

EXPANDING SUPPORT ROLES FOR 10TH MEDICAL REGIMENT: PRE AND POST HEALTH SCREENINGS OF NATIONAL GUARD SOLDIERS AND AIRMEN

Colonel (MD) H. Wayne Nelson, Ph.D.

The Maryland Defense Force's (MDDF's) 10th Medical Regiment (10MEDRGT) is arguably the most active state defense force (SDF) medical command in the nation¹ and is clearly the most creative in charting new avenues of service to both civil and military authorities in its home state of Maryland and outside at the request of and in support of the Maryland National Guard (MDNG).

Perhaps the most significant of these is the support that the 10th Medical Regiment (often referred to herein as the 10th) provides to soldiers and airmen of the MDNG by assuming, on a regular basis, the lead "provider" role in the Department of Defense (DOD) Post-Deployment Health Reassessment Program (PDHRA). This Federally mandated force health protection initiative is intended to "enhance the deployment-related continuum of care" by helping soldiers "reveal" both blatant and latent chronic mental and physical health problems triggered during the soldier's prior deployment in one of the world's hot spots (Post-Deployment Health Reassessment, 2006).

Success in this undertaking has led the MDNG to request similar assistance from the 10MEDRGT in their Family Assistance Soldier Reintegration Program, Periodic Health Assessment Program, and Soldier Readiness Program for mobilization.

THE POST DEPLOYMENT HEALTH REASSESSMENT

The Post Deployment Health Reassessment (PDHRA) program, at least in its current form, is relatively new, having only been mandated by the Assistant Secretary of Defense for Health Affairs in March 2005 (Deployment Health Clinical Center, 2007). The 10MEDRGT has participated in these proactive health outreach screenings since September 2006, and have since consistently taken a lead role in conducting both physical and mental health assessment interviews to an estimated 1000 MDNG Soldiers and Airmen.

A PDHRA screening is at once both an intimate and hands-off process, all "recent" history, with no physical – no clinical probing or prodding. The PDHRA screening revolves around detailed health interviews based on the five page DOD health self-assessment DD Form 2900. This structured questionnaire is designed to systematically collect health needs data in ways that are more reliable than might be collected through a more subjective interview process. DD Form 2900 is specially designed to help soldiers identify any chronic injuries as well as any lingering or newly emergent behavioral problems which may develop after the soldier's or airman's combat or operational service "since the full psychological impact of their deployment may not manifest until long after they have returned home" (Nelson & Bond, 2007).

¹ The Texas State Guard Medical Brigade has also been active during Hurricanes Rita and Katrina (Greenstone, 2006 and 2007) and on the Texas-Mexican border (Benner, 2007).

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Preparing for the PDHRA

Ideally the on-site PDHRA screening occurs between 90 and 180 days after the soldier returns and has completed an initial “hands-on” post deployment “physical and socio-emotional health evaluation” (Bond and Nelson, 2007). At no later than sixth months after return, the soldier is ordered up with other unit members for the on-site PDHRA screening where he or she fills out the self-report component of the DD Form 2900 questionnaire and presents it to screening and assessment professionals for review.

When the soldier has completed the form, a clinician, either a qualified physician, physician’s assistant or nurse practitioner will conduct interviews to further assess the soldier or airman’s state of well being across all health dimensions including aspects of their “family and social adjustment,” which is then reviewed by a duly licensed mental health worker (Post Deployment Health Reassessment, 2006). At this point, the provider fills out page 4 of DD Form 2900 and may recommend further evaluation or to make treatment referrals which are documented on Department of the Army DA form 2173 to assure that they are provided.

Initially, the 10th’s involvement was exclusively in the mental health arena. This mirrors the PDHRA’s particular emphasis in this respect, which has, as a core goal the rooting out of any tell-tale signs of Post-Traumatic Stress Disorder, depression, or anxiety, as well as any syndromic signs of probable self medication, such as excessive drinking, and so forth – all of which not only harm the “affected soldier but to the soldier’s family as well” (Bond and Nelson, 2007). Major (MD) Marcus Ritter, M.D., a psychiatrist and the 10MEDRGT’s mental health team leader, was largely responsible for this early mental health component and was ably supported with only six of his licensed mental health team members. Though few, they were sufficient for the task at hand, and performed so well that it became obvious to the NG that 10MEDRGT medical personnel could make similar contributions for the medical PDHRA component.

Plans for an expanded MDDF role were developed by 10MEDRGT Deputy Commander for Professional Services, Lieutenant Colonel (MD) James Doyle, M.D. In November 2006, Lieutenant Colonel Michael Gafney, Maryland Army National Guard (MDARNG), the PDHRA program manager for the MDARNG, conducted the first of several ninety minute sessions to orient MDDF and Veterans Administration medical providers to the PDHRA process. Two additional sessions were held in December. By January 2007, 30 members of the 10th (which has about 115 clinical personnel) were officially qualified for this ground-breaking expansion to perform work on a voluntary basis which had previously been done exclusively by expensive DOD contractors.

Enough MDDF medical providers (eleven) were trained and ready for the 3 December 2006 PDHRA screening at the Baltimore Medical Center, which was to provide health outreach to the MDNG’s 243rd Engineering Company that had served in Iraq and had taken heavy casualties.

Conducting the PDHRA

The screening began when 95 of these soldiers viewed the educational film, BATTLEMIND which explained how their combat and operational training and experience prepares them for the trials of war, but may also make them vulnerable to the often delayed effects of pure and excessive stress once the pressure is off, the adrenaline drains, and the survival switch needs to be turned off, but doesn’t. After watching the film, the soldiers next met with the medical clinicians to engage in the DD Form

2900 evaluation and interview process. Again this health interview was designed to detect any lurking health conditions that might allow the earliest possible detection as well as an early cure, avoiding the costs and inconvenience of tertiary care which often comes too late to fully maximize the soldier's remaining health potential – to say nothing of being more intensive and intrusive.

Afterwards, the soldiers had the opportunity to meet with members of the MDDF behavioral health team who are not only legally qualified, but highly skilled at detecting the symptoms of mental disorders as well as understanding their causes. They are also adept at helping people get past the false and unfair stigma that is often associated with mental illness in order to breakdown any harmful barriers that might prevent the soldier's acceptance of needed socioemotional treatment.

Results of the PDHRA

Before the day was out, the clinical evaluators along with NG and Veteran Administration support personnel arranged referrals and treatment for soldiers of the 243rd as needed (Bond and Nelson, 2007). In this connection, an after action report filed by Major Ritter showed that of the 95 participants, 71 soldiers (78%) were identified as needing additional care, including 70 needing primary care, and 31 who also mental health treatment. This is a very high referral rate, which the 10th's Commander, Colonel (MD) Robert A. Barish, M.D., recognized as clearly underlining the need for this valuable early detection and disease prevention program and the 10th's "capacity to get the job done."

Since then, the MDDF has been involved in PDHRA screenings about every other month in February, April, June, August, and November of 2007. For these, an average of 13 MDDF clinicians (including both mental and behavioral health professionals) under the direction of either Lieutenant Colonel (MD) Doyle, M.D., or Lieutenant Colonel (MD) Charles Wiles, M.D., as officers in charge, reviewed an average of 76 service members per session, according to the following breakdown:

3 December 2006	–	102
11 February 2007	–	81
22 April 2007	–	55
23 June 2007	–	102
25 August 2007	–	56
3 November 2007	–	62

Of course, not all of these screenings had as high a referral rate as was experienced by the hard hit 243rd Engineering Company.

Much more typical, for example, was the 3 November 2007 PDHRA that saw only 65 soldiers reviewed, of which 20 (30%) were referred for medical treatment, and an additional 15 who received mental health referrals. Sadly, and not for the first time, two soldiers were found to be in such dire need of care that they had to be hospitalized immediately. Major Ritter reports (Ritter, 2007) that, on average, this is much more typical, as about 30% of all soldiers reviewed by MDDF personnel thus far receive some kind of referral. Interestingly, at the other end of the spectrum, when the 10th screened a special forces unit they made no mental health referrals.

Future PDHRAs

10MEDRGT personnel continue to be recruited and trained for the ongoing PDHRA missions which are expected to continue throughout 2008 at the levels experienced in 2007. The 10th's role has received attention from Maryland Adjutant General, Major General Bruce F. Tuxill, who praised the unit's role in maximizing the NG's potential to achieve its PDHRA goals (Tuxill, 2007), a sentiment that was echoed by the MDDF's Commanding General, Brigadier General (MD) Courtney Wilson, who took the occasion to echo the "compliments of the MDNG for the 10th's incredible support of the PDHRA mission. It is quite clear to all that they would not be able to fulfill ... or even come close to fulfilling ... this [PDHRA] requirement without the MDDF 10MEDRGT."

FAMILY ASSISTANCE AND SOLDIER REINTEGRATION

The 10th is not resting on these laurels, and its health service involvement is far from being limited to the PDHRAs. The Mental Health Team, for example, is involved in other initiatives to help promote positive soldier outreach. To this end, a memorandum of understanding amongst the MDDF, the Maryland Department of Health and Mental Hygiene, and the MDNG gave Major Ritter and his mental health team the go-ahead to finish training and to deploy the estimated 200 mental health providers as that have been identified by the mental health commission to fully support the MDNG Family Readiness Groups (FRGs).

The goal of this effort is to provide psychosocial and psycho-educational support/resiliency to the families throughout the deployment cycle. The first MDDF workshop in support of this mission was entitled "Responding to the Mental Health Needs of Service Men and Women and Their Families." This fulfilled the Joint Mental Health Commission's (chaired by the 10th's Major Ritter) mission to train qualified mental health personnel to serve as a resource for families of deployed soldiers. The 31 participants were provided solid, expert best-practice advice designed to empower them as effective mental health resource brokers to FRGs. Topics ranged from teaching personal resiliency to coping with how prolonged deployment may affect a soldier's readjustment upon returning, including its potential impact on spousal relationships and parenting.

By providing such train-the-trainers sessions, MDDF mental health providers can serve as a real force multipliers, magnifying any one-on-one clinical contribution that might be made by an individual MDDF practitioner to empower other, non-military clinicians and volunteers, to help NG families deal with mobilization and subsequent return and reintegration.

These goals are also part of a statewide post-deployment soldier reintegration program that is now in the planning phase for all of Maryland's veterans under the executive agency of the NG. The gist of this multi-faceted, multi-agency approach to assuring the veteran's maximum adjustment after homecoming will be to provide services designed to capture veterans who fall between the mental health service gaps because such services are so poorly targeted and highly fragmented.

The needs are difficult to access without some real study or competent help from a knowledgeable guide to point the way. To be sure, this reintegration role will be much bigger than can be filled by volunteers alone, military or otherwise; however, the MDDF mental health team has been involved in the planning of this NG initiative and will continue to recruit and train clinicians and other volunteers to meet its objectives of helping soldiers and their families in need.

PERIODIC HEALTH ASSESSMENTS

Soon after the 10MEDRGT's service during the Katrina recovery, its leadership began to explore new ways to develop its NG support role. One role that was explored initially was to involve MDDF physicians in the annual periodic health assessments (PHAs) which are performed to closely monitor the health status of Maryland's soldiers and airmen. PDHRA priorities, other competing tasks and staffing constraints, pushed this mission to the back burner for about two years, but the idea was given new life when Lieutenant Colonel Howard Bond (MDARNG). Lieutenant Colonel Bond, a former MDDF physician who had joined the MDARNG, returned to his old unit with a formal request for PHA support, which was quickly approved by Colonel (MD) Barish, the 10th's Commander, and set in motion by the unit's Deputy Commander for Professional Services, Lieutenant Colonel (MD) Doyle. In December 2007 Lieutenant Colonel (MD) Doyle and Lieutenant Colonel (MD) Wiles attended a planning session at the Beacham Clinic at the Camp Fretterd Military Reservation in Reisterstown, Maryland to further develop the MDDF role and to observe the PHA process.

They met with Acting State Surgeon, Colonel Gladden and other key personnel (Doyle, 2007). Shortly thereafter, MDARNG Lieutenant Colonel Bond relayed the request that the program would start with two trained MDDF providers being used each day of the 12-13 January 2008 drill to perform PHAs. The MDNG also requested that two MDDF providers be available to assist/observe at an upcoming Soldier Readiness Program (SRP) mobilization. Since the Beacham clinic is so small, plans for the immediate future call for the MDDF to supply only 1-2 providers (physicians, nurse practitioners, physician assistants) per day for a total of 2-4 provider-days per month at this site (Doyle, 2007). An Initial training offered on relatively short notice by Lieutenant Colonel Bond, ARNG, in December 2007 saw four MDDF physicians and four Physician Assistants in attendance boding well for the program's success. Additional PHA training sessions were slated for January and February 2008.

On 12 January 2008, CPT Fox (MDARNG), the Deputy State Surgeon, contacted LTC (MD) Doyle (Doyle, 2007a; Doyle, 2007b) with the first specific request for an expanded NG support mission involving the 10th's nurses. He called for four nurses to assist in purified protein derivative (PPD-tuberculin) placement of about 100 returning NG Aviation Depot Roundabout Unit and Kosovo Force personnel at two armories. MDDF physicians will interpret the PPD results.

Support of the MDNG has been a core mission of the MDDF since its reauthorization in 1985, and providing medical and health support to the MDNG has been a specific goal of the MDDF since 2001. However, prior to the Katrina disaster in September 2005 the capacity of the MDDF's medical command to deliver health support to the NG was limited. Ironically, Katrina changed all that by giving the old MDDF Medical Command (MEDCOM), now 10th Medical Regiment (in a nod to the historic unit's "Maryland State Guard" past) a platform to shine and show its Military Essential Task List (METL) capabilities; thus, a viable medical unit that could actually provide real service, to real people, in real need.

The widely recognized and published Katrina success (Nelson, et al., 2006 and 2007) was a unit recruitment boon that allowed the 10th to build a critical mass of highly qualified medical and allied health volunteers who were able to make a meaningful and sustained contribution to the MDNG in fulfillment of the unit's internal military support mission as well as confirming its capacity; thus, fulfilling its motto *Officio Vocante Parati*-- Ready when called.

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