VA MEDICAL CENTER
Location

Service name POLICY MEMORANDUM
NO…….……# Date

Name of Project/Program

I. PURPOSE:

To establish policy, responsibility, and procedures for the (name of program/project).

II. POLICY:

(name of program/project) utilizes a seamless interdisciplinary approach to coordinating care across all settings, episodes of illness and at the appropriate level of care. Care coordination involves a process of needs identification and service coordination designed to maximize function and independence while also recognizing an individuals right to self-determination. The fundamental components of care coordination are screening, assessment, care planning, implementation, monitoring and evaluation.

III. RESPONSIBILITY:

(Program/project name) is under the direction of the (who) for (Service name). The (who) is responsible for the daily operation of the program including training of staff and patients in the use of telehealth equipment.

IV. PROCEDURE:

A. Eligibility for (program/project name): All patients and caregivers as applicable will be assessed for enrollment in the program/project. The following criteria are considered in selecting patients:

1. Have chronic conditions, including but not limited to, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes mellitus (DM), hypertension (HTN), and conditions such that technology and care coordination could improve resource utilization and clinical outcomes.

2. Receives home infusion therapy or needs palliative care due to terminal illness.

3. Has a wound (surgical, vascular or pressure) that requires care.

4. Requires more than one nursing home visit per week due to severity of illness and need for monitoring, management or education.

5. Patients will have had two (2) or more hospital admissions or emergency room visits in the preceding fiscal year.

6. Will be enrolled in a Primary Care Clinic with greater than fourteen (14) outpatient visits in the preceding fiscal year.

7. Have greater than ten (10) active medication prescriptions.

8. The home environment is such that daily care and medical problems can be managed in the home. Access to utilities and safety concerns are addressed for appropriate installation of equipment.

9. The patient and caregiver accept the technology in the home.

10. The patient and caregiver demonstrate competency in using and maintaining telehealth equipment.

11. Other circumstances that may improve quality of life and improve clinical outcomes.

B. Exclusion criteria:

1. Is unwilling or unable to give consent.
2. Is unwilling or unable to operate telehealth equipment.
3. Is uncooperative or combative.
4. Does not have a compatible phone line.
5. Does not have a history of non-compliance or behaviors such as active substance use that might impact on the safety of staff and equipment in the home.

C. Referrals: Referrals to the (program/project name) will be accepted from both inpatient and outpatient settings and by any clinical staff. Referrals should be sent via electronic consult to (program/project name). Referrals will be answered within seven (7) working days from referral request date.

D. Initiation of care: The following criteria will be used to enroll new patients into the (Program/ Project):

1. Informed written consent will be obtained from the patient or caregiver before initiation of the technology.

2. A baseline survey for assessing function and well-being will be administered at the start of the project and at designated intervals during the project.

3. A patient telehealth satisfaction questionnaire will be administered at appropriate intervals after the start of the project for each patient.

4. An initial home or office visit will be done to conduct an initial assessment and to review installation and instruction of equipment.

5. During the home or office visit, an assessment will be conducted to determine access to utilities and address any safety issues related to installation of equipment.

6. During the home or office visit, patients and/or caregivers will demonstrate competency in equipment use and maintenance.

7. Audio/video visits and telephone calls may be provided when needed by physicians, nurse practitioners, registered nurses, social workers, rehab therapists, dietitians or others within the scope of practice of the interdisciplinary team.

8. Patients and/or caregivers will be given instructions on whom to call in case of an emergency.

D. Coordination of Care: Care coordination is provided to ensure the implementation of program/project goals, to avoid duplication of services, and to ensure continuity of care in the event of consultation with other professionals, admission to the hospital or discharge to other levels of care settings.

1. Informal communication with the primary care providers as needed, will be utilized through the computerized patient record system (CPRS), e-mail, and phone contacts as appropriate. In addition, a an updated progress note or quarterly note will be generated to communicate to the primary care providers the patient's progress in the program.

2. Will collaborate with the primary care team regarding changes in a patient's condition as needed through telephone, visit notes, and a view alert on progress note.

3. Audio/video visits and other services provided by the (program/project team) will be entered into the computerized patient record system (CPRS). The base station will be located in a secure office. Access to the online software will be by password to protect patient confidentiality.

4. Home visits, office visits, and video technology visits will be scheduled by the (project/program staff) according to the needs of patients.

5. If a patient is admitted to the hospital, the (program/project staff) will follow the course of hospitalization and follow up after discharge as appropriate.

6. In the event of a natural disaster that causes power failure, all patients will have (discuss back-up plan for equipment used). After this time, if power is not restored, patients will be contacted by phone until the power is restored to the appliance. For audio/video telehealth equipment, in the event of power failure, all patients will be contacted by phone until power is restored.

E. Accessibility: The (program/project name) office is open from 7:30am to 4:30pm, Monday to Friday. During the administrative workweek, patients and caregivers can call the program office for questions or problems. On off-tours, weekends, and holidays, patients and caregivers are instructed to call the after hours Telecare Line. Staff will at that time determine if evaluation is indicated. Emergencies are to be referred to 911 as appropriate.

F. Discharge: (program/project name) may be terminated when:

1. The patient is admitted to a nursing home setting as a long-term or permanent placement.

2. The patient/caregiver no longer wish to participate in the project.

3. The patient has permanently relocated outside of (VA catchment area)

4. The patient has achieved clinical goals.

When (program/project) services are terminated, the equipment will be retrieved at that time and patient satisfaction, self-efficacy, and function will be assessed as appropriate. The summary of care and recommendations for further intervention will be incorporated into the medical record.

G. Safety Management: Staff members will follow established guidelines and practice safety procedures and regulations of the (name) VA medical center. Patient and caregiver safety will be a priority during planning and implementation of care. Staff will participate in programs and inservices regarding safety by (name) VA medical center and will use professional assessment skills and good judgement in all work-related activities.

1. Patient Safety: The initial assessment will include patient and caregiver safety in the home. Include in written patient material will be safety and appropriate use of equipment.

   a. Patient accidents/incidents will be reported to the primary provider and the risk management team, and documented as appropriate. Incident reports will be completed per (name) VA medical center protocol.

   b. Patient accident/incidents, which must be reported as required by State statute, to the State Department of Children and Family Services abuse hotline, include patient abuse, neglect, and living conditions which place the patient in imminent danger. The primary care social worker will be notified of any reports made. The report will be documented as required by medical center policy.

2. Staff Safety: All accidents/incidents involving employees will be reported as soon as possible to the immediate supervisor and employee health.

   a. Staff will contact the patient/caregiver prior to making the initial home visit, and schedule at a mutually convenient time.

   b. The (project/program staff) will assess if the neighborhood or house appears unsafe. If uncomfortable with the situation, the appointment may be rescheduled, and two staff members return together at a later date/time. Patient/caregiver will be notified of delay.

   c. The (staff) will always be notified of planned home visits and visits will be scheduled during daylight hours.

   d. Staff members will not enter a home unless invited to do so

by the patient or caregiver. Should a problem be encountered, the visit will not be made. The patient will be contacted as to their intentions regarding program inclusion.

e. Staff will keep cell phones on at all times while in the field.

f. Staff will drive a government vehicle safely, wear seatbelts and keep doors locked.

V. OTHER

None

VI. REFERENCES:

VHA Directive 2002-042: The Credentialing and Privileging of VHA Health Care Providers Remotely Delivering Health Care to Patients at Home, in Vet Centers, and in Non-health Care Settings via Telemedicine and/or Telehealth

American Telemedicine Association: Telehomecare Clinical Guidelines

American Geriatrics Society (2000). Care Management Position Statement.

VII. FOLLOW-UP RESPONSIBILITY:

(name of supervising person and Service)

VIII. RECISSION

This (Service) Policy Memorandum will remain in effected until rescinded.