Appendix D: Force Level Behavioral Healthcare Delivery System Model

A. Introduction

The MNF-I Surgeon requested that MHAT III provide a Force level behavioral health policy addressing the needs of the MNF-I Area of Operation. The following outlines a series of behavioral health issues and recommendations, and provides a structure to include the designation of a MNF-I BH consultant to assist the MNF-I Surgeon in meeting the needs of coalition forces.

B. Background

Behavioral health treatment delivery in an operational environment has markedly evolved in theory, policy, and practice during the last one hundred and fifty years. Terms such as "nostalgia", "shell shock", "battle fatigue", and "combat stress" all describe a psychological and emotional state that can have a significant impact on the individual and subsequently on unit readiness to successfully complete the mission. Research and field experience have demonstrated that timely and appropriate intervention can greatly reduce morbidity and return the individual to duty expeditiously. The current scenario in OIF is that of a mature theater with units in fixed bases performing repetitive but potentially very dangerous missions. Multi-service medical assets comprising several echelons of care are distributed throughout theater under the management of the MNF-I Surgeon. Behavioral health assets are also located throughout the theater, some co-located with medical units and others freestanding. The consistent impression by MHAT III upon surveying units all over theater was that excellent behavioral health prevention, intervention, and care was being provided by extremely motivated and caring behavioral health personnel. However, a central behavioral health management system did not appear to exist at the time of the MHAT III visit, an opinion stated by numerous behavioral health personnel interviewed throughout theater. Even though the current theater has matured and is relatively static with fixed bases and units undergoing planned rotations, results of the MHAT III assessment showed that behavioral health issues continue to be prevalent, validating the need for the continued presence of behavioral health assets. Such assets can be maximally utilized through a centrally managed delivery system that endorses proper distribution of assets, performance improvement, and patient safety.

C. References

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AR40-66, Medical Record Administration and Healthcare Documentation, 2004

AR 600-85, Army Substance Abuse Program, 2001

AR 600-63, Army Health Promotion, 1996

DA Pam 600-24, Suicide Prevention and Psychological Autopsy, 1988

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Mental Health Advisory Team-II Report, 2005

OTSG Memorandum on Army Suicide Event Report requirement, 2004

DoD/VA Clinical Practice Guideline for Post Traumatic Stress Disorder, www.oqp.med.va.gov/cpg/PTSD/PTSD_Base.htm

Army Suicide Event Report, Version 2.2, 2005

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Air Force Suicide Event Surveillance System, 2nd Edition (SESS-2)

OPNAVINST 1720.4, Suicide Prevention Program, 2005

Department of Navy Suicide Incident Report (DONSIR)

OTSG Memorandum, establishing criteria for use of the ASER, June 2004

ASD, Health Affairs Memorandum, establishing policy for use of psychological autopsy, June 2001

D. Structure

1. Structure of system

Managed at Force level by Behavioral Health Consultant appointed by Force Surgeon

Behavioral health assets in theater

- MNC-I
  - *Corps command level*
    1. Behavioral health consultant to Corps Surgeon
    2. Behavioral health staff officer(s)
  - *Medical brigade*

1. Behavioral health staff officer(s): may be same personnel as Corps level
2. Multifunctional Medical Battalion (MMB) behavioral health personnel
3. Combat Stress Control unit assets
4. Combat Support Hospital behavioral health assets

Division level

1. Division behavioral health officer and NCOIC
2. Brigade combat teams: behavioral health officer and 91X(s)

Other service medical assets

Air Force Evacuation Hospital

Marine Corps/Navy assets

Coalition partner assets

2. Behavioral health leadership

Force level behavioral health consultant

Appointed to serve under Force Surgeon

Primary point of contact for OTSG behavioral health consultants regarding behavioral health related issues within theater

Organizes and hosts a quarterly BH provider summit

attended by regional behavioral health consultants and as many other BH providers as mission will allow

CME activities will be offered

Manages behavioral health-related issues within theater to include

distribution of assets

establishes and oversees a theater-wide performance improvement program to include

requiring regional behavioral health consultants to establish regional behavioral health PI program

provider performance review: ensures behavioral health units have mechanism to assess performance of BH providers

utilization management: analyzes behavioral healthcare delivery data to ensure high quality behavioral healthcare is being provided at appropriate level

risk management:

serves as liaison to Force Surgeon on behavioral health risk management issues

tasks regional behavioral health consultants to assign risk management case reviews as indicated

patient safety: addresses behavioral health-related patient safety issues within theater such as adverse medication reactions, episodes of self harm or completed suicide, or injuries incurred while behavioral health patient under care at a medical treatment facility

provider health: consults on psychological, emotional, or substance abuse provider health issues

Provider orientation

coordinates with AMEDD Center and School in the development and implementation of provider OIF deployment orientation program to include instruction on current practice guidelines for treatment of Post Traumatic Stress Disorder and Acute Stress Disorder, either via CD or web-based

through regional behavioral health consultants, medical unit commanders verify that BH providers have completed orientation either prior to deployment or shortly after arrival in theater

Workload tracking

Credentialing

through regional behavioral health consultants, ensures all local behavioral health unit commanders have reviewed their providers' credentials for proper scope of practice pertaining to current clinical duties

serves as theater behavioral health consultant for credentialing issues involving behavioral healthcare providers

Continuing professional education:

tasks regional behavioral health consultants to develop mechanism to track that behavioral health providers are participating in CE, through local in-services, distance learning or theater/region sponsored training

organizes CE track at quarterly force level behavioral health summit

Continuity of Care

Record maintenance

Disposition of records

Deployment Cycle Support: through regional BH consultants, ensures that units have planned for and established an infrastructure at home base prior to redeployment of unit to address behavioral health needs of service members and families

Regional Behavioral Health Consultants

Appointed by senior medical officer in region to serve as liaison to MNF-I BH Consultant

Will make recommendations to MNF-I BH Consultant regarding BH staffing needs to include proposed shift in resources within region

Is region BH point of contact for:

Performance improvement
Risk management
Workload tracking
Provider health
Suicide event tracking for completion and submission through respective services' required reporting systems

Advises region leadership on behavioral health issues

Provides consultation to BH colleagues within regions

E. Quality Improvement (AR 40-68)

Performance Improvement: each individual behavioral unit providing care and intervention to service members will establish and run a performance

improvement program in accordance with respective services' requirements. The following is applicable only to Army Medical Department units.

- Performance Assessment (Chapter 5): accomplished through activities such as chart reviews, supervision and documented performance feedback by peers

- Peer Review (Chapter 6): mechanism is in place to conduct formal peer review of practice of behavioral health provider, when indicated

- Credentialing (Chapter 7)

  - Clinical privileges of behavioral healthcare providers are maintained and monitored IAW theater policy

  - Supervisors of credentialed behavioral health providers

    - Review privileges upon arrival to ensure duties fall within scope of privileges

    - Conduct provider clinical performance review when required (e.g., renewal of clinical privileges)

    - Develop a program of continuing professional healthcare education to enable providers to maintain competency within their scope of practice

    - When feasible, allow providers to participate in formal Continuing Education

  - Provider Categories

    - Advanced Practice Registered Nurse: Psychiatric Clinical Nurse Specialist (Paragraph 7-4f)

    - Behavioral Health Practitioner (7-6)

    - Clinical Psychologist (7-9)

    - Clinical Social Worker (7-10)

    - Occupational Therapist (7-13)

    - Physician: Psychiatrist (7-15)

    - Psychological Associate (7-19)

Provider Health (Chapter 11)

Behavioral healthcare providers

Become familiar with identification, treatment, and management of healthcare personnel impairment concerning psychiatric, substance abuse, and emotional issues (Paragraphs 11-4 &5)

Serve as the local subject matter expert on the topics of healthcare provider "burn out" and compassion fatigue

Be prepared to serve on Impaired Healthcare Personnel Program committee as behavioral health representative

Medical unit commander

Consults with behavioral health professional when there is issue of possible healthcare provider impairment due to psychiatric, emotional, or cognitive issue

Risk Management (Chapter 13)

Each behavioral health unit will have Risk Management as part of its performance improvement program

Risk management issues will be assessed and elevated, if indicated, as per local policy

Behavioral health unit commander will oversee local evaluation of local BH risk management issues

MNF-I Behavioral Health Consultant is the Force BH risk management program proponent with issues elevated through regional BH consultants

F. Workload Reporting, Tracking and Analysis

MNF-I Behavioral Health Consultant will work through respective services' behavioral health consultants to:

Ensure reporting tool captures accurate workload credit for all behavioral health tasks (education, prevention, restoration, reconditioning, intervention, treatment, command consultation).

Behavioral health units are provided feedback as to workload profile compared to other units.

Use workload data as one parameter in planning distribution of resources.

Regional behavioral health consultants will track workload reporting of BH units within region.

BH unit leaders will ensure that providers are familiar with workload reporting procedures and will monitor individual provider workload.

G. Continuity of Care

Behavioral health treatment record maintenance (AR 40-66) or in accordance with respective services' regulations

Documentation standards as per AR 40-66 and MNF-I policy

BH record documentation will be standardized throughout theater.

Monitored by MNF-I BH Consultant through regional BH consultant.

Establish criteria for a document to be considered a BH record.

BH units will conduct quarterly chart reviews for all providers and report results through PI program.

Documentation issues and questions will be addressed through regional BH consultants to MNF-I BH Consultant.

Disposition of BH records upon redeployment

MNF-I BH Consultant will develop policy for:

Security and transport of behavioral health records.

Original record retained by redeploying BH treatment unit and if service member remains in theater, then copy of record is produced and given to BH unit taking over case.

Service member redeploys and BH unit providing treatment remains in theater, then SM is provided with a treatment summary of BH care to include recommendation for follow-up treatment upon redeployment.

Regional BH consultants will ensure policy is being followed in respective region.

Patient referral

Within behavioral health system

MNF-I BH Consultant will develop and implement policy regarding provider communication, documentation, and treatment planning between two behavioral health units.

Regional behavioral health consultants will monitor referral process within region to ensure policy is being followed.

Coordination with non-behavioral healthcare providers

MNF-I BH Consultant will work with Force Surgeon or designated clinical representative to develop policy of referral process between BH and non-BH healthcare providers to include

Oral referral communication

Documentation standard
- In making referral
- In answering consult

Evacuation

MNF-I BH Consultant

Ensures documentation standards for BH evacuations out of theater are included in theater BH provider orientation

Coordinates with chief of behavioral health at USAF evacuation hospital to ensure proper documentation and oral communication are being provided by BH professionals evacuating patients out of theater

Liaisons with chief of behavioral health at Landstuhl Regional Medical Center to ensure proper documentation and oral communication is occurring between theater BH providers and receiving LRMC providers

Regional behavioral health consultants

Monitor quality of documentation of BH evacuations within respective region

Track evacuation rate within region and report to MNF-I BH Consultant

H. Behavioral Health Staffing

History

MHAT-II report presented a complex behavioral health staffing model based upon troop population

calculated staffing ratio based upon a series of variables and assumptions

MNF-I BH Consultant will collaborate with Force level medical staffing planners to recommend allocation of resources both at time of BH unit deployment into theater and through periodic re-analysis

factors considered include MHAT-II staffing model, workload data, organic behavioral health assets available, and analysis of intensity of combat action throughout theater

regional behavioral health consultants will recommend shifting of BH resources within region contingent upon agreement of commanders controlling those resources

I. Suicide Prevention Program

Oversight of program by MNF-I Chaplain

Components of program

Prevention

Service members continue to get prevention training prior to deployment, R&R leave, and leaving theater

Proponent: MNC-I Chaplain

Intervention

Provide DA designated training for key personnel on crisis intervention

Goal of at least one service member trained per company sized element

Proponent: MNF-I Chaplain

Surveillance/Analysis

Compile and analyze data

Service-specific suicide event report for all completed suicides and non lethal events resulting in evacuation and/or hospitalization for all personnel

Psychological autopsy will be requested through MNF-I surgeon for all equivocal deaths

Proponent: MNF-I BH Consultant reporting to MNF-I Surgeon

J. Summary

The OIF area of operations continues to be a highly complex and challenging environment, producing stress on service members and leadership. Behavioral health has had an important multi-faceted (education, prevention, intervention, treatment) role in maintaining the health and welfare of service members, directly contributing to mission readiness. As identified through the findings of MHAT-III, the prolonged mission involving combat operations directed at the Global War on Terrorism has produced a large cohort of service members who have served on two or more combat deployments. Research has estimated that up to one-fifth of this group may be affected by significant behavioral health issues as these Soldiers deploy for additional tours of combat duty. A coordinated, consistent, and well monitored behavioral healthcare delivery system must be established within theater and integrated into the overall Deployment Cycle Support process.