alliance for the Mentally Ill
  - 211, United Way Helpline

Providing information outreach on the Home Telehealth program should ideally begin during the planning phase and continue throughout the life of the program. Outreach should include internal and external stakeholders. Sharing of information early will also encourage buy-in from healthcare providers and other clinicians whose collaboration will be vital to the success of the program.

Educational programs, technology fairs, luncheons or related events can be used to spread the word and build a base of support for the program. Working through the local public affairs office, press releases to the local media-newspapers, TV and radio stations should also be considered. The National Telehealth Training Team continually creates and collects educational and promotional tools for staff to use for this purpose.

15. Policy

15.1 Privacy

VA follows current federal and VA security policies, applicable federal law, standards and guidance, and NIST (National Institute of Standards and Technology) guidelines for privacy. The VA Directive and Handbook 6500, Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program, is one of the essential publications, along with other VA Directives on Secure Wireless Technology, Secure External Connections, Internet/Intranet Services, System Life Cycle, Information Security Contingency Planning, VA Identity and Access Management, and Mobile Device Security Policy to name a few policies.

The Security Domain describes what VA must do to protect sensitive, customer and employee information and ensure its cyberspace ecosystem is secure, ready, resilient, and resistant to threats, unauthorized access, and vulnerabilities. Information about VA security content is captured in the VA Enterprise Architecture Repository (VEAR).

These policies are applicable to all areas of remote monitoring/Home Telehealth, VVC (VA Video Connect), SFT (Store-and-Forward Telehealth) and CVT (Clinical Video Telehealth).

15.2 Managing VA-Issued Technology When Veterans Geographically Relocate

Historically, Veterans with VA-Issued technology were asked to return their technology to the facility that originally issued it. The Veterans would then receive new technology from the facility that serves the Veteran's new location.

This guidance was revised in August 2018. Facilities may instead allow Veterans to keep their VA-Issued technology as long as the Care Coordinator has spoken with and confirmed with the receiving program they will receive care upon arrival and the receiving facility is using the equipment the Veteran currently has. In the event the receiving site reports a delay in the Veteran being enrolled or receiving care, it would be best to have the equipment returned and then issue new equipment when care can begin.

If the Veteran takes their equipment with them, the leaving site will "Disenroll/Unassign" the device and Service Fees in ROES. The new site will order Service Fees which gives them a new task order. The receiving site should update the Veteran's record in ROES and "Authorize" the device. The device will remain *registered* and *authorized* to the *original* site until it is returned back to the DLC. The receiving facility will not see the device on the ROES Report, only Service Fees. The leaving site ROES Report will not show Service Fees but will show the device until it is returned to the DLC. Facilities should be prepared for this issue if Veterans are allowed to keep VA-Issued technology when relocating.

Appendix A: Resources and Links

The Following Links Will Direct You to Related Resources

Table 1: Resources and Links

Resource	Link
Clinical Care Reminders and Dialogs This document releases new national reminders, reminder dialogs, and TIU progress note titles that will be used by Care Coordinators managing patients enrolled in **Home Telehealth** programs.	https://vaww.infoshare.va.gov/sites/telehealth/docs/ht-rmd-usrgd.docx
Conditions of Participation This is a tool developed by VHA Telehealth Service's Quality Management team to assist VISNs a step by step process and list of criteria to evaluate and assure safe, effective Veteran care.	http://vaww.infoshare.va.gov/sites/telehealth/docs/Forms/cop.aspx
Continuum of Care and Categories of Care Guidance These tools include the actual Continuum of Care Form (CCF) that is completed on every Home Telehealth patient and the guidance document that explains each of the forms sections as well as the definition of each Home Telehealth Category of Care.	http://vaww.infoshare.va.gov/sites/telehealth/docs/ccf-coc.docx
Documentation Review Tool This tool is to assist in the peer review of documentation.	http://vaww.infoshare.va.gov/sites/telehealth/docs/ht-doc-rvw-tl.xlsx
Enrollment Agreement This document provides documentation for the required verbal consent in Home Telehealth.	http://vaww.infoshare.va.gov/sites/telehealth/docs/ht-ec-agrmnt.docx
Facility Telehealth Coordinator Competencies This document assists in providing guidance on the skills and knowledge component of the Facility Telehealth Coordinator (FTC) position.	http://vaww.telehealth.va.gov/roles/ftc/index.asp
FAQ for the use of LPNs in Home Telehealth Frequently Asked Questions about the use of LPN's in Home Telehealth.	http://vaww.infoshare.va.gov/sites/telehealth/docs/ht-lpn-faq.doc
Using Group Notes **This document provides assistance in how to use group notes for documenting monthly monitoring.**	https://vaww.infoshare.va.gov/sites/telehealth/docs/gnwd.pdf

Resource	Link
Home Telehealth National TeleMental Health User Manual This guide provides **Home Telehealth** staff with helpful information for promoting **Home Telehealth** to mental health patients and on managing mental health patients within **Home Telehealth**.	http://vaww.infoshare.va.gov/sites/telehealth/docs/ht-htmh-usrgd.docx
National Guidance to Ensure Continuity of Operations for Home Telehealth Document Created by the Office of Health Informatics: Connected Care/Telehealth Services, Washington DC, in Consultation with the Home Telehealth Emergency and Disaster Planning Ad Hoc Committee.	http://vaww.infoshare.va.gov/sites/telehealth/docs/ht-ncg-emg.doc
PATIENT ALIGNED CARE TEAMS Whitepaper 2012 This document reviews the history and the need for primary care and mental health teams to interact with **Home Telehealth** programs to improve patient outcomes.	http://vaww.infoshare.va.gov/sites/telehealth/docs/ht-Patient Aligned Care Teams -id-wp.docx
Patient Participation Toolkit – June 2012 A policy to guide the **Home Telehealth** community on patient participation in the **Home Telehealth** program.	http://vaww.infoshare.va.gov/sites/telehealth/docs/ht-nrspndr-tlkt.docx
ROES User Guide The Home Telehealth ROES user guide provides information and instructions to employees of VHA ordering and tracking Home Telehealth devices.	http://vaww.infoshare.va.gov/sites/telehealth/docs/roes-usr-gde.docx
SUD DMP Brochure This brochure provides a brief glimpse of the Substance Use Disorder DMP to help both the clinician as well as the Veteran understand the purpose of the program as well as what to expect each and every day.	http://vaww.infoshare.va.gov/sites/telehealth/docs/SUD_DMP_Br.pdf
SUD DMP workbook This workbook was created by the field to support the tremendous amount of work the Veteran is asked to do in the SUD DMP.	http://vaww.infoshare.va.gov/sites/telehealth/docs/SUDWkbk.docx
Technology Algorithm Used to determine best fiscally responsible type of technology to assign based on specific Veteran need.	http://vaww.infoshare.va.gov/sites/telehealth/docs/ht-tchgrd-algthm.xls

Resource	Link
Telehealth Reports Guide A guide to help staff get data reports, review "help" documents and review data definitions.	https://securereports2.vssc.med.va.gov/Reports/Pages/Report.aspx?ItemPath=%2fTeleHealth%2fTelehealthGuide&ViewMode=Detail
TeleMOVE! Manual Supplement This Supplement provides standard guidance to implement and monitor quality of delivering care to Veterans via telehealth technology.	http://vaww.infoshare.va.gov/sites/telehealth/docs/tmove-spp.pdf
VHA Case Management Standards of Practice 2013 This Veterans Health Administration (VHA) Handbook establishes procedures and identifies standards of practice for a collaborative Department of Veterans Affairs (VA) patient case management model.	http://vaww.infoshare.va.gov/sites/telehealth/docs/ht-cmhb.pdf
Video Technology Use in Home Telehealth This document describes business, clinical and technology requirements and considerations for use of video for home telehealth visits with enrolled Veterans.	https://vaww.infoshare.va.gov/sites/telehealth/docs/ht-vid-use.docx

Appendix B: Acronyms

Acronyms Listed in Home Telehealth Ops Manual

Table 2: Table of Acronyms

Acronym	Description
ACM	Acute Care Management
ADLs	Activities of Daily Living
APN	Advanced Practice Nurse
ARC	Allocation Resource Center
BDOC	Bed Days of Care
CAC	Clinical Applications Coordinator
CBOC	Community Based Outpatient Clinic
CBT	Clinic Based Telehealth
CCF	Continuum of Care Form
CCHT	Care Coordination Home Telehealth
CCM	Chronical Care Management
CDC	Center for Disease Control and Prevention
CLC	Community Living Center
COP	Conditions of Participation
COOP	Continuity of Operations
COPD	Chronic Obstructive Pulmonary Disease
CPRS	Computerized Patient Record System
CVT	Clinic Video Telehealth
DLC	Denver Acquisition and Logistics Center
DMP	Disease Management Protocol
DSS	Decision Support Services
EMR	Electronic Medical Record
EWL	Electronic Wait List
FTC	Facility Telehealth Coordinator
FTEE	Full-time Employee Equivalent
HBPC	Home-Based Primary Care
HCS	Healthcare Systems
HIPA A	Health Insurance Portability and Accountability Act
HP/DP	Health Promotion/Disease Prevention
HT	Home Telehealth
ICD	Internal Classification of Diseases
IHTA	Integrated Home Telehealth Application
IVR	Interactive Voice Response

Acronym	Description
LPN	Licensed Practical Nurse
LVN	Licensed Vocational Nurse
MOU	Memorandum of Understanding
MTBI	Mild Traumatic Brain Injury
MSA	Medical Support Assistants
NIC	Non-institutional Care
NCPS	National Center for Patient Safety
NPCD	National Patient Care Database
OHI	Office of Health Informatics (Connected Care/Telehealth Services)
OI&T	Office of Information and Technology
PACT	Patient-Aligned Care Team
PCE	Patient Care Encounter
PCP	Primary Care Physician
PCTOC	Primary Care Telehealth Outreach Clinic
PDCA	Plan-Do-Check-Act
PDSA	Plan-Do-Study-Act
POTS	Plain Old Telephone Service
PTSD	Post-Traumatic Stress Disorder
QIR	Quality Improvement Report
RN	Registered Nurse
RNCM	RN Case Managers
RME	Reusable Medical Equipment
ROES	Remote Order Entry System
SCAN-ECHO	Specialty Care Access Network - Extension for Community Healthcare Outcomes
SCI	Spinal Cord Injury
SFT	Store-and-Forward Telehealth
SMART	Simple and Specific, Measurable, Achievable and Attainable, Relevant and Realistic and Timely
SME	Subject Matter Expert
SOP	Standard Operating Procedures
SUD	Substance Use Disorder
SW	Social Worker
TCT	Telehealth Clinic Technician
TMS	Talent Management System
TSA	Telehealth Service Agreement
TSS	Telehealth Scheduling System

Acronym	Description
TUG	Technology User Group
VA	Veterans Affairs
VACO	Veterans Affairs Central Office
VAMC	Veterans Affairs Medical Center
VA-TAMMCS	Vision Analysis - Team, Aim, Map, Measure, Change, and Sustain
VERA	Veteran's Equitable Resource Allocation
VHA	Veterans' Health Administration
VISN	Veteran Integrated Service Network
VSSC	Veterans Support Service Center

Appendix C: Endorsement of Home Telehealth Operations Manual

I have reviewed this Home Telehealth Operations Manual and approve the content, guidance, and processes. I fully endorse the publishing of this Manual as a VHA standard guide for implementation of Home Telehealth.

Catherine A Buck 477760 Digitally signed by Catherine A Buck 477760 Date: 2019.07.11 13:35:06 -04'00'

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