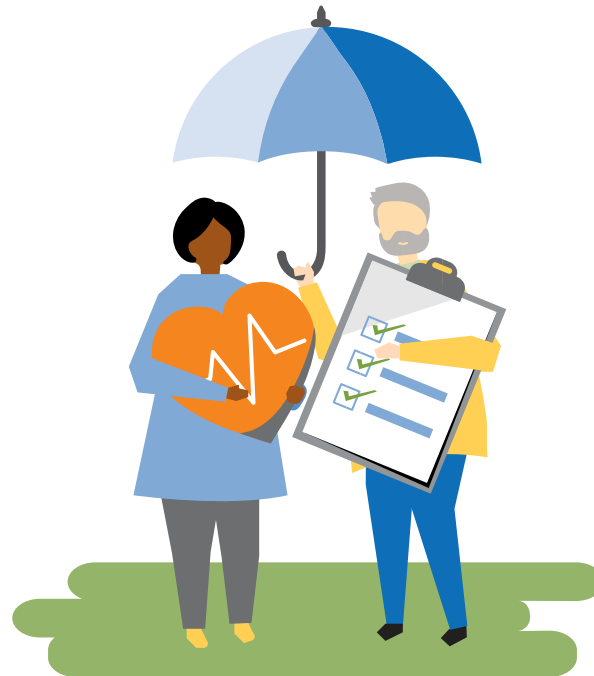


Tele-Nutrition Frontline Operations Toolkit





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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.



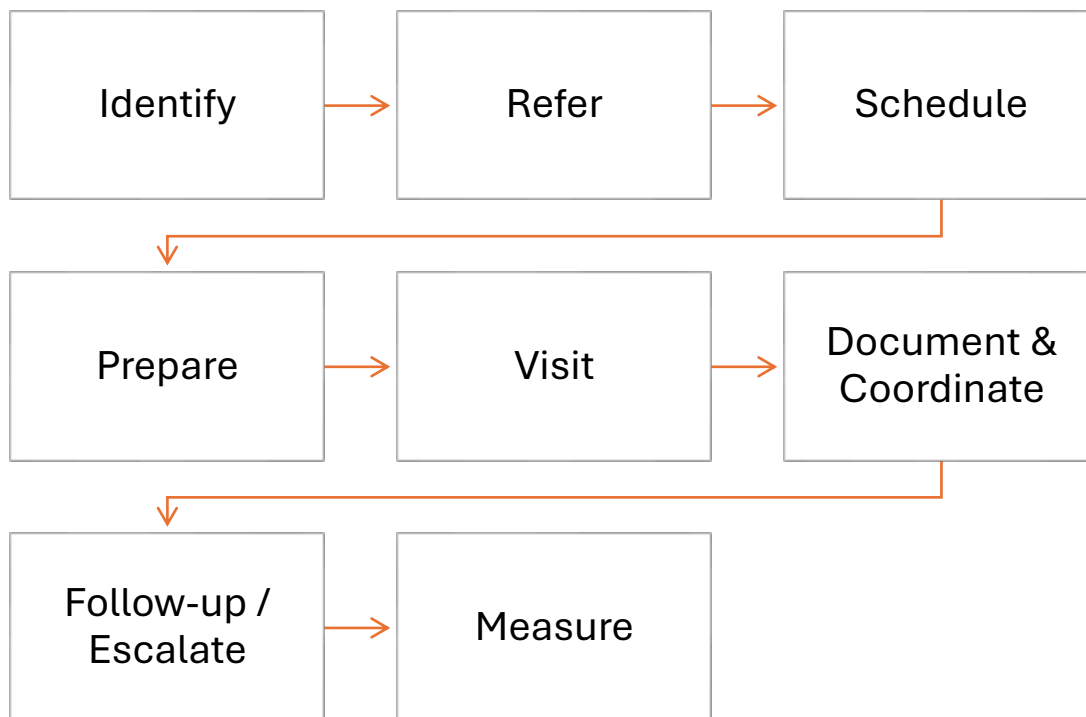
Tele-Nutrition Executive Quick Start

A toolkit for turning tele-nutrition strategy into a reliable patient workflow

How to use this toolkit

Work through the patient journey in order. Adapt each checklist to your organization, scope of service, workforce, technology, and patient population. Validate current policy, professional practice, privacy, and billing requirements with your internal specialists.

Tele-Nutrition Patient Journey



1. Identify: Who is the service for?

- Define the target population and access problem.
- Create simple inclusion criteria staff can apply consistently.
- Define situations that require clinician review before scheduling virtually.
- Define when an in-person service or another level of care is the better pathway.
- Avoid making technology ownership or high digital skill an unnecessary barrier when another workable modality exists.

Frontline question

Can the scheduler or referring team explain who the service is for and what happens when telehealth is not a good fit?

2. Refer: Ensure a complete handoff

A referral should give the nutrition professional enough context to prepare without forcing the patient to repeat the entire story.

- Reason for referral and patient goals, when known
- Relevant diagnoses, history, allergies/intolerances, medications, labs, and recent clinical information as appropriate
- Language and interpreter needs
- Accessibility or accommodation needs
- Preferred contact method and caregiver involvement, when appropriate
- Known food access or resource concerns
- Any urgency, safety concern, or follow-up deadline

3. Schedule: Offer the right modality

Ask	If yes	Action
Is a virtual visit clinically appropriate for this need?	Proceed	If uncertain, route for clinical review.
Can the patient use the selected technology comfortably?	Proceed or provide support	Offer a readiness check, caregiver support, or available alternative.
Does the patient need an interpreter or accommodation?	Arrange before the visit	Confirm the virtual platform and workflow support the need.
Does the patient prefer virtual care?	Honor preference when feasible	Offer another appropriate pathway when available.

4. Prepare: Patient readiness checklist

- ☐ Confirm date, time, modality, and how to connect.
- ☐ Explain who will join the visit and what to expect.
- ☐ Complete a technology check when needed.
- ☐ Arrange interpreter or accessibility support before the appointment.
- ☐ Ask the patient to have a current medication/supplement list available.
- ☐ Request food records, measurements, or other information the care team will use
- ☐ Encourage patients to join from a safe, comfortable place.
- ☐ Provide a contact number or process for connection problems.
- ☐ Explain what to do for urgent or emergency concerns.

Patient-facing scheduling script

"Your nutrition visit can be completed by telehealth video visit. Before we schedule, I'd like to make sure this option works for you. Do you have a device with a camera and connection you are comfortable using? Do you need an interpreter, accessibility support, or help getting connected? If telehealth is not a good fit, we can discuss the other options available to you."

5. Visit: A reliable virtual encounter

1. Confirm patient identity and follow organizational telehealth procedures.
2. Confirm that the patient can see/hear or otherwise communicate effectively and address interpreter/accessibility needs.
3. Clarify the patient's goals and what matters most today.
4. Complete the nutrition assessment appropriate to the service and scope.
5. Discuss food availability, affordability, cultural preferences, household context, cooking resources, and other practical barriers that affect the plan.
6. Co-create a small number of realistic goals.

7. Confirm the patient understands the plan using teach-back or another appropriate method.
8. Agree on follow-up, what the patient should track (if anything), and when to contact the care team sooner.

6. Document and coordinate

Use your organization's approved documentation standards and templates. The record should support continuity: another team member should be able to understand what was assessed, what was agreed upon, what follow-up is expected, and whether any concern needs action.

- Document the care plan and patient goals.
- Record relevant access barriers and supports provided.
- Route recommendations or concerns to the appropriate care-team member.
- Close the loop on referrals to community food or support resources when your workflow includes them.
- Follow your organization's requirements for documenting the telehealth encounter.
- Consult policy, compliance, and billing specialists for current organization-specific requirements.

7. Follow-up and escalation

Situation	Front-line response	Owner to define locally
Unable to connect	Use approved troubleshooting steps; move to an available alternative only when appropriate; reschedule when needed.	Scheduling / support
New clinical concern	Pause routine workflow and route according to clinical escalation protocol.	Clinical team
Patient cannot obtain recommended foods	Adapt the plan and connect to available food/community resources.	Nutrition / care team

Data or log suggests deterioration	Follow the program's defined review and escalation pathway.	Assigned reviewer
Telehealth no longer fits the need	Transition to appropriate in-person or other care pathway.	Clinical team

8. Digital tools: optional, purposeful, governed

Food logs, portals, connected devices, mobile apps, and AI-enabled tools can support selected workflows, but none should be added simply because it is available.

Before adding a tool, ask	Operational decision
What problem does it solve?	Name the specific use case.
Who needs to use it?	Patient/staff roles and training.
What information will it collect?	Minimum necessary data.
Who reviews the information?	Named role/coverage.
How often is it reviewed?	Expected cadence and response time.
What triggers action?	Threshold or escalation workflow.
Can patients opt for another workable approach?	Alternative access pathway.
Has the organization approved the tool?	Privacy, security, clinical, vendor, and governance review.

9. Role-based launch checklist

Schedulers / Front Desk	☐ Know eligibility and routing rules ☐ Use the patient readiness questions ☐ Know interpreter/accessibility workflow ☐ Know connection-support and rescheduling pathway
Clinical / Nutrition Team	☐ Know virtual vs in-person criteria ☐ Use standard assessment and documentation workflow ☐ Know escalation and care coordination pathways ☐ Set realistic patient goals and follow-up
Operations / Program Lead	☐ Monitor referral-to-visit flow ☐ Review technical failures and no-shows ☐ Maintain training and job aids ☐ Run pilot huddles and improvement cycles

IT / Digital Health	☐ Support platform reliability and access ☐ Maintain approved technical support route ☐ Support privacy/security requirements ☐ Track recurring technical barriers
Billing / Policy / Compliance Specialists	☐ Advise the program on current requirements ☐ Review workflows and documentation expectations ☐ Update teams when relevant requirements change

10. Pilot dashboard

Keep the first dashboard small enough to use. Review weekly during the pilot and less frequently once the workflow is stable.

ACCESS referral volume, time to first appointment, completed visits, successful connection rate	WORKFLOW referral completeness, readiness checks completed, follow-up completion, technical support volume
EXPERIENCE patient usefulness/convenience feedback, staff experience, common barriers	CLINICAL a small set of measures appropriate to the target population
BALANCING MEASURES staff workload, message volume, repeat work, complaints, safety events or escalations	

11. 60-90 Day Pilot Huddle Questions

- Are the right patients reaching the service?
- Where are referrals or appointments getting stuck?
- Which patients are having difficulty accessing the virtual service and why?
- Are we collecting any information we do not use?
- What is creating unnecessary work?
- What do patients say is helping or getting in the way?

- Are staff clear about roles and escalation?
- What should we change before expanding?

Ready-to-use implementation worksheet

Access problem we are solving:

Target population:

Service(s) offered:

Telehealth modality/modalities:

Clinical owner:

Operational owner:

Referral source(s):

Virtual-to-in-person escalation path:

Interpreter/accessibility process:

Technology support contact/process:

Patient-generated data we will collect and why:

Who reviews those data and how often:

Primary pilot measures:

Pilot start and review dates:

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