

Post-Deployment Health Reassessment (PDHRA)

Clinician Training

June 2005

Purpose of the Post-Deployment Health Reassessment (PDHRA)

- The Post-Deployment Health

Reassessment is really about keeping our commitment to service members returning from operational deployment

Description of the PDHRA

- The Post-Deployment Health Reassessment emphasizes global health
 - ◆ Three to six months post-deployment
 - ◆ Active Duty, Reserve, Guard personnel
 - ◆ Personnel separated from military service

PDHRA Key Elements

- Outreach
- Education
- Health Reassessment
- Detailed Evaluation and Treatment
- Follow-up and Case Management

Impact of Physical and Emotional Stress on Service Members

- Physical and emotional stress of deployment can have health impact
- Health issues don't always manifest immediately after deployment
- Screening and assessment three to six months post-deployment proactively identifies health concerns expressed by service members since they have returned home
- Adds to continuum of force health protection, further assuring optimal health and readiness of our service members

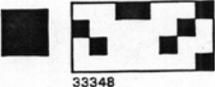
PDHRA Process

- Service member will complete their portion of the DD Form 2900
- Service member will discuss health concerns with provider
- Health care provider will complete assessment and document on DD Form 2900
- Health care provider will refer for further evaluation and treatment, as indicated

DD Form 2900

Initial Step in PDHRA Process

- Demographics and health screening questions to be completed by the military service member
- Health Care Provider interview and review of reported health concerns, documented in Provider section of DD Form 2900



POST-DEPLOYMENT HEALTH REASSESSMENT (PDHRA)



33348

Authority: 10 U.S.C. 136 Chapter 55. 1074f, 3013, 5013, 8013 and E.O. 9397

Principal Purpose: To assess your state of health after deployment in support of military operations and to assist military healthcare providers, including behavioral health providers, in identifying present and future medical care needs you may have. The information you provide may result in a referral for additional healthcare that may include behavioral healthcare.

Routine Use: To other Federal and State agencies and civilian healthcare providers as necessary in order to provide necessary medical care and treatment. Responses may be used to guide possible referrals.

Disclosure: Disclosure is voluntary.

INSTRUCTIONS: Please read each question completely and carefully before making your selections. Provide a response for each question. If you do not understand a question, ask the administrator. Please respond based on your **MOST RECENT DEPLOYMENT.**

Demographics

Last Name

Today's Date (dd/mm/yyyy)

First Name

MI

DOB (dd/mm/yyyy)

Date arrived theater (mm/yyyy)

Date departed theater (mm/yyyy)

Social Security Number

Gender

- Male
- Female

Service Branch

- Air Force
- Army
- Navy
- Marine Corps
- Coast Guard
- Other

Status Prior to Deployment

- Active Duty
- Selected Reserves - Reserve - Unit
- Selected Reserves - Reserve - AGR
- Selected Reserves - Reserve - IMA
- Selected Reserves - National Guard - Unit
- Selected Reserves - National Guard - AGR
- Ready Reserves - IRR
- Ready Reserves - ING
- Civilian Government Employee
- Other

Pay Grade

- E1 O01 W1
- E2 O02 W2
- E3 O03 W3
- E4 O04 W4
- E5 O05 W5
- E6 O06
- E7 O07 Other
- E8 O08
- E9 O09
- O10

Marital Status

- Never Married
- Married
- Separated
- Divorced
- Widowed

Location of Operation

- Iraq
- Afghanistan
- Kuwait
- Qatar
- Bosnia/Kosovo
- SW Asia - other
- Africa
- South America
- North America
- Australia
- Europe
- On a ship
- Other:

Since return from deployment I have:

- Maintained/returned to previous status
- Transitioned to Selected Reserves: _____
- Transitioned to Ready Reserves: _____
- Retired from Military Service
- Separated from Military Service

Current Contact Information:

Phone: _____

Cell: _____

DSN: _____

Email: _____

Address: _____

Total Deployments in Past 5 Years:

- | | | |
|---------------------------------|---------------------------------|---------------------------------|
| OIF | OEF | Other |
| <input type="radio"/> 1 | <input type="radio"/> 1 | <input type="radio"/> 1 |
| <input type="radio"/> 2 | <input type="radio"/> 2 | <input type="radio"/> 2 |
| <input type="radio"/> 3 | <input type="radio"/> 3 | <input type="radio"/> 3 |
| <input type="radio"/> 4 | <input type="radio"/> 4 | <input type="radio"/> 4 |
| <input type="radio"/> 5 or more | <input type="radio"/> 5 or more | <input type="radio"/> 5 or more |

Current Unit of Assignment

Current Assignment Location

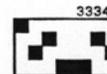
Point of Contact who can always reach you:

Name: _____

Phone: _____

Email: _____

Mailing Address: _____



33348



1. Overall, how would you rate your health during the PAST MONTH?
 Excellent Very Good Good Fair Poor
2. Compared to before your most recent deployment, how would you rate your health in general now?
 Much better now than before I deployed
 Somewhat better now than before I deployed
 About the same as before I deployed
 Somewhat worse now than before I deployed
 Much worse now than before I deployed
3. Since you returned from deployment, about how many times have you seen a healthcare provider for any reason, such as in sick call, emergency room, primary care, family doctor, or mental health provider?
 No visits 1 visit 2-3 visits 4-5 visits Over 6 visits
4. Since you returned from deployment, have you been hospitalized? Yes No
5. During your deployment, were you wounded, injured, assaulted or otherwise physically hurt? Yes No
IF NO, skip to Question 6.
- 5a. **IF YES**, are you still having problems related to this wound, assault, or injury? Yes No Unsure
6. Other than wounds or injuries, do you currently have a health concern or condition that you feel is related to your deployment? Yes No Unsure
IF NO, skip to Question 7.
- 6a. **IF YES**, please mark the item(s) that best describe your deployment-related condition or concern:
- | | |
|---|---|
| <input type="radio"/> Chronic cough | <input type="radio"/> Redness of eyes with tearing |
| <input type="radio"/> Runny nose | <input type="radio"/> Dimming of vision, like the lights were going out |
| <input type="radio"/> Fever | <input type="radio"/> Chest pain or pressure |
| <input type="radio"/> Weakness | <input type="radio"/> Dizziness, fainting, light headedness |
| <input type="radio"/> Headaches | <input type="radio"/> Difficulty breathing |
| <input type="radio"/> Swollen, stiff or painful joints | <input type="radio"/> Diarrhea, vomiting, or frequent indigestion |
| <input type="radio"/> Back pain | <input type="radio"/> Problems sleeping or still feeling tired after sleeping |
| <input type="radio"/> Muscle aches | <input type="radio"/> Difficulty remembering |
| <input type="radio"/> Numbness or tingling in hands or feet | <input type="radio"/> Increased irritability |
| <input type="radio"/> Skin diseases or rashes | <input type="radio"/> Taking more risks such as driving faster |
| <input type="radio"/> Ringing of the ears | <input type="radio"/> Other: _____ |
7. Do you have any persistent major concerns regarding the health effects of something you believe you may have been exposed to or encountered while deployed? Yes No
IF NO, skip to Question 8.
- 7a. **IF YES**, please mark the item(s) that best describe your concern:
- | | |
|--|--|
| <input type="radio"/> DEET insect repellent applied to skin | <input type="radio"/> Paints |
| <input type="radio"/> Pesticide-treated uniforms | <input type="radio"/> Radiation |
| <input type="radio"/> Environmental pesticides (like area fogging) | <input type="radio"/> Radar/microwaves |
| <input type="radio"/> Flea or tick collars | <input type="radio"/> Lasers |
| <input type="radio"/> Pesticide strips | <input type="radio"/> Loud noises |
| <input type="radio"/> Smoke from oil fire | <input type="radio"/> Excessive vibration |
| <input type="radio"/> Smoke from burning trash or feces | <input type="radio"/> Industrial pollution |
| <input type="radio"/> Vehicle or truck exhaust fumes | <input type="radio"/> Sand/dust |
| <input type="radio"/> Tent heater smoke | <input type="radio"/> Blast or motor vehicle accident |
| <input type="radio"/> JP8 or other fuels | <input type="radio"/> Depleted Uranium (if yes, explain) |
| <input type="radio"/> Fog oils (smoke screen) | <input type="radio"/> Other: _____ |
| <input type="radio"/> Solvents | |



8. Since return from your deployment, have you had serious conflicts with your spouse, family members, close friends, or at work that continue to cause you worry or concern? Yes No Unsure
9. Have you had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you
- a. Have had any nightmares about it or thought about it when you did not want to Yes No
- b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it Yes No
- c. Were constantly on guard, watchful, or easily startled Yes No
- d. Felt numb or detached from others, activities, or your surroundings Yes No
10. a. In the PAST MONTH, did you use alcohol more than you meant to? Yes No
- b. In the PAST MONTH, have you felt that you wanted to or needed to cut down on your drinking? Yes No
11. Over the PAST MONTH, have you been bothered by the following problems?
- | | Not at all | Few or several days | More than half the days | Nearly every day |
|--|-----------------------|-----------------------|-------------------------|-----------------------|
| a. Little interest or pleasure in doing things | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. Feeling down, depressed, or hopeless | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
12. If you checked off any problems or concerns on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
- Not difficult at all Somewhat difficult Very difficult Extremely difficult
13. Would you like to schedule a visit with a healthcare provider to further discuss your health concern(s)? Yes No
14. Are you currently interested in receiving information or assistance for a stress, emotional or alcohol concern? Yes No
15. Are you currently interested in receiving assistance for a family or relationship concern? Yes No
16. Would you like to schedule a visit with a chaplain or a community support counselor? Yes No

Health Care Provider Only

SERVICE MEMBER'S SOCIAL SECURITY #

□□□□ - □□□□ - □□□□□□

DATE (dd/mm/yyyy)

□□ / □□ / □□□□

Provider Review and Interview

1. Review symptoms and deployment concerns identified on form:
 - Confirmed screening results as reported
 - Screening results modified, amended, clarified during interview.

2. Ask behavioral risk questions.
 - a. Over the PAST MONTH, have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way? Yes No
 IF YES, about how often have you been bothered by these thoughts? Very few days More than half of the time Nearly every day
 - b. Since return from your deployment, have you had thoughts or concerns that you might hurt or lose control with someone? Yes No Unsure
3. IF YES OR UNSURE to behavioral risk questions, conduct risk assessment.
 - a. Does member pose a current risk for harm to self or others? No, not a current risk Yes, poses a current risk Unsure, referred
 - b. Outcome of assessment Immediate referral Routine follow-up referral Referral not indicated
4. Record additional questions or concerns identified by patient during interview: _____

Assessment and Referral: After my interview with the service member and review of this form, there is a need for further evaluation and follow-up as indicated below. (More than one may be noted for patients with multiple concerns.)

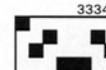
| 5. Identified Concerns | Minor Concern | Major Concern | Already Under Care | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| | | | Yes | No |
| <input type="radio"/> Physical Symptom | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> Exposure Concern | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> Depression Symptoms | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> PTSD Symptoms | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> Anger/Aggression | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> Suicidal Ideation | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> Social/Family Conflict | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> Alcohol Use | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> Other: _____ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> None | | | | |

| | |
|--------------------------------------|---|
| 7. Comments: _____ _____ _____ | 6. Referral Information <input type="radio"/> a. No referral made <input type="radio"/> b. Immediate/emergent care <input type="radio"/> c. Primary Care, Family Practice <input type="radio"/> d. Specialty Care: _____ <input type="radio"/> e. Behavioral Health in Primary Care <input type="radio"/> f. Mental Health Specialty Care <input type="radio"/> g. Case Manager, Care Manager <input type="radio"/> h. Substance Abuse Program <input type="radio"/> i. Health Promotion, Health Education <input type="radio"/> j. Other Healthcare Service <input type="radio"/> k. Chaplain <input type="radio"/> l. Family Support, Community Service <input type="radio"/> m. Military OneSource <input type="radio"/> n. Other: _____ |
|--------------------------------------|---|

| | |
|--|------------------------------------|
| 8. Provider a. Name (Last, First) _____ _____ b. Signature and stamp: _____ | ICD-9 Code for this visit: V70.5_6 |
|--|------------------------------------|

Ancillary Staff/Administrative Section

9. Member was provided the following:
 - Health Education and Information
 - Health Care Benefits and Resources Information
 - Appointment Assistance
 - Service member declined to complete form
 - Service member declined to complete interview/assessment
 - Service member declined referral for services
 - Other: _____
10. Referral made to the following healthcare or support system:
 - Military Treatment Facility
 - Division/Line-Based Medical Resource
 - VA Medical Center or Community Clinic
 - Vet Center
 - TRICARE Provider
 - Contract Support: _____
 - Community Service: _____
 - Other: _____
 - None

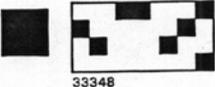


What is the Clinician's Role in the PDHRA Screening Process?

- Learn about the purpose & nature of the PDHRA process
- Establish a trusting, positive partnership with returning service members
- Review screening instrument (DD Form 2900) and determine if additional evaluation or treatment is needed
- Make referrals as appropriate

Provider Sensitivity is Key: ENVITE

- E – Demonstrate Empathy
- N – Non-confrontational approach
- V – Validate the decision to seek care
- I – Inform with solid scientific information
- T – Take action
- E – Enlist cooperation



POST-DEPLOYMENT HEALTH REASSESSMENT (PDHRA)



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Today's Date (dd/mm/yyyy)

First Name

MI

DOB (dd/mm/yyyy)

Date arrived theater (mm/yyyy)

Date departed theater (mm/yyyy)

Social Security Number

Gender

- Male
- Female

Service Branch

- Air Force
- Army
- Navy
- Marine Corps
- Coast Guard
- Other

Status Prior to Deployment

- Active Duty
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Pay Grade

- E1 O01 W1
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- E4 O04 W4
- E5 O05 W5
- E6 O06
- E7 O07 Other
- E8 O08
- E9 O09
- O10

Marital Status

- Never Married
- Married
- Separated
- Divorced
- Widowed

Location of Operation

- Iraq
- Afghanistan
- Kuwait
- Qatar
- Bosnia/Kosovo
- SW Asia - other
- Africa
- South America
- North America
- Australia
- Europe
- On a ship
- Other:

Since return from deployment I have:

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Current Contact Information:

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- | | | |
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| <input type="radio"/> 4 | <input type="radio"/> 4 | <input type="radio"/> 4 |
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Current Unit of Assignment

Current Assignment Location

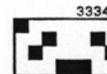
Point of Contact who can always reach you:

Name: _____

Phone: _____

Email: _____

Mailing Address: _____



33348



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| <input type="radio"/> Smoke from burning trash or feces | <input type="radio"/> Industrial pollution |
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| <input type="radio"/> Tent heater smoke | <input type="radio"/> Blast or motor vehicle accident |
| <input type="radio"/> JP8 or other fuels | <input type="radio"/> Depleted Uranium (if yes, explain) |
| <input type="radio"/> Fog oils (smoke screen) | <input type="radio"/> Other: _____ |
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8. Since return from your deployment, have you had serious conflicts with your spouse, family members, close friends, or at work that continue to cause you worry or concern? Yes No Unsure
9. Have you had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you
- a. Have had any nightmares about it or thought about it when you did not want to Yes No
 - b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it Yes No
 - c. Were constantly on guard, watchful, or easily startled Yes No
 - d. Felt numb or detached from others, activities, or your surroundings Yes No
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12. If you checked off any problems or concerns on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
- Not difficult at all Somewhat difficult Very difficult Extremely difficult
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14. Are you currently interested in receiving information or assistance for a stress, emotional or alcohol concern? Yes No
15. Are you currently interested in receiving assistance for a family or relationship concern? Yes No
16. Would you like to schedule a visit with a chaplain or a community support counselor? Yes No

Questions 1-6 (General Health)

- Demographics
- Overall health status
- Comparison of Post- to Pre-Deployment Health status
- Injuries, wounds, or assaults during deployment
- Health care use since return from deployment
- Current health concerns that service member believes are related to the most recent deployment

Questions 1-6

Role of Health Care Provider

- Develop a sense of service member's general health through interviewing
- Review service member's DD Forms 2795 and 2796 and other health records available
- Refer health concerns identified during interview to Primary Care Provider (PCP) for evaluation and treatment or specialty care if warranted
- Attend to urgent or emergent care needs

Referrals for the Reserve & Guard

- Reserve Component and Guard members may seek treatment at
 - ◆ Department of Veterans Affairs (VA) hospitals and clinics
 - ◆ Vet Centers
 - ◆ MTF and TRICARE benefits as appropriate
 - ◆ Check current guidance on LOD and MMSO requirements
 - ◆ Military OneSource for preclinical counseling
 - ◆ www.militaryonesource.com
 - ◆ Stateside: 800-342-9647
 - ◆ Overseas: 800-3429-6477
 - ◆ Overseas Collect: 1-484-530-5908

Question 7 (Exposure Concerns)

- “Do you have any persistent major concerns regarding the health effects of something you believe you may have been exposed to or encountered while deployed?”
- Question 7 – Exposure worry or concern even in absence of symptoms
- Effective health risk communication and education needed to discuss exposure concerns

Question 7

Role of Health Care Provider

- Determine if the service member has concerns
- Can the concerns be answered by the screening health care provider with information/risk communication tools at hand?
- If significant health effect, or cannot be answered by screening provider:
 - ◆ Refer for follow-up with PCP or specialist
 - ◆ Provide information on resources available

Resources for Exposure Concerns

- DoD Deployment Health Clinical Center (DHCC)
www.pdhealth.mil
- US Army Center for Health Promotion and Preventive Medicine (USACHPPM)
chppm-www.apgea.army.mil
- DoD Deployment Health Support Directorate
www.deploymentlink.osd.mil

Questions 8-12

(Mental Health Screening)

- Covers domains:
 - ◆ Interpersonal conflict, adjustment difficulties
 - ◆ May refer to Military OneSource
 - www.militaryonesource.com
 - Stateside: 800-342-9647
 - Overseas: 800-3429-6477
 - Overseas Collect: 1-484-530-5908
 - ◆ Alcohol Abuse, PTSD, Depression
- May refer to preclinical counseling services such as Military OneSource, chaplain, or appropriate community resource
- May refer to clinical services such as primary care or specialty care

Problems Accessing Mental Health Care

- Those most in need of mental health care may not actively seek treatment
- Fear of potential stigma associated with mental health concerns
- Inadequate knowledge about how to access mental health care
- Barriers to care: misinformation, misunderstanding, knowledge deficits

Question 12 (Functional Impairment)

- Question 12: “If you checked off any problems or concerns on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?”
 - ◆ How have the veteran’s problems impacted home, work, and school life
 - ◆ Some distress is not uncommon or abnormal post-deployment, especially if death or injury to unit members
 - ◆ Functional impairment aids referral decision-making
 - ◆ Impairment generally calls for medical treatment
 - ◆ No impairment may best use preclinical counseling

Mental Health Question 8

Role of Health Care Provider

- Question 8 : “Since return from your deployment, have you had serious conflicts with your spouse, family members, close friends, or at work that continue to cause you worry or concern?”
- Referral to Military OneSource for marriage and family counseling, work adjustment counseling, or other preclinical counseling

Mental Health Question 9 (PTSD and Acute Stress Disorder)

- Question 9: “Have you had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you . . .[had]
- Four questions on screening questionnaire:
 - ◆ Nightmares, intrusive thoughts
 - ◆ Avoidance of situations, thoughts related to trauma
 - ◆ Constantly on guard, watchful, easily startled
 - ◆ Numb or detached from others, surroundings
- Increasing positive symptoms = risk of PTSD
- Always consider functional impairment to determine treatment/referral needs

Mental Health Question 10 (Alcohol Abuse)

- Question 10 assesses for alcohol abuse:
 - ◆ “In the PAST MONTH, did you use alcohol more than you meant to?”
 - ◆ “In the PAST MONTH, have you felt that you wanted or needed to cut down on your drinking?”
 - ◆ One positive should lead to additional queries
 - ◆ Alcohol abuse a prevalent problem
 - ◆ Supplemental guidance available in Substance Use Disorder Clinical Practice Guideline
 - ◆ Guidelines available on www.pdhealth.mil

Mental Health Question 11 (Clinical Depression)

- PHQ 2 - Two questions have been shown to be effective for identifying patients who may be depressed:
 - ◆ “Over the PAST MONTH, have you been bothered by the following problems:
 - ◆ Little interest or pleasure in doing things?
 - ◆ Feeling down, depressed or hopeless?”

Mental Health Question 11

Role of the Health Care Provider

- If service member's response to both questions is "no", the screen is negative
- If the service member responded "yes" to either question, ask more detailed questions: S-I-G-E-C-A-P-S
 - ◆ How have you been sleeping?
 - ◆ Have you been pursuing interests, entertainment, fun?
 - ◆ Have you been feeling down on yourself?
 - ◆ How is your energy?
 - ◆ How is your concentration?
 - ◆ What about your appetite?
 - ◆ Do you find yourself moving slowly or speeded up?
 - ◆ How does the future look to you? (Hopelessness and helplessness add to suicide potential)

Questions 13 through 16 (Self-Referral)

- Questions 14 through 16 provide opportunity for self-referral or care preference:
 - ◆ Information and assistance for stress, emotional, alcohol concerns?
 - ◆ Assistance for family or relationship concerns?
 - ◆ Visit with chaplain or community support counselor?

Completing the PDHRA Form

- Service member completes demographics and self-report portions of DD Form 2900
- Clinician reviews responses and completes Provider's section of DD Form 2900

Health Care Provider Only

SERVICE MEMBER'S SOCIAL SECURITY #

□□□□ - □□□□ - □□□□□□

DATE (dd/mm/yyyy)

□□ / □□ / □□□□

Provider Review and Interview

1. Review symptoms and deployment concerns identified on form:
 - Confirmed screening results as reported
 - Screening results modified, amended, clarified during interview.

2. Ask behavioral risk questions.
 - a. Over the PAST MONTH, have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way? Yes No
 IF YES, about how often have you been bothered by these thoughts? Very few days More than half of the time Nearly every day
 - b. Since return from your deployment, have you had thoughts or concerns that you might hurt or lose control with someone? Yes No Unsure

3. IF YES OR UNSURE to behavioral risk questions, conduct risk assessment.
 - a. Does member pose a current risk for harm to self or others? No, not a current risk Yes, poses a current risk Unsure, referred
 - b. Outcome of assessment Immediate referral Routine follow-up referral Referral not indicated

4. Record additional questions or concerns identified by patient during interview: _____

Assessment and Referral: After my interview with the service member and review of this form, there is a need for further evaluation and follow-up as indicated below. (More than one may be noted for patients with multiple concerns.)

| 5. Identified Concerns | Minor Concern | Major Concern | Already Under Care | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| | | | Yes | No |
| <input type="radio"/> Physical Symptom | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> Exposure Concern | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> Depression Symptoms | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> PTSD Symptoms | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> Anger/Aggression | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> Suicidal Ideation | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> Social/Family Conflict | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> Alcohol Use | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> Other: _____ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> None | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

| | |
|--------------------------------------|---|
| 7. Comments: _____ _____ _____ | 6. Referral Information <input type="radio"/> a. No referral made <input type="radio"/> b. Immediate/emergent care <input type="radio"/> c. Primary Care, Family Practice <input type="radio"/> d. Specialty Care: _____ <input type="radio"/> e. Behavioral Health in Primary Care <input type="radio"/> f. Mental Health Specialty Care <input type="radio"/> g. Case Manager, Care Manager <input type="radio"/> h. Substance Abuse Program <input type="radio"/> i. Health Promotion, Health Education <input type="radio"/> j. Other Healthcare Service <input type="radio"/> k. Chaplain <input type="radio"/> l. Family Support, Community Service <input type="radio"/> m. Military OneSource <input type="radio"/> n. Other: _____ |
|--------------------------------------|---|

| | |
|---|------------------------------------|
| 8. Provider a. Name (Last, First) _____ b. Signature and stamp: _____ | ICD-9 Code for this visit: V70.5_6 |
|---|------------------------------------|

Ancillary Staff/Administrative Section

9. Member was provided the following:
 - Health Education and Information
 - Health Care Benefits and Resources Information
 - Appointment Assistance
 - Service member declined to complete form
 - Service member declined to complete interview/assessment
 - Service member declined referral for services
 - Other: _____

10. Referral made to the following healthcare or support system:
 - Military Treatment Facility
 - Division/Line-Based Medical Resource
 - VA Medical Center or Community Clinic
 - Vet Center
 - TRICARE Provider
 - Contract Support: _____
 - Community Service: _____
 - Other: _____
 - None



Provider Review and Interview

- Item 1 – Screening HCP reviews and discusses with service member responses to Questions 1-16
- All positive responses should be pursued
- HCP indicates in Item 1:
 - ◆ Are screening results confirmed as reported by service member?
 - ◆ Should screening results be modified, amended, or clarified based on the HCP interview?

Provider Review and Interview – Items 2, 3, 4 (Behavioral Risk)

- Items 2 and 3 are an assessment of potential for harming self or harming others
- In Item 4, the screening HCP can record any additional questions or concerns identified during the interview

Behavioral Risk Screening

- Behavioral Risk Question is Item 2 in Provider Review and Interview section:
 - ◆ “Over the PAST MONTH, have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?”
 - ◆ “IF YES, about how often have you been bothered by these thoughts?”
 - ◆ “Since return from your deployment, have you had thoughts or concerns that you might hurt or lose control with someone?”

Behavioral Risk Screening (Cont)

- Item 3 in Provider Review and Interview section:
 - ◆ IF YES or UNSURE to behavioral risk questions, conduct risk assessment
 - ◆ Does member pose a current risk for harm to self or others? No, not a current risk; Yes, poses a current risk; Unsure, referred
 - ◆ Outcome of assessment: immediate referral, routine follow-up referral, referral not indicated

Assessment and Referral

- Item 5: Identified service member's concerns
 - ◆ What are the service member's identified concerns?
 - ◆ Major or minor concerns?
 - ◆ Is the service member already under care?
- Item 6: What referrals need to be made?
- Item 7: Any additional information the HCP feels is important?
- Item 8: HCP must print, sign, and use signature stamp

Resources for Clinicians: Medical and Behavioral Health

- DoD/VA Clinical Practice Guidelines
www.oqp.med.va.gov/cpg
- Deployment Health Clinical Center,
866-558-1627, www.pdhealth.mil
- MyHealtheVet
www.myhealth.va.gov

Mental Health Resources

- MilitaryOneSource
www.militaryonesource.com
- My HealthVet
www.myhealth.va.gov
- National Center for PTS
www.ncptsd.org
- Deployment Health Clinical Center
www.pdhealth.mil
- Deployment Health Support Directorate
www.deploymentlink.osd.mil

Mental Health Resources (Cont)

- National Institute of Mental Health (2002)
Mental Health and Mass Violence
www.nimh.nih.gov/research/massviolence.pdf
- Iraq War Clinician Guide, 2nd Edition,
802-296-5132 www.ncptsd.org
- Veterans Health Initiative 2001-2004 VHI
Courses www.va.gov.vhi
- Screening for Mental Health, Inc.
www.mentalhealthscreening.org

Ancillary Staff/Administrative

- Two administrative questions (Items 9 and 10):
 - ◆ Type of health information provided to the service member
 - ◆ Type of referrals that were made
 - ◆ Did the service member accept the referral, or decline to complete the form?

PDHRA Key Elements

- Outreach
- Education
- Health Reassessment
- Detailed Evaluation and Treatment
- Follow-up and Case Management

Documenting PDHRA Results

- DD Form 2900 completed electronically
- Reviewed in paper format with service member, but results from PDHRA entered electronically
- Complete paper copy printed and placed in service member's medical record (DoD) or given to service member if separated

Documenting PDHRA Results (Cont)

- PDHRA forwarded electronically
- Stored and included in Defense Medical Surveillance System
- Referrals documented on PDHRA and SF513 (Consultation Request) when available

Additional Guidance & Support

- Additional clinical guidance and support materials available at:
 - ◆ www.pdhealth.mil
 - ◆ pdhealth@na.amedd.army.mil
 - ◆ Deployment Health Clinician Helpline:
1-866-559-1627 DSN: 642-0907
 - ◆ DoD Patient Helpline:
1-800-796-9699 DSN: 662-3577
 - ◆ DoD Helpline from Europe: 00800-8666-8666