

**Statement of
Patricia Ryan MS RN
VISN 8 Community Care Coordination Service
VHA Office of Care Coordination
Department of Veterans Affairs
Before the
Sub-Committee on Health
Committee on Veterans' Affairs
U.S. House of Representatives**

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Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to speak with you today about the role telemedicine plays in the care of veterans in their home. My name is Patricia Ryan; I am the Director of the Community Care Coordination Service in the Sunshine Network, Veterans Integrated Service Network (VISN) 8. I also serve in the capacity of Acting Associate Chief Consultant in the national VA Office of Care Coordination.

The Care Coordination/ Home Telehealth Program began enrolling veterans in April 2000 in VISN 8, which includes north Florida, southern Georgia, Puerto Rico, and the Virgin Islands. The program was established to meet the needs of a frail older adult population who has multiple chronic diseases such as diabetes, hypertension, chronic obstructive pulmonary disease, stroke, mental illness, and heart disease; who live in their own homes and in their own communities, but who, because of both their age and complex health problems are at risk for institutionalization, but may well refuse to give up their independence. The complexity of their health problems have caused not only multiple hospital admissions, but also many clinic and urgent care visits and complex medication regimens. Their health problems have really reduced the ability of this population to self-manage their chronic diseases. With 49 percent of the veteran population over 65 and averaging three or more chronic health problems, the clinical imperative is evident to develop a program that would extend health care services to assist veterans in managing their chronic diseases

after they leave the hospital and clinic. Given the influx of veterans to our Network, there was an imperative to develop ways to deliver care to veterans efficiently and, with the use of telehealth technologies, to provide coordination of complex care remotely. Our primary purpose in VISN 8 was to develop a system that centered clinical care on the needs of veterans in their homes, redefining traditional care management and using home Telehealth technologies to coordinate VA care across the entire continuum of services. In the past, care or case management was defined by an episode of care, either in the clinic or hospital, with maybe a set number of phone calls to follow up with the veteran after discharge. The Care Coordination program combines the role of a care coordinator with home telehealth technologies that allow us to provide the veteran consistent follow up that transcends clinical programs and physical settings. Whether the veteran had a cardiology, primary care, or mental health appointment, the care coordinator is responsible for being a team member with the selected service, providing a clinical thread between specialists and general care, and providing consistent information on the veteran's response to treatment at home. We developed a process of care focusing on veterans' needs, not on the characteristics of a specific clinical service. Our goal was to improve access to care and provide the right care in the right place at the right time. Through the use of the electronic medical record, we are able to provide information on veteran response to care as we receive it, and not wait until the veteran appears at the clinic or hospital. This does not replace or substitute for the patient-provider relationship; rather, it extends the association into the home. Frequently, follow-up clinic visits are scheduled just in case there is the potential for decline in condition or to check on progress of treatment. The ongoing connection through home telehealth provides for just in time care that is based on both subjective and objective clinical information.

The VISN 8 care coordination program has served over 3,500 veterans in the last five years with a current census of over 2,700. We have 21 programs across the Network that serve many populations, from frail older adults with multiple chronic medical conditions, veterans with mental health problems, a

large population of veterans with diabetes and heart failure, and a wound care program that serves the spinal cord population at the San Juan VA medical Center (VAMC). We have identified and deployed a process that includes technology in the home but is not built around a specific technology. There are four components to care coordination: care/case management, disease management, self-management of chronic disease, and technology that assists in delivering the components. All veterans are not alike, and home telehealth technologies have different levels of features. An algorithm was developed to match the level of technology to clinical need and the veteran's ability to operate the technology. All devices operate on plain old telephone system lines.

Our success has been outstanding, and we have excellent clinical and satisfaction outcomes to validate this. Customer satisfaction is measured annually and has been above 95 percent for the last three years in both the care coordination process as well as ease in use of the technology. For our veterans enrolled in the Heart Failure programs, the average blood pressure reduced from 131/73 to 119/69, and there was documented adherence to clinical treatment. There was a weight reduction of 5-10lbs. Medication adjustments are made based on a range of clinical information that is received daily from the telehealth device, not just on clinic visit information. All of the diabetics enrolled in the program across VISN 8 have shown significant improvement in diabetes control, blood pressure, and weight management. Our wound care program in Puerto Rico manages spinal cord veterans who have both pressure ulcers and diabetes. Over the life of a spinal cord patient, 25 percent of treatment is for pressure ulcers. By keeping veterans in their own homes and providing care remotely, we have reduced the time to heal pressure ulcers in this population, some of whom live on St. Thomas and would need special air transport to the San Juan VAMC. In addition to clinical improvements, we have an average 40 percent reduction in hospital admissions and a 49 percent reduction in beds days of care for those admissions.

Over 80 percent of our veterans are on an in-home messaging device that is twice the size of a caller ID box and is connected to the home telephone. The

care coordinator will select a defined dialogue to load on the machine. The dialogues are developed with the messaging unit company to deliver designated questions daily for 365 days. The questions are based on national practice guidelines and reviewed by VA staff. The questions ask about symptoms, knowledge (patient education), and behaviors (health habits and daily activities). This gives the veteran a daily reminder of what to monitor and also provides education in a format based on how they answer the questions. The messaging device will buzz until the veteran answers the questions. This gives the veteran the tools and information they need to manage their chronic conditions. The veterans also know that if there is a change in their condition or they have a question, the care coordinator can access the appropriate health care team within VA to assist them. As I previously mentioned, we also use a variety of technologies in the care coordination program in addition to the messaging devices, such as telemonitors, videophones, and cameras for our wound care program. I cannot stress enough that technology is used based on the veteran's clinical need.

One of the populations that we serve in VISN 8 is a palliative care population that grew out of a cancer program we started with the National Cancer Institute. We have a chaplain who is one of the care coordinators for this special population. One of our veterans was near the end of his life and able to remain at home. His son was a police officer in a distant town who was shot while on duty and could not travel to Florida after the incident to visit his bedridden father. Through our Care Coordination programs, we were able to issue videophones so these two men could be together remotely via video and voice in a time of crisis and at the end of the father's life.

Mr. Chairman, my father and all my uncles were WWII veterans, so I grew up with the proud knowledge of the importance of veterans to this country. I have worked in VA Care Coordination and Geriatrics since 1984. I cannot stress enough what a privilege and honor it is to serve all veterans. Thank you for your time and attention. I will now be happy to answer any questions you might have.