

Telehealth Implementation Toolkit





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ABOUT CTRC

The California Telehealth Resource Center (CTRC) offers no-cost, unbiased training, educational resources, and technical assistance to help California providers and patients get the most from telehealth. As the federally designated telehealth resource center for the region, we offer unbiased tools and services based upon proven telehealth practices. We create lasting change and improvement by focusing on implementation, sustainability, reimbursement and policy, integration, workflows, and patient/provider adoption.

As part of the National Consortium of Telehealth Resource Centers and the OCHIN family of companies, CTRC assists thousands of providers and patients annually. We have extensive experience supporting the healthcare safety net, rural and urban providers, and patients and families throughout California who would otherwise be unable to access quality healthcare due to geographic isolation, language/cultural barriers, lack of insurance, disability, homelessness, and more.



Purpose and Audience

This toolkit is designed for health organizations implementing or expanding a telehealth program. It is intentionally operational. It does not assume a large implementation office, dedicated telehealth department, sophisticated analytics team, or unlimited broadband. Instead, it helps a cross-functional team move from a defined access problem to a safe, usable, measurable, sustainable telehealth service.

The Operating Principle

Consider beginning with the care-access problem rather than the technology. Start with the care-access problem, design the service around patients and frontline work, select technology that supports the model, launch in a controlled way, measure whether it works, and consider scaling when the model is reliable enough to support replication.

What This Toolkit Is

- A step-by-step implementation guide.
- A working workbook with decision tools, checklists, scripts, templates, and stage gates.
- An adaptation of evidence-informed telehealth implementation practices.
- A structure for documenting decisions so lessons can be shared, repeated, and scaled.

What This Toolkit Is Not

- A legal opinion or compliance manual.
- A vendor selection list or endorsement.
- A promise that every telehealth modality is reimbursable for every service or payer.
- A one-size-fits-all clinical protocol.
- A requirement to complete every worksheet. Use what advances the program and document why other tools are not applicable.

Evidence-Informed Design

Federal telehealth guidance recommends understanding the community, creating a business plan, planning workflow, preparing patients, evaluating performance, and considering sustainability from the beginning. This toolkit converts those principles into a seven-stage operational sequence.

Evidence principle	How it appears in this toolkit
Know The Community	Needs assessment, patient interviews, access barriers, connectivity and access assessment.
Plan The Workflow	End-to-end workflow mapping, failure-mode review, scripts, role assignment, simulation.
Prepare Patients and Staff	Readiness screening, patient instructions, staff competency, digital support.
Evaluate Deliberately	Baseline, metric definitions, scorecard, patient/provider feedback, access review.
Plan Sustainability Early	Business case in Design; sustainability stress test and operating model in Sustain.
Adapt To Organizational Context	Minimum viable approach, role stacking, low-volume economics, broadband alternatives, regional partnerships.
Learn And Disseminate	Issue log, lessons learned, replication package, scale-readiness assessment.

How To Use the Toolkit

Operations teams should avoid treating all digital health services as interchangeable. Different care scenarios require different modalities, workflows, staffing structures, and reimbursement pathways.

1. Name an accountable program owner and clinical champion.
2. Complete the 10-minute starting-point assessment.
3. Enter the toolkit at the stage that matches your current maturity.
4. At the beginning of each stage, agree on the stage outcome and recommended deliverables.

5. Use the step-by-step guidance to make decisions; complete the worksheets that support those decisions.
6. When schedule pressure is present, the team may wish to review unresolved risks, document proposed mitigations, and agree on conditions before moving forward.
7. Maintain one implementation record containing the completed tools, decisions, metrics, issue log, and lessons learned.
8. Revisit earlier stages whenever evidence, policy, staffing, technology, or patient needs change.

Find Your Starting Point

Current State	Recommended Entry Point
We are exploring telehealth or have grant funding but no defined use case.	ASSESS
We know the care/access problem and population but not the operating model.	DESIGN
We have a defined model/vendor and need to operationalize it.	BUILD
We are ready to pilot or go live.	LAUNCH
We are live and need to understand performance and value.	MEASURE
We need a durable post-grant operating model.	SUSTAIN
We have a stable program and want to expand to another site/service/population.	SCALE

10-Minute Starting-Point Assessment

- ☐ We can state the care-access problem in one sentence.
- ☐ We know which patient population is most affected.
- ☐ We have baseline evidence showing the problem exists.
- ☐ We have an executive sponsor and clinical champion.
- ☐ We understand the current-state patient and staff workflow.
- ☐ We have considered broadband, device, language, disability, and digital-literacy barriers.
- ☐ We have selected or narrowed the telehealth model/modality.
- ☐ We have a preliminary staffing and technology approach.
- ☐ We know what success will look like and how we will measure it.
- ☐ We have discussed how the program will continue after start-up funding.

Assessment Results

0-3 Checked: start at Assess.

4-6 Checked: start at Design and validate missing Assess items.

7-8 Checked: start at Build.

9-10 Checked: use the stage gates to determine whether Launch, Measure, Sustain, or Scale is the appropriate entry point.

Implementation Framework at a Glance

Stage	Key question	Recommended outputs	Typical decision
1. Assess	Are we solving the right problem?	Problem statement; baseline; readiness assessment; stakeholder map; risk profile.	Proceed / redefine / stop.
2. Design	What should the program look like?	Care model; modality; eligibility; patient journey; RACI; access plan; business case.	Approve design / revise.
3. Build	How will it work every day?	Workflows; policies/protocols; technology configuration; scripts; training; downtime/escalation plan.	Ready / ready with conditions / additional preparation recommended for pilot.
4. Launch	Can we start safely and learn quickly?	Pilot plan; simulation; go-live support; issue log; 30-day optimization review.	Continue / optimize / revisit.
5. Measure	Is it working, for whom, and at what cost?	Scorecard; metric definitions; feedback; QI priorities.	Maintain / redesign / expand.
6. Sustain	Can it continue after start-up funding?	Cost model; sustainability stress test; operating ownership; 12-month plan.	Institutionalize / restructure / retire.
7. Scale	What is ready to spread?	Scale assessment; replication package; adaptation plan; lessons learned.	Optimize / adapt / replicate.

The Minimum Viable Telehealth Program

A minimum viable telehealth program is not a lower-quality program. It is the smallest operational model that can deliver the intended service safely, reliably, equitably, and measurably. It is especially useful in all settings where staff may hold multiple roles and patient volume may not justify enterprise-scale infrastructure.

- ☐ Defined clinical/access use case and target population.
- ☐ Accountable executive/program owner and clinical champion.
- ☐ Clinical appropriateness and in-person conversion criteria.
- ☐ End-to-end workflow with named owners.
- ☐ Approved technology and connectivity fallback.
- ☐ Patient preparation and support pathway.
- ☐ Staff training and competency validation.
- ☐ Emergency, downtime, and technical-failure procedures.
- ☐ Documentation, coding, billing, privacy, security, and consent workflows validated against current requirements.
- ☐ Baseline and small set of measures.
- ☐ Plan for issue escalation and continuous improvement.

STAGE 1 — ASSESS

Recommended Way to Use This Stage

Consider inviting a small cross-functional group that includes clinical, operational, data, technology, and patient or community perspectives. The group may review available local data, describe the current care pathway, complete only the assessment tools that add value, and record assumptions that still need confirmation.

A useful outcome is a shared problem statement, baseline, readiness action list, stakeholder map, and documented recommendation to proceed, proceed with conditions, or refine the proposed approach.

Key question: Are we solving the right problem?

Stage Outcome

A defensible problem statement, baseline, readiness profile, stakeholder map, and decision that telehealth is a plausible intervention.

Why This Stage Matters

Telehealth programs are vulnerable to solution-first thinking: a platform becomes available, grant funds are awarded, or a partner offers a service, and the organization begins implementation before defining the problem. Assessment reverses that sequence. The team first defines the access or care gap, determines who experiences it, documents the current state, and tests whether telehealth addresses the root cause.

Step 1. Define The Problem

What is the problem? Write the problem without using the word telehealth.	Who is affected? Identify the population and geography served.
What is the current pathway? Describe the current process from need to completed care.	Why is it happening? Separate symptoms from underlying causes. A high no-show rate may reflect transportation, appointment timing, digital access, etc.
Why does it matter? In terms of access, quality, experience, workforce, cost, or CalRHT objectives.	If nothing changes? What happens if the organization does nothing?

Sample Problem Statement:

'Adults with poorly controlled diabetes in our service area wait an average of X days for specialty support and travel Y miles for endocrinology.'

Tool 1A — Problem Definition Canvas

Use this before discussing technology or vendors.

Prompt	Working response
What problem are we trying to solve?	
Who experiences the problem most?	
What evidence shows the problem exists?	
What is the current care pathway?	
Where does the pathway fail or create burden?	
What are the likely root causes?	
What outcome would improve if the problem were solved?	
What is the consequence of doing nothing?	
What is the consequence of doing nothing?	

Step 2. Establish A Baseline

A baseline creates the comparison point for later evaluation. Use data already available before creating new collection burden. Acceptable baseline sources may include EHR reports, referral logs, scheduling data, claims, patient surveys, staff estimates validated by sampling, travel-distance estimates, partner data, or manual review.

Domain	Possible baseline measures	Questions
Access	Days to next appointment; referral completion; travel distance/time; service availability.	How difficult is it to obtain the service today?
Utilization	Visits; referrals; no-shows; cancellations; transfers.	What volume exists and where is it lost?
Quality	Condition-specific clinical/process measures.	What clinical gap should the program influence?
Experience	Patient/provider satisfaction; burden; complaints.	What is frustrating or burdensome now?
Workforce	Vacancies; coverage gaps; specialist availability; overtime.	Is workforce scarcity part of the problem?
Financial	Current cost; transfer cost; leakage; avoidable utilization.	What is the current economic burden?

Tool 1B — Baseline Worksheet

Choose only measures that help define the problem or later judge success.

Prompt	Working response
Measure	
Baseline period	
Baseline value	
Data source	
Data owner	
Data quality limitations	
Why this measure matters	

Step 3. Understanding The Community and Digital Context

Telehealth guidance emphasizes understanding internet access, missing services, local care availability, patient needs, and receptiveness to telehealth. It is recommended that the team avoid inferring digital readiness from age, income, or geography alone and instead invite input from patients and frontline staff.

Suggested Patient/Community Interview Opening and Checklist

Use the following script and checklist during a listening session, phone interview, or brief survey.

We are looking at ways to make care easier to access. We are not assuming virtual care is the answer. I would like to understand what makes it difficult to get this care today, what might make a virtual option useful, and what could make it harder to use.

- | | |
|--|--|
| ☐ Device access, data limits, and shared devices. | ☐ Private space at home or availability of a local originating/access site. |
| ☐ Comfort with video, phone, messaging, portals, or remote devices. | ☐ Trust, privacy concerns, and preference for in-person care. |
| ☐ Language and interpreter needs. | ☐ Caregiver involvement. |
| ☐ Disability and accessibility needs. | ☐ Prior telehealth experiences and failure points. |



Telehealth Reality Check

Consider whether a failed video visit reflects connectivity, device, authentication, privacy, or instruction barriers rather than patient resistance. The cause may be bandwidth, device age, authentication burden, portal complexity, lack of private space, or unclear instructions.

Step 4. Assess Organizational Readiness

Readiness is the organization's capacity to implement change now. A low score is useful information, not a reason to abandon the idea. The goal is to identify gaps the team may wish to address or mitigate.

Readiness Domain	1 — Low	3 — Developing	5 — Strong
Leadership	No sponsor or competing priorities.	Sponsor identified; decisions slow.	Active sponsor; clear authority and priority.
Clinical	No champion; unclear fit.	Some clinician interest; criteria incomplete.	Champion engaged; clinical model supported.
Operations	No owner; workflow unknown.	Owner identified; workflow partially mapped.	Dedicated ownership; workflow capacity understood.
Technology	Unknown requirements/connectivity.	Basic platform available; integration/support gaps.	Requirements validated; support and integration planned.
Patient Readiness	Assumed, not assessed.	Some feedback collected.	Needs, barriers, alternatives, and supports defined.
Data	No baseline or reporting owner.	Some data available manually.	Baseline and repeatable reporting available.
Finance	Funding only; no operating model.	Costs known; revenue/value uncertain.	Cost, reimbursement/value, and post-grant plan defined.
Compliance	Requirements not reviewed.	Review underway.	Applicable requirements assigned and validated.
Partnerships	Dependencies unclear.	Partners identified.	Roles, capacity, and agreements understood.
Change Capacity	Staff overloaded; no training plan.	Competing work acknowledged.	Capacity protected; training/change plan feasible.

Tool 1C — Readiness Action Plan

For each domain above, complete the following table. Give each domain a score between 1-5 and create an action for any score below 4.

Prompt	Working response
Domain and score	
Evidence for score	
Gap	
Mitigation/action	
Owner	
Due date	
Residual risk	

Step 5. Map stakeholders and governance

Telehealth crosses clinical care, operations, technology, finance, privacy/security, data, and patient experience. Small organizations may have one person covering several functions. Map functions, not titles.

Stakeholder	Why they matter	Engage when
Executive sponsor	Removes barriers; approves resources; owns strategic alignment.	Assess onward.
Clinical champion	Defines clinical appropriateness and builds peer trust.	Assess onward.
Program/implementation lead	Coordinates work and decisions.	Assess onward.
Front desk/scheduling	Owens key patient access steps.	Design/Build.
Nursing/MA	Prepares patients and supports visits.	Design/Build.
IT/security	Validates technology, support, security, connectivity.	Design/Build.
Billing/revenue cycle	Validates payer/coding workflow.	Design/Build.
Compliance/privacy	Validates requirements and policy.	Design/Build.
Quality/data	Defines baseline and measurement.	Assess onward.
Patient/community representatives	Tests usability and access assumptions.	Assess onward.
External partner/specialist	Defines service capacity, handoffs, agreements.	Assess/Design.

Tool 1D — Stakeholder Map

List people by function; one person may fill several roles.

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Prompt	Working response
Function/stakeholder	
Name	
Role in implementation	
Decision authority	
How/when to engage	
Risk if not engaged	

Step 6. Decide Whether Telehealth Is Appropriate

- ☐ The problem includes an access, distance, workforce, coordination, monitoring, or continuity barrier that telehealth can plausibly reduce.
- ☐ The clinical service can be delivered safely through the proposed modality for at least a defined subset of patients.
- ☐ A non-telehealth pathway remains available when virtual care is inappropriate or unwanted.
- ☐ The intervention does not create more burden than the current state for the intended population.
- ☐ The organization can reasonably close critical readiness gaps.
- ☐ There is a plausible path to measurement and sustainability.



Stage 1 Gate

Proceed to **Design** only when the team can state:

'We are addressing [problem] for [population]. Our baseline is [evidence]. Telehealth may help by [mechanism]. The critical readiness gaps are [gaps], and we have a plan to address them.'

STAGE 2 — DESIGN

Recommended way to use this stage

Consider using one representative patient journey and one representative provider workflow to make the design concrete. The team may compare modalities, agree on eligibility and alternative pathways, assign roles, identify access supports, and document technology needs only after the care model is clear.

A useful outcome is a service specification that two different team members can explain consistently, including who the service is for, how it works, what support is available, and how success will be recognized.

Key question: What should the program actually look like?

Stage Outcome

A defined care model, modality, patient eligibility criteria, patient journey, roles, technology requirements, access safeguards, measurement concept, and preliminary business case.

Step 1. Define The Service Model

Design the service before selecting technology. The same platform can support very different clinical models, and the same care need can often be addressed through multiple modalities.

Need	Possible model	Design questions
Direct access to clinician	Patient-to-provider video/audio/hybrid	Which visits are appropriate? What requires in-person examination?
Specialty shortage	Hub-and-spoke specialty telehealth	Who presents the patient? Which diagnostics may be most appropriate to obtain locally?
Provider expertise gap	Provider-to-provider e-consult/telementoring	What information may support an effective consultation? Who owns follow-up?
Longitudinal monitoring	Remote patient monitoring	Who reviews data? What thresholds trigger action?
Asynchronous need	Store-and-forward / secure messaging	What response time and clinical scope are safe?

Need	Possible model	Design questions
Multi-site workforce coverage	Virtual staffing / tele-rounding	How are handoffs, credentialing, and local support handled?

Tool 2A — Service Model Canvas

Describe the service in operational terms.

Prompt	Working response
Clinical service/use case	
Target population	
Primary modality	
Secondary/fallback modality	
Provider location	
Patient location(s)	
Local support to consider	
Visit frequency/duration	
Referral source	
What remains in person	
Expected volume	
Expected outcome	

Step 2. Define Clinical Appropriateness and Eligibility

Eligibility should support access without becoming a hidden barrier. Use exclusion criteria only when there is a clinical, safety, operational, or regulatory reason.

Decision area	Define before launch
Visit type	Which new, follow-up, urgent, chronic-care, consult, or monitoring encounters qualify?
Clinical acuity	What symptoms/findings require in-person or emergency evaluation?
Exam needs	What may be difficult to assess adequately through telehealth?
Diagnostics	What labs, imaging, vitals, or devices are needed before/during the visit?
Communication	Interpreter, caregiver, cognitive, hearing, visual, or other accommodations.
Technology	

Decision area	Define before launch
Patient preference	How patients choose virtual vs. in-person care.
Location	Any requirements related to patient/provider location and emergency response.

Tool 2B — Eligibility Rules

Turn clinical judgment into a consistent operational rule.

Prompt	Working response
Appropriate visit types	
Conditional visit types	
Not appropriate for telehealth	
Pre-visit information to consider	
Diagnostics or vital signs to consider	
Technology/access requirements	
Approved accommodations	
Approved fallback pathway	
Who resolves uncertain eligibility	

Step 3. Design The Patient Journey

The patient experience begins before the video connection. Map awareness, scheduling, preparation, check-in, the clinical encounter, troubleshooting, follow-up, and feedback.

Journey step	Design standard	Common failure
Awareness	Plain-language explanation of what telehealth is and why offered.	Patients think virtual is mandatory or lower quality.
Scheduling	Correct visit type; eligibility and support needs identified.	Wrong visit booked; needs discovered at visit time.
Preparation	Simple instructions; reminders; test option.	Long instructions; portal dependency; no support contact.
Check-in	Identity/location/callback; recommended intake completed.	Patient waits without knowing status.
Encounter	Clinically appropriate virtual workflow.	Provider improvises; limitations not addressed.

Journey step	Design standard	Common failure
Failure pathway	Clear technical and clinical fallback.	Repeated reconnect attempts with no decision threshold.
Follow-up	Orders/referrals/AVS and next steps close the loop.	Virtual visit ends but downstream care fails.
Feedback	Brief and accessible.	No learning from patient friction.

Tool 2C — Patient Journey Map

Complete from the patient's perspective.

Prompt	Working response
How the patient learns telehealth is available	
How choice is presented	
How eligibility is determined	
How support/accommodation needs are identified	
What the patient receives before the visit	
How the patient checks in	
What the patient experiences during the visit	
What happens if technology fails	
How follow-up care is completed	
How feedback is collected	

Step 4. Design For Access and Accessibility

Access is an operating requirement. A telehealth program can improve access for some patients while creating new barriers for others. Build alternatives into the standard pathway.

- ☐ Low-bandwidth or non-video pathway exists when clinically appropriate.
- ☐ Site-based access option is considered where home connectivity is unreliable.
- ☐ Patient does not need to own a specific premium device unless clinically necessary.
- ☐ Interpreter workflow works in the telehealth platform and fallback modality.
- ☐ Accessibility features and reasonable accommodations are tested.
- ☐ Instructions use plain language and are available in needed languages/formats.
- ☐ Authentication and portal steps are minimized where possible.
- ☐ Caregiver participation is supported with patient permission.
- ☐ In-person care remains available when clinically appropriate and preferred.
- ☐ Measurement plan can detect differences in access, completion, failure, experience, or outcomes.

Tool 2D — Access Barrier Review

Identify who could be unintentionally excluded.

Prompt	Working response
Population/group	
Potential barrier	
How the current design creates or worsens the barrier	
Mitigation	
Alternative pathway	
How we will know the mitigation works	

Step 5. Define Roles and Governance

Decision	Accountable role should be explicit
Clinical appropriateness	Clinical leader/champion
Program performance	Program owner
Workflow changes	Operations + clinical governance
Technology configuration/support	IT/telehealth support
Privacy/security incidents	Designated privacy/security function
Billing/coding decisions	Revenue cycle/compliance
Data definitions	Quality/data owner
Patient complaints/access issues	Patient experience/program owner
Expansion decisions	Executive sponsor/governance group

Tool 2E — RACI

A RACI matrix is a responsibility assignment tool used in project management to clarify who does what on every task, decision, or deliverable within a project. The acronym stands for Responsible, Accountable, Consulted, and Informed, four roles that, when mapped clearly, eliminate ambiguity and keep projects moving.

Code	Stands for	This is the person who...
R	Responsible	Responsible for performing the task or creating the resource
A	Accountable	Accountable for the task or document
C	Consult	Provides support for the task
I	Inform	Informed of the task progress, barriers, or results

Code	Team Member or Role	Activity, Task, or Resource

Step 6. Define Technology Requirements

Write requirements from the workflow. Avoid evaluating vendors only on feature lists.

Requirement Domain	Questions
Patient usability	How many steps to connect? Is an account needed? Mobile-friendly? Languages? Accessibility?
Clinical usability	Does it support the visit model, peripherals, multi-party visits, documentation flow?
Connectivity	How does it perform with weak bandwidth? What happens when video degrades?
Integration	EHR, scheduling, SSO, messaging, RPM data, reporting.
Support	Hours, response times, implementation support, patient support.
Security/privacy	Organizational security requirements, access controls, auditability, data handling.
Data	Export, dashboard, encounter metadata, ownership, retention.
Reliability	Uptime, downtime communication, business continuity.
Contract	Pricing, minimum volume, renewal, termination, data portability, implementation fees.

Tool 2F — Technology Requirements

Consider documenting essential requirements before vendor demonstrations.

Prompt	Working response
Essential clinical functions to consider	
Essential patient-usability functions to consider	
Essential accessibility and language functions to consider	
Connectivity requirements	
Integration requirements	
Security/privacy requirements	
Reporting/data requirements	
Support requirements	
Contract/financial requirements	
Nice-to-have functions	
Deal breakers	

Step 7. Build The Preliminary Business Case

The business case should include financial and non-financial value. In most settings, low volume can make a purely visit-margin calculation incomplete. Consider workforce leverage, avoided travel, reduced transfer, referral retention, improved access, quality, and strategic value, while keeping financial and non-financial benefits clearly separated.

Tool 2G — Preliminary Business Case

Use ranges when exact numbers are not yet available.

Prompt	Working response
Expected monthly volume	
Expected payer mix / payment pathway	
Expected recurring revenue or value mechanism	
One-time implementation costs	
Recurring technology costs	
Recurring staffing costs	
Partner/specialist costs	
Training/support costs	
Expected avoided costs or retained value	
Non-financial benefits	
Key assumptions	
Break-even or sustainability question to validate	



Stage 2 Gate

The design is ready for Build when the team can explain the service model in plain language, identify who is eligible, walk through the future-state patient journey, name every accountable function, state technology requirements, identify access safeguards, and describe the preliminary operating economics.

STAGE 3 — BUILD

Recommended Way to Use This Stage

Consider building the workflow with the people who will perform it. Walking through a realistic patient scenario from referral through follow-up can help identify unclear ownership, missing information, avoidable burden, and contingency needs. It may be helpful to test one normal scenario and several failure scenarios before finalizing procedures.

A useful outcome is a connected set of workflows, scripts, patient instructions, escalation and downtime pathways, configured technology, and role-based training materials that staff can use during a real visit.

Key question: How will the service work every day?

Stage Outcome

A complete operational package: workflows, scripts, technology configuration, clinical/operational protocols, patient materials, training, downtime/escalation plans, and go-live readiness.

Step 1. Build The End-To-End Workflow

Telehealth changes the work before, during, and after the encounter. Federal guidance identifies scheduling, billing, check-in, appointment structure, triage, consent, documentation, preparation, accommodations, troubleshooting, and follow-up as common workflow impacts. Map every handoff.

Workflow step	Minimum design questions
Referral/order	Who initiates? What information may support an effective consultation? How is urgency handled?
Eligibility	Who checks appropriateness? What happens when criteria are unclear?
Scheduling	Visit type, duration, patient location, provider schedule, instructions.
Pre-visit	Consent process, forms, diagnostics, device test, interpreter, caregiver.
Check-in/rooming	Identity, location, callback, privacy, medication/vitals, chief concern.
Encounter	Opening script, consent, exam approach, documentation, participant roles.
Technical failure	Troubleshooting sequence, time threshold, fallback, reschedule.
Clinical escalation	Emergency, urgent in-person, routine in-person conversion.

Workflow step	Minimum design questions
Billing	Coding, modifiers/place-of-service as applicable, eligibility/coverage workflow.
Follow-up	AVS, next appointment, care coordination, patient questions.
Data	What is captured automatically vs. manually and by whom.

Tool 3A — Workflow Build Sheet

Complete one sheet for each major telehealth use case.

Prompt	Working response
Step	
Trigger	
Responsible role	
Action	
System/tool	
Information to consider	
Output	
Exception/failure path	
Escalation owner	

Step 2. Conduct a failure-mode review

Before launch, ask how each workflow step could fail and what the patient would experience. Focus first on failures that could affect safety, privacy, access, or continuity.

Failure	Possible impact	Example mitigation
Wrong visit type scheduled	The clinical need may be better supported through another modality or an in-person pathway.	Eligibility decision support; scheduler escalation.
Patient has difficulty connecting	Missed care; frustration.	Test link, support number, fallback modality/site/in-person.
Patient location unknown	Emergency response delay.	Standard visit opening and documentation.
Interpreter not connected	Communication/safety risk.	Interpreter booking and platform test.
Provider no-show/delay	Patient abandons visit.	Status communication and callback process.
Order does not route	Care plan incomplete.	Closed-loop follow-up queue.

Failure	Possible impact	Example mitigation
Platform outage	Multiple disrupted visits.	Downtime protocol and communication tree.
RPM alert not reviewed	Clinical risk.	Named monitoring owner, coverage, thresholds, audit.

Tool 3B — Failure Mode and Mitigation

Prioritize high-impact and high-likelihood failures.

Prompt	Working response
Workflow step	
How it could fail	
Patient/clinical impact	
Likelihood	
Existing control	
Additional mitigation	
Owner	
How tested	

Step 3. Standardize Patient-Facing Communication

Scheduling Script: Use When Offering Telehealth.

Your care team offers this service through telehealth. It may allow you to meet with your care team without traveling to the clinic. We can help determine whether a virtual visit is appropriate for what you need. Would you like me to explain how the visit works?

When a patient says, 'I am not good with technology.' Avoid Making Assumptions.

That is okay. We can explain the steps and, if available, help you test the connection before the visit. We can also review other care options if telehealth does not work well for you.

When A Patient Says, 'I Do Not Have A Computer.' Explore Approved Alternatives.

You may be able to use a smartphone or tablet, depending on the visit. We can also check whether another approved option, such as a local telehealth site, phone visit when appropriate, or in-person appointment, is available.

When A Patient Asks, 'Is It Private?' Use Organization-Approved Language.

We use our organization's approved telehealth process and privacy practices. I can explain how to prepare for a more private visit and answer questions about the platform or connect you with the appropriate team member.

When A Patient Asks, 'Will Insurance Pay for It?' Avoid Guaranteeing Coverage Or Patient Cost.

Coverage can depend on your health plan, the service, and current rules. We will follow our normal benefit and billing process and can tell you what information is available before the visit.

Pre-visit Reminder: Adapt Channel and Language to The Patient.

You are scheduled for a telehealth visit on [date] at [time]. Please use the instructions we sent to test your connection before the visit. Choose a private, well-lit space if possible and keep your phone nearby in case we need to call you. If you have trouble connecting, call [support number].

Visit Opening: Adapt To Organizational Policy and Clinical Context.

Before we begin, I want to confirm your name and date of birth, where you are physically located right now, and the best phone number to reach you if we get disconnected. Is anyone else present with you? Are you comfortable continuing by telehealth today?

Technology Failure Transition: Set A Clear Threshold.

We have tried to reconnect and the connection is still not reliable enough for this visit. Based on what you need today, the next safest option is [approved fallback]. I will explain what happens next.

California Practice Module — Telehealth Consent

Recommended outcome: A brief, easy-to-understand consent process that fits into the typical visit workflow and leaves a clear, retrievable record.

California Implementation Context

California Business and Professions Code section 2290.5 generally calls for the provider initiating telehealth to inform the patient about telehealth, obtain verbal or written consent before care is delivered, and document the consent. Organizations are

encouraged to confirm current requirements for the service, modality, payer, patient population, and clinician type, and to use language approved by their compliance, privacy, clinical, and billing resources. This section is an implementation aid, not legal advice.

Recommended Consent Workflow

Workflow Point	Recommended Action	Documentation Or Owner
1. Configure	Approve plain-language consent wording for applicable services and modalities. Decide who may obtain consent and where it will be recorded.	Approved policy, script, EHR field, and responsible role
2. Schedule and prepare	Offer available care options without pressure. Identify language or accessibility needs and check whether consent is already documented for the planned modality.	Scheduler or registration staff; consent-status field
3. Obtain before service	Confirm the patient or representative's identity and authority when applicable. Explain telehealth using approved language, invite questions, and obtain verbal or written consent before the service begins.	Trained staff member or initiating provider
4. Document	Record the date, method, modality, patient or representative, person obtaining consent, language or interpreter support, and location of any signed form. Note required information communicated and any limits, refusal, or withdrawal.	Structured EHR field, consent form, or encounter note
5. Begin the visit	Confirm identity, physical location, callback number, privacy, and who is present. Ask whether the patient is comfortable proceeding. If the modality or decision-maker changes, recheck the applicable consent pathway.	Clinician or rooming staff; visit note

Suggested Patient Conversation

"Before we begin, I would like to explain how telehealth works and make sure you are comfortable using it. You may ask questions at any time. Depending on the services available to you, you may request in-person care, and choosing not to use telehealth will not affect your ability to receive future covered care. Telehealth may have technology or privacy limitations, and we will explain what happens if the visit cannot continue safely. Do you have any questions? Do you agree to receive this service by [video/audio-only] telehealth?"

The team may use teach-back, qualified language assistance, or another accessible format when helpful. Patients should have a meaningful opportunity to understand, ask questions, and choose without pressure.

Documentation Checklist

- ☐ Consent was obtained before the applicable telehealth service.
- ☐ Verbal, written, or electronic method and video or audio-only modality are identified.
- ☐ Patient or authorized representative and the person obtaining consent are identified.
- ☐ Date, language or interpreter support, and signed-form location are recorded when applicable.
- ☐ Required patient information and any questions, limits, refusal, withdrawal, or alternative offered are documented.
- ☐ The record is visible to the appropriate care team and can be audited.

Sample Documentation Phrase

"Before the [video/audio-only] telehealth service, [patient/authorized representative] received the organization's approved telehealth information and had an opportunity to ask questions. [Verbal/written/electronic] consent was [obtained/verified] by [name/role] on [date/time]. Communication occurred in [language] with [interpreter/accessibility support, if applicable]. [Any limitation, refusal, withdrawal, or alternative offered.] Documentation is located in [EHR field/form/note]."

Before Launch

The team may test the workflow with a new patient, returning patient, video visit, audio-only visit, interpreter-supported visit, and a patient who declines or changes modality. Confirm who explains telehealth, who obtains consent, when it occurs, where it is documented, and what staff should do when the standard pathway does not fit.

Step 4. Build Patient Preparation

- ☐ Appointment date/time and time zone are clear.
- ☐ Connection method/link is easy to find.
- ☐ Device/browser/app requirements are stated simply.
- ☐ Patient understands an account or portal login may be needed.
- ☐ Test option or support contact is available when feasible.
- ☐ Patient knows what information, medications, devices, or readings to have ready.
- ☐ Patient knows whether a caregiver or interpreter may be helpful.
- ☐ Privacy and environment tips are included without shaming patients who lack private space.
- ☐ Fallback instructions are explicit.
- ☐ Urgent/emergency disclaimer and contact process are appropriate to the service.

Tool 3C — Patient Instruction Builder

Use plain language; keep the final patient version as short as possible.

Prompt	Working response
How to connect	
What device/app/browser is needed	
What to do before the visit	
What to have ready	
How to request language/accessibility support	
What to do if connection fails	
Support contact	
What to expect during the visit	
What happens after the visit	

Step 5. Build Technical Support and Downtime

1. List the five most common connection problems expected for your platform.
2. Create a first-line troubleshooting guide that non-IT staff can follow.
3. Set a time threshold after which the team stops troubleshooting and moves to an approved fallback.
4. Define who can authorize a modality change, reschedule, or in-person conversion.
5. Create an organization-wide outage process for multiple affected visits.
6. Document how technology failures are captured for improvement.

Tool 3D — Technical Failure Protocol

Post this where frontline staff can access it quickly.

Prompt	Working response
Problem	
First action	
Second action	
Maximum troubleshooting time	
Approved fallback	
Who makes final decision	
Patient communication	
Documentation requirement	
Escalation contact	

Step 6. Build clinical escalation and emergency response

Telehealth does not remove the need for emergency planning. The workflow should account for patient location, callback information, urgent findings, inability to complete an adequate assessment, and conversion to in-person or emergency care.

- ☐ Patient location and callback number are confirmed when appropriate to the service.
- ☐ Clinical red flags requiring emergency response are defined.
- ☐ Urgent same-day in-person pathway is defined.
- ☐ Routine in-person conversion pathway is defined.
- ☐ Local emergency response information is available for the service area.
- ☐ Staff know who remains connected with the patient during escalation.
- ☐ Documentation requirements are clear.
- ☐ Safety events are reviewed through the organization's existing quality/safety process.

Tool 3E — Escalation Matrix

Clinical leadership review and approval are recommended before the workflow is finalized.

Prompt	Working response
Trigger/condition	
Immediate action	
Who is notified	
Patient instruction	
Destination/pathway	
Documentation	
Post-event review	

Step 7. Validate Regulatory, Privacy, Security, Billing, and Credentialing Requirements

Requirements change and vary by service, profession, payer, patient/provider location, and organizational setting. Assign a named owner to validate current requirements before launch and at defined intervals.

Domain	Validate
Licensure/scope	Provider authorization for patient location and service.
Credentialing/privileging	Requirements for participating organizations and providers.
Consent	Current federal/state/organizational requirements and documentation.
Privacy/security	Approved platform, access, data handling, environment, incident response.
Prescribing	Current rules applicable to the medication/service.
Documentation	Telehealth-specific elements and organizational standards.
Coding/billing	Current payer rules, service eligibility, modifiers/place of service as applicable.
Accessibility	Applicable accessibility requirements and accommodations.
Record retention/data	Ownership, storage, export, retention, and partner responsibilities.

Tool 3F — Requirements Validation Log

Use links to authoritative sources and date every validation.

Prompt	Working response
Domain	
Requirement/question	
Authoritative source	
Decision/interpretation	
Owner	
Date validated	
Next review date	
Workflow/policy impacted	

Step 8. Select/Configure Technology

Score Area	Weight Suggestion	What Good Looks Like
Clinical workflow fit	20%	Supports the actual care model without workarounds that create risk.
Patient usability	15%	Few steps, mobile-friendly, understandable, accessible.
Reliability/connectivity	15%	Works under realistic conditions; clear fallback.
Integration	10%	Fits scheduling/EHR/data workflow.
Security/privacy	15%	Meets organizational requirements and supports auditability.
Support	10%	Implementation and operational support match program needs.
Data/reporting	5%	Provides usable data for performance management.
Cost/contract	10%	Transparent total cost, flexible volume, acceptable exit/data terms.

Tool 3G — Vendor/Technology Scorecard

Score 1-5, apply weights, and document evidence rather than impressions.

Score area	Weight	Vendor A	Vendor B	Notes
Clinical workflow fit	20%			
Patient usability	15%			
Reliability/connectivity	15%			
Integration	10%			
Security/privacy	15%			
Support	10%			
Data/reporting	5%			
Cost/contract	10%			

Step 9. Train By Role and Validate Competency

Training attendance is not competency. Use role-specific practice and simulation.

Role	Minimum competency
Scheduler	Explains service; selects correct visit type; identifies support needs; knows escalation.
Clinical support	Prepares/rooms patient; supports devices; follows safety/escalation workflow.
Provider	Determines appropriateness; conducts virtual assessment; documents; converts care when needed.

Role	Minimum competency
Billing	Applies current organizational billing workflow and escalates uncertainty.
IT/support	Resolves common issues; communicates outages; tracks patterns.
Program lead	Runs issue review, measurement, change control, and stakeholder communication.

Tool 3H — Competency Sign-Off

Validate through demonstration, scenario, or supervised practice.

Prompt	Working response
Role/person	
Recommended competency	
Training completed	
Demonstrated successfully	
Gap/remediation	
Validated by	
Date	

Step 10. Simulate Before Launch

- | | |
|--|---|
| ☐ Routine successful visit. | ☐ Provider is delayed. |
| ☐ Patient cannot open link. | ☐ Patient is in an unexpected location. |
| ☐ Video fails; audio remains available. | ☐ Urgent clinical concern emerges. |
| ☐ Patient needs interpreter or caregiver. | ☐ Platform outage affects multiple visits. |
| ☐ Patient has low digital literacy. | ☐ Post-visit order/referral fails. |
| | ☐ Billing/documentation edge case. |



Stage 3 Gate

Before launch, it is recommended that the team successfully complete a simulated visit from scheduling through follow-up, including at least one technical failure and one clinical escalation scenario. If a safety-critical item remains unresolved, additional preparation is recommended before launch.

STAGE 4 — LAUNCH

Recommended way to use this stage

A limited pilot may provide the team with time to learn while maintaining manageable support. Consider confirming readiness with the people responsible for clinical care, operations, patient support, technology, privacy, billing, and measurement. Open items may be carried as conditions when an owner, target date, and appropriate interim control are documented.

A useful outcome is a shared launch decision, support schedule, issue-triage process, communication plan, and first 7-day and 30-day review dates.

Key question: Can we start safely and learn quickly?

Stage Outcome

A controlled pilot or go-live with real-time support, an issue log, rapid improvement cadence, and a formal 30-day decision.

Launch Strategy

Whenever feasible, begin with a bounded pilot: a defined service, small provider group, manageable patient cohort, and clear support window. The goal is not to prove perfection. The goal is to discover friction while the team has enough capacity to respond.

Timing	Primary work
T-30 to T-15	Finalize workflows, technology, patient materials, training, baseline, pilot cohort.
T-14 to T-8	Simulation; patient journey testing; billing/documentation validation; partner testing.
T-7 to T-1	Final readiness review; communications; staffing/support schedule; contingency review.
Go-live day	Visible support; issue capture; rapid escalation; protect staff time.
Days 1-7	Daily huddle; correct high-friction workflow issues; monitor safety/access.
Days 8-30	Reduce huddle frequency as stable; review early data and experience.
Day 30	Formal Go / Optimize / Revisit decision.

Tool 4A — Launch Plan

Use dates and named owners.

Prompt	Working response
Pilot scope	
Go-live date	
Providers/sites	
Expected patient volume	
Support coverage	
Training completion	
Simulation completion	
Patient communication	
Partner communication	
Baseline captured	
Day-1 huddle time	
Day-30 review date	

Launch Recommendation Review

- ☐ No unresolved safety-critical workflow gap.
- ☐ Clinical eligibility and escalation approved.
- ☐ Technology tested in realistic conditions.
- ☐ Patient support/fallback pathway staffed.
- ☐ Documentation and billing workflow validated.
- ☐ Recommended staff competency demonstrated.
- ☐ Partner dependencies confirmed.
- ☐ Baseline and data capture ready.
- ☐ Non-critical issues have owner and mitigation.
- ☐ Executive/clinical owner accepts residual risk.

Daily Launch Huddle



Five-question Huddle

10-15 minutes

What worked? What created friction for patients? What created friction for staff? Were there any safety, privacy, billing, or technology concerns? What will we change today, who owns it, and how will we know the change helped?

Tool 4B — Issue Log

Capture patterns and close the loop.

Prompt	Working response
Date/time	
Patient/site/provider context	
Workflow step	
Issue	
Impact	
Immediate workaround	
Safety/privacy/billing flag	
Root cause	
Owner	
Due date	
Resolution	
Recurring?	

30-day Review

Question	Evidence to review
Can patients access the service?	Scheduling, completion, no-show, technical failure, patient feedback.
Can staff deliver it reliably?	Workflow adherence, training gaps, issue log, staff feedback.
Is it clinically appropriate?	Escalations, conversions, safety events, clinical feedback.
Is technology adequate?	Failure rate, support tickets, outage pattern, patient usability.
Is the program creating value?	Early access, quality, experience, workforce, financial indicators.
Are some groups experiencing more friction?	Stratified access/failure/experience data where feasible.

Question	Evidence to review
What may be helpful to address before expansion?	Open issues and root causes.



Day-30 Decision

- PROCEED:** Continue with the current scope or expand gradually.
- REFINE:** Maintain a limited pilot while addressing defined gaps.
- REVISIT:** Consider pausing expansion while a material safety, workflow, technology, staffing, compliance, or financial issue is resolved.

STAGE 5 — MEASURE

Recommended Way to Use This Stage

Consider beginning with the original access or care problem and selecting a small measure set that supports decisions. For each measure, the team may define the population, calculation, source, owner, review frequency, target, and action threshold before reporting begins.

A useful outcome is a practical scorecard that combines outcomes, operations, experience, access, and financial or strategic value without creating an unsustainable reporting burden.

Key Question: Is it working, for whom, and at what cost?

Stage Outcome

A focused scorecard, defined measures, baseline comparison, patient/provider feedback, access review, and improvement priorities.

Measurement Principles

Start With the Problem Statement Measures should show whether the original problem is improving.	Keep the Core Set Small More metrics do not automatically lead to better management.
Define Measures Clearly Two people should be able to calculate each measure the same way.	Use Balanced Measures Include outcome, process, experience, access, and financial/value measures.
Use Data for Decisions Data should guide decisions, not only support grant reporting.	Adjust the Review Cadence Review measures frequently during implementation, then reduce the cadence once performance stabilizes.

Recommended Scorecard Architecture

Domain	Examples
Primary outcome	Condition-specific outcome, referral completion, time to specialty care, avoidable transfer.
Access	Wait time, travel avoided, completed visits, new service availability, no-show.
Experience	Ease of connection, communication quality, willingness to use again.
Quality	Clinical/process measure, follow-up completion, escalation appropriateness.
Access	Completion/failure/experience by geography, language, age, connectivity, or other relevant factors.
Operations	Visit completion, technical failure, in-person conversion, cycle time, staff time.
Financial/value	Cost per encounter, revenue, avoided travel/transfer, retained referral, budget impact.
CalRHT alignment	Relevant Transformative Care Model or grant-recommended measures.

Tool 5A — Scorecard Builder

Begin with 1 primary outcome, 3-5 operational/access measures, 1 patient experience measure, and 1 access measure.

Prompt	Working response
Measure	
Domain	
Definition	
Baseline	
Target	
Data source	
Owner	
Review cadence	
Action threshold	

Define Measures Before Reporting

Tool 5B — Metric Definition Sheet

Complete one per core measure.

Prompt	Working Response
Metric Name	
Purpose	
Numerator	
Denominator	
Inclusion Criteria	
Exclusion Criteria	
Data Source	
Baseline Period/Value	
Target	
Reporting Frequency	
Stratification	
Known Limitations	
Action If Below Target	

Patient Experience

Optional Survey Introduction

Keep the survey brief.

We are working to improve our telehealth service. Your answers will help us understand what was easy, what was difficult, and what we should change.

Question	Response
It was easy to connect to my visit.	1 Strongly disagree – 5 Strongly agree
I could communicate effectively with my care team.	1–5
Telehealth made it easier for me to receive care.	1–5
I would use telehealth again when it is appropriate for my care.	1–5
What made the visit easier?	Open text
What should we improve?	Open text

Provider/Staff Experience

Question	Response
The workflow is clear.	1 Strongly disagree – 5 Strongly agree
The technology supports the clinical workflow.	1–5
I know what to do when telehealth is not appropriate.	1–5
I can get help when technical problems occur.	1–5
Telehealth improves access/value for the intended population.	1–5
What creates the most friction?	Open text
What one change would improve the program?	Open text

Access Review

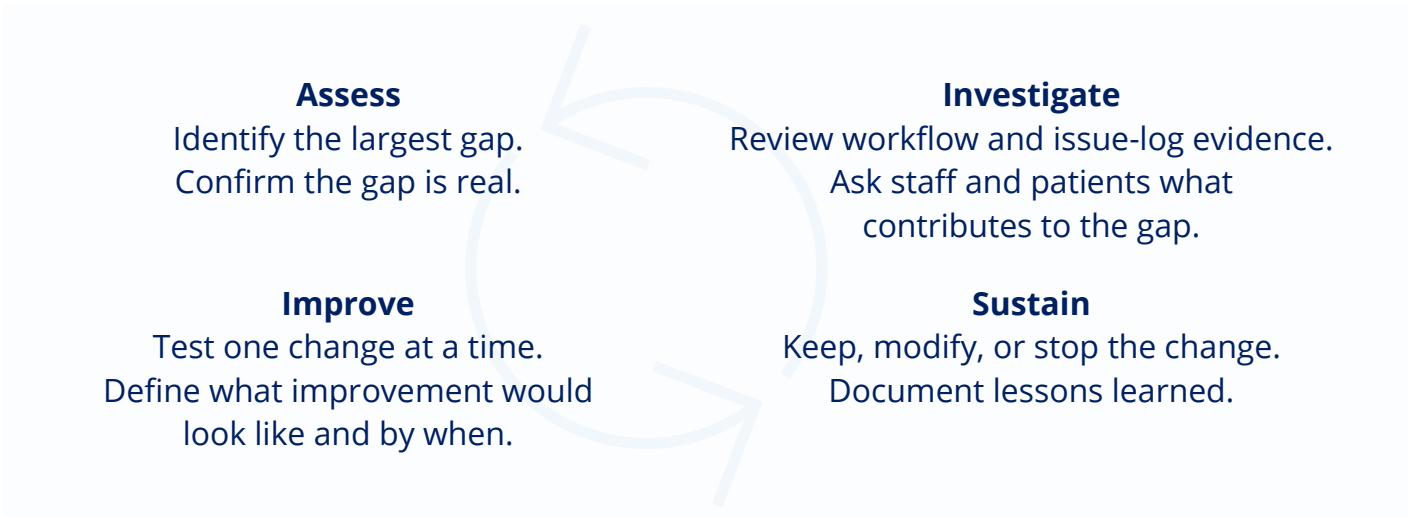
Overall averages can hide unequal performance. Where feasible and appropriate, examine who is offered telehealth, who accepts it, who successfully completes it, who experiences technical failure, who converts to in-person care, and who reports poor experience.

Tool 5C — Access Performance Review

Use only stratifications that are meaningful, lawful, and available.

Prompt	Working response
Measure	
Population/geography comparison	
Observed difference	
Possible explanation	
Additional data needed	
Action	
Owner	
Recheck date	

Continuous Improvement



Tool 5D — Improvement Cycle

Use for each prioritized change.

Prompt	Working response
Problem	
Evidence	

Prompt	Working response
Root-cause hypothesis	
Change to test	
Owner	
Start date	
Measure	
Expected result	
Actual result	
Decision: adopt / adapt / abandon	
Lesson learned	



Stage 5 Gate

The program is ready to move into formal sustainability planning when leaders can explain what value the program creates, where it underperforms, whether performance differs across populations, and which measures will be maintained as routine operations.

STAGE 6 — SUSTAIN

Recommended Way to Use This Stage

Sustainability planning may be most useful when it begins while implementation funding is still available. Consider reviewing recurring work and cost, clinical and patient value, workforce capacity, partner commitments, technology dependencies, reimbursement assumptions, and leadership ownership together.

A useful outcome is an explicit recommendation to continue, modify, integrate, replace, or conclude the program, supported by a 12-month action plan and named owners.

Key Question: Can the program continue after start-up funding?

Stage Outcome

A durable ownership model, true-cost view, sustainability stress test, financing/value strategy, technology lifecycle plan, and 12-month action plan

Sustainability Is More Than Reimbursement

Telehealth sustainability depends on measurable value, adoption, workflow integration, training/support, technology maintenance, regulatory awareness, partnerships, and financing. Grant funding can create the program, but long-term operations require the work to become part of normal care delivery.

Step 1. Run the sustainability stress test

Tool 6A — Sustainability Stress Test

Ask: If implementation funding ended tomorrow, what would stop?

Prompt	Working response
Staffing that depends on temporary funds	
Technology/licenses that depend on temporary funds	
Patient support that depends on temporary funds	
Partner/specialist services that depend on temporary funds	
Data/reporting that depends on temporary funds	
Training/onboarding that depends on temporary funds	
Outreach/marketing that depends on temporary funds	
Current reimbursement/value mechanism	
Executive/program ownership after grant	
Overall rating: Sustainable / At Risk / Grant Dependent	

Step 2. Calculate True Operating Cost

Cost category	Include
Personnel	Clinical, scheduling, support, program management, data, billing, IT.
Technology	Licenses, interfaces, devices, peripherals, replacement, maintenance.
Connectivity	Broadband, cellular, backup connections, site costs.
Partner services	Specialist contracts, platform fees, interpretation, technical services.
Training	Onboarding, competency, refreshers, new-hire training.
Compliance/security	Assessments, contract review, security controls, monitoring.
Patient support	Navigation, device/connectivity assistance, outreach.
Data/quality	Reporting, analytics, survey tools, improvement work.

Tool 6B — Annual Cost Inventory

Separate one-time implementation costs from recurring operating costs.

Prompt	Working response
Cost item	
One-time or recurring	
Annual amount	
Fixed or volume-dependent	
Current funding source	
Future funding source	
Can cost be reduced without harming quality/access?	

Step 3. Define The Value Mechanism

A sustainable program may rely on more than direct fee-for-service revenue. Document the mechanism explicitly and avoid double-counting.

Value Mechanism	Examples
Direct revenue	Billable encounters or monitoring services where applicable.
Avoided cost	Reduced transfers, travel support, contract coverage, avoidable utilization.
Retained value	Reduced referral leakage, retained downstream care, workforce capacity.
Quality/value-based performance	Contribution to quality, access, total-cost, or contract goals.
Strategic/community value	Service availability, access, recruitment/retention, partnership value.

Tool 6C — Value Case

Keep financial and non-financial value distinct.

Prompt	Working response
Value mechanism	
How telehealth creates the value	
Evidence/data source	
Annual estimated value	
Confidence level	
Who realizes the value	
Can the program capture or finance against this value?	

Step 4. Institutionalizing Ownership

Governance	Operations	Technology	Compliance
☐ Permanent operational owner	☐ New-hire telehealth training	☐ Technology owner assigned	☐ Policy review cadence
☐ Clinical governance accountability	☐ Routine performance management	☐ Lifecycle budget	☐ Contract ownership
☐ Annual executive review	☐ Patient support embedded in workflows		

Tool 6D — Sustainability Action Plan

Prioritize the few actions most likely to determine durability.

Prompt	Working response
Risk/opportunity	
Action	
Owner	
Due date	
Resource to consider	
Success measure	
Status	
Executive decision needed	



Telehealth Reality Check
Consider documenting strategic value beyond direct visit margin.

STAGE 7 — SCALE

Recommended Way to Use This Stage

Consider scaling through a controlled replication cycle rather than copying the current model without adaptation. The originating team and receiving site may review evidence, distinguish core components from locally adaptable elements, assess local readiness, and agree on support and measurement during the first 90 days.

A useful outcome is a replication package, site-specific adaptation record, local readiness plan, and decision point for continuing, refining, or slowing expansion.

Key Question: What appears ready to scale, and what may benefit from local adaptation?

Stage Outcome

A scale-readiness decision, replication package, local adaptation method, lessons-learned brief, and 90-day expansion plan

Focus on Reliable Spread, Not Just Adding Technology.

Scale means reproducing the value of a working care model in another setting, population, site, service, or region. The new setting may require different staffing, connectivity, partnerships, patient support, or workflow. Standardize the core model and adapt the implementation.

Step 1. Assess Readiness to Scale

Domain	Evidence of readiness
Clinical/quality	Desired outcomes are stable or improving.
Patient adoption	Target population can access and use the service.
Provider/staff adoption	Workflow is understood and accepted.
Reliability	Technical and operational failures are controlled.
Access	No unaddressed major access disparity created by the model.
Financial/value	Operating case is understood and acceptable.
Leadership	Sponsor supports expansion and resource implications.
Workforce	Capacity exists to support another site/service.
Partnerships	Dependencies can expand or be replicated.
Replicability	Core elements and local adaptations are distinguishable.

Tool 7A — Scale Readiness Score

Score 1-5 and cite evidence.

Prompt	Working response
Domain	
Score	
Evidence	
Risk	
Recommended action before expansion	

Interpretation

Mostly 1-2 = Optimize before expansion.

Mostly 3 = Adapt and test in one additional setting.

Mostly 4-5 = Replicate with standardized onboarding and local adaptation.

Step 2. Separate Core from Adaptable Components

Core — standardize	Adaptable — localize
Clinical safety criteria	Staff titles and role combinations
Recommended workflow outcomes	Exact workflow sequence where local systems differ
Minimum data definitions	Reporting tools
Escalation principles	Local emergency/in-person destinations
Patient rights/choice principles	Communication channels and local language needs
Technology functional requirements	Specific configuration when approved alternatives exist
Quality expectations	Implementation timeline

Tool 7B — Core vs. Adaptable

Use before onboarding a new site.

Prompt	Working response
Program component	
Core or adaptable	

Prompt	Working response
Why	
Minimum standard	
Allowed local variation	
Who approves variation	

Step 3. Build The Replication Package

- | | |
|---|---|
| ☐ Problem statement and target population. | ☐ Training and competency tools. |
| ☐ Care model and eligibility criteria. | ☐ Patient materials. |
| ☐ Patient journey. | ☐ Scorecard and metric definitions. |
| ☐ Workflow maps and scripts. | ☐ Known failure modes and mitigations. |
| ☐ Roles/RACI. | ☐ Cost/value assumptions. |
| ☐ Technology requirements and configuration assumptions. | ☐ Implementation timeline. |
| ☐ Policies/protocols and requirements validation log. | ☐ Lessons learned. |
| | ☐ Local adaptation checklist. |

Step 4. Capture Lessons with Context

Tool 7C — Lessons Learned Brief

A useful lesson explains the condition under which something worked.

Prompt	Working response
What problem did we solve?	
What worked?	
What did not work?	
What changed after launch?	
What conditions were essential to success?	
What context affected the result?	

Prompt	Working response
What should another organization avoid?	
What should remain standardized?	
What should be adapted locally?	
What evidence supports scale?	

Step 5. Use A 90-Day Expansion Cycle

Days 1-30	Days 31-60	Days 61-90
Local Assessment	Configuration	Bounded Pilot
Stakeholder Engagement	Agreements	Issue Review
Baseline	Training	Measurement
Workflow Gap Analysis	Patient Materials	Optimization
Adaptation Decisions	Simulation	Expansion Decision
	Readiness Review	

Tool 7D — 90-Day Expansion Plan

Use one plan per new site/service/population.

Prompt	Working response
Expansion target	
Local sponsor/champion	
Days 1-30 milestones	
Days 31-60 milestones	
Days 61-90 milestones	
Local adaptations	
Shared resources	
Key risks	
Recommended decision criteria	
Day-90 decision	



Stage 7 Gate

Scale only when the program has evidence of value and reliability, the core model is documented, local adaptation is intentional, and the organization has capacity to support expansion without degrading the original service.

Special Module — Connectivity and Digital Access

Connectivity is not merely an IT issue; it is a care-access variable. Programs should design around the real connectivity conditions of the population rather than ideal broadband assumptions.

Decision type	Recommended owner
Clinical model/eligibility	Clinical governance
Workflow and staffing	Operations + clinical
Technology selection/configuration	Program + clinical + IT/security
Patient communication	Program + patient experience/compliance as applicable
Billing/coding	Revenue cycle/compliance
Safety incident response	Existing safety/quality structure
Performance targets	Program + quality + sponsor
Scale/retire decision	Executive governance

Connectivity Planning

- ☐ Map known weak-connectivity areas using available local knowledge and broadband data.
- ☐ Test the platform on typical patient devices and weaker connections.
- ☐ Define minimum bandwidth/device assumptions but avoid unnecessary technical requirements.
- ☐ Identify whether telephone, asynchronous, site-based, or in-person alternatives are clinically and operationally acceptable.

- ☐ Plan for cellular dead zones and platform outages.
- ☐ Consider local libraries, clinics, schools, community centers, or partner sites only when privacy, staffing, access, and operational requirements can be met.
- ☐ Track technical failures by geography or connection type when feasible.

Connectivity Risk Map

Use local knowledge; precision is less important than identifying operational risk.

Prompt	Working response
Community/ZIP/service area	
Known connectivity concern	
Patient impact	
Approved alternative	
Local access site/partner	
Action needed	

Special Module — Governance, Risk, and Decision Rights

Telehealth decisions can become fragmented when no group owns the whole service. Establish lightweight governance proportionate to program size.

Decision Type	Recommended Owner
Clinical model/eligibility	Clinical governance
Workflow and staffing	Operations + clinical
Technology selection/configuration	Program + clinical + IT/security
Patient communication	Program + patient experience/compliance as applicable
Billing/coding	Revenue cycle/compliance
Safety incident response	Existing safety/quality structure
Performance targets	Program + quality + sponsor
Scale/retire decision	Executive governance

Risk Register

Review weekly during Build/Launch and monthly after stabilization. A risk register is a tool used to identify, track, and manage risks that could affect a project, program, or initiative. It helps teams proactively address issues before they become major problems.

Risk Register Elements

Element	Description
Risk	A description of the potential event or issue that could negatively affect objectives.
Category	The type of risk (e.g., Operational, Financial, Technical, Clinical, Compliance, Security, Reputational).
Likelihood	The probability that the risk will occur (Rare, Unlikely, Possible, Likely, or Almost Certain)
Impact	The severity of the consequences if the risk occurs (Negligible Impact, Minor Impact, Moderate Impact, Significant Impact, Severe, Critical Impact)
Mitigation	Actions taken to reduce the likelihood or impact of the risk.
Owner	The individual responsible for monitoring and managing the risk.
Status	Current state of the risk (e.g., Open, Monitoring, Mitigated, Closed).

Risk	Category	Likelihood	Impact	Mitigation	Owner	Status

Quick Reference Library

Go-Live Checklist

- ☐ Problem, population, model, and eligibility approved.
- ☐ Executive sponsor and clinical champion active.
- ☐ Workflow tested end-to-end.
- ☐ Clinical escalation and emergency pathways approved.
- ☐ Technology configured and tested under realistic conditions.
- ☐ Patient instructions and support pathway ready.
- ☐ Interpreter/accessibility workflow tested.
- ☐ Staff training and competency complete.
- ☐ Documentation and billing workflows validated.
- ☐ Privacy/security and other applicable requirements validated.
- ☐ Downtime/technical failure protocol ready.
- ☐ Partner dependencies confirmed.
- ☐ Baseline captured and scorecard defined.
- ☐ Issue log and huddle cadence ready.
- ☐ Residual risks documented and accepted by accountable leaders.

Provider Quick Guide

- ☐ Confirm visit is appropriate for telehealth.
- ☐ Confirm identity, location, callback, and participants as recommended by the organization's policy or workflow.
- ☐ Establish privacy/communication conditions.
- ☐ Conduct the visit using telehealth-appropriate clinical technique.
- ☐ Recognize limitations and convert/escalate when needed.

- ☐ Document according to organizational standards.
- ☐ Close the loop on orders, referrals, follow-up, and patient questions.
- ☐ Report technology or workflow issues that could recur.

Scheduler Quick Guide

- ☐ Offer telehealth as an option when appropriate; preserve patient choice.
- ☐ Use the approved eligibility decision process.
- ☐ Select the correct visit type/duration.
- ☐ Identify interpreter, accessibility, caregiver, device, and connectivity needs.
- ☐ Send the correct instructions.
- ☐ Offer test/support pathway when available.
- ☐ Know when and how to escalate uncertain eligibility.
- ☐ Document recommended scheduling information.

Patient Support Quick Guide

- ☐ Use plain language and one step at a time.
- ☐ Confirm what device the patient is actually using.
- ☐ Consider whether a technical or access barrier may be affecting participation before concluding that patient is not interested.
- ☐ Use the approved troubleshooting sequence.
- ☐ Stop troubleshooting at the defined threshold.
- ☐ Move to the approved fallback without making the patient repeatedly restart.
- ☐ Document recurring issues for improvement.

Expanded Working Tools

Recommended completion approach

Each tool may be completed in a short working session led by one facilitator and one note-taker. Before the session, the facilitator may gather available data, current workflows, relevant policies, partner information, and prior decisions. During the session, the group can focus on decisions and assumptions rather than perfect wording.

After the session, the tool owner may summarize open questions, assign follow-up owners and target dates, attach supporting evidence, and bring only material decisions or risks to the appropriate leader. Teams may leave a field blank when it is not applicable and briefly note why.

Use these field-ready tools alongside the corresponding stage chapters. Each tool identifies the decision to make, the people who should participate, the evidence to retain, and the minimum conditions for moving forward. Complete only the tools that match your program and maturity.

Before You Begin

- ✓ Assign one owner for each tool, even when several people contribute.
- ✓ Use plain language and record assumptions. If an answer is unknown, name who will find it and by when.
- ✓ Separate minimum requirements from enhancements. A small and/or rural organization should be able to identify a safe, workable starting point.
- ✓ Retain the completed tool, supporting evidence, and approval in the implementation record.

Stage 1 Working Tool — Telehealth Opportunity Brief

Decision supported: Confirm that telehealth addresses a defined access or care problem before selecting a platform or vendor.

Suggested participants: Executive sponsor, clinical lead, operations lead, frontline staff, data/evaluation lead, patient or community representative, and partner representative when applicable.

Prompt	Team Response
The access or care problem we are solving	
Population and geography affected	
What patients experience today, including travel, delay, missed care, or fragmented care	
Current baseline and data source	
Why telehealth may be appropriate	
Why telehealth may not be appropriate for some patients or situations	
Proposed telehealth service and modality	
Expected improvement within 6–12 months	
Primary access barrier and planned mitigation	
Executive sponsor and accountable program owner	

Evidence Checklist

- ☐ The need is supported by local data and at least one patient, community, or frontline perspective.
- ☐ The baseline uses a clearly defined measure, time period, and data source.
- ☐ The team considered non-telehealth alternatives and documented why telehealth adds value.
- ☐ Patients who may be excluded by language, disability, device access, digital literacy, privacy, or connectivity are identified.
- ☐ The proposed service aligns with the funded project scope and intended CalRHT result.
- ☐ A named leader accepts accountability for the next stage.

Stage-gate Decision

Decision	Select one and explain
Proceed	☐ The problem, population, baseline, and expected result are sufficiently defined.
Proceed With Conditions	☐ Proceed after the following actions are completed: _____
Revisit / Refine the Design	☐ Telehealth is not yet the right intervention or material risks remain unresolved.
Approval	Name / role: _____ Date: _____

Stage 2 Working Tool — Service Design Specification

Decision supported: Translate the opportunity into a specific, testable operating model that staff, patients, partners, and vendors can understand consistently.

Design Element	Write-In Specification
Service name and clinical use case	Team notes / decision:
Eligible patients	Include clinical, geographic, age, payer, referral, language, and technology criteria as applicable.
Not appropriate / exclusion criteria	Describe clinical, safety, examination, emergency, consent, privacy, or technology limitations.
Modality and fallback	Primary: _____ Fallback: _____ Conditions for fallback: _____
Originating and distant locations	Team notes / decision:
Referral source and acceptance process	Team notes / decision:
Visit frequency, duration, and capacity	Team notes / decision:
Care-team roles	Who schedules, prepares, rooms, provides care, troubleshooting, documents, bills, and follows up?
Partner responsibilities	Team notes / decision:
Integrations and data exchange to consider	Team notes / decision:
Patient access supports	Interpreter, accessibility, caregiver, device, private space, digital navigator, transportation fallback.
Success definition	One primary outcome, 3–5 operating measures, one experience measure, and one access measure.

Design Review Checklist

- ☐ Eligibility and exclusion rules are specific enough for two staff members to reach the same decision.
- ☐ The model describes what happens when video is unavailable or clinically insufficient.
- ☐ Every handoff has a named role, expected time, and communication method.
- ☐ Patient choice is preserved; declining telehealth does not create an inappropriate barrier to care.
- ☐ Interpreter, accessibility, privacy, caregiver, and digital-support needs are built into the patient journey.
- ☐ Technology requirements were derived from the care model and workflow, not vendor marketing.
- ☐ The preliminary financial model identifies start-up cost, recurring cost, likely revenue or avoided cost, and major assumptions.

Stage 3 Working Tool — End-to-End Workflow Builder

Suggested approach: Begin with the event that starts the referral and continue through results, follow-up, and closure. The team may complete one row for each meaningful handoff, name the role rather than a specific person, and note the information or system needed at that moment. A walk-through with frontline staff and one realistic patient scenario can help confirm that the sequence is workable.

Workflow step	Owner	Information to consider or system	Standard work / script	Failure path and escalation
Referral received				
Eligibility confirmed				
Patient offered telehealth				
Appointment scheduled				

Workflow step	Owner	Information to consider or system	Standard work / script	Failure path and escalation
Consent / notices completed				
Technology and access needs checked				
Pre-visit preparation completed				
Patient connected and identity/location confirmed				
Clinical encounter completed				
Orders, referrals, or prescriptions routed				
Documentation and billing completed				
Follow-up closed				

Workflow Validation Checklist

- ☐ The workflow has a clear start and end point.
- ☐ Every step has one accountable owner, even when multiple roles assist.
- ☐ Information to consider is available at the time the role needs it.
- ☐ The workflow specifies how language, disability, caregiver, privacy, and digital-support needs are identified and addressed.
- ☐ Clinical escalation, emergency response, technology failure, patient disconnection, and provider delay have documented paths.
- ☐ The team tested documentation, coding, charge capture, claim submission, and denial follow-up.
- ☐ Partner handoffs include confirmation that the receiving party accepted the task.
- ☐ A frontline staff member and a patient representative reviewed the workflow for burden and clarity.

Workflow Walk-Through Questions

- ✓ Where could the patient become confused or stop?
- ✓ Where might work be duplicated?
- ✓ Which step depends on one person?
- ✓ Where could a delay create clinical risk?
- ✓ What happens outside normal business hours?
- ✓ What information is re-entered rather than exchanged
- ✓ Which workaround may be helpful to resolve before launch?

Stage 3 Working Tool — Patient Readiness and Support

Suggested approach: A scheduler, medical assistant, digital navigator, or other designated team member may use these questions during scheduling or pre-visit outreach. The intent is to match support to the patient and preserve choice, rather than exclude someone because support is needed. Teams may adapt the wording to local workflow, language, and accessibility needs.

Readiness area	Ask or verify	Response / support plan
Patient choice	Would you like a telehealth visit, or would you prefer another available option?	
Device	What device will you use? Does it have a working camera, microphone, and power source?	
Connectivity	Where will you connect? Is video reliable there?	
Digital confidence	Would you like help joining or testing the visit?	
Language	What language do you prefer for care and instructions?	
Accessibility	Do you need captioning, screen-reader compatibility, relay, mobility support, or another accommodation?	
Privacy	Do you have a place where you can speak privately?	
Caregiver / support person	Would you like someone to help or participate?	
Clinical equipment	Will the visit require a scale, blood pressure cuff, thermometer, or other device?	
	If video does not work, what should we do and what number should we call?	

Suggested Closing Script

"Thank you. Based on what you shared, we will [describe support]. Before the visit, we will [test/call/send instructions]. If the video does not work, we will [fallback]. You may contact [name/number] for help. If you decide telehealth is not right for you, please let us know so we can discuss available options."

Stage 4 Working Tool — Go-Live Readiness Review

Suggested rating: Ready = complete and verified; Ready with conditions = an open item has an owner, target date, and appropriate interim control; Additional preparation recommended = the team would benefit from further work before launch. If a safety-critical item needs additional preparation, the team may wish to delay launch or narrow the pilot until an appropriate control is in place.

Readiness Domain	Acceptance Criteria	Rating / Evidence / Owner
Clinical model	Eligibility, exclusions, escalation, emergency response, and in-person conversion are approved by the clinical lead.	☐ Ready ☐ Ready with conditions ☐ Additional preparation recommended Evidence/owner: _____
Workflow	The complete patient and provider journey has been tested, including partner handoffs.	☐ Ready ☐ Ready with conditions ☐ Additional preparation recommended Evidence/owner: _____
Technology	Production configuration, access, devices, audio/video, interfaces, and security controls are verified.	☐ Ready ☐ Ready with conditions ☐ Additional preparation recommended Evidence/owner: _____
Downtime	Video failure, platform outage, power loss, connectivity loss, and vendor support pathways are tested.	☐ Ready ☐ Ready with conditions ☐ Additional preparation recommended Evidence/owner: _____
Patient support	Instructions, reminders, interpreter/accessibility support, digital navigation, and contact route are ready.	☐ Ready ☐ Ready with conditions ☐ Additional preparation recommended Evidence/owner: _____
Workforce	Each role completed training and demonstrated competency; coverage and backup assignments are confirmed.	☐ Ready ☐ Ready with conditions ☐ Additional preparation recommended Evidence/owner: _____
Documentation / billing	Templates, orders, coding, charge capture, claim workflow, and denial monitoring are validated.	☐ Ready ☐ Ready with conditions

Readiness Domain	Acceptance Criteria	Rating / Evidence / Owner
		☐ Additional preparation recommended Evidence/owner: _____
Privacy / compliance	Current requirements were validated by authorized organizational resources; consent and notices are ready.	☐ Ready ☐ Ready with conditions ☐ Additional preparation recommended Evidence/owner: _____
Measurement	Baseline, definitions, data owners, collection method, and first review date are documented.	☐ Ready ☐ Ready with conditions ☐ Additional preparation recommended Evidence/owner: _____
Launch support	Daily huddle, issue log, command contacts, severity levels, escalation times, and decision rights are scheduled.	☐ Ready ☐ Ready with conditions ☐ Additional preparation recommended Evidence/owner: _____

Launch Recommendation

Decision record	Write-in
Decision	☐ Proceed ☐ Proceed with conditions ☐ Additional preparation recommended
Conditions / unresolved risks	
Recommended action, owner, due date	
Clinical approval	Name: _____ Date: _____
Operational approval	Name: _____ Date: _____
Executive approval	Name: _____ Date: _____

Stage 4 Working Tool — Launch Huddle and Issue Triage

Suggested approach: A brief daily huddle may be helpful during the initial launch period. The facilitator can review facts, patient or staff impact, open risks, owners, and near-term actions. Larger redesign questions may be recorded for a separate improvement discussion so the huddle remains focused and supportive.

Huddle prompt	Response
What worked since the last huddle?	
How many visits were scheduled, attempted, completed, converted, or cancelled?	

Huddle prompt		Response
Were there patient-safety, privacy, accessibility or access concerns?		
What issue occurred most often?		
What requires action today, by whom, and by when?		
What should be communicated to staff, patients, partners, or leaders?		
Does any issue require pausing or narrowing the service?		
Severity	Definition	Response expectation
1 — Immediate attention recommended	Immediate patient-safety, privacy/security, or enterprise outage risk.	Prompt review by the appropriate clinical, privacy, security, operational, or executive leader is recommended; the leader may consider narrowing or temporarily holding the affected service.
2 — Prompt attention recommended	The visit may not be able to proceed, or a repeated issue may affect multiple patients or staff.	Same-day ownership, a clearly communicated interim pathway, and follow-up monitoring are recommended.
3 — Planned attention recommended	Workaround exists but creates delay, burden, or inconsistent practice.	The team may assign an owner and target resolution within the agreed launch window.
4 — Future enhancement	Enhancement, isolated inconvenience, or future optimization idea.	Log for scheduled review; may be scheduled after launch stabilization.

Stage 5 Working Tool — Telehealth Performance Scorecard

Consider selecting one primary outcome, three to five operational measures, one experience measure, and one access measure. For each measure, document the Baseline → Target → Actual → Recommended Action, and the measure owner and review date.

Measure	Definition / source	Baseline	Target	Actual	Action / owner
Primary outcome					
Access measure					
Utilization measure					
Reliability measure					
Workflow measure					
Patient experience					
Access measure					

Metric Quality Checklist

- ☐ The numerator, denominator, exclusions, unit, data source, and reporting period are defined.
- ☐ The baseline and target use the same definition.
- ☐ A named owner can access the data without unsustainable manual effort.
- ☐ Results can be segmented, when lawful and feasible, to identify uneven access or outcomes.
- ☐ The team defined what result triggers investigation or action.
- ☐ The measure supports a program decision; it is not collected only because it is available.
- ☐ Qualitative patient and staff feedback is reviewed alongside numeric results.

Monthly Interpretation

Question	Team response
What changed, for whom, and compared with what baseline?	
Is the result likely due to implementation, external conditions, data quality, or chance?	
What subgroup, site, modality, provider, or workflow step should be examined?	
What single change will we test next?	
Who owns the change and when will we review it?	

Stage 6 Working Tool — Sustainability Plan

Suggested timing: The team may wish to begin this review approximately six months before time-limited implementation funding ends, or earlier when major contracts or staffing decisions require additional lead time. Sustainability means the clinical, operational, workforce, technology, partnership, data, and financial components can continue reliably.

Domain	Current State / Evidence	Risk After Funding	Action	Owner / Due Date
Clinical value		☐ Low ☐ Med ☐ High		
Patient demand and access		☐ Low ☐ Med ☐ High		
Provider and staff adoption		☐ Low ☐ Med ☐ High		
Workforce capacity / backup		☐ Low ☐ Med ☐ High		
Technology / licensing / support		☐ Low ☐ Med ☐ High		
Partner commitments		☐ Low ☐ Med ☐ High		
Data / reporting capacity		☐ Low ☐ Med ☐ High		
Reimbursement / revenue		☐ Low ☐ Med ☐ High		
Avoided cost / strategic value		☐ Low ☐ Med ☐ High		
Leadership / governance		☐ Low ☐ Med ☐ High		

Sustainability Decision Checklist

- ☐ Recurring staffing, licensing, equipment, connectivity, partner, training, and reporting costs are known.
- ☐ The organization has identified the funding or value mechanism for each recurring cost.
- ☐ Critical work is embedded in standard roles and procedures rather than dependent on one grant-funded champion.
- ☐ The program has documented demand, quality, access, experience, access, and financial evidence for leadership review.

- ☐ Vendor and partner agreements have renewal, exit, data-access, continuity, and performance provisions.
- ☐ Training, competency validation, policy review, technology review, and measure review have ongoing owners and schedules.
- ☐ Leadership has made an explicit continue, modify, integrate, replace, or stop decision.

Stage 7 Working Tool — Scale Readiness and Replication Plan

Suggested approach: Consider expansion when the current model is sufficiently reliable to explain, teach, support, and measure. Expansion can mean a new site, population, service, partner, modality, or region; each may require adaptation.

Readiness Area	Evidence To Consider	Suggested Rating 0-2 & Team Notes
Clinical benefit	Outcome is stable enough to justify expansion.	
Patient access and experience	Patients can use the service and key barriers are mitigated.	
Access	Performance has been reviewed across relevant populations and locations.	
Workflow reliability	Standard work is followed and common failures are controlled.	
Workforce	Training, capacity, backup, and local ownership are available.	
Technology	Platform, devices, interfaces, support, and connectivity are stable.	
Financial viability	Expansion and recurring costs have an identified value mechanism.	
Partner readiness	Roles, service levels, data exchange, and escalation are agreed.	
Replicability	Core components, adaptable components, tools, and lessons are documented.	
Governance	A sponsor, local owner, decision rights, risks, and review cadence are defined.	

Scoring Guide:

0 = absent or unproven

1 = partially demonstrated or dependent on conditions

2 = demonstrated and documented

0–9: optimize before scaling

10–15: scale only with specified conditions and close support scaling

16–20: ready for a controlled replication cycle.

Replication Element	Core: Recommended For Consistency	Adaptable: May Change Locally	Local Decision / Owner
Clinical eligibility and safety			
Patient journey and support			
Staff roles and training			
Technology and connectivity			
Partner workflow			
Measurement definitions			
Policy / compliance controls			

Worked Example — Fictional Health Organization

The following example demonstrates how the tools connect. It is fictional and should not be interpreted as a recommended clinical model or payer strategy.

Scenario

Sierra Valley Rural Health Network operates two primary care clinics serving a geographically dispersed population. Patients referred for endocrinology frequently travel more than 90 minutes each way. Referral completion is inconsistent, and primary care clinicians report difficulty obtaining timely specialist input for adults with poorly controlled diabetes.

Assess

Element	Example
Problem	Adults with poorly controlled diabetes face long travel and delayed specialty access.
Population	Established adult primary-care patients meeting locally defined clinical criteria.
Baseline	Median specialty wait 63 days; 41% referral completion; average one-way travel estimate 78 miles.
Root causes	Specialist shortage, travel burden, missed work/caregiver burden.
Readiness gap	No standardized telehealth specialty workflow; limited patient tech support.
Decision	Proceed to design a hybrid specialist telehealth model.

Design

Element	Example
Model	Patient at local clinic connects to remote endocrinologist with local MA support.
Why site-based initially	Reduces home broadband/device variability and enables vitals/labs review.
Eligibility	Stable ambulatory patients; urgent/complex exam needs use in-person pathway.
Patient journey	PCP referral → eligibility → local telehealth appointment → pre-visit labs → clinic rooming → remote specialist → PCP follow-up.
Access safeguard	Interpreter scheduling and transportation support to local clinic; home video considered later.
Primary outcome	Specialty referral completion.
Secondary measures	Wait time, no-show, patient travel avoided, technical failure, patient experience.

Build

The team maps referral, scheduling, lab completion, rooming, remote specialist connection, documentation exchange, recommendations, PCP follow-up, and billing. Simulations reveal that lab results are not consistently available to the specialist. The workflow is changed so the telehealth coordinator confirms recommended results 48 hours before the visit.

Launch

The organization pilots with one specialist, one clinic, and six appointment slots per week. Daily huddles during week one identify two recurring issues: patients arrive at the clinic but the specialist schedule changed without notification, and interpreter links are not included in the remote provider's calendar. Both become formal workflow steps.

Measure

Measure	Baseline	30-day example	Interpretation
Referral completion	41%	72%	Improving; continue.
Median wait	63 days	31 days	Improving.
No-show	18%	11%	Improving.
Technical failure	N/A	8%	Above target; investigate.
Patient ease of access	N/A	4.5/5	Strong early experience.

Sustain

The program identifies recurring costs for coordinator time, clinic room use, technology, specialist contract, interpreter support, and data reporting. Direct reimbursement alone does not fully explain the value, so the organization also quantifies retained referrals, reduced travel burden, and workforce support. Leadership decides to fund the coordinator function within access operations if six-month performance remains above target.

Scale

After six months, the workflow is stable and the team packages the eligibility rules, lab checklist, scheduling workflow, specialist calendar requirements, interpreter process, scorecard, and known failure modes. The second clinic completes a 30-day local assessment before using the same model.

Appendix A — Master Implementation Workplan

Workstream	Task	Owner	Start	Due	Status	Dependency	Decision/notes
	Assess						
	Design						
	Build						
	Launch						
	Measure						
	Sustain						
	Scale						

Appendix B — Decision Log

Date	Decision	Options considered	Decision owner	Rationale/evidence	Impact	Revisit date

Appendix C — Meeting Agenda: Implementation Team

1. Safety/access issues requiring immediate action.

2. Progress against current stage deliverables.

3. Open decisions and blockers.

4. Issue/risk register review.

5. Patient/frontline feedback.

6. Metrics available.

7. Actions, owners, due dates.

8. Decisions to escalate.

Appendix D — Stage-Gate Sign-Off

Stage	Recommended outputs complete?	Priority risks and considerations	Decision	Decision owner	Date
Assess					
Design					
Build					
Launch					
Measure					
Sustain					
Scale					

Appendix E — Telehealth Program Charter

Program Charter

Use this charter template to document the project rationale, scope, governance, major deliverables, references, approvals, and revision history. Replace the shaded prompts with project-specific information. Use after Assess and update after Design.

Telehealth Program Charter

I. Background & Problem Statement

Name of Organization	
Project Name	
Version Number	
Revision Date	
Prepared By	
Project Sponsor	

Project Background

Share background information that explains how this project came to be. Include relevant organizational, clinical, operational, community, or strategic context.

Problem Statement

Describe the clinical and/or business challenge that prompted the project. Explain why the project is needed and, if applicable, why current services or workflows are inadequate. This statement should establish the foundation for the project and any subsequent needs analysis.

II. Project Description & Scope

Descriptive Overview

Describe the project and its overall scope. Clearly state boundaries and limitations so all parties understand what the project does and does not include. Revise this charter as project details evolve.

Goals & Objectives

List the project goals and measurable objectives. Whenever possible, define the desired result, measure, target, and target date.

Goal / Objective	Measure or Indicator	Target	Target Date

Project Scope

Summarize the project scope and any limitations. Use the inclusion and exclusion tables to make boundaries explicit.

Project Inclusions

In Scope	Description / Notes

Project Exclusions

Out of Scope	Description / Rationale

Assumptions

Document assumptions related to need, clinical services, business operations, technology, resources, scope, expectations, dependencies, and schedules.

Assumption	Impact if Incorrect	Validation / Owner

Constraints

Document limits imposed on the project, including schedule, budget, staffing, procurement, policy, compliance, infrastructure, and technology.

Constraint	Project Impact	Response / Mitigation

Major Project Deliverables & Milestones

Identify key deliverables and decision points. Include planned completion dates and the person or group responsible.

Milestone / Deliverable	Planned Completion Date	Owner	Status / Notes

III. Governance & Oversight

Development Team

Identify project sponsors, stakeholders, subject matter experts, operational leads, implementation partners, and eventual project owners. Define responsibilities clearly to reduce confusion later.

Team Member / Group	Role	Responsibility	Decision Authority

Sponsorship & Ownership

Identify who has authority over the project. Include project ownership, executive sponsorship, external oversight bodies, committees, and organizational policies that guide decisions.

IV. Reference Materials

Documents & Resources

List related documents, policies, assessments, contracts, standards, data sources, or other materials that help explain the project scope, need, requirements, or decisions.

Document / Resource	Location / Link	Purpose / Relevance	Owner

V. Approvals & Revision History

Approvals

Approval indicates a shared understanding of the charter’s purpose, direction, scope, and requirements, and agreement to move the project forward.

Approver Name	Title / Role	Signature	Date

Appendix F — Data Collection Plan

Metric	Definition	Source	Collection method	Owner	Frequency	Baseline	Target	Stratification

Appendix G — Telehealth Policy/Procedure Inventory

Policy/procedure	Existing?	Update needed?	Owner	Due date
Telehealth clinical workflow				
Consent				
Privacy/security				
Emergency/escalation				
Downtime/business continuity				
Documentation				
Billing/coding				
Credentialing/privileging				
Prescribing, if applicable				
Patient complaints/accessibility				
RPM monitoring, if applicable				

Appendix H — Requirements Review Calendar

Domain	Owner	Authoritative source	Last validated	Next review	Change identified	Action
Licensure/scope						
Consent						
Privacy/security						
Prescribing						
Billing/reimbursement						
Credentialing/privileging						
Accessibility						
Grant/program requirements						

Appendix I — Telehealth Implementation Quick Checklist

Stage	Recommended evidence	Complete
ASSESS	Problem statement; baseline; readiness assessment; stakeholder map.	☐
DESIGN	Care model; eligibility; patient journey; RACI; access plan; business case.	☐
BUILD	Workflow; scripts; requirements validation; technology; training; escalation; readiness.	☐
LAUNCH	Pilot plan; simulations; issue log; 30-day decision.	☐
MEASURE	Scorecard; definitions; patient/staff feedback; improvement plan.	☐
SUSTAIN	Stress test; true cost; value case; ownership; 12-month plan.	☐
SCALE	Readiness; core/adaptable; replication package; lessons; 90-day plan.	☐

References

American Medical Association (AMA). *AMA Telehealth Implementation Playbook.* [Telehealth Implementation Playbook overview | American Medical Association](#)

California Department of Health Care Services (DHCS). *Telehealth Frequently Asked Questions.* <https://www.dhcs.ca.gov/providers-partners/telehealth-frequently-asked-questions/#Prov>

Centers for Medicare & Medicaid Services (CMS). Telehealth and virtual care guidance, reimbursement, and compliance resources. [Telehealth | CMS](#)

