Virtual Care in Context During COVID-19:

VA Telehealth in Primary Care, Community Care Urgent Care, and State Veterans' Nursing Homes

CORE Cyberseminar Series

July 7, 2021

CONNECTED CARE

Announcements

1. Schedule of VC CORE 2022 Cyberseminars: 1st Wednesdays at 1 PM EST
   - February 2
   - May 4
   - October 5
   - If interested in presenting in February, please contact VHAVirtualCareCORE@va.gov
2. Network Update and Open Forum: Monday, December 6, 3 PM EST
   - Email VHAVirtualCareCORE@va.gov for invite

Presenters

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Telehealth Services in Primary Care at the VA Greater Los Angeles Healthcare System during COVID-19

Claudia Der-Martirosian, PhD

Core Investigator | Health Research Scientist

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VA HSR&D CYBERSEMINAR

December 1, 2021, 10am PT (1pm ET)

VA | U.S. Department of Veterans Affairs

Background & Objectives

- Use of real-time synchronous video technologies has been increasing at the VA in the past two decades
- With the onset of COVID-19, there was a rapid expansion of video-based care at the VA, nationwide
- Primary care (PC) is a gateway to all other care in the VA
- This study examines the use of telehealth services in PC at one VA medical center, Greater Los Angeles (GLA) during COVID-19

Study Aims

- **Aim 1**: To examine the use of telehealth services in PC at GLA during COVID-19
- **Aim 2**: To identify patient, provider, and site characteristics of telehealth use at GLA during COVID-19
- **Aim 3**: To understand barriers and facilitators to the implementation process of telehealth services at GLA during COVID-19

Study Methods

- Mixed Methods (9-month rapid study, parallel Q/Q)
  - VA administrative/clinical encounter data from VA Corporate Data Warehouse (CDW)
    - Study Cohort: at least one PC visit at GLA 12-months prior to March 1, 2020

	Onset of COVID-19	Number of Visits	Number of Patients
Primary Care	Before	299,881	64,361
	After	247,849	48,729

  - One-on-one, 45-minute interviews with GLA clinicians & other staff
    - Study Participants: 19 interviews w/ physicians, NPs, LVNs, RNs, SWs, MSA supervisors, and other staff at GLA PC clinics
    - July – October 2020

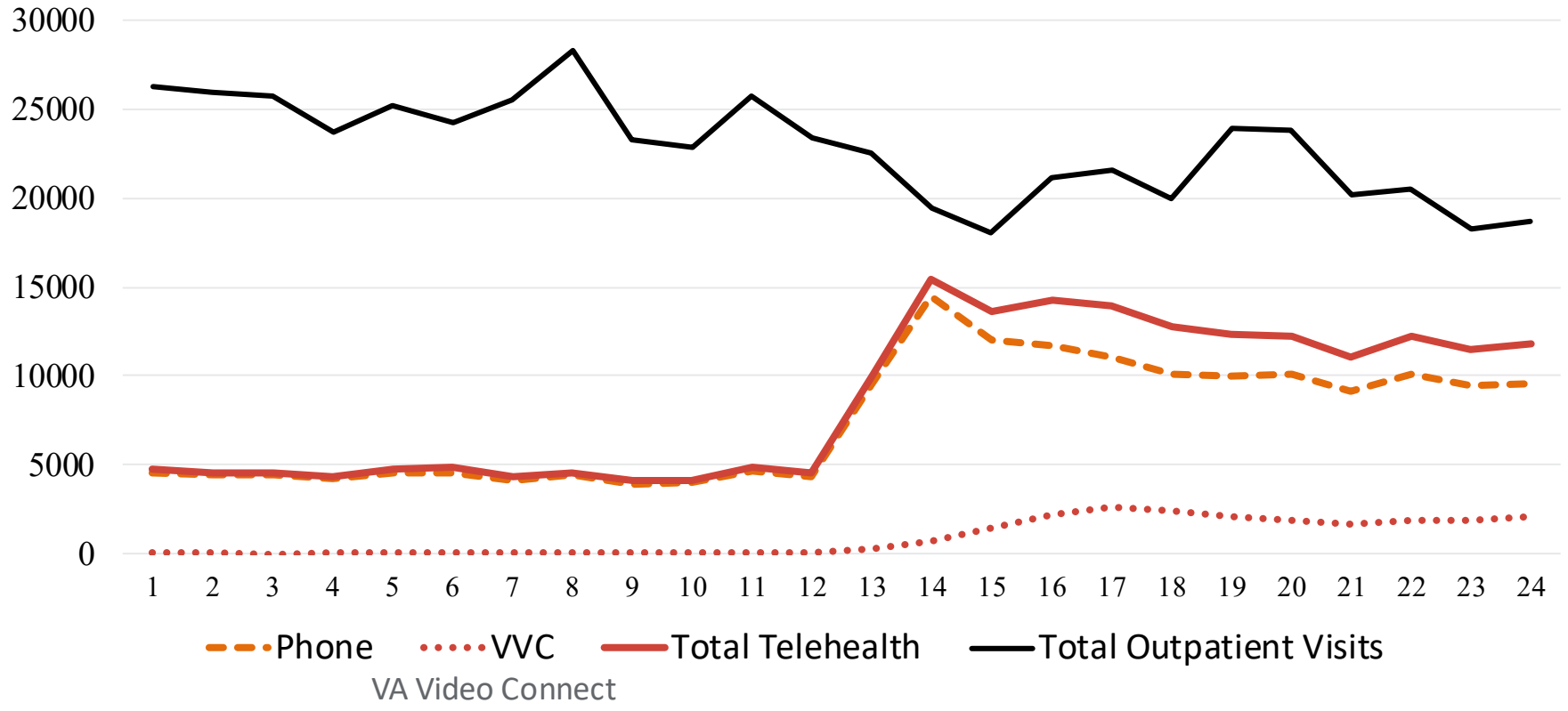
Analytic Approach

- **Quant**: Individual-level interrupted time series analysis using segmented logistic regression (predicting telehealth use) on repeated monthly observations over 24-months* (Aims 1 & 2)
  - Four segments:
    A) pre-COVID
    B) onset of COVID (stay-at-home orders)
    C) lifting of stay-at-home orders
    D) start of the 2020-2021 flu season
  - Study covariates: age, gender, race/ethnicity, marital status, health insurance, health risk factors (Nosos)
  - Adjusted for patient- and provider-level clustering
- **Qual**: Rapid content analysis (Aim 3)
  - all interviews were transcribed and summarized into major themes

*12-months before and 12-months after onset of COVID-19 (set at March 1, 2020)

Telehealth Modality

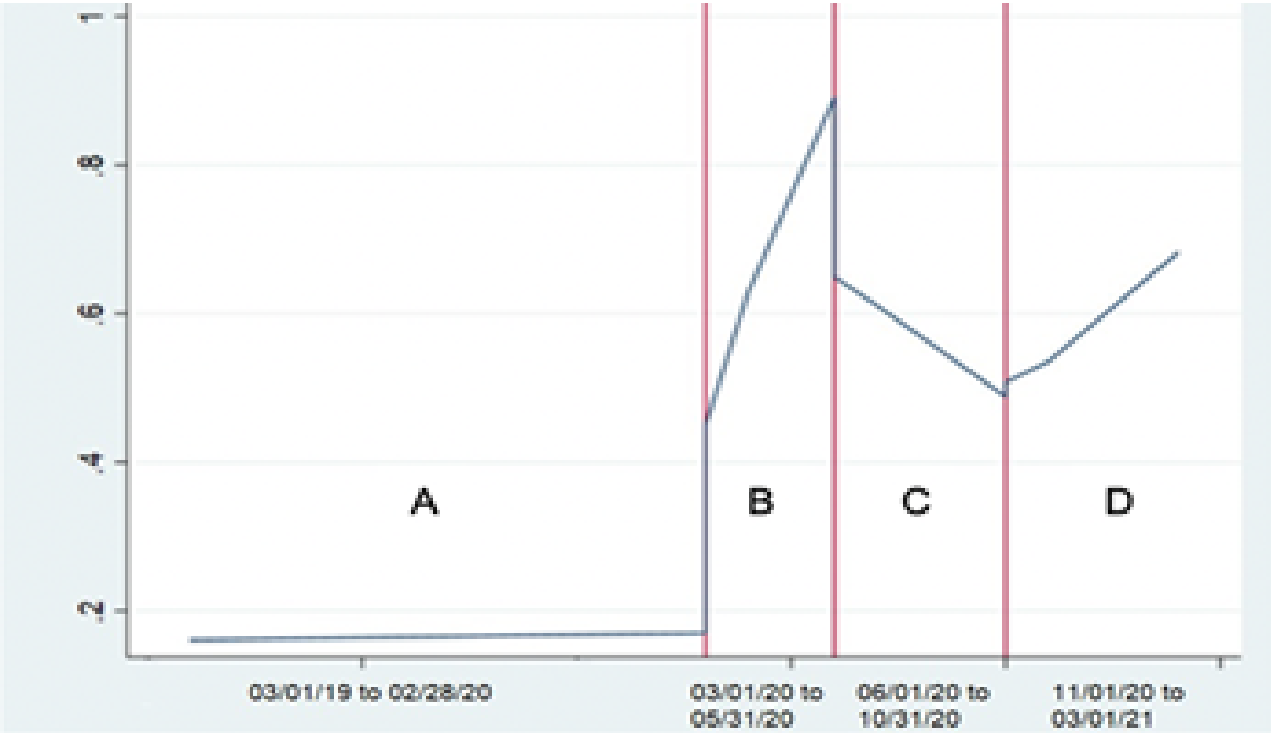
Figure 1*. Total Number of Outpatient Encounters in Primary Care at GLA (March 2019 through March 2021) by Care Delivery Method



*Der-Martirosian C, Wyte-Lake T, Balut M, Chu K, Heyworth L, Leung L, Ziaeian B, Tubbesing S, Mullur R, Dobalian A Implementation of Telehealth Services at the VA during COVID-19.JMIR Formative Research. 2021;5(9):e29429 URL: https://formative.jmir.org/2021/9/e29429. DOI: 10.2196/29429

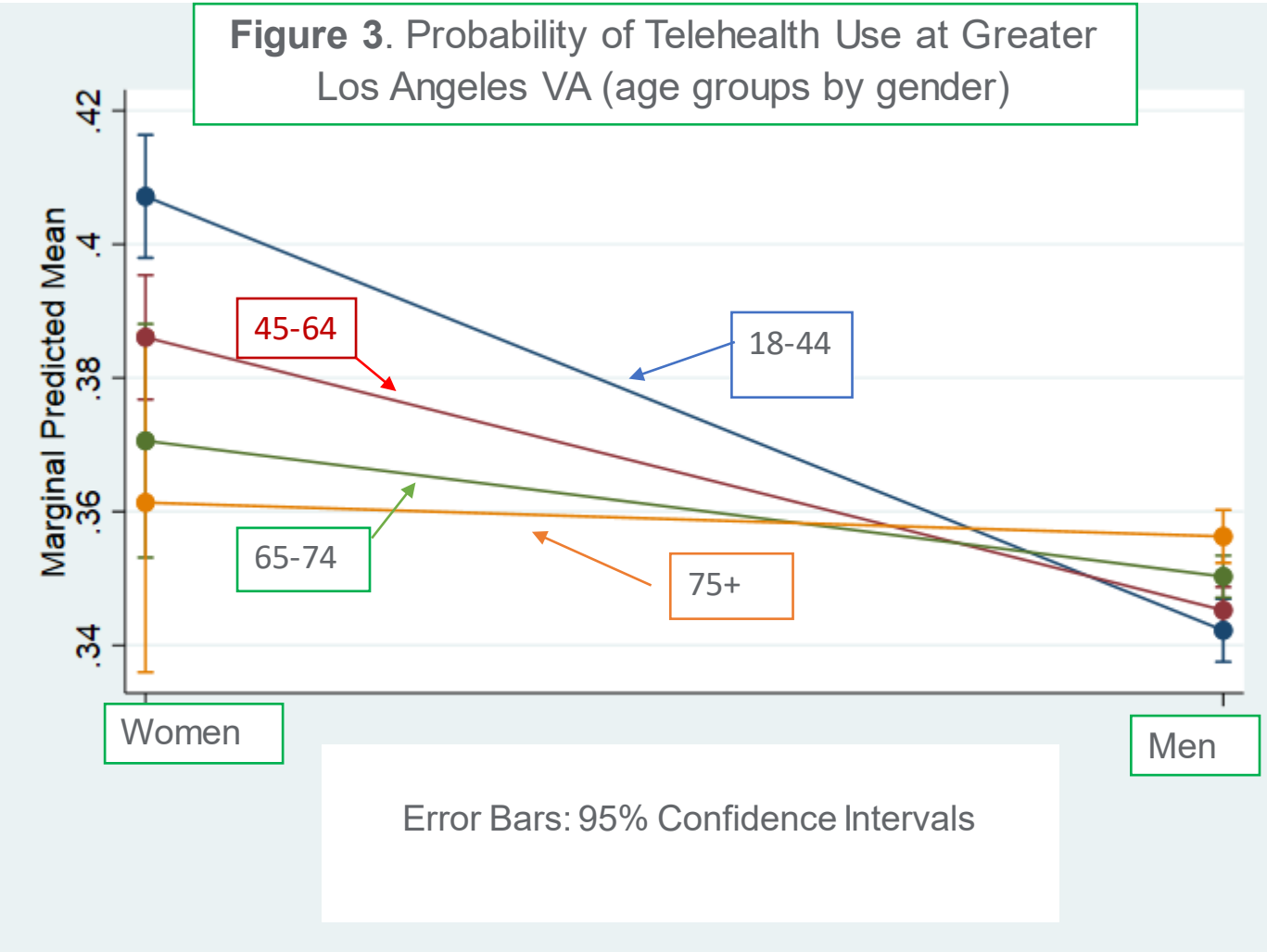
Telehealth use by stay-at-home orders

Figure 2. Probability of Telehealth Use at Greater Los Angeles (March 2019 through March 2021)



(A) Before COVID-19
(B) Stay-home-orders initiated
(C) Lifting of stay-at-home orders
(D) Re-instating of social-distance policies for flu season

Telehealth use by gender & age



Results

Women are more likely to use telehealth services* in PC compared to men, except for older Veterans

Ages 18-44:
Women (40.7%)
Men (34.2%)

Ages 45-64:
Women (38.6%)
Men (34.5%)

Ages 65-74:
Women (37.1%)
Men (35.0%)

Ages 75+:
Women (36.1%)
Men (35.6%)

*Telephone or video

Telehealth use by race/ethnicity

- VA GLA Primary Care Patients:
  - 43% White
  - 21% Non-Hispanic African American
  - 18% Hispanic

Race/Ethnicity*	Telehealth Use** Odds Ratio (95% CI)	Video Care Odds Ratio (95% CI)
African American	1.09 (95% CI: 1.05-1.13)	0.76 (95% CI: 0.69-0.83)
Hispanic	0.93 (95% CI: 0.89-0.96)	0.85 (95% CI: 0.77-0.93)
*Reference Category: White **Telephone or Video		
Adjusted for: age, gender, race/ethnicity, marital status, health insurance, health risk, provider type, site type, as well as patient- and provider-level clustering		

Telehealth use by provider type

VA has a complex team-based primary care model, which is patient-aligned care teams (PACT) with interdisciplinary teams of clinicians:

- physicians (MD), nurse practitioners (NP), patient assistants (PA), registered nurse (RN) care managers, licensed vocational nurses (LVN), pharmacists (Pharm), medical assistants (MSA), nutritionists/dieticians (DT), social workers (SW), mental health providers (MH)

Provider Type*	Telehealth Use** Odds Ratio (95% CI)	Video Care Odds Ratio (95% CI)
Social Workers, Pharmacists, Dietitians	5.05 (95% CI: 4.81-5.31)	0.15 (95% CI: 0.13-0.16)
Mental Health Providers	1.84 (95% CI: 1.46-2.31)	17.02 (95% CI: 11.54-0.25.11)
*Reference Category: MDs, NPs, PAs (combined in one group) **Telephone or Video		
Adjusted for: age, gender, race/ethnicity, marital status, health insurance, health risk, provider type, site type, as well as patient- and provider-level clustering		

Telehealth use by site type

- VA has a main medical facility, which is often connected to surrounding community outpatient centers; they are often located in less urban/rural areas.
- This study includes West LA (main medical facility) vs. all surrounding community clinics

Site Type*	Telehealth Use** Odds Ratio (95% CI)	Video Care Odds Ratio (95% CI)
West LA Medical Facility	0.52 (95% CI: 0.49-0.53)	2.06 (95% CI: 1.92-2.23)
*Reference: Category: Community-based outpatient clinics **Telephone or Video		
Adjusted for: age, gender, race/ethnicity, marital status, health insurance, health risk, provider type, site type, as well as patient- and provider-level clustering		

Barriers & Facilitators

Barriers to telehealth use:

- Patient's access to technology, and camera-enabled devices and internet connectivity
- Lack of IT support
- Scheduling challenges
- Patient preference
- Type of service/visit

Facilitators to telehealth use:

- Prior telehealth experience
- Telehealth champions
- Reorganization of workflows
- Peer-to-peer provider trainings
- Assisting patients (video/IT consultations)
- VA iPad program

Interview Quotes

"I think it was February or March [2020] that we really had a large push to do more telemedicine because of the pandemic. And at that time, we were using a lot more telephone visits and trying to push VA Video Connect (VVC) whenever possible. Telephone visits certainly were a lot more widespread because of the technology that was used, and most of the patients have regular telephone technology available." [Physician]

"Primary care is large, and so we had to have provider champions. We had to have nursing champions. We have MSA champions. And those people are the superusers, I guess. And so, staff would be able to go to them, e-mail them about different questions or issues they were having." [Nurse Manager]

Study Limitations

- This study is based on one VA medical facility (GLA) and surrounding community clinics that are in an urban/suburban area, which limits the generalizability of study findings to other VA facilities
- The patient population served by GLA, and surrounding community clinics, might differ from other VA facilities in California and other states, which further limits generalizability
- Telehealth use within VA may not be generalizable to other non-VA healthcare systems
  - However, lessons learned might be applicable to non-VA systems, as well as other VA facilities
- The study did not have access to other provider or site variables, such as provider's age, provider's comfort with telehealth; or site IT resources or telehealth trainings and champions

Conclusions

- Implementation of complex healthcare delivery methods, such as telehealth services at a large integrated healthcare system (VA), requires multi-level evaluations
- At the patient level, racial/ethnic, gender, and age disparities in telehealth/video use can help us understand the digital divide and how access to telehealth services can be improved for all patients
- At the provider level, a greater understanding of which types of PC providers are more/less likely to use phone vs. video, and which types of PC services are better suited for phone vs. video, can better guide integration of telehealth services in clinical practice
- At the site level, differences may allude to various factors affecting phone/video use, such as urban vs. less urban or rural areas, or differences in site infrastructure, support, or resources
- Multi-level assessment can help standardize implementation of telehealth, especially video-based care, to maximize efficiency, increase access to care, improve quality of virtual care, and facilitate scale-up in PC

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- This work is supported by VEMEC, Veterans Health Administration (VHA), Office of Patient Care Services (Population Health).
- The views expressed in this presentation are those of the presenter(s) and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the US government.
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Center for the Study of Healthcare Innovation, Implementation & Policy

Veterans' Use of Telehealth for VA Community Care Urgent Care During the Early COVID-19 Pandemic

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VA HSR&D Cyberseminar
December 1st, 2021

VA | U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

Disclaimers & Funding

- No Conflicts of Interest

- Views are my own; do not necessarily represent those of VA

VA Community Care (CC) Urgent Care

- Benefit established with VA MISSION Act of 2018
- VA-enrolled Veterans can use selected non-VA urgent care/ retail health clinics
- Some Veterans will pay $30 co-payment
  - Depends on priority group, number of times used in year
- Since start of COVID-19 pandemic, telehealth has been an option

Objectives

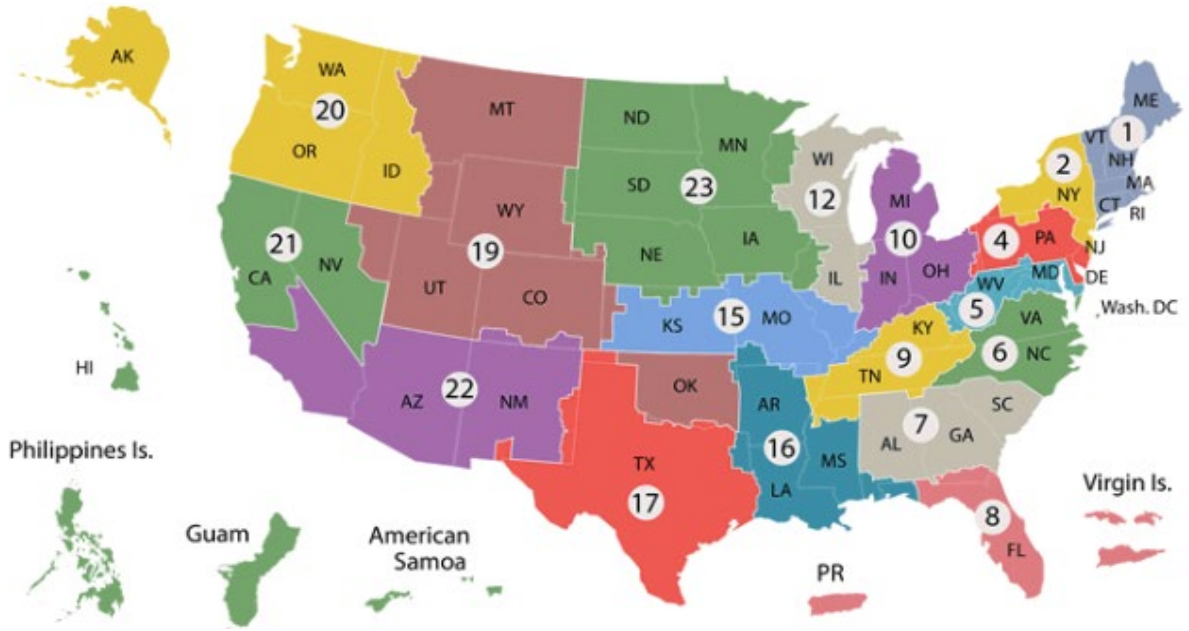
- To assess the extent to which, during the initial phase of the COVID-19 pandemic:
  - Veterans used telehealth for CC urgent care with, or instead of in-person care
  - Characteristics of Veterans who used telehealth versus in-person CC urgent care
  - Telehealth arrangements for CC urgent care
  - Veteran CC urgent care decision-making and experiences

Methods

- Convergent parallel mixed methods approach
  - Quantitative analysis of CC urgent care claims, VA clinical and administrative data
  - Performed semi-structured interviews with Veteran CC urgent care telehealth users
  - Combined quantitative and qualitative findings

Setting and Population

- Veterans residing in VISNs 21 & 22; claims within same VISNs
  - Other than Philippines, Guam, and American Samoa



Quantitative Methods

- All claims for service March 1st – September 30th, 2020
  - Received by Office of Community Care by June 8th, 2021

- Telehealth visits identified

Place of Service Code	**02**
Revenue Code	**780**
Modifier Codes	**95, GT, GQ, G0**
CPT Codes	**99422, 99423, 99441, 99442, 99443, G2012**

Quantitative Methods (cont'd)

- Veterans classified as having
  a) Telehealth visits only
     or
  b) Both telehealth and in-person visits
     or
  c) In-person visits only

- Linked to: VA Corporate Data Warehouse; VA ADUSH Enrollment File; VA Planning Systems Support Group Enrollee File; Centers for Disease Control Social Vulnerability Index

Quantitative Methods

Multinomial logit modeling –

1) Veterans w/ telehealth visits only v. in-person visits only
2) Veterans w/ tele-health and in-person visits v. in-person visits only

Predisposing Characteristics: age, gender, race/ethnicity, Charlson comorbidity index, Veteran enrollment priority group, social vulnerability index

Enabling Characteristics: urbanicity, distance from Veteran residence to clinic used

Need Characteristics: visit potentially related to COVID, having procedure usually requiring in-person visit

Qualitative Methods

- Semi-structured telephone interviews with 27 Veterans: (by claims) one or more CC urgent care telehealth visits May 28th - September 30th, 2020

- Selection quota – not more than 30% of interviews were with Veterans with COVID-related claims

Qualitative Methods

- Veterans described:
  - telehealth modality used
  - other care arrangement details
  - decision-making surrounding use of telehealth versus in-person care
  - experiences with care received
- Interviews recorded, transcribed, summarized with template, placed in matrices
- Team-based consensus-driven discussion to reveal themes

Results

- 16,815 visits by 13,469 unique Veterans
- 230 (1.4%) visits used telehealth

Type of Visit(s)	Veterans - # (%)
Telehealth Only	81 (0.6%)
Telehealth & In-person	101 (0.8%)
In-person only	13,287 (98.7%)

Adjusted Relative Risks: Telehealth Only v. In-person Only

Characteristic	Telehealth Only Visits	p-value
Age, per 1 year	0.99 (0.97, 1.00)	0.070
Gender		
Male	ref	
Female	0.74 (0.38-1.41)	0.354
Race/ethnicity		
White, Non-Hispanic	ref	
Black, Non-Hispanic	**2.22 (1.19, 4.13)**	**0.012**
Hispanic	1.39 (0.80, 2.41)	0.141
Other, Non-Hispanic	0.55 (0.17, 1.80)	0.321
Missing, Declined	1.30 (0.50, 3.37)	0.585
Charlson comorbidity index, per 1pt	0.84 (0.66, 1.07)	0.166
Veteran enrollment priority group		
1-5	ref	
6-8	0.74 (0.35, 1.56)	0.433

Characteristic	Telehealth Only Visits	p-value
Social vulnerability index, per decile	1.00 (1.00, 1.01)	0.258
Urbanicity		
Rural	ref	
Urban	**2.00 (1.00, 4.00)**	**0.049**
Distance Veteran residence to UC clinic		
<5 miles	ref	
5 to <15 miles	**3.18 (1.72, 5.87)**	**<0.001**
15 or more miles	**3.69 (1.95, 6.99)**	**<0.001**
Visit related to COVID	**2.50 (1.58, 3.93)**	**<0.001**
Visit without required in-person procedure	**24.24 (5.9, 98.9)**	**<0.001**

Adjusted Relative Risks: Tele-health+ In-person v. In-person Only

Characteristic	Telehealth + In-Person Visits	p-value
Age, per 1 year	1.00 (0.98, 1.01)	0.766
Gender		
Male	ref	
Female	0.98 (0.56, 1.70)	0.946
Race/ethnicity		
White, Non-Hispanic	ref	
Black, Non-Hispanic	1.28 (0.68, 2.43)	0.443
Hispanic	0.99 (0.57, 1.71)	0.957
Other, Non-Hispanic	**1.87 (1.00, 3.47)**	**0.049**
Missing, Declined	0.79 (0.28, 2.19)	0.648
Charlson comorbidity index, per 1pt	0.98 (0.84, 1.15)	0.827
Veteran enrollment priority group		
1-5	ref	
6-8	1.25 (0.72, 2.16)	0.429

Characteristic	Telehealth + In-Person Visits	p-value
Social vulnerability index, per decile	1.00 (0.99, 1.01)	0.739
Urbanicity		
Rural	ref	
Urban	**4.49 (2.04, 9.89)**	**<0.001**
Distance Veteran residence to UC clinic		
<5 miles	Ref	
5 to <15 miles	**1.26 (0.76, 2.10)**	**0.370**
15 or more miles	**2.70 (1.67, 4.36)**	**<0.001**
Visit related to COVID	**2.90 (1.93, 4.37)**	**<0.001**
Visit without required in-person procedure	**1.46 (0.94, 2.25)**	**0.091**

Care Modalities/Arrangements

- ~ Equal distribution of interviewees recalling care by video; telephone (no video component); in-person only (without telehealth component)
  - All recalling in-person only were for COVID-testing only
- Among in-person + telehealth:
  - Commonly reported that telehealth visit was follow-up from in-person visit
    - Provide test results, reassess symptoms
  - Less commonly in-person visit followed telehealth visit when issue not completely resolved

Care Arrangements (cont'd)

- Sometimes clinic staff saw Veteran in-person, provider was remote

> *"I sat in the parking lot while they sat inside the building. They came out and took my temperature, you know, my oxygen saturation levels, and then I talked to a doctor over the telephone"*

- Sometimes staff came to Veteran's home

> *"The urgent care showed up at my house with their portable units. And then they got the monitor out and they took my temperature and there was the whole nine yards right there…When I seen that doctor, it was by video. They set up the monitor and everything and plugged it in and got her on the thing and then I showed her what my problem was…They did all the vitals and they had all the equipment to do everything with."*

Veteran Decision-making

- In-person care often not available

> *"I drove down that morning to the urgent care and I saw the place was locked and they requested a phone visit."*

- When in-person care available, COVID-19 concerns affected decision-making

> *"My biggest fear was going in ... with other people who might be infected with COVID, right? Being a teleconference just made it very, very easy."*

Veteran Decision-making (cont'd)

- Logistics & Convenience

> *"And there was no way I could get to where I was going because I had no transportation to get there."*

> *"I didn't have to make a drive over to the urgent care, sit and wait, you know, I was able to sit at the comfort of my house, and see the provider face to face via phone."*

- Self-assessments of Severity

> *"If it had needed to go any more in-depth or involved than that it would have been an issue but so long as that person is just asking questions or, you know, just looking at something I think [telehealth] is okay."*

Veteran Experiences

- Most Veterans were highly satisfied

> *"I just love it. It's really worked—it's worked really well for me."*

- A few Veterans did have negative experiences

> *"I feel like because of the lack of actually a doctor being able to see me, I didn't get the proper care and I had to schedule a second visit with the urgent care, because they did nothing for me."*

- Most Veterans reported minimal to no technological difficulties

Summary

- Use of telehealth for CC urgent care was uncommon
- Telehealth-only users more likely to be non-Hispanic Black, live in urban communities, further from the clinic used, and have COVID-related visits
- Wide variation in telehealth modalities used
- Decision-making often influenced by clinic availability and other logistics
- Veterans were generally satisfied with care

Discussion

- Telehealth use lower than expected
  - May be explained by wide availability of telehealth within VA

- Telehealth use higher among non-Hispanic Black and other non-White/Black Veterans
  - Others have documented similar pattern among Veterans using VA care, and in general population
  - Early COVID-19 pandemic disproportionately affected Black communities

Discussion (cont'd)

- Telehealth associated with longer distance between Veteran residence and the clinic used
  - Reinforces: telehealth overcomes transportation barriers
- Veterans using telehealth were more likely to live in urban, rather than rural, communities
  - opposing direction with distance suggest that unmeasured factors may be influencing finding
    - e.g., lower broadband availability, differences in COVID prevalences/ perceptions, rural clinics retained more in-person care access

Discussion (con't)

- Telehealth was used for follow-up after in-person visits
  - May increase overall costs of Community Care
  - Would VA Primary Care follow-up for CC urgent care be more effective/efficient?

Limitations

- Claims-based data was unable to distinguish between video and telephone visits
  - Potential racial, ethnic and community differences in video versus telephone-only telehealth?
  - How do telehealth care modalities affect care quality?
- Veterans residing in the western region of the United States
  - Are there regional differences?
- Limited to initial 7 months of pandemic
  - What has changed over the course of the pandemic?

Conclusions

- Telehealth care for VA CC urgent care, although uncommonly used in the early pandemic, played an important role in providing access to care for Veterans

- Future work should assess:
  - Changes in telehealth use with progression of pandemic
  - Potential geographic differences
  - Impacts on care quality
  - Effectiveness & efficiency of follow-up care coordination
  - Veteran outcomes
  - Impacts on costs

Thank you

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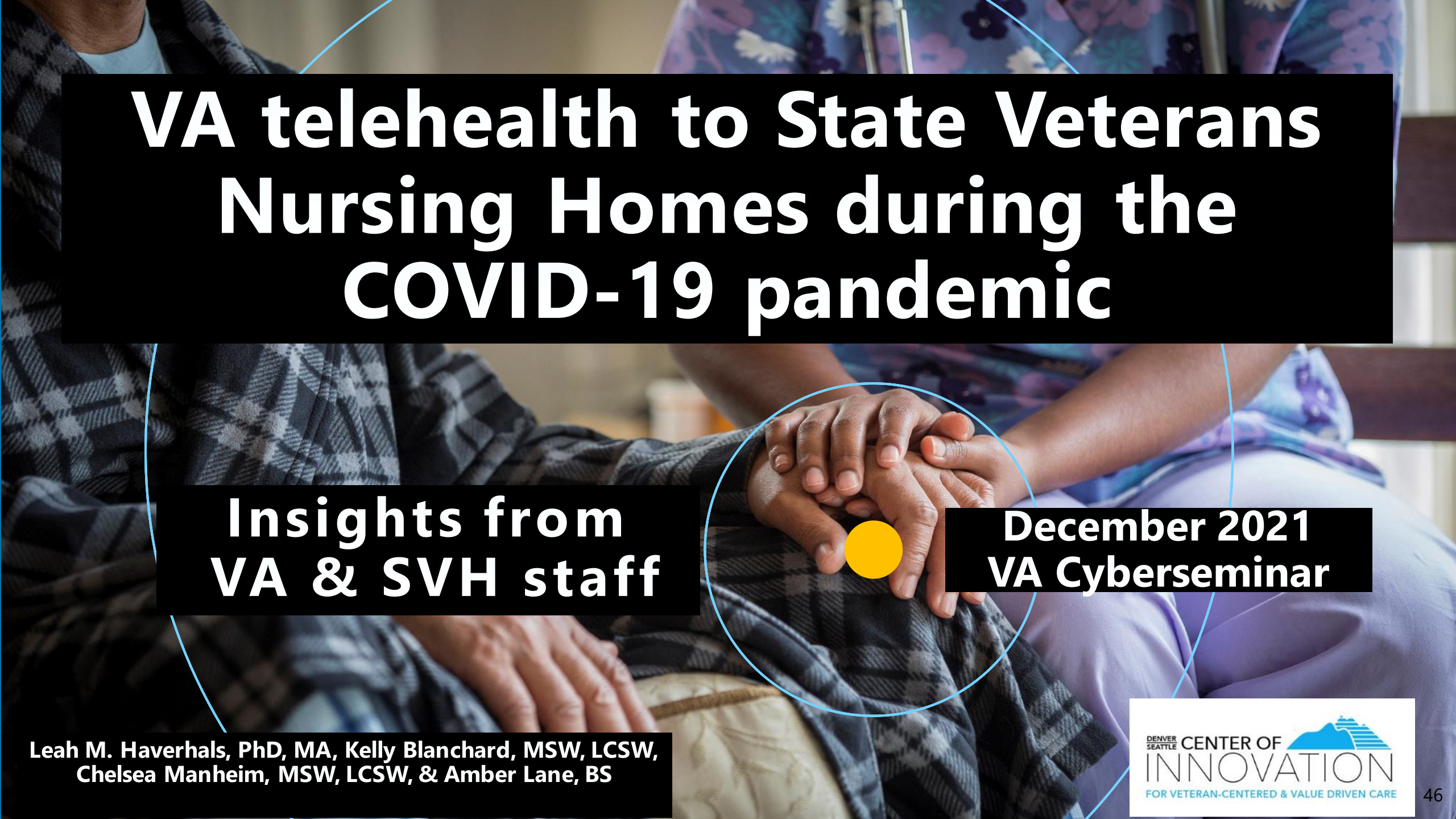


VA telehealth to State Veterans Nursing Homes during the COVID-19 pandemic

Insights from VA & SVH staff

December 2021
VA Cyberseminar

Leah M. Haverhals, PhD, MA, Kelly Blanchard, MSW, LCSW, Chelsea Manheim, MSW, LCSW, & Amber Lane, BS

DENVER SEATTLE CENTER OF INNOVATION
FOR VETERAN-CENTERED & VALUE DRIVEN CARE

OBJECTIVE

Conduct Needs Assessment Surveys & In-Depth Interviews with VA & State Veterans Nursing Home staff related to changes in care delivery influenced by the COVID-19 pandemic

Our focus:

- How the pandemic influenced delivery of VA telehealth (TH) to State Veterans' (SVH) Nursing Homes
- What lessons were learned/barriers identified to overcome
- What sustainable changes can be made

“During COVID restrictions, Veterans would not have been able to see any providers had it not been for tele-visits.”

—State Veterans Home Social Worker at an Urban SVH

DATA COLLECTED

Surveys & In-Depth Interviews collected from April - July 2021 with:

- VA SVH Liaisons
- VISN Telehealth Leads
- VA Staff that attended former VA to SVH telehealth monthly call
- VA Facility Telehealth Coordinators (FTCs)
- VA TCTs
- SVH Administrators/Staff

VA & SVH Respondents of In-Depth Interviews & Surveys across 31 States/Territories

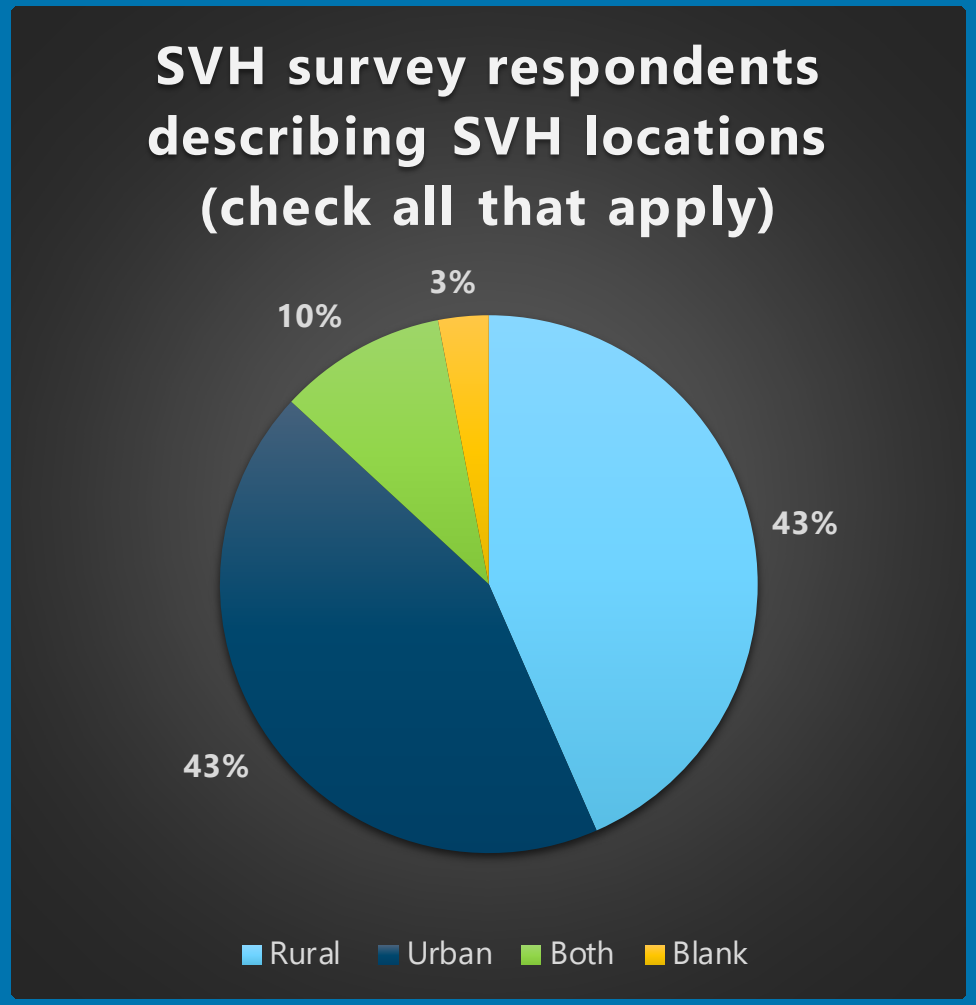
VA Staff

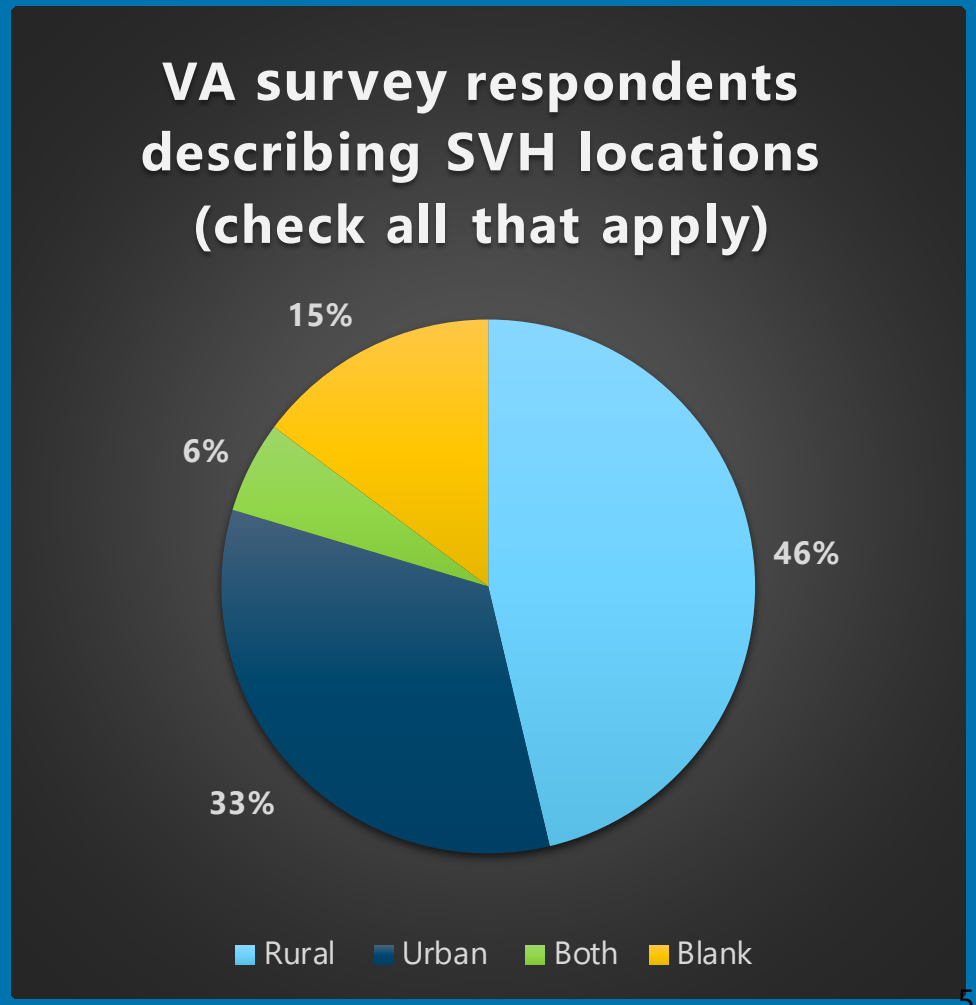
- N=18 In-Depth interviews
- N=54 surveys

SVH Staff

- N=6 In-Depth interviews
- N=30 Surveys

Rural vs Urban





COVID Changes

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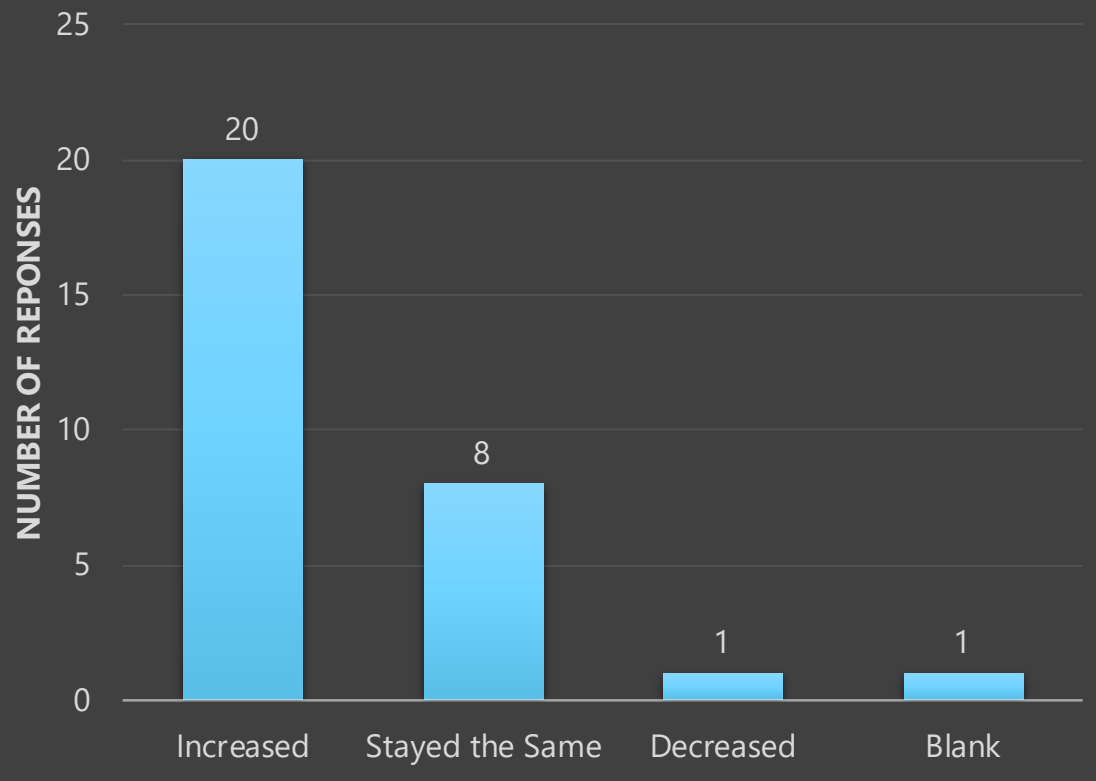
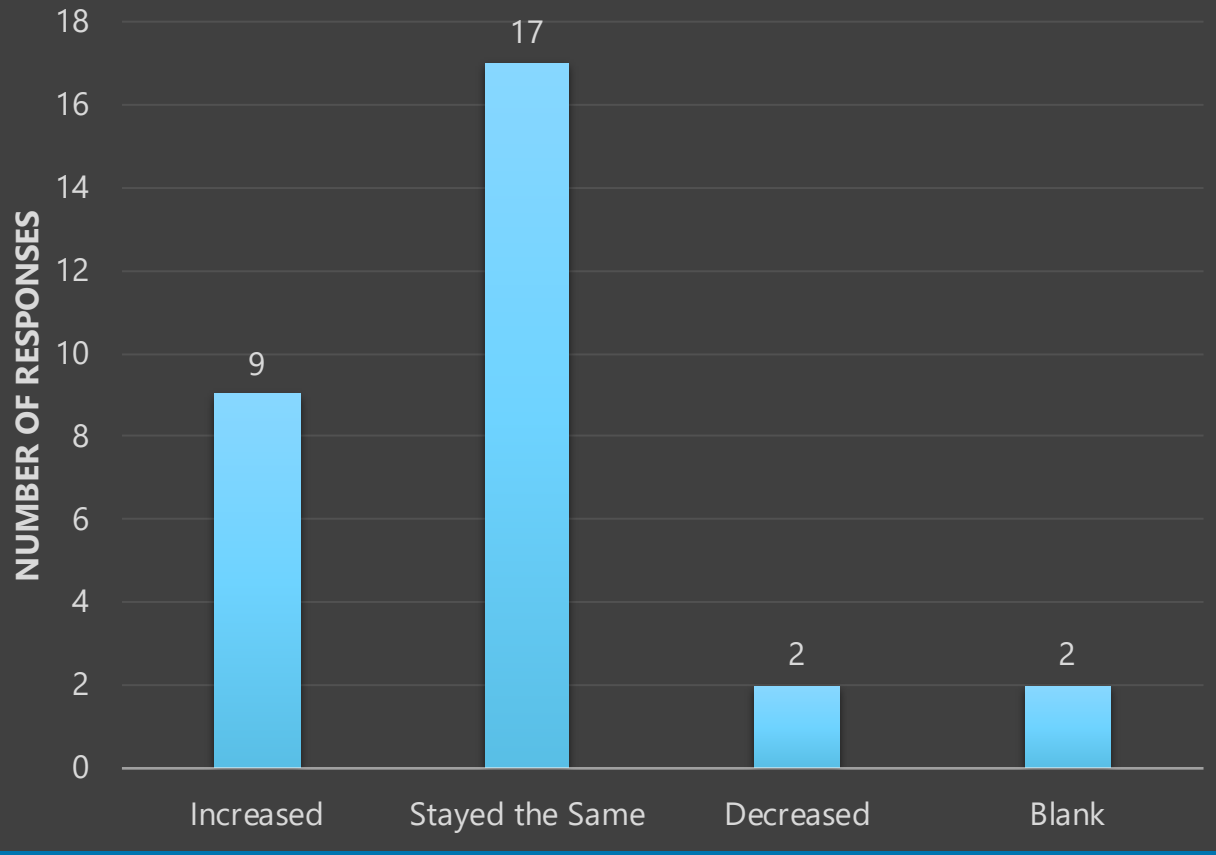
Increases in TH to SVHs (SVH Data)

66% increase in the number of Veterans receiving VA telehealth services at SVHs since the COVID-19 pandemic began

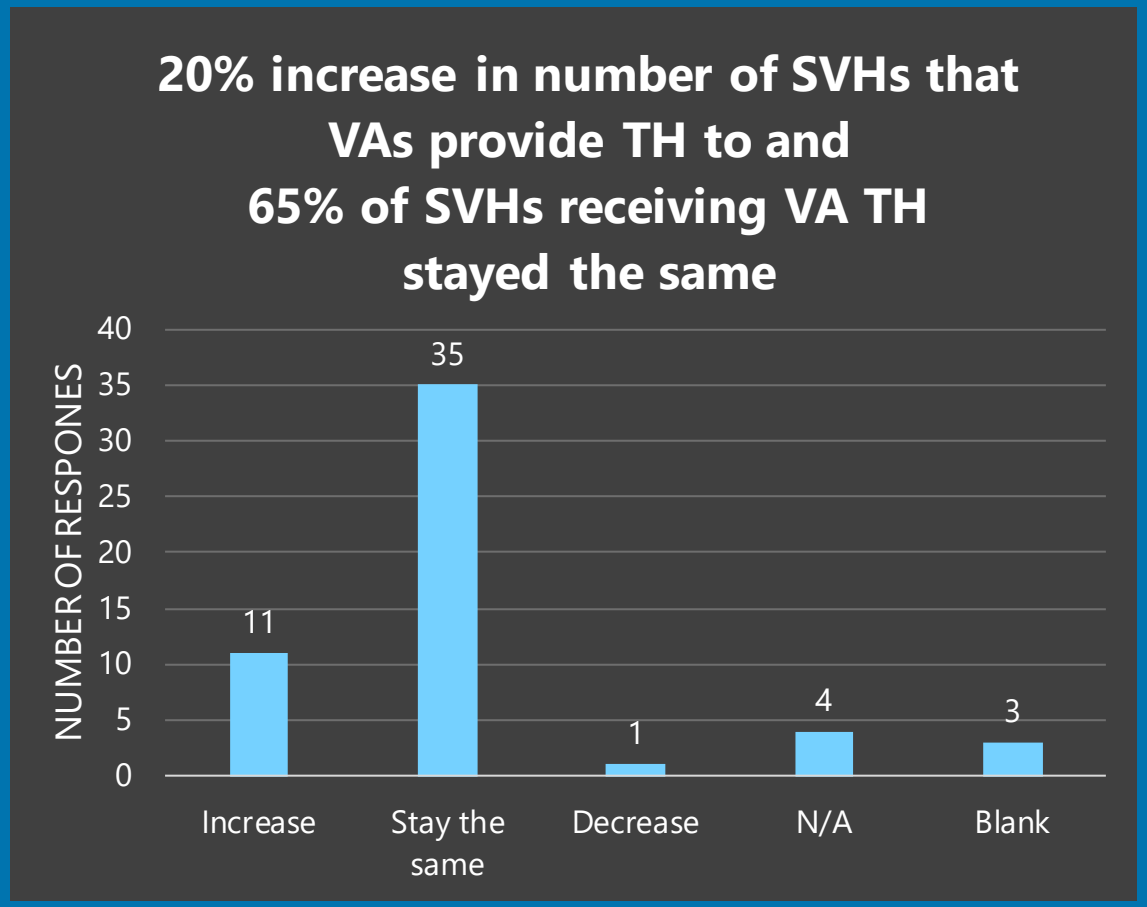


30% increase in VA telehealth visits for Veterans who received TH services prior to the pandemic



TH Changes since Pandemic Began (VA Data)

Only 10% of SVH & 13% of VA respondents noted that TH paused



"This [adding TH] was one of the first steps we made at the very beginning of the Pandemic and truly made a difference in the care of our Veterans."

— VA FTC & Nurse Manager

Increases in & Challenges to VA TH Delivery (SVH Data)

Reasons TH care increased

- 37% (11/30) started for the first time due to pandemic
- Increase facility safety
- Could not go to in-person visits so pivoted to TH
- Some VA specialties only doing TH during pandemic
- Did not need TH before pandemic

Reasons TH care decreased / paused / could not begin

- TH providers left VA
- Connectivity issues
- Did not have correct equipment
- Executing MOUs problematic before COVID

TH Changes Since Pandemic Began (VA Data)

"When I came back from spring break, life was not what it was the week before and that's how fast it changed at the state home. I was not allowed to be at [the SVH] at all at that point in time."

— TCT

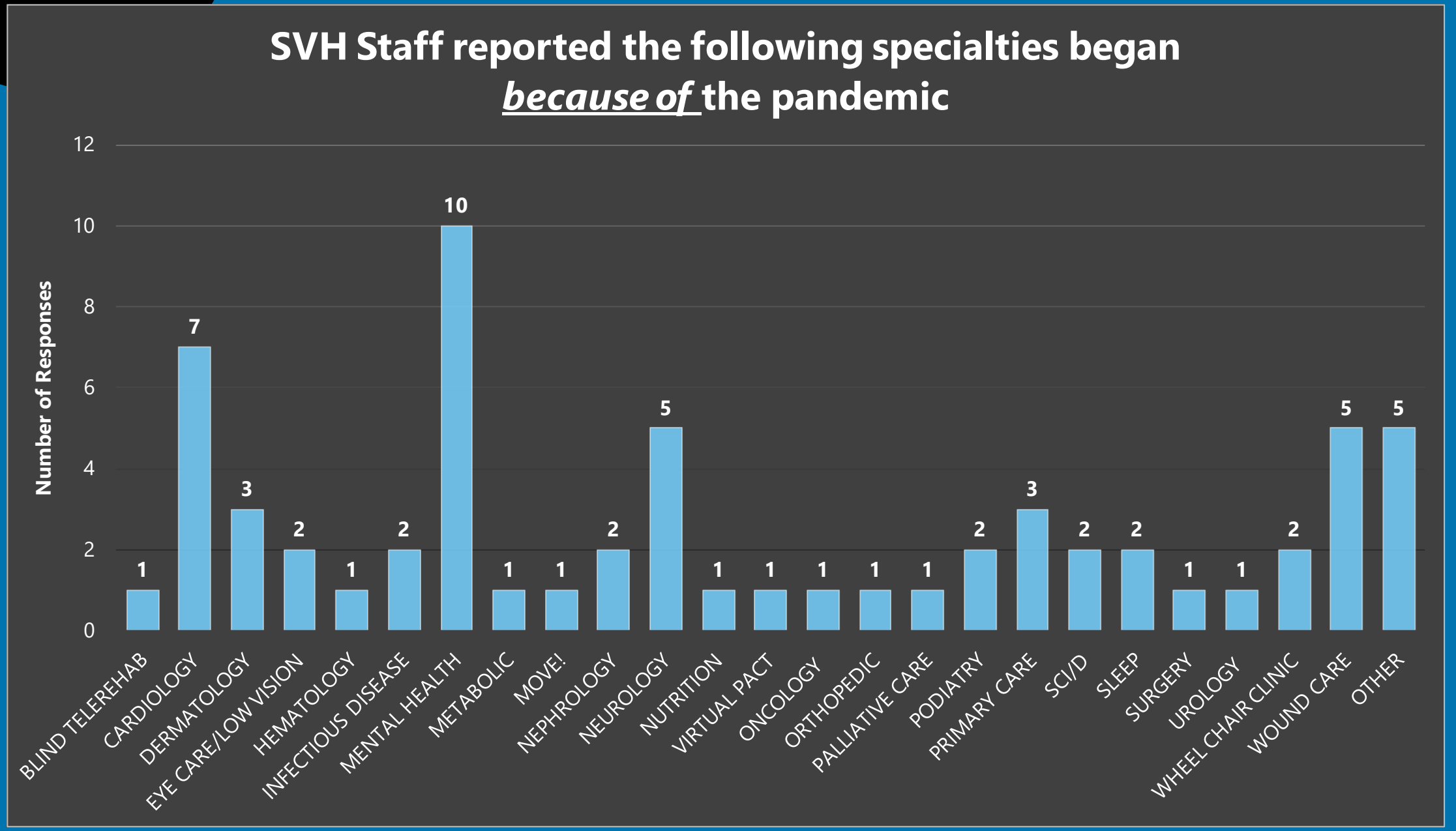
"I would say when positivity rates really, really went through the roof at the State Veterans Home, which it did, I would say that the decrease was there specifically, just because of, not only, not only had the State Veterans Home been hit hard, but the staff working in the State Veterans Home got hit pretty hard."

— FTC

"I would say limited to the fact of pandemic and then once that hit, it's gonna be a broken record for a lot of us. It will be... a little bit of buy-in, but once the pandemic hit, specially when everything was on lockdown, they realized the viability of it [TH], and they realized the ease of it [TH], and so, yeah, the adoption of it was very high."

— FTC

SVH Data

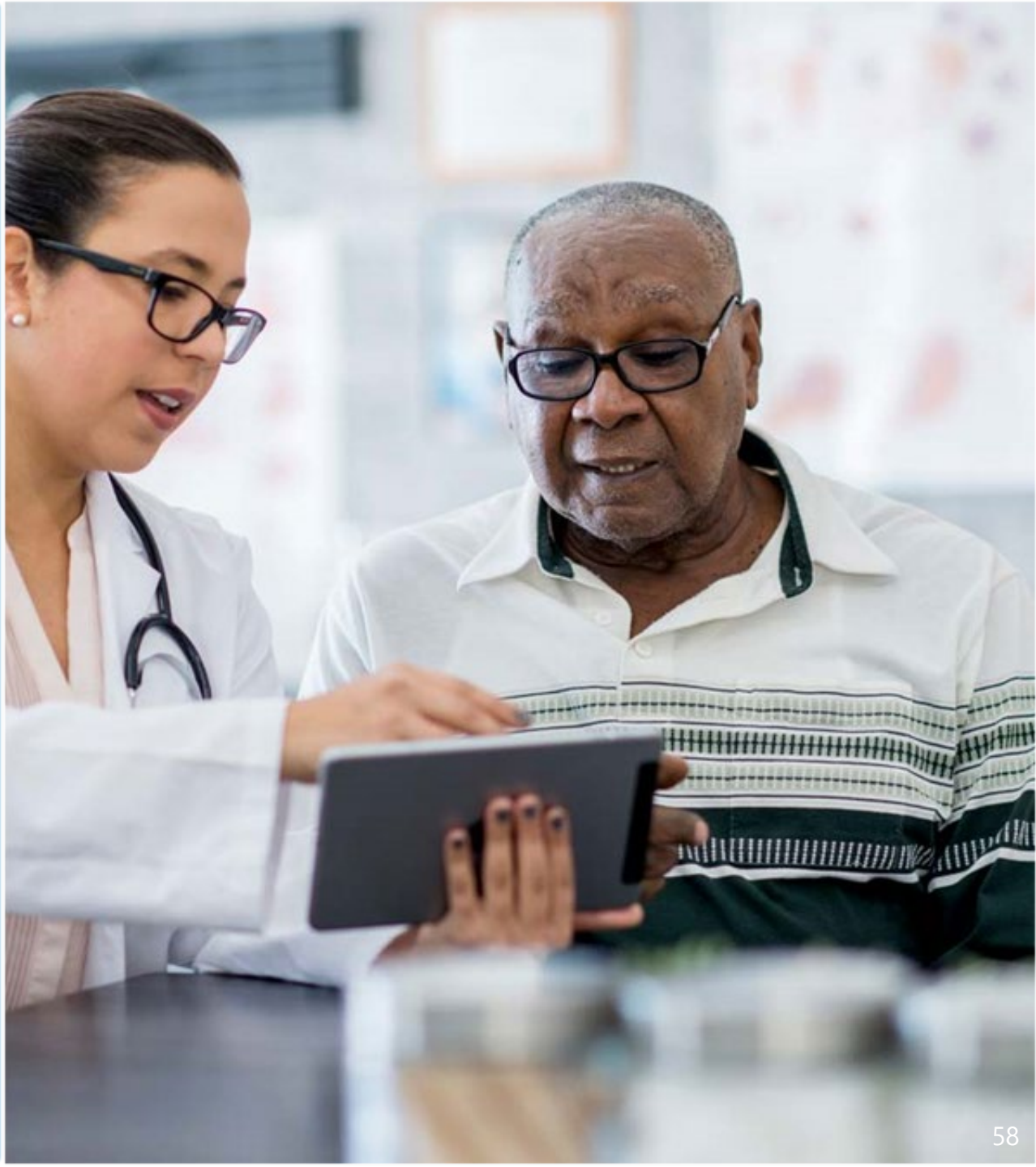

SVH Staff reported the following specialties began *because of* the pandemic
Number of Responses
0
2
4
6
8
10
12
1
7
3
2
1
2
10
1
1
2
5
1
1
1
1
1
2
3
2
2
1
1
2
5
5
BLIND TELEREHAB
CARDIOLOGY
DERMATOLOGY
EYE CARE/LOW VISION
HEMATOLOGY
INFECTIOUS DISEASE
MENTAL HEALTH
METABOLIC
MOVE!
NEPHROLOGY
NEUROLOGY
NUTRITION
VIRTUAL PACT
ONCOLOGY
ORTHOPEDIC
PALLIATIVE CARE
PODIATRY
PRIMARY CARE
SCI/D
SLEEP
SURGERY
UROLOGY
WHEEL CHAIR CLINIC
WOUND CARE
OTHER

Models of Care

TH Care Technician (TCT) going to the SVH

Or

SVH assisting in visits



SVH Perspectives on VA TH Visits

"At this time, [TH is] more work for staff coordinating and conducting the visit, however, it is better for the resident. May need to work on workflow internally to improve the user experience and to become more efficient."

–SVH Manager

"Having a telehealth option allows the resident to be seen in their original environment and does not require extra staff/services for transport."

–SVH Supervisor

63% of SVH staff felt TH visits increased efficiency for SVH Staff, including increasing access to care & decreasing travel and demand on Veterans & Staff

"The Nurse is able to present and is able to answer more questions and convey the residents' concerns. The nurse will know the plan of care expected after the visit. If a resident goes out of the facility to an appointment and we do not have notes when they return the staff does not know what is discussed at the visit until the typed notes arrive. Residents will often not be able to answer the questions or be able to express the concerns on why they needed the specialty appointment."

–SVH Manager

VA Perspectives on TH Visits

"I think for some individuals travelling to the VA is difficult and the VA being able to come to them is a blessing. Their needs are being met in a more timely manner with the use of telehealth."

–VA Liaison to SVHs

Saves:
Staff Time
Travel Time
Money

Decreases:
Wait Times
Infection Risks

"Less missed opportunities, less risk of infection spread during the pandemic."

–VA Liaison to SVHs

"It (telehealth) provides the Veterans a means to 'see' their provider and interact with the staff. The SVH does not have to rely on transporting Veterans to appointments in bad weather, when the Veteran is unable to travel due to illness, injury or refusal. It can save time and money to have a visit where an issue can be addressed via video instead of traveling to a VA. There are so many reasons why this is a great service."

–VA Vocational Rehabilitation Specialist

Telehealth Barriers to Overcome

Strategies to Address Barriers

Technology

- Collaborate with VA IT & BioMed
- Use static link for VVC
- Specific SVH staff emails for VVC
- Prep/start device in advance of TH visit
- Request more iPads

Veteran Needs

- Secure adequate equipment
- Request peripherals for proper exam
- TH Room in quiet area, no disturbances
- Place call button next to Veteran to get assistance if needing during TH visit
- TH visit reminder the day before

Staff Needs

- TCT has access to VA records & can print on site at SVH
- SVH provide names of staff who need training
- VA provide trainings remotely

Communication

- VA provide updated phone numbers for tech/VVC support & specialty care
- SVH provide staff numbers to VA of who assists for TH
- Use established contacts to connect to others

TSAs/MOUs

- Connecting with the needed SVH Staff
- Leadership on board at SVH & VA

Conclusions

Sustainable changes that can be made: How to best continue to build connections to improve delivery of VA to SVH telehealth services

VA TH increased during the pandemic, with VA and SVH staff navigating challenges to continue coordination of care for SVH Veterans

A TH model with a TCT and a model with SVH staff assisting in TH visits can be effective, but POCs on both ends are critical

Communication & coordination are key to effectively delivering TH to SVHs and includes building strong relationships & providing appropriate equipment/training

Learning Group Sessions we held

Goal: to build relationships, partnerships, and connect sites trying to start TH to those with expertise

Audience:
VA Staff

Audience:
SVH Staff and Administrators

Audience:
Both VA and SVH Staff

Questions?

THANK YOU

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THANK YOU!

Questions

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@VA_VCCORE

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