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Streamlining the Response to Positive Mental Health Concerns on the Air Force Web-Based Periodic Health Assessment

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STREAMLINING THE RESPONSE TO POSITIVE MENTAL HEALTH CONCERNS ON THE AIR FORCE WEB-BASED PERIODIC HEALTH ASSESSMENT

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has been approved as meeting the requirement for the Degree of Doctor of Nursing Practice in College of Natural and Health Sciences, School of Nursing, Program of Nursing Practice

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The Air Force requires each airman (service member) accomplish a Web-based periodic health assessment (Web-PHA) yearly. This is a well-established health assessment program mandated and well-embedded within the Air Force that includes the Air National Guard. The Web-PHA is an on-line, self-administered health questionnaire. The questions were developed by a Department of Defense team guided by nationally recognized health screening and counseling recommendations. At the 140th Medical Group at Buckley Air Force Base in Aurora, Colorado, "trained" health technicians run the Web-PHA program. After an in-depth review of the current processes, it was found the Air Force, including this Air National Guard unit, did not provide any formal mental health education and training specific to the Web-PHA program. Nor did the 140th Medical Group have a unit-specific protocol to address mental health concerns.

The purpose of this process improvement project was to improve the processes associated with the current mental health portion of the 140th Medical Group's Web-PHA program. The aim was to obtain information from a panel of experts using the Delphi technique to advise and guide current and future training practices of health technicians running the program. This occurred in three phases. The first phase was targeted at developing an education program. The second phase included the development of a

protocol and algorithm described by the Air Force Instruction (AFI 44-108, 2014). Finally, the third phase described a future pilot study not part of this capstone project and was for planning purposes only.

To evaluate this project, both pre and post education tests were administered with an improvement from 44% (pre) to 85.2% (post)--a 41.2% increase. Feedback on both the education and Web-PHA mental health protocol (MHP) was all positive. Overall, this capstone project recognized the lack of mental health education, identified the current Web-PHA process, and developed a successful, much-needed streamlined approach for education and a Web-PHA MHP for the trained health technician to follow.

DEDICATION AND ACKNOWLEDGEMENTS

This capstone project is dedicated to my husband Joe and three daughters: Aubrie, Sophia, and Scarlett. Without their unwavering support throughout this entire venture, this achievement would not have been possible.

I would like to extend my sincere gratitude to my entire capstone committee for their support and guidance during this project. Dr. Kathleen Dunemn, my capstone chair, thank you for all of your hard work, expertise, direction, and support. Your help was invaluable to my successful completion of the DNP program. My community chair, Lieutenant Colonel James Chappell, your involvement and feedback with my capstone project was much appreciated. To my other committee members, Dr. Lori Clukey and Dr. Vicki Wilson, I am grateful for all the valued guidance given on my process improvement development and implementation.

Finally, I would like to recognize all of my family and friends who stood by me over the last four plus years. You watched my girls, gave words of encouragement, provided coffee, supplied me with candy, and supported my dream! Thank You!

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

AF	Air Force
AFI	Air Force Instruction
AHRQ	Agency for Healthcare Quality and Research
ANG	Air National Guard
ASIMS	Aerospace Information Management System
CDC	Centers for Disease Control and Prevention
CPG	Clinical Practice Guideline
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECOMS	Executive Committee of the Medical Staff
GAD	Generalized Anxiety Disorder
MDG	Medical Group
MHP	Mental Health Protocol
MTF	Medical Treatment Facility
PHQ	Patient Health Questionnaire
PTSD	Posttraumatic Stress Disorder
RESPECT-Mil	Re-Engineering Systems of Primary Care Treatment in the Military
SGH	Chief of Medical Staff
SGP	Chief of Aerospace Medicine
SGN	Chief of Nursing Services

USPSTF	United States Preventative Services Task Force
UTA	Unit Training Assembly
Web-PHA	Web-based Periodic Health Assessment
WHO	World Health Organization

CHAPTER I

PROBLEM STATEMENT

Background and Significance

Over 9.8 million adults aged 18 years and older in the United States have a serious mental illness and in 2014, 11.8 million adults needed some sort of mental health treatment or counseling (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016). Mental health is a significant issue in the United States as is the mental well-being of those serving in the Colorado Air National Guard (ANG). "The suicide rate among male and female veterans and military service members exceeds the national rate for the general population" (SAMHSA, 2015). The U.S. Preventative Services Task Force (USPSTF; 2016) recommends screening adults for depression and gives the recommendation a "B" grade. A grade of B is a suggested practice that should be offered or provided (USPSTF, 2016). "There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial" (USPSTF, 2016, para. 2). The Air Force has tried to identify and combat mental health issues by using a Web-based periodic health assessment (Web-PHA) that was created in 2006 but not fully implemented until 2009 to screen all airmen (including Air National Guard members) annually on different facets of their life. This assessment screens the member for depression per USPSTF recommendations as well as for anxiety and posttraumatic stress disorder (PTSD), which are areas of concern for the military.

Anxiety is the most common mental health disorder in the United States and affects 40 million adults (Anxiety and Depression Association of America [ADAA], 2016). According to the U.S. Department of Defense, approximately 40,000 military members who have returned from Iraq and Afghanistan have been officially diagnosed with PTSD since 2003 (ADAA, 2016). Rates for PTSD are over three times higher in those military members deployed to a combat zone versus those not deployed (ADAA, 2016). According to the RAND Corporation, one in five military members return with symptoms of PTSD or major depression, yet only half have sought treatment (ADAA, 2016).

Financial Impact

The effects of mental illness on the economy are hard to estimate since expenses encompass the cost of care, loss of income due to unemployment, expenses for services and social support, medications, and indirect costs due to chronic disability (Insel, 2011). The Agency for Healthcare Research and Quality (AHRQ) estimated that costs in the United States for mental illness care in 2006 were $57.5 billion (Insel, 2011). This is equivalent to what was spent on healthcare costs for cancer. The World Health Organization (WHO) reported, “Mental illnesses are the leading cause of disability adjusted life years worldwide” (Insel, 2011, para. 3). The global cost for mental illness reached almost $2.5 trillion in 2010 and is expected to reach $6 trillion by 2030 (Insel, 2011). “Mental illness costs are the largest single source; larger than cardiovascular disease, chronic respiratory disease, cancer or diabetes” (Insel, 2011, para. 4). The Department of Defense spent $958 million on mental health services and treatment in 2012, which is double of what was spent in 2007 (Brewin, 2013). Between 2007 and

2012, $4 billion was spent on mental health treatment for active duty members and $461 million was spent for Guard and Reserve members (Brewin, 2013); this shows the increasing trend of mental health needs within the military. Screening and identifying those at risk early on might deflect some of these costs.

The National Guard

The National Guard consists of two branches--Army and Air Force. It is different from the Active Duty component, although it is considered part of the Reserves. The National Guard is federally funded like the Active Duty and Reserve sectors but controlled by the state. Guard members engage in numerous activities that include local emergencies and national disasters. Just like its counterparts, the Air National Guard can deploy to foreign countries and war zones. The U.S. military has increasingly relied on the National Guard and Reserve components since 2001 to meet operational demands (Cohen, Fink, Sampson, & Galea, 2015, p. 7). "Differences in preparation and military engagement experiences between active component and reserve component forces have long suggested that the psychiatric consequences of military engagement differ by component" (Cohen et al., 2015, p. 7). Over 250,000 Guard members deployed to Iraq or Afghanistan in support of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF; SAMHSA, 2010). The literature found the uniqueness of leading a civilian life and working a civilian job with military obligations, training, and deployment mixed in could lead to an increased prevalence of mental health disorders among the reserve population. "Reserve component service members face particular readjustment challenges that have been documented to increase their psychiatric disorder burden, relative to their active component counterparts" (Cohen et al., 2015, p. 8). These

challenges include deploying without their assigned unit, leading to decreased unit cohesion and social support, uncertainty of re-employment upon return, and returning to civilian life with expectations of quick adjustment (Cohen et al. 2015, p. 8). These stressors can cause increased mental health concerns among reserve components that differ from those on active duty. One of the key issues is reserve members do not have the same health benefits as those of active duty members so resources may be limited. Active duty members have resources available at no cost to them that are covered by their insurance to seek mental health services, counseling, and medications if needed. National Guardsmen are limited to non-medical base services and what their own civilian insurance covers at an out-of-pocket expense to them.

Military Idiosyncrasies

Another facet unique to the military is the concern for rank. In the Air Force, there are both Officer and Enlisted corps. Officers always out-rank the Enlisted; however, lower ranking officers may not hold as much respect among others as higher ranked Enlisted members. This can also cause issues when a lower ranking Enlisted member contacts an Officer specifically about a sensitive subject like mental health. No matter how professional the enlisted member may be, an officer or higher ranking enlisted member may not feel comfortable talking at length or going into detail about problems they may or may not be having. Mental health has a stigma in the military and can hold up members from being eligible to deploy or attending additional training.

> According to Substance Abuse and Mental Health Services Administrations (SAMHSA), service members frequently cite fear of personal embarrassment, disappointing comrades, losing the opportunity for career advancement, and dishonorable discharge as motivations to hide symptoms of mental illness from family, friends and colleagues. (American Psychological Association [APA], 2016)

Current Program Process

The 140th Wing located at Buckley Air Force Base has approximately 1,500 Airmen assigned to their Air National Guard unit. Currently, the 140th Medical Group (MDG) references Air Force Instruction 44-170 (AFI 44-170; 2014) on the requirements for contacting airmen based on Web-PHA findings, which is mandated by the U.S. Air Force. When first inquiring about the Web-PHA program, the questions asked, along with how they led to a priority or critical, were somewhat of a mystery and staff were unaware of what screening tools were included. Information about the Web-PHA is difficult to come by nor is there a document explaining the process to those using it. Thorough interviews were done with the "trained" health technician running the program, the previous trained health technician who is still at the unit but in another position, and the 4N Functional who is the "expert" health technician in charge. The current health technician had on-the-job training by the previous technician who ran the program. The Air Force does not provide any specific training geared toward the Web-PHA program. The trained health technician has had some college courses in psychology, suicide awareness, and prevention training from the Air Force Advanced Leadership School and is a 4N051 (Aerospace Medical Technician), which is upgrade training that covers some mental health education but can differ from person to person running the program. Since the trained health technician is a technician who is supposedly trained at doing Web-PHAs, there should be documentation of this in the Air Force Training Record, which is where specific competencies are entered.

The current Web-PHA process includes the unit trained health technician (who holds an Emergency Medical Technician certification) pulling any priority or critical

Web-PHAs daily from the Aerospace Information Management System (ASIMS) and contacting the member. The Air Force Instruction (AFI) specifically authorizes Air National Guard medical personnel to follow up on priority and critical responses by the next unit training assembly (UTA), which is the once a month duty when traditional guardsmen report. The AFI goes on to say, "The person who contacts the Airman will be determined by the expertise required by the AF Web-PHA responses" (AFI 44-170, 2014, p. 15). There are no clear-cut rules on what or who determines what "expertise" is or who should be contacting the airman of concern. Since the 140th MDG has a full time trained health technician dedicated to the Web-PHA program, members with positive concerns are contacted during the week, which is sooner then the instruction requires. The communication is documented on a Standard Form 600 (nursing note) to be filed in the member's medical chart. Paper charts are still being used at the 140th MDG, although there are future plans to transition to computer-based documentation. If the member is unable to be reached, a message is left and documented. The airman's unit health monitor might also be contacted if the member is unable to be reached and there is a significant concern (i.e., critical response); however, there are no specific written guidelines for this. There is no current consensus or documented rule on how many times a member should be contacted for a critical or priority response before closing out the record. During the interview, it was identified that many of the members who are called for priority mental health concerns deny it. Per the unit health technician, many Web-PHAs flag for PTSD or depression and when the member is reached, they don't know why that came up or why their Web-PHA was flagged. It is believed by the technician that they either did not answer the asked question correctly or the problem was more

situational at the time and not bothering them now. Other than asking the member if they are feeling depressed, anxious, or have a history of PTSD, no other screening questions are asked unless something else comes up during the conversation. The technician states he does offer referral information to the base psychologist, chaplain, and militaryonesource.com when necessary. The 140th Medical Group has no mental health professionals and they rely on the member self-referring to family advocacy where he/she is able to get in contact with the base psychologist. Feedback from members who have utilized this service has been mixed as there is only one base psychologist; some feel it is not a helpful service.

There can be numerous reasons the Web-PHA flagged for priority or critical mental health concerns might be missed. By talking through a depression, anxiety, or PTSD questionnaire, this might lead to why a member is flagged positive or might give clearance to an erroneous entry if there is confusion to why the Web-PHA alerted. A flaw noticed while reviewing completed Web-PHAs with positive responses was the results given to both the patient and medical unit did not score the screenings administered but instead just identified a possible concern for depression, anxiety, or PTSD. Instead of the priority or critical notification giving a depression, anxiety, or PTSD score, it would say the following:

- Patient reports symptoms consistent with depression
- Patient reports significant concerns or distress with the following: stress or emotional concerns
- Patient reports symptoms consistent with a PTSD disorder

Members could then opt to enter specific information if they wished to give further explanation on what was going on in their lives. Some choose to while others leave the comment section blank. The member also has the option to check a box that states, "The patient reports interest in receiving information or assistance for a stress, emotional or alcohol concern." Members may also flag for checking the following box: "The patient reports they would like assistance for a family or relationship concern. Recommend further assessment and referral." These statements are what the trained health technician has to go off of when contacting members.

A retrospective analysis of the data was collected by the author from ASIMS, which showed that from June 2015 through December 2015, 715 Web-PHAs were completed. Of those 715 Web PHAs, 77 were priorities and there were no critical responses. Of the 77 priorities, 34 (44%) were of mental health concern. The high number of mental health related concerns among the priority findings showed the significance of the need for both education and a streamlined protocol for contacting patients with concerns. The Chief of Aerospace Medicine (SGP), Chief of Medical Staff (SGH), and Chief of Nursing Services (SGN) are supposed to "develop procedures to implement PHA-associated clinical practice guidelines (CPGs) and quality assurance processes through technician level reviews" (AFI 44-170, 2014, p. 6). The guidance given by AFI 44-170 can be vague, especially involving mental health. The 140th MDG has not created any specific education, written guidelines, or protocols for the health technician to follow nor have there been any technician level reviews to guide implementation of a process.

Having a formal education process about the mental health portion of the Web-PHA and a written protocol are critical due to the increased rates of suicide and high turnover of personnel in the military. Job change is frequent due to unit re-organization, promotions, transfers, and minimal manning. Having proper education for the technician along with a protocol to follow would allow the technician to easily respond to positive mental health concerns on Web-PHAs and for turning the program over to the next person when necessary.

Project Objectives

There were three objectives for this capstone project. The first objective was to identify the current Web-PHA process. The second objective was to identify what was addressed, what questions were asked, and how critical and priority findings were flagged with regard to mental health on the Web-PHA. The third objective was to use the first two objectives to build an education program and to create an evidence-based protocol for the trained health technician to use when contacting positive mental health Web-PHAs. These objectives clarified what mental health screening tools were being used for depression, anxiety, and PTSD in order to educate staff contact with members. Once these objectives were complete, a pilot study was deployed to assess the process improvement protocol. Qualitative data were then collected through individual interviews of the trained health technician and observations. The goal was to obtain approval for future permanent acceptance and implementation.

Purpose

Due to the uniqueness of members serving in the Air National Guard, identifying those with mental health concerns and finding help for them was a challenge. Reservists

face diverse challenges among their active duty counterparts with reintegration to civilian life. This is where the Web-PHA could come into play and intervene on behalf of those who are struggling and where a streamlined protocol for identifying and contacting those with positive mental health concerns would be beneficial. An improvement in the processes associated with the mental health aspects of the Web-PHA program is imperative due to recent statistics of increased suicides among National Guard members. "Suicides jumped by a third in 2015 from the year before, according to the Department of Defense. The number of guardsmen who took their own lives went from 91 in 2014 to 121 last year" (National Guard Association of the United States [NGAUS], 2016). This includes 100 guardsmen from the Army and 21 from the Air Force (NAGUS, 2016). The entire reserve sector suffered 209 suicides in 2015, which was up from 170 in 2014 (NAGUS, 2016).

The aim of this process improvement project was to obtain information from a panel of experts at the140th Medical Group in order to advise and guide current and future training and practice of health technicians running the Web-PHA program. Turnover is high in the military; in the past four years, three different technicians have run the program at the 140th Medical Group. Information was sought from the expert panel members and occurred in three phases. The *first* phase was targeted at developing an education program, a competency checklist (pre and post education implementation), and a continuity folder for the trained health technician and other staff involved in the Web-PHA program since one does not currently exist. The *second* phase included the development of a protocol and algorithm as described by the Air Force Instruction (AFI 44-108, 2014), which has not been created for the technician to follow. Of note, a pilot

study will be planned in the future to assess the structure, processes, and outcomes of the education program, competency checklist, protocol, and algorithm in the *third* phase--this third phase/pilot study was not part of this DNP project; it is for future planning purposes only**.** Thus, only the planning of the pilot study was part of this DNP capstone process improvement project as the execution of the pilot study was not part of the project.

The education program and protocol were guided by AFI 44-170 (2014) evidence-based mental health screening tools already used in the Web-PHA: the RESPECT-Mil program, the Stetler Theory Framework, and from collaboration by the medical staff at the 140th Medical Group using the Delphi technique. The protocol also included an algorithm to guide the health technician through the decision-making process more easily. The algorithm was part of the protocol and was a basic summary of decisions the trained health technician would need to make based of the guidance given by AFI 44-170. This process improvement project was called the Web-PHA mental health protocol (Web-PHA MHP). The goal was that Web-PHAs with "priority" or "critical" mental health concerns would be screened further by using a developed, standardized, evidence-based protocol tool by a trained health technician nurse or provider.

Theoretical Framework

Change in general is hard but practice change can be even harder. The Stetler Model (2001) is an excellent evidence-based practice model that could be used for program planning and implementation (see Figure 1). This model allows practitioners to assess how study findings and other relevant evidence could be used in practice using five phases (Stetler, 2001):

- Phase I: Preparation
- Phase II: Validation
- Phase III: Comparative Evaluation/Decision Making
- Phase IV: Translation/Application
- Phase V: Evaluation

Each of the phases is designed to facilitate critical thinking about the practical application of research findings; result is the use of evidence in context of daily practice and mitigates. some of the human errors made in decision making (National Collaborating Centre for Methods and Tools, 2011). This model was used in the development of the Web-PHA MHP.

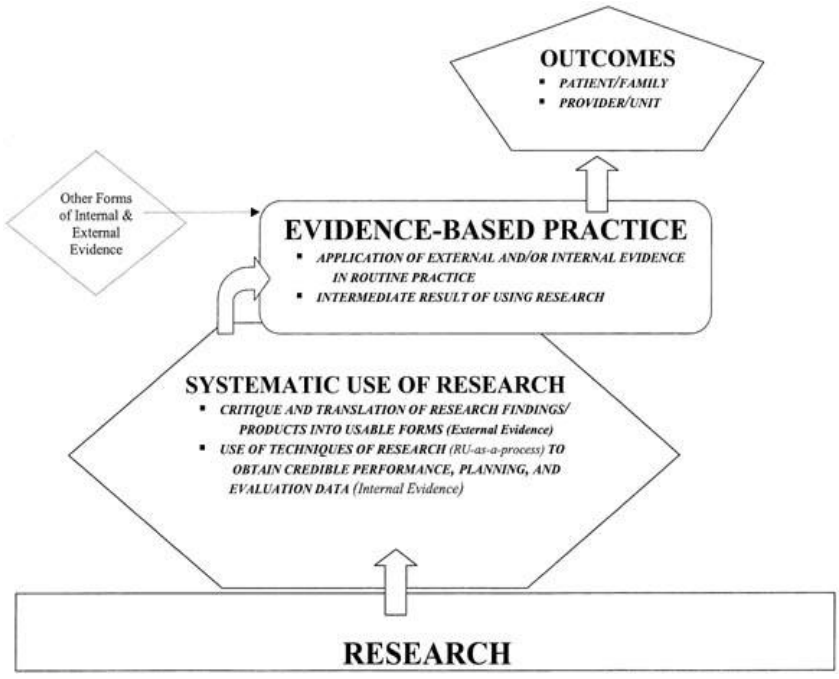

Figure 1. From research to outcomes with evidence-based practice (Stetler, 2001, p. 273).

Summary

After review of the AFI 44-170 (2014) and the 140th MDG's current program, one of the biggest weaknesses that stood out was large unknowns about the Web-PHA. There was also very little literature available on the Web-PHA and no written process for contacting members. Another huge issue was there was no specific training or education for those reviewing the Web-PHA (specifically the trained health technician). Guidance given by the AFI 44-170 was not clear in many areas, leaving crucial items open to interpretation. The U.S. Air Force uses the Web-PHA to screen all airmen yearly; the tool is well embedded within the Air National Guard. While the screening tools used were evidence-based, only one article was located on how well the Web-PHA worked for mental health screening. No updates were located since the Web-PHA program was first deployed between 2007 and 2009.

Identifying who should be contacting or following up with a priority or critical response (health technician, nurse or provider) would be helpful, specifically if the member had significant mental health concerns. With manning being minimal at the 140th MDG, options were limited so following the communication recommendations given by Re-Engineering Systems of Primary Care Treatment in the Military (RESPECT-Mil; Barry & Oxman, 2008) might help with this barrier. It was a system designed to enhance the recognition and management of PTSD and depression. The RESPECT-Mil program designed by the U.S. Department of Defense Deployment Health Center for the U.S. Army stated:

> Use of systematic approaches has been extended to depression care with demonstrated improved outcomes. These approaches (including tools, routines, and clear responsibilities) assure that key questions about family and personal history are asked, suicide ideation is explored, evidence-based patient education is

> provided, and response to treatment is monitored closely. At least (20) randomized controlled trials have shown substantial improvements in depression using systematic approaches. (Barry & Oxman, 2008, p. 7)

The RESPECT-Mil program gives guidance on screening, diagnosis, and follow-up care. This includes communication techniques and written scripts for those contacting patients with mental health concerns. These items come from the three component model (3CM) used extensively and successfully in the civilian world for depression and PTSD (Barry & Oxman, 2008, p. 5). The RESPECT-Mil gives a script to start the conversation when contacting a member about mental health concerns. The advice from them is the contact is made at the request of the provider. This might let the member be more open and honest about his/her current situation if the provider has asked the technician to make the call. By using preferred terminology, the barriers of rank and mental health stigma might be overlooked by the person being contacted. Having RESPECT-Mil training might prove to be very beneficial for the trained health technician dealing with mental health concerns.

The RESPECT-Mil was first tested for feasibility as a quality improvement project at Ft. Bragg within a highly deployable unit over a 16-month period. Of the 4,159 screened, approximately 10% were positive and enrolled into the feasibility study (Engle et al., 2008, p. 938). The study was very successful among those who chose to participate with a reduction of five points or more on the PTSD and depression screenings (Engle et al., 2008, p. 938). There were no significant or serious adverse events including suicide. Mental health stigma was a significant challenge during the study. “Thirty-five percent of those positive for depression or PTSD refused mental

health treatment or follow-up" (Engle et al., 2008, p. 939). Overall, the program was considered a success and was directed to be used at 17 other Army medical facilities.

Throughout the review process of the Web-PHA AFI and the 140th MDG program, lack of any formal education or training was identified for this capstone process improvement project; these issues need to be examined and a streamlined education and training program needs to be developed for the health technician and any other health professional involved in the Web-PHA program to follow.

CHAPTER II

LITERATURE REVIEW AND SYNTHESIS

Significant research has been conducted on mental illness and mental illness in the military but little research was found specific to the AF Web-PHA (AFI 44-170, 2014). The Web-PHA was initiated to serve as a preventative health assessment to maximize the wellbeing of Airmen while ensuring mobility readiness. This preventative-screening tool is mandated yearly. If a member deploys, there is a similar screening program called the Deployment Health Program that takes over screenings and is administered numerous times within the year after a member returns. The purpose of this literature review was to analyze and critically review the research on mental health screening, web-based screening programs, the Air Force Web-PHA screening tool, and implementation of a standard protocol in response to mental health concerns. The following (P) Population, (I) Intervention, (C) Comparison, (O) Outcome question (PICO) guided this literature search: Among the 140th Colorado Air National Guardsmen completing a Web-based periodic health assessment, does implementing a formal education platform for mental health related positive responses versus not using a formal education platform affect addressing these concerns in a more streamlined and effective manner? The results of this literature review and synthesis were utilized to build the Web-PHA MHP as a process improvement for positive mental health responses with a "priority" or "critical" flag at the 140th Medical Group.

Methods

Prior to designing the 140th Medical Group Web-PHA (AFI 44-170, 2014) education platform and protocol, an extensive electronic search of the literature was conducted on the following online databases: CINAHL, Cochrane Library, MEDLINE, PubMed, Wiley Online Library, National Institute of Mental Health, USPSTF, SAMSHA, AHRQ, Google Scholar, and the CDC. Keywords used for searches included several combinations of the following: mental health in the military; screening for depression, anxiety, and PTSD; evidence-based mental health screening tools; web-based screening effectiveness; and Air Force Web-based Periodic Health Assessment. Searches were restricted to those articles published in English and evidence-based or peer-reviewed journal articles within the past 10 years. The last search for relevant studies was conducted on March 24, 2016. Thirty-nine articles were reviewed including six systematic reviews, 19 research articles, and 12 general articles. No specific research could be located with regard to this specific capstone project.

Air Force Periodic Web-Based Health Assessment

The Air Force Web-PHA (AFI 44-170, 2014) is a web-based, self-administered health questionnaire that every Airman is required to do yearly at a minimum.

> These questions were developed by a Department of Defense team who were guided by the health screening and counseling recommendations of the USPSTF, U.S. Department of Agriculture, American College of Sports Medicine, American Heart Association, and other organizations; and used well-tested public domain questions and responses sets, such as the Behavioral Risk Factor Surveillance System and Alcohol Use Disorders Identification Test. (Santos, 2009, p. 6).

This questionnaire is usually done the month of the member's birth date. The Web-PHA focuses on three dimensions of mental health: general anxiety/panic disorder, depression, and posttraumatic stress disorder (PTSD). The questions are asked in an algorithm type

format--positive answers lead to further questioning. These algorithms were developed by the United States Air Force (USAF) Informatics Division based on the American Psychiatric Association's (2000) *Diagnostic and Statistical Manual of Mental Health Disorders*, 4th edition (DSM-IV) guidelines (Madrid, 2010). The algorithms for depression (see Figure 2), anxiety/panic disorder (see Figure 3), and PTSD (see Figure 4) show how questions are asked and reach a priority or critical response. These assessments allow an airman's healthcare team to be alerted if any concerns arise or are reported. That being said, the airman has to be forthcoming in order to be flagged for concern . The AFI 44-170 (2014) that guides the Web-PHA, *Preventative Health Assessment* (see Appendix A), states, "Air Reserve Component members will be notified of any critical or priority findings at the end of their Air Force Web-PHA session and will be directed to seek civilian medical care as appropriate" (p. 16).

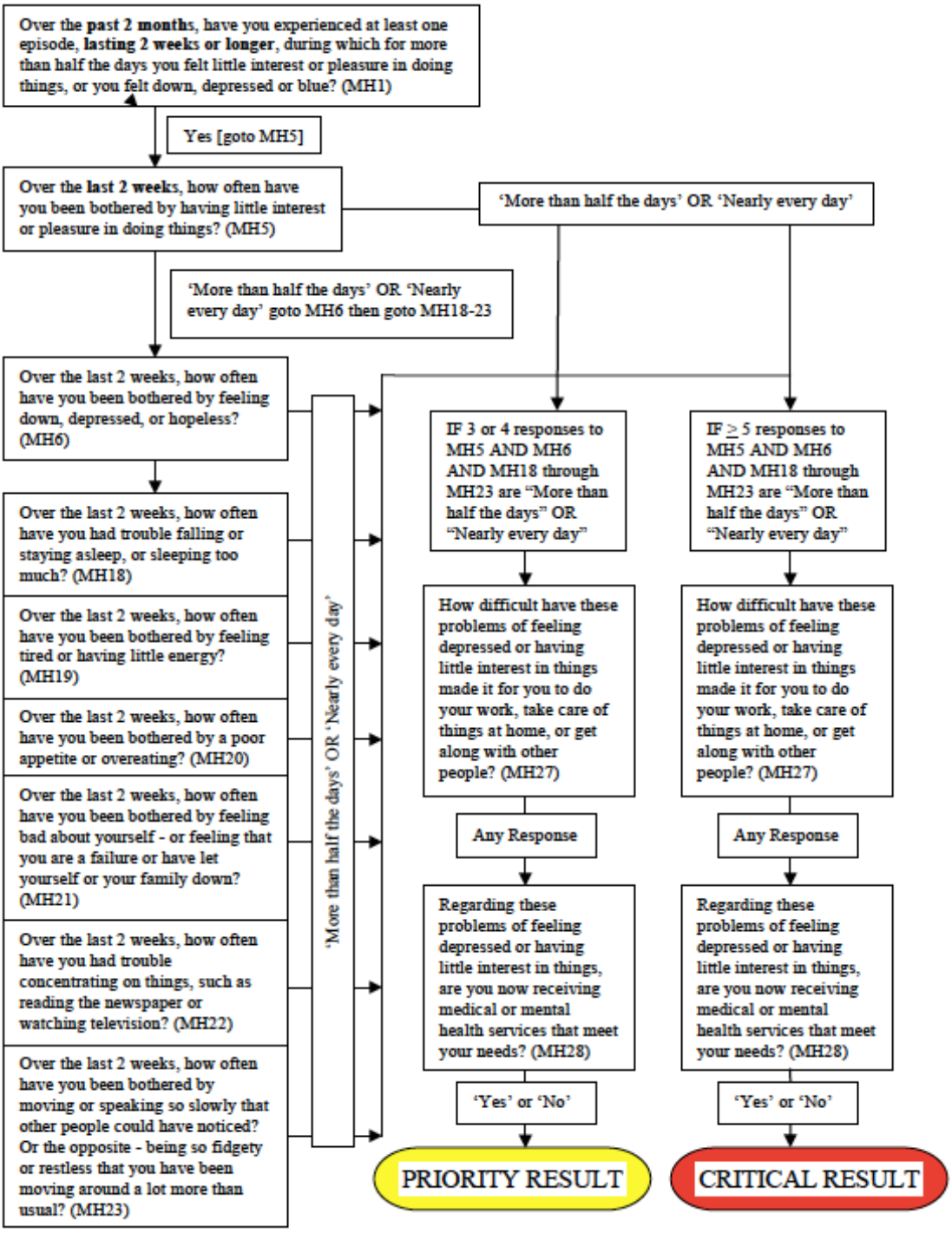

Figure 2. Air Force web-preventive health assessment mental health questions to assess for depression (Madrid, 2010).

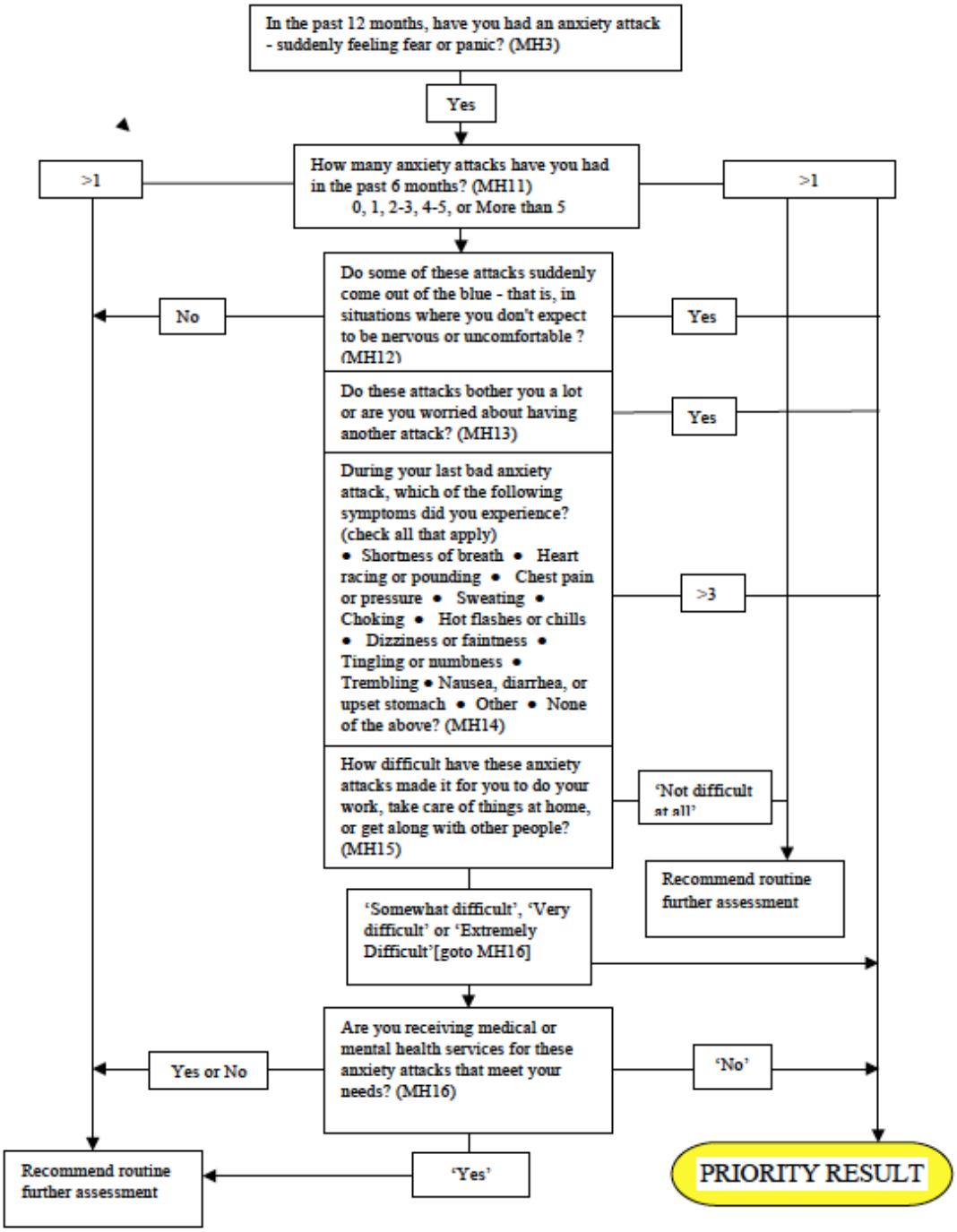

Figure 3. Air Force web-preventive health assessment mental health questions to assess for anxiety (Madrid, 2010)

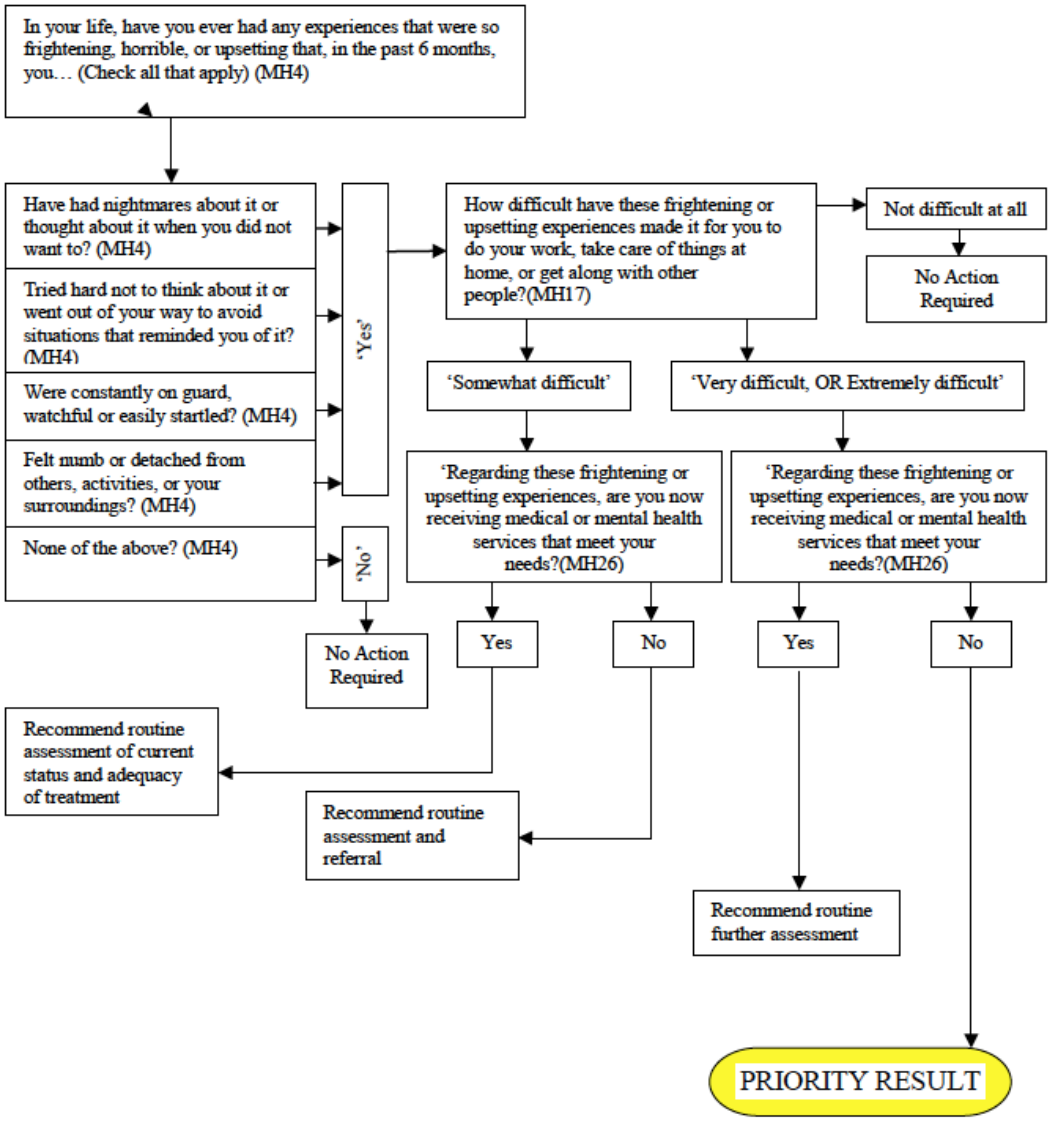

Figure 4. Air Force web-preventive health assessment mental health questions to assess for posttraumatic stress disorder (Madrid, 2010).

The depression-screening algorithm uses the Patient Health Questionnaire-2 (PHQ-2) followed by the Patient Health Questionnare-9 (PHQ-9) if the PHQ-2 was positive. The PHQ-2 is a two question screening tool used as a first step approach in identifying those at risk for depression and is based on a point system. Patients who screen positive are then further evaluated with a PHQ-9 (see Appendix B), which asks

nine more in-depth questions (also based on a point system) to see if there is a possible depressive disorder present. A score of 1-4 is minimal depression, 5-9 is mild depression, 10-14 is moderate depression, 15-19 is moderately severe depression, and 20-27 is severe depression (USPSTF, 2016). Anxiety/panic disorder is screened with the General Anxiety Disorder 7-item (GAD-7) scale (see Appendix C), which is also based on a point system and scores are calculated by assigning a 0, 1, 2, or 3 based on the response to each question. Scores of 5, 10, and 15 are the cut-off for mild, moderate, and severe anxiety (Spitzer, Kroenke, Williams, & Lowe, 2006). The primary care PTSD screen (PC-PTSD) consists of four questions based on a yes or no answer (see Appendix D). Any three "yes" answers would be considered positive and require further assessment.

Analysis of the Literature

Mental Health Screening

A statistical analysis was done in a two-phase assessment from April 2010 to January 2011 on currently serving active duty Australian Navy, Army, and Air Force personnel making up a mental health prevalence and well-being study (Searle et al., 2014). The study focused on screening for mental health disorders. It discussed the use of these tools in several nations including the United States, finding the effectiveness of military screening programs remained unknown (Searle et al., 2014, p. 32). "It is vital that military forces can be confident their screening measures are identifying the correct people and that benefits of screening outweigh risks" (Searle et al., 2014, p. 32). Additionally, positive self-administered screenings need to be followed up by a "brief semi-structured interview to contextualize questionnaire responses and provide brief

intervention" (Searle et al., 2014, p. 33). Mental health screening is endorsed by the Centers for Disease Control and Prevention (CDC) and refers to a web-based mental health screening through the screening for mental health (SMH) program. This program targets many different ages and groups of people including the military population. "Mental health and wellness professionals are turning to mental health screenings as a viable way to identify potential conditions" (Screening for Mental Health [SMH], 2016, para. 1). The online assessment is anonymous and is an effective way to recognize members who are at risk or who are suffering from mental health disorders. When a member has a positive screening online, community resources and referrals are given.

Patient Health Questionnaire-9

Wells, Horton, LeardMann, Jacobson, and Boyko (2013) discussed the PHQ-9 with regard to the ninth question, which asks about suicidal thoughts. This was studied at length in their millennium cohort study that used a self-reported questionnaire to screen for depressive disorders in the largest longitudinal cohort study in military history due to increased concerns about suicide. This study included over 150,000 service members. The PHQ-9 "has been shown to have a high sensitivity (0.93) and specificity (0.89) and correlates well with a diagnosis of depression as outlined in the *Diagnostics and Statistical Manual of Mental Disorders* (Wells et al., 2013. p. 78). Not all practices endorse asking the ninth question of the PHQ-9 but it is the gold standard. The study revealed that asking the first eight questions identified depression at the same rate as asking all nine questions; however, in the military, the PHQ-9 is needed due to increased scrutiny surrounding suicide.

Web-Based Mental Health Screening

A randomized controlled study by Kravitz et al. (2013) showed that a tailored interactive multimedia computer program (IMCP) used prior to a primary care visit resulted in the recommendation of prescription antidepressants, a mental health referral, or both. The IMCP was shown to be an effective way for patients to screen themselves with the PHQ-9 for mental health concerns and this type of intervention is effective for increasing recognition. The study included 925 eligible patients from seven clinical sites.

Mental Health Care in the Military

The RAND Corporation (Hepner et al., 2016) for objective analysis and effective solutions published *Areas of Excellence and Need for Improvement Found in Quality of Mental Health Care Provided by the Military*. "Regardless of where they serve, where they live or who they are, all members of the U.S. Armed Forces should receive high-quality mental health care" (Hepner et al., 2016, p. 4). The study gave recommendations to include

> establishing an enterprise-wide performance measurement, monitoring and improvement system that included high-priority standardized metrics to assess care for psychological health conditions and investigate the reasons for significant variation in quality of care for psychological conditions by service branch, region and service member characteristics. (Hepner, 2016, Recommendations, para 1)

A systematic review study was conducted by Cohen et al. (2015) that suggested psychiatric consequences differ between the active and reserve military components. Due to the increased reliance on National Guard and Reserve components, the prevalence of mental health disorders was greater at 14.5% versus 11.7% and more frequently involved alcohol use disorders (Cohen et al., 2015. p. 1). The study identified the need

for more standardized documentation, mental health resources, and mitigating strategies to reduce the psychiatric burden among the Guard and Reserve.

Air Force Instruction 44-170

This Air Force Instruction (2014) is instrumental to the WEB-PHA process and supplies minimum guidance and procedures for the Air Force Preventive Health Assessment (PHA) program, also known as the Periodic Health Assessment (PHA) in the Air Reserve Corps (ARC). "The intent of the PHA program is two fold: to recommend evidence-based, cost effective preventative health services, and to identify and document potential duty limiting conditions" (AFI 44-170, 2014, p. 3). This instruction was used in the formulation of the Web-PHA protocol as directed. The one difference between the Web-PHA and the many other screening tools is the Web-PHA is not anonymous and is not voluntary. It is mandated that each service member in the Air Force have a Web-PHA yearly.

Web-Preventive Health Assessment

A published thesis written by Michael Madrid (2010) on the *Air Force Web Preventive Health Assessment Mental Health Screening Effectiveness* found that out of 211,485 active duty Air Force members who completed a Web-PHA assessment, 1.2% (2,458) had a "priority" or "critical" response to the mental health screening section. This study focused on a correlation between positive mental health screenings (priority/critical) and actual diagnosis of an International Statistical Classification of Diseases and Related Health Problems (ICD)-9 mental health disorder. The study showed depressive symptoms had greater sensitivity with women, those 30-years-old or older, and those enlisted who reported receiving adequate care (Madrid, 2010, p. 31).

Screening for panic disorder and PTSD had low sensitivity, specificity, and positive predictive value across the board. "The AF Web PHA does not appear to effectively find mental health disease (sensitivity) nor does it appear that a positive screening result actually predicts disease" (Madrid, 2010, p. 35). Overall, the Web PHA has the ability to verify the lack of mental health disease (specificity; Madrid, 2010, p. 35).

Developing a Mental Health Protocol

Implementing Evidence-Based Mental Health Care in Low Resource Settings: A Focus on Safety Planning Procedures by Murray et al. (2014) gives policy recommendations on how to handle safety risks such as suicidal ideation, homicidal ideation, and intimate partner violence. "Lower resource settings have several challenges, such as limited trained personnel and a lack of government resources set aside for mental health" (Murray et al, 2014, p. 168). The article discusses steps in developing a protocol to include involving stakeholders, collecting resources within the infrastructure and the community, creating lists and flow sheets, and developing training for implementation. These steps encourage following and documenting a chain of contact and ongoing case consultation.

Re-Engineering Systems of Primary Care Treatment in the Military

"RESPECT-MIL is an innovative program to provide systematic evidence based care to Soldier's with symptoms of depression and PTSD in the primary care setting" (Pickett et al., 2015, p. 302). This program provides information and training on how to screen patients for depression and PTSD and on how to communicate with them about their behavioral health issues. Policies, directives, fact sheets, clinical tools, training materials, and related links are available for use, although they are focused on military

members on active duty with access to military healthcare and resources. The RESPECT-Mil *Care Facilitator Reference Manual* (Barry & Oxman, 2008) document provides a planning care facilitator contact and conducting calls chapter that gives a number of useful principles for those engaging in telephone follow-up with military members.

The Delphi Technique

This technique utilizes a consensus method that includes at least two or more rounds of questions to a group of panelists who are selected by their relevant expertise. The goal is for consensus among panelists. The Delphi technique was used to validate quality measurement in the primary care setting where evidence was lacking and opinions differed. The objectives of the study were to

> (1) describe differences in panel ratings on the quality of primary mental health care services by patient, career, professional and managerial panels within the Delphi procedure; and (2) to explore why different panels and panelists rate quality indicators of primary mental health care differently. (Campbell, Shield, Rogers, & Gask, 2004, p. 428)

Through two rounds of Delphi, the study concluded primary mental health care has significant differences of opinions and views on the quality of care. The authors interviewed panelists after the question rounds and found answers and ratings were influenced by their "past experience, expectations, definitions or quality of care and perceived power relationships between stakeholders" (Campbell et al., 2004, p. 428).

The Stetler Model

This model is utilized to research evidence-based promotion in nursing. Stetler (2001) provided a comprehensive framework to enhance the use of research, which can be used on an institutional or individual level. "At the institutional level, synthesized

research knowledge is used to develop or update protocols, algorithms, policies, procedures, or other formal programs implemented in the institutions" (Groves, Burns & Gray, 2012, p. 493). On the individual level, nurses, including practitioners, can summarize the literature and research to use as knowledge to make practice decisions.

Application of a Theoretical Framework: Stetler Model

The Stetler (2001) model is a five-phase framework that makes up and follows a pre-implementation, implementation, and post-implementation structure. Phase I consists of identifying the purpose such as a need to solve a problem or revise an existing policy (Stetler, 2001). Currently at the 140th MDG, there is no standardized education or protocol for contacting patients with priority or critical mental health responses on the Web-PHA. Having formal education as well as a written document to follow and reference would make contacting individuals more meaningful. The AFI 44-170 (2014) mentions business rules should be developed regarding the Web-PHA process and military treatment facility instructions regarding procedures to implement PHA-associated clinical practice guidelines and quality assurance processes should be developed (p. 6). Using evidence to solve the problem in this phase helps to identify measurable outcomes for Phase V.

Phase II assesses each source of evidence. The credibility and applicability of each study or tool is evaluated for practical use. The Web-PHA screens airmen with three different tools to include depression, anxiety, and PTSD. These tools are evidence-based and recommended as "gold standards" in the primary care setting and military setting for screening purposes. However, these tools are unknown to staff contacting

members. These screening tools, RESPECT-Mil (Barry & Oxman, 2008), and other information used were assessed through the extensive literature review.

Phase III involves organizing and displaying the summarized findings from across all validated sources (Stetler, 2001). The USPSTF (2016) guidelines for depression, as well as the GAD-7 and PTSD screens that are evidence-based and recommended, are being used to screen for mental health concerns. Education and a Web-PHA protocol have been designed by consulting these evidence-based tools--the AFI 44-170 (2014), RESPECT-Mil (Barry & Oxman, 2008) and by using the Delphi technique (Hsu & Sandford, 2007). The Delphi technique consists of developing a consensus of opinion concerning a specific topic. "It is well suited as a means and method for consensus-building by using a series of questionnaires to collect data from a panel of selected subjects" (Hsu & Sandford, 2007, p. 1). Rounds of questions are sent out for expert opinion with a goal of consensus.

Phase IV articulates the "how-tos" of implementation (Stetler, 2001). Evidence-based research along with a formal collection of reasoning using the Delphi technique was used to develop the education and Web-PHA protocol. This protocol was for use on any Airmen in the 140th Wing with a positive mental health response that had a priority or critical flag. Appropriate and reasoned variation was used in certain cases as deemed necessary due to rank or specific concerns that might deviate from the protocol itself. A plan for formal dissemination of the protocol was the goal but was not part of this capstone project.

Finally, Phase V is to clarify expected outcomes. The goal of this capstone process improvement project was to educate staff contacting members with mental health

concerns as well as streamlining the flow of identifying, contacting, and querying about the positive mental health concerns that had been flagged. By having a standardized method, hopefully more Airmen would benefit from being contacted, being referred to appropriate services and ultimately decreased bad outcomes. "Lack of knowledge and skills pertaining to research use and evidence-informed practice can inhibit appropriate and effective use" (Stetler, 2001, para. 5). This is what happened at the 140th Medical Group. The medical team was well-engaged and willing but had not been provided with the tools to manage mental health concerns within the Web-PHA process. Getting the leadership's support for an evidence-informed practice culture, engaging and implementing the protocol, as well as supporting and maintaining it long term were key to its success.

Summary

Throughout the literature review, a common theme was identified. However, more studies and research needs to be done on the effectiveness of screening for mental illness, specifically computer-based. Many different programs have been developed to address positive screenings but no specific guidelines have been published nor are any geared toward the Air National Guard. Numerous programs are specific to active duty military members but those in a guard or reserve status do not receive healthcare services through the military. The RESPECT-Mil has training and information for those contacting positive mental health concerns; however, it is geared toward the active duty component. The SAMHSA (2010) published the *Understanding the Military: The Institution, the Culture, and the* People document for civilian healthcare personnel treating those with mental health conditions to be able to understand the gravity of

military service, which can be utilized by civilian medical professionals to comprehend the military culture.

Research is limited overall on the Air Force Web-PHA and the AFI 44-170 (2014) that guides the Web-PHA process, does not discuss what is included in the mental health screening, or how effective it is in identifying members in need. Evidence-based practice guidelines to screen for depression, anxiety, and PTSD are available and used in the Web-PHA screening for mental health disorders per the U.S. Air Force Healthcare Informatics Division according to DSM IV (APA, 2000) guidelines, which have not been updated to the more recent DSM V (APA, 2015) guidelines. National Guard members face unique challenges that set them apart from their active duty components regarding civilian healthcare and jobs along with the additional duties of military service. This makes developing a specific protocol for responding to priority and critical mental health concerns a priority.

CHAPTER III

EVIDENCE-BASED PROJECT PLAN

The overall aim of this project was to standardize the education and response of the health technician to positive Web-PHA mental health concerns in Airmen at the 140th Wing located at Buckley Air Force Base in Aurora, Colorado. No evidence-based formal education or guideline is currently available for this specific situation but there is reasonable evidence in the literature that could be synthesized into one. Further evidence had been gathered from surveys of those involved in the Web-PHA process for medical expertise using the Delphi technique and by using the Stetler (2001) theoretical framework. The interventions were divided into three phases.

Data Collection Procedures

Two separate Delphi studies were developed and administered in two separate phases for this project. Phase One--Delphi Study #1 focused on building an education, learning materials, and competency assessment list for trained health technicians. Phase Two--Delphi Study #2 focused on building a protocol and algorithm for the Web-PHA process. The protocol and algorithm were needed to guide the practice of the medical technicians as they interacted with Air Guard members during the Web-PHA process. The first round of each of the two Delphi studies consisted of open-ended questions and followed the systematic steps of the Delphi technique. The following methodical steps were followed to reach the goal of consensus and informed agreement among the experts

on specific issues. Return of the surveys by the participants was considered consent as the no-signature consent form was attached to the surveys (see Appendix E). The anticipated time constraint for each of the panel experts was approximately 15 minutes per round per Delphi study. It was anticipated that each study (please note: there were two Delphi studies) would consist of a minimum of at least two rounds.

After the potential experts had been identified for each of the Delphi Studies, each person (for each Delphi study) was sent an electronic letter explaining the purpose of the survey as well as the first round of open-ended questions for that particular Delphi study. An electronic reminder was sent after one week to those who had not returned the study.

Phase One: Delphi Study #1

Qualitative data gathered with the Delphi technique for the first round of Delphi Study #1 focused on determining what education should be included for the trained health technician in the Web-PHA process in order to target what type of learning program needed to be developed (see Appendix F). The responses from the seven open ended questions in round one were reviewed and categorized by the author who created a list of themes and summary statements. These results were developed into questions for the second round of Delphi Study #1. The second round consisted of a summary from round one for review along with closed ended questions developed directly from round one. Round two responses were primarily quantitative in nature with the goal of panel consensus (greater than 70% concurrence among he panel members on all items will equal consensus). A third round was not needed due to consensus within the second round.

Phase Two: Delphi Study #2

Qualitative data gathered for the first round of the Delphi Study #2 with regard to the second phase of this project was done by using the Delphi technique as well as to build a protocol and algorithm for the trained health technician to follow (see Appendix G). These questions were developed from areas left open to interpretation in the Air Force Instruction 44-170 (2014) that guides the Air Force Web-PHA process. Six open-ended questions were asked to address these gaps. The answers were compiled from round one and a summary was sent out to the panelists along with questions for round two. Round two consisted of close-ended questions that came from the responses from round one. Round two responses were primarily quantitative in nature with the goal of panel consensus (greater than 70% concurrence among the panel members on all items will equal consensus). A third round was not conducted due to consensus within round two.

In both Delphi studies, the second round of Delphi surveys was collected separately (just like round one), reviewed, and analyzed to see whether a third or more round would be needed. The idea was to continue to structure further rounds from the answers of the previous rounds to reach consensus, although most Delphi studies consist of two to three rounds. Opportunity for comments was also given in each round.

Phase Three: Proposed Pilot Study

This phase was for planning purposes only and was not carried out during this capstone project. The plan was to develop a pilot study for the future in order to evaluate the education, competency assessments, protocol and algorithm in use as developed through Phase One (Delphi Study #1) and Phase Two (Delphi Study #2) of this DNP

process improvement project. The pilot study planned for the future would assess this structure, processes, and outcomes of the aspects of the mental health portion of the annual Web-PHA requirement. Again this phase was for planning purposes only and was not carried out during this capstone project.

Project Design

Design

A non-experimental field study approach was used to under-pin this process improvement project. The Delphi survey data collection technique was utilized to query a panel of experts. This technique was a consensus method, which included two rounds of questions to a group of panelists. These panelists were selected by their relevant expertise. The goal was for consensus among panelists.

> The Delphi technique is a widely used and accepted method for gathering data from respondents within their domain of expertise. The technique is designed as a group communication process, which aims to achieve a convergence of opinion on a specific real-world issue. (Hsu & Sandford, 2007, p. 1)

Participants

Participants eligible for this process improvement project panel were limited due to assigned manning of the program at the 140th Medical Group. Potential participants included the Chief of Medical Staff, Chief of Nursing Services, one clinical nurse, three providers, the 4N Functional who is the technician in charge, as well as the current and previous health technicians for the program located at the 140th Medical Group at Buckley Air Force Base in Aurora, Colorado. All of these members are part of the Air National Guard and are health professionals directly involved with the Web-PHA process. The author, who is also the Chief Nurse, was working in a student role.

Participation was voluntary and anonymous. All surveys were sent out electronically. The goal was a minimum of four participants per round of each Delphi survey.

Data Analysis Procedures

Data were analyzed qualitatively and quantitatively by the author using standard techniques. Narrative information provided by the expert panel was summarized and assessed for themes. The summary and themes generated from both Round #1 narrative components of each Delphi study provided the foundation for quantitative questions for Round #2 of each Delphi study. All other descriptive or ranked data were analyzed quantitatively through the use of descriptive and parametric or nonparametric statistical methods. Nonparametric statistical methods would have been used if the number of the panel was less than 30 (Shah & Kalaian, 2009). If the number in the panel was 30 or greater, then parametric statistical methods would be used. The author's research advisor has experience and expertise in the conduct of the Delphi study method and in the use of both qualitative and qualitative data analysis techniques.

Timeline

The timeline for development of this project was as follows:

1. Pre-implementation
    - Idea approval from chairperson--November 2015
    - Needs Assessment--November 2015/January 2016
    - Process improvement development--January to March 2016
    - Final approval from committee--March 2016
    - Defense of Capstone proposal--April 2016
    - Institutional Review Board approval as appropriate--April 2016

2. Implementation

    - Process improvement implementation of Web-PHA education--April to May 2016

3. Post-Implementation

    - Evaluation--May 2016
    - Conclusion, recommendations and implications--May 2016
    - Final defense of completed Capstone--May 2016
    - Proposed Pilot Study--TBD for future implementation

Resources

Limited resources were needed to implement this process improvement protocol. This project was implemented after a successful proposal defense and University of Northern Colorado Institutional Review Board (IRB) approval in April of 2016 at the 140th Medical Group at Buckley Air Force Base in Aurora, Colorado (see Appendix H). The education platform, protocol, and algorithm development was done by the capstone author with support from the DNP Capstone Project Community Member and Project Coach/Mentor (see Appendix I). Screening tools used for this protocol were supplied by the USPSTF, Veterans Affairs, and Substance Abuse and Mental Health Services Administration. The RESPECT-Mil program was created by international experts in primary care management of depression and PTSD with a goal of training how to screen patients and communicating with them about behavioral health issues. These government agencies provided the tools for download free of charge. The written materials, which included the screening tool templates, Web-PHA depression, anxiety and PTSD question algorithms, and Web-PHA MHP were printed and supplied by the 140th Medical Group.

Education and training on the Web-PHA MHP was done by the capstone author and during duty hours with the designated health technicians assigned to the program. No other additional resources or budgetary items were required.

Evaluation Plan

To evaluate the education program, a pre- and post-implementation questionnaire was used to assess knowledge and to look for areas that needed improvement or expansion. A certificate and competency checklist was generated for each person who attended and successfully completed the education so it could be filed in their education and training folders to prove training was conducted. Another way to evaluate this program would be by doing a short pilot study. Continual observation and feedback would be needed over time if implementation was accepted. "A pilot study is a requisite initial step in exploring a novel intervention or an innovative application of an intervention" (Leon, Davis, & Kramer, 2011, p. 626). By doing a pilot study, modifications could be identified and put into practice. This exploratory venture would hopefully lead to a standardized approach to implementing evidence-based screening tools and outcomes with regard to positive mental health concerns on the Web-PHA. "Pilot studies are a necessary first step in exploring novel interventions and novel applications of interventions-whether in a new patient population or with a novel delivery system" (Leon et al., 2011, p. 628). Mental health research and recommendations can change at any given time and those changes would need to be incorporated into the protocol. This education and protocol should be reviewed on a yearly basis. Fortunately, the Air Force requires yearly review and biennial updates to all documents per AFI 33-360 (2015).

Summary

The project design for the formal education and Web-PHA MHP was based on evidence in the literature, expert opinion by stakeholders involved using a consensus method with the Delphi technique (Hsu & Sandford, 2007), the Stetler (2001) model, AFI 44-170 (2014) guidance on the Web-PHA, and the RESPECT-Mil (Barry & Oxman, 2008) program that gives training and recommendations on how to communicate and document mental health concerns with the military population. Since the health technicians are now educated and trained on the Web-PHA, the Web-PHA MHP could be implemented. Doing a short pilot study could help detect any identified flaws, holes, or deficits, leading to an improved and more useful protocol with the goal of giving members at the 140th Air National Guard the best mental health screening available. Ideally, this protocol could be used in any Air National Guard unit, resulting in better mental health outcomes.

CHAPTER IV

RESULTS

Survey Tool

The Delphi technique was used for the preparatory work in both Phase One and Phase Two of this project and played a large part in building the protocol and algorithm for Phase Three. The Delphi technique was originally developed by Olaf Helmer and Norman Dalkey in the 1950s by the RAND Corporation (Custer, Scarcella, & Stewart, 1999). It was used by the military to systematically solicit the beliefs of experts in relation to national defense issues. The term originated from Greek mythology; the Delphi technique might be thought of as an "expert brainstorm. The Delphi group (panel of experts) was sent a series of questionnaires through a facilitator who supervised the process. The panel of experts did not meet face-to-face and all communication was done in writing. The panel members were chosen because of their relevant expertise on the subject.

Personnel at the 140th medical group who are directly involved in the Web-PHA process made up the expert panel. Questionnaires were sent out and written responses were collected and analyzed to determine conflict or convergence of viewpoints on each question. The facilitator gathered, summarized, and then gave collected feedback to all group members. The Delphi group members were kept separate to avoid problems with group dynamics. This process was repeated until consensus was reached.

Objectives

The first objective was to identify the current Web-PHA process, which was done through technician level interview, review of AFI 44-170, and surveys sent out using the Delphi technique about the Web-PHA program. The second objective was to identify the Web-PHA addresses, what questions were asked, and how critical and priority findings were flagged with regard to mental health concerns. This was accomplished by a thorough review of the literature, the guiding AFI 44-170, and direct observation in ASIMS. The third objective was to use the first two objectives to build an education program and create an evidence-based protocol for the trained health technician to use when contacting positive mental health Web-PHAs. The third objective was divided into phases to determine the education needed and what items would be included within the protocol and algorithm.

Phase One, Delphi #1: Round One

Phase one of this project focused on the building of an education platform for the "trained" health technician, since one did not currently exist. The first Delphi survey sent out consisted of seven open-ended questions. This was done with a no-signature consent form in which return of the survey was deemed as consent (Appendix E). They were sent out to a panel of six experts at the 140th Medical Group who were directly involved with the Web-PHA program--five experts participated. These experts consisted of two health technicians, one nurse, and two physicians. All of the questions in the survey were prefaced with the following phrase: "In regards to the mental health portion of the Web-PHA program."

Question one stated: What type of education have you received on the Web-PHA program? Table 1 provides comments from experts regarding the education they received on the Web-PHA program.

Table 1

Comments from Experts Regarding Education Received

Panelist	Responses
1.	No specific mental health training.
2.	The standard training for this position from the previous employee regarding AFIs.
3.	AFI guidance is the predominant education we receive on this program.
4.	I guess just HIPAA training and the knowledge I've gained over the years working as a medic.
5.	On the job training with another physician, reading the Air Force Regulations short 3-4 hour group web training.

Question two stated: Have you received any mental health training? Table 2 provides comments from experts regarding specific mental health training.

Table 2

Comments from Experts Regarding Specific Mental Health Training

Panelist	Responses
1.	Yes as an RN. No specific training for web-pha.
2.	I have taken multiple courses in psychology and mental disorders. I have also been trained in providing security for SI, HI and mood disorders.
3.	Yes, as an emergency physician I have received mental health training in recognizing mental health emergencies and how to respond to them.
4.	Yes, I'm a certified mental health first responder.
5.	Yes, medical school and some in residency.

Question three stated: What education would be helpful to you? Table 3 provides comments from experts regarding specific education that would be helpful.

Table 3

Comments from Experts Regarding Specific Education That Would Be Helpful

Panelist	Responses
1.	Where to chart pt responses and contact info for mental health fellows.
2.	Best practice ideas, staying current with AFIs.
3.	Continuing education on traumatic brain injury and PTSD from the military would be useful.
4.	Maybe a broader knowledge of medications?
5.	PHA class outlining the web assessment algorithm and the process it uses to add additional questions based on the response given.

Question four stated: What information would you like provided about the Web-PHA program? Table 4 provides comments from experts regarding information needed on the Web-PHA program.

Table 4

Comments from Experts Regarding Information Needed on the Web-Based Periodic Health Assessment Program

Panelist	Responses
1.	Same as above
2.	N/A
3.	Perhaps how exactly they decide what makes a priority or critical flag.
4.	None
5.	As above. An understanding of how the web-PHA is structured

Question five stated: Which mental health screening tools are used? Table 5 provides comments from experts regarding mental health screening tools used. Question six stated: What concerns do you have about the mental health portion of the Web-PHA? Table 6 provides comments from experts about the mental health portion of the Web-PHA.

Table 5

Comments from Experts Regarding Mental Health Screening Tools Used

Panelist	Responses
1.	I can't remember specific pha mental health questions at this time.
2.	Over the phone one on one conversations with the member
3.	A variety of tools it appears.
4.	Not sure what you mean.....
5.	Would not know unless told.

Table 6

Comments from Experts Regarding Concerns About the Mental Health Portion of the Web-Based Periodic Health Assessment

Panelist	Responses
1.	I do not feel that there are questions that address PTSD. I can't remember if suicidal ideation are addressed. I feel that this area isn't well addressed in the web-pha
2.	It doesn’t accurately flag mental health related issues.
3.	Predominant concern of mine is that we do not have licensed providers or nurses available full-time to review the daily Web-PHA results.
4.	I think sometimes it may get overlooked or not taken as serious as it should be. We are following the AFI by calling the members immediately, but I guess we are doing the best we can over the phone with the patient.
5.	Some members can provide false information due to fear of how the answers could affect their military career.

Question seven stated: What makes a priority or critical mental health concern flag? Table 7 provides comments from experts regarding what makes a priority or a critical flag.

Table 7

Comments from Experts Regarding What Makes a Priority or Critical Flag

Panelist	Responses
1.	Suicidal ideations.
2.	When a member checks a certain set of boxes that causes a flag within the system.
3.	Not clear to me.
4.	I'm not sure. I haven't tested it myself to find out. I'm guessing there are many things that will flag priority. Drinking too much, not getting enough sleep, and feeling depressed
5.	Any suggestions of potential violence to self or others, worsening depression, new medication added since last web-PHA or member with concerns in which they would like to speak with a health care member.

Phase One, Delphi #1: Round Two

Data were gathered from round one and themes were created into six "Yes" or "No" questions. These questions were sent out to the panelists individually with all of the comments from the first round for their review. This was done with a no-signature consent form in which return of the survey was deemed as consent (see Appendix E). The experts were also given a comment section for their use if needed. All of the questions in the survey were prefaced with the following phrase: "In regards to the

mental health portion of the Web-PHA program: Please answer YES or NO to each question below."

1. Do you agree that you have not received any formal education specific to the mental health portion of the Web-PHA program, other then referencing the AFI?
2. Will education on what mental health questions are asked, when to contact a patient, what questions to ask the patient and where to document the encounter be helpful?
3. Will information on how a critical or priority flag is generated for mental health concerns be valuable to you?
4. Do you agree that you are unsure about which mental health screening tools are used on the Web-PHA?
5. Would knowing how to appropriately administer and score the specific mental health screening tools included in the Web-PHA be helpful for you?
6. Due to the multiple concerns about the mental health portion of Web-PHA, would a protocol and algorithm help you to work through mental health concerns?

There was unanimous consensus among the panelists within the second round. All six questions were answered as "Yes." There was no need for a third round as all of the experts felt there was need for more education and training on the mental health portion of the Web-PHA. Comments were also left and taken into consideration during the building of the education, protocol, and algorithm.

> Having knowledge of the tool and how it works usually improves the implementation of the tool and allows for greater understanding of the tool and

> helps to prioritize concerns. The tool as a whole would make more sense if the parts were understood. Although a protocol and algorithm would not necessarily fit every case, it would provide a framework for assessment of the individuals needs and improve the functionality of the tool.

Phase Two, Delphi #2: Round One

Qualitative data gathering for round one, of Phase Two was done by using the Delphi Technique, which was developed from areas left open to interpretation in the AFI 44-170 that guides the Air Force Web-PHA process. Six open-ended questions were asked in order to address the gap in the Web-PHA MHP and were sent out to five experts within the 140th Medical Group with a no-signature consent form in which return of the survey was deemed as consent (see Appendix E). Four experts participated in the survey, which consisted of three health technicians and one physician who were directly involved with the Web-PHA program.

Question one stated: Who should be contacting mental health critical or priority responses? This was addressed due to mental health stigma in the military and because the AFI 44-170 (2014) stated: "The person who contacts the Airman (trained health technician, nurse, or provider) will be determined by the expertise required by AF Web-PHA responses" (p. 15). Table 8 provides comments from panelists regarding who should contact patients.

Table 8

Comments from Panelists Regarding Who Should Contact Patients

Panelist	Responses
1.	4N051, 4N071, Mental Health Counselor, RN, Provider.
2.	The Full time Med Tech or Admin Tech should be contacting the members as is being done now. We do not want critical or priority responses waiting until next UTA. They are being referred to chaplain services, VA, or psych services as appropriate. It seems to be working well. If problems, the issue should be escalated to nursing then to the physicians as appropriate or to Rebecca.
3.	The individuals reviewing the WebHA.
4.	The patient care team nurse (or ARC health technician).

Question two stated: Is there a certain rank that is appropriate for contacting positive mental health concerns? This was addressed because rank of the trained health technician could be an issue with some members and rank is part of the military culture. The current health technician is enlisted. Table 9 provides comments from panelists regarding rank.

Table 9

Comments from Panelists Regarding Rank

Panelist	Responses
1.	E-4 and above, it depends on the maturity level of the individual.
2.	I don't think so. What matters is the individual's health and so it shouldn't matter what rank the person is for contacting.
3.	No rank, but MDG requires at the minimum that a 5 skill level medic (fulltime health tech) F/U on Mental Health when an RN is not available.
4.	The rank should be at least a SSgt or higher.

Question three stated: Should priorities wait to be contacted at the next UTA as dictated in the AFI? This question directed attention to the timeframe of contact. The Air Force sets a requirement for the active duty to contact members with a critical response in one duty day and a priority response in three duty days. The Air National Guard has a requirement for the next UTA. Since the 140th MDG is a Guard unit, it might wait until the next UTA per the AFI but since they have a full time trained health technician running the program, should they follow the active duty requirements? Table 10 provides comments from panelists regarding when to contact priority flags.

Table 10

Comments from Panelists Regarding When to Contact Priority Flags

Panelist	Responses
1.	No, if a full time staff member is available, the priority/critical member should be contacted as soon as possible.
2.	No.
3.	No we try to follow the AD standard of all Critical findings must being addressed within one duty day and all Priority findings must being addressed within three duty days.
4.	No, priorities should not wait. Simply touching base with them is most appropriate. We do not want a priority progressing to a critical when it could have been addressed.

Question four stated: What mental health concerns would the providers want to see? This was discussed to establish when a member should be scheduled with a provider. This would help guide the technician for scheduling follow-up for the member, and for use in creating the algorithm. Table 11 provides comments from panelists regarding when to schedule patients with a provider.

Table 11

Comments from Panelists Regarding When to Schedule Patients with a Provider

Panelist	Responses
1.	Depression, PTSD - psychological problems, substance abuse, physical abuse, marital problems.
2.	Any issue which raises concern for the members safety or anyone else safety such as family or co-workers.
3.	They would want to see members with critical/priority PHA responses and HI/SI responses.
4.	This question isn't very clear to me, but I'm going to say any patient that states they are a danger to themselves or those around them.

Question five stated: Should the PHQ-9 be asked and documented in the chart? This question focused on the PHQ-9 depression screening and whether or not it should be asked in order to document a score since scores are not generated on the Web-PHA. Table 12 provides comments from panelists regarding whether the PHQ-9 should be asked and documented in the chart.

Table 12

Comments from Panelists Regarding whether the PHQ-9 Should Be Asked and Documented in the Chart

Panelist	Responses
1.	The PHQ-9 should be completed by a member during a follow-up provider visit. Depending on the situation, parts of the PHQ-9 could be asked.
2.	I think it should be in there at least once every 5 years.
3.	PHA will prompt more detailed questions based on responses given, but I suppose that could be added. It couldn't hurt.
4.	I feel that it should be include in the chart. We ask, it needs to be documented legally.

Question six stated: How many times should we contact a patient if they are unable to be reached for a critical or priority response? This was to determine how many times a member should be contacted about positive mental health concerns since this was not addressed in the AFI 44-170. Table 13 provides comments from panelists regarding how many times a patient should be contacted if they are unable to be reached for a critical or priority response.

Table 13

Comments from Panelists Regarding How Many Times a Patient Should Be Contacted If They Are Unable To Be Reached for a Critical or Priority Response

Panelist	Responses
1.	Every attempt should be given to contact the member. If the member is unavailable during the week, the member should be contacted during UTA.
2.	Twice.
3.	We continue to try to reach them by phone for allowable time and then contact their Commander or 1Sgt to make face to face contact with them if we are unable to reach by phone.
4.	A minimum of 3 separate "documented" attempts. This is not only a patient safety issue, but a medical-legal issue. I would ask LtCol Cowan, but I feel that if it is "critical", and the member cannot be contacted after 3 attempts, the issue should be elevated to the members commander or 1st Sgt.

Phase Two, Delphi #2: Round Two

After the answers were compiled from round one, all answers were sent back to the panelists for review along with questions for round two. Round two consisted of seven “Yes” or “No” questions (see Appendix G) that came out of the responses from round one. An area for comments was also provided. This survey was also sent with a no-signature informed consent where return of the survey was deemed as consent. There were plans for a third round but due to unanimous consensus among the panelists in the second round, this was not needed.

Web-Based Periodic Health Assessment Education

The information gathered in phase one from the literature, AFI 44-170, and through the Delphi studies helped to build the education platform for those contacting members with positive mental health concerns. This education was done through a PowerPoint presentation given to four health technicians and one nurse who are involved in the Web-PHA program. The presentation (see Appendix J) addressed the following critical topic areas:

- Mental Health Significance In the Military
- What Is The AF Web-PHA
- AFI 44-170
- What Mental Health Disorders Are Being Screened
- What Screening Tools Are Used
- What Triggers A Priority Or Critical Flag
- What To Do With A Mental Health Concern
- Web-PHA MHP
- Communication Techniques
- Documentation

Before the education was presented a pre-test (see Appendix K) was given to assess knowledge. This was followed by a post-test (see Appendix L) after the presentation to assess gained knowledge. Prior to the education, the staff's average pre-test score was a 44%. After the education was given, post-test scores improved to 85.2% with a 41.2% increase in knowledge about the Web-PHA and mental health in the military. The test

consisted of 10 questions directly related to the Web-PHA program, mental health screenings used, AFI 44-170, and the impact of mental health in the military.

Education Evaluation

After the education and tests were administered, an evaluation (see Appendix M) on the education presentation was completed by all of the participants to receive feedback. A traditional 5-point Likert scale was used: 1--*Strongly Disagree,* 2--*Disagree*, 3--*Indifferent*, 4—*Agree*, and 5--*Strongly Agree.* The average score on the Likert scale evaluation was 5--*Strongly Agree.* Since there was also opportunity for comments, the panelists made the following statements regarding specific ways to improve the educational presentation: "Great job?", "Great presentation!", "Thank you, these tools are great!", and "Nope."

Web-Based Periodic Health Assessment
Mental Health Protocol

The Web-PHA MHP (see Appendix N) was reviewed and discussed at length with the technicians during the education presentation. This protocol was unit specific and would supplement the AFI 44-170 (2014) governing the PHA process. The Web-PHA MHP was set up by this author as an operating instruction (OI) using the 140th Wing's OI template. According to paragraph 1 of this protocol:

> This instruction implements portions of AFI 44-170, *Preventive Health Assessment*. The purpose of this instruction is to establish a protocol for priority and critical mental health responses in regards to the Web-Based Periodic Health Assessments for all members assigned to the Colorado Air National Guard. This instruction requires collecting and maintaining information protected by the *Privacy Act of 1974*. All records created as a result of processes prescribed in this publication are maintained in accordance with AFMAN 33-363, *Management of Records*, and disposed of in accordance with the Air Force Records Disposition Schedule (RDS) located at https://afrims.amc.af.mil/.

The Web-PHA MHP includes information on

- Depression Response
- PTSD
- Anxiety or Panic Disorder
- Suicidality

It also included an algorithm with steps to help the trained health technician quickly make decisions on what to do with a critical or priority mental health concern and where to route the Web-PHA. The protocol and algorithm were reviewed at length during the education presentation. After review of the protocol and talking through the included communication techniques and algorithm, a questionnaire (see Appendix O) was given to the technicians to evaluate the Web-PHA MHP. This questionnaire included nine questions.

1. Do you have a better understanding of the Web-PHA program after reading the protocol? The panelists all responded that they understood the protocol.
2. Do you understand how to use the mental health screening tools included in the protocol? Three panelists indicated they understood how to use the mental health screening tools included in the protocol and one panelist said, "Yes, it was made easy."
3. Are the screening tools helpful? The panelists all agreed they found the screening tools helpful.
4. Do you think the Web-PHA MHP will be helpful when talking to members about depression, anxiety, and PTSD? The panelists all agreed the Web-

PHA MHP was helpful when talking to members about depression, anxiety, and PTSD.

5. Do you have any concerns about the protocol? Four panelists indicated they had no concerns about the protocol and one panelist said, "No, but will review again."
6. Is there anything you would add to the protocol? Four panelists had no additions to the protocol and one panelist commented, "No not yet."
7. Is there anything you would take out of the protocol? The panelists all agreed they had no subtractions from the protocol.
8. Is this protocol something you would consider using permanently? Four panelists indicated they would consider using the protocol on a permanent basis but one panelist indicated, "Not sure yet."

There was also an option to leave questions and comments where either "none" or "thank you" was left. Verbal feedback included the following comments:

- "I really like the communication techniques you went over. I think a script would be very helpful for me, as I am unsure of what to say sometimes."
- "I am not sure someone would open up to me and tell me what is going on with them. I think these scripts and questions to ask might make the member and myself more comfortable."

Key Facilitators

Facilitators for objectives one and two included the personnel at the 140th Medical Group. Support from the Commander, Chief of Aerospace Medicine (SGP), Chief of Medical Staff (SGH), nurse, and health technicians were invaluable. They were key to

identifying the current Web-PHA program and process. In particular, the SGH, who is also the community chair, was able to give helpful insight into areas lacking within the Web-PHA program. With the input from the experts at the Medical Group along with a thorough literature review, objectives one and two were satisfied. Objective three was accomplished through data collection from objectives one and two along with the Delphi survey results that led to the development of an education platform for the trained health technician and a protocol and algorithm for them to follow.

Technology instrumental to the author of this capstone project included online research, literature review, and e-mail among others. These resources helped drive the project forward. The Delphi technique also proved to be a tremendous selection for data analysis as there were only a few experts to query. The Delphi technique helped keep the time constraints down for the expert panelists. Each expert panelist was individually valuable during the surveys due to his/her particular background, education, experience, and training within the military and Web-PHA process.

The committee chair and mentor for this project was instrumental. Her expertise, guidance, direction, and substantial military background were extremely influential during the process. The other committee members and their pool of knowledge and support also guided this capstone.

Key Barriers

As mentioned above, the staff directly involved with the Web-PHA process was limited, making the expert panel narrow with this Delphi study. The Web-PHA program is a one-man shop with two other technicians available for back-up if needed. There are no full time nurses, physicians, or mental health personnel at the 140th Medical Group

during the week. Another barrier was the Air Force must comply at a minimum with the Air Force Instruction 44-170 that governs the periodic health assessment program. This limited variation to the program but also left a lot of areas open to interpretation.

Information regarding the Web-PHA program specifically related to mental health was extremely limited as was the knowledge about it by the military members involved in the program at the unit. This made the first two objectives difficult to achieve. Little literature was available and the unit itself did not have an identified written program. The technician running the program was trained on the job and had recently taken over the Web-PHA program within the last year so knowledge was limited. There was also concern about making the technician feel inadequate for the position. That was not the intention of the project. The intention was for a process improvement but when there is only one person doing the job, it is difficult to not feel like you are "stepping on toes." During this project, the technician who is enlisted was promoted to Staff Sergeant who is considered a non-commissioned officer in charge compared to a senior airman, which gives him more rank and ultimately more reverence. As mentioned previously, stigma in the military is an issue as well as is rank when talking about sensitive subjects. No full time medical officers were present during the week to handle phone calls about mental health issues so the trained health technician becoming a Staff Sergeant was ultimately beneficial but still could be considered a barrier.

Time was also of essence during this process improvement for the committee, members of the 140th Medical Group, and for the author. The Delphi surveys might have been burdensome for the expert panels, especially since there were two of them. There

was also education, pre- and post-tests, and an evaluation to complete by the technicians. The time commitment by the expert panels was greatly appreciated.

Unintended Consequences

Identifying a huge gap in the military mental health system within the Air National Guard and the Air Force was both positive and negative. The positive was the issue was identified at the unit level and this process improvement capstone project was created to increase mental health knowledge about the Web-PHA and how it functioned. This will hopefully prepare the trained health technicians running the program, give them the tools they need, and some guidance to follow, which has been lacking. If this capstone helps just one military member suffering with mental health concerns, then it was worth it!

There were also negative consequences. The fact that there is such a gap in military mental health is somewhat inexcusable. Why has no education been given on the Web-PHA when it has been around since 2006? Why is the literature so limited on the Web-PHA program in general? Why are the questions in relation to mental health not readily available to medical personnel running the Web-PHA programs? These questions and many more came about during this project. With mental health issues and suicide on the rise within the Air National Guard, one would think that focusing on education at the lowest level (those running the Web-PHA programs) would be where to start. Many programs are available to members suffering from mental health issues but without the tools to identify those in need, many members are probably not getting the help they need.

Summary

By achieving the first two objectives and first two phases, the education platform, protocol, and algorithm could be built to complete the third objective. The education was deemed successful as shown by the education evaluations received and the increase in post-test scores. The Web-PHA MHP surveys and feedback proved a protocol is needed and would be useful for the trained health technician. A competency checklist (see Appendix P) was created so all of the training materials and education can be documented accurately for the trained health technician. Ultimately, the third phase, which includes a proposed pilot study, would be helpful in assessing the education, protocol, and algorithm fully. This future evaluation might lead the way to areas that need more attention, expansion, or change.

CHAPTER V

RECOMMENDATIONS AND IMPLICATIONS

A need was identified for a more streamlined response to mental health concerns on the Air Force Web-PHA. This was realized by a lack of education and information about the mental health portions of the Web-PHA. An education platform and protocol for contacting patient was then created during this capstone process. This was achieved through the three stated objectives. After completion of this capstone, the author plans to continue the education platform and create a continuity binder that includes the PowerPoint slides, post-test, certificate, and competency checklist to document the Web-PHA mental health training for those involved in the process. This education could also be used for all providers and nurses who see patients during drill weekends. This would help to better understand the Web-PHA process and be able to further screen patients with concerns during the routine UTA PHA appointments and scheduled appointments by the trained health technician.

More research needs to be done on the Web-PHA in general as there is a lack of available literature, thus creating barriers to the overall program. The literature search was minimal due to this. The Air Force needs to release more information, education, and direction regarding the mental health portions of the Web-PHA. These areas of concern were highlighted by the expert panelists using the Delphi technique. Their answers shed light on the lack of awareness, information, and education about the

process. Having the support of the medical group commander, SGP, SGH, and by the author being the chief nurse, hopefully this process improvement will continue, mature, and develop into a permanent change to how the Web-PHA program is run.

Enhances Culmination as Partnership, Implements, Evaluates (EC as PIE)

"The goal of the doctor of nursing practice (DNP) programs should be to produce nurses that are uniquely prepared to bridge the gap between the discovery of new knowledge and the scholarship of translation, application, an integration of this new knowledge in practice" (Waldrop, Caruso, Fuchs, & Hypes, 2014, p. 300). A five-point system the American Association of Colleges of Nursing (AACN) came up with to determine if the final outcomes of a DNP project meets standards was developed: EC as PIE (E= Enhances, C= Culmination, P= Partnerships, I= Implements, E= Evaluates) (Waldrop et al., 2014). The idea was each of these items would come together to form a complete pie.

- Enhances--"Enhances health outcomes, practice outcomes or health care policy" (Waldrop et al., 2014, p. 301). This process improvement capstone project validated the current Web-PHA process; there was much room for improvements, which were achieved with the creation of an education program for the trained health technician and a protocol to follow for continuity. This is a more efficient model of care that can replace the previous model (i.e., process improvement).
- Culmination--"Reflect a culmination of practice inquiry" (Waldrop et al., 2014, p. 302). The author identified the topic and used her knowledge gained through the University of Northern Colorado's DNP program to

enact change. This specific capstone project is practical and is likely to be used at the 140th Medical Group. It is also something that can be easily implemented within other units and possibly adapted by the Air Force. Currently the 140th uses a paper record but the communication techniques and mental health screening tools could be interfaced with an electronic health record.

- Partnerships--"Require engagement in partnerships" (Waldrop et al., 2014, p. 302). As the chief nurse at the 140th Medical Group, the author works as part of a collaborative and interprofessional team with other providers within the military. This education platform and protocol could be ultimately approved by the Executive Committee of the Medical Staff and become obligatory. There is also potential for this process improvement or a portion of it to become policy Air Force wide.
- Implement--"Implement/Apply/Translate evidence into practice" (Waldrop et al., 2014, p. 302). Considering that mental health is a hot topic and issue currently, applying this particular process improvement is imperative due to gaps found in the literature and practice of the current Web-PHA process. Decreasing the mental health burden and ultimately suicides within the Air National Guard is a huge societal value that might be achievable.
- Evaluation--"Require evaluation of health care, practice, or policy outcomes" (Waldrop et al., 2014, p. 302). Since the health technicians are now trained, a pilot study could be deployed to fully evaluate the technicians' training and the use of the protocol. By doing this, the newly

implemented system could be evaluated at both the technician and population levels.

Ongoing Activities/Evaluations

Even though not part of this capstone project, there are plans to continue this process improvement with a pilot study in order to evaluate this project in its entirety. The proposed pilot study is the third and final phase. At some point and with approval from the 140th Medical Group, a short pilot can be done to see if the protocol and algorithm are actually useful for the trained health technician. This pilot would specifically challenge the functionality of the communication techniques coming from RESPECT-Mil *Care Facilitator Manuel* (Barry & Oxman, 2008) for depression and PTSD, and from the *Clinical Practice Guidelines, Management of Anxiety Disorders* (Swinson, 2006) interview questions to screen for anxiety symptoms. These communication cues along with data supplied using the Delphi surveys by the expert panelists, mental health screening tools identified in the WEB-PHA, and guidance from the AFI 44-170 went into the building of the protocol.

Phase Three: Proposed Pilot Study

A structured approach to a pilot study developed by Kasunic (2004) from Carnegie Mellon University and sponsored by the U.S. Department of Defense includes five areas: (a) plan and design the pilot study, (b) train personnel to accomplish change, (c) support and monitor the study, (d) evaluate pilot results, and (e) make recommendations and improve (Kasunic, 2004).

Planning and designing the pilot study. This consists of deciding how success will be measured, where the pilot study will be conducted, designing the approach using scientific principles, and writing down the plan. The problem at the 140th MDG is there is no unit-based written guideline or protocol for the trained health technician to follow for

positive mental health concerns on the Web-PHA. However, there is instruction given by AFI 44-170 (2014) on minimum requirements of contacting a member with a critical or priority response, yet does not go into any specifics about what to do for mental health responses other than stating that the unit "develops Executive Committee of the Medical Staff (ECOMS)-approved PHA protocols and MTF instructions" (AFI 44-170, 2014, p. 6), which has not been done. This is where the gap lies. Pilot study success would be based on achieving the intended outcome of the Web-PHA protocol being easy to use and permanently implemented. Success could be measured through qualitative measures to include interviews with those using the tool, observations, and possibly comparing documentation on those with positive mental health concerns the month before implementation against the month after implementation. This would allow for comparison between pre-protocol and post-protocol data collection. Education and training on the protocol would be key to a successful pilot along with follow-up throughout the study period to make sure things are going well and no questions have arisen that need to be addressed.

This process improvement project pilot study could be generalized as all National Guard units have a Web-PHA program and follow the AFI 44-170 (2014). The Web-PHA MHP and education could be instituted system-wide if successful as mental health is a system and organizational-wide problem. It could be adapted as each unit should have a trained health technician or nurse running the Web-PHA program. One area of concern was it was difficult to control variables involving people (Kasunic, 2004): "The characteristics of the experimental medium (i.e. the people using the solution component)

may influence the results and the type of feedback that you obtain after you introduce the change" (p. 19).

Training personnel to accomplish change. Training on the Web-PHA MHP would include what mental health questions were asked and how the protocol would be performed and used. How to document the use of the Web-PHA MHP in the member's chart and how to obtain additional help if problems arise would be discussed during education. Feedback mechanisms would be included in the training approach and consist of feedback from the champion and observing the use of the Web-PHA MHP being used to make sure understanding is present.

Supporting and monitoring the pilot effort. Unanticipated results should be expected when conducting a pilot study. The personnel conducting the pilot are key and would help when problems are exposed. Support would be essential to provide quick solutions to glitches in the new process. The trained health technician would be assigned as the primary point of contact and be responsible for ensuring performance indicators are tracked throughout the pilot effort. Problems and issues would be documented as they arose during the process and reported to the author.

Evaluate pilot results. Performance measurements and indicators would be compiled through interviewing the technician running the program and through a survey. A lessons learned interview would be done to get feedback on what worked well and what did not, ideas for improvement, and suggestions for solutions. Consideration for anonymous feedback could be done on those members whom the Web-PHA MHP was used on if time permitted.

Make recommendations and improve. Feedback from the pilot study would be key to moving forward. Figure 5 from Kasunic (2004) describes outcomes and solutions for follow-up steps to improve moving forward with the project. Communication by meeting with the chairpersons, trained health technicians, and stakeholders involved to review the pilot study, make recommendations, and identify the next steps would bring closure to the pilot effort. In an ideal world without time constraints, conducting multiple pilot studies would lead to more reliable information for decision-making (Kasunic, 2004, p. 37).

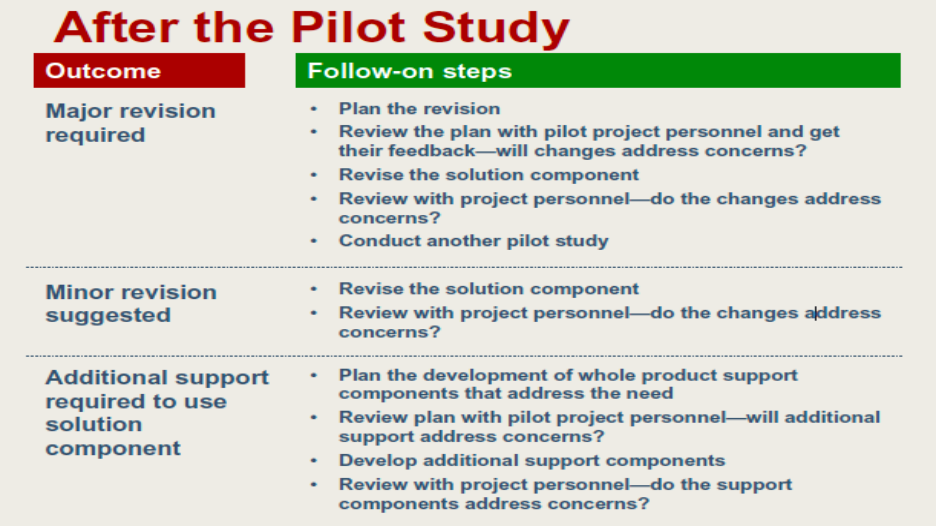

Figure 5. After the pilot study (Kasunic, 2004).

The pilot study might reduce the risk of rolling out a flawed process. "The idea behind a pilot study is to test the solution component within a controlled environment before the component is sanctioned for broader use" (Kasunic, 2004, p. 38).

Summary

This process improvement capstone project just highlighted a small portion of the mental health issues that need to be addressed within the military. The Air National Guard has made great strides at improving mental health disparities, yet there is still great room for enhancement. The Web-PHA program is instrumental in identifying members in need of mental health services and now trained health technicians have the tools they need to further screen, communicate, and refer. Hopefully this program will help service members get the aid they need. When programs like the Web-PHA program are built, a training program and manual about the contents needs to be distributed to those using it so there is better understanding in order to fully recognize the issues going on with those being flagged for concern. Mental health concerns are not the only items for which the trained health technician has to contact members, there are many other things to include: misuse of alcohol, drugs, abuse, etc. The hope is for further education and continuity of the Web-PHA program. This capstone focused on education and the development of a mental health protocol for the trained health technician to fulfill the requirements of AFI 44-170 (2014), create continuity, and ultimately give Airmen the best mental health screening and services available.

REFERENCES

Air Force Instruction 33-360. (2015). *Communications and information*. Retrieved from http://static.e-publishing.af.mil/production/1/saf_aa/publication/afi33-360/afi33-360.pdf

Air Force Instruction 44-170. (2014). *Preventative health assessment.* Retrieved from http://static.e-publishing.af.mil/production/1/af_sg/publication/afi44-170/afi44-170.pdf

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: American Psychiatric Association. doi:10.1176/appi.books.9780890423349

American Psychiatric Association. (2015). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association. doi:org/10.1176/appi.books.9780890425596

American Psychological Association. (2016). *The critical need for mental health professionals trained to treat post-traumatic stress disorder and traumatic brain injury.* Retrieved from http://www.apa.org/about/gr/issues/military/critical-need.aspx

Anxiety and Depression Association of America. (2016). *Frequently asked questions*. Retrieved from http://www.adaa.org/living-with-anxiety/ask-and-learn/faqs#n17

Barry, S. L., & Oxman, T. E. (2008). *RESPECT-Mil care facilitator manual three component model: For primary care management of depression and PTSD (military version).* Retrieved from: http://www.pdhealth.mil/respect-mil/downloads/FAC_Final.pdf

Brewin, B. (2013). *The cost of mental health care in the military: $4.5 billion since 2007.* Retrieved from http://www.defenseone.com/management/2013/08/cost-mental-health-care-military-45-billion-2007/69203/

Campbell, S. M., Shield, T., Rogers, A., & Gask, L. (2004). How do stakeholder groups vary in a Delphi technique about primary mental health care and what factors influence their ratings? *Quality and Safety in Health Care, 13*(6), 428-434. doi:10.1136/qshc.2003.007815

Cohen, G. H., Fink, D. S., Sampson, L., & Galea, S. (2015). *Mental health among reserve component military service members and veterans.* Retrieved from http://epirev.oxfordjournals.org/content/early/2015/01/15/epirev.mxu007.full.pdf

Custer, R. L., Scarcella, J. A., & Stewart, B. R. (1999). The modified Delphi technique-A rotational modification. *Journal of Career and Technical Education, 15*(2).

Engle, C. C., Oxman, T., Yamamoto, C., Gould, D., Barry, S., Stewart, P., ...Dietrich, A. J. (2008). RESPECT-Mil: feasibility of a systems-level collaborative care approach to depression and post-traumatic stress disorder in military primary care. *Military Medicine, 173*(10), 935-940.

Groves, S. K., Burns, N., & Gray, J. (2012). *The practice of nursing research: Appraisal, synthesis, and generation of evidence*. Philadelphia, PA: Elsevier Health Sciences.

Hepner, K. A. (2016). *Areas of excellence and need for improvement found in quality of mental health care provided by the military.* Retrieved from http://www.rand.org/news/press/2016/02/18.html

Hepner, K. A., Sloss, E. M., Roth, C. P., Krull, H., Paddock, S. M., Moen, S., ...Pincus, H. A. (2016). *Quality of care for PTSD and depression in the military health system: Phase I report*. Santa Monica, CA: Rand Corporation.

Hsu, C. C., & Sandford, B. A. (2007). The Delphi technique: Making sense of consensus. *Practical Assessment, Research & Evaluation, 12*(10), 1-8.

Insel, T. (2011). *National Institute of Mental Health director's blog: The global cost of mental illness*. Retrieved from http://www.nimh.nih.gov/about/director/2011/the-global-cost-of-mental-illness.shtml.

Kasunic, M. (2004). *Conducting effective pilot studies*. Retrieved from:http://resources.sei.cmu.edu/asset_files/presentation/2004_017_001_22829.pdf

Kravitz, R. L., Franks, P., Feldman, M. D., Tancredi, D. J., Slee, C. A., Epstein, R. M., …Jerant, A. (2013). Patient engagement programs for recognition and initial treatment of depression in primary care: A randomized trial. *JAMA, 310*(17),1818-1828. doi:10.1001/jama.2013.280038

Leon, A. C., Davis, L. L., & Kraemer, H. C. (2011). The role and interpretation of pilot studies in clinical research. *Journal of Psychiatric Research, 45*(5), 626-629. doi:10.1016/j.jpsychires.2010.10.008.

Madrid, M. (2010). *Air Force web preventive health assessment (AF WEBPHA) mental health screening effectiveness* (Order No. 1483272). Retrieved from http://0-search.proquest.com.source.unco.edu/docview/821241771?accountid=12832

Murray, L. K., Skavenski, S., Bass, J., Wilcox, H., Bolton, P., Imasiku, M., &Mayeya, J. (2014). Implementing evidence-based mental health care in low-resource settings: A focus on safety planning procedures. *Journal of Cognitive Psychotherapy, 28*(3), 168-185.

National Collaborating Centre for Methods and Tools. (2011). *Stetler model of evidence-based practice.* Retrieved from http://www.nccmt.ca/resources/ search/83.

National Guard Association of the United States. (2016). *National Guard suicides spike in 2015.* Retrieved from: http://www.ngaus.org/newsroom/news/national-guard- suicides-spike-2015

Pickett, T., Rothman, D., Crawford, E. F., Brancu, M., Fairbank, J. A., & Kudler, H. S. (2015). Mental health among military personnel and veterans. *North Carolina Medical Journal, 76*(5), 299-306.

Santos, A. J. S. D. (2009). *Association of self-reported physical activity and performance in the physical fitness assessment among Airmen*. Available from http://pqdtopen.proquest.com/doc/305010427.html?FMT=ABS

Screening for Mental Health. (2016). *Military programs.* Retrieved from: https://mentalhealthscreening.org/programs/military/

Searle, A. K., Van Hooff, M., McFarlane, A. C., Davies, C. E., Fairweather-Schmidt, A. K., Hodson, S. E., ...Steele, N. (2014). The validity of military screening for mental health problems: diagnostic accuracy of the PCL, K10 and AUDIT scales in an entire military population. *International Journal of Methods in Psychiatric Research*, *24*(1), 32-45.

Shah, H. A., & Kalaian, S. A. (2009). Which is the best parametric statistical method for analyzing Delphi data?. *Journal of Modern Applied Statistical Methods*, *8*(1), 20.

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Lowe. B. (2006). A brief measure for assessing generalized anxiety disorder (GAD-7). *Arch Inern Med., 166,*1092-1097.

Stetler, C. (2001). Updating the Stetler model of research utilization to facilitate evidence-based practice. *Nursing Outlook, 49,* 272-279. doi:10.1067/mno.2001.120517

Substance Abuse and Mental Health Services Administration. (2010). *Understanding the military: The institution, the culture, and the people*. Retrieved from http://www.samhsa.gov/sites/default/files/military_white_paper_final.pdf

Substance Abuse and Mental Health Services Administration. (2016). *Prevention of substance abuse and mental illness*. Retrieved from http://www.samhsa.gov/prevention

Swinson, R. P. (2006). Clinical practice guidelines: Management of anxiety disorders. *The Canadian Journal of Psychiatry*, *51*(2). Retrieved from: https://ww1.cpa-apc.org/Publications/CJP/supplements/july2006/anxiety_guidelines_2006.pdf

U.S. Preventative Services Task Force. (2016). *Depression in adults: Screening.* Retrieved from: http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening1

Waldrop, J., Caruso, D., Fuchs, M. A., & Hypes, K. (2014). EC as PIE: Five criteria for executing a successful DNP final project. *Journal of Professional Nursing, 30*(4), 300-306.

Wells, T. S., Horton, J. L., LeardMann, C. A., Jacobson, I. G., & Boyko, E. J. (2013). A comparison of the PRIME-MD PHQ-9 and PHQ-8 in a large military prospective study, the Millennium Cohort Study. *Journal of Affective Disorders, 148*(1), 77-83.

APPENDIX A

AIR FORCE INSTRUCTION 44-170--PREVENTATIVE HEALTH ASSESSMENT

BY ORDER OF THE
SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 44-170

30 JANUARY 2014

Medical

PREVENTIVE HEALTH ASSESSMENT

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements Air Force Policy Directive (AFPD) 44-1, *Medical Operations*; AFPD 10-2, *Readiness*; AFPD 40-1, *Health Promotion*; and Health Affairs Policy Memo 06-006, *Periodic Health Assessment for Active Duty and Selected Reserve Members*. This instruction augments Air Force Instruction (AFI) 10-250, *Individual Medical Readiness*; AFI 40-102, *Tobacco Use in the Air Force*; and AFI 48-123, *Medical Examinations and Standards*. It establishes procedures, requirements, recording of medical standards for Air Force (AF) periodic/preventive health assessments (PHAs), and applies to all active duty (AD) Airmen, Air National Guard (ANG) members, and AF Reserve (AFR). (**Note:** ANG and AFR will be collectively referred to as Air Reserve Component (ARC)). This publication requires the collection and maintenance of information protected by the Privacy Act (PA) of 1974 (Title 5 United States Code Section 552a), Title 10 United States Code Sections 8013 and 8067(d), and Executive Order 9397, *Numbering System for Federal Accounts Relating to Individual Persons*, as amended by Executive Order 13478, Amendments to Executive Order 9397, *Relating to Federal Agency Use of Social Security Numbers*, authorize the collection and maintenance of records prescribed in this publication. Forms affected by the PA must have an appropriate PA statement. System of records notice F044 AF SG E, Medical Record System, applies. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with (IAW) AF Manual (AFMAN) 33-363, *Management of Records*, and disposed of IAW AF Records Information Management System (AFRIMS) Records Disposition Schedule (RDS). All records should also be maintained IAW AFI 41-210, *Patient Administration Functions*. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF Form 847, *Recommendation for Change of Publication*; route AF Forms 847 from the field through the appropriate functional chain of

command. This publication may be supplemented at any level, but all direct supplements must be routed to the OPR of this publication for coordination prior to certification and approval. The authorities to waive wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See AFI 33-360, *Publications and Forms Management*, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternatively, to the Publication OPR for non-tiered compliance items.

SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. Tiers have been added to wing-level and below directives, which indicate waiver authority. "How to" information has been removed from this instruction and added to the PHA Guide found on the Knowledge Exchange (Kx) website.

Chapter 1

OVERVIEW, ROLES, AND RESPONSIBILITIES

1.1. Overview. This instruction provides guidance and procedures for the AF Preventive Health Assessment (PHA) program, also known as the Periodic Health Assessment (PHA) program in the ARC. The intent of the PHA program is two-fold: to recommend evidence-based, cost-effective preventive health services, and to identify and document potential duty-limiting conditions. Force Health Management Element (FHME) PHA Cell (hereafter referred to as PHA Cell) will perform all non-flyer PHAs; Flight and Operational Medicine Clinic (FOMC) will perform all PHAs for its empanelment (not applicable to ARC); and PHAs for Personnel Reliability, Biological Personnel Reliability, or Presidential Support Programs (PRP/BPRP/PSP) personnel will be performed by those designated IAW local business rules.

1.2. Roles and Responsibilities.

1.2.1. AF Surgeon General (AF/SG). The OPR for the AF PHA program. Ensures medical resources are planned, programmed, and budgeted to meet PHA requirements.

1.2.2. Assistant Surgeon General for Healthcare Operations (AF/SG3). OPR for instructions and guidance for PHA program policy.

1.2.2.1. Provides instructions and guidance ensuring Airmen meet Department of Defense (DoD) PHA requirements.

1.2.2.2. Represents the AF at the DoD Force Health Protection Council and Defense Health Board who advise the Service Surgeons General and DoD on PHA instructions and guidance.

1.2.2.3. Approval authority for Major Command (MAJCOM), Direct Reporting Unit (DRU), and Air Reserve Component variations to this instruction.

1.2.3. Air Force Medical Support Agency (AFMSA). Develops and updates PHA instructions and guidance in coordination with Medical Treatment Facilities (MTFs), MAJCOMs, and the AF/SG.

1.2.4. Air Force Medical Operations Agency (AFMOA).

1.2.4.1. Reviews/updates the PHA Guide and PHA business rule algorithms contained within Aeromedical Services Information Management System (ASIMS) and the AF Web-based Health Assessment (Web HA) at least yearly.

1.2.4.2. Approves and, when necessary, develops PHA-related patient education materials.

1.2.4.3. Maintains and updates the PHA Kx website https://kx2.afms.mil/kj/kx1/PHA/Pages/home.aspx.

1.2.4.4. Identifies and defines clinical requirements to enhance information management tool functionality in support of annual PHA process.

1.2.5. Air Force Surgeon General's Office of Chief Information Officer (AF/SG6). Develops, deploys, maintains, and updates clinical support tools including the ASIMS application and the AF Web HA.

1.2.6. MAJCOM or DRU Commander.

1.2.6.1. OPR for developing instructions and processes to ensure Airmen assigned to geographically separated units (GSUs) meet PHA requirements as defined in 2.4.

1.2.6.1.1. Coordinates the implementation of instructions and publications with AF/SG3.

1.2.6.1.2. For the purposes of this AFI, a GSU is broadly defined as any organization (military installation, embassy, university, etc.) in which Airmen assigned to that organization are not in close proximity with the PHA Cell/FOMC responsible for administering their PHAs. What entails "close proximity" shall be locally defined.

1.2.6.2. Monitors and reviews the PHA status of geographically separated Airmen or delegates this responsibility to the GSU Commander (CC).

1.2.6.3. Appoints Unit Health Monitors (UHMs) at GSUs or delegates this responsibility to the GSU/CC.

1.2.6.4. Ensures subordinate GSU/CCs comply with delegated duties and requirements in 1.2.9.

1.2.7. Air Reserve Component (ARC).

1.2.7.1. The AF Reserve Command Surgeon (AFRC/SG) is the OPR for PHA instructions and guidance for the Air Reserve including Individual Ready Reservists and Individual Mobility Augmentees (IMAs). AFRC/SG will maintain and update the AFRC PHA Guide and modify AFMOA-developed PHA business rules to meet AFRC-specific requirements as needed and permitted by this AFI. AFRC variations to this AFI must be approved by SG3 (see 1.2.2.3.).

1.2.7.2. The National Guard Bureau Surgeon General (NGB/SG) is the OPR for PHA instructions and guidance for ANG members. ANG/SG oversees the modification of AFMOA-developed PHA business rules to meet ANG-specific requirements as needed and permitted by this AFI. ANG variations to this AFI must be approved by AF/SG3 (see 1.2.2.3.).

1.2.8. Air Force Installation Commander.

1.2.8.1. Establishes a command expectation that unit CCs and individual Airmen will meet PHA requirements IAW HA Policy 06-006, *Periodic Health Assessment Policy for Active Duty and Selected Reserve Members*, DoD Instruction (DoDI) 6025.19, *Individual Medical Readiness*, DoDD 6200.04, *Force Health Protection*, AFI 10-250 and this instruction. (T-0).

1.2.8.2. Directs the AF Military Personnel Flight (MPF) (to include ANG Force Support Squadrons) to add ASIMS/PHA currency status to the virtual MPF permanent change of station (PCS) out-processing checklist. **Note:** Applicable for ARC members transferring to another unit or component. Checking PHA status during out-processing is not required

when PCSing from remote (short tour) AF installations or other geographically separated locations without local AF MTF support. (T-2).

1.2.8.3. In Joint Basing and tenant unit situations where a Sister Service is the lead service, the responsibilities in section 1.2.8. fall to the senior-ranking AF member or his/her delegate. (T-2).

1.2.9. Unit Commander.

1.2.9.1. Establishes a command expectation that individual Airmen will meet PHA requirements IAW HA Policy 06-006, DoDI 6025.19, DoDD 6200.04, AFI 10-250, and this instruction. (T-0).

1.2.9.2. Appoints a UHM in writing and ensures the appointment letter is forwarded to the ASIMS administrator. (T-2).

1.2.10. Unit Health Monitor.

1.2.10.1. Notifies Airmen of due/overdue clinical PHA services, IMR requirements, and Deployment Health Assessments (DHA) completion. (T-2).

1.2.10.2. Monitors compliance status via the ASIMS Web application in coordination with the MTF PHA Cell. Real-time reports are available at https://imr.afms.mil/imr/LoginUnit.aspx. See 2.4.2.1. for the definition of "reporting MTF." (T-2).

1.2.10.3. Assists Airmen with the coordination of follow-up clinical PHA services and IMR requirements. (T-2).

1.2.11. Individual Airman.

1.2.11.1. Will monitor and maintain currency of his/her IMR requirements. IMR status can be monitored using MyIMR at **https://imr.afms.mil/imr/myIMR.aspx** (ARC may also use ARCNet). (T-2).

1.2.11.2. Completes the AF Web HA annually. (T-0).

1.2.11.3. Keeps PHA appointments, follow-up appointments, and other PHA-related suspenses. (T-2).

1.2.11.4. PRP/BPRP/PSP personnel are required to complete the AF Web HA at a MTF (or Guard Medical Unit (GMU) or Reserve Medical Unit (RMU)) computer with results immediately reviewed and addressed by a Competent Medical Authority (CMA) IAW DoD 5210.42-R_AFMAN 10-3902, *Nuclear Weapons Personnel Reliability Program (PRP);* DoDI 5210.89_AFI 10-3901, *Minimum Security Standards for Safeguarding Biological Select Agents and Toxins;* and AFI 31-501, *Personnel Security Program Management*. (T-0).

1.2.12. Medical Treatment Facility CC (MTF/CC), including ANG Medical Group CC (ANG MDG/CC) and Reserve Medical Unit CC (RMU/CC). OPR for the PHA program at the installation level. The abbreviation "MTF" will be used broadly in this instruction to identify all component medical facilities, groups, and units (e.g., RMUs). (T-2).

1.2.12.1. Ensures MTF capabilities and appointment access are adequate to meet PHA requirements and provide sufficient follow-up care IAW TRICARE access standards and other MTF guidance. (T-2).

1.2.12.2. Monitors and enforces MTF compliance with this instruction. (T-2).

1.2.12.3. Plans, budgets, and procures PHA supplies and equipment. (T-2).

1.2.12.4. Maintains and resources the PHA Cell (AD, non-GSU MTFs only). (T-2).

1.2.12.5. Ensures MTF AF Web HA computer stations meet patient and information privacy and security requirements. (T-2).

1.2.13. Chief of Aerospace Medicine (SGP).

1.2.13.1. MTF OPR for clinical oversight of the PHA program. (T-2).

1.2.13.2. In coordination with the Chief of the Medical Staff (SGH), Chief of Nursing Services, Public Health, and senior enlisted functionals:

1.2.13.2.1. Develops Executive Committee of the Medical Staff (ECOMS)-approved PHA protocols and MTF instructions; (T-2).

1.2.13.2.2. Develops procedures to implement PHA-associated clinical practice guidelines (CPGs) and quality assurance processes through technician level reviews (see PHA guide for further details); and (T-2).

1.2.13.2.3. Develops standing orders to enable clinical support personnel to independently order and schedule clinical preventive services (CPS) on behalf of providers IAW the Career Field Education and Training Plan (CFETP). (T-2).

1.2.14. Chief of the Medical Staff (SGH) (For ANG, Chief of Nursing Services).

1.2.14.1. In coordination with the SGP and Public Health, ensures PHA-associated CPS and counseling services are applied consistently and uniformly throughout the MTF. (T-2).

1.2.14.2. Assists the SGP and Public Health in developing MTF instructions, procedures to implement PHA-associated CPGs and quality assurance processes. (T-2).

1.2.14.3. Assists the SGP in developing ECOMS-approved PHA protocols and standing orders to enable clinical support personnel to independently order and schedule CPS on behalf of providers. (T-2).

1.2.14.4. Implements ECOMS-approved processes ensuring appropriate clinical follow-up of PHA-generated laboratory results, consults, and referrals. (T-2).

1.2.14.5. Directs and conducts/delegates the PHA clinical peer-review processes. See PHA guide for further details. (T-2).

1.2.15. Group Practice Manager (GPM) and Health Care Integrator (HCI). Support the PHA Cell and patient care teams in managing appointment access and projecting PHA and CPS demand. (T-2). **Note:** Does not apply to ARC units.

1.2.16. Patient Care Teams (Patient Centered Medical Home or FOMC).

1.2.16.1. Offer indicated CPS, provide and document all counseling, screening 12-lead electrocardiograms, and follow-up care for enrolled Airmen and other service members who receive clinical PHA services from the patient care team IAW HA Policy 06-006 and DoDD 6200.04. (T-0).

1.2.16.2. Clinically manage laboratory results of enrolled Airmen and other service members who receive clinical PHA services from the patient care team. (T-1).

1.2.17. Public Health Flight Commander (For ANG, Chief of Nursing Services).

1.2.17.1. Supervises the PHA program within the PHA Cell. (T-2).

1.2.17.2. Ensures personnel involved in PHA Cell processes are adequately trained, appropriately oriented, and task certified. (T-1).

1.2.17.3. Monitors and tracks administrative performance measures (e.g., timely notification to patient care team of critical/priority findings, close out of PHAs). (T-2).

1.2.18. PHA Cell. **Note:** Health Technician Teams (HTTs) for ANG and Air Reserve Technician (ART) Teams for AFR. (T-1).

1.2.18.1. Acts as the MTF OPR for the administrative management of the PHA program.

1.2.18.2. Manages the administrative tracking, scheduling through UHM (as locally applicable), processing, and quality control of PHAs through technician level reviews (see PHA guide for further details). (T-2). PHA Cell is not required to track ARC or Sister Service PHAs or notify these members that PHAs are due unless specific local processes to conduct these functions are set up with the ARC or Sister Services.

1.2.18.3. Generates a patient listing each duty day and addresses findings IAW this AFI, clinical circumstances, AFMOA and/or locally developed PHA business rules. (T-1).

1.2.18.4. Based on PHA business rules, schedules required appointments with patient care teams and directs patient to ancillary services (e.g., Health and Wellness Center, lab, immunizations). **Exception:** The FOMC will schedule required appointments for its empanelment, HTTs for ANG members and ARTs for AFR members. (T-1).

1.2.18.5. Orders necessary PHA and IMR labs as directed by IMR guidance, PHA business rules, and ECOMS-approved business rule modifications. Patient care clinics are responsible for follow-up of lab results. HTTs/ARTs are responsible to ensure proper follow-up of ARC-ordered labs. **Exception:** The FOMC will order all necessary labs for its empanelment. (T-2).

1.2.18.6. Clinical interventions within the PHA Cell will be limited to directing follow-up care (to the provider, nurse, Health and Wellness Center, etc.); brief counseling and education; distributing AFMOA- or ECOMS-approved, PHA-related, patient education handouts; and weight, height, blood pressure and any other required measurements as prescribed by the 4E CFETP and AFMOA-/ECOMS-approved protocols. **Note:** For ARC, requirements prescribed by 4N CFETP. (T-2).

1.2.18.7. Documents all patient interventions and brief counseling, including attempts to contact member, in the medical record (e.g., the DoD electronic medical record, Armed Forces Health Longitudinal Technology Application (AHLTA) or hard copy if AHLTA not available). (T-2).

1.2.18.8. At in-processing, conducts an initial medical records review (includes ASIMS, hard copy records and AHLTA) to ensure IMR requirements are up-to-date and to identify possible mobility or duty restricting limitations. (T-2). The PHA Cell will forward records requiring further evaluation (e.g., possible AF Form 469, *Duty Limiting Conditions Report,* actions) to the Medical Standards Management Element (MSME). **Exception:** FOMC will conduct medical records review for its empanelment, HTTs for ANG members and ARTs for AFR members. (T-2).

1.2.18.9. At out-processing, forwards records requiring further medical clearance action to the MSME (ref. 1.2.19.). (T-1).

1.2.19. MSME. **Note:** HTTs will perform these tasks for the ANG and ARTs for the AFR.

1.2.19.1. As part of the medical clearance processes IAW 48-149, *Flight and Operational Medicine Program*, ensures PHA currency at the time of the clearance and ensures PHAs will be current throughout professional military education (PME), training/retraining assignments, and during projected overseas PCS transitions. (T-1).

1.2.19.2. Should the member require a PHA, MSME will send the member either to PHA Cell or FOMC to complete. In some cases, PHAs earlier than normally scheduled may be necessary (ref. 2.1.5. and 2.1.7.). (T-1).

Chapter 2

PHA PROGRAM OPERATIONS

2.1. Periodicity of the PHA.

2.1.1. IAW Health Affairs Policy Memo 06-006, the PHA is required annually. This is distinct from IMR policy as it applies to all Airmen, including those who are non-deployable and may be exempt from IMR standards. (T-0).

2.1.2. PHAs become due (turn "yellow") 12 months (366 days) from the last PHA completion date. Once the PHA becomes due, there is a 90-day "yellow" window to accomplish the PHA before the PHA "goes red" and the unit is penalized on their PHA IMR (i.e., the PHA is green for 365 days; turns yellow (due) on day 366, and turns red (overdue) 90 days later on day 456). **Note:** It is not the intent of the 90-day yellow period to establish a de facto 15-month PHA requirement. PHAs performed just prior to the 15-month cut-off should be the rare exception and not the rule. (T-0).

2.1.3. An AF Form 1042, *Medical Recommendation for Flying or Special Operational Duty*, for personnel in special operational duty status, issued in conjunction with PHAs will be valid for the entire green and yellow periods (12 months plus 90 days; 455 days total). (T-2). Reference paragraph 2.1.4.1. for undergraduate pilot training (UPT).

2.1.4. Newly accessed Airmen will have their first PHA accomplished during the first 180 days of their first permanent duty assignment. Upon in-processing, their PHA will be considered to be in a "yellow" status and turn "red" on day 181 if the PHA is not completed. (T-1).

2.1.4.1. A member's PHA should be current prior to beginning active UPT and remain current throughout.

2.1.4.2. If a member was not on AD (e.g., AFROTC/OTS candidates) prior to arrival at UPT or is otherwise not PHA current, then the member will have a PHA accomplished during their in-processing at the UPT base. (T-2).

2.1.5. PHAs will not routinely be completed earlier than 30 days prior to due date (60 days for ARC Airmen) except to accommodate circumstances specified below. **Note:** The element (FHME, FOMC or MSME) servicing the patient will identify the need for an early PHA. (T-1). Reference paragraphs 1.2.19.1., 2.1.6.4., 2.1.7., 2.1.8., or 2.2.10. for specifics regarding these exceptions:

2.1.5.1. As required to coordinate with attending in-residence PME, retraining/training assignments, PCS to remote locations and GSUs (as defined in 1.2.6.2.), and prolonged temporary duties (TDYs); (T-1).

2.1.5.2. Every effort will be made to synchronize the timing of DHA 4 and DHA 5 with a member's PHA IAW NDAA 2010, Sec 708, DoDI 6490.03, *Deployment Health*, and DoDI 6490.12, *Mental Health Assessments for Service Members Deployed in Connection with a Contingency Operation*. A complete DHA Program Guide, with additional information on timing and other requirements can be found on the Kx at **https://**kx2.afms.mil/kj/kx3/deploymenthealth/Pages/home.aspx. (T-0).

2.1.5.3. As permitted by MAJCOM/SGP or AFMSA/SG3PF AF Form 1042 waivers; (T-1).

2.1.5.4. In cases of ANG general officer promotions; and (T-1).

2.1.5.5. As needed to accommodate mandatory occupational and environmental health medical surveillance exams (OEH MSE). (T-1).

2.1.6. Face-to-face provider PHA appointment criteria.

2.1.6.1. Airmen will have a face-to-face preventive health visit with a credentialed provider at least once every three years (ANG every 5 years). Face-to-face provider PHA visits, as well as any non-dental visits, which have an age-, gender-, and risk-based prevention-focused piece, will satisfy this requirement (see PHA guide for further details). Providers are strongly encouraged to accurately code preventive visits with appropriate codes. When such preventive services are provided, patient care teams should also update ASIMS reflecting that a face-to-face prevention visit has occurred. **Note:** ARC medical units are not required to code PHA visits. (T-2).

2.1.6.2. Additional face-to-face provider PHA appointments may be necessary under the following circumstances:

2.1.6.2.1. A patient may request a provider appointment in conjunction with their PHA visit. (T-2).

2.1.6.2.2. As required per PHA business rules. (T-2).

2.1.6.2.3. A provider appointment may be directed by the Airman's patient care team (or surrogate) after AF Web HA, health record review, AHLTA and ASIMS review. The patient care team, led by the provider, will review and document critical/priority/routine health risk assessment findings, and assess if further evaluation is required. (T-1).

2.1.6.3. MAJCOMs and MTFs may modify business rules to require more frequent provider PHA visits; however, ASIMS and AF Web HA software will not be modified to accommodate MAJCOM-specific or MTF-specific business rules. (T-1).

2.1.6.4. PHAs for Airmen requiring an AF Form 1042 will be accomplished as part of their annual face-to-face Flight and Operational Medicine Examination (FOME) (i.e., flying/special duty physical). (T-1). **Note:** The approval authority for extensions or waivers for FOMEs or PHAs is the MAJCOM/SGP or AFMSA/SG3PF.

2.1.7. Airmen PCSing from an AF installation to a remote location or another location without local AF MTF FHME support will have a PHA within 60 days of PCS even if this means accomplishing a PHA earlier than the originally scheduled due date. (T-1). This is necessary to minimize the administrative and logistical burden of performing PHAs at locations without local AF MTF FHME assets.

2.1.8. PHA and deployments. PHAs do not need to be accomplished on deploying Airmen as long as the PHA is current (within 365 days of the last recorded PHA) on the projected deploy date. (T-1).

2.1.8.1. During deployments, Airmen will not be monitored for PHA currency and will be considered exempt from PHA requirements. (T-2).

2.1.8.1.1. Although Airmen will not be monitored for PHA/OEH MSE/FOMEs while deployed, Airmen should not deploy with due/overdue examinations, IMR requirements, or other requirements for these programs. Every effort will be made to conduct prior to deployment. (T-2).

2.1.8.1.2. Upon redeployment, Airmen will be required to update their due/overdue PHA/OEH MSE/FOMEs within 90 days of return. (T-2).

2.1.8.2. If the AF Form 1042 is due to expire during the deployment, the home station FOMC will accomplish a new AF Form 1042 with the extended expiration date (redeployment date plus 90 days). (T-2).

2.1.8.2.1. If the AF Form 1042 holders have a waiver that will expire during the deployment, the home station FOMC will request a waiver extension through the granting waiver authority. ANG members will ensure fly waivers are current throughout the deployment. (T-2). **Note:** The waiver authority may grant the waiver extension to be concurrent with the AF Form 1042 (redeployment date plus 90 days) unless health, safety and/or mission completion would be compromised.

2.1.8.3. For OEH MSEs that will become due or overdue during deployment, FHME will make every effort to conduct prior to deployment IAW AFI 48-145, *Occupational and Environmental Health Program*. If not completed, document the reason why it was not accomplished in the medical record (AHLTA preferably). (T-1). **Exception:** IAW OSHA standards OEH MSEs must be current throughout the deployment for civilian deployers. (T-0).

2.2. PHA Requirements.

2.2.1. IAW HA Policy Memo 06-006 completion of the AF Web HA, a self-report health status tool. (T-0).

2.2.1.1. For deployers, DHA 1, DHA 2, and/or DHA 3 could be used in place of the AF Web HA as the patient self-report health status tool if completed within 60 days of the PHA Cell appointment. **Note:** An interval history will still need to be accomplished and ASIMS updated. (T-2).

2.2.1.2. The AF Web HA must be completed no earlier than 60 days prior to the PHA Cell/FOMC appointment. ARC members will have the Web HA complete prior to PHA appointment. **Note:** PRP/BPRP/PSP personnel are required to complete the AF Web HA at an MTF computer with results immediately reviewed and addressed by a CMA. All other Airmen are strongly encouraged to complete the AF Web HA prior to coming to the MTF for their PHA appointment. (T-1).

2.2.1.3. PHA Cell/FOMC technicians (hereafter referred to collectively as technicians) will check the AF Web HA "Multiple Patient Report" throughout the duty day for all Critical, Priority, and Routine findings from their respective empaneled population. (T-1). These findings will be managed in the following manner: **Note:** See 2.3.9. for ARC members.

2.2.1.3.1. All Critical findings must be addressed within one duty day. All Priority findings must be addressed within three duty days. (T-1).

2.2.1.3.2. Technicians will initiate the telephone consult in AHLTA for Critical and Priority findings; flag it as "high priority" and immediately forward it to the members' patient care team for review. (T-1).

2.2.1.3.3. The patient care team nurse (or ARC health technician) will review all "high priority" flagged PHA telephone consults, contact the member within in the specified timeframe to obtain clinically relevant information via either telephone or an in-person visit, as well as document the encounter in AHLTA or paper record if AHLTA is unavailable. All attempts at patient contact will be documented in AHLTA or paper record if AHLTA is unavailable. The patient care team nurse will forward telephone consults to the provider (or surrogate) for final review, disposition, and signature. **Note:** The date/time the Airman electronically submits his/her AF Web HA and the date/time the patient care team provider signs the "high priority" PHA telephone consult will be used to determine one- and three-duty day suspense compliances for Critical and Priority findings respectfully. (T-1).

2.2.1.3.4. Once Critical and Priority findings have been appropriately addressed, the balance of AF Web HA results and the other PHA (or FOME) requirements may be accomplished at that time (or an appointment made) and completed at a later time. Future follow up appointments should not preclude the closing out of the member's PHA.

2.2.1.3.5. PHAs with Routine AF Web HA findings will undergo a records review to determine the need for further follow up/tests and referral to the members' respective patient care team via standard appointing systems. (T-1).

2.2.2. Technicians will review ASIMS for all due or overdue IMR requirements and direct the member to the appropriate clinic/laboratory to complete any requirements. (T-2).

2.2.3. Technicians will conduct a thorough health record review using the medical record (AHLTA and paper record if AHLTA is not available) for interval medical and surgical history, family history, and currency of clinical preventive services since the members' last PHA. (T-2).

2.2.4. Technicians will identify age and gender specific CPS as directed by the PHA business rules, and document the recommended offerings on the appropriate PHA AHLTA template or paper record if AHLTA is not available. (T-2).

2.2.4.1. The patient care team is responsible for follow-up of any PHA Cell scheduled services.

2.2.4.2. The *United States Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services* is the main source of guidance for CPS and located at http://www.uspreventiveservicestaskforce.org/.

2.2.5. Technicians will ensure there has been an officially measured blood pressure (i.e., medical or dental clinic) within the last 12 months (ANG, within 5 years and AFR, every 3 years). As needed, the technician will accomplish and record blood pressure measurements. (T-1). **Note:** Business rules for blood pressure screening and managing elevated blood pressures are based on the most recent Joint National Committee on Prevention, Detection,

Evaluation, and Treatment of High Blood Pressure Report (http://www.nhlbi.nih.gov/guidelines/hypertension/index.htm).

2.2.6. Technicians will ensure there has been an officially measured weight and officially measured height within the last 12 months (ANG, within 5 years and AFR, every 3 years). Official measurements are limited to clinic- and fitness assessment cell-obtained measurements. Self-reported heights and weights will not be used. As required, technicians will measure and record the Airman's height and/or weight. (T-1).

2.2.7. Body Mass Index (BMI) is automatically calculated in ASIMS and results will be manually transcribed into AHLTA. BMIs will be managed according to PHA business rules. (T-2).

2.2.8. For all ANG members, visual acuity is required every year for flyers and every five years for non-flyers. (T-2).

2.2.9. Technicians will, regarding identified health risks, recommend clinical services, IMR requirements, DLC actions, Review in Lieu of (RILO) actions, Fit for Duty (FFD) determinations, and/or appropriate clinical follow-ups IAW ASIMS/AF Web HA guidance, the *PHA Guide*, and other relevant instructions. (T-2). Note: Records requiring further evaluation for mobility or duty restricting limitations (e.g., duty-limiting conditions >365 days that do not affect mobility) will be referred to the MSME. Duties in this regard will be limited to distributing AFMOA- or ECOMS-approved, PHA-related, patient education handouts. The "Full Patient Report" generated at the end of the AF Web HA will provide Airmen with health education for specific identified risks.

2.2.10. When annual OEH MSE requirements are conducted in conjunction with the PHA (as locally determined), technicians will review ASIMS as part of the PHA health records review. (T-2). If OEH MSEs are to be performed in conjunction with PHAs and OEH MSE requirements preclude PHA intervals greater than 12 months then PHAs may be performed earlier than prescribed to accommodate these requirements.

2.2.11. The PHA portion of the FOME for aviators, Airmen on aeronautical orders, and special operational duty personnel must include an in-person interview with a credentialed military flight surgeon with privileges in the FOMC. (T-1). If the PHA is performed by a non-AF flight surgeon (e.g., Navy, Army, or Coast Guard flight surgeons), it requires review and certification by a base-, GMU-, or RMU-level SGP or, if unavailable, parent MAJCOM/SGP.

2.2.12. The patient care team will use ASIMS and the AF Web HA "AHLTA Copy and Paste report" (or paper copy if AHLTA unavailable) to assess cardiovascular risk in Airmen and counsel them, as needed, to minimize this risk. (T-1). This assessment will be documented by the patient care team in the medical record (paper copy or AHLTA). The Cardiovascular Risk Assessment and Management (CRAM) site (https://kx2.afms.mil/kj/kx8/CRAM/Pages/home.aspx) can assist providers in appropriately assessing and calculating cardiac risk. **Note:** Not applicable for the ANG.

2.2.13. The patient care teams (or their surrogates) must re-validate and renew or revise, as appropriate, the AF Form 469 at each PHA at a minimum IAW AFI10-203. (T-1). The medical record and interval history must be reviewed for conditions that may require an AF Form 469. This review will be documented in the medical record.

2.2.14. As part of the PHA, Airmen will be medically evaluated for clearance to participate in a physical fitness-training program to meet fitness requirements IAW AFI 36-2905, *Fitness Program*. This does not replace screening requirements prior to official fitness assessments. Airmen unable to participate in physical activity sufficient to train to meet fitness requirements should be issued an AF Form 469, with activity restrictions. (T-2).

2.2.15. Airmen who have had an MEB (or FFD) and require subsequent RILOs will have their RILO timelines reviewed by their patient care team during their PHA and as a part of the health records review. While annual RILOs should be coordinated (synchronized) with the annual PHA, the patient care team (or surrogate) must ensure that RILO suspenses are met regardless of an Airman's PHA timeline. Annual RILOs will be coordinated with the MTF Physical Evaluation Board Liaison Officer (PEBLO) and forwarded to AFPC or ARC HQ IAW AFI 41-210. (T-2).

2.2.16. The PHA is "complete" for reporting purposes when the following are accomplished:

2.2.16.1. AHLTA and/or paper medical record review have been completed.

2.2.16.2. The Airman's patient care team (or surrogate) has addressed AF Web HA results including all Critical and Priority findings, and has made definitive care plans and dispositions (referral, appointment, etc.) pertaining to these responses. (T-1).

2.2.16.3. Face-to-face provider visit, if required by 2.1.6., has occurred.

2.2.16.4. CPSs recommended and offered, education and counseling have been scheduled, and referrals placed (e.g., referral to non-military provider, specialty clinic, HAWC, etc.). ARC medical components will document when ARC Airmen are advised to see their non-military patient care team for CPS (ref. 2.3.2.2.). (T-2).

2.2.16.5. Required documentation accomplished by technician and the patient care team (ref. 2.2.16.).

2.2.16.6. The provider has reviewed and signed the PHA, including the PHA AHLTA note. For ANG, qualified health technicians can sign the Web HA with no critical/priority findings and the member has no other PHA requirements. (T-2).

2.2.16.7. The PHA AHLTA note has been accurately coded. PHAs not requiring a face-to-face provider visit should normally be coded with evaluation and management (E/M) code 99420 (0.24 relative value units). PHAs in conjunction with MEBs and RILOs may require E/M disability exam codes. ARC medical units are not required to code PHA visits. (T-2).

2.2.16.8. For personnel requiring the AF Form 1042, it has been completed and recorded in ASIMS at the same time as the PHA.

2.2.16.9. Provider has made a DLC determination, or initiated a diagnostic work-up, if appropriate and/or RILO or FFD actions have been completed. (T-2).

2.2.16.10. The PHA completion date has been recorded in ASIMS by the patient care team, if completing the PHA, or PHA Cell, if completing the PHA. (T-2).

2.2.16.11. CPS results, including laboratory results and completed educational/counseling programs (e.g., tobacco cessation programs), are not required to complete a PHA for ASIMS and unit reporting purposes.

2.2.16.12. Concerns regarding worldwide duty qualifications should be addressed with an AF Form 469 and not delay PHA completion.

2.2.17. Required PHA Documentation.

2.2.17.1. Summary of care note in AHLTA using AFMOA-approved templates (e.g., Tri-Service Workflow AIM) or paper record if AHLTA is unavailable, appropriately coded (if applicable), and signed/co-signed by the Patient Care provider (or surrogate).

2.2.17.2. PHA completion date and provider visit date (if applicable) recorded in ASIMS by PHA Cell or the patient care team, if completing the PHA. (T-2).

2.2.17.3. Completed AF Form 1042 (for personnel who require it).

2.2.17.4. Signed AF Form 469, if renewed, modified, or initiated during the PHA. The AF Form 422, *Notification of Air Force Member's Qualification Status*, is only accomplished when needed (overseas clearance, AFSC retraining, etc.). Refer to AFI 10-203 for further guidance.

2.2.17.5. Documentation in AHLTA of clearance to begin or continue exercise program and/or completed AF Form 469.

2.2.17.6. The section conducting the PHA (i.e., PHA Cell or patient care team) will update the electronic DD Form 2766, *Adult Preventive and Chronic Care Flowsheet,* IAW AFI 41-210. This update to the DD Form 2766 should include previously undocumented significant medical events, allergies, and surgeries in addition to the current PHA activities. (T-2).

2.2.17.7. For ARC, Web HA will be documented in AHLTA or paper record if AHLTA is not available. (T-2).

2.3. ARC.

2.3.1. Reservists and Air Guard members assigned to units with sufficient medical assets will receive their PHAs within their own Reserve or Guard units. (T-2).

2.3.2. When ARC medical resources necessary to complete PHAs are inadequate or unavailable, ARC members are eligible for PHAs and other readiness-related evaluations at other AF MTFs. (T-2).

2.3.2.1. ARC members need not be in military status to schedule MTF appointments, but must be in military status (active, inactive, or points-only) at the time of the medical service. (T-2).

2.3.2.2. ARC members are instructed to see their non-military patient care team for clinical services not covered under these provisions. (T-2).

2.3.3. ARC members assigned to units without local AF MTF support will complete the AF Web HA, will have their responses reviewed by a provider (or a nurse or trained health technician for the ANG) and will, at a minimum, be personally contacted to complete the PHA process. (T-2).

2.3.3.1. The person who contacts the Airman (trained health technician, nurse, or provider) will be determined by the expertise required by AF Web HA responses.

Positive AF Web HA responses may require additional documentation from their non-military patient care team. (T-2).

2.3.3.2. The ART Team or Health Technicians will oversee the completion of PHAs. (T-2).

2.3.4. The Reserve Health Readiness Program (RHRP) may be used to provide PHA services for ARC GSUs and/or units who lack unit medical resources. The RHRP can provide these services through a nationwide network of non-military providers. Email **rhrp@tma.osd.mil** or see either **http://rhrp.fhpr.osd.mil/home.aspx** or **http://www.pdhealth.mil/hss/healthcare_services.asp** for further information about the RHRP. Note: Group events must be requested and approved through ARC Surgeons General OPRs.

2.3.5. ARC members will have annual PHAs conducted using AFMOA-developed business rules. As required, these business rules will be modified to meet special AFR and ANG requirements (1.2.7.1.). (T-1).

2.3.5.1. Reservists will receive PHAs per the latest AFRC/SGP consolidated program memorandum located at https://kx2.afms.mil/kj/kx/AFRCAerospaceMed/Pages/home.aspx. (T-2).

2.3.6. ARC units will process PHAs using FHME surrogates detailed in 1.2.18.1. (T-2).

2.3.7. ARC members not requiring AF Form 1042 will have a face-to-face provider PHA appointment at the following minimum frequency: ANG at least every 5 years and AFR at least every 3 years. **Note:** ARC members requiring AF Form 1042 will have a face-to-face provider PHA annually in conjunction with their FOME (i.e., flying/special duty physical). (T-2).

2.3.8. ANG officers being considered for promotion to general officer or promotion within the general officer ranks must undergo a PHA within 6 months of the recognition board. Forward copy of the PHA to: NGB/SGPF GO EAD REVIEW at **ngb.sggoeadreview@ang.af.mil.** (T-1).

2.3.9. ARC members will be notified of any critical or priority findings at the end of their AF Web HA session and will be directed to seek civilian medical care as appropriate. (T-1).

2.3.9.1. Designated ANG medical personnel will follow-up critical and priority AF Web HA results no later than the next Unit Training Assembly (UTA). (T-1).

2.3.9.2. ART Team will follow up critical findings immediately (until the Reservist is contacted) and priority findings within one week (until the Reservist is contacted). All attempts to contact the member shall be documented. (T-1).

2.3.10. The Readiness Management Group (RMG) has administrative control over IMAs and compliance oversight. The MTF supporting the IMA's AD unit of attachment is the provider for PHA services and shares responsibility with the RMG for tracking, data entry, and compliance. (T-2).

2.3.10.1. The AD MTF is responsible for AF Form 469/422 actions associated with the PHA and the RMG/SG should be notified of all AF Form 469/422 actions through secure e-mail (i.e., ASIMS generated or MiCare) at **afrc.rmgsg@afrc.af.mil.** (T-2).

2.3.11. Expired PHAs in ARC members.

2.3.11.1. Reservists with expired PHAs will be referred to their CCs IAW AFI 36-2254 Vol.1, *Reserve Personnel Participation,* and processed IAW AFI 36-3209, *Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members,* or involuntary transferred to the Individual Ready Reserve in accordance with AFI 36-2115, *Assignments Within the Reserve Components*. (T-2).

2.3.11.2. ANG members with expired PHAs will be referred to their CC and processed IAW AFI 36-3209. (T-2).

2.3.11.3. ARC members involuntarily ordered to AD will not delay such action because of an expired PHA. For those ARC personnel with expired PHAs, PHAs will be accomplished within the first 60 days of AD. Members will not deploy with expired PHA or IMR requirements per 2.1.8.1.1. (T-2).

2.3.12. Service members must have a current PHA prior to transfer to an ARC unit. The PHA must remain current for the first 90 days upon accession to the ARC unit. Prior to accession to ARC, service members with potentially disqualifying conditions IAW 48-123, must be evaluated for fitness for duty (IRILO or MEB). (T-2).

2.4. PHAs for Geographically Separated Airmen.

2.4.1. Geographically separated Airmen are Airmen not collocated on the same installation nor enrolled to the MTF that administers their PHA (the "Reporting MTF", see 2.4.2.1. below). MAJCOM/DRU CCs and unit CCs (if applicable) must ensure their geographically separated Airmen receive an annual PHA. (T-1).

2.4.2. Definitions of Reporting and Supporting MTFs.

2.4.2.1. "Reporting" MTFs are the MTFs accountable to MAJCOM/DRUs for PHA reporting and tracking purposes, and are usually collocated on the same installation as the MAJCOM/DRU. Reporting MTFs provide due/overdue PHA rosters to MAJCOM/DRU CCs and oversee PHA processing for geographically separated Airmen.

2.4.2.2. "Supporting" MTFs are DoD and non-DoD MTFs providing healthcare services to geographically separated Airmen. These supporting MTFs include, but are not limited to, DoD MTFs (AF, Army, or Navy), and, where no DoD MTF exists, approved TRICARE service providers such as U.S. State Department medical facilities and non-military providers.

2.4.3. Geographically separated Airmen with local supporting AF MTFs.

2.4.3.1. Geographically separated Airmen collocated with or near supporting AF MTFs (as determined by MAJCOM/DRU and supporting MTFs) will follow standard PHA instructions and procedures, and receive PHAs and follow-up care at these MTFs. (T-1).

2.4.3.2. Reporting MTF PHA Cells/FOMCs will coordinate with supporting AF MTF PHA Cells/FOMCs to administer and execute PHAs for geographically separated Airmen. (T-1).

2.4.4. Geographically separated Airmen at locations without local AF MTF support but supported by Independent Duty Medical Technicians (IDMTs). (T-1).

2.4.4.1. PHA processes shall be directed by the designated IDMT physician preceptor and administered by the technician at the physician preceptor's assigned MTF. (T-1).

2.4.4.2. PRP/BPRP/PSP at IDMT-staffed GSUs.

2.4.4.2.1. At GSUs with a PRP/BPRP/PSP mission where the medical support is provided by AD IDMTs, the IDMTs may facilitate the gathering of PHA information but the PHA provider for PRP/BPRP/PSP personnel will be a CMA. (T-1).

2.4.4.2.2. At GSUs where the CMA is not collocated with the PRP/BPRP/PSP personnel, the CMA will remotely review PHA results while the Airman waits at the GSU medical facility. (T-1).

2.4.4.2.3. If the remote CMA review cannot be accomplished at the time of the Airman's PHA appointment, the Airman will be suspended from their PRP/BPRP/PSP duties until PHA results are reviewed by the CMA. (T-1).

2.4.5. Geographically separated Airmen at locations without local AF MTF or IDMT support.

2.4.5.1. PHA completion will be monitored and overseen by the GSU AF CC (or equivalent) in coordination with the reporting MTF PHA Cell/FOMC. In situations where no GSU AF CC (or equivalent) exists, the reporting MTF PHA Cell/FOMC will monitor and oversee PHA completion. (T-1).

2.4.5.2. After completing the AF Web HA, geographically separated Airmen without local AF MTF or IDMT support will, at a minimum, be contacted (preferably by phone or video link) by the reporting MTF to review AF Web HA responses, and provide and document appropriate counseling and education. The MTF should develop a process to maximize efficiency in facilitating GSU PHA completion to reduce repeat phone calls. The SGP and SGH shall identify workflow processes to complete GSU PHAs at the appropriate level of care based on ASIMS and AF Web HA reports (e.g., critical and priority responses will be addressed by a credentialed privileged provider, and preventive counseling based on AFMOA- and ECOMS-approved patient education IAW CFETP). (T-1).

2.4.5.3. Clinical PHA services, counseling, and follow-up care will be scheduled by the member or their appointed UHM and be performed at the local supporting non-AF MTF. Some cases (e.g., critical and priority results) will require the reporting MTF PHA personnel to confer directly with medical personnel at the supporting MTF to appropriately transfer care and schedule needed services. The reporting MTF SGP will ensure all care provided by the supporting MTF involving critical and priority AF Web HA responses is reviewed with supporting non-AF MTF personnel within the required time suspenses to ensure appropriateness of care and disposition. See paragraph 2.3.9. for ARC management of critical and priority responses. (T-1).

2.4.5.4. FFD and other military-related medical determinations will be made remotely by the reporting MTF SGP as clinically and administratively appropriate. If this cannot be done, the reporting MTF SGP, with cooperation and assistance of supporting MAJCOM assets (e.g., PACAF, USAFE), will arrange for this determination to be made at a regional DoD MTF. (T-1).

2.4.5.5. The Airman will request that documentation of services provided by the supporting MTF be forwarded (faxed, emailed, or mailed) to the reporting MTF PHA Cell/FOMC for entry into AHLTA and ASIMS. Additionally, upon PCS from a geographically separated location to an AF installation, in-processing will involve a thorough health record review to ensure pertinent interval care (including PHAs and related services) is entered into AHLTA and ASIMS. (T-1).

2.4.5.6. The reporting MTF SGP or designee has final signature authority on PHAs performed at non-AF MTFs. Documentation necessary to complete PHAs for geographically separated Airmen is the same as those listed in 2.2.16. (T-1).

2.4.5.7. In lieu of the remote processes detailed in this section, MTF CCs may choose to periodically send or permanently assign appropriate personnel (providers, technicians, etc.) to larger GSUs to administer PHAs.

2.4.6. In areas where multiple DoD MTFs are located near one another (e.g., the National Capital Region); Airmen may be TRICARE-enrolled at nearby MTFs other than the reporting MTF responsible for administering their PHA. The reporting MTF is still responsible for ensuring these Airmen receive annual PHAs and track compliance. MTFs must develop local instructions and procedures to meet these requirements. Options include, but are not limited to, directing these Airmen back to the reporting MTF to accomplish the PHA, accomplishing these PHAs as "geographically separated PHAs" as defined in this section, or developing other processes and standing agreements with nearby DoD MTFs to accomplish these tasks.

2.5. Support for Sister Service Members' PHAs.

2.5.1. AF MTFs supporting Army, Navy, Marine Corps, and Coast Guard PHA requirements will coordinate with applicable Sister Services' unit administrative or personnel support offices to develop standardized PHA processes specifying requirements, notification and scheduling procedures, and required documentation. (T-1).

2.5.2. Sister Service PHAs will be administered by PHA Cell or FOMC, as appropriate. PHAs administered by PHA Cell will be referred to their patient care team (or surrogate) as directed by locally developed processes. (T-1).

2.5.3. AFMOA/SGPM (via the Kx) will serve as a repository for Sister Service-specific forms, instructions, guidance, and expertise. (T-1).

THOMAS W. TRAVIS
Lieutenant General, USAF, MC, CFS
Surgeon General

APPENDIX B

PATIENT HEALTH QUESTIONNAIRE-9

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, 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 _____

A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005

APPENDIX C

GENERAL ANXIETY DISORDER 7-ITEM SCALE

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

APPENDIX D

PRIMARY CARE POSTTRAUMATIC STRESS DISORDER SCREEN

Primary Care PTSD Screen (PC-PTSD)

Description

The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

Scale

Instructions:

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?

   YES / NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

   YES / NO

3. Were constantly on guard, watchful, or easily startled?

   YES / NO

4. Felt numb or detached from others, activities, or your surroundings?

   YES / NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.

Prins, Ouimette, & Kimerling, 2003

APPENDIX E

INFORMED CONSENT FORMS FOR HUMAN PARTICIPATION IN RESEARCH

UNC

UNIVERSITY OF NORTHERN COLORADO

CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Project Title: Streamlining the Response to Positive Mental Health Concerns on the Air Force Web Based Periodic Health Assessment

Researchers: Amanda Kelly Hill (BSN-DNP Student); Kathleen N. Dunemn, PhD, APRN, CNM, School of Nursing
Phone Number: (970) 351-3081/(803) 409-8391 e-mail:kathleen.dunemn@unco.edu

Phase One: Delphi Study #1

The aim of this process improvement project is to obtain information from a panel of experts at the140th Medical Group in order to advise and guide the current and future training and practice of health technicians and others running the Web-Based Periodic Health Assessment Program (Web-PHA). This **first phase** is targeted at developing an education program, as well as a competency checklist (pre and post education implementation) and continuity folder for the trained health technician and other staff involved in the Web-PHA program since this does not currently exist.

Determining what education should be included for the trained health technician in regards to the mental health portion of the Web-PHA process needs to be investigated. A Delphi survey data collection methodology will be used for the development of the learning program. This is a structured group communication method for soliciting expert opinion about complex problems or novel ideas and creating an agreed view or shared interpretation. In this Delphi study a questionnaire asking your expert opinion will be sent at 1-2 week intervals. It is anticipated that this Delphi study will have 2-3 but no more than 4 rounds of surveys. All Delphi surveys will be sent and returned electronically. It is anticipated that it will take panelist approximately 15 minutes to complete each round of this Delphi Study.

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with the Web-PHA process, having a protocol to follow and by having a standardized education approach and continuity book to consult.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Having read the above and having had an opportunity to ask any questions, please access and complete the attached document "Phase One: Delphi Study # 1 Round 1" of the Streamlining the Response to Positive Mental Health Concerns of the Air Force Web-PHA. Return completed surveys to: wrig2144@bears.unco.edu. If at any time you have any questions please contact one of the undersigned. By completing the questionnaire, you will give us permission for your participation. You may keep this form for future reference. If you have any concerns about your selection or treatment as a research participant, please contact Sherry May, IRB Administrator, Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-1910.

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Amanda Hill, BSN, RN
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970-351-1699

The informed consent information will be emailed and accompany the appropriate Delphi Study

Phase One: Delphi Study #1- Round One Questions:

In regards to the mental health portion of the Web-PHA program:

1. What type of education have you received on the Web-PHA program?

2. Have you received any mental health training?

3. What education would be helpful to you?

4. What information would you like provided about the Web-PHA program?

5. Which mental health screening tools are used?

6. What concerns do you have about the mental health portion of the Web-PHA?

7. What makes a priority or critical mental health concern flag?

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CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Project Title: Streamlining the Response to Positive Mental Health Concerns on the Air Force Web Based Periodic Health Assessment
Researchers: Amanda Kelly Hill (BSN-DNP Student); Kathleen N. Dunemn, PhD, APRN, CNM, School of Nursing
Phone Number: (970) 351-3081/(803) 409-8391 e-mail:kathleen.dunemn@unco.edu

Phase One: Delphi Study #1

The aim of this process improvement project is to obtain information from a panel of experts at the140th Medical Group in order to advise and guide the current and future training and practice of health technicians and others running the Web-Based Periodic Health Assessment Program (Web-PHA). This **first phase** is targeted at developing an education program, as well as a competency checklist (pre and post education implementation) and continuity folder for the trained health technician and other staff involved in the Web-PHA program since this does not currently exist.

Determining what education should be included for the trained health technician in regards to the mental health portion of the Web-PHA process needs to be investigated. A Delphi survey data collection methodology will be used for the development of the learning program. This is a structured group communication method for soliciting expert opinion about complex problems or novel ideas and creating an agreed view or shared interpretation. In this Delphi study a questionnaire asking your expert opinion will be sent at 1-2 week intervals. It is anticipated that this Delphi study will have 2-3 but no more than 4 rounds of surveys. All Delphi surveys will be sent and returned electronically. It is anticipated that it will take panelist approximately 15 minutes to complete each round of this Delphi Study.

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with the Web-PHA process, having a protocol to follow and by having a standardized education approach and continuity book to consult.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Having read the above and having had an opportunity to ask any questions, please access and complete the attached document "Phase One: Delphi Study # 1 Round Two" of the Streamlining the Response to Positive Mental Health Concerns of the Air Force Web-PHA. Return completed surveys to: wrig2144@bears.unco.edu. If at any time you have any questions please contact one of the undersigned. By completing the questionnaire, you will give us permission for your participation. You may keep this form for future reference. If you have any concerns about your selection or treatment as a research participant, please contact Sherry May, IRB Administrator, Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-1910.

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The informed consent information will be emailed and accompany the appropriate Delphi Study

Phase One: Delphi Study #1- Round Two Questions:

In regards to the mental health portion of the Web-PHA program:

Please answer YES or NO to each question below.

1. Do you agree that you have not received any formal education specific to the mental health portion of the Web-PHA program, other then referencing the AFI?

2. Will education on what mental health questions are asked, when to contact a patient, what questions to ask the patient and where to document the encounter be helpful?

3. Will information on how a critical or priority flag is generated for mental health concerns be valuable to you?

4. Do you agree that you are unsure about which mental health screening tools are used on the Web-PHA?

5. Would knowing how to appropriately administer and score the specific mental health screening tools included in the Web-PHA be helpful for you?

6. Due to the multiple concerns about the mental health portion of Web-PHA, would a protocol and algorithm help you to work through mental health concerns?

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CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Project Title: Streamlining the Response to Positive Mental Health Concerns on the Air Force Web Based Periodic Health Assessment

Researchers: Amanda Kelly Hill (BSN-DNP Student); Kathleen N. Dunemn, PhD, APRN, CNM, School of Nursing
Phone Number: (970) 351-3081/(803) 409-8391 e-mail: kathleen.dunemn@unco.edu

Phase Two: Delphi Study # 2

The aim of this process improvement project is to obtain information from a panel of experts at the140th Medical Group in order to advise and guide the current and future training and practice of health technicians and others running the Web Based Periodic Health Assessment Program (Web-PHA program). This **second phase** is targeted at developing a protocol and algorithm as described by the Air Force Instruction (AFI 44-108, 2014), which has not been created for the technician to follow.

The building of a protocol and algorithm for the Web-PHA process based on expert opinion is the goal of this phase. A protocol and algorithm are needed to guide the practice of the medical technicians/staff as they interact with Air Guard members during the response to mental health concerns during the Web-PHA process. A Delphi survey data collection methodology will be used for the development of the protocol and algorithm. The Delphi Method is a structured group communication method for soliciting expert opinion about complex problems or novel ideas and creating an agreed view or shared interpretation. In this Delphi study a questionnaire asking your expert opinion will be sent at 1-2 week intervals. It is anticipated that this Delphi study will have 2-3 but no more than 4 rounds of surveys. All Delphi surveys will be sent and returned electronically. It is anticipated that it will take panelists approximately 15 minutes to complete each round of this Delphi Study.

The purpose of this email is to invite your participation as a virtual panelist and participant. Participation is **voluntary** and all responses will be kept **anonymous**. Your responses may be included in the larger study. The de-identified data will be stored on a thumb drive, in a locked drawer at the 140th MDG, only accessible to the author and her research advisor. There are no foreseeable risks to participants, as this is a process improvement project of a current program already in place and is based on examining the education processes and building of a supporting protocol and algorithm, which is currently lacking. Participants may benefit directly from this project by feeling more comfortable with the Web-PHA process, having a protocol to follow and by having a standardized education approach and continuity book to consult.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be

respected and will not result in loss of benefits to which you are otherwise entitled. Having read the above and having had an opportunity to ask any questions, please access and complete the attached document "Phase Two: Delphi Study # 2 Round 1" of the Streamlining the Response to Positive Mental Health Concerns of the Air Force Web-PHA. Return completed surveys to: wrig2144@bears.unco.edu. If at any time you have any questions please contact one of the undersigned. By completing the Delphi questionnaires, you will give us permission for your participation. You may keep this form for future reference. If you have any concerns about your selection or treatment as a research participant, please contact Sherry May, IRB Administrator, Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-1910.

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The informed consent information will be emailed and accompany the appropriate Delphi Study

Phase Two: Delphi Study #2- Round One Questions:

In regards to the Web-PHA's with mental health concerns:

1. Who should be contacting mental health critical or priority responses?

2. Is there a certain rank that is appropriate for contacting positive mental health concerns?

3. Should priorities wait to be contacted at the next UTA as dictated in the AFI?

4. What mental health concerns would the providers want to see?

5. Should the PHQ-9 be asked and documented in the chart?

6. How many times should we contact a patient if they are unable to be reached for a critical or priority?

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CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Project Title: Streamlining the Response to Positive Mental Health Concerns on the Air Force Web Based Periodic Health Assessment
Researchers: Amanda Kelly Hill (BSN-DNP Student); Kathleen N. Dunemn, PhD, APRN, CNM, School of Nursing
Phone Number: (970) 351-3081/(803) 409-8391 e-mail: kathleen.dunemn@unco.edu

Phase Two: Delphi Study # 2

The aim of this process improvement project is to obtain information from a panel of experts at the140th Medical Group in order to advise and guide the current and future training and practice of health technicians and others running the Web Based Periodic Health Assessment Program (Web-PHA program). This **second phase** is targeted at developing a protocol and algorithm as described by the Air Force Instruction (AFI 44-108, 2014), which has not been created for the technician to follow.

The building of a protocol and algorithm for the Web-PHA process based on expert opinion is the goal of this phase. A protocol and algorithm are needed to guide the practice of the medical technicians/staff as they interact with Air Guard members during the response to mental health concerns during the Web-PHA process. A Delphi survey data collection methodology will be used for the development of the protocol and algorithm. The Delphi Method is a structured group communication method for soliciting expert opinion about complex problems or novel ideas and creating an agreed view or shared interpretation. In this Delphi study a questionnaire asking your expert opinion will be sent at 1-2 week intervals. It is anticipated that this Delphi study will have 2-3 but no more than 4 rounds of surveys. All Delphi surveys will be sent and returned electronically. It is anticipated that it will take panelists approximately 15 minutes to complete each round of this Delphi Study.

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The informed consent information will be emailed and accompany the appropriate Delphi Study

Phase Two: Delphi Study #2- Round Two Questions:

In regards to the Web-PHA's with mental health concerns:

Please review the summary from round one and answer the following questions with a YES or NO.

1. At the 140th MDG a 4N051 or higher, nurse or provider may contact a critical or priority Web-PHA response.

2. Rank is irrelevant when contacting a member as long as they are properly trained, knowledgeable and equipped to manage a member with positive mental health responses on the Web-PHA.

3. Priority and critical Web-PHA responses should be contacted during the week as there is an assigned trained health technician, priority within 3 duty days and critical within 1 duty day.

4. A provider appointment should be made for all members with a critical Web-PHA, suicidal ideation, homicidal ideation, PHQ-9 score of 15 or greater, positive PTSD screen, on new medications for mental health reasons or per patient request.

5. The PHQ-9 should be asked and score documented if depression is the concern on the Web-PHA and the patient is not currently seeking treatment for depression.

6. Members should be contacted a minimum of 3 times with documentation.

7. Unit commander/1st Sgt contact needs to happen for all critical responses who are unable to be reached.

Comments:

APPENDIX F

DELPHI TECHNIQUE ROUND ONE SUMMARY

A summary of the answers received.

1. Who should be contacting mental health critical or priority responses?
    - 4N051, 4N071, Mental Health Counselor, RN, Provider
    - The Full time Med Tech or Admin Tech should be contacting the members as is being done now. We do not want critical or priority responses waiting until next UTA. They are being referred to chaplain services, VA, or psych services as appropriate. It seems to be working well. If problems, the issue should be escalated to nursing then to the physicians as appropriate or to Rebecca.
    - The individuals reviewing the WebHA.
    - The patient care team nurse (or ARC health technician).

2. Is there a certain rank that is appropriate for contacting positive mental health concerns?
    - E-4 and above, it depends on the maturity level of the individual
    - I don't think so. What matters is the individual's health and so it shouldn't matter what rank the person is for contacting.
    - No rank, but MDG requires at the minimum that a 5 skill level medic (fulltime health tech) F/U on Mental Health when an RN is not available.
    - The rank should be at least a SSgt or higher.

3. Should priorities wait to be contacted at the next UTA as dictated in the AFI?
    - No, if a full time staff member is available, the priority/critical member should be contacted as soon as possible.
    - No.
    - No we try to follow the AD standard of all Critical findings must being addressed within one duty day and all Priority findings must being addressed within three duty days.
    - No, priorities should not wait. Simply touching base with them is most appropriate. We do not want a priority progressing to a critical when it could have been addressed.

4. What mental health concerns would the providers want to see?
    - Depression, PTSD - psychological problems, substance abuse, physical abuse, marital problems
    - Any issue which raises concern for the members safety or anyone else safety such as family or co-workers.
    - They would want to members critical/priority PHA responses and HISI responses.
    - This question isn't very clear to me, but I'm going to say any patient that states they are a danger to themselves or those around them.

5. Should the PHQ-9 be asked and documented in the chart?
    - The PHQ-9 should be completed by a member during a follow-up provider visit. Depending on the situation, parts of the PHQ-9 could be asked
    - I think it should be in there at least once every 5 years.
    - PHA will prompt more detailed questions based on responses given, but I suppose that could be added. It couldn't hurt.
    - I feel that it should be include in the chart. We ask, it needs to be documented legally.

6. How many times should we contact a patient if they are unable to be reached for a critical or priority?
    - Every attempt should be given to contact the member. If the member is unavailable during the week, the member should be contacted during UTA
    - Twice.
    - We continue to try to reach them by phone for allowable time and then contact their Commander or 1Sgt to make face to face contact with them if we are unable to reach by phone.
    - A minimum of 3 separate "documented" attempts. This is not only a patient safety issue, but a medical-legal issue. I would ask LtCol Cowan, but I feel that if it is "critical", and the member cannot be contacted after 3 attempts, the issue should be elevated to the members commander or 1rst Sgt.

APPENDIX G

DELPHI TECHNIQUE ROUND TWO

Delphi Technique Round Two

Please review the summary from round one and answer the following questions with a YES or NO.

1. At the 140th MDG a 4N051 or higher, nurse or provider may contact a critical or priority Web-PHA response.

2. Rank is irrelevant when contacting a member as long as they are properly trained, knowledgeable and equipped to manage a member with positive mental health responses on the Web-PHA.

3. Priority and critical Web-PHA responses should be contacted during the week as there is an assigned trained health technician, priority within 3 duty days and critical within 1 duty day.

4. A provider appointment should be made for all members with a critical Web-PHA, suicidal ideation, homicidal ideation, PHQ-9 score of 15 or greater, positive PTSD screen, on new medications for mental health reasons or per patient request.

5. The PHQ-9 should be asked and score documented if depression is the concern on the Web-PHA and the patient is not currently seeking treatment for depression.

6. Members should be contacted a minimum of 3 times with documentation.

7. Unit commander/1st Sgt contact needs to happen for all critical responses who are unable to be reached.

Comments:

APPENDIX H

INSTITUTIONAL REVIEW BOARD APPROVAL

UNIVERSITY OF
NORTHERN COLORADO

Institutional Review Board

DATE:	April 14, 2016
TO:	Amanda Hill
FROM:	University of Northern Colorado (UNCO) IRB
PROJECT TITLE:	[894585-2] Streamlining the Response to Positive Mental Health Concerns on The Air Force Web Based Periodic Health Assessment
SUBMISSION TYPE:	Amendment/Modification
ACTION:	APPROVAL/VERIFICATION OF EXEMPT STATUS
DECISION DATE:	April 14, 2016
EXPIRATION DATE:	April 14, 2020

Thank you for your submission of Amendment/Modification materials for this project. The University of Northern Colorado (UNCO) IRB approves this project and verifies its status as EXEMPT according to federal IRB regulations.

We will retain a copy of this correspondence within our records for a duration of 4 years.

If you have any questions, please contact Sherry May at 970-351-1910 or Sherry.May@unco.edu. Please include your project title and reference number in all correspondence with this committee.

Amanda -

Thank you for making the modifications requested. Please be sure to use all revised documents in your study protocols. Best wishes with this project.

Sincerely,

Dr. Megan Stellino, UNC IRB Co-Chair

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Northern Colorado (UNCO) IRB's records.

APPENDIX I

STATEMENT OF MUTUAL AGREEMENT

Statement of Mutual Agreement

University of Northern Colorado
Doctorate of Nursing Practice Capstone Project
Amanda K. Hill
6 January 2016

The purpose of the "Statement of Mutual Agreement" is to describe the shared view between The 140th Medical Group, at Buckley AFB Colorado and Amanda K. Hill, DNP Candidate from the University of Northern Colorado, concerning her proposed capstone project.

Proposed Project Title:

Streamlining the response to positive mental health concerns on the Air Force Web-based Health Assessment.

Brief Description of Proposed Project:

The purpose for the proposed capstone is to provide a process improvement for the Web-based Health Assessment (Web HA) process at the 140th Colorado Air National Guard Medical Group (140 MDG). The goal of this improvement is to streamline the process of identifying, contacting and referring those airmen with abnormal, priority or critical responses in regards to mental health concerns.

Goal of Capstone Project:

Process improvement to create a protocol/algorithm to direct those who are involved with contacting service members with positive findings on the Web HA, to include using the PHQ-9 screening tool for depression and documenting the score on a SF 600.

Proposed On-site Activities:

AFI review, interviewing health technicians involved in PHA/Web HA process, provider involvement, assessing current protocol, reviewing positive, priority and critical Web HA responses, education and piloting the proposed algorithm.

Confidentiality of Patient Records:

No personally identifiable information will be used. HIPAA will be of utmost importance.

The designated Capstone Community/Agency member will agree to participate in the review and approval of the proposal and presentation of the final version of the project. He/she will attend (on campus or remotely) the meetings for both.

The DNP Capstone project will include a final report, an abstract, potential publication or oral presentation of the report. No personal identifiers will be included and all data will be reported in aggregate form. The author welcomes any comments or suggestions from the Agency, but reserves the right to publish findings and analysis according to professional standards and principles of academic freedom. For any work of a scholarly nature, the Author agrees to follow the Agency preferences in how it is to be named (or not) in the work.

Amanda K Hill — 1-9-16

Signature of Student — Date

9 Jan 2016

Signature of Agency Member, 140 MDG/SGH — Date

9 Jan 16

Signature of 140 MDG/CC — Date

14 Jan 16

Signature of Capstone Chair — Date

APPENDIX J

WEB-BASED PERIODIC HEALTH ASSESSMENT MENTAL HEALTH PROTOCOL

Streamlining the Response to Positive Mental Health Concerns on the Air Force Web Based Periodic Health Assessment

May 2016
By: Amanda Hill, Major, USAF, NC

Objectives

- Mental Health Significance In the Military
- What Is The AF Web-PHA
- AFI 44-170
- What Mental Health Disorders Are Being Screened
- What Screening Tools Are Used
- What Triggers A Priority Or Critical Flag
- What To Do With A Mental Health Concern
- Web-PHA MHP
- Communication Techniques
- Documentation

Mental Health Significance

- "The suicide rate among male and female veterans and military service members exceeds the national rate for the general population" (SAMHSA, 2015).
- "Approximately 40,000 military members who have returned from Iraq and Afghanistan have been officially diagnosed with PTSD since 2003, according to the U.S. Department of Defense (ADAA, 2016).
- PTSD rates are over three times higher in those military members deployed to a combat zone versus those not deployed (ADAA, 2016).

Mental Health Significance

- According to the RAND Corporation one in five military members return with symptoms of PTSD or major depression, yet only half have sought treatment (ADAA, 2016).

National Guard and Mental Health

- The U.S. military has increasingly relied on the National Guard and Reserve components since 2001 to meet operational demands (Cohen et. al., 2015, p. 7).
- Over 250,000 Guard members deployed to Iraq or Afghanistan in support of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) (SAMHSA, 2010).
- "Reserve component service members face particular readjustment challenges that have been documented to increase their psychiatric disorder burden, relative to their active component counterparts" (Cohen et. al., 2015, p. 8).

National Guard and Mental Health

- "Differences in preparation and military engagement experiences between active component and reserve component forces have long suggested that the psychiatric consequences of military engagement differ by component"
- "Suicides jumped by a third in 2015 from the year before, according to the Department of Defense. The number of guardsmen who took their own lives went from 91 in 2014 to 121 last year" (NGAUS, 2016).
- This includes 100 guardsmen from the Army and 21 from the Air (NAGUS, 2016). The entire reserve sector suffered 209 suicides in 2015, which was up from 170 in 2014 (NAGUS, 2016).

AF Web-PHA

- The Air Force has tried to identify and combat mental health issues by using a Web-based Periodic Health Assessment (Web-PHA) that was created in 2006, but not fully implemented until 2009 to screen all airmen (to include Air National Guard members) annually on different facets of their life.
- "These questions were developed by a Department of Defense team who were guided by the health screening and counseling recommendations of the USPSTF, U.S. Department of Agriculture, American College of Sports Medicine, American Heart Association, and other organizations; and used well-tested public domain questions and responses sets, such as the Behavioral Risk Factor Surveillance System and Alcohol Use Disorders Identification Test" (Santos, 2009, p. 6).

AF Web-PHA

- "The intent of the PHA program is two fold: to recommend evidence-based, cost effective preventative health services, and to identify and document potential duty limiting conditions" (AFI 44-170, 2014, p. 3).

AFI 44-170

- The Air Force Instruction (AFI) that guides the Web-PHA is AFI 44-170, *Preventative Health Assessment* (2014).
- This Air Force Instruction is instrumental to the WEB-PHA process and supplies the minimum guidance and procedures for the Air Force Preventive Health Assessment (PHA) program, also known as the Periodic Health Assessment (PHA) in the Air Reserve Corps (ARC).
- "Air Reserve Component members will be notified of any critical or priority findings at the end of their Air Force Web-PHA session and will be directed to seek civilian medical care as appropriate" (AFI 44-170, 2014, pg 16).

AFI 44-170

- Chief of Aerospace Medicine (SGP) is the MTF OPR for clinical oversight of the PHA program.
- In coordination with the Chief of the Medical Staff (SGH), Chief of Nursing Services, Public Health, and senior enlisted functionals:
  - Develops Executive Committee of the Medical Staff (ECCIMS)-approved PHA protocols and MTF instructions;
  - Develops procedures to implement PHA-associated clinical practice guidelines (CPGs) and quality assurance processes through technician level reviews (see PHA guide for further detail); and

AFI 44-170

- Chief of the Medical Staff (SGH) (For ANG, Chief of Nursing Services).
  - In coordination with the SGP and Public Health, ensures PHA-associated CPS and counseling services are applied consistently and uniformly throughout the MTF.
  - Assists the SGP and Public Health in developing MTF instructions, procedures to implement PHA-associated CPGs and quality assurance processes.
  - Assists the SGP in developing ECCIMS-approved PHA protocols and standing orders to enable clinical support personnel to independently order and schedule CPS on behalf of providers.

Web-PHA Audit

- A retrospective analysis of the data in ASIMS showed that from June 2015 through December 2015, there were:
  - 715 Web-PHA's completed
- Of those 715 Web PHA's:
  - 77 were priorities and there were zero critical responses
  - Of the 77 priorities, 34 (44%) were of mental health concern.

Web-PHA Audit

- A flaw that was noticed while reviewing completed Web-PHA's with positive responses, was that the results that are given to both the patient and medical unit do not score the screenings administered, but instead just identify a possible concern for depression, anxiety or PTSD.
- Instead of the priority or critical notification giving a depression, anxiety or PTSD score it will say:
  - "Patient reports symptoms consistent with depression"
  - "Patient reports significant concerns or distress with the following: stress or emotional concerns"
  - "Patient reports symptoms consistent with a PTSD disorder"

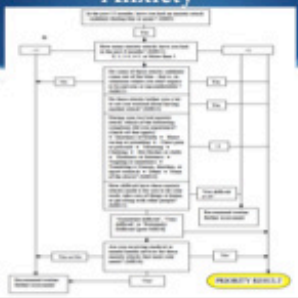
Web-PHA Audit

- The member can then opt to enter specific information if they wish to give further explanation on what is going on in their life. Some choose to, while others leave the comment section blank. The member also has the option to check a box that states:
  - "The patient reports interest in receiving information or assistance for a stress, emotional or alcohol concern."
  - "The patient reports they would like assistance for a family or relationship concern. Recommend further assessment and referral."

Mental Health Screening

- The Web-PHA focuses on three dimensions of mental health: general anxiety/panic disorder, depression and post-traumatic stress disorder (PTSD).
- The questions are asked in an algorithm type format, in which positive answers lead to further questioning.
- These algorithms were developed by the United States Air Force (USAF) Informatics Division based on the American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Health Disorders, 4th edition (DSM-IV) guidelines (Madrid, 2010).

Anxiety



Anxiety

- Anxiety/panic disorder is screened with the General Anxiety Disorder 7-item (GAD-7) scale.
- It is based on a point system and scores are calculated by assigning a 0, 1, 2 or 3 based on the response to each question.
- Scores of 5, 10 and 15 are taken as the cut-off for mild, moderate and severe anxiety (Spitzer, et. al., 2006).

Anxiety

5/13/16

Depression

Depression

- The depression-screening algorithm uses the Patient Health Questionnaire-2 (PHQ-2), followed by the Patient Health Questionnaire-9 (PHQ-9) if the PHQ-2 was positive.
- The PHQ-2 is a two question screening tool that is used as a first step approach in identifying those at risk for depression and is based on a point system.
- Patient's who screen positive are then further evaluated with a PHQ-9, which asks nine more in-depth questions (also based on a point system) to see if there is a possible depressive disorder present.
- A score of 1-4 is minimal depression, 5-9 mild depression, 10-14 moderate depression, 15-19 moderately severe depression and 20-27 is severe depression (USPSTF, 2016).

PHQ-9

PTSD

PTSD

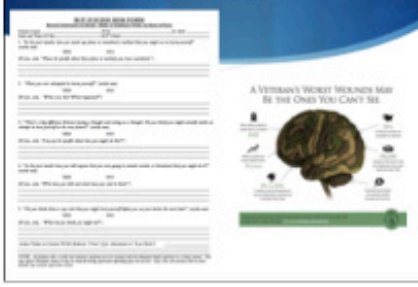
- The Primary Care PTSD screen (PC-PTSD) consists of 4 questions based on a yes or no answer.
- Any three "Yes" answers should be considered positive and would require further assessment.

PTSD

Suicide Risk

- "Traumatic brain injury (TBI) also has been found to be associated with significantly increased risk for suicidal ideation, suicide attempts, and death by suicide, especially when occurring together with psychiatric and/or substance abuse problems (Bryan & Clemans, 2013).
- "Traumatic brain injury is of particular concern among military personnel owing to increased risk of exposure to concussive injuries resulting from explosions or other military training– and combat-related factors" (Bryan & Clemans, 2013).

Suicide Risk



What Do You Do?

- API is vague:
  - "The person who contacts the Airman (trained health technician, nurse, or provider) will be determined by the expertise required by AF Web-PHA responses" (p. 15).
  - "The A&T Team or Health Technicians will oversee the completion of PHAs" (p. 16).
  - "For ANG, qualified health technicians can sign the Web HA with no critical/priority findings and the member has no other PHA requirements" (p. 13).
  - "Positive AF Web HA responses may require additional documentation from their non-military patient care team" (p. 16).
  - "Designated ANG medical personnel will follow-up critical and priority AF Web HA results no later than the next Unit Training Assembly (UTA)" (p. 16).

Survey Results

- Limited to no knowledge about mental health portion of Web-PHA
- No specific training/education available for the Web-PHA
- Vastly different mental health backgrounds
- No written guidelines or documentation
- Concerns about processes with mental health concerns
- When should a member see a provider?
- How many times to contact a patient?

Web-PHA Mental Health Protocol (MHP)

- Written protocol for the trained health technician, nurse or provider to reference for positive mental health concerns.
- Algorithm
- RESPECT-Mil communication techniques
- What to document in the members chart
- Who will sign Web-PHA off
- When does a provider need to see the member

RESPECT-Mil

- Provides systematic evidence based care to Soldier's with symptoms of depression and PTSD in the primary care setting.
- *Care Facilitator Reference Manual* (2008) document provides a planning care facilitator contact and conducting calls chapter that gives a number of useful principles for those engaging in telephone follow-up with military members.
- Gives a script to start the conversation off with when contacting a member about mental health concerns.
- Gives guidance on questions to ask and what to document.

Communication Techniques

- Review of Web-PHA MHP
- WebPHA MHP.doc

Documentation

- SF 600
  - Document each attempt at contact; with date, time and name
  - Use Web-PHA MHP for questions to ask about depression, anxiety or PTSD
  - Document any medications
  - Document if member is seeking mental health services
  - Any SI/HI
  - Use Suicide Risk Form if needed
  - Document services offered
  - Document if provider appointment made

Objectives

- Mental Health Significance In the Military
- What Is The AF Web-PHA
- AFI 44-170
- What Mental Health Disorders Are Being Screened
- What Screening Tools Are Used
- What Triggers A Priority Or Critical Flag
- What To Do With A Mental Health Concern
- Web-PHA MHP
- Communication Techniques
- Documentation

Questions?

Thank You!

References

- See Reference Attachment
- Bryan, C. J., & Clemans, T. A. (2013). Repetitive traumatic brain injury, psychological symptoms, and suicide risk in a clinical sample of deployed military personnel. *JAMA psychiatry, 70*(7), 686-691.

APPENDIX K

PRE-TEST TO ASSESS KNOWLEDGE PRIOR TO PRESENTATION

1. What AFI governs the Web-PHA program?

2. Who has the clinical oversight of the PHA program?

3. How many veteran suicides happen daily?

4. Of those military members with mental health concerns, what percentage actually seek treatment or help?

5. What three dimensions of mental health does the Web-PHA focus on?
    1.
    2.
    3.

6. What mental health screening tools are used?
    1.
    2.
    3.

7. Is the military suicide rate increasing or decreasing?

8. What are the two intents of the Web-PHA program?
    1.
    2.

9. Can a member be required to seek civilian mental health care and bring in documentation?

10. Where is communication with a member documented?

APPENDIX L

POST-TEST TO ASSESS KNOWLEDGE FOLLOWING PRESENTATION

1. What AFI governs the Web-PHA program?

2. Who has the clinical oversight of the PHA program?

3. How many veteran suicides happen daily?

4. Of those military members with mental health concerns, what percentage actually seek treatment or help?

5. What three dimensions of mental health does the Web-PHA focus on?
    1.
    2.
    3.

6. What mental health screening tools are used?
    1.
    2.
    3.

7. Is the military suicide rate increasing or decreasing?

8. What are the two intents of the Web-PHA program?
    1.
    2.

9. Can a member be required to seek civilian mental health care and bring in documentation?

10. Where is communication with a member documented

APPENDIX M

WEB-BASD PERIODIC HEALTH ASSESSMENT AND WEB-BASD PERIODIC HEALTH ASSESSMENT MENTAL HEALTH EDUCATION SURVEY

By completing this survey, I consent for my opinions and answers to be used in the authors capstone project. All responses will be kept anonymous and will not be used for any other purpose.

Signature:_____

Web-PHA Program and Web-PHA MHP Education Survey:

1--Strongly Disagree 2--Disagree 3--Indifference 4--Agree 5--Strongly Agree

1. I feel confident in performing the Web-PHA MHP after hearing the presentation

1 2 3 4 5

2. I understand how to use the PHQ-9, GAD-7 and PC-PTSD screening tools.

1 2 3 4 5

3. The RESPECT-Mil communication techniques are helpful and will be useable when contacting members with mental health concerns.

1 2 3 4 5

4. I now have a stronger understanding of how and why the Web-PHA mental health questions are asked.

1 2 3 4 5

5. The presenter was clear and efficient in presenting the information.

1 2 3 4 5

6. The visual aids were effective in presenting the information

1 2 3 4 5

7. Please list and explain any specific ways to improve this educational presentation.

_____

_____

_____

APPENDIX N

WEB-BASED PERIODIC HEALTH ASSESSMENT MENTAL HEALTH PROTOCOL

COLORADO AIR NATIONAL GUARD
140TH WING
BUCKLEY AIR FORCE BASE, AURORA, COLORADO

COANG XX 44-170

XX February 2016

Medical

Web-Based Periodic Health Assessment Mental Health Protocol

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

ACCESSIBILITY: This publication is available electronically on the 140th Wing Local Area Network.

RELEASABILITY: There are no releasability restrictions on this publication once approved.

OPR: Major Amanda Hill Certified by: 140MDG/CC

This instruction implements portions of AFI 44-170, *Preventive Health Assessment*. The purpose of this instruction is to establish a protocol for priority and critical mental health responses in regards to the Web-Based Periodic Health Assessments for all members assigned to the Colorado Air National Guard. This instruction requires collecting and maintaining information protected by the *Privacy Act of 1974*. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance

with AFMAN 33-363, *Management of Records*, and disposed of in accordance with the Air Force Records Disposition Schedule (RDS) located at https://afrims.amc.af.mil/.

1. Purpose: To standardize the response of the trained health technician in regards to priority and critical Web-PHA mental health concerns by using an evidence-based mental health protocol. This protocol uses evidence based screening tools for depression (PHQ-9), anxiety (GAD-7) and Post Traumatic Stress Disorder (PC-PTSD). Information on contacting members and talking through these concerns is based off the RESPECT-Mil Care Facilitator Manuel that can be located at http://www.pdhealth.mil/respect-mil/downloads/FAC_Final.pdf as well as the Anxiety and Depression Association of America.

2. Applicability: Applicable to all medical personnel contacting members with priority and critical Web-PHA mental health responses.

3. Commander: Insures the full-time medical technicians are performing their duties in accordance with current and applicable directives.

4. Trained Health Technician: Will check the AF Web-PHA "Multiple Patient Report" throughout the duty day for all Critical, Priority, and Routine findings from their respective empaneled population. These findings will be managed in the following manner:

4.1. All Critical findings must be addressed within one duty day. All Priority findings must be addressed within three duty days.

4.2. The health technician will review all "high priority" flagged Web-PHA's, contact the member within in the specified timeframe to obtain clinically relevant information via either

telephone or an in-person visit, as well as document the encounter on a SF600 or in the AHLTA record when available. Follow Web-PHA MHP Algorithm (Attachment 1) for follow up.

4.3. A minimum of 3 attempts should be made to contact the member. All attempts at patient contact will be documented. If appropriate, try contacting the member by e-mail or by Unit Health Monitor (UHM). If a critical response and unable to get a hold of member by phone, contact members 1st Sgt or commander.

Web-Based Periodic Health Assessment Mental Health Protocol

Depression Response:

"Hello, this is (your name) and I work with Dr. X. Is this (patient's name)? Did I catch you at good time when you have a few minutes and some privacy? As you may remember, your Web-HA had some concerns for depression and I am calling to follow-up with you. Do you recall this? . . ."

The Patient might say:

"I don't really feel depressed."

"I don't think that I am that depressed."

"I am really just stressed out."

"I just don't sleep very well so I'm tired."

Explore by asking:

“What do you think is going on?”

Intervene by:

• Explore what they believe having depression means and attempt to dispel myths.

• If a patient continues to be adamant that s/he does not have depression, acknowledge their stance and focus more on what the symptoms are that are bothering him/her. For example, suggest that the medication s/he has been prescribed may easily help relieve their difficulty sleeping.

• If after talking further with the patient, you think that s/he is relaxing more, you might mention depression and/or anxiety/PTSD is a combination of the various symptoms that they are experiencing.....difficulty sleeping, feeling helpless (areas checked on their PHQ-9). . .or. . . easily startled, feeling detached from others, avoiding certain situations/people.

• Inform patient his/her response “I don’t really feel depressed” is fairly common and that depression is more than how one is “feeling,” that is, it is the compilation of multiple symptoms.

• Inform patient that depression quite often results from being “just stressed out,” that is, it’s a fairly common condition following intense or prolonged stress with estimates as high as 25 million Americans per year.

Medications:

• Verify what, if any medications (including dose) have been obtained by the patient (a good tip is to have the patient bring the Rx containers to the phone and read the information on the label)

• Confirm level of dosage/time of day it is being taken

• Confirm the date when medication was started

Psychological Counseling:

• Verify name and type of behavioral health specialist (MD, PhD, MSW, clergy, etc.)

• Inquire whether appointment(s) has been scheduled and/or completed

• Verify the recommended frequency of visits

• Identify any barriers to participating in psychological counseling

Obtaining Patient Responses to the Questions Contained in the PHQ-9

- Administer the PHQ-9 (Attachment 2) if necessary and document score.

Total Score Depression Severity

- 1-4 Minimal depression
- 5-9 Mild depression
- 10-14 Moderate depression
- 15-19 Moderately severe depression
- 20-27 Severe depression

* A score of 10 or greater should be forwarded on to the reviewing provider.

* A score of 15 or greater needs provider follow-up or base services ASAP.

• If there is any positive endorsement of the suicide question, then complete a suicide risk module immediately (Attachment 3).

* Follow Web-PHA MHP Algorithm for follow-up

Next UTA Appointment:

• Confirm schedule follow-up appointment

• Communicate importance of attending the visit

• Identify any barriers to attending the visit

Ending the Call

Patients should always be given a final opportunity to verbalize any concerns by asking, **"Before we hang up, is there anything at all that you are concerns that you haven't already mentioned?"**

Also, patients should be reminded that a brief summary of the conversation and their responses to questions in the PHQ-9 (if utilized during the call) will be sent to the provider for review.

6. PTSD

"Hello, this is (your name) and I work with Dr. X. Is this (patient's name)? Did I catch you at good time when you have a few minutes and some privacy? As you may remember, your Web-PHA had some concerns for PTSD and I am calling to follow-up with you. Do you recall this? . . ."

Patient might say:

"I don't think that I have PTSD. I'm just a little stressed out."

"I need to be really alert – that's how you stay alive."

"I just have a lot going on and so I have bad dreams."

"I'm just jumpy because I have a hard time at my job."

Explore by asking:

"What do you think is going on?"

Intervene by:

• Do they know someone who has PTSD or a mental illness and perhaps this is frightening to them?

• Explore whether they are fearful of military discharge if they receive treatment.

• Explore what they believe having "PTSD" means and attempt to dispel some of the myths.

• If a patient continues to be adamant that they do not have PTSD, acknowledge their stance and focus more on what symptoms they have.

• If after talking further with the patient, you feel s/he is relaxing more, you might mention that "PTSD" is a combination of the various symptoms that they may be experiencing – a sense of hyper-arousal, flashbacks, difficulty sleeping, trying to avoid certain memories, etc. (areas they checked off on the PCL).

• Again, you may normalize the conversation a bit by mentioning prevalence rates—e.g., lifetime prevalence rates for Vietnam veterans are about one in three.

Medications:

• Verify what, if any medications (including dose) have been obtained by the patient (a good tip is to have the patient bring the Rx containers to the phone and read the information on the label)

• Confirm level of dosage/time of day it is being taken

• Confirm the date when medication was started

Psychological Counseling:

- Verify name and type of behavioral health specialist (MD, PhD, MSW, clergy, etc.)
- Inquire whether appointment(s) has been scheduled and/or completed
- Verify the recommended frequency of visits
- Identify any barriers to participating in psychological counseling

Obtain Patient Responses to the Questions Contained in the PC-PTSD

- Administer the PC-PTSD (Attachment 4) if appropriate and document score.
- Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.
- A positive response to the screen does not necessarily indicate that a patient has Posttraumatic Stress Disorder. However, a positive response does indicate that a patient may have PTSD or trauma-related problems and further investigation of trauma symptoms by a mental-health professional may be warranted.

  * A positive response should be forwarded on to the reviewing provider.

  * A positive response with other concerns for depression needs provider follow-up or base services ASAP.

  * Follow Web-PHA MHP Algorithm for follow-up

If the PC-PTSD screening instrument is utilized, clarify responses to determine:

- Whether the patient has had a traumatic experience

"I notice from your answers to our questionnaire that you experience some symptoms of stress. At some point in their lives, many people have experienced extremely distressing events such as combat, physical or sexual assault, or a bad accident, and sometimes those events lead to the kinds of symptoms you have. Have you ever had any experiences like that?"

- Whether endorsed screen items are really trauma-related symptoms

"I see that you have said you have nightmares about or have thought about an upsetting experience when you did not want to. Can you give me an example of a nightmare or thinking about an upsetting experience when you didn't want to?"

If a patient gives an example of a symptom that does not appear to be in response to a traumatic event (e.g., a response to a divorce rather than to a traumatic event), it may be that he or she is ruminating about a negative life event rather experiencing intrusive thoughts about a traumatic stressor.

- Whether endorsed screen items are disruptive to the patient's life

"How have these thoughts, memories, or feelings affected your life? Have they interfered with your relationships? Your work? How about with recreation or your enjoyment of activities?"

Positive responses to these questions in addition to endorsement of trauma symptom items on the PCPTSD Screen indicate an increased likelihood that the patient has PTSD and needs further evaluation.

- Discern whether traumatic events are ongoing in a patient's life

"Are any of these dangerous or life-threatening experiences still continuing in your life now?"

If ongoing family violence is suspected, it is imperative that the patient be told the limits of confidentiality for medical professionals, who are mandated to report suspected ongoing abuse of children and dependent adults. Discussion of possible abuse should take place in the absence of the suspected perpetrator; if the abuser is present, victims may deny abuse for fear of retaliation.

If ongoing threats to safety are present:

• Acknowledge the difficulty in seeking help when the trauma has not stopped.

• Determine if reporting is legally mandated. If it is, develop a plan with the patient to file the report in a way that increases rather than decreases the safety of the patient and his or her loved ones.

Next UTA Appointment:

• Confirm schedule follow-up appointment

• Communicate importance of attending the visit

• Identify any barriers to attending the visit

Ending the Call

Patients should always be given a final opportunity to verbalize any concerns by asking, **"Before we hang up, is there anything at all that you are concerns that you haven't already mentioned?"**

Also, patients should be reminded that a brief summary of the conversation and their responses to questions in the PC-PTSD (if utilized during the call) will be sent to the provider for review.

7. Anxiety or Panic Disorder

"Hello, this is (your name) and I work with Dr. X. Is this (patient's name)? Did I catch you at good time when you have a few minutes and some privacy? As you may remember, your Web-HA had some concerns for Anxiety or Panic Disorder and I am calling to follow-up with you. Do you recall this? . . ."

The Patient might say:

"I was just having a bad day."

"I don't think that I have anxiety, I was just answering truthfully that day."

"I am really just stressed out."

"I haven't been sleeping well."

Explore by asking:

"How have things been going for you recently?"

"Any problems with excessive stress, worry, or anxiety?"

Explore positive responses:

What kinds of things do you worry about?

- Do you worry excessively about everyday things like your family, your health, work or finances? Do friends or loved ones tell you that you worry too much?
- Do you have difficulty controlling your worry, such that the worry keeps you from sleeping or makes you feel physically ill with headaches, stomach troubles, or fatigue?

- Do you have times when you experience a sudden rush of symptoms or uncomfortable physical feelings such as a racing heart or dizziness?
- Do you have feelings of fear or panic at these times?
- Have these spells ever occurred out of the blue, without any obvious trigger or cause?
- Do you avoid situations because you might experience these spells of symptoms or feelings of fear or anxiety?

Obtain Patient Responses to the Questions Contained in the GAD-7

- Administer the GAD-7 (Attachment 5) if appropriate and document score.
- Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.
- A score of 10 or greater should be forwarded on to the reviewing provider.
- A score of 15 or greater needs provider follow-up or base services ASAP.
- Follow Web-PHA MHP Algorithm for follow-up

If any anxiety problem is identified, explore whether the problem causes interference or a high level of distress.

Does this problem with (the symptoms described by the patient) bother you a lot?

Does it interfere with your work, activities, or relationships?

Intervene by:

- Explore whether they are fearful of military discharge if they receive treatment.

- Explore what they believe having "anxiety" means and attempt to dispel some of the myths.
- If a patient continues to be adamant that they do not have anxiety or a panic disorder, acknowledge their stance and focus more on what symptoms they have.
- If after talking further with the patient, you feel s/he is relaxing more, you might mention anxiety is a normal part of living. It's a biological reaction—the body's way of telling us something isn't right. It keeps us from harm's way and prepares us to act quickly in the face of danger. But if your anxiety becomes overwhelming and persistent, or if it interferes with your regular daily activities, or even makes them impossible, you may have an anxiety disorder.

Medications:

- Verify what, if any medications (including dose) have been obtained by the patient (a good tip is to have the patient bring the Rx containers to the phone and read the information on the label)
- Confirm level of dosage/time of day it is being taken
- Confirm the date when medication was started

Psychological Counseling:

- Verify name and type of behavioral health specialist (MD, PhD, MSW, clergy, etc.)
- Inquire whether appointment(s) has been scheduled and/or completed
- Verify the recommended frequency of visits
- Identify any barriers to participating in psychological counseling

Next UTA Appointment:

- Confirm schedule follow-up appointment
- Communicate importance of attending the visit
- Identify any barriers to attending the visit

Ending the Call

Patients should always be given a final opportunity to verbalize any concerns by asking, **"Before we hang up, is there anything at all that you are concerns that you haven't already mentioned?"**

Also, patients should be reminded that a brief summary of the conversation and their responses to questions in the GAD-7 (if utilized during the call) will be sent to the provider for review.

8. Suicidality

Suicidal thoughts are one of the symptoms of depression and may also be present in those with PTSD. Approximately 10 percent of people with untreated major depression eventually commit suicide. Suicidality may not be an emergent (crisis) or urgent symptom, but it is always serious.

There is no good way to predict in the short term who will commit suicide, although long-term risk is correlated with the following risk factors:

- Hopelessness
- Prior suicide attempts
- Living alone

- Comorbid anxiety
- Substance abuse
- Male gender
- Caucasian race
- General medical illnesses
- Family history of substance abuse

Levels of Suicide Risk

Emergent Risk Level:

If the patient has an active desire to commit suicide and has no self-control or external supports for safety (e.g., family and friends) then a safe means for transport to the nearest emergency room setting should be found.

Urgent Risk Level:

If a patient has suicidal plans but is without an active desire to commit suicide. This is an urgent situation and could become an emergent one. The patient should receive a behavioral health assessment within 48 hours from a behavioral health specialist. Take steps to ensure that an assessment will occur. Do NOT leave it up to the patient to arrange this!

Low Risk Level:

If the patient has no suicidal plans and no active desire to commit suicide, he/she would be considered a low risk. Further assessment is not necessary at the time. The health technician should forward on to the provider and document low risk of SI/HI.

Components of an Evaluation for Suicidal Risk

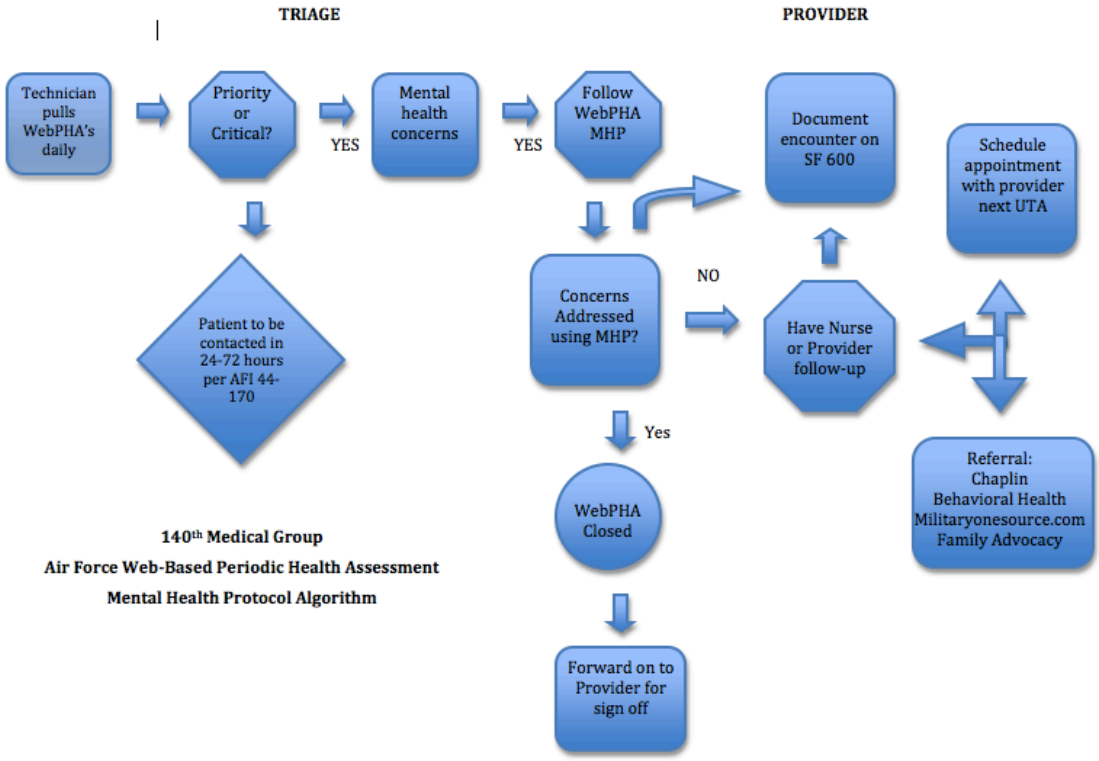
• Presence of suicidal ideation including intent and/or plan

• Access to means for suicide and the lethality of those means

• History and seriousness of previous attempts

• Lack of social support

Attachment 1



140th Medical Group

Air Force Web-Based Periodic Health Assessment

Mental Health Protocol Algorithm

Attachment 2

Evaluation, and Treatment of High Blood Pressure Report (http://www.nhlbi.nih.gov/guidelines/hypertension/index.htm).

2.2.6. Technicians will ensure there has been an officially measured weight and officially measured height within the last 12 months (ANG, within 5 years and AFR, every 3 years). Official measurements are limited to clinic- and fitness assessment cell-obtained measurements. Self-reported heights and weights will not be used. As required, technicians will measure and record the Airman's height and/or weight. (T-1).

2.2.7. Body Mass Index (BMI) is automatically calculated in ASIMS and results will be manually transcribed into AHLTA. BMIs will be managed according to PHA business rules. (T-2).

2.2.8. For all ANG members, visual acuity is required every year for flyers and every five years for non-flyers. (T-2).

2.2.9. Technicians will, regarding identified health risks, recommend clinical services, IMR requirements, DLC actions, Review in Lieu of (RILO) actions, Fit for Duty (FFD) determinations, and/or appropriate clinical follow-ups IAW ASIMS/AF Web HA guidance, the *PHA Guide*, and other relevant instructions. (T-2). Note: Records requiring further evaluation for mobility or duty restricting limitations (e.g., duty-limiting conditions >365 days that do not affect mobility) will be referred to the MSME. Duties in this regard will be limited to distributing AFMOA- or ECOMS-approved, PHA-related, patient education handouts. The "Full Patient Report" generated at the end of the AF Web HA will provide Airmen with health education for specific identified risks.

2.2.10. When annual OEH MSE requirements are conducted in conjunction with the PHA (as locally determined), technicians will review ASIMS as part of the PHA health records review. (T-2). If OEH MSEs are to be performed in conjunction with PHAs and OEH MSE requirements preclude PHA intervals greater than 12 months then PHAs may be performed earlier than prescribed to accommodate these requirements.

2.2.11. The PHA portion of the FOME for aviators, Airmen on aeronautical orders, and special operational duty personnel must include an in-person interview with a credentialed military flight surgeon with privileges in the FOMC. (T-1). If the PHA is performed by a non-AF flight surgeon (e.g., Navy, Army, or Coast Guard flight surgeons), it requires review and certification by a base-, GMU-, or RMU-level SGP or, if unavailable, parent MAJCOM/SGP.

2.2.12. The patient care team will use ASIMS and the AF Web HA "AHLTA Copy and Paste report" (or paper copy if AHLTA unavailable) to assess cardiovascular risk in Airmen and counsel them, as needed, to minimize this risk. (T-1). This assessment will be documented by the patient care team in the medical record (paper copy or AHLTA). The Cardiovascular Risk Assessment and Management (CRAM) site (https://kx2.afms.mil/kj/kx8/CRAM/Pages/home.aspx) can assist providers in appropriately assessing and calculating cardiac risk. **Note:** Not applicable for the ANG.

2.2.13. The patient care teams (or their surrogates) must re-validate and renew or revise, as appropriate, the AF Form 469 at each PHA at a minimum IAW AFI10-203. (T-1). The medical record and interval history must be reviewed for conditions that may require an AF Form 469. This review will be documented in the medical record.

Attachment 3

RCF SUICIDE RISK FORM

Record Statements in Detail – Refer to Guidance Notes on Back of Form

Patient Name: _____ PCM: _____ Pt. ID#: _____
Date and Time of Call_____ RCF Name:_____

1. *"In the past month, have you made any plans or considered a method that you might use to harm yourself"* (circle one)

YES NO

(If yes, ask, "*Please be specific about these plans or methods you have considered.*")

_____
_____
_____

2. "*Have you ever attempted to harm yourself?*" (circle one)

YES NO

(If yes, ask, "*When was this? What happened?*")

_____
_____
_____

3. "*There's a big difference between having a thought and acting on a thought. Do you think you might actually make an attempt to hurt yourself in the near future?*" (circle one)

YES NO

(If yes, ask, "*Can you be specific about how you might do this?*")

_____
_____
_____

4. "*In the past month have you told anyone that you were going to commit suicide, or threatened that you might do it?*" (circle one)

YES NO

(If yes, ask, "*Who have you told and what have you said to them?*")

_____
_____
_____

5. "*Do you think there is any risk that you might hurt yourself before you see your doctor the next time?*" (circle one)

YES NO

(If yes, ask, "*What do you think you might do?*")

_____
_____
_____

Action Taken to Contact PCM (Indicate "None" if pt. determined at "Low Risk") _____
_____
_____

NOTE: All patients with a suicide risk interview conducted are to be reviewed with the behavioral health supervisor in a timely manner. This may require immediate contact or may be conducted during supervision depending upon level of risk. Only a low risk outcome with no active ideation may wait for supervision session.

Attachment 4

Primary Care PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, **in the past month**, you*

1. Have had nightmares about it or thought about it when you did not want to?

YES NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

YES NO

3. Were constantly on guard, watchful, or easily startled?

YES NO

4. Felt numb or detached from others, activities, or your surroundings?

YES NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.

A positive response to the screen does not necessarily indicate that a patient has Posttraumatic Stress Disorder. However, a positive response does indicate that a patient *may* have PTSD or trauma-related problems and further investigation of trauma symptoms by a mental-health professional may be warranted.

If the PC-PTSD screening instrument is utilized, clarify responses to determine:

a. Whether the patient has had a traumatic experience

"I notice from your answers to our questionnaire that you experience some symptoms of stress. At some point in their lives, many people have experienced extremely distressing events such as combat, physical or sexual assault, or a bad accident, and sometimes those events lead to the kinds of symptoms you have. Have you ever had any experiences like that?"

Attachment 5

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

APPENDIX O

TECHNICIAN INTERVIEW QUESTIONS

Technician Interview Questions Regarding Web-PHA MHP:

1. Do you have a better understanding of the Web-PHA program after reading the protocol?

2. Do you understand how to use the mental health screening tools included in the protocol?

3. Are the screening tools helpful?

4. Do you think the Web-PHA MHP will be helpful when talking to members about depression, PTSD and anxiety?

5. Do you have any concerns about the protocol?

6. Is there anything you would add to the protocol?

7. Is there anything you would take out from the protocol?

8. Is this protocol something you would consider using permanently?

9. Questions?

APPENDIX P

AIR FORCE WEB-BASD PERIODIC HEALTH ASSESSMENT AND WEB-BASD PERIODIC HEALTH ASSESSMENT MENTAL HEALTH COMPETENCY CHECKLIST

AF Web-PHA MHP COMPETENCY CHECKLIST

Name:_____

Title:_____Unit: _____

Skills Validation Method of Evaluation: DO-Direct Observation VR-Verbal Response WE-Written Exam OT-Other			
Web-PHA Standardization Process	**Method of Evaluation**	**Initials**	**Comments**
Mental Health:			
PowerPoint Presentation			
Mental Health Protocol			
PHQ-9			
GAD-7			
PC-PTSD			
Suicide Risk Form			
AFI 44-170			

Name of Person Validating the Skills:_____

Signature of Skills Validator:_____Date:_____

I received a copy of the Web-PHA MHP.
I understand the Web-PHA MHP and my role in the process.
I agree with this competency assessment.
I will contact my supervisor, or program manager if I require additional training in the future.

Trainee Signature:_____ Date:_____