The Telemedicine News

Special points of interest:

- 2nd VHA National Telemedicine Conference, June 2, 2001 in Ft. Lauderdale, Florida.

- 6th ATA Annual Meeting June 3-6, 2001 in Ft. Lauderdale, FL.

"A Message From The Acting Chief Consultant"
Telemedicine Grows Throughout VHA

The growing number of telemedicine programs in VHA and the resultant care these provide to veterans has raised the profile of telemedicine both inside and outside the VHA. As would be expected in an organization with the geographical diversity of the VHA there is considerable variation in how telemedicine is used. This variation exists both within and between VISN's. It is true to say that telemedicine has grown throughout VHA due to the energy, enthusiasm, and leadership of creative individuals from a wide range of professional backgrounds. The individuals who are responsible include telemedicine coordinators, project managers, IRM staff, clinicians, and general managers. The common bond linking all these people has been their passionate desire to improve the care of this nation's veterans and help ensure they are not denied healthcare because of the physical barriers of geography, distance and climatic conditions.

The success of telemedicine in the VHA brings with it its own challenges. Currently one of the major challenges is how to transition projects to become mainstream sustainable health care services upon which veterans can depend over the long-term. I believe the key to making this transition happen is the establishment of telemedicine

Adam W. Darkins, M.D.
Acting Chief Consultant of Telemedicine

networks throughout VHA. My evidence for giving this opinion comes from looking at the way that telemedicine is evolving in VISN's currently at the cutting-edge of telemedicine development. In these VISN's we can see the focus of telemedicine moving from its present localization at one hospital site and trying to encompass a broader range of providers in various hospital and CBOC's throughout the VISN.

It is not surprising that bringing together health care providers into a common telemedicine network involves issues common to the creation of any networked structure. Common standards, protocols and guidelines are needed to ensure that free and easy interconnections can take place. This process immediately raises questions about equipment hardware compatibility and physical network configurations. Above and beyond this there are complexities of people networking such as how to schedule appointments for the consultations and for network connection itself. Legal and regulatory issues such as HIPAA , JCAHO and credentialing and privileging also come into play .

Because telemedicine is a new way of delivering health care we often find there

> " Although technology is vital, it is people who ultimately make things happen."

are no off-the-shelf solutions available for these challenges. Although a lack of existing structures provides excitement and it can also cause frustration at the same time. I believe our biggest current challenge is to create the structures that are needed to develop telemedicine networks at the hospital, VISN, and ultimately, the national level. The VHA is in a unique position to create the first truly national telemedicine network in the US. It is our collective task to make sure that if this happens we have a system that can 'plug and play'. It certainly needs to do this better than some computer operating systems we have all grown to love and curse. If we do not achieve reliability and consistency we will not have created a system that is safe and effective for veterans. In which case, the dollars would have been better spent

elsewhere in other areas of patient care. We are in a privileged position in terms of the work we do, who we serve, and the tasks we have confronting us in the future. Watch this space as they say: the focus of the next stage of telemedicine development in VHA crucially needs communication to help us resolve these issues. This newsletter is a new and much needed source of communication and networking for those building sustainable telemedicine programs in VHA. Often people feel the technical development of a network is where the main complexity lies. They are wrong. Although technology is vital, it is people who ultimately make things happen. Our new newsletter is just one part of an evolving communications strategy you will see develop over this next year and that we need your input to create.

"Telemedicine Trailblazer" Dr. Katherine Gianola
Associate Chief of Staff, Information Technology & Telemedicine Programs
By Claudia Zink

The purpose of this article is to introduce one of the VHA telemedicine champions, or "Trail–blazers", as we call them. It has been discovered in the field of social sciences that if you want to replicate successful programs, don't just copy the step-by-step procedures from other projects, but also examine the style of the successful practitioner.* Here we talk with Dr. Katherine Gianola, Associate Chief of Staff Information Technology and Telemedicine Program Section Chief at the Richmond VAMC, Virginia, VISN 6. She shared with us some insights on "How She Did It"! This is valuable information for the rest of us within the VHA trying to build successful telemedicine programs.

What are your current telemedicine project(s)?
I am currently working on a Telemedicine Transplant Program. We also have a contract to provide services via a telemedicine program with the Bureau of Prisons. That is a fee-based program that helps to fund some of our other telemedicine projects. We also have a Congestive Heart Failure home-monitoring program – which has greatly reduced in-patient care. We are just initiating a Wound Care Management program for our patients referred from plastic surgery, vascular, diabetic or other clinics. In that program a digital camera will be used by home care staff and the pictures are sent to the supervising physician.

This will allow for close clinical management with minimal patient travel.
How did you first get involved in telemedicine?
Dr. John Perlin, (who now works at VHA with Dr. Garthwaite on Quality Health Care issues) approached me when the position of Chief of Information Management came open and asked if I would be interested. We had a shared interest in technology and medical care from an end-user standpoint and so this position was a logical extension of that interest and experience.
What aspect of your background served you best for this project?
Leadership skills developed in other projects. There are so many aspects involved in telemedicine that just having technical skills is not enough. To get the big picture, you need to know about more than just information technology. Strong leadership skills are very important. An interest in technology, customer service skills, good patient relations, and the ability to organize multiple projects are the qualities that have helped me. You have to know how to put together a really good business plan for your project. A successful

telemedicine project *has* to make economical sense. It also must have clinical relevance, fill in the gaps where clinical specialties are not available in remote areas, expand care, *AND* show a cost avoidance.

How did you develop your technical knowledge?

Mostly on the job. We have an exceptional Bio-Medical Engineering department here at the Richmond VAMC. I went to them often in the beginning, when I had questions and they would explain things in an easy-to-understand manner. There is a great academic program here in Richmond (Medical College of Virginia at Richmond). They have extensive telemedicine programs. I learned from watching them and doing a lot of collaboration. I developed a network of people also working on telemedicine programs. Attending the VHA national meeting and the ATA (American Telemedicine Association) conference was very helpful. Dr. Adam Darkins and his staff at the VHA national office have been very supportive. People at our VISN and people from VISN 8, like Dr. David Law, and Director Bob Roswell have been extremely helpful source of information and support.

What suggestions would you have for someone else starting a program like this one? (i.e. books to read classes to take people to ask, etc.)

I really liked the article appearing in *Telemedicine Today* entitled, "How Not To Develop Telemedicine Systems",** by Professor Peter Yellowlees, Head, University of Queensland Department of Psychiatry, Australia. The article highlights points on many of the errors we all make when first starting telemedicine programs. I would recommend that each person involved in telemedicine read this article prior to establishing a program!

What have been the greatest challenges and greatest rewards in getting these projects started?

I am very enthusiastic about this new application of healthcare and starting these new projects. Some days it can be very frustrating, but more often it is very rewarding. And, I must admit, I love gadgets as much as the next doctor! But, I have learned that technology is the very last piece to put into the project. Telemedicine projects need to be economically feasible and have a good business plan. Budgets have to include all FTE, travel and training

expenses as well as equipment costs. A good coordinator is important to help the sites to schedule patients and have the equipment ready so that technology does not get in the way of the provider.

I participate in a committee through the Medical College of Virginia to evaluate telemedicine programs all over the state of Virginia. Time and time again, we find programs that were given large sums of money, are no longer seeing patients via telemedicine once grant money has run out. This happens so often because there was no sustainability plan built in to the project, or there was a lack of collaboration between parties and poor support from the top leadership of the facilities.

What I want to say is this: Plan carefully. Develop a project that is financially sustainable and has clinical relevance. There is so much reward personally and professionally in telemedicine - to see for instance, how grateful the veterans are not to have to travel so far for services! I also enjoy seeing how enthusiastic the clinicians are to use the equipment and provide healthcare through technology! The field is exciting and it's wide open, without a lot of precedence. There is plenty of room for all kinds of "Trail-Blazers" in telemedicine. And if I can help, I'll be glad to talk to people about how to get their telemedicine projects started. The VA is a very good place to do these programs and people are very willing to collaborate and support each other.

* Virginia M. Satir, **From Frogs to Princes**, 1985, Science & Behavior Books
** Article entitled "How Not To Set Up Telemedicine Systems", June 2000 Telemedicine Today. URL: http://telemedtoday.com/articlearchive/articles/hownottodeveloptelemedicine.htm

Note: If you know a "Trailblazer", contact Claudia Zink via email at: Claudia.Zink@med.va.gov.
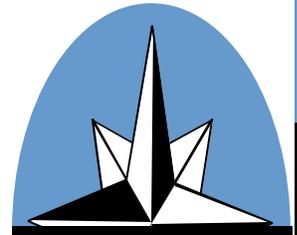
> "A successful telemedicine project has to make economical sense. It also must have clinical relevance, fill in the gaps where clinical specialties are not available in remote areas, expand care, and show a cost avoidance."

Focus on "Transplant Telemedicine at the Richmond VAMC"

By Michelle Hill

Transplant Telemedicine Services began in December 1999 at the Richmond Veterans Affairs Medical Center. Heart, lung, and liver transplant patients from throughout the country, including Puerto Rico, travel to the Richmond VA for care. These patients require specialized, coordinated care throughout the transplant process. Given the extensive pre-transplant protocols, the regimented post-transplant follow-up, and the episodic needs involved with this population, telemedicine seemed an obvious way to eliminate some of the travel. The business case was clear-cut, according to Dr. Gianola—it could save the referring sites the expense of travel to the Richmond VA for scheduled and episodic care, and provide earlier assessment for complications. This article offers a "snapshot" view of the Transplant Telemedicine Program as shared by Dr. Gianola.

The Team: The team is essential for success. In addition to Dr. Gianola, who is the Associate Chief of Staff for Information Technology and the Telemedicine Program Director, the team includes a Telemedicine Coordinator dedicated to the transplant program, lead physicians for Transplant Services, a Transplant Coordinator, the clinicians at the referring sites, and a health economist. Dr. Gianola emphasized that the linchpin for a successful program is a full-time telemedicine coordinator. A coordinator is "worth the weight in gold." The telemedicine coordinator brings the parties together and supports them in the new method of providing services via telemedicine. The health economist, also a physician, is critical to the evaluation of telemedicine services. With the health economist, the team developed a realistic, fundamental model to evaluate the telemedicine services.

Patients Served: The Transplant Telemedicine Program has served forty-five patients at the time of interview. Telemedicine has been used predominantly for liver transplant patient care.

The Equipment: From Dr. Gianola's experience, the technology component is easy. No new equipment was required. The equipment was already in place at the Richmond VA, as well as most of the referring sites. The Richmond VA utilizes the PictureTel Concord 4500 and the Polycom 512, connecting on Integrated Service Digital Network

(ISDN) speeds of 384K to 512 kilobits per sec (Kbps). Not to mistakenly think the technology is faultless—an occasional glitch is the weather. Mother Nature can impede the reliable connections between Richmond and Puerto Rico, or areas across the United States.

The Applications: The program uses several methods to share patient health information. The basics include: 1) videoconferencing, 2) viewing of radiological studies on a light-box via videoconferencing, and 3) the Computerized Patient Record System (CPRS). A Veterans Integrated Service Network (VISN)-wide "web-top" access for CPRS is also currently in use.

Pearls of Wisdom:

Top-down endorsement is key for the implementation of telemedicine. One unexpected challenge reinforced this judgment—the referring physicians did not readily embrace the transplant telemedicine program. The program required a change in the workflow and workload. The direct benefits of this change were not obvious to the referring physician. Moreover, the remote sites felt compelled to have only the referring clinician available for the telemedicine visit, which required difficult coordination, especially across several time zones. Communication with the top administrators as well as clinicians helped foster acceptance of the program. Also, the telemedicine process was adapted to provide flexible coverage for the clinical team—one of several team members could participate, rather than one specific clinician.

A sustainable economic plan is essential, yet complex. After discovering that their initial goals of a cost-benefit analysis for the program were overly ambitious, Dr. Gianola and her team formulated both a short-term and a long-term plan. The short-term plan is to focus the evaluation strategy on "the immediate tangibles", most notably the savings in travel expenses, as well as patient and provider appraisal of the tech-

"Top-down endorsement is key for the implementation of telemedicine."

nology. The long-term goal is to develop a model toward a sustainable economic plan. To work on this formidable ambition, they are in the process of assembling a VISN Telemedicine Sub Council. The council is examining what telemedicine means to all stakeholders. The core group includes information technology leadership and clinical champions.

Funding Source: Funding was acquired with a one-year grant from the Veterans Affairs Telemedicine Strategic Health Care Group which began in July 2000.

Research: The program does not incorporate a research protocol. The Internal Review Board reviewed the program plan and sanctioned it without requiring Human Subjects approvals.

Future Plans: Future plans related to the Transplant Telemedicine Program include adding psychologis ts to the team, developing provider education, and continuing the program beyond the current grant funding.

Other Current and Planned Telemedicine Programs at the Richmond VA:
Neurology, Distance Education, Home Care Congestive Heart Failure Program, Home Care Wound Care Clinic.

NOTE: If you would like your program highlighted in a future article, please contact Michelle Hill via email at: Michelle.Hill@med.va.gov.

Mary Skinner's Tech Corner

TechnoSpeak Simplified

POLYCOM 512

PICTURETEL CONCORD 4500

Both video cameras are ideal for small conference rooms. Good quality video. Voice-tracking camera. Remote control operates camera movement from anywhere in the room. Sends video to a remote location with near real-time projection over an ISDN connection.
For more technical details visit websites:
http://www.tribecaexpress.com/picturetel

http://www.polycom.com
The Basics About Connections
Computer telecommunications has the ability to send and receive audio, video, text, software, and multimedia, and is one of the fastest-growing segments of the telecommunications market. Here are a few basic

definitions about ISDN connections:

Bandwidth

Bandwidth is the amount of data that can be sent through a computer network or telephone line, in a given amount of time.

Integrated Services Digital Network (ISDN)

ISDN is a combination of fiber optic technology and special phone service provided by telephone companies that allows for digital audio and video transmission. Videoconferencing units utilizing ISDN frequently operate between 128 and 512 Kbps, depending on the number of Basic Rate Interface (BRI) lines.

Tips from the Telemedicine Clinician

Dr. Gianola offered a few wise tips for those thinking of creating a video consultation clinic.

1. Do not be seduced into buying the equip-

ment before you are sure there is justification for the technology.

2. Be certain you have the clinical champion willing to use the technology.

3. Most importantly, make sure you have the technical support in place to help facilitate the project.

4. The equipment should be set up in a space ideal for patient privacy (telemedicine room).

5. It is best if you position the telemedicine room within close proximity to the clinicians' usual workspace.

6. It is important to have a networked PC, telephone, and dictation capability available.

7. A flat screen is best for viewing.

8. Always have emergency numbers available.

> "Do not be seduced into buying the equipment...."

Telemedicine Policy Watch
By John Peters

From time to time local and federal entities make changes to how telemedicine will be practiced in this country. While the VA is somewhat unique in that it is a national health care organization, VA personnel need to be aware of any changes (either internal or external to VA) that may affect their daily routines. The intent of this column is to inform you of telemedicine policy changes and what the changes mean to you as a member of the telemedicine community.

FEDERAL NEWS

In some of the final legislation of last year, the 106th Congress passed, and President Clinton signed, H.R. 5661: the Medicare, Medicaid, and State Child Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA) as part of the Consolidated Appropriations Act (CAA) of 2001. BIPA contains a wide assortment of health care service changes designed to have a positive effect on the Medicare program as well as some improvement on the Medicaid program and the SCHIP. (Full text of the bill is available on the

Internet at: http://thomas.loc.gov)

BIPA contains two relatively small sections pertaining to telemedicine: the first section revises how Medicare should reimburse for telemedicine services in rural areas; the second section merely clarifies the role of tele-home health care as a component of, rather than replacement of, traditional home health care plans as covered by Medicare.

BACKGROUND

Health and Human Service's (HHS's) Health Care Financing Administration (HCFA – the federal agency that administers Medicare, etc.) first addressed telemedicine reimbursement after the 105th Congress passed the Balanced Budget Act of 1997 (BBA).

For reasons both practical and political, many believed that HCFA's first attempt to administer BBA's telehealth reimbursement was not completely successful; they felt the HCFA rules did not match with the real world practice of telemedicine. Even worse, the restrictive reimbursement rules

were seen as impediments to the successful integration of telemedicine. Therefore, Congress included telehealth revisions and clarifications in BIPA.

I. Medicare Telehealth Services Reimbursement Revisions effective 10/01/01

BIPA's new *Revision of Medicare Reimbursement For Telehealth Services* section, found under Rural Health Care Improvements section, outlines the following revisions to BBA:

- Eliminates the unpopular fee-splitting provision (i.e. 75% distant site care provider, 25% to care originating site). Instead, the distant site telehealth service provider will now receive 100% of Medicare payment (just as if the service had been provided in person), while the referring practitioner's facility (a.k.a originating site) will receive a $20 facility fee for the period between October 1, 2001 and December 31, 2001, with Medicare Economic Index (MEI) increases to these facility fees in subsequent years,
- Eliminates the requirement that the originating site physician/practitioner present the patient, unless the distant site consulting physician/practitioner deems it medically necessary, and
- Eliminates the requirement that the originating site must be a rural Health Professional Shortage Area (HPSA – defined under section 254e (a)(1)(A) of the Public Health Service Act (Chapter 6A from U.S. Code Title 42 Public Health and Welfare).

Eligible Locations – The physician and facility fee payments are only available for services provided to an "eligible telehealth individual" for a telehealth service furnished at an originating site. BIPA sets forth the following definition of the originating site:

'Originating site' means only those sites (a-e below) at which the eligible telehealth individual is located, at the time the service is furnished via a telecommunications system, and only if such site (a-e below) is:

    (1) In an area that is designated as a rural HPSA;
    (2) In a county that is not included in a Metropolitan Statistical Area; or
    (3) Participating in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.

Sites Description -- The sites referred to in the 3 designated areas above are the following sites (noticeably missing: nursing homes, community mental health centers):

    (a) The office of a physician or practitioner.
    (b) A critical access hospital (as defined in section 1861(mm)(1)*).
    (c) A rural health clinic (as defined in section 1861(aa)(s)*).
    (d) A federally qualified health center (as defined in section 1861(aa)(4)*).
    (e) A hospital (as defined in section 1861 (e)*).

*Title XVIII of the Social Security Act is administered by the Health Care Financing Administration http://www.ssa.gov/OP_Home/ssact/title18/1800.htm#fn001

Eligible Telehealth Services – BIPA defines the term 'telehealth service' to mean professional consultations, office visits, and office psychiatry services (identified as of July 1, 2000, by *HCFA Common Practice Coding System (HCPCS)* codes 99241-99275, 99201-99215, 90804-90809, and 90862 (and as subsequently modified by the Secretary), and any additional service specified by the HHS Secretary. The HHS Secretary shall establish a process that provides, on an annual basis, for the addition or deletion of services (and HCPCS codes), as appropriate, to those specified above.

II. TeleHealth Delivery of Home Health Services

The new Act clarifies that home health agencies may use prospective payment system (PPS) dollars to pay for conventional home health service plans that include tele-home care visits as part of that plan. However, the home health agencies may not:

- Use the tele-home care visits as a substitute for conventional face-to-face visits that are part of the plan of care certified by a physician pursuant to section 1814(a)(2)(C)* or 1835(a)(2)(A)*;
- Count (or add) the tele-home care visits with the conventional face-to-face home care visits in order to upgrade the plan of care into the higher- maintenance/higher-reimbursement-fee category, currently defined, in part by the number of conventional home care visits or personal contacts provided.

BIPA attempts to clarify that nothing in the home health PPS section of the Social Security Act prevents a home health agency from furnishing services via a telecommunication system if such services meet the two caveats above.

Health care providers will need to take care to make sure that the plan of care certified by the physician specifies the expected number of face-to-face home care visits and separately identifies the number of tele-home care visits.

HCFA's interpretation of BIPA's Tele -Home Health section is available on-line at www.hcfa.gov/pubforms/transmit/a0102.pdf

WHAT THIS MEANS TO VHA PERSONNEL

Many within the telemedicine community view BIPA as a significant advancement for telemedicine,
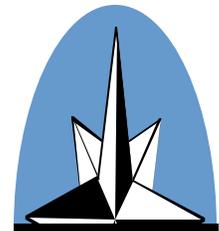
> "Many within the telemedicine community view BIPA as a significant advancement for telemedicine, particularly when considering how close the bill came to not passing."

particularly when considering how close the bill came to not passing. While some barriers were knocked down, much work remains to be done before telemedicine becomes a fully incorporated component of improved health care.

Over the summer HCFA will work to interpret BIPA and your feedback during their open comment period, prior to implementation on the effective date of October 1, 2001.

Once implemented, these revisions are expected to expand the use of telemedicine in rural areas across the country, and therefore in each VISN. And many believe that private payer insurers, who closely follow Medicare's lead, will expand their reimbursement coverage for telehealth care.

FUTURE DEVELOPMENTS

In BIPA, Congress has tasked HHS to produce a study by October 1, 2003 that will help determine:

(A) Settings and sites for the provision of telehealth services that are in addition to those currently permitted;

(B) Additional practitioners (e.g. occupational and speech therapists) that may be reimbursed for furnishing telehealth services; and

(C) Geographic areas in which telehealth services may be reimbursed that are in addition to those authorized by this Act.

This study shall be submitted to Congress together with recommendations for legislation that the HHS Secretary determines appropriate.

POLICY WATCH FEEDBACK

Please let us know if you have a specific federal or state telemedicine policy you would like to see addressed in future issues of the Newsletter. Contact John Peters via email at: John.Peters@med.va.gov.
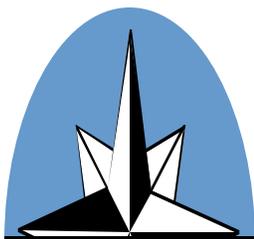
> "Telemedicine is where healthcare professionals and patients connect"
> By Veta D. Brooks

Leading the Way in Rural Tele-Psychiatry

By Veta D. Brooks

This is an overview of an article published in a VHA Highlights issue which demonstrates how telemedicine continues to help our Veterans.

When Veterans living throughout seven rural Appalachian counties in Virginia had to commute for two hours to receive mental health services, the Salem VAMC decided to expand their services and employ telemedicine to get the job done. Utilizing telemedicine, they now provide mental health support services to the Tazewell County VA Community Based Outpatient Clinic (CBOC) in Cedar Bluff, Virginia. This Tele-psychiatry program works in conjunction with a community contract with the Cumberland Mountain Community Service Board (CMCSB) to serve the veterans throughout this rural region. Together, the Salem VAMC and CMCSB upgraded existing equipment and installed a high-speed data line in order to improve the

technical quality during the tele-psychiatry session. The Tele-psychiatry program has received a favorable response from the patients.

The Cumberland Mountain Community Service Board has five years of experience with tele-psychiatry and has received national recognition for its Appal-Link Network. Through the Appal-Link Network, residents of rural Appalachia who had previously required state hospitalization now receive mental health tele-psychiatry services. Telemedicine is where healthcare professionals and patients connect—no doubt about it.

Thank you for the uplifting article, VHA. Keep up the good work, **Salem VAMC**!

Q's & A's
By John Peters

Q: What funding sources are available for implementing/ maintaining my telemedicine project/program? Am I eligible, as a part of a federal health care system, for other federal agencies' grant monies for telemedicine?

A: Your best funding sources for VHA telemedicine projects are:

1. Coordinated through your local VISN or facility. The particular funding source will depend on both the type of telemedicine project/program (i.e. delivery of/access to on-going medical care, or health service research & development project), as well as the type of funds requested (e.g. personnel, equipment, telecomm, training or travel.) Funds are available for research through various mechanisms including Merit Reviews from VA Rehabilitation Research and Development and Health Services Research and Development bodies. Clinical Initiative Program grants are another way to obtain seed money for new telemedicine programs.

2. Since 1998, VA Central Office (VACO) has implemented 3 small grant programs (i.e. 2 for Spinal Cord Injury TeleCare, and 1 for Various TeleCare services including Mental Health, Geriatric, and Transplant) for 1-year telemedicine demonstration projects. There are no immediate plans for any additional grant money from VACO. Should VACO funding become available again in the future, the Telemedicine SHG will use every means possible (e.g. e-mail, newsletter, Web-site, annual mtgs.) to maximize your chances for funding approval.

ALTERNATIVES TO GRANT FUNDS: With guidance from their general counsel's office, some VA Medical Centers have been able to partner with private health care providers and even commercial vendors to become a test or study site for telemedicine projects/programs/products.

VHA NOT ELIGIBLE FOR OTHER FEDERAL AGENCY GRANTS: Unfortunately, because VHA is itself federally funded, it is not eligible for additional federal grant/loan funds through other federal agencies' programs. You should be aware that DoD, NASA, Commerce (TOPS program), Ag (RUS DLT Program), and HHS (OAT Program) all provide funds for telemedicine projects (particularly focused on rural and remote areas) and may have a local presence in your community. And while you may not benefit directly from these funds, you may wish to learn more about how these programs may benefit/have benefited others in your local medical community.

VHA MAY BE ELIGIBLE FOR DISCOUNTED TELECOM SERVICES:

Some rural (and even a few urban) VHA sites may be eligible for discounted telecommunication services under the Universal Service Administrative Company's (USAC's) Rural Health Care Program. USAC is a private non-profit that administers the Universal Service Fund under regulations promulgated by the Federal Communications Commission (FCC). For discount telecom service application deadlines and eligibility requirements please visit USAC at http://www.rhc.universalservice.org

FEEDBACK, COMMENTS, QUESTIONS: If you wish to share any additional funding solutions not mentioned above, please contact John Peters at John.Peters@med.va. gov. For more information visit the websites below:

http://www.usda.gov/rus/telecom/dlt/dlt.htm

http://www.ntia.doc.gov/otiahome/top/

http://telehealth.hrsa.gov/

http://www.rhc.universalservice.org/

For other VHA telemedicine questions you would like addressed in future issues of this newsletter? Please send your response to the VHA Telemedicine Newsletter % Veta.Brooks1@hq.med.va.gov

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The Telemedicine New Staff thanks you for your support and hopes that you enjoy our first issue. The mission of this newsletter is: "*to serve as a conduit to share information, strengthen resources, and promote community for telemedicine within the VHA and with the goal to provide the best quality of care to our patients despite the barriers that distance may impose.*"

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Dr. Katherine Gianola for her "Outstanding Interview"