VHA TELEMEDICINE

THE TELEMEDICINE NEWS

A Community of Interest

Adam W. Darkins, M.D.
Chief Consultant, VHA Telemedicine

On April 26th 2003 we held a VHA telemedicine meeting in the Orlando Convention Center. This was on the Saturday preceding the annual American Telemedicine Association (ATA) meeting. Over 70 of us were able to gather together, some came for the ATA meeting and some only came for our meeting. We were sorry that current travel limitations prevented other old friends from being with us this time. We reviewed the current state of the union of VHA telemedicine and outlined an agenda of developments that we want to take forward over the next year. I am going to leave you in suspense and not fill you in on these activities until our next issue of the newsletter when I will be reporting on the 4th Annual VHA Telemedicine Meeting, which was broadcast via satellite May 19th through 23rd from St Louis. Here I want to cast us back to the first VHA Telemedicine Meeting that we held, in the spring of 2000, the Saturday before the ATA meeting in Phoenix. Before looking at new targets I want to briefly review whether we managed to achieve some of the goals we set for ourselves back then.

Many of us met for the first time in Phoenix. The Telemedicine Strategic Healthcare Group was there in force with John Peters and Veta Brooks and myself, Bob Lane from EES was there to support our fledgling event. Like hosting a party for the first time we did not know whether we would be a small band or a big throng in attendance. There were 90 of us. I want to look back at some of the issues that were so passionately raised then and see how far we have managed to fly with them afterwards. By us, I mean a community of interest. Our community of interest crosses professions and backgrounds. Some of us work in VISN's, in facilities, CBOC's, VACO and in EES. What binds us together is that we have a common interest in using telemedicine to improve the care that is delivered to veteran patients.

In Phoenix, people from many VHA telemedicine programs learnt for the first time about other similar activities going on in the organization. They were not alone and this realization was the impetus for a communication group that was formed with Michelle Hill, Mary Skinner, and Claudia Zink as the standard bearers. An action item they proposed was to develop a newsletter. Now in its 9th edition, the newsletter is going strong and is a vital part of keeping our community together. It is with sadness that we have to report that Michelle Hill has left both Palo VAMC and VHA. She and her husband have moved to live in Seattle. It feels strange to be writing an article without the able hand of Michelle to cajole us, and her keen eye to edit our disparate efforts

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New DSS Coding Guidance for VHA Telehealth:

If it isn't coded, it isn't VHA Telehealth

John Peters, MS

All details of the VHA healthcare, including telehealth, must be recorded using standard VHA medical record documentation procedures. Recent newsletter columns and VAKN broadcasts have alluded to a new coding reference manual for VHA Telehealth. The initial draft of the manual is in final review and will be made available soon to provide guidance on how to best assign workload credit, bill various parties, and receive reimbursement for VHA Telehealth.

In the meantime, this article uses two tables; one for Hospital and Clinic telehealth, and one for Home telehealth to introduce new telehealth codes recently approved, by Decision Support Sciences (DSS), for use in reporting VHA workload to the National Patient Care Database (NPCD) in Austin, TX.

Once telehealth workload data begins to appear in Austin, we will finally be able to state definitively which types of telehealth activity, and how much, is occurring at which VHA sites. Your local DSS Site Managers have begun receiving formal training on these changes and may be your best local expert for questions.

The forthcoming reference manual and online training course, will provide further instruction on the proper use of these codes as well as examples of appropriate CPT codes and billing instruction for reimbursement.

Do you have a specific telehealth coding question? Please send it to John.Peters@hq.med.va.gov

FOR HOSPITAL AND CLINIC TELEMEDICINE (Approved for use by DSS October 2002)

Code	Name	Description
_ _ _690 **(DSS Credit Pair)**	TELEMEDICINE	TELEMEDICINE. Records, at the patient's site (originating site), telemedicine care provided to patients. Telemedicine is the use of electronic communications and information technology to provide and support healthcare when distance separates the participants. This secondary code can be attached to any primary stop code related to the workgroup that provides telemedicine consultations for many types of patient populations. (e.g. tele-dermatology for wound care management, tele-mental health for medication management, tele-geriatric and extended care for vital sign monitoring, etc.) Clarification for on-going telemental health only: Distant provider site records 692 as the credit pair for the patient's site if the patient's site involves a co-presenter, and the co-presenter codes the patient site as 690 Clarification for home telehealth only: distant provider site records 179 (for real-time video) or 684 (for nonvideo intervention) as the credit pair(secondary code) instead of 690 if the patient's site is the patient's home. Secondary Stopcode Use Only
_ _ _692 **(DSS Credit Pair)**	TELEMED CONSULT SAME STATION	Records, at the provider site, telemedicine care provided to patients where the site of the patient and the site of the provider share the same STA3 (Station Number) such as in the case of a CBOC and it's parent station. Clarification for on-going telemental health only: Distant provider site records 692 as the credit pair for the patient's site if the patient's site involves a co-presenter, and the co-presenter codes the patient site as 690 Secondary Stopcode Use Only.
_ _ _693 **(DSS Credit Pair)**	TELEMED CONSULT NOT SAME STATION	Records, at the provider site, telemedicine care provided to patients where the site of the patient and the site of the provider have different STA3 (Station Number). For example, VAMC to VAMC or VAMC #1 to CBOC of VAMC #2. Clarification for Vet Centers: 693 is the only credit pair applicable for telehealth with Vet Centers Secondary Stopcode Use Only.

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A Community of Interest

Adam W. Darkins, M.D.
Chief Consultant, VHA Telemedicine

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into the quality publication that she has helped shape. Not only did she develop the newsletter over the past 4 years, she led a great telemedicine program and has had 2 children. So given her amazing energy and talent let's hope that it's possible to attract Michelle back into both VHA and telemedicine in VISN 20 sometime soon. Best wishes and thanks Michelle.

A major issue that we needed to take forward in Phoenix was that of credentialing and privileging for telemedicine. We subsequently worked closely with Kate Enchelmayer from the Office of Quality and Performance. This collaboration resulted in 2 Directives (available on line http://www.va.gov/telemed). One for credentialing and privileging for telemedicine involving VAMC's and CBOC's and the other involving home-telehealth and VET Centers. With impending changes in the Joint Commission (JCAHO) standards for credentialing and privileging for telemedicine we will need to revisit this topic. In an upcoming issue we will update you on VHA's position in a joint article with Kate Enchelmayer.

Informed consent was another area of concern that we flagged up to take forward in Phoenix. Suzana Fox joined our office to work with the Office of Ethics and us on informed consent for telemedicine. Since departing VHA in December 2002, Suzana leaves the legacy of a telemedicine section to the Office of Ethics Handbook, guidance on informed consent that she helped develop and a 101 course on informed consent for telemedicine that we will be shortly posting on the Telemedicine 101 Web site that is part of the VHA Telemedicine Web site http://vaww.va.gov / telemed/. Informed consent for telehealth will be the subject of another forthcoming article. Thanks to Suzana and good luck to her in the future.

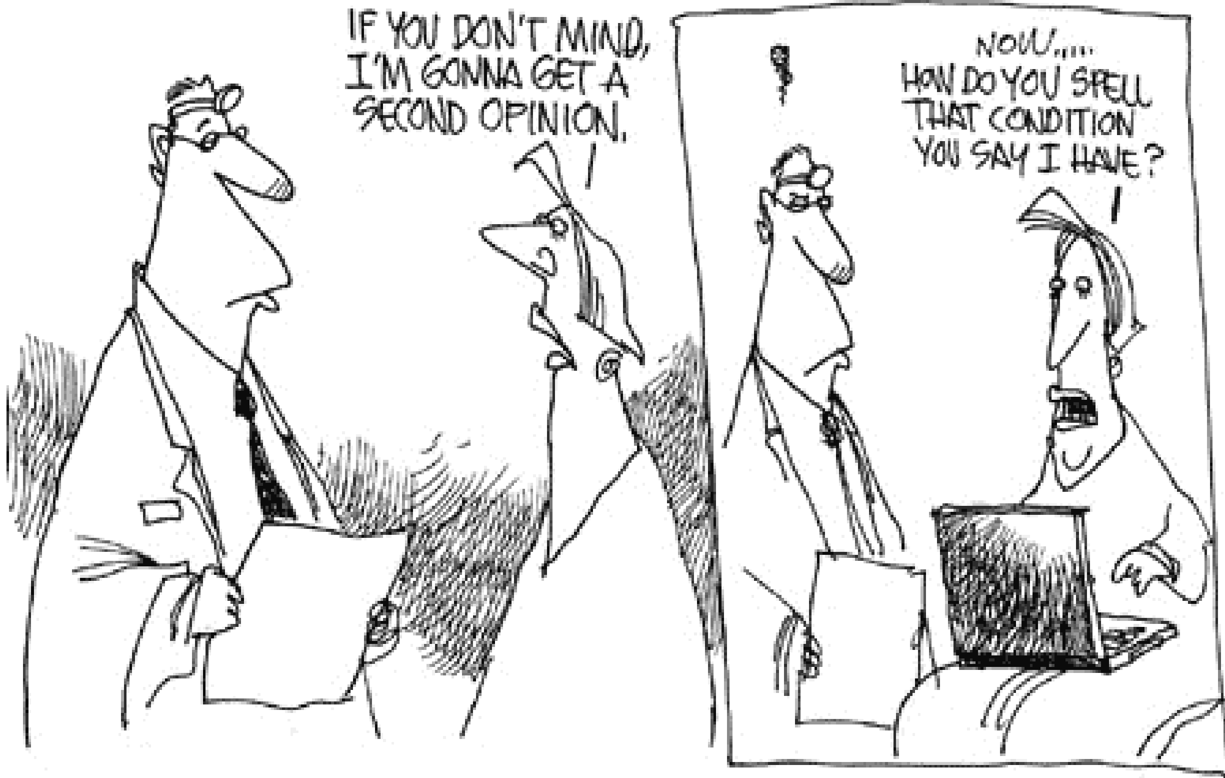
In Phoenix Marlis Meyer, Pat Ryan and Rita Kobb outlined plans for a new program called care coordination that their VISN Director, Dr. Robert Roswell, wanted to take forward in VISN 8. Dr. Roswell's, and their vision was that care coordination using telehealth technologies could make the home into the preferred site of care. The rest is more than history. Dr Roswell is now the VHA's Undersecretary for Health. Very shortly there will be new Office of Care Coordination formed in VACO, which Dr. Roswell has asked me to lead and Pat Ryan will be the Associate Chief Consultant. Watch out for 2 care coordination RFP's between this and the next issue of the newsletter. One RFP will make $1 Million per VISN available to 6 VISNs to develop care coordination programs (in addition to the existing 4 VISNs that now have programs). The second RFP will provide $1 Million to establish an East Coast care coordination training center. Next FY there will be RFPs for a further 10 VISN care coordination programs and central and western training centers. There will be more news on the Office of Care Coordination in the next newsletter.

Teleretinal imaging for diabetic retinopathy screening was discussed at the Phoenix meeting. Since then programs have been instituted in several VISNs. We developed VHA recommendations after a September 2001 meeting and Mary Lawrence, an ophthalmologist from Minneapolis has recently developed a teleretinal imaging toolkit. Hot off the press is the distinct likelihood that there will be an RFP for teleretinal imaging for diabetic retinopathy before the end of this FY.

Things we still need to work on that we started in Phoenix are: a standard VHA-wide position description for telemedicine coordinators and issues associated with privacy and confidentiality for telemedicine that lie outside the electronic patient record.

I believe that we have done well and deserve congratulations. By we I don't mean the Telemedicine SHG, which comprises John, Veta and myself. What has been achieved has been by us working with the wider community of interest that we connect with this newsletter. What we as an SHG are able to achieve depends on the generosity of you and the talents and enthusiasm you have to share. You are a very special group that we are fortunate to work with. So as we lose some people we have been working with and inevitably gain new ones let me close by thanking you all. You are the ones that are making things happen.

HUMOR



FREE Money! Part one...

DoD Telehealth Research Dollars Available for VA

All VHA Telehealth personnel should be aware that the Department of Defense (DoD) is a possible funding source for telehealth research projects. Specifically, the DoD's Telemedicine and Advanced Technology Research Center (TATRC) at the US Army Medical Research and Materiel Command (USAMRMC) makes funds available on a rolling basis through a Broad Agency Announcement (BAA) issued by its contracting agent, the US Army Medical Research Acquisition Activity (USAMRAA).

The first step toward seeking these funds for your telehealth research proposal is to submit a pre-proposal as instructed at the USAMRAA Web site http://www.usamraa.army.mil/pages/pdf/2001_BAA_APPENDICES.pdf

If, prior to submitting your pre-proposal, you would like general information or additional details on any of the groups listed above, you may visit them on the Web:

TATRC http://www.tatrc.org

USAMRMC http://mrmc-www.army.mil

USAMRAA http://www.usamraa.army.mil

... FREE Money! Part two

FCC Dollars Available for RURAL VA Telehealth Telecommunication Service Fees

Are the high costs of telecommunications a barrier to your VA's rural telehealth care project? Is the unavailability of current telecommunications technology a barrier to your VA's rural telehealth care project? All VHA Telehealth personnel should be aware that the Federal Communications Commission (FCC) is a possible funding source for some telecommunication costs for your VA's rural telehealth care programs. Specifically, the FCC's Wireline Competition Bureau's (WCB's) Telecommunications Access Policy Division's (TAPD's) Universal Service Fund makes telecommunication service funds available through the Rural Health Care Provider Program administered by the Universal Service Administration Company's (USAC's) Rural Health Care Division (RHCD).

These FCC funds are available to reduce the costs of bringing current telecommunication technology to rural areas and reduce service rates in rural areas (with fewer telecommunication providers competing to provide service to fewer customers) to the level of telecommunication rates found in the higher volume urban areas.

The first step toward seeking these funds for your VA's rural telehealth program is to obtain a Health Care Provider (HCP) number from RHCD at 1.800. 229.5476 and completing an FCC (Eligibility) Form 465 as instructed at the USAC Web site http://www.rhc.universalservice.org/forms/465inst_y4_5.asp

Unlike other funding sources, this is an entitlement for rural health care providers rather than a competitive grant fund – and the application process has been streamlined to facilitate funding for eligible providers.

If, prior to submitting your eligibility form, you would like general information or additional details on any of the groups listed above, you may visit them on the Web:

FCC http://www.fcc.gov

TAPD http://www.fcc.gov/wcb/tapd/

USAC http://www.universalservice.org

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

Continued

New DSS Coding Guidance for VHA Telehealth:

If it isn't coded, it isn't VHA Telehealth

John Peters, MS

FOR VHA HOME TELEHEALTH (Approved for use by DSS April 2003)

_ _ _179 **(DSS Credit Pair)**	HOME TELEVIDEO CARE	Records workload by VA health care professionals using real-time videoconferencing as a means to replicate aspects of face-to-face assessment and care delive to patients **IN THEIR HOMES**. Assessment and care may include: health/socia evaluations, wound management, exercise plans, patient appearance, monitoring patient self-care, medication management, monitoring vital signs, including pain etc. These telehealth encounters **must be electronically documented in CPRS**, fully meeting criteria for provider encounter. Use provider work-unit related sto as primary, e.g. 170179 – HBPC Physician doing TeleHome care, 323179 – Tele Home Primary Care, 502179 – TeleHome Mental Health. VA Medical Centers providing this care will have made significant investment in the staffing and tech nological infrastructure required to support such complex care provision in the home environment. Not Limited to HBPC. Secondary Stopcode Use Only
683_ _ _ **(DSS Code)**	HOME TELEHEALTH MONITOR ONLY NONVIDEO ***(Non Count)***	Records MAS-non-count monitoring workload by VA health care professionals using non-video electronic in-home monitoring devices for the remote monitoring of patients on a regular basis and interpretation of patient's health care information received through electronic transmission as a means to replicate aspects of face-to-face assessment of patients IN THEIR HOMES using telehealth. Assessment may include: vital signs, self-care, pain management, wound management, medication management, health/social assessment, etc. VA Medical Centers providing this care will have made significant investment in the staffing anc technological infrastructure required to support such complex care provision in
_ _ _684 **(DSS Credit Pair)**	HOME TELEHEALTH INTERVENTION/ NONVIDEO	Records intervention resulting from a clinical change in the patient's condition revealed via HOME HEALTH MONITOR: stopcode 683 necessitating contact with the provider for resolution. This intervention constitutes a clinical encounter must be electronically documented in CPRS. Assessment and care include: vital signs, self-care, pain management, wound management, medication management, health/social assessment, etc. VA Medical Centers providing this care will have made significant investment in the staffing and technological infrastructure required to support such complex care provision in the home environment. Not limited to HBPC. MAS Count. Secondary Stopcode use only.

Making Home into the Preferred Place of Care for Patients

A Message from Proposed Office of Care Coordination

Adam W. Darkins, MD, MPH, FRCS

VHA is embarking on a nationwide roll out of a new model of care delivery that seeks to make the home into the preferred place of care, when appropriate.

Over the last 5 years, the use of information technology has transformed the way VHA provides care for patients. The computerized patient record makes information needed to manage a patient's condition available to a range of different providers at the point of care. Gone is the frustration for patients of having to keep repeating the same basic information such as address, date of birth, symptoms and medications at every stage of the care delivery process. Moreover, charts are no longer missing; and medication errors have been drastically reduced.

Other advances in information technology in VHA are further transforming the convenience of care delivery by electronically connecting patients, in their homes or in assisted living facilities, to computer chat rooms for PTSD support, to monitoring devices for chronic diseases, with video conferencing for consultation advice, and to remotely monitor their vital signs.

VHA's health care delivery is being transformed by the marriage of these new technologies and trained health professionals who coordinate care for patients. As a result, patients show greater than 90 percent satisfaction with such care. They need fewer hospital admissions and outpatient visits and less medication.

From 30,000 to 60,000 veteran patients may initially benefit from this care coordination program that will help manage many chronic diseases. These include diabetes, congestive heart failure, wound care, Alzheimer's and Parkinson's disease and multiple sclerosis.

Most importantly, this program will help to maintain independence in patients with such chronic diseases, help them to live longer in their own homes, and prevent or delay long-term institutional care.

The new Office of Care Coordination is being developed within VHA's Office of Patient Care Services. It will support the national care coordination roll out, provide E-health information to patients and contribute to the patient held record, My Health-e-Vet. The new Office will work collaboratively with VHA, CIO and VISN groups in helping bring care to the patient where, when and how they need it.

Funding Opportunities:

Two 'Care Coordination' Requests for Proposals Coming this Summer

This summer, VHA is expected to make funds available, via two RFP's, to selected VISN's for:

1. **Up to $1M per VISN (maximum 6 VISN's, this RFP) for the implementation of 6 Care Coordination Programs serving at least 1000 veterans within 12 months of funding.**

2. **Up to $1M for one site (this RFP) for the creation of a VHA Care Coordination Training Center offering training, beginning around February 1, 2004, for VHA staff to support national roll-out of VHA Care Coordination.**

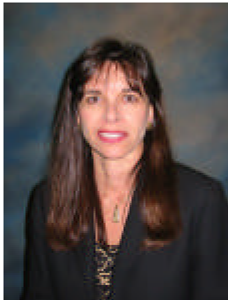
Please contact John Peters for additional information.

VHA Telemental Health Improving Service Access and Quality for Veterans in Every VISN

Linda Godleski, MD

Chair, VHA Telemental Health Field Work Group

VISN 9 Telehealth Coordinator



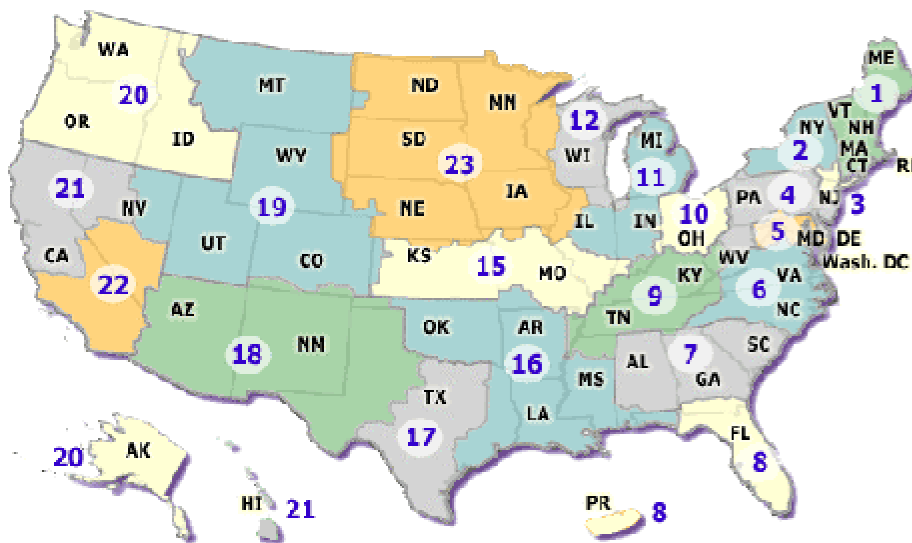
For over five years, VHA Telemental Health (TMH) has improved the quality of services for veterans. As of 2003, all 21 Veterans Integrated Service Networks (VISN's) provide extensive VHA outreach using telemental health technologies at 82 VA Medical Centers and Healthcare Systems. These facilities use THM to augment services to 155 Community Based Outpatient Clinics (CBOC's) and 21 Vet Center programs. Additionally, 29 facilities connect to each other to provide both intra- and inter-VISN TMH referrals and specialty consultation. Most recently, 18 TMH programs are expanding access to mental health care with direct services to veterans' homes and homeless shelters via videophones and remote health monitoring devices. (Please see related Graphic)

In 2002, the VHA Telemental Health Field Work Group was established with the support of the VHA Mental Health and Telemedicine Strategic Healthcare Groups. It is composed of a TMH representative from each of the 21 Veterans Integrated Service Networks (VISN's), and it assists in the development and coordination of VHA TMH services. (Please see related Table to identify your local representative.) Outcomes monitoring will provide a crucial feedback loop for continuous improvement and refinement of telemental health services in the VHA.

Please see the accompanying graphic showing a map of the Veterans Integrated Service Networks (VISN's) with a table listing all telemental health service sites. All VISN's are rapidly expanding their programs and learning from the experiences of each other. Several programs have been identified as best practice models.

For further information, please visit the VHA TMH Link: www.va.gov/telemed

Or contact Linda Godleski, MD, Chair VHA Telemental Health Field Work Group at: Linda.Godleski@med.va.gov



VHA TELEMENTAL HEALTH SERVICE LOCATIONS																						
VISN	1	2	3	4	5	6	7	8	9	10	11	12	15	16	17	18	19	20	21	22	23	Totals
CBOC'S	0	16	2	3	11	2	1	3	2	23	6	3	20	12	1	16	17	6	2	0	10	155
VET CENTERS	0	0	0	2	0	1	1	0	2	0	0	0	0	0	0	2	6	3	0	0	4	21
HOME HEALTH	1	0	0	0	0	0	0	3	0	5	0	0	0	0	0	0	5	1	0	1	1	16
INTER-FACILITY	0	0	2	2	0	0	2	0	9	6	0	3	0	0	0	0	0	0	0	1	4	29
VAMC's	1	5	2	3	3	2	3	5	6	5	3	4	7	6	1	6	5	6	1	2	6	82

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VHA Telemental Health

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VISN 2	Larry Lantinga, PhD
VISN 3	Ronald Fudge, PhD
VISN 4	John Shalanski, DSW
VISN 5	Robin Hindsman, PhD
VISN 6	Michael Hertzberg, PhD
VISN 7	Ellen Clements, RN
VISN 8	Edwin Olsen, MD, JD, MBA
VISN 9	Kendra Weaver, PsyD
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VISN 12	David Cory, MD
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VISN 20	Diane L. Johnson (Puget Sound)
VISN 21	James Breckenridge, PhD
VISN 22	Thomas Garrick, MD
VISN 23	Phillip Ross, Sandra Schmunk, MA

VHA Telemental Health Field Work Group

Established 2002 Recent activities include creation of the VHA Telemental Health Toolkit and completion of a VISN-by-VISN inventory of Telemental Health Activity

How does one digest so much in so little time?

Field report on the 2003 American Telemedicine Association Expo

David Gratz

So, ATA is over and it seems like a blur. My task at ATA was to put together some thoughts, in a video format that's both informative and entertaining, of what it's like to be on the Expo show floor. The video clips were shown during the 4th Annual VHA National meeting that originally aired May 19th-23rd and will be re-broadcast June 9th-13th. (Please see the Employee Education Learning Catalog on VA's Intranet for broadcast times.) With me being "on camera" more than you want to know, it makes the entertainment part challenging. After last year's solo report from the show, I got a little smarter and, this year, took along 4 VHA Telehealth experts, who provided valuable insight into 4 specialty areas. Before I ramble on any further I want to thank them: Rita Kobb for her Home Telehealth wisdom; Dr. Len Goldschmidt for his wit and expertise in Tele-Retinal imaging; Dr. Dennis Oh for his patience with me and guidance in Teledermatology; and last but not least Dr. Linda Godleski for giving us a glance into Telemental Health (Using me as a guinea pig).

The other part of the ATA conference that was stimulating was meeting and filming so many great VHA people running telehealth programs at VA's around the country. There were 13 separate VHA telehealth programs all exhibiting under the VHA Telehealth banner. I thank each and every VHA exhibitor for taking the time to inform me (and all other ATA attendees) about the way VHA is using telemedicine to provide more care for veterans. The exhibitors are a group of "superstars" whose innovative programs are helping VHA revolutionize the future of health care.

What else did I do there besides make 5 movies? Well, scores of vendors demonstrated a lot of interesting products at ATA and I'll mention just a few here as a way to make VHA staff aware of the types of technology available.

In surveying the exhibits at ATA, it seems (based on booth size, at least) that the high-end videoconferencing field is narrowing to just a handful of vendors. However, as is often the case with technology, there are smaller companies making creative innovations. I saw a lot of good products, both desktop and room systems. In terms of connecting systems, IP is definitely the wave of the future, but ISDN is not quite dead yet. In choosing your system remember to work closely with your networking people to ensure that you will have enough pipe (a.k.a. bandwidth) to do video.

Some of the videoconferencing technology is starting to look like something from Star Trek. It's downright sexy looking. Besides aesthetics, the products are getting better in terms of performance also. I like the two 15" dual monitor devices featured by a couple vendors. They are mounted on a roll around pole that you can move with one hand. As far as videoconferencing hardware pricing, it is lower, but it has not dropped like computer hardware pricing. Touch screen is really making inroads into the videoconferencing market and gives the providers easier control of their interface. "User–friendliness" is a big thing in the success of both patient and provider acceptance.

One of the specialty highlight segments we filmed for our VHA National Telehealth Meeting broadcast was for Tele-Dermatology. The first 'telederm' product I noticed was an adaptable light source for illuminating the skin. The compact light integrates a cross-polarization system, 24 bright-white light emitting diodes (LEDs) for natural illumination, and a four-element compound lens to create an epiluminescence microscopy imaging system capable of capturing skin lesion images. Teledermatology programs can use this light with a digital camera, video camcorder or commercially available SLR (plain old single-lens-reflex) camera. I want to encourage everyone working in (or considering) VHA teledermatology to explore products such as this light for store and forward teledermatology and some higher-end cameras for live teledermatology consultations.

I am getting more excited about wireless technologies. It appears that many monitoring devices will become "Bluetooth" or "WiFi" enabled at some point. This will allow for both the home and clinic settings to be mobile and easier to setup. The Department of Defense is in the forefront of these technologies and was showcasing many different products at ATA. TATRC or Telemedicine and Advanced Technology Research Center are the driving force behind much of the DoD's telehealth research. They are looking at small portable commercially available devices to enable both wired and wireless telehealth care. Check out their Web site to see some very innovative products at http://www.tatrc.org

Please stay tuned because I am testing some products that may save us some bucks and be an improvement over some of the things we are currently using. If you have suggestions or comments or would like additional product details please feel free to e-mail me at

David.Gratz@med.va.gov.

The mission of this newsletter is: "to serve as a conduit to share information, strengthen resources, and promote community for telemedicine within the BHA 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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