OMB # 0915-0311
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OAT Website Instructions

Program Home Page

The Program Home Page gives you an overview of the forms you will need to complete, and the status of each of these forms. The top part of the page lets you configure – describe – your program as it functioned during the current reporting period. Once you have configured the specialties, sites and settings served involved in your TM program, all the other forms will self-generate for your specific program configurations, and you can enter data into them.

A pull-down menu at the top of this page allows you to select a reporting period. You can view past reporting periods, or enter data for the current reporting period. Once the reporting period is selected, you will see the current status of each form (complete, in progress). When all forms are shown as complete, indicating that you are finished entering data, *OAT will know that your data reporting is complete*.

Configure this Reporting Period

In order to make this performance measurement tool relevant to your specific telehealth system, you will configure the measurement tool to your specific needs. This makes the forms more manageable and removes forms that do not pertain to your unique system.

To configure the forms for this reporting period, click on the buttons to SETUP SITES, SETUP
SPECIALTIES, and SETUP SETTINGS and select the categories you will use to describe the activity in your telehealth system. For example, SETUP SPECIALTIES asks you to indicate the specialties in which you provided telehealth services during this reporting period. Once you indicate the relevant specialties, subsequent forms will only include your selected specialties.

The lower part of this form contains *4 questions* regarding specific use of your system for supervising, mentoring, and homecare. Please read definitions of these activities carefully and then answer each question to indicate whether or not your system was used for these functions during this reporting period. For example, if you did not provide homecare services, reply ‘no’ to the last question, and the homecare data form will not be created for

you. In response to these answers, forms that are not applicable to your program will be removed from the list on the program homepage.

When you have setup your sites, specialties, and settings, and answered the 4 questions, you should change the STATUS of this form to COMPLETE by clicking the YES button at the bottom of the page. Then click SUBMIT.

****Note: until you mark your configuration as complete, you will not be able to enter any of the other forms!**

Select Sites for this Reporting Period

In this form, you list the sites that were active during this reporting period. If sites have been listed in past reporting periods, simply specify which of the sites remained active during this reporting period.

To list a new site, enter the SITE NAME, TOWN, STATE, ZIP CODE, and FUNCTION in the bottom boxes and click the SUBMIT button. The FUNCTION for a site specifies whether it was a consultant site (also known as hub site) or patient/patient data site (also known as a remote or originating site).

When all of your sites are listed, check the box in the left-most column to indicate which were active in this reporting period (and for which you will be entering data). If you leave this left box unchecked, the site will be recorded as inactive, and will not appear on any subsequent data entry forms.

When you are done, click SUBMIT and you will see the number of active sites you've set up appear on the CONFIGURE REPORT PERIOD page.

Select Specialty Areas for this Reporting Period

In this form, you will indicate the medical specialties and services provided through your telehealth system during this reporting period. If you offered a specialty or service that is not yet on the list, you can create a new one. Please try to use the existing categories if possible, only adding a new one as a last resort when your activity is clearly not described by the existing categories.

Check the box in the left-most column to indicate each of the specialties/services in which you had activity during this reporting period. If you leave this box unchecked, it will be recorded as inactive and that specialty will not appear on any subsequent forms.

When you are done, click SUBMIT and you will see the number of selected specialties/services you have configured appear on the CONFIGURE REPORT PERIOD page.

Select Settings for this Reporting Period

In this form, you will define the settings where patients received care through your telehealth system. If patients were served in a setting not yet listed, you can create a new setting. Please try to use the existing categories if possible, only adding a new one as a last resort when your setting is clearly not described by the existing categories.

Check the box in the left-most column to indicate all the patient settings in which you had activity during this reporting period. If you leave the box unchecked, that setting will be recorded as inactive and will not appear in subsequent forms.

When you are done, click SUBMIT and you will see the number of settings you have activated appear, back on the CONFIGURE REPORT PERIOD page.

Definitions - Settings:

• **Hospital ER**
• **Hospital In-Patient**
• **Hospital Outpatient**
• **Non-Hospital Clinic** (e.g. rural health clinic, migrant health clinic) - Includes settings that do not fall into the other categories. These include: federally qualified health center (e.g. community health center, school-based health center, migrant health clinic), FQHC "look-alike", and rural health clinic.
• **Private Medical Practice or Physician's Office** -This setting includes individual physicians offices or group practice. This also includes a practice of Physician's Assistants (PA) or Licensed Practical Nurses (LPN)
• **Health Department and Mental Health Agency** - Note: These have been combined for convenience purposes.
• **Patient's Home**
• **Licensed Nursing Home**
• **Assisted Living Facility**
• **School**
• **Prison**

Form 1: Specialties and Services

This form allows you to report the number of encounters by specialty/service, by patient care setting, and by type of TM encounter. This is the basic set of 'volume' data OAT will use in describing to Congress the breadth and depth of the grant program.

To complete this form, you will need to have been collecting information during each TM session or encounter all through the reporting period. For each TM encounter, you will need to know and report: the patient setting, the specialty or service, the TM format, and whether a patient was present.

Click on each patient setting to enter data on the encounters that took place for patients in that setting. Enter the number of encounters for each specialty that took place in that patient setting.

Each specialty/service has four columns where data can be entered.

Definitions - Encounter Types:
• **Interactive/Real-Time Encounters (IN)**: Encounters done in an interactive (real-time) video-conferencing format.
• **Patient-Present Encounters (PP)**: Interactive encounters where the patient is present during the consultation.
• **Patient-Not-Present Encounters (NP)**: Interactive encounters where the patient is not present during the consultation.
• **Store-and-Forward Encounters (SF)**: Encounters done in a format where information/images are gathered and sent electronically to be viewed at a later time by a telehealth provider; encounters are not interactive and not in real-time.
• **Biometric Monitoring Interactions (BI)**: Store-and-forward interactions used for telemetry or patient-monitoring, most commonly for home-bound patients. Every 'patient-day' (a day in which a patient received care) should be counted as a separate interaction. However, within a day, measurements reported multiple times should only be counted as one.
• **Other (OT)**: All store-and-forward interactions that do not involve biometric monitoring.
• **Patient-Care Encounters/Sessions** include therapy and counseling (including nutritional, group counseling, etc.) but NOT didactic education, community meetings or administrative sessions (these data are captured in later forms).

All of the data/images for a given patient, on a given day, should be combined and counted once (e.g. 3 x-rays for the same patient problem, sent on the same day, should be counted just once under SFOT, not 3 times). Each unique patient-day should be counted; daily telemetry is counted in days, even if telemetry data were sent several times each day.

Please make every effort to fit your encounter reporting into the specialty/service categories provided, and to use the list of settings provided. If you have questions about how to categorize some types or settings of care, please call for assistance. The website has been structured so that you cannot add new specialties or settings, but if necessary the website support staff will do so. If you have a very unusual specialty with only a few encounters, please use the catch-all 'Other' category. If you indicate that you had encounters taking place in "Non-Hospital Clinic/Non-Physician Providers" a new window will appear asking you to enter data on the sessions in various types of non-hospital clinics.

Finally, at the bottom of the page, enter the number of consultant sites and patient/patient data sites for which data are included on this form. When you are finished, click SUBMIT.

Form 2: Service Availability in Remote Communities

This page will show you a list of the sites you configured for this reporting period, which you specified as active patient/patient data sites. This form asks for information about the

availability of services in the local community served by each of these remote patient sites. You should define ‘local community’ in the way that seems the most sensible for your program; there is no specific rule for defining local community.

If your program provides TM services for specialties not listed, you will have to go back to CONFIGURE YOUR REPORTING PERIOD to add these specialties or services.

You will need an informant in each local community where you have an OAT-funded telemedicine site who can provide information about the services available in the community. Data for this item should be collected no more than two months prior to filling out this form, in order to obtain a "snap-shot" of the care that is available at a given point in time.

For each local community served by one of your patient/patient data sites, click on the link and complete the form that appears. Click ‘Yes’ or ‘No’ to answer each question: whether a specialty/service is available in the local community; whether a visiting specialist provides the service regularly; whether your OAT TM program offers the services to this site; and whether another TM program offers the service/specialty.

Finally, indicate how far one would have to drive from the local community to see a specialist in-person. (For services/specialties already available in the local community, the distance traveled should be 0, since no driving is required.) MapQuest.com may be helpful in determining miles between two points. When you have completed all sites (and changed the status to complete on all sites) click SUBMIT at the bottom of the page.

Form 3: Patient Travel

This data sheet takes a systematic approach to measuring patient travel that is ‘saved’ or avoided through the use of telemedicine. There is a link on this page to an Excel Spreadsheet, which is provided for your convenience. We suggest that you assemble your data by filling out a table like the one in the Excel Spreadsheet. (right-click the link and choose "SAVE TARGET AS..." to download excel file). You will only be reporting the bottom row of totals in the website form, but your report will be more accurate if you assemble your data in this manner.

In the Excel Spreadsheet, enter the names of each consultant site (hub site) and each patient/patient data site (remote or originating site) in columns 1 and 2. For many programs, the telehealth consultant site will be serving all your patient/remote sites; you should still list the consultant site/hub site in column 1.

Estimate the distance between the two (in miles) and enter this number into column 3. This information can be obtained by using MapQuest (www.mapquest.com) or other mapping resources.

Enter the number of patient care sessions between the two locations in column 5. For group sessions/clinics, each patient should be counted separately, as each would have had to travel to get care in-person. For simplicity (and to avoid collecting information from each patient) the distance a patient travels from their home to the remote site is intentionally omitted.

Home patients should be excluded from this entire reporting sheet. Homecare data are collected in Form 11 on this website. *Patients being stabilized prior to transport should be excluded as well,* as their travel is not averted, only delayed.

Columns 4 and 6 in the Excel Spreadsheet will fill in automatically—you do not need to enter anything into these cells. Once your Excel Spreadsheet or paper forms are complete and you have the 3 totals at the bottom, enter these into the website form. Do not send us the Excel Spreadsheet forms; you may wish to file them for your own records.

Definition:
Patient-Care Sessions include therapy and counseling (including nutritional, group, etc.) but *not* didactic education, community meetings or administrative sessions.

Finally, at the bottom of the page, enter the number of consultant sites and patient/patient data sites for which data was included on this form.

When you are finished, click SUBMIT at the bottom of the page.

Form 4: Number of Practitioner Referrals

As telemedicine becomes familiar to rural practitioners, they may rely on it for more patients and for different clinical needs. The expanding reliance on telemedicine is an indicator of its value, and of its acceptance by practitioners. The data all grantees submit will be aggregated to show the percent of referring rural practitioners who had 0-10 referrals, 11-20 referrals, etc. The data will also be aggregated to show the percent of referring practitioners who referred patients for care in 0-5 specialties, 6-10 specialties, etc.

Since the focus here is on the reliance of referring practitioners on telemedicine, you will need to track the number and type of patients each practitioner refers for telemedicine. To do this, you should have been identifying each referring practitioner in your data collection system for every patient encounter.

You will report data on 3 types of referrals:
1.) Clinicians referring from remote site: These are referrals made by a clinician at the patient/patient data location, usually a rural site.
2.) Specialists using TM to see their own patients: These are referrals made by a specialist at the consulting location. This is common for post-discharge follow-up encounters between patients and specialists.
3.) Patient ‘self-referrals’: These are situations where a patient presents at a remote/rural site requesting a TM consult with a specialist, but without a referral from any practitioner – the patient is ‘self-referring’ for telemedicine.

For each clinician referring from a patient/remote site, you should assign a unique and confidential identifier or Code Name that is no more than 4 characters or digits long. You might use the person’s initials, a numerical code, or some other code – *please do not put actual names in this space, as we do not wish to know the names of any clinicians working with your program.*

Enter this Code Name in the box titled “Clinicians Referring from Remote Site – Code Name”, then click ‘Add’. The Code Name you have created for that clinician will then appear in the list, and the list will grow as you add new Code Names.

Next, click on each listed Code Name and enter the number of referrals made by that clinician, in each specialty. Every referral made to your system should be counted. For example, if 1 patient is referred 5 times (whether in the same specialty or 5 separate specialties), this should count as 5 referrals. However, if a patient is referred to a dermatologist and then has several follow-up visits, the follow-ups are not separate referrals and you should report only 1 referral.

Repeat the same steps for “Specialists using TM To See Their Own Patients”.

For patient self-referrals, click on “Patient Self-Referrals/Walk-Ins” and enter the total number of self-referrals in each specialty (you do not need to list patients or give them code names).

Finally, at the bottom of the form, enter the number of consultant sites and patient/patient data sites from which data was reported for this form. Click SUBMIT.

Form 5: Supervision of Students/Trainees

Telemedicine can be used to extend formal clinical educational experiences to remote areas, allowing students interested in rural practice (or already in practice) to pursue their educations in these settings. This form allows you to report the number of sessions conducted over your system, in which students were supervised as part of a formal educational program.

Definitions:
Supervisory Session: TM interactions used for the purpose of overseeing students or trainees involved in formal educational programs. These sessions are used to fulfill formal education, licensure or certification requirements.

Example:
A student PA doing a remote clinical rotation requires a certain number of supervised hours to complete degree requirements; this trainee is supervised by his/her instructor via telemedicine.

For each type of student/trainee where your system was used for supervision, enter the number of sessions taking place during the current data collection period. If you need to add an additional type of student/trainee, use the “Add New Student/Trainee Type” box near the bottom of the form.

If your system was not used to supervise a particular type of student/trained, enter 0 (zero) in the box for number of sessions.

Finally, at the bottom of the form, enter the number of consultant sites and patient/patient data sites from which data was reported for this form.

When you are finished, click SUBMIT.

Form 6: Informal Supervision and Mentoring

Telemedicine is also useful for supervising or mentoring remote practitioners of various kinds who may occasionally require supervision from physicians or other more senior specialists. This supervision may be required by professional practice regulations, or may be requested by remote practitioners on an as-needed basis. Requesting a consult from a colleague is not the same as mentoring and supervision. *Do not include professional consults in this form*.

Definition:
Supervision/Mentoring: Supervision of clinicians that is NOT REQUIRED to meet formal educational requirements. This includes sessions required to meet regulatory practice requirements, as well as supervision/mentoring requested by remote practitioners.

Example 1
A nurse-midwife requires supervision from a physician as part of her on-going provision of services.

Example 2
Voluntary skill enhancement programs or new training activity for nurse's aides.

Example 3
A clinic nurse sutures a patient wound, while being supervised by a hospital-based physician.

For each type of remote practitioner listed, where your system was used for supervision/mentoring outside a formal educational program, enter the number of sessions taking place during the current data collection period. If you need to add a new remote practitioner type, use the "Add New Type of Person Being Supervised/Mentored" box near the bottom of the form.

If your system was not used to supervise or mentor a particular type of remote practitioner, place a 0 (zero) in the box for the number of sessions.

Finally, at the bottom of the form, enter the number of consultant sites and patient/patient data sites from which data was reported for this form.

When you are finished, click SUBMIT.

Form 7: Other Uses of Your System

This form asks you to report on the many ways that communities leverage the availability of telecommunications for purposes beyond clinical patient care. These other services are enabled by the availability of the infrastructure, and demonstrate added value communities realize from having a telemedicine program.

In order to complete this table, you will collect information on sessions that are for purposes other than clinical patient care and record them in the appropriate categories on this form.

Please try to use the categories indicated, unless your unique situation simply does not fit into any of them; in this case, you may create a new category. Be careful to count each session only once, in one category, and to be consistent in how you organize your activities into these categories.

If you create a new category, or your activity fits in a category but is a little different in some way, there is a text box where you can describe what it is you are doing. A very brief explanation will do, and only where you feel that it is essential for explaining your activities.

After establishing all the appropriate categories, enter the number of sessions conducted via your network in each category (regardless of the number of sites participating or the number of individuals participating).

Next enter the average number of sites participating in each session. For example, if you held 8 TM Grand Rounds sessions, you would enter 8 in number of sessions next to Grand Rounds; if 5 remote sites usually participated in these TM Grand Rounds sessions, you would enter a 5 in the box for average number of sites participating.

When you are finished, click SUBMIT.

Form 9: Telehealth Consultants Continuing Participation

One indication of clinician acceptance of telemedicine is whether they continue to participate over time. This page collects information on the number of consultants providing care in this reporting period, and compares this to the previous period to determine how many clinicians continued/discontinued participation. You will not be reporting data at the level of the individual clinician; only aggregate data for the entire program.

List for yourself (on paper, or using a Word or Excel file, etc.) the names of clinicians who provided care via TM in the previous reporting period (6-12 months ago) and make another list for the current reporting period (0-6 months ago). *Do not send these lists to us*. Simply compare your two lists.

Enter the total number of clinicians who provided patient care encounters in the previous reporting period (column 1) and in the current reporting period (column 2). Note: If you are a

brand new program, you will only have data to report for the Current Reporting Period. However, the next reporting period you will have sufficient data to complete the entire table.

Next, consider your list of consultants in the two periods. In the box titled "# Continuing Health Consultants", enter the number of clinicians who provided encounters in BOTH the previous period and the current period; these are continuing consultants.

In the box titled "# New Telehealth Consultants", enter the number of consultants who did not provide TM services in the previous period, but did provide services in the current reporting period. These are new consultants.

Next, identify the consultants who only provided care via TM in the previous period, but not in the current period. These are clinicians who stopped providing TM consults for some reason.

Their reasons for discontinuing are important, and should fall into one of the following categories (you may have to check with some of the consultants to find out why they stopped consulting):

1.) No longer providing care in the health system (retired, moved away, changed affiliation)
2.) Specialty not sought via TM during current reporting period (would have consulted, but wasn't asked)
3.) Declined TM opportunities (was asked to consult, but refused).

Enter the number of discontinuing consultants in these three categories in the corresponding boxes on this form.

Finally, at the bottom of the form, enter the number of consultant sites from which data was reported for this form (it should equal all of your active consultant/hub sites).

When you are finished, click SUBMIT.

Form 10: Referring Practitioners Continuing Participation

Since it takes both a referral and an encounter for telemedicine to happen, acceptance on both ends is important. This data sheet records information much like the last sheet, but focusing on referring practitioners.

You will not be reporting data at the level of the individual clinician; only aggregate data for the entire program. List for your records (on paper, or using a Word or Excel file, etc.) the names of practitioners who referred patients for care via TM in the previous reporting period (6-12 months ago) and make a separate list for the current reporting period (0-6 months ago). *Do not send these lists to us—simply compare your two lists.*

Enter the total number of practitioners who made referrals for patient care encounters in each reporting period. Note: If you are a new program, you will only have data to report for the

Current Reporting Period. However, the next reporting period you will have sufficient data to complete the entire table.

Next, consider your list of TM-referring practitioners in the two periods. In the box titled "# Continuing Referring Practitioners", enter the number who referred patients for TM care in BOTH the previous period and the current period; these are practitioners who continued to refer patients.

In the box titled "# New Referring Practitioners", enter the number of practitioners who only referred patients for TM care during the current period; these are new referrers.

Next, identify the practitioners who only referred patients for care in the previous period, but not in the current period; these are practitioners who stopped (discontinued) referring patients.

These practitioners should fall into one of the following categories (you may have to talk to some of the practitioners to find out why they stopped referring patients):

1.) No longer providing care in the health system (retired, moved away, changed affiliation).
2.) Had no patients needing TM services (would have referred patients if any needed it, but none did).
3.) Declined to refer patients (had patients who might have benefited, but did not to refer them).

Enter the number of practitioners who stopped referring patients, according to the above categories, into the corresponding boxes on the form.

Finally, at the bottom of the form, enter the number of consultant sites and the number of patient/patient data sites, from which data was reported for this form.

When you are finished, click SUBMIT.

Form 11: Homecare

Many OAT programs are now involved in tele-homecare, meeting the needs of homebound patients, especially those who require frequent monitoring. Home health agencies and insurers are interested in improving quality of homecare without increasing costs. Demonstrating the advantages of telemedicine for homebound patients may be useful as you interact with HHAs and insurers. Tele-home care offers many advantages, including reduced travel time and improved productivity through tele-visits compared to in-person home health visits, and improved access/quality through adding care that would not have occurred without telehealth technology.

Most telehealth programs already ask telehealth home nurses to fill out forms reporting date, time, purpose, etc. of their televisits. To demonstrate the progress being made by your telehomecare program, we suggest that you gather three pieces of information on each tele-

home health visit. For this purpose, you would modify your nurse's forms and ask them to record, for each home telehealth visit:

1. Would you have made this visit to the patient's home in-person, if telemedicine were not available? _____ Yes _____No
2. Roundtrip miles to the patient's home. _____ Miles
3. Estimated roundtrip drive time to this patient's home. _____ Minutes

Please Note: This form can only be completed if nurses providing home telehealth care have collected one piece of new information for each visit - whether or not the visit would have happened in-person, in the absence of telemedicine. You won't be able to fill out this form unless the home telehealth nurses are collecting this information on every home televisit.

To facilitate your calculations, we have created an Excel Spreadsheet for you to download (right-click the link and choose "SAVE TARGET AS..." to download excel file) on which you can enter data for each homebound patient. You may find it helpful to download the worksheet, fill it in for each patient, and then enter the totals from the worksheet into the website. The worksheet may contain confidential patient information and should only be used for your records, ***DO NOT SEND US THE WORKSHEETS!*** Note: On the worksheet, only enter data in the unshaded cells. The gray (shaded) cells will be automatically totaled in by Excel.

Once you have completed the Excel worksheet, enter the totals (aggregated data) into the boxes on this form.

Finally, at the bottom of the form, enter the number of consultant sites and patient/patient data sites from which data was reported for this form.

When you are finished, click SUBMIT.

Form 12: Outcome Measures for Chronic Conditions

Outcome Measures for Chronic Disease Care: Spreadsheet Instructions

Patient Privacy: The names or initials you type in this spreadsheet will NEVER be uploaded or saved in the study database and are for your own reference only.

Introduction: The purpose of this spreadsheet is to gather data on patients with chronic conditions, for whom your program provided care other than home-health care; that is, care provided in other settings or through other means. This does not include tele-home health care, which you should report on the accompanying sheet. We are interested in five specific chronic conditions that are the most commonly served by telehealth programs; if you provided care to other types of patients, they are not to be included in this spreadsheet.

Some of the cells in this spreadsheet have drop-down menus and some have cells where you need to type in an answer. The instructions below will clarify which cells will require you to either type an

answer or make a selection in a drop-down menu.

Patient Identifier: For each 6 month period, enter the name or initials of a patient in the top left cell labeled "Patient Identifier". Do not type in the gray areas--you only need to enter information in the white areas. Patient Privacy: The names or initials you type in this spreadsheet will never be uploaded or saved in the study database and are for your own reference only.

Disease Category: Either click on or tab over to the cell on the right labeled "Disease Category" Once you click on this cell, you will see an arrow pointing down--click on the arrow and a drop-down menu will appear. Choose from the following options on the drop-down menu: CHF, Diabetes, Asthma, COPD, Mental Health, or Other Chronic Condition. Choose the category that most closely fits the patient - choose one category only. Note: If you try to type an answer instead of choosing one from the menu, an error message will appear.

Age Category: Click on the next cell to the right labeled "Age Category" and choose a category from the following drop-down menu: <18, 18-64, or 65+.

Note: The next five cells do not have drop-down menus, so you must type in your answer.

Hospitalizations: Enter the number of hospitalizations within the last 6 months that this patient has had. In the next cell, enter the number of these hospitalizations that occurred within 30 days of a discharge. Finally, enter the number of hospitalizations the patient had within 31-60 days after a discharge.

Emergency Department Visits: In the next cell, labeled "# ED visits in 6 months", enter the number of emergency room visits this patient has had within the last six months.

Skilled Nursing/Rehab: In the final cell, labeled "# SNF/rehab admissions in 6 months", enter the number of skilled nursing/rehabilitation admissions that each patient had in the last six months.

Instructions for uploading your spreadsheets:

To upload your Chronic Conditions spreadsheet with your data, click on the Browse button to select the correct file. Once the file is selected, click the ‘Upload Excel File’ button to the right of the Browse button.

After a few seconds, all of you're data will appear on the page in the appropriate columns. Once your data has been successfully uploaded, be sure to fill out the bottom section of the page on the number of ‘Consultant Sites’ and ‘Patient Data Sites’ and click ‘Submit’.

If there are any errors in the uploading process, you will see an indication of this in the farthest right column titled ‘Upload Errors’. If this happens, make sure you are trying to upload the correct file and run the upload again.

Form 13: Telerehabilitation

Telerehabilitation Patient Status: Spreadsheet Instructions

Patient Privacy: The names or initials you type in this spreadsheet will NEVER be uploaded or saved in the study database and are for your own reference only.

Introduction: The purpose of this spreadsheet is to gather data about patients for whom your program provided telerehabilitation services; it does not apply to patients receiving other care/services through your program. We are interested in the telerehab episode - not all care the patient received from injury onwards, but just the portion of their care that was provided through your telerehab program - from admission to telerehab, to completion of telerehab.

Some of the cells in this spreadsheet have drop-down menus and some have cells where you need to type in an answer. The instructions below will clarify where you need to type an answer or make a selection in a drop-down menu.

Patient Identifier: For each 6 month period, enter the name or initials of a patient in the top left cell labeled "Patient Identifier". Do not type in the gray areas--you only need to enter information in the white areas. Patient Privacy: The names or initials you type in this spreadsheet will never be uploaded or saved in the study database and are for your own reference only.

Injury Type: Either click on or tab over to the cell on the right labeled "Injury Type". Once you click on this cell, you will see an arrow pointing down--click on the arrow and a drop-down menu will appear. Choose from the following options on the drop-down menu: Stroke, Other Brain Injury, Orthopedics, Other. Note: If you try to type an answer instead of choosing one from the menu, an error message will appear.
Depression: Click on the next cell to the right under the heading: "Depression". Please note that intake and discharge status specifically refer to Telerehabilitation and not general intake or discharge from a hospital or facility. Click in the first cell, "Intake Status" and enter a number from 0 to 4 (see chart below for the Depression rating system). Do the same for the next cell labeled, "Discharge Status". Note: Both of these cells do not have a drop-down menu, so you must type in your answers.

0 - None
1 - Mild problem, does not interfere
2 - Mild problem, interferes 5-24% of the time
3 - Moderate problem interferes 25-75%
4 - Severe problem interferes more than 75%

Functional Improvement: The next three cells are under the heading: "Functional Improvement". Click on the first cell under "Goal of Rehabilitation" and a drop-down menu will appear. Choose either "Paid Employment" or "Independent Lifestyle". The next two cells, "Intake Status" and "Discharge Status" do not have drop-down menus so you must enter a number from 0 to 4 (see chart below for the Functional Improvement rating system).

0 - Full Time (>30 hours w/o support)
1 - Part Time (3-30 hours w/o support)
2 - Full/Part Time with support

3 - Supervised/Sheltered work
4 - Inactive/Unemployed (fewer than 3 hours)

Overall Functional Status Change: In the final cell labeled: "Overall Functional Status Change", enter a number from 0 to 4 (see chart below for the Overall Functional Status Change rating system).

0 - Full recovery of Functional Status
1 - High level change, but not full recovery
2 - Some change/improvement
3 - No change
4 - Decline

Instructions for uploading your spreadsheets:

To upload your Chronic Conditions spreadsheet with your data, click on the Browse button to select the correct file. Once the file is selected, click the 'Upload Excel File' button to the right of the Browse button.

After a few seconds, all of you're data will appear on the page in the appropriate columns. Once your data has been successfully uploaded, be sure to fill out the bottom section of the page on the number of 'Consultant Sites' and 'Patient Data Sites' and click 'Submit'.

If there are any errors in the uploading process, you will see an indication of this in the farthest right column titled 'Upload Errors'. If this happens, make sure you are trying to upload the correct file and run the upload again.

Form 14: Dermatology

Dermatology: Spreadsheet Instructions

Patient Privacy: The names or initials you type in this spreadsheet will NEVER be uploaded or saved in the study database and are for your own reference only.

Some of the cells in this spreadsheet have drop-down menus and some have cells where you need to type in an answer. The instructions below will clarify which cells will require you to either type an answer or make a selection in a drop-down menu.

Patient Identifier: For each 6 month period, enter the name or initials of a patient in the top left cell labeled "Patient Identifier". Do not type in the gray areas--you only need to enter information in the white areas. Patient Privacy: The names or initials you type in this spreadsheet will never be uploaded or saved in the study database and are for your own reference only.

What technology was used: Either click on or tab over to the cell on the right with the question: "What technology was used?". Once you click on this cell, you will see an arrow pointing down--click on the arrow and a drop-down menu will appear. Choose from "Interactive video", "Store-forward", or "Both" from the drop-down menu to describe the technology used in the patient session.

Technology adequate to make a diagnosis: Click on the next cell to the right with the question "Image adequate to make a diagnosis?". Choose either "Yes" or "No" from the drop-down menu. Note: if you try to type an answer instead of choosing one from the menu, an error message will appear.

In-person visit required for diagnosis: Choose either ""Yes"" or ""No"" in the drop-down menu to answer whether an in-person visit was required in order to make a diagnosis.

What was the primary diagnosis: Move to the next cell and answer the question: ""What was the diagnosis?"" Choose one of the following options from the drop-down menu: Eczema, Papulosquamous, Vesiculobullous, Tumors - benign, Tumors - malignant, Inflammation, Hair/Nails, Systemic Disease, Pigmentation, Infection/Infestation, Other (specify), No Diagnosis.

If primary diagnosis is ""Other"" (col. J) please specify: If you chose ""Other (specify)"" in the drop down menu under the previous column ""What was the primary diagnosis?"", please complete this last column (column J) and type in what the diagnosis was. Do not fill in this column if you did not choose Other (specify) for a diagnosis.

Instructions for uploading your spreadsheets:

To upload your Chronic Conditions spreadsheet with your data, click on the Browse button to select the correct file. Once the file is selected, click the 'Upload Excel File' button to the right of the Browse button.

After a few seconds, all of you're data will appear on the page in the appropriate columns. Once your data has been successfully uploaded, be sure to fill out the bottom section of the page on the number of 'Consultant Sites' and 'Patient Data Sites' and click 'Submit'.

If there are any errors in the uploading process, you will see an indication of this in the farthest right column titled 'Upload Errors'. If this happens, make sure you are trying to upload the correct file and run the upload again.

Form 15: Patients

HRSA is interested in how many patients are served by telehealth, how many of these patients have diabetes, and how many of the latter are in good glucose control. The standard for being in good glucose control is a Hemaglobin A1C test result of 7% or less.

For the first number, count the total individuals whose care was assisted through telehealth during the six-month reporting period.

For the second number, count the diabetic patients who were served by the telehealth program for at least three months out of the six-month reporting period. This should include patients who were already being served when the six-month reporting period began and who continued with the program for at least three more months. This should also include those who entered the program mid-way through the reporting period and remained for at least three months.

For the third number, count the diabetic patients who were served by the telehealth program for at least three months out of the six month reporting period, and whose Hemaglobin A1C test result taken during that time was 7% or less. Do not include patients for whom no Hemaglobin A1C test was taken during the reporting period. Please do not report percentages - these will be calculated by the system after all results are received.