VHA Office of Connected Care

Home Telehealth Operations Manual

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Acknowledgement

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

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Document Version History

Responsible Office

The development and maintenance of this document is the responsibility of the Veterans Health Administration (VHA), Office of Connected Care. Proposed changes to this document should be submitted to Rita. Kobb@va.gov

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1	April 2011		Initial Document Redevelopment
2	December 2011		Bi-annual Review of Manual
3	April 2012		Bi-annual Review of Manual
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5	May 2013		Annual Review of Manual
6	April –June 2016		Annual Review of Manual
7	January 2017		Newly Revised Major Version
8	April 2017		Quarterly Update
		6	Patient Participation 70% requirement at least over 90 days
		12	Employee Education System link not hyperlinked
		15	Co-morbidities for DMPs and category of care for Weight Management
		23	Adding provider reviewing data for HT: The Basics education requirement
		26	Patient Participation 70% requirement at least over 90 days
		29	Returned Merchandise Authorization Process
		33	Home Telehealth Reporting of IT issues
		34	HPDP & standalone prevention DMPs; Weight Management co-morbid & category of care
		35	VA Provider vs VA PCP
		36	Closing CCHT consults to be in compliance with Directive 1232: Consult Processes & Procedures; CHOICE Program

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

Document Revision	Effective Date	Page	Description
		43	Treatment Plan Note
			Enrollment Agreement is now required to support documentation of Veteran's rights & responsibilities for HT Program
		44	Updated content for Continuum of Care Form Note
		45	Updated content for Technology Education & Intervention Notes
		46	Updated content for Periodic Evaluation Note- changed from between 3-6 months to every 6 months
		49	Change in section title from Telephone Encounter & Office Encounter to HT Note. New content added
		49-50	Added content related to Re-enrollment and new note templates with clinical reminders
			Deletion of Patient Self-management courses
		53	Changes in encounter section to reflect release of new national note titles and templates
		55	
		63-64	Changes in risk management content to include addition of COOP risk stratification levels explanation
		67	Added Clinical Reminders and Dialog document to Resource Table #1

1. Purpose, Development Process and Audience

1.1 Purpose

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

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

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

1.2 Development Process

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

1.3 Audience

Although much of the content of this Operations Manual may be pertinent to HT operations outside of VHA, this document is a resource developed solely for internal VHA Home Telehealth programs. The intended audience is VISN Telehealth leadership, Facility Telehealth Coordinators (FTC), Lead Care Coordinators, Care Coordinators and administrative/technical staff, Telehealth practitioners and VHA staff that provide management and/or support to HT Programs.

2. Home Telehealth: Introduction and History

2.1 Introduction to Home Telehealth

The nation's largest health care system, the Department of Veterans Affairs' (VA's) Veterans Health Administration (VHA), uses a wide variety of communication and information technologies to ensure **e**xcellence in the health care delivered to our nation's Veterans. New information technologies continue to revolutionize health care and VA has been recognized by the Institute of Medicine as a leader in using these technologies to improve the quality of health care delivery. VA's application of three areas of technology -- health informatics, telehealth, and disease management -- enables VA to coordinate the care of Veterans by extending and enhancing current care and case management activities.

The focus of this Operations Manual is HT which primarily occurs between the Veteran in his or her place of residence and a VA clinical setting. Home Telehealth also occurs in other settings and, with the addition of mobile technologies such as Interactive Voice Response (IVR) systems and "Browser" or web-enabled technologies, HT can take place almost anywhere a Veteran chooses.

The term "Home Telehealth" applies to the use of telecommunications technologies to provide clinical 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.

2.2 Definition of Home Telehealth

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

The essence of HT 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 (PACT) and the healthcare system to enable timely care. Use of HT has the potential to reduce clinical complications and the use of healthcare resources that health complications may consume.

The use of technology is only one aspect of HT and a core component of the HT model which includes active care and case management. Case Management paired with technology increases patient satisfaction, improves outcomes and enhances management

of chronic disease through collaboration between the Veteran, the HT clinician (Care Coordinator), and the Veteran's health care team using an interdisciplinary approach.

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

2.3 The Home Telehealth Model

Systematically implementing HT throughout the continuum of care has been a major undertaking for VHA, one that is associated with evidence of clinical and cost effectiveness such as:

- Increased access to health care
- Improved access to primary and specialty care
- Alternatives to long-term institutional care
- Decreased Veteran travel
- Improved clinical outcomes
- Improved Veteran and Provider satisfaction
- Making the Veteran's home the preferred place of care when appropriate

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

2.3.1 The Wagner Chronic Care Model

The Wagner Chronic Care Model identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. There are evidence-based change concepts under each

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

element and in combination they foster productive interactions between informed patients who take an active part in their care and clinicians who have the resources and expertise to assist them.
The Chronic Care Model can be applied to a variety of chronic illnesses, health care settings and target populations. The bottom line is healthier patients, more satisfied providers and cost savings.

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

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

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

2.3.2 Tenets of the Home Telehealth Model

The Model for HT was developed based on the following principles:

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

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

- Screening
- Assessment

- Care planning
- Intervention
- Evaluation

The intent of the HT program is to provide non-urgent/non-emergent care and case management that also includes tracking and trending vital signs, other biometric data and symptoms. On enrollment in the HT program, all patients are given instructions on how to reach a health care professional (e.g., nurse line) after normal work hours or in an emergency at any time during the day. Based on their judgement and when indicated by symptoms being experienced, they are to continue to seek emergency medical assistance using their community resources (such as the Emergency Room or 911, etc.) as they did prior to enrollment in HT. Home Telehealth is **not** a program that provides care and case management 24 hours per day, 7 days per week.

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

2.3.3 Patient Populations and Categories of Care

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

In 2007, Office of Connected Care developed four categories of care in which Veterans enrolled in HT are placed. All patients must be placed in the appropriate Category of Care based on a formal assessment of individual patient health status. The four categories of care and their explanations are below:

- **Non-institutional Care (NIC)**
  - Must meet NIC criteria based on the administration of the Continuum of Care Form (CCF)
  - Has deficits in three or more activities of daily living (ADLs) or one or more behavioral/cognitive deficits or has less than six months to live. If the Veteran does not meet the aforementioned NIC requirements then they can achieve NIC status by having two or more ADL deficits in combination with three or more instrumental activities of daily living (IADLs) deficits or is age 75 or older, lives alone or has 12 or more clinic stops in the past 12 months.
- **Chronic Care Management (CCM)**
  - Does not meet NIC criteria but must meet both below criteria for CCM based on administration of the CCF.

        - Diagnosis of one or more chronic illnesses amenable to HT
        - Requires on-going intensive case management, monitoring and interventions.
- **Acute Care Management (ACC)**
    - Patient has short-term clinical needs such as, but not limited to: post-operative care, transition management or post-hospital care (enrollment<= 6 months).
- **Health Promotion/Disease Prevention (HPDP)**
    - Primary need is for health promotion, disease prevention, and self-management education in maintaining healthy behaviors.
    - Is unable to answer at least 70% of the time through the technology for at least 90 days.

2.4 History of VA Home Telehealth

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

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

- Working with other Services in the Office of Patient Care Services and Office of Connected Care to incorporate telehealth and disease management technologies into routine practice.
- Working alongside or embedded with Patient Aligned Care Teams (PACTs) and other VA offices/departments, clinicians, educators and patient groups to assist patients in easy access to relevant data about their own health status to enable them to actively participate in self-managing their care. An example is participating with other constituents in VHA in the continued development of MyHealtheVet.
- Collaboration with Office of Information Technology (OI&T) to support safe and secure technology.
- Collaboration with Patient Care Services and Office of Connected Care to provide innovation and secure technology.
- Working with the Denver Acquisition and Logistics Center (DALC) to ensure timely purchase, patient assignment, delivery and refurbishment of technology.

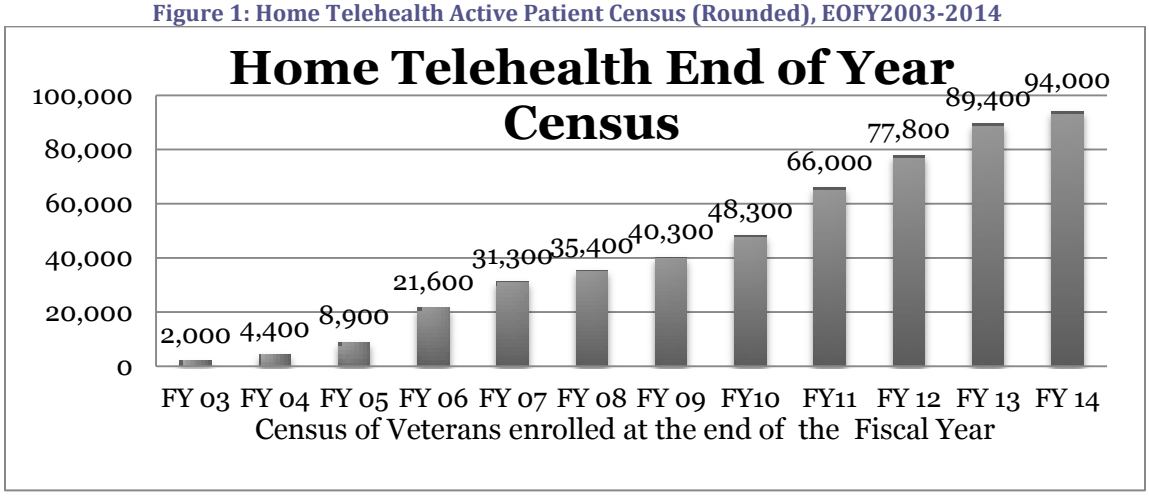
- Linking with other VA offices/departments, clinicians, educators and external caregiver groups to understand the needs of caregivers in the context of telehealth, engaging in activities to support informal caregivers and volunteers and how they need to be considered in the planning and delivery of VHA Office of Connected Care. Making the home the preferred place of care maintains the caregiver in a pivotal position in the care delivery process. Office of Connected Care, in partnership with others, supports the desire of Veteran patients to achieve the following experience from their interactions with VHA: "no decision about me is made without me."

2.5 Growth of Home Telehealth in VA

Since 2003, VHA Telehealth programs have continued to grow. Over 156,000 Veterans were served via the Home Telehealth program care for fiscal year 2015 and at the end of fiscal year 2015 there were more than 96,000 Veterans currently enrolled within approximately 139 HT programs nationally.

The following figures provide the growth of HT within VA since 2003:

Figure 1: Home Telehealth Active Patient Census (Rounded), EOFY2003-2014



*Source: Care Coordination Home Telehealth (CCHT) Data Cube

2.6 Telehealth Organization and Infrastructure

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

Telehealth must be seen as a continuum including clinic-based, home and mobile patient settings, as well as synchronous (Clinical Video Telehealth [CVT]) and asynchronous (Store and Forward Telehealth-SFT) modalities of clinical service delivery.

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

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

2.6.2 National-Level Infrastructure and Oversight

VHA Office of Connected Care provides guidance and support for HT Programs through its national HT Lead and Clinical Nurse Analyst, National Development and Implementation Teams, as well as its Data Analyst and Contracting Representative. In addition, the Quality Team provides support and guidance in the oversight of program responsibilities in providing HT Services through the Conditions of Participation (COP).

3. Planning and Expanding Home Telehealth Programs

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

- A thorough needs assessment, which includes basic infrastructure such as staffing, equipment, space and unmet clinical needs.
- A strong business case which includes an analysis of the return on investment and plan for sustainability, which are essential foundational elements for HT program development.
- A plan for integrating HT services across the continuum of care.

4. Business Case Development

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

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

- Costs associated with equipment, labor and space
- Capital investment, expenses and overhead
- Start-up and ongoing sustainability
- Bed Days of Care (BDOC) reduction costs
- Funding allocations received based on workload that is generated by the program, such as the Veterans Equitable Resource Allocation (VERA) Allocations. The VERA is based on enrollments in NIC and CCM categories of care.

Things to consider when developing the budget proposal:

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

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

- National Implementation Team
- VISN Telehealth Program Managers
- VHA Office of Connected Care Intranet website
- Satellite Broadcasts for telehealth (VA Knowledge Network and re-broadcast on Content Distribution Network). Provides current updates and changes in the field and allows for interaction between the field and subject matter experts.

4.1 Needs Assessment

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

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

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

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

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

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

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

- Access to the targeted population: What specialty population(s) will be served with HT?
- Expected outcomes from both the clinical and business perspectives (i.e., accomplishments using HT)
- Performance measures: What performance measures will HT assist?
- Space and resources available: Is there appropriate space to expand HT?
- Staffing needs: What clinical and other staff will be necessary to expand HT?
- Capacity and workload: How many patients could be enrolled in HT based on the resources available?

- Technical considerations: What types of HT technologies will best serve the identified population? What are the associated costs of that equipment or service?

Information received from the needs assessment will help support a productive clinical strategic plan to expand HT. **The following are key elements that should be included when developing the strategic plan:**

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

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

4.2 Determining Home Telehealth Enrollment Goals and Panel Size

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

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

4.3 Space Planning for Home Telehealth

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

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

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

Telework may be a viable option to resolve space issues because HT does not require daily face-to-face contact. In this consideration, it is recommended there be staff on-site available during working hours to manage walk in visits by patients ensuring the "Right Care at the Right Place at the Right Time". Telework has been successfully implemented as an option for HT in several VISNs. For more information about VHA Telework see Employee Education Service.

4.4 Deploying and Managing Home Telehealth Programs

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

- **Option 1** Program: A widespread, broad service, organizationally separate from any one primary or specialty care service/clinic, providing care and case management to patients with multiple chronic conditions who are receiving care anywhere across the VA healthcare continuum with outreach to non-VA health care settings. For example, the "Rural Home Telehealth Program" located within a VA Medical Center in Florida that reports directly to the Chief of Staff.

- **Option 2** Program: A specialized service, organizationally aligned ('embedded') within an existing service or clinic, focusing care and case management to a limited subset of patients or special populations cared for by that service/clinic, with outreach to other VA and non-VA health care settings for those same patients. For example, a Mental Health HT Program embedded in the Mental Health Outpatient Clinic.

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

4.4.1 Integrating Home Telehealth with Other Services

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

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

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

Home Telehealth team members should perform the following tasks:

- Become visible to Interdisciplinary team members. Create opportunities for frequent formal and informal interactions.
- Collaborate with PACT in the development of patient specific goals and plans of care.
- Share their expertise in care coordination and case management through team huddles, implementation meetings, grand rounds and other meetings.
- Focus documentation on the patient. Focus communication activities on the provider and the RN Care Managers (RNCM) in the interdisciplinary team. Formally share outcome data and performance improvement approaches with the team.

- Collaborate with the team to develop/utilize disease specific treatment/intervention protocols to increase quality and efficiency in providing care.
- Use feedback as an essential tool for continued success.

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

4.4.1.1 Integration with Patient Aligned Care Teams

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

VHA's principles of PACT are as follows:

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

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

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

4.4.1.2 Collaboration with MOVE!

Office of Connected Care and the VHA National Center for Health Prevention and Promotion worked together and deployed a Weight Management (TeleMOVE!) DMP in 2010. A national kick-off helped disseminate information and educate staff about this collaboration.

An implementation guide was developed and is located at the end of this section under Resources. This single DMP is a health promotion/disease prevention (HPDP) Category of Care DMP and has created very healthy and energetic networking with Nutrition and Food Service partners. In 2017 a Weight Management DMP may be combined with other VA DMPs to make a co-morbid or tri-morbid DMP. The stand-alone Weight Management DMP is still considered an HPDP DMP. However, when combined with other VA DMPs the Veteran may be classified as HPDP, CCM or NIC as appropriate through screening with the Continuum of Care Form.

4.4.1.3 Integration with Home Based Primary Care

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

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

4.4.1.4 Integration with Mental Health

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

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

Since this time, Mental Health DMPs such as Depression and Post Traumatic Stress Disorder (PTSD) have been developed and nationally released. Other conditions (e.g., Psychotic Disorder and Bipolar Disorder) have been developed to meet the needs of all Veterans with chronic mental health issues.

4.4.2 Home Telehealth Collaboration Agreements

Facility-developed written service agreements such as HT collaboration agreements or Care Coordination agreements have been used in VHA for many years to define the expectations of care coordination and hand-offs between services. Development of such agreements between PACT teams (and/or specialty care teams) and HT programs are highly encouraged, especially for new HT programs to clearly define the expectations of care coordination. The purpose of such an agreement is to formalize the trust based

relationship between PACT or specialty teams and HT and to ensure that timely, high quality, comprehensive, coordinated and patient-centric care is provided to each Veteran in a safe, effective and efficient manner. The agreement should be reviewed and updated at regular intervals (e.g., such as every two years) and as needed when there are any significant changes. The agreement should clarify the clinical, business and technical details of the care and communication methods between HT and PACT or specialty care teams.

A local agreement between PACT or specialty care teams and HT defines how they will work together to accomplish care management without duplication of services for the patient. Topics for inclusion in the agreement include:

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

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

4.4.3 Clinical Protocols

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

other members of the team. The development, approval, and use of such protocols need to follow local policy requirements.

Human Resources, Key Positions, Roles and Responsibilities

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

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

Key Positions in Home Telehealth:

- Care Coordinator
- Lead Care Coordinator
- Facility Telehealth Coordinator (FTC)
- Home Telehealth Support Staff
- Home Telehealth Master Preceptor
- Home Telehealth Preceptor
- Home Telehealth Clinical Champion
- VISN Home Telehealth Program Manager

4.5 Care Coordinators

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

not have the necessary skills to function as a Care Coordinator. The role requires significant assessment skills and duties required outside their scope of practice. There are however, many duties that the LPN can support in HT. The resource, LPN FAQs, explains the LPN duties in detail.

Responsibilities of Care Coordinators may include:

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

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

4.6 Lead Care Coordinators

Lead Care Coordinators have all the same competencies and training as Care Coordinators, but in addition, they perform administrative or supervisory duties as well (as listed below). Lead Care Coordinators may be Registered Nurses (RN), Nurse Practitioners (NP), Licensed Clinical Social Workers (SW) or other professional staff members (such as dietitians, physical or occupational therapists, pharmacists, etc.). They are encouraged to apply for participation in the HT Master Preceptor Program.

Responsibilities of Lead Care Coordinator may include:

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

4.7 Facility Telehealth Coordinator (FTC)

The VAMC-level FTC is a key player for success. This position is usually but not always responsible for the operation of all telehealth programs within the facility. The FTC may be

responsible for the overall planning, coordination, implementation and evaluation of clinical applications of all telehealth programs, (HT, CVT, SFT) based on facility needs. If appropriate, the FTC must have a good understanding of the HT program and must work collaboratively with both the VISN-level Telehealth Program Manager and the HT Lead to optimize the HT program at the facility.

4.8 Home Telehealth Support Staff

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

Responsibilities of Support Staff may include the following:

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

4.9 Home Telehealth Master Preceptor

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

4.10 Home Telehealth Preceptor

This role, previously known as Support Preceptors, helps in the preparation of fully trained HT field support staff in meeting Veteran healthcare needs. These staff provide a vital service in the day-to-day operations of the HT program. This program supports the on-going mission and vision of the local, VISN and national levels. Individuals eligible for this role might include: PSAs, Medical Support Assistants, LPNs, Health Technicians or TCTs.

4.11 Home Telehealth Clinical Champion

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

Characteristics of the Clinical Champion include:

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

4.12 VISN Home Telehealth Program Manager

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

5. Staff Education, Training and Competency

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

To achieve these skills everyone involved in HT will have formal training and skill assessment that includes clinical, business and technical elements. The VHA's National Implementation Team provides a training plan of 'critical', 'need to know' and 'nice to know' training offerings. The training plan is located on the Office of Connected Care website.

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

Long-term sustainability of any telehealth program requires methodical planning and evaluation. It is important to train, develop and empower staff, as well as to provide appropriate feedback to enhance job satisfaction and improve their tenure. . (E.g. data on utilization outcomes, reductions in BDOC, reduced emergency room visits, patient and provider satisfaction, etc.). Clinical, technical and business elements need to be assessed and analyzed using data collection, as well as the design of business operations to ensure that processes are in place to enable effective, efficient and sustainable HT programs. A process must be put into place to ensure information on performance improvement and clinical outcomes related to HT programs are shared and disseminated with both facility and VISN Quality Management and leadership.

6. Orientation

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

6.1 National Implementation Team

VHA Connected Care operates an integrated National Implementation Team (previously known as the National Telehealth Training & Resource Center), devoted to providing training and skill evaluation for the three telehealth areas: CVT, HT and SFT. In most instances, these training opportunities are primarily offered virtually to allow for convenient access for VA staff nationally.

The National Implementation Team provides staff and administrators with the training tools and performance support requested and required. The team provides training and serves as a resource for HT programs. In addition, team staff provide support to ensure case management skills are developed so that HT staff provide safe, high-quality care as directed through the Conditions of Participation (COP), an internal accreditation process (refer to Section 13: Workload Capture and Data Management for more detailed information). Established in 2004, the National Home Telehealth Training Team (now the National Implementation Team) continues to update and add learning opportunities in a variety of modalities:

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

7. Home Telehealth Clinical Pathway and Care Coordination Process

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

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

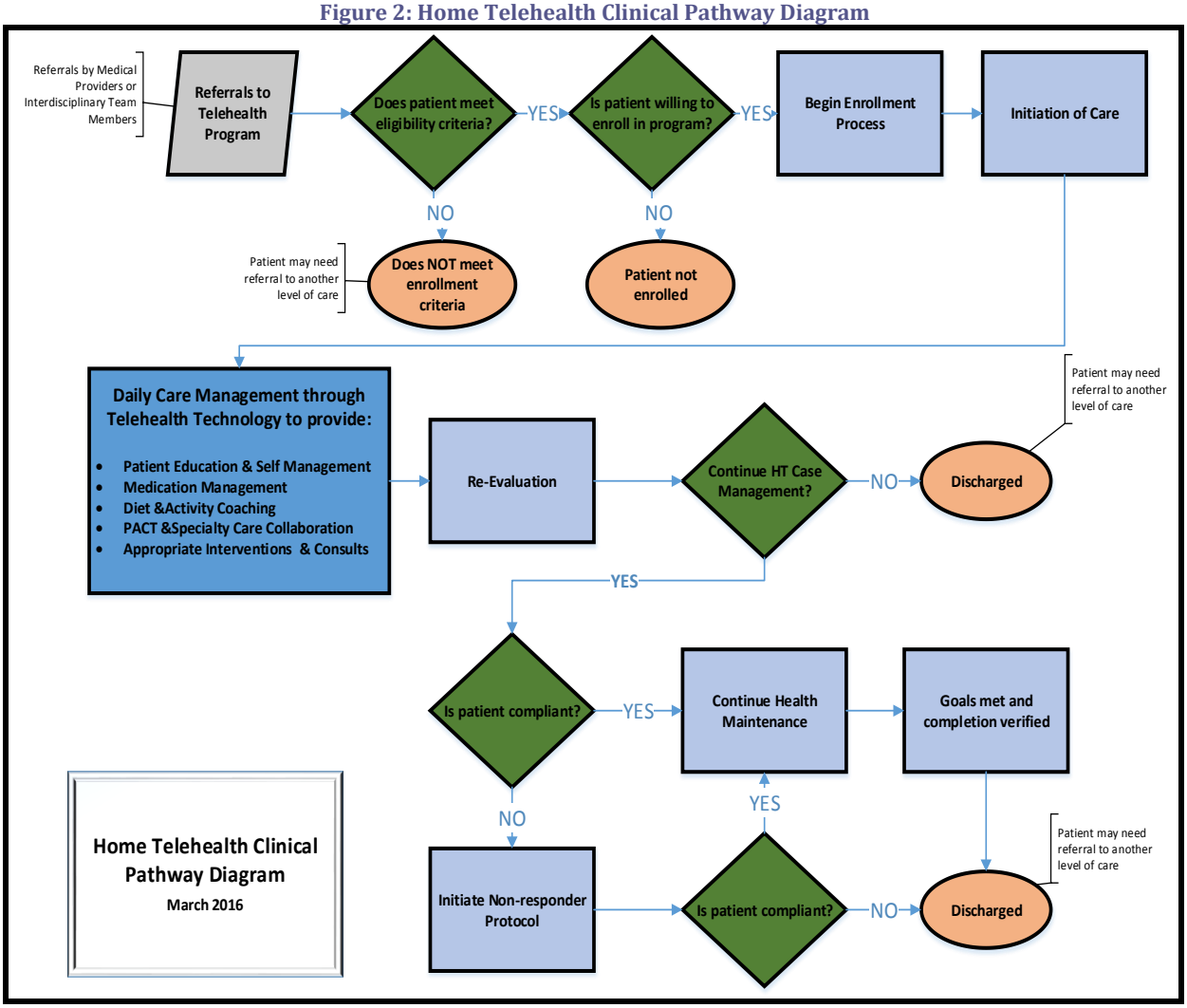
It is critical that HT staff, most importantly Care Coordinators, understand that they are care and case managers and as such, they are expected to be an advocate for the Veterans across the VA and non-VA healthcare continuum. Home Telehealth is not simply a "vital sign monitoring program" and is not intended to be implemented as a silo within the VA healthcare system. Care Coordinators coordinate care; they are care and case managers and they are in an optimum position to coordinate care across Service Lines and assist with transitions between both inpatient and outpatient settings. Understanding the expectations of care that this role provides can be best described through the clinical processes within the HT model and the related CPRS medical record documentation standards (Section 11: *Documentation Standards*)

The fundamental Home Telehealth Care Coordination process and communication flow is illustrated in figure 1 below and can be summarized into three (3) phases:

- Screening and Identifying Appropriate Veterans for Enrollment into the HT program
- Assessing and developing a plan of care
- Ongoing care coordination - care management, case management and monitoring
- Disenrollment/transition to other services

This section provides further detail of key components of the Home Telehealth process of care – technology and disease management protocols (DMPs) – that need to be understood in order to fully comprehend the HT clinical pathway, including standards and process of care, which are fully described in Section11: *Documentation Standards*

Figure 2: Home Telehealth Clinical Pathway Diagram



The following sections briefly describe the essential elements within the Home Telehealth Clinical Pathway. Detailed information on Home Telehealth notes and templates are provided within section 11: Documentation Standards. Some of these elements may vary slightly depending on local policy.

7.1 Screening and Identifying Appropriate Veterans for Enrollment into the Home Telehealth Program

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

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

Current VHA priorities is not only access to care, Veteran choice, but also Suicide Prevention. HT plays a key role in identifying those at risk for suicide and other mental health issues. All Veterans enrolled in HT are screened for acute and on going MH issues and care needs. Interventions and referrals are to be made as appropriate to meet the needs of the Veteran and or caregiver.

7.2 Ongoing Care Coordination - Care Management, Case Management and Monitoring

One of the foundational components of Home Telehealth is to provide ongoing, longitudinal monitoring and assessment; these are the essential elements of daily case management of enrolled Veterans. This includes analyzing all of the Veteran's daily responses to DMP questions and other health-related data and determining if timely intervention is required by the Care Coordinator using clinical judgement within their scope of practice. The Care Coordinator must follow agreed communication protocols or Standard Operating Procedures (SOP) as appropriate for their worksite for any responses and data that are not within expected parameters to ensure appropriate team members are alerted to changes in health status and can assist with timely interventions and adjustments to care plans. If any interventions are indicated, the Veteran is contacted by phone. At this time, the data is validated with the Veteran; further assessment is done, again analyzed and then communicated to appropriate healthcare providers. Education is provided which covers a variety of things including but not limited to any medication management and adjustment in collaboration with the provider. Referrals to other services may also be part of the intervention provided. All of these elements must be documented in the Veteran's Electronic Medical Record. Further follow up and reassessment, along with other case management activities with the Veteran and/or others, may be required after the intervention and must also be documented. Care Coordinators will conduct on going chart reviews as part of their routine case management and process of care for evaluation of Veterans current needs, overall status, and changes that may have occurred.

Ongoing assessment occurs with each submission by the patient and can include multiple other interactions. For example, Veterans are provided a phone number to reach their

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

Sometimes Veterans may not participate as expected. This is not uncommon, but requires communication and follow up to review with the Veteran the benefits of participation and the goals of care. National guidance recommends that contact should be attempted when the Veteran has not participated in utilizing their assigned technology as clinically indicated but no more than three consecutive days. It is important to communicate with the Veteran quickly to try to re-engage the Veteran in full participation in the Home Telehealth program regularly and ensure their well being and safety.

7.3 Discharge/ Transition to other Services

Consideration for discharge from the HT program (other than a definitive discharge at time of a patient's death) should occur if:

- Patient is admitted to a nursing home setting as a long-term or permanent placement
- Veteran or Caregiver no longer desires participation in the program
- Patient has permanently relocated outside of (VA catchment area)
- Patient has not met required 70% participation for at least 90 days.
- Patient has been a non-responder for 30 days or more (considering specific patient situation)
- Patient has achieved goals / transition to another program may be appropriate

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

8. Home Telehealth Technology

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

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

8.1 Home Telehealth Technology Platforms-VA Approved

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

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

- **In-Home Messaging Device (IHMD)**. An IHMD is a unit that provides a set of questions and answers as well as education and self-management skill building opportunities via a Disease Management Protocol (DMP). Patient responses are sent to staff and are then risk stratified for timely intervention in the vendor website. Data from IHMDs can be transmitted via the phone line (Plain Old Telephone Service (POTS)), Internet Protocol (IP) or cellular modem (either integrated in the hub device or a separate modem attached to the hub device).
- **Interactive Voice Response (IVR) Technology**. (IVR) technology provides a messaging service using DMPs that are accessed from a land telephone line or cell

phone. The Veteran can use his or her voice or touch the number pad on the phone to generate answers to questions about his or her health for submission back to his or her VA Care Coordinator. The mode of transmission could either be by POTS or by the patient's own cellular phone service. This device can call the veteran if the veteran has not responded by a certain time daily and can support our forgetful enrollee.

- **Internet Browser Technology**. Browser is the latest addition to the Home Telehealth technology portfolio that provides greater flexibility for delivery of patient care. This technology allows patients to securely receive and transmit DMPs via any internet-enabled device such as a smart phone, tablet, laptop, or home PC via login to a secure vendor website.
- **Video**. Video is a HT device or platform that uses both audio and visual components, which may include peripheral devices such as stethoscopes and other vital sign monitoring devices. All video technologies must transmit via IP (Internet Protocol) as a minimum requirement.
- **Home Telehealth Peripheral Devices**. Home Telehealth peripheral devices are used in conjunction with the main HT device (hub unit), such as the telemonitor or messaging device, based on clinical application. Typically, these devices are blood pressure monitors, heart rate monitors, weight scales, stethoscopes, glucometers, and pulse oximeters. Some of these peripheral devices connect by a cable to the hub unit, are integrated within the hub device itself (such as a blood pressure monitor) or may connect wirelessly via Bluetooth for uploading vital signs or other biometric data. At this time, IVR and Browser patients can only self-report (manual entry) biometric data. In the future, Bluetooth connections for these technologies may also be available. Stand-alone devices can still be ordered for IVR and Browser patients for collection of data to enter manually. Home Telehealth staff, as part of the comprehensive assessment of each patient, determine the appropriate type of peripheral device, based on specific patient need. For example, patients with difficulty manual dexterity may require a tethered or integrated device.
- **Cellular modems**. Cellular modems are considered a mode of transmission. These can be integrated in the home messaging device or a separate, tethered modem. They provide secure transmission to and from the units in instances where POTS transmission is not available or reliable. Cellular modems are not the same as IVR (which uses the patient's own cellular plan or phone service). Cellular modems allow full DMP content to be delivered to and from the patient via the IHMD securely to the vendors' website.

8.2 Telehealth Technology Ordering, Inventory and Support

There are specific vendors for HT technologies under a national contract. Information on vendors and related technical content is available on the Office of Connected Care' website

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

Some very important considerations for planning and process:

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

8.3 Denver Acquisition and Logistics Center (DALC)

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

The DALC is the supplying organization for all HT technologies, providing distribution services and contracting support to Office of Connected Care and Prosthetics and Sensory Aides Service (PSAS) with respect to the VHA Home Telehealth Program. The DALC provides logistics support for: purchasing and distribution, database management, IT, customers and vendor payment. This support includes, but is not limited to, the following for Home Telehealth programs nationally:

- Acquires, receives, stores, accounts for, ships and pays invoices for Telehealth equipment identified by the National Program Office for VHA Office of Connected Care
- Orders, tracks and pays invoices for all licensing and/or service fees
- Provides information on orders placed and assigned for HT
- Installs batteries and sets the date and time in the devices before they are sent to the Veteran
- Maintains a centralized database of all registered devices by serial number, Veteran name and current location of device/deployment status
- Maintains a centralized database of licenses
- Receives Telehealth devices that are returned by the Veteran
- Refurbishes returned devices or provides for proper disposition
- Tests each device for operability and data removal prior to postal delivery to the Veteran
- Manages the payment of vendor services

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

Home Telehealth technology is ordered from the DALC through the Remote Order Entry System (ROES). All Telehealth staff may order Telehealth services and equipment via ROES

including: VISN Telehealth Program Managers, FTCs (Facility Telehealth Coordinators), TCTs (Telehealth Clinical Technicians), Home Telehealth (HT) Care Coordinators, HT Leads, HT PSAs (Program Support Assistants), and any future Telehealth Services roles.

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

As detailed in the ROES training, any non-clinician ordering in ROES will be ordering based on the clinician's directions. For Veterans referred via consult to the HT program, the ordering communication to the non-clinician could be from the initial assessment note completed by the HT.

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

8.4 Matching Technologies to Clinical Need

An effective tool to help address matching the appropriate technology to the Veteran is the Home Telehealth Technology Algorithm and GRID. The Technology GRID & Algorithm organizes the various technologies and functions, costs, availability of national Disease Management Protocols (DMPs) in addition to the technical needs of the specific clinical application. It also addresses the clinical, sensory, and functional aspects needed to use the technology successfully to help staff evaluate and select appropriate technologies and systems.

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

The maintenance of telehealth technology involves collaboration between numerous entities (The Denver Acquisition and Logistics Center (DALC), Prosthetics and Sensory Aids Service (PSAS), Office of Information Technology (OI&T), the National Center for Patient Safety, the respective HT vendors under contract with VA to provide HT technology and service, HT staff, and VHA Office of Connected Care).

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

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

- Instruct patient to call when they receive their unit.
- When the patient calls, the HT staff member either:
    A. Confirms the serial number *(If the patient is unable to do that then step "B" below is used)*
    B. Instructs the patient to immediately send data that is verified by the HT staff on the vendor desktop with date/time/vital sign values.
- All first time transmissions from a new device issued to a patient should be validated with the patient or caregiver.
- If support staff confirms, the Care Coordinator would still review vital signs as per normal daily review.

The validation steps above should be documented in the patient's medical record. This can be done as an addendum to the Tech Education Note, which is the note title used when staff is explaining/educating/training Veterans or family related to the technology, for a new patient. For a current patient getting a new replacement unit, a new note or addendum (as appropriate) should be entered.

Return Merchandise Authorization (RMA)

1. With the implementation of the 2017 HT contract the Office of Connected Care will no longer restrict customer service communications between the vendor and any Home Telehealth patients. Home Telehealth vendors will now be able to receive phone calls directly from Veterans or caregivers and make calls in response to Veterans or caregivers queries in reference to technology trouble-shooting issues, such as re-setting passwords. HT staff should still troubleshoot technology issues with Veterans who call the HT program and if unable to resolve, can connect the Veteran with the appropriate vendor help desk. HT staff will not be assisting Veterans with password resets.
2. Because of the change in customer service policy, if a vendor customer service representative receives a call or is on a call and the Veteran or caregiver communicates any information outside of technical issues (such as a medical health issue, mental health issue or talk of suicide) the representative should immediately:
    - Identify themselves as "I am not a trained health professional, but I will assist you in getting someone that can help you." Then immediately direct the Veteran or caregiver to hang-up and dial 911, or the National VA Crisis Line at 1-800-273-8255 for assistance.

- Vendor determines what items fall under warranty and assigns an RMA number
- HT staff orders a retrieval kit
- Vendor notifies DALCTELEHEALTHSUPPORT@va.gov mail group of the RMA (this is the first notice to the DALC of the RMA)
- Once the device returns to the DALC and is processed, a credit will be applied to the site

For defective devices outside of warranty please email: dalctelehealthsupport@va.gov, Ronald.graham@va.gov or frank.gallegos@va.gov

Home Telehealth Reporting of IT issues:

Purpose: To describe the formal process for Home Telehealth staff to report IT issues affecting patient care and normal workflows. This will assure timely response as well as a formal tracking mechanism. Examples of IT issues include: VistA integration delays or error messages that prevent patient Activation or Inactivation, Patient Identity errors, inability to access vendor websites, delays in vendor websites, and patient reports of vendor technology issues such as transmission delays or inability to receive or transmit data.

Steps:

3. If it is a specific vendor issue, contact the vendor help desk (including VistA issues)
4. Report to the local Information Resource Management (IRM) or Clinical Applications Coordinator(CAC) (varies by site)
5. Report to IRM or CAC that it is a HT issue and if it appropriate, affects patient care.
6. Report the issue to the National Service Desk following directions below:
   - Call **National Service Desk** (NSD) at **888-326-6780** to report an **Incident** or request a **Service Request**.
   - The following information will be required to be supplied to the Service Desk personnel to complete the Incident Report:
     - Application Name: **Home Telehealth**
     - Vendor Name if applicable
     - End-User Requesting Support: (Name; Phone Number; Email Address)
     - Description of Request(Outage, Request for OIT Support):
     - **For Incidents:**
       - Affected Number of End-users:
       - Location of the Affected End-users:
       - Time the outage occurred:
       - Duration of the outage:
       - Is patient care impacted?
       - Number of patients impacted?
       - Are critical business functions impacted?
       - Has the contingency plan been activated?
   - A ticket will be generated and the POC requesting the service will receive an Email with the ticket information. A Subject Matter Expert will be assigned to triage the Incident and resolve the problem.

7. If you do not receive a response within 24 hours, please notify Catherine Buck, HT Program Lead, and George Blankenship, OIT

8.6 Technology User Group

Each VISN has at least one representative on the national Home Telehealth Technology User Group (TUG). This group meets monthly and is led by the national Home Telehealth Lead and Clinical Nurse Analyst. The purpose of this group is to provide a communication process throughout all levels of HT - local, VISN and national - to discuss technology issues, concerns, and needs. Each VISN TUG representative is a critical communication link in this process. All staff should be aware of who their VISN TUG representative is and report any concerns to them. In additions, each VISN TUG representative should play an active role in VISN wide communication of issues discussed on the national TUG call back to their VISN colleagues. This could occur as part of a standing agenda item for any routine VISN-wide HT meetings. Often, the TUG call is a source for determining new issues that impact the program at large and works to resolve those with the vendors and others as appropriate.

9. Disease Management Protocols (DMPs)

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

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

As of fiscal year 2016, Office of Connected Care as of FY2016 is no longer developing its own national VHA standardized DMPs (described below). Instead, Office of Connected Care will continue to annually review current VHA content to ensure national clinical guidelines are met and to address any other changes put forward by field staff. In addition, Office of Connected Care through the National Telehealth Training, Quality and Development's Teams will review new vendor DMPs to ensure VA standardized core content is included as well as clinical guidelines are adhered to.

In the past, if a VHA DMP title existed for a specific disease or condition, Care Coordinators were required to use the VHA version instead of any vendor-created version for the same disease or condition. This has changed with the implementation of the 2017 HT contract. . Care Coordinators may choose to use any DMP either VHA or vendor-developed, that in their clinical judgement best meets the needs of their patient. If a vendor-developed DMP is chosen, the VISN in which the vendor-developed DMP is used will be responsible for ensuring that the vendor-developed DMP meets national clinical practice guidelines which can be found at: https://www.healthquality.va.gov, has VHA core content and is safe for use with patients. VISNs should continue to use the current process they have in place for approving DMP use and content.

In the past, VHA has not had co-morbid or tri-morbid DMP versions. Past approved practice was for Care Coordinators not to combine VHA DMPs together or combine VHA DMPs with vendor-developed DMPs. This has changed with the implementation of the 2017 HT contract. Care Coordinators may choose to combine VHA or vendor-developed DMPs into

co-morbid or tri-morbid DMPs that in their clinical judgement best meets the needs of their patient. This includes VHA Weight Management and Tobacco Cessation DMPs. In addition, these previously Health Promotion Disease Management stand-alone DMPs could now be classified as NIC or CCM depending on the Continuum of Care Form Assessment as long as the Veteran is assigned a co-morbid or tri-morbid DMP If these types of DMP combinations are chosen, the VISN in which the combination DMPs are used, is responsible for ensuring that the combination DMP meets national clinical guidelines, has VHA core content, does not have duplicate content and is safe for use with patients. VISNs should continue to use the current process they have in place for approving DMP use and content.

9.1 DMP Types

- **"Core" DMPs**: These VA developed DMPs are defined as "Core" because each Home Telehealth vendor is contractually required to provide each of these nationally standardized and approved VA DMPs over their technology platforms. Currently these include: Heart Failure (HF), Chronic Obstructive Pulmonary Disease (COPD), Depression, Hypertension (HTN) and Diabetes (DM); Weight Management (WM); Chronic Kidney Disease (CKD); Dementia; Hepatitis C Virus (HCV); Mild Traumatic Brain Injury (mTBI); Multiple Sclerosis (MS); Palliative Care; PTSD; Substance Use Disorder; Tobacco Cessation; Stable and Able - HUDVASH (Homeless); Bi-polar Disorder and Psychotic Disorder.
- **VHA Standardized DMPs**: This term refers to those DMPs the VHA Office of Connected Care and designated Subject Matter Experts (SME) developed to ensure the quality and safety of the content of DMPs that are provided to Veterans across all applicable vendor technology platforms. All "Core" DMPs are standardized. Please refer to the Home Office of Connected Care Technology webpage for the Technology Algorithm and GRID which includes a current listing of available VHA DMPs.
- **Vendor Developed DMPs**: These DMPs have been totally developed by the vendor. If a VISN or local site desires to utilize a vendor-developed DMP that has not been nationally standardized by VHA or approved under the national contract (See Core DMPs above), they must seek this authorization through their VISN Chief Medical Officer or designee before they may be utilized. Any and all funding for this request will be managed by the requesting VISN or site and any and all changes to the DMP that may or may not affect national clinical guidelines are the responsibility of the VISN.
- **Comorbid and trimorbid DMPs**: The VHA Standardized DMPs are all focused on a single disease state. Currently, our only vendor offers their own co-morbid combinations. In addition there is also the opportunity to combine VA DMPs together. For example Weight Management may now be made a co-morbid by combining it with any other VA DMP. However, these combinations must be reviewed and go through the approval process of each individual VISN before use.

9.2 DMP Processes

9.2.1 Annual Review Process

VHA DMPs will be reviewed annually by SME groups and the National Telehealth Training Team for changes in clinical practice guidelines and reported issues from the HT community. Currently two to three DMPs are reviewed per month.

Care Coordinators send issues or requests for revisions to the DMP to the National Telehealth Training Team for review to determine if concerns are safety or non-safety issues. Non-safety issues or revisions will be addressed at the next annual review unless the HT Team determines the issue needs to be changed sooner. For any issues reported to the National Telehealth Training Team that are determined to be safety issues, Care Coordinators will be instructed to initiate a quality improvement request (QIR). Vendors have seven days to resolve safety issues.

The HT community is also notified of the national release of any new VHA DMPs through the VA national alert. All released DMPs are posted on the VHA Office of Connected Care web page.

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

9.2.2 DMP Versioning

There is a specific, required nomenclature for all DMPs so that the DMP data sent from each of the vendors to VHA Office of Connected Care is uniform and provides for accurate capture of these DMP assignments in the HT data reports. All VHA DMPs that are annually reviewed will receive the next numeric designation once approved. For example, TeleMOVE! Version 2.0 is reviewed in 2016 and once approved the version becomes 3.0.

9.2.3 Setting alert parameters

Alert parameters must be set for each biometric data element monitored. Although the vendors have default parameters, the HT alert parameters are individualized according to the Veteran's current health status and must be set so that the Care Coordinator is alerted when there is a change in the Veterans health status. Alert parameters should be meaningful and specific to each Veteran. Alert parameters that are not set or are set incorrectly may result in unnecessary daily red alerts. When correctly set, alert parameters will help to improve time and efficiency in case management. For example; if a Veteran is enrolled into a hypertension DMP with a baseline blood pressure of 170/90 and he/she is starting new blood pressure medications, the high parameter should not be set at 140/90. This would result in the Care Coordinator receiving daily red alerts. The high parameter should be set above the patient's baseline (171-175/91-95) to ensure that the blood pressure is not trending upward. As the patient responds to the new medication, the high parameter can be adjusted down as the patient's BP comes down. By doing this, the parameters will encourage more efficient case management of the individual's health status. Alert parameters within the DMP are not to be confused with clinical targets or

goals. These are usually set by the provider in his/her discussion with the Veteran and are individualized. For example; a Veteran may come from Provider A with a blood pressure systolic target goal of 120 and a diastolic target goal of 75. But his/her actual blood pressure is consistently running 169/90. Parameters should not be set at 120/75. Set the high alert parameters above 169/90 to ensure the Veteran does not trend upward; set low alert parameters below 120/75 in case the Veteran goes too low. The Care Coordinator uses their clinical judgement for each individual veteran's situation to determine the most effective alert parameter settings.

9.2.4 Data Review

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

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

All alerts, especially red (high) and yellow (medium) should be reviewed daily. Reviewing yellow alerts can inform the Care Coordinator of impending problems and identify patterns of risk for individual patients. Local program policy procedures regarding alert reviews should be followed.

10. Documentation Standards

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

10.1 Documentation of Case Management Activities

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

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

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

The following documentation is completed:

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

- CCF every 6 months per VERA requirements for NIC & CCM patients and also for significant changes in condition for all patients.
- Caregiver burden assessments as needed

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

10.2 The Home Telehealth Consult Referral

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

10.2.1 Completing the Screening Note

Once a consult is received for enrollment in HT, the Care Coordinator reviews the patient's EMR to ensure they meet program criteria and makes the initial contact with the patient to evaluate further suitability for program services. Best practices indicate Veterans are more likely to consent to HT enrollment when they have participated in decision making on the need for program services prior to the consult placement. This screening is then documented in the EMR and the consult is completed and closed, regardless of whether the Veteran does or does not meet criteria for enrollment into the HT program. It will suffice to close the consult with the screening note and final disposition of the Veteran such as "The Veteran verbally agrees to participate in the HT program. An appointment was set up for

enrollment two weeks from today", or "The Veteran has declined enrollment", or "The Veteran does not meet criteria for enrollment."

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

10.2.2 Content within the Consult

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

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

If the Veteran and/or caregiver are willing to participate, the next assessment is the type of technology that would be best for the Veteran. Many factors are considered when making the right technology choice for the Veteran. Cognitive, emotional and physical needs are evaluated. The home environment as well as availability of a land phone line, cell phone or internet, are important considerations. The HT Technology Algorithm GRID is a valuable tool to aid in decision making. Cost is also an important consideration, which is why the cost is also included on the HT Technology Algorithm GRID as staff need to select technology that is appropriate for the specific needs of the patient while being fiscally responsible.

Although the need for a written consent no longer exists, the verbal consent must be documented in CPRS within the Initial Assessment and Treatment Plan Note. The "Patient Enrollment Agreement "replaces the previously required written informed consent, as per policy in the VA Informed Consent Handbook. This Patient Enrollment Agreement is required and available in the Resources section.

In addition to outlining the Veterans' responsibilities, the Patient Enrollment Agreement includes the following elements:

- This required document helps the patient be fully informed of the risks and benefits of HT and procedures.
- The patient must give verbal permission as consent at the time of enrollment for HT service prior to the initiation of the HT program.
- The Enrollment Agreement documents that Veteran patients enrolled in the HT programs formally accept their role, agree to specific rights and undertake to perform required responsibilities that are necessary to ensure the care they receive is safe, appropriate and cost-effective.

- Veterans are informed that they have the right to refuse HT services without negating their right to future healthcare.

10.3 Initial Assessment and Treatment Plan Note (Assessment, Review of Systems, Goal-setting and Planning)

The initial assessment and review of systems may be performed over the phone or in person to include a thorough review of the Veteran EMR. This is a comprehensive case management assessment (or review of systems) which includes identification of specific problems, comprehensive medication management, goals targeting development of a HT treatment plan, which is an extension of the Veteran's overall treatment plan. The review of systems is not to be confused with a physical assessment of the patient. For specialties like Nutrition Services or Homeless Veterans who have their own specific assessment documentation requirements – it is recommended that a reference to that note be placed within the Home Telehealth Assessment & Treatment template rather than repeating the same information to avoid duplication of efforts. An HT template exists to help the Care Coordinator document all necessary elements in the review of systems. The Initial Evaluation and Treatment Plan note should show a signed "Receipt Acknowledged" as an additional signer by the primary care provider (or referring provider if not the primary care provider) and any other appropriate care providers in the EMR serving the Veteran. Including the provider and other appropriate clinicians as additional signers identifies the collaborative relationship between these individuals and the Home Telehealth Program. This relationship is a requirement not only for the Conditions of Participation but for the Joint Commission as well. Staff should use the "Additional Signers" function for this communication purpose.

The HT treatment plan needs to be individualized to the Veteran and include specific interventions that the Care Coordinator will provide to the Veteran to meet their health care goals. The goals of care are established with the Veteran, the provider and the Care Coordinator. The goals for our Veterans need to be SMART, which means Simple and Specific, Measureable, Achievable and Attainable, Relevant and Realistic and Time framed.

The treatment plan is then regularly readdressed at least every 6 months (unless otherwise designated to be done earlier by local policy.) All documentation by the Care Coordinator is based upon the individual's scope of practice (i.e. RN, RD or SW).

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

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

Other components of the initial assessment documentation for enrollment in the HT program are the CCF, (to determine Category of Care assignment), the Caregiver Burden Assessment template, and the Tech Education and Installation. These notes must be completed prior to the 683 note (Monthly Note) as separate notes, or can be included in the documentation for the overall Evaluation and Treatment Plan note. They are listed as separate notes below.

10.4 Continuum of Care Form (CCF) template

The CCF was developed from the Geriatric Evaluation and Assessment Tool used in Long-term Care. The CCF, like its predecessor, assesses functional abilities for activities of daily living (ADLs), instrumental activities of daily living (IADLs) and cognitive/behavioral function. This assessment generates the Category of Care assignment for each Home Telehealth patient. The Category of Care is directly linked to Veterans Equitable Resource Allocation (VERA) funding especially for Non-institutional Care (NIC) and Chronic Care Management (CCM) classified Veterans. The CCF is completed upon enrollment for **all Home Telehealth patients** and can be documented in the evaluation treatment plan or stand separately. The CCF is then updated every six months for all Non-institutional Care (NIC) as well as Chronic Care Management (CCM) Categories of Care. Also, the CCF must be updated anytime there is a significant change in health status. Completing the CCF to determine Category of Care is done upon enrollment for all Veterans and then updated every six months for NIC and CCM patients and for any patient at any time there is a significant change in condition. Any CCM or NIC categorized Veterans who are assigned to Health Promotion Disease Prevention (HPDP) because they do not respond to their technology at least 70% of the time within a 90 day period, still require a Category of Care reassessment via the CCF at least every six months. Response statistics are made available via the vendor technology.

10.5 Caregiver Burden Assessment template

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

may be utilized to assist the caregiver and, in so doing, assist the Veteran. This assessment may be utilized at any point in the process of care in addition to the initial assessment process. There is an electronic note title and template to document the assessment.

10.6 Technology Education Note

The Veteran and or his/her caregiver are assessed by the Care Coordinator to determine which technology best meets the Veteran's needs. The HT Technology GRID & Algorithm should be used to determine appropriateness of technology related to functional, cognitive, environmental and financial considerations. The HT staff then educates the Veteran and/or caregiver on the technology installed or implemented. Program Support staff can assist with equipment issues with oversite from a Care Coordinator. The Veteran/caregiver competency in utilizing the technology is assessed using the appropriate note title and template guidance. This note and template is to be used upon initial enrollment or as needed to document any changes related to technology. Trouble-shooting technology is to be documented with this note title as well but the template may not be needed and can be cancelled allowing for free text documentation. The "Tech Education" clinic is to be set-up with stop codes 674/685 which are Non-count. Care Coordinators providing trouble-shooting for technology issues in addition to providing clinical care or assessment during the same encounter can use the "HT Note" instead of the "Tech Education Note" in order to get workload credit

10.7 Intervention Note

Central to the Care Coordinator's role is reviewing the daily information submitted by Veterans on their panel, including vital sign measurements, answers to questions that assess the Veteran's understanding of their disease process, as well as the Veteran's responses to other questions. The Care Coordinator, using clinical judgement and following their scope of practice, may contact the patient to verify the responses and complete an assessment in order to address the Veteran's care needs, provide case management and patient education and develop an appropriate plan of care. A Home Telehealth intervention with a patient should occur whenever there are findings from the data submitted by a Veteran that are outside of established parameters or otherwise concerning to the Care Coordinator and that require direct communication with the Veteran/caregiver to further assess and resolve those concerns. There must be contact with the Veteran or caregiver for this note to be an encounter note. If a Care Coordinator is unable to connect with the Veteran or caregiver then the note is not an encounter. Programs have the option to use the Intervention Note to document unsuccessful attempts to reach the Veteran / caregiver but then the note must be marked historical . The template for the Intervention Note has a required field to complete an encounter, therefore the template must be canceled and a free text note entered. The other option is to use the HT Note which would also need to be marked historical. The Care Coordinator should continue attempts to reach the Veteran. Once the Veteran is reached, the Intervention Note and template should be used completing the encounter. Not all interventions require a PCP notification or signature. However, the PCP should be notified of significant findings or the need for further

assessment or action based upon the clinical judgement and within the scope of practice of the Care Coordinator.

10.8 Monthly Monitoring Note

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

10.9 Periodic Evaluation Note

The Periodic Evaluation note is a reassessment of the Veteran and is completed at regular intervals and as needed based on local policy. The minimum requirement is every six months. This review must include direct input from the Veterans and/or caregiver either via phone or office visit. The Periodic Evaluation note contains a review of systems; comprehensive medication management; analysis of ongoing and new problems; summary of biometric data from the vendor website; review of SMART goals and interventions; review of the Veteran's progress to goals; summary and evaluation; new goals and interventions as appropriate and recommendations. Just like the Initial Evaluation and Treatment Plan, the Periodic Evaluation Note should show a "Receipt Acknowledged" as an additional signer by the primary care provider (or referring provider if not the primary care provider) and any other appropriate care providers in the EMR serving the Veteran. Again this is to demonstrate the on-going collaborative relationship with the Home Telehealth Program.

This note includes the following:

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

Category of Care Screening for NIC and CCM patients is done every 6 months, on any patient regardless of Category of Care for changes in condition and for non-responsiveness to technology as appropriate. .

10.10 HT Note

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

10.11 Discharge Note

The Veteran may remain in the Home Telehealth program as long as the program is providing benefit for the Veteran and, if in the absence of the program's services, there is or would be significant risk of decompensation. These benefits should be documented in the EMR as part of the periodic reassessment. If there is no benefit for the patient remaining in the program, then disenrollment should occur and if appropriate, the Veteran may be transitioned to other clinical programs such as HBPC. Other possible reasons for disenrollment include:

- Admitted to a nursing home setting as a long-term or permanent placement
- No longer desires participation in the program
- Has permanently relocated outside of local VA catchment area
- Has achieved clinical goals
- Non-adherent to daily participation (<70% responding for 90 days)
- Is not expressing interest in improving self-management of their chronic disease
- Is significantly abusing substances and not verbalizing or making plans to get help
- Becomes a danger to themselves or others
- Needs exceed program services
- Is out of the home or service areas for 30 days or more
- At the request of the healthcare provider
- Deceased

10.12 Re-enrollment

For any re-enrollments, new initial assessment and treatment plan must be completed. This is necessary to ensure that associated clinical reminders built into the templates will function as planned. An addendum to prior enrollment notes after an "official discharge" (a discharge that was completed using the templates) will not trigger any of the clinical reminders on the re-enrollment.

10.13 Patient Participation

VHA Office of Connected Care expects that Home Telehealth programs achieve a minimum 70% response rate consistently from each patient on their assigned technology. A patient who does not respond at least 70% of the time over a three month period must be categorized as Health Promotion Disease Prevention (HPDP) or disenrolled from the program. Although select individual patients may not be expected to achieve a 70% response rate, there must be clear documentation in the EMR of the reason(s) an alternate plan of care is being utilized and listing specific benefit(s) the patient derives from the alternative plan. These patients must be categorized as HPDP if they are retained in the HT program.

11. Patient and Caregiver Self-Management Education

The level of independence that Veterans can achieve is directly related to their ability to successfully self-manage their health conditions. The Home Telehealth model of care is a Veteran centric model that recognizes the importance of caregivers in keeping Veterans as independent as possible for as long as possible. Home Telehealth follows the principles of patient-centered care. According to the Office of Patient Centered Care and Cultural Transformation- Patient Centered Care is a system that prioritizes the Veteran and their values, and partners with them to create a personalized, proactive strategy to optimize health and well-being. Patient-centered care is a strategic priority.

11.1 VA Health Care Delivery

A VHA Strategic Goal is to provide Veterans personalized, proactive, and patient-driven health care. (VHA 2013 – 2018 Strategic Plan)

VA health care providers collaborate with HT programs and Veterans to create a personalized, proactive strategy to optimize health and well-being, while providing state-of-the art disease management.

There are many benefits to using HT. Among those is that HT can move the site of care for patients with chronic diseases from hospitals into the home. HT may be particularly beneficial for the frail elderly who have mobility limitations and diminished access to transportation.

Benefits of Home Telehealth for families:

- Improves ability to remain in their own home
- Empowerment to manage their own health needs
- Increased emotional support from their healthcare team
- A greater sense of access and security with their health status
- A decrease in healthcare costs while maintaining a high satisfaction with healthcare
- Proactive care in preventing healthcare crises

Benefits of Home Telehealth for Caregivers:

- Having their loved one at home for as long as possible
- Empowered to address their own needs to support care of their loved one
- Increased emotional support from their loved ones' healthcare team
- A greater sense of access and security for their questions

11.2 Patient Self-Management

Office of Connected Care was the national lead in 2006 for helping develop VHA's approach to patient self-management. Office of Connected Care, with the help of experts in the field,

developed a national campaign to raise awareness about the importance of self-management. This campaign coined the phrase “My Life, My Health, My Choices.”

My Life, My Health, My Choices

Office of Connected Care developed a national definition, educational resources for clinicians and patients and a clearinghouse for outreach materials. The Office of Connected Care believes patient self-management skill building within HT programs is a valuable tool that provides the framework and tools for our Veterans with chronic diseases to be active, informed and successful partners with VA Healthcare Professionals.

Self-Management:

- Fosters independence and increases the Veterans' sense of safety and comfort.
- Increases the Veterans' ability to make informed choices, accepting responsibility for his/her own actions/behaviors, which improves adherence to treatment plans that they helped to formulate.
- Provides assistance to the health care team in meeting the Veterans' goals.
- Improves access to care for Veterans by keeping the patient as well as possible-utilizing consistent monitoring through Home Telehealth and assessment to minimize/prevent chronic disease exacerbations and complications- reducing the demand for acute care services on the health care system.
- Decreases utilization of high cost acute episodes of care (thereby reducing the cost of health care for these patients).
- Improves Veteran and staff satisfaction by: increasing consensus on treatment goals and treatment plans, making them collaborative and much more likely to be complied with – improving the Veteran's health.
- Improves access to care for patients when they really need it.

11.2.1 Clinician Definition

Patient Self-management enables the individual to partner in an on-going trusting relationship with the healthcare team in activities and programs to:

- Understand, actively participate and take responsibility for his/her condition(s)
- Work together on an individualized treatment plan with the provider which takes into account the identified needs/goals and preferences of the patient, caregiver/family & healthcare team
- Develop and enhance skills and use resources that support adapting and living with acute and chronic problem(s) as well as protecting and promoting health and quality of life

11.2.2 Patient Definition (As written for use with patients)

Patient Self-management allows you, your caregiver/family and healthcare team to work together to:

- Learn about your condition(s)

- Learn how you and your family can help
- Learn what skills you need
- Learn what help and resources are available
- Learn what you can do
- Improve access to your healthcare team
- Help you do what you want and need for your health and life

The Patient Self-Management Tool Kit will provide resources to support clinicians and managers in implementing or further developing patient self-management activities in the home, community, Veterans Affairs Medical Centers and outpatient clinics, to improve the health of Veteran patients and their experience with the VA health care system. This guide will be updated as new materials and tools become available.

12. Workload Capture and Data Management

12.1 Coding and Workload Credit

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

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

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

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

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

12.2 Completing the Encounter Information

Encounters occur in the outpatient setting and are captured via Patient Care Encounter (PCE) software. An encounter is a professional contact between a patient and a health care provider vested with responsibility for diagnosing, evaluating and treating the patient's

condition. Contact can include face-to-face interactions or those accomplished via telecommunications technology.

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

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

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

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

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

The monthly note is known as the 'Home Telehealth Monthly Monitor' or Summary of Episode Note. This is sometimes referred to as the 683, the DSS primary stop code. The 683 note is not intended for use as a clinical summary note. Optimally it is entered monthly starting with the month of enrollment and ending with the month of discharge. In the event the Veteran is not able/or is not responding, or partially responding to the DMP, the Care Coordinator must determine if this note should be completed for that month as the note documents response to technology and data monitoring for the month.

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

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

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

12.3 Veterans Equitable Resource Allocation (VERA) for Home Telehealth

In FY 2010, two new VERA patient classifications were added for HT (notated as CCHT in VERA literature). One is for patients enrolled in the Chronic Care Management (CCM) Category of Care, and the other classification is for the Non-Institutional Care (NIC) Category of Care. Detailed specifics of the VERA Patient Classification Criteria can be found in the VERA Patient Classification Manual on the Allocation Resource Center Website.

Data validation is essential in assuring that qualified workload is captured for performance targets, outcomes evaluation and VERA capture. Various reports are available to assist the field in tracking progress towards meeting targets and identifying coding and workload capture errors. To access data on VERA, select the Allocation Resource Center (ARC) link found in the Resource section.

13. Quality Management

13.1 Conditions of Participation

VHA Office of Connected Care is responsible for an internal accreditation process for the Quality Management of all Telehealth programs in the VHA. The standards utilized for Telehealth programs are known as the Conditions of Participation (COP). The COPs reflect the clinical, business and technology processes essential to the safe and effective provision of care. They are required for all Telehealth programs operating within VHA, including HT programs.

VHA Office of Connected Care uses a uniform process to facilitate the development, approval and internal certification or designation of Telehealth programs using the COPs as the core component. This designation process requires a successful review utilizing a combination of: interviews with key staff members at all levels of the network; review of relevant performance improvement and other data and documentation; and use of tracer methodology where appropriate. This designation is officially granted when the VISN completes all requirements for improvements, if any, documented in the COP report. It is important to note that Core Telehealth COPs apply to all Telehealth programs.

A COP review process is conducted via periodic VISN-wide site visits and reviews (about every two years) by VHA Office of Connected Care Quality Team. In addition, the Quality Team provides consultation and linkage to both field and system expertise to assist in this rapidly changing area of patient centered care. The designation process is essential for any model or application of Home Telehealth implemented, regardless of organizational alignment. With each cycle of VISN COP reviews, the requirements for conformance with the COPs are successively escalated and, in some cases, additional COP elements are added as needed.

The internal accreditation process using the COP has been thoroughly reviewed with The Joint Commission and they are familiar with the process VHA Office of Connected Care utilizes for Quality Management of Telehealth programs. The COPs are meant to ensure high quality, safe programs and prepare the staff for any other kind of survey, including The Joint Commission.

13.1.1 External Accreditation

The Joint Commission and other external accrediting bodies may review some or all components of HT programs in the course of their surveys, using their usual review processes. Home Telehealth programs are surveyed by The Joint Commission where they are organizationally aligned. Home Telehealth patients might be identified during a typical tracer activity during a survey of any type. Tracer Methodology, as utilized by The Joint Commission is a system that involves surveyors actually 'tracing' a patient from their entry to care through the continuum of care to ensure adequate communication and safety measures necessary for quality outcomes are in place. This Joint Commission tracer

activity may lead to review of any aspect of the HT program including, but not limited to: privacy/confidentiality, infection control practices, clinical documentation, orientation/training/competency, performance improvement, etc. However there are no separate or focused reviews of Telehealth programs and there are no separate Joint Commission standards for HT.

13.2 Process and Performance Improvement

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

The idea of improving product and service delivery has a long history. Some process improvement models have endured because of their proven success. However, not all of these methods employ the same approach or involve exactly the same steps. Some of the more successful approaches include Toyota's production management system, 'Lean Thinking' and the well- known Six Sigma quality system. In VHA, the Total Quality Management approach to performance improvement along with the use of the 'Plan-Do-Study-Act' (PDSA) or 'Plan-Do-Check-Act' (PDCA) framework for continuous quality improvement has been utilized for several years. VHA uses the Vision-Analysis-Team-Aim-Map-Measure-Change-Sustain (VA-TAMMCS). More information on this method can be found at: VATAMMCS outline.

Here is an example of the PDCA/PDSA format:

PLAN Each Care Coordinator will track and trend changes in weight for loss & gain.

DO All Care Coordinators will track A1C results from the EMR quarterly for each diabetic patient during the 90-day summary note, data will be posted to the HT data management tracking spread sheet as utilized by the program.

CHECK/STUDY All Care Coordinators will review trend data for patterns and send copy to provider and Veteran.

ACT Based upon above outcome data, determine if HT program practice change needs to happen; and share outcome results with providers, PACT, Leadership at least once during the fiscal year.

VHA has made tremendous efforts to promote systematic, practical process and performance improvement using these approaches. It has been noted in literature that programs following a systematic process greatly increase their chances for successful systems redesign and performance improvement. The COPs require that each VISN identify, require and monitor core quality and performance indicators for all HT programs.

These indicators might be designed for a variety of clinical, business or technology areas related to HT including, but not limited to, aspects of utilization, access, clinical outcomes, cost, quality of life, patient satisfaction, functional status, or provider satisfaction.

Whenever possible, indicators should be collected from data that are electronically available for review and tracking. Utilizing data from the performance improvement process, each program should communicate program experiences to program staff and others as appropriate, identifying opportunities for improvement and developing action plans, as necessary, to assure continuous program improvement. Utilization of the same indicators across similar HT programs with a VISN would provide the ability to compare and benchmark results. Use of a VISN-level score card for reporting of performance data and outcomes is highly recommended.

Suggested topics for continuous performance improvement initiatives include:

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

Once data is collected, the data must be aggregated and analyzed. Various statistical evaluations can be used from very simple to complex analysis to determine significance

and outliers. Once outliers have been identified then a plan of action must be developed. The plan of action must incorporate these elements to be successful:

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

13.3 Documentation/Process of Care Documentation Audit

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

Care Coordinator peer review general information:

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

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

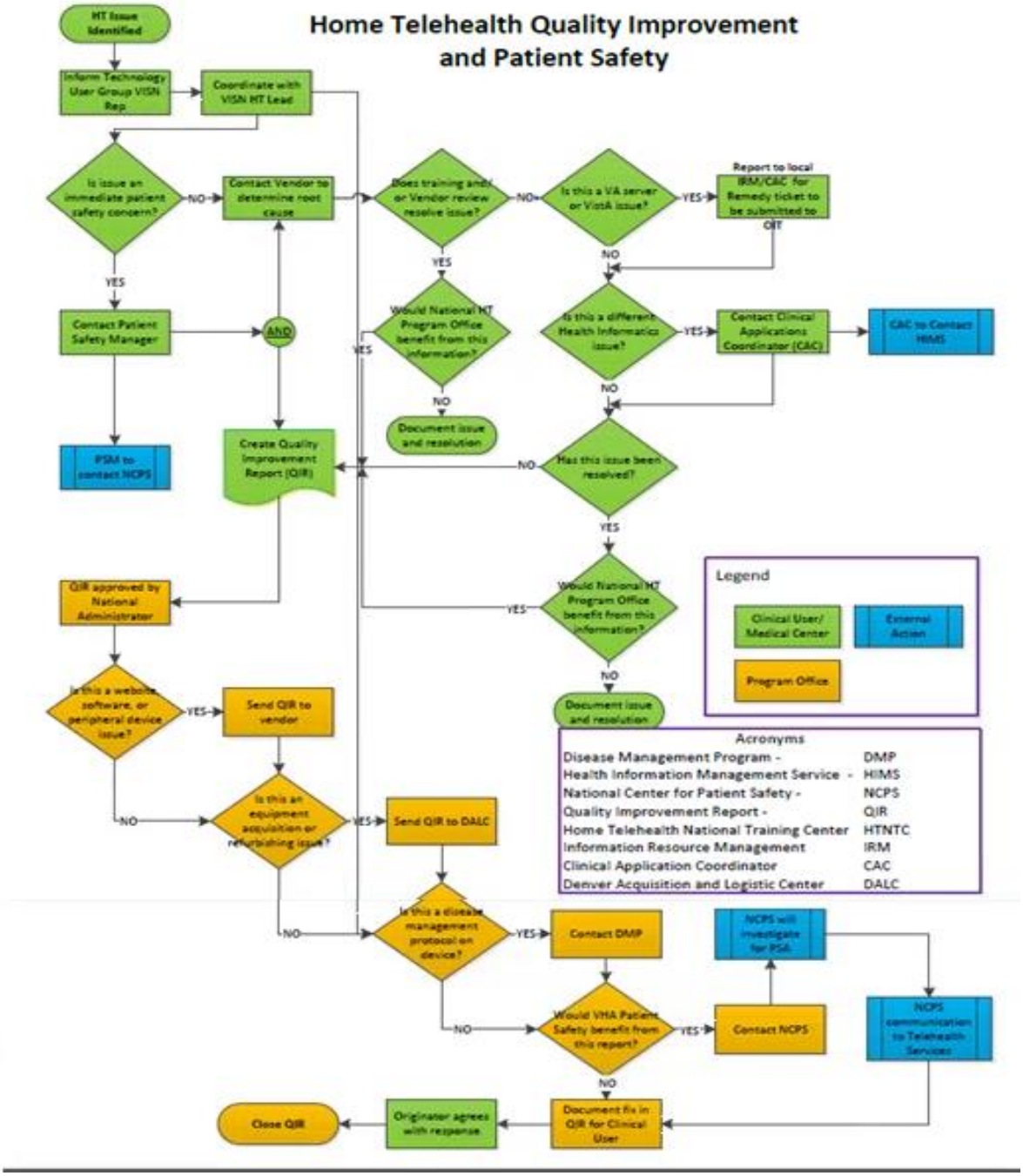
13.4 Quality Improvement Report (QIR) Process

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

The QIR is submitted through the Integrated Home Telehealth Application (IHTA) to the National QIR administrator, who in turn sends it to the vendor when appropriate. The vendor must respond within 7 days and indicate plans for correction. The IHTA is fully automated and the Home Telehealth staff are able to review the history and progress of HT vendor issues via a centralized database.

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

Figure 3: Home Telehealth Quality Improvement and Patient Safety



14. Risk Management

The HT program is not an emergent or urgent care program. Veteran data is not expected to be reviewed over a weekend or holidays. It is designed to provide case management and chronic disease management. With that being said, the following are some important patient safety considerations for planning and operating Home Telehealth Programs and should be communicated to patients:

- Emergency procedures should be thoroughly documented and locally available. All Home Telehealth staff should be familiar with local procedures including those for Mental Health.

- In the preparation for the need of emergency care, Home Telehealth staff should educate patients upon enrollment on disaster planning and to contact 911 or other local emergency services and to not use the HT program as an emergency service provider. Staff should also inform patients that VA does not guarantee payment for non-VA Emergency care and to contact an eligibility specialist for details for emergent care coverage.

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

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

Level 1 (High Priority)-Needs immediate evaluation (select all that apply)

Veteran lives alone with cognitive impairment, psychological diagnosis with possibility of decompensation related to disaster and/or unable to access resources.

Veteran is on life support, oxygen or ventilator-dependent.

Veteran with caregiver that is low functioning, cognitively impaired and cannot access resources.

Veteran is dependent for assistance with medication management and/or unable to self-administer insulin or is unstable on coumadin.

Interruption of health services would severely impact Veteran's ability to meet basic physiological and safety needs.

Level 2 (Moderate Priority)-Needs to be evaluated within 3-7 days (select all that apply)

Veteran is able to manage for 3-7 days without HT intervention.

Veteran is unable to carry out medical plan of care independently for more than 3-7 days.

Phone call required if Veteran is dependent on HT for medication refills.

Level 3 (Low Priority)-Can go 7-14 days without Home Telehealth intervention (select all that apply)

Veteran has physical, emotional and local resources and is able to access these.

Veteran has a caregiver that is not cognitively or physically impaired.

Veteran has friends or family able to assist with accessing resources.

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

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

15. Information Outreach

As a basic principle, information outreach is about means of communication. Information outreach strategies, though varied, are all aimed at convincing people to use particular products or services. Home Telehealth program leadership should plan their information outreach strategies and performance to keep their stakeholders aware of the value of HT to Veterans.

Development of partnerships is a fundamental strength and challenge of the HT program. By its nature, HT can reduce workload and stretch limited health care resources, thus potentially increasing the need for collaborations within VA health care entities. Additionally, through cooperative efforts with local Veteran organizations the program can be promoted to potential Veterans in need of service. One significant advantage of Home Telehealth is the potential for improving access to care while unburdening the workload of PACT staff.

VA partners for consideration:

- **Healthcare partners**
  - Patient Aligned Care Teams (PACT)
  - Local specialists (i.e., Cardiology, Neurology, etc.)
  - Mental Health & Social Work Leadership
  - Diabetic Educators
  - Operations Enduring Freedom/Operations Iraqi Freedom Program Managers
  - Suicide Prevention Coordinators
  - Women Veteran Program Managers (WVPM)
  - Caregiver Support
- **Veteran Service Organizations and other partners**
  - American Legion
  - Veterans of Foreign Wars
  - Disabled American Veterans
  - State and local Veterans agencies and organizations
  - local VSO (Veterans Service Officer)
  - local Voluntary Service staff
  - local social services offices/public health office
  - local charitable organizations
  - National Alliance for the Mentally Ill
  - 211, United Way Helpline

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

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

Appendix A: Resources and Links

The Following Links Will Direct You to Related Resources

Table 1: Resources and Links

Resource	Link
Clinic Reminders and Dialogs This document releases new national reminders, reminder dialogs, and TIU progress note titles that will be used by Care Coordinators managing patients enrolled in HT programs.	https://vaww.infoshare.va.gov/sites/telehealth/docs/ht-rmd-usrgd.docx
Conditions of Participation This is a tool developed by VHA Telehealth Service's Quality Management team to assist VISNs a step by step process and list of criteria to evaluate and assure safe, effective Veteran care.	http://vaww.infoshare.va.gov/sites/telehealth/docs/Forms/cop.aspx
Continuum of Care and Categories of Care Guidance These tools include the actual Continuum of Care Form (CCF) that is completed on every Home Telehealth patient and the guidance document that explains each of the forms sections as well as the definition of each Home Telehealth Category of Care.	http://vaww.infoshare.va.gov/sites/telehealth/docs/ccf-coc.docx
Documentation Review Tool This tool is to assist in the peer performance.	http://vaww.infoshare.va.gov/sites/telehealth/docs/ht-doc-rvw-tl.xlsx
Enrollment Agreement This document provides documentation for the required verbal consent in Home Telehealth.	http://vaww.infoshare.va.gov/sites/telehealth/docs/ht-ec-agrmnt.docx
Facility Telehealth Coordinator Competencies This document assists in providing guidance on the skills and knowledge component of the Facility Telehealth Coordinator (FTC) position.	http://vaww.telehealth.va.gov/roles/ftc/index.asp
FAQ for the use of LPNs in HT Frequently Asked Questions about the use of LPN's in Home Telehealth.	http://vaww.infoshare.va.gov/sites/telehealth/docs/ht-lpn-faq.doc
Home Telehealth National TeleMental Health User Manual This guide provides HT staff with helpful information for promoting HT to mental health provides and on managing mental health patients within HT.	http://vaww.infoshare.va.gov/sites/telehealth/docs/ht-htmh-usrgd.docx
Home Telehealth VistA Integration Toolkit Health Level 7 International (HL7) provides a comprehensive framework and related standards for the electronic health information that supports clinical practice in hospital systems. More information can be found here.	http://vaww.va.gov/techsvc/projects/HomeTelehealth_Toolkit.asp
National Guidance to Ensure Continuity of Operations for Home Telehealth	http://vaww.infoshare.va.gov/sites/telehealth/docs/ht-ncg-emg.doc

Resource	Link
Document Created by the VHA Office of Connected Care, Washington DC, in Consultation with the Home Telehealth Emergency and Disaster Planning Ad Hoc Committee.	
PACT Whitepaper 2012 This document reviews the history and the need for primary care and mental health teams to interact with HT programs to improve patient outcomes.	http://vaww.infoshare.va.gov/sites/telehealth/docs/ht-pact-id-wp.docx
Pain Management Toolkit This toolkit provides strategies for pain management.	
Patient Participation Guidance A toolkit for successfully managing non-responders and the national guidance document that defines what non-response is and procedures for follow-up	http://vaww.infoshare.va.gov/sites/telehealth/docs/ht-pp-gdnce.docx
Patient Self-Management Tool Kit A guide to implement and promote Self-Management skill building for Veterans.	http://vaww.infoshare.va.gov/sites/telehealth/docs/patpart-tk.docx
ROES User Guide The Home Telehealth ROES user guide provides information and instructions to employees of VHA ordering and tracking Home Telehealth devices.	http://vaww.infoshare.va.gov/sites/telehealth/docs/roes-usr-gde.docx
SUD DMP Brochure This brochure provides a brief glimpse of the 27 day Substance Use Disorder DMP to help both the clinician as well as the Veteran understand the purpose of the program as well as what to expect each and every day.	http://vaww.infoshare.va.gov/sites/telehealth/docs/SUD_DMP_Br.pdf
SUD DMP workbook This workbook was created by the field to support the tremendous amount of work the Veteran is asked to do in the SUD DMP.	http://vaww.infoshare.va.gov/sites/telehealth/docs/SUDWkbk.docx
Technology Algorithm Used to determine best fiscally responsible type of technology to assign based on specific Veteran need.	http://vaww.infoshare.va.gov/sites/telehealth/docs/ht-tchgrd-algthm.xls
Telehealth Reports Guide A guide to help staff get data reports, review "help" documents and review data definitions.	https://securereports2.vssc.med.va.gov/Reports/Pages/Report.aspx?ItemPath=%2fTeleHealth%2fTelehealthGuide&ViewMode=Detail
TeleMOVE! Manual Supplement This Supplement provides standard guidance to implement and monitor quality of delivering care to Veterans via telehealth technology.	http://vaww.infoshare.va.gov/sites/telehealth/docs/tmove-spp.pdf
Patient Participation Toolkit – June 2012 A policy to guide the HT community on patient participation in the HT program.	http://vaww.infoshare.va.gov/sites/telehealth/docs/ht-nrspndr-tlkt.docx
VHA Case Management Standards of Practice 2013	http://vaww.infoshare.va.gov/site

Resource	Link
This Veterans Health Administration (VHA) Handbook establishes procedures and identifies standards of practice for a collaborative Department of Veterans Affairs (VA) patient case management model.	s/telehealth/docs/ht-cmhb.pdf

Appendix B: Acronyms

Table 2: Table of Acronyms

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

Acronym	Description
MTBI	Mild Traumatic Brain Injury
MSA	Medical Support Assistants
NIC	Non-institutional Care
NCPS	National Center for Patient Safety
NPCD	National Patient Care Database
OI&T	Office of Information and Technology
OCC	Office of Connected Care
PACT	Patient-Aligned Care Team
PCE	Patient Care Encounter
PCP	Primary Care Physician
PCTOC	Primary Care Telehealth Outreach Clinics
PDCA	Plan-Do-Check-Act
PDSA	Plan-Do-Study-Act
POTS	Plain Old Telephone Service
PTSD	Post-Traumatic Stress Disorder
QIR	Quality Improvement Report
RN	Registered Nurse
RNCM	RN Case Managers
RME	Reusable Medical Equipment
ROES	Remote Order Entry System
SCAN-ECHO	Specialty Care Access Network - Extension for Community Healthcare Outcomes
SCI	Spinal Cord Injury
SFT	Store-and-Forward Telehealth
SMART	Simple and Specific, Measureable, Achievable and Attainable, Relevant and Realistic and Timely
SME	Subject Matter Expert
SOP	Standard Operating Procedures
SUD	Substance Use Disorder
SW	Social Worker
TCT	Telehealth Clinical Technician
TMS	Talent Management System
TSA	Office of Connected Care Agreement
TSS	Telehealth Scheduling System
TUG	Technology User Group
VA	Veterans Affairs
VACO	Veterans Affairs Central Office
VAMC	Veterans Affairs Medical Center
VA-TAMMCS	Vision Analysis - Team, Aim, Map, Measure, Change, and Sustain

Acronym	Description
VERA	Veteran's Equitable Resource Allocation
VHA	Veterans Health Administration
VISN	Veteran Integrated Service Network
VSSC	Veterans Support Service Center

Appendix C: Endorsement of Home Telehealth Operations Manual

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

Cathy Buck

March 8, 2018

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Date