Appendix C: Army case Charlie

Site Charlie Behavioral Health System of Care

Jayakanth Srinivasan[1] and Julia DiBenigno

Executive Summary

In October 2013, members of the MIT Behavioral Health Participatory Action Research team visited Site Charlie to better understand the behavioral health system of care in the installation. The installation is home to over 17,000 Soldiers distributed across two major command structures: a division command with approximately 10,000 Soldiers and a theater sustainment command (TSC) with approximately 6000 Soldiers. The installation has a unique configuration of behavioral health services owing to its close proximity to a large Army hospital. Over five days, we interviewed 38 key stakeholders drawn from command (18), medical (17) and installation services (4). In addition, we engaged with small groups of these stakeholders through 13 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 two years, the Behavioral Health (BH) system of care at the installation has evolved to focus on the primary care needs of active duty Soldiers, with family members and other specialty care services being performed in the off-post hospital. An ideal BH system of care would provide full spectrum services (including substance use) to all key population groups on the installation; however, the current architecture splits care across installations and commands, making it more difficult to coordinate care and effectively exploit scare BH resources. The Behavioral Health Service Line (BHSL) provides a model for thinking about care in an installation, however, they only have the capacity to support the outpatient care needs of 12,000 of the over 17000 soldiers. Similarly, the off-post hospital does not have the capacity to support the demand for intensive outpatient services in substance use and BH.

The implementation of the BHSL is a major transformation for both the installation and the off-post hospital. Both locations have had to manage hiring issues raised because of sequestration – with the hiring team treating BH hires as being part of the required 20% reduction. This lack of providers has limited the roll out of both behavioral health in primary care, as well as the Embedded Behavioral Health (EBH) model for outpatient care. A key attribute for an effective system of care is the ability to route the patient to the right level of care. In Site Charlie, primary care providers are not yet comfortable dealing with mild-to-moderate behavioral health conditions; as a result they are sending

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all patients to BH, essentially flooding the system. Site Charlie is also dealing with the issues of shifting from the traditional command support alignment of Behavioral Health Officers and trainees to the EBH model.

The foundation for patient-center care is to ensuring timely and quality care. The lack of assets has forced long wait times for appointments, and fragmentation of care – both with clinical behavioral health service as well as with substance use care. Both the EBH model and the Health of the Force (HOF) meetings are designed to bring together key subject matter experts together to develop shared situational awareness of Soldier wellbeing and create coordinated action plans. Site Charlie is in the process of getting the right people to these meetings and establishing a consistent battle rhythm for their execution. For example, there is no shared SOP across the various battalions with respect to the ownership and execution of high-risk team meetings. Similarly the meetings prescribed by the EBH model such as the multi-disciplinary treatment-planning meeting do not have active ASAP participation.

There are three unique practices and innovations at Site Charlie that address Army-wide challenges in implementing a common behavioral health system of care:

1. PCS Scrub: BH Technicians at Site Charlie execute a review of the medical record for every inprocessing Soldier and family member and offer them BH services if needed. This is the first installation we visited that executes this process.

2. Engagement of 1st line Supervisor: one of the battalion high-risk team meetings we observed actively engaged the first-line supervisor to gain a deeper understanding of the context behind Soldier behaviors and actions taken. This also provided the battalion commander an opportunity to mentor both the company command team and the first line supervisor.

3. Developing Shared Vocabulary: the division has also placed significant effort in using the Ready and Resilient campaign as a means of building a shared language across line, medical and installation assets. The BH chief has also incorporated the vocabulary as part of new provider onboarding.

Site Charlie and the off-post hospital are in the process of transforming the BH system of care. Senior leaders have to understand the flow of Soldiers and family members between the locations, and recognize the differences in mission profiles. There are nine near-term leader actions that are needed to more ensure the transformation occurs more effectively:

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

2. Clearer communication is needed between Behavioral Health Service Line leadership and the hospital leadership team to resolve the confusion regarding

the use of CART and other BHSL incentives.

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. PA training is needed on basic psychotropic use to enable effective triaging of patients.

5. A shared SOP is needed between the off-post hospital and Site Charlie to ensure proper Soldier handoff from inpatient care.

6. There is a need for an additional intensive outpatient program (IOP) on the installation help manage the transition from inpatient care.

7. ASAP providers should be encouraged to participate in the EBH multi-disciplinary treatment planning meetings.

8. A shared SOP has to be established for the execution of the battalion high-risk team meetings.

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

Site Charlie Behavioral Health System of Care

Jayakanth Srinivasan[2] and Julia DiBenigno

Introduction

In October 2013, members of the MIT Behavioral Health Participatory Action Research team visited Site Charlie to better understand the behavioral health system of care in the installation. The installation is home to over 17,000 Soldiers distributed across two major command structures: a division command with approximately 10,000 Soldiers and a theater sustainment command (TSC) with approximately 6000 Soldiers. The installation has a unique configuration of behavioral health services owing to its close proximity to a large Army hospital. Over five days, we interviewed 38 key stakeholders drawn from command (18), medical (17) and installation services (4). In addition, we engaged with small groups of these stakeholders through 13 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. In this paper, we summarize the key insights from our site visit, and highlight areas where senior leadership intervention is needed.

Over the last two years, the Behavioral Health (BH) system of care at the installation has evolved to focus on the primary care needs of active duty Soldiers, with family members and other specialty care services being performed in the off-post hospital. This represents a significant shift in both the command structure and in resource allocation across the different care locations. In 2011, the off-post hospital retained overall command and control of services, with different departments owning different services on the installation. This led to confusion with respect to where the principal responsibility for managing the BH care for the Soldier resided, and how care was coordinated across the various departments. The reorganization into a BH service line at the installation and an integrated BH department at the hospital has provided greater visibility into the clinical BH system. This visibility has highlighted some of the key challenges associated with short staffing in the installation, hiring and retaining BH providers, difficulties in ensuring quality of clinical BH care, and the need for greater clarity in the role of line assets (both BH officers and BH technicians).

A deeper understanding of the system of care also allowed us to identify capability gaps in this clinical system of care. The installation is not currently staffed to effectively support the outpatient needs of Soldiers in non-divisional units, Soldiers in the Warrior Transition Unit (WTU) and family members. They have not yet rolled out BH services in the Soldier Centered Medical Home – a capability that would enable the installation to better utilize their limited BH assets. Currently there are no intensive outpatient services on the installation, and limited capacity at the off-post hospital for intensive outpatient services. When it comes to coordinating care for the Soldier, two key disconnects were

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identified: the poor handoff between inpatient care and outpatient care, and the coordination of care between ASAP and BH. The issue of the poor handoff has been recognized by both the off-post hospital and the installation, but a solution was still being developed. Individual commanders and BH providers had established working relationships with specific ASAP counselors, but the turnover of ASAP providers and the lack of a consistent battle rhythm for developing shared understanding of Soldier wellbeing interfered with care coordination.

Shared situational awareness of Soldier mental health conditions is established using the e-profile system and DA-3822. The BH team on the installation has expanded profile privileges to the whole team, and put in a quality control process to ensure that actionable information is shared with command. A critical gap that we observed was the lack of face-to-face meetings where all BH providers (both clinical and non-clinical) and the battalion command team could meet at the same time. There was significant variation in the battalion-level health of the force meetings with respect to battle rhythm, stakeholder participation and resultant action.

We also observed a number of unique practices and innovations at Site Charlie that address Army-wide challenges in implementing a common behavioral health system of care. This is the first installation we visited that actively ensures that no Soldier or family member slips through the cracks when they PCS from another installation. One of the battalion high-risk team meetings we observed actively engaged the first-line supervisor to gain a deeper understanding of the context behind Soldier behaviors and actions taken. This also provided the battalion commander an opportunity to mentor both the company command team and the first line supervisor. The division has also placed significant effort in using the Ready and Resilient campaign as a means of building a shared vocabulary across line, medical and installation assets.

Evolution of the System of Care

Historically, the clinic on the installation has been seen as a remote clinic of the hospital with the different services being managed through the different departments in the hospital. Previously, when we visited Site Charlie in 2011, the principal services on the installation were provided through a behavioral health clinic for active duty Soldiers, and a child, adolescent and family clinic focused on family care and adolescent issues. The Soldier behavioral health clinic was in the process of being organized into teams of providers aligned to the units to promote a greater appreciation for the operational tempo.

In 2011, the hospital owned nine additional lines of services provided on the installation, as shown in Figure 1. The school-based behavioral health program was owned by the Department of Psychiatry, the telemental health screenings and services were owned by the Department of Psychology, the Family Advocacy Program was owned by the Department of Social Work, the Assessments for children with ADHD was owned by the Department of Pediatrics, care for Soldiers in the Warrior Transition Unit was provided by both the WTU social workers and Department of Psychology, TBI services was owned by Family Medicine, and graduate residents in Psychology and Psychiatry were doing operational residency training at the installation. This architecture created confusion

over ownership of Soldier care, and also created challenges for managing the delivery of mental health services.

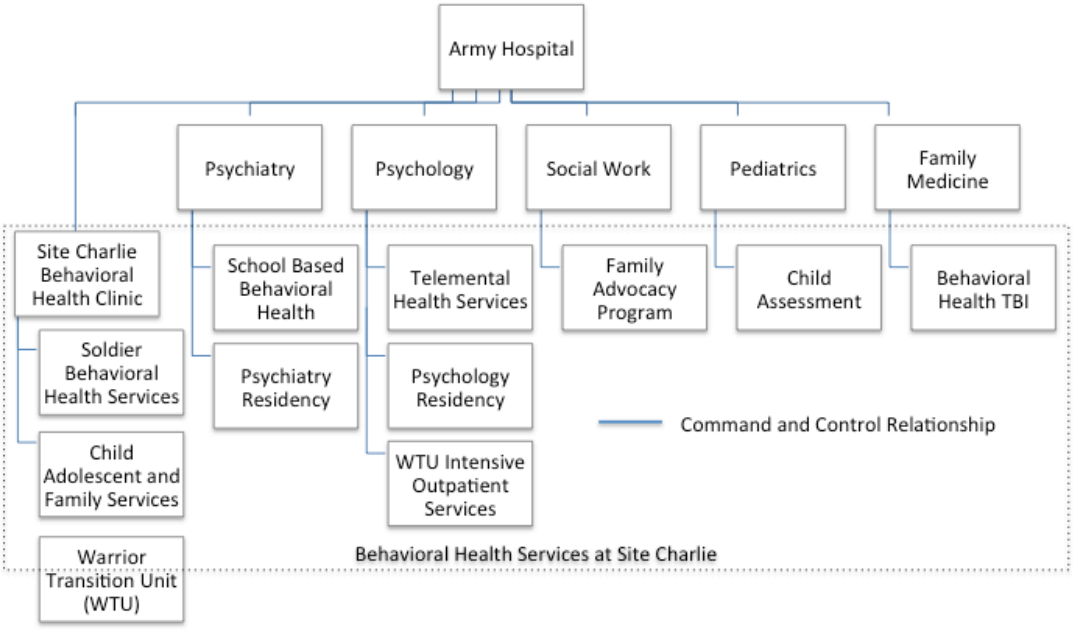

Figure 1: *Architecture and Ownership of Behavioral Health Services in 2011*

In October 2013, the hospital reorganized into an integrated Department of Behavioral Health based on an Army-wide initiative to establish a standard behavioral health system of care across the enterprise[3]. The hospital provides adult behavioral health services, family behavioral health services, social work services, intensive outpatient services for both mental health and substance dependence, and in-patient psychiatric care. Additionally, the integrated department continues to support the hospital graduate education mission in psychiatry and psychology. They continue to provide care for WTU Soldiers through the WTU Wellness Program. The telebehavioral health services have been reorganized under the regional medical command because it is a shared service across all the installations in the region. The hospital also serves as the principal source of specialty care for all four services in the region. This joint mission impacts the operating procedures used to transition patients from inpatient care back to the outpatient setting. It also impacts the capacity to provide services to Soldiers.

[3] MEDCOM Behavioral Health System of Care required the establishment of an Integrated Department of Behavioral Health by 1 Oct 2013. The need for better coordination and management of limited mental health resources is also emphasized in the Corrective Action Plan proposed by the Army Task Force on Behavioral Health.

Today, the behavioral health department at Site Charlie is organized as a separate service line that is responsible for providing outpatient services to all Soldiers and their families on the installation. In summer of 2013, the outpatient Soldier clinic was divided into two clinics, one covering one brigade combat team (BCT), the combat aviation brigade (CAB) and division headquarters Soldiers, while the other clinic is providing care to the other brigade combat team (BCT) and theater sustainment command (TSC) Soldiers. The long-term vision of the installation is to transition to true EBH clinics that are located in the brigade footprint for the BCTs and the CAB.

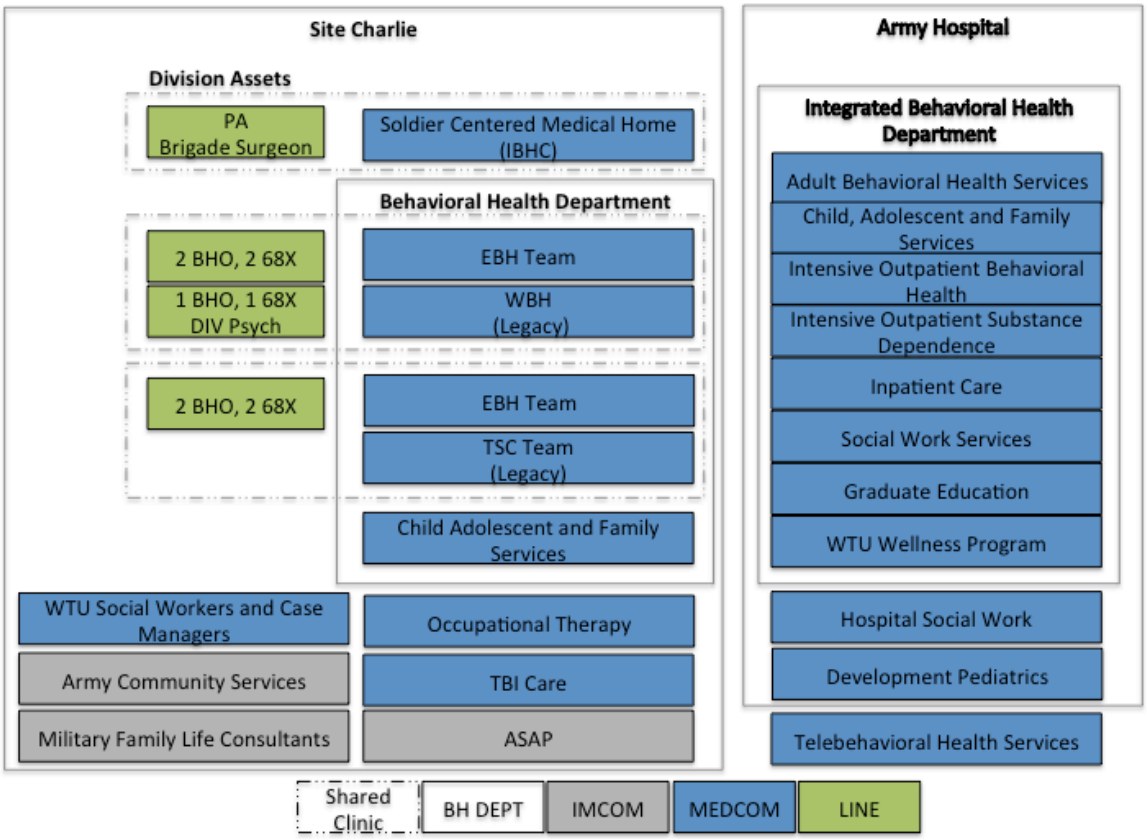

Figure 2: *Current Organization and Ownership of Behavioral Health Services*

The installation currently has almost 17,000 Soldiers but they are currently staffed to provide services to 12,000[4] Soldiers. This creates a challenge with respect to distributing scarce behavioral health assets to cover all the needs of the population on the installation. While Site Charlie has a Child, Adolescent and Family service, there is significant uncertainty with respect to the future of that service as there are insufficient providers to meet the demand of active duty Soldiers. Currently most family members

[4] Based on the MEDCOM staffing ratio of 1 behavioral health provider per 600 Soldiers.

are either sent to the Army hospital or referred to the network for services (even though there are concerns about the availability of child psychiatric services in the region).

To meet the existing demand for mental health services by Soldiers, the installation leverages medical assets drawn from the line units. There are currently five behavioral health officers (psychologists and social workers) and five behavioral health technicians from the division who provide clinical care to Soldiers from their units. These providers, who are required to provide 20 hours clinical time per week under Borrowed Military Manpower guidelines, work in the clinic associated with their unit. The table of organization and equipment (TO&E) for Theater Support Commands (TSC) only authorizes a command surgeon[5] who is typically not a behavioral health provider. Given that the TSC units on the installation do not have any behavioral health officers assigned to them, the behavioral health department at Site Charlie has to provide all the outpatient clinical care. Prior to our visit, there had been a number of suicides in the TSC units. As a result, the behavioral health chief had to restructure the teams to surge additional assets to those units.

Understanding Soldier Flow

The behavioral health system of care for Soldiers at Site Charlie is best understood across three broad care streams of clinical mental health, substance use, and preventative/non-clinical counseling. Figure 3 shows the seven documented access pathways that Soldiers use to obtain clinical services at one of the outpatient clinics: through a referral from another specialty clinic, a self-referral, a walk-in, a command referral, a referral from screening at the SRP site, a referral from the emergency room for follow-up care, or a safety check when they transition from inpatient care to outpatient care. The head of behavioral health estimated that the command referral pathway was a small segment (< 5%) of the total volume of patients seen, and that recent DoD policy guidance[6] on the use of command referrals had made the process more effective.

If a Soldier conducting his/her deployment screenings is identified as needing additional behavioral health screening by the primary care providers, they are sent to a behavioral health technician who establishes a telebehavioral health consult with providers at the regional telebehavioral health cell. In 2012-2013, this cell of providers conducted 9198 encounters with 1956 unique patients (1185 of these patients had only a single visit. The telehealth option is offered to Soldiers who would prefer an alternate modality to visiting the behavioral health clinic, but it creates a potential gap where ownership of the care for that Soldier is split between the on-installation team responsible for the Soldier's care and the remote provider.

[5] See ATP 4-94 Theater Sustainment Command

[6] DoDI 6490.4 Mental Health Evaluations of Members of the Military Services

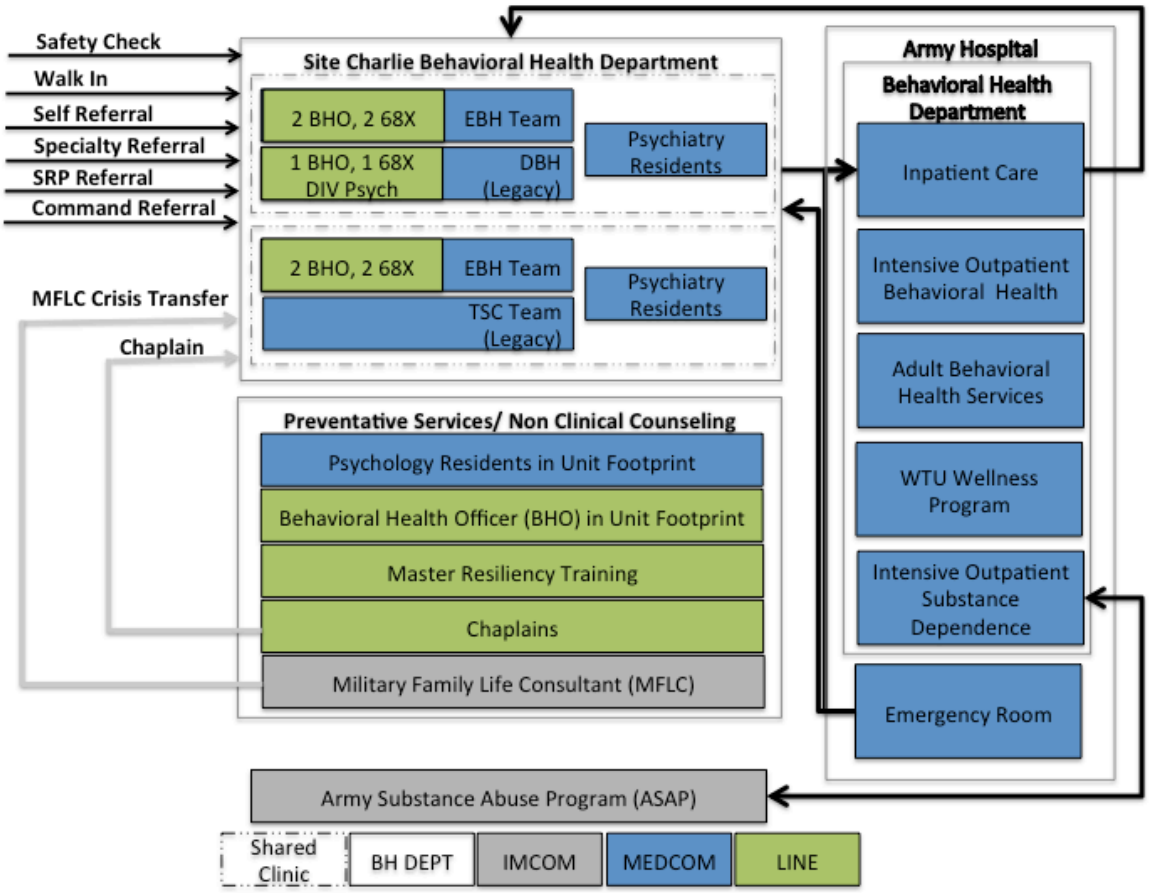

Figure 3: *Key Soldier Pathways Through the Behavioral Health System of Care*

When a Soldier needs urgent care during regular work hours, they are seen in the clinic they are assigned to, and a determination is made whether they need inpatient care or whether care can be provided in the outpatient setting. When the Soldier is in crisis during off-duty hours, they are seen in the emergency room at the off-post Army hospital where the soldier is either admitted or a handoff is made to the unit with a referral to outpatient care on the installation.

The behavioral health leadership at Site Charlie has made a conscious decision to ensure that all outpatient care for active duty Soldiers is provided through aligned teams of providers on the installation. Because they do not have sufficient providers to fully staff all of the teams, they have co-located two teams of providers per clinic, with the providers in the same clinic providing walk-in coverage and surge capacity to the other team on an as needed basis. They have further augmented these teams of MEDCOM providers (uniformed, civilian and contractors) with uniformed behavioral health providers from the line and graduate education programs.

When a Soldier is seen to require more intensive care, they are sent to the hospital either to an intensive outpatient program or to inpatient care. Given the shortage of network capacity to provide intensive outpatient care, Soldiers have to wait 8 weeks to get into the intensive outpatient program in the hospital. Similarly, the wait times to get follow on care after the initial safety check for a Soldier released from inpatient care is 6-8 weeks. This coordination of care when a Soldier transitions echelons of care is a gap that

the installation is currently working to fix and is discussed in greater detail in the care coordination section.

The second care stream is the preventative and non-clinical counseling services. These are services focused on enabling Soldier/family wellness and any counseling services provided are not documented in the medical record. There are two pathways that a Soldier can take from this stream into the clinical system of care, either through a chaplain referral or a Military Family Life Consultant (MFLC) referral (often when the Soldier is in crisis). These referrals are not formal referrals and are not traceable through the data captured in the referral management system. According to policy guidelines, there is a clear delineation of clinical responsibilities between the MFLC and the behavioral health clinic. The MFLCs are not authorized to provide services to a Soldier or family member for a clinical diagnosis, however, that boundary is fuzzy at best. Another source of undocumented care is Army One Source where a service member or their dependents can access up to 12 non-clinical counseling sessions to address family and adjustment challenges. There is partial visibility into the volume of care provided through Army OneSource because the services are paid for by TRICARE.

Behavioral Health Officers (BHOs) are expected to provide command consultation and psycho-social education within the unit footprint. They are expected to spend their non-clinical hours educating command and Soldiers about mental health issues, participating in high-risk team meetings, and serving as a bridge between the MEDCOM providers and command. The work of the BHOs is complemented by Master Resiliency Trainers (MRTs) who focus on teaching the 12 resiliency competencies to their Soldiers. These MRTs work within the framework of the larger Army *Ready and Resilient Campaign (R2C)*[7] of their respective command structures.

The heterogeneous nature of Soldiers being drawn from a division and from a theater sustainment command raises challenges with respect to campaign alignment and execution. The division has developed a campaign plan focused on providing Soldiers, family members, and Army civilians with the principles, programs and tools needed to maximize their individual potential and face the physical and psychological challenges of sustained operations. The division leadership has emphasized the need for building mental and physical toughness as a foundation for driving success in both operational and garrison contexts. The division-specific strategic communication and campaign plans are built around *Comprehensive Soldier and Family Fitness*[8] and tied to the larger R2C. These efforts, however, are only enforceable for Soldiers in the division. Given the separation of the senior leadership team of the TSC from their Soldiers (TSC headquarters is on a different installation), it is unclear how the division's campaign applies to those TSC Soldiers. This understanding of the installation population is important because both groups rely heavily on MEDCOM behavioral health providers to

[7] http://www.army.mil/readyandresilient

[8] Army Directive 2013-07 (Comprehensive Soldier and Family Fitness Program). http://csf2.army.mil/

provide care to their Soldiers and provide the needed situational awareness to the local command teams.

The third key care stream is substance use care. Soldiers in this installation can either self refer to ASAP or be command referred into the program. The ASAP mission in the installation is both education and treatment focused. When a Soldier is determined to have a substance dependence issue, his or her command team is invited to meet with the ASAP team to map out the treatment plan and ensure compliance to the treatment plan. When a Soldier is seen to need more intense therapy, they are sent to the intensive outpatient program at the hospital. Again, capacity limitations in both the ASAP program on the installation (they have lost a number of providers), and the inability to hire additional providers in the off-post hospital have resulted in long wait times for intensive outpatient programs.

Since the inpatient ward at the hospital is a triservice facility, they have to rely on the TRICARE network to provide detoxification services. Given that Site Charlie does not have local inpatient care for substance use, they have to send the Soldiers to other states for residential substance dependence treatments. There are also issues with cost coverage for soldiers transferred to a residential treatment facility. If the Soldier was directly transferred from the inpatient psychiatric ward, the cost was borne by MEDCOM. If the transfer was made from an outpatient setting, the cost was borne by the command teams out of their operational budgets. This creates a unique pathway to residential substance use treatment where a Soldier is first admitted to the inpatient psychiatric ward and then transferred to a different facility. While this issue was not consistently raised, it creates a potential barrier for soldiers receiving needed care, as some command teams were resistant to covering the costs from their operational budgets.

Challenges in Hiring and Retaining Behavioral Health Providers

One of the key limitations at Site Charlie is the insufficient capacity to provide care, even for active duty Soldiers. Using the desired staffing ratio of 1 provider per 600 Soldiers, they currently have the capacity to provide care for approximately 12000 soldiers of 17000 on post Soldiers. The staffing plan to roll out Embedded Behavioral Health on the installation was designed to first meet the needs of the BCTs and the CAB, with hiring actions for the TSC mapped out to subsequent years. A recent increase in sentinel events (suicides, suicide attempts) highlighted the urgent need for a fully staffed team of providers to support the approximately 6000 TSC Soldiers. The lack of organic behavioral health assets in the TSC further added to the need to effectively provide situational awareness to the TSC command teams about the behavioral health status of their Soldiers. The BH leadership team made the difficult decision to spread limited behavioral health assets across the installation to ensure a minimum level care to all Soldiers. Even though MEDCOM had centrally allocated funding to support the hiring of additional providers, there were local roadblocks to hiring providers. The local hiring office attempted to meet the 20% cut enforced by sequestration by applying a hiring freeze to all positions, even though behavioral health was exempt from those cuts. An additional point of emphasis is that Site Charlie, unlike most other Army posts, is expanding its mission and size, leading to potential increases in demand for services.

The decision to spread out assets to minimally cover all Soldiers has prevented the Embedded Behavioral Health model itself from fully rolling-out, as the EBH teams are all half-staffed or less[9]. Of the two BCTs with aligned teams of providers, one was short three providers and was relying on psychology interns within the brigade footprint to serve as force extenders, while the other had lost three providers to a combination of workload and pay scale issues. Further, a large component of clinical care (approximately 12000 of the approximately 27000 behavioral health encounters on the installation) is provided by Licensed Clinical Social Workers (LCSWs), despite a mismatch of position authorizations. Under the EBH model, LCSWs are slotted for GS-12 positions, while the same providers under the legacy behavioral health clinic were slotted at GS-11. The LCSWs who were realigned into the EBH teams were promised promotions into the GS-12 positions. Unfortunately, the former BH Chief was unable to deliver on this promise because the centralized hiring office required an open competition for those positions— effectively making these providers compete for jobs they were already performing against an open field. Delays in hiring have also occurred because of preferential hiring for veterans, even when they are unqualified to meet the role requirements of Embedded Behavioral Health.

This persistent short staffing has two major impacts outside of clinical quality of care: provider burnout and lack of meaningful relationships between command teams and providers. As one provider shared:

> *I get my job satisfaction from being an effective therapist. When I see a patient four times in four months, I feel ineffective. …I love my job and it has been sad to see my passion decrease over time to the point of burnout.*

This same argument on the workload leading to burnout was highlighted by psychiatrists who felt that the acuity of the trauma patients they were seeing was so high that it was unfair for them to add new patients in their panel when they were not able to graduate their old patients. The psychiatrists emphasized that the remuneration for psychiatrists in the installation was the highest in the geographical area, but the workload was negatively impacting their quality of life and the quality of care they were providing patients.

The military is unique in that Soldiers predominantly receive care within their occupational environments, and command teams play a significant role in Soldier recovery and wellness. The short staffing of EBH teams has resulted in the teams being unable to provide battalion-level alignment of individual providers, which in turn impacts the ability of the providers and command teams to develop meaningful relationships. This has also required the Behavioral Health Officers (BHOs) to spend more time in the clinics providing clinical care, negatively impacting their staff officer function.

[9] The EBH operational manual prescribes a team of 6 therapists and 1 prescriber per BCT sized element.

Challenges in Ensuring Quality of Care

Like other Army installations, Site Charlie is still in the process of rolling out the Soldier Centered Medical Home, which incorporates the provision of behavioral health services in primary care. Currently there are no behavioral health providers in the primary care setting; as a result, all Soldiers are being seen in the behavioral health clinics. Given that of the approximately 3000 unique Soldiers seen in behavioral health approximately 2000 received less than 4 visits, a majority of these Soldiers are ideal candidates for triage and management in primary care rather than in behavioral health.

When you combine the lack of effective triage with the pervasive short staffing of providers, it impacts the ability of providers to regularly use evidence-based therapies for complex conditions. Providers need to see patients weekly (or at least bi-weekly) for these evidence-based therapies to be effective, but as one therapist explained:

> *These therapies only work if done weekly to be effective, yet I can only see my people every four or five weeks. It is all crisis management.*

In addition, Site Charlie psychiatrists feel the need to overmedicate Soldiers in order to keep them stable because they cannot get Soldiers into regular psychotherapy. One provider explained:

> *These patients should have a course of therapy before a trial of medications. …But all they (therapists) can do is see them once a month and so they need medications because there is no time for therapy. The Soldier comes to me, suffering, so I initiate a medication because there is a lack of therapy support. ...I am overprescribing in an attempt to compensate.*

Psychiatrists also reported having to work with patients who did not desire or require medications. They noted that this was both a function of lack of effective routing by the clinic front desk staff as well as incorrect referrals made by the primary care providers. They expressed frustration at the ineffective use of their valuable and expensive skillset. Many of the primary care providers (typically physician assistants) on the installation are not uniformly comfortable prescribing SSRIs and other psychotropic medications for mild anxiety, depression, and sleep problems, as is a best practice at other posts. Instead, they immediately refer the Soldier to psychiatry. Misuse of the psychiatric specialty may lead to Soldiers otherwise able to return to the mission with therapy being prevented due to initiation of duty limiting medications to maintain clinical stability.

Role and Utilization of Line Assets

There are two groups of line assets that impact the provision of behavioral health services: Mental Health Specialists (68X) and Behavioral Health Officers (BHO). 68Xs are force extenders who can execute some of the screening and intake tasks that otherwise have to be performed by care providers. These 68Xs are vital in combat operations 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. However, they are unable to get the needed time in the clinic to learn from providers. Clinic providers view the 68Xs as unreliable since they are regularly pulled from the clinic to do tasks unrelated to their core military occupation specialty (MOS). Even with the MEDCOM 68X,

providers feel that they cannot count on them to work predictably in the clinic during specified times. One provider explained the dilemma:

> *We have to fight to get help from our 68Xs—there is so much for them to do, but every day they get pulled. …Like I am counting on a 68X and he got pulled to go to help with the bake sale; so they are unreliable. …The line guys don't know they have a field mission and a garrison mission unlike most and are supposed to be spending 50% of their time on clinical, but they are not tasked like that.*

BHOs have the 67D military occupation specialty, and are drawn from social workers (73A) and psychologists (73B) in the medical service corps. While BCTs are authorized two behavioral health officers at the rank of Captain (O-3) and 2 68X at the rank of Sergeant (E5) per the FY14 command plan guidance[10], the guidance does not specify whether the BHO should be a psychologist, social worker or both. While there are acknowledged differences in training (73As are 2-year Master's level providers, while 73Bs are doctoral-level providers), their role requirements as 67D are the same. We observed delineations between the BHOs as the 'Brigade Psychologist' and the 'Brigade Social Worker', which can lead to potential differences in how they execute their clinical and staff roles. For example, in one BCT, we observed the BHO, who was a social worker, spending more time providing clinical care than the BHO who was a psychologist.

These variations in interpretation of the BHO roles can lead to further challenges when the BHO has to serve as the bridge between the EBH team (often civilian) and the command teams they work for. Prior to the introduction of EBH, the BHOs served as the primary source of BH support to command, and are still adjusting to the collaborative approach required between BHO and EBH team. One of the tenets of EBH is the establishment of a team-based approach to behavioral health care where the EBH team has deep understanding of the Soldier in their care, and can effectively interact with command to shape the occupational environment of the Soldier to ensure recovery. This community-based approach requires the BHO to balance his or her role as a clinician and as a special staff officer to the brigade commander. They have to lend credibility to the EBH providers until the team has had an opportunity to earn the trust of the commander. There is overlap between the role of the EBH team leader/aligned EBH provider and the BHO. However, this offers opportunities to ensure the retention of institutional knowledge when the BHO rotates into a different assignment and ensures continuity of care when the unit is in theater. BHOs conducting clinical services outside of the EBH clinics may inadvertently cause confusion for Soldiers and commander's regarding the location and capabilities of behavioral health resources on the installation. The EBH teams are aligned with the Soldier Centered Medical Homes (SCMH) with a complement of case management, high risk tracking, and ancillary support structures. Clinical services offered outside of this established system of care results in parceled, parallel services with potential gaps in critical provider communication and potential cracks in comprehensive Soldier services.

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[10] See http://www.cp26.army.mil/documents/FY14_Command_Plan_Guidance_16JAN12.pdf

Gaps in the Behavioral Health System of Care

An ideal behavioral health system of care would provide full spectrum services (including substance use) to all key population groups on the installation. This service spectrum would start with behavioral health services being provided in primary care and encompass inpatient care. Once a patient requires continued treatment (more than 4 sessions of psychotherapy or needs to see a psychiatrist), the nexus of care, and ownership of the patient over the lifecycle of treatment, is in the outpatient setting. Currently, there are limited behavioral health services being provided in the primary care setting because of lack of internal behavioral health consultants. The unique geographical proximity to an off-post Army hospital has resulted in patients needing care in an intensive outpatient setting or an inpatient setting being routed to the hospital off-post.

There are three population groups that need to be considered in the installation: family members, active duty Soldiers in the warrior transition unit and active duty Soldiers in operational units. Family members are currently either referred to the Army hospital or to the TRICARE network for services. As we noted earlier, there is a shortage of providers in the TRICARE network (especially for child psychiatry), making it imperative for care to be provided in the off-post Army hospital. The hospital has strong outpatient child and adolescent behavioral health services, but the capacity to provide more intensive treatment in intensive outpatient and inpatient settings is limited. There is limited substance use treatment for families outside of an intensive outpatient program. For patients requiring residential treatment, they have to be sent to a different state.

Soldiers in the WTU receive outpatient services though the EBH system and when that system is saturated, they are referred to the off-post Army hospital. WTU Soldiers receive enhanced access to care, essentially putting them at the front of the line for services. These Soldiers require a higher level of treatment and further strain the site Charlie system, as there is no personnel support for this mission. As a result the EBH providers are required to manage the needs of their WTU patients. This results in diminished services for Soldiers in other operational units. In the 2012-2013 time frame, there were approximately 400 unique Soldiers who were seen as part of the WTU case management services. Given the physical separation of the WTU from the location of care, the hospital started a WTU wellness program that is operated out of Site Charlie to reintegrate Soldiers effectively with the community. This program is executed in coordination with a large number of community partners to engage Soldiers in wellness activities. Treatment is provided both on the installation and through in-community activities. When we met with the leadership of the program, they emphasized the positive engagement with the community and the enhanced wellness of the Soldiers in the program. They were, however, not able to provide metrics of enhanced wellness, noting that not all improvement is measurable. This program is currently looking for a new building to continue on-post operations.

Active duty Soldiers in operational units access outpatient services through their aligned clinic on the installation, and are sent to the hospital for intensive outpatient and inpatient services, as shown in Figure 4. There are three key capacity gaps in the system

of care: the lack of internal behavioral health consultants in primary care, the lack of inpatient substance use care, and the lack of intensive outpatient capacity (in both behavioral health and substance use). We have discussed the first two in previous sections and hence focus here on intensive outpatient capacity.

The intensive outpatient program (IOP) has been shown to be effective at helping a Soldier transition from an in-patient care setting back into the operational context. The hospital IOP currently has a capacity to see 10 patients a month, with a wait list for Soldiers to get into the program of 4 to 6 weeks. As a result, Soldiers who need this step down care are either sent to network facilities (which have limited capacity) or their outpatient providers are squeezing them in at lunch or walk-in hours to ensure stability. When discussing the nature of the patients in the IOP, the program head noted that a majority of the Soldiers in the program were high acuity Soldiers who were transitioning out of the Army. The head of behavioral health at Site Charlie has argued for colocation of the program at the installation to increase support for Soldiers who are trying to return to duty – for such Soldiers, the IOP would enable them to effectively participate in unit activities within the scope of their duty limitations. As currently structured, the Soldiers are away from their unit operational context for the duration of the program.

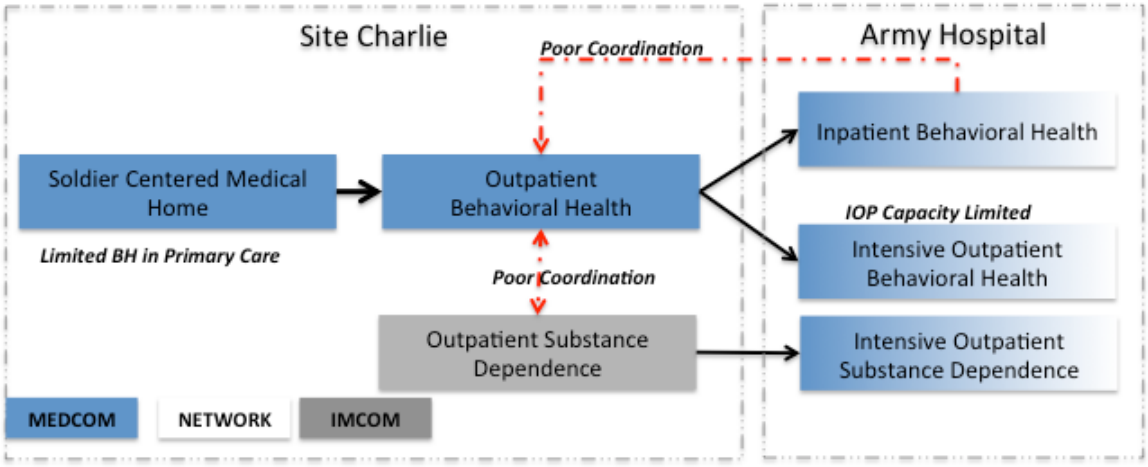

Figure 4: *Active Duty Soldier Care Bottlenecks*

Disconnects in Coordinating Care

We were also able to identify two clinical care coordination disconnects: the handoff between inpatient care and outpatient care, and the coordination of care between ASAP and behavioral health. When a Soldier is released from an inpatient setting, his/her command team is notified of the release, but there is limited coordination with either the outpatient clinical team or the unit's behavioral health officer (BHO) who has to continue the care for that Soldier. The burden of communicating with command often falls on the BHO since the discharge summary does not provide sufficient contextual information to support the transition of that Soldier back into the unit's operational rhythm. The frustration highlighted by the behavioral health officers (BHO) was that command teams were unclear on the level of support and supervision the Soldier needs—if the Soldier

needs to be placed under unit watch, if they need to be assigned to the headquarters function during transition, and if their battle buddy has sufficient understanding to support the Soldiers' transition back into regular unit operations.

The inpatient care team at the hospital emphasized the need for a clinical reason to keep patients in an inpatient setting, even if it meant having to release the Soldier from care on a Friday or during a 4-day weekend. The chief of inpatient care at the hospital noted that per their standard operating procedure, they do not release a Soldier from inpatient care unless they feel the Soldier would be stable for seven days. An added challenge to the handoff is the use of "8 am safety checks"—the protocol was developed to support other services (Navy, Air Force, and Marine Corps) within the hospital's catchment area who preferred that their local provider had eyes on that service member first thing in the morning after an inpatient stay. Even though there were only 400 unique Soldiers admitted to inpatient care in the 2012-2013 period, the requirement to see the Soldier creates disruptions in the providers' schedules. When you add the challenges created by provider shortages, particularly for the TSC Soldiers, a Soldier may need to wait up to six weeks for an outpatient follow-up appointment after the safety check.

Another key coordination gap exists for Soldiers with co-morbid alcohol or substance abuse problems. There is poor communication between ASAP and command, and between ASAP and Behavioral Health. For example, ASAP counselors do not attend the Multi-disciplinary EBH Team meetings where high interest patients who are also being seen by ASAP are discussed, to ensure that care is coordinated. ASAP providers were also absent from battalion health of the force meetings where Soldiers using ASAP services were discussed by command teams. It is important to point out that individual commanders had established working relationships with specific ASAP counselors, but the turnover of ASAP providers and the lack of a consistent battle rhythm for developing shared understanding of Soldier wellbeing interfered with care coordination.

Building Shared Situational Awareness

There are multiple agencies on the installation that provide behavioral health services to a Soldier. Written communication between behavioral health providers and command teams occurs principally through the use of the e-profile system[11] and the DA-3822 Mental Status evaluation form[12]. Historically, psychiatrists exclusively wrote profiles at Site Charlie even though the regulations allowed any doctoral-level provider to write the profile. The current leadership has focused on expanding profile-writing privileges to all providers, and put in a rigorous quality assurance process to ensure that the profiles are appropriately written so command can understand their Soldiers' limitations and make necessary adjustments to their work and training schedules. The leadership team recognizes that providers, particularly those without a military background, require

[11] https://medpros.mods.army.mil/eprofile/Public/About.aspx

[12] See MEDCOM Reg 40-38 Command Directed Behavioral Health Evaluations

training on “Army 101” and on how to communicate with command when a Soldier’s mental health condition interferes with the unit’s mission, in addition to whether they pose a risk to themselves or others. Site Charlie behavioral health has put a policy in place that requires a review of the first three profiles written by a provider by the team lead prior to be being put into e-profile, and that profile reviews become part of their team peer review processes. The gap we observed was the lack of face-to-face meetings where all the providers (line, medical, and installation) and the command teams would meet together to ensure Soldier wellness. Ideally, the command team and the various providers would have a regular operational rhythm for meeting that was synchronized to the health of the force meetings being executed at the brigade and installation levels.

The Community Health Promotion Councils run at the installation and brigade level provide senior commanders with trend information on risky behaviors. The real need is for that information to be shared at the battalion and company levels. The health of the force meetings we observed at Site Charlie did not have an established battle rhythm because the meetings were being initiated either by the BHO or by a nurse case manager who wanted to share trend information gathered by the ‘fusion cell’ program, not by the battalion commander. The fusion cell program was initiated in late 2010 by the hospital as a pilot program to integrate information from diverse sources such as Serious Incidence Reports, blotter information, medical encounters, substance use encounters, family advocacy program cases, and in-theater screenings, to provide a holistic perspective to command about their Soldiers. While the original intent of the program was to predict risky behaviors, over the last two years, the emphasis has shifted to presenting the information to command in the battalion high-risk team meetings. The program provides a valuable service in reconciling data from the various sources, but it is not part of the medical mission of the hospital. This program has recently been reorganized under the regional medical command, but questions on how this effort maps to the G1-led Commanders Risk Reduction Dashboard (CRRD) need to be answered. These battalion-level high-risk team meetings provide a unique opportunity to bring in subject matter experts from ASAP, FAP, and BH to answer questions within the bounds of HIPPA and the Privacy Act to improve situational awareness for command and providers.

Unique Practices at Site Charlie

During our visit, we observed a number of unique practices and innovations at Site Charlie that address some of the Army-wide challenges in implementing an effective behavioral health system of care. A key disconnect in care occurs when service members PCS from one installation to another. Site Charlie has developed a process to ensure that all Soldiers and their families who are in-processing to the installation and need services are offered services. The BH leadership at Site Charlie has instituted a practice of manually inspecting the medical record of every Soldier or family member who is in-processing to see if they have used behavioral health services at their previous post, and if their provider noted in the medical record that continued care was needed. Once someone is determined to need services, they are offered services.

This is the first installation we visited that actively ensures that no Soldier or family member slips through the cracks during this important and often stressful transition period. This process was first initiated by one of the brigade BHOs when there was a leadership vacuum when the division psychiatrist and behavioral health chief positions were vacant. MEDCOM is currently working to automate this care transition through the Behavioral Health Data Portal (BHDP) to automatically flag all incoming Soldiers who need continued services, but the current process provides a critical fail-safe to ensure continuity of care

Another innovation observed at this installation was the inclusion of first line supervisors in one of the battalion high-risk meetings. During the meeting, squad and platoon leaders were invited into the room only to brief the battalion and company commanders on their high-risk Soldiers. At other installations, we have seen the company command teams included at these meetings, even though it is the first line supervisors (team lead and platoon sergeant) who have the most interaction with and ability to impact high-risk Soldier behavior. The inclusion of first line supervisors also provided an opportunity for the battalion commander to directly convey commander's intent on expected leader behaviors and share his/her own experience in dealing with similar situations. This approach to executing the battalion high-risk team meeting is currently being standardized across the division. It is important to note that we still do not have a good understanding of how the TSC executes its battalion-level high-risk team meetings.

Another notable practice was using the Ready and Resilient Campaign (R2C) to establish a shared language across the division so that the skills learned in resiliency training are incorporated into every aspect of a Soldier's life, including their interactions with medical and behavioral health professionals. For example, the BH chief noted that they were going to include customized Ready and Resilient training as part of onboarding new providers so that they can start using the same terms that the MRTs were using in the units. The head of Social Work at the hospital had explicitly developed a mapping of the vocabulary used for cognitive behavioral therapy to that of the core resiliency skills to enable FAP social workers to better communicate with command teams. Another integration point is the use of tailored MRT programs to support at-risk or high-risk Soldiers. At the battalion high-risk team meeting we observed, one of the action plans was to place a Soldier into one of two tracks aimed at improving financial resilience or

overall performance. In effect this program served as a non-clinical skill-building program that could potentially complement a clinical intensive outpatient program.

Finally, Site Charlie actively leverages the availability of psychiatry residents and psychology interns from the off-post hospital. The program provides unique benefits as a training tool for these Army providers. It also creates unique challenges with respect to resource management and continuity of care. As a function of the education mission, these providers rotate into different assignments making it difficult to ensure continuity of care. These residents are critical because they serve as surge capacity that enables the BH Chief to move personnel to meet planned (for example redeployments) and unplanned spikes in demand (for example, sentinel events such as suicides). The use of psychology interns as force extenders in the unit footprint is critical for their operational psychology skills development, but it is critical to separate between psychosocial education and therapy in the unit footprint.

Path Forward

The behavioral health system of care is still evolving at Site Charlie. The current capacity constraints in the installation have resulted in a parsing of the overall clinical mission into three broad streams of care: outpatient behavioral health care for Soldiers in operational units provided on installation, while both WTU Soldiers and family members are sent to the off-post hospital. Both Site Charlie and the hospital are making progress towards moving care to the point of need, recognizing that Soldiers going to the off-post hospital for an outpatient appointment typically miss a half or full day of work, even though they only have to travel 17 miles to the hospital.

We have identified a number of gaps in this report, and the BH chief at site Charlie is already working to close them. We recognize that to address some critical areas, such as the shortage of on-post providers, cooperation and collaboration will be needed from the senior leadership at Site Charlie and the off-post Army hospital.

The final architecture of the system of care at Site Charlie will be significantly impacted by the parallel transformation that is currently underway at the off-post hospital. The resistance to redistributing scarce behavioral health assets to Site Charlie is further exacerbated by the differences in mission between the two locations: a primary care focus on Soldiers in the installation versus a specialty care focus for all services in the catchment area at the off-post hospital. Both locations are trying to recapture care that has been previously sent to the TRICARE network but are not currently staffed to do so. *Senior leader action is needed to ensure that behavioral health hiring actions are not subject to sequester induced hiring limits.*

Key enablers to the transformation efforts in both Site Charlie and the hospital are the implementation of the Behavioral Health Data Portal to measure clinical outcomes, and the implementation of the new Capacity Planning and Resourcing Tool (CART) for managing provider productivity. For the first time, BH leadership and command teams will be able to objectively track whether a Soldier is actually getting better. This is a major change for providers who see it as potentially intruding on their clinical judgment and will require active training and oversight to become institutionalized. We also observed confusion in the hospital regarding how the CART tool would truly impact

practice management. *Clearer communication is needed between Behavioral Health Service Line leadership and the hospital leadership team to resolve the confusion regarding the use of CART and other BHSL incentives.*

The vision at Site Charlie is to establish EBH teams to support both the BCTs and the CAB with behavioral health clinics that are in or near their footprints. Current efforts are limited by the lack of personnel to fully staff the teams. In addition, the EBH operational model requires providers to actively engage command. The BH leadership team has put in place better onboarding training as well as review processes to ensure that providers are able to write informative profiles and DA-3822s to communicate meaningfully with command. As we noted earlier, the BHO is a critical bridge between command teams and the EBH team. The BHOs at Site Charlie have established deep relationships with their command teams, but have not been able to consistently leverage the capability of their EBH counterparts in command consultation and unit psychosocial education. *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.*

When discussing the gaps in the system of care, we highlighted the lack of integrated behavioral health consultants in primary care, as well as the reluctance of Physician Assistants in starting patients on SSRIs for mild to moderate depression and anxiety. *PA training is needed on basic psychotropic use* to enable effective triaging of patients.

We also highlighted the lack of follow on care when a Soldier transitions from in-patient care to an outpatient setting. The BH leadership team is currently working on establishing a shared standard operating procedure with the hospital to ensure that sufficient information is made available to both command teams and the behavioral heath care team responsible for the soldier for managing soldier transition to unit operational tempo. We have seen other installations with on-post IOPs that are focused on enabling Soldiers to return to duty and stay connected to their units while undergoing treatment. Soldiers who are physically capable of doing PT spend half a duty day with their units and the rest of the day at the IOP receiving care. These other installations with an on-post IOP have reported more effective use of inpatient facilities. Given the lack of intensive outpatient care slots in the hospital, *the possibility of establishing an additional intensive outpatient program (IOP) on the installation should be explored.*

We highlighted a key gap in care coordination between Soldiers in ASAP and BH. *ASAP providers should be encouraged to participate in the EBH multi-disciplinary treatment planning meetings*. Unlike some other installations, ASAP is making a conscious effort to conform to the Army regulation of adequately documenting clinical care in the medical record, even though they have been encouraged by their higher headquarters to document minimally.

Ensuring the mental health of Soldiers and their families is as much a command function as it is a clinical function. We noticed significant variation in the execution of the battalion high-risk team meetings with respect to the stakeholders present in the meeting, and when the meetings were held. *A shared SOP is needed for the execution of the battalion high-risk team meetings.* Such an SOP should also encourage the participation of key subject matter experts from ASAP, FAP and BH. We recognize the

valuable role that the fusion cell reports play in enabling commander situational awareness; however, an assessment needs to be made with respect to the overlap with the proposed Commanders Risk Reduction Dashboard.

Behavioral Health representation is needed at the installation level to ensure population health trends are monitored and there is a BH voice at the installation who can advise senior leadership on staffing and the needed allocation of behavioral health providers to ensure care for all Soldiers on post. *The Installation Director of Psychological Health is required by DoDI 6490.09 and needs to be implemented urgently.* Ideally, the Chief of BH at the installation would be dual-hatted into this role (as specified in OTSG/MEDCOM Policy Memo 13-059). This person would be able to discuss the needs of the unique population distribution at Site Charlie (division and TSC Soldiers) with the senior mission commander to ensure equitable care for all Soldiers on the installation.

As we noted in the previous section, there are a number of unique best practices at Site Charlie. The screening process to ensure that no Soldier or family member falls out of care is unique and needs to be shared across the whole Army enterprise. Similarly, the use of the first line supervisor to brief on their soldiers during battalion health of the force meetings was highlighted as being effective at giving the battalion commander greater contextual understanding of the Soldier's risky behavior, and providing that first line supervision with valuable face time with the battalion commander. We recognize the planning burden of engaging these first line supervisors, and the risk of taking away leaders from their units. In addition, Site Charlie's attempt at using the R2C as a shared vocabulary addresses a known gap across the various stakeholders providing care to the Soldier. The program's effectiveness should be assessed longitudinally after roll out to determine if this approach should be adopted by other installations.