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COMSUBLANT/COMSUBPACINST 6490.1A
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COMSUBLANT/COMSUBPAC INSTRUCTION 6490.1A

From: Commander, Submarine Force Atlantic
Commander Submarine Force, U.S. Pacific Fleet

Subj: SUBMARINE FORCE EMBEDDED MENTAL HEALTH PROGRAM

Ref: (a) DoDINST 6490.03
(b) DoDINST 6490.04
(c) DoDINST 6490.05
(d) DoDINST 6490.06
(e) DoDINST 6490.08
(f) DoDINST 6490.11
(g) OPNAVINST 1720.4A
(h) Manual of the Medical Department MANMED (P-117)
(i) OPNAVINST 5350.4D
(j) VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide
(k) DHA Healthcare Provider's Practice Guide for the Utilization of Behavioral Health Technicians
(l) BUMED NOTICE 6520 29 SEP 2020
(m) COMSUBLANT/COMSUBPACINST 6000.2E Standard Submarine Medical Procedures Manual

1. Purpose. To promulgate and consolidate guidance for the management of Submarine Force Embedded Mental Health Programs (eMHP) and personnel.

2. Cancellation. COMSUBLANT/COMSUBPACINST 6490.1

3. Discussion. The primary mission of the eMHP is to optimize Submariner psychological well-being and enhance warfighting readiness. This will be achieved through prevention, which assists Sailors before they develop mental health issues, and through a responsive approach assisting Sailors who have already developed mental health concerns.

4. Scope. While the directives and the information in this instruction are not all encompassing, they address most of the common medical administrative situations and issues expected to be encountered by Submarine Force eMHP personnel. eMHP teams will use this instruction as their basic procedures manual. This instruction shall be reviewed in its entirety.

5. Applicability. The provisions of this instruction apply to the administration of eMHP Teams.

6. Changes to this Manual. Since medical policies and procedures evolve dynamically, medical instructions can change frequently; therefore, recommendations for changes or suggestions intended to increase the effectiveness of this instruction are encouraged and should be promptly forwarded through the administrative chain of command.

7. Records Management. Records created as a result of this instruction regardless of format or media, must be maintained and dispositioned for the standard subject identification codes (SSIC) 1000 through 13000 series per the records disposition schedules located on the Department of the Navy/Assistant for Administration (DON/AA), Directives and Records Management Division (DRMD) portal page at https://portal.secnav.navy.mil/orgs/DUSNM/DONAA/DRM/Records-and-Information-Management/Approved%20Record%20Schedules/Forms/AllItems.aspx.

8. Review and Effective Date. Per OPNAVINST 5215.17A, COMSUBLANT and COMSUBPAC will review this instruction annually around the anniversary of its issuance date to ensure applicability, currency, and consistency with Federal, Department of Defense, Secretary of the Navy, and Navy policy and statutory authority using OPNAV 5215/40 Review of Instruction. This instruction will be in effect for ten years, unless revised or cancelled in the interim, and will be reissued by the 10-year anniversary date if it is still required, unless it meets one of the exceptions in OPNAVINST 5215.17A, paragraph 9. Otherwise, if the instruction is no longer required, it will be processed for cancellation as soon as the need for cancellation is known following the guidance in OPNAV Manual 5215.1 of May 2016.

B. L. CONVERSE

D. L. CAUDLE

Releasability and distribution:
This instruction is cleared for public release with personnel holding a military Command Access Card (CAC) and is available electronically via COMSUBLANT and COMSUBPAC websites at: https://cffo.fleetforces.navy.smil.mil/csl/default.aspx and https://cffo.fleetforces.navy.smil.mil/csp-nf/.

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RECORD OF CHANGES

Change Number	Date of Change	Date Entered:	Entered By:

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The Submariner, the Submarine Force, and Embedded Mental Health

Since the beginning of the use of military submarines in the US Armed Forces, it has been recognized that these highly capable platforms would need to be commanded and crewed by exceptional people who would be able to excel under the physical and mental demands required. Today, we ask even more from the people and the platforms that are the backbone of our dominance in the undersea environment. The requirement that our people work to the edge of their abilities has natural consequences. This instruction addresses these natural consequences and reaffirms the commitment of the Submarine Force to the current and future success of each of these volunteers.

The stress that our people experience is very real and ever-present. It requires the application of solid leadership and personnel management practices in order to maintain the crew in top fighting form. Even with outstanding leadership at every level, some of us may be pushed beyond our limits by the demands of our work and our personal lives. In these situations, it is not uncommon to see a drop in the performance and efficiency of these submariners. Frequently, this is a temporary phenomenon which will be able to be rectified by the individual with understanding and support from their leadership. However, this will not always be the case, and Sailors can begin to feel hopeless, alone, and marginalized in the worst of these situations. This can lead to dangerous aggression directed inward (self-harm or suicide) or outward (assault or homicide).

Not only do we as a Force reject these destructive outcomes, we reject the loss of a single Sailor who can be restored to their previous level of functioning, or better. We hold that there is inherent value in submarine service for the nation, for the Navy, and for each submariner. It is a desirable and achievable goal for us to have each individual who has completed their service to be more capable and mentally tougher than when they enlisted or were commissioned.

This instruction delineates the expectations for and organizes the efforts of the individual Sailor, the line commanders, and the embedded mental health providers. It focuses on the response to those Sailors who have been identified or who have identified themselves as potential stress casualties or as potentially suffering from disabling mental illness. The focus of this response is to ensure the safety of our Sailors and to provide them with the support that they require in order to continue and expand upon their successes as submariners. This response must allow for the continued autonomy and dignity of the Sailor.

It is our firm belief that proper execution of this instruction and its underlying ideals will strengthen the individual Sailors, strengthen the Submarine Force, and support good order and discipline. It outlines a compassionate, fair, and transparent system which allows Sailors opportunities for success, allows commands to lead, and allows mental health providers to heal.

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CHAPTER 1
INTRODUCTION

1.1. General Information. The Embedded Mental Health Program (eMHP) model is a performance & resilience based approach balancing what is right for the individual and the organization. The eMHP will provide for patients' needs with a focus on improving them personally and professionally, enhancing their warfighting readiness, and meeting the operational goals of the unit and the Force.

a. The cornerstone of the eMHP model is the recognition of the inherently stressful nature of military service generally and the unique demands of the submarine service specifically. Effective coping and stress management skills are absolutely necessary for success and deficits in these areas can quickly lead to stress injuries and adjustment challenges. Stress injuries and adjustment challenges are not necessarily indicative of mental illness, but if not appropriately addressed, over time, can impair the individual's ability to function socially and occupationally. This recognition leads to a focus on evaluating patients, providing coping skills and other applicable therapies, and making medical referrals when appropriate. Providers also communicate with Sailors' chains of command, consistent with instruction, seeking high quality collateral information to ensure accuracy of diagnoses, treatment plans, and disposition recommendations. The model empowers Sailors to focus on their health, make informed decisions, and utilize resources within their parent commands. Thereby, the model allows commands to support their crew member's mental health needs and permits the eMHP to effectively render care. In practice, Resilience and Toughness at the waterfront are built on the following factors:

(1) Communication: Effective communication with patients and leaders allows for transparency, trust, and fidelity to the patient and unit.

(2) Confidentiality: Any submariner can seek mental health care and have the details of his or her care remain confidential with the exception of disclosures required by law or instruction. These disclosures are governed in part by reference (e).

(3) Immediacy: eMHPs are readily available to deliver care and other services in a timely fashion. The goal is to meet the need as early as possible.

(4) Proximity: eMHPs are permanently assigned to their respective submarine homeport, located near their patient population, making it possible to render care rapidly.

(5) Expectancy: Operational commanders maintain the expectation that service members will remain within the unit or return to the unit if removed with the exception of those with a mental health disability or disqualifying condition. The eMHP identifies those with mental health disabilities or disqualifying conditions and makes appropriate disposition decisions. The eMHP promotes long-term resiliency and coping mechanisms with the understanding that clinical services are focused on restoring and improving mental well-being.

b. eMHP is an evolving field of practice where providers offer balanced, well-reasoned guidance to operational commands with respect to the mental health of individuals and units while providing compassionate and ethical care to individual Sailors.

c. Regarding submarine Sailors in a transient (unplanned removal from parent command) status, it is imperative to move them towards dispositions as safely and efficiently as possible as referenced in Appendix A. The uncertainty surrounding delayed dispositional decisions has been observed to be a significant stressor for these Sailors and thus harmful to their overall wellness.

CHAPTER 2
ORGANIZATION AND RESPONSIBILITIES

2.1. Embedded Mental Health Team. An embedded mental health team is more than just a satellite clinic or dedicated provider of mental health services. The team delivers a broad spectrum of advice and interventions informed by their integration into the warfighting community. Assigned as members of the respective Squadron or Naval Submarine Support Command (NSSC) Staffs, the eMHP teams meet their proximity and immediacy goals by delivering consultation and outreach mental health services where needed the most: at the waterfront. They coordinate, in concert with homeport medical departments and Unit Medical Department Representatives (MDRs) , to ensure that comprehensive mental health care is delivered and that all associated administrative and suitability requirements have been considered.

2.2. Personnel Policies

a. eMHP Teams are comprised of:

(1) Command Mental Health Officer (CMHO) (Clinical Psychologist or Board Eligible or Board Certified Psychiatrist)

(2) Senior Hospital Corpsman: HM1 with NEC L24A (Behavioral Health Tech) or with NEC L01A (Submarine Independent Duty Corpsman/IDC)

(3) Junior Hospital Corpsman (HM3 or HM2) with L24A (Behavioral Health Tech); previous operational experience is desired but not required

b. If an eMHP has a Mental Health IDC, the IDC may support the mission of the Medical Department to the extent that it does not interfere with their assigned duties as a member of the eMHP team.

NOTE: Medical Department IDC's are vetted with different requirements than that of eMHP IDC's. Any use of the eMHP IDC outside of their eMHP role and duties should be limited to less than one fifth of their working hours and should contribute to the maintenance of IDC Medical.

c. eMHP personnel watch standing policy. In order for eMHP personnel to remain flexible in their schedules and available to meet the needs of Commands and their respective patient populations, eMHP personnel should only stand watches associated with their primary mission (e.g., eMHP personnel should partner with Medical Department leadership to manage after hour mental health crises). eMHP personnel may consider career enhancing qualifications involving watchstanding on a not to interfere basis.

2.3. Force Surgeon. The eMHP shall be administered under the clinical cognizance of the respective TYCOM Surgeon. He/she is overall responsible for ensuring proper manning, delivery of care and that clinical quality assurance guidelines are met. The Force Surgeon is the privileging authority for all permanently assigned eMHP Mental Health Officers under their respective Force per COMSUBPAC/COMSUBLANT 6320.7 (Series).

2.4. Force Psychiatrist. The Force Psychiatrist works with the Force Psychologist to provide governance and administrative oversight functions under the direction of the respective Force Surgeon to ensure program alignment and execution while serving as a staff officer and subject matter expert for their respective TYCOM. The Force Psychiatrist shall:

a. Be a board eligible or board certified psychiatrist. Previous embedded mental health experience is preferred, but not required. The psychiatry specialty leader is encouraged to collaborate with the respective TYCOM in the identification and selection of the ideal candidate for the Force Psychiatrist position.

b. Provide professional, clinical, and administrative counsel to eMHP teams.

c. Provide clinical input to TYCOM medical staff and homeport medical departments with regards to Mental Health related disqualification and waiver request proceedings.

d. Oversee peer review program for all licensed eMHP Mental Health Officers under their cognizance. Ensuring QA reporting is completed using current BUMED peer review standards and report back to the Force Surgeon at the conclusion of each quarter. New providers will complete a Focused Professional Practice Evaluation (FPPE), and then will be monitored within the Ongoing Professional Proactive Evaluation (OPPE) process. Providers will receive their first Performance Appraisal Report (PAR) after two years on station, then again upon their departure.

(1) Each Force Psychiatrist will complete professional practice reviews on each other at the appropriate periodicity. Force Psychiatrists from other operational communities may also participate in the review process.

(2) Command Mental Health Officers are encouraged to participate in the peer review process with their local MTF at the discretion of the Force Psychiatrist, but their professional practice reviews will remain under the purview of the Force Psychiatrist.

e. Work in concert with Force Surgeon and the Force Psychologist to develop/strengthen relationships with mental health teams/resources at shore based MTF's and other military or civilian facilities

f. Provide direct patient care for local, afloat submarine Sailors as directed by the Force Surgeon.

g. Coordinate with the Force Psychologist to develop an annual site visit plan for their respective submarine homeports and have the plan approved by their Force Surgeon. Additional site visits will be approved by the Force Surgeon as needed. The composition of the site visit team will be approved by the Force Surgeon.

2.5. Force Psychologist. The Force Psychologist works with the Force Psychiatrist to provide governance and administrative oversight functions under the direction of the respective TYCOM Surgeon to ensure program alignment and execution while serving as a staff officer and subject matter expert for their respective TYCOM. The Force Psychologist shall:

a. Be a licensed clinical psychologist. Board certification by the American Board of Professional Psychology is preferred, but not required. Previous embedded mental health experience is required given the career path of navy psychologists and the seniority of the force position. The psychology specialty leader is encouraged to collaborate with the respective TYCOM Surgeon in the identification and selection of the ideal candidate for the Force Psychologist position.

b. Provide professional clinical and administrative counsel to eMHP teams.

c. Provide mentorship to eMHP clinical psychologists.

d. Work with the Force Psychiatrist to ensure quarterly QA reporting is completed using current BUMED peer review standards and report back to the Force Surgeon at the conclusion of each quarter.

e. Work under the Force Surgeon and the Force Psychiatrist to develop/strengthen relationships with mental health teams/resources at shore based MTF's and other military or civilian facilities.

f. Provide direct patient care for local, afloat submarine Sailors as directed by the TYCOM Surgeon.

g. Coordinate with the Force Psychiatrist to develop an annual site visit plan for their respective submarine homeports and have the plan approved by their Force Surgeon. Additional site visits will be approved by the Force Surgeon as needed. The composition of the site visit team will be approved by the Force Surgeon.

2.6. Commodore/Commanding Officer. Shall have overall administrative responsibility of the Embedded Mental Health Program team assigned under his/her command. Shall encourage and support the eMHP Mental Health Officer in developing individual and personal relationships with the Commanding Officers of the operational submarine commands in the homeport. Will understand that the majority of the interactions with subordinate commanders will be kept in confidence. Any concerns regarding danger to unit or mission will be reported. The

Commodore/Commanding Officer is responsible for establishing and maintaining a local instruction on transient personnel throughput. Appendix A is an example of such a model based on best practices from across the seven submarine homeports.

2.7. Unit Medical Department Representative (MDR). The MDR, a submarine IDC who works under the supervision of an Undersea Medical Officer, is the primary care provider for the crew members assigned to their unit. As such, they receive communications from specialists (including mental health providers) and have access to medical records. This puts the MDR in a position of great responsibility. Per COMSUBLANT/COMSUBPACINST 6000.2E, the MDR has the responsibility to keep the Commanding Officer and the Chain of Command informed of conditions that affect the health, safety, and readiness of all command personnel. Per the DoDI 6490.08, all providers have the responsibility to limit disclosures regarding mental health care to commands to specific circumstances. The MDR will be familiar with the guidance of both of these instructions. The MDR will seek guidance from their supervising UMO in cases where the instructions or their applicability are unclear.

2.8. Command Mental Health Officer (CMHO). The Command Mental Health Officer exercises administrative oversight of the eMHP on behalf of their Commodore or Commanding Officer, and clinical oversight on behalf of their respective Force Surgeon. Whether assigned as a special staff officer to the Squadron Commodore or Commanding Officer of the Naval Submarine Support Command, the eMHP Officer serves as the "Command Mental Health Officer" for all operational submarine units within their submarine homeport, to include Group, Squadron(s), Submarines, and NSSC.

a. Shall be a licensed clinical psychologist or board eligible or board certified psychiatrist.

NOTE: In cases where personnel are assigned based on Memorandum of Agreement (MOA) with shore based Military Treatment Facilities (BSO-18), it is acceptable for an eMHP Officer to be a Clinical Psychologist (CP), Psychiatrist (P), Mental Health Nurse Practitioner (PMHNP), or Licensed Clinical Social Worker (LCSW).

b. Shall provide clinical input to homeport Medical Departments as pertains to mental health related disqualification and waiver request proceedings. The CMHO determines mental health fitness for duty. The CMHO makes suitability recommendations to the UMO. If the CMHO and UMO disagree regarding suitability, the CMHO is encouraged to discuss suitability concerns with the Force Mental Health Officer.

c. Shall provide appropriate mental health education to all enlisted members of the eMHP team and afloat Independent Duty Corpsman within their geographic region.

d. Shall serve as the supervising provider of the enlisted members of the eMHP Team ensuring that the team acts in accordance with this instruction with regards to patient care, administrative processes, command consultation, training, and quality assurance. For example, the CMHO is responsible for ensuring that patient care is goal driven and properly documented.

e. Shall conduct a medical record review no less than every 14 days for afloat command Sailors receiving mental health care exclusively outside of the embedded mental health program. This review should evaluate patient compliance with care recommendations and participation in care. The review will be documented in the electronic medical record.

f. When transferring care, shall communicate with the provider or clinic receiving care and document the communication in the medical record.

g. After a treatment plan is established, shall notify the UMO and service member's IDC of the plan and shall document this with a note.

2.9. eMHP Team LCPO/LPO. Responsible to the CMHO to ensure proper employment of the eMHP team.

a. Coordinate personnel assignments to ensure meeting day-to-day requirements of the team.

b. Advise the CMHO on enlisted matters as they pertain to the professional development of assigned personnel.

c. Advise CMHO on homeport outreach and engagement strategies and develop all enlisted personnel on the team.

d. Maintain communications with Submarine leaders, Chiefs and LPO's to inform leadership about available eMHP services and to receive feedback on the services provided.

e. Under the supervision of the CMHO, function as a care extender by conducting intake and special program interviews, providing counseling, providing crisis intervention, making safety assessments, delivering training topics relevant to eMHP, and participating in case management consistent with their training and experience as IDCs.

f. Perform appropriate triage upon intake assessing and advising on the acuity level of individual patients.

g. If the LCPO/LPO is a Submarine Independent Duty Corpsman, he/she will maintain certification per OPNAVINST 6400.1 series. The respective Squadron or NSSC Undersea Medical Officer (UMO) will serve as the IDC's Physician Supervisor.

2.10. eMHP Team Behavioral Health Technician. Responsible to the CMHO in providing administrative and clinical support as necessary to meet the mission of the eMHP team.

a. Under the supervision of the CMHO, function as a care extender in accordance with reference (k), by conducting intake and special program interviews, providing counseling, providing crisis intervention, making safety assessments, administering and scoring

psychometric testing, delivering training topics relevant to eMHP, participating in case management, and supervising group sessions consistent with reference (k).

b. Perform appropriate triage upon intake assessing and advising on the acuity level of individual patients.

c. Actively participate in initial qualifications, ongoing training, and quality assurance reviews as detailed in this instruction.

CHAPTER 3
eMHP ADMINISTRATION

3.1. Health Records. All patient medical records shall be managed in accordance with MANMED Ch 16.

a. Clinical encounters shall be documented within the approved EHR (AHLTA/GENESIS) and formatted consistent with current clinical practice guidelines for patient records. Documentation in the EHR shall be in enough detail for another practitioner to assume the care of the patient at any time and to stand-alone legally.

b. During the production of medical records that will ultimately be uploaded to the electronic health record (EHR), a certain amount of paper records will be generated. Some of these records must be maintained for seven years (e.g., consent forms), but other documents do not need to be maintained for protracted periods (e.g., release of information forms). If records are scanned into the EHR, then paper copies may be destroyed. If paper records are stored within the clinic, then they must be in secured locations and lockers (locked stowage/care area). These work product records do not substitute or alleviate any requirements for documentation in the EHR.

c. Provider work product may be retained at the discretion of the CMHO. Provider work product documents (paper or electronic) are not to be considered medical records. The primary medical record is contained in the EHR.

3.2. Privacy Act/HIPAA. Details concerning general requirements and applicability of the Privacy Act & Health Insurance Portability and Accountability Act (HIPAA) compliance laws within the Naval Service are contained in MANMED and SECNAVINST 5211 series. While the detailed administration of this program is complex, the purpose is to prevent the unlawful disclosure of Personally Identifiable Information (PII) and Protected Health Information (PHI).

3.3. Correspondence and Related Procedures. Official correspondence related to the eMHP shall meet the requirements of the Navy Correspondence Manual and local policies.

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CHAPTER 4
HEALTH CARE DELIVERY

4.1. Homeport Data Tracking. Each homeport Commodore and NSSC Commanding Officer is encouraged to develop a transient personnel data tracking system such that trends in personnel attrition and disposition outcomes can be readily identified. Such information allows for early identification of negative trends and the timely development of intervention strategies.

4.2. Routine Medical Consultation. Individuals may self-refer for evaluation and care, which includes following suggestions and encouragement from immediate CoC, peers, and family. All referrals from the CO (command directed) and IDC (voluntary) shall be made utilizing the referral form in Appendix B, which can be submitted via encrypted email or paper copy. While not limited to the following, the below consultative services should be made available by each eMHP team:

a. Complete psychological evaluation & diagnosis to include psychological testing at the discretion of the eMHP provider.

b. Substance abuse evaluations and referral.

c. Evaluation for appropriateness of family and/or command involvement in prescribed therapies.

d. Individual psychotherapy.

e. Group psychotherapy.

f. Medication referral for non-prescribing providers and management for prescribing providers.

g. Referral to a Chaplain, Ombudsman, Fleet and Family Support Center, and other available care options.

4.3. Emergent Medical Consultations. Patients who present with emergent mental health conditions require immediate evaluation and intervention.

a. During normal working hours, patients shall be evaluated for acuity by the BHT or the CMHO and referred to the nearest MTF if necessary. The local UMO can assess the need for elevation of care if neither the BHT nor the CMHO are available.

b. Outside of normal working hours, patients with suicidal ideation/gesture/attempt shall be referred to the nearest MTF Emergency Room for evaluation and disposition. ISIC and Submarine IDCs shall inform the eMHP team when such patients are sent to the local MTF

under these circumstances. If the local eMHP has a written and approved policy for care outside of normal working hours, this policy may be adhered to in place of immediate referral to the MTF.

c. Homicidal ideation shall be referred to the nearest MTF Emergency Room or law enforcement as necessary for disposition. Any threats of harm made against an identifiable person or persons will be reported consistent with instruction. In situations where the Sailor is experiencing homicidal thoughts, the focus is on potential victim(s). The CoC will: 1) maintain positive control of a potentially homicidal Sailor, 2) involve law enforcement if appropriate, and 3) consult with the CMHO regarding disposition.

d. Once emergent patients are stabilized and returned to the unit, the eMHP will conduct follow up care as indicated. The standard practice is to see patients within seven days of discharge from a psychiatric inpatient unit. However, eMHPs should aspire to see such patients the next working day.

4.4. Additional Services. eMHP teams are expected to spend approximately one-third to one-half of their time performing preventive or outreach activities. Those can include (but are not limited to) the following:

a. Unit training (stress management, sleep hygiene, etc.).

b. Unit visits (on the deckplate) to communicate with leadership MDR and crewmembers.

c. Pre and post-deployment briefings.

d. Group educational sessions.

e. Executive, Personal, or Group Coaching for leaders.

f. Provide rapid crisis response in support of Command in the wake of a traumatic event or critical incident (e.g., death of crewmember) in accordance with reference (l).

4.5. Command Directed Evaluations. Referrals for command directed evaluations shall be made utilizing the referral form in Appendix B, which can be submitted via encrypted email or hard copy. Copy of the referral form should be uploaded into the EHR at the time of evaluation of the member.

4.6. Special Duty Considerations

a. Limited Duty (LIMDU) and Physical Evaluation Boards (PEB): In any case where the eMHP provider determines that a patient will not be fit to return to duty due to a physical disability condition, for an extended period of time (in most cases this will be 90 days or more),

the patient will be placed on LIMDU or PEB by the CMHO. If there is a good probability of returning to Sailor to a submarine post-LIMDU, then a CMHO may elect to retain control of the Sailor's care. If there is a low probability of returning a Sailor to a submarine post-LIMDU, then the CMHO should transfer the Sailor's care to the local MTF in most cases.

b. Submarine Disqualifying conditions: The CMHO, upon diagnosing a patient with a disqualifying condition, shall coordinate with the respective UMO to initiate disqualification and/or waiver proceedings.

4.7. Transitions of Care. Transitions of care from one provider to another are potentially problematic. Reasonable efforts will be made to communicate directly with providers who are transferring care of service members to the eMHP Team, who are assuming care of service members from the eMHP Team, or who are providing care in place of the eMHP Team. This coordination of care will be documented in the service member's electronic health record. Situations which can give rise to these potentially dangerous transitions include: referral to the emergency room, hospital discharge, temporary reassignment, permanent change of station, initiation of limited duty, loss of facility or base access, incarceration, request for a change in provider, completion of a course of care, and referral to temporary care not offered by the eMHP Team.

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CHAPTER 5
QUALITY ASSURANCE, CERTIFICATION, TRAINING AND REVIEW

5.1. General Information. All licensed providers supporting the operational forces are credentialed by U.S. Fleet Forces Command and Privileged by their respective TYCOM surgeon. The purpose of these programs is to provide professional review of health care delivery in order to improve the quality of care. The following references shall be utilized in the execution of each eMHP quality review program:

a. OPNAVINST 6320.7A, Health Care Quality Assurance Policies for Operating Forces.

b. COMSUBLANT/COMSUBPACINST 6320.7A, Health Care Quality Assurance/ Improvement program.

c. OPNAVINST 6400.1D, Training, Certification, Supervision, and Employment of Independent Duty Corpsman.

d. COMSUBLANT/COMSUBPACINST 6400.2A, Certification, Training and Use of Independent Duty Corpsman.

e. DHA Healthcare Providers Practice Guide for the Utilization of Behavioral Health Technicians.

5.2. Licensed Mental Health Officer. It is expected that embedded mental health providers practice the full scope of their professional credentials and actively pursue additional qualifications within their respective specialties to broaden their scope of care. All eMHP Clinical Psychologists are encouraged to pursue board certification through the American Board of Professional Psychology if not already board certified. All eMHP Psychiatrists are encouraged to pursue board certification through the American Board of Psychiatry and Neurology if not already board certified.

5.3. Continuing Medical Education. A medical continuing education program is required in order to maintain national accreditation standards for professionals and to meet the criteria of State Boards of licensure. Program guidelines can be found in BUMEDINST 1520.34B. IDCs are required to participate in a continuing medical education program OPNAVINST 6400.1D. Guidance for Behavioral Health Technicians is contained in Appendix D.

5.4. Standard of Care Focused Professional Practice Evaluation. If a provider is failing to meet professional practice standards, a Standard of Care Focused Professional Practice Evaluation (SOCFPPE) will be discussed with the Force Surgeon. If the Force Surgeon directs, a SOCFPPE will be initiated. If the provider successfully completes the SOCFPPE, they will be returned to the OPPE process. If the provider fails to successfully complete the SOCFPPE, the Force Psychiatrist will discuss next steps with the Force Surgeon and Force Psychologist.

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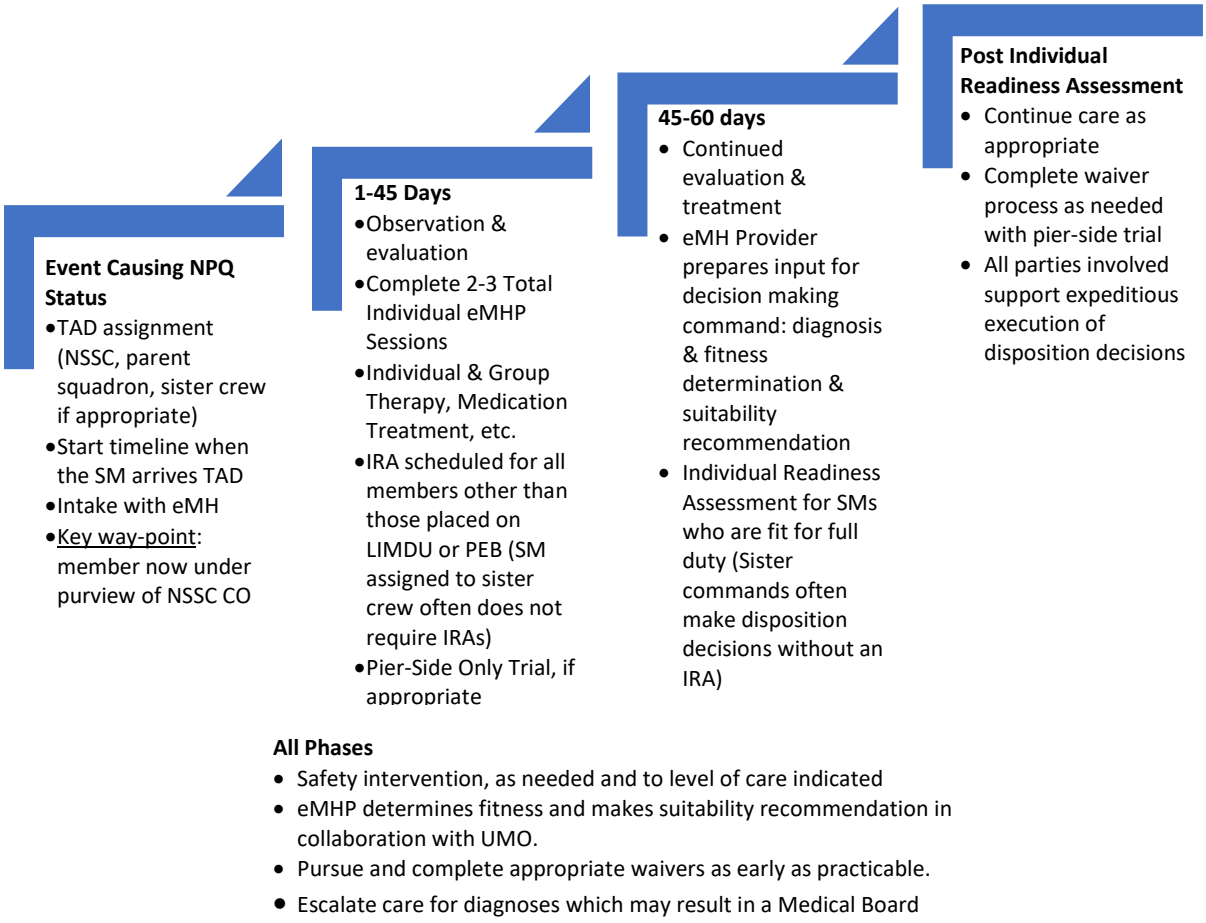
APPENDIX A

eMH Tracking & Treatment Model



1) SM has event resulting in change in status to Not Physically Qualified (NPQ). The SM is sent TAD to NSSC, parent squadron, or if necessary the sister crew (for two crewed vessels). If not already complete, an intake evaluation is conducted by embedded mental health (eMH). Evaluation and treatment period begins. Local line organization (NSSC or parent squadron) begins administrative tracking. Member is provided a "Welcome Memo" by NSSC leadership outlining expectations, including roles and responsibility for Mental Health evaluation and treatment upon checking into the Command. Alternately, responsibilities and expectations of the SM are briefed at the eMH intake evaluation.

2) After the initial eMH evaluation, the treatment plan is established and consultation is completed with the UMO, SM's IDC, and SM's Chain of Command.

3) At this point, an up to 45-day observation and evaluation period begins. At the end of this time period, the SM will have an established mental health diagnosis, an ongoing treatment plan with specified goals, an initial disposition plan, a determination of fitness for duty, and a recommendation regarding suitability made in collaboration with the UMO. This time may also include more intensive treatments such as the Substance Abuse Rehabilitation Program (SARP) or an Intensive Outpatient Program (IOP). eMH providers will make recommendations to line commanders regarding the impact of such referrals and programs on this timeline.

Potential Medical Dispositions, determined in collaboration by eMHP and UMO include:

a. SM is found fit for full duty & suitable for continued submarine service and nuclear field duty
b. Referral to DAPA and/or SARP for evaluation and treatment of substance use disorder
c. Referral for evaluation for medication and/or medication management
d. Submarine and/or Nuclear Field Duty Disqualification
e. Placement on Limited Duty
f. Referral to Integrated Disability Evaluation System (IDES) for a Physical Evaluation Board (PEB)
g. Recommendation for Administrative Separation for Conditions not amounting to a Disability (CnD) per MILPERSMAN 1900-120

4) Treatment consists of a combination of group sessions and individual sessions with the Behavioral Health Technician (if present) and one of the licensed providers. As available and as appropriate, the SM will be referred to group therapy covering various topics (Cognitive Behavioral Therapy, Problem Solving, and Coping Skills). At each individual encounter, the member's fitness and suitability will be assessed and documented in the medical record. If indicated, this time will include medication evaluation and/or management. Medications are typically started by the UMO, who will consult with the respective Force Psychiatrist, as appropriate. Complex medication cases are to be referred to and managed by psychiatry at the local MTF.

5) As soon as appropriate (normally between 45 and 60 days from the initial evaluation), an Individual Readiness Assessment (IRA) is convened if required. The IRA will be convened by the line officer to whom the SM is assigned, and it will include Stakeholders and Subject Matter Experts (SMEs): UMO, eMH, NSSC CO, CMC, JAG, current supervisors, and representative(s) from parent command (if SM has been reassigned). This list of stakeholders and SMEs may be adjusted by the line commander convening the IRA to address the needs of individual situations. The input of the eMH provider into this board consists of diagnosis and fitness/suitability assessment.

Potential Disposition Decisions as a result of the IRA include:

Medical Dispositions (normally determined and executed without an IRA, but these options remain viable and may be indicated should new information come to light in the IRA):

a. Return to duty fit for full duty and suitable (waiver process will be started or completed)
b. Submarine and/or Nuclear Field Duty Disqualification
c. Placement on Limited Duty
d. Referral to IDES for a PEB
e. Recommendation for Administrative Separation for CnD per MILPERSMAN 1900-120 (including member initiated)

Administrative Dispositions (Acted Upon by Line Commanders)

a. Continue with original command
b. Transfer to a different afloat command
c. Administrative Separation for Misconduct
d. Administrative Separation for Performance per MILPERSMAN 1910-156
e. Forced Rate Conversion due to Sub DQ

6) Utilizing all input and information provided by SMEs and stakeholders, the appropriate line commander will make the final disposition decision (aside from medical dispositions recommended by eMH or UMO). In cases of Dual Processing, a PEB and administrative processing will proceed simultaneously.

7) Administrative tracking of all service members covered by this process is the responsibility of the applicable line organization (NSSC, Squadron, sister command, or original command) with appropriate inputs from mental health, medical, and administrative departments (days TAD, scheduling of the IRA, status of waivers, etc.).

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APPENDIX B
Embedded Mental Health Referral
(Not required for self-referral)

Individual to be evaluated		
Name	Date of Birth	DoD ID Number
Command's IDC	Phone Number	Command

Complete this section for Command Directed Evaluations

Type of Evaluation (DoDI 6490.04 Encl 3, Paragraphs 2.b, 2.c, and 3)		
☐ Non-emergency Command Directed Evaluation		
☐ Emergency Command Directed Evaluation		
☐ Informal, Non-mandatory Recommendation for Evaluation*		
*Informal recommendation does not always compel report to commander per DODI 6490.08		
Commanding Officer (CO) Directing Evaluation		
Name	Signature	Date
Phone Number	Alternate Phone Number	Email Address
Person designated in writing to receive evaluation reports (if different from CO)		
Name	Phone Number	Email Address

Reason for Evaluation (Use additional pages as needed)
Please include to the extent practicable first hand accounts, times, dates, and direct quotes

Specific Concerns to be Addressed in Evaluation (Use additional pages as needed)

Mental Health Officer Name	Signature	Date

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APPENDIX C

PEER REVIEW OF PATIENT RECORDS
(Initial Assessment / SPEC)

Provider Reviewed:	**Patient Initials/Last four of SSN/Encounter Date**				
Reviewer:					
Period Reviewed:					
Mark each block as Y, N, NA, or * (for a clarifying comment)					
INITIAL INFORMATION / HPI					
Note completed within 3 working days					
Adequate documentation of Presenting Problem/Chief Complaint					
PSYCHOSOCIAL / DEVELOPMENTAL HISTORY					
Family History					
Social History/Current Social Support					
Religious Preference/ Spiritual Practice					
Trauma and Abuse History (physical, sexual, or emotional)					
MILITARY HISTORY					
Military service/ deployment history					
Combat/Blast exposure/TBI					
MEDICAL/PSYCHIATRIC HISTORY					
Allergies (PRESCRIBERS ONLY)					
Current Medications					
Medical History					
Past Psychiatric History					
Alcohol / Substance History, including Rehab Tx					
Pain Assessment					
ASSESSMENT					
Mental Status Exam					
Safety Risk Assessment					
Domestic Violence Assessment					
Do history, exam, and tests support diagnosis?					
PLAN / RECOMMENDATIONS					
Fitness For Duty / Suitability for Service					
Plan for Follow-up Care					
Goals / Measurable Objectives					
Safety concerns adequately addressed?					
Informed Consent given for NEW medications (PRESCRIBERS)					
Labs and diagnostic studies ordered as appropriate (PRESCRIBERS)					
COORDINATION OF CARE					
Did provider document that Learning Needs Assessment was reviewed?					
If indicated – Family or Command involvement					
If indicated- Coordination with other providers					
Statement regarding patient's understanding, informed consent and participation in treatment plan					

All "**N**" items should be explained in the Comments below. An "N" mark does not mean the chart is unsatisfactory.

Comments: _____

_____

_____

Recommended Action: ☐ None ☐ Discussed with Provider ☐ Forward to Specialty Leader

Reviewer Signature/Date: _____

Provider Signature/Date: _____

Force MH Action Taken: _____

Provider Action Taken: _____

Provider Signature/Date: _____

The reviewed records are: ☐ Satisfactory ☐ Unsatisfactory

Force MH Signature/Date: _____

PEER REVIEW OF PATIENT RECORDS
(Follow-up Sessions / FTR)

Provider Reviewed:	**Patient Initials/Last four of SSN/Encounter Date**				
Reviewer:					
Period Reviewed:					
Mark each block as Y, N, NA, or * (for a clarifying comment)					
RECORD REVIEW					
Note completed within 3 working days					
Duration of appointment documented (PSYCHOTHERAPY)					
CURRENT SESSION/SUBJECTIVE					
Relevant Interim History & Changes in Symptoms/Stressors documented					
For Group Notes – Group Objectives addressed					
FOR PRESCRIBERS:					
Current medication regimen documented					
Medication Side-effects (or absence) documented					
Medication Reconciliation documented					
Significant Lab Results appropriately addressed					
Informed consent for NEW prescribed medication documented					
OBJECTIVE FINDINGS					
Mental Status Exam documented					
Pain Assessment documented					
Safety Risk Assessment documented					
Domestic Violence Assessment documented					
Learning Needs Assessment review documented					
ASSESSMENT/PLAN / RECOMMENDATIONS					
Diagnosis appropriate					
Safety concerns adequately addressed					
Fitness For Duty / Suitability for Service assessment documented					
Follow-up Care plan appropriate and documented					
Goals / Measurable Objectives documented					
COORDINATION OF CARE					
If indicated – Family or Command involvement					
If indicated- Coordination with other providers					

All "**N**" items should be explained in the Comments below. An "N" mark does not mean the chart is unsatisfactory.

Comments: _____

_____

_____

Recommended Action: ☐ None ☐ Discussed with Provider ☐ Forward to Specialty Leader

Reviewer Signature/Date: _____

Provider Signature/Date: _____

Force MH Action Taken: _____

Provider Action Taken: _____

Provider Signature/Date: _____

The reviewed records are: ☐ Satisfactory ☐ Unsatisfactory

Force MH
Signature/Date: _____

APPENDIX D

Qualification, Training, and Quality Assurance for Behavioral Health Technicians

1. Purpose. To standardize and formalize the training of the Behavioral Health Technicians (BHTs) within the Submarine Force Embedded Mental Health Program (eMHP).

2. Discussion. BHTs assigned to the Submarine Force eMHP are required to operate in a challenging community accustomed to strict compliance to instructions and regulations. To establish and maintain credibility, BHTs need to rapidly learn and demonstrate mastery of administrative processes, governing instructions, and a wide range of clinical skills. It is important that the BHT participates in a robust continuing education program including periodic performance evaluations. Peer review and record review requirements are not included in this program as the documentation produced by the BHT is reviewed and cosigned by the supervising provider.

3. Administrative Requirements. The BHT will maintain a physical training binder that contains this Appendix, their initial qualification documents (Enclosure 1), and other training documentation (normally recorded on Enclosure 2). As part of their check out process, they will digitize the pages in their binder and submit them to their supervising provider for retention. After this process, the BHT may keep the physical records or destroy them.

4. Qualification Requirements. BHTs will complete the Qualification Standard for eMHP Behavioral Health Technicians (Enclosure 1) within 30 days of completing the check in process of their parent organization. If the BHT is unable to complete the Qualification Standard in this amount of time, then the supervising provider will work with the BHT to identify any factors working against their successful completion of this requirement. They will then work together to create a qualification plan and appropriate timeline for completion. This training plan and timeline will be formalized in a memorandum and maintained as part of the BHT's training binder. It will also address likely administrative and disciplinary steps that may be triggered by failure to complete the revised qualification plan. This process may be used if a BHT is removed from some or all of their duties by their supervising provider, and a requalification is warranted.

5. Continuing Education Requirements. BHTs and their supervising providers will maintain a record of training conducted. Enclosure 2 will be used to document all training, but documentation produced by outside entities such as completion certificates may be used. Training may consist of case reviews, review of documentation, observation of licensed providers performing clinical interactions, attendance to formal training, self-study topics with knowledge checks by the supervising provider, or other activities that serve to refresh or expand the knowledge, skills, and abilities of the BHT. If an outside training activity includes some type of demonstration of skills or test, then the supervising provider does not need to perform a spot check with the BHT of the topics covered. BHTs are required to have one hour of continuing training each month.

6. Performance Evaluation Requirements. Performance evaluations are a special type of continuing education. The supervising provider will perform and document an observed patient interaction each quarter. These evaluations will include an overall assessment of the performance of the BHT (satisfactory or unsatisfactory) and topics discussed as a result of the observed session. Unsatisfactory will be used to identify interactions where patient safety was in danger of being compromised. If the BHT operates in multiple types of patient interactions (individual, group, or other), then a performance evaluation will be conducted for each type of interaction each quarter.

7. Program Review. Compliance with the requirements detailed in this Appendix will be verified by the Force Psychiatrist or Force Psychologist as part of the periodic site visits. This review will be documented on the form in Enclosure 2 of this Appendix.

Qualification Standard for eMHP Behavioral Health Technicians

Name:	Start Date:	
	Completion Date:	
Knowledge/Skill/Ability Requirement	Licensed Provider's Signature	Date
1. Read & demonstrate understanding of DHA Guidance on the use of BHTs		
2. Explain the requirements of BHT supervision		
3. Explain the elements of an intake session		
4. Explain the elements of a safety assessment		
5. Demonstrate the ability to create a safety plan		
6. Read & demonstrate an understanding of DODI 6490.08		
7. Explain the difference between a clinical and a non-clinical encounter		
8. Explain the administration and use of the PHQ-9, GAD-7, AUDIT, PCL-5, and OQ 45.2		
9. Demonstrate the ability to administer the psychological testing		
10. Discuss communication with local ERs, hospitals, and clinics		
11. Discuss local referrals (Chaplain, MFSC, etc.)		
12. Demonstrate an understanding of the LIMDU and PEB process		
13. Demonstrate the ability to schedule appointments for providers		

14. Read & demonstrate understanding of the MANMED psychological qualification requirements for submarine & nuclear field duty		
15. Read COMSUBLANT/COMSUBPAC INST 6490.1 (Series)		
16. Discuss organization of the eMHP Team		
17. Discuss submarine basic military courtesies		
18. Discuss submarine force organization		
19. Discuss the purpose and execution of boat walkthroughs		
20. Discuss expected communications with IDC		
21. Demonstrate an understanding of the eMH Tracking & Treatment Model		
22. Discuss the purpose of and the preparation for patient coordination meetings		
23. Discuss the purpose of and the preparation for an IRA		
24. Demonstrate an understanding of BHT training & evaluation requirements		
25. Read & demonstrate understanding of COMSUBLANT/COMSUBPAC INST 6400.4		
26. Demonstrate the ability to coordinate collection of executive coaching releases/consents		
27. Demonstrate the ability to administer executive coaching assessments		

Documentation of eMHP BHT Training

Date	Topic and Provider Signature

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