



ANNEX C

EVACUATION ASSESSMENT

OPERATION IRAQI FREEDOM (OIF-II)

MENTAL HEALTH ADVISORY TEAM (MHAT-II)

30 January 2005

Chartered by
The U.S. Army Surgeon General

This is an annex to the Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II) Report addressing the behavioral health evacuation system in OIF-II (including Kuwait and Iraq). The findings were obtained from many sources to include interviews, record reviews, and Department of Defense- (DoD-) supported databases.

The views expressed in this report are those of the authors and do not necessarily represent the official policy or position of the Department of Defense (DoD), the U.S. Army, or the Office of The Surgeon General (OTSG).

ANNEX C

TABLE OF CONTENTS

(See note on the last page (C-5) of the Table of Contents.)

<u>INTRODUCTION</u>	C-6
<u>FINDINGS</u>	C-6
Table 1: Comparison of Army Evacuations/100,000 Soldiers.....	C-6
Table 2: Behavioral Health Evacuation Rates in Previous Military Operations*	C-7
<u>RECOMMENDATIONS</u>	C-7
Immediate Implementation.....	C-7
Future Implementation	C-7
<u>METHODS</u>	C-8
I. Evacuation Rates	C-8
Source of Data.....	C-8
Inclusion Criteria for OIF-II Army Evacuations.....	C-8
Inclusion Criteria for Behavioral Health Evacuations.....	C-8
Evacuation Rate per 100,000 Soldiers.....	C-8
II. Evacuee Chart Review.....	C-9
Source of Data.....	C-9
Method of Analysis	C-9
III. Behavioral Health Interviews	C-9
Instrument Development.....	C-9
Interview Method.....	C-9
Analysis of Surveys and Interviews	C-9
<u>RESULTS</u>	C-10
I. Evacuation Rates	C-10
Total Army OIF-II Evacuations	C-10
Table 3: Total Army OIF-II Evacuations	C-10
Table 4: Army Evacuations per 100,000 Soldiers by Month (March-September).....	C-10
Chart 1: Army Evacuations per 100,000 Soldiers	C-11
Behavioral Health Evacuations.....	C-11
Table 5: Army OIF-II Behavioral Health Evacuations.....	C-11

ANNEX C

TABLE OF CONTENTS
(Continued)

Table 6: Army Evacuations per 100,000 Soldiers by Month (March-September)	C-12
Chart 2: Army Behavioral Health Evacuations per 100,000 Soldiers.....	C-12
Table 7: Behavioral Health Evacuees Given a Non-Psychiatry Designator.....	C-13
Table 8: Evacuations by Medical Surgical Specialty (1 March-26 September 2004)	C-14
Chart 3: All Army OIF-II Evacuations per 100,000 Soldiers by Month Compared with Behavioral Health Evacuations per 100,000 Soldiers.....	C-15
II. Evacuee Chart Review	C-15
LRMC Chart Review.....	C-15
Table 9: Demographics.....	C-16
Table 10: Behavioral Health Disorders in OIF-II.....	C-17
Table 11: Behavioral Health Disorders at Discharge from LRMC ...	C-17
Table 12: Percent Change in Diagnoses from OIF-I to OIF-II.....	C-17
Table 13: OIF-II Diagnoses Remaining Unchanged at LRMC.....	C-18
Table 14: Expanded List of Behavioral Health Disorders	C-19
Table 15: Medication Prescribed in OIF-II and LRMC.....	C-20
Table 16: Return-to-Duty Rates.....	C-21
Table 17: Documentation in LRMC Charts	C-21
III. Evacuation Policy.....	C-22
IV. LRMC Behavioral Health Interviews and Evacuation Procedures	C-22
<u>Arrival</u>	C-22
<u>Triage</u>	C-22
<u>Duration of Stay</u>	C-22
<u>Outpatient</u>	C-22
<u>Standards of Care</u>	C-23
<u>Treatment Initiatives</u>	C-23
<u>Evacuee Accountability</u>	C-23
<u>Documentation from OIF-II</u>	C-23
<u>Command Notification of Evacuation Progress</u>	C-24
<u>Suicides and Uniform Code of Military Justice (UCMJ) Issues</u>	C-24
<u>Alcohol Use by Evacuees</u>	C-24
<u>LRMC Recommendations for Improved Evacuations</u>	C-24
V. LRMC Evacuee Interviews.....	C-25

ANNEX C

TABLE OF CONTENTS
(Continued)

<u>APPENDIX 1: DESCRIPTION OF DEPARTMENT OF DEFENSE-SUPPORTED</u>	
<u>DATABASES</u>	C-27
Transportation Command Regulating Command and Control Evacuation System (TRAC2ES).....	C-27
Patient Accounting and Reporting Real-Time Tracking System (PARRTS).....	C-27
Medical Occupational Data System (MODS).....	C-27
<u>APPENDIX 2: THE MHAT-II LANDSTUHL REGIONAL MEDICAL</u>	
<u>CENTER VISIT</u>	C-28
Purpose.....	C-28
Personnel.....	C-28
Command and Control.....	C-28
Method.....	C-29
Step 1: Preparation for MHAT-II Visit	C-29
In-Brief	C-29
Behavioral Health Provider Interviews	C-29
Behavioral Health Evacuee Interviews	C-29
Behavioral Health Evacuee Record Review.....	C-29
Miscellaneous Evacuation Records	C-30
Out-Brief	C-30
Step 2: In-Brief	C-30
Step 3: Sub-Team Tasks	C-30
Sub-Team 1	C-30
Behavioral Health Provider Interviews.....	C-30
Behavioral Health Evacuee Interviews.....	C-31
Miscellaneous Evacuation Records.....	C-31
Sub-Team 2	C-32
Behavioral Health Evacuee Record Review	C-32
Step 4: Out-Brief	C-32
<i>TAB A: The LRMC Behavioral Health Provider Interview</i>	C-33
<i>LRMC Behavioral Health Provider Interview Questions</i>	C-33
<i>I. EVACUEE ARRIVAL</i>	C-33
<i>II. PATIENT CARE</i>	C-35
<i>III. EVACUEE DEPARTURE</i>	C-37
<i>IV. TRAC2ES</i>	C-38
<i>V. ESCORTS</i>	C-39

ANNEX C

TABLE OF CONTENTS
(Continued)

TAB B: The LRMC Behavioral Health Evacuee Interview.....C-40

LRMC Army OIF-II Behavioral Health Evacuee Interview

Questions..... C-40

Customer Satisfaction..... C-40

TAB C: The MHAT-II In-Brief PowerPoint Presentation C-41

NOTE: For the purpose of brevity, the following acronyms may be used (instead of spelling out the words) in this Table of Contents.

- *LRMC: Landstuhl Regional Medical Center*
- *MHAT: Mental Health Advisory Team*
- *OIF: Operation Iraqi Freedom*
- *TRAC2ES: Transportation Command Regulating Command and Control Evacuation System (TRAC2ES)*

INTRODUCTION

The Mental Health Advisory Team (MHAT-II) charter called for an examination of Army behavioral health (BH) evacuations from Operation Iraqi Freedom (OIF-II). This report focuses on the relative evacuation rates for medical-surgical specialties, evacuee demographics and diagnoses, and clinical/administrative procedures. These findings are compared with those identified in the MHAT-I report.

In keeping with the MHAT-II charter, this report focuses on BH relevant aspects of the medical evacuation process. It does not explore other clinical, logistical, or administrative issues (e.g., delays in evacuation; standing operating procedures (SOPs) by tactical and strategic medical evacuation flight teams; and clinical services in flight).

FINDINGS

1. For the same 7-month period (1 March—30 September), 25% fewer Soldiers were evacuated for BH problems in 2004 than those evacuated in 2003. Similarly, evacuations for all medical-surgical problems fell 12.1% in the same time frame.

Evacuation Source	# of Evacuations	Evacuations/ 100K Soldiers	% Difference from Year Before
OIF-I Evacuations (2003)	7415	4877	-
OIF-II Evacuations (2004)	4152	4288	-12.1%
OIF-I Behavioral Health Evacuations (2003)	527	347	-
OIF-II Behavioral Health Evacuations (2004)	251	260	-25%

Behavioral health accounted for only 6.0% of all OIF-II Army medical-surgical evacuations, falling from 7.1% from OIF-I. When compared with other medical-surgical specialties, BH was the fourth leading evacuator from OIF-II, falling from third in the year before.

Put into a historical perspective, the percentage of OIF-II behavioral health to all evacuations fell within the parameters of past military operations (see Table 2).

Military Operation	Behavioral Health Evacuations/ All Evacuations	%
Desert Storm/Desert Shield	215/6316	3.4%
Somalia	22/538	4.1%
OIF-II (Mar-Sep 04)	251/4152	6.0%
OIF-I (Mar-Sep 03)	527/7415	7.1%
Afghanistan (2003)	10/119	8.4%
Kosovo/Bosnia**	60/253	23.7%

** Provided by the AMEDD Center & School, Directorate of Combat and Doctrine Development.*
*** The number of physical battle injuries requiring evacuation markedly impacts the percentage of behavioral health evacuations/all evacuations. A peacekeeping mission is likely to have few battle injuries; thereby, behavioral health's representation is increased.*

2. Evacuation procedures and policies have matured as evidenced by written SOPs, increased accountability, efficient information tracking, and improved transmission of clinical information between levels of care.

Landstuhl Regional Medical Center (LRMC) has made marked improvements in the evacuation procedures since MHAT-I's visit. The Deployed Warrior Medical Management Center (DWMMC) has completed its critical SOPs. Transmission of clinical information from OIF-II to LRMC substantially improved from OIF-I (83.5% v. 44.8%). Landstuhl Regional Medical Center BH records were assembled in accordance with hospital SOPs. Landstuhl Regional Medical Center clinical documentation was forwarded to the next level of care in 92.7% of cases. Interviews with evacuees indicated that they were very satisfied with their care during the evacuation process. The Office of The Surgeon General (OTSG) Evacuation database sufficiently tracked patients evacuated from theater. Landstuhl Regional Medical Center's BH providers report that Transportation Command Regulating Command and Control Evacuation System (TRAC2ES)/Patient Movement Record's (PMR's) clinical utility continues to improve.

RECOMMENDATIONS

Immediate Implementation

- 1. Develop performance improvement data entry procedures to improve the clinical utility of TRAC2ES/PMR.**

Future Implementation

- 1. Study the feasibility of developing a tactical and strategic evacuation tracking system for efficient clinical and administrative information flow.**

Medical Command (MEDCOM) should establish a joint process action team (PAT) to study the feasibility of an evacuation database system capable of clinical, tracking, and analytical functions. It must be readily available, secure, and tailored to the needs of line commanders, medical personnel, medical regulating planners, and medical planners.

METHODS

I. Evacuation Rates

Source of Data: As in the MHAT-I analysis, MHAT-II relied on the OTSG Evacuation database,¹ which combined information from other Department of Defense (DoD) databases: TRAC2ES, PARRTS, and Medical Occupational Data System (MODS) (see Appendix 1 for further details on each database).

Inclusion Criteria for OIF-II Army Evacuations: To prepare the OTSG Evacuation database for analysis, MHAT-II subjected all entries to specific inclusion criteria. To be included in the OIF-II Army Evacuation database, entries had to satisfy the following inclusion criteria: 1) must have Army as the branch designator; 2) must have Iraq as the operational event designator; and 3) must have a date between 1 March and 26 September 2004 as the date designator. The MHAT-II eliminated any updated entries that did not satisfy the inclusion criteria. Remaining blank entries were assumed to fulfill the inclusion criteria. The final database contained all OIF-II Army Evacuations from 1 March to 26 September 2004.

Inclusion Criteria for Behavioral Health Evacuations: To prepare the OIF-II Army Evacuee database for BH evacuation analysis, MHAT-II subjected all entries to inclusion criteria. To be included in the OIF-II Army Behavioral Health Evacuee database, all entries must have satisfied either of the following inclusion criteria: 1) must have psychiatry as the medical-surgical specialty designator; or 2) must have a history highlighting BH reasons for evacuation (e.g., intentionally self-inflicted wounds, overdose, or psychiatric diagnosis). The MHAT-II members reviewed the histories of those entries without a psychiatry medical-surgical designator for inclusion in the database. The MHAT-II reviewed all entries with a psychiatry designator, and included only those with a history consistent with a BH condition. The final database contained all Army OIF-II Behavioral Health Evacuees between 1 March and 26 September 2004.

Evacuation Rate per 100,000 Soldiers: To determine the evacuation rate per 100,000 Soldiers, the number of evacuations was divided by the average force population in OIF-II from 1 March to 30 September 2004, and then multiplied by 100,000.

¹ MHAT-II considered using Deployed Warrior Medical Management Center's Patient Information Application (PIA). However, it followed only LRMC OIF-II evacuees, unlike the OTSG database, which tracked all evacuees regardless of their destination. MHAT-II also considered using TRAC2ES database itself, but opted for the OTSG Evacuation database given that it contained TRAC2ES data as well as information from other medical databases (e.g. PARRTS and MODS).

To determine the evacuation rate per 100,000 Soldiers by month, evacuations with known dates were sorted by month, divided by the force population during that respective month, and then multiplied by 100,000.

Because evacuees were not systematically given a Reserve Component (RC) or Active Component (AC) in the database, it was not possible to compare the rates of these two groups.

II. Evacuee Chart Review

Source of Data: The MHAT –II developed a plan for evacuee chart review at LRMC (see Appendix 1 for details). The LRMC team consisted of three researchers from WRAIR (Europe) and the former psychology consultant to The Surgeon General (TSG). This team conducted the protocol over a 1-week period, and submitted data to MHAT-II for use in this report.

The MHAT-II used the OTSG evacuee database to identify Army BH evacuees who were transferred from OIF-II to LRMC from 1 March to 30 September 2004. For each identified evacuee, MHAT requested his/her patient records for review. The LRMC team reviewed the charts for information identified in the research protocol and entered this information into a Microsoft Access file or Word document.

Method of Analysis: Analysis of the LRMC Chart Review database used tools in Microsoft Access and Excel. Sorting results were compared to the total number of database entries for the purpose of generating a ratio or percent value.

III. Behavioral Health Interviews

Instrument Development: The MHAT-II developed interview instruments for BH providers and BH evacuees at LRMC. Questions focused on evacuation procedures, clinical services, and command and control. The interview questions for BH providers are available for review in Appendix 2; questions for evacuees are in Appendix 3.

Unstructured interviews were conducted with Multi-National Corps-Iraq (MNC-I) and Combined Forces Land Combat Command (CFLCC) surgeons and their staffs to elicit information regarding evacuation policies and procedures.

Interview Method: Structured interviews were conducted in small groups, comprised of three to five BH personnel. The former psychology consultant to TSG conducted the interviews. Interviews required approximately 1 to 1½ hours to complete. Limits of confidentiality were reviewed with interview participants. Interview notes were taken during the session, and later these notes were entered into a database for analysis.

Analysis of Surveys and Interviews: Tool in Microsoft Access was used to analyze the surveys and interview database. Results were compared to the raw number of database entries for the purpose of generating a ratio or percent value.

RESULTS

I. Evacuation Rates

Total Army OIF-II Evacuations: The Army OIF-II Evacuee database contained entries for 4,152 Soldiers evacuated from OIF-II from 1 March to 26 September 2004 (210 days; approximately 7 months). On the average, 19.8 evacuees were evacuated per day, and 593 evacuees were evacuated per month.

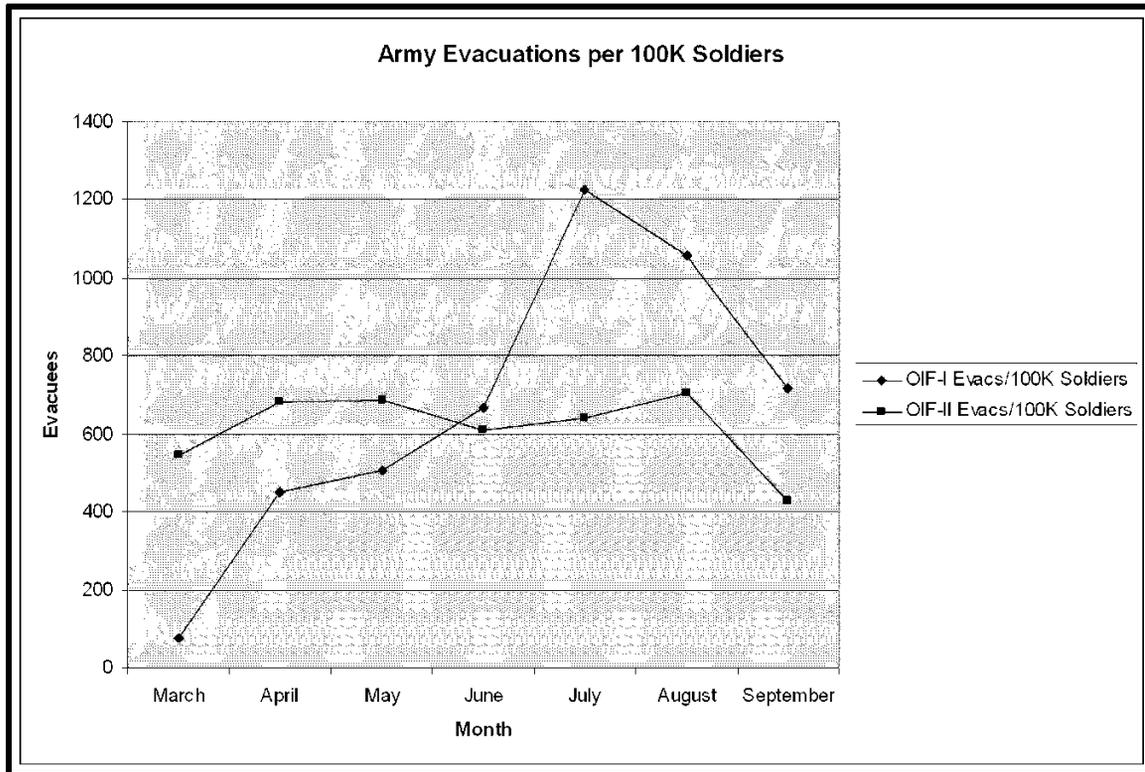
In comparison with OIF-I, evacuation rates were 12.1% lower in OIF-II. Table 3 compares total number of evacuations, average monthly and daily evacuations, and evacuations per 100,000 Soldiers.

	Total Evacuations	Average Evacuations per Month	Average Evacuations per Day	Evacuations per 100,000 Soldiers
OIF-I (1 Mar – 30 Sep 03)	7415	1059	34.6	4877
OIF-II (1 Mar – 26 Sep 04)	4152	593.1	19.8	4288

Table 4 compares Army evacuations per 100,000 Soldier by month (March through September) for OIF-I and OIF-II. Chart 1 shows this same information graphically.

	Mar	Apr	May	Jun	Jul	Aug	Sep
OIF-I	76	452	506	668	1225	1057	717
OIF-II	546	684	687	612	639	705	425

Chart 1: Army Evacuations per 100,000 Soldiers



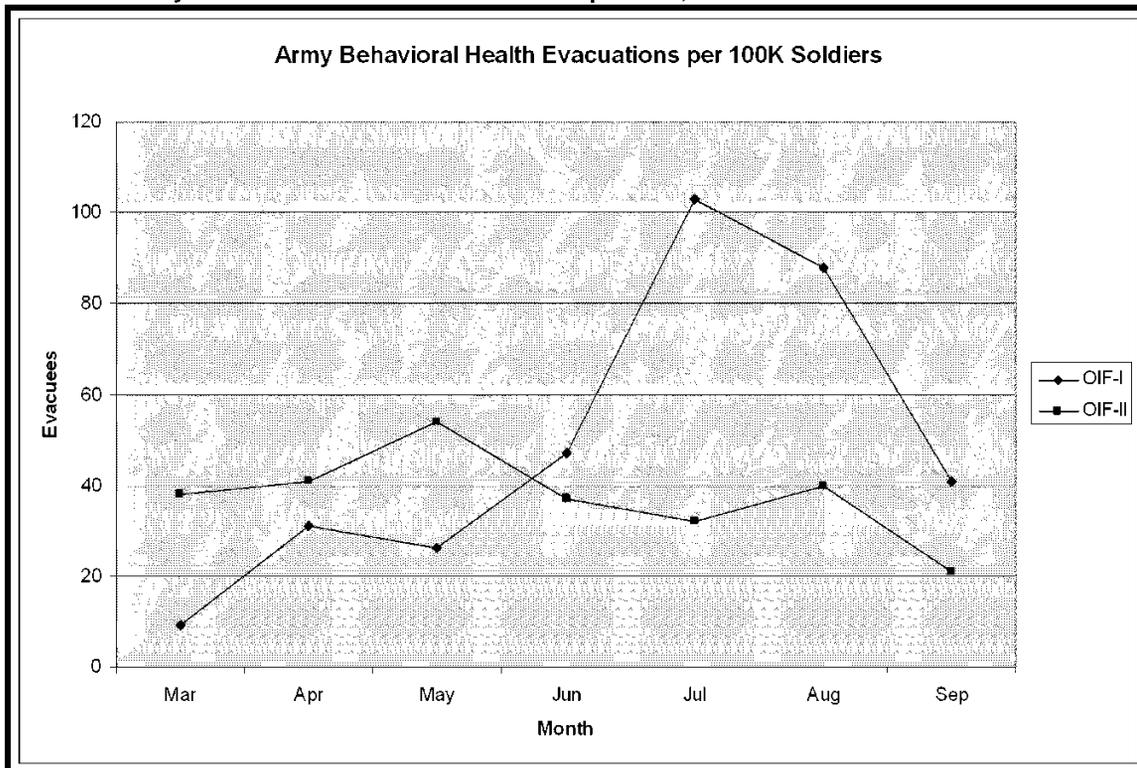
Behavioral Health Evacuations: There were 251 Army OIF-II behavioral health evacuations from 1 March to 26 September 2004 (210 days; approximately 7 months). On the average, 19.8 evacuees were evacuated per day, and 593 evacuees were evacuated per month. The rate of BH evacuations per 100,000 Soldiers was 260.2. Table 5 compares BH evacuations in OIF-I with OIF-II.

	Behavioral Health Evacuations	Average Evacuations per Month	Average Evacuations per Day	Evacuations per 100,000 Soldiers
OIF-I (1 Mar – 30 Sep 03)	527	75	2.5	346.6
OIF-II (1 Mar – 26 Sep 04)	251	36	1.2	260.2

Table 6 compares BH evacuations per 100,000 Soldiers by month (March through September) for OIF-I and OIF-II. Chart 2 shows this same information graphically.

	Mar	Apr	May	Jun	Jul	Aug	Sep
OIF-I	9	31	26	47	103	88	41
OIF-II	36	42	54	38	26	35	21

Chart 2: Army Behavioral Health Evacuations per 100,000 Soldiers



Of all Army OIF-II behavioral health evacuations, 232 Soldiers were designated as *psychiatry* evacuations (i.e., entries with the psychiatry medical-surgical specialty designator). Of the 232 psychiatry evacuations, 3 were eliminated because their histories were not consistent with a BH issue. Review of the history fields from the 3,920 medical-surgical specialty-designated evacuations revealed that 22 entries were related to BH issues (see Table 7); these entries were included in the final dataset, bringing the total number of entries to 251.

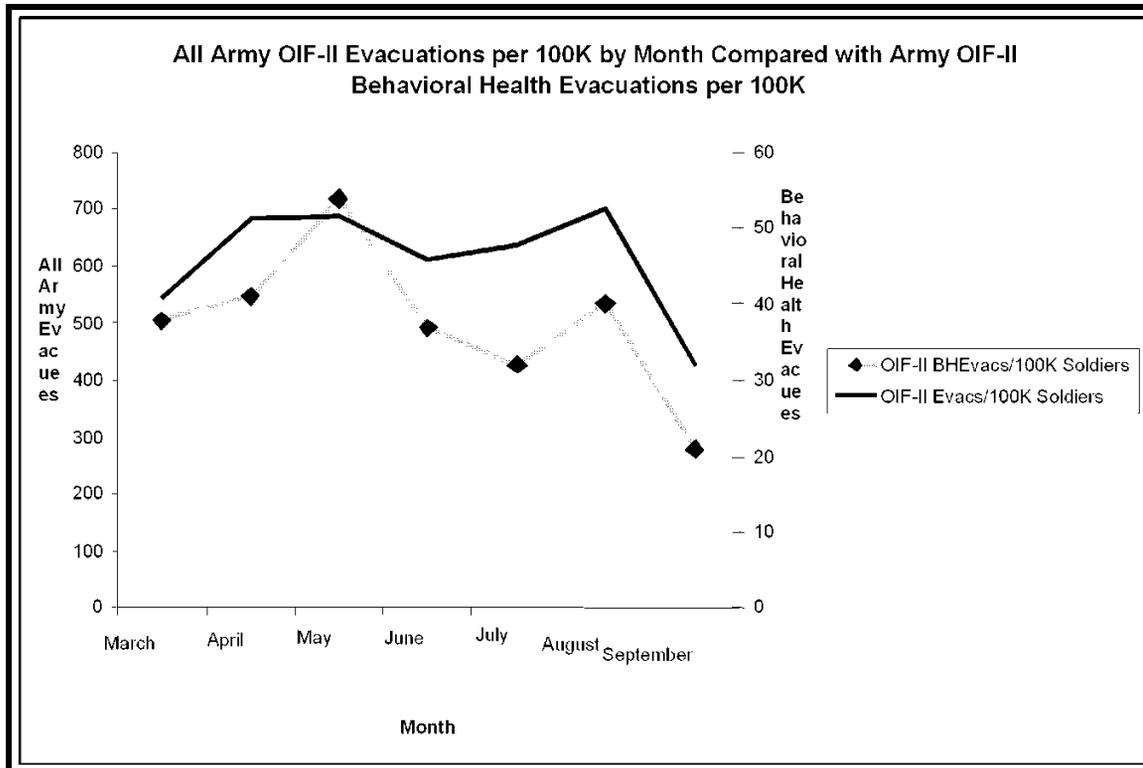
Medical-Surgical Specialty	Behavioral Health Issue	Number of Evacuations
Gastrointestinal	Adjustment Disorder	1
	Depression	1
General Surgery	Depression	1
	Self-inflicted Gun Shot Wound	5
Neurology	Various psychiatric disorders	6
Neurosurgery	Overdose	1
	Psychological factors	1
Orthopedic	Psychosis	1
	PTSD/Alcohol Dependence	1
Podiatry	Self-Inflicted Gunshot Wound	1
Pulmonary	Overdose	1
	Adjustment Disorder	1
	Panic Attack	1
Total		22

Comparisons of evacuations by medical-surgical specialty are shown in Table 8. In comparison with 1 March-30 September 2003, BH moved from the third leading evacuating medical-surgical specialty to fourth in 1 March-26 September 2004. Neurosurgery rose from the fifth to third leading evacuating specialty; however, its evacuations only exceed BH by one. Of note, general surgery experienced the greatest increase in evacuations (60%) when compared to other specialties.

Medical-Surgical Specialty	# Evacuations	% of All OIF-II Evacuations	OIF-II Evacuations per 100,000 Soldiers	% Change from OIF-I Evacuations per 100,000 Soldiers
General Surgery	1066	25.7%	1101	60%
Orthopedic	969	23.3%	1001	-24%
Neurosurgery	253	6.1%	261	15%
Psychiatry (Behavioral Health)	232 (251)	5.6% (6.0%)	240 (260)	-29% (-25%)
Cardiac	224	5.4%	231	18%
Internal Medicine	221	5.3%	228	29%
Urology	186	4.5%	192	6%
Neurology	175	4.2%	181	-44%
Ear Nose Throat	120	2.9%	124	-12%
Gastrointestinal	97	2.3%	100	-36%
Ophthalmology	96	2.3%	99	-12%
Pulmonary	96	2.3%	99	-40%
GYN	85	2.0%	88	-56%
Oncology	53	1.3%	55	-14%
Dermatology	45	1.1%	46	-63%
Burn Surgery	42	1.0%	43	-26%
Oral Surgery	35	0.8%	36	96%
Renal	24	0.6%	25	-35%
Infectious Disease	21	0.5%	22	-52%
Obstetrics	19	0.5%	20	-74%
Podiatry	19	0.5%	20	-32%
Endocrine	14	0.3%	14	-57%
Rheumatology	14	0.3%	14	-37%
Dental	9	0.2%	9	-66%
Thoracic	9	0.2%	9	102%
Maxofacial Surgery	8	0.2%	8	-10%
Audiology	7	0.2%	7	-65%
Hematology	7	0.2%	7	-61%
Vascular Surgery	4	0.1%	4	0%
Metabolic	1	0.0%	1	-98%
Unknown	1	0.0%	1	-93%
Total Evacuation	4152	100.0%	4288	-12.1%

Chart 3 compares Army OIF-II evacuations per 100,000 Soldiers by month with BH evacuations per 100,000 Soldiers during 1 March-26 September 2004. This chart shows the relationship between the two curves graphically. As all evacuations rise or fall, BH evacuations reflect these changes as well.

Chart 3: All Army OIF-II Evacuations per 100,000 Soldiers by Month Compared with Behavioral Health Evacuations per 100,000 Soldiers



II. Evacuee Chart Review

Landstuhl Regional Medical Center Chart Review: Landstuhl Regional Medical Center provided 273 OIF-II evacuee BH charts for review (82 inpatient; 189 outpatient; and 2 both in- and outpatient charts). Thirty-five of these charts (13%) belonged to evacuees who were originally transferred out of OIF-II for nonbehavioral health reasons.

The Behavioral Health Service maintained Landstuhl Regional Medical Center's charts. Each record was comprised of various administrative and clinical documents, and maintained like those of other patients.

Tables 9, 10, and 11 summarize the demographic characteristics; diagnosed BH disorders in OIF-II; and diagnosed BH disorder at discharge from LRMC. Operation Iraqi Freedom (OIF-II) demographics were comparable to OIF-I. Table 12 shows that the percentage of Adjustment Disorders diagnosed at LRMC fell nearly 14% (i.e., from 39.43 in OIF-I to 25.64% in OIF-II).

Category	#	%
Enlisted	196	90.5%
Officer	12	4.4%
Warrant Officer	8	2.9%
Unknown	6	2.2%
Male	237	86.8%
Female	36	13.2%
Active Component	167	61.2%
Reserve Component	99	36.3%
Unknown Component	7	2.6%

Table 10: Behavioral Health Disorders in OIF-II

Category	#	%
Mood Disorders	88	32.23%
Unknown	66	24.18%
Anxiety Disorders	42	15.38%
Adjustment Disorders	37	13.55%
Psychotic Disorders	13	4.76%
Other	11	4.03%
Personality Disorders	8	2.93%
Substance Abuse Disorders	7	2.56%
V Codes	1	0.37%
No Diagnosis	0	0.00%

Table 11: Behavioral Health Disorders at Discharge from LRMC

Category	#	%
Mood Disorders	81	29.67%
Adjustment Disorders	70	25.64%
Anxiety Disorders	59	21.61%
Unknown	22	8.06%
Psychotic Disorders	11	4.03%
Personality Disorders	10	3.66%
Other	9	3.30%
Substance Abuse Disorders	9	3.30%
V Codes	2	0.73%
No Diagnosis	0	0.00%

Table 12: % Change in Diagnoses from OIF-I to OIF-II

Disorder Category	OIF-I	OIF-II	% Change
Adjustment Disorders	39.43%	25.64%	-13.79%
Other	5.02%	3.30%	-1.72%
No Diagnosis	1.43%	0.00%	-1.43%
Personality Disorders	4.66%	3.66%	-1.00%
V Codes	0.72%	0.73%	0.01%
Substance Abuse Disorders	1.08%	3.30%	2.22%
Psychotic Disorders	1.79%	4.03%	2.24%
Anxiety Disorders	19.35%	21.61%	2.26%
Mood Disorders	25.09%	29.67%	4.58%
Unknown	1.43%	8.06%	6.63%

Table 13 reveals many diagnoses in OIF-II did not change by time of discharge at LRMC. Over 80% of Adjustment Disorders diagnosed in theater remained the same by the time the evacuees left LRMC.

Category	# OIF Dx	# OIF-II Dx Unchanged at LRMC	% Unchanged
Adjustment Disorders	37	31	83.78%
Substance Abuse Disorders	7	6	85.71%
Anxiety Disorders	42	34	80.95%
Mood Disorders	88	58	65.91%
Psychotic Disorders	13	8	61.54%
Personality Disorders	11	6	54.55%
Other	8	2	25.00%
V Codes	1	0	0.00%

Table 14 shows all BH diagnoses given at LRMC and their corresponding percentages.

Table 14: Expanded List of Behavioral Health Disorders		
Diagnosis	#	%
Adjustment Disorders	70	25.64%
Mood Disorders	81	29.67%
Bipolar Disorder	(19)	(6.96%)
Depressive Disorder NOS	(17)	(6.23%)
Dysthymic Disorder	(1)	(0.37%)
Major Depressive Disorder	(42)	(15.38%)
Mood Disorder NOS	(2)	(0.73%)
Anxiety Disorders	55	20.15%
Acute Stress Disorder	(19)	(6.96%)
Anxiety Disorder NOS	(9)	(3.30%)
Generalized Anxiety Disorder	(6)	(2.20%)
OCD	(2)	(0.73%)
Panic Disorder	(5)	(1.83%)
PTSD	(13)	(4.76%)
Simple Phobia	(1)	(.037%)
Other Disorders	10	3.66%
ADHD	(1)	(0.37%)
Cognitive Disorder NOS	(1)	(0.37%)
Conversion Disorder	(3)	(1.10%)
Dissociative Disorder	(1)	(0.37%)
Intermittent Explosive Disorder	(1)	(0.37%)
Sleep Disorder NOS	(1)	(0.37%)
Somatoform Disorder NOS	(2)	(0.73%)
Personality Disorders	12	4.40%
Psychotic Disorders	6	4.03%
Brief Psychotic Disorder	(3)	(1.10%)
Psychotic Disorder NOS	(6)	(2.20%)
Schizoaffective Disorder	(1)	(0.37%)
Schizophreniform Disorder	(1)	(0.37%)
Substance Disorders	9	3.30%
Alcohol Dependence	(4)	(1.47%)
Benzodiazepine Abuse	(1)	(0.37%)
Inhalant Abuse	(1)	(0.37%)
Substance Abuse	(3)	(1.10%)
Unknown	23	8.42%
V Code	2	0.73%
Total	273	100.00%

Table 15 indicates how many evacuees were prescribed psychotropic medications in OIF-II and at LRMC. In comparison with OIF-I, OIF-II saw a 21% increase in evacuees who were prescribed medication (39.07% to 60.44%). Evacuees who received medication throughout evacuation increased from 29.39% in OIF-I (82 evacuees out of 279) to 58.57% in OIF-II (147 evacuees out of 251).

Those evacuees not receiving any medication during their evacuation dropped from 25.8 % in OIF-I (i.e., 72 evacuees without prescriptions out of 279) to 10.7% in OIF-II (i.e., 27 evacuees without prescriptions out of 251).

Table 15: Medication Prescribed in OIF-II and LRMC						
		LRMC			#	
		Yes	No	Unknown	OIF	% OIF
OIF-II	Yes	147	17	1	165	60.44%
	No	21	27	2	50	18.32%
	Unknown	16	4	6	26	9.52%
# LRMC		184	48	9	273	
% LRMC		67.40%	17.58%	3.30%		

Table 16 shows the return-to-duty rates from LRMC to OIF-II by inpatient/outpatient status, and by diagnosis. Only 7 (2.56%) evacuees were returned to duty from 1 March to 30 September 2004. In contrast, OIF-I returned 10 (3.58%) evacuees to duty from 1 March to 30 September 2003.

Patient Status	#	# Returned to Duty in OIF-II	%
Inpatient Only	82	0	0%
Outpatient Only	189	7	3.70%
Both	2	0	0%
Total	273	7	2.56%
Diagnosis	#	# Returned to Duty in OIF-II	%
Adjustment Disorder	70	1	1.43%
Alcohol Dependence	4	1	25.00%
Depressive DO NOS	17	1	5.88%
Mood DO NOS	2	1	50.00%
Personality DO	12	1	8.33%
Unknown	23	2	8.70%

Table 17 shows the documentation found on evacuee BH inpatient and outpatient charts at LRMC. Transmission of OIF-II clinical documentation increased from 44.8% in OIF-I (125 charts out of 279) to 83.5% in OIF-II (228 charts out of 251). Either OIF-II clinical or TRAC2ES documentation was on 96.4% of LRMC charts.

OIF-II Clinical Documentation	#	%
Yes	228	83.5%
No	19	7.0%
Unknown	26	9.5%
LRMC Clinical Documentation Forwarded to Next Level of Care		
Yes	253	92.7%
No	5	1.8%
Unknown	14	5.1%
Patient Movement Request (or TRAC2ES)		
Yes	192	70.3%
No	55	20.1%
Unknown	25	9.2%
OIF-II Clinical Documentation and TRAC2ES		
Either present	243	96.4%
Neither present	4	1.5%

III. Evacuation Policy

Evacuation Policy of CFLCC and MNC-I: Discussions with Corps Surgeons at CFLCC and MNC-I revealed that there was no change in the evacuation policy of 7 days. An extended evacuation policy was considered impractical because it would require additional medical assets in theater. Instead, BH cases were given the flexibility to extend beyond the 7-day window, based on the clinician's assessment of return-to-duty potential.

During the Combat and Operational Stress Control Conference held in September 2004, BH providers reported adherence to the theater evacuation policy. Evacuations out of theater were made only after 1) a good faith effort to address the issue in theater failed; 2) if Soldiers were unable to adequately contribute to the mission; or 3) if they were dangerous to self or others. Behavioral health providers indicated that they kept patients in theater beyond the 7-day evacuation window on a case-by-case basis, and reported that this arrangement had worked well.

IV. Landstuhl Regional Medical Center Behavioral Health Interviews and Evacuation Procedures

Arrival: All evacuees arrive at Ramstein Air Force Base (AFB) in accordance with the United States Air Force (USAF) medical evacuation procedures. Ambulatory evacuees are transported by bus or ambulance as required. All evacuees arrive at the emergency room or, based on their condition, may go directly to the appropriate ward. During duty hours, personnel evacuated due to a BH issue are directed to report to the Outpatient Psychiatry Service, Division of Behavioral Health, where an initial assessment is conducted within 1 to 2 hours of arrival based on the number of evacuees. Operation Iraqi Freedom (OIF-II) evacuees have first priority in the walk-in clinic. After duty hours, the BH provider on-call is contacted and comes to the emergency room to conduct the assessment.

Triage: All evacuees are triaged and evaluated by the doctoral-level behavioral healthcare provider. The criteria for hospitalization are identical to those applied to all BH assessments. These criteria hinge on the degree of dangerousness to self or others. Additional criteria are employed on a case-by-case basis such as any unique medical issues requiring inpatient management. Admission procedures for the BH evacuee are essentially identical to those for other admissions. As with all patients who exhibit suicidal or homicidal behavior, the OIF-II evacuee who exhibits these behaviors is hospitalized and evacuated consistent with USAF regulations for patients in this status.

Duration of Stay: Hospital stays vary from 4 to 6 days based on the availability of evacuation aircraft.

Outpatient: Outpatient evacuees are housed at Kleber Kaserne, located approximately 30 minutes from LRMC. The facility is a converted administrative and housing unit with a maximum capacity of 400 persons. The census is usually 200 to 250. The population consists of all ambulatory evacuees to include those with psychiatric diagnoses.

Command and control consists of a detachment commander, first sergeant, and operations noncommissioned officer (NCO). Daily formations are at 0600, and Soldiers are required to have a pass to proceed outside the immediate Kaiserslautern/Landstuhl area.

Additional control measures include the use of unit liaisons. These are individuals from the evacuees' unit who meet the arriving bus and are responsible along with the Deployed Warrior Medical Management Center (DWMMC) for monitoring the evacuee's progress through the medical system.

Overall responsibility for the Kleber facility and monitoring all evacuees is the DWMMC. The DWMMC maintains the Patient Information Application (PIA) database, which tracks the evacuee from date of arrival to date of departure, and provides status updates to the command while the evacuee is at LRMC. The PIA is accessible by providers, DWMMC personnel, and unit liaisons on the LRMC intranet.

All BH outpatient evacuees receive a memorandum (attached) from the Chief, Department of Psychiatry, providing instructions concerning contacting their unit liaison, leave requirements, and the prohibition of the consumption of alcoholic beverages.

Standards of Care: In all areas, the evacuee standards of care are identical to those provided to non-OIF-II patients. With respect to access to care, the OIF-II evacuees' access is superior in that they receive immediate attention upon arrival and are not appointed for a later date. Evacuee charts are subject to existing quality improvement SOPs and are not evaluated separately.

Treatment Initiatives: The relative brief stay of most evacuees (4-6 days) does not permit the development of initiatives requiring extensive follow-up. However, three areas of care are subject to immediate intervention and monitoring. Patient safety issues are assessed immediately following arrival at LRMC, and a determination of inpatient versus outpatient status is made. In addition, patients often arrive with sleep disturbance and anxiety symptoms. Immediate medical management has been highly effective in the amelioration of these symptoms.

Evacuee Accountability: The DWMMC has responsibility for all patient evaluation, treatment, disposition, and accountability while at LRMC. The DWMMC also maintains a PIA on the LRMC intranet. This PIA provides a wealth of data on each patient to include date of arrival, current medical status, and projected departure date.

Documentation from OIF-II: The evacuees arrive with a TRAC2ES/PMR, which details the circumstances that prompted the evacuation. Although the majority of these reports are thorough, there have been occasions where patients arrived with little or no information. Because of this lack of information, it is difficult to provide feedback to these providers.

Although not strictly medical information, the PMR is very helpful to have information from the Soldier's command concerning his performance and expectations concerning return to duty. Also e-mail addresses and other access points for the referring provider are helpful in planning dispositions and providing any requested feedback from the referring provider.

Feedback is not routinely provided to the referring provider due to lack of contact information.

According to LRMC staff, the clinical utility of TRAC2ES/PMR data is improving, and this facilitates disposition of an evacuee. The range for both inpatients and outpatients is 4 to 6 days.

In the absence of clinical documentation from the referring unit, an effort is made to contact the unit and determine the reason for evacuation. Without this information, the information provided by the evacuee determines the management. In cases where it is considered that no psychiatric condition is present which warrants evacuation, the recommendation is that the Soldier returns to duty. These cases without psychiatric documentation usually occur in patients evacuated due to medical reasons other than psychiatric.

Command Notification of Evacuation Progress: The unit liaison is aware of disposition, and where contact information exists, both the CONUS receiving facility and the OIF-II referring facility are notified. Behavioral health does not provide disposition back to the OIF-II command.

Suicides and Uniform Code of Military Justice (UCMJ) Issues: No evacuee has committed suicide and no assaults have been reported. One BH evacuee is under investigation for violation of the no movement policies and other possible UCMJ actions.

Alcohol Use by Evacuees: All BH evacuees are directed via memorandum from the Chief, Department of Psychiatry, to abstain from the use of alcohol. Incidents of misuse or abuse are reported to the Soldier's command and addressed clinically as required.

LRMC Recommendations for Improved Evacuations: LRMC personnel proposed making changes in two areas that might enhance the quality of care for evacuees.

Unstructured interviews with LRMC Command, BH providers, medical personnel, and chaplains indicated that Landstuhl Regional Medical Center personnel were directly impacted by the ongoing care demands of OIF-II evacuees. Landstuhl Regional Medical Center Command considers this issue important and requests that the MHAT-II consider the following recommendations.

- 1) Provide two BH providers with specialized expertise in the care and management of healthcare provider stress.

LRMC Rationale for 1). The LRMC staff is comprised of both active and United States Army Reserve (USAR) component personnel. These individuals provide care for many seriously injured personnel from all services. Interviews with BH providers, medical/surgical providers, chaplains, and LRMC leadership confirm the stress attendant to these duties. Landstuhl Regional Medical Center receives three to six buses of injured service members each day. Implementation of a “therapy by walking around” model, as was accomplished by Operation Solace, could assist the providers in managing this stressful duty. Additionally, these augmentees could enhance the Department of Psychiatry consultation liaison services for the intensive care unit (ICU) and medical and surgical patients.

- 2) Recommend that MHAT-II address this need for increased psychiatric inpatient capacity at LRMC.

LRMC Rationale for 2). LRMC serves a catchment area of 400,000 beneficiaries. It has an 18-bed inpatient psychiatry capacity. A proposed increase to a 26-bed unit is pending funding by MEDCOM. As active duty admissions surge due to periodic OIF-II requirements, care for family members becomes an issue as these beneficiaries must be hospitalized in German medical treatment facilities (MTFs).

V. Landstuhl Regional Medical Center Evacuee Interviews

Two BH evacuees were interviewed. One was an inpatient who had arrived on the day of this interview. The other was an outpatient who had arrived two days prior to this interview. Responses to the specific questions are summarized below. Although the interviews were conducted separately, the responses are consolidated for the purpose of this report. Both evacuees were informed concerning the purpose of this interview, the MHAT-II charter, and right to decline participation. Each evacuee was assured that only his/her responses to the questions and no identifying information would be included in the report. Both evacuees were cooperative and freely participated in the interviews.

Both evacuees described their care as excellent during all stages of their evacuation. Each complimented the care received through combat stress control (CSC) units. The evacuees described themselves as reluctant to leave the theater, but described their care in positive terms.

Both described support from caregivers and their duty units during the initial stages of the evaluation. One evacuee noted that his battalion commander came to the CSC unit to check on him prior to evacuation. They both noted that medical personnel ensured accountability for all ambulatory evacuees throughout the process.

Neither evacuee had any recommendations to improve his experience. However, one did note somewhat humorously that a “hot in-flight meal” would have been preferable to a meal-ready-to-eat (MRE).

One evacuee returned with an escort. This evacuee described the escort as very helpful. Both evacuees described the reception processing at Ramstein and LRMC as efficient. Neither required specialized medical care. However, one stated that had it been necessary, she was confident that it would have been provided. This evacuee stated that, throughout the flight, nursing staff regularly checked on their status and offered assistance.

APPENDIX 1

DESCRIPTION OF DEPARTMENT OF DEFENSE-SUPPORTED DATABASES

Transportation Command Regulating Command and Control Evacuation System (TRAC2ES)

Transportation Command Regulating Command and Control Evacuation System (TRAC2ES) is a web tool that tracks and manages casualty evacuations and patient movement. The present system was deployed nearly 2 years ago to monitor the movement of casualties out of a combat zone. The Transportation Command took over the responsibility for TRAC2ES in 1993; the casualty-evacuation management software was developed in response to widespread complaints following the 1991 Persian Gulf War that it was difficult to track and locate wounded service members being treated at military care centers and hospitals. Typical scenarios for the applicability for TRAC2ES, commanders on the ground determine that casualties need to be evacuated and transported to a medical facility. The command will contact the so-called "patient movement requirement center," a facility set up to support a specific conflict. The center, in turn, will request the aircraft and crews to transport those patients.

Although TRAC2ES was designed to track evacuees like cargo shipments, healthcare providers have relied on its clinical data entries whenever medical/BH records did not accompany the evacuee.

Patient Accounting and Reporting Real-Time Tracking System (PARRTS)

The purpose of the PARRTS is to report special interest patients as required by MEDCOM Regulation 40-7, Reporting of Special Interest Personnel. It is an interactive web-based data entry system used by Army MTFs and deployed medical assets. Manually, data are inputted via the U. S. Army Patient Administration Systems and Biostatistics Activity (PASBA) Restricted Web Site. Users of the PARRTS are senior staff members of the OTSG and MEDCOM, patient administration personnel at MTFs, and PASBA Input Sections.

Medical Occupational Data System (MODS)

The Medical Occupational Data System (MODS) is a database that helps personnel managers, special pay clerks, Professional Filler System (PROFIS) managers, manpower managers, and medical readiness managers make operational data simpler. The MODS provides Army Medical Department (AMEDD) human resource and soldier readiness processing (SRP) site managers with a responsive and reliable information management data system for all categories of military and Department of Army (DA) civilian medical support personnel. The data that are the basis for MODS are pulled from 18 different major Army and DoD databases.

APPENDIX 2

THE MENTAL HEALTH ADVISORY TEAM (MHAT-II) LANDSTUHL REGIONAL MEDICAL CENTER (LRMC) VISIT

Purpose

To provide structure and method to collect LRMC's Army Operation Iraqi Freedom (OIF-II) behavioral health (BH) evacuation data for the MHAT-II report.

Personnel

The MHAT-II, that will collect BH evacuation data at LRMC, is comprised of the following two sub-teams:

- Sub-team 1, consisting of one senior Army BH clinician, will conduct the Behavioral Health Provider Interviews and Behavioral Health Evacuee Interviews, and will request Miscellaneous Evacuation-Related Records. The Sub-team 1 leader is also designated as the Senior Team Leader and will oversee the MHAT-II Landstuhl Regional Medical Center visit.
- Sub-team 2, consisting of three U.S. Army Research Unit-Europe (USAMRU-E) personnel, will conduct the Behavioral Health Evacuee Record Review.

Command and Control

Each sub-team has a designated team leader who reports to the Senior Team Leader. The designated Senior Team Leader oversees the MHAT-II visit, liaisons with LRMC leadership, and reports to Colonel (b)(6)-2 through daily situation reports (SITREPs).

Instruments to be used during the collection of LRMC's Army OIF-II behavioral health data are:

- The Europe Regional Medical Command (ERMC) Clinician:
 - Behavioral Health Provider Interview (TAB A).
 - Behavioral Health Evacuee Interview (TAB B).
 - Request for Miscellaneous Evacuation Related Records.
- The MHAT-II In-Brief PowerPoint Presentation (TAB C).
- The Behavioral Health Evacuee Record Review (see TAB C, slide 8).
- The Operation Iraqi Freedom (OIF-II) MHAT-II Charter (Appendix 1 to Report).

Method

- **Step 1: Preparation for the MHAT-II Visit**

- Colonel ^{(b)(6)-2} will contact the LRMC command to arrange visit date, time, and place. In this contact, team membership, method of data collection, sources of data, and logistical support are identified (see Visit Preparation Worksheet). Specifically, Colonel ^{(b)(6)-2} will arrange the following events and corresponding details:

- **In-Brief:** Date, time, place, and point of contact for the Senior Team Leader's in-brief with the LRMC Commander, DCCS, DCA, DCN, and other key personnel designated by the Commander. Estimated duration: 1 hour

- **Behavioral Health Provider Interviews:** Date, time, place, and point of contact for Sub-team 1's individual interviews or group interview—depending on staff availability—with the following BH personnel:

- Chief, Department of Psychiatry.
- Chief, Psychology Service.
- Chief, Social Work Service.
- Chief, Patient Administration Division.
- Chief, In-Patient Psychiatry.
- Chief, Outpatient Psychiatry.
- Chief, Deployed Warrior Medical Management Center.

Estimated duration: 1-1/2 hour per interview

- **Behavioral Health Evacuee Interviews:** Date, time, place, and point of contact for Sub-Team 1's individual interviews with two Army OIF-II behavioral health evacuees. Estimated duration: 30 minutes per interview

- **Behavioral Health Evacuee Record Review**

- Point(s) of contact (POCs) for collection of BH inpatient and outpatient records

- Identification and collection of all Army OIF-II behavioral health inpatient and outpatient records from 1 March through 30 September 2004 for review

- Point of contact for space/computer/telephone logistical support
 - Date, times, and place for Sub-team 2's Army OIF-II behavioral health patient record review. Estimated duration: 5 days

- **Miscellaneous Evacuation Records**

- The POC for the DWMMC and an electronic copy of its standing operating procedures (SOPs). Estimated duration: 30 minutes
- Point(s) of contact for BH evacuee tracking databases unique to LRMC, and electronic copies (if available). Estimated duration: 30 minutes
- **Out-Brief:** Date, time, place, and point of contact for the Senior Team Leader's in-brief with the LRMC Commander, DCCS, DCA, DCN, and other key personnel designated by the Commander. Estimated duration: 1 hour
 - Colonel (b)(6)-2 will provide LRMC leaders copies of MHAT's Patient Record Review instruments, Behavioral Health Provider Interview instruments, and Behavioral Health Evacuee Interview instruments on request.
 - Colonel (b)(6)-2 will provide the completed Visit Preparation Worksheet to the Senior Team Leader prior to the visit.
 - The Senior Team Leader will confirm arrangements with points of contact prior to the team's arrival date.

- **Step 2: In-Brief**

- The Senior Team Leader will meet with the LRMC Commander, DCCS, DCA, DCN, and other key personnel designated by the Commander. Other MHAT-II members may be present at the discretion of the Senior Team Leader.
- In the briefing, the Senior Team Leader will discuss the MHAT-II's charter; proponent; purpose for visiting LRMC; team membership; requested data sources; each sub-team's data collection methods; use of data to develop the MHAT-II report for the OTSG; visit timeline; team contact numbers; and request to out-brief LRMC leadership at the mission's completion (see TAB C, MHAT-II In-Brief PowerPoint presentation).

- **Step 3: Sub-Team Tasks**

- **Sub-Team 1**

- **Behavioral Health Provider Interviews**

- Sub-team 1 will meet with BH providers as previously arranged. Individual and/or group interviews are permitted.
- Before asking questions from the Behavioral Health Provider Interview Worksheet, the interviewer will review the following information with the interviewee: MHAT-II's charter; proponent; purpose for visiting LRMC; purpose of the interview; limits of confidentiality regarding information; use of interview data to

develop the MHAT-II report for the OTSG; and the right to refuse participation in the interview.

- Interview questions are listed in the Behavioral Health Provider Interview Worksheet (see TAB A). Interviewers should write interviewee responses verbatim, whenever possible, in the space provided on the worksheet.

- After the interview, written responses will be typed into the electronic Behavioral Health Provider Interview Worksheet. A completed electronic copy will be given to the Senior Team Leader for final transmission to

Colonel (b)(6)-2

- **Behavioral Health Evacuee Interviews**

- Sub-team 1 will meet with BH evacuees as previously arranged. To maintain privacy, only individual interviews are permitted.

- Before asking questions from the Behavioral Health Evacuee Interview Worksheet, the interviewer will review the following information with the interviewee: MHAT-II's charter; proponent; purpose for visiting LRMC; purpose of the interview; lack of confidentiality regarding information provided by interviewee (note: no patient identifying data will be documented); use of interview data to develop the MHAT-II report for the OTSG; and the right to refuse participation in the interview.

- Interview questions are listed in the Behavioral Health Evacuee Interview Worksheet (see TAB B). Interviewers should write interviewee responses verbatim, whenever possible, in the space provided on the worksheet.

- After the interview, written responses will be typed into the electronic Behavioral Health Evacuee Interview Worksheet. A completed electronic copy will be given to the Senior Team Leader for final transmission to Colonel Patterson.

- **Miscellaneous Evacuation Records**

- Sub-team 1 will coordinate with the point of contact of the DWMMC and will collect an electronic copy of its SOPs. This electronic copy will be given to the Senior Team Leader for final transmission to Colonel (b)(6)-2

- Sub-team 1 will coordinate with the POC(s) for any BH evacuee tracking databases unique to LRMC, and will collect an electronic copy of the databases. Electronic copies will be given to the Senior Team Leader for final transmission to Colonel (b)(6)-2

- **Sub-Team 2**

- **Behavioral Health Evacuee Record Review**

- Sub-team 2 will confirm arrangements with the point(s) of contact for patient record collection and with the point of contact for space/computer/telephone logistical support after the In-Brief.

- Sub-team 2 members will use the Microsoft Access file, LPMC Evacuee Record Review, to record data collected from each BH evacuee's inpatient and/or outpatient record (see TAB C, slide 8, for LPMC Database Fields).

- Each Sub-team 2 member will have a copy of this Microsoft Access file saved on his/her laptop computer. The copy will be named in accordance with this format: "Name of reviewer – LPMC Evacuee Record Review – Date." For example: "Leavitt – LPMC Evacuee Record Review – 30 Sep 04."

- After completing the record review, an electronic copy of each reviewer's Microsoft Access file will be given to the Senior Team Leader for final transmission to Colonel (b)(6)-2

- **Step 4: Out-Brief**

- The Senior Team Leader will discuss preliminary findings and observations with Colonel (b)(6)-2 prior to the out-brief. All collected electronic files and documents will be forwarded to Colonel (b)(6)-2 for review. Out-briefing content will be coordinated with Colonel (b)(6)-2

- The Senior Team Leader will meet with the LPMC Commander, DCCS, DCA, DCN, and other key personnel designated by the Commander. Other MHAT-II members may be present at the discretion of the Senior Team Leader.

- In the briefing, the Senior Team Leader will thank LPMC leadership support for the MHAT-II mission; discuss preliminary findings in accordance with Colonel (b)(6)-2 guidance; provide contact information to follow up with team members and/or Colonel (b)(6)-2; and answer questions.

TAB A: THE Mental Health Advisory Team (MHAT-II) Landstuhl Regional Medical Center (LRMC) Visit Behavioral Health Provider Interview Questions Handout

LRMC Behavioral Health Provider Interview Questions

Date: Location: Interviewer:

Interviewee(s):

Group Number:

Positions/Titles:

AOCs:

I. EVACUEE ARRIVAL

1. Where do evacuees arrive in Germany? When do they typically arrive? How do they arrive (e.g., bus, ambulance, or other)?

2. How are evacuees transported to LRMC? Who transports them?

3. When is the initial BH assessment conducted? How many hours after the evacuees' arrival? Who conducts the assessment? How long does a typical assessment last? Where is the assessment conducted?

4. How is inpatient and outpatient status determined? What are the criteria? Who makes this decision?

5. Do the procedures for admitting a BH evacuee differ from a "routine" BH admission? How soon after admission is a treatment plan developed?

6. Where are outpatient evacuees housed? How are they monitored? Who supervises them? Are there any safety considerations for these outpatients? For example, is access to alcohol limited; is their movement controlled, etc.? How is accountability maintained?

7. What medical records should arrive with the OIF-II evacuee? Are the medical records or documentation arriving with the patient from the OIF-II Theater?

8. What medical information is helpful in managing your mental health patient?

9. Is the evacuee's clinical documentation valuable to you during the evaluation phase?

10. Do you provide input and feedback to the sending BH provider regarding the value, accuracy, and integrity and transported clinical documentation?

11. Is the evacuee's TRAC2ES documentation valuable to you during the evaluation phase?

II. PATIENT CARE

1. What is the typical length of stay for inpatients? Outpatients? Who decides how long these patients stay at LRMC?

2. When an OIF-II patient escalates with suicidal and/or homicidal behavior, how does that impact the management of the patient throughout the evacuation process?

3. Has any evacuee in LRMC's care committed suicide, assaulted others, or broken the law?

4. How do you manage patients who do not have a clear reason for evacuation (e.g., no clinical documentation, no Axis I diagnosis, malingering)?

5. Who alerts the OIF-II command about the disposition plan? How is the patient notified? Do you alert the next higher level of care?

6. What types of behavior have occurred that have warranted the Uniform Code of Military Justice (UCMJ)? Who has administrative control of the evacuees and is it enforced?

7. What additional resources or staffing do you need to provide care to evacuees?

8. Do the outpatient evacuee standards of care approximate those of partial or outpatient in general?

9. How many BH providers deliver care to the OIF evacuees?

10. How do you know if your treatment initiatives for OIF-II evacuees are effective? What are the measurable outcomes for these findings?

11. What criteria are used to determine if evacuation to a higher level of care is needed? Who makes the decision?

12. Are there specific treatment initiatives for evacuees? Inpatients? Outpatients?

13. Are there SOPs for BH evacuee evaluation, treatment, disposition, and accountability processes?

14. What is the policy concerning alcohol use? How has it compromised clinical status of OIF-II evacuees?

15. How is the final evacuation disposition determined?

16. How do you determine whether an evacuee should return to OIF-II? Do you have a SOP or policy? If so, may we receive an electronic copy?

III. EVACUEE DEPARTURE

1. Has LRMC developed any specific forms to be used for evaluation and treatment of OIF evacuees? If so, may we receive an electronic copy of these forms?
2. How do you decide where to evacuate a patient? Who decides this?
3. How is the evacuee sent from LRMC to CONUS/OCONUS? Who manages the administrative process? Who manages the medical process? From where does the evacuee depart?
4. What medical records should be sent with the patient upon further evacuation from LRMC?
5. Do you have e-mail addresses and telephone numbers for points of contact for BH providers in OIF-II? OCONUS? CONUS? If so, may we receive a copy of your list(s)?
6. Do you notify the rear detachment before initiating the patient's evacuation to the next level of care? The final MTF destination? Deployment Cycle Support care managers?
7. Do you provide input to the receiving BH provider regarding the value, accuracy, and integrity of the patient's transported clinical documentation?

IV. TRAC2ES

1. Has the PAD established a quality improvement process to minimize errors in TRAC2ES data entry?

2. Do you monitor the quality, accuracy, and value of TRAC2ES information?

3. Is there a quality improvement program for evacuee charts? If so, may we have a copy of the SOP?

4. Is there a quality improvement program for the implementation of LRMC evacuee policy and procedures? If so, may we have a copy of the SOP?

5. What information in TRAC2ES needs to be included for it to be useful?

6. What factors lead you to this conclusion about TRAC2ES documentation?

7. How would you rate the value and quality of the documents accompanying OIF-II evacuees?

8. What factors lead you to this conclusion about evacuee documentation?

V. ESCORTS

1. How are escorts managed (e.g., fed, housed, accounted for) once they arrive at LRMC? Are/is there a policy and/or SOP governing escort management at LRMC?
2. How is it decided whether or not to send an escort? How are escorts selected? What training is provided to the escorts (specifically regarding safety)?
3. What do escorts do if there is a problem (e.g., who are their POCs if a problem arises)? What accommodations are escorts given?
4. Are there problems with the escort system? Do you have a SOP that is applied to the responsibility of escorts; if so, may we have a copy of the SOP?

TAB B: The Mental Health Advisory Team (MHAT-II) Landstuhl Regional Medical Center (LRMC) Visit Behavioral Health Evacuee Interview Questions Handout

LRMC Army OIF-II Behavioral Health Evacuee Interview Questions

Date:

Location:

Interviewer:

Interviewee(s):

Group Number:

Positions/Titles:

AOCs:

Customer Satisfaction:

1. Were you satisfied with the care received during the evacuation process (at origin, during travel, at destination)?
2. What factors led you to this conclusion?
3. What would have made your experience better?
4. What kinds of treatment did you receive during the evacuation process?

TAB C: THE Mental Health Advisory Team (MHAT-II) In-Brief PowerPoint Presentation