Appendix B: Army case Alpha

Site Alpha Behavioral Health System of Care

Jayakanth Srinivasan[1] and Julia DiBenigno

Executive Summary

In November 2011, members of the MIT Behavioral Health Participatory Action Research team visited Site Alpha to better understand the behavioral health system of care in the installation. The installation is home to over 22,000 Soldiers (and over 42,000 family members) drawn from an infantry division and other operational units. The infantry division commander serves as the senior commander for the installation. Over four days, we interviewed 20 key stakeholders drawn from command, medical and installation services. In addition, we engaged with small groups of these stakeholders through 9 focus groups and 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. Over the last year, we have continued to interact with the BH leadership at the installation to understand changes and improvements to the system of care.

The foundation of any behavioral health system of care is the ability to provide quality care to Soldiers and Family members. Site Alpha was one of the first sites to implement Embedded Behavioral Health and has grown over the last three years to establish a mature behavioral health system of care that includes intensive outpatient care. It is one of the few installations that we have visited that has operationalized the idea of patient-centered behavioral health care for active duty Soldiers in Brigade Combat Teams. They are in the process of scaling those concepts to Soldiers in non-BTC units, and for family members.

Site Alpha's ability to implement their behavioral health system of care is based on their engaged senior leadership whose focus is on ensuring soldier wellness rather than on organizational boundaries. The Behavioral Health team has developed meetings and tools for creating shared situational awareness within clinical stakeholders, as well as across clinical and operational stakeholders. The collaborative health promotion and risk reduction efforts are still maturing on the installation and actively involve key subject matter experts to allow command team to gain a deep understanding of the clinical, operational and social aspects of a Soldiers life.

There are unique practices at Site Alpha that address Army-wide challenges of implementing a patient-centric behavioral health system of care:

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1. Exploiting Behavioral Health Capabilities at the Soldier Readiness Processing site: Site Alpha is one of the few installations we have visited that has dedicated behavioral health providers at the SRP to support second level screening, in-processing and out-processing of Soldiers. This location serves as the single location that a Soldier access for all key transitions.

2. Connect Care Meetings: bring together network inpatient providers to the installation to ensure Army appropriate care provision and handoff coordination when the Soldier is released from inpatient care. The Joint Commission has validated this as a best practice during their recent visit to the installation.

3. Multi-Disciplinary Treatment Planning Meetings: These meetings bring together key clinical stakeholders from IMCOM, MEDCOM and FORSCOM to develop shared treatment plans for patients with complex or acute behavioral health conditions. While these meetings are specified in the EBH manual, Site Alpha is one of the few installations that has obtained active participation from ASAP, FAP and FORSCOM providers.

4. Intensive Outpatient Program: Site Alpha has a unique intensive outpatient program that is structured to address combat related trauma, as well as the step down needs of Soldiers transitioning from an inpatient program.

5. ASAP Alignment to Units and Documentation in Medical Record: Site Alpha was one of the first installations to align their ASAP teams to units. This ensured a consistent interface to command teams. Additionally ASAP at Site Alpha has chosen to document fully in the medical record to ensure consistent care for Soldiers.

6. Key SME Participation in High Risk Team Meetings: While there is variation in the execution of the high risk team meetings, Site Alpha has established a consistent participation of key subject matter experts from Behavioral Health, FAP and ASAP to ensure command team have a holistic understanding of Soldier wellness.

Site Alpha has a mature system of care but continues to struggle with resourcing constrains and resource utilization. There are a number of near term actions that require senior leader attention:

1. Senior leader action is needed to ensure that behavioral health and ASAP hiring actions are not negatively impacted by sequester-induced hiring limits.

2. An Installation Director of Psychological Health should be assigned as required by DoDI 6490.09.

3. A clear delineation of BHO roles and responsibilities as a critical member of the EBH and Command teams is needed to maximize the effectiveness of both the EBH team and the BHO.

4. Clear guidance is needed from Warrior Transition Command on the delineation of clinical, operational and risk assessment roles of WTU social workers

5. Clear definition is needed from MEDCOM on the role of Internal Behavioral Health Consultants from Patient Centered Medical Home to Specialty Behavioral Health Services.

6. Revised guidance is needed on the utilization of behavioral health provider incentives including retention, relocation, on the spot awards within the Integrated Resourcing and Incentive System.

7. Clearer guidance is needed from MEDCOM on reinvestment of funds obtained through improvements to the behavioral health system of care. Specifically delineate processes through which an MTF may increase capacity in the direct care system.

8. Training is needed to support junior line leader (company level and below) understanding of behavioral health services with an emphasis on the benefits of appropriate behavioral health services utilization.

Site Alpha Behavioral Health System of Care[2]

Jayakanth Srinivasan[3] and Julia DiBenigno

Introduction

In November 2011, members of the MIT Behavioral Health Participatory Action Research team visited Site Alpha to better understand the behavioral health system of care in the installation. The installation is home to over 22,000 Soldiers (and over 42,000 family members) drawn from an infantry division and other operational units. The infantry division commander serves as the senior commander for the installation. Over four days, we interviewed 20 key stakeholders drawn from command, medical and installation services. In addition, we engaged with small groups of these stakeholders through 9 focus groups and 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. Over the last year, we have continued to interact with the BH leadership at the installation to understand changes and improvements to the system of care.

In this paper we describe the evolution of system of care on the installation, addressing both the documented and undocumented avenues of behavioral health services on the installation. The lack of capacity to provide on-post care for family members and retirees has resulted in increased utilization of the purchased care network to support their care. We identify the key organizational arrangements and processes established by the behavioral health system of care to capture soldiers at key transition points: for deployment and redeployment through the Soldier Readiness Process site, for purchased inpatient to on-post care through the Connect Care meetings. We discuss how the Behavioral Health leadership has transformed the lack of on-post inpatient care facilities from a system weakness into system strength through active collaboration with purchased inpatient care providers.

Since Site Alpha has focused on developing a full spectrum of behavioral health services to support chronic patients as well as non-acute outpatient care, we discuss both the on-post services to chronic patients through an intensive outpatient program, as well as the mature roll out of Embedded Behavioral Health (EBH) on the installation. We discuss two of the key challenges with institutionalizing EBH in terms of initial care fragmentation and single points of failure due to provider attrition. One of the strengths of EBH is the ability to establish shared situational awareness between key clinical and operational stakeholders. We detail out the key meetings and tools used to establish situational awareness among clinical stakeholders.

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The challenges at Site Alpha revolve around the lack of assets or inability to exploit existing assets to provide on-post care for key population groups such as Soldiers in the WTU, Soldiers in non-Brigade Combat Team units, and Family members. We discuss the commonly acknowledged delays or freezes for hiring additional providers in the MTF due to a lack of understanding both of the cap limits on personnel and the new Behavioral Health Service Line structure. We highlight the ambiguity with respect to the utilization of key non Behavioral Health Department assets such as Behavioral Health Officers and WTU Social Workers. We focus on some of the variation in the execution of meetings used by command teams to bridge across the clinical, social and operational components of a Soldiers' life to highlight possible areas for improvement.

Evolution of the System of Care

Over the last two years, the Behavioral Health (BH) system of care at Site Alpha has evolved from centrally providing specialty-care focused services at the on-post Army community hospital, to providing distributed behavioral health services at point of need through embedded behavioral health clinics. The installation has the capacity to provide the full spectrum of BH services as shown in Figure 1. Providers from Forces Command (FORSCOM), Installation Management Command (IMCOM) and Medical Command (MEDCOM) provide direct care to Soldiers and their families. When demand exceeds the on-installation capacity to provide care, care is sourced from a large network of TRICARE providers around the installation.

Documented BH care ranges from routine screening at Soldier Readiness Processing (SRP), outpatient care in distributed EBH clinics or the centralized BH clinic, intensive-outpatient care and in-patient care. Undocumented care ranges from the guidance provided by the Master Resiliency Trainers (MRTs), spiritual services provided by Chaplains, to non-medical counseling[4] provided by Army One Source and Military Family Life Consultants (MFLC). The patient population at Site Alpha can be parsed into four groups: dependents & retirees; Soldiers in a Brigade Combat Team (BCT); Soldiers in non-BCT units; and Soldiers in the Warrior Transition Units (WTUs). Currently a majority of the dependents and retirees are routed to the TRICARE network for care. There is a focused effort on the part of the BH leadership to increase care provided on the installation to this population through a new a Child, Adolescent and Family Clinic (CAFAC), however, they do not have the provider capacity to support the entire population. Of the active duty population, the system of care is best defined for Soldiers who are part of a BCT. The Embedded Behavioral Health (EBH) clinic acts as the principal provider of all outpatient BH care and case management services for BCT Soldiers. A dedicated team in the central BH clinic provides outpatient care for Soldiers in non-BCT units. WTU Soldiers split their care between the WTU social work team and the central BH clinic based on the complexity of their case, and the workload of the WTU

[4] Military One Source and the Military Family Life Consultants are governed by DODI 6490.06 (http://www.dtic.mil/whs/directives/corres/pdf/649006p.pdf)

social work team. In addition to the care provided in the BH clinics, Soldiers have access to IMCOM provided financial services, family services, and substance dependence services.

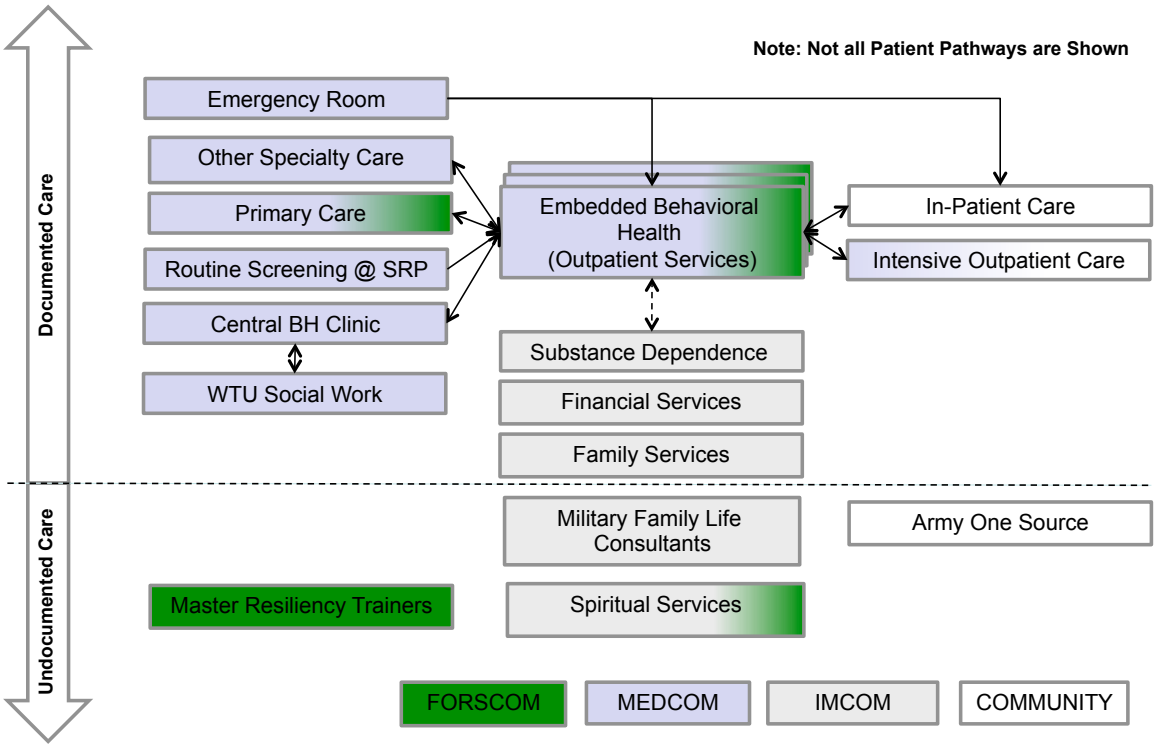

Figure 1: *Site Alpha Behavioral Health System of Care*

A Soldier enters the BH system of care through a provider referral (routine screening, primary care, specialty care, emergency room), a command directed mental health evaluation, or by walking-in to a BH clinic. Once a soldier is associated with an outpatient clinic, that location becomes the integration point for all of their care. When a soldier needs a higher echelon of care, their BH provider refers them to either an intensive outpatient program or to inpatient care. In-patient care is provided either on post (the 16 bed in-patient ward has just completed renovation, and will be reopened in Spring 2014) or through the TRICARE network. When a patient is sent to a higher echelon of care, they are required to visit their aligned provider on the completion of a course of treatment. This allows the provider to support the Soldier's return to duty with any necessary outpatient care.

Services such as financial services, family services, and substance dependence care are documented, and can be tracked by leadership. Family services, including the family advocacy program, pull resources from both MEDCOM and IMCOM. The patient advocates are typically from IMCOM, while MEDCOM assets provide the required clinical counseling. Similarly MEDCOM and FORSCOM assets provide BH care and primary care.

When a soldier or their family seeks confidential non-medical counseling they can access either Army One Source or MFLC. The care is not documented, and information is not formally shared with command or other BH providers. When a soldier or family member needs medical counseling, they are directed to the emergency room, the BH clinic whose catchment area they fall into or to obtain a referral to the TRICARE network. Chaplains provide spiritual services that includes counseling and in some cases marriage and family therapy. The utilization of assets drawn from multiple organizations, and distribution of care across multiple locations highlights the need for mechanisms for shared situational awareness about the care being provided to a soldier. Site Alpha utilizes group meetings with representatives from all organizations as discussed in the shared situational awareness section.

Exploiting Soldier Readiness Process Capabilities

Soldier Readiness Processing (SRP) is a required procedure executed at Army installations when a Soldier is either getting ready to deploy or returning from a deployment. Typically, there are two levels of behavioral health screening executed at the SRP site: an initial screen carried out by a primary care provider, and a second-level screen carried out either by an in-person behavioral health provider or by a telebehavioral health provider. Site Alpha is unique in its use of a dedicated team[5] of LCSWs at the SRP site to carry out second level screening. Between Oct 1, 2011 and September 30, 2013, they carried out 34,007 encounters for 25,240 unique Soldiers at the SRP site (summarized in in Table 1) using a mix of privileged (i.e., permitted to prescribe) behavioral health providers, behavioral health technicians and nurse case managers.

When Soldiers are identified in the primary care screen as needing additional behavioral health services, Soldiers are given the choice of seeing a provider in person at the SRP site or a telebehavioral health provider[6]. If a Soldier chooses the telebehavioral health option, they first meet with a Behavioral Health Technician who initiates the video link with the remote provider, and follows up with the remote provider after the session is complete to determine further actions. In the time period analyzed there were 4203 encounters that were staffed only by technicians[7]. Even though the follow up care rate

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[5] In the time period of analysis, there were thirteen privileged providers coded against BFD2 or BFE2. Of these providers, five are currently part of other behavioral health services on the installation, and three no longer provide care on the installation.

[6] Currently 25% are randomly chosen, and a Soldier can always decline to use telebehavioral health services.

[7] An encounter is identified as only being staffed by a behavioral health technician if there are no other privileged providers seeing the patient in the same day, in the same MEPRS code

with telebehavioral health is small, it is unclear how care is coordinated for soldiers using this modality. Additionally, it raises the possibility of care fragmentation where a Soldier is seeing a prescriber on the installation, and a psychotherapist via telebehavioral health. Unlike fragmentation when care is split between purchased care and direct care, care is documented in AHLTA for review and analysis.

Table 1: Soldier Readiness Processing Utilization October 2011 – September 2013
(Note: BFD2 and BFE2 were included to determine all encounters @ SRP site)

Encounters	Unique Soldiers
1	18600
2	4964
3	1336
4	267
> 5	73
Unique Soldiers	**25,240**
Total SRP Encounters	**34, 007**

Of the 25,240 Soldiers that were screened, 60% received no follow on care, and 26% (6,457) received continued behavioral health services. There is significant variation at Site Alpha in how EBH providers are used to carry out the third level screening. In 2011, they piloted a program wherein the EBH team had a psychologist or a psychiatrist at the SRP site to ensure that a Soldier deemed as needing continued care met a team provider in person, and received their follow on appointment. Currently each EBH team processes the intake differently. The SRP site ensures a warm handoff either by scheduling an appointment for the Soldier, walking them in to their EBH clinic or with a co-located EBH provider. The data highlights the same variation. Of the Soldiers receiving continued care after SRP screening, 523 were seen the same day in an EBH clinic, 452 were seen next day, and 2462 were seen within 30 days in an EBH clinic. Part of the rationale for the variance in handoffs was the lower number of Soldiers being caught in a pre-deployment screen. As one SRP provider noted:

> *Four years ago, we used to get 120 behavioral health flag soldiers during SRP and now we only get four or five so there's many fewer surprises right before deployment.*

When a Soldier is redeploying from theater, they have established an effective handoff between pre-screening in theater using the Down Range Assessment Tool to the SRP site. The Unit Behavioral Health Officer (BHO) is responsible for carrying out the

redeployment screening and sending the information via secure email to the SRP site. As the SRP chief noted:

> *The unit BHOs screens the Soldiers downrange prior to redeployment and gives us two weeks notice so we can prepare for them at home.*

This ensures that the SRP team has the data available prior to the Soldiers arriving at the installation. The SRP team provides walk-in services for Soldiers who may not have been identified as needing BH services, and supports telebehavioral health screening for Soldiers at other installations. The SRP team is also responsible for executing the BH transition clearance review for Soldiers who are leaving the installation or leaving the Army (including chapter separations). For Soldiers identified as needing continued BH services, their information is forwarded to the next duty station via secure email to the receiving installation's point of contact. The challenge, however, is in ensuring that the point of contact on the receiving installation is the right person. As the SRP chief noted:

> *One of the issues is that not all bases have SRP's and we don't know which unit the person is going to be assigned to. The contact should be the behavioral health department, not the SRP, but we don't always know who to contact.*

Managing Inpatient Utilization

When we visited Site Alpha, they were in the process of updating their psychiatric inpatient ward. Consequently, they had to send all of their acute psychiatric patients to the TRICARE network. In the October 2010 – September 2013 timeframe, Site Alpha had 3903 admissions for 2349 patients that accounted for 39,862 bed days of purchased inpatient psychiatric care. Of these patients, 1665 had a one-time inpatient admission, 389 had two visits, and 295 patients had 3 or more visits[8]. This increased reliance on the purchased care network led to an increased emphasis by the behavioral health leadership team on ensuring effective coordination for Soldiers using those facilities.

They established a utilization management meeting to ensure that care was being utilized appropriately. At first these meetings were focused solely on utilization and care coordination including expected release dates and handoffs between the installation and the care facility. The utilization manager used the example of substance dependence withdrawal to highlight the need for utilization management. TMA guidelines provide for a minimum of 7 days of inpatient stay for alcohol withdrawal and 14 days for opiate withdrawal, however network providers wanted to keep patients in their facility for 28 days. Having these providers share their treatment plans for long stays has helped the installation better manage the use of those facilities. Currently the utilization manager

[8] The chronic patients > 3 visits accounted for 18483 bed days, the patients with two visits accounted for 8,294 bed days.

has been able to negotiate an agreement wherein long stays that exceed the minimum guaranteed stays are approved in 3-day increments.

In February 2012, they expanded the meeting into a *Connect Care* meeting that uses treatment planning as the core of the meeting, and creates the mentality of starting discharge planning at admission time. These meetings included nurse case managers and the Site Alpha psychiatrist who owned that patients care, to ensure follow on care and safety planning. This increased utilization of network facilities, surfaced the differences between Army practices for inpatient care and the practices used in those facilities. These differences included basic awareness of Army culture and regulations to more specific aspects such as guidelines on deployment limiting conditions and compliance to Health Affairs guidelines on use of atypical anti-psychotics. One of the nurse case managers provided a powerful example of cultural attunement:

> *There was a new hospital that has a long-term care philosophy and it was making promises to patients that they wouldn't be able to keep because of our (Army's) restrictions. So now we can coach them and say that's not appropriate here. We've met with the head of the hospital and now it's a win-win.*

These meetings also provided the BH Chief with an opportunity to address those differences. For example, at the meeting we observed, the BH Chief emphasized to a provider from a network hospital:

> *The patient is on Seroquel …*[9] *As long as we are documenting it, it helps us justify the use. A HA memo went out that all atypical antipsychotics need a rationale – so far we just needed it in your notes so we can justify it.*

These meetings have created an environment where information could be shared between providers to improve the overall quality of care for that Soldier. When asked about the effectiveness of the meetings, one of the network providers noted:

> *I like that we meet weekly so I know whether the Soldiers are working the system or they should be staying. It helps us meet your (the Army's) needs.*

An installation provider added to that comment:

> *Now there is a bidirectional flow where we share facts on the patient that he may not have shared with you (Network Provider). The meeting does a good job with safety planning. We've been doing it for 10 months so far and the patients really benefit.*

[9] Case specific discussion omitted

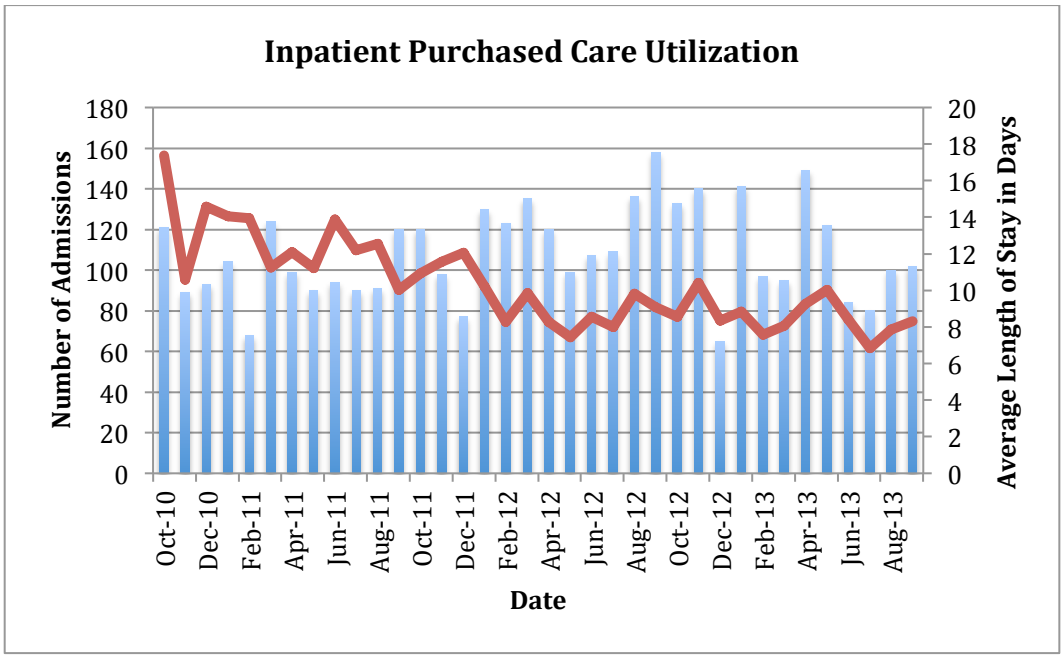

Figure 2: *Network Utilization of Acute Psychiatric Care at Site Alpha*

The BH Chief believes that the Connect Care meetings has enabled Site Alpha to both improve the quality of care for Soldiers, and also ensure that they were using the limited network capacity effectively. Their average length of stay (Figure 2) is similar to the direct care average length of stay at other installations. He also attributed their lower re-admissions rate to the presence of an intensive outpatient program that provided both step-down care, and other services.

Leveraging On-Post Intensive Outpatient Care

Site Alpha established an intensive outpatient program (IOP) in early 2010 with an investment of $320,000[10] to provide intermediate to higher-level care for Soldiers with combat trauma-related conditions. Over time, they recognized the need for supporting three overlapping subpopulations of Soldiers: Soldiers transitioning from inpatient care back to their units, Soldiers needing to develop skills to address deployment related stressors, and Soldiers needing to process combat trauma. The IOP has three care tracks to support each of those population groups, and staffed it with a behavioral health provider and a social services assistant. In addition, a nurse case manager ensures that care is coordinated for Soldiers in the IOP. Due to BH staffing shortages, the IOP relies heavily on two Red Cross volunteers to support operations 40 hours a week.

[10] The obligated an additional $470,000 in FY 11 before rolling the program into the core behavioral health operating budget.

The IOP was designed with a 4 hours a day block structure, to ensure that the Soldier remained connected to her/his operational unit. The length of the treatment program is a function of the track that the Soldier participates in. The *Stabilization* track is an open group step down program that is offered 3 days a week for a five-week period. In June 2013, there were 13 Soldiers in the track, and 3 Soldiers on the wait list. Referrals to this track are made either during the Connect Care meetings as part of discharge planning or by the treating provider during a post-hospitalization safety check. As of September 2013, 185 soldiers had completed the *Stabilization* track, while 11 had dropped out. They currently run two open groups in the *Resiliency* track for Soldiers needing to develop skills to address issues such as interpersonal relationships, emotional regulation, building distress tolerance and mindfulness. The groups meet 4 days a week for 5 weeks. The groups were intentionally split into the morning group and the afternoon group to enable physically able soldiers to participate in morning PT with their units. In June 2013, they had 27 Soldiers enrolled in the Resiliency groups and 7 Soldiers on their wait list. As of September 2013, the Resiliency track had graduated 382 patients, while 52 had dropped out. The *Trauma Resolution* track is a six week long closed group that meets 4 days a week, targeting Soldiers with PTSD or PTSD spectrum symptoms. Since the group operates in cohort format, there were 16 soldiers in the June 2013 waitlist. As of September 2013, the track had graduated 151 patients, while 23 had dropped out.

The IOP at Site Alpha is unique in its routine use of pre and post outcome measurement across all the tracks[11]. While the process is currently manual and longitudinal tracking of patients after they leave the program is difficult,[12] the installation-wide adoption of the Behavioral Health Data Portal provides an opportunity to truly understand the clinical impact of the program. The fiscal impact of an IOP is easier to see. At a minimum this program has saved the hospital almost 2.5 million dollars[13] in purchased intensive outpatient care. There is an additional cost avoidance component that was raised by the IOP chief, who cited a small sample follow up study with 20 patients, where they found there were no follow on hospitalizations. When discussing the *Trauma Resolution* track,

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[11] The Stabilization track collected data using OQ-45. PCL-C, PCL-M, BAI, BDI, Audit and LockeWallace. The Resiliency track uses an Insomnia scale in addition to those used in the Stabilization track. The Trauma Resolution track uses the OQ-45, PCL-M and the Trauma Symptom Inventory.

[12] In one follow up study, they were able to get 30-day post-graduation data from 25 patients. That number fell to 11 patients for 90-day post-graduation data.

[13] The IOP lead at Site Alpha estimates a per day cost of the on-post IOP to be $90 - $100, as opposed to $275- $390 for purchased care. There are 14,039 patient days of care that were utilized by patients who completed care (we excluded the 86 patients who dropped out of care because it was not clear as to when they dropped out of care). Using a lower end estimated of $175 difference between direct and purchased care IOP, the savings are calculated at $2,456,825.

the IOP chief emphasized the strength of the program in providing care to Soldiers while retaining their occupational environment, and further emphasized the cost avoidance of routing the patient to the appropriate level of care. When the installation did not have the IOP in place, they were forced to send patients with moderate to acute PTSD to a residential facility[14].

Currently the care provided in the IOP is not captured under a separate MEPRS code. The only way to determine when a patient entered the IOP and when they graduated is by using the S9480 CPT code[15], or by looking at individual provider notes in the medical record. The new MEPRS code under the Behavioral Health Service Line architecture should provide better transparency into patient flows through the entire system.

Institutionalizing Embedded Behavioral Health

Site Alpha was one of the first installations to execute Embedded Behavioral Health (EBH). The EBH model's use of a team of providers for a BCT was expected to create a smaller population (~4500 Soldiers) for the providers to focus on, as opposed to a single centralized clinic with the whole installation as the population of interest (~22500 Soldiers). Pushing the alignment down further to one provider per battalion was intended to create a single point of contact for command teams to enquire about their soldiers. This contact with command would also enable the provider to more effectively track where the Soldier's unit is in the deployment cycle. When we first visited in 2011, they had rolled out EBH to two BCTs and were in the process of establishing it as an installation wide approach. Today, they are fully rolled out for all existing BCTs and were in the process of developing a strategy for managing the new Combat aviation brigade.

EBH clinics focus on providing care at the point of need; hence care facilities need to be located within walking distance of the Soldier's workplace. Given the time lags in military construction, Site Alpha chose to use semi-permanent re-locatable buildings and outfit them to meet The Joint Commission standards. While the cost for these building was initially borne by the installation itself, funding support has since been established at MEDCOM to support the creation of new facilities on other installations. One of the concerns with establishing care facilities within the brigade footprint was the potential to increase the stigma for seeking care. Currently, the EBH clinics at Site Alpha do not formally measure stigma, however, the overall utilization of mental health services at the EBH clinics has increased over the last three years.

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[14] Using prior cost data of a residential PTSD program of $25000 per patient, and a lower end estimate of a quarter of the Trauma Resolution track patients being routed to the IOP as opposed to inpatient care, the lower end cost avoidance estimate is $925,000.

[15] Between October 2011 - September 2013, the S9480 CPT code accounted for 10395 encounters for 487 patients

EBH clinics were first piloted on the installation in 2010 – 2011, and became the principal mode of outpatient care delivery for Soldiers in the 2011 – 2012 timeframe. In that timeframe, there were 7698 unique patients seen in EBH clinics, with 4444 patients receiving clinical care for the first time in the EBH clinics. Of the 3254 patients whose clinical care was split between EBH clinics and non-EBH clinics, 2771 were in continued care[16] (738 saw their provider in the EBH Clinic, while 2033 saw a different provider). This 45% initial fragmentation of care is one of the key switching costs that needs to be actively managed when establishing EBH. The other key challenge is the creation of a single point of failure due to provider attrition. Over the last two years, 29 of the 74 privileged providers have left EBH clinics (Table 2), ten within the first six months of starting in an EBH clinic.

Table 2: Provider Attrition in EBH Clinics

Provider Type	# Left EBH	Providers
Psychiatrist	5	11
Psychiatric Nurse Practitioner	3	5
Psychologist	5	22
Licensed Clinical Social Worker	16	36
Total Providers	29	74

This initial provider attrition makes it harder to keep a patient engaged in care. One provider framed it through the experience of a soldier going through his medical board:

> *He is on his fifth provider. He has significant psychosis and needs continuity of care and he's on his third psychologist. The patient will come in and ask, will you be my provider from here on out? And you can't promise him yes.*

Providers also highlighted the impact of additional duties that an EBH provider was required to carry out in addition to direct patient care. One of the providers discussed the skills needed for being successful in EBH as:

> *You need a sense of humor, very strong clinical skills, and the ability to be flexible. If you want a job where you consistently spend 50 min. with patients and then use 10 min. for notes you're not going to do well because of all the extra work we do – triage, hospital discharges, responding to crisis, command calls all in addition to that therapy hour. And it's hard to fit all of these extra things in.*

[16] Continued care is defined as having received more than 4 visits with a prescriber.

One of the goals of EBH was to improve the experience of care for Soldiers by reducing fragmentation of care in the direct care system. There is a known issue when care is split between the direct care system (care provided on the installation) and the purchased care system (when care is provided by TRICARE providers). Site Alpha has made a concerted effort to ensure that medication management for all Soldiers is carried out on the installation. As one provider framed it:

> *We end up having to refer off post and the nurse becomes an assistant case manager. So we are sending people off post and then case managing them. They are required to check in every three months for an assessment.*

In the October 2010 – September 2011 timeframe, providers with prescribing privileges[17] provided a total of 15200 encounters to 3584 patients. For the 1,276 patients in continued care[18], 616 saw more than one prescriber, a prescriber care fragmentation of 48.27%. Since EBH was being stood up in this year, there were only 1380 encounters documented[19] for 487 patients. Of the 121 patients in continued care, 18 patients saw more than one prescriber. This small sample reduction in care fragmentation to 14.88% highlighted the potential of EBH in improving care quality. We expanded the analysis to look at care provided in the Oct 2011 – September 2013 timeframe, when EBH clinics became the primary location for outpatient care delivery on the installation. Prescribers in EBH clinics provided 9872 encounters for 2107 patients. As shown in Table 3, we identified a subpopulation of 958 EBH patients (accounting for 7,967 encounters) in continued care. Within this subpopulation, 242 soldiers saw more than one prescriber[20]. We drilled down deeper into the data to determine the root causes of the care fragmentation, and found that in 213 of those cases, the fragmentation was a result of provider attrition. In the same time, prescribers in other clinics on the installation provided 16740 encounters for 3,9O6 unique patients. In the non-EBH population there were 1,303 unique patients in continued care (accounting for 12,978 encounters), of whom 550 saw more than one prescriber. When provider attrition was taken into account, this number fell to 431 patients. In summary, prescriber care fragmentation for EBH clinics was found to be at 25.26%, and fell to 3.03% when provider attrition was accounted for. In contrast, prescriber care fragmentation for other clinics was found to be at 42.21% and fell to 33.08% when provider attrition was taken into account.

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[17] We included care provided by both Psychiatrists and Psychiatric Nurse Practitioners

[18] Continued care is defined as having received more than 4 visits with a prescriber.

[19] Care documented under the BFD4 MEPRS code

[20] One of the providers raised the concern of prescriber fragmentation when a Soldier moves between brigades on the installation. The current data structure is agnostic to BCTs.

Table 3: Soldier Visits to Prescribing Providers in EBH Clinics

# Prescriber Visits	Unique Soldiers	Total Encounters
1	632	632
2	278	556
3	239	717
>=4	958	7967
	2107	**9872**

Shared Clinical Situational Awareness within EBH Teams

EBH teams in Site Alpha have developed a number of team meetings, structural arrangements, and artifacts to develop a shared understanding of the current state of a Soldier's health. They leverage interdisciplinary meetings (detailed in Table 4) to track key transition points including operational transition points (Serious Incident Report (SIR), being part of a high risk list, and redeployment from theater) and medical transition points (Medical Evacuations from Theater, In-Patient admissions, In-Patient releases, Suicidal Ideation and Homicidal Ideation). These transitions unfold over time and involve both clinical and non-clinical stakeholders within the larger enterprise.

The Morning Report is a daily meeting that teams use to identify Soldiers who need acute care (ER visits, inpatient admissions, suicidal/homicidal ideations) during off-duty hours, as well as identify Soldiers returning from inpatient care. Currently, the team nurse case manager manually collects and stores the information in a locally developed database. 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. As one provider noted:

> *We've been doing it for a while, since the beginning, since April 2011. We could cut it shorter. It is 30 min. out of our day. But it is a good start to the day to know what's going on with everyone schedule for the day.*

Table 4: Interdisciplinary Meetings to Develop Shared Clinical Awareness

Meeting	Stakeholders Involved
Morning Report	EBH Team
Daily Standup	EBH Team
Multi-Disciplinary Treatment Planning Meeting	EBH Team (including Brigade BHO), Brigade Surgeon, ASAP, FAP
Connect Care Meeting	BH Leadership Team, Intensive Care Community Providers
Battalion and Brigade High Risk Team Meetings	EBH provider, Brigade Surgeon, Battalion PA, Brigade BHO, Brigade Chaplain, ASAP Provider, MFLC, Company Command Teams
Community Health Promotion Council	Division and Brigade Command Teams, Installation Leadership, MTF Leadership, Representative from All Key services

This meeting also provides an opportunity for providers to share operationally relevant information such as training schedules and deployments. As one provider framed it:

> *We had 915 people we saw last month because a unit deployed. When people are about to deploy we have to deal with the 'crisis du jour'*

The EBH lead at Site Alpha developed a simple quad chart covering Personnel, Current Operations (CUOPS), Future Operations (FUOPS), and HQ Report, as shown in Figure 3. Personnel issues include open hiring actions, incoming personnel, pending losses, gaps in capability, and the staffing levels of the FORSCOM Behavioral Health Officers. This is particularly important given the time delays in staffing and attrition of EBH providers. The CUOPS and FUOPS include both actions relevant to internal EBH team operations as well as the operations of the aligned brigade. The unit status in CUOPS discusses whether there are any upcoming deployment related training, deployments or redeployments. The section also includes key EBH operational attributes such as the appointment wait times, no show rates, and administrative separations. MTFs have a financial incentive for minimizing no-show rates, and an additional notification

requirement[21] when a Soldier misses a behavioral health appointment. For example, one of the teams found that they had inappropriate referrals, and their initial no-show rates were high; they initiated an introduction to behavioral health group as a way of giving Soldiers the ability to make informed decisions about the kind of care they wanted to receive. As one provider framed it:

> *We had inappropriate walk-ins and we need to guide them to more appropriate care, such as groups … Many urgent walk-ins come in saying "I got a (speeding) ticket" which is not a behavioral health issue. They don't know what "in crisis" means. So we refer them to introduction to behavioral health.*

Site Alpha internal policy requires the use of the 96153 CPT code for capturing the introduction to EBH class, however, we were only able to find 298 such encounters (of 84,212 EBH encounters) between October 2011 – September 2013. Expanding to all group psychotherapy in EBH clinics (using 96153, 90853 and 90857 CPT codes), we found 2456 unique patients in group therapy, of which 1320 patients had 4 or more individual provider visits after their group therapy session.

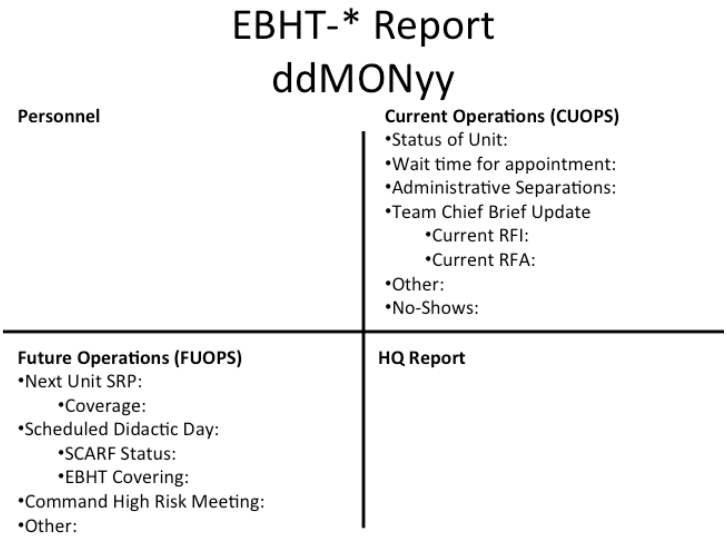

Figure 3: *EBH Team Report Template*

The rationale presented for using groups was based on an estimate that 10% – 15% of people in the introduction to EBH groups were dealing with financial, legal or

[21] MEDCOM Policy 11-061 Policy for Procedures Following Missed Behavioral Health Appointments

adjustment disorders, hence, the groups would also be effective at triaging patients to the right level of care. This rationale can be tested once the coding is effectively implemented.

The FUOPS section focuses on upcoming operational events such as the next SRP date, and determining which provider is going to provide on-site coverage for third level screening. It places emphasis on team learning (didactic days), supervision, and cross coverage issues to ensure coordinated care. The template also uses the five dimensions of Status, Certainty, Autonomy, Relatedness and Fairness (SCARF[22]) for identifying threats to the effectiveness of EBH (both clinical and operational), and maximizing impact of EBH.

A key ongoing challenge that they are working on is command meetings. The EBH chief recognized the challenges of trying to synchronize across two organizations, noting:

> *It is very challenging with scheduling command meetings and keeping them fixed on the calendar. They (line leadership) need to work better on keeping command meetings on the calendar because the meetings keep getting changed. It also speaks to a difference in flexibility. Command is very flexible and change meetings times all the time, but we (MEDCOM) are not flexible because we have patients with fixed appointments.*

This template enables providers to make more informed decisions on the care they provide soldiers, as they obtain a macro understanding of current and near-term occupational stressors (training exercises, upcoming deployments) impacting a patient's improvement. It also provides the BH leadership with a planning tool for managing provider schedules and ensuring access to care. For example, they now use the template as the single source of data to track administrative separations (as opposed to tracking each individual administrative separation) and have dedicated a single provider to managing this process, enabling other providers to focus on clinical care.

Multi-Disciplinary Treatment Planning to Coordinate On Installation Care

The Multi-Disciplinary Treatment Planning (MDTP) meetings bring together key stakeholders from across various organizations involved in the behavioral health of a Soldier, including the brigade surgeon, substance dependence care, and family advocacy. Members from Army Community Services who provide non-medical services are also invited to participate on an as needed basis. This allows providers across the larger system of care to coordinate care for complex cases. The BH Chief noted:

> *Those same people have ASAP, FAP (Family Advocacy Planning), behavioral health, so it's good to communicate since were all caring for the same people. If we all had these little fiefdoms, it would not work.*

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[22] See Rock D., "SCARF: a brain-based model for collaborating and influencing others", NeuroLeadership Journal, Vol 1, 2008, for a longer discussion on the five dimensions.

In the October 2011 – September 2013 timeframe, there were 10973 unique patients seen in EBH clinics, of whom 3169[23] were also seen either in the WTU or in FAP. These patients on average saw eight different providers and received care in four locations[24]. Our encounter data currently does not provide visibility into the ASAP population, but we believe that the comorbid population is large enough to require ASAP participation in the MDTP.

At one of the MDTPs we observed, the key stakeholders present in the room in addition to the EBH team were the brigade BHO, an ASAP representative, a FAP representative, and a representative from the Child and Family Program. The BH Chief emphasized that the teams in general were doing a great job of having the key stakeholders present for MDTPs, noting the ability to get support the Soldier with family issues:

> *Having FAP/CAFAC in the room allows them to do preemptive stuff. They can do preemptive reach out to the Soldier when he or she has a family issue and offer behavioral health services.*

The FAP Chief echoed the same perspective in a separate interview, noting:

> *FAP and CAFAC used to have poor communication and had their own little fiefdoms. Relationships have improved for three reasons: Firstly, they spoke at each other's clinic about what they do. Secondly we've changed our reporting process so that we call each other not just communicate electronically. We call each other to decide on tough cases. Finally, providers are getting feedback through the meetings.*

The Brigade BHO emphasized the advantage of having a clear understanding of the care for all the soldiers in the brigade, noting:

> *I go to these large brigade meetings, I see the same names again and again. I feel like I really know what's going on with the brigade because of these meetings. As BHO I can hear all the medical stuff and then translate it to command in their language. Helps with situational awareness so there's no surprises.*

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[23] We identified EBH patients as those seen in the BFD4 MEPRS code. We then parsed the data to identify if Soldiers in the EBH clinic were seen either in the Family Advocacy Program (FAZF), the Social Work/FAP Clinic (BFDC and BFEA), or for Case Management in the WTU (FAZ2) or for Clinical Care in the WTU (FAZW).

[24]The mean number of providers was 8.804354686, with a standard deviation of4.9638433831, the mean number of locations was 4.343010413, with a standard deviation of 1.4818075742

Collaborative Health Promotion and Risk Reduction

Site Alpha uses two sets of meetings to support health promotion and risk reduction that relates to behavioral health: the Community Health Promotion Council and the High Risk Team meetings at the Brigade and Battalion level. One of the battalion commanders we interviewed identified three "huddles": the legal huddle, the IDES huddle and the high-risk huddle. These meetings focused on bring the battalion and company command teams (officers and NCOs) together to identify at-risk soldiers and ensure that the soldier had access to resources needed to address the challenges that she or he was facing. The Battalion high-risk team meetings explicitly identify soldiers who have either exhibited some form of risky behavior (for example appearing in a serious incident report for driving under the influence or domestic violence) or are have been identified by their immediate leadership team as being high risk. The huddles are differentiated by their focus and the participation of subject matter experts (SMEs) such as the Chaplain, the brigade Behavioral Health Officer, the Military Family Life Consultant, and the EBH provider and ASAP provider assigned to the battalion.

Participation in the meeting allowed the SMEs to share HIPPA and Privacy Act compliant information with the command team as a whole. In the battalion high risk team meeting that we observed, each of the company command teams had submitted a power point slide on each soldier they had identified as being at risk (indicated by an amber or red on the slide). At the time of the visit, they were transitioning from the FORSCOM Risk Assessment Tool, to the Soldier Leader Risk Reduction Tool for assessing whether a soldier was at risk. The tool itself is designed to codify known risky behaviors and provide command teams with a framework for thinking about risk, while allowing them to use leader discretion in determining the level of risk. Each company commander briefed the group on the current status of the soldier, the actions that were currently being taken to help the soldier lower their risk status, and any help that was needed by the company command team.

The battalion commander used the meeting as an opportunity to further explain his command philosophy to the leaders present in the room. Two examples are worth discussing in greater detail – a soldier who was being separated from the Army, and a soldier who was facing marital difficulties. When talking about the soldier being separated, the battalion commander specifically asked about the soldier's transition plan:

> *Does the soldier know about the post 9/11 GI bill and does he have a job lined up?*

The battalion commander encouraged the company command team to be more engaged in establishing and tracking the transition plan, noting:

> *That is one more person that is going out into the community that is going to carry the message about the Army.*

When discussing the soldier who was facing marital difficulties, the battalion commander made it a point to explicitly identify the SMEs that were in the room and ask whether they could share any additional information about the soldier. This surfaced further information in terms of the reconciliation between the solider and their spouse,

as well as information regarding services that the soldier had accessed. The meeting highlighted the command teams focus on the restoring soldier well-being.

Company commanders would start some of the briefs with:

> *He is a good soldier, who had some issues – we are helping him work through it.*

A focus in the meeting was to discuss why a soldier either lowered their risk from red -> amber or amber -> green, or whose risk was elevated. One of the innovations at Site Alpha is the inclusion of the top performers in the same meeting as the high-risk soldiers. The rationale that was shared by the battalion commander was his concern that the meeting discussing only high-risk soldiers was exhausting to the company command teams, and having them discuss their high performing soldiers allowed a richer conversation of developmental counseling.

A similar meeting is executed at the brigade level focusing on the top five at-risk soldiers from each battalion within the brigade.

The Community Health Promotion Council (CHPC) brings together the top leadership in the installation including the senior mission commander, the installation commander, the brigade leadership teams, and medical leadership team, to discuss population level trends captured in the installation risk reduction report. Subject matter experts highlight emergent challenges – for instance an uptick in strangulations or DUIs, and the leaders can direct action as needed. These meetings spanning multiple levels of command and multiple organizations are aimed at developing shared situational awareness starting with the individual and expanding to the installation as a whole. These meetings are not yet integrated or standardized through infrastructure or policy. As the CHPC coordinator noted:

> *We change command every two years, so we reinvent the wheel for a while and then we go back to what works. So we went to four working groups, and then to nine, and now back to four. And I look at these four as a package.*

Site Alpha has created the framework for developing shared situational awareness through the CHPC coordinator. Currently Site Alpha uses contract personnel to staff this position, causing annual uncertainty on whether that position will continue to be staffed. Given the lack of Army-wide standard practice[25] and role definitions with respect to the CHPC, the CHPC coordinator has to rely on personal relationships and act in the name of the senior commander to have data shared, and meetings coordinated. The CHPC coordinator summarized the challenge as:

> *They don't work for me and so I have to "remind them" I can't task them. So when I send e-mails I tend to cc everybody.*

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[25] The Army Ready and Resilient Campaign now makes the CHPC the focal point of all ready and resilient efforts, and the Army resiliency directorate is in the process of developing Army-wide guidance on the participation in and uses of the CHPC.

Care for Soldiers in the Warrior Transition Unit

Site Alpha has the capacity to fit up to 480 Soldiers in Warrior Transition Unit (WTU). These Soldiers are organized into two companies that are filled on a space available basis[26]. Their patient population includes Soldiers from the Active Component, the Army National Guard and the Army Reserves. The WTU commander characterized the patient population as:

> *Of the 400 plus people at the WTU, only eight have physical wounds, the rest have behavioral health or TBI issues. Half of the people are combat wounded, 75 to 80% have behavioral health as their primary or secondary diagnosis.*

Despite having a large WTU, providers highlighted the difficulty in getting Soldiers into the WTU. One provider noted:

> *It's hard to get into the WTU. You can get some Congressman's pet project in there, but there are 1300 people in MEB, and there are only 50 or 100 beds in the WTU (for the Active Component) so 1100 are back in their units.*

The WTU commander acknowledged the problem, noting the disparity between WTU acceptance criteria:

> *The biggest challenge we face is that it's harder for an active-duty soldier to get into the WTU than a reservist or National Guard who only needs to stub their toe and they're in.*

The WTU care team is built around a WTU surgeon and a team of Licensed Clinical Social Workers and Nurse Case Managers. The BH Chief recognized the importance of managing a high acuity population at the point of need, and has a collocated psychiatrist dedicated to care for WTU soldiers. In the October 2011 – September 2013 timeframe, there were 4,650 Soldiers case managed in the WTU. Of these patients, 1639 Soldiers were in continued care[27]. Site Alpha was one of the first installations to build-in BH care capacity into the WTU. Over the last two years, they have started utilizing the capacity to provide initial care for their WTU Soldiers. As the WTU commander noted:

> *We send some Soldiers out to the hospital, but we try to use in-house first. We prefer in-house so they can't play mom against dad and we're all singing the same tune.*

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[26] Unlike other installations where one company is almost exclusively soldiers with deployment related conditions

[27] WTU case management encounters were distributed as follows: 1933 Soldiers had one instance of case management, 710 Soldiers had 2 instances of case management, 368 Soldiers had 3 instances of case management, and the rest had 4 or more instances.

Site Alpha recognized the challenge of not having visibility into the care provided for the WTU soldiers. They started documenting clinical care using the FAZW code in June 2013, and over that time frame provided 1480 encounters to 281 unique patients.

Resourcing Challenges

The BH Chief noted that for the first time in recent memory, all the units were actually home. This increase in the active duty population has reduced the overall flexibility in moving assets from one care location to another, as the number of providers is relatively static (Figure 4). For instance, even though the rear-detachment of a deployed BCT has a large number of soldiers seeking behavioral health care, it may not require the full complement of providers. The providers who are not needed for care provision for the rear detachment can then be moved to meet surge requirements at other clinics. In other words, the BH chief had the flexibility to play a "shell game" with providers so that they do not have to send active duty soldiers into the TRICARE network. Ensuring that there are sufficient providers to meet the demands of the active duty population is a strategic challenge, and any movement in personnel has immediate effects in terms of access to care and continuity of care, and in the long-term effects in terms of overall quality of care. As the BH chief noted:

> *The staffing challenge is now akin to playing chess.*

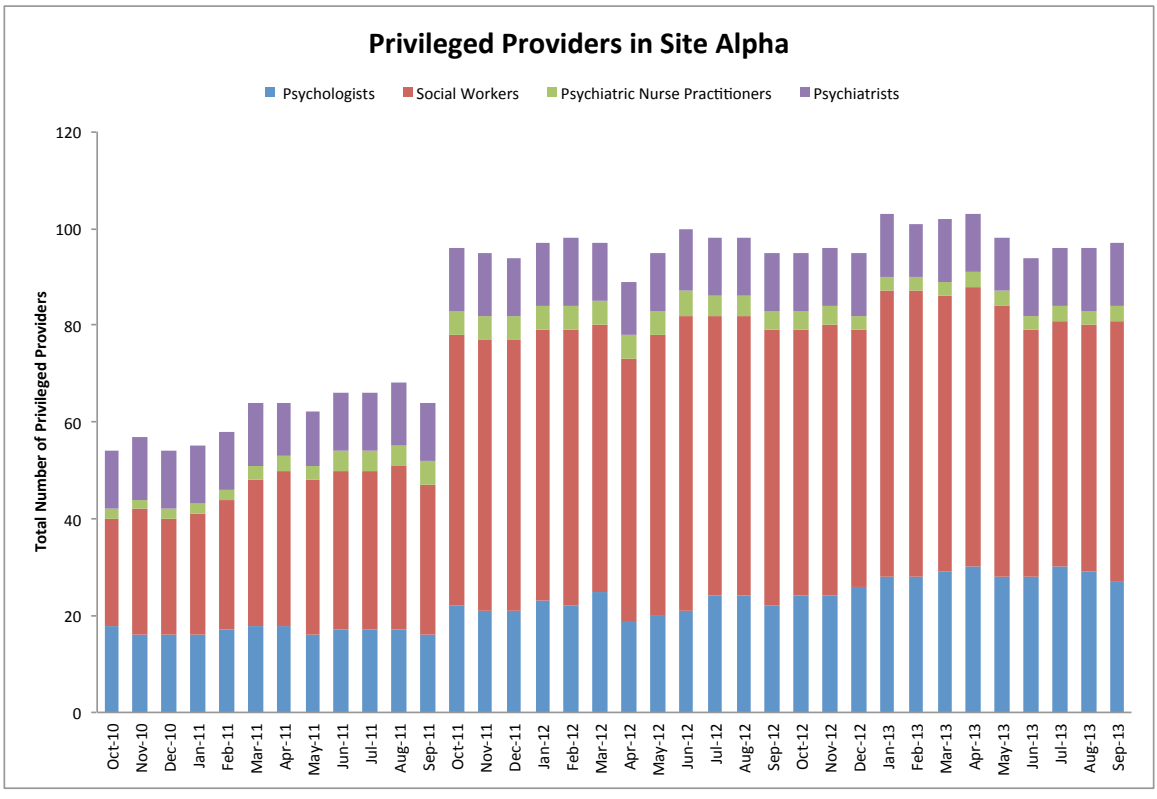

Figure 4: *Privileged Providers at Site Alpha*

Additionally, BRAC related movements are also increasing the overall population on the post. For example, they are expecting the arrival of a combat aviation brigade (CAB), with 3500 new active duty soldiers and associated dependents, but they do not currently have the capacity to provide direct care for even the active duty soldiers in the CAB. The BH chief highlighted this shortage, noting that if they were not able to grow their organic capability within the MTF, they would have to send the entire CAB population into the TRICARE network. In addition to the larger challenge of lack of capacity to provide care, there are specific challenges with respect to resourcing behavioral health in three key areas: hiring providers for EBH teams; care provision for the tenant units; and utilization of key BH assets including FORSCOM Behavioral Health Officer (BHO), WTU social workers and force extenders like 68X.

The EBH Operations Manual defines the required staffing for a multi-disciplinary EBH team to be one Licensed Clinical Social Worker (LCSW) or psychologist for each battalion size unit (600-900 Soldiers), a prescriber for the brigade as a whole (a psychiatrist or psychiatric nurse practitioner), in addition to the needed support staff of BH technicians and/or Social Service Assistants, front desk staff and nursing staff. Despite the financial incentives like higher pay grade for social workers and hiring bonuses, and being in a cosmopolitan location, hiring qualified providers has been challenging (See Figure 5 for evolution of privileged provider staffing in EBH clinics). The deputy chief of EBH actively works with the on-site hiring organization as well as the Army HQ level function to closely manage the hiring process. The average time to fill a position varies based on the provider type, with LCSWs taking on average 3 months, to having unfilled prescriber positions for over a year. Even in the cases that they have been able to hire providers, they have not been able to retain them as discussed in the section on Institutionalizing EBH.

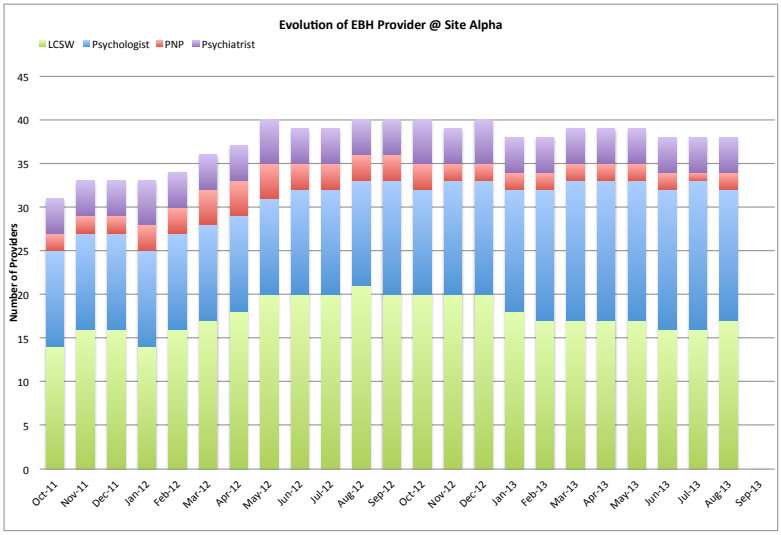

Figure 5: *Evolution of Privileged Providers in EBH*

Non-BCT units such as the MPs, sustainment brigades, and engineers do not have organic medical assets. As a result, they rely heavily on the MTF to provide both primary and specialty care services (including behavioral health). This lack of organic assets

comes to the forefront when medical readiness has to be assessed. As one line leader noted:

> *We don't have our own physician assistants let alone behavioral health officers, even though we have a large number of soldiers with behavioral health issues.*

Site Alpha is one of the few installations where an EBH team is aligned to support non-BCT units. Unlike regular EBH teams where the PA/BHO executes a majority of the medical readiness related staff functions for the brigade, providers in this EBH team are treated de-facto staff officers to the leadership of the tenant units. While the EBH model has built in time to support command consultation, it cannot support the level of engagement sought by the non-BCT units. The medical staffing model for such units needs to be developed so as to maximize the effectiveness of scarce BH assets.

As noted in the architecture of care section, the pool of BH assets is distributed across multiple organizational units. The role of organic assets like the division psychiatrist and brigade behavioral health officers in the EBH context is still unclear. While there are agreements between FORSCOM and MEDCOM on the use of 'borrowed military manpower,' the utilization of organic BH assets needs to be refined further. Given that the EBH teams by design meet some staff officer functions through command consultation and psychosocial education, there should be more clinical time available to the BHO – but command teams see them as officers who can be tasked to meet other staff requirements. Questions related to minimal patient contact hours, maintaining panels of patients, and allowing the clinic to template the BHO currently have to be determined by each individual EBH team.

Uniformed Behavioral Health Technicians (68X) are force extenders who can execute some of the screening and intake tasks that have to be otherwise performed by care providers. 68X are vital in theater because they are often the first line of BH care for soldiers. Developing and sustaining their skills in garrison is critical to the overall BH mission capability. The FORSCOM 68X's have been able to get 50% of clinical time needed to retain their skill levels. The same could not be said for the MEDCOM 68X's, who are seen as moveable personnel to execute non-BH related tasks. Even within the MEDCOM pool of assets, the role of the WTU Social Workers remains unclear. They are licensed clinical social workers that are credentialed through the MTF, but are not managed by the BH chief. They have a defined population in the warrior transition unit, but clinical care is not specified as a part of their core responsibilities. This is an issue that needs to be addressed at the enterprise level. Site Alpha is one of the few installations where there is agreement between the BH chief and the head of WTU social work regarding the use of WTU social workers for clinical care, but the management of these providers is managed at the WTU itself, and is not necessarily transparent to the MTF.

Discussion

Site Alpha was one of the first sites to implement Embedded Behavioral Health and has grown over the last three years to establish a mature behavioral health system of care. It

is one of the few installations that we have visited that has effectively operationalized the idea of patient-centered behavioral health care for active duty Soldiers. The strengths of the installation can be organized around the themes of engaged senior leadership, shared situational awareness of clinical stakeholders, effectively connecting clinical and operational stakeholders, collaborative health promotion and risk reduction, and innovative care programs.

One of the core strengths of Site Alpha is its engaged leadership team that has framed Behavioral Health as a critical enabler for overall Health Promotion and Risk Reduction. Their senior leaders have emphasized a culture of shared ownership of Soldier care irrespective of whether the service is owned by MEDCOM, FORSCOM or IMCOM. Even though clinical care is being split across multiple organizations (both on post and off-post), Site Alpha focuses on establishing and sustaining shared situational awareness across all the key stakeholders. They achieve this common operating picture using a series of in-person meetings, and using AHLTA to document patient care. For example, Site Alpha is one of the few installations that documents substance dependence care in the medical record. The ASAP chief noted:

> *We document in AHLTA because the care of patients requires it. IMCOM wants documentation hand written and mailed in secret, but we don't treat patients as numeric codes… It's a confidentiality issue – behavioral health needs to know but primary care does not always need to know. It's about who has the right to know.*

The Connect Care meetings at Site Alpha ensure that Soldiers receiving inpatient care off post are getting care to Army standards. The Joint Commission also identified this meeting as a best practice for inpatient care management. This meeting and the Multi Disciplinary treatment planning meetings have also helped ensure that care is coordinated at the WTU, ASAP and FAP.

Site Alpha has focused on designing the system of care to connect clinical and operational stakeholders. For example, the EBH model pushes alignment down to the battalion level, creating a single point of contact for command teams within a battalion. Site Alpha was one of the first installations to align ASAP providers to individual units. Discussing the impact of the new alignment, the ASAP chief noted:

> *Command only needs to see one ASAP counselor not seven, and we can check to see whether someone (a soldier) is lying to us with command. The alignment has made a huge difference in quality of care. They used to have to go all over to see how three or four patients were doing but now they can talk to just one contact.*

Site Alpha uses a series of health promotion and risk reduction meetings at the battalion, brigade and installation levels to ensure shared leader understanding of the Soldier behaviors and trends relevant to that level of analysis. They use the Community Health Promotion Council as the mechanism for synchronizing installation level focus areas and associated actions. While there is variation in the execution of the high-risk team meetings, they have established a system to have the key stakeholders in the room with command teams.

The key challenges at Site Alpha are around the themes of resourcing behavioral health, and educating leadership to create a culture supportive of behavioral health.

Even though there are no hiring restrictions placed by the Behavioral Health Service Line, they have not been able to get hiring actions moved forward at the MTF. There is a potential misunderstanding at the MTF with respect to cap limits on hiring and implications of force downsizing for behavioral health. The BH chief noted the inability to offer retention or relocation bonuses. The hiring bottleneck has increased the workload on providers in short-staffed EBH teams. As one of the providers discussed the impact of the workload on being able to provide good quality care:

> *We're booked out for a month and have to bump people for crises and we're burned-out. How can you provide EBT if you can't see people regularly? I'm booked out for the next two months and I'm working late and during lunch, but I can't do it all.*

The quotes from EBH providers from two different teams highlights the importance of continued education of leaders across all levels:

> *Our brigade hustles to behavior health because they want to get them out of the Army, and want to set them up (for a separation). On other units the command really take care of the patients and help them stay on the unit and manage it well. The difference is in command climate. When you know a patient is being pushed out, there's no way to tell the commander that it's their culture.*
>
> *We've had four losses in the brigade (suicides) and some leadership has not bought into behavioral health.*

The Division surgeon further echoed the need for leader education, noting:

> *Many senior commanders have seen the height of TBI and PTSD and are very supportive, but some have been jaded and have a misunderstanding of behavioral health…There is a lack of understanding of how behavioral health works, especially with junior leadership, and a perception that sending someone to behavioral health is sending them "to the crazy farm".*

Path Forward

The foundation of any behavioral health system of care is the ability to provide quality care to Soldiers and Family members. Site Alpha was one of the first installations to implement Embedded Behavioral Health and has grown over the last three years to establish a mature behavioral health system of care that includes on-post care for high acuity patients through their intensive outpatient program. It is one of the few installations that we have visited that has operationalized the idea of patient-centered behavioral health care for active duty Soldiers in Brigade Combat Teams. They are in the process of scaling those concepts to Soldiers in non-BTC units, and for family members.

Site Alpha's ability to implement their behavioral health system of care is based on their engaged senior leadership whose focus is on ensuring soldier wellness rather than on organizational boundaries. The Behavioral Health team has developed meetings and tools for creating shared situational awareness within clinical stakeholders, as well as across clinical and operational stakeholders. The collaborative health promotion and risk reduction efforts are still maturing on the installation and actively involve key subject matter experts to allow command team to gain a deep understanding of the clinical, operational and social aspects of a Soldiers life.

There are unique practices at Site Alpha that address Army-wide challenges of implementing a patient-centric behavioral health system of care:

1. Exploiting Behavioral Health Capabilities at the Soldier Readiness Processing site: Site Alpha is one of the few installations we have visited that has dedicated behavioral health providers at the SRP to support second level screening, in-processing and out-processing of Soldiers. This location serves as the single location that a Soldier access for all key transitions.

2. Connect Care Meetings: bring together network inpatient providers to the installation to ensure Army appropriate care provision and handoff coordination when the Soldier is released from inpatient care. The Joint Commission has validated this as a best practice during their recent visit to the installation.

3. Multi-Disciplinary Treatment Planning Meetings: These meetings bring together key clinical stakeholders from IMCOM, MEDCOM and FORSCOM to develop shared treatment plans for patients with complex or acute behavioral health conditions. While these meetings are specified in the EBH manual, Site Alpha is one of the few installations that has obtained active participation from ASAP, FAP and FORSCOM providers.

4. Intensive Outpatient Program: Site Alpha has a unique intensive outpatient program that is structured to address combat related trauma, as well as the step down needs of Soldiers transitioning from an inpatient program.

5. ASAP Alignment to Units and Documentation in Medical Record: Site Alpha was one of the first installations to align their ASAP teams to units. This ensured a consistent interface to command teams. Additionally ASAP at Site Alpha has chosen to document fully in the medical record to ensure consistent care for Soldiers.

6. Key SME Participation in High Risk Team Meetings: While there is variation in the execution of the high risk team meetings, Site Alpha has established a consistent participation of key subject matter experts from Behavioral Health, FAP and ASAP to ensure command team have a holistic understanding of Soldier wellness.

Site Alpha has a mature system of care but continues to struggle with resourcing constrains and resource utilization. There are a number of near term actions that require senior leader attention:

1. Senior leader action is needed to ensure that behavioral health and ASAP hiring actions are not negatively impacted by sequester-induced hiring limits.

2. An Installation Director of Psychological Health should be assigned as required by DoDI 6490.09.

3. A clear delineation of BHO roles and responsibilities as a critical member of the EBH and Command teams is needed to maximize the effectiveness of both the EBH team and the BHO.

4. Clear guidance is needed from Warrior Transition Command on the delineation of clinical, operational and risk assessment roles of WTU social workers

5. Clear definition is needed from MEDCOM on the role of Internal Behavioral Health Consultants from Patient Centered Medical Home to Specialty Behavioral Health Services.

6. Revised guidance is needed on the utilization of behavioral health provider incentives including retention, relocation, on the spot awards within the Integrated Resourcing and Incentive System.

7. Clearer guidance is needed from MEDCOM on reinvestment of funds obtained through improvements to the behavioral health system of care. Specifically delineate processes through which an MTF may increase capacity in the direct care system.

8. Training is needed to support junior line leader (company level and below) understanding of behavioral health services with an emphasis on the benefits of appropriate behavioral health services utilization.