VA Connects: Telemental Health Regional Center

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Telemental Health

 Defined by Veterans Health Administration (VHA)

“the wider application of care and case management principles to the delivery of health care services using health informatics, disease management and telehealth technologies to facilitate access to care and improve the health of designated individuals and populations with the intent of providing care in the right place at the right time.”

1VA Telehealth Services, 2013
Telemental Health (cont.)

- TMH refers to behavioral health services that are provided using communication technology\(^2\)
- Examples are conducting assessments or providing psychoeducation or psychotherapy skills by telephone, interactive monitoring equipment, personal data assistants, computer, and video conferencing links

\(^2\)National Center for PTSD Fact Sheet: “PTSD and Telemental Health”
“This revised VHA Handbook defines minimum clinical requirements... to ensure that all veterans, *wherever they obtain care in VHA*, have access to needed mental health services.” (VHA Handbook, p. 1).

“All veterans with PTSD must have access to Cognitive Processing Therapy (CPT) or Prolonged Exposure (PE) Therapy. Large and mid-sized CBOCs may provide these services through telemental health when necessary.” (VHA Handbook, p. 29).
Overview of Demographics

**Highly Rural:** Any area with less than 7 civilians per square mile

**Rural Areas:** All areas except urban

**Urban Areas:** 50,000 or more persons
Where Veterans Live

VA Enrollees: 38% Rural

- Rural: 36.3%
- Urban: 62.2%
- Highly Rural: 1.5%

VHA Office of Rural Health, 2006
Rural Health Challenges

- Rural veterans are poorer, have higher disease burdens, have worse health outcomes, and are less likely to have alternative health insurance\(^3\)
- Veterans in rural settings report lower health-related (physical and mental) quality-of-life scores\(^4\)
- Rural veterans make up a disproportionately high share of returning Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans\(^5\)

\(^3\)Wallace et al., 2006; \(^4\)Weeks et al., 2004; \(^5\)National Priorities Project
Rural areas face:

- Significant challenges in recruiting and retaining health care professionals
- Higher costs associated with delivering care in rural areas (significant barriers to access)
Many Veterans who live in rural settings do not have access to in-person empirically supported psychotherapies (limited time; gas is $4/gallon).

Veterans with PTSD may also avoid driving (especially due to fears of roadside bombs), crowds, and government institutions for treatment.

Veterans may be more comfortable and have better access with treatment via video link.
Videoconferencing Psychotherapy

- Videoconferencing Psychotherapy (VCP) is similar to commercial software like Skype or Face-Time.
- Our review of 65 studies of VCP found that it is feasible and is found to have similar clinical outcomes to traditional in-person psychotherapy⁶

⁶Backhaus et al (2012)
November 2011, Telemental Health, VASDHS awarded funds from VACO to expand Evidence Based Practices for PTSD throughout VISN 22

- $600,000 per year through FY 2014

March 2012, TMH, VASDHS awarded funds from VACO to develop Pilot Regional Clinic for EBP for PTSD via TMH

- $244,448 first year; $325,931 for subsequent years-through FY 2014
VA Central Office chose three sites
- San Diego VA, VISN 22
- Charleston VA, VISN 7
- San Antonio VA, VISN 17

Goals of the Centers:
- Implement EBP for PTSD via TMH throughout regions
- Increase access to EBPs for veterans diagnosed with PTSD
- Standardize procedures for developing TMH clinics
- Provide consultation to other VISNs, sites establishing TMH programs
Mandated to provide time-limited therapies for veterans with primary diagnosis of PTSD

- Cognitive Processing Therapy (CPT) and/or Prolonged Exposure Therapy (PE)
  - **CPT** - approximately 12 weekly (50 minute) individual therapy sessions focusing on identifying how traumatic experiences changed thoughts and beliefs and how these thoughts influence feelings and behaviors.
  - **PE** - approximately 8-15 weekly (90 minute) individual therapy sessions focusing on education about treatment and common reactions to trauma, breathing retraining, in-vivo exposure, and imaginal exposure.
• VACO/Office of Mental Health staff overseeing program: Bradley Karlin, Ph.D., Tracey Smith, Ph.D., and Matthew Yoder, Ph.D.
  – Drs. Paulus, Thorp, and Williams meet monthly with VACO representatives as well as provide reports on various measures:
    • Hiring Status
    • Clinic Implementation
    • Encounters/Uniques
    • No-Show Rate
    • Mileage/Amount Saved in Travel Pay
    • Quality of Call/Connection
VA Connects: TMH Program Staff

- Martin P. Paulus, M.D., Director of Telemental Health and TMH Regional Center (Psychiatry)
- Steven R. Thorp, Ph.D., ABPP, Co-Director of TMH Regional Center (Clinical Research)
- Kathryn E. Williams, Ph.D., Co-Director of TMH Regional Center (Clinical application and Supervision)
- 11 Therapists (9 Psychologists, 2 Social Workers, 1 MFT)
- 2 Psychological Technicians

In addition to these hires, we utilize support staff at each site where services have been established
Implementation of Program

Steps to setting up a clinic (brief overview)

- Contact VA Healthcare System
- Identify Potential Sites
- Memorandum of Understanding
- Service Agreement
- Obtain CPRS Access
- Build TMH Clinics
- Inter-facility Consult
- Inservice to Local Providers
- Identify Potential patients via Dashboard and MH referrals
- Test Session
- First Patient Scheduled
Needs Assessment

- Description of Program (overview and goals)
  - Proposed locations/modalities (clinic or home)
  - Frequency of service
  - Identification of population to be served
  - Staffing requirements and availability
  - Availability of Space
  - Equipment and Connectivity
Communication

- Formal and/or Informal means
  - Proposals to anticipated sites
  - Email/Phone Program Chiefs/Coordinators

Once site has been selected

- Identify key players- Executive, Administrative, Clinical
  - Identify a “Champion” for troubleshooting
  - Establish time for weekly contact to evaluate progress
Formal Agreements

✧ Developing Memorandum of Understanding

✧ Credentialing and Privileging
  1. Sites can agree to recognize the credentialing and privileging of provider site (preferred)
  2. Remote site can request full credentialing and privileging of providers at each site (time consuming)

✧ Licensure:
  ✧ Federal share licensure: In the VA license is recognized across other VA sites
  ✧ Outside of VA depends on Laws of each state.
    ✧ May require provider to be licensed in state of patient
Formal Agreements (cont.)

-service agreements
- identify key contacts at provider site and remote site
  - clinical staff
  - it assistance
  - schedulers/administration
- outline specifications of clinic days/times
- daily procedures necessary for clinic visits
- designation what each staff member’s responsibility
- sharing of credentialing/privileging
Service Agreements (cont.)

- Preferred communication methods
- Overview of program necessities
  - Equipment (computer based or vtel) - fax, phone
  - Soundproof room
  - Trash Can/ Kleenex
  - Contact list for patients
- Emergency Procedures
Emergency Procedure

- Each clinic is responsible for having plan in place
- Telehealth providers assist remote clinic staff with implementation
- Dangerousness
- Involuntary/Voluntary Psychiatric Hospitalization
- Medical Emergency
- Transportation
- Pharmacy
- Laboratory
- Equipment Breakdown
- Referral Sources
Implementation

♦ Obtain access to medical records at patient site

♦ Identify list of note titles, procedures at patient site

♦ If hub/spoke services: likely chart two systems (patient/provider)

♦ Clinic building- logistics/workload credit/billing
Implementation (cont.)

- Preliminary Tests (essential for success)
  - Test call (equipment, phone, etc.)
  - Test fax numbers, troubleshoot difficulties
  - Emergency procedures

- Generating Referrals
  - Presentations live or videoconference to remote site
  - Utilizing clinics wait-lists
  - Utilize performance measures
## Overview of Regional Center Sites

### VISN 22

<table>
<thead>
<tr>
<th>VA San Diego</th>
<th>GLA VA</th>
<th>Long Beach VA</th>
<th>Southern Nevada VA</th>
</tr>
</thead>
<tbody>
<tr>
<td>El Centro</td>
<td>Santa Barbara</td>
<td>Santa Ana</td>
<td>Northwest Clinic</td>
</tr>
<tr>
<td>Chula Vista</td>
<td>Oxnard</td>
<td>Anaheim</td>
<td>Northeast Clinic</td>
</tr>
<tr>
<td>Escondido</td>
<td>Bakersfield</td>
<td>In-Home</td>
<td>Southwest Clinic</td>
</tr>
<tr>
<td>Oceanside</td>
<td>Santa Maria</td>
<td></td>
<td>Southeast Clinic</td>
</tr>
<tr>
<td>Mission Valley</td>
<td></td>
<td></td>
<td>In-Home</td>
</tr>
<tr>
<td>In-Home</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Outside VISN

<table>
<thead>
<tr>
<th>VISN 20/ Portland VA</th>
<th>VISN 21/ San Francisco VA</th>
<th>VISN 20/ Anchorage VA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bend, OR</td>
<td>Santa Rosa, CA</td>
<td>TBD</td>
</tr>
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</table>
## Regional Center Progress

### Workload FY 2012 (1.75 providers)

<table>
<thead>
<tr>
<th>Clinic (FY 2012)</th>
<th>Encounters</th>
<th>Uniques</th>
<th>Mileage</th>
<th>Travel $</th>
</tr>
</thead>
<tbody>
<tr>
<td>El Centro</td>
<td>478</td>
<td>70</td>
<td>95600</td>
<td>$39,674</td>
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<tr>
<td>Chula Vista</td>
<td>5</td>
<td>1</td>
<td>100</td>
<td>$41.50</td>
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<tr>
<td>Escondido</td>
<td>7</td>
<td>1</td>
<td>70</td>
<td>$2905</td>
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<tr>
<td>Las Vegas</td>
<td>15</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Santa Barbara</td>
<td>9</td>
<td>4</td>
<td>1350</td>
<td>$560.25</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>514</strong></td>
<td><strong>75</strong></td>
<td><strong>97120</strong></td>
<td><strong>$40,304.80</strong></td>
</tr>
</tbody>
</table>
## Regional Center Progress
### Workload October 1, 2013- August 9, 2013

<table>
<thead>
<tr>
<th>Clinic (FY2013)</th>
<th>Encounters</th>
<th>Uniques</th>
<th>Mileage</th>
<th>Travel $</th>
</tr>
</thead>
<tbody>
<tr>
<td>El Centro</td>
<td>439</td>
<td>85</td>
<td>96580</td>
<td>$40,080.70</td>
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<tr>
<td>Chula Vista</td>
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<td>21</td>
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<td>6</td>
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<td>0</td>
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<tr>
<td>Santa Barbara</td>
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<td>18</td>
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<td>Bakersfield</td>
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<td>7</td>
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<tr>
<td>Oxnard</td>
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<td>2</td>
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</tr>
<tr>
<td>Bend, OR***</td>
<td>41</td>
<td>3</td>
<td>8200</td>
<td>$3403</td>
</tr>
<tr>
<td>In-Home</td>
<td>68</td>
<td>20</td>
<td>1400</td>
<td>$581</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1096</strong></td>
<td><strong>204</strong></td>
<td><strong>131,535</strong></td>
<td><strong>$54,587.03</strong></td>
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</table>
Regional Center Progress

- San Diego Regional Site is the **only** Pilot site to go across VISN and outside of VISN as of 9/2013
- San Diego site exceeded workload of other sites even with \( \frac{1}{2} \) the number of providers
- Pilot Telemental Health In-Home
Home Based Telemental Health

♦ Establish procedures similar to clinic based care, difference Emergency Procedures
  ♦ Identification of Primary Support Person
  ♦ Emergency Plan completed prior to session

♦ Software platform that is Federal Information Processing Standards (FIPS) compliant
  ♦ Cisco Telepresence/Jabber
  ♦ VSEE
Home Based Telemental Health (cont.)

- PILOT: VASDHC: In-home telemental health.
  - As of 8/9/2013: 68 Encounters and 20 Uniques
- Steps involved:
  1. Verify patient has computer, webcam, microphone, and high speed internet
  2. ROI for Primary Support System
  3. Waiver/Agree to download software
  4. Located in a private place within the U.S.
  5. Call in at appt. time
  6. Agree on homework exchange procedures/assessments
Home Based Telemental Health

- San Diego VA current Exclusions for In-Home TMH (based on recommendations from Office of Telehealth Services and Clinical Research):
  - imminent suicidality or homicidality
  - Axis II diagnosis
  - Acute/untreated substance disorders
  - Psychotic disorders
  - Bipolar disorder
  - Significant Sensory Deficits
  - Dementia
These exclusion criteria have been established in order to minimize risk and minimize potential adverse events.

- September 2010, Ft. Stewart, GA, Army Veteran took hostages after having session via videoconferencing.
- 2012 in El Centro veteran arrived for Telemental Health appointment with weapon and police had to be called.
Potential Concerns/Issues

• Limited space
  • Clinic space with CVT equipment shared by other telehealth specialties

• Communication with staff at patient site

• Duplicate Charting- Provider site CPRS and Patient site CPRS
Benefits of Regional Center

• Providing services to veterans who are unable to access EBP for PTSD

• Privacy of treatment, especially when CVT rooms are used for other telehealth specialties or treatment offered in-home

• Employees at remote sites receiving treatment by a provider they don’t work with face-to-face
Benefits of Regional Center

• Innovative program serves as a model for the VA Nationwide and other healthcare programs
  - Drs. Paulus, Thorp, and Williams have given interviews and presentations demonstrating the success of San Diego VA’s unique program
Skype therapy? It's working for veterans-

Los Angeles Times, July 4, 2013 by Tony Perry

Veteran Ruben Moreno Garcia has been working with his VA therapist for two years — but they've never met face-to-face
PTSD Coach
Future Directions:
Smart Phone Applications

♦ Portable: Can be used by active duty military in the field; emergency personnel; clients who have limited mobility or who are in institutions far from specialists; actigraphy

♦ Example: PTSD Coach\(^1\): Information on PTSD and treatments; Tools for screening and tracking symptoms; Convenient, easy-to-use skills to help manage symptoms; Direct links to support and help

\(^1\)Created by the VA's National Center for PTSD and the DoD's National Center for Telehealth and Technology.
VA Connects

Thank You