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**Evaluation of an Educational Training on Telehealth Utilization Rates and Hospital
Readmissions in a Home Health Setting**

by


Gabrielle A. Coomer

Paper submitted in partial fulfillment of the
requirements for the degree of

Doctor of Nursing Practice

School of Nursing, University of Louisville

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Dedication

I want to dedicate this manuscript to my loving husband, Dustin, for his patience and continued support throughout this program. To my mother, Jamie, and mother-in-law Margaret, for being great listeners through all my frustrations and always encouraging me to continue.

Finally, I dedicate this manuscript to my late father, Joey, and grandfather, Billy, for encouraging me to become a nurse practitioner. I hope I have made you all proud and will always think of you in everything I do. Thank you all for your support.

Acknowledgments

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Abstract

Background: Hospital readmissions are on the rise and continue to be a concern within healthcare due to their effects on the quality of care and healthcare costs. Telehealth strategies have been utilized across healthcare settings to improve hospital readmission rates.

Purpose: The purpose of this project was to evaluate the effectiveness of a telehealth training program in increasing telehealth utilization rates and reducing the acute care hospitalization rate within a single home health agency.

Intervention: A 30-minute PowerPoint presentation on the definition of telehealth, goals, and benefits of telehealth, patient eligibility, special considerations for clinicians, billing and coding guidelines, documentation requirements, discussion with patients on telehealth usage, role-playing exercises, and a mock telehealth visit was conducted for all field clinicians after the mandatory patient care conference. Following the education session, an eight-month evaluation was completed to compare telehealth enrollment, utilization, and hospital readmission rates before and after the training.

Results: Telehealth enrollment significantly increased over the eight-month evaluation period, indicated by an increase from zero to 39 patients enrolled. The 60-day ACH rate decreased from 25.4% to 14.2% during the evaluation period, reaching statistical significance ($p < .001$)

Discussion: Implementing telehealth training is an effective way to increase telehealth utilization rates and decrease ACH rates within a home health setting.

Keywords: home health, telehealth, telehealth training, hospitalizations

Evaluation of an Educational Training on Telehealth Utilization Rates and Hospital Readmissions in a Home Health Setting

Hospital readmissions are on the rise and continue to be a concern within healthcare due to their effects on the quality of care and healthcare costs (Weiss et al., 2021). In 2018, there were 3.8 million readmissions within 30 days of hospital discharge, with Medicare being the leading payer of hospital readmissions. There were 2,290,100 readmissions that Medicare paid for, averaging \$15,500 per admission (Weiss et al., 2021). The top five reasons for readmission included sepsis, heart failure, diabetes mellitus, chronic obstructive pulmonary disease, and pneumonia (Weiss et al., 2021). Patients with these illnesses are commonly seen in the home health setting, with many patients suffering from multiple comorbidities. These are often the same patients who have a hospital readmission after beginning home health services.

Background

Hospital readmissions are a significant issue in healthcare. Medicare is the biggest payer of home health care and has recently changed its reimbursement model to the home health value-based purchasing model. According to the Centers for Medicare & Medicaid Services (CMS), the purpose of this model is to "support greater quality and care efficiency in Medicare-certified home health agencies" (2021). The incentive-based model reimburses home health agencies based on the quality of care. One of the outcomes measured is acute care hospitalizations (ACH). Home health agencies are reimbursed based on their rates of hospital readmissions, with lower ACH rates indicating higher reimbursement. In addition, the ACH rate is a Centers for Medicare and Medicaid quality measure, which is publicly accessible. Patients wishing to receive home health services can access this information when determining which agency to choose. High hospitalization rates may deter patients from the agency, thereby decreasing profits. Decreasing

hospital readmissions is, therefore, a top priority for this agency to ensure adequate reimbursement.

A review of hospitalization data from a single home health agency found the following results. The all-cause ACH rate between January 2023 and July 2023 was 25.4%. Of these patients, 23% of them were Medicare recipients. The primary reasons for hospitalization were congestive heart failure, respiratory infections, urinary tract infections, and skin infections. Home health national data from CMS indicates that the national average of ACH in home health is 14.2%, indicating the need for improvement within this office. Telehealth was introduced in the agency after the COVID-19 pandemic to supplement in-person visits, particularly for high-risk patients. The technology is available via the Microsoft Bookings app within this agency; however, a discussion with the agency's Director of Operations showed that telehealth visits were not being utilized. Specifically, this agency is the only office within the seven-office region not using telehealth, with zero percent of patients enrolled at admission as of July 2023. Further discussion with the Director highlighted the need for a formal telehealth training program for clinicians at this agency. Discussions with the staff at the agency highlighted the following reasons for not using telehealth: lack of understanding of patient enrollment, confusion on using the Microsoft Bookings app, lack of internet connections, poor patient understanding of telehealth's purpose, and lack of knowledge of how to communicate with elderly adults. These discussions provided the basis for this project.

Purpose and Specific Aims

Evidence has shown that telehealth can be an effective tool to help reduce hospital readmission rates in various settings. The purpose of this project was to evaluate the effectiveness of a telehealth training program in reducing the acute care hospitalization rate

within a single home health agency. The first aim was to compare the number of patients enrolled in telehealth at admission before the telehealth training and during the evaluation post-training. The second aim was to compare the number of telehealth visits made by clinicians after enrollment before and after the telehealth training.

Conceptual Framework

This program evaluation project was guided by the “ADKAR” model of change developed by Jeffrey Hiatt (Woods, 2023). The Acronym ADKAR stands for the five outcomes needed for successful change: awareness, desire, knowledge, ability, and reinforcement, and is centered on the idea that successful change can only happen when individuals within the company change (Woods, 2023). The first step is creating awareness of the need to change and communicating the need with stakeholders and individuals directly involved. A vital component is allowing open dialogue between everyone involved to ask questions and share experiences around the specific need for change. Awareness for this evaluation project was established early on by providing information on the importance of telehealth and statistics regarding current telehealth and hospitalization trends within the care center. All staff members were included in this discussion.

The second step is creating the desire to want to change. People do not respond well and lack the desire to change when they feel forced to change. By setting up the platform for dialogue in the previous phase and regularly following up, employees feel more involved in the process and are more likely to want to change when their voice is heard.

The third component of the model is providing knowledge on how to make change through education and training. This training considered the responsibilities of all involved team members and provided information on the tools, skills, and processes needed to implement new

change while also considering the time required for the change. This step was crucial for this evaluation process and involved the actual telehealth training provided to the staff.

The fourth component of this model centers around the ability of staff members to perform a specific task and have confidence in their ability to perform the designated task. This process involves evaluating ongoing performance and offering guidance based on feedback, including potential obstacles. This change aspect occurred during phase two of the project, which was the evaluation of telehealth utilization and hospital admission rates within the care center.

This model's fifth and final component is reinforcing the new process. It is essential to maintain ongoing enthusiasm and desire for the recent change. During this stage, feedback from staff is still considered valuable to ensure the long-term success of the implemented change. The reinforcement component was ongoing throughout this project. However, it was an essential component during phase two of the project, looking at the long-term future of the program implementation. Figure 1 illustrates the five components of the ADKAR model and their relationship to the stages of change.

Review of Literature

Hospital stays affect patients, families, healthcare workers, and health systems in various ways. Frequently hospitalized patients have higher stress levels, anxiety, loss of function, and depression (Alzahrani, 2021). Patients often decline because of multiple hospital stays, increasing morbidity and mortality. Current literature supports using telehealth interventions to address hospital readmissions across various settings. Despite the success of telehealth interventions, there remains a lack of research regarding telehealth in the home health setting, specifically within the last five years. Due to this, the date range for this literature review was extended to the previous ten years.

Specific telehealth interventions identified within the literature include video/audio technology, telemonitoring devices, and interactive voice calls. Telemonitoring was used in multiple studies and included monitoring devices such as a blood pressure cuff, scale, pulse oximeter, and medication dispenser (Liang et al., 2021; Lelli et al., 2019; Long et al., 2017; Seto et al., 2012). Patients use the devices to monitor their vital signs, and results are wirelessly sent to their healthcare provider, who could change their care plan before the patient goes to the hospital. O'Connor et al. (2016) developed a telehealth program utilizing wireless tablets for data transmission within a home health setting. Eight hundred eighteen home health patients were given a tablet for which they would input vital signs. Additional data monitored included food intake over the last 24 hours, new symptoms, medication issues, and weight. All data was wirelessly transmitted to the assigned nurse, who would follow up with the patient via phone and provide education, then follow up with the provider to make any recommended changes. The program trial was a yearlong and resulted in an all-cause 30-day readmission rate of 19.3% (O'Connor et al., 2016). Continued use of the telehealth system showed a 30-day readmission rate of 5.2% after three years, a 14% reduction from pre-telehealth implementation. The evaluation component was a critical component of this study that was lacking in other studies. The home health agency reviewed the readmission data monthly to continuously improve the process. Each readmission is reviewed by clinical and administrative staff via case conferences to determine what processes could have resulted in a different outcome and to identify trends. A similar study conducted by Woods and Snow (2013) demonstrated a significantly lower ACH rate for patients receiving telemonitoring compared to the non-telemonitoring group (1.7 vs 4.4 hospitalizations per 1,000 home health days). In addition, the telemonitoring intervention decreased emergency department (ED) usage (1.9 vs 5.3 per 1,000 home health days),

IVR calls within three weeks post-hospital discharge showed an improvement in readmission rates, with one readmission avoided for every 8.8 patients treated and an improvement in medication adherence and perceived self-support (Piette et al., 2021). The content of standard voice calls included goal setting, discussion of available resources for patients, and patient barriers to creating an overall patient-centered health plan. Results of a randomized controlled trial indicated that a follow-up telehealth call within 24 hours post-discharge helped identify new problems and review discharge instructions with a slight improvement in readmission rates (Van Loon-van Gaalen et al., 2021). A case study conducted within a home health corporation in three states demonstrated an average 30-day hospital readmission rate of 7.1% between January and June of 2019 after the introduction of telehealth (Health Recovery Solutions, n.d.). There were 350 patients monitored via telehealth. Clinicians observed patients' vital signs, symptoms, medication difficulties, and general health status and followed up on all patients identified as high-risk. One of the study's results was an increase in patients who were proactive in their care and noticed worsening symptoms earlier before reaching an emergency-level crisis. A similar case study in Colorado using weekly virtual visits to review care plans and assess patient status showed an average 6.6% 30-day hospital readmission rate with a 90% telehealth program adherence between August 2020 and June 2021 (Health Recovery Solutions, n.d.). A retrospective chart review completed by Thomason et al. (2015) highlighted an 11% reduction in hospital readmission rates in home health patients utilizing telehealth during a 22-month time frame (21% and 10%, respectively).

One of the barriers identified in telehealth usage is a lack of knowledge on how to use telehealth technology. Thomason et al. (2015) indicated that patients often need multiple home visits with reinforcement on how to use the technology before they feel competent enough to use

it independently. Without reinforcements, patient nonadherence may become a problem. To bridge this gap, Thomason et al. (2015) recommended that patients have a caregiver present during the education in addition to leaving written instructions.

In summary, telehealth has been shown to help healthcare providers deliver quality patient care by providing additional tools for symptom management and allowing for earlier recognition of worsening symptoms, which can help decrease the number of patients requiring emergency care. The most common modality utilized was telemonitoring devices; however, this is only feasible for some home health agencies as these devices can be costly. Although they improved hospitalization rates, interactive voice calls are generic and not individualized to patient needs. This project focused on video/audio telehealth visits only, as the necessary software was already in place and was cost-effective for the agency.

Method

Design

The design for this project was a program evaluation to evaluate the effectiveness of a telehealth training program on utilization rates of telehealth and overall hospitalization rates after implementation. The project occurred in two phases. The first phase was the pre telehealth data collection and the telehealth training. The second phase was the evaluation period after the training. Midterm data was collected in December 2023, with results from August through December 2023. The final data collection occurred at the end of May 2024; the results were from January to May 2024. Post-implementation data was analyzed to determine if the educational intervention successfully improved the outcomes mentioned above and to help guide future educational sessions.

Setting

This project occurred in a single home health agency servicing eight rural counties. The agency accepts patients recently discharged from a hospital, rehabilitation facility, or provider office. The agency has an average census of 140-160 patients at a time, primarily patients over age 65, and Medicare is the primary payor. At the time of this project, there were 18 staff members at the agency, not including the Director of Operations.

Sample

The target population of this project included the field clinicians working in this office, who were responsible for conducting the telehealth visits. Inclusion criteria included registered nurses, licensed practical nurses, physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, and speech therapists, regardless of employment status (FT, PT, PRN). In addition, the participants were required to be present during the weekly care conference. The Clinical Manager and the Director were also included, as they assisted with data collection.

Context

As mentioned, discussions with key stakeholders revealed the need for telehealth training at this home agency due to the lack of a formal training program, zero percent telehealth enrollment rates, and high hospitalization rates. Stakeholders involved in this project included the Director of Operations, the clinical staff, and the Clinical Manager.

The Director of Operations was a prime facilitator in this project and was in full support. She was responsible for helping to identify the current problem and assisted in data collection. One potential barrier identified in the success of this project was a lack of clinician motivation, willingness, and disinterest in the project. This is where the ADKAR model of change became essential to ensure the staff's desire to change. Another potential barrier included a lack of

follow-through by the clinical staff in telehealth utilization. There was a potential for the telehealth utilization rates to improve initially but decline over time unless reassessment and continual reinforcements were provided.

Ethics

This program evaluation proposal received approval from the University of Louisville IRB. No IRB approval was required from the project site. Permission to conduct the project was received by the Director of Operations of Amedisys Home Health, Jeffersonville, Indiana. No patient-identifiable data was needed for the implementation of this project. Telehealth visits were conducted using the Microsoft Teams and Microsoft Bookings apps, accessed via a secure link sent to the patient's preferred email address or cell phone. To protect patients' privacy, telehealth visits were only conducted if the patient was in their home and the clinician was in a private setting away from others.

Intervention Implementation

Before completing the training, the Director of Operations gave verbal and written approval. Phase I of this project included the pre-intervention data collection and the telehealth training. The student evaluator, assisted by the Director, collected hospital admission data via the Strategic Healthcare Programs System [SHP] and hospital hold records. Telehealth enrollment and visit utilization rates were collected via chart audits between January 2023 and July 2023. Participants were notified via email one month before the training was implemented and reminded of it during the patient care conference the week before implementation. All employees were required to attend regardless of employment status.

On the educational training day, all participants were given a handout of the telehealth guidelines and a printed step-by-step instruction sheet on performing a telehealth visit. A 30-

minute PowerPoint presentation developed by this student was displayed on the projector in the office's conference room after the patient care conference at the beginning of August 2023. The content provided in the PowerPoint was based on current guidelines for the home health agency along with Medicare guidelines. Specific information included in the presentation included the definition of telehealth, goals, and benefits of telehealth, patient eligibility, special considerations for clinicians, billing and coding guidelines, documentation requirements, discussion with patients on telehealth usage, role-playing exercises, and a mock telehealth visit. Participants were given 10 minutes after the presentation for questions and discussion. A digital copy of the presentation was emailed to all participants. Participants signed an attendance log for records at the end of the presentation. The home health agency provided the projector screen, paper, ink, office space, and printer usage. Participants were compensated for their time to attend the presentation as part of the weekly patient care conference.

Phase II of this project involved data collection and evaluation post-training. Specific data collected included hospital readmission rates, the number of patients enrolled in telehealth visits (video or audio), and the number of telehealth visits made by clinicians. Post-intervention data collection occurred between August 2023 and May 2024, with midterm check-in occurring in December 2023. Hospital readmission rates were collected via the Strategic Healthcare Programs System [SHP] and hospital hold records. Enrollment and utilization rates were collected via retrospective chart review.

Measures

The outcomes measured in this project included the acute care hospitalization rate, patient telehealth enrollment rate, and telehealth visit utilization rate. All post-implementation data was collected during the same time, beginning in August 2023 and ending in April 2024.

Acute Care Hospitalization

The acute care hospitalization [ACH] rate is the percentage of home health patients admitted to an acute care hospital within 60 days of home health admission. Baseline data was obtained before the training session. Following the training, the ACH data was obtained at four and eight months using the strategic healthcare programs system and hospital hold records. The eight-month evaluation period's ACH data was compared to pre-training implementation.

Patient Enrollment in Telehealth

For this project, patient telehealth enrollment is defined as any patient enrolled in the telehealth pathway at admission and includes both video and audio telehealth. Patient enrollment in telehealth was measured using a retrospective chart review, as no current system automatically tracks patient enrollment. Data was collected at baseline, with data check-in at four and eight months post-training. The post-data was evaluated and compared to pre-training data after the eight-month post-implementation period.

Telehealth Visit Utilization Rate

The visit utilization rate is the number of telehealth visits made by the clinicians during the evaluation period. The utilization rate was measured using a retrospective chart review to determine if patients enrolled in the telehealth pathway received a telehealth visit by the clinician. The chart review specifically looked at the coordination notes to determine if documentation was completed for the telehealth visit. As with patient enrollment, data was collected at baseline, four months, and eight months post-training sessions.

Data Analysis

Quantitative data analysis was performed to determine if there were statistically significant changes in telehealth enrollment, visit utilization, and hospital readmissions after

completing staff telehealth training. Paired t-tests were conducted through the Statistical Package for Social Sciences (SPSS) Version 28.0.1. For the change of the mean value to be considered significant, the p-value for paired sample t-tests needed to be less than 0.05. Data was collected at four months and compared to baseline data. The final data collection occurred eight months after the implementation of the telehealth training and was compared to the four-month data and baseline data. Staff members provided feedback at the four- and eight-month data collection on the progress of telehealth usage and the training. Feedback was analyzed using a thematic analysis to determine how the telehealth training can be improved in the future.

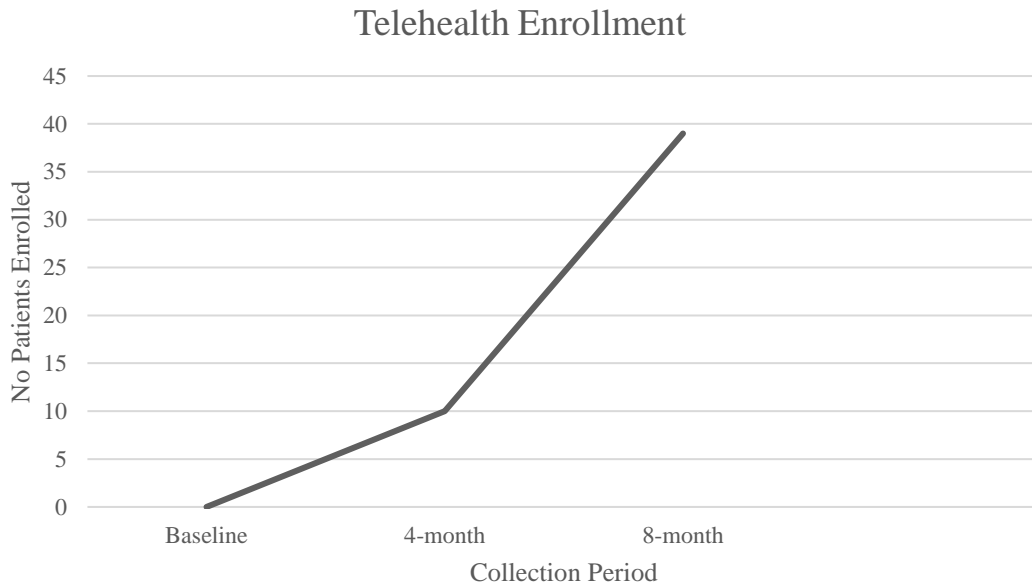
Results

Patient Enrollment

The number of patients enrolled in the telehealth pathway at admission was collected via retrospective chart review at the end of December 2023 at the four-month check. This included data from August 2023 until December 2023. During this collection period, 0.066% (n=10) of patients were enrolled in the telehealth pathway at admission. The paired sample *t*-test results revealed $p < .001$ indicating a significant increase in telehealth enrollment between pre-training and four-month post-training data sample (n=150). The second data collection period occurred at eight months and included data from January 2024 to May 2024. During this collection period, there were 39 patients enrolled in telehealth, or 24.5% of the patients. Analysis also demonstrated a significant increase in enrollment between the four month and eight months check in, $p < .001$). Figure 2 demonstrates the trend in patients enrolled during the evaluation period.

Figure 2

Telehealth Enrollment

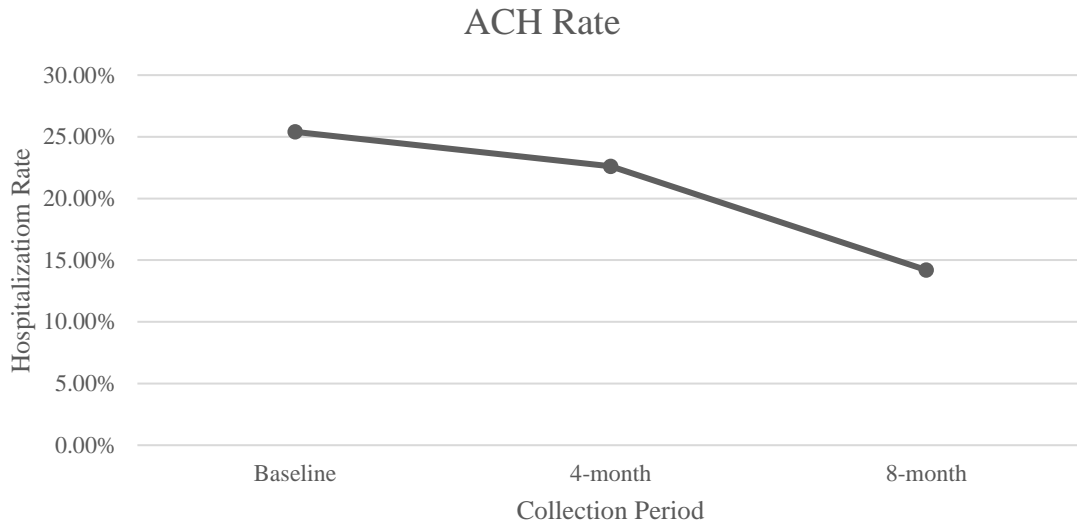


Acute Care Hospitalization

The acute care hospitalization rate was analyzed using a paired *t*-test to determine if there was a statistical difference in the hospitalization rate after the implementation of the telehealth training program. The four-month data check-in showed an average ACH rate of 22.6% between August 1, 2023, and December 31, 2023, with 34 hospitalizations within 60 days of home health admission. This is in comparison to the 25.4% ACH rate at baseline. There was a significant decrease in the ACH rate at the four-month check compared to baseline data, $p < .001$ (two-tailed). The final data collection showed an average ACH rate of 14.2 % between January 1, 2024, and May 31, 2024, with 21 hospitalizations within 60 days of admission. Figure 3 details the trend in the ACH rate over the evaluation period.

Figure 3

Trend in Acute Care Hospitalizations



Telehealth Visit Utilization Rate

The telehealth utilization rate was collected via retrospective chart review at the four-month check-in at the end of December 2023. This included data from August 2023 until December 2023. There were 15 telehealth visits made during this period: 12 audio-only phone visits and three video visits. The paired sample t-test results revealed $p < .001$, indicating a significant increase in telehealth utilization rates between the pre-training and four-month post-training data sample ($n=159$). The second data collection period occurred at eight months and included data from January 2024 to May 2024. During this second data collection period, 39 telehealth visits were made. Of these visits, 36 were audio only, and three were video visits. Figure 4 demonstrates the trend in telehealth utilization over the evaluation period, while Figure 5 details the types of telehealth visits performed during each evaluation period.

Figure 4

Telehealth Utilization after enrollment

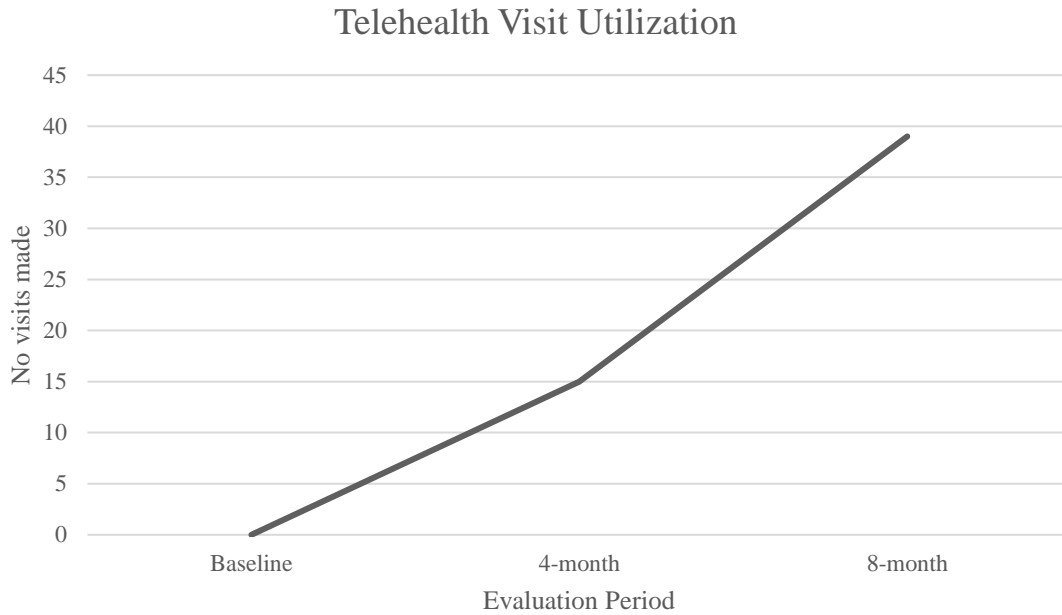
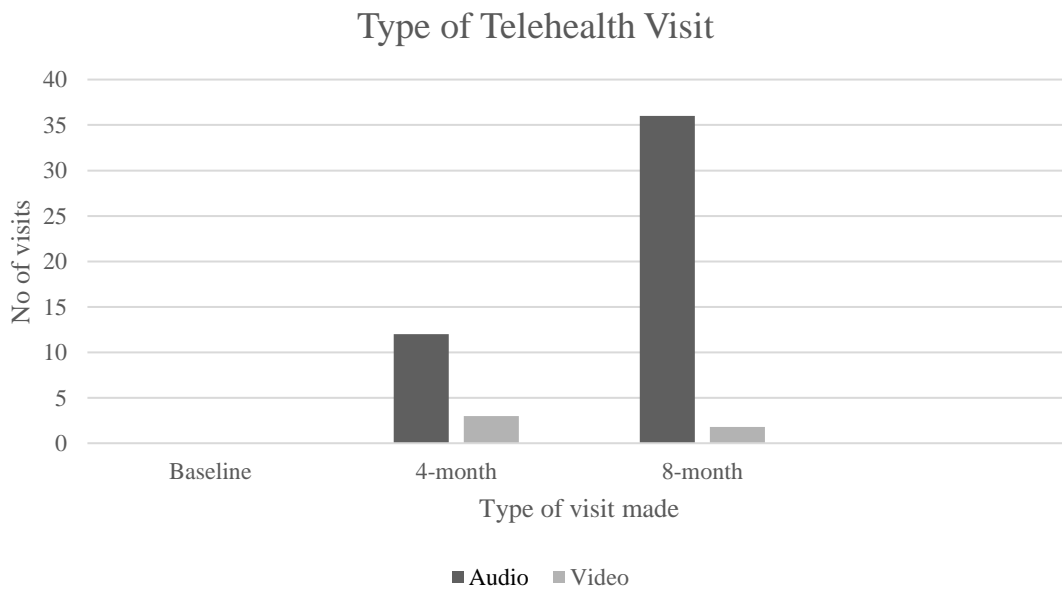


Figure 5

Types of Telehealth Visits Made



Discussions with other care centers

After data collection was completed and analyzed, the student evaluator discussed with the directors of the regional care centers their understanding and usage of telehealth. Among the seven care centers, only one other center had higher utilization than this clinical site, with a total of 32 telehealth visits. The other care centers had fewer than seven visits within the same period. Lack of understanding of proper usage/ selection of patients for telehealth was a common cause of lack of utilization within the care centers. To overcome this barrier, one Director suggested having the clinical managers review charts for high-risk patients and automatically enroll them from the back office.

Staff members within this project site were asked to provide feedback on telehealth utilization throughout the project. During the four-month check, the staff indicated three main themes. First, lack of compensation was a driving factor for not utilizing telehealth. The visit rates for telehealth visits are lower than traditional home visits (0.25 points vs 0.90 points) despite requiring the same documentation and education. Therefore, staff felt that telehealth was not worth it. Lack of phone service and internet access was also highlighted as a barrier to using telehealth due to the geographic region serviced by the care center. Staff indicated that patients had difficulties accessing the internet for video visits and poor service for phone calls. Lastly, staff members indicated a need for more time during initial admission visits to educate patients on accessing the video visits, which was further complicated if no caregiver was available to assist the patients. Discussions during the eight-month period yielded the same results, with staff members indicating no change in the barriers to usage.

Discussion

This program evaluation determined the feasibility of a short educational intervention to increase the utilization of telehealth visits within the home health setting. The clinical significance of this project was demonstrated by the increase in telehealth enrollment by staff members over the eight months from zero patients to 39 patients. In addition, the ACH rate demonstrated a downward trend during the same eight-month period, from 25.4% to 14.2%. The ending ACH rate met the CMS national average of 14.2, meeting this benchmark. Results from this project support literature indicating the successful usage of telehealth in the reduction of rehospitalizations.

Limitations

There were several limitations within this quality improvement project. First, education was provided only once during the project. There was a high staff turnover rate during the project duration. Due to this, many new staff members were not included in the educational session. Second, changes were made to the telehealth admission pathways, which omitted the ability to perform as-needed (PRN) telehealth visits, potentially limiting opportunities for additional telehealth visits. This project did not account for extraneous variables, including patients receiving additional telemonitoring from other providers, which may skew the results of ACH rates. Finally, there was no formal system for analyzing charts to ensure accuracy in documentation if a telehealth visit was made. Therefore, telehealth visits could have been completed without completing the narrative note, affecting the actual number of telehealth visits completed during this evaluation period.

Conclusion

Telehealth provides an alternative to traditional visits in the home health setting and can improve hospital readmission rates. This project supports educational training in telehealth to

improve awareness of telehealth usage and increase overall telehealth utilization rates.

Considerations for future implementation of the educational session should include multiple education sessions, particularly for new hires. In addition, it would be worth considering an annual review of the education for all staff regardless of employment status. The implementation of telehealth training would be sustainable for the care center due to the cost-effectiveness of providing the training. It could easily be implemented in other care centers. Finally, the development of an electronic system to monitor telehealth visits should be considered in order to reduce the amount of time required to analyze data. Decreasing the time required for data collection and analysis would allow for improvements to be made in future educational interventions.

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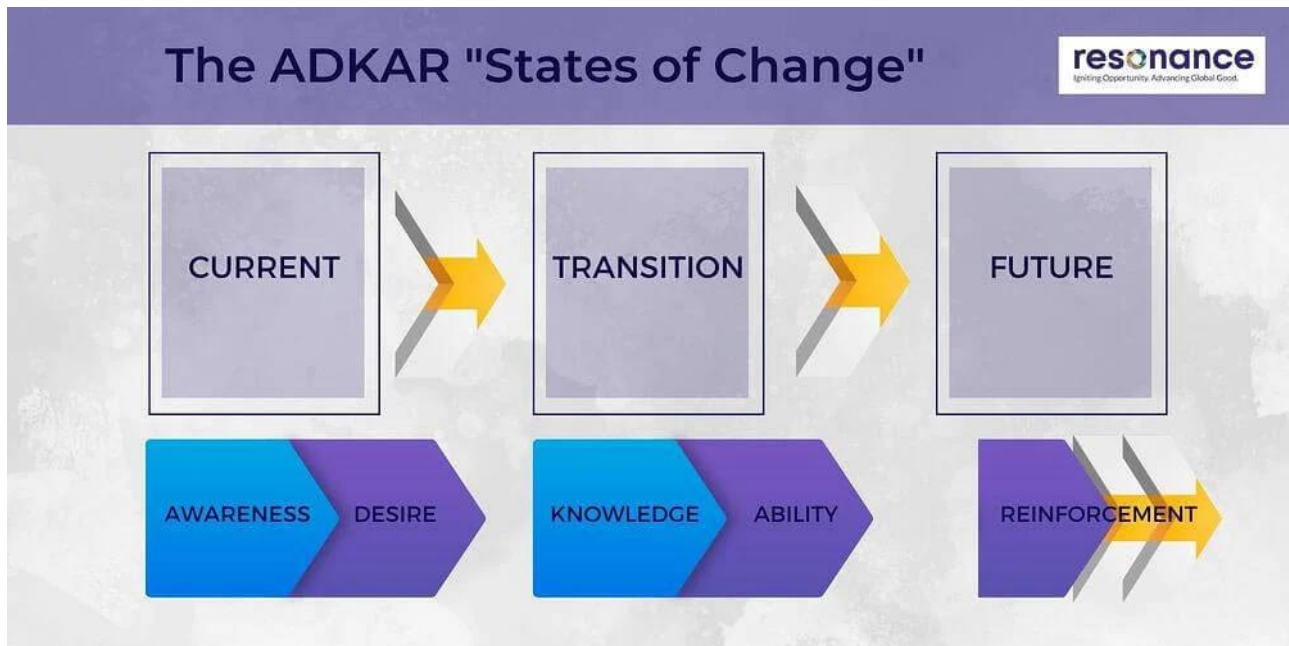
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Figure 1

The ADKAR "States of Change"



Appendix A
Letter of Support



11/5/23

To whom it may concern:

The purpose of this letter is to inform you that I approve of Gabrielle Coomer's DNP project which focuses on improving clinician knowledge and use of telehealth visits.

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Appendix B

Training Material

Telehealth in Home Health

1. What is Telehealth?
 - Telehealth is the use of technology, including tablets, smartphones, and computers, to access healthcare information remotely.
 - The goals of telehealth include:
 - i. Making access to healthcare more readily available
 - ii. Keeping individuals safe from diseases such as COVID-19
 - iii. Making services available to those with transportation issues
 - iv. Improve coordination of care between medical providers and patients
2. Benefits of Telehealth
 - Promotes self-management of health conditions.
 - Encourages patient engagement in the plan of care.
 - Allows for assessment of patient/caregiver understanding of education.
 - Identifies new or worsening symptoms before the next in-person visit and before the patient goes to the hospital.
 - Allows supervisory staff to assess if the plan of care is being followed and the effectiveness of the plan.
3. Who is Eligible?
 - Medicare patients
 - VA patients effective 2023
4. Special Considerations
 - Clinicians should not complete more than two telehealth visits in a row without making an in-person visit.
 - Telehealth visits must be related to the skilled services provided in the care episode.
 - Should not be doing telehealth visits without the telehealth pathway on the 485. You can add telehealth at any point during the episode of care by calling the ordering provider, obtaining an order to add telehealth visits, and doing a plan of care update.
5. Billing and Coding
 - Visits are non-billable; therefore, it does not cost the patient any extra
 - The assigned point value for a video visit is 0.3 productivity points, and the given point value for audio telehealth visits is 0.2 productivity points.
6. Documentation
 - Must clearly demonstrate skill provided and need for services, although there is no specific required minimum time for telehealth visits.
 - Documentation must show how the visit relates to the plan of care.

- If unable to perform a video visit (XX11V), the clinician can change the code within the visit to a phone visit (XX11PH) by clicking the unexpected event tab.
 - A full assessment with a detailed description of what the patient says; do not put yes/no answers.
 - Any abnormal findings, and what follow-up interventions were provided.
 - What education was provided, and provide details on the patient's level of understanding?
7. When should I use and not use telehealth?
- USE FOR
 - i. Education/teaching to patients and caregivers and reinforcement of education as needed.
 - ii. observation/assessment of self-care activities
 - Do NOT use
 - i. For hands-on teaching for skills better provided in person (e.g., tube feed administration or wound care)
 - ii. During the same day as an in-person visit by the same discipline unless a unique reason
 - iii. Without providers' orders to do so
 - iv. If the patient is unavailable for a visit– the clinician cannot perform the visit with the caregiver alone.
 - v. For scheduling visits
 - vi. For clinician preference, however, it may be helpful in certain weather conditions.
8. Addressing Telehealth Visits with Patients
- If the patient does not have a device for video calls, audio-only telehealth should be considered. Telehealth calls may help provide education in cases where video is not needed.
 - Do a practice call at the start of care to show patients how the system works. May also have a family member present for reinforcements.
 - Provide written step-by-step instructions on the process (these are located at the start of care binders) along with troubleshooting.
 - Recognize that older adults may not feel comfortable using technology and allow them additional time to understand how the system works.
 - Ensure patients understand the benefits of using telehealth and obtain informed consent before beginning telehealth.
 - Individuals without access to the internet may qualify for federal support programs through the Affordable Connectivity Program or Lifeline program.
9. Role Playing Exercise
10. Mock Visit and Questions
11. Resources
- Alliance for Patient Access. (2022, March 23). Telehealth: The Balanced Approach [Video]. YouTube. <https://www.youtube.com/watch?v=I1drm2zKTaI>

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