VHA Telehealth

NEWSLETTER

Over 450 Attend Nat'l Meeting

VHA's first National Care Coordination and Telehealth Leadership forum was held February 17th-19th in St. Petersburg, FL.

This year's meeting merged the 5th Annual National Telehealth Meeting with the 2nd Annual National VHA Care Coordination Meeting.

The meeting brought together a capacity crowd of various VHA communities (e.g., Care Coordination, Nursing, Telehealth, Social Work, Home Based Primary Care, Surgical Services, Employee Education, Office of Information, VistA,

Island Grand Conference Center
St. Petersburg Beach, FL

Workload Coding, Rehabilitation, Mental Health, Dermatology, et al) to discuss national issues, such as start-up programs, quality and outcomes, training and workload credit.

Please see related articles and photos inside.

New Websites Launch

VHA's Office of Care Coordination has launched a new Internet Web site at http://www.va.gov/occ and its Telehealth Strategic Health Care Group has updated and re-launched its Web site at http://www.va.gov/telehealth On both sites you will find the latest information about each program, including staff contact information.

Please visit us now at:

http://www.va.gov/occ   and

http://www.va.gov/telehealth

VHA Care Coordination/Telehealth
CROSSING BOUNDARIES

By Adam W. Darkins

VHA's first Care Coordination/ Telehealth Leadership Meeting took place between 17th and 19th February 2004 in St Pete Beach Florida and was a great success. The drive for the meeting was to satisfy a widely voiced demand from people throughout VHA for a VHA-focused gathering. Our previous face-to-face telehealth meetings in VHA have been attended by between 70 and 100 people. Our current meeting had 463 attendees. Had it not been for limitations in conference space and hotel room restrictions we would have hosted over 600 attendees. We had to close registration in early February and apologize to those who wanted to come to the meeting but were unable to do so. For VHA staff that missed the Florida meeting we are planning

National meeting attendees prepare for plenary session

a virtual meeting that will go out by satellite over VAKN Monday through Friday between March 29th and April 2nd 2004, at 12 Noon Central, for 90 minutes each day. (Please see page 8 for additional details.)

The Office of Care Coordination (OCC) is taking the number of attendees and the highly positive evaluations of the meeting as an endorsement for having a combined care coordination and telehealth meeting. VHA's National Care Coordination initiative is taking forward Institute of Medicine recommendations that health care systems coor-

dinate care and utilize information technology to improve clinical outcomes. Implementing these recommendations across a large integrated health care system like VHA is a vast undertaking. VHA has a head start in doing so by virtue of its electronic patient record. VHA is now moving forward to use using home telehealth, disease management and health informatics technologies to coordinate care with the vision that the home is the preferred place of care. This initial program is Care Coordination/ Home Telehealth (CCHT).

Adam Darkins, MD
is the Chief Consultant for VHA's Office of Care Coordination & VHA's Telehealth Strategic Health Care Group

CROSSING BOUNDARIES (Continued)

(Continued from page 2)

Our recent national meeting provided a venue where VHA staff from a wide range of disciplines and interests came together. The commonality among the various groups was how to center care on the veteran patient and support the care giver, when this is required. VHA is in the process of developing the information technology infrastructure necessary to support CCHT. This is a complex process but less so than the myriad of people processes that need to be co-ordinated to enable the right care to happen in the right place at the right time. OCC is seeking to develop several staff positions to help with the development work associated with implementing CCHT. Initially this will involve positions in clinical practice development and quality assurance. OCC is currently exploring the possibility of creating 2 such positions that are in-tended to be based at the VISN level and 50% OCC funded and 50% VISN funded. Initially it is anticipated that these positions will be piloted in selected VISNs but when they become vacant they will be open to all VISNs via a competitive selection process.

The value of these joint positions is that leading edge policy and strategy development can be combined with practical experience that is close to the clinical delivery of care. The challenges of implementing CCHT are less in the concept than they are in the reality. It is rarely a single major barrier that hinders program development in telehealth. It is usually dozens of routine process issues that need to be harmonized. An important principle underlying the implementation of CCHT in VHA is that the systems we are creating should enable veterans to receive the same

> **VHA's national care coordination initiative is taking forward Institute of Medicine recommendations that health care systems coordinate care and utilize information technology to improve clinical outcomes.**

National meeting breakout session

CROSSING BOUNDARIES (Continued)

(Continued from page 3)

care in different places at different times. Such a system is the antithesis of how health care systems have been previously constructed. Healthcare has been characterized by its variability and not its uniformity and interoperability. This is not for one moment to suggest that people are all the same and need to be treated in a regimented and prescriptive manner. The joint positions that OCC is seeking to establish at the VISN level are intended to help with replicating systems across VISNs in a way that should "plug-and-play" for the veteran patient. The snowbird traveling from Seattle to Tucson should be able to receive the same care using the same technology in both locations.

Inconsistencies and miscommunications continue to create potholes on the route towards a continuum of care in all healthcare systems and

Care Coordination Training Session at VHA National Meeting

patients repeatedly fall into these potholes. This happens because health care is stovepiped. Bridging the boundaries that create these isolated stovepipes is a vital component of coordinating care and

implementing new information technologies. VHA is a unique organization and OCC is fortunate to be charged with implementing CCHT in an environment where facilities, VISNs, and VACO staff are willing to cross boundaries in support of improving the care to veterans. OCC is grateful for the support of VISN8 and EES in helping with arrangements for the meeting and all the facilities and VISNs that funded their staff to attend this groundbreaking meeting and make it so successful.

For VHA Staff unable to attend the meeting in Florida, we are planning a virtual National Meeting Monday March 29th through Friday April 2nd on VAKN.

VHA National Care Coordination Training Center Unveils Care Coordination Curriculum

By Rita Kobb, MS

The Sunshine Training Center located at the Lake City Division of the North Florida/South Georgia Veterans Health System in VISN 8 unveiled its care coordination curriculum last week at the national Care Coordination and Telehealth Leadership Forum in St. Petersburg Beach, Florida. Staff from VISN 8, VISN 1, and the Employee Education System (EES) developed the national curriculum outline shared with conference attendees. The curriculum consists of three required core modules: Module 1-Basic Building Blocks of Care Coordination and Home Telehealth; Module 2-Technical Operations, and Module 3-Clinical Operations. In addition to the three core modules that will be required for all staff participating in care coordination activities, there are three optional modules as well. These optional modules include: Module 4-Skill Sets and Resources for Care Coordination, Module 5-Administrative, Business and Clinical Workshops, and Module 6-External Review Preparedness. All modules will be available as on-line courses except for Module 5 that will be offered for customized face-to-face training to meet the unique needs and goals of requesting facilities or networks.

In keeping with the requirements of the training center Request For Proposal, a broad and diverse group incorporating multidisciplinary perspectives will develop curriculum content. To meet this requirement, a call for content writers was given at the conference. More than thirty

VHA staff, from all over the country, signed up to provide expertise in the development of the on-line curriculum. The first module in the core curriculum will be available for learners beginning May 1, 2004. Subsequent modules will follow. Originally, a Home Telehealth 101 Course was to be available April 1, 2004 to serve as a mandatory prerequisite for staff for the national core curriculum. Due to the similar content of Home Telehealth 101 and the Basic Building Blocks Module 1, the 101 Course content will be folded into Module 1 of the Care Coordination curriculum, and staff will only be required to take Module 1 – and not both courses. This will allow the quality content developed for the 101 course to still be used for training, without burdening staff with additional education.

Three REQUIRED Modules
1. Basic Building Blocks
2. Technical Operations
3. Clinical Operations
Three ELECTIVE Modules
4. Skill Sets and Resources
5. Admin, Business, Clinical Workshops
6. External Review Prep

At Your Service

Facilities or networks interested in organizing either site visits to the Sunshine Training Center or, alternatively, arranging for training center staff to travel out to the network can contact Rita Kobb, Training Center Director (386-754-6437), rita.kobb@med.va.gov to discuss arrangements.

Please See TC Staff Photos on Next Page

VHA National Care Coordination Training Center
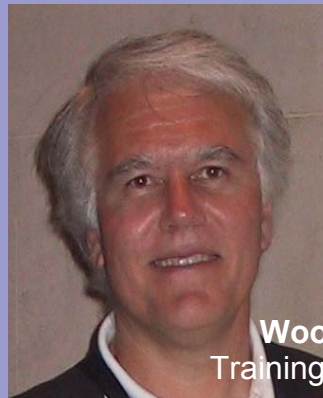# Meet the Training Center Staff

Rita Kobb MN, GNP
Training Center Director
Education Program Specialist

Donna Vogel RN,MSN
Director, Care Management
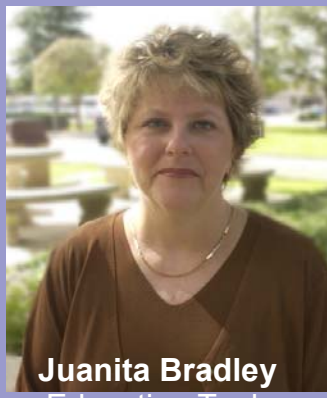Connecticut Healthcare System
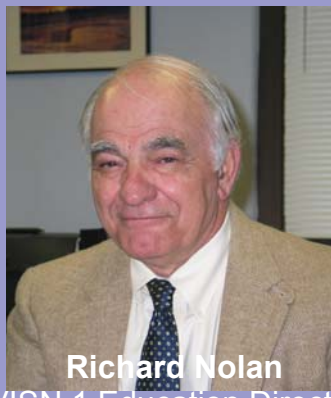
Robert Lodge LCSW
Training Specialist

Woody Levin
Training IT Specialist

Victoria Clark RN, MSN
EES Education Special-

Juanita Bradley
Education Tech

Richard Nolan
VISN 1 Education Director

Chris Boyd PhD
EES

John Ollander
Audio-Video Production
Specialist

VHA National Care Coordination & Telehealth
Leadership Forum 2004

PANELS

POSTERS

PRESENTERS

SPECIAL THANKS:
Photography by
John Ollander

VHA National Care Coordination & Telehealth
Leadership Forum 2004

**PLAN
NOW**

**JOIN
US**

**NEXT
YEAR**

Photography by John Ollander

Knowledge NETWORK *Knowledge* NETWORK *Knowledge* NETWORK

1. BEGINNING MONDAY MARCH 29

CARE COORDINATION/TELEHEALTH

Virtual National Meeting 2004

Mon **March 29** **(Noon Central)**

- Current VHA Status—Care Coordination/Telehealth

Tues **March 30** **(Noon Central)**

- Care Coordination Clinical View

Wed **March 31** **(Noon Central)**

- Care Coordination Technical View

Thurs **April 1** **(Noon Central)**

- CC Organizational Development & Clinical Champions

Fri **April 2** **(Noon Central)**

- Patient Self Management—Care Giver Perspective

2. COMING THURSDAY APRIL 8

CARE COORDINATION/HOME TELEHEALTH

Care Giver at Home

Thurs April 8 (Noon Central)

Knowledge NETWORK *Knowledge* NETWORK *Knowledge* NETWORK

VA Employees may see complete program details in the

Employee Education System Learning Catalog vaww.sites.lrn.va.gov/vacatalog/

VHA Telehealth Trailblazers

Kimberly Coplin

Saving Veterans' Eyesight in VISN 16

Out in Muskogee, Oklahoma there is an elderly veteran who is caregiver and transport driver for his wife undergoing cancer treatment—even though he is legally blind in one eye. When his 'good eye' began to fail he headed to the Muskogee VA Medical Center where the local Teleophthalmology team took images of his eye and passed them 250 miles to VAMC Little Rock for interpretation by a specialist. The news from Little Rock was not good: a choroidal neovascular membrane had developed as a complication of his age-

VHA Telehealth Trailblazers

related macular degeneration. Within minutes the veteran learned he needed to travel the next day to Little Rock for treatment to save his eyesight. The procedure was a success, and today the veteran continues to care for his wife and continues to visit the Muskogee VAMC to monitor for recurrence, with the Little Rock specialists, via VISN 16's Teleophthalmology program.

This is just one example of how VHA is using telehealth technology to improve veterans' health care and lives. And of course, the technology is nothing without a team of dedicated professionals who make it all work with the veteran.

At the VHA's National Care Coordination and Telehealth Leadership Forum, I was fortunate to meet up with **Kimberly Coplin** who is the Teleophthalmology Program Administrator for the VISN 16 team based at the Little Rock VAMC. Kimberly provided me with an overview of the VISN 16 program, including how it all began, how it has succeeded and grown, and where they are headed next. As you will read in the interview below, Kimberly stresses the value of all the VISN 16 team members comprising the successful program.

John Peters: *Thanks Kimberly for taking time to let us know about the VISN 16 Teleophthalmology Program. Can you start with an overview of why the program exists and how it got started?*

Kimberly Coplin: Well, the patient need presented itself. We were seeing approximately 25, 000 patients per year for eye exams, and we began to experience a substantial increase in referral appointments from primary care physicians at remote facilities. We developed the VISN 16 teleophthalmology program to address the needs of all VISN 16 patients, local and remote, requiring retina specialist consultation as well as the needs of VISN 16 diabetic patients requiring yearly eye exams.

JP: *Annual exams are required because diabetic retinopathy is a leading cause of vision loss and blindness in America?*

KC: That's right, and even though it turns out most of the diabetic patients will screen normal, our practice had been to schedule an appointment for them in the eye clinic for screening. These additional screening appointments filled already scarce appointment slots and increased the wait times for all eye clinic appointments. The teleophthalmology program created by VISN 16 has allowed us to increase access to care while simultaneously decreasing eye clinic wait times for all patients (local or remote) and decrease travel expenditures for remote patients.

JP: *And when you say VISN 16 you mean...?*

KC: It is a team approach in VISN 16: VISN leadership (Dee Marshall—Telemedicine Manager, and Ken Allen– Imaging/Equipment Manager), biomedical engineering (Ronald

VISN 16 Trailblazers

Hutchins, Charlie Amato, and Steve Lewis), Office of Information (Dennis Newkirk and OI staff at all sites), and Ophthalmology (Drs. Michael F. Brown and Ammar Safar, and myself), Optometry (Drs. Horn, Egusa, Harris, Polasek, Urban, Lindforfer, and Andersen) and finally the camera vendors.

VISN 16 Teleophthalmology fundus camera system

JP: *Speaking of cameras, how much hardware did your project require?*

KC: Our VISN supplied funding for cameras at 11 VHA sites including VAMC New Orleans that supports facilities in Biloxi, MS and Shreveport, Alexandria, and Baton Rouge, LA; VAMC Houston; VAMC Little Rock that supports Muskogee, OK, Mount Vernon, MO, Fayetteville and North Little Rock, AR, as well as acting as backup for the New Orleans network. As it turned out, selection and purchase of the camera systems was the most time consuming part of our implementation process. Once the cameras were purchased and installed, the rest of the implementation went smoothly.

JP: *Has your teleophthalmology solution worked for VISN 16?*

KC: Yes. Before the development of the teleophthalmology program, new patient referrals from remote VHA clinics comprised almost half (47%) of our retina clinic appointment slots, now that number has been reduced to about 6% as most patients receive retina specialist opinion remotely via our teleophthalmology program. This has reduced wait times for all retina patients and allowed early intervention for patients determined to have pathology requiring treatment. We intervene at early stage of disease thus improving visual outcomes and

VISN 16 Trailblazers

avoiding the cost of advanced treatment options required in late stage disease.

**JP**: *So, are there plans to build on this success?*

KC: Yes. We would love to expand the program and are currently looking for possible funding sources for additional equipment. Also, in addition to referrals from Diabetes and Primary care, the eye clinic receives a lot of referrals from Rheumatology (approximately 15 per week) for screening prior to institution of Plaquenil therapy; in Little Rock, we have designed and implemented a teleophthalmology screening for these rheumatology patients and may expand to include other network sites already linked to Little Rock.

 JP: *Any telehealth plans beyond direct clinical screening for patients?*

KC: Yes. We are also interested in the educational applications of telehealth. We have developed and are currently testing an interactive videoconferencing network, for training purposes, with all of our remote sites. Within the next 2 months, we plan to have monthly educational conferences to help train photographers, at any interested sites. The training will include the basics of fundus photography (we want to augment the typical 3-4 hours of imager training provided by vendors) as well as fluorescein angiography.

Additionally, we want to use the same videoconferencing question and answer presentation format to provide training on retinal pathology to interested VISN 16 residents, optometrists, and ophthalmologists. Once successful locally, we would like to expand these educational videoconferences nationwide in VHA.

And finally, Ophthalmic pathology is another area of interest . We are evaluating external digital cameras and microscope cameras at this time. We intend to be able to tak a picture of a gross lesion in clinic and upload the image into VHA's VistA information system where it can be paired with a corresponding pa-
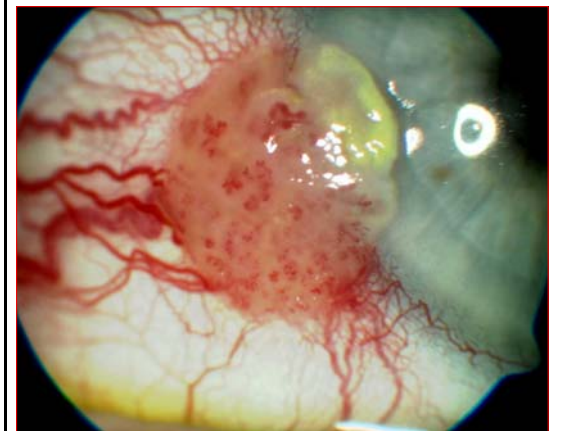
VISN 16 Teleophthalmology Images

thology slide.

JP: *Any other lessons learned?*

KC: Three biggest are: 1. Focus on veteran; 2. Team Sport—you need all departments; 3. Hire a program Administrator/Coordinator so providers are free to provide care.

VHA TELEREHABILITATION
Using Technology to Improve Function

By Cathy Cruise, MD

The field of tele-rehabilitation offers exciting opportunities to enhance care delivery. Statistics from the Administration on Aging reveal that 74% of individuals over age 80 report at least one disability and 35% report needing assistance as a result of the disability. Further, there has been shown to be a strong relationship between disability status and reported health care status.

Through both home and clinic telehealth approaches veterans have been able to receive rehabilitative interventions that might otherwise not have been possible.

In this article, I will present a sample of different tele-rehabilitation programs within VHA.

One of the most innovative approaches to home tele-rehabilitation is embodied in

Veteran uses a PC in the Gainesville VAMC LAMP project

the Low ADL (Activities of Daily Living) Monitoring Program (LAMP) established by the rehabilitation team at the Gainesville VAMC. The LAMP Program utilizes a variety of technology including telephones, in-home messaging devices, monitors with peripheral equipment and personal computers to help veterans who require personal assistance with at least two basic Activities of Daily Living. Daily to weekly monitoring is provided not only for

self-care skills and abilities but disease management, mobility and falls, medication compliance, home exercise programs and reminders for scheduled clinic visits and immunizations. Veterans have benefited through receipt of assistive technology and adaptive equipment, home environmental modifications, training and education and referrals for additional services.

Additional home tele-health pilot projects are underway throughout VA. Of particular note is a program at the Seattle VAMC that targets veterans who are medically complex, socially fragile or who have had a recent discharge after change in function. Not only have veterans been extremely satisfied with the home health interventions, but also physician, nursing and at-home caregiver staff have loved the program.

The use of telehealth technology to provide remote rehabilitation clinic access has been very successful as well. Applications in rural areas have involved Wheelchair Clinics, Prosthetic and Orthotic Clinics and Speech and Audiology

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**About the Author:
Dr. Cathy Cruise**
is a Physiatrist at the VA New York Harbor Healthcare System and a member of the national VA PM&R Field Advisory Board. She is shepherding the implementation of Care Coordination/Telehealth Programs in VISN 3.

TELEREHABILITATION (Continued)

Clinics.

The rehabilitation teams at the Kansas City and Poplar Bluff VAMCs have been able to save veterans over eight hours of travel time by holding a monthly clinic in which patients are evaluated for electric lift chairs and electric mobility items remotely. A physiatrist is stationed in Kansas City while a therapist in Poplar Bluff performs motor strength and range of motion assessments as well as transfers the veteran and assists with gait to allow full evaluation. The result has been that evaluations for lift chairs have been accomplished within 15 minutes and evaluations for electric mobility devices have been accomplished within 30 minutes, both resulting in tremendous veteran satisfaction.

Within the same VISN, a remote Prosthetic and Orthotic Clinic is held. In this case a physiatrist is stationed in St. Louis while the veteran and local clinic team including a physical therapist, prosthetist and orthotist are located in Marion, Illinois. Through this biweekly clinic, veterans who might otherwise not be able to receive prosthetic and orthotic devices have received the equipment they need. Over four hours of travel per veteran has been saved, resulting in great veteran satisfaction.

An additional application of remote rehabilitation clinic access is utilized at the Denver VAMC. Here speech therapy services are provided remotely through a weekly clinic in which a speech pathologist in Denver provides therapy to veterans in Colorado Springs. Not only has this clinic eliminated the need for travel but it has eliminated the need for fee basis care in this area.

Tremendous possibilities exist for providing tele-rehabilitation interventions to both multiple sclerosis and spinal cord injury patients. An Internet enabled delivery approach to neurocognitive assessment is being developed by the East Coast Multiple Sclerosis Center of Excellence in Baltimore and the use of in-home messaging devices is being explored to manage symptoms in this population. Video monitors with attached peripheral equipment have been used successfully with veterans with Spinal Cord Injury in VISN 3. Additional programs, particularly focusing on wound care in this population, are being developed. Finally, utilization of in-home messaging devices to provide monitoring to the frail elderly and veterans post-inpatient rehabilitation unit discharge are being developed.

LAMP program home environment outfitted with adaptive devices

In addition to monitoring out-

TELEREHABILITATION (Continued)

comes such as number of hospitalizations, number of emergency room and clinic visits, costs and veteran satisfaction, physical medicine and rehabilitation staff are in a very unique position to monitor function through the use of the Functional Status and Outcomes Database (FSOD). Through FSOD we can collect outcome data on cases of new stroke, amputation and brain injury, comparing cases with tele-health intervention to those with traditional care through carefully designed research studies.

'The use of telehealth technology to provide remote rehabilitation clinic access has been very successful as well.'

'Applications in rural areas have involved Wheelchair Clinics, Prosthetic and Orthotic Clinics and Speech and Audiology Clinics.'

The opportunities tele-rehabilitation offers are endless. All rehabilitation professionals are encouraged to explore and utilize tele-health technology in creative ways to enhance the excellent care provided to veterans throughout the country.

VISN 8 LAMP program veteran's home environment outfitted with adaptive device

NEWSLETTER

Mission

Serve as a conduit for information sharing,

strengthen resources, and

promote community for telehealth within the VHA,

with the ultimate goal being: to provide the best quality of care to our patients

despite the barriers that distance and/or time may impose.

Staff

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FeedBack

Please drop us a line and tell us what you think, or make a suggestion about

content for future issues. We would love to hear from you. Please contact:

John Peters on (202)273-8508 or john.peters@hq.med.va.gov

Next Issue

Coming late May 2004.