

# Implementing the Post-Deployment Health Practice Guideline

*Lessons from the  
Field Demonstration*

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# SUMMARY

The Clinical Practice Guideline for Post-Deployment Health (PDH) Evaluation and Management was established jointly by the Department of Veterans Affairs (VA) and the Office of the Secretary of Defense/Office of Health Affairs (OSD/HA) (DoD and VA, 2000). The guideline was developed in response to concerns by the U.S. Congress about inadequacies in military health care for Gulf War veterans as well as Institute of Medicine recommendations that post-deployment health care should be based on evidence-based practice guidelines and delivered by primary care providers (IOM, 1997; IOM, 1998). The objectives of the PDH guideline are to strengthen the capacity to provide effective military health care for patients with PDH concerns and to place responsibility for this care in the hands of primary care providers. The guideline has three basic components:

- Screening of all patients during outpatient clinic visits to identify whether their health concerns for those visits are deployment-related.
- Classification of each identified PDH patient into one of three categories based on the deployment-related concern: asymptomatic with a health concern, having an identifiable diagnosis (e.g., poison ivy rash), or having medically unexplained physical symptoms (MUPS).
- Management of the patient according to the type of problem identified.

OSD/HA and the DoD Deployment Health Clinical Center (DHCC) implemented the PDH practice guideline across the Department of Defense (DoD) health system beginning in January 2002. Technical and administrative support was provided by the Army Quality Management Directorate (in Army MEDCOM) and the Army Center for Health Promotion and Preventive Medicine (CHPPM).

Beginning in March 2001, the guideline and its supporting elements were field-tested at three demonstration sites: McGuire Air Force Base (AFB), N.J.; Camp Lejeune, N.C.; and Fort Bragg, N.C. The purpose of the demonstration was to test and refine the PDH guideline, its supporting tool kit, and policies and methods for implementation activities by both

local MTFs and the system. These three sites were selected so the guideline could be tested in three of the armed services and also because these installations have high-tempo military deployments.

RAND performed two sets of site visits during the demonstration to learn from the sites' experiences with the implementation process and to obtain their feedback on the PDH guideline itself and on the tool kit of materials developed to support its use. We conducted the first visits in June 2001 and the second visits in September 2001, and representatives from the sponsoring entities also participated to observe the sites' experiences and viewpoints. This documented briefing reports on the findings of the evaluation.

## **IMPLEMENTATION ACTIONS AND EFFECTS**

The demonstration sites established similar administrative processes for implementing the PDH guideline, which focused on the first two guideline components of identifying and classifying patients with PDH concerns. All three sites introduced use of a screening question to ask all patients if the reason for their clinic visit was deployment-related. Few patients were identified as having PDH concerns, although these numbers would be expected to increase following large sustained deployments. Specific findings include the following:

- Fewer than 1 to 2 percent of all patients with visits at each site reported having a PDH concern in response to the screening question.
- Nearly all PDH patients identified had readily definable diagnoses (e.g., poison ivy, sprained ankle, depression). Only a few patients were coded as having MUPS.
- Patients generally responded positively to being asked if their health problem or concern was deployment-related, but many were curious why they were being asked and some wanted to know how the information would be used.
- The sites reported that asking the screening question had little effect on staff workload. For most, it had become just one of the several "vital signs" they had to check.
- Providers reported making no change in their clinical practices as a result of the PDH guideline. Several indicated they had

experience dealing with MUPS cases and that the guideline was consistent with their practices.

- Primary care providers often did not notice the positive responses on the charts for patients identified with a PDH concern. Thus, the providers neither discussed the concerns with the patients nor assigned the PDH diagnosis codes for their visits.

The sites were generally successful in identifying PDH patients with the screening question, and providers were able to classify these patients readily by type of concern (when they noticed them). Because so few PDH patients were identified, the sites could not fully test procedures for managing care for these patients. Thus, little could be learned from the demonstration about methods and issues involved with the third component of the practice guideline. When large-scale deployments occur, clinic staff workload should not increase much, but the number of PDH patients identified will increase, and MTF providers likely will be more aware of them. It will be important for OSD/HA to be ready to provide additional training and support for providers at such times.

## LESSONS FROM THE DEMONSTRATION

**For local health facilities.** To use the PDH guideline effectively, each facility will need to develop a structured plan to incrementally introduce the guideline to all clinics, battalion aid stations (BASs), and troop medical clinics (TMCs). Resources needed to support the process should be provided, and, before starting implementation, all key clinical and administrative procedures and materials should be tested and in place. The goal should be to “institutionalize” new practices and monitoring processes quickly as part of the routine clinic processes. These provisions include the following:

- Proactive and ongoing educational activities to train all staff effectively on the guideline, including both providers and ancillary staff.
- Careful preparation of the clinic staff who will ask the screening question, so they can work effectively with patients and answer patients’ questions about the screening and how reporting a PDH concern might affect them.
- Follow-up procedures for patients reporting deployment-related concerns to ensure that providers address the concerns, that

patient visits are coded and documented correctly, and that provisions are made for subsequent care.

**For the system.** The sites raised a number of items that the OSD/HA leadership team considered in preparing for systemwide use of the PDH guideline.

- The purpose of the PDH guideline needs to be communicated clearly, including specification of the portals and encounters for which it applies.
- In response to feedback from the sites, existing materials in the PDH tool kit were revised and new materials were added; this process of small-scale testing of materials should continue as new tools are introduced.
- A variety of tools should be provided in multiple media for educating providers, clinic staff, and patients on the guideline's purpose and contents.
- Separate information packages should be developed for MTF commanders and division surgeons, each of whom has jurisdiction of some of the local health facilities.
- The wording of the PDH screening question should be standardized to ensure that all facilities use the same criteria to identify PDH patients.
- The section of the PDH guideline on management of patients with MUPS should be clarified, including guidance for provider education and use of forms.
- Facilities should be informed clearly on what they are expected to report to OSD/HA regarding implementation progress and effects on PDH care.
- Facilities should be given instructions on coding of PDH diagnoses in automated systems and on procedures to enter the screening question on automated SF-600 forms.
- Beneficiaries should be educated about the PDH guideline to encourage their participation and to prevent misunderstandings about why they are being asked about PDH concerns.

- The DHCC Web site should be expanded so providers can get specific information on deployments, exposures, and risks for subareas within each deployment location.

## **SYSTEM ISSUES FOR POLICY ATTENTION**

We list here four key system problems identified in the evaluation that require OSD/HA action to support successful use of the PDH guideline:

- The MTFs should be given clear policy and procedural guidance on the definition and coding of “PDH” in relation to patients reporting health concerns related to an anticipated or current deployment. During the demonstrations, the distinction among health problems occurring before, during, or after deployments was found to be an artificial one from the perspective of the patients. As a result of these findings, OSD/HA is considering establishment of a broader Military Occupational Hazard Guideline that would cover management of military-related health problems regardless of when they arise.
- A mechanism should be created to ensure that primary care providers across the system are engaged in PDH care under normal circumstances and are prepared to serve large volumes of PDH patients after major deployments.
- New mechanisms are needed to ensure that contract providers and staff participate in the use of the PDH guideline and related clinic procedures.
- Patient screening data identify only PDH patients who have a concern and come in for care. Current OSD/HA work on a database to track PDH patients from multiple data sources is needed and important.