VHA Connected
Care/Telehealth

Connected Care/ Telehealth Manual

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We would like to thank the entire Telehealth Services team for their contributions and many revisions and reviews. For questions, please contact the quality and training team at VHA_10P8_TH_DIQ@va.gov.

Document Version History

Responsible Office

The development and maintenance of this document is the responsibility of the Veterans Health Administration (VHA), VHA Office of Health Informatics: Connected Care/Telehealth. Proposed changes to this document should be submitted to VHA_10P8_TH_DIQ@va.gov. To see if there is any have been updates after the most recent revision, view the Telehealth Manual Update Log on the Telehealth Intranet Site.

Document Revision	Effective Date	Page	Description
1	November 2018	*N/A*	Initial Document Development.

1. Overview

1.1 Background

Operating the nation's largest healthcare system, the Veterans Health Administration (VHA) uses a wide variety of communication and information technologies to ensure excellence in the health care it delivers to our nation's Veterans. New technologies are revolutionizing health care and the Department of Veterans Affairs (VA) has been recognized as a leader in using these technologies to improve the quality of its care delivery. VHA uses health informatics, virtual environments, quality controls, case management, staff resources and human factors to improve the Veterans' healthcare experience and access to care. Telehealth also expands healthcare capacity and improves Veterans' health not just in the implementation of telehealth technologies but also in delivering quality healthcare services to Veterans.

The Veteran's choice in how and where care is delivered is a major focus and guides telehealth programs' operations. When clinically appropriate, Veterans should be offered telehealth as an option for appointments. Telehealth and its infrastructure support Veterans' choice to obtain VA quality care from anywhere. One of the Veterans' preferred locations for obtaining care is in their homes. VA Video Connect allows Veterans to have an outpatient telehealth visit with their provider via a smartphone, tablet, or computer. For more information on VA Video Connect see the VA Video Connect Intranet Site and the VA Video Connect Supplement.

VA has made significant progress to remove barriers and enhance the legal authority of VA healthcare professionals providing quality care through telehealth. Resulting from these efforts are a rule and code popularly known as "Anywhere to Anywhere", which was published in the Federal Register on May 11, 2018 and went into effect on June 11, 2018. Similarly, section 151 was added to 38 USC 1730C of the United States Code on June 6, 2018 and was effective on October 24, 2018. This law is also referred to as the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 which establishes the same authority. This law and rule clarifies notwithstanding any provision of law regarding the licensure of health care professionals, a covered health care professional may practice the health care profession of the health care professional at any location in any State, regardless of where the covered health care professional or the patient is located, if the covered health care professional is using telemedicine to provide treatment to an individual. The provisions of this law shall supersede any provisions of the law of any State to the extent that such provision of State law are inconsistent. No State shall deny or revoke the license, registration, or certification of a covered health care professional who otherwise meets the qualifications of the State for holding the license, registration, or certification on the basis that the covered health care professional has engaged or intends to engage in activity covered by this law.

Further information on the rule is available on the Anywhere to Anywhere intranet page.

1.2 Purpose

This Telehealth Manual establishes standards and procedures to assist VA staff with the integration of Telehealth into routine health care for the benefit of patients, caregivers, families and practitioners. This integration of processes and procedures applies to both establishing a new program and operational standards for an existing Telehealth program. References and links to the relevant VHA Connected Care guidance are provided throughout this manual.

Telehealth leaders from all the Veterans Integrated Service Networks (VISN) comprised the development committee for this Operations Manual, with oversight and leadership from the Quality and Training Division within Connected Care/Telehealth. The committee developed content with the underlying goal of providing the greatest amount of relevant information in the least amount of time. Key staff from VHA Telehealth Services completed final reviews prior to approval and publication.

2. How to use this Telehealth Manual

The Quality and Training Division, under Telehealth Services, developed this Telehealth Manual. It is meant to complement existing VHA clinical and administrative directives and guidelines. These directives and guidelines detail the prerequisites and critical success factors for providing services within the framework of the national, VISN or Veterans Affairs Medical Center (VAMC) strategic plans for telehealth. They assist VHA staff in integrating leading practices and agreed procedures of telehealth into routine care for the benefit of Veterans and practitioners. The content and tools provided within this Operations Manual serve as a resource to improve and expand the delivery of care via telehealth, and to ensure that the efficiency, quality, and sustainability of these services maximize the satisfaction of VHA communities of practice.

This manual describes tools and processes that assist in identifying variables between telehealth and traditional in-person/face-to-face health care. It provides details for the intended audience to gain an understanding of the complex components of developing and managing telehealth programs. This manual also contain links to additional training, tools, and resources that will complement other national, VISN and local requirements ensuring competency and the ability to successfully plan, deploy and manage telehealth programs.

TeleSpecialty Supplements are intended to be used in parallel with this manual, as provided by Connected Care/Telehealth. These supplements complement existing VHA clinical and administrative directives and guidelines. The supplements are extensively vetted by national subject matter experts in the specific specialties. These documents are used when developing and managing any TeleSpecialty care or service within VHA. The TeleSpecialty Supplements may be found in the Telehealth SharePoint in the Master Telehealth Document Library, under the Operations Manuals category.

Although much of the content of this Operations Manual may be pertinent to Telehealth operations outside of VHA, this document is a resource developed solely for internal VHA Telehealth Programs, with the intended audience being VISN Telehealth Leadership, Facility Telehealth Coordinators, Telehealth Clinical Technicians, telehealth practitioners and VHA staff who provide management and/or support to telehealth programs.

The Telehealth Manual is focused on the use of technology to deliver care to Veterans. The Home Telehealth (HT) program is an example of that process. It is a specialty in and of itself and provides clinical care through care coordination. HT Care Coordinators and the HT programs use much of the processes noted in this Operational Manual. Further Guidance can be found in the Home Telehealth Operational Manual.

3. Introduction to VA Telehealth

Telehealth is a group of care delivery modalities that use VHA sanctioned technology to meet security and privacy standards, and to deliver care to Veterans anytime, anywhere while supporting the telehealth vision within virtual care access. Telehealth can be conducted synchronously or asynchronously to accommodate Veteran preference, improve access and build capacity. To ensure safe, effective Veteran care, telehealth is built on an infrastructure that includes unique business, clinical, and technical processes. The telehealth processes are guided by data and need, while meeting quality standards with an emphasis on competent and caring staff. This infrastructure creates a foundation to deliver care that includes the home, clinic and virtual environments.

Telehealth is commonly carried out between a providing facility and a receiving facility. A providing facility is the facility where the provider is physically located and/or assigned to provide patient care. A receiving facility is the facility where the patient is physically located and/or assigned to receive patient care.

Through telehealth, the VA seeks to:

- Increase capacity by better matching clinical supply and demand across the enterprise by redistributing provider services from densely populated, urban centers to rural or other underserved locations.
- Enhance accessibility by moving appointments closer to Veterans, including to their homes or home communities.
- Improve quality by facilitating the engagement between Veterans and the healthcare system in between office visits.

"Veteran Centered Care" is the principle in VHA that ensures Veterans are included in all discussions and decisions of their care. Veteran centered care is personalized, proactive, and Veteran-driven health care. Veteran centered care focuses on discovering the Veteran's goals for

health and vision of living life fully. The healthcare team, including the Veteran and personal support persons, comes together as partners to create and implement the Veteran's plan for health. The telehealth virtual healthcare team includes these principles and provides Veterans with a choice of where, when and how they are provided quality, safe care.

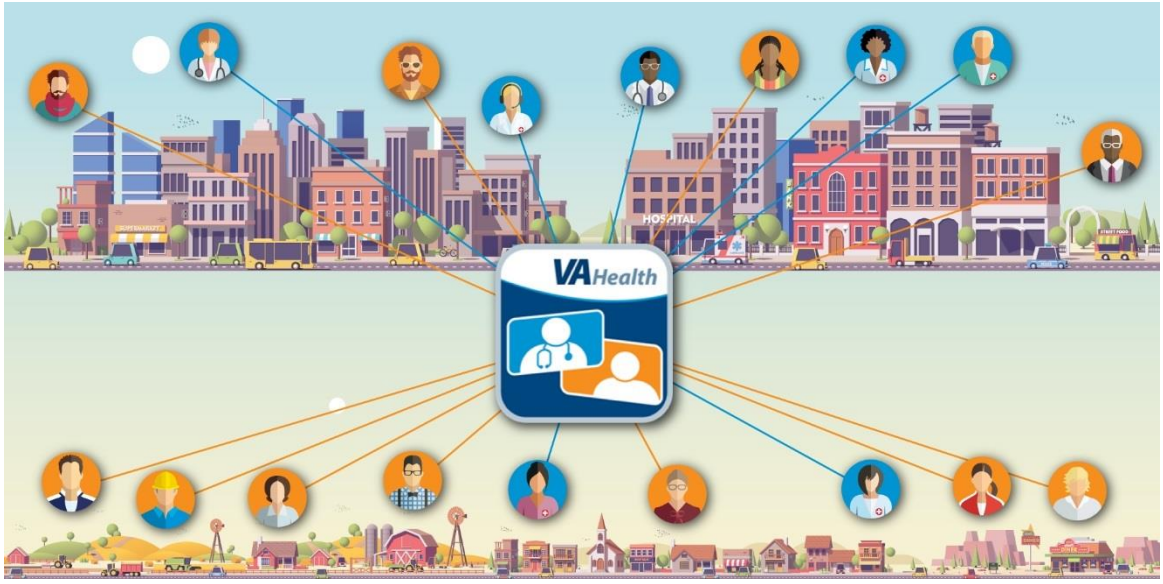
Access to care is important for all Veterans no matter their location. Telehealth technologies can facilitate connecting health care to Veterans anywhere. Veterans' telehealth encounters can be conducted using technology from a variety of places for both the Veteran/patient and the clinician. Environments can include both VA and non-VA locations, including the home, as well as institutional and non-institutional sites of care.

The three types of VHA telehealth care are Synchronous, Asynchronous, and remote monitoring Home Telehealth.

3.1 Synchronous Telehealth

Synchronous telehealth encompasses real-time care delivered to Veterans through interactive video. Synchronous telehealth is available in VA facilities, non-VA facilities, in the Veteran's home, and wherever the Veteran may be located. The "Anywhere-to-Anywhere" rule and code, as well as section 151 of 38 USC 1730C (the MISSION Act of 2018), explicitly authorize VA providers to care for their Veteran patients using telehealth, irrespective of the location of the provider or the Veteran anywhere in the country, including States, Territories, and possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico. This rule and law is expected to expand synchronous care within the VA to underserved areas and improve access to primary and specialty care across the nation. For more information view the Anywhere to Anywhere Intranet Page.

As depicted in the graphic below, synchronous telehealth may occur in nearly any private location that the Veteran desires. This includes non-VA locations such as Veterans Service Organizations (i.e., Veterans of Foreign Wars, American Legion Posts), Federally Qualified Health Centers, community clinics, libraries and churches to name a few. Telehealth care may also occur in VA Medical Centers (VAMCs), Community Based Outpatient Clinics (CBOCs), Primary Care Telehealth Outreach Clinics (PTOCs), VA Centers of Excellence, VA outpatient and inpatient sites of care, Community Living Centers and contract nursing homes. Any of the above can take place between sites of care within the same facility (*Intra*facility) or between facilities (*Inter*facility).



3.2 Asynchronous Telehealth

Asynchronous or Store-and-Forward Telehealth within VA is defined as the use of Telehealth Advisory Board approved technologies and processes to acquire and store clinical information (e.g., data, image, sound and video) that is then forwarded to or retrieved by a provider at a different time for clinical evaluation. Store-and-Forward Telehealth can take place between VA sites of care within the same VISN or between VISNs using a variety of technologies and applications. Telehealth programs also exist between VA sites of care and Non-VA sites of care, including Store-and-Forward Telehealth into Veterans' homes and contract nursing homes.

The Store-and-Forward Telehealth asynchronous model of care in VA uses a recognized or nationally approved clinical pathway utilizing Veterans Information Systems and Technology Architecture (VistA) Imaging or other approved vendor data collection or imaging interface. Nationally standardized Store-and-Forward Telehealth Programs also involve program specific requirements that are identified in the TeleSpecialty Supplements. For more information view the Standardization of Store-and-Forward Telehealth Guidance: Program Recognition document. Another resource is the Standardization of Store-and-Forward Telehealth Guidance, which assists telehealth field staff in the implementation of safe, standardized Store-and-Forward Telehealth programs with national guidance and training. Additionally, the Standardization of Telehealth Competency Assessment Guidance provides recommendations on improving the operations and standardization of Store-and-Forward Telehealth imaging and/or Telehealth Clinical Technician competency assessments.

3.3 Remote Monitoring Home Telehealth

"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.

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.

In the VA, Veterans may be enrolled in Home Telehealth, a specialty program that applies care and case management principles to coordinate care. Home Telehealth uses health informatics, disease management, and technologies such as in-home and mobile monitoring, messaging and/or video technologies to manage 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. Home Telehealth enrolls high-risk Veterans with chronic disease or who are at risk for institutional long-term care. Veterans are also enrolled to benefit from additional health promotion and prevention activities such as weight management and/or tobacco cessation.

Home Telehealth works collaboratively with Patient-Aligned Care Teams and specialty programs such as Mental Health to ensure timely and appropriate care. The use of Home Telehealth has demonstrated the potential to reduce clinical complications and maximize the use of health care resources that health complications may consume, as well as provide proactive and preventative care.

The use of technology is a core component of the Home Telehealth model, which also 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 healthcare team using an interdisciplinary approach.

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 to expand access to case management services.

Refer to the Home Telehealth Operations Manual for information and guidance on the implementation of Home Telehealth.

3.3.1 Low Acuity/Low Intensity Telehealth

Low Acuity/Low Intensity or "L2" Telehealth is an extension of the existing VHA Home Telehealth program. L2 Telehealth offers services to Veteran patients who have stable health conditions (low acuity) and who do not require frequent interventions (low intensity). The L2 Telehealth program complements but does not replace VHA's current Home Telehealth programs. The L2 Telehealth program was developed to expand the size and scope of technology-assisted care, disease and patient self-management services that can support Veterans with chronic conditions. The intention behind L2 Telehealth is that the accepted model(s) of care act as an extension of services beyond that which is currently provided by VHA's Home Telehealth programs. L2 Telehealth programs are designed to utilize platform-independent technologies for Veterans who would benefit from patient education, patient self-management and appropriate input from health professionals. The expected result is an increased ability to manage symptoms, behaviors and lack of knowledge about Veterans' chronic conditions, which in turn leads to avoidable deteriorations, improves Veterans' health, and reduces outpatient visits.

The use of browser technology and utilization of My HealtheVet are core components of the L2 Telehealth model. Other core components include patient monitoring, educational support, and close collaboration with the Patient Aligned Care Teams to provide the comprehensive self-care management necessary to support a holistic, medical home model of care. Self-care management paired with technology increases patient satisfaction, improves outcomes and enhances management of chronic disease through collaboration between the Veteran, the Home Telehealth clinician (called a Care Coordinator), and the Patient Aligned Care Team using an interdisciplinary approach.

Refer to the Home Telehealth Operational Manual for more information.

3.4 Other VA Office of Connected Care Solutions

Administratively, Telehealth Services and Connected Health comprise VHA's Office of Connected Care. Other virtual care solutions of note in VA's Connected Health portfolio include Annie, My HealtheVet, and Web and Mobile Apps. Information about these technologies are available through VHA's Connected Care Digital Health Solutions document.

3.4.1 Annie

Annie is a free text-messaging service that helps providers support Veterans as they engage in self care. Providers can assign specific protocols for self-management of conditions to their Veterans. The Veterans can enter specific Veteran-generated data such as vital signs, into Annie which may be viewable by providers. Annie provides reminders and education to Veterans as well.

Separate versions of the Annie app are provided for Veterans and Clinicians.

3.4.2 My HealtheVet

My HealtheVet enhances Veteran access to VA physicians and medical records. Through My HealtheVet, Veterans can communicate with their providers using secure messaging. Communications include requesting and receiving refills for prescriptions. Veterans are also able to download their personal medical records through the Blue Button functionality of My HealtheVet.

More information is available at the My HealtheVet Intranet Site. There is also a separate Veteran-facing My HealtheVet internet site for Veterans.

3.4.3 Mobile Apps

VA Mobile provides technologies that expand VA clinical care beyond the traditional office visit. It pursues the development of mobile applications for both Veterans and VA care teams that offer secure access to VA patient data and provides more opportunities for Veterans to be active participants in their health care.

The VA App Store now features more than two dozen apps for Veterans and more than a dozen apps for VA healthcare professionals. In addition to being a library for accessing VA's apps, the website is also a resource center. Veterans and VA employees can visit each app's dedicated page and find these educational materials:

- Downloadable Guides – Many app pages include training guides which can be downloaded or printed for easy reference. Look for the Quick Start Guide and/or User Manual buttons under the app name.
- Training Materials – Some apps have this additional information tab, which offers additional images and instructions, and may even include video tutorials.
- Frequently Asked Questions – Many apps also have a Frequently Asked Questions tab. Here, you will find answers to the common questions users have.

More information:

- VA App Store
- VA Mobile Discussion Series
- VA App Store video
- My HealtheVet Community – VA Mobile Apps page

4. Telehealth Organization

Telehealth organization at the National, Veteran Integrated Service Networks (VISN) and the Veterans Affairs Medical Center (VAMC) levels is of utmost importance. The development, coordination, and communication regarding telehealth programming is essential to providing Veterans with quality care. Telehealth implements business practices that improve capacity,

accessibility, quality of care, and Veteran satisfaction using state of the art telehealth technologies. Directives, policies and procedures define the structure of the telehealth services and provide standardization of processes for safe, high quality delivery of care.

4.1 Office of Health Informatics (OHI)

The Office of Health Informatics is aligned under the Principal Deputy Under Secretary for Health (10A) and the Undersecretary for Health (10). Connected Care (10A7D) is one of four divisions within the Office of Health Informatics. The other divisions include Health Informatics (10A7A), Health Information Governance (10A7B) and Strategic Investment Management (10A7C).

4.1.1 Mission

The Office of Health Informatics supports Veteran-centered care by facilitating the deployment of innovative, secure health data systems and collecting, analyzing and disseminating the highest quality health information for Veterans, caregivers, clinicians and administrative staff for decision-making.

4.1.2 Vision

The vision of the Office of Health Informatics is to act as an integral partner to Veterans, caregivers, clinicians, managers and leaders by providing timely, relevant, accurate and secure information that improves Veterans' health and their experience.

4.2 Connected Care

The Office of Health Informatics, Connected Care/Telehealth improves care convenience for Veterans by providing access to medical services from their homes or local clinics. Connected Care helps facilitate ease of Veterans' care by increasing capacity in clinics and providing the option of VA Mobile Telehealth Apps to make accessing VA records easier for both Veterans and health care professionals. To improve care, the VHA Innovation Program, run by Connected Care, hosts annual events that allow healthcare ideas to emerge from the field, leading to new solutions for improving Veterans' overall telehealth experience.

4.3 Telehealth Staffing

Telehealth implements business practices that improve capacity, accessibility, quality of care, and Veteran satisfaction using state of the art telehealth technologies. The value VA derives from telehealth is not in implementing telehealth technologies alone, but in how VA uses 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. VA is recognized as a world leader in the development of telehealth services which are now mission critical to the future direction of VA care to Veterans.

For more information view the VHA Telehealth Intranet Site.

4.3.1 Telehealth Executive Director

Responsible for:

- Providing leadership and oversight that endorses, supports, and promotes telehealth for delivery of comprehensive, coordinated, patient-centered care to all Veterans in VHA.
- Ongoing strategic planning for the development and sustainment of telehealth care in VHA.
- Ensuring adequate resources (staffing, technology, equipment, space, and training) within the Office of Health Informatics-Connected Care/Telehealth section.
- Facilitating and leading inter-service collaboration at the national level to enhance and expand Telehealth with such entities as: Office of Information and Technology (OIT), BioMed, Home Telehealth, contracting and Veteran Services.

4.3.2 Telehealth Deputy Director

Responsible for:

- Providing leadership and support of the mission and vision of the national program office that endorses and promotes Telehealth for delivery of comprehensive, coordinated, patient-centered care to all Veterans in VHA.
- Ongoing strategic planning support for the development and sustainment of telehealth care in VHA.
- Supporting inter-service collaboration at the national level to enhance and expand Telehealth with such entities as: Office of Information and Technology (OIT), Office of Veterans Access to Care (OVAC), BioMed, Veterans' Experience Office, Home Telehealth, contracting and Veteran Services.

4.3.3 Synchronous Lead

Responsible for:

- Assisting staff in aligning work of Telehealth Services with defined national strategies and in making necessary adaptations to accommodate VISN/locality needs when this is required to support their individualized priorities in relation to meeting national strategies.
- Planning work for the area under their oversight to ensure work meets defined patient care needs and aligns with strategic direction of both VA and VHA.
- Providing national guidance and direction to VISN Leads in the area of synchronous video telehealth to support and/or implement nationally agreed-to strategies.
- Supporting strategies to promote the use of synchronous telehealth to Veterans.
- Collaborating with external agencies and organizations, including the Department of Defense, Indian Health Services, Health and Human Services, Veteran Service Organizations, and private entities to expand and enhance the availability of VA health care through telehealth at non-VA locations.

- Assisting the Executive Director and Deputy Director in providing consultations to VISNs and other headquarters' elements on telehealth technologies and services.
- Leading the synchronous video telehealth subcommittee of the National Telehealth Governance Board to align the strategic direction of synchronous video telehealth modalities in VHA with the necessary information and telecommunication technology assets.
- Overseeing the Telehealth Emergency Management Program.
- Coordinating with the Executive Director and Deputy Director on National Reporting.
- Collaborating with the Office of Academic Affiliations (OAA) to incorporate synchronous video telehealth and other programs involving trainees into the training curriculum for existing residencies.
- Managing budget.

4.3.4 Asynchronous Lead

Responsible for:

- Defining and executing enterprise strategy for maintaining and expanding services to Veterans through asynchronous telehealth in collaboration with Connected Care's Executive Director for Telehealth Services and Telehealth Deputy Director.
- Overseeing and managing asynchronous telehealth services and their clinical integration, implementation, related product support and maintenance, clinical quality management and training, and any other areas as designated by the Executive Director or Deputy Director for Telehealth Services.
- Working with Office of Information & Technology (OIT), Health Care Technology Management, Office of Health Informatics (OHI) and other offices to develop and maintain a consistent and reliable enterprise-level infrastructure and the necessary resources for the portfolio of asynchronous telehealth programs nationwide.
- Collaborating with identified VA and VHA Program Offices and/or other staff in the development and implementation of telehealth programs/projects and pilots.
- Preparing horizon scan for future capabilities and requirements.
- Directing colleagues on work and administrative matters pertaining to Asynchronous Telehealth.
- Assisting the Executive Director and Deputy Director in managing the budget to support all Connected Care activities including new asynchronous telehealth products from ideation through development and delivery, measurement and quality review, and all administrative aspects for the asynchronous telehealth program.

4.3.5 Remote Monitoring Home Telehealth Lead

Responsible for:

- Providing expert clinical technical knowledge about Home Telehealth equipment and informatics to assist staff in delivering Home Telehealth to Veterans and their families in keeping with the mission of Connected Care/Telehealth Services.
- Providing leadership and substantial involvement in developing a quality and performance improvement program for Home Telehealth programs related to technologies purchased by VA for the care of Veterans.
- Triaging and prioritizing technology related issues raised by Home Telehealth clinicians nationally, and through analysis, making complex recommendations for integrating program policy and clinical and technical requirements into quality improvements.
- Collaborating with multiple sites across a continuum of care and taking a collaborative and leadership role in working with all levels of staff in developing and implementing Home Telehealth programs for Veterans.

4.3.6 National Technology Manager

Responsible for:

- Planning, budget preparation, coordination and implementation of National Program Technical Initiatives.
- Implementing, managing and evaluating all telehealth technologies/applications, in support of Connected Care and Telehealth.
- Ensuring technology purchased and used is VA approved. To view the approval form, visit the Purchasing/Set-Up Guide in SharePoint.
- Managing budget.
- Coordinating with the National Telehealth Technology Help Desk.

4.3.7 Quality and Training Director

Responsible for:

- Providing oversight, coordination, and leadership in developing and managing the National Telehealth Quality Management/Performance Improvement program.
- Assuring excellence, coherency and consistency with system wide goals and strategic objectives, including VHA's strategic framework for quality.
- Monitoring and evaluating quality of telehealth-based care VHA-wide.
- Implementing national review and periodic revision of VA's internal accreditation process for telehealth programs, called the "Conditions of Participation".
- Facilitating the national reduction of variance in telehealth care, facilitating the integration of quality management into both the VISN and the Telehealth Program Office's day-to-day operations and culture, ensuring that Conditions of Participation and telehealth training products/offerings are well-aligned.

- Implementing Telehealth Education and Training for VA employees, including identifying training needs for different staff populations, training development/design and assessment of training quality/outcomes as they link to Conditions of Participation.
- Overseeing internal review of National Telehealth infrastructure components, such as the National Telehealth Training Center, National Telemental Health Center and other program operations.
- Managing budget and overseeing contracts.
- Directing oversight of Joint Accreditation.

4.4 VISN Roles and Responsibilities

The organizational structure of the VISN Telehealth Program is designed to ensure local control, with proper national and VISN oversight for planning, deployment and operational functions. The following VISN roles and responsibilities are necessary to strategically and adequately support telehealth processes and programs.

Based on need and strategic alignment, VISN Leadership ensures quality of care, improved access, increased capacity and integration of telehealth into routine Veteran care through programmatic oversight of all telehealth clinicians and the assessment and tracking of facility telehealth staff competency. The VISN also acts as a liaison for telehealth programming between Connected Care/ Telehealth and the VAMC telehealth staff.

4.4.1 VISN Director

Responsible for:

- Ensuring implementation of this Manual at all sites of care in the VISN where Veterans receive care via telehealth.
- Providing leadership and oversight that endorses, supports, and promotes telehealth for delivery of comprehensive, coordinated, patient-centered care to Veterans.
- Ongoing strategic planning for the development and sustainment of telehealth care.
- Ensuring adequate resources (e.g., staffing, technology, equipment, space and training).
- Facilitating and supporting inter-service collaboration to enhance and expand telehealth with Office of Information and Technology (OIT), BioMed, Home Telehealth, contracting and Veteran services.

4.4.2 VISN Chief Medical Officer (CMO)

Responsible for:

- Ensuring operations of telehealth throughout the VISN are coordinated with operations of other services aligned with VISN and national VHA initiatives and priorities.
- Designating and providing oversight to a VISN Telehealth Program Manager and establishing responsibilities consistent with telehealth priorities and goals.

- Establishing a standard process for the identification, implementation and sustainment of telehealth, including business, clinical, training, and technical standard processes.
- Ensuring the VISN Telehealth Council/Committee is established and chartered for:
    - Developing strategies and processes for development, deployment and management of telehealth initiates throughout the VISN.
    - Serving as a primary vehicle for communications and dissemination of information regarding local, network and Office of Telehealth Services initiatives and news to all appropriate contacts within the network.
    - Defining processes and standards for VISN telehealth services and their operations.

4.4.3 VISN Telehealth Program Manager

Responsible for:

- Developing, deploying and managing quality of all telehealth programs throughout the VISN.
- Ensuring the national program office's standardized competency assessment program is deployed and tracked appropriately at each facility within their VISN to meet internal and external accreditation requirements.
- Ensuring the national program office's standardized preceptor program is deployed and tracked appropriately at each facility.
- Integrating Conditions of Participation standards into the routine practice of telehealth throughout the VISN.
- Working closely with the VISN Quality Manager to monitor data and performance improvement activities to ensure quality care.

The full scope and training for these responsibilities can be found on the Telehealth VISN Leads intranet page. Due to the size and scope of these responsibilities, VISN level managers for synchronous telehealth, asynchronous telehealth, and Home Telehealth may be necessary.

4.4.4 VISN Quality Manager

Responsible for:

- Maintaining oversight of quality performance data of all telehealth programs.
- Ensuring that telehealth is integrated into the routine managerial practices at the VISN level.
- Working closely with telehealth staff to ensure Conditions of Participation standards and data are continually monitored and performance improvement activities address deficiencies.
- Ensuring Joint Commission standards and expectations are applied to telehealth as with all other modalities and services.

4.4.5 VISN Telehealth Analyst

Responsible for:

- Implementing data acquisition, oversight and analysis to ensure that VISN and facility leadership is informed regarding telehealth specific data.
- Ensuring actions from this data are coordinated with local and VISN outcomes and Quality Management groups as well as the leadership and Telehealth Oversight Committee.

4.4.6 VISN Telehealth Technology Manager

The position reports directly to the VISN Telehealth Manager and works closely with VHA Connected Care, National, Regional, VISN, and facility leaders and staff to incorporate new technology, concepts and programs into new and existing systems.

Responsible for:

- Planning, budget preparation, coordination and implementation of National Program Technical Initiatives.
- Implementing, managing, and evaluating all telehealth technologies/applications, in support of Connected Care and Telehealth within the network.
- Ensuring technology purchased and used is VA approved. To view the approval form visit the Purchasing/Set-Up Guide in SharePoint.
- Serving as the VISN telehealth technology Subject Matter Expert (SME) for all Connected Care Telehealth Technologies.

4.5 Facility Organization

The organizational structure of the Facility Telehealth Program supports the development of Telehealth programs, documentation of workload, measurement of performance, and attention to clinical indicators to ensure safe and effective Veteran care. Based on need and strategic alignment, the facility telehealth leadership is responsible for clinical integration of telehealth to improve access and expand capacity for quality Veteran care. Facility administrative structures are developed locally. Therefore, telehealth must integrate into the organizational structure and report to clinical executive leadership. These individuals provide governance and delineate responsibility for the telehealth process.

4.5.1 Facility Director

Responsible for:

- Ensuring implementation of this Manual at all sites in the Facility where Veterans receive care via telehealth.
- Ongoing strategic planning for the development and sustainment of telehealth care.
- Ensuring adequate resources (e.g., staffing, technology, equipment, space, and training).
- Ensuring a competent staff.

- Facilitating and supporting multi-disciplinary service collaboration to enhance and expand telehealth with Office of Information and Technology (OIT), BioMed, Home Telehealth, contracting and Veteran services.
- Providing leadership that endorses, supports, and promotes telehealth function for delivery of comprehensive, coordinated, Veteran-centered care.
- Collaborating with Facility Service Chiefs, Facility Leadership, and the Quality Management Officer to develop and implement systematic methods for soliciting and analyzing patient input regarding telehealth functions.
- Ensuring overall quality of care and performance improvement for telehealth.

4.5.2 Facility Chief of Staff

Responsible for:

- Complying with all applicable laws, regulations and Information Technology (IT) security mandates.
- Providing leadership and oversight that authorizes and requires telehealth to deliver comprehensive, coordinated, patient-centered care to Veterans.
- Ensuring all requirements are met for deployment, organization, accountability and management of telehealth clinics and patient encounters through the Medical Executives Committee and service lines.
- Ensuring operations of telehealth throughout the facility are coordinated with operations of other services, aligned with facility initiatives and priorities.
- Establishing a standard process for the identification, implementation and sustainment of telehealth programs, which includes business, clinical and technical standardized processes.
- Ensuring the implementation of process for Privileging and Renewal of Privileges for synchronous telehealth and asynchronous telehealth.
- Ensuring the Facility Telehealth Council/Committee is established and chartered for:
    - Developing strategies and processes for development, deployment and management of telehealth initiatives throughout the facility.
    - Using the committee as a primary vehicle for communications and dissemination of information regarding local, network and Office of Telehealth Services initiatives and news to all appropriate contacts within the network.
    - Defining processes and standards for facility telehealth services and their operations.
    - Approving Telehealth Service Agreements.

4.5.3 Facility Quality Manager

Responsible For:

- Ensuring the Receiving Facility and the Providing Facility are meeting Credentialing and Privileging requirements set forth in current policies, regulations, and standards.

- Ensuring telehealth performance indicators/monitors, process deficiencies and improvement plans, and aggregate information related to incidents/complications/deaths will be integrated into the facility's current Quality Management structures and processes.
- Exchanging Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation related data in locations where telehealth services are performed. The specific data, reporting entities and frequency of reporting are specified in the Telehealth Service Agreement.
- Integrating bidirectional data for telehealth providers into accepted practice evaluation methods.
- Monitoring Telehealth Service Agreements in the Telehealth Management Platform to verify provider Credentialing and Privileging.
- Confirming the integration of telehealth in the usual oversight activities of the Quality Management department.

4.5.4 Facility Telehealth Coordinator (FTC)

Responsible for:

- Overseeing execution and operation of telehealth within the facility and other divisions (e.g., CBOCs).
- Planning, coordinating, implementing and evaluating clinical applications of telehealth modalities (e.g., Clinical Video Telehealth, Store-and-Forward Telehealth and Home Telehealth).
- Deploying and overseeing, as designated, the national program office's decentralized competency and preceptor programs.

4.5.5 Facility Telehealth Technology Manager

The position reports directly to the VISN Telehealth Manager and works closely with VHA Connected Care, National, Regional, VISN, and facility leaders and staff to incorporate new technology, concepts and programs into new and existing systems.

Responsible for:

- Planning, budget preparation, coordination and implementation of National Program Technical Initiatives.
- Implementing, managing and evaluating all telehealth technologies/applications, in support of Connected Care and Telehealth within the facility.
- Ensuring technology purchased and used is VA approved. To view the approval form, visit the Purchasing/Set-Up Guide in SharePoint.
- Serving as the facility telehealth technology Subject Matter Expert (SME) for all Connected Care Telehealth Technologies.

4.5.6 Supervisory Telehealth Clinical Technician (TCT)

The Supervisory Telehealth Clinical Technician functions as the direct supervisor of a team of TCTs and may also supervise other telehealth staff. For more information view the Supervisory Telehealth Clinical Technician functional statement.

4.5.7 Lead Telehealth Clinical Technician (TCT)

The Lead Telehealth Clinical Technician's primary function is to provide direct leadership to a team of Telehealth Clinical Technicians, as well as lead initiatives designed to improve the delivery of care to Veterans using telehealth. For more information view the Lead Telehealth Clinical Technician functional statement.

4.5.8 Telehealth Clinical Technician (TCT)

The Telehealth Clinical Technician's primary function is to support telehealth services at a facility level by scheduling telehealth resources and Veterans, providing high level technology support including how to operate medical equipment at clinics.

Based upon Telehealth Clinical Technician pay-grade level there is increasing responsibility. To view the responsibilities for each level, click the corresponding links below:

- Responsibilities for GS 5 TCT
- Responsibilities for GS 6 TCT
- Responsibilities for GS 7 TCT

4.5.9 Telepresenter

The Telepresenter can be any person assisting the clinic-based provider with Veterans through the use of telehealth technology. The Telepresenter is responsible for acting as the hands, eyes, ears, and nose for the provider. Depending on the skills and scope of practice needed for the encounter, the Telepresenter can be a Licensed Independent Provider, Registered Nurse, Licensed Practical Nurse or Telehealth Clinical Technician.

4.5.10 Imager

The Imager is responsible for obtaining telehealth images and providing education to Veterans according to the validated guidelines. Examples include, but are not limited to, operating digital retinal and hand-held imaging systems to acquire non-simultaneous stereoscopic images for retinal screening, and appropriate skin/lesion images for Dermatology.

4.5.11 Teleprovider/Reader

Responsible For:

- Providing clinical care using telehealth technology.
- Understanding asynchronous and synchronous technologies.
- Documenting progress reports and linking them to the Interfacility Consult as needed.

4.5.12 Clinical Champion

Clinical champions are staff who strongly support the implementation or expansion of a telehealth program and are interested in promoting telehealth.

4.5.13 Lead Care Coordinator

The Lead Care Coordinator is a licensed professional who performs administrative duties and provides supervisory oversight to Home Telehealth program staff in day-to-day program operations. In addition, this individual usually coordinates care for a panel of patients throughout the continuum of care to assure that care is timely, appropriate, of high quality and cost effective.

4.5.14 Care Coordinator

Care Coordinators are highly-skilled licensed professionals in Home Telehealth with specialized training and competency. They are responsible for the case management, disease management, Veteran health education and the development of Veteran self-management skills. They are also responsible for appropriate documentation and use of the Computerized Patient Record System (CPRS) and vendor technology platforms.

4.5.15 Preceptor

Master and Telehealth Preceptors are a cadre of experts developed through a comprehensive program. Preceptors in turn help facilitate training and competency efforts within each VISN to promote personal and professional development. This role is fundamental to assisting with the preparation of competent Telehealth field staff in meeting Veteran healthcare needs.

4.5.16 Scheduler

Schedulers' primary function is to support Telehealth services at a facility level by scheduling telehealth appointments.

5. Policy

All care delivered through telehealth must adhere to existing VHA and Medical Center policies. Directives and policies pertinent to telehealth are described in the rest of this section.

5.1 Anywhere-to-Anywhere Telehealth

The "Anywhere-to-Anywhere" rule and code, as well as section 151 of 38 USC 1730C (the MISSION Act of 2018), explicitly authorize VA providers to care for their Veteran patients using telehealth, irrespective of the location of the provider or the Veteran anywhere in the country, including States, Territories, and possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

As a result of the Anywhere to Anywhere Rule and VA Mission Act, VA providers may deliver care by telehealth, regardless of where the covered health care professional or the patient is located, if

the covered health care professional is using telemedicine to provide treatment to an individual. VA providers are now empowered to provide care to Veterans located anywhere in United States territory, with the caveats in the Anywhere to Anywhere ruling.

Further information may be found on the Anywhere to Anywhere Telehealth Intranet Site.

5.2 Memorandum of Understanding

Currently, a signed Memorandum of Understanding, establishing the procedures and responsibilities for privileging-by-proxy, is used to authorize privileging-by-proxy between two facilities.

A VHA Directive is in development to facilitate clinical resource sharing between VA facilities through telehealth by reducing the administrative requirements for telehealth program activation and maintenance while maintaining quality processes that ensure oversight of provider competency. This directive will establish national standard procedures and responsibilities for privileging-by-proxy between VA facilities sharing clinical services through telehealth. It eliminates a requirement for signed Memoranda of Understanding serving the same purpose between VA facilities.

Until the new directive is signed and published, continue to follow existing processes for Memorandums of Understanding.

5.3 Credentialing and Privileging

Credentialing and Privileging (VHA Handbook 1100.19) delineates authorized procedures regarding Credentialing and Privileging in VHA. The process of Credentialing and Privileging allows for complete reviews of staff to ensure providers have the appropriate credentials and requisite competencies for granting privileges. These reviews ensure quality of care, lowered risk for adverse outcomes, and potentially reduces the risk for liability exposure for the facility.

Privileging by proxy is a process established through a MOU and TSA and is consistent with Joint Commission standards to share privileging decisions between facilities within its integrated healthcare system. VA healthcare providers may practice their privileges through telehealth at a Receiving Facility, without being re-credentialed or re-privileged at the Receiving Facility when facilities adhere to the above policy.

Note: If a telehealth provider performs medical duties on-site for a VA medical facility, or otherwise works outside the scope of this directive or an accompanying telehealth service agreement, the provider is no longer considered to be functioning in the role of a telehealth provider and, therefore, must be credentialed and privileged at each facility where they provide this non-Telehealth service in accordance with VHA Handbook 1100.19 - Credentialing and Privileging.

The local quality team is the primary resource for guidance with Credentialing and Privileging.

5.4 Telehealth Teleworking

Telehealth may be used to enable teleworking by employees if appropriate rules and regulations are followed. To be eligible for telework, healthcare professionals must be authorized to provide health care and meet certain requirements.

A directive is forthcoming that will provide additional information on teleworking providers.

5.5 Privacy

The Telehealth Program Office requires a high level of privacy and confidentiality in regard to all telehealth visits. The Telehealth Quality Manager establishes how the interaction with the office of Quality, Safety and Value affects telehealth and oversees development of processes to ensure telehealth is in compliance with privacy requirements.

All VA telehealth visits utilize a private encrypted video network. Visits that occur with a CODEC as an endpoint utilize the Clinical Enterprise Video Network (CEVN). A padlock icon on this screen is evidence that a visit utilizing CEVN is encrypted and private. Virtual medical room visits use the VA Video Connect servers. VA Video Connect is configured to only function when there is encryption.

All VA systems are set up so recording by the system is not possible. Although not common, the course of treatment may indicate the necessity of video or photographic recording as part of treatment. Any recording deemed necessary must be captured using other technologies. When video or photographic recording is done as a part of telehealth treatment, VA Form 10-3203 - Consent for Production and Use of Verbal or Written Statements, Photographs, Digital Images and/or Video or Audio Recordings, must be completed prior to the recording in order to obtain written consent from the patient. This form should be kept as part of the patient electronic health record.

Veterans may choose to record sessions without obtaining the consent of the provider. Providers are recommended to conduct all sessions under the assumption that they are being recorded. While a memo was released on Dec 14, 2017 regarding patient recording on clinical encounters, it has been since rescinded. Refer to the Patient Recording of Clinical Encounters Memo - Rescinded for more information.

5.5.1 Information Security's Role in Privacy

Though separate from each other, the Information Security and Privacy programs collaborate regarding confidentiality, integrity and availability of VA sensitive information.

The VA's security program protects informational 'assets', in any form, so that the information's confidentiality, integrity, and availability are maintained. The VA's privacy program focuses on the

personal information which is collected, maintained and distributed. There are several other differences between VA's security and privacy efforts. The most significant is that privacy is not centrally managed. Privacy Officers report directly to the facility management chain where they are either located or provide support, whereas, all security efforts are centralized under the Office of Information and Technology (OIT).

VA Privacy Officers are an integral part of VA's privacy organization. They represent and respond to privacy matters across VA and help to ensure VA's privacy policies are implemented at the local level. They work in collaboration with the facility Chief Information Officer and the Information System Security Officer to ensure the protection of Veteran and employee data.

The Information System Security Officer and Privacy Officer have roles and responsibilities in the Incident Response process for Incident preparation, prevention, detection, documentation, notification, and reporting. Both the Information System Security Officer and Privacy Officer use the Privacy and Security Event Tracking System for reporting incidents.

The scope and objective for the Information Security Program is to implement and maintain a cybersecurity program to support telehealth programs, which includes telehealth in the highly visible initiatives of Anywhere to Anywhere for Veterans within VHA Telehealth Services; review and audit telehealth systems provided by vendors to our Veterans; and evaluate, review and audit all VHA telehealth services. The Telehealth Cybersecurity Program is incorporated into the Medical Device Protection Program and will leverage their existing policies and guidance for security baseline controls. This will ensure that patient health information and network access is protected from cyberattack and loss.

5.5.2 Privacy for Groups

VHA Directive 2012-036: Identity Authentication for Health Care Services provides policy and procedures for VHA staff to authenticate the identity of individuals requesting medical care, treatment, or healthcare services in person at VA healthcare facilities or through telephonic communications with VHA staff.

Since VHA Directive 2012-036 currently does not specifically refer to virtual visits, the VHA Privacy Office has provided general points for providers to consider:

1. **Treatment Agreements.** From a privacy perspective, a Treatment Agreement should be required that states that family and/or friends need to be announced if they attend a group visit, and that participants will not connect others to the virtual medical room without notifying the group.
2. **Stipulate permission requirements for recording during group visits.** Permission requirements should be stipulated for any recording of group conversations.
3. **Authenticate the identities of group visit patients and guests.** From a privacy stance, there is no set standard for identity authentication; however, there are some

examples/methods that can be used at the provider's discretion. VISNs and/or local facilities may have additional requirements that need to be adhered to.

- Authentication by name and face may be sufficient.
- A roll-call and verification by hand-wave may be sufficient.
- It could be done by signature, for example showing a signed Terms of Engagement or similar document.

4. **Inform participants about recording**. Recording of group sessions by participants is discouraged unless other participants are notified in advance. Since the VA cannot guarantee that some participants are not recording, participants should conduct themselves with the assumption that the session is being recorded.

5.6 Ryan Haight Act (Guidance for Controlled Substances)

The Ryan Haight Online Pharmacy Consumer Protection Act, (Public Law 110-425, 122 Stat. 4820-4834) enacted on October 15, 2008, states that no controlled substance may be delivered, distributed, or dispensed over the Internet (which includes the use of VA Video Connect) without a valid prescription. The VHA National Telehealth Office issued guidance to providers to advise them on best practices to ensure their compliance with the law. Training on the Ryan Haight Act is also available. The Ryan Haight Act 10N Memo outlines this information.

The January 2016 Ryan Haight guidance, attachments and decision making flow charts provides guidelines for VA Providers concerning the prescribing of controlled substances. This guidance is used to ensure the VA provider is compliant with the Ryan Haight Act when the provider and patient are not in the same location. For physicians prescribing FDA approved schedule III and IV controlled substances to treat opioid addiction, there are additional requirements.

Per federal law, providers must complete one in-person medical evaluation of a patient before they can prescribe, renew, or refill controlled substances.

An exception to the in-person requirement applies to providers who have been requested to cover for a provider who is unavailable. As long as the unavailable provider has conducted at least one in–person medical evaluation of the patient within the previous 24 months, the covering provider may prescribe, refill, and renew controlled substances for the unavailable

5.6.1 Registration with the Drug Enforcement Agency

All VHA clinics will be registered with the Drug Enforcement Agency. Guidance is provided for how to submit an application through the Drug Enforcement Agency registration site, including selecting the appropriate clinics from the Drug Enforcement Agency's comprehensive list of VHA clinics. The Telehealth Management Platform also records which patient care sites are Drug Enforcement Agency registered and sends that information to a Teleprovider upon scheduling at that site.

provider's patients.

5.7 State Prescription Drug Monitoring Programs

VHA Directive 1306, known as The Querying State Prescription Drug Monitoring Program, was distributed in October 2016. It establishes responsibilities requiring VHA healthcare providers to query State Prescription Drug Monitoring Programs to support safe and effective prescribing of controlled substances. This Directive encourages facilities to establish local policy and procedures to identify delegates who are authorized to query the Prescription Drug Monitoring Program database on behalf of a controlled substance prescriber, where state laws permit the use of delegates.

Providers who are employed or contracted by the VA, and who act within the scope of their employment or contract, may use a Drug Enforcement Agency registration from any state to prescribe controlled substances to VA patients through Telemedicine.

As a result, providers who are employed or contracted by the VA do not require a Drug Enforcment Agency registration in the specific state where a VA patient is located to prescribe controlled substances when delivering care using Telemedicine.

Refer to VHA Directive 1306 for more information or contact the Office of Patient Care Services at VHA10P4FStaff@va.gov.

5.8 Telehealth by Employees in Training

Guidance for employees who are in training is provided through VHA Handbook 1400.09 – Education of Physicians and Dentists, VHA Handbook 1400.04 – Supervision of Associated Health Trainees and VHA Handbook 1400.01 – Resident Supervision. Questions or concerns should be directed to the Office of Academic Affiliations.

5.9 Transitioning Providers when Veterans Geographically Relocate

Veterans who permanently relocate will benefit from establishing care with providers at their closest VAMC instead of continuing care with providers in their previous geographic area via telehealth. Establishing care at the closest VAMC will facilitate access to healthcare services including primary care, mental health services, and specialty care.

Clinical exceptions for maintaining care via telehealth are rare and will be addressed at the Service Chief level. Alternate clinical solutions will be considered prior to a patient continuing to receive care from their previous provider via telehealth. Any time-limited treatments should be completed before the patient relocates, when possible, instead of continuing them by telehealth.

5.10 VHA Directive 1230 - Outpatient Scheduling Processes and Procedures

It is VHA policy, per VHA Directive 1230 - Outpatient Scheduling Processes and Procedures, that Veterans' appointments are scheduled timely, accurately, and consistently with the goal of scheduling appointments no more than 30 calendar days from the date an appointment is deemed clinically appropriate by a VA healthcare provider or, in the absence of a Patient Indicated Date (PID), 30 calendar days from the date the Veteran requests outpatient healthcare service. When scheduling telehealth appointments, the PID in the two appointments must match and be determined by the referring/ordering provider consistent with VHA scheduling and consult directives. Telehealth specific guidance may be found in the Telehealth Patient Indicated Date (PID) Standard Operating Procedures.

5.11 VHA Directive 1231 - Outpatient Clinic Practice Management

VHA Directive 1231 - Outpatient Clinic Practice Management establishes policy for outpatient clinic practice management. This VHA directive establishes the requirements for clinic practice management capability, responsibilities, definitions, and processes for outpatient clinic practice management.

5.12 VHA Directive 1232 - Consult Processes and Procedures

It is VHA policy, per VHA Directive 1232 - Consult Processes and Procedures, to ensure timely and clinically appropriate care to all Veterans by standardizing and managing consultation processes. The provider entering the consult (the "sending provider") determines the Patient Indicated Date (PID) in collaboration with the Veteran. The PID is the date care is deemed clinically appropriate. The PID is determined based upon the needs of the patient and should be at the earliest appropriate date care is needed. The PID should not be used to indicate the latest appropriate date. The PID may not be changed by the receiving service due to lack of availability of appointments. The date may only be changed if it was entered in error (e.g., a future care consult with a PID of today). The date must either be manually entered into the consult order or generated through an order menu that includes the PID. The PID should be entered into the scheduling package when the appointment is made.

Though VHA Directive 1232 states that consults must be changed from a pending status within 7 calendar days, more recent guidance from the Office of Veterans Access to Care (OVAC) requires updating of consult status within 2 days. For more detailed information and guidance on consult requirements, review the Telehealth Business Basics for Success training.

6. Planning and Developing

Planning is essential; developing a strategy to implement telehealth involves numerous steps. It is recommended that the Telehealth Deployment Checklists (provided for Intrafacility and Interfacility) are used when setting up a new telehealth program. A methodical approach ensures critical elements are not overlooked, which could seriously impact overall program success. Successful telehealth applications integrate technology with clinical program needs.

The general strategy for implementing telehealth in a facility occurs in five (5) stages:

1. **Develop, standardize and maintain** the organizational, clinical, technical and business infrastructure at VAMC and program levels, as a foundation to all telehealth development and operations.
2. **Identify** the healthcare needs of patients which telehealth can address appropriately, safely and cost-effectively, ensuring a thorough analysis of cost/benefit/sustainability.
3. **Determine** suitable telehealth clinical, business and management processes to meet identified healthcare needs.
4. **Design, implement and manage** telehealth programs to meet identified healthcare needs.
5. **Practice** continuous quality improvement processes to optimize telehealth operations at all levels of the organization.

The primary components of planning for integrated VAMC telehealth services include:

- A thorough needs assessment, which includes basic infrastructure such as staffing, equipment and space.
- A strong business case, which includes an analysis of the Return on Investment (ROI) and plan for sustainability, is essential for telehealth program development.
- A well-developed budget, which will identify the resources and provide a foundation to track, report and sustain the program financially, and which provides additional evidence the program is feasible and sustainable.
- Program approval by the Chief of Staff and Service Chief.
- Telehealth Service Agreement with notifications sent to the Chief Medical Officer, Service Chief and Credentialing and Privileging staff along with other involved parties for Intrafacility telehealth. Interfacility telehealth requires Telehealth Service Agreement approval as well as a Memorandum of Understanding.

6.1 Needs Assessment

The needs assessment provides structure to guide users in the development of a program business plan. It identifies the goals and objectives of the project, as well as resources and activities needed to achieve the plan. Information provided from the needs assessment includes targeted population, business perspectives and metrics for performance evaluation. A needs assessment is

also a systematic method of identifying unmet needs of the population and making changes that will benefit the population from an intervention. One may want to consider soliciting the assistance of staff who have expertise in this area (i.e., health systems specialist, health services researcher, etc.) to conduct a formal Needs Assessment. Criteria in the needs assessment appraisal must include the following:

- **Access to the targeted population:** What specialty population(s) will one serve with telehealth?
- **Expected outcomes from both the clinical and business perspectives:** What does one hope to accomplish using telehealth?
- **Performance measures:** What performance measures will telehealth affect?
- **Space and resources available:** Is there appropriate space to conduct a telehealth visit?
- **Staffing needs:** Is there a specialty provider willing and able to use telehealth? Are there other clinical staff that can assist in the telehealth visit? What training may be needed to support/provide telehealth? Are there specific staffing requirements for special populations (e.g., female Telepresenter for women Veterans, and chaperones for gender-specific examinations)?
- **Capacity and workload:** How many specialty clinics could utilize this technology based on the resources available?
- **Technical considerations:** What types of telehealth equipment will best serve a specialty population? Is there adequate bandwidth to support new clinics and/or new equipment?
- **Equipment inventory:** What equipment currently exists to support telehealth? Will it meet the patient needs, as well as information and privacy security, and quality standards of practice?

The telehealth service planner needs to determine the patient population as well as the specific fields of relevance for analyses. Useful data includes:

- Patient data/metrics.
- Documented problems in meeting the needs of a group of patients (e.g., distance and travel barriers, no-shows, medical problems, weather problems, etc.).
- Available resources.
- Workload and clinic capacity.
- Special needs populations.
- Provider data.

Information received from the needs assessment will help support a productive clinical strategic plan to deploy telehealth.

When a proposed telehealth service requires significant resource allocation, the program needs to demonstrate solid evidence the telehealth program provides cost-effective and equal or greater benefits for patients over other Telehealth options or traditional care.

6.2 Business Case Development

A business case is made to ensure the program will provide quality care, a return on the financial investment and have potential for sustainability. The Needs Assessment is also a major component of the business case constructed from:

- The number of patients who have health needs that can be treated via telehealth.
- The cost of providing care via telehealth compared to other methods.
- Given the current demand for primary and specialty care services in VHA and the mandate to improve access to services, especially at geographically remote sites, the need for telehealth will continue.

Factors to consider when developing the business case for telehealth:

- Costs associated with equipment, labor and facilities.
- Capital investment, expenses and overhead.
- Start-up and ongoing sustainability for both the patient and provider sites.
- Complex issues surrounding workload and reimbursement.
- Lifespan of technology.

It is important to develop specific strategies and targets to guide the telehealth program development. Information obtained from the needs assessment should guide the plan. The following are key elements that should be included when developing the strategic plan:

- Focus on the "Who, What, Where, When and How" of both clinical and business aspects of the telehealth program.
- Roles and responsibilities of the team should be well-defined for successful implementation.
- Action items and deadlines should be clear.

6.3 Budget Development

When significant costs are needed to support telehealth, there is a need to assess and plan for funding requests.

Steps to complete when putting together the budget proposal:

- Perform a needs assessment of telehealth services at VISN and/or facility level.
- Identify necessary resources (e.g., telehealth equipment, staffing, furniture, etc.).
- Estimate the cost of resources and establish the budget request.
- Develop a proposal that describes the needs, goals, strategies, investment, evaluation and expected outcomes.
- Document the telehealth program investment payback period.

- Refine and specify estimates for resources as the project is implemented.
- Gather any supporting data reflective of the needs (e.g., wait times, travel cost, etc.); assistance from VISN strategic planners may be required to obtain this data.
- Establish targets for all utilization, expenses and benefits (indirect and direct).
- Evaluate use of legacy resources, space, staff, and equipment.

6.4 Feasibility and Sustainability

Feasibility is defined as the ability for a program to meet a clinical need and achieve specific outcomes.

A sustainable program is developed in such a manner that it will be able to continue functioning long into the future and achieve financial and clinical stability, while meeting clinical outcomes and providing quality care.

Long-term sustainability of effective and efficient telehealth programs requires methodical planning and evaluation. Pilot programs must demonstrate quality and performance outcomes for clinical, technical, and business elements of the program. Ensure pilot programs have processes in place to collect data for assessment and analysis. This information will be utilized by telehealth and vetted through a panel of Subject Matter Experts to develop TeleSpecialty Supplements for enterprise wide dissemination of the program.

Funding to initiate a telehealth program and maintain it for the first one to three years is usually determined in the original Business Plan. Funding can come from a variety of sources (e.g., Rural Health Initiative, VISN, etc.). Veterans Equitable Resource Allocation (VERA) is the typical funding route for sustaining VHA healthcare systems and is effective in the telehealth model. Pro-Rated Patient reimbursement model in VERA is an additional funding route for telehealth programs. When a Veteran receives care at more than one location (when the patient and provider sites are in different facilities or Interfacility), the Veteran is described as having *shared care*. The "Pro-Rated Patient" (PRP) reimbursement is prorated based on the cost of care at each facility. Although distributed between the facilities and VISN, the PRP VERA allocation is equal to and never exceeds one (1).

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

- National Telehealth Synchronous/Asynchronous Leads
- VISN Telehealth Leads/Program Managers
- The Telehealth Services Intranet Site

7. Gaining Approval

The Facility Telehealth program supports the achievement of patient and program outcomes (as identified by the VISN Telehealth Program) in a manner which is consistent with safe practice in a virtual healthcare environment. All Telehealth programs must be approved by the Chief of Staff and Service Chief of the program. This is done at the Executive Committee of the Medical staff or a similar meeting with approval documented in the minutes.

The Memorandum of Understanding is an agreement between two facilities that provide services to Veterans using Telehealth technology, supported by specific business rules related to Credentialing and Privileging. The parties agree to proxy privileging of the providers engaged in the telehealth services, as well as, the process for documentation and sharing of information. The Memorandum of Understanding addresses the resources to be shared, including workload and financial resources for specific services.

Telehealth development and implementation activities must involve those individuals who have ultimate responsibility for governance, administrative and fiscal authority, and oversight of the programs. Examples of the individuals with approval authority include the Chief Medical Officer (CMO), Medical Center Director, Chief of Staff (COS) and Clinical Service Chief for each location involved in the planned telehealth service. Potential programs should be thoroughly vetted and have approval obtained from the governing individuals noted at the VISN and facility levels, depending on the type of program.

7.1 Memorandum of Understanding

A Memorandum of Understanding serves as an agreement between participating facilities. The Memorandum of Understanding defines expectations of the providing facility and the receiving facility regarding Credentialing and Privileging of providers in the provision of telehealth service delivery. The Memorandum of Understanding must be signed by facility leadership at each medical center participating in Interfacility telehealth activities. The Memorandum of Understanding should be reviewed by the Executive Committee of the Medical Staff upon initiation and as defined locally for future reviews. Each participating facility will have in place one (1) Memorandum of Understanding with each of the other participating facilities, signed by Director and Chief of Staff. Medical staff leadership is responsible for monitoring services provided through agreements such as the Telehealth Memorandum of Understanding.

As part of the Memorandum of Understanding, Credentialing and Privileging is established through privileging by proxy. The telehealth providers' practice will be limited to the privileges granted by the Providing Facility, and the providers will deliver services in accordance with a Telehealth Service Agreement. The Telehealth Management Platform streamlines communication of the status and updates for each provider regarding Credentialing and Privileging.

7.2 Telehealth Service Agreement

Telehealth Service Agreement is an agreement that specifies the clinical, business, and technical details of telehealth operations. The Telehealth Service Agreement delineates the variables and responsibilities for safe and effective telehealth service delivery and may be developed in the Telehealth Management Platform.

There are also administrative Telehealth Service Agreements in the Telehealth Management Platform. These Telehealth Service Agreements provide the information required for visit scheduling. Administrative Telehealth Service Agreements expedite the scheduling process in the Telehealth Management Platform since much of the visit specific information has not been added. This allows a Telehealth Service Agreement to be placed in production and used for scheduling in the Telehealth Management Platform, and to notify or obtain administrative approval. Adding visit specific information and provider preferences in the Telehealth Management Platform enable the Telehealth Service Agreement to be used clinically.

7.2.1 Interfacility Telehealth Service Agreement

The Telehealth Service Agreement specifies and governs the details of operations regarding the Interfacility telehealth services between providing and receiving facilities.

Additionally, the Telehealth Service Agreement outlines the variables and responsibilities for safe and effective telehealth service delivery. Facility Telehealth Coordinators from each facility should collaborate with the clinical service chiefs and/or their respective designees to complete the Telehealth Service Agreement. Following completion, the Facility Telehealth Coordinator from each facility should ensure the Telehealth Service Agreement is signed by the Service Chief and Facility Telehealth Coordinator from each of the participating facilities.

The Telehealth Service Agreement should define whether responsibility for ordering labs, writing prescriptions and, most importantly, follow up on critical lab values will be assumed by the referring provider or the Teleprovider.

The Telehealth Service Agreement also:

- Provides specific clinical and patient safety information needed for the remote visit.
- Includes a process and frequency of the review, revision, administrative notification and approval for above.

Among the variables identified in the Telehealth Service Agreement are those which relate specifically to the proxy privileging process for Interfacility telehealth providers, including:

- A list of providers who are privileged at the provider facility to render Interfacility telehealth services for the specific telehealth application.
- Identification if the telehealth service will be Teleconsultation, Telemedicine, or both.

- Specific quality management and patient safety plans and variables, including provider performance indicators for the telehealth service.
- Providing methodology and identifying variables for Focused Professional Practice Evaluation/Ongoing Professional Practice Evaluation data exchange.
- One (1) Telehealth Service Agreement will be in place for each telehealth service, signed by providing and receiving service chiefs as well as Facility Telehealth Coordinators.

7.2.2 Intrafacility Telehealth Service Agreement

The general guidelines for Telehealth Service Agreements in section 7.2, are used for Intrafacility Telehealth Service Agreements. Of note, Intrafacility Telehealth Service Agreements do not require approval. This is a key distinction between the two. Instead, notifications are sent to the Service Chief, Chief of Staff and others as applicable.

8. Clinic Set Up

Clinics serve as a mechanism for scheduling patients and connecting workload coding, charting, and other pertinent encounter information. The workload data that VHA collects supports the continuity of patient care, resource allocation, and performance measurement. Responsibility for establishing clinic set-up varies by facility. See the Clinic Set-Up, Closing the Encounter and Clinic Set-Up Coding documents for additional guidance.

Setting up a telehealth clinic requires collaboration between the Facility Telehealth Coordinator and those who are responsible for setting up clinic profiles. The Facility Telehealth Coordinator should have a listing of the providers involved in the Telehealth clinic, the type of clinic, and the proposed name of the clinic when approaching facility staff to set up a telehealth clinic. The Needs Assessment can help with this. Two clinics must be built, with the exception of VA Video Connect which only requires one clinic.

8.1 Consults

It is VHA policy to ensure timely and clinically appropriate care for all Veterans by standardizing and managing consultation processes. Upon receipt of a consult, the receiving telehealth service must act no later than two (2) days after receipt of the consult request. This is done by scheduling the Veteran or documenting that contact was attempted with the Veteran.

While there are two types of consults used in VHA, the clinical consult is the primary consult used in telehealth. A “clinical consult” is a consult document in the CPRS used as two-way communication on behalf of a patient consisting of a physician or provider (sender) request seeking opinion, advice, or expertise regarding evaluation or management of a specific problem answered by a physician or other healthcare provider (receiver). The CPRS consult package must be used for all clinical consultations. Information specific to the use of consults for Store-and-

Forward Telehealth may be found in the Standardization of Store-and-Forward Telehealth Guidance for Consults.

The other type of consult, an "administrative consult" is used as one-way communication on behalf of a patient to make a clinical request to transfer care or communicate an order or series of orders. Administrative consult orders include requests to schedule where clinical review is not required. With few exceptions, telehealth consults require clinical review and require two-way communication. Therefore, the use of the administrative consult is not recommended.

Provider (distant) sites may choose to set up Telehealth Interfacility Consult (IFC) request forms in the CPRS. This process is more complicated than Intrafacility Consults. This takes coordination between facilities and uses different VistA structures. The Health Informatics Specialist for the local CPRS is the best person to facilitate correspondence with remote/referral site Health Informatics Specialists, to properly set up the Interfacility Consults and to facilitate future changes to the Interfacility Consultations. Direction includes:

- Work with local CPRS Health Informatics Specialists to set up Interfacility Consults.
- Clinic-based Teleconsultations or routine medical follow up encounters (Clinical Video Telehealth and Store-and-Forward Telehealth) are requested by remote facility providers using Interfacility Consults or scheduled by hub site providers as a part of an ongoing provider/patient medical care plan.
- Interfacility Consults will be closed with a consult report title consistent with specific types of service provided and standardized naming conventions.

For more information on consults refer to facility guidance and VHA Directive 1232 - Consult Processes and Procedures.

8.2 Naming Conventions

It is important to use standardized conventions when naming telehealth clinics. Guidance on naming conventions is provided through the Clinic Set-Up document. Standardization is important because teams will know where to go to place information such as documentation, charts noted, labs, and scheduling. Specific clinic locations/titles need to be set up prior to the implementation of the telehealth visits. Staff at the provider site and patient site of the encounters needs to be informed of the correct clinic location/title they need to use. When staff selects a clinic location/title in the CPRS, they cannot see the underlying stop codes that are connected. Therefore, the names of the clinic location/title need to be informative and concise to assist in the correct selection.

The Facility Telehealth Coordinator collaborates with the services at the facility to create a clinic with a standardized name. The Approved Clinic name is what is visible to the provider in the CPRS; the name tells the provider and the healthcare team where to go to place information such as

documentation of care and assists the Telehealth Clinical Technician or Scheduler with scheduling appointments for both the patient site and the provider site.

For guidance on the naming convention, please refer to the Clinic Set-Up guidance document.

8.3 Stop Codes

Stop Codes provide the standardization required to identify workload for all outpatient encounters, inpatient appointments in outpatient clinics, and inpatient professional services. The Facility Telehealth Coordinator collaborates with the services at the facility to create a clinic with a standardized name. A current list of Stop Codes may be found on the Managerial Cost Accounting Intranet site.

For new programs involving multiple VA facilities, there may be administrators who have valid concerns that workload credit is appropriately allocated for the patient site (originating site) vs. provider site (distant site) for telehealth encounters. It is important to involve a local Health Administration Service, Health Information Management Service and Decision Support System (DSS) contact to disseminate and provide advice on changes in telehealth coding guidelines.

Primary Stop Code: The first three digits represent the Primary Stop Code. The Primary Stop Code designates the main clinical group responsible for the care. The Primary Stop Code is the same as an in-person/face-to-face encounter. The patient and provider site of the encounter must have the same Primary Stop Code.

Secondary or Credit Stop Code: The last three digits of the Stop Code Pair contain the secondary Stop Code, or Credit Stop Code, which serves as a modifier to further define the primary work group. The facility uses the Secondary Stop Code to provide additional information about the clinic such as the provider type or if the service was delivered via telehealth technology. The Secondary Stop Code for telehealth is determined by the location of the patient and provider, as well as indicating whether it is Clinical Video Telehealth or Store-and-Forward Telehealth.

CHAR 4 Codes can be added to clinic set up if the secondary credit stop is filled with a Telehealth Stop Code; used in this manner, the CHAR 4 code indicates provider type or other information.

Please note that there are some cases where certain clinics do not have Secondary Stop Codes; however, all Telehealth clinics have Secondary Stop Codes.

Credit Pair: This is the common term used when two Stop Codes, a Primary Stop Code and a Secondary Stop Code, are utilized when establishing a clinic.

Facility Telehealth Coordinators should work with their local Managerial Cost Accounting Office Site team to annually review and verify that the Stop Code associations for their programs are correct. Failing to update Stop Codes or using incorrect Stop Codes can result in loss of workload credit.

The full definition of each Stop Code should be read before the Stop Code is used for a clinic set-up. The long definition, available through the Managerial Cost Accounting Intranet site, outlines the intent of the Stop Code and assists in identifying if the Stop Code should be set-up in the primary or secondary position.

Note: Some Secondary Stop Codes generate copays and others do not. Check with your local business office for information about what copays certain Stop Codes have.

9. Scheduling

Clinical Video Telehealth and Store-and-Forward Telehealth encounters are synchronous and asynchronous events and the scheduling aspects have heightened importance. Clinical Video Telehealth and Store-and-Forward Telehealth encounters can be within a facility or healthcare system (Intrafacility), between facilities or healthcare systems (Interfacility), or the Veteran may be located at a non-VA setting, all of which combines to make Clinical Video Telehealth and Store-and-Forward Telehealth scheduling more complex, for several reasons:

- Typically, each facility (medical center/health care system) has a separate VistA database.
- Two VistA clinics, one for the patient site encounter and one for the provider site encounter, must be scheduled.
- While schedulers usually have access to a VistA system, it can be problematic to obtain access to remote VistA systems.
- Scheduling between remote facilities requires the use of a scheduling package to successfully schedule both sites, including the technology, rooms, staff, and providers into the specific telehealth clinics. ‘

Scheduling must be done in accordance with the Patient Indicated Date, per the Telehealth Patient Indicated Date Standard Operating Procedures (SOP).

9.1 Store-and-Forward Telehealth

Store-and-Forward Telehealth is asynchronous and has dedicated staff, resources, rooms and specialist consultants (i.e., Store-and-Forward Telehealth Readers) that allow for a less complex scheduling system. For a Store-and-Forward Telehealth encounter, scheduling is generally required only at the patient site. The specialist consultant does not require a separate appointment to review patient data and make a recommendation and diagnosis. The Telehealth Management Platform and VistA are the scheduling systems to use for Store-and-Forward Telehealth.

9.2 Packages to Assist with Scheduling

Unlike traditional in-person/face-to-face encounters, Clinical Video Telehealth and Store-and-Forward Telehealth encounters demand the use of and subsequent need for a variety of other resources such as the following:

- Patient (VistA).
- Provider (VistA).
- Gender-specific examinations and procedures.
- Rooms at both sites.
- Technology at both sites.
- Bandwidth.
- Telepresenter (if required).

There are several scheduling packages that can assist with one or more of these elements. The primary scheduling packages are the Telehealth Management Platform, the Scheduling Manager app and the VA Video Connect Manager App.

9.2.1 Telehealth Management Platform

The Telehealth Management Platform is a single, national scheduling resource that is interfaced with VistA. The Telehealth Management Platform allows telehealth programs to manage and schedule many resources (e.g., rooms, technologies, users, etc.), as well as manage Credentialing & Privileging and Telehealth Service Agreements.

It is also possible for the Telehealth Management Platform to be a comprehensive solution for managing many of the processes and resources necessary for telehealth operations. Primary technical features of the Telehealth Management Platform include:

- A comprehensive inventory of resources (e.g., spaces, technologies, Vista clinics, and staff).
- Ability to schedule multiple sites, including patient and provider sites, simultaneously.
- Ability to inventory and schedule resources, such as rooms, equipment and Telepresenter staff.
- Complete Inventory Management of technologies across the VHA enterprise.
- Data Reports.

The Telehealth Management Platform supports service agreement and resource based scheduling structures. The Telehealth Management Platform incorporates the Telehealth Service Agreement to ensure all the clinical, technical, and business elements are in place to support a telehealth encounter in a safe and efficient manner. The Telehealth Service Agreement is key to the resource-based telehealth scheduling. The Telehealth Service Agreement accounts for and brings to bear all the resources needed for the right time and place. This structure affords users of the system a great deal of flexibility to customize and meet local needs and preferences. While it is more time intensive to enter the basic variables and resource packages on the front-end of the scheduling

process, the result is the actual scheduling of the event on the back-end, which is all-inclusive, simple and time-efficient for schedulers and on the fly scheduling.

For additional guidance on how to schedule in Telehealth Management Platform, refer to the Telehealth Management Platform Intranet Page and the Telehealth Management Platform Supplement.

9.2.2 Scheduling Manager App

The Scheduling Manager app is used to schedule VA Video Connect appointments and provides the scheduler a way to send a virtual medical room link to the patient and provider after scheduling the appointment in VistA. A primary and back-up scheduler must be trained within each mental health and primary care clinic to use the Scheduling Manager app. For guidance on how to create a VA Video Connect Scheduled Visit through the Scheduling Manager app, refer to the Scheduling Manager app page, which includes a Scheduling Manager Quick Start Guide and Scheduling Manager User Manual.

9.2.3 Patient Viewer App

The Patient Viewer app may be used to schedule VA Video Connect appointments. Patient Viewer is not integrated with VistA; the VistA appointment must be scheduled separately. For guidance on how to create a VA Video Connect appointment using Patient Viewer, refer to the Patient Viewer app page. Steps to create the appointment are included in the Patient Viewer User Manual.

9.2.4 VA Video Connect Manager (VVC) App

The VA Video Connect (VVC) Manager enables providers to schedule video appointments, view their video appointment schedule and connect to their video appointments through a single app. Through the VVC Manager app, links to scheduled video appointments can be emailed to the provider and the Veteran. The provider is able to directly join a scheduled video appointment by opening the appropriate link in the VVC Manager app.

Only video appointments scheduled using the VVC Manager app, the Scheduling Manager app or VistA System Enhancements (VSE) will be displayed in the VVC Manager app. Currently, video appointments scheduled through the Telehealth Management Platform will not be displayed through the VVC Manager app.

For information on using the Scheduling Manager app, refer to the VA Video Connect Manager app page.

9.3 Scheduling Process

Scheduling telehealth encounters is more complicated than traditional in-person/face-to-face patient encounters. Therefore, detailed guidance on scheduling consults and follow-up appointments within the Patient Indicated Date (PID) is found in the Telehealth Patient Indicated

Date Standard Operating Procedures (SOP). Scheduling procedures from this SOP are detailed below.

When a consult or follow-up appointment is clinically indicated, providers are required to work with the Veteran to establish a date that care is needed. The established date is the Patient Indicated Date (PID) and should be based upon clinical need; the actual date of the consult or follow-up appointment does not have to be the same day as the PID. The actual date of the appointment is negotiated between the scheduler and the Veteran/patient. The actual date of the appointment uses the PID as a reference.

If the Veteran is new to the VA or has requested an appointment outside of regularly scheduled appointments, the PID is the date the Veteran prefers.

10. The Telehealth Visit

Creating the clinical environment and using appropriate communication skills when utilizing telehealth can be a challenge for health care providers who are used to traditional in-person/face-to-face/hands-on encounters with a Veteran. However, it is not about the sophisticated technology in place, rather it is the Veteran's experience which will determine if they want to use telehealth again.

10.1 Clinical Environment and Space

The Facility Director must ensure there is adequate and appropriate space where clinical telehealth encounters will take place. There are some requirements that are standard for all clinical spaces, such as adequate space for special needs patients and/or employees to navigate using wheelchairs.

Different telehealth clinics require different space and equipment. The following examples illustrate the above issue:

- A primary care or specialty care examination room must be fitted with an exam table and other necessary equipment.
- Privacy and confidentiality needs must be recognized and addressed.
- For gender-specific procedures and examinations, clinics need to ensure the clinical environment and spacing of the examination rooms, equipment, and chaperones are considered (see VHA Handbook 1330.01(2) - Health Care Services for Women Veterans).
- For TeleRetinal Imaging, patient (acquisition) sites must provide the space necessary to accommodate the imaging device, workstation and supporting furniture. Rooms require darkening and, preferably, should be in a windowless location or should use complete blackout filters over windows.

- Clinical Video Telehealth often uses group clinics for patient education and group therapy. Space is dependent on the size of the group and the clinical application.

10.2 Guidelines for a Successful Telehealth Visit

There are several important things to consider for a successful telehealth encounter. Providers must be constantly aware they are interacting over a different medium, rather than being in the room with the patient. It is essential to begin each visit with complete introductions for the patient and any caregivers or other support personnel present. All individuals involved on-camera and off-camera will be introduced at both locations. At times, there may be personnel present who are not seen by the patient on the monitor. Nonetheless, these individuals should be identified to ensure the patient has awareness of their presence and participation. This is particularly important for support personnel and students who may present into the patient's view in support or educational roles.

Conducting the physical examination by telehealth follows standard medical guidelines and procedures using telehealth technology.

There are several key guidelines for a successful visit:

- Conduct a Virtual Team Huddle to plan and prepare before the day's scheduled encounters.
- Place privacy sign "Telehealth in Session" on telehealth exam room door.
- Teleprovider must remain in view of the Veteran throughout the visit.
- Maintain clear video and audio transmission.
- Teleprovider must look at camera to maintain eye contact with the Veteran.
- Use Pan, Tilt, and Zoom (P/T/Z) camera functions to provide optimal view of patient examination.
- Patient and provider site use Self View for proper framing and lighting.
- Telepresenter will assist with examination without obstructing the providers view.
- Speak naturally and clearly, and use a normal speaking voice.
- Be camera conscious, keep the camera on the speaker and/or material presented.
- Use presentation mode to share desktop content.
- Speak one-at-a-time in group encounters to ensure understanding.
- Microphones transmit extraneous noises; avoid distracting behaviors, such as side conversations and note passing, interrupting the speaker, finger tapping, paper shuffling and whispering.

10.2.1 Virtual Teams

Human factors involved in a telehealth visit are crucial to a successful service and must be considered when creating telehealth clinics. The major challenges in the implementation and sustainability of programs include working with many individuals, various procedures and guidelines, different work styles, development of position descriptions and functional statements,

biases and human factors. Human factors include the ability to build relationships, communicate effectively and provide quality customer service. The human factors matter most in the Veteran's experience during a telehealth visit. Arguably, the people involved contribute as much toward a successful encounter or service as specialized telehealth equipment or adequate video connections.

One of the critical predictors of a successful and sustainable telehealth program is adequate and competent staff. Telehealth Clinical Technicians provide technical support and a Facility Telehealth Coordinator ensures business and infrastructure processes are in place. The same professional and support staff must be available as in a traditional clinic setting.

10.2.2 Clinical Video Telehealth Groups

The minimum requirements for Clinical Video Telehealth groups mirrors a typical telehealth encounter, including the space for the number of patients at each location; the space should allow for comfortable seating and temperature. The lighting should be adequate to illuminate each person in a room. Technology used should match the purpose of the group and all participants should be "in frame" and heard clearly by the Teleprovider. Emergency procedures should be at the fingertips of the Teleprovider and support staff at the patient site(s).

Examples of Clinical Video Telehealth group therapy include TeleMental Health, TeleMOVE, and Smoking Cessation. Groups can include a mix of in-person/face-to-face encounters at the same time the Teleprovider is connected to a CBOC or multiple CBOCs, forming a larger group. A Telepresenter and/or peripheral devices are not always necessary. It is important that the technology for Clinical Video Telehealth groups includes presentation mode, where the Teleprovider can share slide presentations, their desktop, web pages, drug information, or patient education materials. The patient site can share homework, food diaries, medication bottles, medical paperwork, and whatever the provider would like to see. Installation and configuration courses for the various Codecs are available in the Telehealth Intranet Site, and give instruction for connecting equipment to allow presentation mode.

Group Notes, a companion to the CPRS "Notes" tab, assists providers in documenting group sessions. See the Group Notes User Manual and the Group Notes Workload Documentation documents for detailed guidance on Group Notes.

It is worth noting that the Teleprovider determines the dynamics of the group encounter, plans the layout of the room(s) for the group and camera placement, is responsible for the treatment plan, documents patient consent, writes the group note, and closes the encounter in the CPRS.

10.2.3 Store-and-Forward Telehealth Visit

To conduct a successful Store-and-Forward Telehealth visit, the referring provider must be able to identify patients appropriate for this service based on disease specific screening or for other identified clinical conditions. It is important to begin every Store-and-Forward Telehealth encounter with an appropriate explanation of the purpose of the visit and what will take place,

including obtaining consent from the patient. The referring provider must be fully aware that they may be providing the only face-to-face interaction with the patient related to the condition to be evaluated. The specialist in this case will depend on the information included by the referring provider in the consult and the review of the images or other data to provide diagnosis and treatment recommendations. Therefore, it is critical to obtain and include as much historical and health-related information from the patient not necessarily included in the patient's CPRS medical record. This information can be made available to the specialist, who may make a treatment recommendation as part of the Teleconsulting encounter, without prior interaction with the patient. Just as critical to a successful Store-and-Forward Telehealth consultation is the quality of the images/data captured and forwarded to the specialist provider for determination or diagnosis. Quality standards and policies must be in place to facilitate this process.

There are specific instructions and several key guidelines that are required for a successful Store-and-Forward Telehealth visit:

1. Referring provider must give specific instructions to the Telehealth Technician/Imager and/or the patient to ensure quality images and data are obtained.
2. Referring provider must obtain updated patient health history and include a comprehensive history of present illness in the request consult, if appropriate.
3. Imager/TCT is trained and have appropriate competencies to capture images/data.
4. Equipment is properly maintained and appropriate hygiene measures take place in front of the patient and after the visit.
5. Patient privacy is maintained during the encounter.
6. Appropriate demonstration of the images and/or data to the patient should occur immediately following the imaging/data capture session when applicable.
7. Images/data including patient information must be deleted from the device and/or workstation and the appropriate Quality Assurance/Quality Improvement measures taken while the patient is in the examination room.
8. If third party software is utilized to capture or store patient data, there must be clear guidelines in place to protect patient information.
9. Patient provides consent to the Telehealth Visit.

10.3 Veteran Engagement

The clinician's goal is to utilize telehealth technology to provide optimal patient care and minimize risk. Therefore, exercising clinical judgment at the time of the request for care is imperative for making appropriate decisions regarding patient selection for any modality of care. Providers should consider the following factors when considering the use of telehealth for a given patient:

1. Veteran and/or caregiver consents and can participate in telehealth visit.
2. Veteran is medically and emotionally stable, as deemed by the attending physician responsible for the Veteran's care.

3. Veteran can communicate needs and can understand clinical recommendations.
4. The telehealth visit can meet the Veteran's clinical needs.
5. The Veteran and/or caregiver has the ability and resources to travel to the closest CBOC, or to receive care in the home or other location through a personal or VA issued device. More information on VA Video Connect may be found on the VA Video Connect Supplement.

10.3.1 Prior to the Visit

It is important to ensure that Veterans who have never been exposed to telehealth are oriented to the telehealth program environment and understand their rights, responsibilities and telehealth policies. Patient and Caregiver orientation, education and training are intended to provide the Veteran with a useful array of information and resources. The Veteran centric care model supports and encourages Veterans to be full participants in their care and self-management. To this end, the patient is provided information and training regarding telehealth and how their care is impacted through the telehealth modalities. A thorough explanation on the use of telehealth and uses of new telehealth technologies must occur.

The Patient and Caregiver orientation and education touches on each of the following areas:

- Timely access to primary and specialty care close to the patient's home.
- Decreased travel for the Veteran.
- Privacy (e.g., confidentiality, no recordings of encounter, encryption of transmission).
- Real-time/synchronous communication/interaction with remote provider.
- Technology (e.g., audiovisual devices, peripherals).
- In-person/face-to-face follow up clinic visits may be required.
- Total cost of care is reduced when patient and healthcare provider travel expenses are considered. Costs are also reduced if patients have the support to manage their own care, or get care early in the disease process.
- Surveys gathered after each telehealth encounter show a high level of satisfaction, particularly as it relates to cost and improved access.

10.3.2 Informed Consent

VHA and the Telehealth Services are committed to providing a healthcare environment that supports respect for patients and protects their right to autonomous, informed participation in healthcare decisions. These essential elements of quality health care are noted below and establish a process for informing patients about telehealth care options and obtaining their consent prior to treatment.

VHA Handbook 1004.01 - Informed Consent for Clinical Treatments and Procedures, clarifies and updates VHA's national policy on informed consent. It discusses the goals, scope and key concepts related to patients' informed consent for clinical treatments and procedures and the related responsibilities of VHA staff. Also see VHA Handbook 1200.05 - Requirements for the Protection of

Human Subjects in Research, and VHA Handbook 1058.03 - Assurance of Protection of Human Subjects in Research. Highlights include:

- Patient must be fully informed of the risks and benefits of telehealth services and procedures.
- Patient consent is documented in the encounter note by the Teleprovider.
- Patient has the right to refuse telehealth services.
- Verbal informed consent is obtained from the Veteran by each clinical service prior to the initial telehealth appointment.
- If permanent video or photographic recording is used during the telehealth session, VA Form 10-3203 - Consent for Production and Use of Verbal or Written Statements, Photographs, Digital Images and/or Video or Audio Recordings, must be used and written consent obtained from the patient.
- In the event the telehealth session is part of a research study, written consent must also be obtained per VHA research guidelines.

11. Documenting and Closing the Encounter

Properly documenting and closing the encounter at both the patient and provider sites is of utmost importance for safe patient care, for obtaining workload credit and to prevent orphans. This includes scheduling the appointment in the correct telehealth clinic, checking the patient in upon arrival, completing the progress notes and associated forms, and ensuring the patient encounter was completed to prevent orphans.

The following entry is recommended when documenting Clinic to Clinic and VA Video Connect appointments: *"Visit conducted by clinical video telehealth. Patient verbal consent obtained. Location/emergency number confirmed."*

11.1 Workload Validation and Identification of Orphans

As telehealth continues to expand, it is imperative to monitor, manage and track proper coding to ensure that full workload is received for patient visits. All Clinical Video Telehealth and Store-and-Forward Telehealth visits that are conducted in a facility consist of a match of a patient site and provider site encounter. Both clinical visits must have identical Primary Stop Codes and a Secondary Stop Code that reflects the use of telehealth technology. If there is only one encounter that does not fall into the Clinical Video Telehealth or Store-and-Forward Telehealth business rules, this encounter will be labeled an "orphan". Workload validation is essential in maintaining telehealth clinics and should be monitored regularly.

Common causes of orphans include:

- The Primary Stop Code in both visits are not identical.
- Documentation was created in a non-telehealth clinic.

- Encounter information is missing from one of the encounters (e.g., service connection, diagnosis code, Current Procedural Terminology code).
- Patient side and provider side Store-and-Forward Telehealth documentation was not completed within 72 hours of each other.
- The Store-and-Forward Telehealth patient visit documentation was completed after the provider visit documentation.
    - Store-and-Forward Telehealth documentation on the patient side should always be done first.
- A telehealth clinic was used for a non-telehealth visit in error.
- Multiple encounters/notes were completed for one visit.

Orphans can be reviewed on the VHA Support Service Center (VSSC) data cube in the Telehealth Workload Cube.

For information regarding Clinical Video Telehealth or Store-and-Forward Telehealth Orphans go to the Telehealth Dashboard in the VHA Support Service Center Capital Assets Databases.

11.2 Documentation

The creation of encounter forms, progress notes and consult templates for telehealth clinic visits is essential. Some guidelines include the following:

- Use templated notes to improve clinical efficiency and serve as a guideline(s) for appropriate health information collection.
- Include the location title in encounter forms for all visits (e.g., TeleDermatology, TeleSurgery, TeleSCI, TeleRehabilitation, etc.) and include the appropriate telehealth encounter codes and modifiers.
- Close routine visits that are not consult-specific visits with a progress note (e.g., Surgical Telehealth Progress Note, Primary Care Telehealth Progress Note, etc.)
- Include health factors that integrate with clinical reminders, pertinent physical exam information and numeric data, and include any patient education completed in progress note templates.
- Appropriately document procedures, apart from image acquisition (e.g., testing visual acuity or pupil dilation). Provide safety warnings for pupil dilation to the patient. Additional information may be found in the TeleRetinal Imaging Supplement.
- Use the consult template, which includes reasons for the specialty consult, diagnosis codes for specialty care, information regarding patient consent and/or patient suitability for Clinic-Based Telehealth interactions and other necessary information for the specialist.

11.2.1 Copy and Paste in Telehealth Documentation

Copy and paste functionality must be used with caution. Clinical, ethical, and legal problems may result when text is copied in a matter which implies the author, or someone else, obtained patient

historical information, performed the physical exam, and/or documented a plan of care, when the author (or someone else) did not personally collect the information at the time the patient encounter is documented. Copying information from other documents in VistA, or otherwise importing information/documents (e.g., medication list or problem list) is including unnecessary information which does not assist anyone reading, and makes reading the chart more difficult and time-consuming. Guidelines for "copy and paste," include:

- Never copy the signature block into another note.
- Never copy data identifying a healthcare provider.
- Do not copy entire laboratory findings, imaging reports, and other information in the medical record verbatim in the progress note when it is not specifically addressed or clearly relevant to the care provided.
- Do not re-enter previously recorded data unless specifically required for the assessment of a specific patient problem.
- Identify the source, including date and author, if information is copied and pasted.

Use the functionality of importing data objects into progress notes and other documents judiciously. Additional guidance is available in VHA Handbook 1907.01 - Health Information Management and Health Records.

11.3 Closing the Encounter

Closing the encounter is also an important step in the process. If all else is done correctly and this step is neglected neither site will receive workload credit. The patient site must close their encounter with the appropriate procedure code, and, it is noteworthy, the primary diagnosis code at the patient site and the provider site must match. Once again, additional information related to telehealth coding is available through the Managerial Cost Accounting Office, your local Health Information Management Service and the Telehealth Services SharePoint.

11.3.1 Closing the Provider Side

To close an encounter on the provider side, the following steps are taken:

1. Select the appropriate diagnosis codes from the form.
    - The diagnosis codes are likely prepopulated on the form.
2. Enter the procedure code.
3. Select the synchronous telehealth modifier (95).
4. Under the "visit related to" section answer the "service connected condition" and any other pertinent or required questions.
5. Digitally sign the form.

11.3.2 Closing the Patient Side

To close an encounter on the patient side, the following steps are taken:

1. Under the “visit related to” section, answer the “service connected condition” and any other pertinent or required questions.
2. Select the appropriate diagnosis code that matches the diagnosis code from the provider side.
    - If there is not yet a diagnosis code on the provider encounter form, the Telepresenter may work with the Teleprovider to determine a code most like the code the provider may use e.g., use “Health Maintenance” for a medical appointment.
3. Enter “Q3014” for the originating facility procedure code fee.
4. Enter the provider as the primary provider if not auto populated.
5. Digitally sign the form.

11.4 Interfacility Documentation

One of the key steps in documentation is to ensure the distant site provider writes a progress note/report and links it to the Interfacility Consult (IFC). The originating patient site will also have a record of the progress note/report in the CPRS (without having to view the progress note under the “Remote View” option in CPRS).

This is created because the provider has access to the patient site VistA through the Credentialing and Privileging process, allowing the provider to document the visit, write orders and manage the care of the Veteran.

Pointer notes are an option that meet the requirements for telehealth and are a completed note on the patient side that includes the clinical reminders, orders, etc. with a corresponding “pointer note” on the provider side.

This is an example of a “pointer note” on the provider side: “The telehealth encounter was conducted with Veteran Z (name of patient) at Patient's Medical Center (location of encounter) on ____ (date of encounter). Please see Joint Legacy Viewer for progress note, clinical reminders and patient orders.”

12. Technical Infrastructure

Technical and telecommunication infrastructure and technical support pathways are significant components of the collaboration between the telehealth program, Biomedical Engineering Departments and the Office of Information and Technology (OIT). Standardization of technology and tracking is important for multiple reasons, including connectivity, warranty, equipment refresh, and maximizing utilization. The Telehealth Management Platform is used for standardization of naming and equipment refresh and modernization.

The Telehealth Technology Development/Approval Process must be followed when considering new technology for the delivery of care. The VISN Telehealth Technical Advisory Committee will develop a standard system configuration specific to clinical applications for consideration for review and approval.

There are a variety of technologies currently available for the delivery of care which may be viewed on the Telehealth Intranet Site.

12.1 Telehealth Management Platform Inventory Management

In collaboration with the Contracting Officer's Representative and vendors, the Telehealth Management Platform serves as a one-stop listing of all VHA-purchased telehealth technologies. The Telehealth Management Platform lists types of technologies, peripherals, technology serial numbers, and status of Clinical Enterprise Video Network (CEVN) registration. CEVN is a subnetwork of VA's national OIT network, comprised of about 9,000 video telehealth endpoints in VA sites from Guam to Puerto Rico. The naming of all telehealth technologies across VHA Facilities and Sites will be standardized through the Telehealth Management Platform.

For additional information, refer to the Telehealth Management Platform Supplement and the Inventory Management Intranet Page.

12.2 Denver Logistics Center (DLC)

The VA Denver Logistics Center (DLC) serves many eligible veterans worldwide to distribute VA Video Connect equipment and clinical peripherals. These items are shipped anywhere requested, including to VA facilities and directly to Veterans' homes.

Under no circumstances should equipment received from one Veteran be distributed to another Veteran. All technology must be retrieved from Veterans at the conclusion of the episode of care. This includes when the Veteran is no longer using the equipment for care. It is the responsibility of the personnel in the Veteran's facility to retrieve the equipment and peripherals. The facility must develop a procedure to ensure all equipment is returned following each episode of care. All personnel with Remote Order Entry System access can coordinate retrieval for a Veteran. For instructions on retrieving equipment, see the VA-Issued Tablet SOP.

12.3 National Telehealth Technology Help Desk (NTTHD)

The National Telehealth Technology Help Desk (NTTHD) provides support for the medical care technologies that clinical end-users utilize for direct patient care to Veteran patients. The NTTHD staff coordinates technical support issues related to the level of support. Issues not resolved by NTTHD are escalated to the Office of Information and Technology (OIT) (local, regional and national teams).

NTTHD Roles and Responsibilities:

- Provide network connectivity problem solving.
- E.164 alias issuance and management.
- Remotely troubleshoot endpoints via web-based interface, the Telepresence Management Suite (TMS) and Cisco Unified Communication Manager (CUCM).
- Provide information on Service Maintenance Agreements.
- Provide technical services/support for:
    - CODEC hardware and peripherals.
    - Telehealth Management Platform.
    - VA Video Connect.
    - National recommended technologies.
- Assist Veterans with device setup, test calls, and troubleshooting of difficulties with home/mobile technologies used for VA Video Connect.

NTTHD can assist with:

- Preliminary network connectivity troubleshooting issues.

The National Telehealth Technology Help Desk (NTTHD) hours of operation are Monday - Saturday, 7 am - 11 pm Eastern Time. NTTHD can be contacted at (866-651-3180) and alternatively at (703-234-4483). VA staff may also email NTTHD at VHA_NTTHD@va.gov. For facilities and services operating at times outside of NTTHD's hours of operation, there is after hours assistance available by calling the main phone number.

13. Staff Training

Staff training is the cornerstone of successful telehealth programs. The single greatest challenge, when integrating telehealth systems into the existing traditional clinical environment, is ensuring clinicians are comfortable using new technologies and are aware of the associated clinical and business aspects. Quality and Training have developed multiple sources for training and an extensive library of resources. Refer to the Telehealth Training Field Guidance for direction on training.

Independent learning experiences are available via the following resources:

- Web-based courses.
- Video available on-demand on the Content Distribution Network (CDN).
- VA Knowledge Network (VAKN) live and recorded satellite broadcasts.
- Local, regional and national conferences.

Quality and Training also provides general and role-specific training activities via the following resources:

- Live videoconference and web-conference training sessions.
- Mentor/coach programs.
- Communities of Practice/collaborative learning groups and discussion boards.
- Telehealth laboratories to simulate the experience in the field.

13.1 Staff Competencies

Staff competency refers to the team members' usual clinical position and to a level of proficiency in applying those skills in a telehealth setting. A minimum level of technical competence must be achieved by all staff: clinical, support and administrative. Each of these competencies can be met through completing web-based courses, as well as meeting criteria demonstrated to a trained observer. Competency assessments should come from the point of performance. Oversight for staff competency is the responsibility of the VISN Telehealth Program Manager or their designee, as well as the local supervisor. Professional staff competency can be monitored through Facility Credentialing and Privileging and should be included in staff annual performance evaluations.

More information can be found in the Training Plans by Role page.

13.2 Orientation

New or incoming staff should meet the minimum standards of familiarity with the telehealth environment and technical operations before seeing patients. Staff can complete this orientation via web-based training modules, clinical shadowing experiences, and competency skills assessments. Every staff member is encouraged to practice operation of the technology, even if this isn't a regular part of their job function. Cross-training enables staff to cover when others are absent. Orientation is role specific and required training is available at the VHA Telehealth Services Intranet Site.

14. Quality Management

14.1 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 performance for all VISN/Facility Telehealth programs. The five COP elements reviewed 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 is 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 survey process, which will include the use of all Connected Care/Telehealth and Connected Health COP standards. In this survey process, the Connected Care/Telehealth 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 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. A Connected Care/Telehealth and Connected Health Standard Operating Procedure (SOP) has been developed which provides further details regarding the Connected Care/Telehealth 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.

14.1.1 External Accreditation

The Joint Commission and other external accrediting bodies may review some or all components of telehealth programs during their surveys. Patients using telehealth might be identified during a typical tracer activity during a survey of any type. This may lead to a review of any aspect of the telehealth program including, but not limited to the following:

- Privacy/confidentiality.
- Infection control practices.
- Clinical documentation.

- Orientation/training/competency.
- Performance improvement.
- Credentialing and Privileging, etc.
- Emergency procedures.

14.2 Performance Improvement

COP requires each VISN identify and monitor core quality and performance indicators for its telehealth program. These indicators are related to a variety of clinical, business or technology areas of interest, to include, utilization, access, clinical outcomes, cost, quality of life, patient satisfaction, functional status, or provider satisfaction. Whenever possible, indicators should be collected from electronic data and made available for review and tracking.

Using data from the performance improvement process, each program should communicate program experiences to program staff and others as appropriate, identify opportunities for improvement and develop action plans, as necessary, to ensure continuous program improvement. Utilization of the same indicators across similar programs within a VISN would provide the ability to compare and benchmark results. Use of a VISN-level Scorecard for reporting of performance data and outcomes is highly recommended.

Suggested topics for continuous performance improvement initiatives include:

Clinical

- Specific clinical outcome and process measures for the patient population served by the program.
- Equivalency of outcomes achieved for care using synchronous telehealth compared to customary in-person/face-to-face care.
- Follow up time from consult to treatment.
- Number and/or percentage of unreadable images by imager and location.
- Veteran Satisfaction Survey.

Business

- Track and trend penetration by unique patients and rurality, and number of encounters.
- Track number and type of specialty clinics using telehealth.
- Track and trend percent compliance with matching workload capture across all telehealth programs and sites on both the originating site (OS) and distant site (DS).
- Office of Management & Budget Approved Patient Satisfaction Survey results.
- Provider Satisfaction Survey.
- Improved access to care.
- Impact on time to next appointment for new/established patients.
- Changes in no-show, cancellation, and/or unscheduled visit rates and PID mismatch data.

- Utilization parameters such as admissions, length of stay, ER visits, and/or Primary Care visits.
- Return on Investment.
- Likelihood patient would have traveled to another VA site for care in lieu of telehealth.
- Avoidance of miles traveled by patients and/or providers.
- Avoidance of travel pay costs to patients and/or providers.

Technology

- Number and/or percentage of images located in TeleRetinal Imaging workstations.
- Number and/or percentage of dropped sessions due to technical issues.
- Number and/or percentage of cancelled sessions due to technical issues.
- Number and/or percentage of instances of poor picture quality, pixilation, audio/video lag, etc.

14.3 Telehealth Data Management

Data Management relates to data collected from the patients, providers, staff workload data, and program performance and outcomes data. Based on national and VISN strategic goals, quality indicators should be set with the purpose of monitoring and measuring performance and efficiency of telehealth practices.

At the facility level, data may be extracted from VistA or with a member of the Managerial Cost Accounting Office team for workload review for that facility. Based on pertinent established Stop Codes, these may include data by specialty clinic, number of encounters, number of visits and number of unique Veterans served based on modality. This data may be analyzed to determine growth and expansion of telehealth services. Another use for workload data review is to determine accuracy of coding. In addition to locally-developed reports, there are national reports.

14.4 Telehealth Workload Data Cube

Telehealth Services, in collaboration with the VHA Support Service Center (VSSC), has developed a national telehealth dashboard and data cube for telehealth workload capture data auditing that includes:

- An easily accessible data dashboard to track progress towards accurate workload capture and meeting benchmarks.
- Workload capture shown at both the patient and the provider sites as well as the matching of patient encounters to provider encounters for a complete pairing.
- Workload capture data available for review at VISN, Facility and CBOC levels.
- The ability to identify patient site and provider site encounters that cross facilities or VISNs.

- The ability to identify Stop Code errors that may hinder achievement of accurate workload capture and inclusion in Veterans Equitable Resource Allocation patient classification.
- Easily accessible data formats to review the clinic coding used within telehealth encounters.
- The ability to identify the time in days that it takes for asynchronous encounters to be matched.
- If indicated and with special permission, the ability to drill down to Social Security Number level to further determine workload data errors.

The VSSC Telehealth Cube has an associated Cube Overview document that provides additional information on each of the pre-formatted reports; as well as information to find out what additional education is available for cubes, in general, and education specific to the Telehealth Cube. The associated Data Definitions document provides information on:

- Data sources and business rules of the cube.
- Specific validation to ensure accuracy of the cube.
- Guidance for users to validate activities at station or VISN levels.

The Chief Financial Officers (CFO) Act of 1990 requires the agency to provide for the development and reporting of cost information and the periodic measurement of performance. In addition, the Government Performance and Results Act (GPRA) of 1993 requires each agency to establish performance indicators for each program and to measure or assess relevant program outputs, service levels and outcomes as a basis for comparing actual results with established goals.

Together, these two acts require reporting entities to develop and report cost information on a consistent and regular basis. VHA collects workload data that supports the continuity of patient care, resource allocation, and performance measurement. Thus, it is very important for VISNs and facilities to review/audit their workload data regularly and address any coding or data capture issues that may hamper the accurate capture of workload.

Utilizing a process and performance improvement framework to determine what actions are needed to capture accurate workload is essential to success. This requires first, a data system such as the National Quality Data Scorecard that enables the effective sharing of data along with set benchmarks and balanced metrics to enable comparison of data across teams.

Teams then utilize resources such as the VSSC Telehealth dashboard and workload data cube, VistA error/action reports and VistA file reports for pending consults to analyze their VISN/facility workload capture data. With the help of these reports teams can discover patterns that lead to insights and/or areas that may need improvement.

When process and performance improvement is indicated, a step-by-step action plan to change or correct workload capture is required. All actions are then evaluated utilizing the Telehealth workload cube to determine if the change or corrections in workload capture has led to

improvement. If the data indicates that a change has not occurred, then a new action plan must be developed, acted on and re-evaluated. This cycle continues until the change/correction leads to improvement.

The Plan-Do-Study-Act cycle is part of the Institute for Health Care Improvement Model for Improvement, and is a simple yet powerful tool, based on scientific method for accelerating quality improvement. Once a team has set a goal (utilizing the benchmarks and performance levels set for the VISN within the National Quality Data Scorecard), established its membership (who is responsible to develop the action plan, usually the Facility Telehealth Coordinator and/or Telehealth Clinical Technician), and developed measures to determine whether a change leads to an improvement, the next step is to test a change in the real work setting. The Plan-Do-Study-Act cycle is shorthand for testing a change — by planning it, trying it, observing the results, and acting on what is learned. The steps in the Plan-Do-Study-Act cycle are:

Step 1: Plan — Plan the test or observation, including a plan for collecting data.
Step 2: Do — Try out the test on a small scale.
Step 3: Study — Set aside time to analyze the data and study the results.
Step 4: Act — Refine the change based on what was learned from the test.

The National Quality Data Scorecard is used to score VISN performance in the workload capture/percent matching data element as well as several other quality domains.

15. Risk Management

Risk Management can be defined as a process centered on identification, analysis, treatment and evaluation of real and potential hazards. In the area of telehealth, potential risks for the program are few, although there are areas of concern that may lead to potential patient safety risks. These risks include:

- The safe and effective management of any medical or mental health emergency that may occur during a synchronous encounter.
- Synchronous equipment failure that may prevent the patient and provider encounter from occurring.
- Safe and effective care of the patient who may be severely immunocompromised.

15.1 Medical and Mental Health Emergencies

In a medical or mental health emergency, the telehealth provider who is located at a distance from the patient site is unable to provide direct assistance to the patient and must rely on others at the originating (patient) site to respond safely and effectively. When equipment fails, a backup or contingency plan must be in place to support safe and effective patient care. It is essential that effective risk management policies and procedures are developed and practiced around

contingency planning and emergency management of any synchronous patients. Communications, roles and responsibilities of all staff must be well-defined and clear.

15.1.1 Emergencies for Clinic-Based Telehealth

The following provides some specifics regarding safe and effective emergency management and contingency planning and procedures. In the event an acute event happens to a patient at the site receiving care, emergency procedures must be in place prior to the event. The procedures are addressed in the Telehealth Service Agreement and facility guidance documents. It will be necessary for the Facility Telehealth Coordinator to provide the clinician with the Telehealth Service Agreement that contains all the emergency information.

Examples of key procedures that should be in the Telehealth Service Agreement and in the facility guidance documents include:

- Clinicians should be well-informed of patient site medical and mental health emergency procedures.
- Practice drills should be implemented regularly to determine/mitigate any risk.
- In the case of a medical or mental health emergency, it is recommended the Teleprovider, who is at the distant (provider) site, and cannot provide in-person assistance/care, immediately contact the originating (patient) site staff, who will initiate emergency procedures per local emergency policy.
- Mental health emergencies may require additional emergency response from the community and may involve additional steps depending on the situation. These steps should be clearly documented.
- Teleprovider remains connected to patient site during any medical or mental health emergency.
- Telepresenter initiates emergency procedures and remains with the patient during the emergency, depending on environmental safety.
- A phone must be available in exam room for provider to support emergency issues.
- Alternative forms of communication must be available for patient and provider sites to connect immediately. Some of these alert mechanisms include cell phones, pagers, panic buttons and CPRS alerts.
- A contingency plan should be in place to ensure patient care is not jeopardized, particularly in the event of equipment failure. It is important the Facility Telehealth Coordinator at the originating site synchronize with the specialty provider to offer appropriate intervention for the patient.
- Have back up equipment on hand, especially for those items used often and which are mission critical.
- Determine if parts of the telehealth visit can be done in alternate ways, such as by telephone, while problems are being resolved.

15.1.2 Emergency Procedures for VA Video Connect

Since VA Video Connect occurs in a location other than a clinic, there are additional emergency procedures that are required. This includes knowledge and utilization of Emergency 911 (E911).

A form for E911 is available on the VA Video Connect app which enables providers to pre-validate the availability of Public Service Access Points for Veterans.

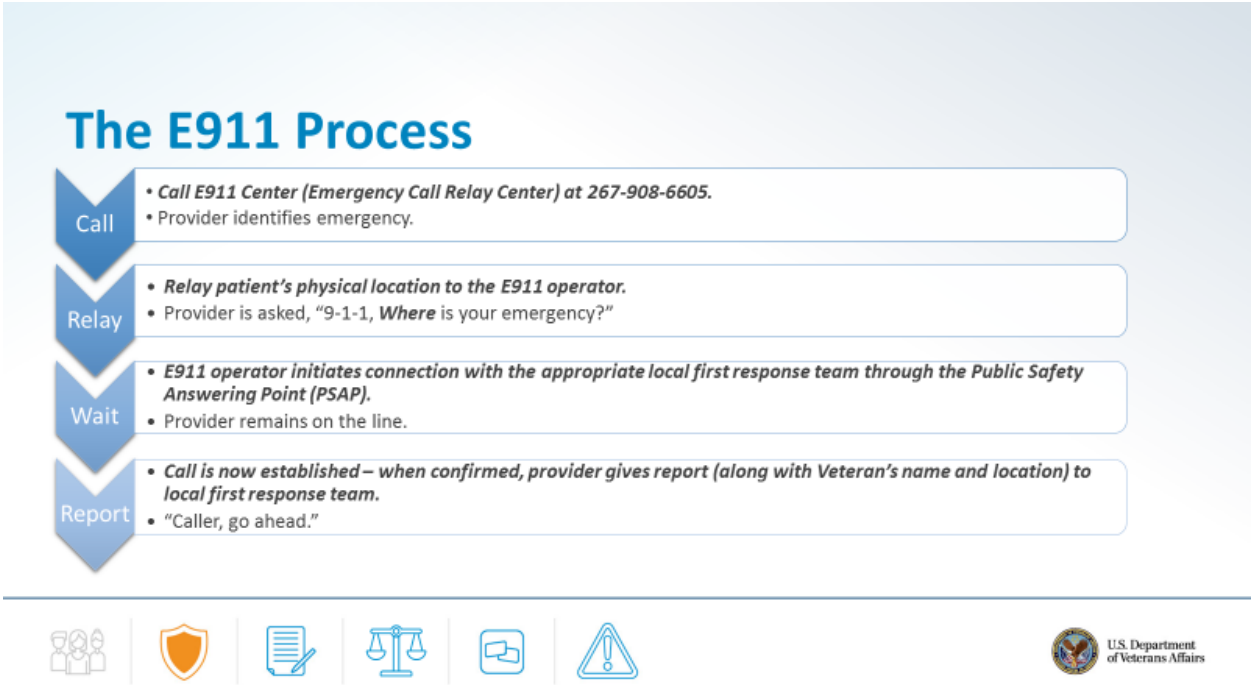
Contact of E911 services should only be used when a number is not available for local emergeny services. E911 is an emergency service and is only to be utilized in the event of an emergency or as deemed clinically appropriate. As a result, test calls to E911 are prohibited.

The E911 operator is not a traditional 911 operator. Rather, the E911 acts as a relay to the traditional 911 operator. The E911 operator is used to connect a provider with the appropriate emergency service for a Veteran. A key function of E911 services is to identify specific location information (e.g., floor or wing that the Veteran is located on) in addition to the Veteran's address. The E911 operator can then convey this detailed location information to a traditional 911 operator.

E911 is a service that providers can use to be routed to emergency dispatch services in the Veteran's area. To use E911, the provider first dials the E911 center also known as the Emergency Call Relay Center at 267-908-6605 and relays the Veteran's location — including the street address, city, state, and ZIP code — to the E911 operator.

The E911 operator will then direct the provider to remain on the line while the call is directed to the patient's local emergency response service through the Public Safety Answering Point, or the PSAP. After connecting with the appropriate emergency response team, the E911 operator will say "Caller, go ahead." The E911 operator will remain on the line until the location of the emergency is verified.

The E911 operator then will disconnect from the call, allowing the provider to speak directly with the local emergency dispatcher. The provider will be asked to relay specific information about the emergency and the patient's name and location to the community dispatcher.



Preferably, the Veteran or their family will make the call to emergency services if capable. In this scenario, the Teleprovider remains in the virtual medical room until emergency response arrives. The Teleprovider does not disconnect from the virtual medical room until a handoff to emergency services has been conducted.

If the Veteran or their family is unable to make the call to emergency services, then the Teleprovider will make the E911 call. The Teleprovider will share the Veteran's location and emergency information with the 911 center.

The Emergency Contact Relay Center's phone number is accessible and staffed 24/7/365. The Emergency Contact Relay Center is able to transfer calls to Public Safety Answering Points in:

1. The continental United States.
2. Hawaii.
3. Alaska.
4. Puerto Rico.
5. The U.S. Virgin Islands.
6. Guam.

Public Safety Answering Points are not available in American Samoa. For sites that do not have Public Safety Answering Points or E911 service, a contact will need to be identified for emergency situations.

15.2 Infection Control and Reusable Medical Equipment (RME)

The primary goal of any infection control program is to protect patients, healthcare workers and their families from communicable diseases. Standard precautions mean all patients are treated as if they have a transmissible blood borne pathogen. Infection control procedures follow local policy. To ensure appropriate infection control guidelines are observed, refer to the local Infection Control Department and the Center for Disease Control and Prevention (CDC) Internet Site.

Telehealth Clinical Pathways may include the use and reuse of diagnostic medical equipment. This equipment is used to transmit synchronous and asynchronous patient data. Reusable Medical Equipment (RME) used in a telehealth encounter must be handled and reprocessed following manufacturer's guidelines. The patient site must follow these guidelines specific to handling and reprocessing contaminated instruments, clinical cart and peripheral equipment, as well as following the recommendations of site-specific Supply, Processing and Distribution (SPD), Infection Control Department, and VHA Guidelines for categorizing and processing critical, semi-critical, and non-critical RME. The patient site may also obtain additional guidance from the CDC internet site.

The condition of the telehealth patient may vary from relatively stable to extremely ill. The treating clinician at the patient site should alert staff involved in the telehealth visit of any specific risks. For specific guidelines and/or recommendations in the safe and effective management of the severely immunosuppressed patient, refer to the CDC Internet Site and the local VAMC Infection Control Department.

For additional guidance on decontamination, high-level disinfection and/or sterilization of critical and semi-critical reusable medical instruments and equipment, refer to VHA Directive 1116(2) - Sterile Processing Services.

16. Information Outreach

In order to begin or expand a telehealth program, information about the program must be communicated to potential users. Information outreach strategies are aimed at encouraging people to try or continue using telehealth. Facility Telehealth Coordinators and VISN Telehealth Leads should carefully plan marketing strategies.

Every outreach program contains these key components:

- Description of products or services.
- Target customers.
- Information promotion and dissemination.
- Performance evaluation.

Information outreach begins during the planning phase and should include internal and external stakeholders. Sharing information early will also encourage buy-in from health care providers and other clinicians, whose collaboration is vital to the success of the program.

16.1 Describing Telehealth Services

It is important to define and describe telehealth for everyone to have a clear understanding of the scope of practice and its application. This will be the educational component of the outreach strategy. Telehealth has been practiced in VHA for over a decade and there is still a need for increased penetration into service delivery. This education needs to be customized to patients, providers, telehealth coordinators and executive leadership. Refer to the Telehealth Services Intranet Site for information, resources, and tools.

16.2 Customers

Telehealth serves the Veteran and the provider because it facilitates the provision and delivery of care. This clinical practice also involves several others. Marketing strategies need to be designed to:

- Target Patients - Identify patient care issues – distance, no-shows, and caregiver burn-out. For the application of any new program, appropriate steps must be taken to ensure patients will receive care enhanced by telehealth related processes. Identification of patients includes recognition of a diagnosis or issue that may benefit from an alternative form of health care. Preparation will include utilizing a checklist to support admission of the patient into a modality, to identify a patient's physical and cognitive capabilities, diagnosis and history of admission or problems, and disease management issues. Veteran selection considerations should be developed and utilized as a standard for providing care. Once standardized considerations are organized and identified, local Managerial Cost Accounting Office staff can be helpful in extracting information to assist in populating new programs.
- Collaboration - VHA is collaborating with many organizations in developing telehealth related activities. For example, the Department of Defense and Indian Health Service have been working collaboratively on multiple VHA Telehealth initiatives. Collaborative efforts lead to stronger programs as the intellectual and physical capital of participating platforms is leveraged and can be structured to more effectively meet program goals.

16.3 Program Promotion

Training resource and program outreach strategies include advertising and direct customer interaction. Dissemination of information through multiple venues is essential. Some of the elements to use include, but are not limited to:

- Direct mail, with informative letters, flyers, brochures, etc.

- Video presentations.
- Telehealth Service Intranet Site and Connected Care Communications Portal provide information to assist in marketing.
- When marketing to leadership and the business office, share:
    - Outcome data.
    - Success stories from colleagues.
    - Performance measures.
    - Monitoring requirements set for telehealth.
- Educational programs, literature and reports, technology fairs, luncheons or related events can be used to build a base of support for the program.
- Press releases to the local media-newspapers, TV and radio stations should be considered, in collaboration with the local Public Affairs Officer.

16.4 Evaluation

After implementing the telehealth program, it is important to evaluate its performance. Every program should have performance standards to compare with actual results. At least quarterly, evaluate if one is moving forward with the plan. Check the following:

- Is the program doing all it can to be customer-oriented?
- Are expectations and goals met?
- Are customers satisfied?
- Are customers, business partners and executive leadership well-aware of Clinic-Based Telehealth opportunities?
- Is everyone engaged in supporting telehealth's operation and growth?

17. Resources

- 38 USC 1730C - Popularly known as VA Mission Act
- Center for Disease Control and Prevention (CDC) Guidelines and Recommendations
- Center for Disease Control and Prevention (CDC) Website
- Intrafacility Deployment Checklist
- Interfacility Deployment Checklist
- Memorandum of Understanding for Telehealth Credentialing and Privileging
- National Telehealth Technology Help Desk (NTTHD)
- Office of Specialty Care Services
- Oversight Committee
- Ryan Haight Online Pharmacy Consumer Protection Act of 2008
- Specialty Care Access Network – Extension for Community Health care
- Telehealth Management Platform
- Telehealth Needs Assessment Template
- Telepresenter Training

- Teleprovider Training
- VHA Credential and Privileging
- VHA Support Service Center
- VHA Telehealth Services Internet
- VHA Telehealth Services Intranet
- VHA Telehealth Services Master Document Library
- VHA Telehealth Services SharePoint

Appendix A: Chief Consultants and Directors Endorsement of Telehealth Manual

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

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