Incident Determination Committee Quality Assurance

Project Summary

January 2020 to July 2024

What

In a Quality Assurance (QA) effort to assess fidelity to the Incident Determination Committee (IDC) and the Air Force Central Registry Board (CRB) model across all Service branches, Military Community Advocacy (MCA) and the Family Translational Research Group (FTRG) at New York University (NYU), and the Clearinghouse for Military Family Readiness at Penn State (Clearinghouse) conducted a multi-phase, multi-year QA of the IDC/CRB across the four Service branches[1].

Why

DoDM 6400.01, Volume 1, July 22, 2019 states "An IDC quality assurance [QA] process must be established for monitoring and QA review of IDC decisions in accordance with Service FAP [Family Advocacy Program] headquarters implementing policies and guidance."

When & How

Between 2020-2022, at the 39 participating installations, trained master reviewers from the Clearinghouse and FTRG team (the QA team) assessed the quality of processes by listening to the IDC/CRB and its related meetings (details below).

IDC/CRB Meeting Observations and Ratings for Case Agreement and Case Quality

The QA team observed and rated case agreement and case quality for 218 IDC/CRB meetings.

Assessment of the case-preparation process across the Service branches could not be conducted due to the lack of procedural standards used in the case preparations. This lack of standards may have diminished the process quality related to FAP IDC/CRB case presentations affecting the thoroughness of the case presentation and alignment with the Decision Tree Algorithm (DTA) (i.e., the criteria for abuse).

Some sites held regular meetings in which cases were formally and methodically reviewed and prepped in advance of an IDC/CRB presentation; however, at other sites, there was no consistent review process.

Implication: Without procedural standards, implementation research indicates that drift and a decrease in quality can be expected. Incidents presented without attendance to DTA criteria and critical factors such as the following:

- credibility of information obtained,
- complete interviews from all parties,
- integrated reports from other agencies (e.g., police report),
- other important qualifying details (e.g., level of force used, clear chronology of events).

1 The Space Force became the fifth branch of the U.S. military after the inception of this study.

Recommendations

The creation of an incident-assessment review template (checklist or standardization tool) would provide a standardized template that could be used across all Service branches to establish consistency.

Establish ongoing professional-development learning experiences.

Result

Incident Assessment trainings across the Services will be offered in October and November 2024.

Observation of Clinical Case Staff Meetings

The QA team observed and assessed meeting quality for 46 Clinical Case Staff Meetings (CCSMs) at 27 installations across the Air Force, Navy, and Marine Corps[2].

Safety plans were not discussed in over one-third of the CCSMs observed; this gap could have significant safety implications for victims.

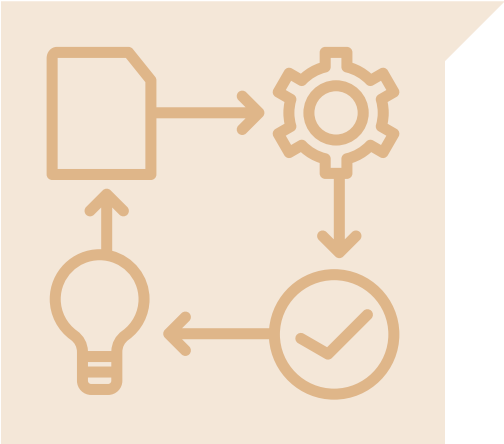
The majority of CCSM meetings observed were used for administrative oversight rather than for supervised clinical case management. In 28% of meetings observed, CCSM members did not offer input on case management.

In about a quarter of the meetings observed, cases were presented by clinicians who had less knowledge about the cases than the clinicians who were assigned to the case in about a quarter of meetings observed. Thus, case conceptualization and treatment plans for comprehensiveness could be impacted.

Recommendations

Create a CCSM standardized template and require this template to be used for treatment planning during the CCSM in order to increase the likelihood that all elements are addressed.

Implement a continuous quality-improvement data-collection process to identify ongoing and emerging areas of need in terms of training and implementation support.



Result

CCSM training for all Service branches was launched in September 2023. Quarterly refresher trainings began in July 2024. Incident Assessment trainings are scheduled to begin in October 2024.

2 Army was excluded from the CCSM assessment component of the QA due to concurrent training and quality assurance processes occurring as part of the adoption of the IDC processes.

Review and Rating of Incident Severity Scales

The QA team observed processes and rated 137 case Incident Severity Scales (ISS) scores with 56 FAP clinicians at 39 installations across the Army, Air Force, Navy, and Marine Corps.

The observed clinicians and the QA team were in agreement on ISS ratings most of the time, and this consensus indicated an overall good agreement with the appropriate use of the tool with the below breakdown by rating severity. Percentages reflect agreement of clinician ISS ratings with the QA team.

- 85% of the time the ISS rating was mild,
- 78% of the time when ISS rating was moderate, and
- 83% of the time the ISS rating was severe.

The highest levels of disagreement were for child emotional and child neglect incidents.

A consistent issue that has direct implications for the IDC/CRB process is the lack of detailed information about the cases. Therefore, a focus should be placed on gathering a more comprehensive assessment of incidents.

The QA team noted that clinicians found several elements challenging, and they included the following:

- assessing the severity of intimate partner emotional abuse, sexual abuse, and child emotional abuse,
- appropriately identifying the most serious injury (i.e., the one to rate using the ISS),
- assessing for reasonable potential for more than inconsequential physical injury, and
- using biased language and focusing on erroneous details and sequences of events that lack a clear timeline.

In addition, the QA team conducted 12 feedback sessions with FAP clinicians from four Service branches.

Overall, FAP clinicians reported confidence in their ability to complete the ISS accurately.

Most clinicians would like additional training and guidance regarding the following:

- Determine how to address "subjective" criteria that they found to be challenging (e.g., questions related to reasonable potential).
- Determine how to appropriately complete the severity scales with limited information (e.g., when a family member declines to be interviewed).

Recommendation

Additional ISS training, support, and monitoring are warranted.

- Provide training across the Service branches that addresses the areas of most need.
- Update and refine the current web-based training for the ISS.
- Implement a continuous quality-improvement plan.

Result

A virtual training was offered across the Service branches in April 2024. This training focused on recent changes to the tool and reviewed the most challenging elements as assessed by the QA team. In 2025, the ISS training will be available on the Clearinghouse's FAP Portal.

Review and Quality Coding of Incident Assessment/ Case Write-Ups

The QA team conducted quality reviews on 354 incident assessment/case write-ups from the Air Force, Navy, and Marine Corps.

The findings indicate that incident-assessment preparation processes and practices vary across Services, and this situation hinders consistency and standardization.

FAP Supervisors (i.e., case presenters at the IDC/CRB) report that most act and impact components of a write-up are adequately reviewed; however, other critical elements (e.g., relevant parties interviewed, logical sequence of events) are reviewed less than 50% of the time.

FAP presenters agreed that the required impact components from case write-ups are primary areas of concern, as such, most cases reviewed had errors in acts/omissions (90%), credibility (86%), and necessary impact information (74%).

Specific problematic areas include the following:

- including irrelevant information (i.e., infidelity or other transgressions not related to the alleged incident) in case write-ups for partner abuse (all types),
- having a lack of adequate impact information related to partner emotional abuse, and
- having a lack of adequate incident assessment of reasonable potential for partner physical abuse.

Findings indicate a need for clinician training that focuses on how to conduct incident assessments and prepare case write-ups in a concise manner that supports the required elements of the DTA/abuse definitions for presentation at the IDC/CRB.

Provide guidance, using standardized processes, and support by offering a standardized template to clinicians to help them present intake and clinical-assessment information in a succinct write-up. Establishing this protocol will help to ensure FAP Supervisors are well equipped with the necessary information for the committee to make accurate incident determinations at the IDC/CRB.

> "The training was helpful to first time users and a good refresher for those who are familiar with the process. Very helpful. It helped explain some of the parts of the assessment in a more precise way.
>
> The examples were great, and I really appreciated the discussion why the example cases received each rating."
>
> *Incident Severity Scales Training Participant*

Recommendation

Develop a standardized, comprehensive incident-assessment training that teaches FAP clinicians how to assess cases that will be presented at the IDC/CRB. In addition, a standardized template should be developed for all Service branches to use as they complete case write-ups. These actions could improve the quality of the case write-ups and enhance the accuracy of the IDC/CRB decisions and treatment outcomes.

Trainings

We created a standardized, comprehensive assessment training of which:

There have been **790 registered participants** for the Clinical Case Staff Meeting trainings to date.

There were **868 registered participants** for the Incident Severity Scales Training in April 2024.

For more information or to request the full reports, send an email to FAPQA@psu.edu.

PennState CLEARINGHOUSE FOR MILITARY FAMILY READINESS

We sincerely thank New York University Family Translational Research Group (FTRG) for their invaluable collaboration and support on the IDC QA project. Their contributions have been instrumental in advancing this applied research to support military families.