



VA's Use of Telemedicine Services During the Pandemic

This technology was used to decrease amputation rates.

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The pandemic hit the healthcare industry, particularly patient access to care, in a way that most podiatrists never anticipated. Mandated shutdowns affected small group practices, hospital-based practices, and government-run facilities. For the VA specifically, all elective face-to-face care was halted for a period of time, with care prioritized to only emergent services and COVID 19-devoted operations. This period varied between facilities and was largely dependent on the number of active COVID cases and the operational needs, and in the case of VA, by each respective facility incident command unit.

Similar to many other healthcare entities, the VA immediately expanded telemedicine operations to meet the demand of care. However, telemedicine comes with some limitations. There is no ability for the provider to touch the foot, which removes the ability to manipulate, palpate pulses, or perform a sensory examination, which are critical for determining a patient's risk for amputation.

The PAVE Directive

VHA Directive 1410 Prevention of Amputations in Veterans Everywhere (PAVE) is policy that establishes surveillance measures for patients who have diagnoses that may increase the risk for amputation (e.g., diabetes, peripheral neuropathy, pe-

ripheral vascular disease, chronic kidney disease, etc.). Any veteran patient with a past medical history that might increase the risk of amputation requires an annual foot exam, inclusive of a visual, circulatory, and neurological assessment. While video telemedicine care can provide a visual assessment to rule out acute processes such as active soft tissue infec-

The Emergence of HELPP

As the pandemic was evolving, podiatrists grew increasingly concerned about patients developing acute processes resulting in limb loss. Like the rest of our professional community, the podiatrists at the Atlanta VA Health Care System knew that a creative approach would be needed to reach patients and minimize the neg-

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tion and ulceration, only a physical visit can fulfill the need to palpate the foot and perform a sensory exam.

The PAVE Directive has been the VA policy for almost 30 years and has been incredibly effective in reducing overall amputation rates, but more importantly, reducing the amputation levels. In addition to requiring an annual foot examination for select patients, it also ensures access to basic foot care services and diabetic footwear to patients confirmed to be at increased risk for amputation. It requires providers to deliver foot health education and requires facilities to report their respective annual amputation rates. The PAVE program is a model of care demonstrating the intended success of preserving limbs and keeping veterans walking.

ative impact from the reduced access to care. Podiatry collaborated with Primary Care, the Technology-based Eye Care Services (TECS) and incident command, to create an opportunity for patients to receive a physical appointment to provide surveillance and address any acute issues. The *High-risk Eye and Limb Preservation Program (HELPP)* was developed to allow patients an eye exam, labs, vitals, general health inventory, and a foot exam. The foot exam was performed by a primary care nurse under video supervision with a podiatrist. This was an opportunity for podiatry to document a foot exam, activate any necessary therapies, and expedite care for the acute foot emergencies that were identified.

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Telemedicine (from page 119)

While navigating the pandemic, it was clear that ensuring access to basic foot care services was still inadequate. Face-to-face clinical operations were still limited and while veteran patients could access care in the community, this process can sometimes take time to execute. In other words, physical, timely care needed to be provided. In understanding that telehealth was likely going to be a permanent healthcare modality, the HELPP program hired intermediate care technicians (ICTs). ICTs are professionals serving in the military as corpsmen or medics who transition from the military to the VA. Podiatrists at the Atlanta VAHCS trained the newly-hired ICTs to perform the basic foot exam and basic foot care, which meant that all patients evaluated in the HELPP program were provided basic foot care, when clinically indicated, at the time of the visit. This was a gamechanger in terms of the ability to reduce complication risk, given that the patients were now receiving real-time basic foot care services.

The Virtual Nurse Triage Clinic

While the telemedicine visits were launched with the HELPP program specifically for patients who had diagnoses that potentially carried an increased risk of amputation, there were other patients potentially with acute foot issues that were not captured. A virtual nurse triage clinic was created for patients contacting the podiatry department requesting an appointment. For these patients, they are offered an appointment within 24 hours of the request. This allows for an RN to visualize the foot, document a physical exam, document the subjective history, and determine acuity.

If the patient is found to be non-acute, the nurse documentation is forwarded to the podiatrist for review, who activates therapy or appropriately refers. It also allows the opportunity for the nurse to provide reassurance to patients who are not clinically acute. When the patient is found to have an acute foot issue at the time of the nurse virtual visit, there is a warm hand-off to a desig-

nated podiatrist who evaluates and proceeds with therapy. Some of these patients who were captured by this modality were acute and necessitated emergent care.

Because both programs, HELPP and the podiatry nurse triage clinic, have captured an overwhelming number of visits with several acute issues identified, these programs were made permanent. Despite clinics re-opening for elective visits, these programs were critical to maintain. Since the launch of the clinics in August 2020,

that was under-utilized prior to the start of the pandemic, but has proven to be an effective means of care in some settings. 2) Providers can earn appropriate workload credit and RVUs if done correctly. 3) Executing these programs has undoubtedly reduced the amputation rates that would have occurred had this proactive approach to healthcare not been instituted. 4) The travel burden and expense for patients have been reduced. Patients can have the CVT/HELPP visit in a clinic geographically located near to them,

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almost 3500 patient encounters have been captured. While less than 2% of the encounters have been noted to be acute and require emergent care, almost 50 patients have had limbs saved because the acute issues were identified in a timely fashion. 48 of the patients seen in these clinics had new onset lower extremity wounds and/or clinical signs of infection. Upon review of the medical records, these patients were expedited to the podiatry clinic (or the vascular surgery clinic when they demonstrated an ischemic component), with none of these patients requiring an amputation.

Prioritizing Video Telehealth from Home

The VA has prioritized the ability for the patient to have video telehealth from home—the agency has executed a tablet loaner program to make devices available to patients, assists with making the veteran patient internet-connected, and educates the patient to effectively have their telehealth visit with the provider. The benefit to the above adopted programs has been multifactorial. 1) Use of clinical video telemedicine (CVT) and VA video connect (VVC), where the patient can be evaluated in a clinical setting or home setting, respectively has maximized the use of telemedicine, far greater than a standard evaluation. It is a modality

eliminating the need to travel to the main medical center, which for some patients can be > 100 miles. The VVC appointment with the nurse occurs in their own home, eliminating the need to leave their house at all.

While telemedicine carries some clinical care limitations, it can be safely and effectively executed for certain conditions and for routine surveillance to avoid acute foot issues from becoming an amputation statistic. Because of its clinical value, telemedicine is a permanent modality within the VA and is a committed piece of the agency's long-term strategic plan. The interesting question is whether the profession (and healthcare in general) would have been more effective in reducing amputation rates pre-pandemic had telemedicine been globally deployed and embraced as it was when the pandemic forced the adoption of this form of patient care. **PM**



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