



NEWSLETTER

November 24, 2003

Volume III Issue III

Nat'l Meeting Set for February

The 5th Annual National VHA Telehealth Meeting will take place February 17th-19th in St. Petersburg, FL.

This year's meeting merges with the 2nd Annual National VHA Care Coordination Meeting, to form what will be the first VHA National Care Coordination and Telehealth Forum.

As with previous meetings, this year's meeting will bring together various VHA Telehealth communities (e.g., Home Telehealth, Telemental Health, Teledermatology, Teleretinal Surveillance, et al)



Island Grand Conference Center
St. Petersburg Beach, FL

to discuss national issues, such as start-up toolkits, and workload credit, etc. related to their respective clinical areas. Like past meetings, this meeting is also open to all VHA staff just beginning to investigate how telehealth applications may assist with their clinical requirements. Besides telehealth, there will

be a meeting track focused solely on Care Coordination programs, and issues involved in the current national rollout initiative intended to use Home Telehealth technology to ensure the right care, at the right time, in the right place.

We hope you are able to attend this meeting, which will be VHA's sole national telehealth meeting for this year.

Unlike past annual meetings, this meeting will not coincide with the annual American Telemedicine Association Meeting and Expo.

VHA Telemedicine is Now VHA Telehealth

Based on feedback from last quarter's newsletter, the VHA Telemedicine community has decided to change its name to VHA Telehealth. The new name is a broader umbrella term that covers not only telemedicine (which traditionally is thought of as a licensed independent health care provider directing/providing clinical treatment when distance separates the participants), but also covers additional related care and support activities from various VHA staff, such as a dietician providing diabetes patient education via videoconferencing.

We will attempt to be consistent in our use of the new

name in all of our communications: in the newsletter, on the Web site, and over the telephone. Feedback is always welcome on this change, or other VHA Telehealth program issues.

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VHA Telehealth Note on Ethics: Wearing the Right Hat and Staying on the Correct Side of the Line

By Adam W. Darkins

The emerging market for Telehealth technologies is growing, although its current size in terms of annual revenue is in the millions rather than the billions of dollars. Our preference for using commercial off-the-shelf technology (COTS) and VHA's expansion plans for Telehealth make us very attractive to sales people from a wide variety of Telehealth and other related companies. Many of us get regular contact from this vendor community. The job of these vendors is to sell their products, and our job, as government employees, is to make sure that we maintain the highest ethical standards in our relationships with them in ensuring that VHA gets the technologies it needs to provide care to veterans. This is a small and highly competitive industry and some of these companies de-



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pend on venture capital or have precarious revenues that affect their public shareholding. A sales contract with VHA may make the dif-

ference between a vendor remaining viable or not, and may make a sales person eligible for a large sales bonus.

Given these underlying commercial drivers, our relationships with vendors are something we must be very clear about. Regrettably, situations happen from time to time when VA employees cross the line and directly favor a vendor in their acquisition practice or inappropriately promote a particular vendor's product. These situations sometimes arise by accident and sometimes by design. The consequences for both VA staff and vendors of crossing the line of propriety can be equally severe and this brings ethics and pragmatism into close alignment. From time to time I realize that someone is in danger of crossing the line and is risking putting themselves, VHA, and the vendor that is seeking to contract with us in jeopardy. When this happens, I offer the same advice that is in this article and thankfully this advice has always been heeded.

In terms of being a VA employee there is no doubt which hat it is that we are wearing, it is a government hat. We are not allowed to wear any other hat and contract with vendors. It's not possible for a VA physician to take responsibility for

a Telehealth program and also award a Telehealth contract to an academic affiliate that he/she works for. It's not possible for a Telehealth coordinator to maintain a shareholding in a Telehealth technology start-up company and at the same time promote the use of this technology to colleagues in VA. Nor can your VA Telehealth status be used to enhance the promotion of a particular product. So, piece of advice number 1. If the hat feels wrong, it probably is, and so either back out of a situation where conflict arises or get ethics advice.

It is the very nature of ethical issues that they are not always clear-cut and that they can create uncertainty and ambiguity. This means that sometimes it may seem unclear what a particular hat represents. If this confusion arises then deal with the ambiguity by determining which hat is which. We cannot endorse a product and approach people to persuade them to buy any particular technology as government employees. But what happens if a colleague asks you what technology you would recommend? Is this an endorsement? If you have knowledge that one product is superior to another, shouldn't you tell people to make sure that VHA gets good value for

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NEW VHA National Care Coordination Training Center Sites Selected

By Rita Kobb, MS and Donna Vogel, MSN

In July of 2003, the Undersecretary for Health created the Office Of Care Coordination. The mission of this office is to support field staff in the national deployment of care coordination and home telehealth.

Part of this support will be provided through the establishment of national training centers for VHA staff.

This past summer, an RFP was initiated to create the first of three (planned) national training centers to train VHA staff in care coordination.

The main mission of the training centers will be to provide education to support the rollout of a national program of care coordination, at the VISN-level, throughout VHA. As indicated in the RFP, the training center is required to develop a core curriculum, create the necessary resources to support training, determine the best methods for this training, and ensure that multi-disciplinary healthcare professionals have the skills and competencies to offer appropriate, safe, and effective care coordination to patients.

Jill Manske, Director of Social Work Service for VHA and a member of the new Office of Care Coordination chaired the national review team that evaluated proposals submitted in response to the RFP. The team awarded the training center to the North Florida/South Georgia Veterans Health System in VISN 8, and also awarded funding to VISN 1's Connecticut Health Care System to provide faculty, develop curriculum and for the development of on-line courses and resources to support the Center through the Employee Education System (EES).



Nat'l Care Coordination Training Center
VA Medical Center Lake City, FL

VISN 8 is no stranger to care coordination having implemented the first model in April 2000 and having successfully served over 2500 veterans since that time. Currently, VISN 8 has 22 active programs and projects providing care coordination and home telehealth services to veterans in Florida and Puerto Rico. The new national Care Coordination training center will be located on the campus of the Lake City, FL VA Medical Center and be called "The Sunshine Center" in honor of VISN 8's support for care coordination and home telehealth.

erans in Florida and Puerto Rico. The new national Care Coordination training center will be located on the campus of the Lake City, FL VA Medical Center and be called "The Sunshine Center" in honor of VISN 8's support for care coordination and home telehealth.

A comprehensive care coordination curriculum will be developed with input from the current care coordination Networks (VISNs 1,2,8,11 & 17) as well as with feedback from the Networks (VISNs 9,10,15,18, 19 & 23) recently selected for implementation of new care coordination programs. The training center will have satellite broadcasts, web-based courses, teleconferences, and a website and newsletter to disseminate information to learners.

For more information about the Training Center and upcoming programs or available resources please contact:

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VHA TELEHEALTH TRAILBLAZERS

VAMC Poplar Bluff's

Sydney & Tim



In this bicentennial year of Lewis & Clark's overland expedition from Missouri to the Pacific, VISN 8's **David Gratz** donned his coonskin cap and set out (via telephone) to Missouri to interview **Sydney Wertenberger** and **Timothy Moore**, two modern-day pioneers standing on the edge looking West (and East, North and South) for new routes to link VHA patients and providers across the region and the nation. In the interview that begins on page 5, David discovers how the Poplar Bluff program 'started with a cart' in 1996 and how after seven years (and a lot of hard work later) won a National VHA Nursing Best Practices Award for their Diabetic Education and Management Telehealth Program.

VHA TELEHEALTH TRAILBLAZERS

By David Gratz

Here we are again with another story about VA superstars. VHA is fortunate to have so many people working and interested in telehealth.

Sydney is a Masters prepared nurse that has been with the VA almost 30 years. She started off as a Clinical Nurse Specialist in Psychiatry with a specialty in addiction therapy. From there, she moved into nursing administration in various VA's around the country receiving ANA certification in Advanced Nursing Administration. Currently, Sydney is the Associate Director Patient Care Services at the John J. Pershing VAMC in Poplar Bluff Missouri.

Tim Moore is a veteran himself, and has worked several roles within the John J. Pershing VAMC, in the travel/consult office, as a patient services assistant, and administrative float. He is in the process of completing his IT degree. He is aligned with the clinical services, and a true patient advocate! He has over 20 years federal service.

David Gratz: *How did you get involved in Telehealth?*

Sydney Wertenberger: The medical center underwent multiple changes 6 or 7 years ago looking at better opportunities for improving and providing care. I was approached from many areas in clinical care to look at this question. In 1996 the medical center purchased a "Telemedicine cart" and it landed in one of my areas. No one knew what to do with this device and I wanted to see how best to utilize this for patient care. This method of care fits into the medical center goals of providing quality, efficient, effective care and improving access to care in a rural environment. We had a terrific need, being a small rural facility. Teledermatology was our first clinic we started and it's still running today. Tim had a strong interest in technology, and a strong interest in helping, as he is also a veteran. His motivation and sustained interest combined with his patient centered focus make him an invaluable asset to this program. He truly is a "techno-wonder! His philosophy is why not—" we can do that!"

DG: *Tell me about your current projects?*

SW: We currently occupy a small wing of the medical center because of our success and consistent usage. We are providing Teledermatology between here and St. Louis VAMC. We have a clinic that evaluates disabled veterans for mobility using various assistive devices. The provider for this clinic is at the Kansas City VAMC. We also provide Telemental health to all our CBOC's using one of the providers in a CBOC. Smoking cessation is also another valuable clinic for us. We actually have over a dozen working telemedicine specialty clinics up and running, with plans for many more. Tim is constantly looking for ways to improve the technical service we provide, and for opportunities to try a new clinical endeavor; a way to keep our patients from traveling while receiving quality patient care. This past year we worked collaboratively with the local community college, and we had our first telemedicine technical internship student experiences here! The entire medical center has caught "telemedicine fever" and provides assistance as well.

TRAILBLAZERS

(Continued from page 5)

Telehome care is also under my purview. We have a small program now using a care coordinator but we were just approved a grant to expand this valuable service.

We have 4 CBOC's and the closest being over 1 hour away and the furthest being 2.5 hours. These clinics provide 70% of all primary care for our patient base. With that being said, we felt that some of performance standards were not being met, particularly assisting patients in having well controlled Hemoglobin A1C. An interdisciplinary plan was developed and implemented to form a team of providers including a RNP, an RN, PharmD and Dietician and they provide this service through multi-point telehealth technologies. This program was successful to the point of a 99% increase in patients enrolled with a 22% decrease in Hemaglobin A1C 35-45- days after completion of the program. This is without any change in their medications. As a matter of fact we have received a national nursing best practice award for this Diabetic Education and Management Program.

DG: *What do feel about your background that gave you a better chance for success in providing Telehealth?*

SW: My versatility, my multi-tasking ability and the fact that I have always thought outside the box. Being "raised" professionally to look for any way to get what the patient needs in the most efficient and effective way possible. The patient is at the heart of any clinical endeavor!

Author's note: Sydney was very gracious in providing this interview as she was getting on a plane to go to DC to receive the award for the Poplar Buff program. She is a humble and hard working career VA employee. It was an honor to interview her.

COMING DECEMBER 18



TO THE
Knowledge
NETWORK

C O D I N G for CARE COORDINATION and TELEHEALTH

Thursday December 18th, 2003

1.00P—2.30P (Eastern)

VAKN Channel 1

*Expert panel will provide **guidance on VHA coding for clinical workload credit, billing and reimbursement** for VHA Care Coordination and Home Telehealth.

*Dial the studio and have your question answered **LIVE** on the air



an

Employee Education System

Production



David Gratz is the VISN 8 Telehealth Coordinator as well as contributor to this newsletter. David is always scouting for new VHA Trailblazers to interview, so please contact him with any leads on 727-398-9411 or david.gratz@med.va.gov



Alaska Federal Health Care Access Network

TELEHEALTH

By Hal Blair & Stewart Ferguson, PhD, & Chris Patricoski, MD

Introduction

A man is having chest pain in a small village along the Yukon River in interior Alaska. A Community Health Aide, the only medical care available in the village, sends an ECG to a supervising physician in Fairbanks – a distance equal to sending the image from Washington DC to Kansas City, Missouri. Within minutes the man is diagnosed with a serious heart condition. Appropriate therapy is mobilized.

A ten-year-old girl is seen by an audiologist in Nome who takes a picture of her eardrum and sends it to an ear specialist in Anchorage – approximately equal to sending the image from Laramie, Wyoming to San Antonio, Texas. Later that day, the otolaryngologist diagnoses her with a cholesteatoma and schedules surgery to avoid hearing loss in the child.

These are but two examples of how the extraordinary technology of the Alaska Federal Health Care Access Network (AFHCAN) is impacting ordinary lives in the far reaches of Alaska.

The Environment

Providing health services in Alaska is no easy matter.

The state is known for its legendary weather, vast size, and dispersed population. Despite its geographic expanse, the state has only 12,200 miles of public roads – a number more akin to the transportation systems of much smaller states, such as Vermont. The lack of connecting road systems results in 75 percent of Alaskan communities and 25 percent of Alaska residents being unable to access a hospital by road. These communities must depend on other modes of transport – such as plane, boat, and snow machine – to access basic medical services.

The Partnership

AFHCAN is an initiative of the Alaska Federal Health Care Partnership (AFHCP) – a cooperative association of federal health care agencies and tribal health care organizations present in Alaska. The agencies of the AFHCP work together to improve health care for the nearly 240,000 federal beneficiaries in Alaska. The Partnership has been recognized nationally for interagency agreements, staff sharing, and efficient use of equipment and resources. Last year, the Partnership received the prestig-

ious AstraZeneca National Managed Health Care Congress Award for “partnerships between military facilities and teaching hospitals/integrated delivery systems.”

In 1998, the Partnership, in coordination with the Alaska Native Health Board, proposed a large telemedicine initiative to enhance access to health care for rural and remote patients and provide previously unknown specialty care to remote regions, known as “the bush”. The vision for the project was for Alaska to embrace the technology age when it came to health care and remote access. In a sense, the Partnership was building upon what health care practitioners do best in Alaska- provide good health care over long distances by communicating and improvising. Hence, AFHCAN was born.

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Please see end of article for co-author and additional AFHCAN information.

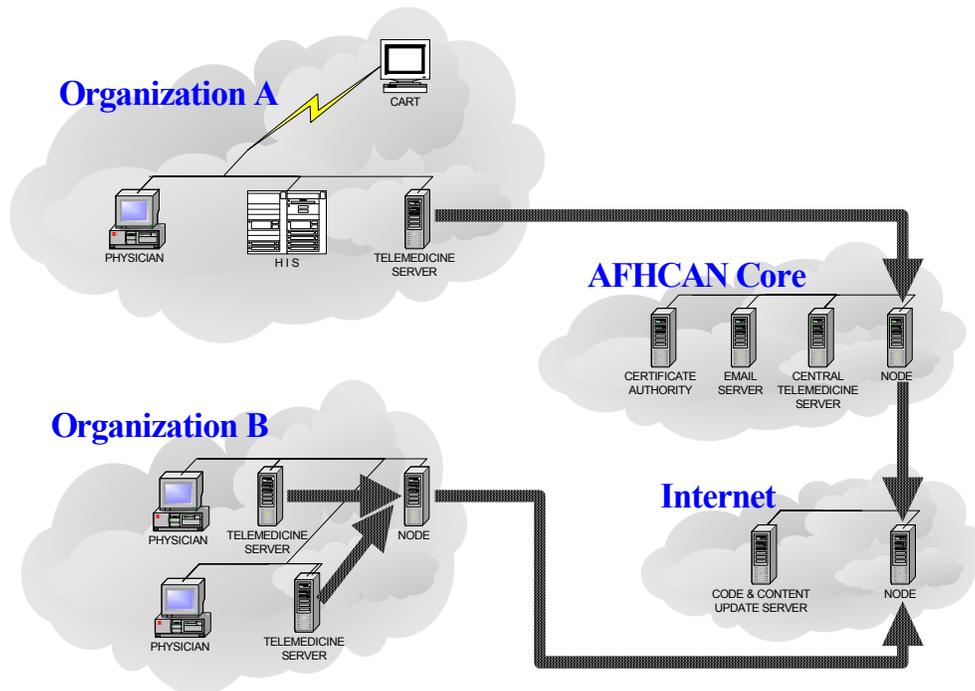
AFHCAN Telehealth (Continued)

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With great distances and extreme weather conditions, Alaska is the right environment for telemedicine. Most communications off the road system are relayed via satellite, and organizations use different telecommunication carriers. AFHCAN worked with organizations and the carriers to develop a cohesive, secure, and efficient telehealth network.

The resulting design allows for health care organizations to purchase dedicated bandwidth from long-distance carriers to a central core in Anchorage. The core leverages the

The Network



capabilities of AT&T Alascom and GCI, the two giants in Alaska long line telecommunications, who work cooperatively to route network traffic among all participating federal and tribal health care organizations in a secure manner. The network is used for a variety of health care applications including store-and-forward telemedicine, access to health records, teleradiology, telephone (voice) traffic, as well as real time video conferencing.

The Cart

AFHCAN has developed a unique telemedicine cart that includes a variety of medical devices (video otoscope, digital camera, ECG and scanner) and may also be attached to other peripherals (e.g. dental camera, other medical scopes).



The AFHCAN cart provides a portable platform supporting medical devices used in the creation of telemedicine cases.

The cart is portable, ergonomic, and sturdy. Stewart Ferguson, PhD, AFHCAN Project Director describes the cart as, "...designed with the idea that this is going in a remote village and we can't afford to go out and fix even the little things." The top tray of the cart is reachable, yet out of the way; the monitor has a wide viewing angle and utilizes the latest touch screen technology; the mouse is infrared; the counter top cut to protect cables; and the heavy items, like the UPS, are on the bottom. Dr. Ferguson notes a reputable company was contracted to build a, "medical cart frame... a system that can be packaged in a small plane and assembled on-site." A wireless capability allows the unit to be moved from room to room. Alaska Clinical Engineering Services, or ACES, has deployed the AFHCAN telemedicine cart to

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VHA Telehealth Note on Ethics (Continued)

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money when purchasing technology? In these situations it helps in staying on the correct side of the line to explicitly take the same approach that the Office of Care Coordination suggests when developing any new Telehealth program. Our advice is to always begin with identifying the patient need you are aiming to serve. Having done this, define what clinical applications can meet this need and then choose the technology that can most appropriately and cost-effectively support these clinical applications. Don't start with a piece of shiny technology. So, if a colleague wants a recommendation from you about what Telehealth technology to use, find out what need this technology is expected to meet? Then explore the clinical applications that meet the need and then help them to make their own decision about which technology to choose. Their choice should be based on objective criteria of functionality and cost in terms of what is the superior technology, if indeed there is a superior technology. So, piece of advice number 2. Make recommendations about technology to colleagues on objective grounds

that relate to defined needs of veterans.

It's simple isn't it, our mission is to serve veterans and focusing on this mission solves so many problems. We are paid to serve veterans and not ourselves. So, piece of advice number 3. If in doubt about what to do, then you

1. If the hat feels wrong, it probably is, and so either back out of a situation where conflict arises or get ethics advice.
2. Make recommendations about technology to colleagues on objective grounds that relate to defined needs of veterans.
3. If in doubt about what to do, then you should ask advice from your local Regional Counsel (RC) or a deputy ethics official in the Office of General Counsel (OGC).
4. Come clean if you either think or know you have a problem with the ethics rules.

should ask advice from your local Regional Counsel (RC) or a deputy ethics official in the Office of General Counsel (OGC) (023) 202-273-6334/6335.

If you realize that you have crossed the line and either unwittingly or deliberately breached the ethics rules then please contact your RC or the OGC. Often the consequences of the original action are far less severe than those

that result from trying to hide the action. So, piece of advice number 4. Come clean if you either think or know you have a problem with the ethics rules.

Wearing the right hat and staying on the correct side of the line is yet another of the many things that Telehealth

coordinators need to know if they are to be successful. The Office of Care Coordination is involved in developing national contracts for Home Telehealth and Teleretinal Imaging technologies. It used to be our custom to regularly communicate with Telehealth coordinators and share unsolicited information

that we received from vendors in a batched e-mail. When we have done this we have accompanied it with the disclaimer that we make absolutely no endorsement about any technology and cannot even assure people that the equipment works or has any of the functionality it is claimed to have. We took this position to help create a wall between the many vendors, who come and see us,

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VHA Telehealth Note on Ethics (Continued)

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and those of you who are involved in directly purchasing equipment. It was an approach intended to avoid your being unnecessarily bothered by vendors or from giving you the mistaken impression that because a vendor meets us at VACO it can be construed as any kind of endorsement for them or their product.

We are about to revisit this policy and in doing so are going to follow our own piece of advice number 2 and contact OGC to make sure we wear the right hat and stay on the correct side of the line. We will let you know when this policy is completed and what it consists of in a later edition of this newsletter. Further information is available on this issue from www.usoge.gov and VA's ethics Web page at <http://vaww.gc.va.gov/ethics/>.

AFHCAN Telehealth (Continued)

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The Software

AFHCAN has also developed the software that is accessible from the over 300 computers and telemedicine carts among the 39 participating health care organizations. The AFHCAN telemedicine software provides “store-and-forward” consultations whereby the medical information is loaded at the remote site, sent, and later viewed at the receiving site. “Software development is quite an endeavor,” explains Chris Patricoski MD AFHCAN Clinical Director. “We started with the request from clinicians to develop an easy-to-use system that moves images. They wanted something like electronic mail, but easier. They wanted the software to integrate with a bunch of medical hardware. They also wanted a lot of features.”

The end product is a web-based application with a simple user interface and robust design. “The software is scaleable, so if you want to utilize fancy electronic history and physical forms you can do so; but if you want to just type a sentence and send a picture of a wound, you can do that too. Basically, you start touching green buttons and before you know it, you have created a case.”

Improving Access to Care

In 1998, Alaska ranked 48th among the states in the ratio of doctors to residents. Only Idaho and Oklahoma had fewer doctors per 100,000 people (State of Alaska Rural Health Plan, 2000). Telemedicine provides the answer to provide doctors to rural Alaskans. Telemedicine technology allows the physician to be brought “virtually” to the patient, rather than bringing the patient to the physician – a situation that is more convenient and more cost-effective.

One advantage of telemedicine is that patients can be referred directly, improving the process for the patient, and making provider-to-provider communications more efficient. Dr. John Kokesh, MD, Chief of the ENT department at the Alaska Native Medical Center has seen telemedicine improve patient access. “Two six-year-old siblings with conductive hearing loss and fluid in both ears were easily diagnosed. They have 30-40 dB hearing loss, which is like walking around all day with you fingers in your ears. This kind of loss in children this age is well known to cause speech and language delay, learning disability, and behavioral problems. (Using tele-

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AFHCAN Telehealth (Continued)

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medicine, they were diagnosed, scheduled, and) ...the cure was the placement of ear tubes.”

An audiologist providing a specialty clinic in a very remote village says, “I was able to clear two elderly patients for hearing aides without requiring that they even leave the village. Under traditional health care delivery, these patients would have had to schedule an appointment months in advance, travel to Nome or Anchorage to see a physician, and wait another couple of months to receive the hearing aids.”



Andrew Tooyak, CHA/P, examines patient's ear using the AFHCAN Telemedicine Cart.

To date, more than 13,000 store-and-forward telemedicine consults have been provided using the AFHCAN telemedicine software. About 75% of the cases have been sent from community health aides to family physicians, 20% from audiologists to otolaryngologists, and the other 5% have been sent to cardiologists or dermatologists. Physicians estimate they are saving travel 30% of the time compared with how they used to triage these kinds of patients in the past. Furthermore, telemedicine is adding to job satisfaction of the community health aides and other rural practitioners. In a survey of providers who use the system, 92% believe telemedicine helps them communicate with a doctor and 80% feel telemedicine makes their job more fun.

Four years ago, clinicians were looking for a store-and-forward application that could transmit 12-lead electrocardiograms. The AFHCAN project office reviewed the possibilities before choosing the IQmark Digital ECG by Midmark Diagnostics. “We initially selected Brentwood/Midmark based on the quality of ECG readings and portability of the hardware. The real benefit, we later learned, came from the cooperative nature of their staff. They worked closely with us, and worked hard to overcome the technical challenges of what we were trying to accomplish,” notes Stewart Ferguson, PhD, AFHCAN Director.

The resulting product is an AFHCAN Telemedicine Cart with a simple user interface, allowing clinicians to select the ECG as one of four biomedical devices. After logging into the software, the user can access any of the biomedical peripherals on the cart with no more than three mouse clicks or presses of the touch screen monitor. The AFHCAN web-based software cleanly interfaces with the IQMark Digital ECG. The ECGs are saved as a case and sent from the server of one health care organization...over satellite...to the server of another health care organization. Active X Controls are utilized initially to display the cardiac waveforms while the clinician is performing the ECG; they are also used later for reading and interpreting the stored data.

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AFHCAN Telehealth (Continued)

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The telemedicine cart and ECG are gaining popularity among clinicians. “The ECG was received from the village Health Aide ...the ECG showed an acute myocardial infarction,” describes Floyd Elterman, MD, of Chief Andrew Isaacs Health Center in Fairbanks, AK. “It was possible to be very definite with the patient, who had no health insurance, about the necessity for hospitalization.”

Approximately 150 sites are utilizing the ECG unit as part of the AFHCAN telemedicine cart. The sites have been deployed sequentially over the past two years and in that time, 671 cases have included an ECG. Each case normally includes three ECGs, so approximately 2000 ECGs have been performed and sent. Most ECGs are performed by Community Health Aides in remote villages and sent to regional Family Physicians, who then, may forward to a Cardiologist in Anchorage, AK.

“ECG transmission from Alaska’s interior villages to Fairbanks physicians...has proven beneficial,” describes Gina Pender MD, staff physician for Chief Andrew Isaacs Health Center. “In some instances, the decision to urgently transfer the patient with acute ECG findings was facilitated...In other cases, ECG telemedicine has prevented unnecessary travel of patients to the acute care setting. During physician medical field visits to the village, the 12 lead ECG unit has been useful in evaluating patients...”

Teleradiology

The AFHCAN network is also used for teleradiology. When a person walks into a rural health facility in Alaska and requires x-rays, it is likely that the data is transmitted to Fairbanks or Anchorage to be read by a board certified Radiologist. There is a national shortage of radiologists, and this puts pressure on hospitals and clinics that are trying to provide high quality radiological services for their clients. In the past 15 years, teleradiology has become part of the normal operating procedure in the lower 48. In Alaska, teleradiology has really expanded in the past five years.

Videoconferencing

Some regions utilize live interactive video for educational, administrative and clinical purposes. This requires videoconferencing equipment, appropriate room with proper lighting, and high bandwidth. Southeast Area Regional Health Corporation (SEARHC) estimates it saves thousands of dollars in travel (each quarter) with its use of videoconferencing.

Dr. J. Michael Orms, Medical Director for Maniilaq Health Center in Kotzebue notes that his staff uses videoconferencing to communicate with community health aides when acute medical problems arise in the remote villages. The same life saving technology can also provide connectivity to necessary vital resources in Anchorage. In June 2003, a woman came to the hospital with an ectopic pregnancy, a dangerous situation requiring surgery. Worse, the pregnancy had ruptured arterial blood vessels. The patient was hemorrhaging; her condition deteriorated rapidly. She needed immediate surgery. But Maniilaq Health Center doesn’t have an operating room, or a surgeon — or anesthesia! ‘Due to heavy fog, there was no way we could medevac [the patient] to a larger facility with an operating room’ said Dr. Orms. ‘There was a high possibility that she would have died even in transit to Anchorage. Using my surgical skill to stop the bleeding was the only choice! Being a family practitioner with some surgical skill — but not a surgeon— I needed some assistance.’

Dr. Orms called Dr. Daniel R. Szekely, Medical Director, Women’s Health, Alaska Native Primary

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AFHCAN Telehealth (Continued)

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Care Center (PCC) at Alaska Native Medical Center (ANMC) in Anchorage. Dr. Orms requested guidance on how to do a laparotomy using local anesthesia. As a result of the call, the staff at the AFHCAN Office contacted and provided an immediate videoconferencing link and Szekely asked Kotzebue's staff to bring its Polycom videoconferencing equipment into the room so he could observe Dr. Orm's surgery from Anchorage. Szekely was able to offer Orms reassurance as well as guidance, based on real-time images transmitted via satellite. The video teleconferencing, said Szekely, 'was an incredible addition to the care of this patient. And, Dr. Orms, in Kotzebue, did a remarkable job!'

'From my perspective, being one of those primary care providers who is on the frontier of Bush Alaska,' Orms said, 'the technology was a vital part of providing appropriate care for that patient. We were able to conduct an exploratory surgery that was a lifesaving procedure for the patient.'

Alaska Telehealth Advisory Council (ATAC)

AFHCAN sponsors the Alaska Telehealth Advisory Council (ATAC), originally commissioned by the Governor to investigate the State's approach to development of telemedicine and teleradiology technology. ATAC is working with state and private agencies to promote telehealth initiatives throughout the state and was instrumental in developing technical guidelines for implementation of Medicare payment for telemedicine services. Other Alaskan telehealth initiatives include the State of Alaska Telepsychiatry program for the Department of Corrections; Providence Alaska Medical Center and its Sakhalin Island Project; and educational programming offered by Alaska Public Health Training Network Section of Community Health and Emergency Medical Services (Alaska Division of Public Health).

The Future

The future looks bright for telemedicine in Alaska. AFHCAN plans to continue in areas of software development, hardware design, and training. AFHCAN recently received a grant from the USDA to provide additional medical peripherals to 160 sites throughout Alaska. There are major efforts underway to offer support and to achieve sustainability. AFHCAN received the 2002 Grace Hopper Government Technology Leadership Award for Improving Services for "transforming how health care is delivered in rural areas." AFHCAN continues to listen to the needs of health care providers as it pushes the limits of technology. The program continues to grow as more and more clinicians find innovative ways to use telemedicine. And, the AFHCP has recently been identified as one of 100 finalists surviving the screening of over 1200 submissions in Harvard University's Kennedy School of Government Innovations in American Government. It may be too early to tell what kind of impact this new technology is having on clinical outcomes. But it is clear, from practitioners in the field, that Partnership is "the right thing to do", and technology is here to stay.



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Learn more about **AFHCAN** on the Web at www.AFHCAN.org



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

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