7. APPENDIX A: ARMY SITE BRAVO CURRENT STATE REPORT

Site Bravo Behavioral Health System of Care[a]
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Introduction

In December 2012, members of the MIT Behavioral Health Participatory Action Research team visited Site Bravo to better understand the current state of the installation's system of care. Over three days, we interviewed 19 key stakeholders drawn from command, medical and installation services. In addition, we engaged with small groups of these stakeholders through 7 focus groups and 12 meetings. These interactions with a broad set of actors across the installation enabled us to better understand the dynamics of the clinical and non-clinical behavioral health systems of care. Since then, we have continued to interact with the BH leadership and other informants at the installation to understand changes and improvements to the system of care, including a recent field trip in June 2014. In this summary we describe the evolution of the system of care on the installation from 2010 to 2013, identify unique practices for care provision and care management, and highlight areas where senior leadership intervention is needed.

Evolution of the System of Care

Over the last five years, Site Bravo has transitioned its primary mission from an installation with a focus on institutional training to a new mission, serving a FORSCOM Heavy Division. Prior to the change in installation mission, the installation's soldier population was around 8,000; however, with the arrival of the combat division and departure of the TRADOC units, the population has grown to nearly 30,000 soldiers. This increase has resulted in a rapid growth of the behavioral health team, and a sense of change fatigue within the behavioral health organization. As the chief noted:

> *"There has been a breakneck pace of change and behavioral health is everyone's new favorite hobby…everyone, including MEDCOM, has too many ideas and not enough resources, so the tempo has been fatiguing and it hurts retention. There is always another e-mail with something else being put on our plates. And some of them are good ideas and there are good intentions, but it's unmanageable."*

In 2011, the direct care Behavioral Health System of care was distributed across five locations on the installation, as shown in Figure 1. The first is a triage and

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assessment clinic that was established to see walk-in patients to ensure access to care, and mitigate symptoms until such time that a provider was available for continued care. Patients presenting with acute symptoms would be referred to the Emergency Room assessment and admission to inpatient care. Outpatient care services were delivered in two clinics – one for service members, and one for both service members and their families. If the installation was not able to meet access to care, they referred Soldiers and family members to the purchased care network. The installation also has an 18-bed inpatient care ward at the Army Community Hospital (which is located off the installation). Because of the high demand for inpatient care, two-purchased care facilities are used to augment the inpatient capabilities of the hospital. The installation also houses a DoD pilot program designed for intensive outpatient care for Soldiers identified as severe, but not acute, PTSD sufferers. Additionally, soldiers admitted to this program must have a minimum of two years remaining on Active Duty and have the endorsement of their chain of command prior to entry.

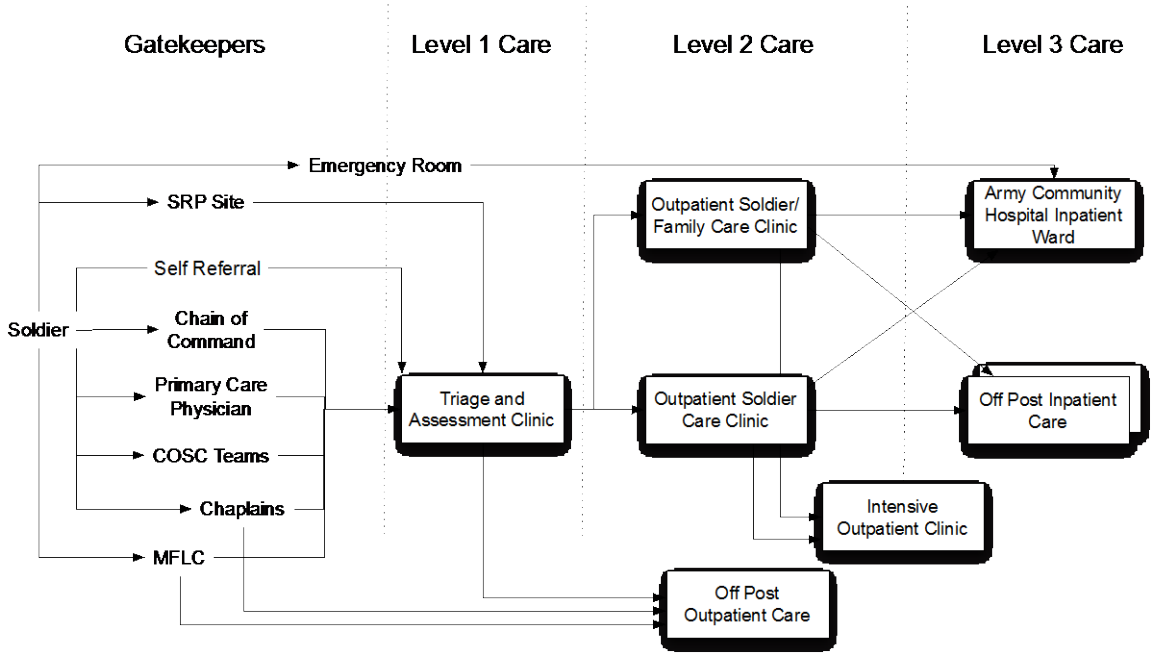


Figure 1 Behavioral Health System of Care in 2010

A unique aspect of this architecture was the use of Combat Operational Stress Control (COSC) Teams staffed by Licensed Clinical Social Workers. These providers served in a variety of roles within units, including advising and assisting commanders in the identification of treatment options and services for medium and high-risk soldiers. Additionally, COSC team members tracked and worked with these Soldiers immediately upon redeployment from theater. While COSC utilization varied from commander to commander, it was generally accepted as a useful resource for command teams. This construct was repurposed into the EBH teams. When discussing the evolution of the system of care, the chief noted:

"We are tied to two twin goals – accessibility, and continuity of care. We meet access hands down with triage via EBH. Continuity of care is the challenge… You can't maximize on two variables so we've gone big into groups and have tiered PTSD care. The first tier is some individual and groups in EBH with EBT stuff. And if that isn't enough, then you get referred to the WRC - a four-week model for PTSD care… and if that's not working, then you go to NICOE."

In 2012, the triage and assessment clinic had been distributed into the EBH clinics and the two outpatient clinics. There were two EBH clinics that had been established as standalone clinics within the brigade footprint, while the remaining units were functionally aligned within the outpatient clinics (Figure 2). As the BH chief noted:

"By my estimation, we have the functional equivalent of EBH but we are not co-located in the foot print. And I think there's nothing wrong with that. Otherwise were going to end up in spaces like 10 office spaces and that's not a long-term solution. It would be a bad move and we have until 2014, so let's do it right and get the funding and make buildings work in redesign spaces."

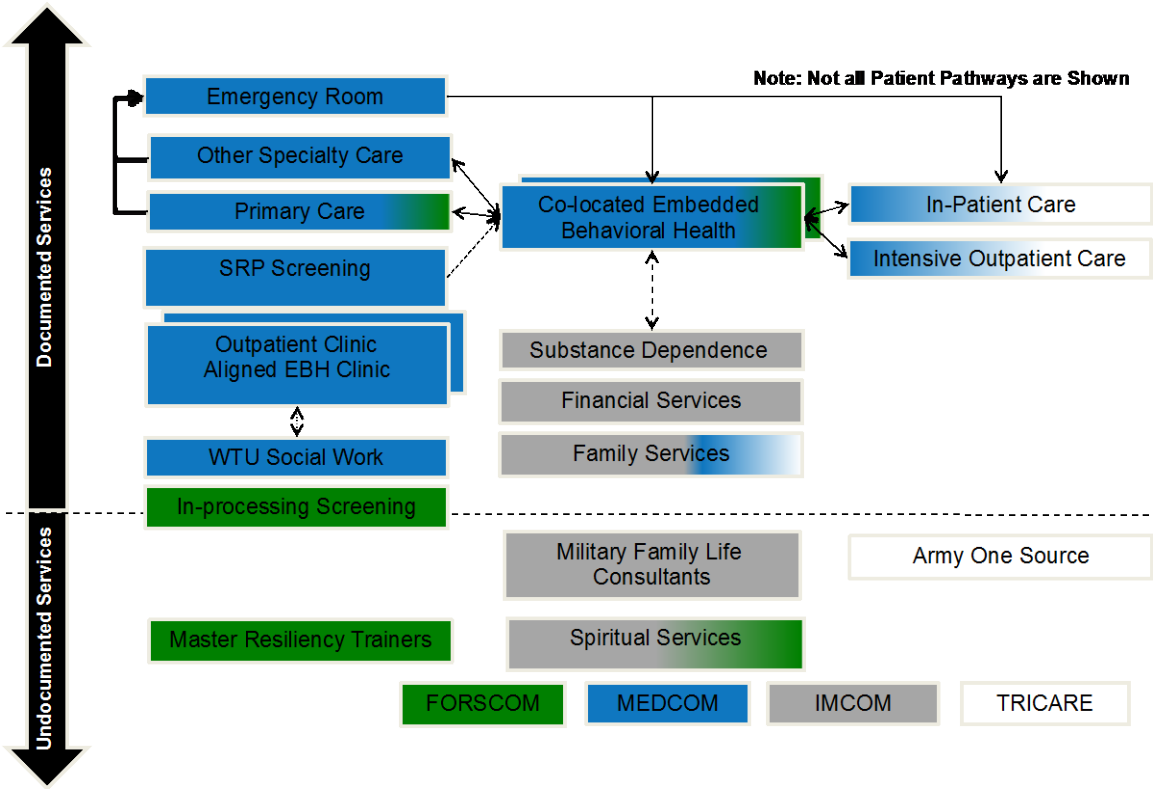


Figure 2 Site Bravo System of Care in 2012

Provider Readiness for Embedded Behavioral Health

A primary objective of the Embedded Behavioral Health model is to improve the relationship between behavioral health and command by assigning a dedicated provider to each battalion and providing sufficient time (twelve hours a week) for providers to regularly consult with command on issues related to soldier safety and mission readiness. By building credible command-provider relationships, it is hoped that commanders will be more supportive of their Soldiers seeking behavioral health care and that the stigma surrounding behavioral health will be reduced through increased command support and education. Operating in EBH requires providers to step outside of their classical training as medical professionals and serve not only the needs of Soldiers as patients, but also the needs of the Army and command in making appropriate disability evaluations and recommending appropriate short and long-term work restrictions for Soldiers who can no longer safely execute their mission. While active-duty Army providers are accustomed to managing these multiple roles and stakeholders, for civilian providers, who constitute the majority of providers at Site Bravo and throughout the Army, this is a major change. Providers expressed concerns about EBH clinics being collocated in the brigade footprint and the increased command contact expected of them in EBH. One provider shared:

> *"…There may be trepidation that the Soldiers will think we're too close with command and are telling them everything if they see me laughing in the hallway with them."*

Commanders and active-duty providers noted that many civilian providers at Site Bravo lacked an understanding of basic Army terminology and organization (e.g., the difference between a battalion and brigade and the level of commanders) and were not trained on how to complete a 5-17 or initiate the IDES process. Provider deficiency in these skills has led to an overburdening of their active duty colleagues with these tasks, rather than engagement in learning these new skills as part of the job requirements of an EBH provider. One active-duty Army provider shared:

> *"We don't train our civilians. To them, the patient is king and asking them to add the unit as a patient and care about long-term wellness of the force is a struggle. It's hard if you have private practitioners who've been out there for 30 years – it's hard asking them to change."*

In addition, the shift from a TRADOC to FORSCOM installation at Site Bravo has changed the management of behavioral health issues from short to longer-term, making it even more important that civilian providers are adequately trained to take into account the unique needs of the Army and command when providing care to Soldiers. There was a widespread lack of understanding of the EBH care model among providers at Site Bravo, in which many inaccurate myths were circulating about EBH, including that providers would lose their jobs in EBH, which fueled provider resistance to fully adopting the EBH model. While some brigades had an

aligned EBH team collocated in the brigade footprint, individual providers had not yet been assigned to a specific battalion, making it difficult for providers to establish accountable and credible relationships with a command counterpart as EBH intends. The basic operational requirements for executing EBH were not clearly communicated to providers, so many of the basic procedures necessary for a multidisciplinary team to work were not occurring. For example, weekly Multi-Disciplinary Treatment Planning meetings or establishing EBH team leads had not occurred on the majority of teams. One provider noted:

> *"We're totally out of the loop here. …There's no team lead. There is no transition. One day they'll say, 'Move your office.'"*

Another concern with the EBH teams was the disconnect between pay scales for Social Workers hired specifically to serve as EBH providers (paid on GS-12 scale), and providers already performing the roles (paid on a GS-11 scale). The BH chief discussed the tensions and resultant attrition as follows:

> *"EBH has been advertised on a onesie and twosie basis and there has been intense competition among peers (for those GS12 slots)... It's been a morale buster. People were hired as G12s with G11s training them. We are moving all social workers to G12s, because they can't just do it for EBH. But that hasn't happened yet, it will, and hopefully it will stop the bleeding of social workers."*

Managing Use of Inpatient Services

Beneficiaries in Site Bravo uses both purchased care inpatient services and direct inpatient care services for behavioral health and substance use conditions as summarized in Table 1 Soldiers accounted for almost 97% of all direct care inpatient bed days (15,140 of a total 15686 bed days). Soldiers and Active Duty Family members accounted for almost 90% of all purchased care inpatient bed days (38075 of a total 42555 bed days).

Table 1 Inpatient Care Use Across Beneficiary Categories

Direct Care	2010 – 2011		2011-2012		2012 – 2013	
Beneficiary	Admissions	Bed Days	Admissions	Bed Days	Admissions	Bed Days
Active Duty	544	4238	661	5947	618	4955
Family Members	5	14	3	5	4	23
Retirees	10	27	8	19	9	24
All Others	34	174	38	138	37	122
Purchased Care	**2010 – 2011**		**2011-2012**		**2012 – 2013**	
Beneficiary	**Admissions**	**Bed Days**	**Admissions**	**Bed Days**	**Admissions**	**Bed Days**
Active Duty	564	10501	482	10247	184	3124
Family Members	302	4760	472	5639	420	4790
Retirees	74	974	99	1405	99	1099
All Others	34	438	29	356	20	208

Data sliced using the Ben Cat Common field – 4 (Active Duty including Activated Guard and Reserve); 1 (Active Duty Families); 2(Retirees); 3(All Others)

The BH leadership at Site Bravo was cognizant of the large number of Soldiers being sent to purchased inpatient care, peaking to over 70 admissions in April and May of 2011, and saw a similar spike a year later in March and April of 2012. Additionally, there was a significant disparity between the length of stays of Soldiers between direct care and purchased care (see Figure 3). To manage this high volume of Soldiers in the network, the BH Chief assigned a senior officer to carry out rounds in the purchased care facilities to identify admitted Soldiers, and collaborate with the providers in that facility to develop a care plan that was compliant with Army standards. This provider noted that a significant number of Soldiers should not have been admitted to inpatient care. They identified two process flows that caused the inappropriate referral: not being evaluated accurately in the MTF Emergency Room (MTF ER), and direct admissions in purchased care. In the first process flow, Soldiers were being evaluated in the MTF ER for a mental health condition. The provider in the ER (not a behavioral health provider) would call the inpatient ward on the installation asking if there was a bed available. If the ward was full, they would automatically refer that Soldier for inpatient care in the purchased care network. The BH leadership reorganized their inpatient services to ensure that there was always a behavioral health provider in the emergency room to carry out an evaluation of the Soldier and determine if they needed to be admitted to the inpatient ward. The second pathway, Soldiers would be referred directly into purchased inpatient care. The inpatient chief detailed out the changes as follows:

> *"It used to be that you went from a partial hospitalization to the civilian ER versus bringing them to us (MTF). Civilian hospitals did with they wanted and didn't think about what we wanted. But now they will call us if the patient is not progressing (in the partial hospitalization program) or if the Soldier shows up (at the civilian hospital), they will send them to our ER."*

The inpatient chief attributed these simple process changes for reduction in purchased care inpatient admissions for Active Duty Soldiers.

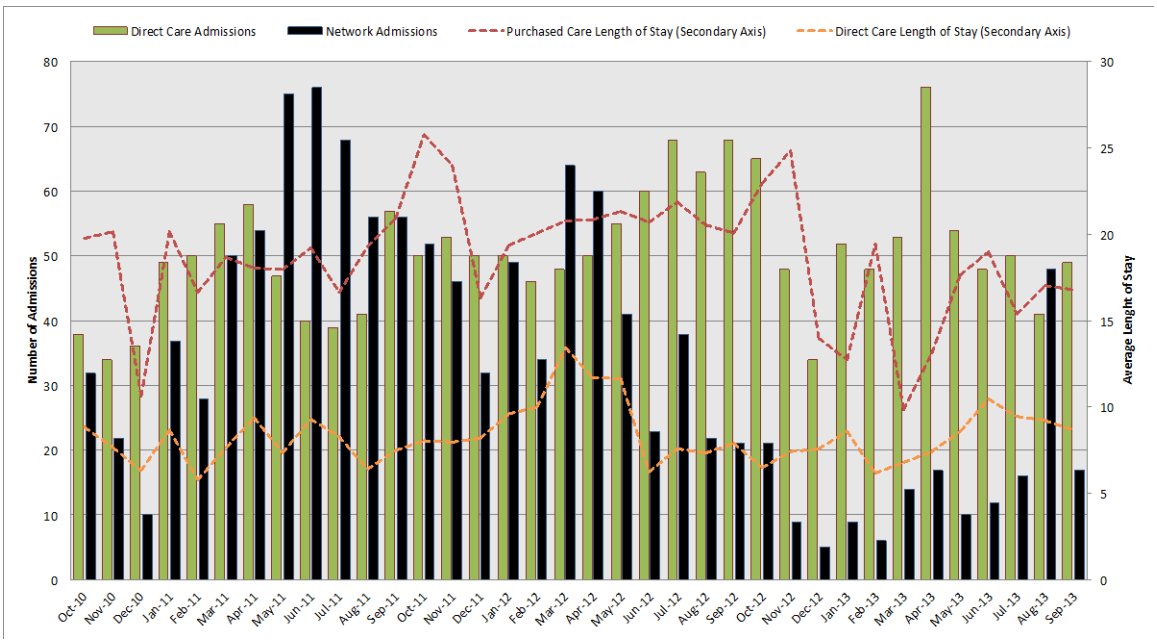


Figure 3 Inpatient Use by Active Duty Soldiers

Providers we interviewed attributed the difference in the length of stay to two factors: civilian providers off-post keep patients too long and Soldiers who wanted to stay in a non-military care setting with less incentive to leave. As one inpatient provider framed it:

> *"The patients don't like the MTF inpatient ward, and we don't keep them here that long – 6.5 days is the average length of stay. They like going to off post care because they get time outside, they can smoke, there's a swimming pool, gym. It's like a vacation"*

In addition to being costly, these extended stays off-post make Soldier reintegration into their unit more difficult. The installation has implemented an additional requirement for EBH case managers to reauthorize off-post inpatient care in 14 day extensions is hoped to reduce inpatient length of stay in the future. This creates an additional case management burden on an already short-staffed team.

Care Transition for Soldiers from Inpatient to Outpatient Care

1488 unique Soldiers accounted for the 1823 admissions in the direct care system, while 943 unique Soldiers accounted for the 943 admissions in the purchased care system. We examined the data on Soldiers with chronic and acute conditions (requiring 3 or more inpatient admissions), and identified 52 Soldiers in direct care system, and 57 Soldiers in the purchased care system. These Soldiers accounted for 8% and 32% of all admissions respectively. We calculated the 7-day follow up after inpatient admissions and 30-day follow up after inpatient admission to understand the effectiveness of handoff by identifying the first encounter after release from the inpatient facility in an outpatient mental health setting. The data summarized in

Table 2, highlight the delay in ensuring follow-on care for Soldiers transitioning from inpatient care. Over the last three years, the handoff for Soldiers in the direct care system has improved significantly with less than 50% being seeing within 30 days to almost 63% being seen. When discussing inpatient to outpatient care handoff the inpatient chief noted:

> *"We have good inpatient to outpatient handoff. Access to care which depends on the EBH clinic. Typically, they are seen the first day they get out of the hospital as a walk-in by an SSA and they decide the treatment plan the same day."*

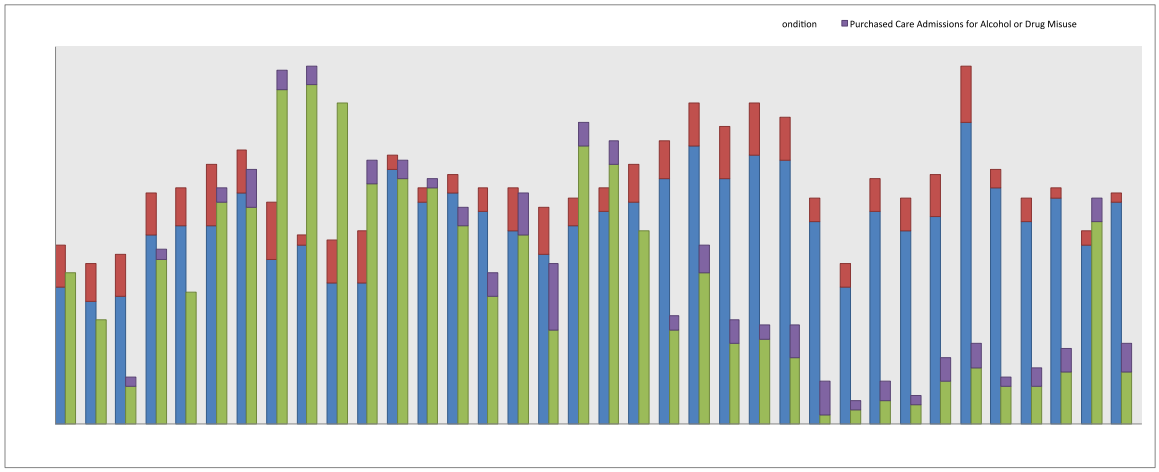
When it comes to purchased inpatient care there remains a consistent challenge in obtaining follow on care within 30 days, with less than 50% of Soldiers seeing a behavioral health provider in the direct care system. One of the potential explanations raised for the delay in follow on care was the reason for admission – mental health versus substance use. Since encounter data for substance use care is not captured in the encounter database, there may be care provided in the Army Substance Abuse Program that is not being overlooked.

Table 2 Inpatient to Outpatient Care Handoff for Soldiers

Year	Admissions	7-Day Follow Up	30-Day Follow Up	> 30 Day or No Follow Up
Direct Care				
2010 - 2011	544	122	113	309
2011-2012	661	123	69	469
2012-2013	618	328	58	232
Purchased Care				
2010 - 2011	564	75	176	313
2011-2012	482	24	77	381
2012-2013	184	22	58	104

We used Major Diagnostic Criteria 19 and 20 to parse purchased care admissions between Mental Health conditions and Substance Use conditions. We used the Diagnosis Related Groups 894-896 and 898-899 to identify patients admitted for substance use conditions in the direct care system. The synthesis of admission information is shown in Figure 4.

Figure 4 Active Duty Inpatient Admissions



The detailed breakdown of admissions in the direct care and purchased care system with follow up care metrics is shown in Table 3. The direct care system has been steadily improving follow up within 7 days of release for a mental health condition, with over half of the Soldiers seeing a mental health professional within seven days. In 2012- 2013 there were over 37% of Soldiers being released from direct inpatient care without a follow up session within 30 days. The data is similar for Soldiers admitted for a substance use issue. When it comes to Soldiers in purchased inpatient care for substance use, the lack of follow on care within thirty days comes to the forefront. Of the 147 Soldier admitted for a substance use condition, 96 were in residential treatment for more than 21 days. Of these 96 Soldiers only 18 received care within 30 days. Of the remaining 78 Soldiers, 6 were readmitted into the direct care system, and 38 Soldiers were never seen in a Behavioral health setting.

Table 3 Soldier Follow Up Care following Inpatient Admission

Year		Admissions	7-Day Follow Up	30-Day Follow Up	> 30 Day or No Follow Up
		Direct Care			
2010 - 2011	Mental Health	437	98	86	253
	Substance Use	107	24	27	56
2011-2012	Mental Health	568	107	53	408
	Substance Use	93	16	16	61
2012-2013	Mental Health	548	298	47	203
	Substance Use	70	30	11	29
		Purchased Care			
2010-2011	Mental Health	532	73	171	288
	Substance Use	32	2	5	25
2011-2012	Mental Health	421	20	73	328
	Substance Use	61	4	4	53
2012-2013	Mental Health	130	18	49	63
	Substance Use	54	4	9	41

Another issue that surfaced in the interviews was the lack of consistency of care in purchased inpatient care. As one inpatient provider framed it:

> *"It's been hard with civilian doctors not getting the Army. There is a decrease in off label use and a decrease in the use of benzos. You'll hear a lot of complaints about all the medications given out at civilian hospitals. Hardly any patients leave without being on four drugs"*

The only partial hospitalization programs exists on the installation is focused on PTSD care. Even with that program, there are questions with respect to the duration of the program and the capacity to see patients. When we discussed the efficacy of the program, the division surgeon noted that they had a 67% return to duty, but most Soldiers ended up exiting either through a medical board or an administrative separation from the Army. A gap in system capacity exists with respect to generic step down care for Soldiers being released from an inpatient care. As an inpatient provider framed it,

> *"We leave it up to the EBH team (to decide on step down care), and put a recommendation in the discharge summary. If someone has PTSD, they typically go to group 4 times a week. It seems to be working... EBH gets all the notes if someone goes from EBH to inpatient"*

Discussing the partial hospitalization program in the purchased care network, and ensuring quality of care, the provider noted,

> *"We did a patient satisfaction review of the PTSD guys and people were really happy with them. The groups were small, and they liked the people running them. Typically we do the first follow-up within two weeks, and then follow up again two to three weeks later with a psychiatrist visit within three weeks and then one within 40 days."*

Behavioral Health Care Provision for Soldiers in the Warrior Transition Unit

One of the enterprise challenges that surfaced in our interviews was the challenge of providing behavioral health care to Soldiers in the Warrior Transition Unit (WTU). In the 2010 – 2013 timeframe, 1855 Soldiers were seen at least once for case management services in the WTU[c]. Of these Soldiers, 1542 received more than five case management sessions. These Soldiers accounted for 274 of the 2766 acute care admissions. The WTU has a team of assets dedicated to ensuring wellness of Soldiers in the unit including squad leaders, nurse case managers and licensed clinical social workers (LCSW). The WTU leadership has aligned LCSWs with Nurse

[c] We identified Soldiers in the WTU using the FAZ2 MEPRS Code for Case Management – GWOT- Warrior in Transition.

Case Managers to ensure greater coordinate of care for Soldiers who are determined to be high risk. Despite the team based approach, there were three broad categories of issues that were surfaced in our interviews: a) the role of the Warrior Transition Unit (WTU) social work team in providing clinical care for Soldiers in the WTU; b) the process of transitioning Soldiers to higher echelons of behavioral health care; and c) the documentation of WTU mental health care.

The providers in the WTU noted that they were historically running 6-7 group therapy sessions using 4 LCSWs, but had received guidance from their regional medical command that their mission was supposed to focus exclusively on risk assessment rather than clinical treatment. There was further tension between the WTU providers and the MTF providers when the WTU Social Work slots became GS-12 positions as opposed to GS-11 positions for the MTF. The MTF providers felt that the WTU providers were credentialed, privileged social workers who were being paid more to do less than what was in the scope of their license. Further exacerbating the tension was the change in policy wherein the work carried out in the WTU was not counted towards the overall behavioral health care provided by the MTF. The argument that surfaced at a recent review was that the WTU had 7 LCSWs so they should be able to provide clinical care for the WTU population. The back-and-forth on providing Soldier care resulted in disconnects in care for these Soldiers. To break through the barriers, an agreement was reached between the WTU and the MTF that the WTU team would provide 6 sessions of supportive counseling, and that the MTF would provide a part time psychiatrist to manage the psychiatric medications. This new arrangement further raises the issue of transitioning a Soldier who has PTSD to a higher echelon of care. In examining the encounter data for WTU Soldiers, 497 of the 1855 Soldiers had an outpatient diagnosis for PTSD. As one provider noted:

> *"I am not going to start CPT when I don't know if I can keep that Soldier for the whole 10 sessions."*

It also highlights the need to clarify the difference, if any, between supportive counseling and therapy. As the WTB surgeon noted,

> *"Its not clear to me what the magical distinction is between supportive counseling versus therapy"*

Providers in the WTU noted that six month prior to our visit, BH had cut off services to Soldiers in the WTU so they were referring Soldiers to the network. However, a large number of those consults were being cancelled, as the WTU did not have the authority to refer Soldiers to the network. One of the providers highlighted the fact that WTU Soldiers were supposed to have enhanced access to care, but they were not getting it. As he said,

> *"You are more likely to get care in the unit than in the WTU."*

This process of referring WTU Soldiers to the network and ensuring access to care was still being resolved when we visited. For cases where the LCSWs felt there was a clear-cut case of PTSD, they are able to refer the soldier to an intensive outpatient program that focused on PTSD care. Similarly, they had evolved the process of getting a Soldier into the inpatient care facility on post to allow them to directly walk a Soldier over with his or her squad leader as opposed to having to send the Soldier to a walk-in clinic for evaluation. This issue of transitioning across echelons of care also holds for when WTU soldiers transition out of in-patient care or intensive outpatient care. If the Soldier was in a network in-patient facility and referred to an intensive outpatient program, then s/he had a step down program otherwise they are seen once by MTF BH and then routed back to the WTU social work team.

The third area of focus is the gathering and documentation of mental health information for Soldiers in the WTU. The policy guidance requires that a provider use multiple paper based instruments to capture data about the Soldier starting with a preliminary behavioral health needs assessment and the behavioral health intake form, and document that information in two information systems: the PBH-TERM and AHLTA. Providers were concerned about the algorithms that classify a Soldier as being high risk as this process limited the use of clinical judgment and Soldiers knew which answers to which questions that made them high risk. In addition the provider has to convert the risk assessment information from the intake documentation to the 4-point scale used in the WTU for the Comprehensive Transition Plan.

Addressing Substance Use Challenges

Substance use prevention, screening and treatment programs have strong leadership support at this installation. The commanding general's policy letters specifically address complying with, and exceeding the Army uri-analysis standards specified in AR 600-85. Incentive programs further support the emphasis on education and prevention. These incentives for units are centered on meeting education goals (quarterly training) and screening goals (no positive tests in the uri-analysis in the quarter). Units that meet these objectives are awarded a training holiday, and units that are able to achieve the objectives for four successive quarters are awarded a 4-day pass at the end of the year. The focus on meeting educational goals also enables providers to go to the units, and "put a face out to command teams." ASAP education is also included in both the 2-week pre-command course as well as the 1st Sergeant's courses.

From a care provision standpoint, the two issues that surfaced were that of documenting substance use related counseling the electronic medical record, and the hiring/retention of key personnel. The ASAP leadership at Site Bravo has focused on ensuring that the notes from clinical encounters are documented in the electronic medical record. As the chief noted:

> *"If we are going to treat the Soldier, support the division surgeon, and the PA's in the units, then it is important for us to document in the electronic medical record. We look at the PA's notes all the time, and it would be unsafe for us not to be sharing that information back."*

To meet the clinical quality requirements of their higher headquarters in IMCOM, ASAP counselors maintain a paper chart to ensure compliance. This issue of parallel documentation/paper based documentation was seen in other installations that we visited as well. When asked about the documented policy guidance regarding not entering the information in the medical record, they noted that it could not be found, and hence they were focused on complying with Chapter 8 of AR 40-88 that explicitly notes that documentation will be carried out in AHLTA. In addition, the fact that each provider was independently licensed, and had an ethical obligation to provide individualized care was highlighted as another key driver for documenting in the electronic medical record.

When discussing human capital, the ASAP chief focused on the challenges of centrally hiring providers, the limited incentives for ASAP providers, and growth challenges for support staff. Unlike other behavioral health hiring efforts, ASAP hiring actions for licensed clinical social workers occur at the GS-11 slot (as opposed to the GS-12 slot for a social worker in an embedded behavioral health clinic) putting them at a competitive disadvantage for talent. In addition to the perceived challenge of not being in a large metropolitan area, the staffing announcements are not continuous, as a result hiring actions have to be initiated repeatedly. Unlike other behavioral health providers, ASAP providers do not receive time off awards or bonuses (since a majority of them are social workers). For more junior personnel like Social Services Assistants (SSAs) they are not allowed patient contact under IMCOM guidelines, and hence cannot make progress towards their licensures, leading to further attrition either internally to MEDCOM or to civilian practices.

In addition to regular ASAP education and counseling programs, they are also implementing the Confidential Alcohol Treatment and Education Pilot (CATEP) program this installation. This program focuses on senior NCOs and officers between the ranks of E8 – O5. It is important to note that the 15 Soldiers are currently enrolled in CATEP are only a fraction of the larger population of about 300 Soldiers who were enrolled in all ASAP programs at the time of our visit. While the program is labeled confidential, treatment is still documented in the medical record, and command is notified if the Soldier violates their treatment. The ASAP director noted:

> *"The Soldier is informed right away that if they violate the protocol of treatment (positive uri-analysis, DUI) ... command will be alerted and they will no longer be enrolled in the CATEP"*

The ASAP director noted that one of the populations of concern was that of mid ranking NCOs (the Staff Sergeants and the Sergeant First Class's) who were "good at

hiding their issues". The ASAP clinic is closed every Thursday afternoon to carry out professional development activities for counselors and for rehabilitation team meetings. This set schedule is aimed to help command teams better plan their schedules and actively engage in supporting the soldier's recovery efforts.

Another alignment strategy that they have utilized to support command teams is creating shared two-hour block of time for all providers supporting a deploying/redeploying unit. This templated time enables a commander to meet all the providers supporting his/her unit without having to individually identify each provider and coordinate meetings with them. When asked about the choice of strategy, the head of ASAP noted that they originally aligned providers to units, but found that they could not meet the two-day turnaround times for access to care without leveraging all available providers. The tradeoff was between access and having a single point of contact. The establishment of standard times for rehabilitation team meetings and templated commander meetings alleviates the command team – ASAP coordination challenges. The issue of care coordination between ASAP providers and other BH providers in MEDCOM is still left to the individual providers themselves.

Standardized Inprocessing

Site Bravo developed a wellness campus to serve as a "one stop shop" for all in-processing Soldiers. The Commanding General has made it a requirement for all Soldiers to be assessed on the five areas of Comprehensive Soldier Fitness—physical, emotional, spiritual, family and social. The results of these assessments are used to help soldiers set goals to improve identified gaps and are shared with the Soldier's command team. Soldiers are also referred to resources within the wellness campus, such as the Alcohol and Substance Abuse Program, financial management courses or nutrition counseling, based on the areas identified as needing reinforcement. For example, assessments may indicate that a Soldier has a lack of skills for managing finances. This gap would be shared with the Soldier and reported to his or her command team, and the Solider would then learn about resources available to improve his or her financial skills in addition to having the support of their command team to develop such skills. Aside from supporting individual Soldier development, the overall wellness of Site Bravo's force is tracked by sharing aggregate assessment results bi-monthly with the senior commander at the installation.

The campus incorporates suicide prevention training into its Welcome Center activities for newly arriving Soldiers during in-processing. Site Bravo is working toward a goal of having 100% of Soldiers trained in the comprehensive suicide prevention training, ASIST. Site Bravo already has the highest rate of ASIST trained Soldiers in Forces Command as well as the lowest suicide rate. ASIST trains Soldiers to identify symptoms of suicidality and appropriately intervene. Site Bravo has adopted a community health view of suicide as a preventable death that is the

responsibility of the community to prevent—rather than an individual mental health problem isolated from community effects. Our interviews surfaced a few challenges that the leadership of the wellness campus is addressing. First, Soldier assessments were frequently delayed in reaching command in the desired timeframe (72 hours) and generally took 2-3 weeks to reach command. Second, compliance for all Soldiers to take the assessments and get ASIST certified has proved challenging given the many op-orders confronting command. Third, campus has many redundancies with the SRP process. Fourth, it is only easily accessible to those living on one side of post—future plans are in the works to build a similar campus on the other side to ensure campus resources are easily accessible to all.

The inprocessing site is amassing a large amount of data from Soldier assessments and is beginning to conduct IRB approved studies on the relationship between their assessments and meaningful outcomes, such as the extent to which high risk behaviors screened during the assessments correlate with command high risk lists, serious incident reports, or unplanned departures. In the future, they hope to provide soldiers with comparative information based on their specific situation. For example, a 40 year old, female Sergeant Major would be compared to others who share her age, gender, and rank on the five dimensions of comprehensive soldier fitness.

Discussion

The behavioral health system of care at Site Bravo is still evolving towards the MEDCOM standard. From a system of care perspective, we have identified five gaps in terms of hand off between Soldier Readiness Processing (SRP) and Behavioral Health, care provision for WTU Soldiers, care transitions from inpatient care to outpatient care, and lack of an on-post general step-down intensive outpatient program, and lack of infrastructure for EBH. When discussing the handoff between SRP site and Behavioral Health, the unit Behavioral Health Officers noted:

> *"They (SRP) will do anything not to make the call, so people get punted … There is regulation on whether someone is deployable or not. If they're not sure, they pass it on. At SRP they give you a piece of paper to go to EBH, so they are not accountable (for deciding someone can't deploy). After they leave SRP, they are given a slip of paper to go see behavioral health and are given a form to give command but to make a Soldier run from one end of the installation to the other can take 45 min., it's insane, and we're losing people in process. Of the 200 Soldiers this morning at SRP, 12 were not checked out, and no one is accountable for them..."*

The second gap relates to the utilization of behavioral health assets in the Warrior Transition Unit, which has been an area of contention between the behavioral health leadership and the WTU. The BH leadership framed the challenge as follows:

> *"It's hard to get WTU providers to care for WTU Soldiers. They have seven or eight licensed clinical social workers who provider services fro 400 Soldiers, so that's 50s per social worker, one of the best ratios ever seen, and yet their LCSWs cannot do treatment – they keep saying we only screen and assess. It is been a long running gun battle"*

This is an issue that is consistent across multiple installations and needs to be addressed at an enterprise level. The third gap relates to transitioning of patients from inpatient care to outpatient care. Units that have an EBH clinic (either aligned or collocated) have established a standard operating procedure for managing the smooth handoff from inpatient care to outpatient care. From an enterprise perspective, the separation of ownership between substance use care within Installation Management Command and mental health care within Medical Command makes it challenging to track the flow of patients. Consider the case of acute patients who are admitted for inpatient care. For patients admitted for a mental health condition, it is possible to track HEDIS measures for 7-day follow up after inpatient admission and 30-day follow up after inpatient admission. Even though alcohol or drug related inpatient admissions only make up for slightly over 11% of all Soldier inpatient admissions (332 of 2977), the existing data is insufficient to show whether effective care transitions occur for those Soldiers.

The fourth gap is the lack of a general intensive outpatient program. The BH chief has highlighted the need to establish such a program. Currently each EBH team has developed their own version of the step down program through groups, and additionally leverage the purchased care network as needed. The roll out of EBH has been ad-hoc and driven by senior leader emphasis on the mechanics of EBH rather than the intent. For example, one of the senior leaders highlighted the ability to execute EBH without adequate infrastructure even though the BH Chief cautioned for the need for adequate infrastructure, noting,

> *"A good lesson you can share with the other installations is that it's a mistake to move out to quickly, and implement to quickly. You don't want to rush into a space that's too small. (For one team) there was not adequate space and then they had no IT."*

The strengths of the installation include documentation of clinical care by ASAP providers in the medical record, the consolidated inprocessing at a single location with mandatory resilience and suicide prevention training, PTSD focused intensive outpatient program, and utilization of behavioral health officers in clinics. Site Bravo is one of the few installation we have visited wherein substance use providers document in the medical record. This enables more effective coordination of care for patients with comorbid alcohol and mental health conditions. From a non-clinical care standpoint, the installation process for managing health and discipline of the force are still evolving.