Pre-visit Prep:

The table below provides guidance on the workflow during the telehealth visit which is organized into pre-visit, during visit, and post-visit activities. We have differentiated between administrative aspects (listed first and shaded in the tables below) and clinical aspects of the telehealth visit since personnel, timing, and workflow may differ. It is important for each organization to determine in advance who is responsible for each task and that the visit is provided in a safe environment (i.e. not while operating a car).

Task	What Specific Activities	Helpful links
Appointment reminder	Reminder to patient (and caregiver as appropriate)	
Address patient concerns re. telehealth platform	• Tech anxiety[1] • Privacy concerns from patients • Lack of trust	◊ *See Table 2, Barriers and Proposed Solutions to Widespread Digital Health Use in Older Adults*[1] ◊ What to expect during the visit (especially if 1st visit for an established patient). *My Action Plan for HF* ◊ Goals of care/patient preferences *My Action Plan for HF*
Technology onboarding/ check in	• Instruct patient re. connecting to telehealth platform (as needed) • Practice session as appropriate	Possible solutions related to socioeconomic, health literacy, and financial barriers reference ◊ *See Table 2, Barriers and Proposed Solutions to Widespread Digital Health Use in Older Adults*[1]
Accommodations for patient/caregiver*	• Visual/auditory acuity • Motor skills, hand-eye coordination • Time to complete physical/mental tasks • Need for interpreter	Possible solutions related to accommodations ◊ *See Table 2, Barriers and Proposed Solutions to Widespread Digital Health Use in Older Adults*[1]
Institutional compliance for telehealth visits; connecting EHR with 3rd party	• Privacy issues	

Table will continue in the next page

EHR = electronic health record; HF = heart failure

[1] Krishnaswami A, Beavers C, Dorsch MP, et al.; Innovations, cardiovascular team and the geriatric cardiology councils, American College of Cardiology. Gerotechnology for older adults with cardiovascular diseases: JACC State-of-the-Art Review. J Am Coll Cardiol. 2020 Dec 1;76(22):2650-2670. doi: 10.1016/j.jacc.2020.09.606

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Pre-visit Prep
(Continued)

Task	What Specific Activities	Helpful links
Patient-generated data	<u>Self-measured (as applicable)</u> • Home BP readings • Heart rate • Daily weights • Oxygen saturation • Physical activity monitor • Dietary log • Blood sugar log • Other standardized forms as applicable (Kansas City Cardiomyopathy Questionnaire, PHQ) to screen for depression, Dyspnea Scale	Resource for patients to track HF symptoms and how symptoms limit activities to share pre-visit. ◊ *Making the Most of My Follow Up Visits* Worksheet for patients to track daily weights and share pre-visit ◊ *My Daily Weight Tracker* link to one page worksheet with blank calendar with daily boxes for recording daily weight
	<u>Remote monitoring data</u> • Data entry into Electronic Health Record (EHR) • Download remote monitoring data (e.g., CardioMEMS, HeartLogic, OptiVol, etc.)	
Medication reconciliation	• Pre-visit versus synchronously	Resource for patients to list current meds, including non-HF meds, to share at the previsit. ◊ *My Action Plan For HF*
Global status update since last visit	• Change of symptoms/any new complaints • NYHA Class • Pre-visit or synchronously	
	<u>Updates since last visit (interim)</u> • Recent hospitalizations/ED visits and if summaries/discharge notes are needed • Outstanding tests (labs, imaging) • Visits to other specialists/PCP notes	For workflow, suggest predesignating who will pull those materials.

BP = blood pressure; ED = emergency department; EHR = electronic health record; HF = heart failure; PCP = primary care provider; PHQ = patient health questionnaire

During Visit:

In this section we acknowledge the possible overlap between what is included in the pre-visit and during visit activities. Some practice settings may combine the pre- and during visit activities (potentially having one team member see the patient before the physician, nurse practitioner, or physician assistant); others with more infrastructure (or contracted pre-visit staff) may keep as distinct activities. Some of the activities may differ depending on whether the patient is relatively new to the practice versus an established patient and whether the patient presents with "acute", "acute on chronic", or "chronic" symptoms. Notably, although the rows may imply a specific order of activities, some activities may occur simultaneously (e.g., when asking questions, education may occur). Although the list is rather exhaustive – it is intended to be used as a checklist of what is potentially applicable at a practice (e.g., some may screen for depression at each pre- or during visit; others may not have a systematic process for depression screening).

Task	What Specific Activities	Helpful links or references as Needed
Other parties joining visit	• Caregiver present for visit; • Other team members may join visit (another subspecialist; CV team members, etc.)	
Review results of patient-generated data • **Prespecified** • **Condition specific** • **Specific for duration (same day, full week, changes, etc.)**	Self-measured (as applicable) • Home BP readings • Daily weights • Heart rate • Oxygen saturation • Physical activity monitor • Other standardized forms as applicable (Kansas City Cardiomyopathy Questionnaire, PHQ) to screen for depression, Dyspnea Scale)	See links above as applicable (if not used in pre-visit)
	Remote monitoring data • Data entry into EHR • Download remote monitoring data • e.g. CardioMEMS, HeartLogic, OptiVol, etc.	
Medication reconciliation	• Confirm if on guideline directed medical therapy (GDMT) including current doses	Resource for clinicians to confirm that patient is on GDMT ◊ *TreatHF App*
Global status update since last visit	• Change of symptoms/any new complaints • Conducted synchronously	
	Updates since last visit (interim) • Recent hospitalizations/ED visits (need summaries/discharge notes) • Pending tests (labs, imaging) • Visits to other specialists/PCP notes	For workflow, suggest predesignating who will pull those materials.

Table will continue in the next page

BP = blood pressure; CV = cardiovascular; ED = emergency department; EHR = electronic health record; GDMT = guideline-directed medical therapy; HF = heart failure; PCP = primary care provider; PHQ = patient health questionnaire

During Visit:
(Continued)

Task	What Specific Activities	Helpful links or references as Needed
Focused ROS, including lifestyle	• Standard ROS questions for HF • Current diet, fluid intake, substance use	Resource for patients and caregivers to use as a checklist ◊ *HF Hospitalization Pathway Toolkit* (Refer to Figure 10)
Modified physical exam for telehealth visit	Note: for workflow need ability to turn camera on patient including preparing the patient for this request • Stand on scales during visit (weight) • Take BP during visit (observe technique) • Neck veins; Use of accessory muscles or dyspnea during conversation with clinician • Extremities (color and edema) • Walk any distance while on camera (6 minute walk down hallway; modified if camera is portable) • Confirm when the last in person physical exam was done	
Patient education	• Visual images of heart etc. to teach (especially for visual learners or those with low literacy) • Virtual tour of pantry (must be preannounced) • Key take away messages for patient and caregiver • Goals of care and tasks for next visit • All questions addressed (making notes of what was deferred to discuss at future visits)	Checklist of what education to include ◊ *HF Hospitalization Pathway Toolkit* (Refer to Figure 10) Visual images of heart for clinicians to refer to during education session ◊ *CardioSmart Heart Explorer App* Infographs for patient education ◊ *Turning Heart Failure Into Heart Success* ◊ *What is Heart Failure?* To use for helping patients/ caregivers identify goals of care and preferences ◊ *My Action Plan for HF*

Table will continue in the next page

BP = blood pressure; HF = heart failure; ROS = review of symptoms

During Visit:
(Continued)

Task	What Specific Activities	Helpful links or references as Needed
Shared decision-making	• ACE-I, ARB, ARNI • SGLT2i • ICD/CRT • LVAD/transplant • Palliative care/hospice	Shared decision-making tools ◊ *For ICDs* ◊ *For LVADs* ◊ *For ACE/ARB vs ARNI*
Final assessment and treatment plan	• Current NYHA Class; Last LVEF • Confirm if on GDMT and if at target doses (if not, why not?) • Changes to treatment plan (meds, devices, lifestyle) • Labs/imaging/tests • Referrals to other clinicians/CV team members (including social worker or patient assistance programs) • Timing interval for next visit (i.e. telephone, virtual, in-person)	Resource for clinicians to confirm GDMT and checklist for follow-up care needed ◊ *HF Hospitalization Pathway Toolkit* (Refer to Figure 11) Resource for patient/caregiver for when to call the CV care team: ◊ *HF Stoplight – When to Call*

ACE-I = Angiotensin-converting enzyme inhibitors; ARB = angiotensin II receptor blockers; ARNI = angiotensin receptor–neprilysin inhibitors; CRT = Cardiac resynchronization therapy; CV = cardiovascular; GDMT = guideline-directed medical therapy; HF = heart failure; ICD = Implantable Cardioverter Defibrillator; LVAD = left ventricular assist device; LVEF = left ventricular ejection fraction; NYHA = New York Heart Association; SGLT-2 = Sodium-glucose co-transporter-2

Post-visit (24-72 hours after visit):

Some of the post-visit activities in the table below may not differ than in person post-visits. However, there is an opportunity with telehealth to improve care. Some of the activities may be done synchronously (by phone call) or asynchronously (by electronic communication through email or other electronic health record (EHR) portal).

Task	What Specific Activities	Helpful links or references as Needed
Status update	• Resolution or improvement of symptoms based on changes made • Patient-generated health data (see during visit section)	Checklist for post-visit: ◊ *HF Hospitalization Pathway Toolkit* (Refer to Figure 13)
Confirmation of instructions/resolution of barriers identified (teach/reteach)	• Prescriptions filled? • Changes made to treatment plan (meds, lifestyle)? • Follow-up from patient assistance programs (co-pays for new meds)	
Review pending results	• Lab/imaging/testing results	
Outstanding questions (from patient or caregiver)	• Address additional questions and reinforce teaching since last visit	
Planning for next visit	• Goals and tasks for next visit • Next visit in person or telehealth? • Date/time of next visit • Date/time of other appointments (for testing or other specialists)	
Quality and satisfaction of visit	• Standardized tools: standardized survey, telehealth usability questionnaire	

HF = heart failure