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Virtual visits, using 2-way real-time remote communication between the patient and the home health clinician, are a valuable adjunct to in-person visits to advance the prescribed plan of care. This article defines virtual visits within the larger context of telehealth and describes how to balance and integrate assessment and teaching modalities across in-person and virtual visits. Protection of patients' rights and privacy and facilitation of face-to-face visits with practitioners are also discussed.

Incorporating Virtual Visits Into the Home Health Plan of Care

The use of telehealth has expanded as vulnerable patients, at increased risk for SARS-CoV-2 viral infections with the resulting COVID-19 illness, isolate at home and are reluctant to have visitors. Virtual visits can be a valuable enhancement to services, in addition to in-person visits, to help patients and home health providers work together to achieve patient goals and complete the prescribed plan of care (Table 1). Because of their effectiveness, virtual visits in home care will continue beyond the current COVID-19 pandemic (Centers for Medicare & Medicaid Services [CMS], 2020a). Virtual visits are appropriate for patients of any acuity level; however, the home health agency may target vulnerable patients who are over age 65 or have one or more chronic conditions such as chronic obstructive pulmonary disease, kidney disease, heart failure, hypertension, obesity, and diabetes to provide closer surveillance (Centers for Disease Control and Prevention, 2020).

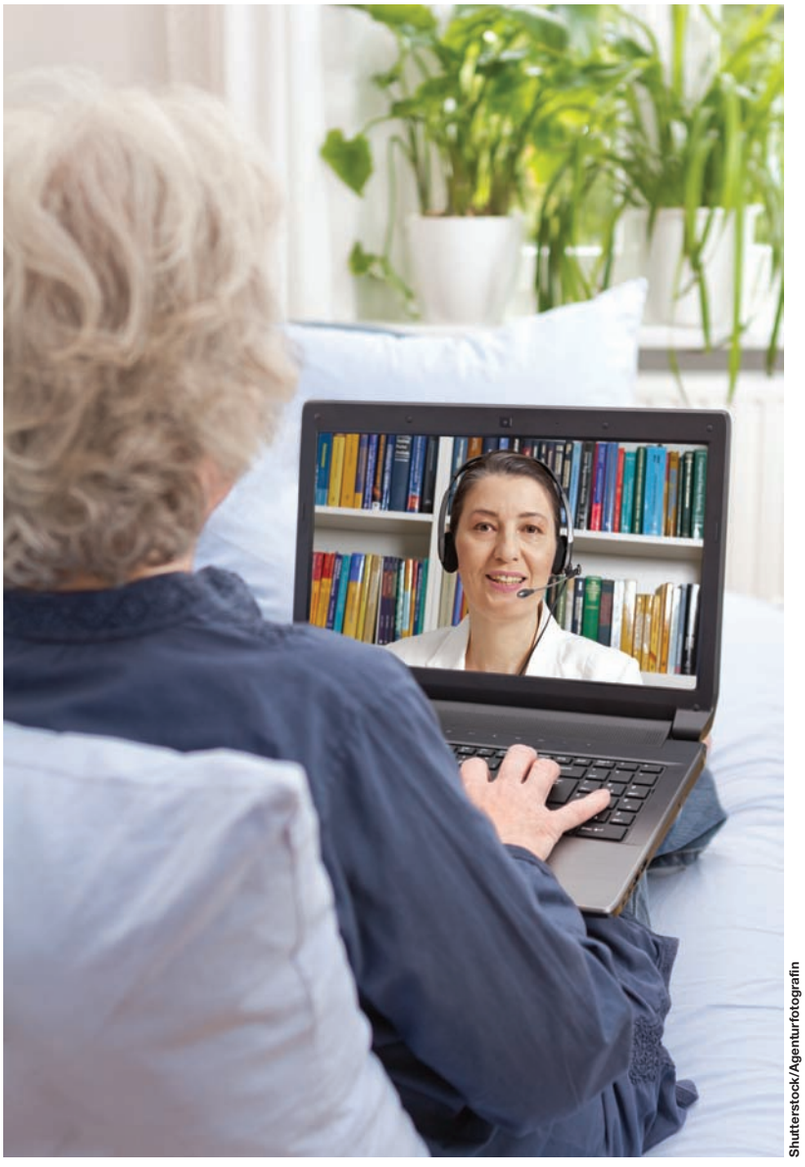
A broad definition of telehealth is the delivery of healthcare interventions, health education, and health monitoring services via remote technologies and can be real-time or asynchronous. Secure texting and email are examples of asynchronous communication. Telehealth can include any of the following:

- Audio-only visits using the patient's home phone or mobile phone.
- Audio-visual visits with 2-way real-time communication.
- Remote patient monitoring that allows for interactions and symptom monitoring including cord-connected and Bluetooth-enabled devices. The devices can send data such as blood pressure, heart rate, weight, oxygen saturation level, and blood glucose readings to providers. The electronic device may read the values back to the patient as well as forward it.
- Wearable sensors with wireless monitoring capabilities and related digital capabilities such as cameras, alerts, and fitness trackers are available for public purchase. Applications include information and chronic care management tools, weight loss programs, smoking cessation, and mental health. The tablet or device may be set up with medication reminders, timing of activity, or daily symptom survey questions.
- Digital photography (CMS, 2020b).

Susan M. Hinck, PhD, APRN, GCNS-BC

Telemedicine is usually in reference to technology used to communicate with practitioners such as advance practice nurses and physicians. The term telemedicine is sometimes used interchangeable with telehealth, but telehealth is a broader array of activities and services.

The Centers for Medicare and Medicaid Services increased support of telehealth in home care in March 2020, during the COVID-19 pandemic. Home health agencies may provide telehealth services to Medicare beneficiaries so long as it is part of the patient's plan of care and does not replace needed in-person visits ordered on the plan (CMS, 2020c). The changes to regulations were finalized later in 2020 stating that the plan of care must describe how the use of telehealth is tied to the patient-specific needs as identified in the comprehensive assessment and how it will help to achieve the goals on the plan of care (CMS, 2020d). Although Medicare does not reimburse home health agencies for telehealth or virtual visits, the virtual visits can decrease the cost of service by progressing the patient's plan of care without an in-person visit that requires travel time and mileage reimbursement.



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For the purpose of this article, the term *virtual visit* is used to discuss real-time remote audio-only or audio-visual visits between the patient and the home health clinician. During the COVID-19 pandemic, telephones or other audio-only devices (CMS, 2020e, p. 60) are allowed. However, further clarification is needed as to whether audio-only virtual visits are allowed when the pandemic ends. The proposed 2020 Federal Register rule states that "Telecommunications technology, as indicated on the plan of care can include remote patient monitoring….and 2-way audio-video telecommunications technology that allows for real-time interaction between the patient and clinician" (CMS, 2020e, p. 109). In its comments to CMS, the National Association for Home Care and Hospice is seeking clarification whether telephonic visits will be allowed after the pandemic.

Equipment

A home health virtual visit may take place with the patient's audio-only phone. Or a virtual visit may be conducted using a smart phone, a 10-inch tablet, or laptop computer that will allow internet connection and both audio and video communication. For remote patient monitoring, the agency

may purchase equipment from a vendor and make a kit for a patient, or may partner with a telehealth company to temporarily supply the equipment. Remote monitoring equipment may include a 10-inch tablet, scale, automatic blood pressure cuff, oxygen monitor, thermometer, glucometer, or other equipment depending on the patient's diagnoses and needs.

Practitioner Order for Telehealth

According to Medicare regulations, the agency cannot substitute a virtual visit for an in-person visit that was ordered in the Plan of Care (POC). If virtual visits are incorporated as part of the POC, they must be practitioner-ordered rather than the agency choosing to substitute telehealth when in-person visits are ordered. The virtual visit must address specific patient needs identified in the comprehensive assessment and incorporate interventions and measurable outcomes identified in the POC.

When possible, include telehealth in the original order (CMS 485 document) for service. An example of ordered frequency is: "SN 2w1, 1w7, and virtual visits 1w8 to address self-management of heart failure." This reads as skilled nurse visits twice a week for 1 week and then once a week for 7 weeks, and virtual visits once a week for 8 weeks. So, in week one, the nurse would provide two in-person visits and one virtual visit. In each week two through eight, the nurse would provide one in-person visit and one virtual visit. An order for "as needed" or "when necessary" (PRN) virtual visits can be included on the POC and must have a description of when that PRN visit would be made. An example of a reason for the PRN virtual visits is to address self-management of symptoms related to the patient's chronic condition (CMS, 2020e).

An order is not needed for a phone call or audio-visual call to check on a patient or to relay information. The difference between a check-up phone call and a virtual visit is that the virtual visit includes assessment and teaching to advance the POC and documentation in the clinical record.

Table 1. Benefits of Virtual Visits

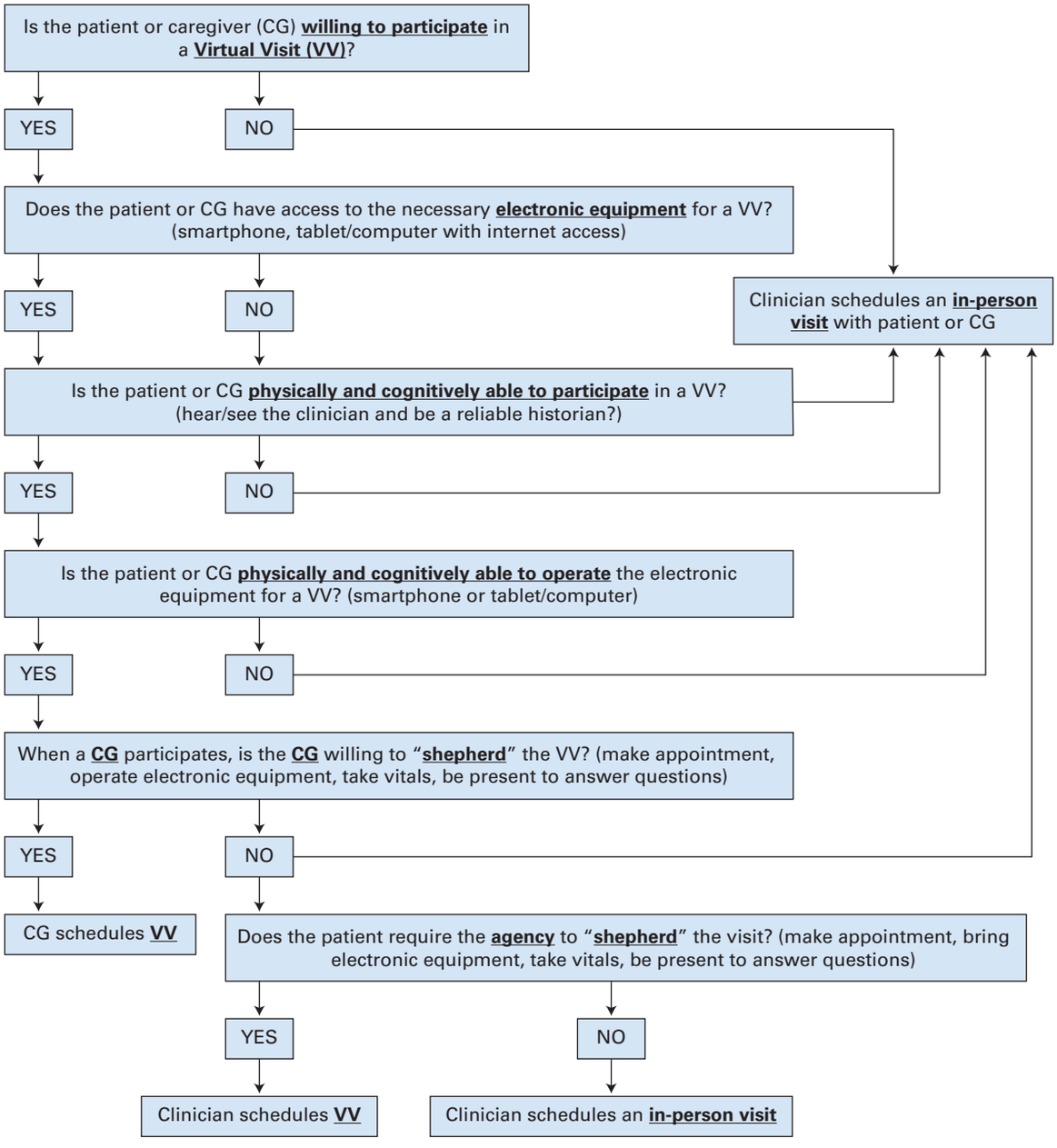
- Keep patients, their caregivers, and staff safe from infection by minimizing the number of in-person visits and increasing the use of virtual care.
- Addresses patient's reluctance to accept in-person visits due to illness or fear of infection.
- May decrease PPE use by 25% or more.
- Facilitate the practitioner's Face-to-Face visit with the patient that is required for Medicare to reimburse for home health services.
- Consumer/patient convenience, especially important for those who cannot physically or financially travel to the provider.
- Real-time patient access to health services to monitor changes in condition, monitor wounds, relay personal health information, and other health interventions.
- Staff can provide reminders to complete treatment such as taking medication, doing a blood glucose test, dressing change, or home exercise program.
- Increase patient engagement with plan of care and provide real-time alerts of nonadherent patients.
- Decrease hospital readmission rates and emergency department utilization by continuous monitoring and real-time interventions.
- Involve caregivers and keep them up to date with their loved one's care plan by including them in the virtual visit.
- Reduce social isolation and alleviate fears.
- Reduce the cost of home health agency staff time and mileage driving to patients.
- Potential to improve the patient experience of care and CMS star ratings.
- Can be used to monitor patients after home health discharge.

Virtual Visits as Part of the POC

How is the decision made whether to provide an in-person visit or virtual visit? The home health agency should have a decision tree or set of criteria to determine when an in-person visit is needed and when a virtual visit is appropriate as illustrated in Figure 1. The comprehensive assessment at start of care and before a new episode of care is required to be an in-person visit and, at that time, the admitting clinician can assess the patient's willingness and ability to take part in a virtual visit. At a minimum, the patient and/or caregiver must be willing to accept a virtual visit, have access to the equipment, and be able to manage the technology of a telephone or tablet. Nonclinical home health staff may assist with use of equipment in the home if needed. As with all areas of the POC, the patient is a full partner in tailoring the combination of in-person and telehealth visits. In-person visits are not to be substituted for virtual visits prescribed in the POC when the patient does not want to use, or is not able to use, virtual visit equipment.

Virtual visits are similar to in-person visits in that patient goals and interventions are addressed at each visit. Goals that address patient knowl-

Figure 1. Virtual visit decision tree.



edge or skill can be met even though visits are not in-person. For example, a goal is that the patient will be able to restate the signs and symptoms of COVID-19 by a specific date. This goal can be accomplished within one or two visits. At the first visit, the clinician provides teaching and confirms the patient's understanding through the teach-back method. At the next visit, the clinician will follow up on patient or caregiver understanding of teaching that was done during the first visit. The clinician will continue to assess for signs and symptoms throughout the episode of care. Similarly, addressing goals related to medication use, disease process, and treatments can be planned out over the weeks. A caution is to avoid teaching several topics during one visit.

Recommendations to incorporate virtual visits into the POC:

1. Front load the first week with in-person visits and use some visit time to train the patient/caregiver on use of the telehealth equipment. In following weeks, reduce in-person frequency to once a week or every other week, depending on patient needs.
2. The agency may have a nonclinician person, instead of a nurse or therapist, go into the home to instruct the patient or caregiver on use of the equipment, thus, not taking the clinician's time to do a task that can be done as well, or better, by a nonclinician.
3. Consistently schedule the same clinicians of each discipline for the patient so that the clinicians can build on their prior teaching and activities. If this is not possible, the primary clinician must be sure that there is a record of what was taught on each visit. This could be included in the narrative note.
4. Plan what goals and interventions will be addressed each week, so there is a cohesive flow between in-person and virtual visits.
5. For some patient monitoring, voice mail can be set up for the patient to make a morning status report on vital signs, zone tools, and health status.

At all visits, including virtual visits, the clinician is to:

- Review the reason for admission and patient goals.
- Assess specific symptoms and knowledge.
- Provide teaching and follow-up understanding of teaching done at prior visit.
- Use teach-back method to review instructions.
- Assign an activity for the patient to complete by the next visit, such as logging daily weights or daily exercise.
- Evaluate patient needs and resources.
- Evaluate patient or caregiver ability and willingness to follow the POC.
- Review any new medications, orders, or protocols.

Table 2 is an example of skilled nurse scheduling incorporating virtual visits for a patient with heart failure. At each visit, whether in-person or virtual, the clinician is also to review the purpose and goals of the visit and have the patient restate or demonstrate an activity, summarize learning from the prior visit, and gain the patient's agreement with the plan for the visit.

Documentation

Document that the virtual visit was provided and whether audio-only or audio and visual technology was used. Include in documentation:

- Names of all persons participating and their role in the encounter
- Patient location
- Start and stop time
- Total time
- With whom you reviewed the purpose of the visit
- From whom you obtained assessment data and who collected the data
- With whom you reviewed the POC
- Specific teaching for every visit and recall of teaching provided at prior visit
- Review what the patient is to achieve before the next visit
- Plan for next visit including an overview of what is to be taught

Table 2. Virtual Visit Content

Visit Sequence	Visit Type	Activities
1st visit	In-Person Comprehensive Assessment	Complete OASIS within 4 hours of visit. Complete essential teaching for the patient to be safe at home.
2nd visit	Virtual Visit	Teach: heart failure terms and signs and symptoms of exacerbation.
3rd visit	In-Person Visit	Review/teach on heart failure medication, heart failure self-management of daily weights, and use of zone tools.
4th visit	Virtual Visit	Assess/teach use of weight log using teach-back method.
5th visit	In-Person Visit	Teach diet and nutrition related to heart failure with hands-on activities (such as label reading in the kitchen).
6th visit	Virtual Visit	Review daily weight log, food log, and salt consumption.

Note. OASIS = Outcome and Assessment Information Set.

- Progress toward goals
- Patient/caregiver response
- If applicable, visualize wounds. A photograph or image can be immediately uploaded to the patient's clinical record.

Patient Rights and Protection

Clinicians conducting virtual visits must protect patient privacy and safety by correctly identifying the patient, as is done during an in-person visit. For a visit that occurs after the start of care visit, the clinician is to identify the patient by at least one method, such as facial recognition, name, or birthdate. Table 3 provides additional recommendations to help you be aware of your environment and to conduct a professional virtual visit.

The consent for home health services that the patient signs at start of care can be an all-in-one application that allows virtual visits, secure patient texting, patient email, patient portal, and care team communication. The agency may need to revise the existing consent form and policies to include these electronic forms of communication.

Secure audio-visual telehealth applications that are Health Insurance Portability and Accountability Act (HIPAA) compliant are available from technology vendors and provide a HIPAA business associate agreement regarding the provision of their video communication products. Non-HIPAA compliant applications can be temporarily used. Effective March 6, 2020, the Office for Civil Rights waived penalties for HIPAA violations against healthcare providers who serve patients in good faith through everyday communications technologies, such as FaceTime, Skype, Zoom, or others during the COVID-19 nationwide public health emergency. Providers are encouraged to notify patients that these third-party applications may pose privacy risks. Video communication applications of Facebook Live, Twitch, and TikTok are public facing and should **not** be used in telehealth (CMS, 2020e).

Face-to-Face Visit Facilitation

A home health agency may assist a patient with a telemedicine visit with a practitioner when the patient is not independent with managing the technology. A face-to-face visit with the physician or nonphysician practitioner (nurse practitioner, clinical nurse specialist, physician assistant) must include audio and visual communication because an audio-only phone call does not meet Medicare guidelines to allow the practitioner to bill Medicare Part B for the visit (CMS, 2020e). When a telemedicine visit takes place, staff from the practitioner's office will call the patient to ask questions about the patient's current health and illness signs and symptoms, review medication, and instruct the patient how to access the portal for the telemedicine contact with the practitioner. For physician/practitioner telemedicine visits, the practitioner must inform the patient that any insurance co-payment or deductible would apply and ask if patient wants to proceed with the televisit. The practitioner must obtain and document in the clinical record the patient's verbal consent for the visit. After staff collect information, the practitioner will enter the visit.

When home health agency staff facilitate the telemedicine visit, the home health clinician is to obtain vital signs, perform physical assessment, and provide details of the assessment to the practitioner. The clinician ensures that the patient can see and hear the practitioner. Home health clinical documentation includes who was in the home, who participated in the telemedicine visit, and information that the clinician provided to the practitioner.

The home health clinician cannot bill for the in-person home health visit if the only purpose of the visit is to assist with the telemedicine visit. Therefore, the clinician must complete and document additional interventions related to the home health POC for the home health agency to bill for the in-person visit.

Table 3. Tips for Virtual Visits

- Be aware of your background and what you are showing to others. Use a clean, uncluttered background.
- Eliminate any identifying information in your background, such as your home address.
- Make sure your background is HIPAA secure with no patient files visible.
- Place camera distance to show your face and shoulders, with camera slightly higher than your eye level, aiming downward.
- Use front lighting on your face.
- Dress professionally and demonstrate good grooming.
- Wear your agency identification badge.
- Be prepared and use assessment guidelines so you include everything you need to address.
- Have the patient hold the thermometer, glucometer, pulse oximeter, or other devices up to the camera so that you can see the readings.
- Complete documentation during and immediately after the visit.

The face-to-face facilitation may be provided by nonclinician staff, which allows each discipline to practice to the top of the license and not spend time on tasks that a nonlicensed person can do. The home health staff facilitator is to arrive at the home with the tablet 15 minutes before the scheduled call with the practitioner. The facilitator opens the tablet and enters the portal to the practitioner, ensures that the patient can see and hear the practitioner, and closes the tablet at the end of the telemedicine visit. The home health agency cannot bill the insurance or patient for a visit made by a nonclinician facilitator.

Conclusion

Since the outbreak of COVID-19, home health clinicians truly are living in a new world of heightened awareness of highly contagious infection. Usual ways of providing care have been disrupted. Challenges have led us to become more resourceful and innovative to meet patients' needs. We have the opportunity to rethink old patterns and strategically use virtual visits in home healthcare to benefit patients, clinicians, and agencies in a more cost-effective way. ☗

Susan M. Hinck, PhD, APRN, GCNS-BC, is Retired Compliance Director, Haven Home Health and Therapy, Ozark, Missouri.

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Address for correspondence: Susan M. Hinck, PhD, APRN, GCNS-BC, 1220 West Lakewood Street, Springfield, MO 65810 (susanhinck@aol.com).

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