



**SOCIOTECHNICAL SYSTEMS
RESEARCH CENTER**

292 Main Street, E38-600
Cambridge, MA 02142
ssrc.mit.edu

MIT SSRC Working Paper

Developing the Embedded Behavioral Health Checklists

Jayakanth Srinivasan

jksrini@mit.edu

Julia DiBenigno

November 20, 2014

Post-Traumatic Stress Innovations: U.S. Military Enterprise Analysis

Sponsored by USAMRMC, contract #W81 XWH 12-2-0016



**Massachusetts
Institute of
Technology**



Table of Contents

Abstract.....	3
Planning Phase Checklist Description.....	4
Implementation Phase Checklist Description	8
Planning Phase Checklist (Owner: BH Chief)	13
Implementation Phase Checklist (Owner: EBH Team Lead)	14
Glossary	15
Author Biographies.....	16
Jayakanth Srinivasan	16
Julia DiBenigno.....	16





Abstract

The Army Embedded Behavioral Health (EBH) model of care was designed to increase access to care and reduce stigma around care seeking by locating care at the point of need. The model makes the EBH clinic the nexus of clinical behavioral health care for patients that fall within that clinic's catchment area. The aligned providers (and the care team as a whole) serve as the principal source of information for command teams about the mental health of the enrollee. Using our field research experiences, we codified the unique challenges in both the planning phase of EBH implementation, and the implementation phase in the form of two checklists that can be used to better manage the change process. The planning phase checklist is owned by an Installation's Behavioral Health (BH) Chief, while the implementation phase checklist is owned by an Installation's EBH Team Lead. In this document we describe both checklists, and include research findings and examples that illustrate the importance of each item on the list.

Planning Phase Checklist Description

EBH is a critical component of the behavioral health system of care, and the implementation of EBH typically involves significant changes across the system including in patient flows, provider allocations and program governance. This large-scale change requires active engagement of and shared understanding by all the key clinical leaders, including the MTF commander, the BH Chief, the local BH administrator, and any additional personnel who have been identified to lead the EBH rollout.

This engagement also ensures that the overview of the model, the implementation plan, and the impact on the installation as a whole can be clearly and consistently communicated to other operational and supporting services stakeholders. We specifically included the BH administrator to ensure that critical infrastructure changes were planned and implemented, and the associated practice management processes such as resource management and incentive maximization could be established consistently.

For large installations, the responsibility of EBH roll out is often assigned to a new service chief. This person should be identified as early as possible and be integrated into the EBH leadership team. This leads to the first item of the planning phase checklist:

1. *Establish EBH leadership team to include:*
 - a. *MTF Commander*
 - b. *Department of BH Chief*
 - c. *BH Administrator*
 - d. *Lead for EBH Rollout (if established as a unique role)*

EBH teams were originally designed to match the Brigade Combat Team (BCT) structure, the organizing structure used by the Army as part of the overall modularization strategy. Unlike the centralized specialty care model that uses the total population of Soldiers and family members as the catchment area, EBH narrows the potential population to a BCT of approximately 4500 Soldiers. This smaller catchment area is expected to allow providers to stay better informed about the operational environment and leadership changes that influence their Soldiers.

In a number of installations, BH services were historically provided from a centralized location without taking into consideration the occupational location of the person seeking care. Transitioning to the EBH model requires the identification and mapping of the physical locations of the various units on the installation before EBH clinics can be located within the unit footprint.

A number of installations have chosen to adopt an “alignment before colocation” strategy for rolling out EBH, especially if they currently have more than one location for providing BH services. For these installations, the identification and mapping process provides valuable input for initiating alignment in a manner that reduces travel time for all key actors involved, including Soldiers, Command teams, and providers. A common refrain from providers in the exploratory fieldwork

was the lack of awareness of who was in the Soldier's chain of command. The mapping process has to include the identification of the brigade and battalion commanders for the aligned clinics. This leads to the second item in the planning phase checklist:

2. *Identify operational units on the installation:*
 - a. *Map locations of all BCT sized units*
 - b. *Identify brigade and battalion commanders for all units*

The prescribed EBH team for a BCT is a fifteen-person team consisting of one prescriber (psychiatrist, psychiatric nurse practitioner), seven psychotherapists (clinical psychologists and licensed clinical social workers), one nurse case manager, and six support personnel (behavioral health technicians, social services assistants, and medical service assistants). For most installations, meeting this staffing requirement requires a reallocation of providers, and additional hiring actions.

A known issue with the implementation of EBH is the initial fragmentation of care when patients and providers are moved into the new model. In some implementations, Soldier treatment was abruptly stopped to enable this transition. The EBH leadership team has to explicitly account for this fragmentation. The recommendation from providers has been to allow providers to keep Soldiers in continued care till they finish their current course of treatment. Soldiers initiating services for the first time are aligned to the EBH team.

One of the challenges that surfaced across all our field research sites has been the need to provide services for non-BCT units. The original EBH roll out plan focused on the BCT units; however, Army leaders have required that EBH be extended to support non-BCT units no later than the end of FY 2016. As with any change effort, the implementation plan has to be accompanied by a communication plan so that providers and command teams have shared situational awareness of the upcoming changes. This leads to the third item on the planning phase checklist:

3. *Define EBH implementation time and staffing plan:*
 - a. *Staffing plan includes provider reallocation and/or hiring actions*
 - b. *Changes to patient panels due to provider reallocations are identified and plans to ensure continuity of care are established.*
 - c. *Co-location timeline for BCTs defined*
 - d. *Alignment/Co-location plan for non-BCT units established*
 - e. *Communications plan developed for engaging providers and command teams*

The Senior Commander's (SC) mission is to care for Soldiers, Families and Civilians and to enable unit readiness. She/he is responsible for synchronizing and integrating Army priorities and initiatives at the installation. Given the importance of EBH to the readiness of the force, it is critical that the change effort receives SC support. At two of the four installations visited, the SC had a vision for EBH that was non-concordant with that of the BH chief. In one case, the EBH roll out plan was changed to meet the needs of non-BCT operational units first, causing frustration for BCT units that were expecting to receive them first. In the other installation, the SC wanted to accelerate EBH



roll out to all units simultaneously. As a result, EBH teams moved into facilities that were not optimal for care delivery. In both cases, the SC was not educated on the requirements for EBH beyond the idea of colocation, or that moving EBH into the unit footprint requires a reframing of BH beyond clinical care to have operational planning implications for command teams. EBH rollout occurs over a number of years, and given the turnover in SC's, SC engagement and education is an ongoing process. This leads to the fourth item on the planning phase checklist:

4. *Educate Senior Commander on the EBH model and obtain buy-in:*
 - a. *Articulate impact of EBH on clinical care provision across the installation*
 - b. *Make infrastructure requirements explicit*
 - c. *Articulate command engagement requirements*

The EBH model uses an integrated team-based care delivery structure to address the care delivery needs of the Soldier while simultaneously ensuring that the mission related information is shared in an accurate and timely manner with command teams. For most providers, being part of an integrated team is a new way of working, and this change surfaces the known disciplinary (e.g. psychiatry, psychology, clinical social work) differences in addition to the challenges of imposing a cross-disciplinary management structure. Providers often have to go beyond their roles as clinicians, to engage command teams with feedback on the ability of the Soldier to execute her/his mission, and other key issues. Typically this feedback is provided via the command consultation process - either face-to-face or by telephone between the provider and the command team.

For occupational assessments, providers use formal communication procedures such as mental status exams and specifications of duty limitations. These procedures are often not part of the academic training that providers receive, but the Army is establishing training programs specifically to fill that gap. In our fieldwork in installations that were beginning to implement EBH, we found that a number of providers were not aware of the existence of the EBH manual. Command teams often complained about civilian provider lack of knowledge of the Army.

The EBH team structure was designed to create a consistent point of contact for command teams to engage with providers within the legal limitations of HIPAA in the military context. This includes sharing context information about Soldiers and learning how the command team can effectively support Soldier recovery. In installations that were just rolling out EBH, command teams and providers perceived each other as not being aware of the military exceptions for HIPAA when it related to the Soldier's ability to execute his/her mission. A concern that surfaced along the same lines from providers was the perception from Soldiers they were treating that command had total access to their care information. These key concerns and the need to train personnel to operate in the EBH context led to the fifth item in the planning phase checklist:

5. *Train clinical care team to operate in EBH:*
 - a. *Train EBH teams on Army 101 including, communicating with command teams, Soldier military occupational specialties, administrative separation, medical separation, mental status evaluations and profiling.*



- b. Educate all stakeholders on HIPAA limitations in the military context*
- c. Distribute EBH manual*
- d. Establish local Standard Operating Procedures for implementing team-based work, including morning standups, multi-disciplinary treatment planning meetings and high-risk team meetings.*
- e. Examine informed consent procedures to ensure providers make explicit to Soldiers what information is disclosable to command.*

The EBH model forces a shift from a centralized care delivery model using existing hospital facilities, to a distributed community-based care delivery model. This requires investments in both physical infrastructure and information infrastructure. Since EBH clinics are designed to be located in the brigade footprint, installations have to either repurpose existing facilities or create new buildings to house the new clinics. In our field research we saw significant variations in the types of facilities used for clinics, ranging from new military construction for clinics to temporary buildings, and in one case, using non-contiguous parts of the brigade headquarters across two floors to house the EBH clinic. It is critical for the EBH planning team to recognize that EBH clinics are clinical spaces that have to meet Joint Commission certification requirements, and that they have to meet Environment of Care (EOC) and Life Safety (LS) requirements that are unique to behavioral health. An infrastructure issue that surfaced in the fieldwork is provider concerns of safety and privacy in semi-permanent and repurposed spaces.

Pushing care to the point of need also makes connectivity to AHLTA and other medical information systems a critical requirement, as providers need to be able to document care in AHLTA, use E-Profile to communicate with command teams, and use BHDP to capture clinical outcome data.

Last but not least, from a practice management perspective the right accounting codes need to be available in order to track performance of the clinic. These infrastructure requirements lead to the sixth item in the planning phase checklist:

- 6. Establish infrastructure to support EBH operations:*
 - a. Facility plan adequately represents Environment of Care (EOC), Life Safety (LS), The Joint Commission (TJC) certification requirements, as well as provider concerns regarding safety and data privacy.*
 - b. Ensure connectivity to clinical care systems such as AHLTA, ESSENTRIS, E-Profile and BHDP.*
 - c. Establish MEPRS codes for EBH clinics*

Implementation Phase Checklist Description

We recognize that for most installations in the Army, the planning phase has been completed. However, the checklist can still serve as a foundation for capturing the evolution of EBH implementation. When it comes to actually establishing an EBH clinic, we observed variations across three areas: building the EBH team, implementing the EBH operating model, and engaging command teams. The implementation phase checklist is organized around those three areas.

The intent behind the fifteen-person team design was to create a nexus of care through aligning a provider to each battalion within the brigade, having a case manager to manage complex cases, and including sufficient support personnel to ensure efficient and effective clinical operations. In addition to these core MTF personnel, behavioral health officers from operational units also provide clinical care at a 0.5 FTE rate at the EBH clinic.

The operational reality that we saw in our field research varied significantly from the model specification. Most EBH teams were understaffed. Even EBH clinics that were staffed to the model specification had to develop unique ways of dealing with staffing mismatches, ranging from using the unit Behavioral Health Officers (BHOs) as the exclusive providers for a battalion, to the EBH team lead serving as the point of contact for the additional battalion commander. In one of the field research sites, the BH chief emphasized lack of demand as one of the key design parameters that they took into consideration when sizing an EBH clinic to have four psychotherapists rather than the seven prescribed. In the EBH model, psychotherapists have their patient care requirements reduced from .75 FTE to 0.65 FTE to support their command engagement and educational activities. This workload requirement was designed with a one-to-one alignment in mind, and alternate model implementations that involve fewer providers require changes to the practice management standards imposed by the Behavioral Health Service Line.

The shortage of providers further highlights the need for maximizing provider time in the clinical care setting, and multiplying their capabilities through care extenders such as case managers, social service assistants (SSA) and behavioral health technicians (68X). The nurse case manager provides all the case management services for a Soldier associated with an EBH clinic. They ensure that Soldiers are compliant with their care (including medication and appointment utilization) and track clinical transitions for complex cases (inpatient admissions, high risk patients). In our field visits, a number of EBH teams had not filled their case manager slots, leaving providers with the added burden of case managing their patients when those patients had to access TRICARE for additional services.

One strategy we observed was the use of alternate work schedules and part-time positions as a means of attracting and retaining providers for key roles. The centralized scheduling system and associated governance processes used in some installations may not support such flexible work, and the EBH team lead has had to develop local workarounds until the enterprise scheduling system is redesigned. In some installations, EBH team leads have focused on training their front

desk personnel to manage all scheduling of providers in the EBH clinic (including BHOs).

The EBH model is built around the idea of enhancing access to care through walk-in appointments. The model prescribes that providers be templated for scheduled appointments four days a week, while supporting walk-in services one day of the week. This requires the EBH clinic to actively plan for and manage those triage days.

Another component for enhancing access within the model is to encourage the use of groups as a way of educating Soldiers on the appropriate usage of behavioral health services, and supporting step-down care when Soldiers are released from inpatient care or intensive outpatient care. Most of these groups are run by a provider with the support of an SSA or 68X. However, a consistent area for concern among EBH providers we interviewed was the lack of predictability with respect to the availability of 68X. Providers felt that 68X were often pulled to execute additional duties and could not be relied upon for consistent care support for their battalions. The need to meet force reduction requirements led to delays in the hiring of support personnel such as medical service assistants and front desk staff. This shortage of front desk personnel led to the utilization of SSAs and 68X to carry out front desk functions, even though they are not trained to support those activities.

Implementing the EBH model can create initial care fragmentation because Soldiers in continued care have to rebuild therapeutic alliance with another provider. The EBH team lead has to actively manage the transition of patient panels to maximize continuity of care where possible.

We are still learning about structuring and managing multidisciplinary behavioral health teams. In the case of EBH teams, a recurrent issue that emerges from the field research is the difficulty of executing clinical supervision and peer-to-peer learning when the team size is so small and the clinics are geographically distributed. The EBH team lead has to establish an SOP to support peer review and clinical supervision that builds the shared knowledge of the team without devolving into disciplinary camps.

In some of the field research sites, the desire to accelerate EBH implementation resulted in poor infrastructure support, especially with respect to documenting in the medical record. EBH team leads have to ensure that AHLTA connectivity, especially for remote connections, is reliable. Providers are required to document care in AHLTA within 72 hours of an encounter. However, EBH teams trying to remotely document in AHLTA using VPN cite the unreliability of the network as a key barrier to meeting that requirement. These issues lead to the first item on the implementation checklist:

1. *Build the EBH team:*
 - a. *Assess clinical and non-clinical workload requirements against available clinical staff*
 - b. *Refine scheduling practices to account for walk-in services and enhance support for Alternate Work Schedules*
 - c. *Assign EBH providers to battalion-sized elements*
 - d. *Align SSAs and 68Xs to battalion-sized elements*



- e. *Train SSAs and 68Xs on MSA, front desk, duties*
- f. *Establish transition plan for changes to patient panels for each EBH provider*
- g. *Design peer review and clinical supervision practices to include Performance Objectives, Case Reviews, and Multi-disciplinary teaming.*
- h. *Ensure direct AHLTA connectivity to avoid reliance on VPN*

The EBH model prescribes a number of team meetings, structural arrangements, and artifacts to develop a shared understanding of the current state of a Soldier's health. It leverages interdisciplinary meetings to track key clinical and operational transition points such as Serious Incident Reports (SIR), redeployment from theater, medical evacuations from theater, in-patient admissions/releases, suicidal ideation and homicidal ideation.

Three of the prescribed meetings are central to establishing the EBH operating model: the morning report, the daily standup and the multidisciplinary team meeting. The morning report is a daily meeting that teams use to identify Soldiers who needed acute care (ER visits, inpatient admissions, suicidal/homicidal ideations) during off-duty hours, as well as identify Soldiers returning from inpatient care or redeploying with a high-risk indicator. The nurse case manager collects and shares the information in morning report. The EBH team uses this information and any additional tacit knowledge residing in other providers in the room about that Soldier to determine the next steps needed from a clinical care standpoint. The Daily Standup is used by the EBH team to share their current status, and ask for support they need with respect to complex cases. This meeting also provides an opportunity for providers to share operationally relevant information such as training schedules and deployments. The Multi-Disciplinary Treatment Planning (MDTP) meeting aims to bring together key clinical stakeholders from across various organizations involved in the behavioral health of a Soldier. In some of the installations we visited, they had not established these meetings. With the MDTP in particular, EBH team leads were either unaware of their ability to invite other clinical stakeholders, or had not surfaced the lack of participation of these other clinical stakeholders up their reporting chain for action. This leads to the second item on the implementation checklist:

- 2. *Establish EBH Operating Model:*
 - a. *Implement Daily Standup Meeting for EBH Team*
 - b. *Utilize Morning Report to identify and manage newly at risk patients*
 - c. *Engage other clinical stakeholders in Multi-Disciplinary Treatment Planning Meeting including FAP, ASAP, Brigade Surgeon, Brigade BHOs, Battalion PAs.*
 - d. *Establish governance processes related to the use of CART, IRIS-BH and BHDP*

A key challenge that EBH tries to overcome is the adversarial relationship between command teams and behavioral health providers. Prior to the establishment of EBH, command teams saw behavioral health as a 'medical problem' with a system of care that was not servicing their Soldiers appropriately. Furthermore, they saw behavioral health as taking away from their fighting force, and being reticent to share information regarding the health and recovery of their Soldier.

Providers saw commanders as uncaring, and in some cases stigmatizing of Soldiers who used behavioral health services. This clinical-operational divide requires both groups of stakeholders to reframe their roles to be collaborative to maximize readiness while at the same time enhancing Soldier health in the EBH model.

This reframing starts with EBH team lead engaging the brigade commander, and the EBH provider engaging their aligned unit leaders. In our field research, we have seen EBH teams where the brigade commander had peripheral awareness about the establishment of an EBH team, and had not met the EBH team lead. This creates a challenge for EBH providers who then have to engage battalion commander(s) with limited to no command guidance and strategic messaging regarding the establishment of EBH. EBH represents a new way of care delivery for command teams, so the provider has to educate the command team on this new way of working, especially with walk-in appointments, and the use of groups such as the 'Introduction to Behavioral Health'.

The actual rubber hits the road when providers have to engage company commanders and 1SGs. Providers often meet with command teams in their place of work to gain a deeper understanding of the occupational context of the unit they are serving. This meeting serves to establish the foundation for an ongoing collaborative relationship regarding the health of the Soldier. A common complaint from command teams prior to the establishment of EBH was that they did not know who the provider was, or how to reach them. The same narrative was heard from providers, noting that command teams changed over frequently, and that there was no way of tracking them.

EBH establishes a single point of contact for the command team to gather behavioral health related information. The Army has focused on developing clear policies and guidelines regarding when health-related information can be shared with command. However, the translation of the policy to practice requires ongoing education and consistent relationships between command teams and providers. The two artifacts that are central to information sharing are the DA Form 3822 used for the mental status evaluation, and the DA Form 3349 for communicating duty limitations for a medical condition. The EBH team lead and EBH provider need to communicate with command teams to ensure that the data presented in these forms for behavioral health conditions is understandable by the Command teams and reflects the occupational environment for the Soldier. This also requires providers to have a clear understanding of where the Soldier is within the deployment cycle.

While most installations that had EBH were operating at or above capacity, we observed EBH team leads leverage strategies such as posting flyers in the Aid Station, troop medical clinic, company headquarters to increase awareness of the service. Some have leveraged command communication channels such as the S3 shop to put out announcements about EBH and how Soldiers can access it. This leads to the third item on the implementation checklist:

3. *Engage command team*
 - a. *EBH Team Lead meets with the Brigade BH Officer and Brigade Surgeon*
 - b. *EBH Team Lead meets with Brigade Command Team(s)*



- c. EBH Provider meets with Battalion Command Team(s) to establish command consultation battle rhythm*
- d. EBH Provider meets with Company Commanders and 1SGs at their place of duty to explain EBH model (including providing command team with a roster of EBH phone numbers and information in writing regarding limits of HIPAA, how triage works, basic information on administrative separations, what types of treatment is available to include groups).*
- e. Obtain Company leadership lists*
- f. Obtain unit progression in ARFORGEN*
- g. Attend Brigade and Battalion High Risk Team Meeting*
- h. Market EBH*

These checklists are living documents that will be updated when we observe new phenomena in the field or uncover new information from our interviews. We believe that they serve as a useful starting point to preempt some of the known challenges with implementing EBH.



Planning Phase Checklist (Owner: BH Chief)

- 1. Establish EBH leadership team to include:**
 - a. MTF Commander
 - b. BH Chief
 - c. BH Administrator
 - d. Lead for EBH Rollout (if established as a unique role)
- 2. Identify operational units on the installation:**
 - a. Map locations of all BCT sized units
 - b. Identify brigade and battalion commanders for all units
- 3. Define EBH implementation time and staffing plan:**
 - a. Staffing plan includes provider reallocation and/or hiring actions
 - b. Changes to patient panels due to provider reallocations are identified and plan to ensure continuity of care are established.
 - c. Co-location timeline for BCTs defined
 - d. Alignment/Co-location plan for non-BCT units established
 - e. Communications plan developed for engaging providers and command teams
- 4. Educate Senior Commander on the EBH model and obtain buy-in:**
 - a. Articulate impact of EBH on clinical care provision across the installation
 - b. Make infrastructure requirements explicit
 - c. Articulate command engagement requirements
- 5. Train clinical care team to operate in EBH:**
 - a. Train EBH teams on Army 101 including, communicating with command teams, Soldier military occupational specialties, administrative separation, medical separation, mental status evaluations and profiling.
 - b. Educate all stakeholders on HIPAA limitations in the military context
 - c. Distribute EBH manual
 - d. Establish local Standard Operating Procedures of implementing team-based work, including morning standups, multi-disciplinary treatment planning meetings and high-risk team meetings.
 - e. Examine informed consent procedures to ensure providers make explicit to Soldiers what information is disclosable to command.
- 6. Establish infrastructure to support EBH operations:**
 - a. Facility plan adequately represents Environment of Care (EOC), Life Safety (LS), The Joint Commission (TJC) certification requirements, as well as provider concerns regarding safety and data privacy.
 - b. Ensure connectivity to clinical care systems such as AHLTA, ESSENTRIS, E-Profile and BHDP.
 - c. Establish MEPRS codes for EBH clinics



Implementation Phase Checklist (Owner: EBH Team Lead)

For each EBH Team:

1. Build the EBH team:

- a. *Assess clinical and non-clinical workload requirements against available clinical staff*
- b. *Refine scheduling practices to account for walk-in services and enhance support for Alternate Work Schedules*
- c. *Assign EBH providers to battalion sized elements*
- d. *Align SSAs and 68Xs to battalion sized elements*
- e. *Train SSAs and 68Xs on MSA, front desk, duties*
- f. *Establish transition plan for changes to patient panels for each EBH provider*
- g. *Design peer review and clinical supervision practices to include Performance Objectives, Case Reviews, and Multi-disciplinary teaming.*
- h. *Ensure AHLTA connectivity (especially with VPN access)*

2. Establish EBH Operating Model:

- a. *Implement Daily Standup Meeting for EBH Team*
- b. *Utilize Morning Report to identify and manage newly at risk patients*
- c. *Engage other clinical stakeholders in Multi-Disciplinary Treatment Planning Meeting including FAP, ASAP, Brigade Surgeon, Brigade BHOs, Battalion PAs.*
- d. *Establish governance processes related to the use of CART, IRIS-BH and BHDP*

3. Engage command team

- a. *EBH Team Lead meets with the Brigade BH Officer and Brigade Surgeon*
- b. *EBH Team Lead meets with Brigade Command Team(s)*
- c. *EBH Provider meets with Battalion Command Team(s) to establish command consultation battle rhythm*
- d. *EBH Provider meets with Company Commanders and 1SGs at their place of duty to explain EBH model (including providing command team with a roster of EBH phone numbers and information in writing regarding limits of HIPAA, how triage works, basic information on administrative separations, what types of treatment is available to include groups).*
- e. *Obtain Company leadership lists*
- f. *Obtain unit progression in ARFORGEN*
- g. *Attend Brigade and Battalion High Risk Team Meeting*
- h. *Market EBH*

Glossary

1SG – First sergeant

68X – Uniformed Behavioral Health Technician

AHLTA – Armed Forces Health Longitudinal Technology Application (electronic health record)

ARFORGEN – Army Force Generation

ASAP – Army Substance Abuse Program

BCT – Brigade Combat Team

BH – Behavioral Health

BHDP – Behavioral Health Data Portal

BHO – Behavioral Health Officer

CART – Capacity and Resourcing Tool

EBH – Embedded Behavioral Health

EOC – Environment of Care

FAP – Family Advocacy Program

HIPAA – Health Information Portability and Accountability Act

IRIS-BH – Integrated Resourcing and Incentive System for Behavioral Health

LS – Life Safety

MSA – Medical Service Assistant

MTF – Military Treatment Facility

PA – Physician Assistant

SC – Senior Commander

SSA – Social Services Assistant

TJC – The Joint Commission

VPN – Virtual Private Network



Author Biographies

Jayakanth Srinivasan

Dr. Jayakanth “JK” Srinivasan is a research scientist at the Sloan School of Management at MIT and a visiting faculty member at the School of Innovation, Design and Engineering at Mälardalen University, Sweden. Over the last decade as an engaged scholar his research has focused on the transformation of knowledge-intensive organizations ranging from governmental agencies to software organizations, and more recently to public sector health care. His 2011 book, *Beyond the Lean Revolution: Achieving Successful and Sustainable Enterprise Transformation* (AMACOM Press), co-authored with Deborah Nightingale, offers seven principles and a roadmap that leaders can use to guide their enterprise transformation efforts. In 2010 Dr. Srinivasan was named a senior member of the Association for Computing Machinery for his research on software organizations.

Since 2010, he has been part of the MIT PTSI team where he leads the research on the mental health systems of care in the Army. In this role he works with graduate students, researchers, and key leaders in the Army to collaboratively evolve both the direct care delivery system and the larger Army environment within which care is provided. Dr. Srinivasan received his doctoral degree from the School of Innovation, Design and Engineering at Mälardalen University. He received his graduate degrees in aeronautics and astronautics from MIT, and avionics engineering from Anna University, and his undergraduate degree in computer engineering from Mangalore University. He is the 2014 recipient of the Army’s Outstanding Civilian Service Award for contributions to improving the Army’s mental health system of care.

Julia DiBenigno

Julia DiBenigno is a doctoral student in the Organization Studies group at the Sloan School of Management at MIT. She has been a member of the MIT PTSI team for the Army since 2012 and is conducting her dissertation research on command-provider relationships in Army Embedded Behavioral Health. Prior to coming to MIT, Julia worked for Deloitte Human Capital Consulting as an organizational change consultant on large enterprise transformation projects. Julia graduated summa cum laude from Columbia University as salutatorian with a degree in Psychology.