



NEWSLETTER

May 27, 2004

Volume IV Issue I

Telehealth Leads Introduced

VHA's Telehealth Strategic Healthcare Group (SHG), in collaboration with the Mental Health SHG, the Rehabilitation SHG, and the Medical-Surgical SHG is pleased to introduce its first three Telehealth Leads: Dr. Cathy Cruise for VHA Telerehabilitation, Dr. Linda Godleski for VHA Telemental Health, and Dr. Scott Hundahl for VHA Telesurgery. Each clinician has voluntarily accepted this honorary position and has agreed to help coordinate efforts in their fields to help produce, with the help of forming Field Work Groups, the vital resources required in



Dr. Cathy Cruise
TeleRehabilitation



Dr. Linda Godleski
TeleMental Health



Dr. Scott Hundahl
TeleSurgery

their respective areas. Common tools created by each group include start-up toolkits, informational Web pages, and a current roster of VHA participants and clinical activity from around the country.

The Telehealth SHG plans to use this strategy to create additional leads for other specialty areas in the months ahead.

Call for Input: Home Telehealth

VA's Office of Information (OI) and VHA's Office of Care Coordination (OCC) are requesting input from VHA staff to determine all desired Home Telehealth patient registration data requirements such as:

1. Name
2. Social Security Number
3. VA's Integrated Control Number (ICN)
4. Date of Birth
5. VistA User Name
6. Initiating Facility
7. Permanent Address?
8. Diagnosis?
9. Others?

Please e-mail suggestions to:

vha_hometele_HL7@med.va.gov

Full Details Inside beginning on Page 13

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VHA Care Coordination/Telehealth

30 Practical Realities for Virtual Services

By Adam W. Darkins

A few years ago the idea that health care might be contracted from overseas seemed a far-fetched, albeit interesting possibility to entertain. Although there had been some examples of doing this, they had been somewhat cumbersome and mostly involved exporting US health care expertise to other countries. As with many other areas of technology, what seemed to be on the distant horizon yesterday is upon us today and may even be disappearing away from us in the rear-view mirror tomorrow.

With the very real difficulties there are in recruiting medical specialties (e.g., radiologists), teleradiology is being vaunted as a solution for how hard-pressed facilities meet these needs, especially in rural areas. The general health care system is taking this solution one step further and is exploring the use of radiologists

based in other countries (e.g., Australia) to provide these services.

Why in the world would the solution to shortage of radiologists in the US be to



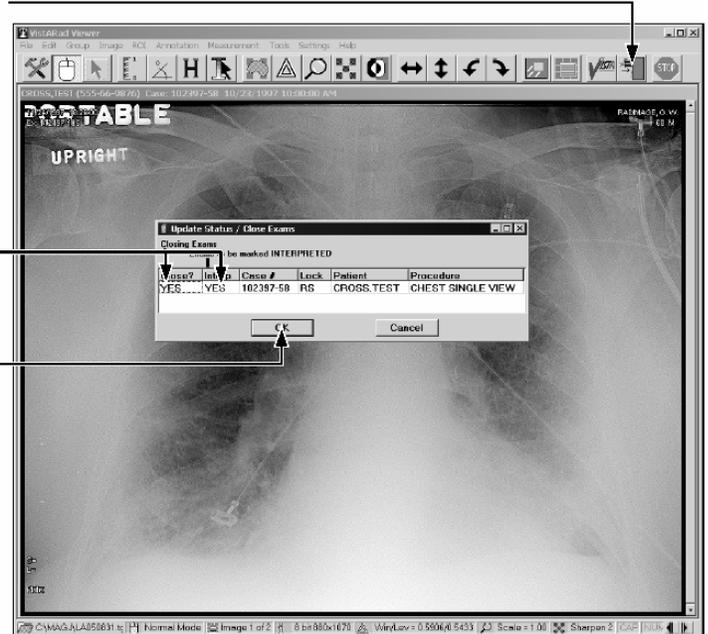
Adam Darkins, MD

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

1. Click to open Update Status/Close Exams window.

2. Verify values in Close and Interp fields. If necessary, click to change.

3. Click OK.



...Teleradiology is being vaunted as a solution for how hard-pressed facilities meet these needs, especially in rural areas.

get this expertise from overseas? One very practical reason is that these services (e.g., reading of emergency x-rays, CT scans and MRI's) are often needed 'after hours'. When it is nighttime in the US it is daytime in Australia. It is comparatively easy to send a store-and-forward image from the continental US to Australia and so, is this a good thing or a bad thing to do?

The purpose of this brief article is not to answer whether it is a good thing or a bad thing rather to highlight the way in which it is so often

the case with telehealth that the devil is in the details and not in the vision or the idea. If so, what are the details that need to be considered?

Clinical Practice - All of care is not suitable to be provided remotely. Telehealth can play a role in supplementing aspects of existing care delivery systems, but not necessarily in replacing them. Offshore may be a supplement rather than a comprehensive solution for providing services.

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VIRTUAL SERVICE, 30 PRACTICAL REALITIES(Cont'd)

(Continued from page 2)

Clinical Supervision - As an example, in telepathology the practitioner providing the remote expert advice assumes responsibility for ensuring the adequate selection, preparation and communication of clinical material by the technician/practitioner at the patient end of the telehealth link. How will such supervisory responsibilities be clearly identified and implemented and maintained?

Clinical Guidelines - How will relevant clinical guidelines be adhered to with training, updates and monitoring mechanisms in place?

Quality and Performance - Appropriate systems should be in place to assess quality. What are the quality and performance measure requirements, including Joint Commission regulations that are pertinent? How do these fit with reciprocal arrangements in the country hosting the service?

Patient Safety - Patient safety concerns are compounded when health care services are provided across organizations. Crossing national boundaries further complicates matters e.g. due to language and differences in clinical practice.

Licensing, Credentialing and Privileging - All practitioners

will need a current US license in the state in which the patient receives consultation/care. How will overseas telehealth service providers be credentialed and privileged?

Peer Review In establishing any overseas telehealth service how will the required peer review processes must be established, conducted and managed?

Technology Standards - What standards need to apply for the interoperability of technologies?

Health Informatics - When telehealth involves low volumes of consultations patient information and reports are often exchanged via facsimile. What arrangements need to be made for electronic data exchange/report transcription?

HIPAA - Do HIPAA regulations apply in another country and are they enforceable? What reciprocal arrangements does the other country have?

Cyber Security - What are the data security requirements of networks that use international carriers?

Integrity of Systems - Are mechanisms needed to cope with complex software integration and virus

(Continued on page 4)

30 Telehealth Issues

At a minimum,

Have you considered...

Clinical

- Clinical Practice
- Clinical Supervision
- Clinical Guidelines
- Quality & Performance
- Patient Safety
- Licenses, Credentials & Privileges

Technical

- Technology Standards
- Health Informatics
- HIPAA
- Cyber Security
- Systems Integrity
- Systems Integration
- Bandwidth & Compression
- Data Storage
- Failsafe Redundancy

Administrative

- Roles & Responsibilities
- Workflow Management
- Training & Education
- Coding Workload Capture
- Vendor Viability
- Service Sustainability
- Contract Monitoring
- Leading vs Bleeding Edge
- Total Costs
- Payment Transactions
- Indemnity Claims
- Financial Risk Mgt
- Duty of Care
- Provider Citizenship*
- Trade Agreements*

*Specific to Overseas Telehealth

VIRTUAL SERVICE, PRACTICAL REALITY(Continued)

(Continued from page 3)

protection? If so are they tried and tested solutions that are operationally mature and not developmental?

Systems Integration - How are IT servers positioned and how are data systems interfaced? Routine systems upgrades must be synchronized without catastrophic system failures.

Telecommunications Bandwidth and Data Compression -The telecommunications bandwidth requirements for any proposed telehealth service must be adequate. Internet protocol (IP) mediated data transfer can create substantial delays in data packet transfer. Therefore, any data compression solutions that are proposed to obviate bandwidth restrictions must conform to accepted standards.

Data Storage - Suitable technologies, together with appropriate policies and procedures, must be in place for the safe and efficient storage of all clinical materials related to and/or generated via telehealth. In the situation of teleradiology and telepathology it may be necessary to make previous studies available for comparisons when reporting. Making these images available in a timely manner may demand considerable bandwidth capacity.

Telecommunications Redundancy and Failsafe Procedures - Currently, there are no definitive standards for the telecommunications infrastructure that supports telehealth, nor for formalizing the necessary backup and redundancy (e.g., of routers and circuits) nationally, let alone internationally.

Roles and Responsibilities - Management roles, responsibilities and associated accountability together with clearly defined lines of communication must be in place. Interface issues, and who and how problems are solved pose particular problems for overseas services.

Workflow and Workflow Management - Any proposed telehealth service involving store-and-forward technologies (asynchronous) must be able to manage workflow. When forwarding clinical materials to designated practitioners for reporting, processes must be in place to ensure that requests are tracked at all times. Mechanisms must be in place to ensure that a patient cannot get inadvertently "dropped from the system".

Training and Education - The training and education needs of staff in relation to the clinical, technology, management and risk management factors must be defined.

Coding and Workload Capture of Clinical Activity - Mechanisms must be in place to code activity and capture workload and these data systems must have the ability to tie outside workload to all commensurate in-house activities for cost and quality analyses.

Sustainability and Viability of Vendors - Deconstructing existing services and reconfiguring these into new virtual services may impact on the continuity of associated services unless accompanied by suitable risk management strategies. Is there a pool of potential vendors to avoid dependency on a sole source of supply?

Sustainability of Services - Should the telehealth service cease or require suspension for clinical, technical, financial or legal reasons, the downstream impact of such a failure on other processes (e.g., elective surgery) may be highly disruptive. Are there suitable risk management strategies in contracts and operating procedures?

Contract Monitoring - Specific indices associated with telehealth must be included in the contract monitoring requirements (e.g., turn around times for reports in teleradiology.)

(Continued on page 5)

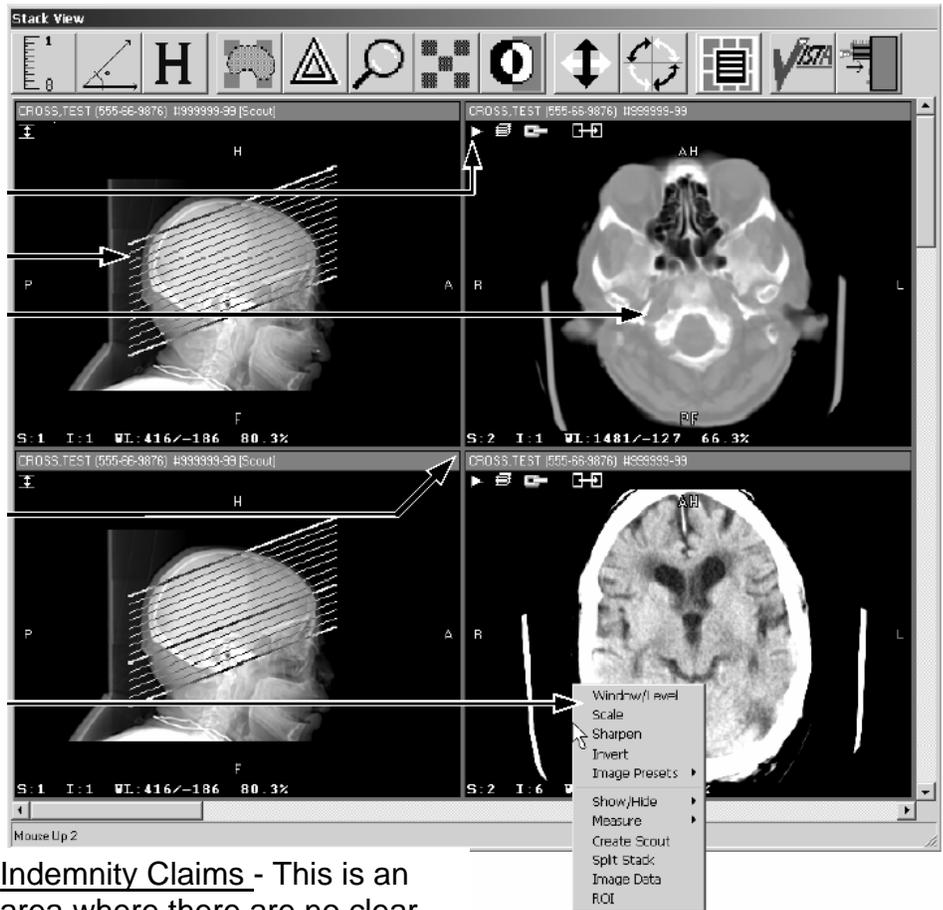
VIRTUAL SERVICE, 30 PRACTICAL REALITIES(Cont'd)

(Continued from page 4)

Leading Edge vs. Bleeding Edge Activities - The concept of using telehealth to draw upon a wider pool of clinical expertise and improve access to health care services at reduced cost is an approach to solving current challenges in providing services. However, the actual costs of developing offshore telehealth systems, on an economic scale that resolves all these outstanding issues and creates robust and sustainable clinical services, is potentially very high.

Identification of All Costs - All costs associated with overseas telehealth services must be clearly identified in advance of establishing these services. Clinician time, technology, software licenses, telecommunications costs, service contracts, billing and insurance/indemnity costs are typical examples of these costs. When considering the cost of such services, in-house costs are often ignored particularly IT support costs.

Mode of Payment and Currency Transactions - Should payments be made in US dollars to lessen the impact of fluctuating currency costs? Currency fluctuations may affect offshore telehealth services as they do any other import.



Indemnity Claims - This is an area where there are no clear legal precedents to offer guidance on how any legal redress should proceed.

Financial Risk Management - What financial redress is there for patients within the USA in relation to the health care services purchased overseas?

Citizenship of Telehealth Practitioners - Unless telehealth is defined in new and specific ways, US and International law may be affected by the citizenship of those providing services.

Trade Agreements - The Trade Agreement Act may relate to foreign contracting for these services?

Duty of Care Given - the multi-faceted nature of the provision of care via telehealth overseas. How is the duty of care adequately covered at both ends of the telehealth link?

In May 2004 VHA established a Teleradiology Healthcare Services Work Group that is comprised of VA Central Office, with VISN and facility based experts to advise on teleradiology issues and make specific recommendations on what, if any role overseas telehealth services could play in VHA in the future.

Care Coordination Home Telehealth CCHT Training Center First Core Course Available Online Now

By Rita Kobb, MN



Rita Kobb MN, GNP
Training Center Dir
Educatn Prog Spec

The national training center and its partners in VISN 1 and EES have been working since February on the development of the first course in the national care coordination and telehealth curriculum. This first course in the core curriculum introduces care coordination and home telehealth (CCHT) and its associated key concepts. It examines how CCHT builds on existing processes in the Veterans Health Administration (VHA) to enhance and extend their impact. It also addresses strategic planning to implement successful CCHT programs.

The first course entitled: Care Coordination and Home Telehealth: The Basics has been broken into two parts for easier learning by students. The first part is 'The Foundation.' This part covers lessons in Implementing Change, the Evolution of Care Coordination, Technology and Network Issues and Program Planning. The second part is 'The Building Blocks.' This part covers lessons in Risk Management, Coding and Workload, Accreditation and Outcomes. It provides an overview for administrative, technical, business, and clinical staff and serves as a foundation for frontline clinical staff as they progress to the remaining required courses of the national core curriculum.

The course became available on-line May 14, 2004. Any VHA staff wishing to take the course can access it from the Office of Care Coordination's (OCC) website at <http://vaww.va.gov/occ>

In addition to the content development authors,

the national training center would also like to acknowledge the work and support of two additional teams who have provided the technical expertise in programming content into web-based applications for students to access on-line. The VISN 1 team led by Woody Levin at West Haven and the EES team led by Ray Spry at Salt Lake City.

Training center staff encourage learners who complete the first course in the core curriculum to take time to evaluate the content and set-up so we can better meet your educational needs in rolling out future courses.

The next core course in the core curriculum is entitled Technical Operations. This course will focus on

technology-related issues such as system design, technology selection and will preview the national contract vendors and their equipment. This course will be available in July.

Course 1: CCHT The Basics (in 2 parts)

**VHA staff wishing to take the course
may access it from the
Office of Care Coordination's (OCC) Website at
<http://vaww.va.gov/occ/trainingcenter/>**

The national training center wishes to acknowledge the contributions of the following authors in developing content for this first course:

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VISN 15

John Peters
Telehealth
OCC

OCC Quality Staff Changes

Welcome Linda and Nancy...



Linda K. Foster, MSN, RN
Acting Quality Manager



Nancy Campbell, MSW
Acting Quality Manager

The Office of Care Coordination welcomes two new members to our staff to help manage Quality issues associated with the implementation of Care Coordination Home Telehealth (CCHT).

Linda Foster is an Indianapolis-based Program Coordinator for VISN 11 Care Management and **Nancy Campbell** is the Chief of Social Work at the VAMC in Cincinnati. (Complete bios now on the OCC Web site) As OCC Quality managers, Linda and Nancy will continue the good work initiated

...Farewell Susan and Wendy

...**Susan McCutcheon** and **Wendy Hepker** joined the Office of Care Coordination in 2003 and immediately went to work conducting on-site visits to help improve the effectiveness and quality of nascent regional CCHT programs through the use of national standards and guidelines. The process they created will be an invaluable model in future reviews as CCHT programs come online in all 21 VHA regions in 2004. The OCC is extremely grateful for their pioneering efforts. Thanks Wendy and Susan.



Susan McCutcheon, RN, EdD
Former Quality Manager



Wendy Hepker, MSW, LICSW
Former Quality Manager



1. Coming Thursday June 10

CARE COORDINATION/TELEHEALTH

VHA TeleRehabilitation

Thursday **June 10** (Noon Central)

- *Dr. Adam Darkins — Chief Consultant Care Coordination*
- *Dr. Cathy Cruise — VHA Lead for TeleRehabilitation*

2. Coming Tuesday June 15

CARE COORDINATION/TELEHEALTH

Caregivers—The Vital Link

Tues **June 15** (Noon Central)

3. Coming Thursday August 12

CARE COORDINATION/TELEHEALTH

VHA Telehealth & VERA

Thurs **August 12** (Noon Central)



VA Employees may see complete program details in the



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

VHA Telehealth Trailblazers

CRAIG



DAVIS

VHA
Network Engineer

with
Designs
on TeleHealth

About 10 years ago, while helping develop a robotic dynamic telepathology system linking the VA Medical Center in Iron Mountain, MI, to a pathologist at the VA Medical Center in Milwaukee, WI, Information Resource Management (IRM) staff member **Craig Davis** was pretty much **just doing it for the technology**. For many network engineers, like Craig, the allure of telemedicine is in the technology.

However, as you will read in the interview beginning on page 11, something happened that shifted

(Continued on page 10)

VHA Telehealth Trailblazers

Craig's perspective. Let's let him explain:

John Peters: *So Craig, thanks for doing this interview. And please start off by telling us what happened that day on Michigan's Upper Peninsula that shifted your perspective from the abstract mechanics of information networking to the clinical realities of telehealth?*

Craig Davis: Well, I first have to explain that we were really hard pressed for pathology services up at Iron Mountain, and the robotic pathology system was being used more and more. And one day, shortly after passing the new telepathology system to the clinical staff for trials, as I stood behind the pathology technician, kind of watching the process, the doctors were moving the microscope stages and searching through the (pathology) slide, very concerned about what they were seeing. I was totally oblivious to the fact that the pathologists were over 200 miles away controlling this microscope in front of me. For once I was observing the clinical process and not paying attention to the technical. Right there, at that moment the doctors were discussing the pathology slide and the possibilities of the patient having high-risk cancer. They were using such skill to make sure that they were absolutely certain about the diagnosis. At that moment, my entire perception of telemedicine changed. Sure it was nice to have the technology, but the absolute bottom line to all of the technological gizmo's and pretty lights is improving patient care. From that day on, I kept the clinical need first in my dealing with telemedicine projects. Simply because of watching the technology being used to help diagnose a patient, I felt like what we were doing was making a difference in peoples lives.

The network engineers need to understand that the clinical services are the most important application running on the network.clinicians should try to understand the most of us are not trained in

JP: *That's a great story, and I imagine more and more 'networking' folks are having experiences similar to yours, as telehealth continues to spread out across VHA. There has been quite a lot of development in VHA Telehealth in the past few years, but, I'm curious, when did you begin working for VA?*

CD: I started in the VA in June of 1989, I think. My first VA was the Aleda E. Lutz VAMC in Saginaw, Mi.

JP: *I know you are in Miami now. What are you doing there?*

CD: I am currently the Assistant Chief of IRM at the Miami VAMC. I am also the senior networking engineer for the facility. I help the Chief run the service and pretty much act as a technical arm of the CIO office for the facility.

JP: *What do you do on a daily/weekly basis, in your current IRM position, that affects telehealth?*

CD: Well, I think that most of my networking duties touch on Telehealth in one way or another. We have recently upgraded the entire LAN to one of the most advanced networks in the VA. Actually, I believe that we now have the largest wireless deployment in the VHA and most likely the VA. The network in of itself has dramatically improved the retrieval times of PAC's images and has allowed for the implementation of video-based Telemedicine. We also have implemented

VHA Telehealth Trailblazers

(Continued from page 10)

the new EES Content Distribution Network E-learning initiative that allows every one of our employees to receive VAKN education live broadcasts, and on-demand video at their desktops. This is directly related to providing Telemedicine education to our clinical staff. More specific to telemedicine, we are working with the Volunteers of America Florida to outfit a fully mobile clinic with satellite technology to bring leading edge Telemedicine to our homeless veteran population. We are utilizing some of the most leading edge satellite technology available to facilitate the project.

JP: *How did you become interested in VHA Telehealth?*

CD: I became interested while at the Saginaw VA. We started to work with VistA Imaging's Dr. Ruth Dayhoff on beta testing the VistA Imaging software. Our dentist was very interested in digital radiovisography and intra-oral imaging. We worked to create a digital dental operation and it was very interesting from a networking standpoint. I really did not have any epiphany with regard to starting in telemedicine, it kind of just slowly grew, as I am sure that it did for most of us. There were very few people involved in telemedicine "back then". I think a lot of us were viewed by our peers as kind of "out there", but that is what it takes sometimes in developing ideas.

...we are not directly responsible for clinical care however, if a clinical process relies on telemedicine then the network engineer becomes a critical component of the clinical process

JP: *I suppose, if done right, IT/Network issues are invisible to veterans, clinicians, and administrators, but what*

Network items/issues would you like to raise the visibility of in order to enhance understanding—What should the non-IT 'civilians' know about networks/infrastructure as related to VHA health care?

CD: They should know that IT infrastructure is a little like the electric company. The product is fairly simple, but the infrastructure to deliver a packet, or current, is VERY complex. People tend to flick on a light switch and the electricity is just "there", but if the electricity fails things tend to fall apart rather quickly. It is the same way with the network, when it is working well people tend not to notice. But when it fails, pretty much everyone notices and we usually are working in an emergency mode. The "network" is a compilation of very complex computer systems, cabling and software. People should be educated on the fact that network resources are finite. The available network resources (bandwidth) are not unlimited and slowdowns, problems do happen. Your network engineers are human and we make mistakes. In the field of telemedicine, there has been a fundamental shift of clinical responsibility to the network engineer. No, we are not directly responsible for clinical care however, if a clinical process relies on telemedicine then the network engineer becomes a critical component of the clinical process. I believe that anyone involved in telemedicine should develop a strong bond between the clinical and technical staff. The network engineers need to understand that the clinical services are the most important application running on the network. In addition, the clinicians should try to understand the most of us are not trained in medicine so our perspective of what is "important" tends to lean towards the technical side of things. I have seen some pretty heated debates between clinicians and network engineers on the topic of who has a more important role in telemedicine.

JP: *What are the 3 biggest changes in IT/Networks that you have seen in the last 1-5-10 and what has been the effect (if any) on VA health care?*

CD: I started in the VA prior to there really being any PC's on peoples desks. I would have to say

VHA Telehealth Trailblazers

(Continued from page 11)

without question that the biggest advance in IT has been the personal computer, that pretty much goes without saying I suppose. But from a networking side of things I would have to say the biggest advancement has surfaced on two fronts in the VA. The first has been a vastly improved network infrastructure on a national scale. We have a pretty robust network of hospitals and I think anyone would be impressed with the level of networking expertise that we have in the VA. Some of the best networking engineers in the entire country work for the VA in my opinion. There is a lot of "in the trenches" networking happening in the VA and we have good people doing incredible things on a daily basis. You simply have to have very capable people in order to maintain a network of over 150 hospitals and 600 or so clinics.

JP: *What may be headed our way in terms of VA health care delivery via the VA Network?*

CD: From a networking standpoint I would say that you will see a lot more wireless and mobile technologies. I think we will see more and more clinical uses of mobile devices. I see a kind of trend developing for working at a patient's home, using telemedicine to augment clinical care at home. As the industry develops more mobile technology, we will see the clinical care being pushed closer to the patient's home.

JP: *Any new developments with the VA Satellite in terms of two-way communication?*

CD: Yes. VISN 8 in cooperation with the Volunteers of America Florida (VOAF) have a mobile clinic. It is literally a CBOC on wheels that was specifically designed to provide care for our homeless veterans. The unit even includes a full dental clinic. We are currently outfitting the unit with a mobile GPS self positioning satellite system. We are also in the process of installing 2 way satellite dishes at Miami, Puerto Rico and the North Florida VA Healthcare system. We are beta testing some very exciting satellite technology which is not yet available to the public. The intent is to have the mobile clinic seamlessly connected to VISN 8 facilities and to utilize telemedicine technology to improve the care to our homeless veteran population. We have a lot of work to do with regard to testing applications and ensuring security of data, but I believe that we will fully succeed. It will be very satisfying to see a mobile clinic serving our veterans and outfitted with advanced communications and telemedicine technologies. It can operate literally anywhere in this hemisphere and will be a dramatic improvement to the quality of healthcare for our homeless vets.

JP: *As you know, we have a big push this year for 'Home Telehealth', do you have any direct involvement with connections into private or group residences of veterans?*

CD: I suppose that the mobile clinic is directly related to this question. In the case of the mobile clinic, our patients do not have a home so we bring the clinic to them. Actually, we could bring the clinic into any situation that would warrant needing emergency medical care (such as a disaster), with access to a pool of specialists.

JP: *Why is the VA the best place right now to be a Network Engineer?*

CD: Because of our mission. I cannot think of a better application of my networking skills than helping veterans and supporting healthcare. It does not hurt that the VA probably has one of the most complex network of hospitals in the nation, and probably the world. It has been a living network laboratory for me the last 16 years and we truly do have a very comprehensive computer network.

OI/OCC CALL FOR INPUT: Home Telehealth Patient Registration Data

By Dan Maloney, MS EE

The Office of Care Coordination (OCC), through the Home Telehealth Program, is currently putting medical devices in patient homes to improve the quality of care and standard of living for veterans throughout the U.S. From the technical point of view, each vendor's medical device communicates with their central collection system (or server) located behind a VA firewall at the Austin Automation Center (AAC). A critical function of the Home Telehealth systems will be their ability to communicate with existing Veteran Health Administration (VHA) computer systems, including VistA. An important part of this communication is the ability to accurately link the patient records in the different systems. This linkage of records is best done by automating the initial

patient registration process in order to eliminate manual data entry errors. For the Home Telehealth systems, this registration process will be initiated by a VistA option

accepted and used both nationally and internationally. Since the publication and widespread implementation of HL7, in 1990, use of the standard has slashed interface

costs by specifying the meaning of events that trigger information flows and the definition of the data fields that flow between systems.

Home Telehealth vendors that will participate as part of the up-coming VHA national contract will be required to incorporate into their systems the ability to accept and send

HL7 messages. At this time the Home Telehealth Program is requiring support for two major messaging events, patient registration and observations transfer. VHA's national contract included detailed definitions of the required HL7 messages.

In support of the registration process, Home Telehealth vendors are required to accept the HL7 registration message, ADT_A01, and provide an acknowledgement. From a VistA menu, the Care Coordinator will select the patient from the list of VistA registered patients and then select the Home Telehealth

(Continued on page 14)

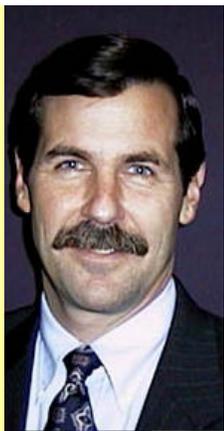
The OI Program Office for Home Telehealth and the OCC are soliciting input on the data requirements of the CCHT patient registration event. If you know of (additional) data fields required to successfully register patients into a Home Telehealth system, Please forward the information to:

hometele_HL7@med.va.gov

that will send an Health Level Seven (HL7) registration message to the Home Telehealth vendor system. The Home Telehealth systems will also use HL7 messages to send information back to the VHA systems.

HL7 is the VA-adopted standard for the exchange of data that supports clinical patient care, and the management and delivery of healthcare services. Exchange is accomplished by defining the protocol for exchanging clinical data between healthcare information systems. As a standard, HL7 is widely

Dan Maloney is Director of Emerging Health Technologies in the Chief Information Office of the Veterans Health Administration within the Department of Veterans Affairs. His major responsibilities involve identifying and piloting emerging technologies that meet existing business



CCHT PATIENT REGISTRATION DATA (Continued)

(Continued from page 13)

vendor service. The message will then be sent from the VistA system to the VA's Vitrea Interface Engine for distribution to the appropriate Home Telehealth system. This process will simplify the registration process for the care coordinator, decrease errors generated by manually entering data, improve data quality and ensure that an accurate link can be made between the patient record in VistA and the record in the Home Telehealth system. Critical requirements in the registration message exchanges are the accurate transfer and storage of the name, social security number and VA's Integrated Control Number (ICN). The ICN is a critical patient identifier data element, linking the Home Telehealth patient data to other medical records stored within any other VHA medical system. Ultimately, the ICN must be stored with the other unique patient identifier information as part of the vendor system and maintained throughout the life of the patient within that system. A sample message structure has been documented to support this interface and can be found on the Home Telehealth Project Web Site at URL: http://vaww.va.gov/techsvc/projects/HomeTelehealth_docs.html.

Observation data will flow from the vendor systems back to a VA central storage system (Health Data Repository - HDR). The sample messages for this data have also been developed and can be found on the Home Telehealth Project Web Site at URL: http://vaww.va.gov/techsvc/projects/HomeTelehealth_docs.html.

Ultimately, this exchange of data will enable all appropriate VHA healthcare providers to access home telehealth data using the Computerized Patient Record System (CPRS) workstation application.

**It is widely understood that Patient Name, Social Security Number, ICN, Date of Birth, VistA user name and Initiating Facility will all be components of the HL7 registration message. Permanent address and diagnosis are other possibilities. The message structure... ..will support a much wider range.... ..If you know of (additional) data fields required to successfully register patients into a Home Telehealth system...
Please forward the information to: hometele_HL7@med.va.gov**

At this time the Office of Information (OI) Program Office for Home Telehealth and the OCC are soliciting input on the data requirements of the registration event. It is widely understood that Patient Name, Social Security Number, ICN, Date of Birth, VistA user name and Initiating Facility will all be components of the HL7 registration message. Permanent address and diagnosis are other possibilities. The message structure, currently identified, by the VHA Home Telehealth HL7 specification will support a much wider range of data elements without major changes. If you know of additional data fields that are required to successfully register patients into a Home Telehealth system please forward the information to the following email address. hometele_HL7@med.va.gov

Additionally, if you have any questions or other comments on the Home Telehealth messaging information provided above, please feel free to send an email to the same address.



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.

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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 August 2004.
