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Message from the Chief

Welcome to Army Telehealth Connections! As we move through the crisp air of autumn, the Telehealth team has been reminded that fall is a season of transition – of changing time, colors, and temperatures. In Army Medicine, we find ourselves in a time of change as well, as we say farewell to our 43rd Surgeon General. LTG Horoho is a visionary leader in telemedicine and connected health. Throughout her tenure, TSG consistently found new opportunities for telehealth to support our partners in health.

You will see LTG Horoho's influence on the progress detailed in this issue. For example, the article on Telemonitoring (TM) (p. 5) is the first in a series of educational articles on key areas endorsed by TSG as part of our Army Telehealth expansion plan. We are gathering data on military use of TM, such as that from Womack's Diabetes Telehealth Clinic (see p. 7), to make informed decisions on enterprise expansion. As another example, our progress in "Operational Tele-Behavioral Health" (detailed

on p. 17) directly supports our expansion goal of maturing telehealth in operational environments / combat zones. Additionally, please see Regional Health Command – Europe's progress on using telehealth cart technology for acute primary care (p. 15), bringing Army Medicine closer to achieving the vision of a virtual Patient-Centered Medical Home.

Finally, please don't miss the embedded pdf on p. 19. It is a copy of the 43rd Surgeon General's Thoughts on Connecting Health Globally. In that document, you will find a little about our history and current capabilities as well as our vision for the future.

Thank you, LTG Horoho, for your vision and support. You will be greatly missed, but your influence on Army Telehealth will be felt for a long time to come.

- Colleen Rye, Ph.D.Chief,
Telehealth Service Line



FY15 Telehealth Fiscal Incentives Awarded to Health Readiness Platforms Commanders

4th quarter and FY15 totals are in for telehealth incentive payouts in the Integrated Resourcing & Incentive System (IRIS). Over \$470,300 was awarded in the 4th quarter. Six Health Readiness Platforms (HRPs) are in the top 20% for telehealth workload and earned over \$327,400 in the 4th Quarter (Table 1). Tripler Army Medical Center currently leads the pack.

The same six HRPs account for approximately 70% of the total TH workload and IRIS payouts for FY 15. The total FY15 payout for all of MEDCOM HRPs was \$2,042,865 (Table 2).

Kudos to the Commanders of these six facilities for their consistent leadership in TH workload and incentive payouts. They are best practice leaders for Army Telehealth! Who thinks their HRP can make the cut in FY16?

For guidance or assistance on integrating or expanding telehealth capabilities to other clinical specialties, visit the THSL's SharePoint for products to adopt and integrate TH in an Operating Company Model methodology.

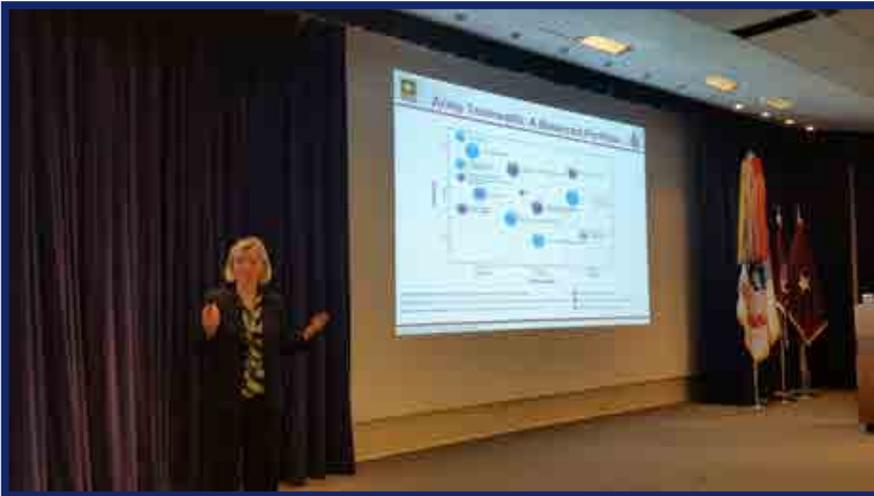
Table 1

IRIS dates are Aug 2014 through Jul 2015			
HRPs with Top 20% of Telehealth Workload			
Health Readiness Platform	Encounter or Teleconsultation From		4QFY15 Incentive
	Patient Site	Provider Site	
Tripler Army Medical Center + Hub	1,680	3,237	\$106,740
San Antonio Military Medical Center + Hub	25	3,692	\$74,465
Kimbrough Ambulatory Care Center + Hub	1,401	2,011	\$75,245
Darnall Army Community Hospital	1,768	0	\$44,200
Guthrie Ambulatory Health Care Center	589	0	\$14,725
Brian Allgood Army Community Hospital	352	163	\$12,060
4th Qtr Incentive			\$327,435

Table 2

Health Readiness Platform	Encounter or Teleconsultation From		FY15 Incentive
	Patient Site	Provider Site	
Tripler Army Medical Center + Hub	8,586	11,452	\$443,690
San Antonio Military Medical Center + Hub	98	15,228	\$307,010
Kimbrough Ambulatory Care Center + Hub	5,834	6,892	\$283,690
Darnall Army Community Hospital	7,543	0	\$188,575
Guthrie Ambulatory Health Care Center	3,429	0	\$85,725
Brian Allgood Army Community Hospital	2,625	566	\$76,945
Cumulative Incentive			\$1,385,635
Total being paid out in FY15			\$2,042,865

Army THSL Director at the Decision Science Leaders Camp



Dr. Colleen Rye speaks at a morning plenary session at the Decision Science Training Camp for Leaders. The training session focused on the skills and knowledge needed for Command Teams, who were gathered from around the world at Camp Robinson (outside Little Rock, Arkansas).

On August 26, 2015, Dr. Colleen Rye (Chief of the Army Telehealth Service Line) spoke at the morning plenary session of the Decision Science Training Camp for Leaders at Camp Robinson, Arkansas. In her remarks, Dr. Rye outlined Army Telehealth's current capabilities and highlighted products developed to help Command Teams continue to implement a global Operating Company Model. Dr. Rye also engaged with the group about Army Telehealth's vision for the future, noting key elements of Army Medicine's three-year telehealth expansion plan, the Connected, Consistent Patient Experience. Command Teams from across Army Medicine were able to give their input into areas ripe for expansion in telehealth.

The Decision Science Camp is one of a series of trainings offered by the U.S. Army Medical Command G 8/9 directorate. Decision Science Training Camp for Leaders

focused on the skills and knowledge needed for Command Teams, who were gathered from around the world at Camp Robinson (outside Little Rock, Arkansas) to learn from each other and from the speakers on best practices in key areas for Army Medicine.



Dr. Colleen Rye explains the products developed to help Command Teams using an Operating Company Model concept. Products include telehealth education and training, communications materials, an online business intelligence portal with a comprehensive suite of metrics, and a system of monetary incentives to encourage local investment in telehealth capabilities. Products also include policy, standard operating procedures, and development guides to ensure standardized telehealth processes across the world.

Telehealth Cart and Remote Monitoring Devices Displayed at the Medical Association of the United States Army (MEDAUSA) Conference

COL Danny Jaghab (OTSG Telehealth Service Line, THSL) and MSG Alexander (Regional Health Command – Atlantic, RHC-A) attended the MEDAUSA conference on 22 September 2015 to showcase telehealth carts and remote monitoring devices used in clinical settings throughout the MEDCOM. The conference and the display were well attended by many senior leaders.



The telehealth display at MEDAUSA

(Left to right) MSG Jason Alexander (RHC-A), GEN(R) Gordon R. Sullivan (AUSA President), and COL Danny Jaghab (OTSG THSL).



Telehealth 101 Corner: Telemonitoring (TM) / Remote Patient Monitoring (RHM)

Telemonitoring (TM) is defined as a set of clinical tools and services designed to monitor the health status of at-risk patients managing chronic conditions. TM uses information and network technologies to provide these services at a distance to support “connecting health globally.” The case for TM has been posited as key to the delivery of cost-effective care for chronic illness because it has the potential to:

- 1) address the need for patient engagement in outcomes by promoting adherence to treatment guidelines and awareness of the importance of self-health management; and
- 2) enable provider situational awareness of patient status and out of range conditions outside of office visits.

TM includes identification and notification of pre-defined physiological events and threshold states such as are present in the development of adverse medical conditions. This supports earlier intervention to prevent or reduce the risk of disease exacerbation and potentially prevent hospital readmissions. The most prevalent use case is chronic disease management (CDM) supporting a variety of conditions ranging from diabetes mellitus (DM), asthma, cardiovascular diseases (CVD), hypertension, and chronic obstructive pulmonary disease (COPD) among other conditions. TM also goes by a variety of monikers including remote patient monitoring, mobile health (mHealth), e-Health, telemedicine, telecare and telehealth. The term “telemonitoring” will be used here because of its precision and prevalence in the evidence base.

“Automated Hovering”

In the July 2012 issue of the New England Journal of Medicine, Dr. David Asch introduced the concept of “automated hovering” in healthcare. He implored medical

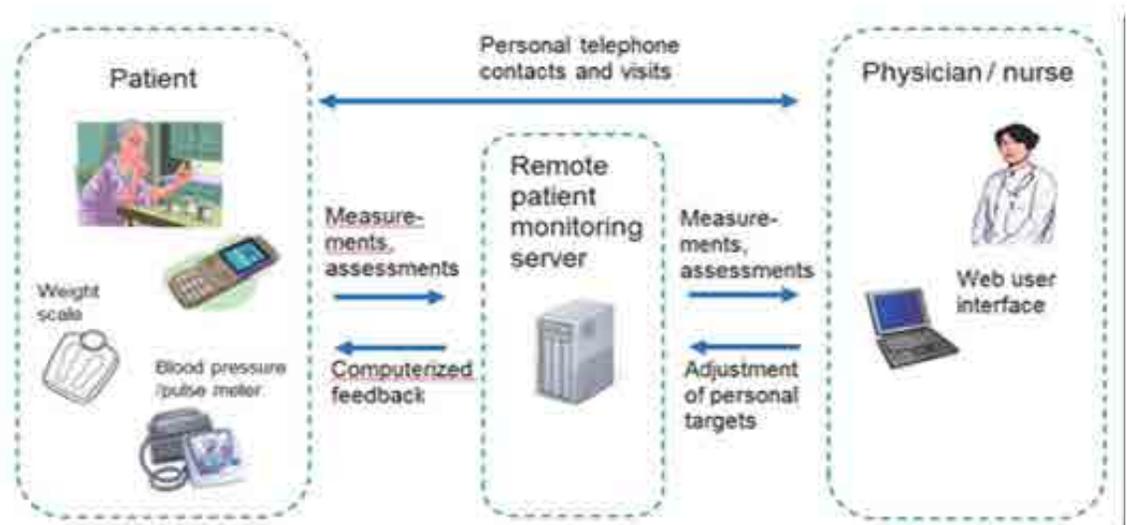


Figure 1: A Representative Telemonitoring System for CVD and Diabetes

professionals to remember that high-risk patients managing chronic illness spend 5,000 waking hours per year outside of clinical encounters. This is in contrast to the typical handful of hours each year a patient may spend in the doctor's office. During this time patients are making fundamental decisions on medications, lifestyle and other activities that can profoundly affect their health. Patients frequently struggle to manage multiple medications, follow dietary restrictions, monitor weight, vital signs, undertake a regimen of prescribed exercise, schedule and confirm appointments with multiple specialists as well as obtain transportation. And yet the patient's day-to-day activities are the least visible component to providers, but primarily determine health outcomes. Notably, the 5,000 hours equates directly to the "Lifespace" defined in the Army Medicine 2020 Campaign Plan as a key element in the transition to "a System for Health."

New value-based care models provide greater impetus behind the use of TM tools and services as an integral component of effective chronic care management. This development is anticipated to fuel adoption over the next five years. Figure 1 provides a typical TM system from a 2015 randomized controlled clinical trial (RCT) of a TM system supporting CVD and Diabetes patients.

Clinical Support at Home and Away for Active, Healthier Living

Some definitions of TM focus narrowly on home-based "telecare." However, the ubiquity of smartphones, tablets and Internet access demonstrate that TM "untethers" patients from the bedside or home. Patients and providers are now freed to conduct their normal activities and receive innovative health education and clinical services from any location. This includes access from school, work, travel, and elsewhere in the community. According to a 2015 Pew Research Center Survey, "nearly two-thirds of Americans are

now smartphone owners and, for many, these devices are a key entry point to the online world including, historically underserved disabled and minority populations." Further, seeking information on health conditions (at approximately 62%) is the number one application for smartphone end-users, cutting across age, socio-economic, and other demographic factors. Providers and caregivers are able to subscribe to customized, priority patient status or alerts anywhere, look-up information, and respond immediately and securely from the convenience of their mobile devices.

The latest compiled Level 1 evidence from systematic reviews of randomized clinical, controlled trials (RCTs) demonstrates that TM, as a tool, improves outcomes and fosters self-health management as part of a chronic disease management program following clinical practice guidelines. A summary of the evidence from the most recent systematic reviews on TM effectiveness across a variety of chronic conditions can be found in the upcoming Winter issue of the Army Telehealth Connections Newsletter.



Regional Health Command - Atlantic (RHC-A) Success

Womack Army Medical Center Diabetes Telehealth Clinic

The Womack Army Medical Center Diabetes Telehealth Clinic began in the 1990s as a way to improve care to Soldiers newly diagnosed with type 1 diabetes. Unlike those with type 2 diabetes, all patients with type 1 diabetes require intensive management with basal and bolus insulin therapy. This requires highly intensive training to not only maintain excellent control, but to do so in a way that is safe yet without hindering personal or military lifestyle. The latter is of significant concern to Soldiers as retention in the military after diagnosis is difficult unless the Soldier can clearly demonstrate the ability to perform self-care. Furthermore, fitness for duty determination involves not only the personal ability to manage diabetes, but also the ability for the Soldier to manage their duty assignments that include deployments.

The frequent face-to-face meetings that were required before the availability of advanced technology typically precluded a favorable re-integration into the operational tempo of the unit.

Ultimately our goal was to safely deploy Soldiers with type 1 diabetes.¹ In the last decade, formal deployment criteria has been published in AR 40-501 that outlines several key components that must be met to include adequate control and avoidance of dangerous hypoglycemia.² With this criteria in mind, we adopted a policy to treat all Soldiers as if they were elite Olympic endurance athletes with type 1 diabetes. This type of training and subsequent monitoring require very frequent follow-up and immediate access for trouble-shooting. Conventional medical care cannot accommodate such attention to detail.



Insulin pumps and continuous glucose transmitters used in the Womack pilot.

Therefore, our clinic opted to use a wide-variety of available platforms to provide telehealth to our Soldiers. Later, this was extended to pediatric and pregnant patients who required intensive management. Obstetric patients in particular would be expected to fare well since our clinic requires twice a week data reviews, a frequency that may preclude face-to-face visits.

The Diabetes Telehealth Clinic maximally utilizes the technologic capacity of commercially available FDA approved products. Our Certified Diabetes Educator/Certified Pump Trainer regularly communicates with the manufacturers by troubleshooting and suggesting improvements to products. Ultimately, all patients with type 1 diabetes in our clinic are advised to utilize an insulin pump and continuous glucose sensor. These devices allow for remote download that can be transmitted by email to the provider or via secure proprietary web site.

Formal consent for electronic transmission of data is obtained and documented via MEDCOM FORM 756. All contacts are entered into the electronic health record and maximally coded per guidelines established by our business office. Downloaded data includes precise details of insulin dosages to include basal and bolus rates, carbohydrates consumed, amount and timing of insulin boluses, activity markers, and compliance with pump requirements such as changing of tubing and self-monitoring of blood glucose.

Additionally, the continuous glucose sensor measures sugars every 10 seconds and provides real-time average values every 5 minutes. The sensor has predictive alarms for high and low sugar threshold and additionally can alarm when the rate of lowering is predictive of pending hypoglycemia. One of the sensors currently available has the ability to provide actual simultaneous real-time values to not only the patient, but also the diabetes team. Using such technologies, we are able to

review downloads from anywhere in the world via internet access. Furthermore, at times when very frequent reviews are beneficial, such as training for an endurance event or initial insulin pump start-up, daily downloads can easily be accomplished with 24/7 feedback.

In addition to web-based downloads and other electronic access, all patients enrolled into the telehealth clinic are given 24/7 pager and cell-phone access to the diabetes team to provide immediate instruction for urgent issues such as recurrent or single serious hypoglycemic event, sickness and risk for diabetic ketoacidosis, and insulin pump failure. Our ultimate goal of utilizing any venue other than face-to-face was to provide the most efficient and efficacious care possible to assist our Warfighters.

Our experience with telehealth in pediatric and active duty Soldiers has been documented.

Furthermore, we have used individual patient data collected via remote transmission to document safe glucose profiles during various military activities such as high-altitude/low-opening and static line airborne operations, standard physical training, and athletic events such as a variety of team sports, 400 mile



(Left to right) Jon Cucura CDE; SSG George Morrison, SFC Alan Haddon, Dr. Sammy Choi

cycling events, and ultra-marathons. Such highly detailed data has been used to provide documentation for the MEB/PEB process directly contributing to the vast majority of our Soldiers being found fit for duty. Without telehealth, the training and documentation required by face-to-face visits would likely have precluded such a successful outcome.

Finally, our patient satisfaction has been very high as demonstrated by the numerous patient compliments we receive for “getting great care without having to drive to Womack.” The ultimate success for us is when our Soldiers ask us to continue telehealth when they are found fit for duty and move to a new assignment. We have provided this to several Soldiers and are working on formalizing a protocol with their receiving primary care team.

EAMC Tele-Behavioral Health Program Extends ‘5-Star Service’ Beyond Hospital Walls

When Soldiers and other authorized beneficiaries visit Eisenhower Army Medical Center, they are accustomed to receiving two things: a warm personal greeting steeped in traditional southern hospitality and a professional “5-Star Service” ... a hallmark of this world-class healthcare facility.

Rising 13 stories high on a commanding hilltop position, the medical center can be clearly seen for miles around. With the addition of state-of-the-art tele-



capabilities, the facility’s behavioral health providers can now be seen from anywhere in the world.

Originally launched in 2009 as the Southeastern Regional Medical Command’s Behavioral Health Proponency, the TBH capability of EAMC was designed and equipped to

provide seamless behavioral health services to Soldiers in six states plus outlying clinics in Honduras and Puerto Rico. In addition to enhancing access to care, the use of TBH facilitates continuity of care (as opposed to fragmented care) and allows Soldiers to be seen by healthcare providers who understand the military culture and requirements, and reduces medical and travel expenses for Soldiers and their families.

EAMC TBH provides a robust variety of services and capabilities including medical evaluation board, temporary disability retirement list, integrated disability evaluation system appraisals, command directed evaluations, military readiness evaluations, medication management, evidence based psychotherapies such as prolonged exposure,

behavioral health (TBH)



Eisenhower Army Medical Center and Rodriguez Army Health Clinic Create Unique Telehealth Model to Improve Access to Care for Patients Who Need Consultations with Specialists

cognitive processing therapy and cognitive behavioral therapy , psychological assessments, crisis intervention, TBI evaluations, TBH program management consultations, and provider training.

EAMC TBH providers have performed more than 5,700 patient care encounters at a wide variety of locations to include:

- Support to U.S. Army Health Clinic SOUTHCOM in Miami, which has been increasing annually and totals approximately 3,700 appointments to date
- Mobilization and demobilization of Soldiers in support of combat operations overseas; TBH performed more than 1,100 encounters to Reserve and National Guard Soldiers.

Eisenhower Army Medical Center and Rodriguez Army Health Clinic Create Unique Telehealth Model to Improve Access to Care for Patients Who Need Consultations with Specialists

A pilot project between the Eisenhower Army Medical Center (EAMC) and the Rodriguez Army Health Clinic (RAHC) is testing today’s technology to deliver cost-effective remote medical consultations. Dr. Joseph Wood, an Endocrinologist and EAMC’s Chief Medical Information Officer, has partnered with the LTC Sloniker, RAHC Commander, to improve access to care for Soldiers and their families at Fort Buchanan, Puerto Rico. Leveraging synchronous telehealth capabilities, patients are able to receive timely specialized care from a virtual team of nurses and medical specialists.

to leverage telehealth capabilities to improve access to care, efficiency, and recapture purchased care costs

This high-tech model uses nurses from RACH and the Community Care Unit-Puerto Rico to support clinical operations both at EAMC (tele/virtual) and at RACH. RAHC’s nurses provide “virtual” case management, care coordination, and telehealth encounters to enable patients in Puerto Rico to access an Endocrinologist in Georgia.

The telehealth care delivery concept will first be used with endocrinology patients, since there are very few endocrinologists in Puerto Rico, and RAHC patients typically have long waiting times to get an appointment locally. RAHC plans to expand telehealth capabilities to other EAMC specialty clinics. The ultimate goals are



LTC David L. Sloniker, Commander, Rodriguez Army Health Clinic Fort Buchanan, Puerto Rico

A Deputy Commander of Clinical Services (DCCS) Account of a Successful Partnerships:

Dwight Eisenhower Army Medical Center and Lyster Army Health Clinic Received the Army Medicine Wolf Pack Award for Teleradiology Program

Prior to 2013, Lyster Army Health Clinic's (LAHC) in Ft Rucker, met their radiology needs using an in-house Tricare contract radiologist who interpreted exams after normal duty hours. As a result, LAHC providers had limited ability to consult a radiologist to address specific patient concerns and access to a radiologist for emergency or STAT interpretations were not available. Furthermore, the radiology technologists performing the exams did not have consistent access to a radiologist to support an effective quality control program.

In 2012, while serving as the Chief of the Radiology Department, at Dwight David Eisenhower Army Medical Center (DDEAMC) I was contacted by COL James Laterza (then Commander of LAHC and current Commander of Landstuhl Regional Medical Center). Upon discussing the concerns with the delivery of radiology services at LAHC, we felt a telehealth solution most effectively leveraged existing resources and technology at DDEAMC to meet the needs of the patients at LAHC. This discussion ultimately lead to the vision of a patient-centered, cooperative tele-radiology venture, by which DDEAMC would serve as the sole provider for the interpretation of radiology examinations performed at LAHC, as well as the overseer of the quality control program.

As a result of the incredible effort by Active Duty Soldiers and civilians at both medical treatment facilities, this vision was realized in July 2013, and continues to function markedly well to this day. On 13 March 2015, 19 members of DDEAMC and LAHC received the Army Medicine Wolf Pack Award for the first quarter of 2015,

which recognizes exceptional teamwork by an integrated group of military and civilian team members focused on excellence in support of Army Medicine.

From the perspective of a patient at LAHC, the transition to utilization of teleradiology services at DDEAMC was seamless. The acquisition of the imaging study remained the same, as all imaging was still being performed at LAHC. However, once the imaging study was performed, the images were electronically transferred, in a secure fashion, to DDEAMC for interpretation. Upon interpretation by a radiologist at DDEAMC, the results of the study were instantaneously made available to providers at LAHC through the Composite Health Care System



(CHCS) database. While the process, to this point, may not have seemed different to the patient, what they likely noticed was that the results of the study were available in far less time than under the previous process. In fact, after implementation of this teleradiology service, the average time from study acquisition to the reporting of results (turnaround time) decreased to less than 4 hours, compared to greater than 14 hour turnaround times under the previous arrangement. Additionally, feedback on patient studies to the LAHC provider and patients was dramatically accelerated with the decreased turnaround times.

An additional benefit to patients at LAHC that resulted from this teleradiology program was improved access to a wider variety of imaging examinations due to the presence of multiple subspecialty-trained radiologists at DDEAMC, that were not previously present at LAHC. Although, it may not have been transparent to the patients, safety was improved with this process as well. Due to faster turnaround times, concerning abnormalities could be identified sooner and relayed to the patient's provider by the radiologist at DDEAMC, such that prompt medical care could be provided in the minimum amount of time. Furthermore, providers at LAHC now gained reliable telephonic access to a radiologist at DDEAMC for expert consultation to assist them with patient care decisions, at all hours of the day/night, a service that simply was not available in past. From a quality perspective, DDEAMC offered LAHC expert oversight of quality control in all imaging modalities ensuring optimal technical performance of patient's imaging examinations.

Notably, overall costs to LAHC and the Army enterprise were decreased with the use of teleradiology. Before LAHC and DDEAMC entered into this partnership, the previous arrangement was that a TRICARE contract radiologist would interpret studies at LAHC and

bill professional fees to the TRICARE contract vehicle. This arrangement resulted in an average total cost to LAHC for professional fees of approximately \$170,000, annually. By making use of transient capacity at DDEAMC (spreading the work of one radiologist at LAHC to ten radiologists at DDEAMC), the Tricare contract was no longer needed. As a result, the cost to the government was effectively erased with a minimum, immediate and recurring direct cost savings to the Army enterprise of over \$170,000, annually.

Data relative to patient satisfaction were not collected as there were no specific changes to the overall experience to the patient having a radiologic study performed at LAHC. Again, for the patient this transition was seamless. However, surveys of LAHC providers were obtained to evaluate provider perceptions and satisfaction with the teleradiology support from DDEAMC. The survey results revealed an overwhelmingly positive response from the providers at LAHC in 3 key service areas: quality, convenience, and timeliness of reporting results.



*LTC Paul Michaud, DCCS
Paul Michaud, M.D., Ed. M., P.T., Deputy Commander for Clinical Services, Nuclear Radiologist, Reynolds Army Community Hospital, Ft Sill, OK*

Regional Health Command Central (RHC-C) Success

Army Surgeon General Email Teleconsultation Program during Wartime

The following information was presented at the 2015 AMEDD at War, Lessons Learned Conference.

The Army Surgeon General's email teleconsultation program is available to deployed healthcare providers of all branches of the United States military. The US Army Medical Command and the Supreme Headquarters Allied Powers Europe signed a Memorandum of Understanding to permit North Atlantic Treaty Organization healthcare providers deployed to Afghanistan to use the program. Deployed providers include physicians, physician assistants, nurses, independent duty medical technicians (IDMT) and Special Forces medics.

Here are what some of the deployed providers have said about the program:

Feedback from Deployed Providers:

- I have found teledermatology to be a great idea. I was able to send my patient back to performing his duties in an environment where commanders cannot afford to lose Soldiers for long periods of time. By getting brigade surgeons to email the program prior to sending them to the CSH will keep Soldiers doing their duty.
- The program has been very well received out here and has helped tremendously in the management of patients.
- This service is a real life saver! It's like having my own personal team of specialists... this is outstanding. I do not know how I did it before this service was created!

- I was truly amazed (at the response of the consultants). The consultants jumped on the consult and the first response by Dr. S got me in the blink of an eye before I could even make my way to our TOC to run the case by the XX eye specialists. Not only did I avoid waking up the XX eye specialists last night but more importantly avoided an unnecessary MEDEVAC.
- I am redeploying shortly. I want to tell you how valuable this system has been. My first deployment was to XX in 2000 and if this system had been available then, medical care would have vastly improved.



Regional Health Command - Pacific (RHC-P) Success

Acute Primary Care via Synchronous Telehealth

Regional Health Command Europe (RHC-E) telehealth completed a six month project evaluating the use of synchronous telehealth (TH) for acute care complaints at a single Army Health Clinic (AHC). Same-day TH appointments were offered when all same-day in-clinic appointments with primary care providers were exhausted. During this six month project which ended May 2015, four volunteer providers completed 143 synchronous TH encounters. The success demonstrated was a combination of technical and clinical planning, establishing appropriate inclusion and exclusion criteria, and using presenters well-versed in TH (Figure).

Provider and patient satisfaction were extremely high with nearly every patient pleased to have been offered a same day appointment that if not available would have resulted in a deferral to the local German emergency room at a cost of approximately 200-400 Euros (\$225-\$450) per patient. Mr. Irfan Bojicic, the clinic telehealth nurse, said "my patients are greatly surprised by our capabilities, happy to have this option, and would like to use telehealth again."

The PolyCom HDX9000 Medical Cart® and TH cart devices included a general exam camera, otoscope, and stethoscope. Mr. Bojicic assisted by performing an initial brief presentation to the TH provider which in less than 2 minutes explained the telehealth workflow process

which included the 2-patient identifier, consent form completion, intake screening questions, medication reconciliation, vital signs, and the chief complaint.

This acute care pilot, which is similar to civilian TH studies, demonstrated that synchronous TH is an effective option for the delivery of high-quality, routine medical care for minor illnesses, injuries, and other non-emergent conditions in the primary care setting. Further, the ability of TH to be part of the "medical neighborhood" complementing the Primary Care Medical Home (PCMH) remains a key component within RHC-E.



Inclusion Criteria

- All Adults FOR Acute Care
- Children 2 and older Acute Care
- Upper and Lower Respiratory Infections
- Asthma and Allergies (Acute Exacerbations)
- Rashes/Poison ivy
- Gastroenteritis/GI Complaints
- Pink eye
- Urinary tract infection
- Ear infections
- Minor Orthopedic Injuries
- Physical Exams (CYS Physicals, Sports, PHA's, PDHA's, PdPHA's)

Exclusion Criteria

- Chronic Care
- Emergency Care
- Physical Therapy
- Public Health
- Optometry
- EDIS/Social Work Services
- Child Psychiatry (2 FTE)
- TBI (.5 FTE Case Manager)
- Polytrauma – more than one system injured should first be seen in Emergency Department (i.e. hit head and possible broken bone in extremity after fall)
- Female abdominal pain



The Mission of Operational Tele-Behavioral Health (OTBH) Continues to Make a Difference

You have completed your Battle-Space Circulations each month until now – this time the trip keeps being delayed by weather. You have patients at three separate locations. Some are critically short of medications; others need follow-up care, still others need a professional consultation, sooner rather than later. What can you do right now? Answer: Go “virtual” - make your clinical rounds via telemedicine!

Tele-Behavioral Health (TBH) is a treatment delivery modality that has been used in the CENTCOM AOR since 2010, when TATRC was directed by the Army Surgeon General to develop and support an in-theater Operational Tele-Behavioral Health (OTBH) system. TATRC was once again selected for a unique mission because of its proven ability to create and implement just-in-time solutions to complex organizational challenges. According to COL Lisa Breitenbach, MC, CENTCOM Theater Mental Health Consultant, “OTBH’s primary use is to deliver comprehensive Behavioral Health (BH) services to areas lacking BH (staff) assets. Remote locations with minimal staffing and sites

where travel was difficult and/or dangerous were selected.” Medical Signalers configured assured military communications to support each remote site, adding a tele-component to their already challenging mission set. Their actions facilitated this long-term tele-clinical success story.

By the end of 2011, the TBH system was seeing 20% of all theater mental health encounters. During the next three years, TBH accounted for over 2,000 visits each year, through a network of 87 sites in all four regional commands. The CENTCOM Mental Health Consultant provided clinical over-watch of all in-country patient encounter, face-to-face and TBH, with no significant difference in patient outcomes.

The USA Public Health Command patient survey reported a key factoid, ... “that nearly 72% of theater tele-behavior health patients reported they would not have sought BH care if the tele-care had not been available.” Today, the current distribution of BH assets in the CENTCOM - AOR is the ideal environment for the use of TBH by



LTC Rafael G. Semidel, Sr., M.D., DABFM
Psychiatrist, 883rd Med Det. (CSC) TF Prospect, Iraq



tele-BH system test, Iraq

facilitating the access to subspecialty skills for psychotherapy, psychopharmacology and administrative evaluations. Communication with Service Members, professional colleagues and commanders can be achieved without the risks and disruption of travel, according to Mr. Dave Williams, FACHE, TATRC, Project Manager.

Going “virtual” and using telemedicine, allows greater flexibility to providers, and greater access to patients in different locations.

It has been a really productive afternoon, nine patients in three locations – each seen and seen by “virtual face-to-face”. Each patient received personalized care, medication and lab work. Each episode was electronically documented in their long term medical record and each patient experienced the difference telemedicine could make as a force multiplier for their medical well-being.

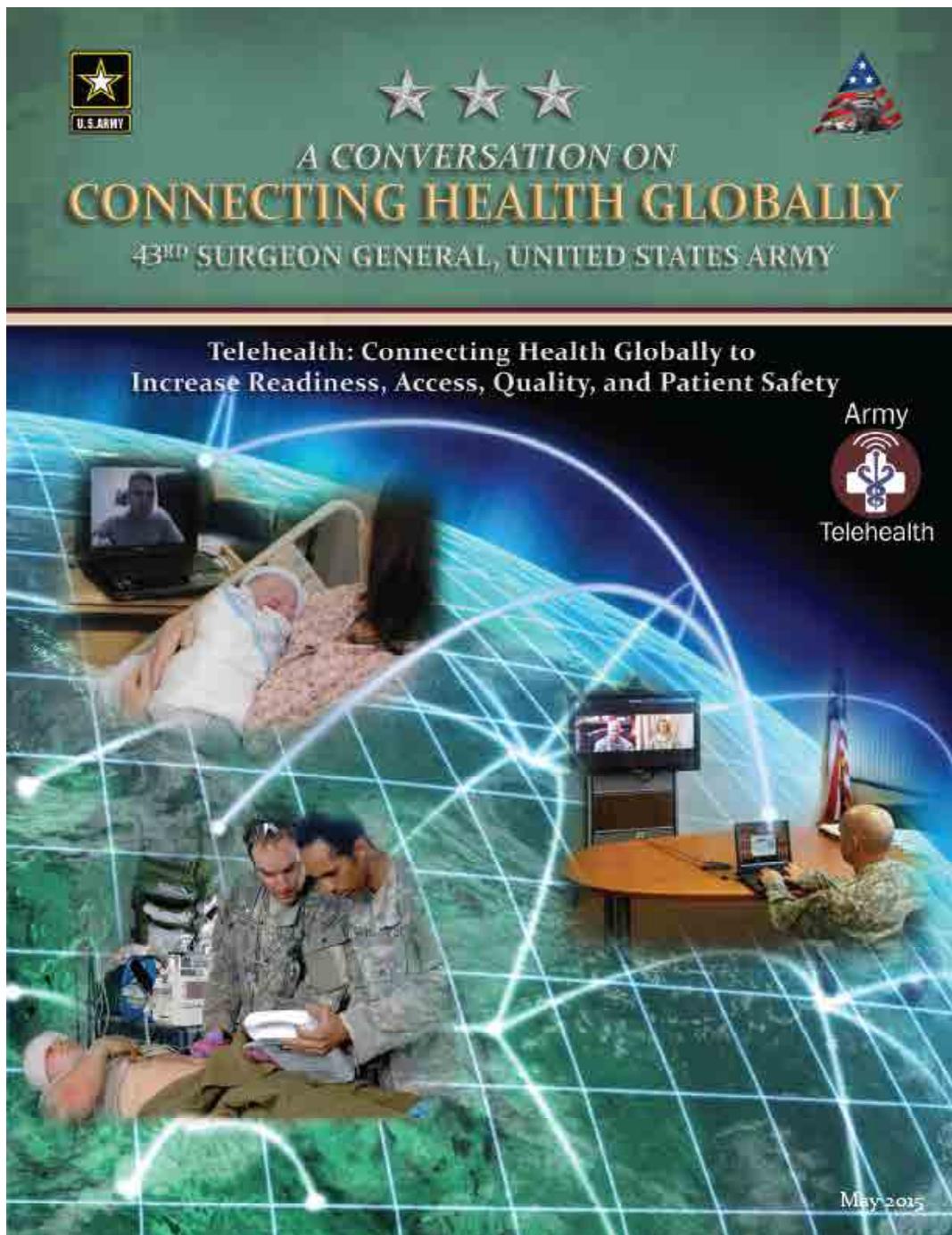
THSL Members



THSL Members David Putnam, Kimiesha Henderson, MAJ (P) Maria Shelton with The Surgeon General LTG Patricia Horoho

New Product: TSG's 43rd Thoughts on Connecting Health Globally

Click the image below to view a PDF of our Army Surgeon General's thought on telehealth!"



**For More Information Contact
Your Regional Telehealth POC**

PRMC (808) 433-4500

WRMC (253) 967-9751

(210) 355-5272

SRMC (210) 295-2060

(210) 295-2510

NRMC (571) 231-5404

(571) 231-5401

ERMC 496 302 68732

**Learn more about
Army Telehealth:**

[http://armymedicine.mil/
Pages/telehealth.aspx](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](https://amp.amedd.army.mil/com/tsl/SitePages/Home.aspx)

The OTSG Telehealth Service Line Team

Chief:

(703) 681-4426

Deputy Chief:

(210) 221-7256

Policy Lead:

(703) 681-4423

Analytics Lead:

(210) 221-7079

Communications and Evaluation Telehealth Lead:

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