



# TELEMEDICINE NEWS

## “Telemedicine Trailblazer”

**Ms. Rita Kobb**

*Nurse Practitioner, Extended Care*

*Lake City, VAMC, Florida*

*By Claudia Zink*

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What does it take to be great at telemedicine? To find the answers look to the people who are doing great things. In this article, we talk with **Rita Kobb, NP, from VISN 8** to learn some of her secrets for success!

*What are your current telemedicine projects and how have you been involved?*

Our telemedicine “projects” are actually part of a new service line started by Dr. Roswell, Network Director of VISN 8—the **VISN 8, Home & Community Care Service Line**. Dr. Roswell saw great potential with telemedicine and wanted to implement it into a service line in our network. To get a start, he put together a taskforce staffed by people from all over the network. In fact, Marlis Meyer was the chairperson and I was on that taskforce to develop a conceptual model of the service line and outline how things would best work.

We worked on the taskforce for almost a full year and as part of that process sent out requests for proposals to be funded. I was on the review team for that. We reviewed over 24 proposals in the first round. We then se-



lected a few of those proposals as submitted, and gave others feedback to revise this or that before we could provide support. In that first round, we funded eight distinct projects across the network. Those eight projects became the basis of our service line that incorporates a new care coordination process combined with innovative technology. From these first projects, we set out to determine what would be the “best practice” for the overall program.

*This is a big project – how did you get started?*

As part of the conceptual model group, we began with conducting a network-wide needs assessment. We sent out surveys to patients, their families, and their caregivers. An important factor in development of this service line was our use of *focus groups*. We had a huge meeting in Orlando with the Veterans Service Organization membership. We also had focus groups of patients, families and caregivers. These forums were invaluable because we were able to find out what people really wanted. In addition, we

did surveys of clinicians. Finally, we took a look at all the information we collected about the needs of our “customers” and used this to develop our service line.

Looking back, I think the reason why we have had a little less difficulty than some other telemedicine programs is because we built a model with a process first and then later we looked at what technologies were out there and how they would fit into that model – not the other way around.

***How did you develop your technical knowledge of telemedicine?***

During the development stages of our program, we talked to a number of people already doing telemedicine programs around the country. Going to conferences like the one presented by the American Telemedicine Association was a very important way to pick up information on technology and various programs. A really great resource for me has been the federal government telemedicine web site:

<http://www.tmgateway.org/>

***What aspect from your past work experience has been the most helpful to you in this program?***

**Team building**—definitely! Why? There are so many aspects to telemedicine that involve working with many

people—different departments, patients, caregivers and families. It requires significant teamwork skills to pull everyone together to get something done.

***How do you keep everyone motivated and encouraged through the “ups and downs” of starting a program?***

Feed them! [*What is it about food as a motivator? It works!*] Seriously, we have a strong and supportive service line to begin with. There are 37 permanent staff members (both full and part-time) in this service line and we are all pretty committed to making the programs work.

***What has been the most rewarding aspect of this program for you?***

Being part of the process of building something that can make such a significant difference in the quality of our patients’ healthcare.

**Author’s note:** What I learned from Rita: preparation, preparation, preparation! Look at the process their group used – one year of preparation and investigation before the implementation. We don’t always have a year to do planning, but the steps they took in the process were notable. Not to forget the importance of feeding your team! Thanks, Rita!



**“How do you keep everyone motivated and encouraged through the ‘ups and downs’ of starting a program?  
Feed them!”**

# TECH CORNER

*By Mary Skinner*

VISN 8 Home & Community Care Service Line uses several telehealth products in their program. Below you will find a simple description obtained from these products' Internet websites, as well as the URLs where you can find additional information.

## American Telecare AVIVA 1010

The AVIVA Home Telemedicine System consists of the Central Station, which connects via plain old telephone service (POTS) to the Patient Station which is placed in the patient's residence. The system features live two-way audio/video combined with medical peripherals such as a telephonic stethoscope and blood pressure meter (standard with each patient station), as well as a glucose meter, digital pulse oximeter and digital scale (optional).

<http://www.americantelecare.com>

## C-Phone

The C-Phone is a videoconferencing device that can run over POTS or ISDN lines. At this time, there are no peripheral devices with these units.

<http://www.cphone.com/>

## Paltalk

Paltalk is an Internet communication software that combines instant messaging and Internet telephone capability (telephony). It features the ability to communicate verbally or typewritten on existing Internet access and is available at no cost. It can be downloaded free from the website, where you will find additional information on the software.

<http://www.paltalk.com>



## Polaroid High Definition Grid Film

Polaroid GridFilm allows you to produce photos with a standard grid developed on each picture. GridFilm can be used for measuring and documenting existing conditions, wound healing, therapy progression, posture and alignment, range of motion, and limb extension. The grid acts as a scale, allowing you to take measurements and compare photographs over time.

[http://digitalimage.polaroid.com/products/instant\\_cameras/film/gridfilm/index.html](http://digitalimage.polaroid.com/products/instant_cameras/film/gridfilm/index.html)

## Health Hero® Health Buddy®

The Health Hero Platform is a one-to-many, two-way communications link between healthcare providers and patients. It consists of the Health Hero® iCare Desktop™, a web-based application used by the nurse/care manager to deliver and review patient responses and the Health Hero® Health Buddy® appliance, used by the patient to receive and respond to the nurse/care manager.

<http://www.hhn.com/products>

## TeleVyou Videophones

The TeleVyou 500 videophone, by Treudox Technology Corporation (Taiwan), allows users to make full color-motion video calls over POTS lines. The TeleVyou unit contains the viewer and software needed to make a video call at the same cost as an ordinary phone call. It offers a built-in pan/tilt/zoom camera with privacy feature and offers ports for additional cameras.

<http://www.videophoneconnection.com>

## Innovation in Care Using Technology: Focus on “VISN 8 Home & Community Care Service Line

By Michelle Hill and Rita Kobb



The VISN 8 Home & Community Care Service Line was highlighted during the 2<sup>nd</sup> Annual VHA Telemedicine Meeting in Ft. Lauderdale and will serve as the focus program for our newsletter. As you will read, this service line is proving to be a successful model of innovative practice that incorporates technology.

In 1998, Dr. Robert Roswell, VISN 8 Director and a true visionary, initiated plans for developing the service line. He asked Marlis Meyer to lead the strategic planning group based on her demonstrated interest and vision. Ms. Meyer began working with Dr. Roswell to explore and develop a model of care that incorporates technology to provide more cost effective and better quality services that help shift the focus of care from the “episodic” inpatient setting into the “continuum” afforded in the outpatient setting. After the work of several task forces and strategic planning groups and incorporating input from patient, caregiver, clinician and Veterans Service Organization focus groups and surveys, the service line was born in 1999.

The product of this visionary thought and rigorous planning is the VISN 8 Home & Community Care Service Line. The service line model is built on the framework of “care coordination.” Care coordination is a process that follows and provides for the veterans, regardless of physical setting or particular health care episode. The concept is based on case management ideals, but applied to “virtual” –ly any setting. It is not linked to a service or location and provides a continuum of care to the veteran.

As may be expected, this accomplishment required substantial VISN leadership commitment. In addition to the investment in planning and core leadership staff, Dr. Roswell committed over \$5 million dollars to support “care coordination” projects. A Request for Proposals was sent out across the network and the initial programs are the result of the approved projects. What follows is a concise summary of the service line, as provided by Rita Kobb, Project Manager/Care Coordinator for the Rural Home Care Project in Lake City, Florida and the North Florida/ South Georgia Veterans Health System.—Michelle

The VISN 8 Home & Community Care Service Line Model was developed in 1999. As part of its implementation, requests for proposals were submitted from all over the Sunshine Network for clinical demonstration projects that used care coordination and innovative technology for meeting the needs of high-risk, high-cost veterans. Eight projects were funded beginning April 2000 with the goal of exploring and testing best practices. The care coordination process, in combination with technology and collaboration with the primary care provider, has been effective in keeping veterans in the least restrictive environment for the longest possible time. Since the early implementation, the Service Line has added two new projects for a total of ten. This article provides a brief overview of the clinical demonstration projects, patient outcomes, and lessons learned.

**The Service Line Team:** The leadership includes Marlis Meyer who is the Acting Service Line Director, Patricia Ryan, Clinical Program Director, and Lynn Fry, Program Support Assistant. The Service Line is a virtual system that is headquartered at Bay Pines. Chronic medical disease management projects are located at San Juan, Miami, Fort Myers Outpatient Clinic, and the North Florida/ South Georgia Veterans Health System. Mental Health projects are located at West Palm, Bay Pines, Tampa, and the North Florida/ South Georgia Veterans Health System. A Spinal Cord Injury Project has just been approved at San Juan. The core project teams include care coordinators who serve as liaison to coordinate the care of a panel of patients (60-250 for the mental health projects and 100-500 for the medical chronic disease projects), program assistants, and clinical providers.

**Patients Served:** The Service Line currently has 1000 patients across the Network and continues to add veterans daily—all patients are served in some way by technology and telemedicine. Patients served have been identified as generally complex, high-risk, and high-cost veterans with chronic health conditions such as diabetes, hypertension, heart failure, emphysema, depression, schizophrenia, post-traumatic stress, and bi-polar disorders. A large number are elderly. Veterans are followed in their homes or in congregate settings such as assisted living.

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**Technology:** The Service Line utilizes a variety of tools to meet the needs of our patients. We have developed an algorithm to help guide the best choice of technology to suit the patient—one size does not fit all. We are currently using traditional telehealth home monitors with and without peripheral devices like glucometers, weight scales, and pulse oximetry (American Telecare, C-Phone, TeleVyou); personal computers with web cams and internet chat rooms (PAL talk software); in-home messaging device with disease management dialogues (Health Buddy); and special wound care cameras (Polaroid with grid film).

**Research:** Though not research projects, for authorization to publish patient outcomes, each project received Internal Review Board approval through an exempt, expedited review. Informed consent is provided to all veterans enrolled in the service line projects.

**Outcomes:** The Service Line leadership presented 6 month pre- and post- outcomes data at the VHA Telemedicine Day and ATA conferences. These early findings showed a 74% reduction in overall healthcare costs. This significant savings resulted from reduced hospitalizations, bed days of care, ER and outpatient visits, and the number of prescriptions. In addition, patient and provider satisfaction has been extremely high with both the care coordination and technology facets. Veterans report an improved perception of their physical and mental health since becoming enrolled in the projects.

#### Lessons Learned:

##### **Care Coordination is the Key.**

Technology has proven itself to be an effective healthcare management tool. However, without the dedication and commitment of expert staff the tools would be meaningless. *The process, not the technology*, makes the greater difference in meeting the needs of our veterans.

##### **Simple is always better.**

Because the technology being used is meant for the home it is important to remember that often there is no one else there to help operate it. Keeping devices easy to use and understand reduces patient and provider frustrations.

##### **One size does not fit all.**

All veterans are not created equal when it comes to choosing the best home technology to meet their needs. The Service Line care coordinators and Clinical Program Director have developed an algorithm that assists staff to make the most effective choice.

#### ***The Program should drive the technology, not the other way around.***

Our Service Line has been successful because we have let patients' needs drive our services. In turn our services have guided us in the selection of appropriate technologies. We have not built our model upon any specific technology rather we have used the technology as a tool to manage our veterans effectively.

#### **Publications and Interviews:**

Easing the Elderly on Line in Search of Health Information. *Medical News & Perspectives* (Interview) JAMA, Vol 285, No 12. March 2001.

Improving Care for the Elderly Through Technology. *Great Ideas for Long-term care Newsletter*, Vol. 15 No. 4, April 2001.

VA technology Gives Eldercare a Boost. *Caring for the Ages Newsletter*, Vol 2, No. I, January 2001.

Gator Nurses on Cutting Edge of Technology Initiative. *The GATOR Nurse*, Vol. VI No. 1, Winter 2001.

Technology: Improving Eldercare in the New Millennium. *Vital Signs*, Vol. X, No. 21, November 2000.

Lifeview In-home Care Monitors (Interview). *Veterans Health System Journal (VHSJ)*, Vol. 5, Issue 9, October 2000.



*“A Message from the Acting Chief Consultant”*  
**The Second VHA National Telemedicine Meeting**  
*By Dr. Adam W. Darkins*

The Fort Lauderdale Convention Center in Florida was a wonderful venue for the 2<sup>nd</sup> VHA National Telemedicine Meeting on June 2<sup>nd</sup>, 2001. As with our very first meeting a year ago, this year's meeting immediately preceded the American Telemedicine Association (ATA) Conference. The success we had last year in linking our meeting with the ATA Conference prompted the Departments of Defense and Commerce to hold similar agency-wide telemedicine meetings on the same day as ours.

Eighty-five people from VHA came to our meeting, including attendees from Hawaii, Puerto-Rico and throughout the Continental USA. This turnout was remarkable given that it was held on a hot Saturday in Florida during early June and that people were all funded by their local facility or VISN to attend. It seemed that all possible professions, disciplines and backgrounds of those involved in telemedicine were represented. These included VISN Directors, Clinical Managers, Telemedicine Committee Chairs, Telemedicine Coordinators, Clinicians, Health Services R&D, Medical Media, Counseling and Readjustment Services, Administrative Support Personnel, BioMed and IRM.

We were fortunate to have Dr. Robert Roswell, the VISN 8 Director to give us a keynote address. Dr. Roswell focused his talk on the importance of telemedicine as an enabling technology. He stressed how this must be a technology that helps us meet the health needs of veterans and we should not pursue the technology for its own sake. Dr. Roswell's talk was followed by telemedicine presentations from VISN 8. These presentations showed how the VISN has adhered to this vision in establishing telemedicine services in sites ranging from San Juan to Lake City and in settings from patients own homes to large academic medical centers. The VISN 8 experience resonated with other VISN's who are also helping lead the charge of telemedicine development in VHA.



The morning session ended with a review of the telemedicine activities of VET centers around the country presented by the Re-adjustment Counseling Service. Twenty VET centers are actively developing telemedicine programs. Telemedicine has become a critical component the strategy of VET centers in meeting their unique mission. As the health needs of the Viet Nam veteran population are changing, and as other sections of the veteran population also access these services telemedicine is helping link them into the wider VHA healthcare system.

The afternoon session began with feedback from the workgroups that were established last year to tackle key issues facing telemedicine development in VHA. The activities of these groups include are summarized in an article to follow. In the past year these workgroups have generated substantive products that are being shared and are helping develop telemedicine throughout VHA. The workgroups are taking a VHA-wide perspective to resolve challenges that must be met if VHA is to develop a nationwide telemedicine resource.

The feedback from the workgroups was followed by breakout sessions on tele-home care, a telemedicine project grantee meeting, acute services, tele-mental health and management issues in telemedicine. The common themes that emerged from these sessions included:

- the paucity of evidence-based telemedicine outcomes in the literature;
- the need to promote and create incentive for telemedicine to be accepted as a core service of the VHA;
- the critical need for telemedicine training;
- that telemedicine development requires more resources

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The meeting concluded by defining major elements of work that the Telemedicine Strategic Healthcare Group would take forward over the next 12 months. This work plan includes:

1. Defining relationships with Biomed and IRM
2. Holding a symposium on VHA criteria for teleophthalmology implementation
3. Establishing telemedicine as a critical component of multiple sclerosis centers
4. Linking next year's VHA national telemedicine meeting with ATA meeting
5. Creating, in the next 4 months, a VHA coding manual for telemedicine
6. Holding satellite downlink broadcasts on telepsychiatry and telecardiology
7. Analyzing risk management and redundancy issues in relation to VISTA integration

The presence of other federal agencies provided an opportunity for a meeting of the various agencies on Sunday 3<sup>rd</sup> June to discuss common issues affecting telemedicine development. This was somewhat unfocused and exploratory as such ad hoc first meetings tend to be. This was clearly a platform that can be developed so that next year in can be a source for the exchange of ideas,

exploration of possible collaborations and sharing of lessons learned between federal agencies.

A sizeable VHA contingent attended the ATA meeting itself. This VHA representation was reflected in the VHA telemedicine exhibition, the scientific sessions and the poster sessions. Because of the number of VHA telemedicine programs and their size, complexity and sophistication VHA was again acknowledged as a leader in telemedicine development at the conference.

Next year's 3<sup>rd</sup> National VHA Telemedicine Meeting will take place in late May or early June of 2002 and be held at the Los Angeles, Downtown Convention Center. VHA telemedicine projects from the West Coast will be showcased in the morning sessions and the intention is to have similar feedback and breakout sessions in the afternoon. The program committee will be formed in the coming 2 months and information updates about the conference will be available in forthcoming issues of this VHA Telemedicine Newsletter. I want to conclude by thanking all those who came to this years meeting and all those who presented. We missed those that could not attend and hope to see you next year in LA.

## ***VHA Telemedicine Working Groups Report at National VHA Telemedicine Conference: First Year of Progress***

*By John Peters*



During an afternoon session of the 2<sup>nd</sup> VHA National Telemedicine Meeting in Ft. Lauderdale, FL on June 2<sup>nd</sup>, 2001, VHA Telemedicine Working Group leaders reported their group's accomplishments since formation during last year's national meeting.

The table to follow summarizes the information presented during the session. This summary provides some background for each group, a list of accomplishments, a list of future tasks and a point of contact. The summary is intended for those who were unable to join us for the conference, as well as a recap for those in attendance.

All VHA personnel (regardless of experience level) are encouraged to support these burgeoning working groups (or suggest the creation of additional groups) to help create products needed to support further development of VHA Telemedicine.

*Please refer to workgroup and progress report chart on next page.*

Work Group Name	Purpose	Accomplished 2001	Actions for 2002	POC
1. Activity/Inventory	Produce accurate tracking of VHA Telemedicine Activity (e.g. Who is providing VHA tele-home care?) and Inventory of telemedicine hardware, software and infrastructure (e.g. What video teleconferencing equipment is being used for VHA tele-mental health care? What is the minimum bandwidth employed?)	Self-reporting tmed activity Web-survey tool prototype created at <a href="http://vawww.va.gov/telemed/SpecialtySurvey/index.cfm">vawww.va.gov/telemed/SpecialtySurvey/index.cfm</a>	Work to continue to refine/expand Web-survey tool. Perhaps? integrate with workload coding software.	John Peters at 202.273.8508 or <a href="mailto:john.peters@hq.med.va.gov">john.peters@hq.med.va.gov</a>
2. Technical/Product Review	Produce a technical information resource for non-technical people involved with VHA Telemedicine. The goal was to provide 'Consumer Reports'-type information about telemedicine hardware, software, service and infrastructure requirements for VHA Telemedicine programs.	Technical Product review appears in quarterly VHA Telemedicine newsletter (VHA Telemedicine News).	Consider expanding activity Web-survey tool (see 1. above) to include anecdotal reporting/rating for products/services.	John Peters at 202.273.8508 or <a href="mailto:john.peters@hq.med.va.gov">john.peters@hq.med.va.gov</a>
3. Communications	Promote communication related to VHA Telemedicine for the benefit of the organization and the veterans that it serves.	Surveyed existing communication mechanisms and established VHA Telemedicine Communications representatives for each VISN. Created and distributed VHA Telemedicine News newsletter.	Continue with newsletter production/distribution. Strengthen communication representative network amongst VISN's. Share accomplishments of all working groups with the VHA telemedicine community.	Michelle Hill at 650.493.5000x63869 or <a href="mailto:michelle.hill@med.va.gov">michelle.hill@med.va.gov</a>
4. Credentialing & Privileging	Provide VHA Telemedicine programs/projects occurring in various health care and non-health care setting with a point of contact for clear and consistent guidance/training on credentialing & privileging for telemedicine that is consistent with or in some cases proactively helping to create JCAHO standards.	Created and issued two draft VHA Directives for C&P for Telemedicine; One directive is for traditional health care settings (e.g. medical centers and clinics), the other is for non-traditional health care settings (e.g. VET Centers, and private residences.) Produced 90-minute training session on Telemedicine C&P presented live in April 2001 with repeat showings on VA's Knowledge Network satellite system.	Issue and Review effects of two directives. Coordinate VHA C&P standard with DoD and BoP. Create Web-based training for C&P for Telemedicine.	Adam Darkins at 303.393.4645 or <a href="mailto:adam.darkins@med.va.gov">adam.darkins@med.va.gov</a>

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Work Group Name	Purpose	Accomplished 2001	Actions for 2002	POC
5. Training	Help create a consistently trained VHA Telemedicine workforce to help ensure the development of a VHA Telemedicine network.	Produced three 90-minute training courses delivered over the VA's Knowledge Network satellite. Produced VHA Telemedicine 101 training curriculum presented in seven 50-minute sessions during the week-long VA Information Technology Conference.	Introduce Web-based training courses. Continue to develop and produce conventional satellite broadcast interactive training courses to provide guidance for telemedicine practitioners on policies and procedures.	Adam Darkins at 303.393.4645 or <a href="mailto:adam.darkins@med.va.gov">adam.darkins@med.va.gov</a>
6. Outcomes/ Satisfaction	Create survey tools used to generate nationally consistent data sets by measuring patient and provider satisfaction using a core set of validated questions across all VHA telemedicine programs/projects. To create adjunct survey tools customized for individual VHA telemedicine programs/projects.	Patient satisfaction survey currently being validated by veteran group in VISN 19; Report due this summer. Provider satisfaction survey drafted and presented to VHA telemedicine group for comment.	Refine and validate Provider satisfaction survey.	Bonnie Wakefield at 319.338.0581.6810 or <a href="mailto:bonnie.wakefield@med.va.gov">bonnie.wakefield@med.va.gov</a>
7. Policy/Procedures	Create a Central Office repository/clearinghouse for VHA Telemedicine Policies and Procedures.	No activity this year.	Create VHA Telemedicine Web page repository/clearinghouse for VHA Telemedicine Policies.	John Peters at 202.273.8508 or <a href="mailto:john.peters@hq.med.va.gov">john.peters@hq.med.va.gov</a>
8. Strategic Planning	Create a strategic plan for VHA Telemedicine and to be a resource to individual VHA projects/programs, facilities or VISN's who wish to create their own strategic plan that is in keeping with the existing (broadly written) VHA Telemedicine strategic plan at <a href="http://vawww.va.gov/telemed/tmedshg/">vawww.va.gov/telemed/tmedshg/</a>	Cataloged existing telemedicine strategic plans.	Reactively provide guidance for VHA facilities, VISN's or programs wishing to create a telemedicine strategic plan.	Claudia Zink at 206.277.6259 or <a href="mailto:claudia.zink@med.va.gov">claudia.zink@med.va.gov</a>
9. Reimbursement & Coding	Establish VHA guidance on workload coding and reimbursement issues for telemedicine practitioners in the VHA.	Drafted guidelines for proper coding for two main telemedicine scenarios (1. Between two VAMC's 2. Between one VAMC and one CBOC)	Provide VHA wide reimbursement training via VA Knowledge Network (VA's Employee Education Service Satellite Broadcast) Create guidance for all existing/emerging VHA Telemedicine scenarios	Ellen Clements at 706.733.0188.2689 or <a href="mailto:ellen.clements@med.va.gov">ellen.clements@med.va.gov</a>
10. Career Development	Create resources to foster telemedicine practitioner career and program development	Cataloged telemedicine practitioner jobs descriptions. Spotlighted telemedicine practitioner as trailblazing role model in quarterly VHA Telemedicine newsletter.	Continue 'trailblazer' profile column in quarterly newsletter. Monitor Web re-design and offer input on training and Clinical Resource features.	Claudia Zink at 206.277.6259 or <a href="mailto:claudia.zink@med.va.gov">claudia.zink@med.va.gov</a>

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Work Group Name	Purpose	Accomplished 2001	Actions for 2002	POC
11. Marketing	Market VHA Telemedicine projects/programs/activity within and outside VHA.	VHA Expo at ATA 2000 VHA Expo at ATA 2001 Contributed to VHA Telemedicine newsletter	VHA Expo at 2002 Continue to contribute to VHA Telemedicine quarterly newsletter	Mary Skinner at 650.493.5000.60459 or <a href="mailto:mary.skinner2@med.va.gov">mary.skinner2@med.va.gov</a>
12. Privacy	Create information security/patient privacy guidance for VHA Telemedicine projects.	Newly forming group	Create information security/patient privacy guidance in accordance with the Health Information Portability and Accountability Act (HIPAA).	John Peters at 202.273.8508 or <a href="mailto:john.peters@hq.med.va.gov">john.peters@hq.med.va.gov</a>

# Telemedicine Policy Watch

By John S. Peters



## VHA/JCAHO C&P NEWS

Credentialing & privileging (C&P) requirements help ensure patient safety by documenting that practitioners are qualified and competent to provide particular clinical services at a particular site with its given resources. Telemedicine introduces unique circumstances by providing clinical services involving multiple sites. For example, the medical staff at each site may not know each other or the details of each other's qualifications and privileges. This type of circumstance led to consideration of additional C&P requirements expressly for telemedicine.

In January 2001, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) introduced a new standard for C&P of medical staff using telemedicine.

In order for the Department of Veterans Affairs (VA) to meet JCAHO's standard, the Veterans Health Administration's (VHA's) Telemedicine Strategic Healthcare Group (SHG 11T) coordinated a collaborative effort, amongst the VA's Office of the Undersecretary for Health, VHA's Office of Quality and Performance, VHA Telemedicine's C&P Working Group and JCAHO, to create VHA Directives for C&P of practitioners using telemedicine.

Two separate VHA Directives, one for formal healthcare settings (e.g. VA Medical Centers or Community-Based Outpatient Clinics), and another for other healthcare settings (e.g. VET Centers, community halls, private residences, etc) were required to cover the full spectrum of VHA telemedicine activity.

These new directives were developed to achieve the following goals: provide clear guidance to meet the JCAHO standard for C&P of telemedicine activity; minimize any

possible confusion by maintaining consistency between the new directives and the existing C&P process for conventional (non-telemedicine) health care practice; and lastly, to harmonize, where possible, with the earlier guidance for C&P for telemedicine in VHA.

These are the first VHA Directives created for C&P of Telemedicine Services. Since there is no separate licensing or accreditation process for telemedicine, these directives do not contain any instruction for separate licensing or accreditation for practitioners using telemedicine. Rather, the new directives detail how existing (non-telemedicine) C&P guidance, contained in VHA Handbook 1100.19 (dated March 4, 1999), needs to be amended to meet the new JCAHO standards for telemedicine.

### Consultation vs. Care

In its January 2001 C&P of Telemedicine standard, JCAHO makes a fundamental distinction between C&P requirements for telemedicine depending on whether the purpose of the telemedicine episode is merely for *consultation* or to actually deliver *care*. *Consultation* is defined as when a practitioner using telemedicine provides advice or recommendation, to a requesting practitioner, without writing orders in the patient's chart or directly assuming responsibility for care of the patient. *Care* is defined as when a practitioner using telemedicine treats, prescribes medication or makes a clinical diagnosis, and in doing so, directly takes responsibility for the clinical supervision or direction of the patient at the remote site. In order to meet the JCAHO standard, the VHA Directive on C&P of Telemedicine in formal healthcare settings makes this same distinction between consultation and care. In day-to-day clinical practice, the distinction between consultation and

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care, based on the definitions found in the VHA Directive, is left to the informed judgment of the sites involved in the telemedicine service.

The C&P requirements for telemedicine care, where the practitioner is responsible for the direct management of the remote patient via telemedicine, are more stringent than the C&P requirements for telemedicine consultation, where the practitioner merely offers advice to the remote site. The C&P requirements for care using telemedicine are equivalent to the C&P requirements for face-to-face care. For example, a Community Based Outpatient Clinic's (CBOC's) C&P documentation for telemedicine care, from its VA Medical Center-based dermatologist, is equivalent to the CBOC C&P documentation required when the dermatologist physically travels to provide care face-to-face.

### VHA C&P Responsibilities

The site director has the ultimate responsibility for ensuring that all activity (including telemedicine) fits within the scope of practice of the practitioner subject to existing C&P requirements of VHA Handbook 1100.19. Any C&P concerns regarding telemedicine should be taken to the appropriate Veterans Integrated Service Network (VISN) clinical service manager for resolution. The VISN or VISN's will broker/coordinate all inter-site agreements for telemedicine services. VHA Telemedicine Strategic Healthcare Group (SHG 11T) will be responsible for collecting feedback comments regarding the new directives, as well as updating the directives.

### VHA Directive Guidance

Here is a brief synopsis of the two VHA Directives on C&P of telemedicine:

(For completeness, everyone is encouraged to study the entire documents in their DRAFT form at

<http://vaww.ees.lrn.va.gov/products/handouts/telemedicine/CP%20Hospitals%20and%20Clinics.doc> and <http://vaww.ees.lrn.va.gov/products/handouts/telemedicine/CP%20remote%20health%20care.doc4.doc>:

**1. FORMAL HEALTHCARE SETTINGS:** Credentialing and Privileging of Telemedicine and Telehealth Services Provided in HOSPITALS and CLINICS:

- a. CREDENTIALING for REMOTE site (Where the Patient is Located) – Telemedicine practitioners' credentialing information must be immediately available (via Credential Transfer Brief or (in future) VetPro) at the REMOTE site where the veteran/patient is physically located.
- b. PRIVILEGING for REMOTE site when **CONSULTATIVE ADVICE PROVIDED** from afar – If telemedicine practitioners are providing consultative advice on a diagnosis, prognosis and/or therapy (i.e. 'consultation' as defined in JCAHO standard), then

the telemedicine practitioners' privileging information must be immediately available (via secure e-mail, fax or conventional mail) at the REMOTE site where the veteran/patient is physically located.

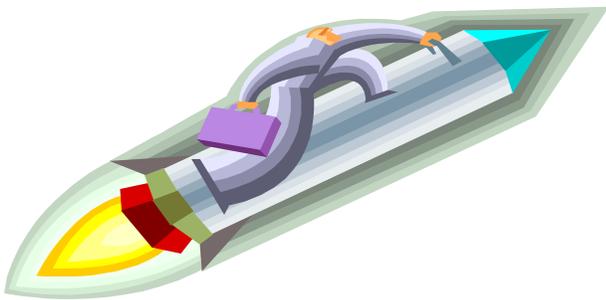
- c. C&P for REMOTE site and SPECIALIST CENTER site (Where the Practitioner is Located) when **CARE PROVIDED** from afar – If practitioners are directing, diagnosing or otherwise providing clinical care using telemedicine, they must meet the C&P requirements of both sites (i.e. where the veteran/patient is physically located (REMOTE site) and where the practitioner is physically located (SPECIALIST CENTER site)). Telemedicine practitioners' credentialing information must be immediately available (via Credential Transfer Brief or (in future) VetPro) at the REMOTE site where the veteran/patient is physically located. Telemedicine practitioners' current privileges, from the SPECIALIST CENTER site where the practitioner is physically located, must be made available to the REMOTE site where the patient is physically located. A separate delineation and granting of privileges must be made by the REMOTE site where the patient is physically located. Any consideration regarding the practitioner's use of telemedicine equipment to deliver care (i.e. training in operating the equipment and suitability of the equipment) should be encompassed during the privileging process.
- d. C& P for SPECIALIST CENTER site – Telemedicine practitioners must meet the C&P requirements of the SPECIALIST CENTER site where they are physically located.
- e. NPDB REQUIRED at REMOTE site – The REMOTE site where the patient is physically located must first query the National Practitioner Data Bank regarding practitioner's suitability prior to the practitioner being allowed to commence delivering care via telemedicine.

**2. OTHER HEALTHCARE SETTINGS:** Credentialing and Privileging of Telemedicine and Telehealth Services Provided in NON-HEALTHCARE SETTINGS (e.g. VET Centers, veteran patient's homes, community halls, etc.)

- a. JCAHO C&P STANDARDS DO NOT (Currently) APPLY TO OTHER HEALTHCARE SETTINGS – Administratively, no C&P of telemedicine practitioners can be done at other (than formal) healthcare REMOTE sites.
- b. C&P for SPECIALIST CENTER site – Telemedicine practitioners must meet the VHA C&P requirements of the SPECIALIST CENTER site where they are physically located. The VISN or VISN's will broker/coordinate all inter-site agreements for telemedicine services.

(Continues on Page 12)

- c C&P for REMOTE site – Telemedicine practitioners' current C&P information (if requested by the veteran/patient) must be immediately available (in accordance with the Privacy Act System of Records Notice for C&P), from the SPECIALIST CENTER site where the practitioner is physically located, to the REMOTE site where the veteran/patient is physically located.
- d DOCUMENTATION for REMOTE site – REMOTE site medical record documentation must adhere with current VHA policies of the affiliated SPECIALIST CENTER site.
- e ADHERENCE TO DIRECTIVE APPENDIX



*For those of you who were unable to attend ATA, here is a view of a program that the newsletter staff found to be state-of-the-art and interesting to share:*

Salinas Valley Memorial Hospital in Salinas, California, is now the only non-university hospital in a partnership with The National Aeronautics and Space Administration (NASA). In September 1998, the hospital signed a Space Act Agreement with NASA in which The Cleveland Clinic and Stanford University Medical Center also participated. A second Space Act Agreement was signed in April 2000 to develop for healthcare applications the NASA Virtual Glovebox (VGX) originally designed for the International Space Station.

NASA Ames Research Center at Moffett Field in Mountain View, California needed a hospital partner with an extraordinary commitment to technology. The partnership with Salinas Valley Memorial Healthcare System was a natural one given that the mission of both organizations is to use technology to serve humankind. The long-term goal is to provide a virtual medical environment that will ensure the health of astronauts as they probe deeper into space. These same technologies will be used to create the Virtual Collaborative Clinic which will "bring the clinic to the patient" through high-performance networks. Salinas Valley Memorial Healthcare System, under the direction of President/CEO Sam W. Downing, is in the

GUIDELINES – SPECIALIST CENTER site and affiliated REMOTE site must adhere to the list of 'Patient Criteria', 'Practitioner (Health Provider) Criteria' and 'Technical Criteria' contained in Appendix 1. of the relevant directive. These criteria provide standards to ensure the quality of care provided is satisfactory.

**POLICY WATCH FEEDBACK** Please let us know if you have any comments or questions about this article, or if you have another 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@hq.med.va.gov](mailto:John.Peters@hq.med.va.gov)

## VIRTUAL MEDICINE

Provided by Robert Smith,  
Liaison SVMHS/NASA

process of building an Image Network that will dramatically increase the immediacy, and therefore the quality, of patient care. Working closely with the NASA Ames Research's Center for Bioinformatics, Salinas Valley Memorial Hospital's Radiology Department is seeking to achieve a high-tech diagnostic capability known as image fusion. Image fusion takes data from diagnostic tools such as the MRI, CT, ultrasound and PET and merges it into a four-dimensional image. This ability is a giant step toward future development where two physicians at different sites will be able to enter a high fidelity, high resolution hologram, feel and manipulate its parts (tactile sensitivity/forced-feedback) while they talk to one another.

Future applications are expected to be discovered and might include: advanced 3-D and 4-D simulation of complex and difficult surgical procedures that allow for refinements to be made and tested prior to the actual surgery; medical school students or physicians seeking to expand and hone their skills will have the ability to perform virtual surgery giving them the next best thing to on-the-job training; patients in immediate need of life-saving treatment can be cared for at a remote location by a team of specialists through virtual medicine; and conferring physicians from around the world can simultaneously view three and four-dimensional images of patient organs to determine optimum courses of treatment.

# Questions & Answers

*By Claudia Zink*



*I saw some great technical equipment at the ATA conference! When they know I am a VHA employee, several of the vendors tell me, "Our equipment is on the GSA schedule" or "Our product is going to be on the GSA schedule very soon."*

***Question: What exactly does this mean and what benefit is it to my program?***

General Services Administration (GSA) is one of the three central management agencies in the Federal Government. (The Office of Personnel Management and the Office of Management and Budget are the others.)

GSA's "Federal Supply Schedules" are large contracts through which federal customers can acquire more than "4 million products and services directly from more than 8,000 commercial suppliers." They offer a vast array of brand name products ranging from office supplies and copier paper, to systems furniture, computers and laboratory supplies. They also cover services as diverse as accounting to graphic design to landscaping. The information technology (IT) supplies available on GSA schedules are growing in number everyday.

GSA's technical and acquisition experts can provide consultation to guide us through the process of selecting and acquiring critical IT products and services. "Working with industry partners, these GSA professionals help agencies assess their needs, develop requirements, prepare and advertise solicitations according to federal procurement regulations, evaluate offers, choose a contractor, award the contract, manage the contract, and ana-

lyze the results." [*Wow, I should have contacted GSA on some of our projects!*]

***Is it mandatory that we purchase our equipment through GSA?***

No, it is not mandatory, for two reasons: one, the particular equipment you need may not be available on any GSA schedule; two, the vendor you are working through may offer you a lower price.

***What are the advantages of going through GSA?***

If your vendor is not on the GSA schedule, your purchasing agent will have an obligation to check for comparison prices to get the best deal. If the project exceeds a certain price, the project may have to be offered out for competitive bids. It really is an advantage to us if the vendor does have a GSA contract, in terms of efficiency as well as economy, since the bidding process can take months. A GSA contract is helpful to the vendor too. This pre-qualification process limits the chances that a vendor of our choosing may not be the vendor ultimately selected. That scenario can be disappointing for both the vendor and the program staff who have been building a working relationship.

\* GSA web site: <http://www.gsa.gov/Portal/main.jsp?tab=home>

VHA Source: Marian Allen, Technical Support Team Leader, VA Puget Sound

**Next month's Question: What does the FDA have to do with telemedicine equipment?**

## The Telemedicine News Staff at ATA



Dr. Adam W. Darkins (Inset)  
Writer

Veta D. Brooks,	Claudia Zink,	Michelle Hill,	Mary Skinner,	and John Peters
Publisher	Writer	Editor/Writer	Writer	Writer

The Telemedicine News staff thanks you for your support and hopes that you enjoy our second 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.”*

Special thanks to Ms. Rita Kobb and Mr. Robert Smith for their contributions!