

DOT MIL DOCS
DMD 92 - COL ENGEL ON CONTINUITY

Q: Hello. And welcome. You're listening to Dot Mil Docs, the military health system's official podcast. I'm Elizabeth Lockwood. And today is Thursday, January 7th, 2010. We here at the military health system hope you had a restful holiday season and that your new year is off to a fantastic start. Today, we are joined by Colonel Charles Engel, Director of the DOD Deployment Health Clinical Center at Walter Reed Army Medical Center. Colonel Engel is also the Senior Scientist at the Center for the Study of Traumatic Stress as well as an Associate Professor and Associate Chair at the Department of Psychiatry at the Uniformed Services University School of Medicine. Colonel Engel joins us today to talk about the deployment and health continuity of care for mental health that heals the wounded and builds their trust. Colonel Engel, welcome to Dot Mil Docs.

A: Thanks for having me.

Q: Absolutely. To get us started, can you tell us a little bit about this continuity of care? And how it fits into more traditional ways of healing, like antibiotics, vaccines and magnetic resonance imaging.

A: Yes. Well, continuity of care is really something that's basic to all forms of care, whether it's an alternative

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form of medical care or surgical care or basic primary care. And it's the extent to which a person has a continuous relationship with their doctor and with the health care setting. And there's a number of different features of it. It's kind of a fuzzy notion that is not black or white necessarily, grey. And there are shades of it.

But things that are important to it are factors like do you have a doctor that you can call your own? And is that ... does that doctor know you? Do they know your family? Is there a sense that you have that when you go to see the doctor that there's going to be a follow-up plan that's put into place and that you'll understand that follow-up. When a test ... when a test is ordered, are you confident that you will hear the results of that test, either from your doctor or from a member of the clinical staff. And these factors are things that are indicators, if you will, of continuity of care.

Q: Okay. So one main way that patients can know that they're really receiving good continuity of care is just knowing their doctor and knowing that their doctor has a personal interest in their own case.

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A: Right. And if you think of medical care almost like a string that happens over a period of time. And at various points in the string, there are knots which stand for the times that you get ill. And you'd like to know that there are things that join those knots together. So you'd like to have a sense that your doctor and to some extent the clinical staff at the place where you receive your care understands your big picture, your health picture. And it's not just, you know, you come into the clinic one day. You see a doctor you've never seen before who may have to start from scratch and try and understand who you are, what your preferences are and also what's your health status that day.

Q: So then tell me why continuity of care is so important. How does it make a difference in the patient's medical experience?

A: Well, continuity of care is important from a number of different perspectives. I mean, I think if you want to divide care up into broad aspects, there's a part that's related to technology and technical competence. And then there's another part which is ... we can call it sort of the human side of care. And, you know, both aspects are very important. But often, the technical side gets

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emphasized to the loss of the human side. And if there's not a relationship, if there's not a sense that the doctor has the patient's best interest at heart, knows what their preferences are, that maybe the patient will be less likely to follow their instructions. Whether that's instructions to exercise or instructions to take a certain medicine for one of their medical problems.

So, in essence, you know, the world's best therapy can be undone if continuity is not sound. That if there's not that joining between the knots, if you will, that even the best therapies don't get used by the patient. And another reason why continuity is important is that very seldom in medicine, in any area of medicine, do we find the first treatment that we try right up front works great and is well tolerated with no side effects.

In order to identify the most effective therapy, there's sort of necessarily a little bit of a trial and error process. In order to do that, you have to be able to see the patient over time. And it helps if it's the same person seeing the person over time. And it helps if the doctor knows what it is that you're looking for, the

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patient, and the result from this treatment. So sometimes identifying an effective treatment out of the options available is essentially something that can't be done if there's not good continuity.

Q: Right. So you're kind of learning from past experiences what is best for this particular patient.

A: And designing future care, yes.

Q: Okay. So then how is the military health system doing in terms of providing continuity of care to all its service members and families?

A: Well, I think that all health care systems have a particular challenge in this area. You know, medicine has focused a great deal on its business model so to speak, trying to essentially stay fiscally active, fiscally viable. That's created situations where there's increasing pressure to reduce time with the patient. And sometimes it can create sort of chaotic systems. This is again not just a military health system challenge.

I think one of the reasons that the military health system has some particular advantages is that you can argue that while those factors play an increasing role in our setting, that we're still ... we still have kind of buffer from

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those factors. That, you know, there's no pressure on clinicians to make certain decisions based on cost. But there is the opportunity to take the time that's needed for patients to get to know them.

I'd say challenges that we have in our setting is that we are a military setting. And that we have both the clinicians, the doctors, providers themselves, as well as the patients who are in uniform. And those who are not in uniform, their family, who are moving. And if it's not a deployment, they may be moving to another place. That becomes a threat to continuity of care. There are ways around it. You can develop sound structures in care. You can develop good information systems.

And I'd say that's another distinctive advantage that the military health system has as well as the VA health system. These are large health care systems where you can develop a coherent information system that can be used to guide care over the patient's lifetime. Out in private practice, they may not have ... they may not have that luxury. So we have strengths and weaknesses. I think that all settings have a

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long ways to go in this area in the military in that sense is not an exception.

Q: Okay. So what are some of the solutions then that we can use to improve the continuity of health care within the military health system?

A: Well, I think maybe one example that I might use would be a program that we're running, a worldwide program. It's called RESPCT-MIL and that's an acronym. RESPCT-MIL for re-engineering systems and primary care treatment in the Military. And specifically, we're focusing on some psychological health conditions in primary care, the diagnosis and management of depression and post-traumatic stress disorder. Which is, as you know, because of the use of deployments that this has become an increasing sort of public health issue for us in the military.

So we want to be on top of this. Actually, this is probably a perfect example where continuity is crucial. Because if you're not seeing the same doctor every time around, it becomes very hard for patients to share some things that maybe quite sensitive for them and are quite unique to them. So, what we are doing in RESPCT-MIL is really sort of three major components. We're setting up

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the way that care is designed in these clinics. So that it empowers the doctor to improve the continuity of care. It empowers the clinics to improve the continuity of care.

We're setting up the three main components of the RESPECT-MIL program are a prepared primary care practice, the use of a care manager resource and enhancing the connection, the interface, if you will, with the specialist, the behavioral health specialist. And so using a screener in a clinic and having all that information brought to the clinician. So he or she can use their time as best they can.

And then using the care manager to ensure that that touchstone, that one person that can follow them if they get to know very well, that's helping that primary care doctor. And making sure that the specialist is looking in and providing advice. It's a team approach to care. And it's I think probably if you were to use one word to capture how best to improve continuity, it's working as a team.

Q: Okay. So it sounds like it's not just about providing top notch care. It's also about building trust between the

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patient and the doctor and making sure everyone's working together to deliver the best care possible.

COLONEL ENGEL: Yes. And I would say that top notch care really values trust as the essential ingredient. Again, if you trust your doctor, if you have confidence in your doctor, you're more likely ... many studies show that you're more likely to do what he or she is asking you to do. And so, and interestingly, it's not always the characteristic of that doctor that cause us to trust or not trust the doctor. It's often the extent to which the system that surrounds that doctor is supporting the doctor in the tasks that he or she has to do over the course of the day to take care of patients.

So in RESPCT-MIL, what we've done is setup a process that's predictable. Clinicians know it's going to happen. They know how to setup the right relationship with a nurse for people who have needs. They know what the specialist will be in that. And the clinician ... and the patient also has the opportunity to understand how that's going to work. There's literature that helps them to understand the reason that they're in the program and the goals of the program and so on. So these things all foster confidence, not only

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in the program, but really in the clinician. And that is what will make or break often the success or failure of treatment.

Q: Okay. We're going to take a quick break for the Dot Mil Docs Health Beat, news and information from the military health system. When we come back, we'll talk to Colonel Engel about the future of continuity and ways that the military health system can improve upon the care they offer service members and their families. Dot Mil Docs health beat.

MR. RUSSELL CARLSON: A team of scientists at the Uniformed Services University of the Health Sciences and the National Institutes of Health have published research finding that girls who participated in interpersonal psychotherapy may prevent excessive weight gain. The girls who participated in interpersonal psychotherapy were better able to prevent their body mass index from increasing excessively over the course of a year compared to girls who took traditional health education classes. Marion Tanasky Kraft, Ph.D., an Assistant Professor at USU, said, "If interpersonal psychotherapy proves to be effective, we may be able to prevent not only excessive weight gain, but the development

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of related adverse health conditions in a subset of susceptible youth."

Five severely wounded veterans returned to Iraq last week as part of the third installment of an evolving program to help wounded warriors heal from traumatic combat injuries. The group consisting of amputees and severe burn victims visited deployed paratroopers of the 82nd Airborne Division as part of Operation Proper Exit, a program designed to return the injured to the scene of their battlefield injuries to help them find psychological closure. The program has so far helped eighteen wounded soldiers and Marines move on with their lives. The nonprofit Troops First Foundation that runs the program is working to bring groups of wounded warriors like this to Iraq every month.

And finally, members of the U.S. Air Force Theater Hospital at Joint Base Balad in Iraq are training Iraqi defense ministry medical personnel as part of the new American Iraqi air medical evacuation and medical provider training course. The training enables Iraqis to study burn care as well as observe and practice proper medical evacuation techniques. Air Force Captain Elizabeth Hotels, a 332nd

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expeditionary medical group civil military operations officer, said, "The ultimate goal of this military-to-military medical capacity building program is to help establish an Iraqi military air medical evacuation program with trained flight surgeons, flight nurses and medivac technicians. That is your Dot Mil Docs Health Beat. All these stories and more are online at health.mil. For the military health system, I'm Russell Carlson.

Q: Welcome back to Dot Mil Docs. Today, Colonel Charles Engle, Director of the Deployment Health Clinical Center is talking with us about the mental health continuity of care available to service members. I heard a little bit about a program I guess called specialized care programs. How did these fit in with RESPCT.MIL? Or are they related at all?

A: Well, the specialized care program is if you think of medical care as being along a broad spectrum, that there are essentially care programs that involve people who aren't in care at all, you know, information, education, things that are out there for people who aren't necessarily receiving care. And then, you know, there's primary care for people who are coming in with different kinds of problems with general doctors.

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And then there are specialty care programs. When a patient has been followed in primary care and things aren't working in terms of the approach to their issues, their needs are bigger. Then we have two versions of the specialized care program which are designed to help that patient get back on track and get engaged in a more kind of long term relationship with their system and with their doctor. We have one that focuses on various kinds of symptoms. These are often medical unexplained. But they're also things that can be quite disabling for patients such as the name that comes to mind is chronic pain in all of its shapes and sizes.

So we have a program for patients with chronic pain that they link to their military service. We have another one for patients with psychological health issues related to their military service. And then those issues get bigger than can be handled with local resources, then there's the opportunity to come into this program. We do what we do through a continuity lens. So these programs are ... each one is three weeks long. The content is slightly different in each. Because there are different kinds of health challenges.

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But after the person finishes the three weeks, in both cases we have a care management piece of it that is designed to guide them back to where they're going to be working and living and receiving health care after the program. It's that transition that can be the place where things can fall apart in usual health care relationships with these between kinds of points. You know, between DOD and VA. Between DOD and TriCare. Between so on. We can think of many different examples of this.

If we have someone to help us, to shepherd us, over those humps, it can make sure that we ... that the right course that we get started on to a three week intensive experience like the specialized care program that you have the chance to stay on track in that. So I think that's really how I would relate the specialized care programs to this notion of continuity of care.

Q: Right. Okay. So specialized care programs really allow the continuity to expand and contract to meet the needs of every single service member within the system.

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A: Yeah, and I think that what happens with a lot of people with chronic conditions, whether they're psychological health or whether they're more physical health like chronic pain is that their health care gets kind of discombobulated, that there's a lot of voices involved. And it gets confusing. Different people are putting the patient on different medicines or giving different conflicting advice. What we try to do is come up with a coherent message and set priorities for each patient over the course of that three week program. And then sort of a shepherd, a care manager, that then follows them over time and make sure that that all kind of stays together and doesn't fall apart.

Q: Excellent. So to kind of wrap up, can you give us a concrete example then from work that you're working on now to show us how the continuity of care really applies to an individual person?

A: I think that there are different examples. I've given you a couple of programmatic examples. The RESPECT-MIL program where we're emphasizing continuity in the specialized care program. I think that there are some specific examples in terms of care situations where it, you know, might help people to connect with the no show. But, for instance,

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there's a ... we now know through a number of different studies that people that become depressed after they have a heart attack are more likely to die than people who don't become depressed after having a heart attack.

We know that there are some factors that mediate that. There may be some biological factors. But there's certainly some psychosocial factors that make people who become depressed, that they're involved in habits that aren't healthy. They may ... they're less likely to quit smoking. They're less likely to take their cardiac medicines and so on. And so one way that continuity of care can work is to ensure that a patient who is in that kind of a situation understands and gets help with in taking the medicines that they need to take and help with some of the health behaviors that maybe defeating what they're trying to do.

A second example that I would give is I would use the example of depression. Where there was an editorial published about the treatment of depression in primary care that said essentially that the treatment that you pick

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matters less than following the patient up and making sure that it works effectively. If it doesn't, then switch.

And so often in the treatment of depression as in the treatment of pain and other chronic conditions, you will put somebody on a medicine. And because of a variety of different pressures, it maybe some months, even years before somebody goes back to ask them again is this medicine working? Are you still taking it? And what we know about depression is that the first try is only effective about maybe a third to 40 percent of the time. And we're confident we can help depression get better if we follow it up and if we adjust treatment. If we don't, then outcomes are definitely not going to be as good. So these are some concrete examples of how continuity can make you or break you all the way from something like just not feeling well as in depression to death and dying post infarction, depression.

Q: Colonel Engel, I want to thank you so much for speaking with us today about the continuity of care. I can really see how this particular approach to health care can really make an impact on the lives of the service members receiving it.

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A: Yeah. Well, thanks for having me.

Q: That does it for us this weekend, Dot Mil Docs. Join us next week when Dot Mil Docs returns with a visit from Brigadier General Ronda Kornum, Director of Comprehensive Soldier Fitness. Brigadier General Kornum will be joining us to discuss how comprehensive soldier fitness increases the resilience of soldiers and families by increasing their physical, emotional, social, spiritual and family strengths. Until then, see you on Health Dot Mil.

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