A Service-Line Approach to Managing Integrated Mental Healthcare Services in the

United States Army

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Introduction

The United States Army is in the midst of building an integrated mental healthcare system from a policy-coordinated collection of independent military treatment facilities (MTFs). Before the wars in Iraq and Afghanistan, mental healthcare was delivered across all Army MTFs using hospital-centered services in discipline-specific departments of psychiatry, psychology, social work, and substance use. Each MTF was an organized delivery system (1), with clinical and fiscal accountability for the outcomes and the health status of its local beneficiary population. Every MTF developed its own department-specific services portfolio to meet the clinical care needs of its beneficiary base. Since incidence rates of mental health conditions were relatively stable prior to 2004 (2), these service portfolio variations across departments did not result in a change in the overarching organization of mental healthcare, and there was limited focus on understanding the impact of these variations on access to care or quality of care.

The rapid increase in mental health disorders as a result of continued engagement in two wars (3) raised public awareness of capacity challenges within the military, and prompted internal (4) and external (5) examination of military mental healthcare. In recognition of the rapidly increasing need, the United States Congress directed allocation of almost 2.7 billion dollars between 2007 and 2010, for research on, and treatment of, psychological health and traumatic brain injury related conditions (6). This continuous
investment over a four-year period created an additional source funding that enabled MTF commanders to garner more resources for their MTF and develop location-unique programs, which in turn translated into significant non-standardized program proliferation across the Army and the Department of Defense (7). This funding availability also led to mental healthcare services being delivered in diverse venues such as sleep clinics and concussion clinics, as shown in Figure 1. The resulting variation from one MTF to the next shattered the equifinality (8) in mental healthcare systems designs across the Army.

Figure 1 Change in Organization and Management of Mental Healthcare in the Army 2003 - 2011

The modular management system that was developed before 2004 to ensure policy coordination and fiscal discipline was limited in its ability to important Army-wide questions on capacity to provide mental healthcare, quality of care provided, and overall care effectiveness. The Army developed a standardized mental healthcare system (9) as a first step to answer such questions. This new system necessitated a new management
framework that addressed the unique characteristics of an integrated delivery system. In this paper we provide a brief overview the modular management approach that was used to ensure fiscal discipline across the collection of independent MTFs. We then lay out the characteristics for managing an integrated delivery system, and discuss how the service line approach adopted by the Army meets those requirements. Finally we map out the challenges ahead for the Army, and the lessons learned that are transferrable to other integrated delivery systems.

**Modular Management of a Collection of Independent MTFs**

Berwick (10) argues that any healthcare system can be understood at four levels of analysis: the healthcare environment, the organizations supporting Microsystems, clinical Microsystems, and the patient experience of care. This multi-level analysis approach can be used to understand the modular approach used for managing mental healthcare in the Army, when healthcare services were organized across a collection of independent MTFs. The Office of the Surgeon General (OTSG) managed the healthcare environment, and the individual MTFs retained responsibility for planning, organization, and delivery of local healthcare services (including mental healthcare).

OTSG centrally controlled funding, and provided policy guidance on key areas such as access to care and clinical workload requirements. MTFs were given the autonomy to design their own system of care. The management at the healthcare environment level was limited to ensuring fiscal discipline, business plan performance, and policy compliance. Measures at the OTSG level focused on macro variables such as access to first appointment and volume of care provided. These measures had limited
correlation to the actual quality of care provided, and in some cases drove unintended behaviors. For instance, the focus on access to first appointment resulted in patients being routed to the first available provider, or to a special triage clinic. This translated into highly fragmented care in which patients saw multiple providers before entering into a course of treatment (11). There were discipline-specific subject matter experts or “consultants” at OTSG, but no single entity was responsible for managing consistency in the organization and delivery of mental healthcare and ensuring that centrally developed policies could actually be implemented by MTFs.

Each MTF submitted an annual business plan to OTSG specifying the expected workload measured in relative value units (12), personnel needed to deliver care, and known risks in executing to the plan. The MTF then allocated received funds to the individual departments, and provided centralized support functions such as patient scheduling, staff hiring, provider privileging, and other human resource management functions. Since incentives provided by the healthcare environment level were codified in the business plans, the MTF leadership focused on driving provider productivity to achieve care volume and ensure access to care. The consistent availability of congressionally directed funding between 2007 and 2010 also had an unintended side effect - some MTF commanders chose to reroute core funds that would have been used for mental healthcare to invest in improvements in other departments such as new surgical units and ob-gyn wards. This added additional uncertainty to the service portfolio in the MTF from one year to the next, even within the same MTF.

Clinical microsystems by definition (13) “involve small groups of people working together on a regular basis to provide care to discrete subpopulations of people.” In the
hospital-based provider-centric design, providers were responsible for the entire beneficiary population falling within the MTF catchment area. Care coordination occurred at provider/patient discretion when care was distributed across the different disciplinary departments. This discipline-based organization supported alignment to professional societies and simplified professional development through peer reviews and case consultations. The high care volume degraded such professional community building activities into “check the box” routines that did not actively contribute to learning or quality improvement. The hospital-centered design fragmented further due to rapid program proliferation between 2007 and 2010. From an analysis perspective, this design did not have clinical microsystems, and care coordination was mostly ad-hoc and provider-initiated.

The actual patient experience of mental healthcare from one MTF to the next could not be examined at the Army level because the organization of mental healthcare delivery varied significantly from one location to the next. Even the Army Provider Level Satisfaction Survey (APLSS), which was initiated in 2003 to give providers and clinic leaders insight into patient satisfaction and quality of services (14), is limited to the patient-provider dyad. The APLSS survey instrument is not specific to mental healthcare, and the random algorithm-based patient selection process does not necessarily reflect mental healthcare. In 2011, when a Department of Defense-wide panel was trying to develop metrics to assess mental healthcare performance, the panel (including the author) was briefed that the defense-wide experience of care surveys (15) were not always sent to beneficiaries using mental healthcare services.
Even though the form of the delivery system is not significantly related to patient satisfaction (16), the system design has been shown to impact clinical performance. The modular management approach reflected the limits to managing a collection of independent military treatment facilities when the only control lever is funding. Policy compliance was difficult to achieve because the policies themselves were not always implementable. For example, the Army developed a policy requiring warm handoffs when beneficiaries moved from one MTF to the next, however, the policy was not implementable because there was no single owner of mental healthcare at each MTF. The modular approach was useful and efficient in an environment of predictable demand with a stable delivery system design across the Army. OTSG could delegate planning and operational management of healthcare services to the individual military treatment facilities, and utilize measures of fiscal discipline and process compliance as plausible proxies for performance. The tripling of outpatient services over the last decade (17) and the need to accurately respond to external stakeholders such as congress and advocacy groups on the performance of Army mental healthcare accelerated the need to treat Army mental healthcare as an integrated delivery system.

**Foundations of an Integrated Mental Healthcare System in the Army**

Even though the Army Surgeon General defined Army medicine as an integrated health enterprise (18), the infrastructure was not in place until 2014 for assessing system performance against the Quadruple aim (15) of readiness, population health, experience of care and per capita cost. The Army’s modular healthcare management approach had pushed key integrated delivery system attributes such as reducing fragmentation (19),
managing population health (20), providing accountable care (21), and managing performance (22), down to the individual military treatment facilities. The Army had to develop new tools and processes to provide build these competencies at the Army level.

Three factors further complicated the development of an integrated mental healthcare delivery system: a) mental healthcare has historically been separated from regular healthcare (23); b) the methodologies and theories for describing mental healthcare services are still maturing (24); c) the term integrated mental healthcare has been used to describe a diverse set of designs covering multi-disciplinary lifecycle approaches (25), integrated care pathways (26), care coordination approaches (27), specific models of care delivery such as primary care integration (28, 29), and integrated service networks (30). The Army’s newly developed standard Behavioral Health System of Care (BHSOC) defines the baseline architecture of integrated mental healthcare delivery at the MTF level. The policies and tools developed by the centralized Behavioral Health Service Line (BHSL) establish the infrastructure, processes and tools for connecting care delivery to system performance at various levels of analysis. The BHSOC and the BHSL together enable integrated mental healthcare at both the MTF and the Army.

Behavioral Health System of Care Overview

The BHSOC (shown in Figure 2) adopts a multi-disciplinary patient-centered care-team approach to mental healthcare. It specifies ten standardized clinical microsystems that can be implemented at an MTF, starting with integrated behavioral health that collocates mental health providers in primary care clinics (Level 1 care). This
provides the first level psychotherapy services for beneficiaries, and places the initial medication responsibilities on the primary care providers. Dependent children may also access Level 1 care through School based behavioral health services. If a beneficiary needs more than four psychotherapy sessions or has not improved after an initial course of primary care managed pharmacotherapy, they are referred to specialty care ambulatory services (Level 2 care).

Soldiers in operational units are referred to their assigned embedded behavioral health clinic, while those from other operational units are assigned to a multi-disciplinary clinic. The multidisciplinary clinic also provides specialty services such as psychological testing for all beneficiaries in a military treatment facility. Dependents are referred to the child and family clinic or Telebehavioral health clinics. The telebehavioral health clinics also provide surge capacity at the MTF and remote care to other MTFs. They also perform administrative evaluations and occupational assessments. The specialty care

Figure 2 Integrated Mental Healthcare Delivery Architecture in a Military Treatment Facility
ambulatory clinic assigned to the beneficiary serves as the locus for care management even when the beneficiary uses more intensive services (Level 3 and Level 4 services) such as partial hospitalization programs and residential treatment. The BHSOC combined with additional requirements for managing key care transitions (31), creates the foundations for delivering patient-centered, coordinated care.

_Behavioral Health Service Line Toolset_

The Behavioral Health Service Line (BHSL) is the centralized office responsible for managing implementation and performance of the BHSOC across all Army MTFs. The BHSL develops Army-wide policy, metrics, and integrates information to enable action by Army senior leaders, MTF commanders and Behavioral Health department chiefs, clinic chiefs, and care providers. Army senior leaders manage the healthcare environment by ensuring sufficient resources (funding and personnel) are available to meet the healthcare needs of the Army beneficiary population. MTF commanders and behavioral health department chiefs manage their local healthcare organizations and ensure that the right providers are available in the right clinic. Clinic chiefs manage the practice within their clinical microsystems. Clinical care providers are the critical interface to managing the patient experience of care and engaging commanders when required to ensure medical readiness. Five analysis tools: Military Health System Management Analysis and Report Took (M2), E-profile, Distribution Matrix Tool (DMT), Capacity Assessment and Reporting Tool (CART), and the Behavioral Health Data Portal (BHDP); are used by the BHSL to support the distinct yet related information needs of each of these stakeholder groups.
The BHSL provides senior Army leaders with data on population-level demand for services, costs of providing services, quality of services provided, and the impact of mental illnesses on the readiness of the force. The Armed Forces Longitudinal Health Technology Application (AHLTA), the electronic medical record system currently used by the Army, was designed to promote population health, conduct medical surveillance, support clinical decision making, and support force health protection (32). Even though data captured within AHLTA can be extracted using the Military Health System Management Analysis and Report Tool (M2), these data were not utilized effectively for discussing demand for services or quantifying costs. The BHSL now uses the M2 for evaluating population health and system costs, even though the M2 cost data focuses almost exclusively on the clinical care provided and does not account for other key military mental health activities such as command consultation and administrative evaluations. The establishment of a centralized office in the BHSL enables the implementation and assessment of Army-wide quality measures that were not possible in the modular architecture. Medical readiness data was historically reported using paper based forms, the new E-Profile system (33) allows the BHSL to provide leaders with a medical readiness snapshot across the Army.

MTF commanders and Behavioral Health Chiefs need tools to ensure that they have the right providers in the right clinics. This requires data systems to accurately reflect where and when care is provided. The BHSL has developed a standard accounting infrastructure that mirrors the components of the BHSOC, and allows finer-grained inspection of where care was provided and how patients flow in the system. Leaders managing the healthcare organization need to be able to determine whether they have the
care capacity to meet demand for services. The BHSL uses a hybrid capacity estimation approach codified in the Distribution Matrix Tool (34) that combines population needs, provider productivity requirements, and the care-model specific staffing specifications, to predict the annual expected staffing at the MTF. The DMT enables Behavioral Health Chiefs to identify their expected resource shortfalls and work with the MTF commander to fill the gaps. This is particularly important because it takes MTFs an average of six months to fill an open behavioral health position (and in often significantly longer for critical skill areas such as child psychiatry).

Implementing the BHSOC requires a transformation in the organization of mental health from disciplinary departments to multi-disciplinary clinical Microsystems. Depending on the clinic, providers execute clinical, command consultation, and occupational evaluation functions, and workload standards have to reflect those roles. The BHSL’s new workload standard (35) accounts for the roles provider perform in their specific clinical Microsystems in addition to their disciplinary role. The Capacity Assessment and Reporting Tool (CART) draws data from the human resource management system and the M2 to analyze and compare provider, clinic and MTF performance against minimum expected clinical care delivery. CART enables leaders to drill down to the individual provider level to determine how the Army sees provider utilization and availability for care. It provides a centrally evaluated role-specific performance standard that is shared with all providers. This transparency enables clinic chiefs to manage their practice and improve productivity, and there are no productivity-related surprises during annual provider performance evaluations.
Measurement based care is still at its infancy in mental healthcare practice management (36), and clinic chiefs have historically relied on measures of structure and process as substitutes for clinical effectiveness. The implementation of routine collection of patient self reported outcome data in the Army (37) sets the foundation for moving towards measurement-based care and quality improvement. The Behavioral Health Data Portal (BHDP) automates the capture and reporting of patient-reported outcome data. It was designed to overcome some of the known challenges of routine outcome monitoring in mental health by explicitly minimizing providers’ data collection burden, and giving providers real-time longitudinal visibility of patient-reported outcome data. BHDP serves as a clinical decision support tool for improving patient engagement in care.

BHSL Performance Management

The BHSL performance management system (shown in Figure 3) combines metrics, incentives, and integrates data from the reporting tools into formal governance processes to provide traceability from enterprise goals to actual care delivery.

*Leader Metrics* identify focal areas for Army senior leadership. The six leader metrics are currently tracked as part of monthly Review and Analysis (R&A) sessions provide insights on Army emphasis areas. *Outpatient market share* focuses leader attention on the volume of care that is sourced from the TRICARE network. This is both a source of potential revenue for the MTF as well as a known source of care fragmentation. *Inpatient care utilization* provides an indication of the disease acuity in the population and has a direct impact on medical readiness. Inpatient care is also a key lever in managing costs. Even with the growth in number of Army mental healthcare
providers, there is still a clinical care capacity deficit. *Staffing against DMT* provides Army senior leaders with an overview of known gaps, and provides MTF commanders and behavioral health chiefs with a clear justification for requesting uniformed providers or additional contracted personnel. *Production against CART* ensures that minimum Army workload requirements are being met. *BHDP survey data completion* focuses leader attention specifically on patient engagement in care. *Telebehavioral Health provider utilization* metric alerts leaders to other opportunities for increasing capacity.

![Figure 3 Behavioral Health Service Line Performance Management Framework](image)

*Performance Metrics* are designed for use by the MTF leadership to assess care quality and improve system performance. These metrics include traditional measures of *access to care*, and localized productivity measures such as *Production against CART* and *Staffing against DMT*. They also incorporate quality and safety measures such as the 7-day and 30-day follow up after psychiatric discharge. These MTF level performance metrics also reflect strategic change efforts in the Army such as the *BHDP adoption*.
metric and the TBH utilization by Patient. These metrics also focus on MTF level examination of service quality through BHDP self reported measures of Treatment Alliance.

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**Figure 4 Evolution of Measures and Incentives Reflect System of Care Maturity**

The Integrated Resourcing and Incentive System for Behavioral Health (IRIS-BH) incentives provide monetary rewards to MTFs for accelerating transformation and guiding desired behaviors. In the previous year (Figure 4), there were nine IRIS-BH incentives: compliance to production targets, raw production, availability for patient care,
BH cost, market share, TBH utilization, BHDP adoption, care continuity for PTSD and MDD, and inpatient utilization. Each of those incentives reflected a shift towards a baseline system of care. As the system implementation matured, the governance process enabled the development of refined incentives that focus on rewarding quality of care for PTSD and Major Depressive Disorder (MDD), the diseases that contribute to high service utilization and potentially affect readiness.

MTF-level performance is monitored and managed in monthly Review and Analysis (R&A) meetings. These R&A’s were started in February 2014 as a quarterly meeting focused on assessing progress towards the implementation of the BHSOC (38). The R&A repurposed an existing quarterly meeting focused solely on business plan compliance and funding management, into a monthly meeting focused on a more holistic system performance. In this meeting, leader metrics are discussed, and corrective actions are co-developed with Chief of Behavioral Health at the MTF. These Review and Analysis (R&A) sessions are intended to provide the chiefs with an opportunity to provide input to the larger Army behavioral health strategy and highlight potential priority areas for the following year. The R&A creates a learning process in which incentives and leader metrics serve as markers of system maturity. As the BHSOC implementation has progressed, the leader metrics have also evolved. For example, the current year focuses on improving data quality in the BHDP rather than solely on survey completion in the previous year.

At the MTF level, there may be skill gaps that prevent accurate root cause analysis. Site Assistance Visits (SAVs) provide MTFs with subject matter experts from within the BHSL to provide MTF leadership with a performance assessment of the
installation along with potential courses of action to rectify identified disconnects.

Ongoing academic research also plays a role in continuous improvement through health services research projects where research findings are shared with providers, MTF leaders, and Army leadership.

Discussion

The Army is in the midst of building an integrated mental healthcare system from a collection of independent military treatment facilities (MTFs). The Office of the Surgeon General manages the healthcare environment, and the individual MTFs are responsible for managing the clinical microsystems within their catchment area. The Behavioral Health System of Care (BHSOC) defines the standardized template for integrated mental healthcare in all Army MTFs. This baseline architecture of clinical microsystems provides a starting point for MTFs to tailor implementation to meet the needs of their local population. The Army developed a core set of tools as part of the Behavioral Health Service Line (BHSL) to establish traceability from care delivery to system performance. These tools enable the Army to articulate progress towards the Quadruple Aim: E-Profile data allow leaders at levels to quantify the impact of mental health conditions on medical readiness; M2 provides a snapshot of the disease burden in the population, the volume of care provided, and the cost to provide care; DMT specifies needed capacity to meet the demand for services; CART provides visibility into provider productivity; and BHDP provides insights into clinical care outcomes and patient engagement in care. These tools also support the annual planning process used by the
MTFs by specifying expected staffing and mission based productivity requirements which are critical variables in the business plan.

Conscious goals affect action (39), and even though the Quadruple Aim has been in place since 2012, the Army did not have either an integrated mental healthcare system or management framework to map system changes to goal achievement. The Army metric set enables Army senior leaders to establish specific, if difficult goals, and reward performance through the IRIS-BH. The Review and Analysis process enables leaders to address key factors such as commitment to the change, manage change complexity, and feedback on progress that are essential for a high performance cycle (40). Each MTF only have one behavioral health department chief, and leaders selected into this role often learn on the job. The R&A process should enable MTF behavioral health department chiefs to learn about and learn to be (41) department chiefs as it creates forum for participation and social contact (42). The process also enables BHSL leaders to identify...
bridge any relevance gaps (43) between policies defined at the Army level and practice level needs at military treatment facilities.

All of the change is moot, if it does not translate to improved access to care, and improve quality of care for Army beneficiaries. The multi-disciplinary care-team philosophy underpinning the BHSOC reflects the need to maximize care capacity of existing providers, and the need to bridge the boundaries between professional groups that could potentially retard change (44). It recognizes that translation of system-wide change to treatment-level change depends on the clinicians within the system (45). The development of workload standards reflective of all the work providers do (including clinical care) is a necessary first step. The historical emphasis on productivity without transparency from leadership was a source of frustration among providers. CART provides a starting point for addressing the frustration. For the Army to overcome the known challenges of incorporating evidence based practice into clinical settings (46), two critical factors need to be addressed: the development of a deeper understanding of the care context (47), and the ability to distinguish between gaps between “usual care” and practice guidelines (48). The standardized accounting infrastructure and the BHDP data address both those issues.

The tools within the BHSL are not perfect, but they provide a starting point for examining system wide performance. For example, the initial rollout of the CART surfaced significant data quality challenges, as providers were incorrectly classified in the human resource management system and, in some cases, were not even associated with the MTF at which they were working. The fact that it was being monitored and MTF leaders were held accountable for system performance, focused leader attention on the
problem. Even though the BHSL tracks key population health indicators such as disease burden, suicides, outpatient utilization, and inpatient hospitalization, these data are not consistently shared to the MTFs. The IRIS-BH incentives, and leader metrics have the potential to drive unintended behaviors, as MTFs game a metric or subsume care quality to achieve incentives.

The Army now has a baseline performance management system that can be improved continually to create a learning healthcare system. The performance management system is designed to enable corrective action at the provider, clinic, MTF and Army levels. Peer reviews utilizing outcome data can now enable richer conversations between peers on the perception of care by the patient/client and potential actions to enable recovery. These data can also enable practice management by clinic chiefs to initiate conversations on care termination and case mix adjustments. The performance metrics and leader metrics focus leader attention on key performance areas to ensure patient safety and improve care quality. There remains a risk of being “trapped in the tyranny of the tools” rather than feeling empowered to improve the system of care.

The infrastructure has been built, but the organizational routines associated with translating insights to action are still being refined and institutionalized.

References

14. Gates TM: Quantitative Analysis of Contributing Factors Affecting Patient Satisfaction in Family Medicine Service Clinics at Brooke Army Medical Center; in Army-Baylor University Graduate Program in Health and Business Administration: Baylor University, 2008

Questions and Comments to jksrini@mit.edu
34. OTSG/MEDCOM: Guidance for the Behavioral Health Service Line (BHS) Distribution Matrix Tool (DMT), 2016
38. OTSG/MEDCOM: Operational Order 14-31Behavioral Health Service Line Quarterly Review and Analysis (R&A) Implementation, 2014
46. McCabe OL: Crossing the Quality Chasm in Behavioral Health Care: The Role of Evidence-Based Practice. Professional Psychology: Research and Practice 35:571, 2004