Lessons Learned from Implementing Embedded Behavioral Health at Four Army Installations

Jayakanth Srinivasan

jksrini@mit.edu

Introduction

Embedded Behavioral Health (EBH) is one of the twelve standard clinical microsystems within the integrated behavioral healthcare system (1) in Army military treatment facilities. EBH moves specialty services from a centralized hospital into satellite clinics aligned to operational units, and geographically positioned to be within walking distance of a Soldiers' workplace. The standardized model consists of a 14 member multi-disciplinary team that includes a prescriber, seven psychotherapists, a nurse case manager, two behavioral health technicians/social service assistants, and two front desk personnel. The model was developed with three goals in mind: a) improve access to care for Soldiers in the EBH clinic catchment area; b) Improve mission readiness of the aligned units; c) Shape the occupational environment to enhance recovery. EBH was directed for implementation across the Army in 2012(2), and the Army issued policy guidance later that year (3).

In this paper we present seven lessons learned from longitudinally studying the implementation of EBH at four Army installations, labeled, Alpha, Bravo, Charlie and Delta. We identified three installation-level practices, and three clinic-level practices that were present in successful EBH implementations.

Research Approach

Each installation has a Military Treatment Facility (MTF) that provides healthcare services for Soldiers and their families. MTFs can be classified into three groups (4) with successively narrower responsibilities: Medical Centers, which are large hospitals that serve as referral hospitals for a health services region; Community hospitals which are smaller than medical centers, and provide both inpatient care and ambulatory services; and Medical Clinics, which are only staffed and equipped to provide emergency treatment and ambulatory services. Our study sites included two installations with medical centers, one with a community hospital and one with a medical clinic, as summarized in Table 1. We worked with our Army partners to ensure that these locations to be representative of installations that deploy forces to a combat theater.

We developed a multi-method approach incorporating field research methods (5), participatory action research (6), enterprise analysis approaches (7) and data analytics (8) to gain a holistic understanding of the system of care at each installation. We carried out three rounds of field research during 2011- 2012, 2012-2013, and 2014-2015 in which we visited all four installations for a weeklong period. During each visit, we gathered interview and focus group data from more than 100 informants drawn from 18 key stakeholder groups (9) in three organizations that provide support to Soldiers seeking behavioral health services: a) BH providers(psychiatrists, psychologists, licensed clinical social workers, social service assistants, nurse case managers, behavioral health technicians, clinical care leaders); b) command teams (four levels from company to division); and c) support

services (substance abuse clinical care providers, substance use managers, installation support services, family advocacy services, military family life counselors, chaplains and legal services). We also observed key meetings between clinical and non-clinical stakeholders to understand how EBH teams were implementing prescribed processes. We did not interview Soldiers and family members receiving care, as none of the research team members were clinicians. Data from our interviews and focus groups were rich enough to address issues of organizing, governance, and process improvement, but further research is needed to address the impact on the actual Soldier experience of care.

The ability to triangulate field research findings with actual care delivery data was a critical component of the research design. We used administrative healthcare data for the initial period of EBH rollout between FY2011–FY2013 that captured when a Soldier was seen, the provider they saw, and the diagnostic and procedure codes associated with each visit. These data further deepened our field research based understanding of the dynamics of care delivery, and surfaced disconnects between the installation and the Army perspectives on EBH implementation.

These baseline findings from the first round of visits and the quantitative data analysis provided the foundation for executing ongoing participatory action research. In every field research visit, we met with the senior leadership team from the three organizations on the Army installation to share lessons learned.

Table 1 Comparing Macro Factors Governing EBH Implementation

	Alpha	Bravo	Charlie	Delta
Senior Commander	Division Commander	Division Commander	Division Commander	Corps Commander
Soldier Population	~25,000	~30,000	~20,000	~50,000
MTF Type	Community Hospital	Medical Center	Medical Clinic	Medical Center
Leadership Triad Emphasis	Moving care to point of need for BCTs	Suicide Prevention	Moving care onto installation	Move care to point of need for non-BCTs
Installation Director for Psychological Health	Fully Implemented	Partial Role	Fully Implemented	Partial Role
Supported and Supporting Relationships	Defined	Partially Defined	Defined	Partially Defined
2011-2012 Care Model	EBH-like Pilots	Hospital-Centered	Hospital-Centered on Other installation	Hospital-centered
2012-2013 Care Model	4 EBH Clinics, Area support for non-BCT units	Area support in two distributed clinics with some aligned providers	Clinic Centered, Aligned Providers	EBH clinics for non-BCT units, Area support for BCT units
2014 -2015 Care Model	Full EBH Implementation	2 EBH Clinics and Area Support	Full EBH Implementation	EBH Clinics and Area Support

The field research team conducted a daily retrospective to identify the system strengths and disconnects, which were then aggregated into a final list of findings and recommendations for leader actions. In these visits, we worked with our Army partners to share observations, facilitate discussion, and co-design interventions to improve EBH implementation at the installation and Army levels. We wrote up a case summary at the end of each visit, and revisited our field recommendations to ensure applicability to the larger EBH implementation effort. The research team and the Army behavioral health leadership team carried out regular retrospective reflections on quantitative data analysis to determine whether changes to the system of care were delivering the desired results. The case summaries, field research notes, and recommendations served as the data sources for identifying key lessons learned from the implementation of EBH.

Alignment of Installation Senior Leader Triad on Behavioral Healthcare

Army installations are commanded by a Senior Commander (SC), whose mission is the care of Soldiers, Families and Civilians on the installation, and to enable unit readiness of the units assigned to that installation(10). S/he is often also the mission commander responsible a majority of the operational units, typically a division of 20,000 Soldiers or the corps headquarters and one of its subordinate divisions assigned to the installation. The Garrison Commander (GC) serves as the SC's senior executive for installation activities, and receives her/his funding from Installation Management Command for supporting installation-specific activities such as facilities maintenance, non-clinical counseling services, and 1st level

substance use care. The Army command(s) responsible for the operational units on the installation provide the funding support for mission-related activities. The commander of the installation's military treatment facility is designated as the Director for Health Services (11), serves on the staff of the senior commander. The DHS receives funding for all healthcare services on the installation (with the exception of 1st level substance use care) from the Medical Command. This diverse network of funding and governing policies creates a complex system (shown in Figure 1) that requires cooperation and coordination between the SC, GC, and DHS to define, implement and sustain, a shared vision for behavioral healthcare.
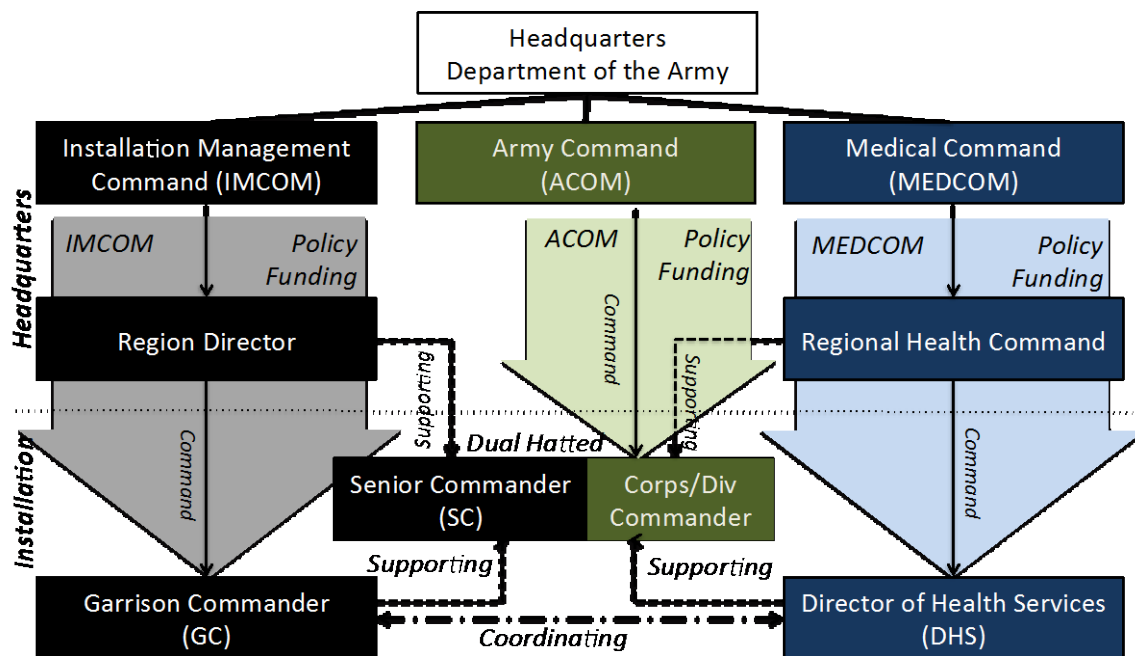

Figure 1 Complex Funding and Reporting Relationships in Army Installations in the United States

During our first round of field research visits (2011 – 2013), the four installations studied had different emphasis areas when it came to behavioral healthcare. Alpha's senior leadership worked together to build a strong guiding

coalition (12) to shift services from the hospital to distribute locations across the installation. Their goal with this design change was to increase access to care and reduce stigma to seeking services. To achieve this goal the SC had to provide resources to acquire the temporary facilities, the GC had to provide the underlying organizational infrastructure, and the DHS had to relocate people from the hospital into the new facilities.

The other three installations had not yet established that guiding coalition. Bravo was growing rapidly from a training installation with less than 20,000 Soldiers to a force projection platform of almost 30,000 Soldiers. This rapid growth infusion of Soldiers led to increases in disciplinary infractions and adverse outcomes such as deaths by suicide. Bravo's SC focused on suicide prevention and worked with the GC to mandate training of all Soldiers in resilience skills. The DHS was trying to grow the department to meet the increasing demands of the population. Behavioral healthcare at Bravo was delivered predominantly from the hospital located outside the installation.

Soldiers in Charlie had historically received all their behavioral health care from a medical center in another installation located 20 miles from Charlie. The SC at Charlie was the mission commander for a majority of the Soldiers on the installation, but there was a strong plurality of Soldier from other commands as well. Charlie's GC was focused on create additional space for integrating substance use care providers into her organization, and the building of a new warrior transition unit. Since Charlie was a clinic attached to a medical center on another

installation, the DHS did not have the authority and political capital needed to acquire more behavioral health assets for the installation.

Delta was the largest installation studied and it had the lowest per capital utilization of behavioral health across the Army. The SC was a corps commander, and was a passionate supporter of behavioral health, but the unit was getting ready to deploy to Afghanistan in the months after the visit. The emphasis across the SC, GC and the DHS was on getting the unit ready to deploy.

In 2012, the Army directed that all Army installations to implement Embedded Behavioral Health for all brigade combat team sized operational units. The new approach forces a shift from a centralized care delivery model using existing hospital facilities to a distributed community-based care delivery model. Achieving this Army-wide directive requires investments in both physical infrastructure and information technology infrastructure. Since EBH clinics are required be located within walking distance of a Soldiers workplace, installations have to either repurpose existing facilities or create new buildings to house the new clinics. This requires active coordination between the SC, GC and DHS.

In our final round of field visits (2014-2015), we observed full implementations of EBH at Alpha and Charlie, while Bravo and Delta were still lagging in the implementation. Bravo had three SC's over the lifecycle of our study: The first focused on suicide prevention; the second wanted EBH to be implemented for all units on the installation, a goal that was not aligned to the Army's EBH roll out strategy; and the third SC was briefed that EBH implementation was fully implemented even when it was not. The GC and DHS were focused on the SCs goals,

and did not assess the impact of those changes on actual care delivery. Delta had two SCs over the lifecycle of the research. A series of adverse outcomes in non-brigade combat team units led the first SC to direct EBH implementation for those units, even though it was not part of the Army-wide implementation plan. The Second SC was a strong supporter of EBH (having previously command in Alpha), but was deployed to Afghanistan shortly after our first visit. It was only in our final visit (three months after the SC returned from Afghanistan) that Delta made progress towards EBH implementation.

There is a critical coordination function that occurs between the GC and DHS when it comes to substance use care. In 2010, the Army moved the responsibility for providing 1st level substance use care from the MTF to the GC. This was carried out under the assumption that integrating prevention and clinical care under one organization would lead to better outcomes. The reality we observed was that care was further fragmented, and that clinical care providers could not coordinate services effectively (13). In our interviews, it was substance use care providers noted that the memorandum of understanding signed between IMCOM and MEDCOM required that IMCOM paid for the infrastructure needed to connect substance use providers to the electronic health record, and that MEDCOM would pay for its maintenance. However, each of the installations had varying degrees of maturity in the implementation. This also resulted in adversarial relationships between substance use care providers and other behavioral health providers, as these providers were required to move into new buildings, creating further separation between substance use care and other behavioral healthcare. Alpha was

the only installation that had the infrastructure established, and the coordination between the GC and DHS ensured that substance use care providers had time in their schedules to attend case coordination and treatment planning meetings.

Implementation of the Installation Director for Psychological Health Role

In 2012, the Department of Defense issued policy (14) that required every installation to designate an individual to be the installation's Director for Psychological Health (DPH) to act as the Senior Commanders principal consultant and advocate for psychological health. In our first round of field research visits, none of the four installations had implemented the role. The BH Chief at Alpha served in a role similar to the DPH (without the role designation), because he had previously served as the division psychiatrist and deployed with Alpha's SC. The Army specifies health system support for maneuver forces (15), such as the division psychiatrist and behavioral health officers. The standard does not allocate a behavioral health subject matter expert for echelons above a division such as a Corps or Army Command. As a result, the Delta SC relied on the Corps Surgeon (usually not a behavioral health provider) to serve as his behavioral health subject matter expert.

In 2014, the Army designated the Chief of Behavioral Health at the installation to serve as its DPH (16). When we carried out our second round of fieldwork, Alpha had fully implemented the DPH role, even though previous BH chief had rotated out to take a different assignment at another installation. Charlie has also implemented the DPH role, as it had gotten a new BH Chief (who was

previously at Alpha). Charlie's BH Chief embraced the role of the DPH, and worked closely with the SC and the DHS to increase behavioral health capacity. Bravo and Delta had not implemented their DPH role. Bravo's BH Chief cited change fatigue within the behavioral health organization, the MTF commander's desire to be the principal advisor to the SC, and the SC's focus on suicide prevention as inhibitors to adopting the DPH role. Delta's BH Chief also cited the "chain of command" at the hospital, and the previous SC's alternate vision EBH implementation as inhibitors to adopting the DPH role.

The differences between the installations that implemented the DPH role and those that did not, is best characterized by the differences in interactions between the BH chief and the SC during the discussion with the SC and his staff at the end of the field research visits at Charlie and Delta. When we summarized the key findings from our visits, the Charlie's SC turned to the BH Chief and asked for his opinion. The BH Chief, who was a Major at the time, said to the SC, "*As your DPH, I would recommend….*" When the exact same situation occurred in Delta, the BH Chief, a Colonel, said to the SC, "*If I was your DPH, I would…*" In Bravo, the BH Chief said after the 3rd field research visit, "*I am still just the BH Chief. The only reason that we got more space for one of the EBH teams was someone complained to the SC in the gym that there was no way to get more providers in that cramped space, and it was affecting access to care for their Soldiers.*"

Adding the role of the DPH to the BH Chief creates a dual reporting relationship to both the SC and the MTF commander, which may be a political hazard for the BH Chief. The SC may not see the need for yet another staff officer

when already have subject matter experts on their staff. The MTF commander may feel that the DPH role undercuts their role as the installation's Director for Health Services. In the installations that were successful at implementing the DPH role, the MTF commander saw the DPH role as "having an extra seat at the table" with the SC, that created more sensemaking opportunities to understand the operational needs of the SC, and for advising the SC on the psychological health needs of her/his Soldiers. Implementing the DPH role provides SC's with a subject matter expert to provide constructive advice on resource requirements, impact of design decisions on Soldier care, and the overall effectiveness of the system of care on readiness.

Define of Supported and Supporting Relationships

In 2012, supported and supporting roles across the various organizations impacting behavioral healthcare on an installation were only defined for the senior leader triad (as shown in Figure 1). The hospital-centered care delivery relied on an area-support model in which all the Soldiers in the installation were seen on a first-come, first-served basis with the first-available provider. This model of care delivery was not conducive to understanding the occupational context as a provider's panel of Soldiers was drawn from multiple units. Similarly command teams did not know which provider to reach out to, in order to get mission-related information about this Soldier. In 2010, the tensions between providers and command teams escalated to the point where the Vice Chief of Staff of the Army to reiterate the guidelines for sharing protected health information with command teams (17). In our first round

of field research visits, only Alpha had a partial definition of supported and supporting relationships across BH and other organizations.

In our first round of field research, we uncovered seven interfaces at the installation-level in which Soldiers are handed off between organizations with different funding sources: BH $\leftrightarrow$ Command Teams; BH $\leftrightarrow$ Warrior Transition Unit; BH $\leftrightarrow$ Substance Use Care; BH $\leftrightarrow$ Purchased Care; BH $\leftrightarrow$ ER; BH $\leftarrow$ Military & Family Life Counselors; and BH $\leftarrow$ Soldier Readiness Processing. The last five interfaces require either coordination of services, or an SOP to ensure a warm handoff occurs across stakeholders. The BH clinics are supposed to be in a supporting role to the Warrior Transition Unit, however, two of the four installations studied (Alpha and Bravo) were exploring alternative arrangements in which the BH clinics would provide care for chronic conditions and the WTU social workers would provide solution focused short-term therapy. Charlie relied on the off-installation hospital, while the BH clinic in Delta provided all the services for their WTU. The critical supported-supporting relationship is between the EBH team and the aligned unit's command team.

The EBH design narrows the catchment area for a care team to a single large unit (a brigade combat team) or a set of smaller units, and aligns individual providers to one or more battalion sized units. This alignment creates a non-clinical role for providers similar to that of the DPH, where the aligned provider serves as a subject matter expert for the battalion commander and provides psychosocial educations to Soldiers in the unit.

Ensure Sufficient Team Staffing

The intent behind the 14-person multi-disciplinary team design is to create a nexus of care through the alignment a psychotherapist to each battalion in the brigade, having a case manager to manage complex cases, and sufficient support personnel to ensure efficient and effective clinical operations. In addition to these core MTF personnel, behavioral health officers from operational units are required to provide clinical care as a 0.5 FTE in their aligned EBH clinic. The operational reality that we saw in our field research varied significantly from the model specification. Most EBH teams were understaffed across all four installations, with provider attrition within the first 100 days being a critical area of concern (18). The new Army force structure reduces the total number of BCTs but increases number of combat battalions by 13, which further exacerbates the alignment challenge. Even the few EBH clinics that were staffed to the model specification had to develop unique ways of dealing with the staffing mismatch, ranging from using the unit Behavioral Health Officers (BHOs) as exclusive providers for a battalion, to the EBH team lead serving as the point of contact for the additional battalion commander. In Delta, the BH chief emphasized the lack of demand as one of the key design parameters that they took into consideration when sizing an EBH clinic to have four psychotherapists rather than the six prescribed. In the EBH model, Psychotherapists have their patient care requirements reduced from .75 FTE to 0.65 FTE to support their command engagement and educational activities. This workload requirement was designed with a one-to-one alignment in mind, and alternate model

implementations that involve fewer providers will require changes to the practice management standards imposed by the Behavioral Health Service Line.

The widespread shortage of providers further highlights the need for maximizing provider time in the clinical care setting, and enhancing their capabilities through care extenders such as case managers, social service assistants (SSA) and behavioral health technicians (68X). The nurse case manager provides all the case management services for a Soldier associated with an EBH clinic. They ensure that Soldiers are compliant with their care (including medication and appointment utilization) and tracks clinical transitions for complex cases (inpatient admissions, high risk patients). Even in our final field visits, EBH teams in Bravo, Charlie and Delta, had not filled their case manager slots, leaving providers with the added burden of case managing their patients. This was noted to be particularly challenging for Soldiers who care was distributed between the direct care and purchased care systems.

One of the strategies BH chiefs used to alleviate this personnel shortage was to use of alternate work schedules and part-time positions as a means of attracting and retaining providers for key roles. The centralized scheduling system and associated governance processes used in some installations may not support such flexible work, and the EBH team lead has to develop local workarounds until the enterprise scheduling system is redesigned. In Charlie and Delta, EBH team leads have focused on training their front desk personnel to manage all scheduling of providers in the EBH clinic (including BHOs).

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

Operationalize the EBH Care Model

EBH providers have to deal with the multiple agencies inherent to military medicine (19). This is even more challenging given the mix of uniformed and civilian providers in the direct care system has changed dramatically over the last decade from being largely uniformed personnel to civilian personnel comprising more than 75 percent of the workforce in FY2013 (20). This civilianization of the behavioral health workforce requires these providers to be acculturated to the Army. Installations with successful EBH implementations adopted a wide range of strategies including sending their providers to an EBH-onboarding course, having

an EBH SAV team visit to advise the EBH team leads, and active mentoring of civilian providers by their military peers.

The EBH model prescribes a number of team meetings, structural arrangements, and artifacts to develop a shared understanding of the current state of a Soldier's health. It leverages interdisciplinary meetings to track key clinical and operational transition points such as Serious Incident Reports(SIR), redeployment from theater, medical evacuations from theater, in-patient admissions/releases, suicidal ideation and homicidal ideation. Two of the meetings are central to establishing the EBH operating model: the morning report/the daily standup and the multidisciplinary team meeting. The morning report/daily standup is the first meeting of the day in which EBH teams use to identify Soldiers who needed acute care (ER visits, inpatient admissions, suicidal/homicidal ideations) during off-duty hours, as well as identify Soldiers returning from inpatient care or redeploying with a high-risk indicator. The nurse case manager collects and shares the information with the EBH team. The EBH team then 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. This meeting is also is used by the EBH team to share their current status, and ask for support they need with respect to complex cases. This meeting also provides an opportunity for providers to share operationally relevant information such as training schedules and deployments. The EBH teams in all four installations executed versions of this meeting.

The Multi-Disciplinary Treatment Planning (MDTP) meetings brings together key clinical stakeholders from across various organizations involved in the behavioral health of a Soldier, including Army Substance Abuse counselors (ASAP), the brigade surgeon, Family Advocacy counselors, BHOs, and Battalion PAs. When we first visited Bravo and Delta, the EBH teams were not carrying out MDTPs. In fact, the first MDTP at Delta was carried out during our field research visit. As one BHO observed in a sidebar: *"We have never done this before, and it is not surprising that no one had anything to say about the other cases."* In Bravo and Delta, some of the EBH team leads were unaware that they could invite other clinical stakeholders to their MDTP. Even in the final round of field visits, EBH team leads in Bravo, Charlie and Delta could not get substance use care providers to attend the MDTPs.

Working with Command Teams

A key challenge that EBH is designed to overcome is the adversarial relationship between command teams and behavioral health providers. Prior to the establishment of EBH, command teams saw behavioral health as a 'medical problem' with a system of care that was not providing appropriate and timely services to their Soldiers. In some cases, they saw behavioral health as a) actively taking away from their fighting force, and b) being reticent to share information regarding the health and recovery of their Soldiers. Conversely, providers saw command teams as uncaring, and in extreme cases responsible for targeting and further stigmatizing Soldiers who used behavioral health services.

This clinical-operational divide requires both groups of stakeholders to reframe their roles and treat operational readiness and receiving behavioral healthcare from being orthogonal goals to being collaborative/reinforcing goals. This reframing occurs when EBH team lead engages the brigade commander and the EBH provider engages the aligned unit leaders. In our field research at both Bravo and Delta, we met EBH teams where the brigade commander had peripheral awareness about the establishment of an EBH team, and had not met the EBH team lead. This creates a challenge for EBH providers who then have to engage the battalion commander(s) with limited to no command guidance and strategic messaging regarding the establishment of EBH. EBH represents a new way of care delivery for command teams, so the EBH provider has to educate the command team on this new way of working, especially regarding the availability of walk-in appointments, and the importance of groups such as the 'Introduction to Behavioral Health' group.

A Soldier's chain of command are critical gatekeepers who can direct a Soldier to services. Even though most of the EBH teams across all four installations were operating at or above capacity, EBH team leads were constantly working to raise awareness of their services through activities such as posting flyers in the Aid Station, troop medical clinic, or company headquarters. Some have even leveraged command communication channels such as the S3 shop to put out announcements about EBH and how Soldiers can access it. The true impact of EBH occurs when providers engage company commanders and 1SGs. When providers meet with command teams in their place of work, they gain a deeper understanding of the

occupational context of the unit they are serving. These command team meetings establish the foundation for an ongoing collaborative relationship regarding the health of the Soldier. A common complaint from command teams prior to the establishment of EBH was: *"I don't know who the provider is, or how to reach them."* Similarly, providers often said, *"command teams change all the time, and we have no way of tracking them."*

EBH establishes a single point of contact for the command team to gather behavioral health related information. The Army has focused on developing clear policies and guidelines regarding when health-related information can be shared with command, however, the translation of the policy to practice requires ongoing education and consistent relationships between command teams and providers. The two artifacts that are central to provider-commander communication are the DA Form 3822 used for mental status evaluations, and the DA Form 3349 for communicating duty limitations for a medical condition. The EBH team lead and EBH provider need to communicate with command teams to ensure that the data presented in these forms for behavioral health conditions is understandable by the Command teams and reflects the occupational environment of the Soldier. The installations with mature EBH implementations were able to construct "win-win" situations that enabled Soldier recovery, while those with less mature implementations continued to have adversarial relationships between command teams and providers. One of the key policy changes was authorizing the aligned Social Workers and Psychologists to write duty-limiting profiles (21, 22). In our final round of field research, only Alpha and Charlie had fully implemented the new

guidance. Bravo had begun training its Social Workers, while Delta's BH Chief remained concerned about the quality of profiles written by non-psychiatrist providers.

Discussion

Embedded Behavioral Health is a critical component of the Army's integrated mental healthcare system. Our longitudinal study of the implementation of EBH at four Army installation has uncovered three installation-level practices that create the environment needed for successful EBH implementation.

The first is ensuring alignment across the senior leadership triad regarding behavioral health. The garrison commander and the director of health services operate in support of the senior commander, so it is critical that s/he understand the spirit of the EBH model, and is aware of the Army EBH rollout plan. Charlie was able to obtain the resources needed to implement EBH for all of its units because the senior commander understood the goals of EBH and was supportive of the DPH's effort to implement EBH. In Delta on the other hand, the SC prioritized EBH implementation for non-BCT units, creating significant hurdles to successful implementation. The Bravo SC interpreted EBH mean colocation without consideration for infrastructure and staffing, as a result, one of the BCTs had an EBH clinic distributed across two floors, and shared a building with the operational unit.

The second is implementing the role of the installation director of psychological health. This is particularly important for installations where the SC is a corps commander and does not have a subject matter expert. Even in the case of

division commanders, the division psychiatrist is often a company grade officer (O-3) or a newly promoted field-grade officer (O-4) with limited clinical experience. Assigning the BH Chief to serve as the DPH often provides the SC with a more experienced clinician, who understands the day-to-day challenges of providing behavioral healthcare to Soldiers and their families. In Alpha and Charlie, the BH Chiefs are trusted to speak in the voice of the DHS for behavioral health issues, and advice the SC on where his/her attention is needed.

The third is the clear definition of supported and supporting relationships between BH and command teams. The EBH model clearly defines the required alignment down to the battalion-level. It also requires command teams to actively work with the provider to shape the occupational environment of the Soldier to promote recovery and restore readiness. In Alpha, we observed units and EBH teams establish transparency by sharing lists of command teams and providers. In Charlie, EBH providers participated in the command high-risk team meetings and served as subject matter experts. In Delta, one of the EBH teams had established deep relationships with the unit, to the point where all the command teams noted, *"If there is a behavioral health issue, we just walk the Soldier across to the EBH Clinic."*

The field research also identified three clinic-level practices that are essential to EBH success. The first is ensuring sufficient staffing for the EBH clinics. Command teams now expect to have a care team with aligned providers, and can potentially lose trust in the system if it is not sufficiently staffed. Alpha was successful in its initial roll out of EBH because of the infusion of providers for EBH clinics. Similarly Charlie was able to implement EBH because providers were reassigned from the

nearby medical center to Charlie. Delta did not have the workload needed to justify fully staffing their EBH clinics, but were also stretched thin because of the alignment of providers to support non-BCT units.

The second practice is in ensuring implementation fidelity when operationalizing the EBH model. EBH providers have to be trained to be culturally competent to manage the multiple agencies inherent to military medicine. EBH relies on a multidisciplinary care team approach involving multiple meetings with clinical and non-clinical stakeholders. The daily standups provide a venue for providers to develop shared situational awareness of potential high-risk and at risk patients. The multi-disciplinary treatment planning meetings provide a venue for all clinical stakeholders to work together to ensure Soldier recovery, and make clinically indicated decisions regarding medical retirement. Alpha and Charlie have fully implemented these meetings, while Bravo and Delta are still maturing in their use of the MDTPs.

The third practice is active engagement of command teams. EBH aims to first create trust between an individual provider and an individual commander. This development of a personal relationship leads to trust and respect for the professional differences between the individuals, which over time leads to institutionalization. EBH is accepted as the default standard of care at Alpha. Command teams at Alpha are taught in the precommand course to ask for "Who is your brigade surgeon? Who is your chaplain? And Who is your EBH team lead?" In Charlie, the EBH providers are invited to all the command high-risk team meetings

and any event where the command team feels the presence of a behavioral health provider is needed.

Active change management is essential for successful EBH implementation. We traced provider resistance in Bravo to a Combat and Operational Stress Control pilot, in which civilian providers were aligned to operational units and carried out "therapy by walking around." These providers were reassigned into EBH units when the pilot was discontinued. Active change management needs to be carried out to educate the triad of senior leaders on the EBH model itself. Bravo's SC focused on moving care to point of need without considering the personnel and physical infrastructure needed. The six practices identified in the paper are organization and process aspects of implementing EBH. They do not reflect the actual patient experience of care. While research has shown EBH is correlated to lower hospitalization rates, more research is needed on the patient experience of care, and clinical care outcomes.

References

1. Hoge CW, Ivany CG, Brusher EA, et al.: Transformation of mental health care for US soldiers and families during the Iraq and Afghanistan wars: where science and politics intersect. American journal of psychiatry, 2015

2. Headquarters Department of the Army: 186/2012 – ALARACT HQDA EXORD 236-12 Army Implementation of Behavioral Health System of Care (BHSOC) Embedded Behavioral Health (EBH). Washington DC, 2012

3.	OTSG/MEDCOM: Operational Order 12-63 Embedded Behavioral Health Team Implementation, 2012

4.	Department of the Army: Army Regulation 40-4: Army Medical Department Facilities Activities. Edited by Medical Service. Washington DC, 1980

5.	Huber GP, Van de Ven AH (ed)^(eds): Longitudinal field research methods: Studying processes of organizational change: Sage, 1995

6.	Reason P, Bradbury H: Handbook of action research: Participative inquiry and practice: Sage, 2001

7.	Nightingale DJ, Srinivasan J: Beyond the Lean Revolution: Achieving Successful and Sustainable Enterprise Transformation. New York: AMACOM Press, 2011

8.	Hersh WR: Healthcare Data Analytics; in Health Informatics: Practical guide for healthcare and information technology professionals. Edited by Hoyt RE, Yoshihashi AK. Pensacola, FL: Lulu. com, 2014

9.	Srinivasan J: Multi-Stakeholder Approach to Understanding Army Mental Health Services Delivery Massachusetts Institute of Technology, 2016

10.	Department of the Army: Army Regulation 600-20: Army Command Policy. Edited by Personnel - General. Washington DC, 2014

11.	U.S. Army War College: 2015- 2016 How the Army Runs A Senior Leader Reference Handbook. Carlisle, PA, 2015

12.	Kotter JP: Leading change: Why transformation efforts fail. Harvard business review 73:59-67, 1995

13. Srinivasan J: Unintended Consequences of Organizational Design Decisions: Case of Army Substance Use Care: Massachusetts Institute of Technology, 2016

14. Department of Defense: Instruction 6490.09 DoD Directors of Psychological Health. Edited by Defense Do, 2012

15. Department of the Army: Army Techniques Publication 4-02.3: Army Health System Support to Maneuver Forces. Edited by Headquarters. Washington DC, 2014

16. Headquarters Department of the Army: ALARACT 080-2014 Director of Psychological Health Program. Washington DC, 2014

17. Headquarters Department of the Army: 160/2010 ALARACT VCSA Sends on Protected Health Information. Washington DC, 2010

18. Srinivasan J: Preliminary Evidence on the Effectivenss of Embedded Behavioral Health: Massachusetts Institute of Technology, 2016

19. Hoyt T: Limits to confidentiality in US Army treatment settings. Military Psychology 25:46, 2013

20. Department of Defense: Final Report to the Secretary of Defense Military Health System Review. Washington DC, 2014

21. OTSG/MEDCOM: Policy Memorandum 15-017 Profile Authority for Social Workers and Use of eProfile by Social Workers and Psychologists, 2015

22. Headquarters Department of the Army: ALARACT 078-2014 Profiling Officer Role for Licensed Clinical Social Workers. Washington DC, 2014