Defense Health Agency

PROCEDURAL INSTRUCTION

NUMBER 6490.12
April 14, 2022

DAD-MA

SUBJECT: Military Behavioral Health Technician (BHT) Management and Utilization

References: See Enclosure 1

1. PURPOSE. This Defense Health Agency-Procedural Instruction (DHA-PI), based on the authority of References (a), (b) and (t), and in accordance with (IAW) the guidance of References (c) through (v), establishes the Defense Health Agency's (DHA) procedures for utilizing Behavioral Health Technicians (BHT) as provider extenders in the Military Health System (MHS).

2. APPLICABILITY. This DHA-PI applies to DHA and DHA Components (activities under the authority, direction, and control of DHA), the Military Departments (MILDEP), all military medical treatment facilities (MTF) and staff supporting the delivery of healthcare to beneficiaries. All organizational entities within the DoD that align with, or are satellites of, an MTF for the purposes of behavioral health practice in MTFs are to comply with this DHA-PI.

3. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to References (a) through (c), to establish uniform accountability and standard utilization for BHTs. This DHA PI addresses utilization of military BHTs within the clinics. As such, there remain references in this DHA PI to Military Department policies, as they are necessary support material. The Military Department policies include guidance on Military Department-specific accession and retention standards, as well as Military Department-specific training requirements that remain difference acoss the Military Departments.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosures 3 through 6.

6. PROPONENT AND WAIVERS. The proponent of this publication is the Deputy Assistant Director (DAD), Medical Affairs (MA). When activities are unable to comply with this publication the activity may request a waiver that must include a justification, including an analysis of the risk associated with not granting the waiver. The activity director or senior leader will submit the waiver request through their supervisory chain to the DAD-MA to determine if the waiver may be granted by the Director, DHA or their designee.

7. RELEASABILITY. **Cleared for public release**. This DHA-PI is available on the Internet from the Health.mil site at: https://health.mil/Reference-Center/Policies and is also available to authorized users from the DHA SharePoint site at: https://info.health.mil/cos/admin/pubs/SitePages/Home.aspx.

8. EFFECTIVE DATE. This DHA-PI:

a. Is effective upon signature.

b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date IAW Reference (c).

9. FORMS. The following DHA forms can be found at: https://info.health.mil/cos/admin/DHA_Forms_Management/Lists/DHA%20Forms%20Management/AllItems.aspx

a. DHA Form 210, BHT Supervision Form

b. DHA Form 211, BHT Weekly Hours Log

/S/
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Director

Enclosures
1. References
2. Responsibilities
3. Procedures
4. BHT Roles and Core Competencies
5. BHT Supervision: Best Practices
6. Sample BHT and Provider Facilitated On-the-Job Training Curriculum Glossary

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ENCLOSURE 1

REFERENCES

(a) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD (HA))," September 30, 2013, as amended
(b) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013
(c) DHA-Procedural Instruction 5025.01, "Publication System," August 24, 2018
(d) DoD Instruction 6490.09, "DoD Directors of Psychological Health," February 27, 2012, as amended
(e) Army Soldier's Manual and Trainer's Guide, "MOS 68X, Behavioral Health Specialist," April 28, 2017[1]
(f) Navy Personnel Command 18068F, "Manual of Navy Enlisted Manpower and Personnel Classifications and Occupational Standards Volume II Navy Enlisted Classifications (NECs)," July 2021
(g) Air Force Specialty Code 4C0X1, "Mental Health Service Specialty," May 1, 2018
(h) DoD Instruction 5015.02, "DoD Records Management Program," February 24, 2015, as amended
(i) DoD Instruction 6040.45, "DoD Health Record Life Cycle Management," November 16, 2015, as amended
(j) Medical Education and Training Campus Curriculum, "Behavioral Health Technician Program Curriculum Plan," 2019[2]
(k) DoD Instruction 1010.04, "Problematic Substance Use by DoD Personnel," February 20, 2014, as amended
(l) DHA-Procedural Instruction 6025.15, "Management of Problematic Substance Use by DoD Personnel," April 16, 2019
(m) DoD Instruction 6490.05, "Maintenance of Psychological Health in Military Operations," November 22, 2011, as amended
(n) BUMED Instruction 1510.27, "Hospital Corpsman Personnel Qualification Standards Program," October 11, 2017
(o) DoD Manual 6025.18, "Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs" March 13, 2019
(p) DoD Instruction 6490.04, "Mental Health Evaluations of Members of the Military Services," March 4, 2013, as amended
(q) DoD Instruction 6490.08, "Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members," August 17, 2011
(r) Air Force Instruction 44-121, "Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program," July 18, 2018, as amended
(s) Bureau of Medicine and Surgery Instruction 5353.4B, "Standards For Provision Of Substance Related Disorder Treatment Services," July 6, 2015

[1] This reference can be found at: https://armypubs.army.mil/epubs/DR_pubs/DR_c/pdf/web/ARN7207_STP-68X14-SM-TG%20FINAL%20WEB.pdf
[2] This reference can be found at: https://info.health.mil/sites/hro/CMT/BH/Library/METC-BHT-Program-Core-Training-Curriculum-(DHA-PI).pdf

(t) Title 10 United States Code Section 1073c
(u) DHA-Procedures Manual 6025.13, "Clinical Quality Management in the Military Health System," August 29, 2019
(v) The Joint Commission (TJC), Hospital, Ambulatory and Behavioral Health Manuals, Current Editions

ENCLOSURE 2

RESPONSIBILITIES

1. DIRECTOR, DHA. Under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness, Assistant Secretary of Defense for Health Affairs, and IAW References (a) through (c), the Director, DHA, will:

a. Oversee compliance with this DHA-PI.

b. Assign responsibility for tracking compliance with the standard processes, procedures, workflows, and necessary training on these processes and procedures outlined in this DHA-PI to the Deputy Assistant Director (DAD), Healthcare Operations (HCO) and DAD, Medical Affairs (MA).

2. DAD, HCO, DHA. The DAD-HCO will:

a. Monitor the implementation and tracking of BHT management and utilization outlined within this DHA-PI.

b. Recommend and evaluate BHT management and utilization support necessary to improve MHS delivery and quality of care outcomes when appropriate.

c. Evaluate and recommend outcome measurements in support of standardized and uniform evaluation of BHT utilization.

d. Advocate for the development and dissemination of educational products, clinical support tools, and applications to assist in training staff, evidence-based care and workflow incorporating BHTs, and standardized BHT utilization and management.

3. DAD, MEDICAL AFFAIRS (MA), DHA. The DAD-MA will ensure:

a. The Behavioral Health Clinical Community coordinates with the DHA DAD-MA Behavioral Health Clinical Management Team (BHCMT) to support BHT services. This support includes, but is not limited to: dissemination of BHT-related clinical practice standards and implementation of BHT clinical competency standards outlined herein.

b. Coordinate with the Psychological Health Center of Excellence to support BHT services through evaluation and research.

c. Coordinate with DHA stakeholders as necessary to support execution, practice standards, research, administration or any other DHA oversight agency that contributes to the utilization of BHTs.

4. BHCMT. The BHCMT will:

a. Utilize expertise to support training, dissemination of BHT-related resources, implementation, evaluation, and research throughout the MHS.

b. Advocate and adhere to DHA policies that support optimal BHT utilization and BHT-focused entities, such as DoD Behavioral Health Technician Work Group (BHTWG).

c. Provide support for BHT services including, but not limited to, dissemination of BHT-related resources, implementation of standards for BHTs, evaluation, and research.

5. DHA MARKETS, DHA MARKET DIRECTORS, DEFENSE HEALTH AGENCY REGIONS, AND SMALL MARKETS AND STAND ALONE MEDICAL TREATMENT FACILITY ORGANIZATION (SSO). The DHA Markets, DHA Market Directors, Defense Health Agency Regions, and SSO will:

a. Verify MTFs deliver BHT services as outlined in this DHA-PI.

b. Identify Service Behavioral Health Leads to support full implementation and compliance with this DHA-PI.

c. Implement BHT management and utilization requirements within the MTFs, Markets, and joint DoD/Department of Veterans Affairs facilities as outlined in this DHA-PI.

d. Ensure MTF Directors, and Behavioral Health Leads comply with the guidance in this DHA-PI, and implement corrective actions or provide additional resources and training, if required.

e. Track and monitor measures to assess MTF standardization, processes, and compliance with the management and utilization of BHTs as outlined in this DHA-PI.

f. Implement and monitor the required BHT-specific education and training activities within the local and regional areas IAW this DHA-PI.

g. Identify additional training requirements for BHTs and those engaged in BHT-facilitated behavioral healthcare.

h. Provide analysis, direction, and support to MTF staff on BHT management and utilization metrics and issues, as needed.

i. Develop, integrate, and effectively utilize BHT management and coordinate between DHA Headquarters (DAD-MA and DAD-HCO) to ensure appropriate utilization of these resources.

7. MTF DIRECTORS. The MTF Directors will:

a. Verify the MTF within their authority deliver BHT services as outlined in this DHA-PI.

b. Ensure clinics and other MTF behavioral health services comply with the guidance of this DHA-PI, and implement corrective actions or provide additional resources and training, if required.

c. Ensure that BHTs have dedicated time set aside for patient care.

d. Track and monitor measures to assess MTF standardization, processes, and compliance with the management and utilization of BHTs as outlined in this DHA-PI.

e. Provide direction and support to MTF staff on BHT management, utilization metrics, and issues as needed.

f. Identify additional training requirements for BHTs and those engaged in BHT-facilitated behavioral healthcare, including substance use disorder (SUD) treatment.

g. Ensure certified BHT files are maintained and tracked through the MTF credentialing office.

h. Develop and integrate BHT management and utilization coordination between DHA Headquarters (MA and HCO), to reduce fragmentation.

8. SENIOR ENLISTED BHT AT A MTF. The senior enlisted BHT at the MTF will, in coordination with the Chief, Department of BHT:

a. Implement and verify that BHT management, training and utilization occurs as outlined in this DHA-PI.

b. Maintain responsibility for annual BHT requirements and ensure performance of BHTs is reflected in annual evaluations.

c. Function as the MTF Director's enlisted behavioral health functional manager and advocate for behavioral health, including the optimal utilization of BHTs.

d. Oversee required outreach and prevention activities involving BHTs.

e. Inform and advocate for installation command, DHA, and the MTF Director on the adequacy of BHT utilization, organizational processes and resources needed to meet the behavioral health needs of the installation using BHT support throughout MTF operations, the deployment cycle, and other surge situations, IAW Reference (d).

ENCLOSURE 3

PROCEDURES

1. MILITARY BHT CAREER DESCRIPTION. Military BHTs are paraprofessional enlisted Service members trained as provider extenders to conduct a multitude of tasks to support the military behavioral health mission in both garrison and deployed operations across the world. The primary functions of BHTs can be divided into four categories: clinical care, case management, operational outreach, and administrative management duties.

2. ROLES AND FUNCTIONS

a. BHTs at the MTF will:

(1) Perform patient care related duties IAW their training and skill level under the oversight of a independently privileged behavioral health provider. Providers who are in a residency or internship program can oversee BHT related duties when they are being precepted by their clinical supervisor.

(2) Participate in Multidisciplinary Clinical Case Conference meetings.

(3) Adhere to documentation standards IAW References (h) and (i) and any DHA policies.

(4) Provide prevention, education, and outreach briefings.

(5) Provide disaster/traumatic event response support IAW existing Service-specific medical and operational readiness policies and procedures.

b. Senior enlisted BHTs at the MTF will, in addition to the above duties as a BHT:

(1) Develop, mentor, and manage enlisted personnel.

(2) Oversee behavioral health in-service and recurring training in coordination with the Chief, Department of BH.

(3) Oversee and monitor proficiency and competency training for enlisted BHT personnel.

(4) Ensure enlisted involvement in clinical care activities is appropriate for training level and experience.

3. INITIAL BHT TRAINING

a. Enlisted personnel begin specialty career training at the Medical Education and Training Campus (METC) at Joint Base San Antonio. The goal of the BHT training program is to prepare MILDEP personnel to serve as entry-level BHTs in both clinical and operational settings, while working under the supervision of a behavioral health provider, trainer, and supervisor.

b. BHT training provides collegiate-level instruction on foundational topics (e.g., ethics, psychopathology) and clinical skills (e.g., interviewing, psychological testing, and counseling). In addition, IAW with MILDEP- specific guidance, BHTs complete up to 203 directed clinical practicum hours. Utilization and training at MTFs should build on the foundational knowledge established at METC, consistent with Reference (j). The MHS strives to provide opportunities for all BHTs to demonstrate that each required competency is maintained.

4. UTILIZATION

a. In order to ensure readiness, military BHTs must be fully utilized in their clinical scope of practice. To support BHT optimization, BHT utilization standards are as follows:

(1) BHTs must accumulate a minimum of 750 patient care hours per year, which averages to approximately 14 hours per week. At least 50 percent (375 hours) of the total accumulated annual hours must be face-to-face patient contact. Examples of clinical activities that count toward face-to-face hours include: intake evaluations, follow-up appointments for counseling, triage assessments, group therapy sessions, and psychological test administration. Appropriate face-to-face utilization occurs when a BHT directly interacts with an individual patient or group of patients face-to-face for a clinical purpose. Face-to-face patient contact can also be accomplished through virtual platforms.

(2) The balance of a BHT's annual hour requirement may be accrued through non face-to-face clinical activities. Examples of activities that count toward this requirement include: clinical documentation, didactic instruction, individual and group supervision, high-risk patient review meetings in which specific case details and patient progress are reviewed and discussed, and multidisciplinary case staffing meetings.

(a) Patient care hours will reflect a range of clinical activities.

(b) Activities that do not count toward patient care hours include routine clinic support activities (e.g., taking vital signs, initiating the Behavioral Health Data Portal during check-in process, checking in patients, routine appointment scheduling, and inpatient 1:1 observation).

(c) Hours also can be accrued through activities in support of operational/embedded behavioral health (such as unit consultation), provided these hours meet the annual requirements. The supporting medical provider at the operational/embedded unit will provide oversight of military BHTs providing activities in those locations.

(3) Due to additional non-commissioned officer responsibilities, the required patient care hours for BHTs in pay grades E-6 and above may be adjusted to a minimum of 250 face-to-face patient contact hours annually. However, BHTs in pay grades E-6 and above who do not meet clinical competency requirements will obtain additional patient contact hours as needed to ensure minimum competencies are met.

(4) BHT utilization will be tracked quarterly by each behavioral health service line, senior enlisted BHT, and the Chief, Department of BH.

b. Clinical performance of BHTs, including utilization and training, will be included in BHT competency assessments.

c. All supervisors with assigned BHTs will review existing policies and procedures related to BHT utilization to ensure their job capabilities are fully maximized.

d. Although not a primary role of BHTs, they may also serve in a secondary and temporary support role for administrative duties such as arranging for behavioral health consultations, assisting patients with form and paperwork completion, and supporting records management. If administrative personnel are not assigned, BHTs may be used in administrative roles for brief periods of coverage only. These coverage periods will not exceed 15 hours per week. Administrative and clerical tasks will primarily be assigned to the administrative specialties.

e. BHTs will additionally comply with all published DHA institutional policies and procedures, patient care objectives, Healthcare Risk Management, and Quality Assurance Programs, Patient Safety Programs and Environmental and Infection control standards.

5. BHTS IN CLINICAL CARE

a. BHTs will be effectively leveraged as provider extenders and members of the treatment team. BHTs provide behavioral health and substance use disorder (SUD) clinical care in outpatient, intensive outpatient, partial hospitalization program, and inpatient settings. IAW their individual skill level and competency, BHTs will provide the following services under appropriate supervision when required:

(1) Individual and group treatment of individuals with behavioral health diagnoses, including SUDs.

(2) Initial intake interviews, triage and screening including use of symptom inventories (e.g., Patient Health Questionnaire-9 (PHQ-9)), risk assessments, psychometric testing (e.g., The Minnesota Multiphasic Personality Inventory-2 (MMPI-2)), diagnostic and biopsychosocial assessments, case management, crisis management, and safety support.

(3) Mental status examinations, psychological testing, collection and recording of psychosocial, and physiological data.

(4) Psychoeducational classes and groups.

(5) Operational outreach, which may include outreach to operational units and disaster and traumatic event response.

(6) Clinical administrative duties, such as documentation of clinical encounters, and review of patient medical records to facilitate continuity of care.

b. As provider extenders, BHTs perform a variety of complex clinical tasks, as indicated by the treating clinical supervisor or appropriately independently privileged provider. Some limitations to the BHT scope of practice include:

(1) BHTs may enter clinical notes but they must have them signed or cosigned by the independently privileged provider. All clinical notes in the electronic health record (EHR) must be signed or co-signed by independently privileged providers. EHR notes must be reviewed and cosigned IAW existing DHA guidelines.

(2) BHTs, in assisting with assessment and report-writing, may draft behavioral health reports but may not finalize the interpretation or sign those reports.

(3) BHTs serving in the role of an Alcohol and Drug Counselor (ADC) must be under supervision, be working toward appropriate certification, or possess such certification in order to work in SUD clinics, IAW References (k) and (l).

(4) BHTs must have direct supervision of patient contact when assessing to inform the supervising provider's diagnosis, treatment planning (initiating or changing a treatment plan), and in crisis/safety situations. See para. 7.a.1., below in this enclosure for the definition of direct supervision.

6. PROFICIENCY TRAINING

a. In order to maintain readiness, it is essential for military BHTs to practice all clinical skills including Combat and Operational Stress Control for use in austere environments, consistent with Reference (m).

b. To fulfill annual training requirements for BHTs, BHTs will complete an annual minimum of 50 hours of didactic training averaging approximately 1 hour per week, in the standard BHT competency skill areas. Qualifying didactics include conferences, formal trainings, workshops, clinically focused continuing education trainings and activities, and any DHA-provided BHT trainings. Didactic training also may be delivered by clinical supervisors, officers overseeing BHTs, or certified BHT ADCs.

7. CLINICAL SUPERVISION

a. Clinical supervision is the process of an independently privileged behavioral health provider reviewing, observing, and accepting responsibility for clinical activities performed by assigned BHT personnel.

(1) Direct Supervision. The clinical supervisor is directly involved in observing and/or monitoring BHT clinical activities as they occur. Resident or internship providers are also permitted to provide direct BHT supervision when clinical activities are under the observation or review of their clinical supervisor.

(a) In direct supervision, the supervising provider has direct contact with a BHT's patient for sufficient time and interaction to validate BHT's assessment (including information gathered to inform the supervising provider's diagnosis), the appropriateness of recommended treatment plan or changes to the treatment plan, and to address any safety issues before the close of the clinical encounter.

(b) Direct supervision should be used in any instance where a BHT is in need of supervision and/or good clinical judgement dictates. Direct supervision is always needed in the following instances: assessing to inform the supervising provider's diagnosis; treatment planning (initiating or changing a treatment plan); and in crisis/safety situations. Direct supervision is not required at every routine, non-acute patient encounters.

1. Eyes-on contact is defined as any direct provider contact with a patient of sufficient length and interaction to validate the assessment and recommendation before a patient departs the appointment. This is typically accomplished by the provider spending a minimum of 15 minutes face-to-face time with the patient to verify the findings of the BHT's encounter, validate the patient's risk assessment, and ensure the patient comprehends their treatment plan.

2. Eyes on contact from a provider is required when there is an initiation of, or change in a patient's risk level, diagnosis, treatment, treatment plan, or mental status.

3. Eyes on contact from a provider is not required when a BHT (with routine supervision for monitoring of case progress) is executing an established treatment plan, conducting psychoeducational groups/classes, and/or if the patient(s) is not at elevated risk of harm to self or others, and there is no change in the above listed circumstances necessitating eyes on provider contact.

(c) The independently privileged behavioral health provider performing the direct supervision must sign/co-sign the BHT's note in the patient record.

(2) Indirect Supervision. The clinical supervisor performs retrospective record reviews with a focus on quality of care, documentation, and the authorized scope of practice including informal consultation prior to implementing or changing a regimen of care.

(3) Case Supervision. The scheduled or unscheduled staffing/review of clinical cases between a BHT and their clinical supervisor. This review or update on the status and progress of a BHT's patients may also include other elements such as treatment planning, supervisor's feedback, skill building, or didactic components. Case supervision may be completed individually or in a group format.

b. Clinical supervision is a collaborative relationship over time, which facilitates and evaluates the supervisee's work, aims to enhance the professional competence and practice of the supervisee, monitors the quality of the services provided, and protects the public.

c. Clinical supervision develops the BHT's clinical skills while providing the required supervisory oversight for non-independently privileged providers. It is imperative that clinical supervisors use evidence-based training methods, and conduct both direct and indirect supervision to assess the competency of BHTs.

d. High quality supervision includes regular observation of the full scope of a BHT's clinical work, evaluation of work quality, provision of feedback, facilitation of BHT self-assessment regarding clinical work, and acquisition of knowledge and skills by instruction, modeling, and mutual problem-solving. Best practices of supervision can be found in Enclosure 5.

e. Clinical supervisors must allow BHTs to demonstrate and maintain clinical skill competency in the required areas. BHT Roles can be found in Enclosure 4.

f. BHTs will be afforded the opportunity to execute the full scope of their skills under appropriate supervision. MTF Directors, MTF Chief, Department of BH, and senior enlisted BHTs at the MTF will ensure BHTs maintain proficiency in clinical duties and will afford BHTs the opportunity and resources necessary to maintain competency.

g. Consistent with clinical supervision standards for other unlicensed behavioral health staff (e.g., psychology and social work interns), BHTs will have clinical supervision with an independently independently privileged behavioral health provider, consisting of:

(1) A minimum of one hour of clinical supervision per week including scheduled/unscheduled supervision sessions. Routine staffing of cases counts toward the supervision requirement, provided staffing incorporates case discussion, feedback, and a didactic/skill-building component.

(2) Individual or group formats, including face-to-face (in-person), video teleconference, or telephonic modalities, at the discretion of the supervising provider and as appropriate to the healthcare setting.

h. Senior enlisted BHTs and clinical supervisors are responsible for maintaining and ensuring supervision requirements are met.

(1) Clinical supervisors will block a minimum of one hour per week in their schedules for BHT supervision and may block additional time to perform other BHT supervision activities

and duties (including, but not limited to, record reviews and weekly training requirements), as determined by additional clinic needs.

(2) Documentation of BHT clinical supervision will be maintained by the BHT functioning as the BHT's clinical supervisor/trainer. See DHA Form 210, BHT Supervision Form as an example to document BHT supervision.

(3) Documentation will follow existing Service-specific policies IAW Enclosure 5 regarding format and frequency of documentation and maintenance of military BHT sustainment training, supervision, completed competencies, and qualifications.

(4) BHTs who fail to meet required standards for skill proficiency will be remediated to the point of proficiency through measures including, but not limited to, increased provider supervision in coordination with the supervisory chain. DHA has authority to modify BHT healthcare delivery capacity within MTFs, to include, but not limited to, assigning administrative duties within MTF clinics, increased clinical supervision or any other clinical or administrative oversight while undergoing proficiency remediation, being consistent with Reference (u). Military Departments retain authority with regard to reassignment, retention or reclassification when remediation efforts are unsuccessful.

8. BHT ADC CERTIFICATION

a. Certain Service BHTs support SUD-specific clinics in the role of ADCs. Service BHTs who hold ADC certification do so under the umbrella of the International Certification & Reciprocity Consortium (IC&RC) for ADCs, an international credentialing organization for prevention, substance use treatment, and recovery professionals. The IC&RC establishes, monitors, and advances reciprocal competency standards for ADCs and provides an internationally recognized ADC certification.

b. Each ADC credential is administered by jurisdictional Military Department-specific boards using competencies and examination developed by the IC&RC. Each board sets its own standards, application processes, timelines, and fees for certification. Military BHTs earn the credential through their Military Department-specific board.

c. Each Military Department has regulations in place that ensure that members awarded certification meet IC&RC minimum certification standards. Each Military Department maintains authority to execute certification board procedures, to include awarding of, suspension of, and revocation of certification as well as review and disposition of ethics violation allegations. This does not preclude the MTF Director from taking appropriate actions under DHA-PM 6025.13, Vols. 1-7, Clinical Quality Management in the Military Health System.

(1) BHTs who hold certifications will have files maintained and monitored with the MTF credentialing office. CCQAS is the system of record for tracking this information. BHTs with certifications will be entered into the CCQAS system.

(2) Consistent with References (r) and (s), BHTs with ADC certifications (e.g., Certified Alcohol and Drug Counselor, Navy Alcohol and Drug Counselor), or who are working toward such a credential, may work in behavioral health settings that provide the direct treatment of SUDs, including Alcohol and Drug Abuse Prevention and Treatment Program, Navy Substance Abuse Rehabilitation Program, and Army Substance Abuse Program. BHTs who have this certification require direct supervision by an independently privileged provider.

(3) BHTs who hold ADC certification may perform duties consistent with the role of an ADC, including establishing a therapeutic relationship with patients and assisting those patients in recognizing how their misuse of substances is interrelated with the life stressors they are experiencing. Certified ADCs practice within the scope of the 12 core functions, as specified by the IC&RC and as directed by an independently privileged healthcare provider. These functions include: patient intake, screening, orientation, assessment, treatment planning, counseling, case management, crisis intervention, education, referral, record-keeping and reporting, and consultation.

(4) Service members who are working towards their certification are permitted to and should shadow providers in clinical duties and practice skills under the supervision of a provider or ADC. Service members who are working towards their certification, or in a formal intern status, shall work under the clinical supervision of a independently privileged provider while developing practice skills and work directly with an ADC whenever possible. Shadowing will follow the process outlined in the DHA-PM 6025.13, vol. 4.

(5) ADCs' responsibilities also include day-to-day oversight of counselors working toward ADC certification, focusing on skill and competency development in substance misuse treatment.

9. MAINTENANCE OF CORE COMPETENCIES

a. The Joint Commission (TJC) will be the basis by which BHT competencies will be evaluated. TJC Standards IAW Reference (u) require organizations to verify and evaluate staff: qualifications; provide orientation to staff; supervise staff effectively; participation in education and training; staff is competent to perform job duties; and staff who assess individuals with substance abuse, dependence and other addictive behaviors and who plan services for and deliver services to those individuals have specific competencies. The organization evaluates staff performance.

b. Military BHTs must demonstrate and maintain competency in the full scope of clinical skills ascribed to BHTs across all services.

c. Behavioral health clinics and programs will utilize structured BHT competency assessments and clinical activity contact hour logs.

d. All BHTs will be evaluated annually to assess their competencies using a BHT competency assessment. Evaluations will be documented in the BHTs MILDEP evaluation reports IAW MILDEP policy guidance.

e. The Chief, Department of BH and senior enlisted BHT personnel will ensure that clinical supervisors complete annual BHT evaluations.

f. BHT patient contact hour logs will include, at minimum: BHT full name, the month covered by the log, a weekly tally of hours spent completing face-to-face patient contact, prevention activities, documentation, supervision (scheduled, unscheduled, and staffing), psychological test administration or scoring, case management, annotation of minimum percentage of face-to-face contact required, and printed name, signature and date of BHT, preceptor, and supervisor (see DHA Form 211, BHT Weekly Hours Log for an example contact hour log).

g. Military BHTs will recertify competencies with a clinical supervisor, the MTF Chief, Department of BH, or a senior enlisted BHT within 90 days prior to deployment or mobilization, upon return from deployment or mobilization, and on return to clinical duties after broadening or developmental special duty assignments.

10. CODING. Coding guidance can be found in the DHA coding manual available at the Publications tab under https://info.health.mil/army/bhsl/Documents/Forms/TabView.aspx.

ENCLOSURE 4

BHT ROLES AND CORE COMPETENCIES

1. CLINICAL CARE. BHTs will be effectively leveraged as provider extenders. BHTs provide clinical care for behavioral health and SUDs in outpatient, intensive outpatient, partial hospitalization, and inpatient settings. BHTs will provide the following services, under appropriate supervision when required:

a. Triage and Screening. BHTs can screen patients for appropriateness, eligibility, level of care, and treatment program admission using a variety of skills such as evaluating psychological, social, and physiological signs/symptoms, identifying co-existing conditions, determining urgency and severity of presentation/symptoms, and eligibility for services. BHTs perform triage services, which commonly involve brief same-day appointments focused on the presenting problem, a safety assessment, and dispositioning.

b. Initial Intake Assessment. BHTs conduct comprehensive intake interviews, gather preliminary assessment data, and brief the provider on the findings including information to inform the provider's diagnosis.

c. Counseling. BHTs perform individual counseling under the supervision of a independently privileged provider. BHTs are trained to deliver brief, solution-focused interventions, particularly for psychosocial concerns and stressors, consistent with evidence-based practice.

d. Safety Support. BHTs are trained to recognize and respond to crisis situations. They implement crisis intervention techniques, and when necessary, can conduct safety planning, assisting the provider in managing high-risk patients. BHTs also provide brief patient monitoring in high-risk situations until transport to a secure facility can be coordinated. BHTs that have completed the requisite passive restraint training (e.g., Prevention and Management of Disruptive Behavior training) function as the team leader and training monitor in inpatient programs that use such techniques.

e. Group Interventions. BHTs provide components of group treatment as an extension or reinforcement to provider-led evidence based therapy protocols. BHTs actively lead psychoeducational and treatment groups that focus on stress, anger, assertiveness, sleep hygiene, tobacco cessation, coping with psychosocial issues, and basic Cognitive Behavioral Therapy techniques. They also facilitate aftercare or recovery groups. BHTs function as co-therapists for protocol-based treatment (i.e., manualized) groups such as Problem Solving Therapy and Cognitive Behavioral Therapy. BHTs screen members for group inclusion, review expectations and parameters for group participation, assist with group therapy notes using templates with subsequent provider review and completion of documentation, and can track group attendance and progress.

f. Reinforcing Clinical Objectives. BHTs actively monitor patients' progress and compliance, reinforce treatment gains, and solidify clinical objectives through close collaboration with the supervising provider. BHTs effectively monitor compliance with homework assignments. They target patient motivation and treatment engagement through the use of motivational interviewing techniques, a standard intervention in substance abuse treatment. BHTs draft preliminary safety plans and review ongoing safety plans for accuracy and compliance. In the inpatient setting, BHTs reinforce adherence to patient's daily goals, bibliotherapy, journaling, or other assignments to support treatment.

g. Psychometric Testing. BHTs administer, score, and assist in the interpretation of a range of tests and measures from psychological symptom inventories (e.g., PHQ-9) to more complex psychodiagnostic and neuropsychological tests, depending on locally available training and supervision and as indicated by the clinical supervisor or independently privileged provider Additionally, BHTs conduct routine screening and administration of treatment-based follow-up/outcome measures used to monitor treatment or symptom change over time. In addition to testing, BHTs assist with report writing by generating draft reports and informing a supervising provider's diagnoses based on assessment results.

h. Medical Tasks. BHTs assist with general medical tasks as dictated by the mission and specific service. If the BHT has completed appropriate trainings, these activities may include: taking vital signs, collecting urine samples, completing lab order paperwork, dispensing medication, drawing blood, administering breathalyzer tests, and collecting data regarding medication compliance.

i. Inpatient Support Activities. On inpatient units, BHTs assist patients and staff on any of the clinical care duties listed above with the addition of patient nutritional needs, hygiene and comfort measures, new patient orientation, and milieu management.

j. Case Management. BHT case management/coordination activities include, but are not limited to, coordinating and participating in treatment team meetings, communicating high interest enrollment/disenrollment, duty limitations, providing safety recommendations to Unit Commanders and primary care providers, and coordinating behavioral health services for patients in transition. During the course of case management duties, BHTs facilitate care, as well as assess, monitor, follow-up, and respond to changes in patients' needs and goals, and create proactive plans of care. BHTs support patients' self-management goals, connect patients to community resources, and facilitate medication reconciliation.

2. OPERATIONAL OUTREACH. BHTs provide behavioral health and substance abuse outreach focused on prevention and education. They may also provide disaster and traumatic event response.

a. Outreach to Operational Units. BHTs provide outreach via group educational briefings on various health and lifestyle topics, consultation with leadership, individual "walk-abouts," and other rapport-building efforts. BHTs most often act independently in these outreach functions as

no direct clinical services are provided, utilizing their aligned supervising provider for support as needed.

b. Disaster or Traumatic Event Response. BHTs participate in disaster or traumatic event response, which may involve providing psychological first aid or other appropriate crisis interventions, consultation with command, and other non-therapeutic outreach activities designed to mitigate the negative impact of exposure to trauma and increase adaptive behaviors.

3. ADMINISTRATIVE MANAGEMENT DUTIES. Although not considered the primary role of BHTs, administrative duties can be a secondary and temporary support role for BHTs. BHTs may be used in administrative roles for brief periods of coverage only. These coverage periods will not exceed 15 hours per week. Administrative and clerical tasks will primarily be assigned to the administrative specialties. BHTs may arrange for behavioral health consultations, and assist patients with form and paperwork completion. They may also assist with record management which would include items such as entering information into records or databases, inspection of patient medical records, and managing medical reports from providers. BHTs trained to submit Patient Safety Reports for unsafe patient care occurring within BH clinics will comply with Reference (u) Volume 2: Patient Safety and Reference (u) Volume 3: Healthcare Risk Management standards.

ENCLOSURE 5

BHT SUPERVISION: LEADING PRACTICES

1. SUPERVISION MODELS. There exist various models of supervision (e.g., developmental models, competency-based models, integrated models). Each supervisor and BHT will work collaboratively to determine which supervision model is appropriate for both parties and for the clinical setting. While it is not within the scope of this DHA-PI to recommend specific BHT supervision models, supervisors will ensure supervision is:

a. Rooted in the individual, beginning with the supervisor's style and approach to leadership.

b. Precise, clear, and consistent.

c. Comprehensive, and uses current scientific- and evidence-based practices.

d. Operational and practical, providing specific concepts and practices in clear, useful, and measurable terms.

e. Outcome-oriented to improve BHT competence, create a sense of mastery and growth for the BHT, and address the needs of the organization, the supervisor, the supervisee, and the patient.

2. GUIDELINES. Clinical supervisors will utilize high quality supervision and direct observation practices, such as the supervising provider-BHT paired team model. Clinical supervision should be developmentally aligned to the BHT's clinical skill level.

a. Ideally, a clinic should be structured such that each BHT is paired with a supervising provider. Supervising provider generally refers to an independently credentialed provider with primary responsibility to provide clinical oversight of the BHT. In this paired team model, each supervising provider works closely with their aligned BHT(s), providing necessary training and supervision. The BHT "shadows" their supervising provider in a number of activities depending on the schedule, clinic demands, level of experience, and provider availability. This structure helps to build confidence in the BHT's skills and capabilities in order for the supervisor to delegate tasks appropriately. Furthermore, this team approach facilitates supervision and role-modeling. When an aligned BHT is side-by-side with their supervising provider as they perform various clinical duties, learning will occur through observation and role-modeling, thereby limiting the amount of additional time needed for a provider to spend training the BHT. With the increase in BHT skill acquisition over time, supervisors increase delegation of clinical tasks to the BHT. As a BHT gains clinical skills, provider templates may be modified for concurrent/staggered intakes or education/counseling sessions. It should be noted that not all BHTs will require this level of supervision and training. Rather, BHTs should continue to receive supervision and training consistent with improving upon their current skills.

b. The execution of BHT and provider alignment will vary from clinic to clinic, due to differences in clinic needs, staffing, and ratio of BHTs to providers. It may be optimal to have the clinic Non-Commissioned Officer tasked to make a schedule of the pairings/assignments IAW clinic needs, and in consultation with clinic leadership and providers on best fit of provider and BHT (considering relevant factors like caseload, supervisory experience, provider and BHT skill and comfort level, etc.).

c. BHTs should be aligned with an identified supervising provider at all times who is responsible for the care the BHT provides. Both the BHT and the aligned supervising provider should be aware of that assignment and any changes to it. Effective team communication within a clinic is key to the successful execution of this provider extender optimization model.

d. The BHT provider extender and provider alignment may change, depending on the need. For example, a BHT could be paired with provider "A" for the first four hours of a shift, during which the BHT conducts a psychoeducational group containing patients from several providers' caseloads. The BHT will draft group progress notes for provider "A" to review, approve, and sign. The BHT could then be aligned with provider "B" for the second four hours of the shift, completing two intakes under their supervision. Provider "B" is responsible for the provider portions of the intake which includes reviewing and signing off on documentation completed under their supervision. In this fashion, several providers and patients benefit from having BHTs optimized as provider extenders.

e. Supervisors adhere to the same standards and ethics as apply to their licensed/certified discipline. In addition to their own profession's ethical codes, supervisors will:

(1) Uphold the highest professional standards of the field. Supervisors should remain cognizant that less professional distance separates BHT and patient and at times they may be in the same unit or living quarters. This makes dual relationship considerations a particularly important focus of patient assignment and supervision focus.

(2) Seek professional help (outside the work setting) when personal issues interfere with their clinical and/or supervisory functioning.

(3) Conduct themselves in a manner that models and sets an example for unit mission, vision, philosophy, wellness, recovery, and consumer satisfaction.

(4) Reinforce zero tolerance for interactions that are not professional, courteous, and compassionate.

(5) Treat supervisees, colleagues, peers, and patients with dignity, respect, and honesty.

(6) Adhere to the standards and regulations of confidentiality IAW References (o) through (q) and applicable federal/state law. This applies to the supervisory relationship as well as the healthcare provider role.

f. Other standardized training/competency documentation forms may be utilized at select commands. It is recommended supervisors consult with The senior enlisted BHT personnel also supervising BHTs in their clinical setting for more information on appropriately documenting BHT training and supervision.

ENCLOSURE 6

SAMPLE BHT AND PROVIDER FACILITATED ON-THE-JOB TRAINING CURRICULUM

Date	Topic	Instructor(s)
9 AUG	DoDI 6490.08 Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members, 17 Aug 2011	Senior Enlisted BHT
16 AUG	Healthcare and Emergency Treatment	Senior Enlisted BHT
23 AUG	DoDI 6490.04 Mental Health Evaluations of Members of the Military Services, 22 Apr 2020	Senior Enlisted BHT
30 AUG	Risk Assessment	Military Provider and/or Civilian Provider
6 SEP	DHA-PI 6025.15 Management of Problematic Substance Use by DoD Personnel, 16 Apr 2019	Senior Enlisted BHT
13 SEP	Anatomy and Physiology	Senior Enlisted BHT
27 SEP	Mental Status Exam	Military Provider and Civilian Provider
4 OCT	Health Record Maintenance	BHT
11 OCT	Walk-ins	BHTs
18 OCT	Outpatient Groups	Military Provider and BHT
25 OCT	Diagnosis Part I	Military Provider and Civilian Provider
1 NOV	DoDI 6490.05 Maintenance of Psychological Health in Military Operations 29 May 2020	Senior Enlisted BHT
8 NOV	Preventative Medicine Programs	Senior Enlisted BHT
15 NOV	Leadership 101	Senior Enlisted BHTs
22 NOV	Diagnosis Part II	Military Provider and Civilian Provider
29 NOV	Clinical Support Services (Laboratory)	Senior Enlisted BHT
6 DEC	Intensive Outpatient Program/TBI Overview	Senior Enlisted BHTs
13 DEC	Clinical Support Services (Pharmacy)	Senior Enlisted BHT

Date	Topic	Instructor(s)
20 DEC	Crisis Intervention	Military Provider and Civilian Provider
27 DEC	Personality Disorders	Military Provider and Civilian Provider
3 JAN	Psychiatry and Medication Management	Military or Civilian Psychiatrist

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

ADC	Alcohol and Drug Counselor
BHCMT	Behavioral Health Clinical Management Team
BHT	Behavioral Health Technician
BHTWG	Behavioral Health Technician Work Group
DAD	Deputy Assistant Director
DHA	Defense Health Agency
DHA-PI	Defense Health Agency-Procedural Instruction
EHR	electronic health record
HCO	Healthcare Operations
IC&RC	International Certification & Reciprocity Consortium
MA	Medical Affairs
METC	Medical Education and Training Campus
MHS	Military Health System
MILDEP	Military Department
MMPI-2	Minnesota Multiphasic Personality Inventory 2
MTF	military medical treatment facility
PHQ-9	Patient Health Questionnaire-9
RVU	Relative Value Unit
SUD	Substance Use Disorder

PART II. DEFINITIONS

Unless otherwise noted, these terms and their definitions are for the purposes of this DHA-PI.

behavioral health. The integration of behavioral, psychosocial, emotional, and biomedical science knowledge and techniques, and their application to prevention, diagnosis, and treat a person's mental well-being, their ability to function in everyday life, their quality of life, and their concept of self. Clinical problem presentations and treatment services include, but are not limited to: stress, depression and other mood disorders, anxiety, posttraumatic stress disorder, SUDs, relationship problems, grief, and attention-deficit/hyperactivity disorder.

BHT. An enlisted Service member, civil service, or contract employee trained to conduct tasks to support the military behavioral health mission in both garrison and deployed operations across the world. Primary functions of BHTs include: clinical care, case management, operational outreach, and administrative management duties. For the purposes of this DHA-PI, the term "BHT" also applies to any uniformed personnel assigned to BHT roles, such as defined in References (e), (f), and (g).

BHTWG. The BHTWG is a chartered work group established in February 2017 that reports to the DHA BHCC and is comprised of representatives from each MILDEP, METC, and the National Capital Region Market. The work group is chaired by a representative from the Psychological Health Center of Excellence, who oversees the advancement of its core objectives, including the aggregation, analysis, and dissemination of knowledge and expertise in support of the military BHT profession.

Combat and Operational Stress Control. Programs that support psychological health in military operations and the early detection and management of combat and operational stress reactions in order to preserve mission effectiveness and warfighting capabilities and mitigate the adverse physical and psychological consequences of exposure to severe stress.

continuing education. Education beyond initial academic or professional preparation approved by an appropriate certifying professional organization that is relevant to the type of care or service delivered in an organization.

core competency. Minimum knowledge, skills, and abilities that are required to perform assigned duties.

independently privileged behavioral health (mental health) provider. A psychiatrist or psychiatric nurse practitioner, psychologist, social worker, or other independently privileged provider of behavioral/mental healthcare.

independently privileged provider. An individual who possesses appropriate credentials and is granted authorized clinical privileges to diagnose, initiate, alter, or terminate regimens of healthcare within a defined scope of practice.

provider extender. A trained paraprofessional authorized to provide basic services under the supervision of a independently privileged provider.

psychoeducational. Education offered to people with behavioral health, substance abuse, and medical conditions, potential causes of and contributing factor to their condition(s), the rationale for using a particular treatment, intervention, or behavioral change might be effective for reducing their symptoms.

preceptor. A clinical peer who has been appointed in writing to evaluate a healthcare provider's clinical practice. The preceptor is designated for consultation, clinical feedback, and general oversight of the clinical activities of the provider. A preceptor may review medical records, and conduct direct observation of a provider's practice, however they are not required to be present

for or approve the provider's procedures or clinical decisions since the provider's clinical privilege(s)/practice is not restricted in any manner.

supervision. The process of reviewing, observing, and accepting responsibility for assigned personnel.