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## Message from the Chief

*Two roads diverged in a wood,  
and I— I took the one less  
traveled by, And that has made all  
the difference.*

– Robert Frost

In Army Telehealth, we think a great deal about transformation. How to transform our current health care system using advanced telehealth technologies. How to transform the patient experience so that our beneficiaries receive care when and where they need it. And how to transform our culture, so that telehealth is well-used within the toolkit of every clinician in Army Medicine. As we move towards the Army Surgeon General's vision of "virtual when we can, live and in-person when needed", there is a great deal of change ahead. The transformational road of virtual care is certainly the road less traveled, but it will make all the difference in providing quality care for our Soldiers, families, retirees, and civilians – our partners in health.

As you read the current issue, we invite you to sample stories on how Army Medicine is

accomplishing positive transformation towards a world of care provided through telehealth. We are honored to have several of our facility Commanders share their strategies in building successful telehealth services and how they have taken the road less traveled to innovate for their patients. We are excited to see how general surgery patients in Europe are now benefiting from less travel and time away from duty while our surgeons are able to keep up critical wartime skills. And the Telehealth Service Line is happy to provide some new tools to assist in transformation, all part of our growing "telehealth toolkit" designed to assist our community in expanding the use of virtual care in the Army.

Thank you for taking the time to learn more about some exciting good news in Army Telehealth. As we continue to take the innovative road less traveled, we invite you to join us. Your involvement will make all the difference. Together, we'll change the face of Army medicine.

Serving to Heal, Honored to Serve.

Colleen Rye, Ph.D.



## Second Quarter TH Fiscal Incentives Awarded to MTF Commanders

### Second Quarter TH Fiscal Incentives Awarded to MTF Commanders

The results are in! Second quarter TH incentives from the Integrated Resourcing and Incentive System (IRIS) have been awarded to MTF Commanders (see Table 1). The results are excellent; over \$300,000 was awarded in this second quarter alone. Translated from dollars to visits, this is a 21% increase from the same time period in FY14.

The FY15 IRIS incentives for TH are phase 1 of the Connected, Consistent Patient Experience (CCPE), Army TH's three-year expansion plan. In FY15, Army Medicine facilities receive \$20 at the provider site and \$25 at the patient site

for all provider-patient visits and provider-provider consultations using TH. This payment is in addition to the RVU values that facilities already receive. IRIS incentives offset the resource costs associated with developing TH and give Commanders the flexibility to build TH in areas most needed for their population. MTF Commanders can use the FY15 incentive dollars to develop additional TH capabilities in advance of FY16 Performance Planning targets for minimum TH capabilities.

This quarter TAMC still remains in the lead, I wonder if anyone will take it from them next quarter. Let's watch and see the MTFs perform next quarter!

Table 1

Medical Treatment Facility	MTFs with Top 20% of Telehealth Workload		2QFY15 Incentive
	Encounter or Teleconsultation From Patient Site	Encounter or Teleconsultation From Provider Site	
Tripler Army Medical Center + Hub	2,396	2,121	\$102,320
San Antonio Military Medical Center + Hub	25	3,183	\$64,285
Kimbrough Ambulatory Care Center + Hub	1,336	1,548	\$64,360
Darnall Army Community Hospital	1,498	0	\$37,450
Guthrie Ambulatory Health Care Center	878	0	\$21,950
Brian Allgood Army Community Hospital	617	98	\$17,385
<b>2nd Qtr Incentive</b>			<b>\$307,750</b>

Table 2

Medical Treatment Facility	Encounter or Teleconsultation From		Year to Date Incentive
	Patient Site	Provider Site	
Tripler Army Medical Center + Hub	4,771	4,808	\$215,435
San Antonio Military Medical Center + Hub	51	7,370	\$148,675
Kimbrough Ambulatory Care Center + Hub	2,680	2,999	\$126,980
Darnall Army Community Hospital	3,887	0	\$97,175
Guthrie Ambulatory Health Care Center	1,884	0	\$47,100
Brian Allgood Army Community Hospital	1,502	165	\$40,850
<b>Cumulative Incentive</b>			<b>\$676,215</b>

## Top Commanders Discuss their Successful Strategies in Prioritizing TH Services



### **COL David Dunning, Commander of Tripler Army Medical Center: Facility awarded \$239,520 (YTD)**

"We believe in using telehealth because it brings healthcare to the patient. This is nowhere more important than in the Pacific AOR. In the Pacific the next closest expert may be 6-12 hours away by plane. It is essential in providing the highest quality/safest healthcare to our patients and critical to multi-service cooperation.

We attribute our success in using telehealth to a dedicated group of individuals/team who are passionate about this mission. For a select group of people it is either their full time job or a significant collateral. They are local, regional, and DoD recognized experts who have driven us forward but have also provided site assistance visits to help others establish their programs. This was demonstrated in a joint fashion at Naval Medical Center Portsmouth by adoption of our system as they stood up their own program. Those efforts had the additional benefit to our program by preparing Navy providers who later find themselves in the Pacific AOR linked back to Tripler."



### **COL Patricia Darnauer, Commander of Carl Rogers Darnall Army Medical Center: Facility awarded \$94,125 (YTD)**

"We believe in using telehealth because it allows us to increase our capacity to provide timely access to quality care. As one of Southern Regional Medical Command's major users of tele-behavioral health, the support we receive from San Antonio, Maryland, and Hawaii allows us to connect providers and patients. This was especially significant in the aftermath of the Fort Hood shooting incidents. Our ability to leverage telehealth providers allowed us to meet the increased behavioral health demand of the community. The use of telehealth is a win-win situation for the MTF and the patients.

At CRDAMC, as well as all the other Army Medicine MTFs, providing timely access to care is one of our highest priorities, and telehealth enables our ability to provide access. Using telehealth allows us to meet our access goals as well as keep our promise to the Fort Hood community."



### **COL Matthew Mattner, Commander, Fort Drum MEDDAC: Facility awarded \$47,150 (YTD)**

"I believe in using telehealth because it expands the treatment resources and capabilities when the demand for a particular service does not require a full-time provider and/or when the demand for a particular service exceeds the availability of local providers. This benefit is particularly useful in a location like Fort Drum where patient demand or provider availability is limited more than in a larger metropolitan area. We have some challenges recruiting specialists to Southern Canada, and these challenges are met with telehealth capabilities that connect the patients to the providers.

I attribute my success in using telehealth to ensuring that the support staff is available on our side (the patient side) in order to make sure patients receive the same level of patient-centered care from their telehealth provider as they would from an on-site provider. Being patient-focused and thinking of the patient experience for the care they receive is important, and it helps ensure the patient returns for additional telehealth care."

# Spread the News...

## **Help spread the news about the successes of Telehealth!**

To have your telehealth "Good News Story" or clinical telehealth champions featured in our next Army Telehealth Connections newsletter, send an email to:  
[usarmy.ncr.hqda-otsg.mbx.telehealth@mail.mil](mailto:usarmy.ncr.hqda-otsg.mbx.telehealth@mail.mil)

Telehealth

## Army THSL at the American Telemedicine Association Conference

On May 4, 2015, Dr. Colleen Rye (Chief of the Army TH Service Line) served on a panel entitled “Learning from Large Scale Telemedicine Initiatives” at the American Telemedicine Association (ATA) Annual International Meeting. As part of the panel, Dr. Rye spoke together with telemedicine authorities on successful business strategies in telemedicine. In her remarks, Dr. Rye highlighted Army TH’s Global Operating Company Model and described how Army Medicine has accomplished its current worldwide TH implementation in several areas such as telebehavioral health. Dr. Rye also described key elements of Army Medicine’s three-year TH expansion plan, the Connected, Consistent Patient Experience (CCPE). COL Danny Jaghab from the Army TH Service Line also attended the

conference to enhance Army TH collaborative relationships.

In its 20th year, the Annual ATA International Meeting is the leading conference worldwide in the telemedicine, telehealth, and mHealth space. This year’s conference was held at the Los Angeles Convention Center.



Dr. Colleen Rye speaks on the Army TH Global Operating Company Model at the American Telemedicine Association Conference. In its 20th year, the Conference was held at the Los Angeles Convention Center.

## Army THSL at the Annual Summit of the Mid-Atlantic Telehealth Resource Center

On March 31, 2015, Dr. Colleen Rye (Chief of the Army TH Service Line) served on a panel entitled “Telehealth Outside the Box” at the Annual Summit of the Mid-Atlantic Telehealth Resource Center (MATRC). Dr. Rye spoke alongside telehealth leaders on creative uses of telehealth, including provider types and settings where the potential for telehealth has not yet been realized. In her remarks, Dr. Rye highlighted Army TH’s Global Operating Company Model and described how Army Medicine has accomplished its current worldwide TH implementation in several areas such as telebehavioral health. Dr. Rye also described key elements of Army Medicine’s

three-year TH expansion plan, the Connected, Consistent Patient Experience (CCPE). MAJ(P) Maria Shelton from the Army TH Service Line also attended the conference to identify civilian industry best practices.

MATRC is one of 14 telehealth resource centers (TRCs) across the nation and is funded by the U.S. Department of Health and Human Services Administration. This year’s Summit, entitled “Shaping the Future of Healthcare through Innovation and Technology”, was held at The Greenbrier, White Sulphur Springs, West Virginia.

## Mobile Health Innovation Center Research Findings to be Featured in a Special Edition of the Journal of the American Medical Informatics Association

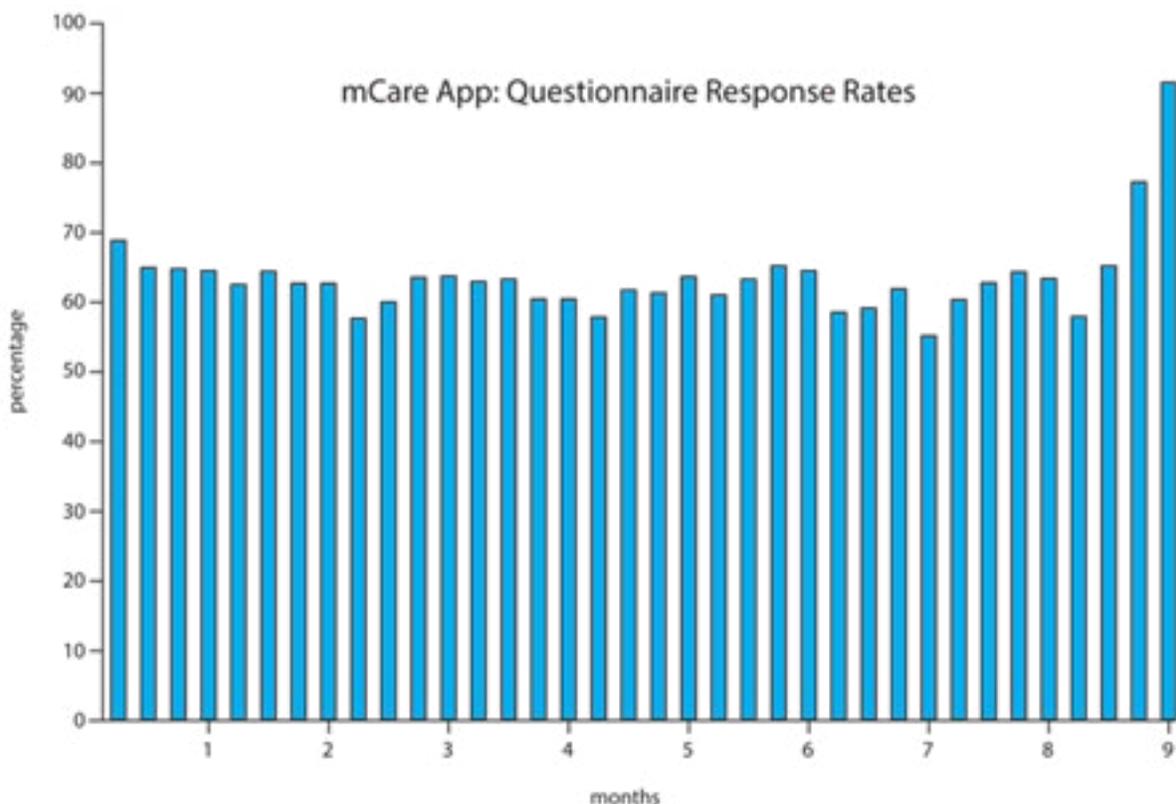
### What makes a mobile health initiative successful?

There are a plethora of mobile apps available to patients, but achieving long term, sustained use of these tools over time is challenging. Little is known about whether patients with specific challenges, including traumatic brain injury (TBI), post-traumatic stress (PTS) and/or behavioral health (BH) issues will adopt and use a mobile application in a sustained fashion.

TATRC’s Mobile Health Innovation Center (MHIC) recently completed a comprehensive analysis of clinical research data using the mCare mobile application as an augment to standard care for wounded warriors. Part of this analysis included a focused evaluation of patient engagement with the mCare mobile app, with a sub-analysis of special populations, including TBI, PTS, and BH. The analysis found that mCare patient’s

level of engagement significantly surpassed market trends. Industry data shows that less than 40% of mobile apps are even opened by users six months after they are downloaded. But the research data shows that over the course of a nine month study, patients were responding through the mCare app at the same, or even higher rates than they did in the first month of use (see graph below).

Furthermore the analysis showed there were no statistical differences between special populations (e.g. TBI, PTS and BH) and other mCare users. The results of this patient engagement analysis are currently in press and will be featured in an upcoming edition of the Journal of the American Medical Informatics Association.



## European Regional Medical Command (ERMC) Success

### Real-Time Telehealth for General Surgery Patients in the European Region

The Army Telehealth Service Line vision aims, "To place standardized use of Telehealth (TH) into the toolkit of every clinician in Army Medicine..." At Landstuhl Regional Medical Center, surgeons are taking this to heart and moving forward with innovative, synchronous (e.g. real-time clinical VTC) TH initiatives, utilizing existing TH resources to bridge the distance gap in the region for the benefit of patients, surgeons and hospital. In CY2014, general surgeons at Landstuhl completed 123 synchronous initial and follow-up TH encounters for 101 general surgery patients resulting in 91 completed, scheduled or recommended surgeries; this is a TH to OR yield ratio of 90%. This article illustrates how general and other surgical sub-specialties at Landstuhl have come to use innovative approaches to successfully integrate synchronous TH into their routine clinic practices.

After more than a decade of caring for thousands of wounded soldiers, Landstuhl Regional Medical Center saw a precipitous drop off in the number of OR cases beginning in late 2013 and into 2014. At the same time, the strategic

requirement for forward positioned general surgeons in Europe has not changed. During the OIF and OEF contingencies, many surgery patients from throughout the Landstuhl catchment area were sent to the Tricare Preferred Provider Network (PPN), bypassing Landstuhl Surgical Services. Surgical readiness is vital to the Army Medical Mission and that means surgeons need to be busy operating when not deployed.

In 2014, the general surgery clinic staff at Landstuhl began to explore ways to re-capture elective surgical cases. Landstuhl Regional Medical Center in Landstuhl, Germany is surrounded by 13 clinics in Europe ranging from a 2- to 12-hour drive. Synchronous TH was seen as a way to bridge these distances. The Landstuhl ENT clinic had successfully employed synchronous TH with Bavarian Army Clinics, and the general surgery service used this experience to guide development of its program.

The process started with development of a general surgery clinic SOP and appointing guidelines for TH. The team developed clearly defined roles and activities codified in an SOP so that everyone understood the process from the onset. One

of the guiding principles was that the process should be an enduring one and that the effort would not be dependent on any one individual surgeon. Integration of TH into regular clinic activities was important.

Another principle employed was that of 'incrementalism' – start slow and fine-tune processes early on. TH tasks were divided into: (1) pre-appointment TH activities; (2) day of appointment activities for both the originating and distant sites; and (3) post TH appointment activities including surgical scheduling and pre-op issues.

Participants in this writing process included a general surgeon Clinic Chief, two surgical PA's, and the clinic head nurse and NCOIC. Appointment guidelines limited the surgery conditions to hernias, gallbladder, hemorrhoids, pilonidal cysts, lipomas, gynecomastia and bariatrics. The team chose conditions that could either be visible using the general exam camera at the originating site, or in the case of gallbladder and hernias, could additionally have the diagnosis confirmed by an imaging study. The team excluded conditions requiring a nuanced physical exam or complex decision making based on physical exam such as breast masses

and complex abdominal pain problems, cancer, etc. Participants understood that all surgical conditions are not appropriate for TH.

In order for TH to be effective for surgery patients and other medical specialties, competent, consistent patient presenters were needed at the originating sites. As of 2014, most synchronous TH encounters in ERMC were primarily behavioral health counseling and nutritional medicine. As Landstuhl began to increase utilization of existing resources for TH, the need for well trained, competent and consistent presenters for specialty encounters grew. This need led to implementation of the TH Nurse Care Coordinator Program in which full-time TH RN's were hired to staff the major patient centers of Wiesbaden, Stuttgart and Vilseck Army Health Clinics. These nurses participated in direct hands-on training with surgical and medical specialists at Landstuhl and have proved critical in creating a robust, effective TH effort. Moreover,

these nurses act as clinic ambassadors for TH, educating clinic staff on TH issues such as specialty appointing guidelines.

In the past, general surgery patients coming from distant Army Clinics in Europe would have required several trips to Landstuhl for an initial appointment, the day of surgery, and then follow-ups. Synchronous telehealth streamlines the patient care process, reducing most patient travel for just the procedural appointment. This saves thousands in travel costs and lost productivity. Because the patient sees the surgeon on the initial appointment virtually, the team builds into their process that consents are signed and an exam is re-accomplished in person in the AM before surgery by both surgeon and anesthesiologist. To further save time for patients, 12 CRNA's are trained to perform TH pre-op appointments.

Surgeon buy-in has been excellent because surgeons understand that seeing a TH patient results in a 90% chance

of a surgery – much higher than routine clinic visits. Patient satisfaction as well is very high.

The TH efforts of the Landstuhl general surgery staff have resulted in high quality, seamless, and predictable TH activities which continue today. Synchronous TH for surgery patients at Landstuhl is growing. There are now seven general surgeons conducting synchronous TH encounters. The general surgery clinic has seen the same number of TH patient encounters in the first three months of FY 2015 as in the entire FY2014, and other surgical services want to participate. In addition to current synchronous TH surgical services including orthopedics, ortho spine, ENT and general surgery, ERMC is in the process of bringing online plastic surgery and gynecology TH surgical services as well. Innovative and enduring synchronous TH programs are now in the toolkits of surgeons at Landstuhl, resulting in tangible benefits to surgeons and patients alike.



"MAJ Seth Miller is one of seven general surgeons seeing patients at Landstuhl Regional Medical Center via synchronous telehealth."

Photo credit for telehealth encounter photo: Phillip Jones, LRMC PAO Photographer.

## Northern Regional Medical Command (NRMC) Success

### *A Psychiatrist's Testimonial Using Telebehavioral health*

The following case describes an outstanding example illustrating the privilege and satisfaction of working in Telebehavioral health as a psychiatrist.

The patient is a married woman, age 50, suffering depressive and anxiety disorders. She also suffers multiple significant medical illnesses, including brittle Diabetes Mellitus I, systemic lupus erythematosus with hepatic manifestations, and bladder and musculoskeletal pain.

In a routine follow up visit discussing the benefits she receives from her psychotropic regimen, she noted that she felt physically more unwell than usual. I suggested she go to emergency services following the visit, due to her

complaint of swelling of hands and feet. A few moments later she became dizzy, unable to speak and said she knew she was quickly becoming hypoglycemic. She had no drink or sugar with her. Her blood sugar self-tested in low 60's. I called the Aberdeen Behavioral Health Clinic, TBH Point of Contact and requested urgent help with food or a drink due to diabetic hypoglycemia.

Within seconds it seemed, there were three people in the room, including a primary care physician, to assist. I was of course present as a 4th person, albeit on the VTC screen and suggested a wheel chair be brought in. An ambulance had already been called. The patient's blood sugar soon restored to 115. Later, she was diagnosed in the E.R. to have a purulent thumb infection requiring surgical intervention.

This case illustrates very well the team readiness that is present, the responsivity in crisis, and the value of training in protocol for the Clinic Staff in telebehavioral health. This all provides support to the patient and the treating psychiatrist, yet still maintains the closed door privacy of the consulting room.



# Pacific Regional Medical Command (PRMC) Success

## *PATH Increases Access to Specialty Care in Remote and Overseas Duty Stations*

When we think about the benefits of telehealth, quality and access to high quality care are often the first things we consider. Telehealth makes services available to patients who might not otherwise get the care they need because it isn't readily available in their area. This is especially common for military service members and their families who are stationed in remote locations.

While all military sites have primary care providers, most do not have an entire complement of specialists and therefore must rely on community civilian resources. Often these civilian resources are limited, and it becomes even more challenging for our bases in foreign countries where language and cultural barriers are common. In the Pacific, primary care clinics and community hospitals are scattered throughout Japan, Guam, and South Korea but the military specialty care is thousands of miles away at Tripler Army Medical Center (TAMC) in Hawaii. For this reason the Pacific Asynchronous Tele-Health (PATH) system was created in 2000 to give overseas primary care providers online access to specialists at TAMC.

PATH is a web-based, asynchronous (store-&-forward), HIPAA-compliant platform used for provider-to-provider teleconsultation. Hosted at TAMC, the PATH website enables overseas providers to submit patient consultations which are screened and forwarded to appropriate specialists for feedback regarding further diagnosis and treatment options. A review of 1,000 teleconsultations completed between January 2006 and March 2009 looked at consultation characteristics and outcomes (Telemedicine and e-Health, 2011). The researchers found that PATH provided quick access to high-quality specialty care for patients who might otherwise require transfer to a distant medical facility for advanced care.

It is not hard to imagine that PATH affords more timely access to specialty care, but how does this method of care delivery impact healthcare costs? Travel from the Western Pacific to Hawaii is incredibly costly (airfare, lodging, per diem) and also results in lost duty time for service members which negatively impacts readiness. Review of 1,000 teleconsultations revealed that up to 43% of face-to-face

specialist visits were avoided by provider-to-provider teleconsultation via the PATH platform. This translates to savings of nearly \$750,000 per year for the DoD in the Pacific region alone and does not include the obvious benefits to force readiness through reduction of missed duty days. Additionally, those that do require face-to-face specialty visits are now coordinated in a much more efficient manner, often having preliminary evaluations prior to travel which reduces the total time away from their duty station. Thus, provider-to-provider teleconsultation provides rapid care to those who need it most and allows many others to remain at their duty station, all while reducing healthcare expenditures for the DoD.

**Background:** Tripler Army Medical Center (TAMC) serves as the DoD's tertiary medical care facility for the Western Pacific military treatment facilities (MTFs) in Japan, South Korea, and Guam which have limited or no access to local teleconsultation capabilities. This unique medical and geographic situation created the need for asynchronous teleconsultation capabilities between Western Pacific Military Treatment Facilities and TAMC.

**System Description:** PATH is a web-based asynchronous (store-&-forward), HIPAA-compliant platform used for provider-to-provider teleconsultation. Hosted at TAMC, the PATH website enables remote providers to submit patient consultations which are screened and forwarded to appropriate specialists for feedback regarding further diagnosis and treatment options. Appropriate specialists at TAMC are screened by the clinical scenario, and supplementary multimedia as dictated by the clinical scenario. Consultations are screened by appropriate specialists at TAMC and forwarded to the physician managers at TAMC. Other DoD providers can be available at TAMC, other DoD providers can be screened by the clinical scenario, and supplementary multimedia as dictated by the clinical scenario. Consultations are screened by appropriate specialists at TAMC and forwarded to the physician managers at TAMC. Other DoD providers can be available at TAMC, other DoD providers can be screened by the clinical scenario, and supplementary multimedia as dictated by the clinical scenario.

**Effectiveness System Impact:** The Pacific Asynchronous TeleHealth (PATH) System has significantly reduced healthcare access and cost savings. A 2011 review of 1,000 teleconsultations revealed that up to 43% of face-to-face specialist visits were avoided by provider-to-provider teleconsultation via the PATH platform. This translates to savings of nearly \$750,000 per year for the DoD in the Pacific region alone and does not include the obvious benefits to force readiness through reduction of missed duty days. Additionally, those that do require face-to-face specialty visits are now coordinated in a much more efficient manner, often having preliminary evaluations prior to travel which reduces the total time away from their duty station. Thus, provider-to-provider teleconsultation provides rapid care to those who need it most and allows many others to remain at their duty station, all while reducing healthcare expenditures for the DoD.

**Conclusions:**

- 1) PATH improves access to care in remote locations
- 2) PATH provides quality subspecialty care to patients in remote locations where local expertise is unavailable or limited
- 3) PATH reduces costs by at least \$200,000 per year by preventing unnecessary air evacuations and face-to-face consultations
- 4) PATH captures workload for consultants and

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 System Administrator: Nolan Carpenter

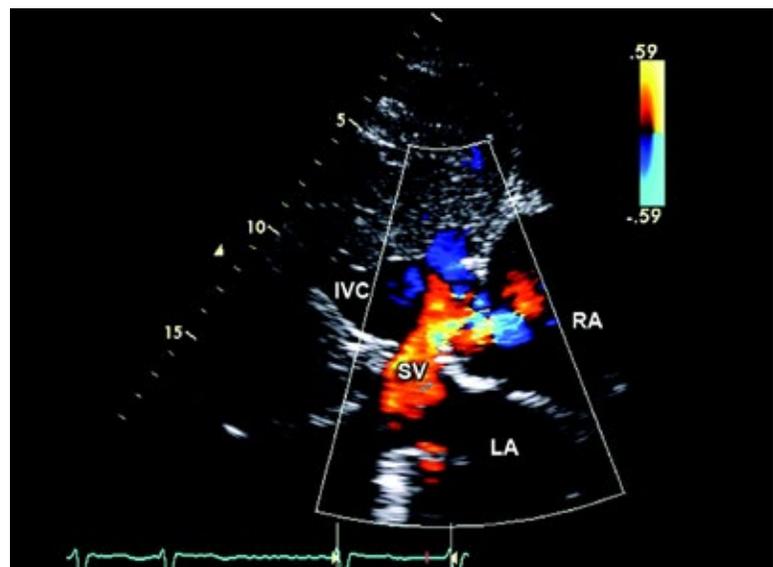
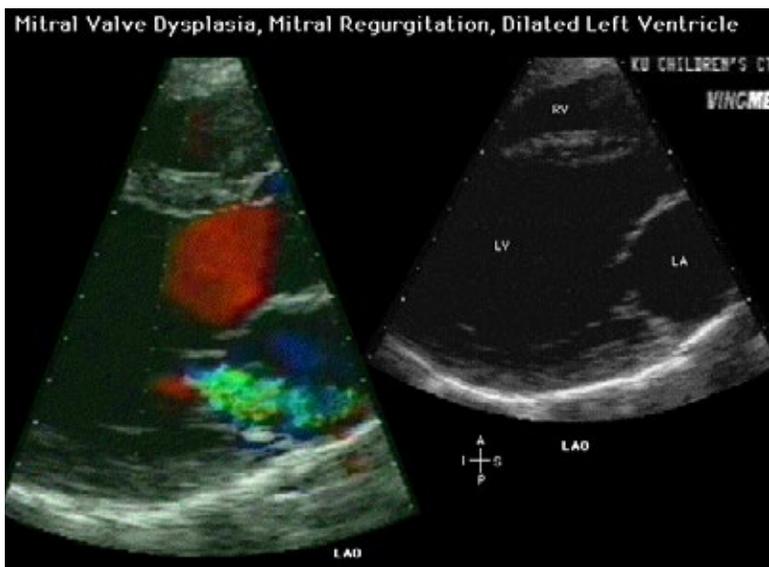
## Western Regional Medical Command (WRMC) Success

### *Pediatric Teleechocardiogram Services in the Western Region*

The one-time cost of equipment to provide pediatric teleechocardiograms? About \$50,000. Being able to emergently rule out within hours of birth a potentially serious heart defect in a newborn? Priceless!

Such are the outcomes for the Madigan Army Medical Center (MAMC) Pediatric Teleechocardiogram Service, currently available for use by Bassett Army Community Hospital (Fort Wainwright, AK), Weed Army Community Hospital (Fort Irwin, CA), and Naval Hospitals Bremerton and Oak Harbor (Puget Sound). This service allows a pediatric cardiologist at MAMC to evaluate and diagnose in real time by video camera a newborn with a heart murmur or suspected heart defect with parent and pediatrician participation. If necessary, the echocardiogram can be done in the newborn nursery by moving the required equipment where it needs to be. Emergent echos are scheduled with the MAMC pediatric cardiologist by phone, less-emergent echos can be scheduled by secure email. Each visit

averages 60 minutes and is conducted as any other telehealth visit with the introduction between the pediatrician and newborn parents and the pediatric cardiologist being done by video camera. The echocardiogram is done by the pediatrician at the originating site placing the video camera, which is connected to the ultrasound, on the baby's chest. The ultrasound equipment and video camera at the originating site is connected to an ethernet port, and the information is transmitted to the pediatric cardiologist. The entire study is done live, and at the conclusion of the exam a plan for treatment discussed, agreed upon, and implemented. This service is an example of the power of telehealth, how it can provide exceptional customer service, excellent patient care, and reduce the burden of either family members or providers having to travel long distances for care.



## Southern Regional Medical Command (SRMC) Success

### *Email Teleconsultation Program Booming!*

The Army Garrison-Theater Teleconsultations Program for Deployed Providers supports deployed healthcare providers using a secure email-based system that operates 24 hours a day / 7 days a week / 365 days a year. The program began in April 2004 with dermatology as the test specialty. This was followed by ophthalmology. Soon other specialties joined the program. Currently there are over 30 specialties participating in the program. 20 specialties are organized by email utility accounts in which the consultants receive and answer consultations. Another 12+ specialties are reached through a generic email account managed by referral manager who sends the consultation to the consultant(s).

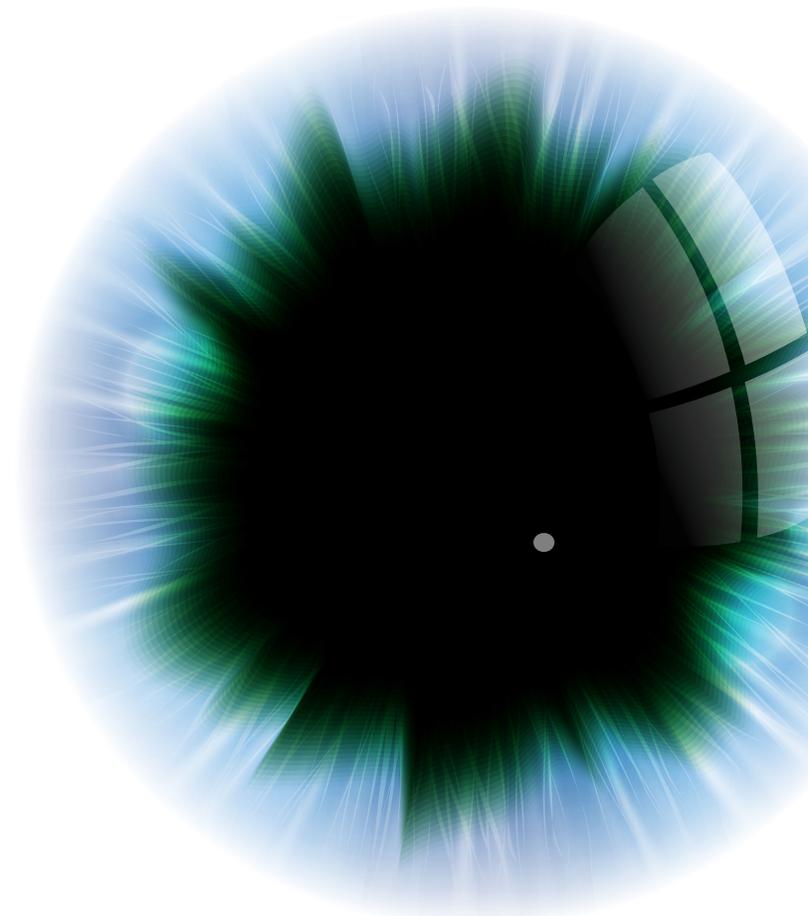
The email teleconsultation program answered 58 consultations in May bringing the total to 12,756 consultations since April 2004. The average reply time was 5 hours 22 minutes. Dermatology and orthopedics were the most requested specialties. May was the busiest month in FY15 so far with 13 consultations received from Afghanistan. The Navy at sea sent 7 consultations. Our NATO partners were also supported with 4 consultations received from two Australian physicians supporting the coalition forces in Afghanistan. We received our first consultation from Gabon (West Africa) and our first consultations from the USS Dewey and the USS New York.

A related program is the SRMC Teledermatology program. In May, the SRMC teledermatology program answered 140 consultations. Fort Hood was the leading Army facility while Cannon AFB was the leading Air Force facility. SRMC began

its support of Fort Wainwright, Alaska during the summer underlap. SRMC also agreed to support Maxwell, Tyndall and Altus AFB during an underlap as well; support will begin in July.

Together, the Army Garrison-Theater Teleconsultations Program for Deployed Providers and the SRMC Teledermatology program are serving to heal, honored to serve!

New Products: Telehealth Coding Cards – Have both cards with perforated edges to cut and use at the computer.



# Telehealth Coding Card

The Telehealth Service Line is developing new tools for you every day. These are all part of our growing “telehealth toolkit” designed to assist our community in expanding the use of virtual care in the Army. Below you should find a Telehealth Coding Card for providers -- a shortcut guide to coding for TH. The card is set up to be printed on a 8.5”x11” sheet of paper. Just cut along the red dotted line and fold along the gray dotted line, and you’re set. Putting this next to your computer can help you remember how to code for TH. Remember -- correct coding for TH is required to earn IRIS incentive payments!

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<p><b>Documenting Telehealth Encounters in AHLTA</b>  <b>At the ORIGINAL site (where patient is located)</b></p> <p><b>STEP 1.</b> Create a 'Walk-in' appointment when patient checks in on the day telehealth appointment is scheduled.</p> <p><b>STEP 2.</b> Go to the S/O Module. In the HPI Tab, click the large '+,' sign next to "Encounter Background Information." Make the following or similar entry in the free-text field: "Patient appointment for telehealth with (Name of Specialist at location of Specialist or Specialty Care Clinic)" If using a template such as AIM-TSWF-Core, make the entry in the History field or box of the template.</p> <p><b>STEP 3.</b> Go to the AP Module. In most cases, enter the Diagnosis V68.81 (visit for: refer patient without exam or treatment). Please see note below. Enter the (HOPCS) Procedure Q3014. (Telehealth Originating Site Facility Fee)</p> <p><b>STEP 4.</b> Go to the Disposition Module. In the 'Billing and Admin' Section, answer 'No', in most cases, to 'Meets Outpatient Visit Criteria (Workload)?' Please see note below.</p> <p><b>STEP 5.</b> Sign the encounter note.  <i>NOTE: Document the required specialty-specific protocols in the respective AHLTA modules, e.g. vital signs, height and weight, in the Vitals Signs Module, etc. Document all procedures.</i>                  The level of patient-provider interaction will determine if the encounter meets outpatient criteria, what the diagnosis(es) should be, and what E&amp;M code to use.</p> <p><b>STEP 6.</b> Document any time spent on Telehealth Activities in DMHRSI using appropriate MEPRS FCC and -.99 subtask code.</p>	<p><b>Documenting Telehealth Encounters in AHLTA</b>  <b>At the DISTANT site (where specialist is located)</b></p> <p><b>STEP 1.</b> Go to the Appointment Module. Double click on the patient's appointment to open the encounter.</p> <p><b>STEP 2.</b> Document the encounter as usual, as in face-to-face visit. Complete the Vital Signs, S/O and AP Modules as normal, with or without the use of AIM-TSWF-specialty templates. Include the appropriate procedure codes in the AP module.</p> <p><b>STEP 3.</b> Add the applicable GT or GQ modifier. Go to the AP Module.                  a. <i>Select CPT code in Procedure Tab</i>                  - Ensure that the appropriate procedure is documented.                  - Double click the procedure to open the Procedure Modifier window.                  - Click the drop-down arrow to show the list of modifiers.                  - Scroll-down and select 'GT' or 'GQ' whichever applies.                  b. <i>If the E&amp;M Code is other than 99499</i>                  - Click the 'Additional E&amp;M Coding' tab.                  - Click the drop-down arrow to show the list of modifiers.                  - Scroll-down and select 'GT' or 'GQ' as appropriate.  <i>REMINDER: Add the Diagnosis V15.52 in the AP Module if the telehealth encounter is secondary to TB!</i></p> <p><b>STEP 4.</b> Sign the encounter note. Telehealth Modifier Definitions:                  GT - Via Interactive Video/Audio Communication (for synchronous, real-time telehealth encounter)                  GQ - Via Asynchronous Telecommunications System (for asynchronous, "store and forward" telehealth encounter)</p> <p><b>STEP 5.</b> Document any time spent on Telehealth Activities in DMHRSI using appropriate MEPRS FCC and -.99 subtask code.</p>
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## For More Information Contact Your Regional Telehealth POC

**PRMC** (808) 433-4500

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**WRMC** (253) 967-9751

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(210) 355-5272  
**SRMC** (210) 295-2060  
(210) 295-2510

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(571) 231-5404  
**NRMC** (571) 231-5401

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**ERMC** 496 302 68732

### Learn more about Army Telehealth:

<http://armymedicine.mil/Pages/telehealth.aspx>

### The Army Telehealth Service Line Collaboration site (CAC-enabled)

<https://amp.amedd.army.mil/com/tsl/SitePages/Home.aspx>

## The OTSG Telehealth Service Line Team

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