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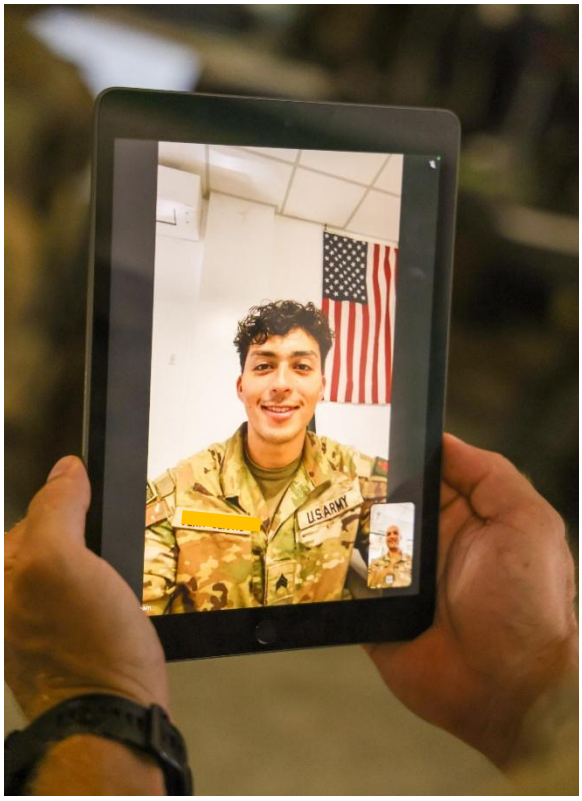

Observations and Recommendations for Implementing Tactical Behavioral Telehealth

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EXECUTIVE SUMMARY

During Joint Pacific Multinational Readiness Center (JPMRC) rotation 25-01 in Hawaii and Salakanib-Balikatan (SABAK) 25 Pacific Pathways rotation in the Philippines, Task Force Gimlet successfully implemented and tested "Tactical Behavior Telehealth (TBT). TBT allows Soldiers in tactical environments, with limited access to care, to virtually connect with healthcare professionals. Building on successful telehealth use during the COVID-19 pandemic, this testing moved the concept into a field environment.[1]

Modern technology expands healthcare access, particularly in areas where it was previously limited. TBT works by enabling Soldiers at a Role 1 facility to use devices like iPads or computers to connect with Embedded Behavioral Health (EBH) personnel at Role 2 or higher locations via a Military Health System (MHS) video conferencing platform.[2] Research indicates that Soldiers report similar satisfaction levels with virtual and in-person behavioral health treatment.[3]

As one medical professional journal noted, today's technology can "expand the geographic reach of health care services and improve access to care" that may not have been possible before.[4] Specifically, readily available data transports now allow units to access "reach-back" resources and potentially reduce the need for medical evacuation (MEDEVAC). This is especially valuable in the Pacific region, where units may operate in archipelagos with limited and dispersed resources.

Recognizing that EBH resources would not deploy with the unit and accounting for the geographical dispersion of the unit during SABAK 25, the UMT focused on TBT as a critical resource. Ultimately, the team's goal was to enable Soldiers to connect with specialty behavioral health providers to support real-world situations requiring assessment and treatment.

METHOD

During JPMRC 25-01 and SABAK 25, the Task Force Gimlet Unit Ministry Team (UMT) tested the TBT concept. The team aimed to verify the efficacy and connectivity of MHS Video Connect across all available data transports and establish virtual sessions from Role 1 to behavioral health providers at Role 2.

RESULTS

During the JPMRC 25-01 rotation, the UMT tested the capability to deliver behavioral health care remotely using MHS Video Connect over available secure data transports, including cellular telecommunication enabled devices (MiFi pucks) and low Earth orbit satellite networks (Storm and Starlink). Even though Starlink was the only system that could provide sufficient bandwidth to support a stable video connection, early stages of fielding and implementation limited the number points the unit could access.

The unit was able to successfully conduct a virtual session with behavioral health providers, but personnel had to relocate to Starlink access points, because it was not available at Role 1 or Role 2 locations.

Throughout JPMRC 25-01, Role 1 personnel performed psychological triage on a total of three Soldiers and determined that each of them needed next level of care for behavioral health assessment and treatment. Additionally, all three required ground MEDEVAC transport between Role 1 and Role 2, which were separated by approximately 20 miles. The Soldiers remained overnight at the Role 2 facility so providers could complete assessment and treatment. One Soldier required evacuation to Role 3 (Tripler Army Medical Center) for advanced care, while two returned to duty after treatment at the Role 2. Role 2 specialists could have used TBT to initially assess these patients virtually, potentially conserving MEDEVAC resources. Had TBT been available, the two return to duty Soldiers could have received treatment from Role 1 personnel under the guidance of Role 2 specialists.

Several months later, TF Gimlet deployed to the Philippines in support of SABAK 25 without EBH personnel. This made TBT with Schofield Barracks the primary method for deployed Soldiers to access behavioral health specialty care. The unit received additional Starlink systems, resulting in dedicated data connections at the co-located Role 1/2. During deployment, TF Gimlet used TBT to connect Soldiers to EBH specialty providers in response to three real-world situations:

Situation 1: A Soldier experienced a traumatic event early in the deployment that triggered multiple adverse symptoms. Following interventions conducted by the unit chaplain and Role 1/2 medical personnel, it was determined that the patient required next-level care. The patient was able to successfully connect with a specialty provider via MHS Video Connect for further assessment and treatment. He conducted regular virtual appointments with a provider and remained on deployment until the first scheduled main body redeployment.

Situation 2: A senior leader already receiving care from EBH experienced an intense onset of symptoms partway through the deployment. He was able to resume treatment with his assigned specialty provider via MHS Video Connect.

Scenario 3: A Soldier exhibiting possible suicidal ideations was brought to Role 1/2. Following initial assessment, a specialist virtually connected to evaluate the patient and determined the Soldier was unfit to remain on deployment and arranged for redeployment and escort to Tripler Army Medical Center. Following treatment, the patient returned to duty with the unit's rear detachment.

INTEGRATING TELEBEHAVIORAL HEALTH FOR FUTURE OPERATIONS

TBT offers significant potential to deliver specialized behavioral care for remote operational environments, mirroring the successful implementation in garrison locations and veteran care facilities.[5] As commanders and medical personnel plan for large-scale combat operations, they should include TBT as a solution to manage potential surges in casualties and conserve resources.[6]

TBT proved invaluable during TF Gimlet's dispersed operations in the Pacific Theater (SABAK 25), connecting Soldiers with behavioral health providers when in-person care was impossible.

To further enhance TBT, we recommend exploring additional low-bandwidth virtual tools through initiatives like the Army Software Factory, Army Application Lab (AAL), or "Hacking for Defense (H4D)." Successfully implementing TBT at the point of need requires coordinated planning between medical, signal, and operations teams to create a virtual "mesh network" of providers that enables a hybrid care model across distances.

1. Joseph Lacdan, “Telehealth, virtual counseling available to Soldiers,” *Army News Service*, April 13, 2020, https://www.army.mil/article/234510/telehealth_virtual_counseling_available_to_soldiers

2. U.S. Army soldier assigned to the 25th Infantry Division at Fort Magsaysay Military Reservation, Philippines, connects virtually with an EBH specialist on a TBT device May 25, 2025 (U.S. Army photo by Sgt. Brandon Roland).

3. Maurice L. Sipos et al., “Postdeployment Behavioral Health Screening: Face-to-Face Versus Virtual Behavioral Health Interviews,” *Military Medicine* 177, no. 5 (2021): 525-530, https://doi.org/10.7205/MILMED-D-11-00399.

4. Shilpa N. Gajarawala et al., “Telehealth benefits and barriers,” *The Journal for Nurse Practitioners* 17, no. 2 (2021): 218-221, https://www.npjournal.org/article/S1555-4155(20)30515-8/fulltext.

5. VA’s Office of Connected Care, “Telehealth and virtual tools deliver high-quality care to rural veterans,” 16 April 2024, https://news.va.gov/130255/telehealth-virtual-tools-deliver-rural-veterans.

6. James Hubbard, “Setting Conditions for Success: What Commanders Must Consider when Preparing for Sustainment During Large Scale Combat Operations,” *Center for Army Lessons Learned* 22-657 (2022): 19-26, https://api.army.mil/e2/c/downloads/2022/07/12/a3664d84/22-657.pdf.