

ARMY TELEHEALTH CONNECTIONS

Newsletter from the U.S. Army's Telehealth Office

*Special
Edition
2016*

Army Medicine's Telehealth in Primary Care Spring 2016 Special Edition

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Eisenhower Army Medical Center



Blanchfield Army Community Hospital



Landstuhl Regional Medical Center



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Welcome to a special edition of Army Telehealth Connections! Excitement about Telehealth expansion is building in Army Medicine, and our facilities are making great strides in growing our longstanding use of virtual tools. Perhaps nowhere is the excitement and progress greater than in primary care settings. And it's easy to understand why. Telehealth can increase readiness, our number one goal. For example, when a Soldier in Europe completes their Periodic Health Assessment through one of our Virtual Readiness Clinics, they train longer and are more available for the mission (versus the alternative of sometimes traveling hundreds of miles for the encounter). You'll find more on this smart new process from Europe in this issue. Telehealth can also increase access to care, solving short-term capacity challenges by cross-leveraging available provider time across hundreds or even thousands of miles. In this issue, you'll learn more about how we're increasing access to care by connecting low acuity patients in the Ft. Campbell Emergency Department to primary care providers at Ft. Gordon. The in-process results are excellent - patients are receiving after hours care in a timelier manner, and we're finding that it enhances

satisfaction too. Speaking of patient satisfaction, our patients around the world are finding better interactions with their providers through the use of digital tools. Imagine seeing inside your own ear with a digital otoscope (and then really understanding why you need to take that medication!) Consider also a family member in Germany that connects to their specialist across large distances from their local Primary Care Clinic; they find convenience and comfort in their own language and accepted care modalities. (More on these vignettes from our Commanding General and Commander perspectives that follow...) Additionally, telehealth enhances quality. Please don't miss Pacific's successes in training primary care clinicians in expert pain management approaches, with excellent results for chronic pain polypharmacy high utilizer patients.

Thanks for stopping by to learn more from our Army Telehealth community about some exciting new developments, and please let us know if you have more lessons to share. Together, we'll enhance readiness, access, and quality for the people whom we are privileged to serve.

Colleen Rye, PhD



Atlantic Telehealth in Primary Care

From the Regional Health Command – Atlantic (RHC- A)

The Digital Transformation

I'm going to date myself a little bit here. When I was a child and young adult and we needed access to our money, we went to the bank, filled out the withdrawal slip (or deposit slip), stood in what we hoped to be a short line, and had a face-to-face encounter with the teller at a time convenient to the bank. It wasn't necessarily convenient for the customer; they even called it "banker's hours".

The objective—getting our money—was accomplished, but it required significant effort and time. Often more time than we would have wanted to dedicate to the task. Today, we can access our accounts anytime from anywhere with an Internet connection. Brick-and-mortar banks still exist with the same limited hours for customers who need the specialized assistance of a teller, account representative, or loan officer.

The same concept can be applied to healthcare. As the former Army Medicine Functional Champion

for the electronic health record, I believe that digital communication can be an influential force in helping improve patient care, patient satisfaction, and even health outcomes, all of which are key to access, quality and safety.

Healthcare delivery is being transformed by advances in e-health and by empowered, Internet-savvy people. Our patients, especially those who have come of age since the Internet, are ready to become partners in their own health and to take advantage of online processes, health portals, physician web pages, and e-mail.

During the last few years, the military health system has launched a few tech-based healthcare solutions such as Army secure messaging, TRICARE Online, and Nurse Advice Lines. These tech solutions allow our patients to get the answers they need to routine questions, arrange appointments and referrals, and request prescription refills all from their home, office or while on the road without having to make a trip to one of our medical facilities.



Brig. Gen. Ron Place, MD
Commanding General



Our region is using telemedicine to bridge the distance between our patients and providers.

These processes are designed to make healthcare more accessible no matter where the patient may be. Technological solutions mean that our patients don't have to visit the treatment facility for non-urgent, routine healthcare, for every educational interaction, or administrative tasks. This frees our staff to address the more complex healthcare delivery needs that require a clinic visit, which can help improve access to care.

Our ability to provide the care our patients need is critical to our success as a health care system. If we don't get it right, then what value do we bring to our patients? The digital transformation era is here. I challenge all of you to embrace the technology and optimize our future relevance.

Telehealth (TH) Pilot to Support Overburdened Emergency Department (ED)

Many Army hospital emergency departments (EDs) experience overcrowding and extensive wait times. At the same time, data demonstrate that up to 75% of ED visits could be handled directly by primary care physicians – including such conditions as colds, chronic pain and prescription refills. Telehealth (TH) could enable a timely alternative in the provision of medical services to military members and their families in these situations. Using video-teleconferencing (VTC), patients presenting with non-acute conditions in the ED can connect with primary care clinicians in other locations that have periodic excess time in their schedules.

To assess the feasibility of alleviating overcrowded EDs with TH, a six-month pilot beginning February 2, 2016 was endorsed by the Vice Chief of Staff of the Army (VCSA) and directed by the then Army Deputy

Surgeon General (DSG).

The ED at Fort Campbell's Blanchfield Army Community Hospital (BACH) was chosen as the site connecting eligible patients to primary care providers (PCPs) from a distance at Fort Gordon (DDEAMC). The initial response team coordinating the pilot at BACH consists of a triage nurse, medic, and clinical leader (charge nurse). A BACH pharmacy technician, at the ready to deliver prescriptions to the ED as required, and the



DDEAMC Primary Care telehealth champions

offsite providers at DDEAMC (445 miles away) round out the core team. Newly developed processes ensure that patient quality and safety are not compromised and that the volume of patients will not change BACH's current Army Medical Home (AMH) model or ED workflow. At its core, an existing redirect process at BACH connects patients with lower-acuity conditions (identified as Emergency Severity Index (ESI) category 4 or 5) to off-site providers. The patient must also consent to the telehealth encounter.

The technology includes a telemedicine station configured with a variety of peripheral instruments to screen the patient accurately at the point of care. The capabilities range from HD VTC cameras, to store-and-forward capture technology, to connected peripherals (stethoscope, EKG monitor, spirometer and otoscope). Thus, real-time clinical data and virtual interactions are possible and support a variety of pilot program metrics. Furthermore, laboratory and imaging tests can be ordered and reviewed by the PCP. The approach provides a hub where a secure and comprehensive telemedicine encounter can take place.

Two rooms at BACH are designated for telemedicine encounters. Operating hours are Sunday through Thursday from 15:00 to 23:00. Once completed, the pilot results will be assessed for impact on: wait times, length of encounter, and readmission to the ED within 30 days for the same condition.

The biggest challenges are expected to come from synchronizing care between the two healthcare teams in separate locations and refining the patient encounter to incorporate TH seamlessly. Standardized criteria for ensuring communication channels remain open throughout the encounter are pivotal to successful outcomes.

There are many anticipated benefits.

The pilot is expected to meet the senior leadership objectives to leverage TH more fully throughout the continuum of care. Integrating collaboration between the emergency and primary care fields may lead to an increase in patient satisfaction. Additional expected outcomes include a decrease in costs (attributed to reductions in unnecessary care), and improved patient safety and quality.



DDEAMC Primary Care TH Champions

With the prior information as background, let's hear the perspectives of leaders and providers on the ground:

Improving Patient Access, Soldier Readiness

According to Master Sgt. Jason Alexander, RHC-A (P) Clinical Operations NCO, many ill patients use the emergency department after hours due to the unavailability of their primary physician. With the pilot, RHC-A staff are helping the emergency department staff at BACH focus on more seriously ill or injured patients.

Accessibility involves establishing an "on-demand" Virtual Patient-Centered Medical Home (PCMH) to redirect non-urgent care

patients from BACH's emergency room in Kentucky to an area where they can be screened and evaluated by qualified telehealth physicians working at DDEAMC in Georgia. The team also extends beyond RHC-A to include combat medics and nurses from Fort Campbell's 86th Combat Support Hospital. This team is receiving training on the equipment and processes to evaluate the feasibility of using telehealth with forward deployed units.

"The objective here is not just reduce wait times but to assist people who leave because they are tired of waiting and leave without being seen," said Alexander. "So the 'left without being seen' rate should drop, our wait times should drop, and the quality of the encounter and handoff by redirect to primary care should improve as we integrate our systems inside the hospital."

Lt. Col. Kevin Horde, a family medicine physician from Fort Benning's Martin Army Community Hospital supporting the pilot at DDEAMC, had no telehealth experience before joining the team.

"It's a great opportunity to move our care

delivery to the next level," he said.

To prepare for his first virtual patient, Horde undertook online TH training and became credentialed to practice at both DDEAMC (his base of operations) and BACH. Hours of practical experience followed under the tutelage of Dr. Wood, chief of telehealth at DDEAMC. Simulated patients and scenarios helped familiarize Horde, and other RHC-A physicians, with the virtual exam process.

"With that very first patient, I had a little anxiety despite all of the training," Horde said. "Family medicine is hands-on. But the technology actually enabled me to experience a great interaction with the patient. I was surprised."

"After the nurses in the room with the patient explain the process, I am introduced via the videoconference screen," he added. "Usually the patient's first reaction is a smile. I think they are curious about being a part of this [pilot] and interested in the entire process because it is new. We work together as a team and that is what the patient-physician relationship should be."



BACH Team incorporates the PCMH Team Huddle into the Virtual Primary Care TH Process



BACH Patient Administration (PAD) Non-Commissioned Officer (NCO) conducting training on patient registration for pilot participants.

Voluntary surveys given to patients after the exam indicate they believed the medical problem was adequately addressed and are satisfied with the telehealth experience.

Overall, BG Ron Place, RHC-A Commanding General notes: ***"Bringing the right care, by the right person, at the right time, and in the right format will enable us to transform our delivery of care and improve patient access to that care."***

Telehealth in Primary Care - the Medic's Perspective

Our current mission is to emulate the redirect process of BACH. That process takes patients with a lower triage category and connects them to a Primary Care Manager (PCM) in the Family Care Clinics. We use our telehealth equipment to link ED patients via VTC with a doctor at Fort Gordon after normal duty hours, when the most patients utilize the ED.

The biggest part of our job is as a care coordinator, ensuring potential patients are good candidates for our program and the necessary processes are followed. We had to

become Patient Administration/Dispositions (PAD) experts to register remote patients in the Fort Gordon DEERS database (CHCS). This required countless hours of teamwork and training to ensure timely and quality registrations. We also worked closely with the Triage Nurse and Clinical Lead (Charge Nurse) to select appropriate patients for the program.

All in all, we're very excited about this program. MSG Alexander with the regional level Telehealth Program stated "VTC medicine is the future" and we completely agree. These services will not eliminate the need for face-to-face visits but will instead cater to those people who want to remain in their homes and see a doctor. So far, we have had nothing but positive feedback from our patients regarding their experiences.



BACH Medic practicing with peripherals in order to assist PCM in the pilot.



BACH Medics see first-hand how clear the images can be in real-time.

Early Patients' Comments Using Telehealth at BACH:

"The experience was awesome and very informative." – 2/18/2016

"Good experience. I'm glad the nurse thought I was a good candidate for this option. In my experience, an ER visit takes at LEAST 2 hours. I was in and out in an hour." – 2/17/2016

"That was awesome! Thanks!!!" – 2/17/2016

"Please continue to use Telehealth. No more long wait times." – 2/17/2016

"Great concept for helping soldiers in a combat environment. I received the same care over a teleconference as I would have in person. Great tool for the future." – 2/28/2016

"This is a great program. Expand it and use it more. The new technology here at BACH is AMAZING! I was able to be seen by a physician for a minor problem without tying up a room and physician and taking away from more serious patients." – 3/1/2016

"I felt like the doctor was right in the room with me and the RN was very nice. Now that I am registered, I feel it would not take as long to be seen this way. I liked being seen this way. I love that I will not have to go to the pharmacy, that my meds will be handed to me. A PLUS!!." – 3/1/2016

"Very satisfied with this visit! Would actually prefer this method." – 3/1/2016

"I thought this was a brilliant way to handle the situation my son needed to be seen for. I'm glad it was available." – 3/7/2016

"It was great and fast. Very efficient and convenient. Thank you for offering this service." – 3/7/2016

"This is much better than service provided in person. JOB WELL DONE." – 3/9/2016

"Seems like the start of an amazing medical asset!" – 3/10/2016



Telehealth in Primary Care at Blanchfield Army Community Hospital (BACH) –the Leadership Perspective:



COL TELITA CROSLAND, MD
Commander

Telehealth impacts readiness, since as we learn how to use it in a garrison environment, we will be better prepared and more comfortable with the prospect of using TH in a deployed environment. It allows us to approve a concept where we can deliver safe, quality care remotely...Telehealth expands our potential to deliver care to our beneficiaries, by enabling our health system to meet the needs of our patients in a more efficient manner. It has the potential to project worldwide capabilities from home soil allowing us to better support deployed service members.

I find it fascinating when we utilize what we call a peripheral, with a technician doing an exam that translates to what the physician sees. We didn't stop doing the things we needed to do to deliver safe care, we figured out how to use technology to do that. They looked in my ear a little while ago using the otoscope, and I've never seen my own ear drum before. Not only could I see it, but it looked better

than when I looked in a more narrow field as a physician; the technology magnifies things and makes them more visible, helping me make better decisions clinically. So it's a way to open up access, not at the expense of quality. In fact, some may argue it's done a little better because we have this technology...

Telehealth in Primary Care at Dwight D. Eisenhower Army Medical Center (DDEAMC) - the Leadership Perspective:

The innovation of Telehealth will be part of the transformation of primary care delivery during this century. It has the potential to largely replace face-to-face (F2F) consultations in the same way digital photography replaced Ektachrome film. DDEAMC has the technology and more importantly the positive attitudes to lead the MHS in this groundbreaking innovation.

The burden of Telehealth training and credentialing fell on those who were interested and dedicated to taking part in this technology demonstration program. There were no special incentives other than the pride of acting as pioneers in changing the way we experience primary care.

Telehealth will revolutionize the delivery of many types of healthcare, starting with primary care, and will completely change the calculus on what access to care means among the MHS stakeholders. This successful pilot in primary care will establish the credibility to extend the reach of telehealth technology to medical and surgical specialties. This is ground breaking work that will usher in a new century of access and quality.

Imagine a future where you open a MHS smart phone app and you are able to make an appointment ... that is the future of Army Medicine.



COL Michael Weber, MD
Commander

European Telehealth in Primary Care

From the Regional Health Command – Europe (RHC-E)



BG Norvell V. Coots, MD
*Commander RHCE and U.S. Army
Europe Command Surgeon*

Regional Health Command Europe is an ideal environment to capitalize on the benefits of telehealth. Telehealth allows us to mitigate short term access to care challenges by virtually cross-leveling providers from other clinics. This affords patients the option of care in a familiar surrounding with staff they are familiar with and trust, while decreasing reliance on emergency rooms and unnecessary network care.

The preparation of the staff members at the Wiesbaden Army Health Clinic was similar to concierge service at a hotel. The needs of the staff were carefully listened to, evaluated and tailored to each individual in the team. Creating a staff with high confidence in the use of Telehealth is a huge factor for the patient enjoying the care experience and also instilling great confidence in the staff and process. The patient surveys revealed a 99% highly satisfied with the care rating, exceeding MEDCOM standards.

The impact for the patient is high quality health care in a "Virtual Cloud" of trust and confidence with their physician and presenting nurse. For the community, the impact is keeping the community members at their Primary Care Medical Home, as they expect, maintaining uninterrupted care at that clinic. The impact for the provider/support staff is that they can reach out to their medical community in times of transition, such as summer moves, and rely upon the balance of the medical region to support the Patient Centered Medical Home at the home clinic. The impact of the pilot for the Wiesbaden organization and other Primary Care Medical Homes in our Region is the pride and ability to support their most important mission which is to care for the patient, using telehealth as a tool to ensure that capability.

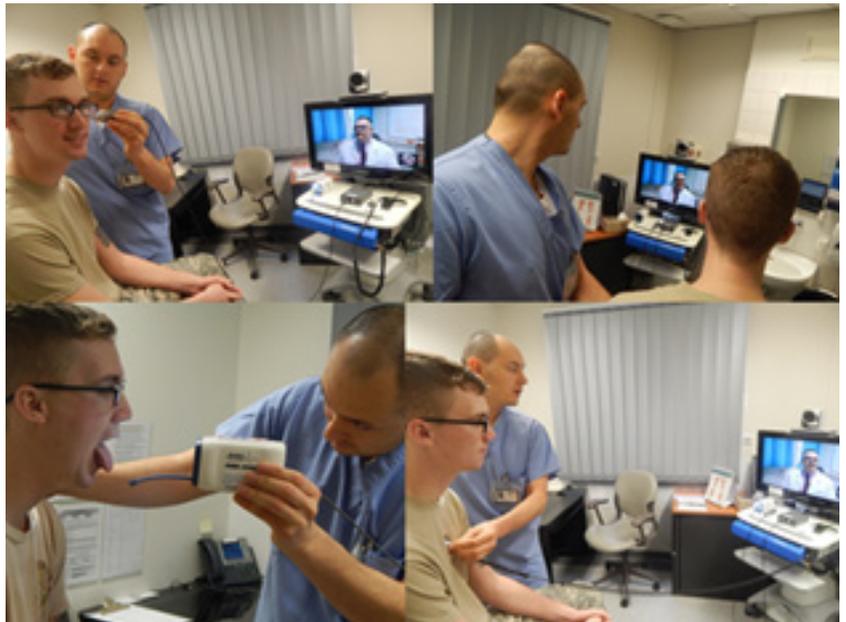
For the AMEDD this pilot demonstrates that Telehealth is a modality of care that makes every clinic a part of the Medical Center neighborhood. The impact for Army Medicine is that Primary Care and the use of Telehealth is another awesome opportunity to ensure that the Soldiers, Airmen, Sailors and Marines with their family members enjoy the care the Army Medical Family can provide as well as to our Retirees and DOD Civilians.

Telehealth platforms allow us to optimize readiness across multiple domains while enhancing the quality and access to care in remote locations. Telehealth can be leveraged to improve the medical readiness of Soldiers by allowing the completion of deployment

and periodic health assessments as well as ensuring accurate medical profiling is performed. Telehealth will also continue to contribute to the maintenance of a ready medical force by ensuring our active duty medical specialists maintain their skills by evaluating a broad range of medical conditions. With Landstuhl Regional Medical Center serving as the primary evacuation hub for three geographical combatant commands, we are ideally situated to establish a hub-and-spoke telehealth network to provide primary and specialty care to Service members and their Families in remote assignments and embassy postings across Europe, Asia, and Africa.

European Region Telehealth Success Story: **A Primary Care Experience with Synchronous Telehealth. “You may now enter the ‘Virtual Exam Room’”**

The Landstuhl Regional Medical Center (LRMC) Telehealth Program Office (THPO) and the Wiesbaden Army Health Clinic (WAHC) completed a six month pilot project evaluating the use of synchronous Telehealth (TH) for acute care complaints in a primary care setting. Four providers completed 143 synchronous TH encounters between December 2014 and May 2015. The Pilot successfully demonstrated that many acute care complaints can be evaluated and treated successfully via synchronous TH using existing information technology (IT) and TH infrastructure. Notably, provider and patient satisfaction were found to be very high. Nearly every patient who participated viewed their experience positively and was pleased with the same day appointment via TH that would not have been available otherwise. Competent



RHCE Primary Care Telehealth Staff in action

nurse presentation of patients, experienced providers and excellent infrastructure all contributed to quality encounters and pilot success.

Implementation of this complex effort required a rethinking of the delivery of care at the Wiesbaden AHC by the clinic staff, providers and the patients themselves. Potential barriers identified included resistance from medical personnel, lack of staff technical expertise, and difficulties in coordinating services. In October 2014 the Landstuhl THPO and the Wiesbaden staff began meeting to work through the technical and clinical issues by developing Process and Appointing Guidelines. By the time of implementation in December 2014, clear guidelines were in place, with tasks and roles defined. This effort coincided with the hiring of a full time TH nurse at Wiesbaden to assist with specialty as well as primary care presentations in the TH exam room. Inclusion criteria were carefully selected with the recognition that not all medical

conditions are appropriate for TH encounters. For example, the team excluded females with the complaint of abdominal pain as this may require a more nuanced physical exam. Same day TH appointments were offered to patients only after all clinic same-day appointments with Primary Care Managers were exhausted. The process workflow provided standardized methods with the MEDCOM TH framework. For example, all patients were consented for TH and provider notes documented in the patient's outpatient medical record (AHLTA). Charts were peer-reviewed to ensure high quality care.

The set-up provided high quality tools to perform comprehensive assessments of patients for most primary care/sick call complaints within the appointing guidelines. The Telehealth Cart devices included a general exam camera, otoscope and stethoscope (Figure 3) at the originating site (WAHC). The HD screen on the TH Cart provided a good face-to-face interview platform during the history-taking. IT technicians from the

Figure 3: Instrumentation on the Telehealth Medical Cart for patient assessment.



Stethoscope



Otoscope with Imaging Box



General Exam Camera

LRMC Video Network Center (VNC) installed VTC on providers' desktops at LRMC. The four providers were able to see these patients from their own offices at LRMC. Geography is not a limiting factor with distant site providers. At the initiation of every medical VTC encounter, the technicians assigned the encounter a unique PIN number to ensure a secure and private connection. The VNC quality-checked the audio and video of each encounter and was available for additional technical support, although technical issues were rare. Bandwidth within the network was sufficient for good audio/video quality with near negligible network delay.

The idea of seeing patients from a distance via TH was a new concept for most providers and acceptance was not always immediate. However, over time, providers recognized that high quality encounters and a high level of both patient and provider satisfaction could be achieved with a well-designed TH effort. Provider acceptance and satisfaction with

the pilot was generally very good. Providers involved in the pilot developed a strong appreciation for the high quality of both the IT connections and TH medical devices. Confidence in the pilot was enhanced through the provision of alternate clinic providers and local emergency services at the originating site.

The providers volunteering for the pilot from LRMC consisted of two experienced physician assistants, a primary care nurse practitioner and a family practitioner with additional specialty in occupational health and travel medicine. These providers completed 143 synchronous TH encounters with the Wiesbaden AHC between 1 December, 2014 and 31 May, 2015. Patients were seen in an afternoon clinic consisting of seven same day 20 minute slots twice weekly on Mondays and Wednesdays. The encounters mirrored the inclusion criteria closely (table 1). Nurses assisted by performing an initial brief presentation to the distant provider covering intake screening questions, current medication list and summarizing the chief

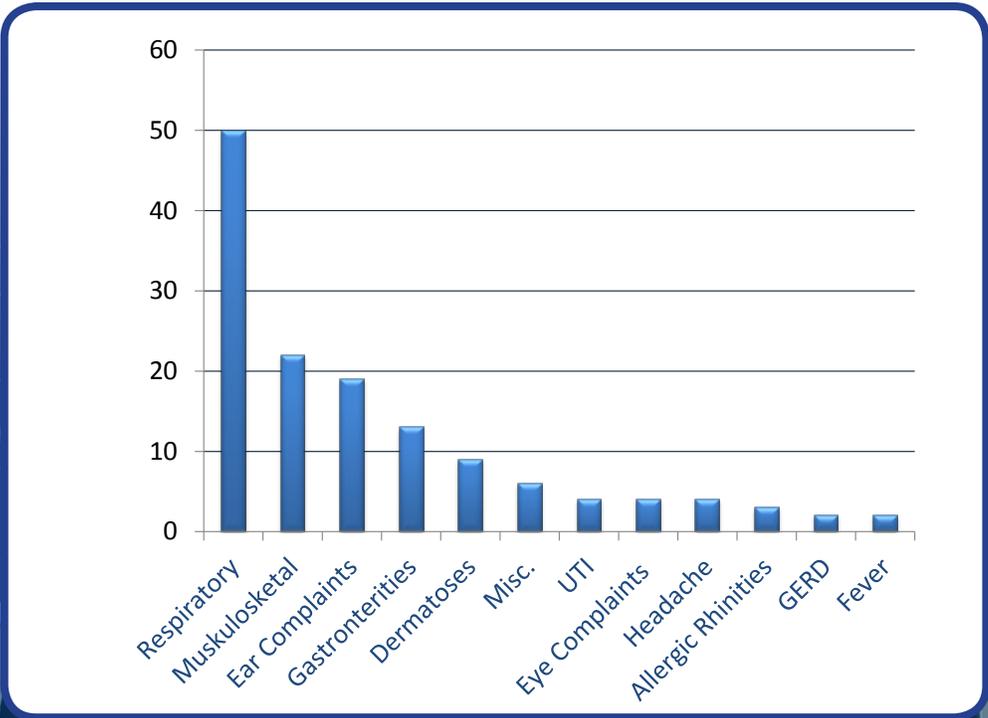


Table 1: Diagnosis Breakdown

complaint. Providers noted satisfaction with the capabilities of the TH equipment including the general exam camera, and fiber optic otoscope. Some minor difficulty was noted with the telephonic stethoscope. It seemed to perform well for heart sounds when the distant provider wore headphones, but for breath sounds it seemed less useful owing perhaps to cord or connection interference noise. One patient with flank pain and pyuria evaluated during a TH encounter was referred to the ED and found to have an obstructing ureteral stone requiring urgent stenting. With the aid of the TH nurse assisting in the exam and local labs, the more urgent nature of the complaint was quickly identified by the TH participants and the patient was triaged properly. Overall, technical support issues were managed successfully by the TH provider.

The Primary Care TH clinic with Wiesbaden continues today on a limited basis as we evaluate the feasibility of adopting a broader Primary Care TH effort. There will always be occasional provider shortages affecting access due to seasonal rotations, provider deployments, emergency leaves, etc. Telehealth can be the equalizer to address unevenness in provider availability within a group of clinics over a broad geographic area. The strength of TH is its ability to optimize scattered resources and deliver high quality care independent of geographic constraints. This pilot demonstrated that Synchronous Telehealth can be 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.

Figure 1: Pilot Primary Care Telehealth Appointment Guidelines:

<u>Inclusion Criteria</u>	<u>Exclusion Criteria</u>
<ul style="list-style-type: none"> • All adults for acute care • Children aged 2 and older acute care • Upper and lower respiratory infections • Asthma and allergies (acute exacerbation) • Gastroenteritis and GI complaints • Pink eye • Rashes • Urinary Tract infection • Ear infections • Minor orthopedic injuries • Physical exams (CYS physicals, sports, PHA, PDHA and PdPHAs) 	<ul style="list-style-type: none"> • Chronic care • Emergency Care • Physical therapy • Public health • Optometry • EDS and Social work • Child psychology • TBI • Female abdominal pain

New RHC-E Publication:

A Primary Care Telehealth Experience in a US Army Correctional Facility in Germany

Abstract:

Objective: To assess the feasibility of using telehealth (TH) equipment and infrastructure within the US Army's European Theater to evaluate and treat inmates with general medical complaints, and perform physicals and medical safety checks in a US Army Correctional Facility (CORFAC).

Methods and Materials: Synchronous TH encounters were performed using Polycom RealPresence software on providers' computers with high definition cameras on monitors at distant sites and PolyCom HDX9000 Practitioner Cart along with AMD Global Telemedicine devices at the originating site within the CORFAC. These devices included an AMD-2500 General Exam Camera, AMD Fiber optic Oscope, and AMD Telephonic Stethoscope. Patient consent for TH was obtained, and they were seen in the Medical Dispensary with Army Medics presenting the patients to the providers via TH.

Results: From May 22, 2014, to January 12, 2015, a physician assistant, nurse practitioner, and 4 physicians completed 177 synchronous TH encounters primarily at a CORFAC in Mannheim, Germany. Of these 177 encounters, 114 were Special Housing Unit (SHU) safety checks and 63 encounters were for physicals, medication management, and a variety of medical complaints including acute infections, abdominal pain, and musculoskeletal and dermatological complaints.

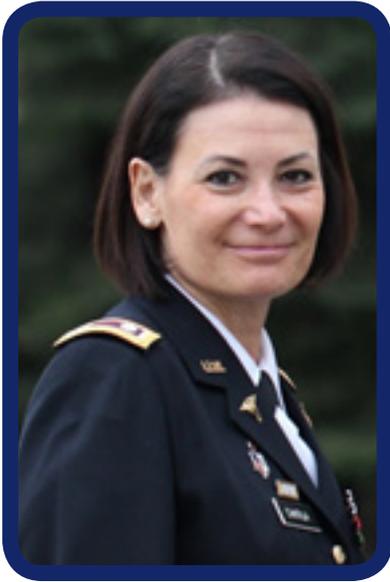
Conclusion: Synchronous TH was an effective option for the delivery of high quality routine medical care for minor illnesses, injuries, and other non-urgent conditions, as well as for general physicals and SHU checks in a correctional facility. Acceptance by providers and clinic staff was found to be high. Inmates were generally satisfied with their TH encounters. However, some inmates reported a preference to see provider's in-person, highlighting one of the challenges with acceptance of telehealth programs.

Swift CC, Cain SM, Needham, M.. AMEDD Journal. 2016(1); 76-80

Full text article link here: http://www.cs.amedd.army.mil/amedd_journal.aspx



From the Vilseck Health Clinic Commander's Perspective



COL Amal Chatila FNP, AN
Commander, Vilseck Health Clinic

As a patient, telehealth was about convenience, comfort and sustainability.

Convenience because it is very close to where I work in Bavaria Germany, comfort because of no language barriers, no unforeseen requirements or changes. I have been getting care in DOD MTFs for many years and I know the system- Telehealth afforded me the ability to stay within a comfortable and known safe setting.

Sustainable because I knew that my record will be in the MHS electronic record not only right away but also forever; it is ready for my PCM to see immediately if needed. The note from the specialist and if need be then my Telehealth provider can very easily communicate with my PCM. I know that when we go off post our notes eventually make it in the record, but to me this was more tangible and immediate.

As a provider- it was fun, I was able to show parents and patients exactly what I was seeing when looking at an ear or a throat etc. It was a great way to communicate with some of the teenagers and kids as well- they understand

the age of electronics more than anyone. Also it provided a great service to a sister clinic that had a need by providing timely access to care. As a provider and leader with administrative responsibilities, it was also convenient as I did not have to leave my office. The biggest benefit was of course to me as a patient, I knew I was getting or could provide safe, quality care saving patients from going off post for visits and venturing into a potentially new and stressful experience.

As a Commander, I love when my Soldiers use telehealth because for me it is equal to readiness. There is no lag in access to care, no gap in information being available- it is in real time. If a patient needs a profile, the telehealth provider is going to put it in eProfile and the same day I am getting notification. My Soldiers either return to duty quickly or if they have a limiting condition that I need to be aware of the telehealth encounters allow me to shift my resources and mission appropriately: support the Soldier and meet mission simultaneously.

Telehealth is a win for me three ways: as a patient, as a provider, and as a commander.

COL Chatila's experience as a patient was filmed by AFN as 30-second spotlight with a voiceover offering information on the 5Ws (who, what, where, when and why) of telehealth. This spotlight also included a listing of all the RHCE clinics that offer the service and is another prime example of the outreach of the telehealth team. <https://www.facebook.com/afnbavaria/videos/10153980947842520/>

Regional Health Command Europe (RHCE) tackles readiness

In the European Region, primary care drives the Army Chief of Staff's priority: readiness. To help advance this priority, RHCE is extending primary care with the creation of the first Virtual Readiness Clinic. For remotely located Service Members (SM), this is their link back to the Military Medical System. Examples of services provided in Virtual Readiness Clinics include performing Periodic Health Assessments, profile extensions, Post Deployment Health Assessments (PDHAs), Post Deployment Health Review Assessments (PDHRAs), weight management counseling, basic primary care, behavioral health, neurology, predeployment assessments, and security screening.

This service is especially useful as RHCE covers beneficiaries in over 96 countries and 138 remote sites and embassies. Not

only does RHCE support the European Command (EUCOM), but also the African Command (AFRICOM), the Central Command (CENTCOM), the Southern Command (SOCOM), the United States Airforce (USAF), the United States Navy (USN), the Department of State, and other DoD and U.S. government agencies. Virtual Readiness Clinics bridge geographic distance to support readiness.

Overall, Virtual Readiness Clinics are another way that TH is a force multiplier in achieving the military commander's need for ready Soldiers.

Examples of TH's power and appropriate use for readiness and primary care include the improvements demonstrated by the Virtual Readiness Clinic in Norway (Figure 1).



Virtual Readiness Cloud in Norway

①



②



1) Mr. White reviewing labs with MSgt Johnson who will present patient.
2) Dual discussion on labs, patient status. Patient will follow for presentation.

Who: Mr. James White & Senior MSgt Johnson
What: The team accomplished exceptional Medical Readiness with Armed Forces North Battalion in Norway.
When: Over the last year, once per week a provider and the clinical lead meet virtually.
Where: NATO Clinic located in Stravanger Norway, Regional Health Command Europe and Landstuhl Regional Medical Center.
Why: To accomplish Service Member readiness and healthcare by performing PHAs, profile extension, PDHAs, PDHRAs, weight management counseling, discussion of medical complaints, security screening, predeployment assessments, basic primary care, Behavioral Health and Neurology.
Priority: Readiness/Medical Diplomacy

Results: Virtual cloud keeps these 63 Service Members mission ready. Soldier readiness, specifically improved from 60% to 93%; keeping Service Members from having to travel for readiness leads to less travel risk; with 252 travel days saved, over 2,016 hours of work not lost, and \$26K travel dollars avoided.

Figure 1: Poster presentation on Virtual Readiness

Pacific Telehealth in Primary Care

From the Regional Health Command – Pacific (RHC-P)

Army Comprehensive Pain Management in Primary Care and ECHO Telementoring

Chronic pain is a complex and growing concern in today's military environment, with pain being the most frequent complaint reported during primary care visits. Pain management cases often present complex barriers to quality care, including the need for specialty care consults due to limited training in managing such patients at the primary care level.

To address these barriers to care, Army Regional Commands have joined world-wide telementoring initiatives to empower primary care providers. Since August 2013, the Interdisciplinary Pain Management Center (IMPC) at Tripler Army Medical Center (TAMC) has been conducting Army Pain ECHO (Extension of Community Health Outcomes) sessions in the Pacific.

Using VTC technologies, pain management specialists at TAMC meet with primary care providers from various facilities on a weekly basis to discuss patient cases and provide didactic learning. These sessions are available to primary care clinics at TAMC, Schofield Barracks Health Clinic,

Warrior Ohana Medical Home, multiple camps in Korea, and Japan.

Under the Medical Home concept, MEDCOM mandated establishment of a Comprehensive Pain Management Program (CPMP) in March 2014. All medical homes were to designate one primary care provider as a Primary Care Pain Champion (PCPC). This aligned nicely with the ECHO program as a vehicle for training the PCPC and providing a venue for case discussions. The use of the PCPC and ECHO is a "force multiplier" concept where providers build their individual capacity and confidence in managing chronic pain patients in facilities across the Pacific and other remote locations. Cases are discussed in a structured format amongst a group of providers. As a result, multiple providers have noted they are more confident discussing treatment with patients knowing their peers and pain specialists have reviewed and agreed with their treatment plans.

Care of complex pain patients in the Medical Home is a multidisciplinary effort with a team lead by the PCPC

and including a Nurse Case Manager, a Pharmacist, and, as needed, a behavioral health specialist. The team is supported at a distance by the Integrated Pain Management staff via the ECHO telementoring sessions. Goals are to reduce opioid use, increase use of other pain treatment modalities and decrease emergency room visits and inpatient hospitalizations.

Cases are tracked and results published quarterly based on data from the Patient Administration Systems, Biostatistics Activity (PASBA) and Chronic Pain Polypharmacy, High Utilizer Patient (CHUP) systems. The case lists are in a secure file and available for

each clinic to closely monitor. The program has been in existence for 18 months and has already achieved significant results within the region. This includes a 34% reduction in CHUP patients, a reduction in CHUP opioid prescriptions from 78,000 to 2,222, a reduction in CHUP encounters from 37,732 to 4,461 and a 33% decline in pain consults sent out to purchased care providers. The High Utilizers reported in the Command Management System (CMS) decreased by 1,000, a steep 33% decline. Cost savings has amounted to approximately \$6,200,000.



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Telehealth:

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The OTSG Army Telehealth
Team Collaboration site
(CAC-enabled)

[https://amp.amedd.army.
mil/com/tsl/SitePages/
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