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**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**

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides guidance for the credentialing and privileging of VHA health care providers (physicians and others) who use telehealth to deliver health care services to veterans in their homes, Vet centers, and other non-health care settings (e.g., community halls, community residential care (CRC) homes, etc.).

2. BACKGROUND

NOTE: VHA Directive 2001-055, Credentialing And Privileging of Telemedicine and Telehealth Services Provided in Hospitals and Clinics, only covers Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) accredited institutions, i.e., formal health care setting in contra distinction to this directive which deals with other non-JCAHO accredited health care settings.

a. VHA can only offer telehealth to patients at home, in Vet Centers, and in non-health care settings when it enhances patient care, and under circumstances where direct “hands-on care” is not possible nor a necessary requirement of the patient’s treatment and/or care in the judgment of the patient’s health care provider.

b. The increasing level of sophistication of telehealth technologies and progressive reductions in their cost now enables health care providers and patients to interact in new ways and in alternative settings that were neither previously possible, nor envisaged. For example, psychiatrists in VA medical centers can provide remote video-based telehealth consultations to patients with post-traumatic stress disorder (PTSD) in Vet Centers; primary care physicians can conduct video-based telehealth consultations with patients in their homes; and homecare-nursing staff can remotely monitor the vital signs of patients at home.

c. VHA has begun to introduce telehealth into these various new settings to help meet the health care needs of veterans by overcoming barriers of distance and time, and to improve access to care. This benefit is seen in remote or isolated areas where telehealth can enhance the continuity of care by linking health care delivery programs that may span the hospital and the community.

d. Adopting telehealth as an innovative tool to improve health care delivery creates new challenges for VHA in reconciling its existing policies and procedures (e.g., credentialing and privileging of health care providers) with new practices that include telehealth. Telehealth may raise issues concerning who provides care to the patient and about the appropriateness of the setting(s) in which this care is provided. To adequately address these issues, health care organizations and patients need to be assured that all providers who use telehealth have the required skills and competencies to deliver care in the setting(s) in which it is used.

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e. It is incumbent that VHA offers one standard for the delivery of care regardless of how and where this care is provided to veteran patients. To meet this requirement, VHA must harmonize how care is provided between various care settings when telehealth is used. The credentialing and privileging of health care providers who use telehealth is an initial area where VHA has addressed this issue. *NOTE: The Joint Commission on the Accreditation of Healthcare Organizations issued standards for the credentialing and privileging of independent licensed providers who practice using telemedicine in January 2001 (see subpar. 5b).*

f. When VHA uses telehealth to deliver health care in settings that lie outside VA medical centers and Community-based Outpatient Clinics (CBOCs), standards set by organizations, such as JCAHO and the Commission on Accreditation of Rehabilitation Facilities (CARF), may not be readily applicable. This situation exists because the precise role of telehealth and how far it should be considered as simply mirroring conventional health care practice is a matter of ongoing debate within the general health care community. Previous discussions between JCAHO and VHA clarified that JCAHO standards for the credentialing and privileging of physicians using telemedicine (see subpar. 5b), do not apply in homecare, Vet centers, and other non-formal health care settings (see subpar. 5c). VHA providers using telehealth in these settings need only meet VHA's standard credentialing and privileging requirements that are applicable at the facility (see subpar. 5d) (VA medical center or CBOC) from which they provide the delivery of conventional (face-to-face) care.

g. In the absence of current VHA, JCAHO and CARF standards for the use of telehealth outside VA medical center and CBOC settings, the VHA Telemedicine Strategic Healthcare Group (SHG) has developed guidelines for this purpose (see Att. A). These guidelines offer interim guidance pending the development of formal VHA telehealth guidelines and/or standards for the delivery of health care into the home using telehealth that are planned to be created later.

h. **Definitions**

(1) **Telemedicine.** Telemedicine involves the use of electronic communications and information technology to provide and support health care when distance separates the participants (see subpar. 5a). Telemedicine covers both health care providers interacting with patients, and patients interacting with other patients. Some providers of telemedicine prefer using the word telehealth when these activities center on providing care in the home and in non-hospital settings. Telehealth and telemedicine are used interchangeably throughout this document. For the purposes of this directive, telehealth includes video-based telehealth consultations and remote monitoring of vital signs, but it specifically excludes traditional telephone consultations.

(2) **Credentialing.** The term "credentialing" refers to the systematic process of verifying and evaluating qualifications and other credentials, including licensure, required education, relevant training and experience, current competence, and health status. Credentialing is required to ensure an applicant has the required education, training, experience, physical and mental health, and skill to fulfill the requirements of the position and to support the requested clinical privileges.

(3) **Clinical Privileging.** Clinical privileging refers to the process by which a licensed practitioner is permitted by law and the practitioner's health care facility to practice independently, and to provide medical or other patient care services within the scope of the

individual's license, based on the individual's clinical competence as determined by peer references, professional experiences, health status (as it relates to the individual's ability to perform the requested clinical privileges), education, training, and licensure.

(4) **Licensed Independent Practitioner.** The term “licensed independent practitioner” refers to an individual permitted by law (the statute which defines the terms and conditions of the practitioner’s license) and the facility to provide patient care services independently, i.e., without supervision or direction, within the scope of the individual’s license and in accordance with individually granted clinical privileges.

3. POLICY: It is VHA policy that all licensed independent practitioners delivering health care services remotely to patients’ homes, Vet Centers, and non-health care settings using telehealth must be appropriately credentialed and privileged at the VA medical center or CBOC through which they work, in accordance with the VHA Handbook 1100.19’s guidance for delivering conventional (face-to-face) care delivery. **NOTE:** *When delivering these telehealth services within VHA, this care must adhere to the guidelines contained in Attachment A.*

4. ACTIONS

a. **Medical Center Director.** The medical center Director, at the site from which the licensed independent practitioner delivering telehealth is working, is responsible for ensuring that:

(1) The appropriate staff is identified to deliver health care services remotely into non-health care settings.

(2) The appropriate equipment and telecommunications platforms required for the delivery of remote care via telehealth are identified.

(3) The appropriate staff establishes procedures and processes for the identification of veterans and patients who will benefit from using telehealth delivered to non-health care settings.

(4) Adequate health care records are kept to document the health care provided via telehealth, including patient visits, clinical progress, and all other activities related to a remote health care visit, and these must be placed in the patient’s medical record. Standard VHA medical record documentation procedures must be followed to include recording the data at the parent facility where the provider is physically located. **NOTE:** *Since remote health care delivery into non-health care settings is an extension of the VA medical center, medical record documentation must adhere with current VHA and local medical center policies.*

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(5) All health care providers delivering telehealth services are credentialed and privileged in accordance with the requirements identified in VHA Handbook 1100.19, Credentialing and Privileging.

(6) All telehealth activity taking place in non-health care settings remote from VA medical centers and other sites is within the scope of practice, current credentials and privileges, and current competencies of the relevant health care provider. *NOTE: In the event there are any concerns about the adequacy of any existing remote health care delivery health care providers, tools, or arrangements to deliver remote health care, these must be taken to the appropriate network clinical service manager for discussion and resolution.*

(7) Providers who are tasked to deliver remote health care into non-health care settings must:

(a) Be appropriately qualified to deliver care to a population with unique health care needs in a way that is an extension of the VA medical center or CBOC.

(b) Upon request, ensure that copies of the provider's privileges that pertain to the telehealth services that the patient receives from a VA medical center or CBOC are made available to the patient. If copies of these privileges are made available, it must be done in accordance with the Privacy Act (see subpar. 5e).

b. **Chief Consultant, Telemedicine Strategic Healthcare Group (11T).** The Chief Consultant, Telemedicine Strategic Healthcare Group (11T) is responsible for the monitoring and implementation of telehealth policy.

5. REFERENCES

a. Field, M., ed. Institute of Medicine. Telemedicine, A Guide to Assessing Telecommunications in Healthcare, National Academy Press, 1996.

b. http://www.jcaho.org/standard/medicalstaff_rev.html.

c. Minutes from the meeting between JCAHO representatives, the VHA Telemedicine Strategic Healthcare Group, VHA Credentialing and Privileging staff, and VISN 20 in Vancouver, WA, January 2001.

d. VHA Handbook 1100.19, Credentialing and Privileging.

e. Privacy Act System of Records Notice for Healthcare Provider Records (77VA10Q).

6. FOLLOW-UP RESPONSIBILITY: The Chief Consultant, Telemedicine Strategic Healthcare Group (11T) is responsible for contents of this directive. Questions may be referred to 202-273-8563.

7. RESCISSIONS: None. This VHA Directive expires July 31, 2007.

S/ Jonathan B. Perlin, M.D. for
Robert H. Roswell, M.D.
Under Secretary for Health

Attachment

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ATTACHMENT A

**INTERIM VETERANS HEALTH ADMINISTRATION (VHA) GUIDANCE WHEN
USING TELEHEALTH TO DELIVER HEALTH CARE SERVICES INTO
HOME AND VET CENTER SETTINGS TO ACCOMPANY PROVIDER
CREDENTIALING AND PRIVILEGING REQUIREMENTS**

NOTE: Adapted from American Telemedicine Association Homecare Standards 2000

1. PATIENT CRITERIA

a. A written informed consent that is in accordance with the guidance of Veterans Health Administration (VHA) Handbook 1004.1, Informed Consent, must be obtained from each patient, or authorized surrogate, before telehealth is used to deliver care. Reasons outlining why it was decided to use telehealth must be included in a written treatment and/or care plan in the patient's clinical record. Written informed consent for telemedicine need only be obtained at the commencement of each treatment and/or care program. It is not required for each individual episode of care within the program of treatment and/or care. Whenever written consent for telehealth is obtained it must be clearly explained to the patient. The patient is free to reject this mode of care delivery in favor of conventional health care delivery systems without fear of any subsequent prejudice to the care the patient will receive.

b. A new and separate written informed consent is required in the case of a new intervention or significant change from a current treatment plan.

c. In the event that a permanent photographic or video recording of all or part of a telehealth consultation is sought, Department of Veterans Affairs (VA) Form 10-3203, Consent for Use of Picture or Voice, must be used.

d. In the event that the telehealth delivery system is part of a research study, written consent must be obtained from each patient, or the patient's surrogate, and the appropriate patient information materials provided. This pre-condition must be met before telehealth is used in the associated care delivery process or any patient data are collected for research purposes.

e. Before the initial use of telehealth, an assessment must be made to determine whether each patient and/or caregiver can appropriately use the equipment, understand how to seek advice, and obtain help if needed. The provider must document that all relevant safety concerns relating to the installation and use of the equipment have been adequately addressed. If the patient and/or a caregiver fail to adequately demonstrate these competencies, and as a result telehealth is considered inappropriate to use, a record of this giving the reasons why this decision was reached must be placed in the patient's chart.

f. Patients receiving health care services via telehealth who require an interpreter must have this need appropriately identified and met. Suitable translation services in the appropriate health care setting must then be provided in accordance with current VHA policies and procedures.

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g. The needs of patients with impairments or disabilities who are eligible for care using telehealth must be met in accordance with current VHA policies.

h. Patients, or authorized surrogates, must be made aware of all those who are present during telehealth, and give their verbal permission for the inclusion of each person in advance of the telehealth commencing. Should a staff member, visitor, or another person arrive unexpectedly at either the consulting end or during telehealth, the consultation must be halted and the patient made aware of the presence of this person(s). Before proceeding further with telehealth, the patient's verbal approval must be obtained before any such person may observe and/or participate in telehealth. If any additional site joins telehealth in progress, the patient must be made aware of this participation and give verbal approval before telehealth continues. A record of obtaining the patient's verbal approval(s) must be entered in the patient's record.

i. The collection of patient satisfaction data relating to telehealth should be routinely included in the continuous quality improvement (CQI) process.

j. The first and last home visit to the patient's site should take place in person, and not be via telehealth. *NOTE: It is recognized that in some instances circumstances may preclude this; e.g., in the event the patient is transferred to another environment of care or dies.*

2. HEALTH CARE PROVIDER CRITERIA

a. Providers can only offer telehealth to patients at home, in Vet Centers, and in non-health care settings when it enhances patient care, and under circumstances where direct "hands-on care" is not possible nor a necessary requirement of the patient's treatment and/or care in the judgment of the patient's health care provider.

b. Before initiating telehealth, a progress note must be written by the health care provider, who will deliver the telehealth service, describing how the remote care of this patient at home, in a Vet center or in a non-health care setting fits into a comprehensive treatment care plan.

c. The facility Director, who oversees the VA medical center or community-based outpatient clinic (CBOC) from which telehealth services are being provided, has the ultimate responsibility for ensuring the required policies, procedures and processes are in place to guarantee telehealth is provided in a safe manner and meet the needs of veteran patients appropriately.

d. The facility Director is responsible for ensuring that the relevant staff routinely document, in the patient's medical record, all information pertaining to telehealth visits, including: informed consent, training and education, patient visits, clinical progress, and all other activities related to telehealth.

e. The facility Director is responsible for ensuring the appropriate staff members are designated to deliver telehealth to patients at home, in Vet centers and in non-health care settings. In addition, the facility Director is responsible for ensuring that the appropriate processes are in place for credentialing and privileging. It may be appropriate that Registered Nurses, Social Workers, Licensed Practical Nurses, Physical Therapists, Speech Therapists, Occupational Therapists, Nutritionalists, Physicians, Nurses, Nurse Practitioners, and other

health care providers to offer telehealth as part of delivering services in non-health care settings. The criteria on which such judgments are made must include an assessment of whether this manner of health care delivery fits within each category of health care provider's pre-existing scope of practice.

f. The facility Director is responsible for ensuring processes are in place to make sure that the appropriate equipment and required telecommunications platform is selected to support every intended type of care provided via telehealth from the facility.

g. The health care provider, and when appropriate, the patient or the patient's authorized surrogate, must document telehealth in the patient's chart.

h. All telehealth providers must be suitably trained in the use of telehealth, and have demonstrated their ability to perform telehealth and monitor patient physiological data adequately with the technology.

i. In case of equipment failure during telehealth, a direct patient referral must be scheduled as soon as it is deemed appropriate by the health care provider to ensure adherence to the treatment and/or care plan.

j. Health care providers who use telehealth must receive the appropriate training and adequately demonstrate their ability to use the technology correctly and troubleshoot common problems. Explicit guidelines must exist for them to follow in the event of equipment failure. Continued training must be provided and their ongoing competency in the delivery of telehealth must be assessed.

k. Contracts for telehealth services need to require that telehealth be performed by individuals appropriately licensed to engage in telehealth across state lines. Note that when dealing with Federal entities, additional licenses that authorize the provision of telehealth services in the relevant states may not be required. Some states do not allow telehealth across state lines unless the provider is licensed in the state where the patient is physically located when delivering telehealth. In these states, the clinical indemnity coverage of contract practitioners may be void, even if they are credentialed and privileged within VA. Prior to the commencement of services by contract physicians providing telehealth or remotely monitoring physiological data from veteran patients, the state medical board in the state in which the physician and patient are physically located must be consulted. **NOTE:** *The opinion of the local counsel needs to be sought on this matter.*

l. Any planned changes in the frequency of telehealth to non-health care settings are to be treated like a change to any other part of the treatment care plan and must be approved by the physician responsible for this aspect of the patient's care.

m. At the onset of telehealth, "in-person training" is to be provided along with clear written information regarding the use of the equipment.

n. Patients must be given clear written instructions about whom they should contact in the event of a medical emergency. **NOTE:** *Patients need to be regularly reminded in writing not to*

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rely on telehealth as their primary emergency medical response system. Doing so can create a potential delay in their contacting "911" emergency care services or traveling to an emergency room.

o. A plan of action regarding how unscheduled telehealth can be provided, if required, is to be documented by providers. **NOTE:** *This must include arrangements for how supervisors, or other staff in the office, will be readily available in case the patient care manager is absent.*

p. Telehealth to non-health care sites is to be incorporated into clinical guidelines and care pathways for telehealth whenever appropriate.

q. The presence of a 24-hour telehealth coverage system depends on local factors, and its availability will vary from program to program. The hours of care delivery for each service must be documented and made available to patients in advance. Clear written instructions must be provided to patients and/or caregivers to use if there is a need to contact an after-hours care provider; in case the patient and/or the caregiver fail to make contact, include details as to the alternate back up and emergency arrangements.

3. TECHNOLOGY CRITERIA

a. A governing tenet when using telehealth is that the use of the technology must be based on the patient's clinical and functional needs. Based on the clinical needs of the patient, many components may be included such as: two-way interactive video, telephonic stethoscope, blood pressure and pulse measurement. Other optional equipment that may be included are: oximetry, scales, electro-cardiographs (EKG), glucometers, coagulation monitors, and other medical devices.

b. The equipment based at the central station of each floor of the facility must include a login code and password protection to maintain security of access to the telehealth system.

c. The privacy and confidentiality of all patient data must conform to relevant standards including the Privacy Act (see Privacy Act System of Records Notice for Healthcare Provider Records (77VA10Q)), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

d. When appropriate, after installation, the telehealth system is to be checked for accuracy against the corresponding standard clinical measurement devices. **NOTE:** *When manufacturing, industry, or other calibration or measurement standards exist, these must be followed and documented.*

e. Procedures must be written and in place to clean and maintain equipment when required (e.g., infection control standards and routine overhaul and checking). These procedures may be necessary at the time of installation, while in the home, and/or when the time comes to return the equipment to the VA medical center or CBOC.

f. Installation kits are to be made with written instructions for the staff. These kits are to include the necessary supplies to ensure the best data quality (e.g., lighting). **NOTE:** *A process*

must be devised for the delivery of any required supplies according to the characteristics of the site and the technology chosen.

g. Part of the assessment of an individual patient to see whether telehealth is an appropriate tool to be used in the patient's care is checking the patient's ability to adequately use and maintain the equipment. These competencies need to be reassessed at installation and as required.

h. Instructions on who to call for questions and concerns regarding equipment must be provided to patients and any staff who may have contact with the patient.