Network Governance for the Provision of Behavioral Health Services to the US Army.

By

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B.S. Civil Engineering
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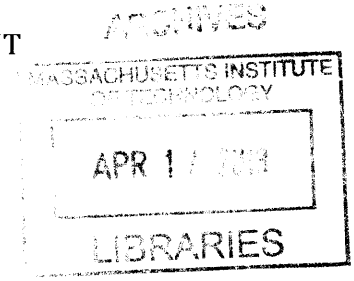

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Submitted to the Engineering Systems Division on July 13, 2012
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ABSTRACT

Under a charter from the Chairman of the Joint Chiefs of Staff, the author participated in a study of the military's behavioral health system for the purpose of determining the means and effectiveness of that system for the treatment of PTSD and related conditions. This work focuses on the architecture and means of control over the existing arrangement of semi-independent enterprises, organized into functional work groups that necessarily collaborate to provide a full spectrum of behavioral health services to service members and their families.

The author suggests a rearrangement of the system architecture to enable integrated work across organizational boundaries in order to reduce waste generated through structural inefficiencies. Implementation of network architecture and control relies heavily on the development of shared strategic objectives that direct network processes in supporting overall organizational goals. Further, performance measurement systems and stakeholder behavior change through use of incentives are used as the drivers of inter-enterprise process development. Finally, a governance structure, focused on development of integrative processes and outcomes is established to foster inter-organizational relationships, direct process improvement, and resolve system conflicts.

Thesis Supervisor: Jayakanth Srinivasan
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I would like to thank the following people for giving me the opportunity to do this work. We are not just the product of our own actions on life's journey, but instead we are the product of all of the people that make the journey with us. Thank you to the following people for helping me along the way, and I hope that you've learned as much from me as I have from you.

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To my friends and professors at MIT, thank you for broadening my world. You have shown a soldier that there are correct ways to think and solve problems that aren't the Army way. The richness of my experience over the past two years has been life changing, and I will always treasure the time that we've spent together. I would like to specifically thank Pat Hale and Professor Nightingale for opening the door for me, so I could participate in this program. Thanks to JK Srinivasan for pushing me to always ask "why," and to see things in ways that challenge my perceptions.

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Contents

Chapter 1 – Intent

1.1 Introduction and Research Objective

Government organizations' hierarchical structure, specifically that of the military, is a critical component to its success in the active execution of its primary mission, to overcome any nations responsible for aggressive acts that imperil the peace and security of the United States (U.S. House of Representatives, 2011). This same organizational architecture, however, often inhibits the efficient and effective execution of operations at home station due to the rigid adherence to functional silos. This system of organizations generates significant process waste (Nightingale and Srinivasan, 2010) through overlapping capabilities and duplication of effort. The phenomenon is well observed in the interaction of the organizations on an Army installation that provide behavioral health services to soldiers and their families.

As a result of ten years of conflict in Iraq and Afghanistan, the need for the provision of behavioral health treatment is overwhelming. Approximately twenty percent of the two million soldiers deployed to Iraq and Afghanistan over the past decade suffer from Post Traumatic Stress Disorder (PTSD) (Dao, 2010), but the Army's current system for preventing, recognizing, and treating this condition is highly fragmented and not suited for providing the volume of treatment required by veterans returning from combat. Each Army installation has an array of organizations that contribute to the provision of behavioral health care, although very few of these stakeholders have cooperative relationships or an agreed-upon

common purpose. Structural inefficiencies (Nightingale and Srinivasan, 2010) result from these organizations having separate and often incompatible purposes, incentive systems, and governance structure; and they encounter difficulties in working together, even in instances in which the stakeholders wish to cooperate.

The Department of Army recognizes that its soldiers *are* the Army, and not just *in* the Army (Department of the Army, 2005), and it has an obligation to take care of its most precious resource. Because of the great increase in soldiers' demand for behavioral health services and the potentially catastrophic outcome of not treating the condition, it is imperative that the Army eliminate waste within the system that deliver on this need. Although integrating all of the stakeholders in the system's architecture will not eliminate all waste, it is likely that cultivation of deliberate value exchange relationships will enable a dramatic increase in the fidelity of behavioral health services, reduction in process waste, and will enable identification of other opportunities for waste reduction and increases in effectiveness.

This work has two fundamental objectives. The first is to **define the current state** organizational architecture specific to the unit of analysis, an Army installation. This will require an analysis of all of the stakeholders within the behavioral health system, their processes, their incentives, and their interaction with the system's other stakeholders. The second objective is to use the products from the current state analysis to **develop an idealized control architecture for the system, giving particular attention to the governance structure, artifacts, and policies required to manage this complex system**. By completing these objectives, the work should answer the question, "What are the critical components

for generating coordinated, mutually beneficial, and customer-oriented behavior in a public network?"

1.2 Expected Application of this Research

The immediate goal of this work is to provide a holistic assessment of the structure of the Army's Behavioral Health System by a proven theoretical framework as well as an implementable architectural solution that will allow all of the system's stakeholders to achieve their own goals, but most importantly, to serve soldiers and their families in a coordinated, efficient, and effective manner. The military's budget is decreasing; however, the military healthcare budget is increasing, partially in response to an all-time high demand for Behavioral Health services (Department of the Army, 2012), and the Department of Defense has stated that it is imperative that the military uses its resources in a more disciplined fashion (Department of Defense, 2012). The application of lean enterprise principles to the system is very likely to precipitate an expansion of capability through the unification of effort and elimination of systemic waste.

Provision of behavioral health services unites, as this research will show, stakeholders from all segments of the military, and it is likely that an integration effort for this purpose will be scalable to other organizations and purposes. As stated above, government organizations are designed as hierarchies, and cooperation outside functional workgroups, although often necessary, is difficult due to reporting structure and often-competing organizational goals. Military organizations in particular are designed to work independently and to trust that other organizations will execute their mission as defined by shared headquarters in

support of one another. While this model is works well in combat operations, it does not work well at home station where disparate reporting chains do not reach a point of confluence at an operationally practical level. The outcome is that the installation's organizations work alongside each other but are only informally unified in purpose and effort. The military enterprise can greatly benefit from adopting modern business enterprise techniques, and if it can apply lean enterprise principles at the installation level, gaps and overlaps may be reduced, eliminating structural inefficiencies and process wastes in its systems.

In addition to direct application, this work attempts to build on/continue the work of the scholars who study organizational and system architecture, the integration of stakeholders into an effective enterprise, and the governance of enterprises and networks. Additionally, this thesis will serve to continue research into organizations as systems, transformation of enterprises, systems thinking, and holistic enterprise architecting.

1.3 Research Framework and Data Collection

This work utilizes, as its means of organization analysis, the Enterprise Strategic Analysis for Transformation (Nightingale, Stanke, and Bryan, 2008). Using this framework, the thesis examines the enterprise objectives, the stakeholders, and processes, and performance metrics of the Army's Behavioral Health system. Additionally, the thesis employs System Architecture (Crowley, 2011) tools to examine the needs and goals of the stakeholders, as well as Enterprise Architecting (Nightingale and Rhodes, 2011) concepts to holistically evaluate the functionality of the enterprise and to determine the dominant drivers of the system's performance.

The second half of the work, the development of an idealized future state, will likewise use Enterprise Architecting tools, but will also incorporate a review of literature regarding network governance to determine additional means that may be required for the oversight and control of a multi-enterprise network.

The information that this thesis examines for defining the stakeholders, processes, the enterprise(s), resources, and laws/policies is derived from two primary sources. First, the examination of Army Regulations, Field Manuals, laws, and public policy informed the work of the responsibilities and relationships of the stakeholder organizations, as well as the hierarchical relationships, confluences of the hierarchies, and mandated value exchanges. Second, the author conducted over 300 hours of interviews with stakeholders at five military installations as well as a series of meetings with the Army and Military Health System's senior leaders. The author structured the interviews so that each respondent, regardless of organizational affiliation, answered the same basic questions; although interviews were tailored to accommodate differences in organizational ecosystems and purposes. These semi-formal interviews and meetings yielded a practical understanding of the implementation of the systems described in Regulations, policies, and laws as well as the important emergent finding that each installation's Behavioral Health system is unique, and that the proper unit of analysis is, in fact, the installation.

1.4 Boundaries

An important aspect of an engineering systems approach to problem solving is a definition of the system boundary, and this thesis must adhere to that principle,

as the military's health system extends well beyond the individual installation and an examination thereof is well outside the scope of this work. As stated above, the unit of analysis for this thesis is the military installation, which is a city unto itself. Any analysis of organizations outside the military installation or its surrounding community is only undertaken to understand applicable influences on the interactions inside the boundaries of the system.

This work does not intend to examine or influence the actions of medical professionals in the execution of their clinical duties. The author and his organization have no level of expertise in psychiatry or any related field, and no inferences should be made regarding the analysis or conclusions that would presume such training. This is a system/organizational engineering study, and work related to the medical field is limited strictly to the systems and organizations in which medical professionals work.

This thesis is not a quantitative analysis of process flows or monetary exchanges. Since each installation is unique and dynamic, and the Army population is in a nearly constant state of flux, it is impractical to conduct high precision value stream mapping or like activity to identify trends and outliers for a work that intends to examine organizations and their relationships at the macro level. Detailed, quantitative, analysis and process mapping with "the Army" as the unit of analysis is being undertaken as a part of the larger research effort at MIT, and may be cited in this thesis for use as examples or evidence for specific points, but quantitative measurement is not the primary focus of this work.

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Chapter 2 - Defining the Enterprises

In order to understand the installation's behavioral health system, we must first understand the stakeholders in the system, their purposes, the behaviors upon which they are evaluated, and the incentives that the stakeholders are offered for delivering on their value proposition. Next, we must understand the behaviors, needs, and interactions of the organizations and their respective stakeholders. At the conclusion of the analysis, we will see that the behavioral health system is not one, but three distinct enterprises that interact in formal and informal exchanges for the purpose of providing mental health care to soldiers. These three enterprises are Forces Command, Medical Command, and Installation Command.

What is an Enterprise?

An enterprise is a complex entity with a specific purpose, which is to fulfill its value proposition – that is, its reason for being. An enterprise has distributed leadership and diverse stakeholders who share some interests in common.

- Deborah J. Nightingale and Jayakanth Srinivasan. *Beyond the Lean Revolution.*

2.1 US Army Forces Command

2.1.1 Objectives: The mission of the US Army Forces Command (FORSCOM) is to train, mobilize, deploy, sustain, transform and reconstitute conventional forces in order to provide a sustained flow of relevant and ready land power to combatant commanders worldwide in defense of the nation.[i]

In plain terms, this organization's value proposition is to prepare combat units for deployment to execute combat operations. Preparing for war and fighting a war are two distinctly different endeavors, and FORSCOM headquarters is not a warfighting organization. Instead it is a force projection organization that prepares its subordinates for transfer to headquarters that are charged with actively executing operations. For example, FORSCOM units are assigned to the US Army Central Command (CENTCOM) for execution of combat operations in the Middle East, to US Army Africa Command for operations in Africa, etc. When these units return to their home station they are transferred back to FORSCOM.

2.1.2 Structure: FORSCOM's subordinates are organized into a hierarchy that include five Army Corps, each with approximately 50,000 soldiers, and is commanded by a Lieutenant General. Each Corps is composed of two to five Divisions, which consist of approximately 18,000 soldiers. The Army currently has ten Active Duty divisions. The Division Commander is a Major General, who also serves as the Senior Mission Commander on his installation. This means that he is in charge of his Division,

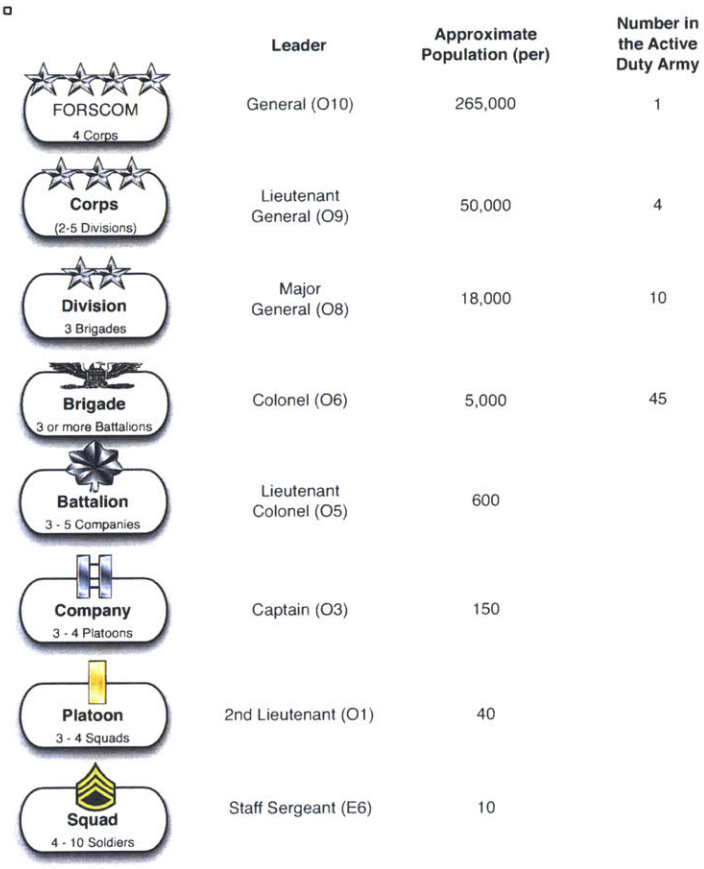

Figure 2.1 Organizational Structure of FORSCOM's Operating Forces

but also has ultimate oversight of the installation's programs, services, and physical property that makes up the actual installation.[ii]

Each Division is composed of three Brigades, or Brigade Combat Teams (BCT), each of which are commanded by a Colonel and have approximately 5,000 soldiers. The BCT is the smallest independently deployable unit. The structure of these units is shown in Figure 2.1[iii].

2.1.3 Performance Measures: The fundamental metric that drives leader actions for operating forces on the installation is readiness, which is registered with the Department of the Army (DA) Staff and the Office of the Secretary of Defense (OSD) for planning and reporting to the US Government through the use of the Commander's Unit Status Report. [iv] This report is given monthly, and requires the commander to give information on the following readiness areas:

1. **Personnel Readiness (P-Level):** The P-level describes the number of soldiers in a unit that are assigned, physically present or can be present within 72 hours, and meet medical readiness criteria. The medical criterion is the deployable/non-deployable determination of physicians that care for the unit's soldiers. For current operations these physicians use the Central Command's Individual Protection and Individual-Unit Deployment Policy (Mod 11) in addition to traditionally used standards to determine medical readiness.[v] For a unit to be considered deployable, it must have an aggregate 90% or greater P-Level.
2. **Training Readiness (T-Level):** The T-Level is the commander's assessment of the ability of his/her unit's capability to execute the tasks associated with the core

functions expected of the organization. For a unit to be considered "trained" it must be able to collectively execute its essential tasks with a minimum of 85% proficiency.

3. **Equipment on Hand (S-Level):** The S-Level is an assessment of the mission essential equipment available to the organization. For a unit be deployable by the S-Level, it must have over 90% of its authorized mission essential equipment.

4. **Equipment Readiness/Serviceability Level (C-Level):** The C-Level is an indicator of how well the unit is maintaining its mission essential equipment on hand. The threshold for deployability by the C-Level is 90%, meaning that based on the authorized quantity of mission items, 90% must be in a serviceable state of repair.

2.1.4 Incentives: Army leaders in FORSCOM units are incentivized to achieve the specified readiness goals through career advancement and opportunities for positions of increased responsibility. Each year Army leaders formally assess the performance of subordinates in their assigned roles. Each officer's role is clearly defined at the beginning of the rating period through a specified set of responsibilities and annual performance objectives. For commanders in operational units, the duty will always charge him or her with the welfare and readiness of the unit.[vi] With regard to the P-Level and the T-Level, this means that the commander is directly responsible for making sure that the soldiers in the unit are ready and trained to execute their mission essential tasks in accordance with his or her parent unit's deployment timing. Although Army regulations specifically states that the Commander's Unit Status Report shall not be used as an evaluation tool, Army leaders are assessed on their ability to generate mission ready units. Leaders who are not able to adequately prepare their units and achieve a P-Level of 1 are typically replaced and

rarely have the opportunity to advance in their careers to positions of increased responsibility.

2.1.5 FORSCOM on the Installation: At the typical installation, which is our unit of analysis, FORSCOM's senior representative is a Division Commander, who is the top of the chain of command for the installation. The exceptions to this rule are installations where a Corps or higher headquarters is collocated with the division.[1] The Division Commander and his staff generally support three brigades, each of which has a staff that mirrors its division counterpart in terms of their primary duties. The staff members who affect soldiers' mental health care are:

1. Division Surgeon. The Division Surgeon is the lead primary care provider for the Division. He or she advises the commander on the medical readiness of the division, and oversees and coordinates the Brigade Surgeons. The Brigade Surgeons, in turn, advise the Brigade Commanders and oversee the Battalion Primary Care Providers. The battalion is the lowest echelon with an organic medical asset. The Battalion Primary Care Provider, a Physician's Assistant, directs the unit medics.

2. Division Pychiatrist. The Division Psychiatrist advises the Division Commander on the Behavioral Health needs and disposition of the unit, provides specialty care to the soldiers in the Division, and oversees the Brigade Psychiatric Officers, who are Licensed Clinical Social Workers or Clinical Psychologists. The Brigade is the Army's lowest echelon with organic behavioral health support.

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[1] The highest headquarters located at most Army installations is the Division, however, some installations are home to Corps and Division Headquarters. At these locations the Corps Commander serves as the Senior Mission Commander.

3. Division Chaplain. The Division Chaplain advises the commander on the spiritual wellbeing of the unit and provides pastoral support to the division's soldiers. Additionally, the Chaplain oversees, coordinates, and mentors the Brigade Chaplains and Chaplain Assistants. The Brigade Chaplains in turn, oversee, mentor, and coordinate their respective Battalion Chaplains and their assistants. The Battalion is the lowest echelon with organic chaplain support.

4. Family Readiness Support Assistants (FRSA) and Family Readiness Groups (FRG). The fourth group shown in Figure 2.**2** is the FRSA and FRG. Assigned at the Brigade and Battalion Levels, FRSAs are government employees who assist the unit Commander in disseminating information to family members, aggregating information on the unit's families, advising family members on needed programs and services on the installation, and coordinating the Family Readiness Groups to provide any necessary direct support to families of unit personnel. The Family Readiness Groups directly support and inform family members on behalf of the commander. The FRG leaders are not paid employees, and are typically the spouses of the commanders or other senior unit personnel. The Family Readiness Group is a mandated Commander's program.

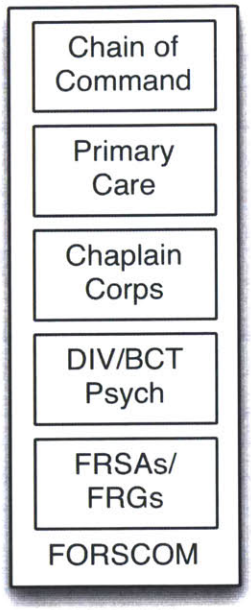

Figure 2.2. FORSCOM Stakeholders on the Installation

2.1.6 Needs of the Stakeholders

- **Chain of Command**: The chain of command is the agent in the system responsible for execution of the Army's warfighting mission, and adherence to unit deployability and

readiness standards. Unit commanders' main needs from the behavioral health system are timely courses of treatment that return soldiers to a deployable condition and usable information regarding the disposition/fitness for duty of the soldiers who remain within care. Implicit in this second need is effective information exchange with both primary and specialty care providers regarding the soldiers for which they are responsible and in trust to execute difficult and dangerous training and combat missions.

- **Primary Care Providers**: The fundamental need of primary care physicians, outside the needs associated with the provision of clinical care, is centered on effective information exchange with other stakeholders within the system. Primary Care Providers generally form relationships easily with the chain of command, the chaplain corps, the unit psychiatric provider, and the family readiness support assistant due to close proximity and shared strategic objectives. Relationships with institutional medical providers outside FORSCOM are more difficult since they are separated in mission and space. Automated means of information distribution allow the distribution of electronic medical records among all and post providers; however, limitations in the military's information systems reduce the fidelity of information transfer.
- **Chaplain Corps**: Chaplains serve as a first line of defense for behavioral health, due to constant proximity to soldiers, and their implicit confidentiality that guarantees their accessibility for soldiers who need nonclinical counseling. When soldier issues exceed those treatable within the chaplains' set of competencies, the chaplain may refer soldiers, with their permission, to primary care providers or directly to behavioral health specialty care through self-referral. Regarding the chaplaincy needs, chaplains require time with the soldier and the trust of the chain of command and unit medical providers to serve as

the first line of behavioral health defense. Again physical proximity and shared strategic objectives make the chaplain and effective part of the unit–based coordinated care team.

- **Unit Psychiatric Provider**: The unit based psychiatric care provider is assigned at the BCT level and is the first specialty care provider for behavioral health available to soldiers within FORSCOM units. Because these providers are assigned one per brigade (4000 soldiers), their primary need is time to provide care and access to patient populations. BCT providers remarked that the bulk of their time is occupied by staff functions and travel to and from unit areas.
- **Soldiers**: Soldiers are not listed as a stakeholder in the behavioral health system, because they are viewed as the customer of the services provided by that system. Soldiers, for the purpose of this work, are assigned to FORSCOM, and their job is to train for and execute mission essential tasks.

Soldiers who have behavioral health needs require first support from their chain of command for referral into the system. Stakeholders acknowledged that stigma associated with behavioral health challenges frustrates soldiers in regard to freely seeking care. Many respondents have stated that soldiers who genuinely need behavioral healthcare are often hesitant to seek the services because they believe their peers and their leaders will consider them weak. Army leaders who understand that behavioral health challenges are real and potentially debilitating will encourage their soldiers to find providers who can help them get back to 100%, so that they are individually ready for deployment, thus increasing the unit's deployment capability.

Next, soldiers require behavioral health care that is both accessible and responsive to their needs. Care providers who are centrally located but are prohibitively far away

from patient populations make care delivery difficult in terms of accessibility. Likewise, providers who have schedules that are completely full are unable to provide treatment and the frequency required to make the desired progress in overcoming behavioral health–related illness. Soldiers and providers alike have noted that the overwhelming numbers of patients seeking behavioral healthcare have caused providers to be inaccessible for this reason.

Finally, soldiers need behavioral health options that will allow them to return to duty in a fully mission capable condition. This implies the need for treatment that is both effective and timely since the military has time-based criteria for determining whether a soldier is getting better, defined as deployable, and if these criteria are not met, then the soldier is processed for elimination from the service.

2.2 US Army Medical Command

2.2.1 Objectives: The stated mission of the US Army Medical Command (MEDCOM) is to execute a coordinated, synchronized, and integrated comprehensive Soldier Medical Readiness Campaign Plan to support Army Force Generation (ARFORGEN) in each of its phases to increase the medical readiness of the Army. MEDCOM seeks to meet this objective through five distinct strategic objectives:

1. Optimize medical readiness systems through early and effective identification of Medically Not Ready (MNR) soldiers.
2. Enhance soldier care in order to increase medical readiness by implementing Medical Management Programs for MNR soldiers.

3. Improve health and fitness, and reduce injury rates through integrated health promotion and injury prevention, and human performance optimization programs.
4. "The fourth Line of Effort is Effectiveness of the Soldier Medical Readiness Campaign with an objective of ensuring strategic effectiveness."
5. Effectively communicate the Soldier Medical Readiness Campaign Plan to all stakeholders. [vii]

2.2.2 Structure: The US Army Medical Command is lead by the Army Surgeon General, who is dual-hatted as the MEDCOM Commander. This officer is located in Washington DC, and leads five Regional Medical Commands. The Regional Medical Commands serve the regions shown in Figure 2.**4**, below. At the installation level, MEDCOM's senior representative is the Military Treatment Facility (MTF) Commander, an Army Colonel, who is a medical doctor. This officer has oversight over all MEDCOM activities on the installation, and he or she reports to the Regional Medical Command Commander. The MFT Commander is responsible for each MEDCOM clinic on the installation, which are respectively lead by a Lieutenant Colonel or Department of the Army (DA) Civilian. MEDCOM units are not deployable, although military providers

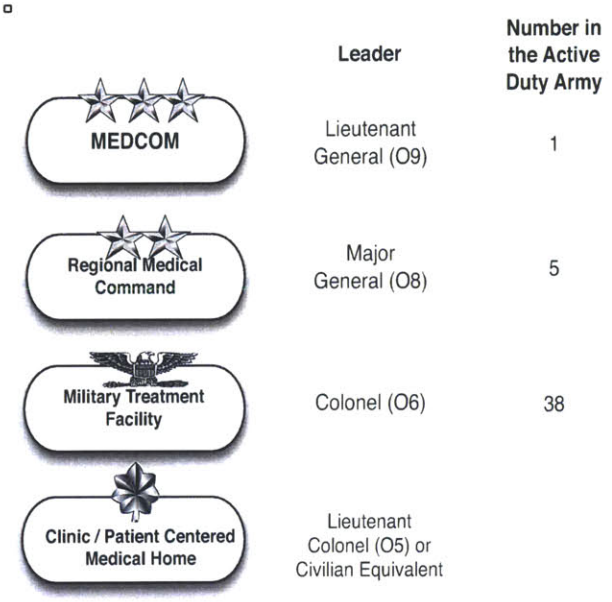

Figure 2.3. Organizational Structure of MEDCOM's Generating Units.

within MEDCOM may be tasked individually to support fixed medical facilities or operational units belonging to Combatant Commanders.

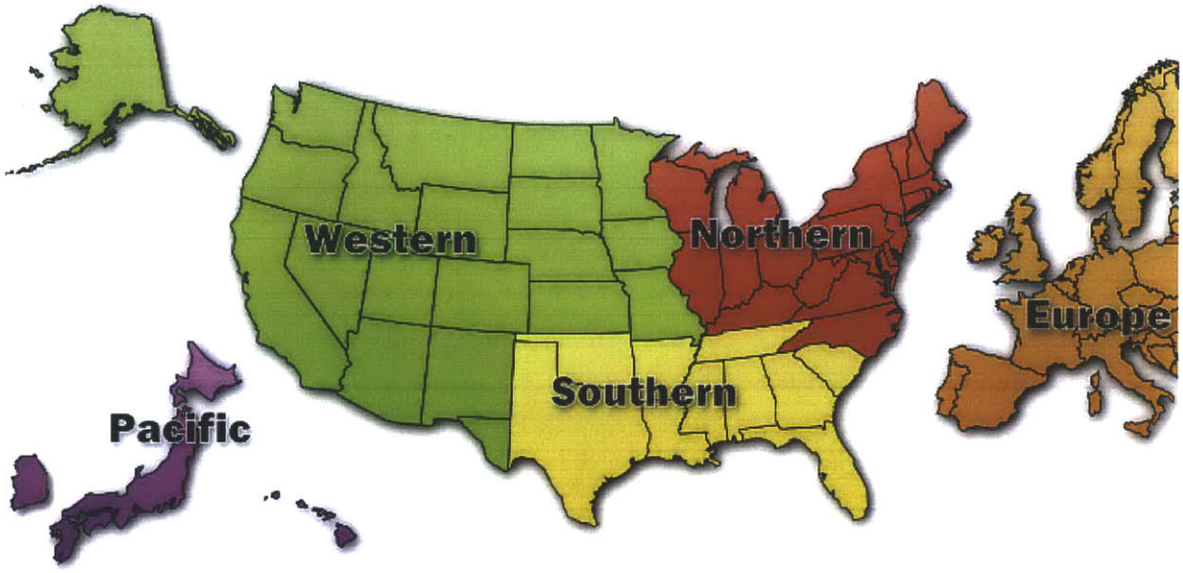

Figure 2.4. US Army Medical Regions (source: http://www.armymedicine.army.mil/hc/mtfs.html)

2.2.3 Performance Measures: The primary metric for evaluation of MEDCOM activities at the installation level is production of Relative Value Units (RVU).[viii] RVU generation is a measure of provider productivity, earned through patient encounters. This metric is used nationally to gauge the resources applied to a medical task, and it has a significant impact on resource acquisition in the medical community.[ix] It is a non-monetary measurement unit, and it is scaled to match the level of expertise of the medical provider and the intensity of the procedure being performed.[x]

The measurement of RVU generation allows for fair compensation proportional to resources applied to a medical task, but it also serves as an indicator for the number of providers needed on an installation. Essentially, if RVU production is higher than expected, then the installation can justify a request for additional providers or staff. If

RVU generation is less than that expected, then resources can be reallocated to a location of higher need. For example, the assessed need for Psychiatric Nurse Practitioners is a function of the RVUs generated by Psychiatrists on an installation. MEDCOM expects a Psychiatrist, Psychologists, and Social Workers to generate a requisite number of RVUs daily in the conduct of clinical care. Support staff in a medical facility also generate RVUs, although at a lower rate than the providers listed above. For example, an enlisted Psych Tech earns 0.82 RVUs for tasks associated with his or her primary duties; administrative support personnel ear 0.5 RVUs per task.[xi]

The second metric that affects MEDCOM action at the installation level is Access to Care. The MTF is evaluated on its ability to provide appointments for acute care patients within 24 hours of initial triage. For behavioral health, acute patients are those who are suicidal, homicidal, or psychotic. Specialty care appointments for non-acute patients must be made within 28 calendar days of triage, and since Behavioral Health is specialty care, a provider must see a soldier within a month. If MEDCOM cannot achieve this timing, then providers off the installation, in the TRICARE insurance network must see the patients within the requisite time.

Next, MEDCOM is evaluated on patient satisfaction; however, for the following types of patient encounters, patient satisfaction is not measured[xii]:

- Psychiatry
- Psychology
- Mental Health
- Social Work
- Substance Abuse
- Community Health

2.2.4 Incentives: As with the officers in FORSCOM, MEDCOM's officers are incentivized to execute on the measured behaviors by career advancement both in terms of promotions and positions of increased responsibility. Civilian providers are incentivized to generate RVUs, so that their job continues to exist. Unlike their military counterparts, civilian providers can receive pay increases for excellent job performance, but they can be promoted to positions of increased responsibility the same as military officers.

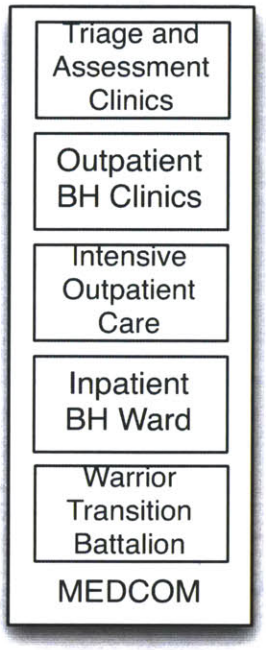

Figure 2.5. MEDCOM's Behavioral Health Stakeholders on the Installation.

2.2.5 MEDCOM on the Installation: Regarding behavioral health, MEDCOM operates the activities shown in Figure 2.5 that provide Behavioral Health care to soldiers and family members.

- **Triage and Assessment Clinics.** The Triage and Assessment Clinic is the stakeholder in the Army's behavioral health system that serves as a formal point of entry into MEDCOM's care delivery architecture. The clinic makes the determination whether a patient is suicidal, homicidal, psychotic, or routine, and schedules follow on care in accordance with access to care standards. In some locations, the Triage and Assessment Clinic has the capability to prescribe medications for the mitigation of symptoms associated with mental health diagnoses for patients who are routine and need to wait 28 days to see an outpatient provider. For patients who are not routine, the clinic makes an immediate referral to the Inpatient Behavioral Health Ward.
- **Outpatient Clinics.** Clinics that provide outpatient behavioral health care serve two

purposes within the system. The first of these is to provide therapy for soldiers who are identified as routine. The clinic's cadre of providers sees non-acute patients within 28 days of their initial triage to pursue a course of treatment according to each patient's needs. After the initial visit, these clinics schedule patients according to a six-week template of patients, which typically means that a soldier can see his or her therapist once every month and a half.

The second purpose of the outpatient care clinics is to conduct triage on all patients of who arrive for care. Because of the protracted timeframe between visits, the condition of previously non-acute soldiers may have changed between visits. This constant triage serves as a safeguard for patients and for those with whom they come in contact.

Outpatient clinics require a cadre of providers appropriate for the patient load for which they must provide care. When providers are insufficient to meet the demands of the patient population, patients must be referred to the TRICARE network, which may provide behavioral health services in civilian clinics, but at a greater monetary cost to the MEDCOM.

- **MTF Inpatient Behavioral Health Ward**. The primary purpose of the inpatient ward is to provide an intensive combination of psychotherapy, pharmacotherapy, med management and supervision to those patients identified as homicidal, suicidal, or psychotic by the triage function of the system. As with the outpatient care clinics the inpatient ward executes a volume of care provision commensurate with the number of providers available in the facility. Likewise, in instances when the demand for inpatient care exceeds the supply (a function of providers and operating beds) urgent need

patients are referred to the TRICARE network for inpatient care.

- **Intensive Outpatient Program (IOP).** The IOP is for soldiers who are diagnosed with moderate to severe PTSD. For the period of enrollment, the patient's place of duty is the treatment facility in which they are treated in a variety of treatment modalities for the entire workday. The program treats soldiers in groups, so that in addition to individual therapies, group therapies may also be leveraged and a support network is pre-established for graduates. The downside to the cohort model is low throughput, but positive results, which are the focus of the program, rather than throughput, demonstrate that the treatment regimen is effective. Of the programs observed, over 50% of the soldiers admitted into the program are returned to duty successfully, which is remarkable.

The administrators of the programs cite the program's ability to take the time to focus on treatment with measurable patient outcomes is the reason for the program's success. Leaders of the program have concerns for the soldiers who return to inhospitable units that are focused on the patient's absence rather than his or her success in getting the help that he/she needed. Returning to a toxic environment, according to leaders, can easily reverse the progress made in the program.

- **Warrior Transition Unit (WTU)**. The Warrior Transition Unit site a serves as an intensive case management activity for soldiers assigned. In the case that soldiers require intense treatment, cannot perform their primary duties for a period of time greater than six months, and is approved for admittance by the leadership of the WTU, the hospital commander, and the installation's senior mission commander, a soldier may be transferred from his combat unit to the Warrior Transition Unit. The entire cadre at the

WTU is trained for handling medical information for the soldiers in their charge. The unit has a staff of nurse case managers that work closely with the unit's chain of command to ensure coordination of care for the soldiers assigned. This unit is committed to returning soldiers to duty or processing them for elimination from the service within one year of assignment to the organization. For soldiers who exceed the one-year mark, the warrior transition unit leader must account for them by name to the senior mission commander monthly with a plan of action.

2.2.6 Needs of the Stakeholders:

- **Triage, Outpatient, and Inpatient Care Clinics:** The primary needs of all of these clinics can be broken down into two categories.

First, each activity requires the appropriate resources, both in terms of quality and quantity, to execute its function commensurate with the demand of the patient population, so that it may deliver care in accordance with MEDCOM's performance measurement criteria. For example, the Inpatient Ward requires both clinical and non-clinical staff, operating beds, and hospital support such as pharmacy and logistics functions. If the ward does not have the capacity to meet the demand, it must rely on civilian providers in the TRICARE network to cover the shortfall in care provision, again at significantly increased cost to MEDCOM. In the case of the IOP, the program needs staff and facilities to accommodate the demand for its services. In each of these programs observed, the wait time for enrollment exceeded three months.

The second need of these activities is information. Information flows both in and out of these clinics is critical to the system's overall success. The military uses the Armed Forces Health Longitudinal Technology Application (AHLTA) to record and transmit for

the sharing of provider notes among medical professionals and encounter coding (for RVU accounting). The clinics also require conduits to 1) transmit information to the operational units that need fit for duty or limited duty recommendations for the soldiers that execute the units' mission essential tasks, and 2) collect information from the units on patient backgrounds and histories, since the providers are not organic to or physically near the units. Finally, the clinics require conduits to civilian providers who provide behavioral health care to military patients for the transmission of diagnoses, provider notes, and prescription information.

- **Warrior Transition Unit:** The needs of this unit stem from the short timeframe for which they expect to have soldiers assigned. The unit needs the cooperation of medical providers to allow WTU patients to bypass long queues for medical services. Additionally this unit requires enhanced facilities for housing soldiers who live on the installation, and a large staff capable of maintaining contact with soldiers who do not live on the installation.

2.3 US Army Installation Command

2.3.1 Objectives: The US Army Installation Command (IMCOM) provides facilities, support, and services necessary for the readiness of the soldiers and the family members of the soldiers assigned to the units on the installation. Additionally, IMCOM is responsible for providing the physical infrastructure for the support of mission requirements; this includes training areas, buildings, roads, and utilities. The published mission statement of IMCOM is "is to provide Soldiers, Civilians and their Families with a

quality of life commensurate with the quality of their service." [xiii] The IMCOM Commander proposes six distinct focus areas to address this mission and objectives.

1. **Soldier, Family, and Civilian Readiness.** In this focus area, IMCOM has committed to creating and maintaining the infrastructure and services that are needed to support mission readiness in accordance with the dynamic requirements of the Army Force Generation process. An important component of supporting organizations with dynamic needs is the careful integration of services, which IMCOM proposes to execute through its Community Health Promotion Council (CHPC). Finally, IMCOM leverages Family Support Groups (FRG) and FORSCOM Rear Detachments to maintain links with the families who remain at home station when FORSCOM units deploy.
2. **Soldier, Family, and Civilian Well Being.** The stated objective of this focus area is to "ensure Soldiers, Families, and Civilian employees are being cared for, and [IMCOM's] programs and services enhance community life, foster readiness, promote mental and physical fitness, and deliver a quality working and living environment." The primary agent of this area is Army Community Services (ACS), which coordinates soldier and family support services, emergency financial support, the Military Family Life Counselor (MFLC) program.
3. **Leader and Workforce Development.** This IMCOM focus area is centered on organizational and individual self-improvement, so that its employees may continuously improve capabilities and process for serving the needs of soldiers and their families.

4. **Installation Readiness**. Here, IMCOM focuses on stewardship of resources and facilities that it utilizes for soldier and unit training as well as family programs. This is a focus area because of the requirement to provide dynamic support to the ever-evolving missions of the FORSCOM units assigned to the installation.
5. **Safety**. IMCOM focuses on safety in its activities in order to preserve the readiness of the soldiers that it supports as well as the mission readiness of its own soldiers and civilians.
6. **Energy and Water Efficiency and Security**. Finally, as the enterprise responsible for the installation's physical infrastructure and utilities, IMCOM is focused on being responsible stewards of the resources that it uses to support readiness.

2.3.2 Structure: The US Army Installation Command is lead by a Lieutenant General, a three-star general, who commands five regions; two in the United States, One each in Europe, Korea, and the Pacific region.xiv Members of the Government's Senior Executive Service (SES), commonly described as the Army's "civilian generals", direct IMCOM Regions, illustrated in Figure 2.6.

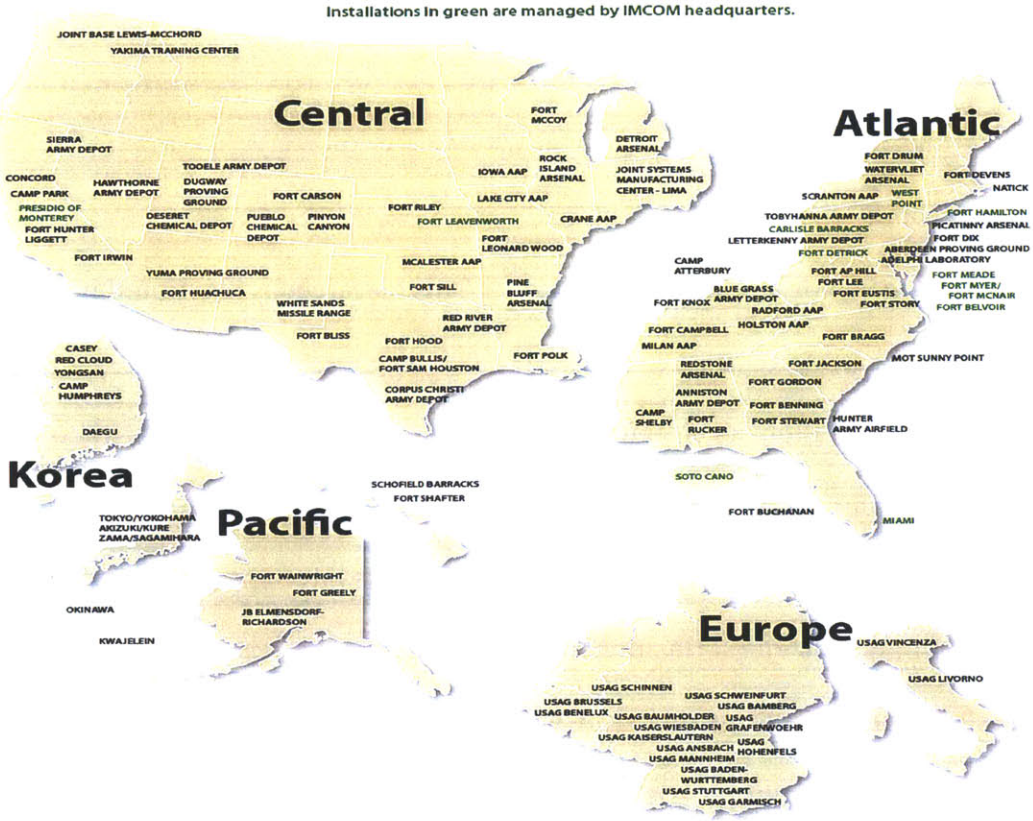

Figure 2.6 IMCOM Regions. (source: http://www.imcom.army.mil/hq/about/regions/)

IMCOM's senior representative at the installation level is the Garrison Commander, an Army Colonel, who is charged with providing support to the Senior Mission Commander as described in the IMCOM Objectives. Finally, IMCOM's programs and services on the installation are each lead by a Department of the Army Civilian. These leaders report directly to the Garrison Commander, who reports to both the IMCOM Regional Director and the Senior Mission Commander.[xv] This hierarchy is illustrated in Figure 2.7.

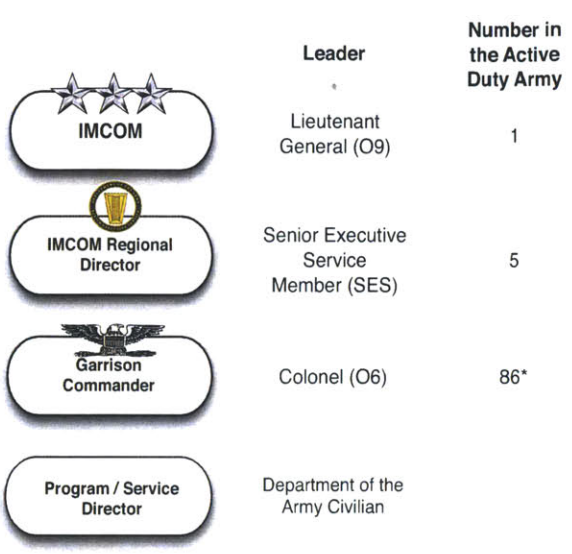

Figure 2.7. IMCOM Structure. *IMCOM Operates 86 Posts, Camps, and Stations, however, only 10 installations behave as described in this document. The remaining installations are small and/or do not have a warfighting mission.

2.3.3 Performance Measures

At the installation level, IMCOM has 61 metrics associated with their six focus areas described above. With regard to the execution of Behavioral Health and associated services, the following six performance measures assess IMCOM's behaviors that support soldier and family Behavioral Health needs.

1. **Risk Reduction program "shot group" rating**. The Installation Risk Reduction plan measures fourteen risk behaviors. Reduction of the proliferation of these behaviors is indicative of a successful program. See Appendix A for a description of this program.
2. **Garrisons with an established Community Health Promotion Council (CHPC)**. Success in this area is the presence of a CHPC that delivers the value required in the

Army's Health Promotion Regulation. In short, the CHPC is required to execute the installation's Suicide Prevention, Risk Reduction, and Community Health Programs.[xvi]

3. **Garrisons with ARFORGEN support requirements providing a standardized ARFORGEN support plan.** This metric assesses IMCOM's dynamic support to the specific needs of FORSCOM units both in terms of mission support and the pre- and post-deployment needs of soldiers and their families.
4. **Soldiers completing Soldier Readiness Processing (SRP) requirements.** This performance measure assesses FORSCOM unit commanders' satisfaction with the SRP's support to their deployment and redeployment medical, behavioral, and administrative needs.
5. **Army Community Service (ACS) Accreditation.** This metric measures the quality of ACS performance through comparing the number of ACS organizations that are accredited to the total number of organizations that are providing ACS services.
6. **Military Family Life Consultant (MFLC) Effectiveness.** This performance measure assesses the percentage of garrisons with MFLCs that are meeting the Office of the Secretary of Defense (OSD) minimum for contacts per day.

2.3.4 Incentives

Military leaders, just like their peers in FORSCOM and MEDCOM are incentivized to execute through promotions, leadership opportunities, and career advancement. Officers and NCOs assigned to IMCOM units are evaluated on their ability to increase performance in their organizations in regard to the behaviors that IMCOM and the Senior

Mission Commander measures. Civilians in the system are likewise measured on their ability to deliver on IMCOM's measured behaviors. Department of the Army (DA) Civilians can choose to advance or to remain in positions in which they may build expertise over a career. DA Civilians, although they may choose not advance in pay grade, may be incentivized through cash rewards for performance and/or increases in pay based on time in their grade.

2.3.5 IMCOM on the Installation

- **Army Substance Abuse Program (ASAP):** The Army Substance Abuse program serves to strengthen the fighting force and enhance readiness through drug and alcohol education and prevention programs, and installation-level risk reduction. ASAP also provides substance abuse counseling and treatment, and it has the capability to execute psychoanalysis for triage and, at a limited scope, psychotherapy, generally offered by an organic psychiatrist. Finally, ASAP serves as an aggregator of the manifestations of risk behavior in conjunction with the installation's risk reduction program.

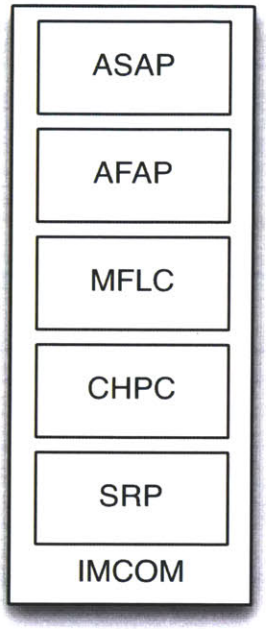

Figure 2.8 IMCOM's Behavioral Health Stakeholders on the Installation

- **Army Family Advocacy Program (AFAP)**: "The Family Advocacy Program provides information designed to support strong, self-reliant families and enhance coping skills. The program educates families about child and spouse abuse, as well as abuse prevention, education, intervention and treatment. Other programs include new parent support, victim advocate, sexual assault prevention and response and parenting classes."[xvii]

- **Military Family Life Counselors (MFLC)**: The MFLC serves as an independent Licensed Clinical Social Worker assigned to a BCT and provides "as needed" clinical counseling to soldiers and family members. Since the MFLC is accountable to the installation through Army Community Services, there is no requirement for informing command or medical providers of the details of their services. Soldiers enjoy this program because of the confidentiality and the location of the MFLC to their work areas.
- **Community Health Promotion Council**: The Community Health Promotion Council serves as an informal integrator of stakeholders and services on the installation. Interviews with CHPC directors show that that success in this endeavor is a function of deliberate cultivation of personal relationships with leaders in each stakeholder organization since, "attendance is mandated, but participation is not." The council is responsible for coordination of suicide prevention, community health, and risk reduction, and does so through the formation of working groups to address targeted areas of concern, defined in the council's quarterly meetings. Concerned stakeholders from across organizations (FORSCOM/MEDCOM/IMCOM) work together toward cooperatively developed programs developed to solve issues at the installation level. Finally, the CHPC is the integrator of risk data that is aggregated by ASAP and the DES for evaluating the installation's risk reduction program.
- **Soldier Readiness Processing (SRP) station**: The SRP station executes medical and administrative processing for soldiers deploying to or from combat operations. The "one stop shop" is designed to provide an easy place for soldiers and their commanders to correct deficiencies in deployment readiness or to identify medical or administrative issues generated during deployment. This stakeholder fits in to the Behavioral Health

enterprise through evaluating the results of the PDHA and FORSCOM Risk Assessment Tool, and then linking high and medium-risk soldiers with a counselor as soon as they get off the [redeployment] plane. In addition to actively linking high-risk soldiers with counselors, the SRP Station screens every soldier in order to determine Behavioral Health needs not identified by standard instruments.

- **Directorate of Emergency Services (DES)**: The Directorate of Emergency Services is responsible for the installation's Military Police, Fire Department, and EMS. The DES fits into the Behavioral Health enterprise as the second aggregator of risk data associated with the installation's risk data. In effect, any risk data collected by the Military Police is transmitted to the CHPC through the DES. CHPC directors report that this information must be manually extracted from the police blotter, the daily report of all serious incidents in which the MPs were involved.

2.3.6 Needs of the Stakeholders

- **Army Substance Abuse Program.** ASAP requires access to the soldier and the cooperation of the chain of command for supervision of outpatient-based treatment programs. From medical providers, ASAP requires credentialing of its providers and facility, since one of its activities is medical treatment. Additionally, ASAP requires the support of MEDCOM for the treatment of comorbid patients who have Behavioral Health and Substance Abuse illnesses. Finally, ASAP requires information sharing with all other stakeholders for the collection of installation risk-behavior statistics, as they are one of two aggregators of data required by the FORSCOM Installation Risk Reduction Program.
- **Army Family Advocacy Program.** AFAP requires cooperation of and information from the Directorate of Emergency Services for notification of serious events, the Chain of

Command for information on soldier history as it relates to family matters and time for soldiers to attend training. Likewise, the program requires continuous access to the soldiers who are required to complete mandated training or counseling. This means that commands must remain engaged with AFAP, recognizing the value added by the organization's expertise instead of attempting to deal with issues from a position of less expertise in the field.

- **Community Health Promotion Council.** The fundamental need of the CHPC is active participation from the council members as well as cooperation among the stakeholders. The council is bound by a Letter of Agreement (LOA), but not by policy or law. The most successful CHPC directors observed continuously build and maintain strong personal relationships with the members of the council. Since only attendance is mandated, buy in from the leadership of each involved organization is vital to the success of the program.
- **Military Family Life Counselors.** Due to the MFLC's reporting chain and confidentiality, they only have one real need – access to the soldiers. MFLCs at all sites report that initial cooperation of the Chain of Command is difficult, but as commanders recognize the value added, access increases proportionally.
- **Soldier Readiness Processing Station.** The station, although owned and managed by IMCOM, depends on MEDCOM and FORSCOM for qualified providers who may execute the screenings. Likewise, the site depends on the Chain of Command and Primary Care providers to transmit the data collected through the PDHA and FORSCOM Risk Assessment Tool to home station prior to redeployment, so that the SRP site can analyze the data before the soldiers arrive.

2.4 Chapter Summary

Although the clinical elements of the Army's behavioral health system are isolated to MEDCOM, and ASAP, each of the three enterprises contribute necessary value for the generation of a complete system of Behavioral Health care. Stakeholders in this collection of enterprises must work cooperatively in order to adequately coordinate a full spectrum of programs and services. The enterprises measure performance that is aligned to their own strategic objectives, however, as we will see in the next chapter, fulfillment of individual enterprise strategic objectives does not always functionally align with the shared goal of readiness, which is underpinned by the mental health of soldiers.

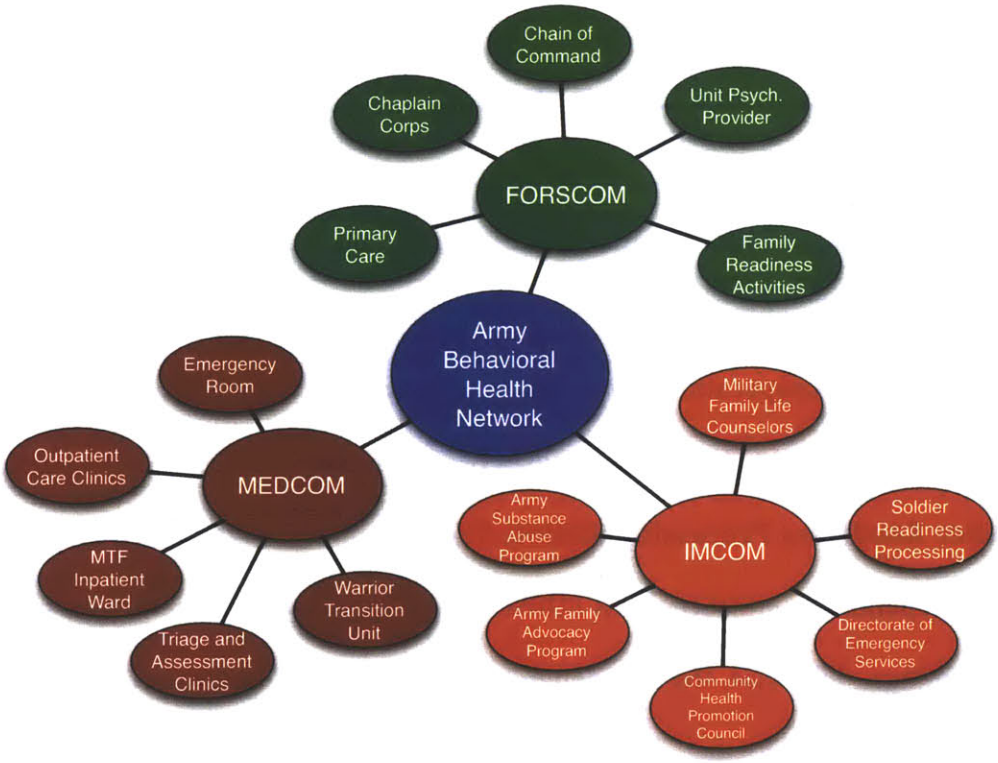

Figure **Error! No text of specified style in document.**.9 The Army Behavioral Health Network.

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[ii] Headquarters, Department of the Army. *Army Regulation 600-20. Army Command Policy.* Headquarters, Department of the Army. Washington, DC. 2011. Print
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[viii] St. Andrews, John "Study of the Relative Value Unit as a Practice Management Tool for Provider Productivity." Baylor University, 2003. Print.
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[x] St. Andrews. "Study of the Relative Value Unit as a Practice Management Tool for Provider Productivity."
[xi] Manpower Clinical Models Branch, Manpower Division. "ASAM IV – Behavioral Health Model." Directorate of Program Analysis and Evaluation. August 2010.
[xii] Office of the Surgeon General. "Provider-Level Patient Satisfaction Survey Program – Program Overview Briefing." Washington, DC. March 2005.
[xiii] US Army Installation Command. *Installation Management Campaign Plan.* US Army Installation Command. 4.0 ed. Washington, DC: US Army, 2011. Print.
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[xv] US Army. *Army Regulation 600-20. Army Command Policy.*
[xvi] US Army. *Army Regulation 600-63. Army Health Promotion.* US Army. Washington, DC. 2010. Print
[xvii] Headquarters, Department of the Army. *Army Regulation 608-18. The Army Family Advocacy Program.* Headquarters, Department of the Army. Washington, DC. 2011. Print

Chapter 3 – Execution

With an understanding that the Army's Behavioral Health system is a cooperative effort of three enterprises, it is appropriate to examine the behaviors of the enterprises as they relate to the provision of Behavioral Health services to service members. First we will examine the effect of performance measurement on the behavior of each enterprise in terms of its inner workings and inter-enterprise behavior. Next, we will discuss communication and cooperation between the enterprises in an effort to understand how the stakeholders work together. Finally, we will focus on the role of incentives in generating behaviors that contribute to the overall goal of improving the behavioral health status of soldiers and their families. While the analysis of the interaction of the systems is not exhaustive, it is intended to illustrate the most salient issues that the network must overcome.

3.1 Performance Measurement Driving Behavior – Each enterprise uses performance measurement techniques to gauge value delivery for its own set of strategic objectives. These metrics drive the behaviors of the stakeholders within each, as the system of incentives for the stakeholders reward execution and improvement of measured behaviors. Although performance measurement within the enterprises is aligned to objectives of the primary organizations, it often produces effects that do not benefit, or are blatantly counterproductive, to the interests of the others enterprises.

3.1.1 FORSCOM. With its mission to prepare units for deployment and its requirement to maintain readiness levels, leaders of FORSCOM units at the

installation level are measured on their abilities to achieve readiness levels commensurate with their position in Army's Force Generation Cycle (See Appendix B – Summary of the Army Force Generation Cycle). In terms of mission readiness, this is an appropriate metric, as it links directly to FORSCOM's strategic objectives. In terms of the Behavioral Health of the soldiers in the units, however, performance measurement is driving counterproductive behaviors.

In units that are approaching their deployment dates, an excess of Medically Non Ready (MNR) soldiers may cause an unacceptable reduction of the P level below 90%. Since the P-Level encapsulates both the number of soldiers assigned to the units, relative to the number authorized (strength), as well as the medical readiness of the soldiers assigned, it is not enough for commanders to transfer MNR soldiers to another unit. Instead, commanders are forced to transfer MNR soldiers to another unit whose position in the deployment cycle permits a lower P-Level, and from that unit pull a medically ready soldier. In effect FORSCOM units cannibalize medically ready soldiers from units on disparate deployment cycles in order to satisfy the expectations of their own performance metrics. It is important to note that the units that are not next in the deployment queue are most often reconstituting after a deployment of their own, in accordance with the ARFORGEN cycle. Swapping soldiers allows the deploying unit to meet the required readiness levels for both strength and readiness.

While this behavior has the positive effect of meeting combat readiness requirements, it also has two likely outcomes that are negative. First, mission ready soldiers who are picked from "off-cycle" units will continue to deploy at a higher

than expected frequency, resulting in greater than expected exposure to both physical and mental combat stresses. The soldiers in the reconstituting units are in a programmed period of rest and personal reconstitution in preparation for deployment in the parent unit's timeline.[i] This increase in deployment tempo proportionally increases the likelihood that the medically ready soldier will become MNR.

Second, if commanders of FORSCOM units induce reduced medical readiness rates through selective controlled substitution of soldiers, then FORSCOM should expect longer term Army-wide reduction in medical readiness. This exact phenomenon was observed at Site C, where commanders report an entire BCT that is below its expected medical readiness due to this practice.

Although this behavior is counterproductive to the long-term health of the force, we cannot blame the commanders of FORSCOM units for this activity. The Army's mission is to overcome any nations responsible for aggressive acts that imperil the peace and security of the United States[ii], and FORSCOM's part in this mission is to produce mission ready units to execute combat operations; it has developed metrics over decades that appropriately measure its ability to execute this mission. Commanders are incentivized for this behavior, as described in Chapter 2, so their best way to ensure their own career progression while at home station is to generate units that meet the prescribed readiness rates, both in terms of training and personnel. We see here that performance measurement is driving behavior, but the prescribed behavior generates unintended consequences that are counterproductive in the long term.

This counterproductive behavior is detrimental not only to FORSCOM and its soldiers. This behavior likewise increases the MEDCOM workload by inducing a higher than expected rate of Behavioral Health problems. IMCOM is likewise affected because as deployment frequency increases for selected soldiers, utilization rates to IMCOM programs and services will likely increase proportionally.

3.1.2 MEDCOM. The US Army Medical Command's reliance on the Relative Value Unit (RVU) for fair compensation and personnel requirement forecasting provides a second example of performance measurement driving behavior and unintended second order effects across the Army's behavioral health system. The requirement to maximize RVU generation without an outcomes metric[iii] incentivizes MEDCOM to focus on throughput of patients rather than to take time to focus on improving the behavioral health of the system's customers.

As with FORSCOM's readiness metric, MEDCOM's RVU is completely appropriate for that enterprise, if that enterprise's behavior had no impact on the others. The business operations side of the Military Treatment Facility uses this metric to ensure that the proper number of providers is present, and that those providers are productive enough to ensure a constant stream of revenue for the clinics. Since MEDCOM does not measure patient satisfaction for Behavioral Health activities, and there are no patient outcome measures in place, the RVU is the only performance measurement tool at the installation. Organizations will always "execute and improve upon what is measured,"[iv] and the effect is that medical providers are only incentivized to, in the words of one head of Behavioral Health, "move meat through the system."[v]

MEDCOM's exclusive use of this performance metric is counterproductive to its stated mission, to "...increase the medical readiness of the Army."[vi] In interviews with XX installation level medical providers, not a single respondent reported that any entity is measuring medical outcomes. This confirms that the *primary* focus of the clinical portion of the Army's behavioral health system is focused on revenue generation, instead of improving the health and readiness of patients. It should be noted though, that this is not just an Army problem; the National Institute of Medicine has identified that this same phenomenon occurs nationwide, and further recognizes that this shortcoming in the medical system must be corrected.[vii]

Once again, we observe a system with performance measurement driving counterproductive behavior and employees who are only incentivized to execute this behavior. In an interview with a MEDCOM psychiatrist, the respondent was asked what would happen if providers slowed down and focused on patient outcomes. The doctor replied that if [he] does not produce enough RVUs monthly, the MTF's Business Operations division "hammers the clinic chief."[viii] Since there is only one element of performance with which clinical providers can quantifiably stand out from their peers, then this is where they must excel if they wish to advance in their careers. We cannot assess blame to any provider or leader in this system for promoting this behavior, but instead we must attribute the system of performance measurement that drives it.

In visits to five Army installations, we universally observe clinical providers and chiefs who are exasperated by the system in which they must work. The level of demand for Behavioral Health services creates a capacity deficit, evidenced by six-

week wait times for appointments at every site. Across all the sites, clinical respondents have noted that they see patients before duty hours, during lunch hours, and choose to do documentation at home or after duty hours in order to provide as much service to soldiers as is needed. One clinical provider stated that he and his peers are providing excellent medical service "despite the system."[ix] This level of dedication is commendable, and speaks to the desire of clinicians to do the very best that they can; however, MEDCOM should expect that provider burnout will eventually degrade the quality of care delivered. Clinical providers at all sites state the same.

This suggestion of quality degradation returns us to an important aspect of performance measurement. Since there is no measurement of patient satisfaction for Behavioral Health services, nor is there a metric for outcomes, then it is not possible to gauge system improvement in terms of value delivery to the customer. MEDCOM's performance measurement system for Behavioral Health perpetuates continued reduction in quality of care in exchange for increased quantity of care. In a visit to a non-Army installation, the MTF Commander stated, in response to a question about the effect of increased RVU generation requirements on provider job satisfaction, "No one has quit on me yet, so it must not be that bad."[x] Although this attitude represents an extreme case it speaks to an acceptance, or worse an embrace, of the system deficiencies caused by performance measurement.

In addition to the negative effects of improper performance measurement on the internal behavior of the MEDCOM system, this system affects FORSCOM as well. Soldiers who are identified as a potential threat to themselves, others, or the unit

mission are made, appropriately, NMR by the clinical portion of the Behavioral Health system. Since that system does not incentivize improvement of its patients' health status, then the NMR soldier is added to the six-week queue for continued treatment at that interval. FORSCOM units, in turn, have their P-Level reduced by the MNR soldier, and there is a reduction in the unit's net T-Level due to the absence from training of that soldier as well as those required to provide supervision for the NMR soldier. The reduction in readiness and requirement for constant supervision of the NMR soldier generally precipitates a less-friendly environment for the soldier who needs Behavioral Health care, and adds to the stigma associated with Behavioral Health.

3.1.3 IMCOM. The Installation Command's performance measurement system, as described in Chapter 2, has two foci. The first set of metrics centers on the existence of a few specified programs and compliance to minimum standards for their operations, and the second set creates linkages to the needs of IMCOM's customers. This second focus and the outcomes associated with the programs measured by the respective metrics provide the first instance in which one enterprise serves another in both word and deed.

Two of the six metrics that IMCOM uses to assess the performance of its organizations, as related to the Behavioral Health system, are rated simply on the existence of a program, but not on the quality of the services delivered by those programs. These performance measurements: 1) garrisons with an established CHPH, and ACS Accreditation, only measure the presence of the programs. This means that the onus for creating the presumably desired functionality in the

operation of these programs falls exclusively on the directors and installation-level leaders. We observed this phenomenon in the varied quality these programs at the four sites that we visited, and can be illustrated in comparing two Community Health Promotion Councils. The CHPC at Site A was an active and dynamic program that engaged stakeholders from all enterprises to build a highly functional coalition with specific goals for reducing risk, preventing suicides, and enhancing community health. The director of the Site A program relied heavily on building functional personal relationships with the leadership of each of the Council's organizations. FORSCOM and MEDCOM leaders at the Site were very pleased, and referred to the CHPC director by name as someone who was doing excellent work with regard to the installation's Behavioral Health system.

Conversely, at Site C the CHPC director stated explicitly that he had "no idea what the CHPC was supposed to do."[xi] To be fair, this director had only been in the job for six months, and had developed a long-term vision for what he wanted his program to be; but the program had generated no actions or outcomes at the time of the interview. The program at Site C, despite its lack of functionality, met all of the standards set forth in the Army's Community Health regulation that covered the existence of CHPC, and was could thus be measured as a success by IMCOM's metrics.

The point to be taken from these two examples is that simply measuring the existence of a program or service does nothing to guarantee their actual performance. Improperly devised performance measurements, although well intentioned, may result in lost opportunities and resources applied to non-functional activities.

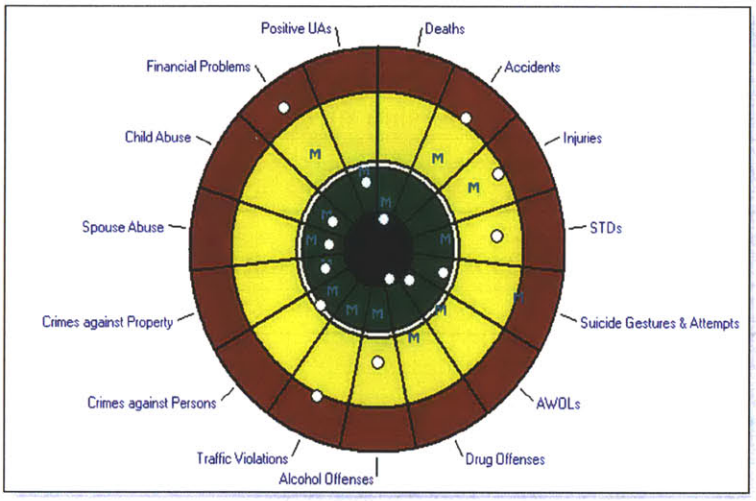

Figure 3.1 Installation Risk Reduction Shot Group

While two of the six IMCOM metrics are not tied to actual performance, the remaining four measure program value delivery through quantifiable success measures. A good example is the Installation Risk Reduction "Shot Group" Rating. This metric helps to assess the success of IMCOM programs in reducing manifestations of the risk behaviors shown in Figure 3.**1**. As manifestations decrease, the indicators move closer to the middle of the bull's-eye, tightening the "shot group." IMCOM controls programs that are aimed at reducing the frequency of all of the fifteen risk behaviors. This technique measures the effectiveness of IMCOM's programs, which in turn pays a direct benefit to FORSCOM by increasing

readiness of its soldiers, and to MEDCOM by proportionally reducing the demand for medical services through reduction of injury outcomes associated with the behaviors.

We see in this section that metrics that measure behaviors that are beneficial to enterprise may generate unintended and counterproductive consequences for other actors in the system. Although these performance measures often generate action that directly benefits the primary enterprise, we occasionally observe a misalignment of outcome with intent as we see with MEDCOM. Finally, in FORSCOM we observed behavior, driven by metrics, which yielded a short-term solution, but transformed into a potential long-term problem.

3.2 Information and Knowledge Management: The next area of focus in the Army's behavioral health system is the role of communication within and between the enterprises. We will see that the three enterprises have internally focused systems that demonstrate little consideration of the impacts of their practices on the other stakeholders in the behavioral health system. The only exceptions that we will observe are those information flows that are specifically needed to satisfy performance measurement criteria or those mandated by policy.

3.2.1. FORSCOM: Commanders in FORSCOM units frequently receive new soldiers of all ranks into their organizations, as military personnel change units about once every three years. This presents a leadership challenge for the unit leadership, as there is no pre-planned transmission of information regarding the soldiers who move to a new unit. This issue relates to Behavioral Health in two ways. First, the Army Human Resources Command's policy [xii] regarding post-deployment

stabilization (rest) periods disintegrates chains of command and teams who have a baseline for "normal" for each other well before the expected period for the manifestation of abnormal behaviors associated with Post Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD). Without a knowledge capture mechanism for this type of data and a deliberate transmission of the data to the new unit, the inherent understanding of typical behavior for an individual is lost when his or her peers and leaders change, due either to soldier or leader movement. If soldier actions deviate, then the new leadership has no benchmark for how far the soldier's behavior has shifted.

Second is the need for effective integration of knowledge capture in the deployed environment. Both commanders and Behavioral Health providers have stated a need for documentation of traumatic incidents during deployments that could serve as a trigger for PTSD or for mTBI/TBI. There is information that is currently captured in the CENTCOM Combined Information Data Network Exchange (CIDNE) tool, which could potentially be leveraged, but is currently not exploited by FORSCOM leaders or MEDCOM providers. Although some units have undertaken efforts to record such incidents, this is not an Army-wide practice. The effect of a missing knowledge management mechanism is twofold. First, leaders have no traceability to link abnormal behaviors to potential root causes in those soldiers who do not self-identify for Behavioral Health needs. Second, providers cannot identify soldiers who self identify for combat-related Behavioral Health issues with no associated root cause.

The effect of inadequate knowledge management and information systems is twofold. First, leaders in FORSCOM units are unable to adequately understand the current condition of their soldiers' mental state, relative to a historical baseline. Second, FORSCOM units are unable to provide an accurate medical history to clinical providers in MEDCOM and IMCOM. This effect creates an effective state of isolation from, but dependence on, the other enterprises for treating the behavioral health needs of FORSCOM's soldiers.

3.2.2. MEDCOM: As with FORSCOM, the US Army Medical Command has internal information systems problems, and a significant challenge in the execution of knowledge sharing that it must overcome to effectively support the Behavioral Health services demand of its customer, FORSCOM units. MEDCOM utilizes disconnected, unreliable information systems that inhibit top performance from the enterprise and frustrate medical providers. Likewise, there is a widespread rejection of knowledge sharing with FORSCOM due to concerns over the impact of releasing protected information on professional licenses. Combined, these two factors result in an enterprise that has ownership of extremely important behavioral health information, but is either unable or unwilling to share it with other enterprises who desperately need it.

MEDCOM uses the Armed Forces Health Longitudinal Technology Application (AHLTA), a portion of the military's electronic medical records system, to document and transmit medical clinical information between clinical providers and their staffs who require access. The underlying system, the Composite Health

Care System (CHCS), was created to combine all medical data collection and scheduling into a single system.

Providers at every site have stated that AHLTA is the single biggest frustration in their day-to-day operations due to its unfriendly interface, unreliability, and limitations on data entry capabilities. A clinical behavioral health provider at one site stated that "in a twenty minute patient encounter, I spend ten minutes just trying to get the computer to work,"[xiii] when commenting on the difficult AHLTA interface. Another, when asked about AHLTA's reliability, noted that, "every day there is cursing up and down this [clinic] hallway because of AHLTA crashes."[xiv] Finally, regarding the ability of AHLTA's data entry limitations, the size of a standard Behavioral Health clinical input form (OQ45) exceeds the system's upload limit, frustrating a patient's continuity of care as he or she moves from provider to provider. The inconveniences of the information system primarily affect medical providers, but the outcome of the combined issues affects the entire system, as a difficult and unreliable information system yields diminished information fidelity for all those who rely on AHLTA. Both MEDCOM providers and FORSCOM commanders use this information; the former as a repository for the accumulated medical knowledge, and the latter, to inform mission readiness and administrative decisions on each soldier.

Commanders in FORSCOM must rely on the opinions and decisions of MEDCOM's Behavioral Health to inform their readiness and administrative decisions. The standard means of communication between clinicians and commanders is the Department of the Army Form 3349 (Appendix C), a two-page

form that allows the clinician to describe the physical limitations imposed by a soldier's medical condition. Providers and Commanders at each site report that the form is inadequate for reporting behavioral health states and associated limitations. The result is the necessity for in-person or telephonic communication between the two parties.

It is in this communication that we observe the knowledge sharing policy that inhibits the much needed flow of information between the enterprises. In thirteen interview sessions with 110 total respondents from the Chain of Command, at three FORSCOM installations[xv], there was a uniform response that personal information protection under the Health Insurance Privacy and Accountability Act (HIPAA) was held up as an impediment to successful information exchange with Behavioral Health providers. Conversely, over 75% of the 33 clinical providers interviewed stated that they cannot or would not share protected information with commanders due to concerns over patient privacy and fear of losing their medical license due to a HIPAA violation. This is troubling for two reasons: first, commanders are responsible for the health and welfare of their soldiers as well as mission readiness. If a provider has information that the commander needs in order to execute on these responsibilities, particularly if the soldier is a danger to himself or others, then that information must be shared. Second, DoD regulations and MEDCOM guidance require that this information must be shared.

DoD Instruction 6490.08 (August 17, 2011) requires that Behavioral Health providers notify commanders of soldier behavioral health conditions that could precipitate harm to self, to others, to the mission, or in circumstances "in which

proper execution of the military mission" would require notification. The notification to commanders must include the diagnosis, treatment plan, the impact on duty or mission, the prognosis, duty limitations, and any implications on the safety of the soldier or others. Further, ALARACT 160/2010 – *VCSA Sends on Protected Health Information (PHI)* makes clear that health care providers and commanders must have a dialogue beyond the DD 3349 form described above. Finally, DoD Instruction 6025.18-R, paragraphs C1.2.5 and C7.11, state that commanders have the right to their soldiers' medical and behavioral health records for the purpose of determining fitness for duty, and OTSG/MEDCOM Policy Memo 10-042 details the procedure for commanders and unit medical personnel to obtain the information.

Taken together, these documents assert that if a provider recognizes a condition that will cause a soldier to be unable or even less able, to perform his mission essential tasks, then the provider must clearly articulate that to the command. The failure to follow means one of two things: either MTF Commanders are not enforcing the Department of Defense and MEDCOM guidance, or these instructions have not been published to the clinicians who serve FORSCOM and its soldiers.

3.2.3 IMCOM: In an organization whose performance metrics generate some programs that are proactively customer serving and some programs that are inwardly focused, we should expect varied effectiveness in knowledge management and communication. This is precisely what was observed. In this section we will discuss instances of IMCOM programs, Soldier Readiness Processing (SRP) and the

Army Substance Abuse Program (ASAP). These programs each have regular interaction with both FORSCOM and MEDCOM, but only SRP has performance metrics that directly support cooperation.

The Soldier Readiness Processing station is an IMCOM activity that is staffed with MEDCOM clinical providers, and serves FORSCOM. For the purposes of Behavioral Health, SRP receives FORSCOM-generated soldier risk assessments while soldiers are still deployed in order to provide targeted Behavioral Health services to those pre-identified as high and medium risk. This is an example of knowledge management and communication between the enterprises that is appropriate and successful. IMCOM coordinates resources from one enterprise into a directed response to the needs identified from knowledge transmitted from the third.

Upon arrival at home station, every soldier participates in a short behavioral health consultation with a MEDCOM-provided clinician in order to provide a second layer of detection for those who may not have been identified by the "downrange" assessment tools. Here we see a structural inefficiency in the system caused by improper information flows and inter-enterprise coordination. Clinical providers working at the SRP stations do not generate clinical referrals to MEDCOM's Behavioral Health clinics. Instead, the SRP providers refer those identified as high or medium risk back to the FORSCOM Primary Care providers, so that the Primary Care provider may make the referral to MEDCOM. The rationale behind this has been explained in different ways at different sites. Some sites report that if SRP generates a referral, then the feedback structure flows back, inappropriately, to SRP rather than to the soldier's Primary Care clinician. Others report that the reason for

the procedure is keep Primary Care and the unit in the information loop. Regardless of the rationale, this creates duplication of effort, and it begs the question why FORSCOM's organic clinicians do not supervise and participate in their own SRP process.

Despite the inefficiencies, we observe in IMCOM's SRP the first glimpses of deliberate inter-enterprise cooperation with consistent patterns of information flows and knowledge management procedures. In the Army Substance Abuse Program (ASAP), however, we observe knowledge management procedures that do not assist the other enterprises with work that must be done cooperatively in order to fully serve the soldier's behavioral health needs.

Patients enter ASAP through soldier self-referral, command referral, or clinical referral from Behavioral Health. Whatever the means of entry into the program, ASAP begins treatment of patients with an extensive clinical intake, executed by a counselor using the ASAP Clinical Assessment Form (ACAF) (see Appendix D). This intake requires two hours, and afterward the counselor must enter this same information into a series of paper form, (Appendix D) , which requires approximately one hour. Finally, to finish the intake the counselor enters a very short note into AHLTA to inform other clinical providers that the soldier "saw an ASAP counselor on a specific date for substance abuse treatment for a specified period of time."[xvi] The patient's first encounter with ASAP, in total, consists of two hours of filling out a form with a counselor and no real treatment. Further, counselors with over fifteen years of experience, report that they spend over three

hours filling out redundant forms when a one-hour evaluation and one-page narrative in an AHLTA note would suffice.

MEDCOM and FORSCOM are impacted by these procedures each in their own way. First, MEDCOM is unable to see, through AHLTA, any actionable information regarding the patient's substance abuse/dependence or the course of treatment. MEDCOM clinicians stated that, "I don't think [ASAP is] doing any documentation at all, and we don't get anything useful from the two-sentence AHLTA note that [ASAP] generates."[xvii] The result is that a comorbid patient that enters Behavioral Health or a Medical Evaluation board must undergo a MEDCOM-specific clinical intake or unnecessary back-and-forth clinical referrals for drug dependence, duplicating effort and further overwhelming clinical resources.

This has a second order effect on FORSCOM. When an NMR soldier in a FORSCOM unit is being processed for discharge from the Army, the period of reduced unit readiness is extended due to the need for redundant clinical procedures for substance abuse evaluation. Finally, FORSCOM is affected by ASAP's knowledge management procedures due to the diminished ASAP capacity caused by the unnecessarily heavy administrative load per patient.

3.3 Incentives:

3.3.1 Stakeholders: Actors in the system are incentivized to deliver on the measured behavior, but little else with regard to the other enterprises. We see the impacts in the knowledge sharing and communication between the enterprises. With few exceptions, the incentivized behavior does not involve working with agencies outside of, or often within, a stakeholder's own enterprise.

In nearly every interview at every site, the stakeholders understood that they could be doing more to coordinate the care for soldiers. Further, many stakeholders understand the overall goals of the others, and they articulate the desire to work closer with the rest of the behavioral health system. Unfortunately, the system is overwhelmed with patients, and stakeholders are far too busy to stop and take time to do anything other than what is being measured. To slow down will cause a reduction in performance, and incentives will proportionally decrease. "People can know what is the right thing want to do it deep down in their hearts, but at the end of the day they will do what they get paid to do."[xviii]

3.3.2 Customers: A group that has not been discussed here, but has a significant impact on the Army's behavioral health system, is the patients. Commanders and clinicians universally report that the overwhelming majority of patients who use behavioral health resources are the junior soldiers in the 18-24 year old demographic. These soldiers are those who generate the greatest demand on the system for a couple reasons. First, this is the Army's largest demographic, and second, it is the 18 to 24 year old junior enlisted soldier who occupies the front lines in combat operations.

These soldiers generally enter the Army straight out of high school. The Army is their first real job, and for many it is their only opportunity to get a job with any upward mobility.[1] The military presents a unique "opportunity" for those who choose to leverage the disability and benefits system for their own gain. The

[1] This is the experience of the author, and is representative of most of the young people that enlist in the Army.

disjointed and overwhelmed behavioral health system is extremely vulnerable to those seeking secondary gain for falsely obtaining a PTSD diagnosis. Soldiers who receive this diagnosis can get a guaranteed 50% disability that generates lifetime monetary payments as well as preferential treatment for employment and government programs. Additionally, soldiers who leverage the system can remove themselves from the deployment cycle and can use duty-limiting diagnoses to avoid any undesirable conditions. This situation is further enabled by a system that "is never going to tell anyone *no* if they say they have PTSD,"[xix] "...because no one wants to be the [clinician] who gets their name on CNN as the doctor who signed off as someone [who committed a crime or committed suicide] as *ok*."[xx]

The patients of the system understand the vulnerabilities, and we cannot attribute complete blame to the soldiers who take advantage, as they are passively incentivized to do it. A lifetime benefits versus fighting for a job in an uncertain economy; safe, limited duty in the United States versus deployment to combat in Afghanistan – these are the choices that the system affords 18 to 24 year olds. The owners of the system should not be surprised when soldiers use weaknesses for their own gain.

The outcome of this unintended system of incentives falls on first on FORSCOM units, as every soldier who falsely seeks Behavioral Health care and receives a duty limiting diagnosis reduces the unit's P-Level and in turn their T-Level as described above. Commanders who see these soldiers every day, on and off duty express that they are very frustrated by this behavior, but "are powerless to stop it, as they cannot tell a soldier that he or she cannot go to the doctor."[xxi] This

frustration extends to the whole unit's attitude toward Behavioral Health, as it is perceived as a "safe place where soldiers can go to avoid anything they don't want to do."[xxii]

More importantly, soldiers leveraging this system vulnerability affect the soldiers who truly need Behavioral Health services, but do not want to be perceived as working the system. One commander reported that, "it's heartbreaking to see a guy who you really know needs help, but just refuses to go because he doesn't want to be thought of as a malingerer."[xxiii]

MEDCOM and IMCOM providers are affected by this behavior because soldiers who unnecessarily seek Behavioral Health care overwhelm clinical capacity. Providers and commanders report that the percentage of soldiers seeking behavioral health care that are seeking secondary gain is alarmingly high. Clinicians "have to see everyone who comes in the door though, because [they] can't turn away someone who may have a real need."[xxiv]

3.4 Chapter Summary:

The Army's behavioral health system is rife with well-intentioned performance measurement, underpinned by rigid incentive systems that generate unintended consequences in the form of dysfunctional inter-enterprise behavior. Both the clinical and non-clinical portions of the system are overwhelmed with demand – some true and some artificial, that precludes individual stakeholders from maintaining working relationships, aside from those specifically measured or mandated by policy, across functional silos. It seems that the solution to these system challenges could be to align the strategic objectives of the three enterprises

for the purposes of improving the multi-enterprise behavioral health network, and to impose a governance structure that transcends the three hierarchies. This structure must measure performance across the three enterprises and incentivize cooperative behaviors in order to force mutually beneficial behavior from all stakeholders in the interest of soldier health and system effectiveness and efficiency.

In the following three chapters, we will explore potential solutions that address these challenges.

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[i] Headquarters, Department of the Army. *Army Regulation 525-29. Army Force Generation.* Washington, DC. Headquarters, Department of the Army. March 2011. Print.
[ii] U.S. House of Representatives. "10 USC Title 10 - Armed Forces." Washington, DC. 2011. Print.
[iii] MTF Business Planners. Personal Interview with Dr. Jayakanth Srinivasan. Site A. June 2012.
[iv] Dick Lewis. "Integrating the Lean Enterprise." Cambridge, Massachusetts. November 2010.
[v] Division Surgeon. Personal Interview. Site F. May 2012.
[vi] US Army Medical Command. *Soldier Medical Readiness Campaign Plan.* 1.2 ed. Washington, DC: Office of the Surgeon General of the Army, 2011. Print.
[vii] Institute of Medicine. For the Public's Health: The Role of Measurement in Action and Accountability. Washington, DC. The National Academies Press. 2011. Print
[viii] Behavioral Health Clinical Provider. Personal Interview. Site E. December 2011.
[ix] Behavioral Health Clinical Provider. Personal Interview. Site F. May 2012
[x] Military Treatment Facility Commander. Personal Interview with Dr. Jayakanth Srinivasan. Site D. December 2012.
[xi] Community Health Promotion Council Director. Personal Interview. Site C. December 2012.
[xii] Vice Chief of Staff of the Army. ALARACT 078/2009 – Active Army (AA) Unit Stop Loss/Stop Movement (SL/SM) Policy for Units Scheduled to Deploy OCONUS for OIF and OEF Operations Update/Revision. Washington, DC. 2009. Print.
[xiii] Behavioral Health Clinic Chief. Personal Interview. Site E. December 2011
[xiv] Behavioral Health Clinical Provider. Personal Interview. Site C. December 2011.
[xv] FORSCOM Unit Commanders. Series of Interviews. Sites A, C, E, F. October 2011 – May 2012.
[xvi] Army Substance Abuse Program Director. Personal Interview. Site F. May 2012.
[xvii] Nurse Case Managers. Personal Interview. Site F. May 2012.

[xviii] Byrnes, Jonathan. "Case Studies in Logistics and Supply Chain Management." Cambridge, Massachusetts. March 2012.
[xix] Clinical Medical Provider. Personal Interview. Site F. May 2012.
[xx] Behavioral Health Inpatient Clinic Chief. Personal Interview. Site C. December 2012.
[xxi] Battalion Commander. Personal Interview. Site A. October 2011.
[xxii] Battalion Command Sergeant Major. Personal Interview. Site D. December 2011.
[xxiii] Company Commander, Site A
[xxiv] Triage and Assessment Clinic Director, Site D.

Chapter 4 – Unity of Effort

One of the limitations of the hierarchical configuration of the current Behavioral Health network is that each enterprise is incentivized to act independently, with little regard to the others. As we have observed in the previous chapter, each enterprise pursues its own strategic objectives which, when examined at face value, are aligned to enable mission readiness. Closer examination yielded a view of three enterprises as being unlinked and myopically intent on achieving their own goals.

Allee (2000) defines *value* as currency in a network as transactions of goods, services, and revenue; knowledge; and intangible benefits.[i] Recurring value exchanges between the enterprises in the Behavioral Health network are not well coordinated and system performance suffers as a consequence. When the needs of the system's ultimate customer, the soldier, exceeds the capabilities of one enterprise the handoff to the next agency is clumsy and unstandardized. In plain terms, when a soldier's needs cannot be met by one organization on the installation he/she is "passed over the wall" to the next with almost no coordination of care.

A first step toward integrating the three enterprises for the purpose of delivering Behavioral Health care is to develop a common focus for all stakeholders involved in the coordinated provision of these services. A clearly defined and communicated set of objectives that are aimed at an overarching system goal will act as a catalyst for the integration of Behavioral Health processes.

There is a broad range of literature describing research and theory regarding unification of complex systems of organizations. A common theme in academic and

practitioner writing is the need for cooperative action toward a shared end state. A review of some of these writings will inform a thoughtful establishment of network wide strategic goals.

4.1 Literature Review

Cebul, Rebitzer, Taylor, and Votruba (2008) assert that efficiency and effectiveness of a health care network is directly linked to the degree of coordination in that network over a period of time. Health care system underperformance results from system stakeholders intent on seeking their own goals and objectives ahead of cooperation with other stakeholders. Fragmentation of a system further yields competition that reduces coordination as well as quality of care, and it increases resource utilization. Cooperation in a health care system that considers the specialized capabilities of the different organizations, enhancement of information flows, and deliberate integration of the stakeholders results, over time, in marked improvement of system performance.[ii]

Koza and Lewin (1998) support this view in that strategic alliances with an exploitation strategy, that is the goal of leveraging stakeholder strengths toward a common goal, have a greater probability for success due to cooperative goal seeking.[iii] This assertion that firms benefit from participation in network relationships is likewise held up by Holm, Eriksson, and Johanson (1999), who state that firms are able to generate greater value in cooperative partnerships than the members of the network could produce independently.[iv]

Nightingale and Srinivasan (2011) describe strategic objectives as the enterprise's goals which, when achieved will enhance the enterprise's ability to deliver on its value proposition, or reason for being. These objectives should reflect the needs of the overall

enterprise, but should also address the needs of the stakeholders and their value propositions. Finally, processes that the enterprise executes to create collective value should link to enterprise objectives and each should be gauged by appropriate metrics. The authors stress the need for a holistic approach to enterprise transformation with an emphasis on effectiveness before efficiency.[v] This emphasis on value production for both the stakeholders and the overall enterprise is echoed by Murman et al. (2002) who explain that participation in a multi-organization enterprise must produce a benefit to justify the effort expended toward cooperative goals.[vi]

Campbell and Alexander (1997) state the need for firms to clearly distinguish their purpose for existence and to understand insights for value creation. It is from those insights that strategy must be developed.[vii] Professor Richard Rumelt (2011) presents three elements that he considers crucial for the establishment of an effective strategic plan for organizations. He asserts that these three elements transcend specific industries, and he provides anecdotes drawn from his vast consulting experience as well as history as evidence for his points.

Rumelt's second tenent in his framework for strategy development is the necessity for a guiding principal that will drive actions for moving the company from where it is to where it wants to be. In plain terms, the company must have a meaningful strategic objective that serves as the anchor for its long term plans. This is where companies use an understanding of their competitors and environment, so they can array their own capabilities and strengths to provide an advantage.[viii]

Army Doctrine Publication 3-0, Unified Land Operations (2011) provides the overarching doctrinal guidance for Army operations. Most importantly to this work, it details the top-level concept of the Army's Operations Structure. Here the publication gives the framework for prioritizing effort among subordinate organizations one the basis of the criticality to mission success. The organization that is most important for achieving success is designated as the operation's main effort. Other organizations in Army operations are designated as supporting efforts, which serve to support the success of the main effort.[ix]

In the classical text on military strategy, *On War*, Carl von Clausewitz (1873) describes unity of effort as synchronization of many organizations, under a common command, toward a common objective in order to achieve the maximum possible effect. Unity of command and effort result in coordinated action that may achieve far more than the unsynchronized individual efforts of units deployed individually.[x]

The literature on informs our thinking of the importance of several aspects regarding strategy development for the Behavioral Health network. First is the potential for emergent network outcomes that are possible through coordinating and leveraging the unique capabilities of the stakeholders. Second, strategic objectives should be considered as a set of guiding principles to which plans are anchored, instead of considering the objectives plans unto themselves. Finally, network strategy should be devised to deliver on the overall value proposition, but should advancement toward the objectives should yield benefits to all of the stakeholders.

4.2 The Need for Shared Objectives.

The first step toward improving the performance of the behavioral health system is to unify the focus of the enterprises. FORSCOM, MEDCOM, and IMCOM and their representatives on the installation, shown in Figure 4.1 must cooperate on specific activities that contribute to the behavioral health system, but are chiefly concerned with execution of their own goals per their incentive structure. Since each enterprise is focused on its own strategic objectives, then there is little cause for cooperative endeavors, which is concurrent with the findings of Cebul et al (2008). With a unified purpose, achieved through the development of shared strategic objectives, the network may begin to realize integrated behaviors that eliminate duplications of effort as well as information gaps, improving overall network performance.

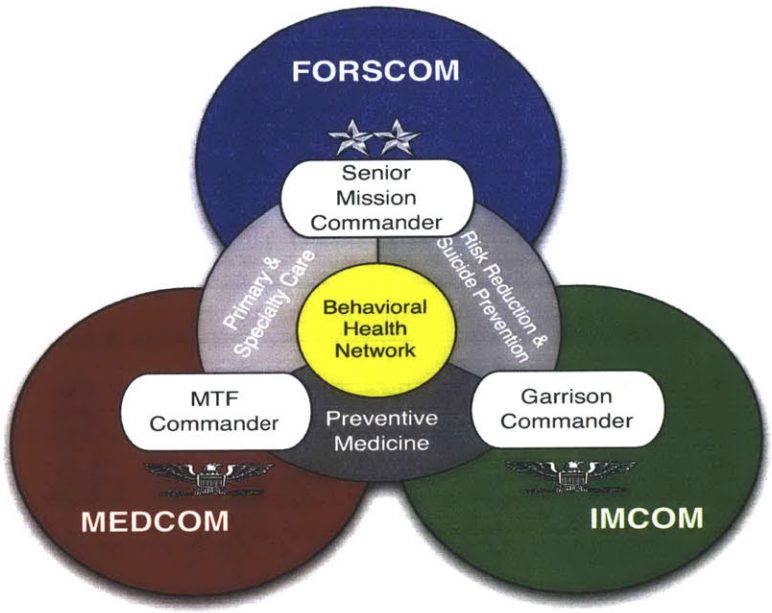

Figure 4.1 Installation Behavioral Health Network Leadership

The outcome of a unification of purpose in the system will be the designation of one enterprise as the value-delivery agent, and the others as supporting activities that directly enable that lead agent to execute the goals of the top-level organization. Nightingale and Srinivasan (2011) assert the need for identification of an enterprise value proposition as the reason for being, development of strategic objectives that support that proposition, and alignment of integrated enterprise processes to fulfill those objectives. Execution of this assertion aligns the purposes of the stakeholder organizations toward a common goal, and integration of the stakeholders requires the establishment of standardized and effective value exchanges in support of effective and efficient delivery on the system's overall objective.

Army doctrine (APD 3-0) mandates, in combat operations, the appointment of a *main effort* and *supporting efforts*. The main effort is the "designated subordinate unit whose mission at a given point in time is most critical to overall mission success. Supporting efforts are designated subordinate units with missions that support the success of the main effort." [xi] In practical terms, the main effort is the primary agent in the top-level organization's delivery on its value proposition. Supporting efforts are stakeholders that deliver value that directly enables the primary agent to deliver on the value proposition on behalf of the enterprise.

Unification of the Army's behavioral health system must begin with an analysis of the system's overall value proposition and continue with the development of common strategic objectives as a basis for defining integrated processes that minimize waste in stakeholder value exchanges. Identification of the system's value proposition will define which enterprise is the main effort, and which are the supporting efforts, enabling positive

synergistic behavior, vice the disjointed and inwardly focused activities we observe in the current state.

> The mission of Forces Command is to train, mobilize, deploy, sustain, transform and reconstitute conventional forces in order to provide a sustained flow of relevant and ready land power to combatant commanders worldwide in defense of the nation.
>
> FORSCOM Campaign Plan, 2012-2015

Unlike informally aligned business networks, a common headquarters oversees the Army's operationally independent enterprises, and this headquarters, the Department of the Army has a congressionally mandated value proposition; "The mission of the Army is to overcome any nations responsible for aggressive acts that imperil the peace and security of the United States."[xii] When we compare this mission, or value proposition, of the top-level organization against the objectives of its subordinates, then it is obvious that FORSCOM is the Army's main effort. Strategic objectives for the Behavioral Health system must reflect this and directly support the main effort's mission, effectively designating MEDCOM and IMCOM as supporting efforts.

Creation of the Behavioral Health system's objectives must be developed by the top-level organization for multiple reasons. First, definition of strategic objectives must come from this first echelon above the others; else the leaders of the individual enterprises will likely continue pursuit of their own objectives without regard to the other enterprises in accordance with their individual incentive systems. Second, top-level guidance for the system protects systemic evolution from New Leadership Failure (Nightingale and Srinivasan, 2011), in which new enterprise leaders take the organization in a new direction with no regard to previous goals and progress. If the system's goals are established and

codified by the top-level organization, then new leaders for the subordinate enterprises will be unable to halt or reverse the integration process. Finally, policy created at the top level may be implemented as a standard across all installations, reducing variation in the system and uncertainty over the priority of local versus Army policies.

The first operational confluence of all three enterprises in the Behavioral Health system is the office of the Vice Chief of Staff of the Army (VCSA), who acts as a Chief Operating Officer for the Department of the Army, managing policy and resources for the whole Army. Leaders of the three enterprises report directly to the VCSA, as shown in Figure 4.2. This is important because the reporting relationships between the enterprises' representatives at the installation level (ref: Figure 4.1) are not as rigid as those at the top level. If common strategic objectives are developed at the top level, cooperatively with the leaders of the three enterprises, then the network may proceed with a unity of effort[xiii] and the development of processes that support the effective and efficient value exchanges among the stakeholders.

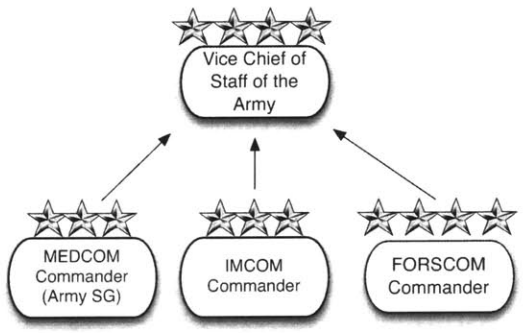

Figure 4.2. Operational Confluence of the Behavioral Health Network.

We observe the alternative unified effort in the current state. Chapter two of this document details what appears to be dovetailing organizational goals for the three enterprises, but we observe and describe in Chapter Three the effects that flow down from unsynchronized efforts. Disjointed, and inwardly focused efforts result in a behavioral health system that underperforms in supporting the top-level organization's value

proposition. This underperformance can be directly traced to uncoordinated actions that attempt to provide behavioral health services to a common customer, the soldier.

4.3 Proposed Strategic Objectives

If we consider FORSCOM as the Army's primary agent, or main effort, in delivering on its value proposition, then the Behavioral Health network's strategic objectives should reflect that, and the capabilities of the supporting efforts should be considered and incorporated into the shared system goals. A final examination of the FORSCOM mission, above, through the lens of the elements that providing behavioral health services, yields three key words. The first of these, *ready*, describes the overall goal of the Behavioral Health network, as this is the overall goal of the main effort as evidenced not only by the mission statement, but also the enterprise's performance measurement system. If the Army's main effort's goal is to be ready to conduct combat operations, then the Army's Behavioral Health network must focus primarily on medical readiness in support of that goal.

Objective 1: Maximize individual medical readiness. The first strategic objective of the Army's behavioral health network should focus on the main effort's value proposition, which is likewise nested in the parent organization's value proposition. Providing relevant and ready forces to combatant commanders requires all home station activity to center on ensuring that people, units, and equipment are ready to perform combat operations. Since the three enterprises participating in the behavioral health network have a stake in increasing the readiness level of soldiers, as defined by Army-wide standards[xiv], and

succeed in this endeavor through cooperative efforts, the first strategic objective must reflect this need for cooperative engagement.[1]

It is important to make the distinction between individual and unit medical readiness, as IMCOM and MEDCOM cannot directly affect the readiness levels of units. Additionally as we have observed, commanders of combat units currently affect unit readiness through substitution of medically ready and non-ready soldiers to affect unit readiness commensurate with the requirements of the Army Force Generation cycle. By focusing on individual readiness the system is forced to focus on medical outcomes for those with positive prognoses and expeditious discharges for those soldiers who are not expected to make a recovery that would allow the soldier to return to duty.

A behavioral health network strategy, cooperatively executed by the stakeholders (Fuchs et al., 2000)[xv], will enhance the Army's ability to deliver on its value proposition through an increase in the collective P-Level of warfighting units. Again we assume that FORSCOM is the Army's main effort, and that MEDCOM and IMCOM are supporting efforts. A strategic objective that links the three enterprises for collaborative efforts, aimed at a goal that each can affect, will encourage the development of integrated processes. Integration of the network processes should yield a reduction in structural inefficiencies, reducing costs for each, and an increase in soldier-centric care planning.

Objective 2. Build resilient soldiers through proactive education and skills development to mitigate self-imposed stresses. The second proposed objective for the behavioral health

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[1] There is important work to be accomplished in standardizing "readiness" across Behavioral Health providers. The authors found, during data collection, that there is widespread disagreement and/or lack of knowledge regarding what constitutes a status of "medically ready." Establishment of such a standard is outside the scope of this work, but must be addressed if standardization of network outcomes is a long term goal.

system is tied to *training* and *sustaining* of the Army's forces. Respondents at each site at which data was collected state that soldiers in the 18 to 24 year old demographic demonstrate a reduced capability to effectively deal with finances, relationships, sleep hygiene, use of alcohol, and the stress that mismanagement of each brings. These same sources report that combat-related stresses are fifth (or lower) on the list of those who cause soldiers to become NMR for Behavioral Health[xvi]. Commanders, Primary Care Physicians, and Behavioral Health providers alike state that the combination of combat stresses with the self-imposed stresses that results in duty-limiting conditions.

When we consider that that the Army's largest demographic is the 18 to 24 year old age group, then it follows that the behavioral health network must work together to teach this group to effectively deal with self-imposed stressors and stress. Development of an integrated, comprehensive system for training soldiers requires utilization and coordination of capabilities that are distributed across the network. Each enterprise has unique capabilities for building resilience, and by allowing each to concentrate on its organic competencies, mission overlap may be reduced and synchronization of training programs can yield positive synergistic behaviors that accomplish a greater end with an overall reduction in resource requirements.

As an example, IMCOM's Army Community Services employs financial counselors who are uniquely suited to proactively educate soldiers about financial management, the Family Life Chaplains in FORSCOM's Chaplain Corps are able to push relationship education, and MEDCOM's Department of Behavioral Health has organic social workers who can teach stress reduction techniques to soldiers before problems arise. Respondents at all sites report, and are frustrated by the fact, that all of these services are strictly

reactive, and by the time a soldier comes into contact with a professional he or she is already in crisis.

By coordinating and integrating resilience training to prevent crises the network enhances soldiers' abilities to reduce self-imposed stressors that reduce the collective capability to deliver on the organization's value proposition. Again, this must be approached as a collective and coordinated effort in order to preclude gaps and overlaps.

The Army has implemented an effort to holistically address soldier wellbeing through its Comprehensive Soldier Fitness (CSF) program (reference: Appendix E). The program addresses five areas that, together, generate fitness. These factors, Physical, Emotional, Spiritual, Social, and Family, are used as the framework in which resilience or strength should be improved. This program, since it is already in place, could be leveraged as a basis for stress reduction and mitigation efforts.

The Army has already started fielding a Master Resiliency Trainer (MRT) program that equips selected unit personnel to train basic stress reduction skills at the unit level, but those who have received the training report that their MRT duties are second in priority to their combat mission, and that they are unable to be everywhere, all the time. The MRT program is a step forward, but is no substitute for proactive professionally executed resiliency education. Again, to provide a comprehensive program, then the entire behavioral health network, to include clinical and non-clinical stakeholders, should embrace stress reduction and mitigation as one of its objectives.

Objective 3. Facilitate successful and expeditious transition to civilian life for soldiers who cannot meet medical readiness standards. Although some soldiers can be treated for Behavioral Health conditions and return to duty, not every soldier has a positive prognosis.

In order to meet the mission of reconstituting combat forces, it becomes necessary to discharge permanently NMR soldiers from the service. The separations process involves all three enterprises, and to be executed expeditiously will require integrated, standardized processes that reach across the three. This objective must be pursued in terms of efficiency and quality, as it is essential to deliver all appropriate services to separating soldiers with the intent of preparing them as well as possible for success outside the military.

The reason that this objective is important, in terms of delivery on the Army's value proposition is that separation of NMR solders makes room for replacements in FORSCOM units and reduces the demand for services from IMCOM and MEDCOM. By Army policy a FORSCOM unit may not request a replacement for an MNR soldier until that soldier is separated from the service, and respondents at all sites report that the current separation process for Behavioral Health reasons requires, on average, one year. For the year that the soldier is in the process the unit has reduced readiness and must expend human resources to ensure that the soldier's medical and administrative needs are met. Likewise for that year, IMCOM and MEDCOM must commit resources to both care delivery and the separation process. If the timeframe for separations is reduced all three organizations benefit. The separating soldier also benefits from the potential gains presented by a more efficient and effective separations effort. He or she is able to leave the military and enter a new career more quickly instead of waiting for the system while they are unable to contribute to the unit mission.

Streamlining the separations process requires contributions from all three enterprises, and if network processes are developed to improve efficiency and effectiveness, all stakeholders will benefit. Additionally, improvement on this objective, as

with the others, will enhance the parent organization's ability to deliver on its value proposition.

4.4 Chapter Summary

The Army's Behavioral Health network must develop shared strategic objectives for the three contributing enterprises. These objectives will serve as an overarching set of goals that drive integrated behavior toward a unified purpose. The network should identify its collective value proposition as well as the stakeholder, or in this case the enterprise, that is the primary value delivery agent or in the Army's terms, the main effort. Network strategic objectives should focus on the value delivery agent's value proposition in order to enhance the delivery of the network's mission, but improvement of network processes linked to those objectives should likewise benefit all stakeholders.

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Chapter 5 – Performance Measurement and Incentives

A unified set of network objectives is a first step toward integration of the three enterprises that contribute to Behavioral Health care provision. It is unlikely, however, that stakeholders will change their behavior and establish effective cooperative processes based solely on a call to unification through a set of altruistic goals. Without a persistent mechanism for affecting system behaviors, the thoughtfully established network objectives will likely turn out as the latest buzzwords that adorn PowerPoint briefings but generate no action beyond the status quo.

"Behavior that is measured is executed and improved upon"[i] is noted by many as common wisdom in commercial industries as well as in the military. The Army executes quarterly briefings in which subordinate leaders stand and individually account for their organizations' performance to their superiors. Underperforming organizations are "assisted" by their superiors in order to bring organizational functionality up to standard. Extra assistance from higher headquarters brings with it extra scrutiny, so junior leaders strive to meet and exceed the standards in reportable behaviors, often at the expense of other activities.

In order to induce behavioral change in the network, leadership must install a system of measurement and accountability for desired cooperative behaviors. The measured behaviors should be representative of the desired network outcomes.

Otherwise, performance measurement will generate unproductive or disruptive activity when stakeholders apply resources to those behaviors that are measured but not related to Behavioral Health network functionality.

5.1 Literature Review

Merrick, Garnick, Horgan, and Hodgkin (2002) analyze the use of quality management activities in behavioral health organizations. The authors proposed that in Managed Care Organizations cost savings had overtaken quality of care as a primary focus. The research found that patient satisfaction surveys and adherence to practice guidelines were the most common benchmarks for quality assurance used in three quarters of organizations surveyed. Conversely, use of clinical outcomes as quality measurement criteria were only used by half of those clinics surveyed. The authors propose that patient satisfaction and utilization of standard processes were reported out to organizations responsible for the clinics, while clinical outcomes were reported out, infrequently, to those purchasing clinical services.[ii]

Bititci, Carrie, and MdDevitt (1997) describe performance measurement as a critical driver of management and pursuit of strategic goals, and they cite integrity and deployment as the keys to success in measurement system development. [iii] Friedman, Kokia, and Shemer (2003) confirm these findings in their description of the Israeli HMO model that seeks to maximize the quality of clinical care within the constraints imposed by resources and government policies. This system links clinical processes to performance measurement criteria, which are specifically developed to improve upon strategic goals. The authors found that quality of health

care increases and costs are regulated when system goals, metrics, and processes are developed in concert. Additionally, information flow and cooperation in the network improved when performance measurement was used as an integration catalyst.[iv] Chennell et al. (2000) likewise address the potential for achieving success through alignment of measurement systems with strategic goals and tactical level processes.[v]

Neely, Gregory, and Platts (2005) describe performance measurement as the quantification of action, and by measuring action performance is enhanced. The authors go on to differentiate between effective and efficient action and assert that effective performance measurement systems may improve each.[vi]

Sydow and Windeler (2003) examine the applicability of Structuration theory to evaluation of networks of organizations. Using this theory the authors examine the evolutionary development of interfirm networks in as a social system whose behavior depends on its structure. Network effectiveness likely depends on a combination of "trust, fairness reciprocity, mutual commitment" and the collective will of the stakeholders to succeed. The writers conclude that due to dynamic complexity, performance of interfirm networks is very difficult to assess at high levels of granularity; however, specific network outcomes may be gauged and evaluate over time.[vii]

Neely (1999) discusses the need for improvement of performance measurement in many organizations, first because of a lack of integration with business processes and second because of poor, or no, linkages to company strategy. Conversely, the author cites a 1996 study that found companies who are high

performers consistently have financial and non-financial performance metrics that are understood by managers. These metrics are tied to strategic goals and are regularly updated as the company and its goals change. The author states in this work that re-engineering of processes necessitates a change to performance measurement systems to reflect the desired outcomes of the new processes. Unfortunately there is no universal, definitive set of criteria that, when improved upon, can assure success, further necessitating regular attention to its measurement systems.[viii]

Kaplan and Norton (2001) expand on Kaplan and Norton's (1992) Balanced Scorecard[ix] work to describe how measurement of leading indicators can allow proactive organizational leadership. This stands in contrast to their original work in which they used financial indicators as performance indicators, as financial criteria lag performance and induce reactive management.[x] Bourne et al. (2000) also stress the importance of performance measurement in achieving strategic success. Additionally, they emphasize the need for vigilance in continuous alignment of measurement systems with strategy, noting that the findings of effective measurement can greatly affect strategic system management.[xi]

Neely et al. (1994) acknowledge early in their work that performance measurement drives behavior in organizations and thus the execution of strategic plans. Further, the writers hypothesize that leaders will place greater emphasis on performance metrics that most closely align with their company's primary tasks. In their research they found that the hypothesis was true for companies whose competed on product quality, but was false for companies that achieved competitive

advantage with price. Further, companies who compete on price were found to use on-time delivery of the product as their primary performance measure. The conclusion of the work was that strategic goals for a firm are achieved through consistent decision-making and execution. Utilization of appropriate metrics in gauging performance is a tool that leaders may use to induce the desired behavior in their organizations.[xii]

The pervasive themes in the performance measurement literature inform us that alignment of strategic goals to measurement systems is an enabler for long-term success. Long-term success, however, is contingent on maintaining a continuous alignment of the two. Finally, measurement of activity drives behavior and improvement. Measurement systems, if implemented properly can be a powerful tool for strategic level management and decision making.

5.2 Metrics Development. In Chapter 3 we saw the effect of performance measurement on the network, producing inwardly focused and often counterproductive behavior. Neely, et al acknowledge, and evidence in this case confirms, that performance measurement drives organizational behavior an in turn the execution of strategy. If the Behavioral Health network is unified in effort under thoughtfully developed strategic objectives, then network performance must be evaluated under performance measurement criteria commensurate with those objectives.

The top-level goals of the network focus on integrated, full-spectrum behavioral health care delivery to the soldier, but current performance measurement criteria encourage behavior that does not consider other network

stakeholders. For this reason the Behavioral Health network must develop metrics that adequately measure the desired cooperative behaviors. If network-specific metrics are not developed, then we should not expect change in behavior. MIT Professor Jonathan Byrnes stated this idea succinctly: "People can know what the right thing is, and they can want to do it deep down in their heart. At the end of the day though, they're going to do what you pay them to do."[xiii]

An Army General Officer echoed this idea when he said that we must be extremely careful in metrics development because organizations will do "whatever they have to do to turn their indicators green on their PowerPoint slides."[xiv] By this he meant that if a leader is required to explain his organization's status to an agency to which he reports, then all of his resources will go into meeting the standards as measured by superiors.

Measurement of cooperative behaviors is imperative for affecting this type of behavior, but the network leaders must limit measurement to high-level activities. Sydow and Windeler's (2003) work informs us that due to dynamic complexity of interfirm behaviors, the level of granularity for these metrics must be maintained at level that promotes the desired results, and not the specifics. If performance measurement is kept at a sufficiently broad level, then the stakeholders in the network are able to innovate at the tactical level over time and refine integrative value exchanges that account for local constraints. This is consistent with the Lean Enterprise principle "People, not just processes, effectuate lean value."[xv]

In order to gauge the functionality of the network in improving collaborative behaviors, we must quantifiably measure those behaviors. Objective and

comparable measurement of network performance allows leader attention and influence to underperforming areas and transfer of demonstrated best practices to other installations. This is a further call for the development of well-thought-out metrics in order to avoid the management misstep of wanting what is measured rather than measuring what is wanted.[xvi] Thoughtful high level metrics that quantifiably and objectively measure desired outcomes will allow leaders to evaluate performance over time and apply resources or policy changes as needed to promote desired behaviors that are not being adequately met. If we accept that stakeholders will apply their resources toward evaluated behaviors, then leaders must ensure that network metrics are directly representative of the outcomes of the desired behaviors.

Since three enterprises contribute to the desired network outcomes, metrics developers should consider that most interactions exclude one enterprise. The non-participating enterprise should not be held accountable for exchanges in which they do not participate. Figure 5.1 shows the broad-themed activities shared by the network, and it is at this level that metrics should be

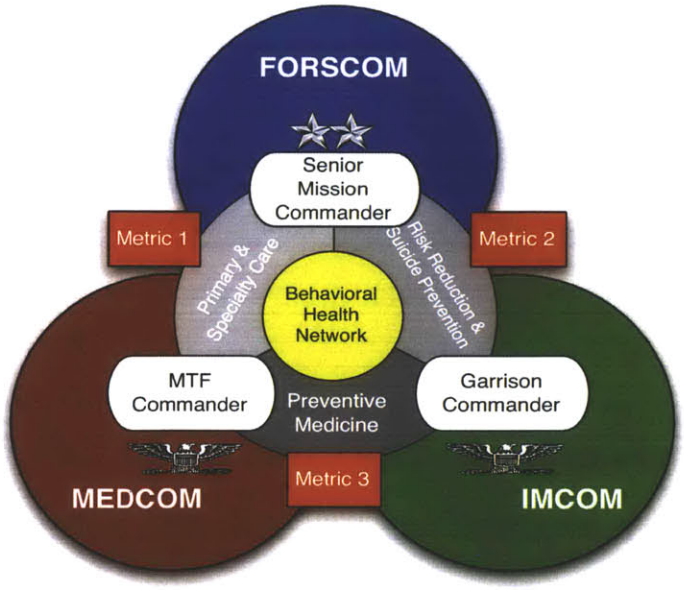

Figure 5.1. Cooperative Behaviors and Measurement Points for Network Metrics.

established. This creates a system of measurement in which enterprise leaders at the installation levels are evaluated on their work with each of the other enterprise leaders and enable a holistic approach to network behavior modification to align with network strategy. This holistic approach in consistent with the Neely's finding for the effect of performance measurement on companies who focus on quality rather than financial rewards.

Finally, metrics developers should gauge activities that involve all three enterprises and use those for an overall network health indicator. Although most value exchanges involve two enterprises, there are some activities that require input from all three, and these should be used as the installation's highest-level metrics for evaluating progress over time. Since activities that require all three enterprises will likewise require a more complex, or at least more numerous, set of inter-enterprise value exchanges, it follows that progress in those criteria will be indicative of the maturity of the network integration.

5.3 Metrics Developers.

Freidman, Kokia, and Shemer (20030 stated that quality of care and cost savings are best achieved when metrics are developed concurrently and as a complement to strategic goals. Since senior leaders develop the strategic objectives for the network it follows that these same leaders should develop the performance metrics by which installations Behavioral Health network will be measured. Metrics should be cooperatively developed by the top-level leaders of the Army with the leaders of the three applicable enterprises, shown in Figure 5.2 to ensure adequate

accounting of shared activities and to show leader buy-in to the change to the status quo in accordance with Enterprise Transformation Principles.[xvii]

Development of these performance measures by the top-level leaders serves two additional purposes. First, as Neely (1999) points out, it is important to continuously re-evaluate measurement systems, and since the standardized metrics will span many installations, it is necessary for revisions to the measurement system to be executed at such a level that can standardize the full organization. Second, top-level leaders are the overseers of the network at every installation. If objective, quantifiable comparison of installations and subordinate leader performance is a desired attribute of the measurement system, then standardization of the system, driven from the top down, is critical to success.

5.4 Incentive Systems

As discussed in Chapter 2, the incentive systems for military and Department of the Army Civilians is static, and cannot be changed without a change in law. Because of this we must consider modification to the incentives themselves as a constraint to transformation of the network. Military and civilian annual performance evaluations, however, may be changed simply through a change to Army Regulation, and Army Senior Leadership is empowered to make this sort of change. Incentives for network leaders and stakeholders at all levels should be aligned to Behavioral Health network metrics. With a standardized, objective measurement system in place that gauges the effectiveness of these leaders in generating desired behaviors there is an opportunity for the Army to demonstrate emphasis on improving its Behavioral Health System. Alignment of installation-level leader evaluations, and

thus incentives, to Behavioral Health network will demonstrate leadership emphasis and further force behavioral change.

5.5 Proposed Initial Metrics.

The first set of metrics to consider are those that measure processes that involve only two enterprises. In the interest of leader evaluations, this allows each to be measured in terms of two organizational relationships, which may reveal particularly successful or unsuccessful leaders. Proper use of this technique will prevent one officer from being rated on the merits of another. Proposed Initial Metrics are summarized in Table 5.1 (below).

5.5.1 FORSCOM and MEDCOM. The shared processes for these two enterprises will focus on the administration of Primary Care and Specialty Care. Each enterprise has a stake in the success of the other for this purpose.

Metric 1.1: Duty hours lost due to time spent in Behavioral Health Care (Unit-Based and Outpatient Specialty Care). By measuring soldier duty hours lost due to time in care, with the goal of minimization, we can evaluate the effectiveness of several processes. The first is the shared process of personnel accountability. When soldiers leave their unit area to go to medical care, the unit's readiness decreases, both in terms of personnel and training. Commanders at all sites report that when soldiers go to Behavioral Health care they are gone for, generally, half a duty day. Clinical providers concurrently report that they have very short waiting times in their facilities, and that times for patient encounters are strictly observed. By measuring lost hours, FORSCOM units are compelled to get soldiers to care expeditiously and MEDCOM providers are required to streamline clinical processes

that allow soldiers to minimize time spent waiting for care, so that soldiers can get back to their unit areas.

More importantly, this metric encourages FORSCOM Primary Care Providers and MEDCOM Clinical Providers to seek positive medical outcomes in a timely fashion. If a soldier is in treatment for a protracted period of time, then it is likely that he or she requires a greater number of appointments that would remove him or her from the unit area.

Metric 1.2 Soldier-days lost due to duty limiting behavioral health profiles. If leaders measure the time that soldiers spend on duty limiting profiles that effectively remove them from the unit's readiness numbers, and attempt to minimize this number, performance measurement may affect the two behaviors. First, clinicians will be more likely to write profiles that enable soldiers to continue to perform within the limits of their condition, rather than prohibiting such an array of activities that keeps the soldier from performing any mission tasks. Second, minimization of this metric will likely cause FORSCOM units to engage the Behavioral Health system so that unit Primary Care Physicians may oversee a treatment plan that facilitates quicker recovery.

5.5.2. FORSCOM and IMCOM. These two enterprises work together to execute risk reduction, suicide prevention, and substance abuse treatment. Network metrics for this relationship will focus on the risk behavior reduction and on successful completion of the ASAP Program.

Metric 2.1 Soldier days lost due to preventable incidents related to manifestations of identified risk behaviors. IMCOM's Community Health

Promotion Council, Directorate of Emergency Services, and ASAP each work to provide prevention programs and education for risk behaviors (reference Figure 3.1) and to track manifestations of these behaviors for trend tracking. FORSCOM units execute a robust safety program that includes risk behavior reduction, corresponding to IMCOM's Installation Risk Reduction Program. If minimization of this metric is pursued cooperatively then installation leaders should expect to see progressively improved integration of these programs and a resultant reduction in risk behavior manifestations.

Metric 2.2 Percentage of soldiers successfully completing the ASAP program and returning to duty. The goal of maximizing this metric should prompt action from both enterprises, as the program requires participation from both. First, FORSCOM leaders will likely further engage ASAP for the purpose of developing and executing a tailored recovery program. Additionally, units will be more likely to ensure that soldiers attend all appointments with ASAP Counselors. ASAP personnel will be compelled to track soldiers closely through effective integration exchanges with FORSCOM units. This will likely result in continued enrollment in the program during disruptive periods such as soldier transitions to a new unit, a new installation, or deployment.

5.5.3 IMCOM and MEDCOM. These two organizations work together for several purposes, but the one most closely related to the Army's Behavioral Health network is the Warrior Transition Unit. MEDCOM provides medical support through intensive case management as well as priority for appointments to soldiers in these units. IMCOM extends special institutional services such as family programs and

education to WTU soldiers. These two enterprises already work closely in the WTU processes, and addition of network metrics will encourage improvement in them.

Metric 3.1 Percentage of WTU soldiers returning to military duty. For those soldiers with a positive prognosis but an extended period of convalescence, MEDCOM and IMCOM can execute integrated processes to return soldiers to combat units as quickly as possible. MEDCOM already gives enhanced access to WTU soldiers, enabling them to get all of the clinical treatment that they need to improve their medical conditions. Respondents at all sites indicated that family programs for soldiers in the WTU are particularly important, as Behavioral Health related conditions add exceptional stress to family members. As discussed in Chapter Four, relationship stress is a significant challenge for young soldiers, so integration of family services with clinical Behavioral Health services will likely improve outcomes and timelines for WTU soldiers.

Metric 3.2 Average time for WTU program completion for soldiers leaving the military, with TBD quality measures fulfilled. WTU Commanders have reported frustration with the time required to complete their program for those soldiers who are transitioning out of the military. The WTU Commander at Site A listed administrative processing requirements as his number one issue. These processes are executed by MEDCOM and IMCOM, as soldiers in the WTU are no longer part of FORSCOM units. By streamlining their administrative processes to meet the goal of minimizing completion time these two enterprises would open capacity and relieve resource requirements associated with the WTU.

These same WTU Commanders state that their soldiers are likewise frustrated with the time to complete the program. The soldiers' goal is to complete the program as quickly as possible, so that they may begin a career in a civilian profession. The military owes certain benefits and opportunities to these soldiers, so expeditious transition to civilian life should not out prioritize quality of treatment and quality assurance in WTU processes. For that reason, quality metrics must be strictly observed in these processes.

5.5.4 Full Network. As mentioned above, certain processes require the full Behavioral Health network for execution, and these should be gauged not only to improve performance, but also as an indication of the overall integration of the network. These Behavioral Health processes are both related to separation processes.

Metric 4.1 Average time required for Medical Evaluation Board (MEB)/Integrated Disability Evaluation System (IDES) process completion with TBD quality measures fulfilled. With the exception of the WTU, soldiers who are processing out of the military under MEB/IDES require input from all three enterprises. MEDCOM must execute clinical evaluations and treatment for the duration of the separation process. Additionally, MEDCOM must make a recommendation for disability ratings for separating soldiers. As with WTU separations, IMCOM must provide family and education services during separation, as well as ASAP in applicable cases. FORSCOM must maintain accountability, Primary Care, Commander Evaluations, Administrative, and legal support to separating soldiers. The typical time for a medical separation across the sites is one

year. Through careful integration of processes for the goal of minimizing the time requirement for the separation process, again without sacrificing quality, the entire system and the separating soldier will benefit.

Metric 4.2 Average time required for Chapter separations. As with Medical Separations, Behavioral Health-related administrative discharges require inputs from all three enterprises. For the purposes of performance measurement, the processes are very similar, and minimization of the time requirement will yield benefits for all stakeholders.

Table 5.1 Proposed Initial Behavioral Health Network Performance Measures

Number	Metric Name	Enterprises	Who Measures	Induced Behavior	Outcomes
1.1	Duty hours lost due to time spent in Outpatient Behavioral Health Care.	FORSCOM MEDCOM	FORSCOM Battalions	1. Expeditious movement to and from appointments. 2. Improved clinical support processes	1.Improved accountability. 2.Increased availability for training. 3.Resource conservation for service providers
1.2	Soldier days lost due to duty limiting Behavioral Health profiles	FORSCOM MEDCOM	MEDCOM Behavioral Health Providers	1. Generation of standardized and effective Behavioral Health profiles. 2. Improved communication between commanders and providers 3. Unit action for facilitation of Behavioral Health treatment	1. FORSCOM P-Level increases 2. MEDCOM capacity saturation is reduced by returning NMR soldiers to duty. 3. Shared situational awareness between command teams and providers.
2.1	Soldier days lost due to preventable incidents related to manifestations of identified risk behaviors	FORSCOM IMCOM	FORSCOM Battalions	1.Integration of FORSCOM commanders safety program with IMCOM's installation safety program. 2.Proactive, coordinated safety education.	Coordinated action results in fewer risky activities: 1.IMCOM's "shot group" rating improves. 2.FORSCOM P-Levels improve 3.MEDCOM resources are preserved with respect to clinical treatment of risk manifestation outcomes.
2.2	Percentage of Soldiers completing the ASAP program and returning to duty	FORSCOM IMCOM	IMCOM – ASAP	1.FORSCOM leaders increase participation in recovery plans. 2.ASAP Counselors actively engage unit leaders to maintain accountability and cooperative action.	1.IMCOM's ASAP success rating increases. 2.ASAP completion rate approaches 100%. 3.FORSCOM retains trained soldiers. 4.IMCOM/FORSCOM realizes improvement in risk behavior manifestations. 5.MEDCOM benefits from reduced incidents of substance dependence comorbidity.

Table 5.1 Proposed Initial Behavioral Health Network Performance Measures (continued)

Number	Metric Name	Enterprises	Who Measures	Induced Behavior	Outcomes
3.1	Percentage of WTU soldiers returning to duty	IMCOM MEDCOM	MEDCOM – WTU	1.WTU intensifies focus on positive medical outcomes. 2.IMCOM focuses support services on returning soldiers to duty vs. transition to civilian life.	1.MEDCOM reduces the volume of medical separations, saving resources allocated to those processes. 2.IMCOM career transition services are relieved, and resources may be reallocated to other purposes.
3.2	Average time for WTU program completion for soldiers leaving the military, with TBD quality measures fulfilled.	IMCOM MEDCOM	MEDCOM – WTU	1.Administrative processes synchronized with medical processes. 2.Case management focuses on active coordination of inter- and intra-enterprise processes. 3.IMCOM transition services aggressively provides proactive career training	1.MEDCOM resources realize long-term relief by expeditiously transitioning chronic care patients to civilian providers. 2.IMCOM refines career transition services for increasingly efficient operation. 3.FORSCOM benefits from additional WTU capacity.
4.1	Average time required for Behavioral Health MED Board Separations	FORSCOM IMCOM MEDCOM	FORSCOM Division Staff	1.Integrated value exchange processes are defined, standardized, and improved. 2.Coordination between enterprises yields consistent, quality assured outputs for separations.	1.MEDCOM resources realize long-term relief by expeditiously transitioning chronic care patients to civilian providers. 2.IMCOM refines career transition services for increasingly efficient operation. 3.FORSCOM benefits from increased P-Levels resulting from separation of NMR soldiers.
4.2	Average time required for Behavioral Health Chapter Separations	FORSCOM IMCOM MEDCOM	FORSCOM Division Staff	1.Integrated value exchange processes are defined, standardized, and improved. 2.Coordination between enterprises yields consistent, quality assured outputs for separations.	1.MEDCOM resources realize long-term relief by expeditiously transitioning chronic care patients to civilian providers. 2.IMCOM refines career transition services for increasingly efficient operation. 3.FORSCOM benefits from increased P-Levels resulting from separation of NMR soldiers.

5.6 Chapter Summary

Performance measurement drives behavior in organizations. When organizational goals are aligned with metrics, they have a higher probability of progress toward those goals. Conversely, when metrics do not support desired behavior, and then stakeholders will apply resources to counterproductive actions and are likely to cause dysfunction. Networks with many stakeholders should have metrics at a sufficient level of granularity that measure high-level desired outcomes. This facilitates innovation by stakeholders to overcome dynamic complexity and local

constraints. The thoughtful development of objective performance measurement criteria that measure integrated behavior in a network can enable cooperative behavior as well as a standardized system of evaluation for leaders.

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Chapter 6 – Network Governance

A critical component to an organizational network is a governance structure to direct the actions of the stakeholders in order to maintain unity of effort toward meeting strategic objectives. A network body should not only oversee and direct the actions of the member organizations but also measure network performance over time with the intent of using network resources to assist stakeholders in improving value exchanges that lag in performance.

Installation of a behavioral health network governance body for the Army would ideally leverage existing reporting relationships, but currently faces significant challenges in spanning organizational boundaries. Although policy and regulation changes may be necessary to establish governance for the network, a review of the academic literature may provide insight into the specific leadership structure and capabilities that the Army should consider prior to establishing a controlling body for the multi-enterprise network.

6.1 Literature Review

Provan and Kenis (2008) studied the effects of governance structure on the effectiveness of a network. They state coordination of many organizations into a cooperative network allows for an increased ability to solve complex problems through leveraging of stakeholder competencies for a broad spectrum and holistic approach to the provision of services. For a network with a shared goal it is necessary to install some sort of governing body to direct action, resolve conflict, and properly allocate resources. The three proposed possibilities for governance

structure are Participant Governance, Lead Organization Governance, and Network Administrative Organization. In the first, each organization in the network collaborates with the others to make decisions in a governing council. In Lead Organization Governance, a single stakeholder is charged with coordinating all network activities and decisions for the whole. Finally, a Network Administrative Organization (NAO) could be established as an outside entity that serves as the leader and overseer of network activities. The authors found that in large, complex networks that the NAO was the most likely to be effective, although each of the forms is viable.[i]

Lowndes and Skelcher (2002) emphasize the importance of effective network governance on developing networks for fostering collaborative behavior in instances where stakeholders have no experience working across organizational boundaries.[ii] Complementing this work, Winkler (2006) addresses the role of network leadership in resolving conflicts among stakeholders in goal-driven networks.[iii]

Emerson, Nabatchi, and Balogh (2011) provide a definition for governance in their work that applies well to the concepts presented in this work. By their definition, governance is the "processes and structures of public policy decision making and management that engage people constructively across the boundaries of public agencies, levels of government, and/or the public, private, and civic spheres in order to carry out a public purpose that could not otherwise be accomplished." The work goes on to build a framework for collaborative governance of networks that would enable emergent behavior by through

transparency and accountability to other organizations, overcoming bureaucratic hegemonies that stifle progress. Most important in this work is the description of network behavioral drivers, which include consequential incentives, interdependence, and leadership. The network leader helps to obtain resources beyond those available to individual stakeholders, so that new integrative solutions may be implemented without severely impacting individual stakeholder performance in areas outside the network purview. The authors acknowledge that network leadership is very difficult, as each stakeholder will have responsibilities and reporting requirements outside the network.[iv]

Park (1996) addresses the criticality of network control and the risks and costs of working with other organizations. The author proposes that network governance by an external body is preferable to cooperative control due to the likelihood of stakeholder or lead agency bias toward resource allocation or decisions that favor a specific agency and its reporting/incentive structure. Park states that the establishment of third party control over a set of organizations is difficult to impose upon stakeholders unless that outside agency is mandated by law or, in the case of a hierarchical organization, by a higher headquarters.[v] Calton and Lad (1995) stress the importance of trust relationships between stakeholders as a factor in network control, and emphasize the responsibility of leaders to facilitate trust building among network participants.[vi]

Jones, Hesterly, and Borgatti (1997) propose that for a governance form to do well, it must directly address the uncertainties in the network that emerge from complex value exchanges among stakeholders. Network leadership must be capable

of adapting and preserving value transactions among the stakeholders, given that each of the organizations in the network act autonomously and processes will evolve over time.[vii] Claro, Halelaar, and Omta (2003) confirm the role of network leaders in promoting the maturation of relationships of network agencies over time.[viii] Larson (1992) further asserts the certainty of network evolution over time, and implies that trust and social relations provide limited safeguards to sudden, disruptive changes to network architecture.[ix]

Provan and Milward (1997) analyze four mental health networks to determine factors that contribute to network effectiveness. Among these factors are the maturity of network integration and the modes of network control. The authors state that the critical issue for senior leaders and network planners are the outcomes of the network as a whole, and not the effectiveness of an individual stakeholder. Through integration of services the network may provide a spectrum of coordinated care, holistically addressing the specific needs of a patient through collaboration among experts. Finally, the authors proposed that direct, centralized external control would maximize network effectiveness.[x] Sauvee (2002) asserts that effectiveness of the network as well as efficiency in resource utilization is the crucial components to network success, and the responsibility for each lies on leadership.[xi]

Throughout the literature on network governance we see the theme of leadership involvement stakeholder relationship building, which is sensible because the development of formal processes between independent organizations will certainly generate turbulence between the stakeholders due to the disruption of

existing informal processes. Second, we observe several alternatives to the organizational architecture of governance agent itself. Each alternative appears viable and warrants a consideration of the opportunities and challenges of each alternative. Third, we observe the opportunity for a governance node to leverage the unique capabilities of each stakeholder in the establishment of recurring network processes, so generate an appropriate and comprehensive spectrum of services for each patient entering the system in order to maximize patient and network outcomes.

6.2 Considerations for the Establishment of a Governance Body

Each enterprise and, with few exceptions, the stakeholders involved have interests that lie outside the scope of the Behavioral Health network. Army leaders should expect up front resistance to the imposition of additional requirements and oversight. Likewise, as Sydow and Windeler[xii] point out, cooperative arrangements require time to yield strong results, as maturation of the integration of multiple stakeholders is not a fast process. In a results-driven organization such as the Army the enterprises will likely continue to resist new organizational arrangements throughout the maturation process. For all of these reasons, Army Senior Leaders should observe Park's assertion that enduring policy from a headquarters above the three enterprises should be used to impose a network governance structure.

A governing body for the network must have the authority to reach across and affect necessary change in each of the three enterprises. Emerson et al. emphasize the point that stakeholders must continue to execute the requirements of their parent organizations and formal reporting change. The governing body must

be sensitive to the fact that nearly all stakeholders have primary objectives that fall outside the scope of Behavioral Health network processes. At the same time, the governing body should complement installation level enterprise leaders' efforts to improve functionality across organizational boundaries.

Finally, the network control body should work closely with installation level enterprise leaders when proposing changes to stakeholders' internal processes. As Provan and Milward suggest, the network governance body must concern itself primarily with the overall execution of network goals and cooperative outcomes. Optimization of individual stakeholders by the network governance body is disruptive for two reasons. First, if a specific component of a system is completely optimized, then the overall system cannot be fully optimized.[xiii] Second, affecting the internal processes of a network stakeholder will cause unintended consequences for that stakeholder's performance within its parent enterprise.

6.3 Governance Architectures

Provan and Kenis suggest three alternatives for the architecture of a network governing body. Each of these are viable for the Army's Behavioral Health network and provides unique capabilities and limitations.

6.3.1 Participant Governance. Administration of the Behavioral Health network by its participants would allow direct participation by the commanders and/or representatives of each of the three enterprises on the installation. This sort of arrangement is already in place at each Army installation in the Community Health Promotion Council, and the CHPC could be used as a starting point for a participant governance model.

This architecture is desirable because it allows active participation by each enterprise toward solving local challenges giving real consideration to the limitations of each participant and the costs that alteration of value exchanges and stakeholder processes. Jones et al. state that network leaders must understand the changes in stakeholders over time and how those changes will affect their transactions with other network members. It is likely that individual enterprise leaders will best understand their subordinate organizations and will be able to predict disruptions to network activity.

The downside of this model is the inherent tendency of an organization's leader to seek solutions to problems that are most advantageous to his or her own enterprise. Emerson et al. acknowledge this network leadership difficulty in their work when they state that this type of architecture results in network leaders reporting to two bosses. Since each leader's reporting chain moves away from the installation as shown in Figure 6.1 (next page), it is likely that some institutional bias will affect network decision making.

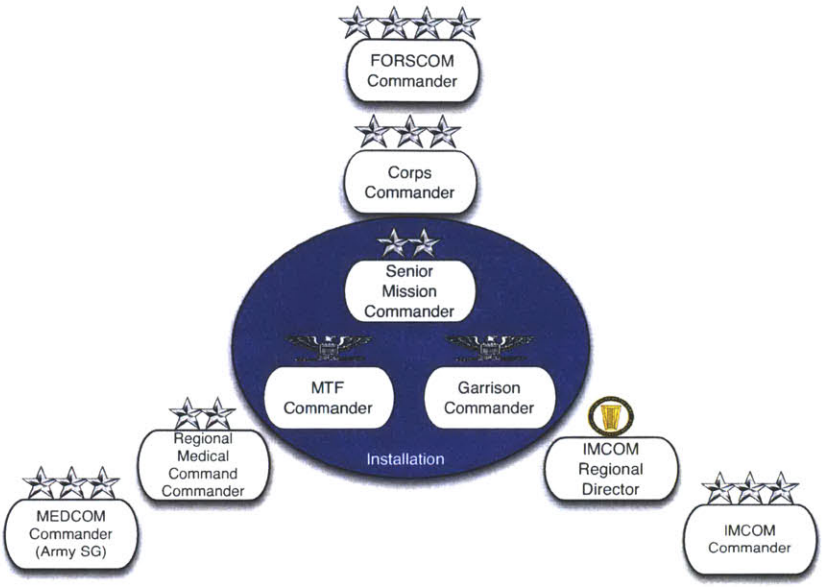

Figure 6.1. Network Leader Reporting Chains

6.3.2 Lead Organization Governance. Network governance by a lead organization would allow for consolidation of decision making authority and would remain most true to Clausewitz's, and the Army's, principle of Unity of Command.[xiv] The Senior Mission Commander would cause FORSCOM to be the lead organization on each installation because of the Army's rank structure. Each of the other enterprise leaders already maintains a reporting relationship with the Senior Mission Commander (SMC), so this arrangement is established.

The upside to this method of governance is that the SMC is ultimately responsible for all activities on the installation already. The addition of Behavioral Health network governance to the SMC will not disrupt the pre-established hierarchy.

This lack of disruption to the hierarchy, while a positive in terms of maintaining established command relationships, is a negative in terms of not

changing the status quo. There is likelihood with this architecture that network governance would yield no benefit to the functionality of the network. In addition to this danger, Park directly addresses the weaknesses of the lead organization governance model, specifically in the potential for lead agency bias and allocation of network resources toward lead agency efforts. Finally, since the SMC is responsible for all activity on the installation, this additional responsibility will most likely be delegated to subordinates, which will include the IMCOM and the MTF Commander.[1]

The final downside to lead agency governance is that the Senior Mission Commander leads a deployable headquarters and is subject to yearlong absences from the installation. This situation, although not impossible to manage, would serve to disrupt network leadership on the installation and to possibly cause distraction for the SMC during combat deployments.

6.3.3 Network Administrative Organization (NAO). Governance by an NAO would require the installation of a new organization outside the FORSCOM/MEDCOM/IMCOM hierarchies to direct network activities and control Behavioral Health network-specific resources. As suggested by Park, a headquarters above the three enterprises on the installation would establish this type of architecture. This form of network governance would be the most resource

[1] The author worked for 18 months in the office of the Senior Mission Commander of an Army installation. Although the SMC is responsible for all activity on the installation, the Commander is too busy to not delegate authority for nearly every activity. The rule is that the Commander must understand where he or she is most needed and to position him/herself at that spot. The most important place changes from hour to hour, so it is imperative that the commander delegates authority to subordinates to act on his behalf when he/she must be located elsewhere.

intensive of the three up front, since it requires new personnel, buildings, and equipment.

The NAO would facilitate unbiased network decision making, resource allocation, conflict resolution, and performance measurement for the three enterprises. Since the mandate for such an organization would originate from a headquarters above the installation's three enterprises, presumably the Vice Chief of Staff of the Army, it could likewise serve as a standardization node for Behavioral Health networks across the Army. Finally, since the NAO is detached from the other organizations on the installation, it could devote all of its resources to the improvement of the network effectiveness.

The challenges to the NAO governance structure also lie in its detachment from the other enterprises. Since this organization is an "outsider" it is less likely to be attuned to dynamic behaviors and structures of the stakeholders than the enterprise leaders would be. Also, this body would be less sensitive to stakeholder requirements that fall outside the Behavioral Health network processes. The leader and staff of the NAO would have to work very closely with the installation's enterprise leaders to remain well informed and integrated into the network that it oversees.

6.4 Recommendation for Governance Structure

Because of the need for Army-wide standardization and organizational learning, a Network Administrative Organization, chartered by the VCSA, is most likely to succeed in governing a Army installation's Behavioral Health network. Provan and Kenis, Park, and Provan and Milward all favor the NAO for large, complex networks

for a number of reasons. Although this governance architecture requires resources up front, its advantages present a great opportunity for long-term effectiveness.

The NAO's exclusive mission of developing the Behavioral Health network would allow it to focus on developing inter-enterprise value exchanges in a way that the other forms of governance could not. Likewise, the NAO could use objective performance measurement data to inform enterprise leaders and stakeholders of areas that need immediate improvement, and it could concurrently work to develop solutions that benefit the stakeholders, their parent enterprises, and the Behavioral Health network. Finally, since the NAO reports directly to the Office of the VCSA, it can serve as a network knowledge capture mechanism to record effective practices and share them among the Behavioral Health NAOs across the Army.

6.4 Chapter Summary

The final component to coordinating an Army Behavioral Health network is Network Governance. A governing body must be capable of affecting behavior in all of the network's stakeholders in order to unify effort toward the accomplishment of the network strategic goals. Although there are several viable architectures for network control the academic literature as well as practical considerations favor the establishment of an external governance agency to execute decision making, performance measurement, resource allocation, and conflict resolution at the installation level; and knowledge management at the Army level.

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[v] Park, Seung Ho. "Managing an Interorganizational Network: A Framework of the Institutional Mechanism for Network Control." *Organization Studies* 17.5 (1996): 795-824. Print.

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[xii] Sydow, Jorg, and Arnold Windeler. "Organizing and Evaluating Interfirm Networks: A Structurationist Perspective on Network Processes and Effectiveness." *Organization Science* 9.3 (1998): 265-84. Print.

[xiii] Ackoff, Russel L. *Ackoff's Best: His Classic Writings on Management.* New York: Wiley, 1999. Print.

[xiv] Headquarters, Department of the Army. "Army Doctrine Publication 3-0: Unified Land Operations." Washington, DC. October, 2011. Print

Chapter 7 – Lessons Learned

7.1 Conclusions

Behavioral Health provision is different than any other activity that the Army executes at home station, because it requires action that crosses enterprise boundaries and chains of command. None of the organizations involved is able to independently generate the desired value, and disjointed or piecemeal attempts to improve behaviors have proven to produce substandard system performance.

Stakeholders in all three enterprises must understand that for the purposes of Behavioral Health, they are truly interdependent. The need for full-spectrum, coordinated care requires expertise beyond what may be found in any single organization in the system. This work does not call for the addition or subtraction of services or programs, as the Army already has a broad range of capabilities on each installation. Rather, this work asserts the need for integration of clinical and non-clinical; command-driven, and installation-based programs and services to yield an emergent cooperative care system that is both effective and efficient.

To achieve this end, the enterprises must have common strategic goals that allow them to work together in a united effort. These strategic objectives should be specific in regard to the capabilities of the network, and linked to the objective of the larger organization. In this case, the network's objectives center on the cooperative and coordinated provision of Behavioral Health services to soldiers, but the objectives directly support the mission of readiness.

In the current state we observed that on paper the three enterprises each list readiness or support to readiness as a strategic goal, but in execution there is little evidence of cross-organization integration indicative of a system with a shared purpose. Stated bluntly, FORSCOM units are frequently guilty of suppressing demand for Behavioral Health services either for the purposes of maintaining P-Levels or by attempting to provide services that are better provided by legitimate clinical experts. MEDCOM behaves more like a system of civilian community hospitals that provides support to individuals who happen to be part of warfighting units, rather than the larger Army mission. IMCOM likewise tends to focus inwardly on making services available as a safety net due to their system of performance measurement, but executes few proactive programs that prevent Behavioral Health emergencies. Establishment of a common objectives could serve as a catalyst for generation of integrated behaviors with a proactive focus on an "ounce of prevention" rather than a reactive system that applies a "pound of cure" in an uncoordinated fashion.

In Chapters Two and Four we discussed the reasons for behaviors that defy or support cooperative action. We should not attribute blame for inwardly focused behaviors to the system stakeholders, as each focuses on measured and incentivized behaviors. Most interviewees stated frustration due to thier inability to do what was needed, in terms of working together with other organizations, due to a need to focus on the actions that they had to do because of existing measurement systems. In order to bring about a change in stakeholder action, the network leaders must install a measurement and accountability system that links expected behaviors to

desired network outcomes. If leaders desire a certain action, then that action should be measured and stakeholders should report their own performance to network leaders. Otherwise, leaders should expect no change.

Finally, the installation of a network governance node is necessary to coordinate integrated action across organizational boundaries. Retaining the traditional hierarchical control fits well into the Army mold but, as discussed in Chapter Six, is subject to many limitations and constraints. Although lead agency or stakeholder driven governance are viable alternatives, the literature and practical considerations favor the implementation of an independent governing body chartered by, and acting on the authority of, the Army's senior leadership. Authority in this governing body must be limited to activities that contribute to desired network outcomes, and must come with a mandate for coordination with installation level leaders, so not to disrupt execution of the enterprises' primary value propositions.

The establishment of a Behavioral Health network should not be expected to be an easy endeavor, nor should anyone involved expect quick results. A change in architecture or processes, particularly of the magnitude described in this work, will always result in an initial period of underperformance[i], but should be expected to generate significant improvement in Behavioral Health provision over time. The principles that underpin this work[ii] have been proven to generate successful outcomes in the transformation of disjointed systems of organizations, but the timeframe for appreciable maturation is typically expected to be around five years[iii]. As stated previously, the Army is a results-driven system, and due to quick leader

turnover it is organizationally impatient. Network leaders should expect a resistance to implementation but should likewise expect, if they are patient, organizational change that exceeds previous outcomes and makes a greater contribution to the Army mission.

7.2 Areas for Further Research

One of the issues that was discovered in the process of data collection is the impact of physical architecture on network performance. Location of Behavioral Health services affects both care delivery and information flows among the stakeholders. The Army has likewise recognized this phenomenon, and has introduced the Embedded Behavioral Health architecture, which will place MEDCOM-owned clinical providers within the Brigade Combat Team footprint. Units outfitted with this architecture report both quantitative and qualitative improvements in performance over the centralized specialty care architectures that most installations use. Further study into this area could inform network leaders on the effects of physical proximity on network integration and performance.

A second area for further study is the relationship between comprehensive patient knowledge management and network performance. Respondents at each of the sites where data was collected reported discontinuities in knowledge management systems, which resulted in an impediment to coordinated care among stakeholders. As an example, MEDCOM maintains an electronic medical record on each patient that is protected by policy from non-clinical providers, and by practice from commanders, who may benefit from the information contained within. Likewise, FORSCOM units maintain local records of periodic performance

evaluations, which could be, but are not, used to inform clinical providers of patient background for both clinical treatment and for the separations process. Further research into the integration of knowledge management systems and network performance could inform network leaders of a possible multiplier to network performance.

Finally, further research should be conducted on the development of performance metrics that are used to assess network performance. Specific consideration should be given to the appropriate level of granularity of these metrics, and the effect of network metrics on existing stakeholder processes. This type of work could be used to specify the required fidelity for performance measurement in the Behavioral Health network and the potential for excessively rigid measurement systems that could stifle innovation at the individual stakeholder level.

7.3 Hurdles

To call the proposition of breaking down organizational boundaries in Army organizations *radical* is a tremendous understatement. The Army has operated as a hierarchy with semi-independent functional workgroups for its entire 237 years. Military history texts attribute decentralized leadership and independence in fighting units as a key to the American Army's tradition of success in battles. Every soldier knows what it means when another tells him or her to "stay out of my lane," which is to say that someone or some other organization is encroaching his or her assigned area of responsibility. Leaders should expect organizations to balk at the

perception of working for another organization when that organization should be able to work on its own.

The adoption of a new organizational architecture would present a major shift in culture and would require non-trivial changes to Army policies. Likewise, operational level leaders will likely resist the addition of a measurement system that holds them accountable for cooperative relationships as they have historically been evaluated exclusively on individual performance. These leaders will likely be uncomfortable with career risk associated with evaluations that depend partially on another member's abilities and performance.

The final, and tallest, hurdle is the difference in MEDCOM and FORSCOM organizational cultures and the inherent clashes in value propositions. In the current state, and I say this from first hand experience, FORSCOM commanders are loathe to allow a medical doctor to affect the operation of a combat unit. Likewise, Army doctors generally resent the idea that a non-medical officer could affect clinical processes. I have been on the receiving end of this resentment several times during data collection for this study. A former Vice Chief of Staff of the Army best represents this idea in the recounting of an encounter with an MTF Commander, four ranks lower than the VCSA, who informed the VCSA that he [the doctor] would not follow the guidance given by the VCSA, because the VCSA was not a doctor and could not tell him [the doctor] how to run his clinic.

In simple terms most FORSCOM Commanders and MEDCOM clinicians have a dysfunctional, adversarial relationship. A Division Command Sergeant Major at one of the data collection sites remarked, correctly I believe, that the reason for this

dysfunction are that neither understands the mission of the other, and the near total lack of communication between the enterprises.

Combined, these reasons demand the need for buy-in and oversight by the Army's senior leadership during implementation. The leaders of the three enterprises must drive this change effort under the mandate of the VCSA's office. Without top-level emphasis and control, reinforced with enduring policy change, any of these three challenges could present a disruptive force that could derail execution.

7.4 Insights

Throughout the course of this work I have discovered a great deal about an organization that I previously thought that I knew a lot about. The biggest single lesson learned from this effort is the value in understanding why people and organizations act like they do. Collection of raw data through activities such as value stream mapping and stakeholder surveys are effective for determination of the *who*, *what*, *how*, and *when* of a problem. At a micro level these four pieces of data may perfectly inform process improvement efforts that yield effective and sustainable solutions that affect stakeholder value exchanges.

In eighteen years of military service and six years of civilian education in engineering and management I've learned that the people in the system and the decisions that they make lie both at the root and the solution of every system problem. Despite the military's world-class technology, behind all the moving pieces in complex organizations, every business is a *people* business. Only through communicating with people can you find out the *why* of a problem. This means

getting out of the office and working quite a lot of people with a system as complex as the Army, because everyone has a story, and only through hearing many of the stories may you begin to triangulate the truth.

Dr. Srinivasan and I have spent over 250 hours interviewing over 500 representatives of the stakeholders at five installations, and in every visit we've found something new. We have sat through many interviews that, after the respondent had left the room, prompted comments like, "this is exactly the same story we heard at the last site. I think we've got this stakeholder figured out." In some cases, it's the fourth or fifth iteration of interviews with, as an example, ASAP Counselors, yields the *ah-ha* moment that opens the door to the *why of the problem* gold mine.

All of this is to say that I've gained an appreciation for what it takes to determine causes and solutions to real-world problems, and that is an open-minded approach to fact gathering. I've learned to enjoy discovering something that surprises me, even when that something nullifies my preliminary conclusions and initial solutions to problems that I've solidified in my mind. I know now that I need to always strive to learn something more and to be pleased when I get to introduce solution 2.0.

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[i] Forrester, Jay W. *Industrial Dynamics.* System Dynamics. Cambridge, MA.: MIT Press, 1961. Print.

[ii] Nightingale, Deborah J., and Jayakanth Srinivasan. *Beyond the Lean Revolution.* 1st ed. Cambridge, Massachusetts. 2010. Print.

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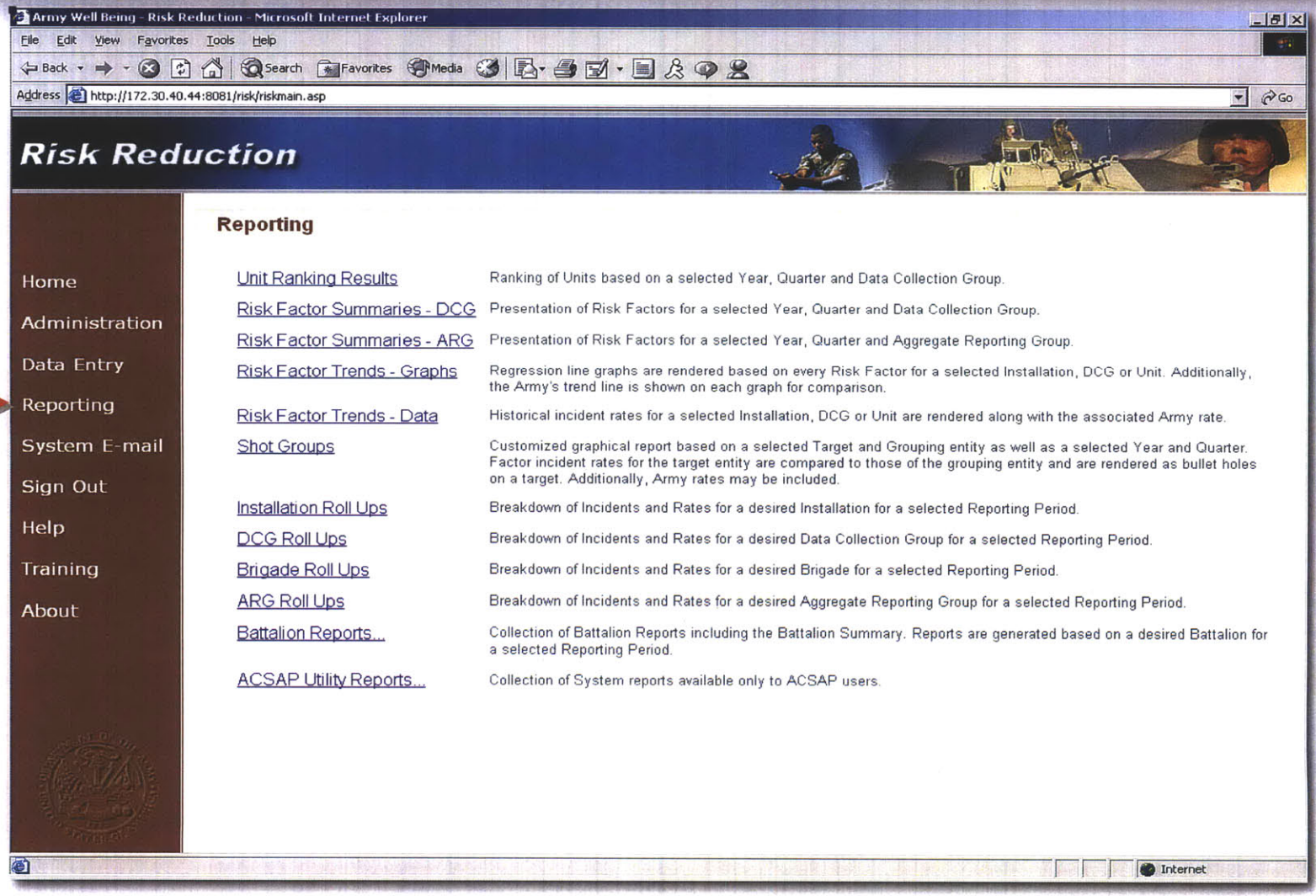
Appendix A – Installation Risk Reduction Briefing

Source: Army Substance Abuse Program. "Web Based Risk Reduction." Ft. Benning, GA. 2011. <http://www.benning.army.mil/garrison/dhr/ASAP/content/PDF/RISK%20brief%20-%20mock.pdf>

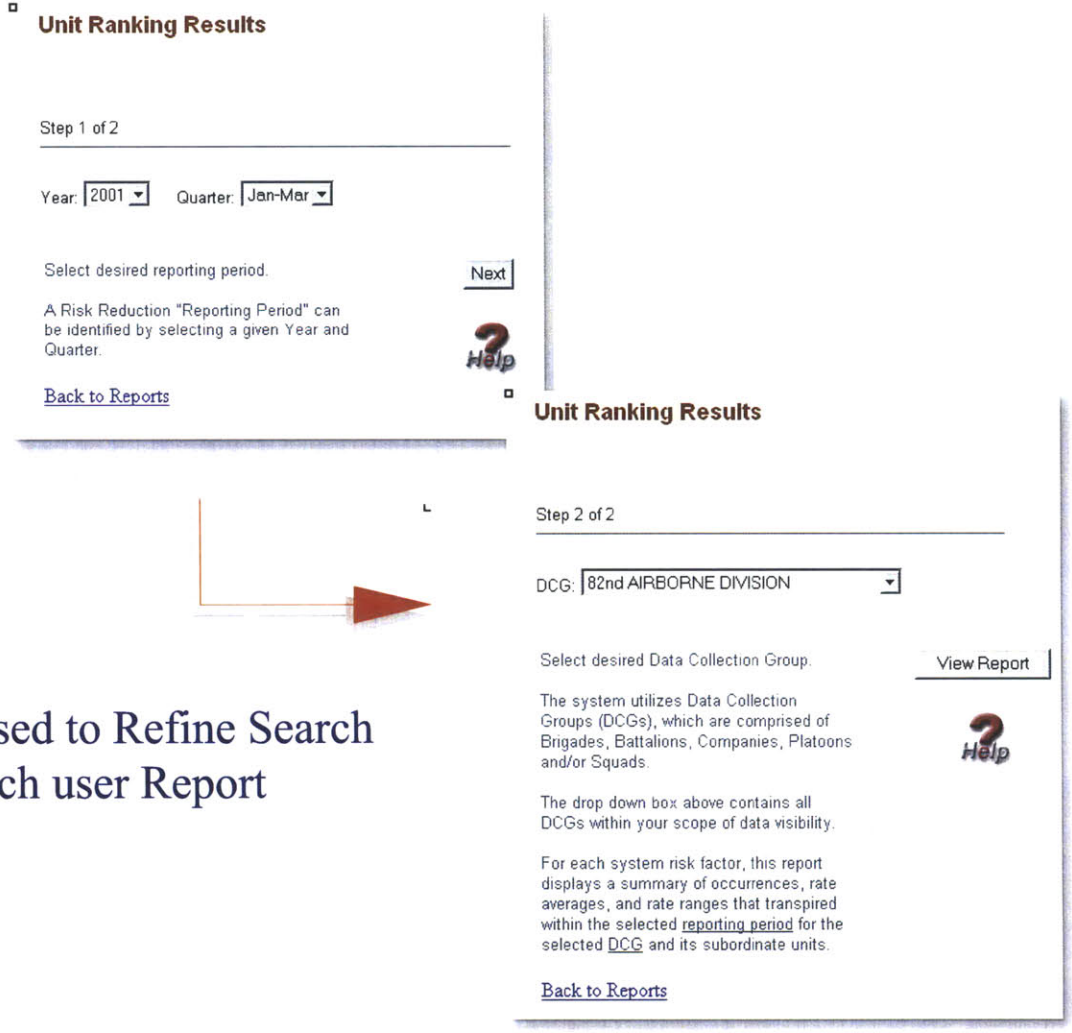
WEB BASED RISK REDUCTION

Reporting

Reporting Page



Reports – Wizard Based



Wizards are used to Refine Search Criteria for each user Report

Reports – Cross Reference

Several reports are linked –
Enabling users to cross reference reports

UNIT RANKING RESULTS
TWO METHODS OF SELECTION

FORT KNOX, Fort Knox, Ky — Oct-Dec, 2005

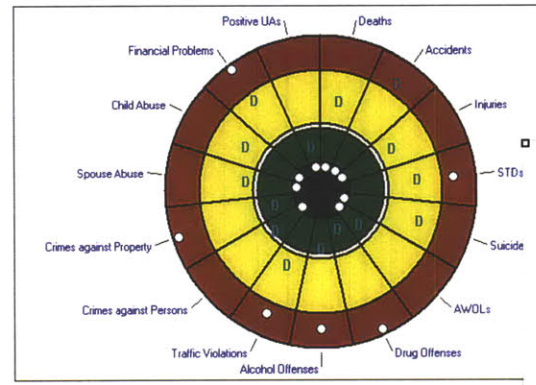
Number of Red Band Bullets [1]				Total Red and Amber Band Bullet Percentages [2]		
UIC	Unit Name	Score	Rank	UIC	Unit Name	Scor
W1L4ZJ	46 AG	4	1	W1L4ZJ	46 AG	171
W1DX1R	NCO Academy	2	2	W1DX1R	2/46 Infantry	1161
W1DXZB	2/16 CAV	2	2	W1DXZB	2/16 CAV	991
W1L4E1	5/15 CAV	2	2	W1L4E1	NCO Academy	990
W1L4ZH	2/46 Infantry	2	2	W1L4ZH	1/16 CAV	916
W0WX24	LEC	2	2	W0WX24	Garrison	735
W2LAAA	MEDDAC	2	2	W2LAAA	LEC	634
W1L4B1	2/81 Armor	1	8	W1L4B1	5/15 CAV	625
T1L4B1	2/81 TR	1	8	T1L4B1	MEDDAC	569
W1DXZA	3/16 CAV	1	8	W1DXZA	2/81 Armor	515
T1L402	3/81 TR	1	8	T1L402	1/81 Armor	456
W1DXZC	1/16 CAV	1	8	W1DXZC	3/16 CAV	396
W6CDAA	Garrison	1	8	W6CDAA	1/46 TR	263
W1DXAA	HHT 16 CAV	0	14	W1DXAA	3/81 TR	242
T1L4A1	1/81 TR	0	14	T1L4A1	2/81 TR	212
S1DXZA	3/16 CAV Students	0	14	S1DXZA	Headquarters 1 ATB	178

Unit Ranking Report can reference unit level Shot Group Reports

RISK FACTOR SHOT GROUP REPORT

W1L4ZJ - 46 AG
Vs.
FORT KNOX

Assigned Strength: 84 — *View Battalion Summary Report* — Oct-Dec, 2005

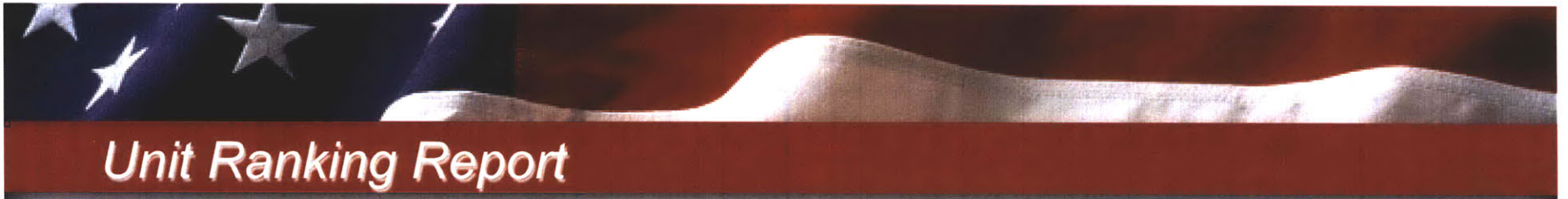


Shot Group Report can reference Summary Reports

	BATTALION: W1L4ZJ	FORT KNOX
Assigned Strength:	84	8,592

A. HIGH RISK BEHAVIOR RATES

	BATTALION: W1L4ZJ		FORT KNOX		
Factor	Actual Incidents	Rate (per 1000)	Total Actual Incidents	DCG Rate (per 1000)	RRP ARMY Rate (per 1000)
1. Deaths	0	0.00	2	0.23	0.16
2. Accidents	0	0.00	8	0.93	0.34
3. Injuries	0	0.00	9	1.05	0.85
4. STDs	1	11.90	55	6.40	4.10
5. Suicide Gestures & Attempts	0	0.00	12	1.40	0.81
6. AWOLs	0	0.00	10	1.16	2.10
7. Drug Offenses	1	11.90	5	0.58	2.05
8. Alcohol Offenses	1	11.90	24	2.79	3.44
9. Traffic Violations	3	35.71	123	14.32	11.92
10. Crimes against Persons	0	0.00	33	3.84	4.36
11. Crimes against Property	1	11.90	8	0.93	2.09
12. Spouse Abuse	0	0.00	12	1.40	1.34
13. Child Abuse	0	0.00	11	1.28	0.99
14. Financial Problems	7	83.33	211	24.56	12.90



Unit Ranking Report

UNIT RANKING RESULTS
TWO METHODS OF SELECTION

Fort Swampy Oct-Dec, 2008

Number of Red Band Bullets [1]

UIC	Unit Name	Score	Rank
WXXXXX	Unit 1	9	1
WXXXXX	Unit 1	7	2
WXXXXX	Unit 1	5	3
WXXXXX	Unit 2	5	3
WXXXXX	Unit 2	4	5
WXXXXX	Unit 3	4	5
WXXXXX	Unit 66	3	7
WXXXXX	Unit 3	3	7
WXXXXX	Unit 44	3	7
WXXXXX	Unit 44	3	7
WXXXXX	Unit 66	2	11
WXXXXX	Unit 49	2	11
WXXXXX	Unit 49	2	11
WXXXXX	Unit 2	2	11
WXXXXX	Unit 44	2	11
WXXXXX	Unit 1	2	11
WXXXXX	Unit 66	2	11
WXXXXX	Unit 1	2	11
WXXXXX	Unit 2	1	19

Total Red and Amber Band Bullet Percentages [2]

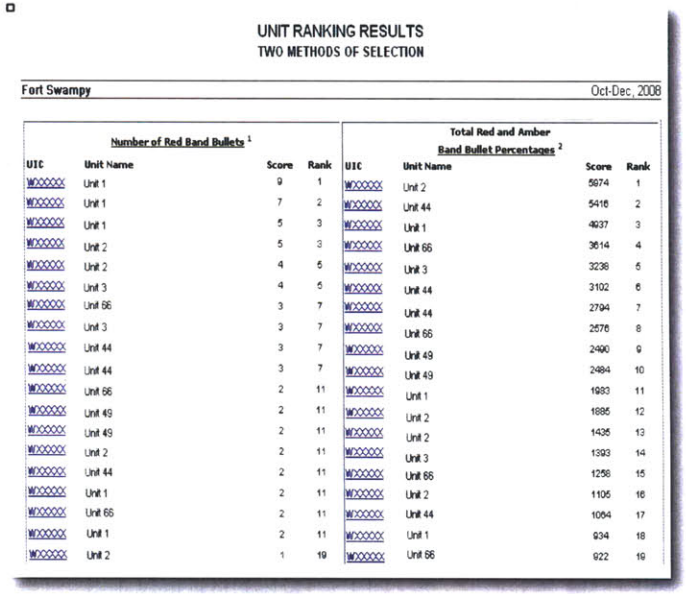
UIC	Unit Name	Score	Rank
WXXXXX	Unit 2	5974	1
WXXXXX	Unit 44	5416	2
WXXXXX	Unit 1	4937	3
WXXXXX	Unit 66	3614	4
WXXXXX	Unit 3	3238	5
WXXXXX	Unit 44	3102	6
WXXXXX	Unit 44	2794	7
WXXXXX	Unit 66	2576	8
WXXXXX	Unit 49	2490	9
WXXXXX	Unit 49	2484	10
WXXXXX	Unit 1	1983	11
WXXXXX	Unit 2	1885	12
WXXXXX	Unit 2	1435	13
WXXXXX	Unit 3	1393	14
WXXXXX	Unit 66	1258	15
WXXXXX	Unit 2	1105	16
WXXXXX	Unit 44	1064	17
WXXXXX	Unit 1	934	18
WXXXXX	Unit 66	922	19

Unit Ranking Report

The Unit Ranking Report displays unit rankings in two ways:

1. The left column displays units with the most risk factors in the red band area of the shot group. The units are sorted and displayed in descending order.

2. The right column displays units based on a score derived from risk factors and the total of each unit divided by RRP Army rate multiplied by 100. The units are again shown in descending order.



UNIT RANKING RESULTS
TWO METHODS OF SELECTION

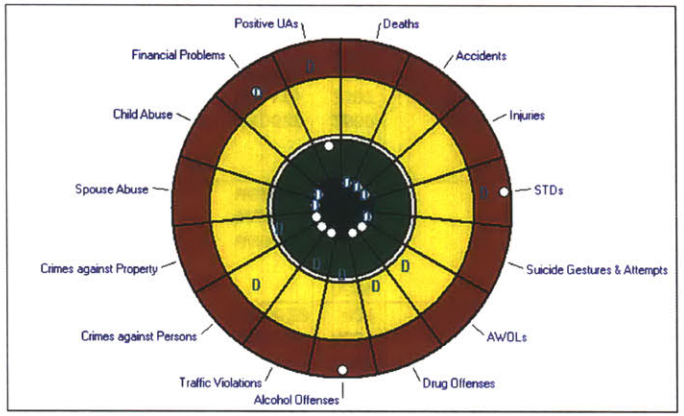
Fort Swampy — Oct-Dec, 2008

Number of Red Band Bullets [1]				Total Red and Amber Band Bullet Percentages [2]			
UIC	Unit Name	Score	Rank	UIC	Unit Name	Score	Rank
WXXXXX	Unit 1	9	1	WXXXXX	Unit 2	5674	1
WXXXXX	Unit 1	7	2	WXXXXX	Unit 44	5416	2
WXXXXX	Unit 1	5	3	WXXXXX	Unit 1	4037	3
WXXXXX	Unit 2	5	3	WXXXXX	Unit 66	3614	4
WXXXXX	Unit 2	4	5	WXXXXX	Unit 3	3236	5
WXXXXX	Unit 3	4	5	WXXXXX	Unit 44	3102	6
WXXXXX	Unit 66	3	7	WXXXXX	Unit 44	2794	7
WXXXXX	Unit 3	3	7	WXXXXX	Unit 66	2576	8
WXXXXX	Unit 44	3	7	WXXXXX	Unit 49	2490	9
WXXXXX	Unit 44	3	7	WXXXXX	Unit 49	2484	10
WXXXXX	Unit 66	2	11	WXXXXX	Unit 1	1983	11
WXXXXX	Unit 49	2	11	WXXXXX	Unit 2	1885	12
WXXXXX	Unit 49	2	11	WXXXXX	Unit 2	1435	13
WXXXXX	Unit 2	2	11	WXXXXX	Unit 3	1393	14
WXXXXX	Unit 44	2	11	WXXXXX	Unit 66	1258	15
WXXXXX	Unit 1	2	11	WXXXXX	Unit 2	1106	16
WXXXXX	Unit 66	2	11	WXXXXX	Unit 44	1064	17
WXXXXX	Unit 1	2	11	WXXXXX	Unit 1	934	18
WXXXXX	Unit 2	1	19	WXXXXX	Unit 66	922	19

Score = Sum (each unit rate / each RRP Army rate) x 100

Unit Ranking Report Scoring Explanation

Assigned Strength: 178 | View Battalion Summary Report | Oct-Dec, 2007



A. HIGH RISK BEHAVIOR RATES

	BATTALION: 008A		I CORPS		
Factor	Actual Incidents	Rate (per 1000)	Total Actual Incidents	DCG Rate (per 1000)	RRP ARMY Rate (per 1000)
1. Deaths	0	0.00	0	0.00	0.18
2. Accidents	0	0.00	0	0.00	0.24
3. Injuries	0	0.00	0	0.00	0.67
4. STDs	6	33.71	57	11.25	4.09
5. Suicide Gestures & Attempts	0	0.00	0	0.00	1.23
6. AWOLs	0	0.00	20	3.95	3.46
7. Drug Offenses	0	0.00	9	1.78	1.61
8. Alcohol Offenses	3	16.85	15	2.96	3.42
9. Traffic Violations	0	0.00	43	8.49	11.82
10. Crimes against Persons	0	0.00	40	7.89	4.52
11. Crimes against Property	0	0.00	8	1.58	1.90
12. Spouse Abuse	0	0.00	0	0.00	1.28
13. Child Abuse	0	0.00	0	0.00	0.88
14. Financial Problems	9	50.56	211	41.64	17.39

(For a selected unit, we take only the factors displayed on the shot group report. Of that group, only the factor rates greater than the RRP Army rate.)

Number of Red Band Bullets [1]				Total Red and Amber Band Bullet Percentages [2]			
UIC	Unit Name	Score	Rank	UIC	Unit Name	Score	Rank
015 E	015 E	7	1	015 E	015 E	11517	1
015 F	015 F	5	2	015 C	015 C	4208	2
015H	015H	5	2	015 A	015 A	3788	3
015 C	015 C	4	4	015H	015H	3257	4
008E	008E	4	4	015 F	015 F	2707	5
009D	009D	4	4	008C	008C	2369	6
015 A	015 A	4	4	008E	008E	2264	7
008C	008C	3	8	009C	009C	2156	8
005A	005A	3	8	009D	009D	2127	9
009A	009A	3	8	008A	008A	1611	10
009C	009C	3	8	009A	009A	1362	11
015 G	015 G	3	8	015 B	015 B	1233	12
008A	008A	3	8	015 G	015 G	1224	13
008B	008B	2	14	015 D	015 D	1166	14
015 D	015 D	2	14	005A	005A	924	15
009E	009E	1	16	008B	008B	872	16
015 B	015 B	1	16	008D	008D	852	17
009B	009B	0	18	009E	009E	399	18
004B	004B	0	18	009B	009B	0	19
008D	008D	0	18	004B	004B	0	19

1 Number of Risk Factors greater than 2X the Army Rate
2 Total percentage score for all Risk Factors greater than the Army Rate

Sum (each unit rate / each RRP Army rate) x 100 = Score

Additional rounding occurs (not shown in explanation).

	008a	Army	Battalion	
STDs	33.7	4.1	8.2	
Alc Offense	16.9	3.4	5.0	
Fin Prob	50.6	17.4	2.9	x100
			16.10	1610

7

Risk Factor Summary Report

RISK FACTORS SUMMARY REPORT (DCG)

Fort Swampy Oct-Dec, 2008

Unit Identification			Selection Method		Reporting Unit Actual Incidents														
Parent ID	Reporting Unit ID	Assigned Unit Strength	Number of Red Band Bullets	Total Red and Outer Amber Band Bullet Percentages	Deaths	Accidents	STDs	Suicide Gestures & Attempts	AWOLs	Drug Offenses	Alcohol Offenses	Traffic violations	Crimes against Persons	Crimes against Property	Spouse Abuse	Child Abuse	Financial Problems	Positive UAs
	WWWM123	148	0	267	0	0	1	0	0	0	0	0	0	0	0	0	5	0
	WWWM123	189	0	302	0	0	1	0	0	0	0	6	0	0	0	0	3	0
	W12AT0	275	0	113	0	0	0	0	0	0	0	5	0	0	0	0	0	0
WW12AA	W99550	1547	0	0	0	0	1	0	0	0	1	11	0	0	0	0	0	0
	WASHXX	4631	0	241	1	0	6	1	14	0	1	2	2	1	0	0	28	4
	W1D5ZB	431	0	280	0	0	0	0	0	0	0	5	0	1	1	0	2	0
Subtotal		6609	0	521	1	0	7	1	14	0	2	18	2	2	1	0	30	4
WWKKAA	WWWM123	301	3	1249	0	0	0	1	2	0	1	14	2	0	0	0	11	0
	WWPOCA	2907	1	752	0	0	4	0	40	3	6	2	5	5	0	0	91	11
	W99550	665	0	159	0	0	1	0	0	0	0	17	1	1	0	0	3	0
Subtotal		3873	4	2160	0	0	5	1	42	3	7	33	8	6	0	0	105	11
WWQQYY	S1D5ZD	2660	0	0	0	0	2	0	1	0	0	3	0	0	0	0	7	0
	W12AT0	3187	0	0	0	0	6	0	3	0	0	2	10	5	0	0	24	3
	WWPOCA	267	2	958	0	0	1	0	0	0	0	6	0	0	1	1	2	0
Subtotal		6114	2	958	0	0	9	0	4	0	0	11	10	5	1	1	33	3
WASHXX	WWPOCA	971	0	0	0	0	1	0	0	0	0	13	1	0	0	0	0	0
	W1E1AA	45	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Subtotal		1016	0	0	0	0	1	0	0	0	0	13	1	0	0	0	0	0
WHE2AA	W12AT0	1209	3	1295	0	0	13	0	6	0	2	52	3	1	2	*	110	9
	WWWM123	1166	2	1350	0	0	8	0	4	0	6	37	5	4	0	0	79	20
Subtotal		2375	5	2645	0	0	21	0	10	0	8	89	8	5	2	0	189	29
TOTALS		20599			1	0	46	2	70	3	17	175	29	18	4	1	365	47

Risk Factor Summary Report

Displays incident data in a spreadsheet like format showing subtotals for parent level units and a grand total for the Data Collection Group.

This is a great report for data entry quality assurance because null data entries show up as asterisks. "*"

RISK FACTORS SUMMARY REPORT (DCG)

Fort Swampy Oct-Dec, 2008

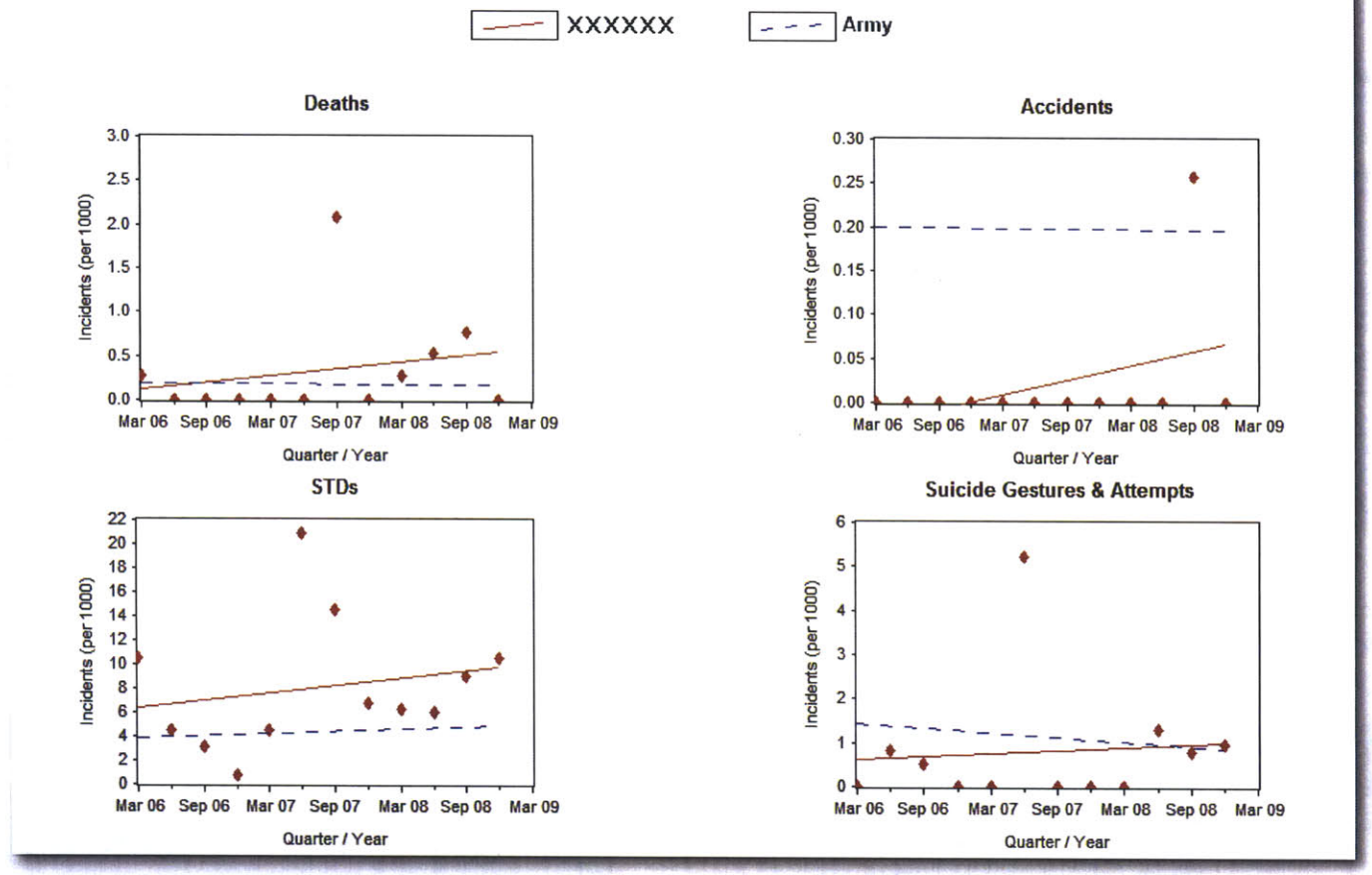
Unit Identification			Selection Method		Reporting Unit Actual Incidents														
Parent ID	Reporting Unit ID	Assigned Unit Strength	Number of Red Band Bullets	Total Red and Outer Amber Band Bullet Percentages	Deaths	Accidents	STDs	Suicide Gestures & Attempts	AWOLs	Drug Offenses	Alcohol Offenses	Traffic Violations	Crimes against Persons	Crimes against Property	Spouse Abuse	Child Abuse	Financial Problems	Positive UAs
	WWW123	148	0	267	0	0	1	0	0	0	0	0	0	0	0	0	5	0
	WWW123	189	0	302	0	0	1	0	0	0	0	6	0	0	0	0	3	0
	W12AT0	275	0	113	0	0	0	0	0	0	0	5	0	0	0	0	0	0
WW12AA	W99550	1547	0	0	0	0	1	0	0	0	1	11	0	0	0	0	0	0
	WASHXX	4631	0	241	1	0	6	1	14	0	1	2	2	1	0	0	28	4
	W1D5ZB	431	0	280	0	0	0	0	0	0	0	5	0	1	1	0	2	0
Subtotal		6609	0	521	1	0	7	1	14	0	2	18	2	2	1	0	30	4
WWKKAA	WWW123	301	3	1249	0	0	0	1	2	0	1	14	2	0	0	0	11	0
	WWPOCA	2907	1	752	0	0	4	0	40	3	6	2	5	5	0	0	91	11
	W99550	665	0	159	0	0	1	0	0	0	0	17	1	1	0	0	3	0
Subtotal		3873	4	2160	0	0	5	1	42	3	7	33	8	6	0	0	105	11
WWQQYY	S1D5ZD	2660	0	0	0	0	2	0	1	0	0	3	0	0	0	0	7	0
	W12AT0	3187	0	0	0	0	6	0	3	0	0	2	10	5	0	0	24	3
	WWPOCA	267	2	958	0	0	1	0	0	0	0	6	0	0	1	1	2	0
Subtotal		6114	2	958	0	0	9	0	4	0	0	11	10	5	1	1	33	3
WASHXX	WWPOCA	971	0	0	0	0	1	0	0	0	0	13	1	0	0	0	0	0
	W1E1AA	45	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Subtotal		1016	0	0	0	0	1	0	0	0	0	13	1	0	0	0	0	0
WHE2AA	W12AT0	1209	3	1295	0	0	13	0	6	0	2	52	3	1	2	*	110	9
	WWW123	1166	2	1350	0	0	8	0	4	0	6	37	5	4	0	0	79	20
Subtotal		2375	5	2645	0	0	21	0	10	0	8	89	8	5	2	0	189	29
TOTALS		20599			1	0	45	2	70	3	17	175	29	18	4	1	365	47

Trend Graph Report

Risk Factor Trends Graph

Brigade: XXXXXX

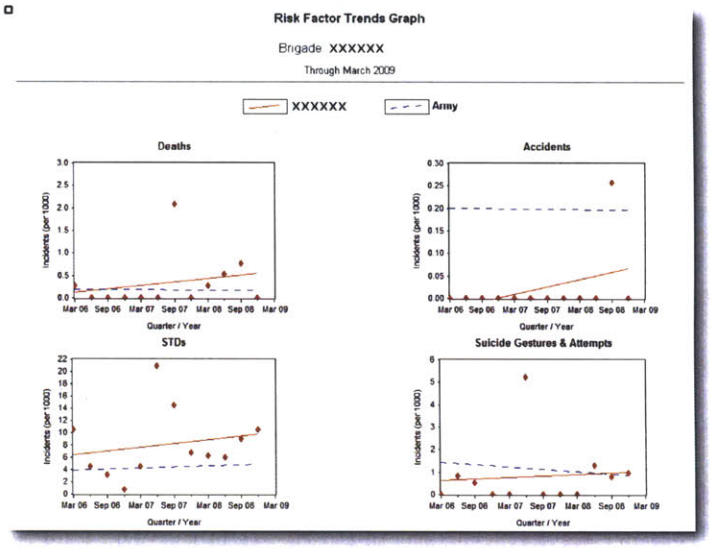
Through March 2009



Trend Graph Report

Displays rates per thousands for each risk factor over a three year period, plotting every quarterly data point.

Also, shows the slope lines for the selected entity in red. This report's comparison level (displayed as a blue dotted line) will default to the RRP Army but, an upper level comparison may be chosen. (i.e. Installation, MACOM, Region)



Trend Data Report

Risk Factor Trend Data

Fort Swampy / Army

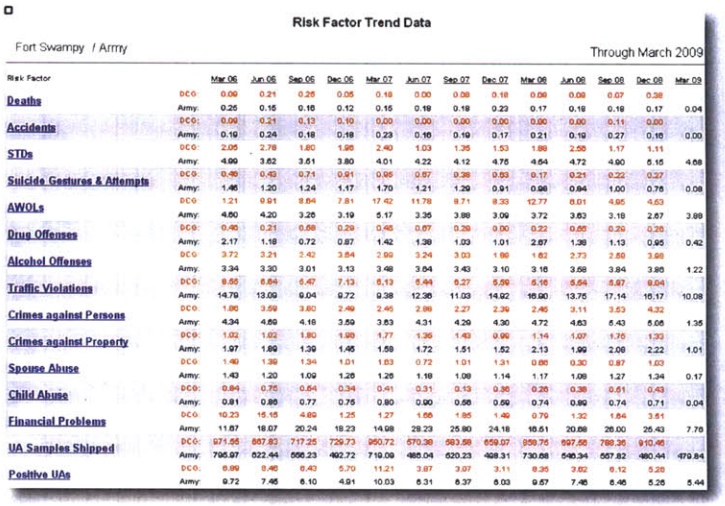
Through March 2009

Risk Factor		Mar 06	Jun 06	Sep 06	Dec 06	Mar 07	Jun 07	Sep 07	Dec 07	Mar 08	Jun 08	Sep 08	Dec 08	Mar 09
Deaths	DCG:	0.09	0.21	0.25	0.05	0.18	0.00	0.08	0.18	0.09	0.09	0.07	0.38	
	Army:	0.25	0.15	0.16	0.12	0.15	0.18	0.18	0.23	0.17	0.18	0.18	0.17	0.04
Accidents	DCG:	0.09	0.21	0.13	0.10	0.00	0.00	0.00	0.00	0.00	0.00	0.11	0.00	
	Army:	0.19	0.24	0.18	0.18	0.23	0.16	0.19	0.17	0.21	0.19	0.27	0.16	0.00
STDs	DCG:	2.05	2.78	1.80	1.96	2.40	1.03	1.35	1.53	1.88	2.56	1.17	1.11	
	Army:	4.99	3.62	3.51	3.80	4.01	4.22	4.12	4.75	4.54	4.72	4.90	5.15	4.68
Suicide Gestures & Attempts	DCG:	0.46	0.43	0.71	0.91	0.95	0.67	0.38	0.63	0.17	0.21	0.22	0.27	
	Army:	1.46	1.20	1.24	1.17	1.70	1.21	1.29	0.91	0.98	0.84	1.00	0.76	0.08
AWOLs	DCG:	1.21	9.91	8.64	7.81	17.42	11.78	8.71	8.33	12.77	6.01	4.95	4.53	
	Army:	4.60	4.20	3.26	3.19	5.17	3.35	3.88	3.09	3.72	3.63	3.18	2.67	3.88
Drug Offenses	DCG:	0.46	0.21	0.58	0.29	0.45	0.67	0.29	0.00	0.22	0.55	0.29	0.26	
	Army:	2.17	1.18	0.72	0.87	1.42	1.38	1.03	1.01	2.67	1.38	1.13	0.95	0.42
Alcohol Offenses	DCG:	3.72	3.21	2.42	3.64	2.99	3.24	3.03	1.89	1.62	2.73	2.59	3.98	
	Army:	3.34	3.30	3.01	3.13	3.48	3.64	3.43	3.10	3.16	3.58	3.84	3.86	1.22
Traffic Violations	DCG:	8.55	6.64	5.47	7.13	6.13	5.44	6.27	5.59	5.16	5.54	5.97	8.04	
	Army:	14.79	13.09	9.04	9.72	9.38	12.36	11.03	14.92	16.90	13.75	17.14	16.17	10.08
Crimes against Persons	DCG:	1.86	3.59	3.80	2.49	2.45	2.88	2.27	2.39	2.45	3.11	3.53	4.32	
	Army:	4.34	4.69	4.18	3.59	3.63	4.31	4.29	4.30	4.72	4.63	5.43	5.06	1.35
Crimes against Property	DCG:	1.02	1.02	1.80	1.96	1.77	1.35	1.43	0.99	1.14	1.07	1.75	1.33	
	Army:	1.97	1.89	1.39	1.45	1.58	1.72	1.51	1.52	2.13	1.99	2.08	2.22	1.01
Spouse Abuse	DCG:	1.49	1.39	1.34	1.01	1.63	0.72	1.01	1.31	0.66	0.30	0.87	1.03	
	Army:	1.43	1.20	1.09	1.26	1.26	1.18	1.08	1.14	1.17	1.08	1.27	1.34	0.17
Child Abuse	DCG:	0.84	0.75	0.54	0.34	0.41	0.31	0.13	0.36	0.26	0.38	0.51	0.43	
	Army:	0.81	0.86	0.77	0.75	0.80	0.90	0.56	0.59	0.74	0.89	0.74	0.71	0.04
Financial Problems	DCG:	10.23	15.15	4.89	1.25	1.27	1.66	1.85	1.49	0.79	1.32	1.64	3.51	
	Army:	11.67	18.07	20.24	18.23	14.98	28.23	25.80	24.18	16.51	20.68	26.00	25.43	7.76
UA Samples Shipped	DCG:	971.55	667.83	717.25	729.73	950.72	570.38	583.58	659.07	858.75	697.56	788.36	910.46	
	Army:	795.97	622.44	556.23	492.72	719.09	486.04	520.23	498.31	730.68	546.34	557.82	480.44	479.84
Positive UAs	DCG:	6.89	8.46	6.43	5.70	11.21	3.87	3.07	3.11	8.35	3.62	6.12	5.26	
	Army:	9.72	7.45	6.10	4.91	10.03	6.31	6.37	6.03	9.57	7.46	6.46	5.26	5.44

Trend Data Report

Displays rates per thousands for each risk factor over a three year period, showing every quarterly rate.

This report's comparison level will default to the RRP Army (shown in black) but, an upper level comparison may be chosen. (i.e. Installation, MACOM, Region)



Risk Factor Trend Data

Fort Swampy / Army — Through March 2009

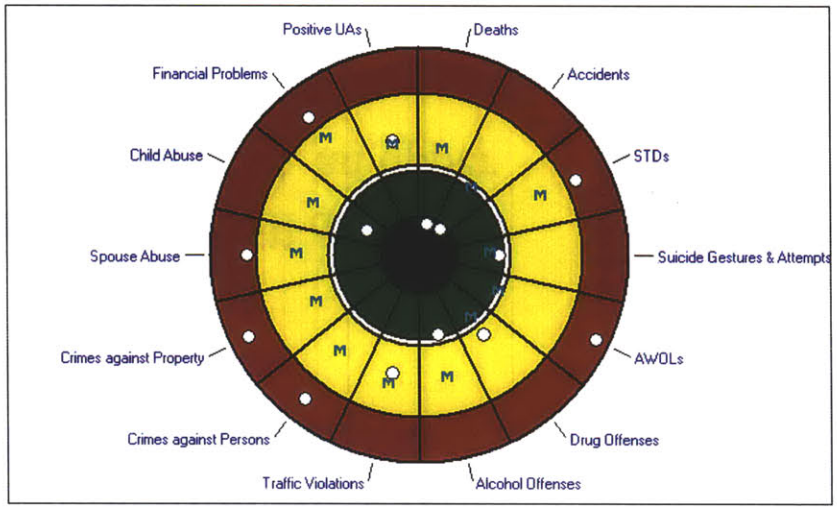
Risk Factor		Mar 06	Jun 06	Sep 06	Dec 06	Mar 07	Jun 07	Sep 07	Dec 07	Mar 08	Jun 08	Sep 08	Dec 08	Mar 09
Deaths	DCO:	0.09	0.21	0.26	0.05	0.18	0.00	0.08	0.18	0.09	0.09	0.07	0.38	
	Army:	0.25	0.16	0.16	0.12	0.15	0.16	0.16	0.23	0.17	0.16	0.19	0.17	0.04
Accidents	DCO:	0.09	0.21	0.13	0.10	0.00	0.00	0.00	0.00	0.00	0.00	0.11	0.00	
	Army:	0.19	0.24	0.18	0.18	0.23	0.16	0.19	0.17	0.21	0.19	0.27	0.16	0.00
STDs	DCO:	2.05	2.78	1.60	1.98	2.40	1.03	1.35	1.53	1.88	2.56	1.17	1.11	
	Army:	4.09	3.62	3.61	3.80	4.01	4.22	4.12	4.75	4.64	4.72	4.90	5.15	4.68
Suicide Gestures & Attempts	DCO:	0.40	0.43	0.71	0.91	0.95	0.67	0.38	0.53	0.17	0.21	0.22	0.27	
	Army:	1.46	1.20	1.24	1.17	1.70	1.21	1.29	0.91	0.98	0.84	1.00	0.78	0.08
AWOLs	DCO:	1.21	0.81	8.64	7.81	17.42	11.78	8.71	8.33	12.77	8.01	4.95	4.53	
	Army:	4.60	4.20	3.26	3.19	5.17	3.35	3.89	3.09	3.72	3.53	3.18	2.67	3.89
Drug Offenses	DCO:	0.40	0.21	0.68	0.29	0.45	0.67	0.28	0.00	0.22	0.55	0.29	0.26	
	Army:	2.17	1.18	0.72	0.87	1.42	1.38	1.03	1.01	2.87	1.38	1.13	0.95	0.42
Alcohol Offenses	DCO:	3.72	3.21	2.42	3.64	2.99	3.24	3.03	1.66	1.62	2.73	2.80	3.68	
	Army:	3.34	3.30	3.01	3.13	3.48	3.64	3.43	3.10	3.16	3.58	3.84	3.85	1.22
Traffic Violations	DCO:	8.56	8.84	6.47	7.13	6.13	5.44	5.27	5.59	5.16	5.54	5.67	9.04	
	Army:	14.79	13.09	9.04	9.72	9.38	12.36	11.03	14.92	16.90	13.75	17.14	16.17	10.08
Crimes against Persons	DCO:	1.66	3.59	3.80	2.49	2.46	2.86	2.27	2.39	2.46	3.11	3.53	4.32	
	Army:	4.34	4.59	4.16	3.59	3.83	4.31	4.29	4.30	4.72	4.63	5.43	5.06	1.35
Crimes against Property	DCO:	1.02	1.02	1.80	1.66	1.77	1.36	1.43	0.99	1.14	1.07	1.76	1.33	
	Army:	1.97	1.89	1.39	1.45	1.58	1.72	1.51	1.52	2.13	1.99	2.08	2.22	1.01
Spouse Abuse	DCO:	1.40	1.39	1.34	1.01	1.83	0.72	1.01	1.31	0.66	0.30	0.87	1.03	
	Army:	1.43	1.20	1.09	1.26	1.26	1.18	1.09	1.14	1.17	1.08	1.27	1.34	0.17
Child Abuse	DCO:	0.84	0.75	0.64	0.34	0.41	0.31	0.13	0.35	0.26	0.38	0.51	0.43	
	Army:	0.81	0.88	0.77	0.75	0.80	0.90	0.66	0.69	0.74	0.89	0.74	0.71	0.04
Financial Problems	DCO:	10.23	15.15	4.89	1.25	1.27	1.68	1.85	1.46	0.79	1.32	1.84	3.51	
	Army:	11.87	18.07	20.24	18.23	14.98	28.29	25.80	24.18	18.61	20.88	26.00	25.43	7.78
UA Samples Shipped	DCO:	971.66	887.83	717.25	729.73	950.72	570.36	583.58	659.07	959.76	697.56	788.36	910.46	
	Army:	795.97	822.44	666.23	492.72	719.09	488.04	620.23	498.31	730.68	546.34	567.82	480.44	479.84
Positive UAs	DCO:	8.09	8.46	6.43	5.70	11.21	3.87	3.07	3.11	8.36	3.62	6.12	5.28	
	Army:	9.72	7.46	6.10	4.91	10.03	5.31	6.37	8.03	9.57	7.46	6.46	5.26	5.44

Shot Group Report

RISK FACTOR SHOT GROUP REPORT

○	XXXXXX
	Vs.
M	ZZZZZZZZZZ

Assigned Strength: 4198 *View Brigade Summary Report* Oct-Dec, 2008



COLOR BAND	DESIGNATION	RATE**
	DANGER ZONE	Greater than 2X Army Rate
	CAUTION ZONE	Greater than Army Rate but less than 2X Army Rate
	RRP ARMY RATE	US Army RRP Rate
	SAFETY ZONE	Less than Army rate
●	BULLSEYE	No Incidents in Reporting Period

* "Bullet Holes" are displayed only for risk factors for which data was reported.

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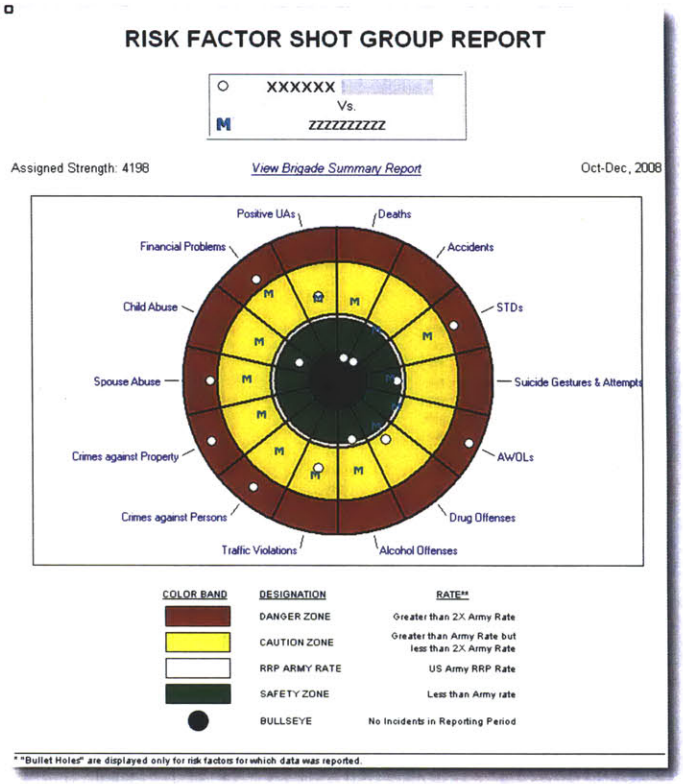
Shot Group Report

The Shot Group is a custom graphical report which ACSAP developed to quickly display possible high-risk areas within a selected group.

Each slice of the report displays one risk factor. The bullet hole displays the selected entity's rate per thousand soldiers as compared to the RRP Army rate per thousand soldiers . The RRP Army rate is displayed as the white section in the chart. Upper level comparison levels are also available in this report.

The color break down is as follows:

COLOR BAND	DESIGNATION	RATE**
	DANGER ZONE	Greater than 2X Army Rate
	CAUTION ZONE	Greater than Army Rate but less than 2X Army Rate
	RRP ARMY RATE	US Army RRP Rate
	SAFETY ZONE	Less than Army rate
●	BULLSEYE	No Incidents in Reporting Period

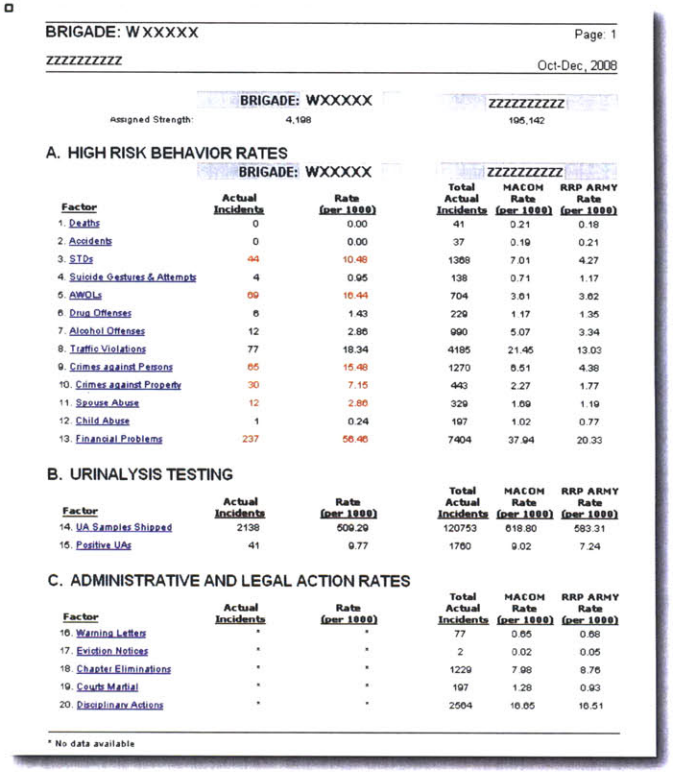


Summary Reports All

The Summary reports show the data that is used to generate a Shot Group Report.

The report displays strength of the group, each risk factor, number of incidents and rate per thousand soldiers per factor. Again, this report has the upper level comparison feature available. If the report was generated from a Shot Group then the comparison level will be passed and displayed.

If the incidents and rate per thousand are displayed in red this means the selected group and/or comparison level was greater that twice the RRP Army rate.



BRIGADE: WXXXXX Page: 1

zzzzzzzzzz Oct-Dec, 2008

	BRIGADE: WXXXXX	zzzzzzzzzz
Assigned Strength:	4,198	195,142

A. HIGH RISK BEHAVIOR RATES

Factor	BRIGADE: WXXXXX Actual Incidents	BRIGADE: WXXXXX Rate (per 1000)	zzzzzzzzzz Total Actual Incidents	zzzzzzzzzz MACOM Rate (per 1000)	zzzzzzzzzz RRP ARMY Rate (per 1000)
1. Deaths	0	0.00	41	0.21	0.18
2. Accidents	0	0.00	37	0.19	0.21
3. STDs	44	10.48	1368	7.01	4.27
4. Suicide Gestures & Attempts	4	0.95	138	0.71	1.17
5. AWOLs	69	16.44	704	3.61	3.62
6. Drug Offenses	6	1.43	229	1.17	1.35
7. Alcohol Offenses	12	2.86	990	5.07	3.34
8. Traffic Violations	77	18.34	4185	21.46	13.03
9. Crimes against Persons	65	15.48	1270	6.51	4.38
10. Crimes against Property	30	7.15	443	2.27	1.77
11. Spouse Abuse	12	2.86	329	1.69	1.19
12. Child Abuse	1	0.24	197	1.02	0.77
13. Financial Problems	237	56.46	7404	37.94	20.33

B. URINALYSIS TESTING

Factor	Actual Incidents	Rate (per 1000)	Total Actual Incidents	MACOM Rate (per 1000)	RRP ARMY Rate (per 1000)
14. UA Samples Shipped	2138	509.29	120753	618.80	583.31
15. Positive UAs	41	9.77	1760	9.02	7.24

C. ADMINISTRATIVE AND LEGAL ACTION RATES

Factor	Actual Incidents	Rate (per 1000)	Total Actual Incidents	MACOM Rate (per 1000)	RRP ARMY Rate (per 1000)
16. Warning Letters	*	*	77	0.65	0.68
17. Eviction Notices	*	*	2	0.02	0.05
18. Chapter Eliminations	*	*	1229	7.98	8.76
19. Courts Martial	*	*	197	1.28	0.93
20. Disciplinary Actions	*	*	2564	16.65	16.51

* No data available

Installation Summary Report

INSTALLATION: Fort Swampy
MACOM: zzzzzzzzzz

Page: 1

Oct-Dec, 2008

	Installation: Fort Swampy	zzzzzzzzzz
Assigned Strength:	38,445	194,813

A. HIGH RISK BEHAVIOR RATES

	Installation: Fort Swampy		zzzzzzzzzz		
Factor	Actual Incidents	Rate (per 1000)	Total Actual Incidents	MACOM Rate (per 1000)	RRP ARMY Rate (per 1000)
1. Deaths	9	0.23	41	0.21	0.18
2. Accidents	0	0.00	37	0.19	0.21
3. STDs	313	8.14	1367	7.02	4.27
4. Suicide Gestures & Attempts	24	0.62	138	0.71	1.17
5. AWOLs	207	5.38	704	3.61	3.62
6. Drug Offenses	22	0.57	229	1.18	1.35
7. Alcohol Offenses	105	2.73	990	5.08	3.34
8. Traffic Violations	269	7.00	4184	21.48	13.03
9. Crimes against Persons	170	4.42	1269	6.51	4.38
10. Crimes against Property	91	2.37	443	2.27	1.77
11. Spouse Abuse	68	1.77	327	1.68	1.19
12. Child Abuse	16	0.42	194	1.00	0.77
13. Financial Problems	2942	76.52	7401	37.99	20.32

B. URINALYSIS TESTING

Factor	Actual Incidents	Rate (per 1000)	Total Actual Incidents	MACOM Rate (per 1000)	RRP ARMY Rate (per 1000)
14. UA Samples Shipped	18996	494.11	120753	619.84	583.33
15. Positive UAs	355	9.23	1760	9.03	7.24

C. ADMINISTRATIVE AND LEGAL ACTION RATES

Factor	Actual Incidents	Rate (per 1000)	Total Actual Incidents	MACOM Rate (per 1000)	RRP ARMY Rate (per 1000)
16. Warning Letters	*	*	77	0.65	0.68
17. Eviction Notices	*	*	2	0.02	0.05
18. Chapter Eliminations	*	*	1228	7.99	8.75
19. Courts Martial	*	*	197	1.28	0.93
20. Disciplinary Actions	*	*	2563	16.68	16.51

* No data available

DCG Summary Report

DCG: Page: 1
MACOM: ZZZZZZZZZZ

Oct-Dec, 2008

	DCG:	ZZZZZZZZZZ
Assigned Strength:	16,458	194,813

A. HIGH RISK BEHAVIOR RATES

	DCG:		ZZZZZZZZZZ		
Factor	Actual Incidents	Rate (per 1000)	Total Actual Incidents	MACOM Rate (per 1000)	RRP ARMY Rate (per 1000)
1. Deaths	4	0.24	41	0.21	0.18
2. Accidents	0	0.00	37	0.19	0.21
3. STDs	169	10.27	1367	7.02	4.27
4. Suicide Gestures & Attempts	13	0.79	138	0.71	1.17
5. AWOLs	191	11.61	704	3.61	3.62
6. Drug Offenses	20	1.22	229	1.18	1.35
7. Alcohol Offenses	69	4.19	990	5.08	3.34
8. Traffic Violations	247	15.01	4184	21.48	13.03
9. Crimes against Persons	152	9.24	1269	6.51	4.38
10. Crimes against Property	81	4.92	443	2.27	1.77
11. Spouse Abuse	40	2.43	327	1.68	1.19
12. Child Abuse	4	0.24	194	1.00	0.77
13. Financial Problems	1290	78.38	7401	37.99	20.32

B. URINALYSIS TESTING

Factor	Actual Incidents	Rate (per 1000)	Total Actual Incidents	MACOM Rate (per 1000)	RRP ARMY Rate (per 1000)
14. UA Samples Shipped	12476	758.05	120753	619.84	583.33
15. Positive UAs	251	15.25	1760	9.03	7.24

C. ADMINISTRATIVE AND LEGAL ACTION RATES

Factor	Actual Incidents	Rate (per 1000)	Total Actual Incidents	MACOM Rate (per 1000)	RRP ARMY Rate (per 1000)
16. Warning Letters	*	*	77	0.65	0.68
17. Eviction Notices	*	*	2	0.02	0.05
18. Chapter Eliminations	*	*	1228	7.99	8.75
19. Courts Martial	*	*	197	1.28	0.93
20. Disciplinary Actions	*	*	2583	16.68	16.51

* No data available

Brigade Summary Report

BRIGADE: WXXXXX Page: 1

zzzzzzzzzz Oct-Dec, 2008

	BRIGADE: WXXXXX	zzzzzzzzzz
Assigned Strength:	4,198	195,142

A. HIGH RISK BEHAVIOR RATES

	BRIGADE: WXXXXX		zzzzzzzzzz		
Factor	Actual Incidents	Rate (per 1000)	Total Actual Incidents	MACOM Rate (per 1000)	RRP ARMY Rate (per 1000)
1. Deaths	0	0.00	41	0.21	0.18
2. Accidents	0	0.00	37	0.19	0.21
3. STDs	44	10.48	1368	7.01	4.27
4. Suicide Gestures & Attempts	4	0.95	138	0.71	1.17
5. AWOLs	69	16.44	704	3.61	3.62
6. Drug Offenses	6	1.43	229	1.17	1.35
7. Alcohol Offenses	12	2.86	990	5.07	3.34
8. Traffic Violations	77	18.34	4185	21.45	13.03
9. Crimes against Persons	65	15.48	1270	6.51	4.38
10. Crimes against Property	30	7.15	443	2.27	1.77
11. Spouse Abuse	12	2.86	329	1.69	1.19
12. Child Abuse	1	0.24	197	1.02	0.77
13. Financial Problems	237	56.46	7404	37.94	20.33

B. URINALYSIS TESTING

Factor	Actual Incidents	Rate (per 1000)	Total Actual Incidents	MACOM Rate (per 1000)	RRP ARMY Rate (per 1000)
14. UA Samples Shipped	2138	509.29	120753	618.80	583.31
15. Positive UAs	41	9.77	1760	9.02	7.24

C. ADMINISTRATIVE AND LEGAL ACTION RATES

Factor	Actual Incidents	Rate (per 1000)	Total Actual Incidents	MACOM Rate (per 1000)	RRP ARMY Rate (per 1000)
16. Warning Letters	*	*	77	0.65	0.68
17. Eviction Notices	*	*	2	0.02	0.05
18. Chapter Eliminations	*	*	1229	7.98	8.76
19. Courts Martial	*	*	197	1.28	0.93
20. Disciplinary Actions	*	*	2564	16.65	16.51

* No data available

Battalion Summary Report

BATTALION:XXXXXX Page: 1
Brigade: XXXXXX
ZZZZZZZZZZ Oct-Dec, 2008

	BATTALION: XXXXXX	ZZZZZZZZZZ
Assigned Strength:	807	195,142

A. HIGH RISK BEHAVIOR RATES

Factor	BATTALION: XXXXXX Actual Incidents	BATTALION: XXXXXX Rate (per 1000)	ZZZZZZZZZZ Total Actual Incidents	ZZZZZZZZZZ MACOM Rate (per 1000)	ZZZZZZZZZZ RRP ARMY Rate (per 1000)
1. Deaths	0	0.00	41	0.21	0.18
2. Accidents	0	0.00	37	0.19	0.21
3. STDs	0	0.00	1368	7.01	4.27
4. Suicide Gestures & Attempts	0	0.00	138	0.71	1.17
5. AWOLs	18	22.30	704	3.61	3.62
6. Drug Offenses	4	4.96	229	1.17	1.35
7. Alcohol Offenses	1	1.24	990	5.07	3.34
8. Traffic Violations	16	19.83	4185	21.45	13.03
9. Crimes against Persons	4	4.96	1270	6.51	4.38
10. Crimes against Property	1	1.24	443	2.27	1.77
11. Spouse Abuse	1	1.24	329	1.69	1.19
12. Child Abuse	0	0.00	197	1.02	0.77
13. Financial Problems	53	65.68	7404	37.94	20.33

B. URINALYSIS TESTING

Factor	Actual Incidents	Rate (per 1000)	Total Actual Incidents	MACOM Rate (per 1000)	RRP ARMY Rate (per 1000)
14. UA Samples Shipped	333	412.64	120753	618.80	583.31
15. Positive UAs	6	7.43	1760	9.02	7.24

C. ADMINISTRATIVE AND LEGAL ACTION RATES

Factor	Actual Incidents	Rate (per 1000)	Total Actual Incidents	MACOM Rate (per 1000)	RRP ARMY Rate (per 1000)
16. Warning Letters	*	*	77	0.65	0.68
17. Eviction Notices	*	*	2	0.02	0.05
18. Chapter Eliminations	*	*	1229	7.98	8.76
19. Courts Martial	*	*	197	1.28	0.93
20. Disciplinary Actions	*	*	2564	16.65	16.51

* No data available

Company Summary Report

COMPANY: XXXXXX
Brigade: XXXXXX
ZZZZZZZZZZ

Oct-Dec, 2008

	COMPANY: XXXXXX	ZZZZZZZZZZ
Assigned Strength:	296	195,142

A. HIGH RISK BEHAVIOR RATES

	COMPANY: XXXXXX		ZZZZZZZZZZ		
Factor	Actual Incidents	Rate (per 1000)	Total Actual Incidents	MACOM Rate (per 1000)	RRP ARMY Rate (per 1000)
1. Deaths	0	0.00	41	0.21	0.18
2. Accidents	0	0.00	37	0.19	0.21
3. STDs	4	13.51	1368	7.01	4.27
4. Suicide Gestures & Attempts	0	0.00	138	0.71	1.17
5. AWOLs	0	0.00	704	3.61	3.62
6. Drug Offenses	0	0.00	229	1.17	1.35
7. Alcohol Offenses	0	0.00	990	5.07	3.34
8. Traffic Violations	0	0.00	4185	21.45	13.03
9. Crimes against Persons	0	0.00	1270	6.51	4.38
10. Crimes against Property	0	0.00	443	2.27	1.77
11. Spouse Abuse	0	0.00	329	1.69	1.19
12. Child Abuse	0	0.00	197	1.02	0.77
13. Financial Problems	0	0.00	7404	37.94	20.33

B. URINALYSIS TESTING

Factor	Actual Incidents	Rate (per 1000)	Total Actual Incidents	MACOM Rate (per 1000)	RRP ARMY Rate (per 1000)
14. UA Samples Shipped	156	527.03	120753	618.80	583.31
15. Positive UAs	1	3.38	1760	9.02	7.24

C. ADMINISTRATIVE AND LEGAL ACTION RATES

Factor	Actual Incidents	Rate (per 1000)	Total Actual Incidents	MACOM Rate (per 1000)	RRP ARMY Rate (per 1000)
16. Warning Letters	*	*	77	0.65	0.68
17. Eviction Notices	*	*	2	0.02	0.05
18. Chapter Eliminations	*	*	1229	7.98	8.76
19. Courts Martial	*	*	197	1.28	0.93
20. Disciplinary Actions	*	*	2564	16.65	16.51

Matrix Report

This report displays Unit risk factor incident rates (per 1,000 Soldiers) for each Unit within the selected Brigade. It also provides a comparison of Unit incident rates to those of:

- All Soldiers in the Brigade
- The Army

Installation data is displayed with a red, amber, or green background, based on incident rates. Red cells are intended to highlight potential problem areas. The legend below the report offers a definition of these background colors. Clicking on a red, amber, or green cell will bring up a trend graph displaying the selected Installation's risk factor incident rates over time.

* Blank cells indicate no data submitted

	All Soldiers		Units						
Risk Factors	Army	1ST	1-7th	1-82nd	15th	2-5th	2-8th	1BCT	BDE
Deaths	0.18	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Accidents	0.21	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
STDs	4.27	10.48	7.79	0.00	23.10	3.86	0.00	13.51	17.70
Suicide Gestures & Attempts	1.17	0.95	2.60	2.59	0.83	1.29	0.00	0.00	0.00
AWOLs	3.62	16.44	20.78	23.32	7.43	32.34	22.30	0.00	0.00
Drug Offenses	1.35	1.43	2.60	0.00	0.00	1.29	4.96	0.00	0.00
Alcohol Offenses	3.34	2.86	2.60	15.54	2.48	1.29	1.24	0.00	0.00
Traffic Violations	13.03	18.34	31.17	20.73	23.93	15.52	19.83	0.00	0.00
Crimes against Persons	4.38	15.48	59.74	0.00	4.96	41.40	4.96	0.00	0.00
Crimes against Property	1.77	7.15	12.99	2.59	0.00	29.75	1.24	0.00	0.00
Spouse Abuse	1.19	2.86	5.19	2.59	5.78	0.00	1.24	0.00	2.95
Child Abuse	0.77	0.24	0.00	0.00	0.00	0.00	0.00	0.00	2.95
Financial Problems	20.33	56.46	111.69	38.86	43.73	69.86	66.68	0.00	56.05
UA Samples Shipped	583.31	509.29	649.16	367.88	375.41	838.29	412.64	627.03	233.04
Positive UAs	7.24	9.77	10.39	0.00	10.73	21.99	7.43	3.36	0.00
Warning Letters	0.88								
Eviction Notices	0.05								
Chapter Eliminations	8.76								
Courts Martial	0.93								
Disciplinary Actions	16.51								

BACKGROUND COLOR	DESIGNATION	COLOR CODE CRITERIA
RED	DANGER ZONE	Greater than 2X Army Rate
AMBER	CAUTION ZONE	Greater than Army Rate but less than 2X Army Rate
GREEN	SAFETY ZONE	Equal To or Less than Army Rate

Matrix Report

The Matrix Report is a custom graphical report which ACSAP developed to mimic a spreadsheet. This report also helps quickly display possible high-risk areas within a selected group.

Each cell of the report displays a color and rate per thousand for one risk factor for one unit. Group comparison levels are displayed on the left after the risk factor names.

The color breakdown is as follows:

	Units						
	1-7th	1-82nd	115th	2-5th	2-8th	1BCT	BDE
	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	7.79	0.00	23.10	3.88	0.00	13.61	17.70
	2.60	2.59	0.83	1.29	0.00	0.00	0.00
	20.78	23.32	7.43	32.34	22.30	0.00	0.00
	2.60	0.00	0.00	1.29	4.96	0.00	0.00
	2.60	15.54	2.48	1.29	1.24	0.00	0.00
	31.17	20.73	23.93	15.52	19.83	0.00	0.00
	59.74	0.00	4.95	41.40	4.96	0.00	0.00
	12.99	2.59	0.00	29.75	1.24	0.00	0.00
	5.19	2.59	5.78	0.00	1.24	0.00	2.95
	0.00	0.00	0.00	0.00	0.00	0.00	2.95
	111.69	38.86	43.73	69.86	65.68	0.00	56.05
	844.16	387.88	375.41	838.29	412.64	527.03	233.04
	10.39	0.00	10.73	21.99	7.43	3.38	0.00

BACKGROUND COLOR	DESIGNATION	COLOR CODE CRITERIA
RED	DANGER ZONE	Greater than 2X Army Rate
AMBER	CAUTION ZONE	Greater than Army Rate but less than 2X Army Rate
GREEN	SAFETY ZONE	Equal To or Less than Army Rate

Matrix Report Trends

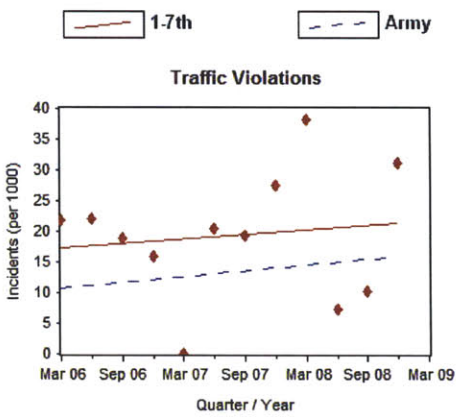
Each cell of the report displays a color and rate per thousand for one risk factor for one unit. By clicking on a cell a new trend line chart with corresponding data is displayed.

Units						
1-7th	1-82nd	115th	2-5th	2-8th	1BCT	BDE
0.00	0.00	0.00	0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00	0.00	0.00	0.00
7.79	0.00	23.10	3.88	0.00	13.51	17.70
2.60	2.59	0.83	1.29	0.00	0.00	0.00
20.78	23.32	7.43	32.34	22.30	0.00	0.00
2.60	0.00	0.00	1.29	4.96	0.00	0.00
2.60	15.54	2.48	1.29	1.24	0.00	0.00
31.17	20.73	23.93	15.52	19.83	0.00	0.00
59.74	0.00	4.95	41.40	4.96	0.00	0.00
12.99	2.59	0.00	29.75	1.24	0.00	0.00
5.19	2.59	5.78	0.00	1.24	0.00	2.95
0.00	0.00	0.00	0.00	0.00	0.00	2.95
111.69	38.86	43.73	69.86	65.68	0.00	56.05
844.16	367.88	375.41	838.29	412.64	527.03	233.04
10.39	0.00	10.73	21.99	7.43	3.38	0.00

Risk Factor Trends Graph

Unit : 1-7th

Through March 2009



1-7th - Historical Data for Traffic Violations

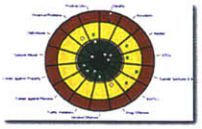
Year	Quarter	Strength	Incidents	Rate
2009	1	*	*	*
2008	4	385	12	31.17
2008	3	392	4	10.20
2008	2	408	3	7.35
2008	1	394	15	38.07
2007	4	73	2	27.40
2007	3	52	1	19.23
2007	2	49	1	20.41
2007	1	37	0	0.00
2006	4	252	4	15.87
2006	3	371	7	18.87
2006	2	363	8	22.04
2006	1	366	8	21.86

Red text indicates Entity rates that are greater than 2X the Army rate

* Indicates No Data

Commanders' Package

Commanders Package - LTC Commander Hood



Shot Group

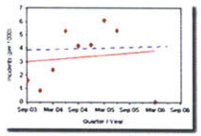
Description: This is a customized graphical report based on current Year and Quarter. Risk factor incident rates for the selected units are compared to those of the parent installation/DCG. Unit incident rates are displayed as bullet holes on a target. Installation/DCG rates are displayed as icons("*"), "D") on the target. The white ring between the green and amber zones represents the overall Army rates for each factor.

Unit Name

1 BCT, 1ST CAV

- 2-8th CAV BN
- 2-5th CAV BN
- HQ, 1BCT, 1CD
- 1-7th ARS BN
- 115th BDE SPT BN
- 1-82nd FA BN
- STB, 1st BDE, 1 CAV

Help



Risk Factor Trends - Graphs

Description: Data points and regression line graphs for the selected unit are displayed for each every Risk Factor over a period of time. Additionally, the installation/DCG's trend line is shown on each graph for comparison. This will allow commanders to compare high risk behavior incidents for their units as compared to the parent installation/DCG.

Unit Name

1 BCT, 1ST CAV

- 2-8th CAV BN
- 2-5th CAV BN
- HQ, 1BCT, 1CD
- 1-7th ARS BN
- 115th BDE SPT BN
- 1-82nd FA BN
- STB, 1st BDE, 1 CAV

Help

Matrix Report

Description: This report displays unit Risk Factor incidence rates for the selected Brigades/Battalions as compared to the overall Army rates rendered in Red/Amber/Green background.

Unit Name

1 BCT, 1ST CAV

BACKGROUND	DESIGNATION	COLOR CODE CRITERIA
RED	DANGER ZONE	Greater than 2X Army Rate
AMBER	CAUTION ZONE	Greater than Army Rate but less than 2X Army Rate
GREEN	SAFETY ZONE	Equal To or Less than Army Rate

Help

R - URI -Summary of Results

Description: This report displays the results of the anonymous reintegration unit risk inventory(R-URI) surveys taken by the selected unit. This will allow a commander to view the survey results of soldiers returning from deployment.

Installation Name

Fort Hood

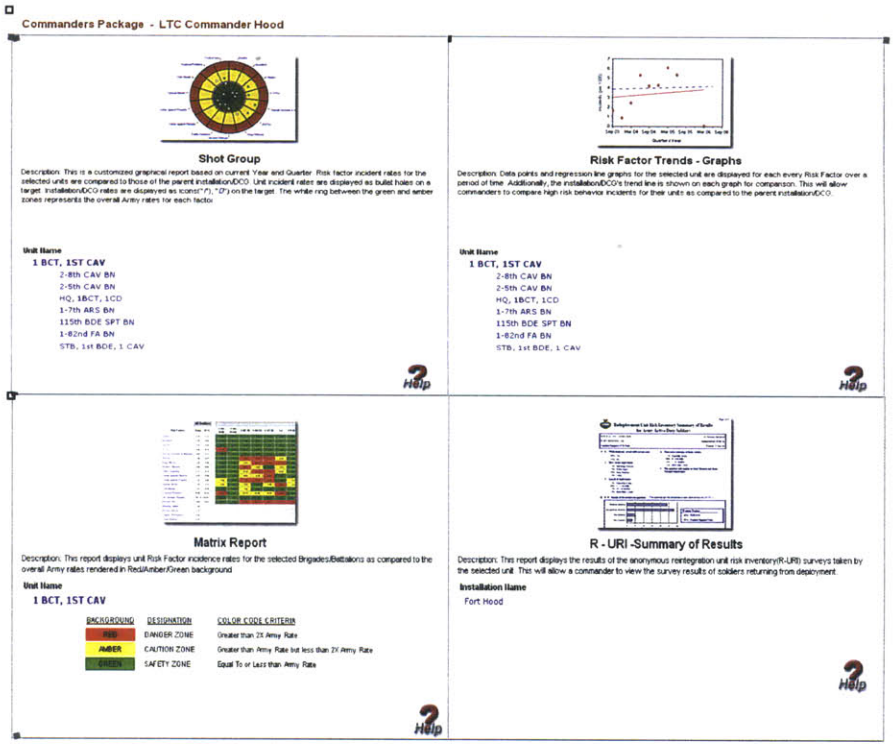
Help

Commanders' Package

The Commanders' Package is a group of reports displayed in a quad slide format based on rights and privileges granted to a commander.

Each quadrant has a specific report chosen to deliver information quickly and efficiently with a minimum of clicking.

Commanders who become familiar with the software can still run reports via the wizards.



R-URI Report

Reintegration Unit Risk Inventory Summary of Results for Army Active Duty Soldiers

XXXXXX
ZZZZZZZZZZ
Combat Support (CS) Unit

67 Persons Surveyed
Administered11 Apr 2008
Printed 6 Apr 2009

A. 1. While deployed, served with current unit:
- 92% Yes
- 8% No

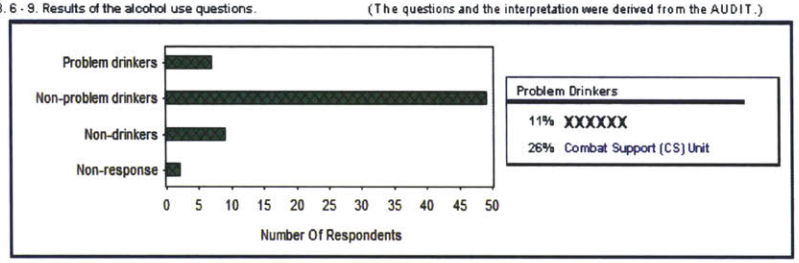
2. Most recent deployment:
- 3% Enduring Freedom
- 0% Noble Eagle
- 97% Iraqi Freedom
- 0% Other

3. Length of deployment:
- 2% 6 months or less
- 83% 7 - 12 months
- 15% 13 - 24 months
- 0% More than 2 years

4. Time since returning to home station:
- 76% 3 months or less
- 16% 4 - 6 months
- 4% 7 - 12 months
- 3% More than 1 year

5. This question only applies to Army Reserve and Army National Guard units.

B. 6 - 9. Results of the alcohol use questions. (The questions and the interpretation were derived from the AUDIT.)



C./D. Overview:

Presents the percentage of respondents making significant (unfavorable) responses to the questions within each survey category.

See next page for results by question.

'**' indicates the unit had a greater percentage of significant responses than did all surveyed units of its unit type.

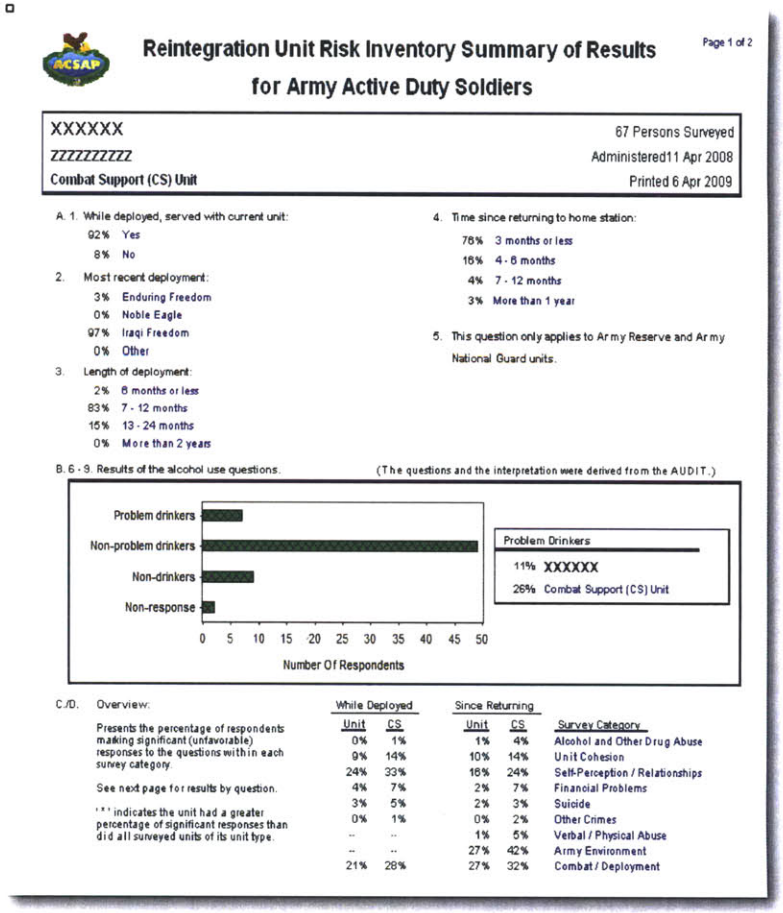
While Deployed		Since Returning		
Unit	CS	Unit	CS	Survey Category
0%	1%	1%	4%	Alcohol and Other Drug Abuse
9%	14%	10%	14%	Unit Cohesion
24%	33%	16%	24%	Self-Perception / Relationships
4%	7%	2%	7%	Financial Problems
3%	5%	2%	3%	Suicide
0%	1%	0%	2%	Other Crimes
--	--	1%	5%	Verbal / Physical Abuse
--	--	27%	42%	Army Environment
21%	28%	27%	32%	Combat / Deployment

R-URI Report

As part of the Deployment Cycle Support Directive ACSAP developed The Reintegration Unit Risk Inventory (R-URI).

The R-URI is a 79-item anonymous questionnaire designed to screen for high-risk behaviors and attitudes affecting unit readiness and personnel well being that may have occurred during deployment or since redeployment.

ACSAP is currently incorporating R-URI reports into the web-based Risk Reduction application.



Reintegration Unit Risk Inventory Summary of Results for Army Active Duty Soldiers

Page 1 of 2

XXXXXX
zzzzzzzzzz
Combat Support (CS) Unit

67 Persons Surveyed
Administered11 Apr 2008
Printed 6 Apr 2009

A. 1. While deployed, served with current unit:
92% Yes
8% No

2. Most recent deployment:
3% Enduring Freedom
0% Noble Eagle
97% Iraqi Freedom
0% Other

3. Length of deployment:
2% 6 months or less
83% 7 - 12 months
15% 13 - 24 months
0% More than 2 years

4. Time since returning to home station:
76% 3 months or less
16% 4 - 6 months
4% 7 - 12 months
3% More than 1 year

5. This question only applies to Army Reserve and Army National Guard units.

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C./D. Overview:

Presents the percentage of respondents marking significant (unfavorable) responses to the questions within each survey category.

See next page for results by question.

'*' indicates the unit had a greater percentage of significant responses than did all surveyed units of its unit type.

While Deployed		Since Returning		
Unit	CS	Unit	CS	Survey Category
0%	1%	1%	4%	Alcohol and Other Drug Abuse
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3%	5%	2%	3%	Suicide
0%	1%	0%	2%	Other Crimes
--	--	1%	5%	Verbal / Physical Abuse
--	--	27%	42%	Army Environment
21%	28%	27%	32%	Combat / Deployment

Don't Risk Readiness !

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Kim.Nguyen@conus.army.mil

Appendix B – 2012 Army Posture Statement, Addendum G: Army Force Generation Cycle (ARFORGEN)

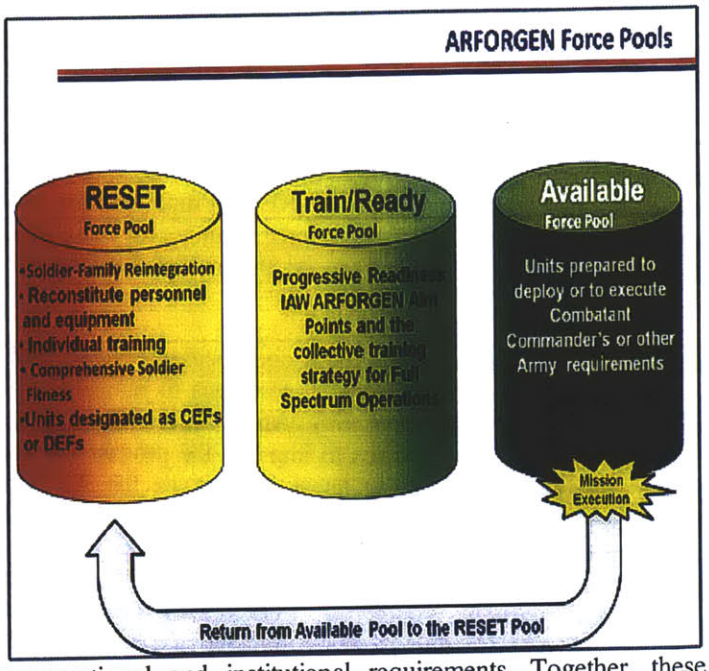
Source: United States Army. "2012 Army Posture Statement, Addendum G: Army Force Generation Cycle (ARFORGEN)." Washington, DC. 2012. <https://secureweb2.hqda.pentagon.mil/vdas_armyposturestatement/2012/addenda/addenda_g.aspx>

2012 Army Posture Statement

Addendum G - Army Force Generation (ARFORGEN)

The Army's Core Process for Force Generation

Originally envisioned as a supply-based model, ARFORGEN has yet to be fully realized given the operational conditions since implementation in 2006. With demand for war-fighting capabilities exceeding the sustainable supply, unit readiness has been consumed as quickly as it has been created. ARFORGEN, though implemented during a period of persistent conflict, has enabled the Army to successfully satisfy the high demand for conventional ground forces. The price of meeting this high operational demand, has been the stress on Soldiers and their Families due to back-to-back deployments; acceptance of strategic risk in other geographical combatant commander (GCC) AORs; and limited capability to meet emerging operational requirements.



ARFORGEN is defined as the structured progression of unit readiness over time, resulting in recurring periods of availability of trained, ready, and cohesive units. These units are prepared for operational deployment in support of combatant commanders and other Army requirements. As the Army continues the transition to a supply-based ARFORGEN model in Fiscal Year 2012, it will be postured to accomplish both emerging and enduring operational and institutional requirements. Together, these requirements drive Army priorities for recruiting, organizing, manning, equipping, training, sustaining, and mobilizing units on a cyclical basis.

Using ARFORGEN, the Army builds readiness as units move through the three force pools: RESET; Train/Ready; and Available. RESET (a six month period for active component (AC) and twelve month period for reserve component (RC)) is a process that systematically restores units to a level of personnel and equipment readiness that permits resumption of collective training in the Train/Ready pool. RESET encompasses those tasks required to reintegrate Soldiers and Families; reconstitute personnel and equipment; and execute individual training and, as units are able, crew and squad level training. It is predicated on the concept of allowing Soldiers and Families the opportunity to recover and reverse the effects associated with a sustained operational tempo. A unit begins planning for RESET during its last six months in the Available pool.

If deployed, reintegration planning and coordination begins based on communication between the forward-deployed unit and the rear detachment. The intent of this early planning is to identify total resource requirements, determine shortfalls, and develop mitigation strategies to eliminate shortfalls so that when the unit returns, a comprehensive and supportable plan is ready for execution.

During the 180 day period prior to redeployment, units redeploy 100 percent of their deployed equipment unless otherwise directed by Headquarters, Department of the Army (HQDA). Units turn-in 100 percent of their Automatic Reset Induction (ARI) items as well as their battle-lost equipment in Theater. Commanders also ensure hand receipt holders conduct 100 percent "eyes on/hands on" inventory of all equipment and develop/update unit training plans and Institutional Training Support Plans (ITSP).

For non-deployed units, the intent for the RESET pool remains the same with an emphasis on Soldier and Family reintegration. Guidelines for RESET are established by HQDA, Army Commands, and Army senior commanders/senior operational commanders within established base operations funding levels and Army priorities for requirements and resourcing.

During RESET, the unit receives its Available pool mission and begins reconstituting personnel and equipment. The Army's Human Resources Command (HRC) fills AC unit field grade, company grade and senior non-commissioned officer positions according to the Army Manning Guidance. HRC also maintains specific enlisted personnel and supply management skills as high as possible within these units to enable ongoing RESET actions. HQDA directs no training above squad level. Additional demands on returning units by senior commanders and/or senior operational commanders are kept to a minimum in order to maximize time available for Soldier and Family reintegration. Additionally, units do not receive equipment that requires new equipment training (NET). Proper Soldier and Family re-integration enhances Soldier fitness and facilitates resilience in the force. Concurrent individual training provides the Soldiers with basic skills and professional development. At the end of the RESET, units are resourced to begin collective training..

The RESET model is brigade-centric and focuses on unit, not individual reconstitution. Manning and equipping Army units during RESET continues to represent significant challenges and requires focused oversight. To address this issue U.S. Army Forces Command (FORSCOM), as the Army Command responsible for RESET, continues to improve the process for integrating and synchronizing resources for building unit readiness. Unit readiness is built via the ARFORGEN Synchronization and Resourcing Conference (ASRC). The ASRC not only looks at a unit holistically, but develops a progressive resourcing strategy for units with resource shortfalls, synchronizes RESET plans for units within the ARFORGEN force pools and provides predictability and visibility of readiness as the unit progresses through RESET. Through this quarterly conference, FORSCOM synchronizespersonnel fill with equipment arrival, transportation, and institutional training. RESET of a unit is measured and tracked through the Army's Unit Status Report (USR).

Following RESET, a unit transitions to the Train/Ready pool where the focus is restoring decisive action war-fighting proficiency through unit collective training and by completing a Maneuver Combat Training Center (MCTC) rotation or exercise. This ensures that the unit is ready to execute its Available pool mission. Upon entering the Available pool, a unit may be designated a Deployment Expeditionary Force (DEF) with an identified operational mission or a decisive action proficient Contingency Expeditionary Force (CEF) to execute a contingency mission, operational plan, or other Army requirement. CEFs may participate in mission options to include: Chemical, Biological, Radiological, Nuclear (CBRN) Consequence Reaction Force; Global Response Force; Regionally Aligned Brigade (responsive to GCCs for training exercises) and Theater Security Cooperation events around the globe (based on mission demand); Prepare to Deploy Order (PTDO) forces in support of Operational Plans (OPLANs); and other validated and approved Joint or Army requirements.

To implement a supply-based ARFORGEN model as originally envisioned, the Army is working to determinethe time and strategic risk involved in producing the model's primary output – a routinely accessible mix of decisive action capable AC and RC units – based on the resources available. This output is not a package or cluster of capabilities that progress through ARFORGEN simultaneously, although

some units may conduct pre-deployment training together. The recent decision to implement a nine month boots-on-ground (BOG) policy, combined with continued high operational demand and anticipated declining resources, will continue to impact the composition of this output for several more years.

The Army has the ability to surge or curtail units moving through the process in response to changing requirements, or to execute a rapid course change driven by many factors such as risk assessments and resources. Regardless of the output's composition, the Army will use aim points, or benchmarks, to synchronize the delivery of Soldiers and equipment with training at specific points during the ARFORGEN progression. The notion of model output will increasingly serve the vital purpose of informing resource programming. Eventually, the Army will provide, on a routine basis, two categories of forces moving through ARFORGEN - the "Mission Force" and a "Surge Force" capable of meeting both current and emergent requirements.

The Mission Force category is defined as the composition of forces (AC and RC) in the Available Force Pool consisting of all DEFs and CEFs. The Mission Force provides the operational depth and strategic flexibility to satisfy combatant commander and Army validated requirements. Included in the Mission Force are theater assigned, globally available forces when in the Available pool. The Surge Force is comprised of a selected number of CEF units in the Train/Ready pool that are designated for use in emergent or contingency operations. The Surge Force includes a number of decisive action capable units that are available for employment after the Mission Force capacity is fully committed or engaged. Alternatively, a unit (or tailored capability) from the Surge Force could be used if it is the most feasible or acceptable course of action to satisfy the force requirement. The Mission and Surge Forces are not part of a large organization or package that progresses concurrently through the ARFORGEN process.

Implementing a supply-based model signals the beginning of predictable unit rotational cycles. The cycles of time deployed and time at home are expressed in terms of BOG:Dwell ratio (1:2 for the AC and 1:4 for the RC). BOG is the term used to describe the time that units are deployed while in the Available pool. During this period they are either executing missions or are poised to perform short-notice emergent requirements. Dwell is the term used to describe the time when Soldiers and units are in the RESET and Train/Ready force pools, respectively.

The development of Mission and Surge forces will enable the Army to satisfy, respectively, the "new normal" demands associated with Theater Security Cooperation activities and restoration of the critically needed operational depth and strategic flexibility for the Nation. Availability of these forces will mitigate the risk associated with the threats the Army and our Nation will confront for the foreseeable future. Importantly, when supply-based ARFORGEN is fully implemented, the Army will finally put into place a force generation construct that enables the National Security Decision Makers to understand the capabilities and limitations of the Army when making decisions to employ the force. Furthermore, when fully institutionalized, supply-based ARFORGEN will enable the National Security Decision Makers to assess strategic risk and allocate the appropriate resources when global demand exceeds the available supply for forces.

The critical contribution and integration of the Army's RC (Army National Guard and the U.S. Army Reserve) to supply-based ARFORGEN is fundamental to meeting our Nation's security requirements. Approximately half of the Army's capability resides in the RC. These units, to include division headquarters, brigade combat teams, functional and multi-functional support brigades and other combat service and sustainment units, are integral to achieving the Mission and Surge forces required by the Nation. To secure a steady and predictable supply of trained and ready cohesive RC units for these categories of forces in a manner that is most cost effective, the Nation must commit resources to operationalize the Army's RC and conceive a way of guaranteeing assured access to its forces. With guaranteed access to the RC, the Army will be able to restore the operational depth and strategic flexibility required of the Nation as

well as begin providing forces to support combatant commander requirements at a tempo sustainable to the all-volunteer force. Accomplishing these strategic objectives requires continued Department of Defense and Congressional support and resolve.

Appendix C – DA Form 3349 (Physical Profile

PHYSICAL PROFILE

For use of this form, see AR 40-501; the proponent agency is the Office of the Surgeon General.

1. MEDICAL CONDITION: *(Description in lay terminology)* ☐ INJURY? Or ☐ ILLNESS/DISEASE?	2. CODES *(Table 7-2 AR 40-501)*	3.	P	U	L	H	E	S
		Temporary						
		Permanent						

4. PROFILE TYPE	YES	NO
a. TEMPORARY PROFILE *(Expiration date YYYYMMDD)* *(Limited to 3 months duration)*	☐	☐
b. PERMANENT PROFILE *(Reviewed and validated with every periodic health assessment or after 5 years from the date of issue)*	☐	☐

5. FUNCTIONAL ACTIVITIES THAT EVERY SOLDIER REGARDLESS OF MOS MUST BE ABLE TO PERFORM. IF SOLDIER CANNOT PERFORM ANY ONE OF THESE TASKS, THEN THE PULHES MUST CONTAIN AT LEAST ONE "3" AND SOLDIER MUST BE REFERRED TO A MEB. CAN THE SOLDIER:

FUNCTIONAL ACTIVITY:	YES	NO
a. Carry and fire individual assigned weapon?	☐	☐
b. Evade direct and indirect fire?	☐	☐
c. Ride in a military vehicle for at least 12 hours per day?	☐	☐
d. Wear a helmet for at least 12 hours per day?	☐	☐
e. Wear body armor for at least 12 hours per day?	☐	☐
f. Wear load bearing equipment (LBE) for at least 12 hours per day?	☐	☐
g. Wear military boots and uniform for at least 12 hours per day?	☐	☐
h. Wear protective mask and MOPP 4 for at least 2 continuous hours per day?	☐	☐
i. Move 40lbs (for example, duffle bag) while wearing usual protective gear (helmet, weapon, body armor and LBE) at least 100 yards?	☐	☐
j. Live in an austere environment without worsening the medical condition?	☐	☐

6. APFT	YES	NO	ALTERNATE APFT *(Fill out if unable to do APFT run otherwise N/A)*	N/A	YES	NO
2 MILE RUN	☐	☐	APFT WALK	☐	☐	☐
APFT SIT-UPS	☐	☐	APFT SWIM	☐	☐	☐
APFT PUSH UPS	☐	☐	APFT BIKE	☐	☐	☐

7. DOES THE SOLDIER MEET RETENTION STANDARDS IAW CHAPTER 3 AR 40-501?

YES ☐ NEEDS MMRB NO ☐ NEEDS MEB

8. FUNCTIONAL LIMITATIONS AND CAPABILITIES AND OTHER COMMENTS:

☐ This temporary profile is an extension of a temporary profile first issued on _____

9. NAME, GRADE & TITLE OF PROFILING OFFICER	10. SIGNATURE	11. DATE *(YYYYMMDD)*

12. NAME & GRADE OF APPROVING AUTHORITY	13. SIGNATURE	14. DATE *(YYYYMMDD)*

15. Commanders can access the electronic profiles of Soldiers in their unit(s) by going to http://www.mods.army.mil/ and clicking on eProfile in the list of applications. Commanders will be required to register and be approved in eProfile before they can gain access to profiles.

16. PATIENT'S IDENTIFICATION	17. HOSPITAL OR MEDICAL FACILITY
a. NAME: *(Last, First)* _____	
b. GRADE/RANK: _____	
c. SSN: _____	
d. UNIT: _____	18. PROFILING OFFICER E-MAIL

PHYSICAL PROFILE - PAGE 2 *(OPTIONAL)*

PATIENT'S NAME	DATE *(YYYYMMDD)*

CONTINUATION *(From page 1, Item 8)*

Appendix D – Army Substance Abuse Program Patient Encounter Forms

ARMY SUBSTANCE ABUSE PROGRAM (ASAP) ENROLLMENT

For use of this form, see AR 40-66; the proponent agency is the OTSG

The person named below is being referred to the ASAP for a comprehensive assessment to determine whether or not the individual meets the criteria for enrollment.

1. Name *(Last, First, MI).*	2. Rank/Grade.	3. SSN.	4. DOB *(YYYYMMDD)*	5. Yrs Act/Fed Svc.

6. Is Servicemember/Employee expected to depart installation within 90 days?	7. Is Servicemember/Employee on flying status?	8. Is Servicemember/Employee involved in Personnel Reliability Program?
☐ YES NO ☐	☐ YES NO ☐	☐ YES NO ☐

9. Type of Referral: Biochemical *(Type Drug)* _____ Self ☐ Command ☐ Supervisor ☐ Investigation/Apprehension ☐ Medical ☐ Other ☐

10. Record of Civilian Arrests/Convictions, Courts Martial, Company Punishments, and Disciplinary Problems, including those Pending: *(Specific dates and offenses)*

11. Performance: *(Give specifics of fair or unsatisfactory ratings)*

Performance/	Efficiency:	Excellent	☐	Good	☐	Fair	☐	Unsatisfactory ☐
Behavioral/	Conduct:	Excellent	☐	Good	☐	Fair	☐	Unsatisfactory ☐

12. Reasons for Referral: *(Check appropriate spaces)*

a. Physical Signs
- ☐ Flushed Face
- ☐ Nervousness
- ☐ Red or Bleary Eyes
- ☐ Hand Tremors
- ☐ Hangovers on the Job
- ☐ Minor Illnesses
- ☐ Minor Injuries
- ☐ Unexcused Absences
- ☐ Other

b. Personality Changes
- ☐ Irritability
- ☐ Increased Defensiveness
- ☐ Increased Use of Excuses
- ☐ Intolerant of Co-workers or Subordinates

c. Other Behavioral Indicators
- ☐ Decreased Quality of Work
- ☐ Sporadic Work
- ☐ Mood Changes after Lunch
- ☐ Drinking Before Lunch
- ☐ Drinking During the Day
- ☐ Drinking After Lunch
- ☐ Drinking During Duty
- ☐ Longer Lunch Hours
- ☐ Absenteeism
- ☐ Improper Use of Drugs
- ☐ Unusual Excuses for Absences
- ☐ Avoidance of Supervisor or associates

d. Behavioral changes needed for soldier/employee to become effective/functioning in until:

13. PATIENT IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility):*

SUMMARY OF OUTPATIENT REHABILITATION EFFORTS

DATE (YYYYMMDD)	TYPE	KEPT	DATE (YYYYMMDD)	TYPE	KEPT	DATE (YYYYMMDD)	TYPE	KEPT	DATE (YYYYMMDD)	TYPE	KEPT

Type Code

S = Screening	I = Individual	G = Group	F = Family
D = CMD Consult	R = RTM	T = Testing	M = MFR
A = Clinical Audit	C = Collateral		

ADDITIONAL CLINICAL TREATMENT

EVENT	DATE (YYYYMMDD)	EVENT	DATE (YYYYMMDD)
Drug & Alcohol Education		Inpatient	
Medical Evaluation		Antabuse	
Detox		Case Staffing	

14. Other Problems. Financial ☐ Marriage/Family ☐ Medical ☐ Other ☐ *(specify)*

15. Is soldier/employee seen by other helping agencies? Chaplain ☐ Other ☐
Community Mental Health Service ☐

16. Commander's/Supervisor's Recommendation:

☐ No further action needed at this time.

☐ Soldier/employee needs alcohol and/or drug education.

☐ I suspect soldier/employee has an alcohol and/or other drug problem.

☐ Other *(specify).*

17. Immediate Supervisor's Name.	18. Date *(YYYYMMDD)*	19. Phone.
20. Commander's/Supervisor's Signature.	21. Date *(YYYYMMDD)*	22. Phone.

REHABILITATION TEAM MEETING RESULTS *(MANDATORY FOR MILITARY)*

Record of contact with commanders/supervisors concerning this referral - Record face-to-face rehabilitation team meeting results or telephone concurrences, to include dates of programmatic agreements.

Note: Results of rehabilitation team meetings must also be recorded on SF 600.

*TO: FROM: DATE: *(YYYYMMDD)*

1. Per your basic memorandum and agreements made during rehabilitation team meeting on _____, the following actions have been taken by the Army Substance Abuse Program (ASAP) in an effort to assist referred soldier/employee with his/her problem(s):

☐ Returned to duty, no further action required.

☐ Placed on extended evaluation (30/60 days).

☐ Alcohol/drug education Date *(YYYYMMDD)* _____ Time: _____ Bldg#: _____

☐ Rehabilitation: Track: _____ Date *(YYYYMMDD)* _____ Time: _____ Bldg#: _____

2. If you have any questions, please call the following counselor: _____

at: _____

Clinical Director _____

** Note for Federal Employees: To be completed **ONLY** with written consent of employee.*

ASAP Supervisor

ARMY SUBSTANCE ABUSE PROGRAM (ASAP)

CLINICAL ASSESSMENT FORM (ACAF)

DATE:

DIRECTIONS: Respond to all questions using BLACK ink only. Be sure to fill in all blanks. Use non-applicable (N/A) if an item does not apply. If you make an error, correct it by drawing a single line over it, and initial above. Should you need additional space, use the remarks section at the end of the form (Section IV), indicating the page and number of the question you are answering. PRINT CLEARLY. If you have any problems filling out this form, please ask for help. A counselor or staff member will review this form with you.

FULL NAME:	
RANK:	
UNIT:	
SSN:	

PRIVACY ACT STATEMENT
AUTHORITY: Title 10 USC, Sections 1095 and 1079b: Executive Order 9397
PRINCIPAL PURPOSE(S): Information will be used to collect from private insurers for medical care provided to the Military Treatment Facility (MTF) patient. Such monetary benefits accruing to the MTF will be used to enhance health care delivery in the MTF.
ROUTINE USE(S): In addition to those disclosu[illegible] generally permitted under 5 USC 552a (b) of the Privacy A[illegible] the information on this form will be released to your insurance company.

ARMY SUBSANCE ABUSE PROGRAM (ASAP)

IDENTIFYING DATA

NAME:
(LAST) (FIRST) (MIDDLE)

Age: DOB: SSN# Ethnicity: Gender: Male Female

Referral Information (Circle one): Bio-Chemical (Urinalysis) Command Referral Self-Referral Medical I/A (DUI)

Who referred you to us? _____

ACTIVE DUTY /EMPLOYMENT HISTORY

Branch of Service: Army Unit: MOS: _____

Job Title:_____ Rank: Highest Rank Held: _____

Time in Service: _____ Time in Unit: _____ # of Combat Deployments: _____ Combat Time: _____

Where you are currently stationed? Ft Drum GT Score: _____

Supervisor: _____ Work Phone #: _____

Commander: _____ Work Phone #: _____

PRIOR MILITARY STATUS (prior service and active duty)

Prior Military Service: ___ YES ___ NO BRANCH:_____ From: _____ To: _____

Highest Rate/Rank: _____

Combat Service? ___ YES ___ NO Combat Location: _____

PTSD Diagnosed? ___ YES ___ NO If YES, where and when diagnosed? _____

Prior PTSD Treatment? ___ YES ___ NO If YES, where and when treated? _____

Demotions? ___ YES ___ NO Reason for any demotions: _____

TYPE OF DISCHARGE: ___ Honorable ___ Dishonorable ___ General ___ Medical ___ NA

___ Other (explain) _____

PERSONAL INFORMATION

Status (select one) ___ Active Duty ___ Retiree ___ Family Member ___ Civilian ___Other

Marital Status: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Sponsor's Name and address (if you are not the sponsor): _____

Emergency Contact (Name, Phone #, and relationship): _____

EDUCATION

What is your total number of years of education completed? _____ H.S. DIPLOMA/G.E.D? YES NO

Year of Graduation/Completion: _____ College Degree(s) Completed: _____ Major: _____

Do you have a history of learning problems, ADD/ADHD, or special education? ..... YES NO

WHAT BRINGS YOU INTO TREATMENT THIS TIME? (Use the Remarks section if you need more space.)_____

_____

PRINTED LAST NAME:	LAST FOUR SSN:

II. DIMENSION 1—A: ALCOHOL & DRUG USE (INCLUDE PAST AND PRESENT)

ALCOHOL & DRUG GRID (Complete fully for all substances used.) Write N/A if never used.	AGE AT FIRST USE	AGE WHEN REGULAR USE BEGAN	NUMBER OF TIMES USED PER WEEK (Past year--if no use in past year, describe period of heaviest use)	AMOUNT USED EACH TIME (Past Year--if no use in past year, describe period of heaviest use)	USUAL WAY USED (Oral, Smoked, Snorted, IM, IV)	DATE OF LAST USE	NUMBER OF TIMES USED IN LAST 30 DAYS
Alcohol (Beer, Wine, Hard Liquor)							
Nicotine (Cigarettes, Cigars, Chewing tobacco, Snuff)							
Marijuana							
Cocaine (Crack)							
Caffeine (coffee, sodas, No-Doze)							
Amphetamines (Methamphetamine, Ecstasy, speed)							
PCP							
Sedative-Hypnotic/ Anxiolytic Benzodiazepines (e.g. Xanax, Valium) Tranquilizers, Quaaludes							
Heroin (Opiates)							
Opioids (e.g. Vicodin, Percocet, Codeine, Oxycontin, Demerol, Methadone)							
Barbiturates (e.g. Nembutal, Seconal, Phenobarbital)							
Inhalants (e.g. Paint, Glue, Gasoline, Aerosols)							
Hallucinogens (e.g. LSD, Mescaline, Peyote, Shrooms)							
Steroids							
Muscle-building Supplements (Rip Fuel)							
Over the Counter (Nyquil, Tylenol,)							
OTHER:							

PATTERN OF USE FOR ALCOHOL (circle primary pattern):

daily	periodic	weekends	Binges	alone	with others	other:

PATTERN OF USE FOR DRUGS (circle primary pattern):

daily	periodic	weekends	Binges	alone	with others	N/A	other:

ALCOHOL USE	**DRUG USE (If you have NEVER used drugs, write N/A)**
Number of times intoxicated in past year:	Number of times high in past year:
Most drinks in one day:	Most amt. used in one day:
Have you noticed your pattern of drinking changing over the past? ___ YES ___ NO	Explain:

PRINTED LAST NAME:	**LAST FOUR SSN:**

1. Have you ever been hospitalized or treated for detoxification? YES NO

2. If yes, how many times and for what substances: _____

3. Have you ever received education or treatment for alcohol or other drug problems? YES NO

Name/Location of Previous Alcohol & Drug Treatment Facilities	Dates of Admission and discharge	Reason for Admission (Alcohol, Drugs or Both?)	Type of Facility (see above)	Did you Complete? (Yes or No)	How long did you stay abstinent after completion?

Include military inpatient and outpatient programs

4. What is the longest period of time you have ever stayed clean and sober?

5. Have you ever overdosed on drugs or alcohol? YES NO

6. If yes, how many times?

7. When was the last time?

8. Has anyone in your immediate family had any problems with alcohol or drugs? YES NO If yes, who? _____

9. Are any of the persons above in recovery, or abstinent at this time?

10. If Yes, then who, and for how long?

11. Were any of the drugs used prescribed by a doctor or dentist? YES NO

12. If yes, which ones?

13. Have you ever used intravenous (IV) drugs? YES NO

14. Have you ever experienced any of the following as a result of alcohol and/or drug use?	HOW MANY TIMES?	DATE OF LAST OCCURENCE
A. Blackouts		
B. Shakes		
C. Eye Openers (drinking in the morning)		
D. Seizures		
E. Hallucinations		
F. Delirium Tremens (DT's)		
G. Flashbacks		
H. Cravings		
I. Passing Out		
J. Tolerance changes		

Dimension 1—B: ALCOHOL & DRUG USE QUESTIONNAIRE (Shaded areas for interviewer use only)		
1. Since you began regular alcohol use, do you drink a lot more or a lot less now to get the same effect?	YES NO	D1
2. How many drinks do you usually have each time you drink? (e.g. six 12 oz beers) How much of your drug do you usually use?		
3. When did you last have a drink or use?		
4. What did you have to drink and/or what did you use?		
5. Have you ever had any withdrawal symptoms when you cut down or stopped using alcohol/drug? (Headache, anxiety, vomiting, tremors, sweating, etc.)?	YES NO	D2
6. Have you ever used alcohol/drug to avoid hangovers, shakes or other symptoms?	YES NO	D2
7. Has there ever been a time in your life when you drank/used daily?	YES NO	D5
For how long?	When was that?	
8. Have you ever taken the risk of driving after drinking/using any amount?	YES NO	D4
9. Have you ever wanted to stop using alcohol/drug, but couldn't?	YES NO	D4
10. Has there been a time when you used alcohol/drug in larger amounts or for longer periods than you intended?	YES NO	D3
11. Has anyone ever objected to your use of alcohol/drug, or expressed concern about your drinking?	YES NO	A4
12. Have you ever felt as though your life revolved around your use?	YES NO	D5
13. Have you ever spent most of the day using alcohol/drug, or getting over the effects of using alcohol?	YES NO	D5
14. Have you ever had problems with memory or concentration because of alcohol/drug use? (include blackouts)	YES NO	D7
15. Have you ever neglected responsibilities to yourself or your family because of alcohol/drug use?	YES NO	A1
16. Have you ever missed school or work (taken sick leave) because of drinking or shown up to work smelling of alcohol/drug use?	YES NO	D6
17. Has your use of alcohol/drug ever caused you to lose a job or be expelled from school?	YES NO	D6
18. Have you ever been unable to do something you planned because of alcohol/drug use?	YES NO	D6
19. Have you ever been stopped or arrested for DUI/DWI?	YES NO	A2
20. Have you ever been arrested for Minor in Possession, Open Container, Drunk and Disorderly, or any other alcohol/drug-related charge? YES NO		A3
21. Have you ever been in a hospital or emergency room because of alcohol/drug use?	YES NO	A2
22. Have you ever continued to drink/use when you knew you had a physical or emotional problem that might become worse with continued use? YES NO		D7
23. Have you ever had an injury while drinking/using?	YES NO	A2
Did you require medical attention?	YES NO	

DIMENSION 2 – BIOMEDICAL CONDITIONS AND COMPLICATIONS

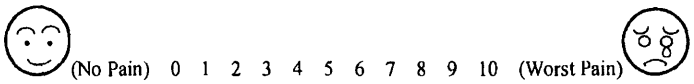
1. How is your overall health now?	EXCELLENT	GOOD	FAIR	POOR	
2. If female, are you pregnant? (If yes, how many weeks)?				YES	NO
3. Are you currently having any physical problems? (If yes, please indicate):				YES	NO
4. Are you currently under a doctor's care? (If yes, please indicate why):					
5. What prescription medications are you currently taking?					
6. What over-the-counter medications are you currently using, or regularly using?					
7. How many times have you visited the ER or been on sick call in the past year? Date of last visit? _____ Reason: _____					

PRINTED LAST NAME:	**LAST FOUR SSN:**

1. Are you being treated for physical pain?..... YES NO

   If yes, explain: _____

2. Indicate current level of physical pain by circling one:



3. Does your physical pain impact on your daily activities?..... YES NO
4. Does your physical pain impact on your substance use?..... YES NO
5. Do you currently have nutritional or dietary concerns? ..... YES NO

   If yes, explain: _____

6. Are you experiencing problems with nausea, vomiting, diarrhea or constipation? ..... YES NO
7. Have you had any significant changes in appetite or weight over the past few months? ..... YES NO
8. How many hours of sleep do you NEED eachnight? _____
9. How many hours of sleep do you GET each night? _____

DIMENSION 3 Emotional/Behavioral or Cognitive Conditions and Complications

1. Are you currently or have you ever had any previous mental health treatment for problems other than alcohol/drug abuse? ..... YES NO

(If yes, when and where) _____

2. Are you currently taking any medications to treat mental health problems? ..... YES NO

(If yes, what and for how long) _____

3. Has anyone in your family ever had any kind of mental health ..... YES NO

(If yes, explain) _____

4. Have you ever had a significant period of any of the following that were not due to the use of alcohol/drug and other drugs?

_____Anxiousness	_____Self-cutting/burning	_____ Violence
_____Sleep Disturbances	_____Hallucinations	_____Low concentration
_____Phobias/Paranoia/Delusions	_____Serious Depression	_____Referral to Mental Health
_____Inducing vomiting/purging	_____Low mood x 2 weeks	_____Death(s) of loved ones
_____Overeating/Starving	_____Uncontrollable Anger	_____ Recurrent thoughts of death
_____ Feelings of worthlessness		_____ Wt loss/gain -5% of wt
_____Reduced interest or pleasure in things		_____ Death(s) of loved ones

5. Have you ever attempted to harm yourself or commit suicide?..... YES NO

   If yes, How many times? _____ When and how? _____

6. Has anyone in your family ever attempted suicide?..... YES NO

   If yes, explain: _____

7. Are you currently thinking of harming yourself or someone else? ..... YES NO

   If yes, please explain: _____

8. Are you CURRENTLY experiencing any of the following: (Check all that apply)

_____Hopelessness	_____Self-destructive Thoughts
_____Decreased Energy	_____Taking Unnecessary Risks
_____Giving Away Valuable Possessions	_____Thoughts of Harming Others
_____Moodiness	_____Serious Problems at Home
_____Preoccupation with Death	_____Serious Financial Problems
_____Sleeping too little or too much	_____Separation or Divorce
_____Feeling Withdrawn	_____Problems with Sexual Functioning/Desire
_____Irritability	_____Eating Too Much/Eating Too Little
_____Unresolved Grief/Loss	_____Frequent Nightmares

9. Have you ever been emotionally, physically, or sexually abused? ..... YES NO

   If yes, by whom? _____ If yes, have you received treatment for this abuse? ..... YES NO

10. Do you have any history of violence toward others? ..... YES NO

If yes, explain: _____

If yes, what is the worst thing you have ever done to someone? _____

Has anyone ever ended up in the hospital because of anger or violence toward others? ..... YES NO

What were the consequences? _____

Did you ever receive treatment for anger or being violent? ..... YES NO

When: _____

11. Are there any current domestic violence incidents? ..... YES NO

Describe incident and consequences: _____

12. Have you ever been accused of physical, mental, or sexual abuse of any of your family members or others? ..... YES NO

DEVELOPMENTAL HISTORY (Check all that applied to you when you were growing up)

_____Had significant childhood illnesses
_____Had disciplinary problems in school
_____Repeated a grade
_____Suspended or thrown out of school
_____Ran away from Home
_____Stole items costing $10.00 or more
_____Broke into cars or homes
_____Hurt people
_____Had adjustment problems in school
_____Was involved in many fights
_____Truant from school more than 10 days in a year
_____Destroyed other's property
_____Set fires
_____Hurt animals
_____Dropped out of school
_____Experienced a traumatic event (death, abuse, etc.)

SEXUAL HISTORY

1. Do you engage a high risk sexual behavior as a result of drinking (Unprotected sex, multiple partners, etc.)? ..... YES NO
2. Do you use any form of birth control? ..... YES NO

If yes, please indicate what form (s): _____

OTHER ADDICITIONS: GAMBLING, INTERNET, SEX

1. What kinds of gambling do you engage in? (circle one) N/A slot machines lottery cards other: _____
2. How many days out of the last 30 have you engaged in any form of gambling? _____ Which kind? _____
3. Would you like help with gambling problems? ..... YES NO
4. How much time and money have you spent on sex during the past year (videos, 900 calls, strip clubs, prostitution, etc.)? _____
5. How much time have you spent on the Internet in the past week? _____ Past month? _____
6. How much time do you spend on the Internet in a typical week viewing sexual material, cyber sex, or flirting? _____

LEGAL HISTORY

1. Do you have any current legal problems or UCMJ action(s) pending? ..... YES NO

If yes, please describe: _____

2. PRIOR LEGAL PROBLEMS:	# of TIMES	DATE(S)	ALCOHOL/DRUG RELATED?	
A. Article 15:	_____	_____	YES	NO
B. Civilian Arrests:	_____	_____	YES	NO
C. Civilian Convictions:	_____	_____	YES	NO
D. Assault/Battery:	_____	_____	YES	NO
E. Domestic Violence:	_____	_____	YES	NO

FAMILY AND SOCIAL HISTORY

1. RELATIONSHIP STATUS : (circle current status)

Single Married Separated Divorced Widowed Living as married

2. How many times married? _____ How many times divorced? _____ Length of first marriage:_____
3. If you are married, is your spouse willing to participate in the spousal program? ..... YES NO
4. If you have a significant other, do you believe this person has problems with alcohol or drugs? ..... YES NO
5. Were you raised in a biological, foster or adoptive family? ..... YES NO
6. Is your mother currently living? Yes No If No, Cause of death:_____
7. Is your father currently living? Yes No If No, Cause of death:_____
8. What is your parents' marital status? STILL MARRIED NEVER MARRIED DIVORCED WIDOWED

   If Parent(s) divorced or widowed, how old were you at time of divorce/death? _____

   Father married _____times Mother married _____times
9. Who raised you?_____ From age_____ to age_____

   If you were not brought up by your parents, who raised you?_____

   Between what years? _____ to _____ Your Birth Order: _____ of _____
10. How much contact did you have with your parents growing up? (if you were not brought up by biological parents, answer based upon your contact with the persons you considered to be your parents):

    Contact with mother growing up: _____ NONE _____ INFREQUENT _____ FREQUENT

    Contact with father growing up: _____ NONE _____ INFREQUENT _____ FREQUENT
11. How many siblings do you have?

    Number of brothers/half or step: _____ Number of sisters/half or step: _____
12. Are you currently involved in an intimate relationship? ..... YES NO
13. Is there any violence in this relationship? ..... YES NO
19. How would you currently describe your relationships with the following people?

    A. SPOUSE:_____

    B. CHILDREN: _____

    C. MOTHER: _____

    D. FATHER: _____

    E. SIBLINGS: _____

DIMENSION 4 –READINESS TO CHANGE

1. Do you think you have an alcohol or drug problem? Why or why not? _____
2. How severe do you think your problem is? (Circle number) *Not at all* 0 1 2 3 4 5 6 7 8 9 10 *Very Severe*
3. How do you rate your level of motivation for treatment at this time? (circle number)

   Nonexistent 0 1 2 3 4 5 6 7 8 9 10 *Very High*
4. Do you feel forced into treatment or actively object to receiving treatment? ..... YES NO
5. Is receiving treatment primarily to avoid a negative consequence or do you feel distressed about your alcohol/drug use? (explain)

   _____
6. If treatment is recommended, will you be willing to participate and do the necessary work? ..... YES NO

DIMENSION 5 –RELAPSE/CONTINUED USE POTENTIAL

1. Have you ever been told that you should seek help for alcohol and/or drug problems? ..... YES NO
2. What skills/tools would have you used to reduce or stop abusing/using alcohol or drugs? ..... YES NO
3. What level would you estimate your craving or desire for alcohol/drugs is this week? (circle number)

   (Low or no cravings) 1 2 3 4 5 6 7 8 9 10 (High cravings or desire)
4. Have you been able to stop using for a period of time and then began using again? ..... YES NO

   When? _____
5. How many times have you relapsed? _____
6. If the recommendation is to enroll, what steps can you take immediately to keep form drinking/drugging? _____
7. If enrolled, can you identify at least one or two things or activities you can plan which will support not drinking/drugging?

   1. _____ 2. _____

DIMENSION 6 –RECOVERY ENVIRONMENT

1. What are your present living arrangements? (circle one) Barracks/Dorms W/ Family W/ Roommate Alone Other
2. Who lives in your home with you now? _____
3. Does the person(s) you are living with drink or use drugs? ..... YES NO
4. Who are your current sources of support for abstinence and recovery: (check all that apply)

SPOUSE/SIGNIFICANT OTHER	___YES	___NO	___N/A	SELF-HELP GROUP	___YES	___NO	___N/A
FAMILY	___YES	___NO	___N/A	CHURCH	___YES	___NO	___N/A
EMPLOYER	___YES	___NO	___N/A	FRIENDS	___YES	___NO	___N/A
OTHER	___YES	___NO	___N/A				

RECREATIONAL/LEISURE

1. What are your favorite leisure activities? _____
2. Describe how you spend a typical weekend: _____

FINANCIAL

1. Are you currently experiencing financial problems? ..... YES NO
2. What impact has your use caused to your financial condition? _____
3. Estimate what you spend weekly on using. _____

SPIRITUAL

1. What is your religious or spiritual orientation? _____
2. Does the church/synagogue/mosque/temple play a role in your life? ..... YES NO
3. Who or what provides you with strength and hope? _____
4. What impact has using had on your spiritual, religious practices, values or family? _____
5. Are there any spiritual/religious impediments or barriers you think may interfere with your treatment? ..... YES NO

   (If yes, specify) _____
6. How much control do you feel you have over your goals and direction of your life? _____
7. Would you like a referral to see a Chaplain or Spiritual Leader? ..... YES NO

CULTURAL

1. What do you consider to be your culture/ethnicity? _____
2. How is sharing of intimate/personal details with "outsiders" viewed by your country? _____
3. Are there any cultural impediments or barriers you think may interfere with your treatment? ..... YES NO

   If yes, please describe: _____
4. How is the sharing of intimate/personal details with "outsiders" viewed by your culture? _____
5. How is the use of alcohol or drugs viewed by your culture? _____

STRENTHS/LIMIATIONS

1. What do you like most about yourself? _____
2. What are your chief talents? _____
3. What do you most dislike about yourself? _____
4. Describe your personality: _____
5. Is there anything else you think your counselor needs to know right now? _____

PATIENT SIGNATURE: _____ DATE: _____

PLEASE STOP AND RETURN THIS FORM TO YOUR COUNSELOR

PRINTED LAST NAME:	**LAST FOUR SSN:**

DSM-IV-TR DIAGNOSTIC GRID

DIMENSION 1. DETOX/WITHDRAWAL + DSM-IV DIAGNOSIS	Circle "E" if symptom ever occurred but was not reported in the past year. Circle "1" if symptom occurred only once in the past year. Circle "2" if symptom occurred two or more times In the past year.									
INDICATOR	**ALC**	**CAN**	**SED/ HYP**	**HAL**	**AMP**	**COC**	**OPI**	**PCP**	**INH**	**OTHER**
1. Tolerance a. increased	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2
b. decreased	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2
2. Withdrawal a. Withdrawal Syndrome	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2
b. Using to avoid withdrawal	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2
3. Using larger amounts or for longer periods of time than intended	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2
4. Desire or unsuccessful attempts to cut down or control use	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2
5. Great deal of time spent obtaining, using, or recovering	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2
6. Social, work, or play activities given up or reduced by use	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2
7. Continued use despite recurrent physical or psychological problems	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2
A1. Failure to fulfill roles at work, school, or home due to use	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2
A2. Recurrent use in hazardous situations	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2
A3. Recurrent legal problems due to use	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2
A4. Continued use despite social or interpersonal problems	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2	E 1 2
DATE OF LAST USE										
SUBSTANCE DEPENDENCE (Pattern of impairment with three or more indicators 1-7 occurring at any time in the last 12 months)	**303.90**	**304.30**	**304.10**	**304.50**	**304.40**	**304.20**	**304.00**	**304.90**	**304.60**	**304.90**
SUBSTANCE ABUSE (Pattern of impairment with one or more of the indicators A1-4 occurring within the last 12 months	**305.00**	**305.20**	**305.40**	**305.30**	**305.70**	**305.60**	**305.50**	**305.90**	**305.90**	**305.90**

I. DSM-IV-TR AXIS I DIAGNOSIS(ES):

1. _____
2. _____
3. _____
4. _____
5. _____

II. CHIEF PROBLEM(S): (note if problem will be addressed, referred, or deferred)

1. _____
2. _____
3. _____
4. _____
5. _____

III. IMMEDIATE TREATMENT RECOMMENDATIONS (Include any referrals to address problems identified above):

_____ Abstinence

_____F/U meeting with ASAP counselor, DATE/Time _____

_____Other (specify) _____

IV. LONG TERM RECOMMENDATIONS (Include any referrals to address problems identified above):

_____ Abstinence

_____Attendance at ADAPT (education/prevention classes)

_____Group therapy ___--week for ___ weeks

_____Individual Counseling: Frequency _____

_____Patient education and evaluation for Antabuse/ Naltrexone

_____Referral to ACS for stress/anger management

_____Referral to Chaplain/Spiritual Advisor

_____Referral to Medical for evaluation/examination

_____Referral for Mental Health evaluation

_____Referral to Nutritionist

(specify)_____

By my signature, I acknowledge that the above diagnosis(es) and immediate treatment recommendations have been explained to me:

PATIENT SIGNATURE:_____ **DATE:**_____

COUNSELOR SIGNATURE: **DATE**

MariaMoustrouphisLCSW, LADC, CCS
ASAP Supervisor

PRINTED LAST NAME:	**LAST FOUR SSN:**

4 Oct 2011

INTEGRATED SUMMARY

1. **IDENTIFYING DATA/DEMOGRAPHICS:** is a 20 year-old single Caucasian male. he is currently working with B CO 1-2 SCR. He has been in his unit for 8 months. He has been enlisted in the Army for 20 months. Deployment history: Patient resides in the barracks. He is a Command-referral for this evaluation for alcohol.

2. **If married, Soldier's permission to call spouse:** Yes / No; Soldier signed DA Form 5018R.
Command consult
Other providers
3. **PRESENTING PROBLEM(S):** Patient reports that "he was .".

4. **ASAM DIMENSIONS**

Dimension 1 – Acute Intoxication and/or Withdrawal Potential: At this time there does not appear to be any current assessed acute levels or intoxication or acknowledged withdrawal symptoms.

Alcohol Use History: Patient reports getting drunk for the first time at age 14. No evidence of acute intoxication/withdrawal at this time. He denies any withdrawal symptoms currently.
ACSAP Background check: Negative.
From age 14 to 18 he reports
He denies a history of past substance abuse treatment. He reports black-outs in the past 12 months and lifetime. He denies history of cravings. Denies any family history of substance problems. **Briefed the patient of his AT RISK status. He verbalized understanding the Genetic Link of substance use.**

Other Substances: Patient denies other substances use.

Patient meets DSM IV-TR criteria for Alcohol Dependence as follows:

- Tolerance (numbers of drinks show increase in tolerance)
- Withdrawal- include nausea, headaches and irritability
- Alcohol is often taken in larger amounts or over a longer period than intended – multiple times per patient's report.
- There is a persistent desire or unsuccessful efforts to cut down alcohol use as per patient's report.
- A GREAT DEAL OF TIME SPENT in activities necessary to OBTAIN the substance. USE the substance, or RECOVER from its effects.
- Important social / occupational / recreational activities are given up or reduced because of alcohol use.
- Alcohol use is continued despite knowledge of having a depressive disorder that is likely to have been caused or exacerbated by alcohol.

Patient meets DSM IV-TR criteria for Alcohol Abuse as follows:
- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home.

- Recurrent substance use in situations in which it is physically hazardous.
- Recurrent substance-related legal problems.
- Continued substance use despite having a persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

Dimension 1 Summary: Patient is free from intoxication or withdrawal symptoms.

Dimension 2 – Biomedical Conditions and Complications:

- **Nutritional/Dietary:** There were no clinical issues assessed concerning patient's Nutritional / Dietary problems – Patient did not acknowledge any problems during the assessment.
- **Pain Management:** Based on the assessed information, there does not appear to be any chronic problems with pain at this time.
- **Tobacco Products:** Based on the complete assessment there is no indication that patient is now using or planning on utilizing tobacco products in the future – not of clinical concern at this time. He is interested to stopping his tobacco use and is aware of the physical / health risks he could face if he continues smoking. The patient is smoking 1 pack of cigarettes a day and was offered a referral to the Medical Clinic for tobacco cessation classes. The patient declined the referral and is aware of the health risks by continuing the use of tobacco products. The patient has been utilizing tobacco products for 8 months or 8 years.
- **TBI:** The patient endorses / denies any concussion, blunt force trauma, or other head injury – and – or loss of consciousness.
- **Relevant Hospitalizations:** Other than for normal physical ailments, there were no significant hospitalizations that would affect patient's treatment at this time.
- **Sleep Complaints:** The patient reports sleeping 5 hours a night and was offered a referral to the Medical Clinic to assess the lack of sleep. The patient declined the referral.
- **Medications**: The patient reports he is not on any medications.

Dimension 2 Summary: The patient's biomedical conditions, if any, are stable enough for the patient to participate in outpatient treatment.

Dimension 3 – Emotional, Behavioral or Cognitive Conditions and Complications:

Patient History / Psychiatric Illnesses: No Mental Health Problems from patient's current or past life assessed.
Stress / Depression / Anger / Anxiety Level Assessment:

- Stress: Some stress due to not getting along with his supervisor.
- Depression: The patient denies any.
- Anger: None reported
- Anxiety: The patient denies any symptoms.

History Of Sexual, Physical Or Emotional Abuse: The patient denies any history of abuse.
Developmental History: The patient denies/endorses numerous development issues.

4 Oct 2011

Sexual History: No indication that patient is now or in the past has engages in high risk sexual behaviors as a result of drinking.
Family History: No assessed problems with Family of Origin mental health problems, suicidal or homicidal history, and no indication of emotional, physical or sexual abuse.
Other Addictions: Gambling, Internet, Sex:

- There does not appear to be any current assessed/acknowledged problems with other addictions: gambling, internet, sex.

Learning Needs:

- Patient's level of education and learning ability was assessed during the screening process – At this time there does not appear to be any cognitive learning problems which will hinder the ability to participate in various aspects of Psycho-Education and therapy.

Current Legal Problems / Concerns: Patient denies any significant legal issues or problems that would affect his treatment at this time.

Dimension 3 Summary: The patient's mental health functioning is stable enough to participate in outpatient treatment.

Dimension 4 –Readiness To Change:

Turning Point for Change: At this time patient does not appear to see the need for any change in substance use behaviors.
Patient Acceptance to Receiving Services: Patient verbalized willingness to obtain the recommended treatment based on this assessment but does not believe that it is necessary.
Level of Motivation for Treatment: "7" on scale of 0-10 (10=high motivation)

Dimension 4 Summary: The patient wants to adhere to the treatment plan and attend all scheduled activities and the patient admits to a substance abuse and mental health problem but requires monitoring and motivating strategies. A structured residential program is not required presently.

Dimension 5 – Relapse, Continued Use or Continued Problem Potential:

Level of Craving/Desire to Use Alcohol/Illicit Drugs: Patient denies/ endorses cravings to used AOD currently.
Skills to Prevent Relapse: N/A /Limited
Trigger Awareness: The patient could not identify any triggers that lead to drinking.
Danger for Continued Distress: Patient does not appear to be in immediate danger of continued severe distress and substance abuse behavior. The patient appears to have sufficient skills to cope with his substance use problems in order to prevent continued use.

Dimension 5 Summary: The patient is able to maintain abstinence and pursue recovery goals with minimal support. /The patient is assessed as being able to achieve or maintain abstinence and recovery goals only with support and scheduled counseling sessions to assist in dealing with issues that include mental preoccupation with alcohol and drugs, cravings,

peer pressure, lifestyle, attitude changes and other treatment plan issues./ The patient does not require an intensive level of supervision and/or inpatient care.

Dimension 6 – Recovery Environment/Living Environment:

Living and Support Environment: Lives in barracks with other soldiers.
Recreational/ Leisure: video games, sports, working out.
Financial and Employment Status: patient report no financial problems.
Spiritual Assessment: The patient does believe in God. The patient's spiritual orientation does not relate to alcohol misuse in terms of how the patient views of self as an individual of value and worth. Patient did not espouse distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values. No religious or spiritual issues were identified that warranted the focus of clinical attention.

Cultural And Ethnic Influences: With the information assessed, there does not appear to be any significant cultural issues or concerns which would affect therapy at this time.

Dimension 6 Summary: The situation characterized by a sufficiently supportive psychosocial environment makes outpatient treatment feasible.

5. DSM-IV-TR DIAGNOSTIC IMPRESSION:

Axis I:	305.00 Alcohol Abuse
	303.90 Alcohol Dependence
	305.10 Nicotine Dependence
	305.20 Cannabis Abuse
	304.40 Cannabis Dependence
Axis II:	V71.09 No Diagnosis
Axis III:	Patient did not acknowledge any medical conditions or pain at this time.
Axis IV:	Occupational Problem
	Legal Problem
Axis V: GAF	Current – 61-70

6. CLINICAL IMPRESSION: Strengths, Barriers, Assets to Treatment.

The patient is a 21 years old single Caucasian male who had 2 alcohol-related incidents. He was charged with being drunk on duty.

MSE: The patient is a 21 year old single Caucasian male that appears to be about his stated age, appropriately attired in duty uniform and well groomed. The patient's attitude was cooperative and an adequate level of rapport was achieved. There were no abnormal behaviors or psychomotor activity noted. The patient's speech was WNR and spontaneous. There

was no perceptual disturbance or abnormal process noted. Affect was WNR. Patient was appropriately oriented. The patient adequately demonstrated an age appropriate general fund of knowledge. Judgment and insight as it relates to alcohol or other drug use appears fair to poor. Patient denies current experience with homicidal/suicidal ideation.

Strengths: "outgoing." Weaknesses: "bad decision-making."

Assessment Interpretation: The patient was administered the following assessment instruments:

a. Alcohol Use Disorders Screening Test (AUDIT) = 10; alcohol-related problem. (A score between 8 and 15 indicates a medium level of alcohol problems and scores of 16 and above indicates a high level of alcohol problems. Scores greater than 20 clearly warrant further diagnostic evaluation for alcohol dependence).
b. Nicotine Questionnaire above = 2; does not meet the criteria for Nicotine Dependence.
c. The patient was administered an OQ-45 questionnaire and had a total score of 67 significant >63; SD=31 significant >36; IR=22 significant >15; SR=14 significant >12. Item #8 (suicide) = 0; item #44=1 (violence).

7. RECOMMENDATIONS: Based on collaborative clinical interview, client input and diagnostic impression, the following recommendations are made:

1. Enrolled in Level I treatment at ASAP.
   - o Group Therapy
   - o Individual Counseling
   - o Prime for Life-Educational Classes.
   - o Attend 2-12 step meetings
2. Attend appointment with MRO to verify diagnosis.
3. Make appointment with Mental Health to address depressive symptoms.
4. Make appointment with the Medical Clinic to address lower back pain.
5. Anger Management Classes.
6. Dietitian to address weight change.
7. Financial Counseling.
8. Tobacco Cessation Classes.

8. INITIAL PLAN:

1. Staff case
2. Contact Command for collateral interview
3. Scheduled RTM with Chain of Command
4. Abstinence

Maria A. Moustrouphis Date:
LCSW, LADC, CCS
ASAP Supervisor

HOSPITAL OR MEDICAL FACILITY	STATUS	RANK/GRADE	DEPART./ SERVICE	RECORD MAINTAINED AT	
Fort Drum ASAP Clinic	AD	E-03	Army	Fort Drum ASAP Clinic	
SPONSOR'S NAME	SSN/ ID NO.		RELATIONSHIP TO SPONSOR	SEX	DOB
			Self	Male	
				REGISTER NO. N/A	UNIT

LIMITS OF CONFIDENTIALITY

For use of this form, see AR 40-66; the proponent agency is OTSG

1. Counselors in the Community Counseling Center (CCC) do the most they can to ensure your confidentiality. There are, however, certain circumstances when disclosure of information to third parties must occur. Information relating to soldiers will be released to individuals within the Armed Forces who have an official need to know. Releases of information to those outside the Armed Forces concerning soldiers, and on all releases of information concerning civilian clients are governed by Part 2, Chapter 1, Title 42, Code of Federal Regulations. Some of the more commonly requires examples are as follows:

a. If a counselor believes you might harm yourself or someone else.

b. If the counselor suspects that you or someone in your family has been involved in child abuse/neglect or spouse abuse.

c. If you or your family are an open case with the Family Advocacy Case Management Team (FACMT) your progress in treatment and any information necessary for the FACMT must be presented to this team.

d. If you are involved in legal actions or proceedings your records and your counselor may be subject to subpoena.

e. If you are involved in, or have been involved in, any illegal activities.

f. For active duty soldiers, if you have been involved in any activities prohibited by army regulation.

g. Commanders of active duty soldiers must be informed of any information pertaining to treatment recommendations and treatment prognosis.

h. Qualified persons involved with quality assurance activities, clinical supervision or approved research projects may be permitted access to your records.

i. If you are involved in a line of duty investigation.

j. If you fall under the nuclear or chemical surety programs then further information may be required to be given to your commander.

2. It is the intent of all CCC personnel to safeguard your confidentiality to the utmost extent afforded by law and Army Regulation. However, total confidentiality in the military is only guaranteed to legal counsel (lawyers) who are representing you. If you have any questions about the above information please discuss them with your counselor BEFORE proceeding with the interview.

3. **STATEMENT OF UNDERSTANDING:** I have read the above and understand that information about me will be safeguarded within the limits of confidentiality outlined above and as contained in the Privacy Act Statement.

Signature	Date

4. **CCC COUNSELOR'S STATEMENT:** I have inquired to ensure that the patient understands the above description of the limits of confidentiality.

Signature	Date

5. **PATIENT IDENTIFICATION** (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility):

ALCOHOL & DRUG ABUSE PREVENTION & CONTROL PROGRAM (ADAPCP) OUTPATIENT MEDICAL RECORDS - PRIVACY ACT INFORMATION

For use of this form, see AR 40-66; the proponent agency is OTSG

This form is not a consent form to release or use health care information about you.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN).
Title V, Public Law 92-129; section 501, 42 USC section 290dd.

2. PRINCIPAL PURPOSES OF OUTPATIENT MEDICAL RECORDS.

a. To provide necessary information to evaluate the existence of and, if appropriate, the nature and extent of the patient's alcohol and other drug problem.

b. To provide baseline information for monitoring the patient's progress during rehabilitation in the ADAPCP.

c. To ensure continuity of care of patient enrolled in ADAPCP rehabilitation.

d. As part of the Active Army soldier's medical record, to provide information to military physicians in diagnosing other medical problems and in prescribing medication.

e. To provide statistical information for program evaluation.

3. PRINCIPAL PURPOSES OF OUTPATIENT MEDICAL RECORDS.

a. Active Army Soldiers. Release of any information from this record is subject to the restrictions of 21 USC 1175 as amended by 88 Stat 137; 42 USC 4582 amended by 88 Stat 131 chapter 1, title 42, Code of Federal Regulations. Under these statues and regulations, disclosure of information that would identify the patient as an abuser of alcohol or other drugs is authorized within the Armed Forces or to those components of the Veterans Administration, furnishing health care to veterans. AR 600-85 further limits disclosure within the Armed Forces to those individuals having an official need to know (for example, the physician or the patient's unit commander). All other disclosures require the written consent of the patient except disclosures (1) to medical personnel outside the Armed Forces to the extent necessary to meet a bona fide medical emergency; (2) to qualified personnel conducting scientific research, management, or financial competent jurisdiction.

b. Civilian employees and other personnel. Release of any information from this record is subject to the restrictions of 21 USC 1175 as amended by 88 Stat 137-42 USC 4582 as amended by 88 Stat 131 and chapter 1, title 42, Code of Federal Regulations. All disclosures require the written consent of the patient except disclosures (1) to medical personnel to the extent necessary to meet a bona fide medical emergency; (2) to qualified personnel conducting scientific research, management, or financial audits or program evaluation or (3) upon the order of a court of competent jurisdiction.

4. MANDATORY / VOLUNTARY DISCLOSURE AND EFFECT ON AN INDIVIDUAL NOT PROVIDING INFORMATION.

a. Disclosure is mandatory for Active Army soldiers. Failure to obey order from competent authority to provide required information may be subject to appropriate disciplinary action under the UCMJ.

b. Disclosure is voluntary for civilian employees and other personnel. The failure to disclose the information will result in a reduced capability of the program to provide treatment and services.

5. Signature of Patient or Sponsor	6. SSN of Member or Sponsor.	7. Date.

ASAP LIMITED USE POLICY (AR 600-85)

The Objective of the Limited Use Policy is to facilitate the identification of alcohol and drug abusers through self-referral, an the treatment and rehabilitation of those abusers who demonstrate the potential for rehabilitation and retention. It is not intended to protect a member who is attempting to avoid disciplinary or adverse administrative action.

Limited Use prohibits the use of the following evidence against a soldier in actions under the Uniform Code of Military Justice or on the issue of characterization of service in separation proceedings:

(1) Mandatory urine or alcohol breath test results taken to determine a soldier's fitness for duty and the need for counseling, rehabilitation, or other medical treatment or in conjunction with a soldier's participation in ASAP.

(2) A soldier's self-referral to ASAP.

(3) Admissions and other information concerning drug or alcohol abuse or possession of drugs incidental to personal use occurring prior to the date of initial referral to ASAP provided voluntarily by a soldier as part of his or her initial entry into ASAP.

(4) Admissions made by a soldier enrolled in ASAP to a physician or ASAP counselor during a scheduled interview concerning drug or alcohol abuse or possession of drugs incidental to personal use occurring prior to the date of initial referral to ASAP.

(5) Information concerning drug or alcohol abuse or possession of drugs incidental to personal use obtained as a result of a soldier's emergency medical care for an actual or possible drug or alcohol overdose, unless such treatment resulted from apprehension by military or civilian law enforcement officials.

The Limited Use Policy does not prevent the counselor from revealing to the appropriate authority, knowledge of certain illegal acts. These would be acts that may have an adverse impact on or compromise mission, national security, or the health and welfare of others. The reporting in such an instance is from the counselor, to clinical director, to Clinical Consultant, to the patient's commander, not directly to any other agency. The commander will report the information to the appropriate authority. Likewise, information that the patient presently possesses illegal drugs or that the patient committed an offense while under the influence of illegal drugs or alcohol is not covered under this policy.

PATIENT RIGHTS
BEHAVIORAL HEALTH DEPARTMENT
COMMUNITY COUNSELING CENTER

1. Every patient shall have his/her fundamental human, civil, constitutional, statutory and individual rights supported and protected by the Community Counseling Center (CCC).

2. The personal dignity of the individual shall be maintained. Access to treatment shall be impartial, that is free of discrimination of race, religion, sex, ethnicity, age or handicap.

3. The personal privacy of the patient shall be maintained within the constraints of the individual treatment and standards governing confidentiality.

4. Each CCC patient shall be informed regarding the following:

   a. His or her rights.

   b. The clinical staff responsible for his or her care and those staff members' professional status and staff relationship.

   c. The nature of the care, procedures, and treatment which he or she will receive.

   d. The present and future use and disposition of products of special observation and audiovisual techniques such as tape recorders, television, movies or photographs.

   e. The risks, side effects, and benefits of all medications and treatment procedures used.

   f. His or her participation in any research project that introduces additional inconvenience or risk.

   g. The alternative treatment procedures that are available.

   h. The right to refuse to participate in any research project, without compromising access to the program's services.

   i. The right to refuse specific medications or treatment.

   j. The program's responsibilities when patient refuses treatment, to terminate the relationship with the patient upon reasonable notice; either at the time of refusal or immediately after patient refuses to attend two consecutive counseling sessions without excuse by the Commander/1SG or appropriate person.

   k. Any proposed change, and the reasons for such change, in the clinical staff responsible for him or her, or any transfer of him or her within or outside the program.

   l. The rules and regulations of the program applicable to his or her conduct.

NAME _____ RANK _____ SSN _____

UNIT _____ DOB _____ DATE _____

SIGNATURE _____ DATE _____

WITNESSED _____ DATE _____

CONFIDENTIAL INFORMATION
NICOTINE QUESTIONNAIRE

- Do you smoke / chew tobacco products: **Yes** **No**
    - o If "**NO**" you do not have to continue with this questionnaire.
- How long have you used tobacco products? **Start (Age) Date**: _____
- Are you interested to stopping your tobacco use? **Yes** **No**
- If you are not interested in stopping your tobacco use, are you aware of the physical / health risks you could face if you continue smoking: **Yes** **No**

Symptom	Yes	No
Do you need markedly increased amounts of Tobacco Products to achieve the desired effect? **Start Amount**: _____ **Using Now:** _____		
When you stop using Tobacco Products do you experience any of the following: - Depression - Insomnia (Cannot Sleep) - Irritability, Frustration or Anger - Anxiety *(Circle All That Apply)* - Difficulty Concentrating - Restlessness - Decreased Heart Rate - Increased Appetite / Weight Gain		
Are you using Tobacco Products in larger amounts / over a longer period than you intend to?		
Have you tried previously to stop, cut down or control your Tobacco Use?		
Do you spend a great deal of time using Tobacco Products (e.g. Chain Smoking / Chewing)?		
Has your social, occupational or recreational activities been hindered / delayed because of your Tobacco Use?		
Have you continued to use Tobacco Products despite your knowledge of possibly having persistent, recurrent or future physical problems?		
TOTAL SYMPTOMS		

_____ _____
Patient's Signature **DATE**

RECORDS MAINTAINED AT: FORT DRUM ASAP	
NAME:	
RANK:	UNIT:
SSN:	DOB:

CONFIDENTIAL INFORMATION

OUTCOME QUESTIONNAIRE (OQ -45.2)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

Name _____

Age: _____ yrs. **Sex:** ☐ M ☐ F

ID # _____

Session # _____ **Date** ____/____/____

		Never	Rarely	Sometimes	Frequently	Almost Always	SD	IR	SR
							DO NOT MARK BELOW		
1.	I get along well with others.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0		☐	
2.	I tire quickly	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
3.	I feel no interest in things.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
4.	I feel stressed at work/school	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
5.	I blame myself for things.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
6.	I feel irritated	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
7.	I feel unhappy in my marriage/significant relationship.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
8.	I have thoughts of ending my life	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
9.	I feel weak.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
10.	I feel fearful	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
11.	After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
12.	I find my work/school satisfying	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0			☐
13.	I am a happy person.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐		
14.	I work/study to much	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
15.	I feel worthless.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
16.	I am concerned about family troubles	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
17.	I have an unfulfilling sex life.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
18.	I feel lonely	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
19.	I have frequent arguments.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
20.	I feel loved and wanted	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0		☐	
21.	I enjoy my spare time.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0			☐
22.	I have difficulty concentrating	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
23.	I feel hopeless about the future.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
24.	I like myself	☐ 4	☐ 1	☐ 2	☐ 1	☐ 0	☐		
25.	Disturbing thoughts come into my mind that I cannot get rid of.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
26.	I feel annoyed by people who criticize my drinking (or drug use) (If not applicable, mark "never")	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
27.	I have an upset stomach.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
28.	I am not working/studying as well as I used to	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
29.	My heart pounds too much.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
30.	I have trouble getting along with friends and close acquaintances	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
31.	I am satisfied with my life.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐		
32.	I have trouble at work/school because of drinking or drug use (If not applicable, mark "never")	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
33.	I feel that something bad is going to happen.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
34.	I have sore muscles	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
35.	I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
36.	I feel nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
37.	I feel my love relationships are full and complete.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0		☐	
38.	I feel that I am not doing well at work/school	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
39.	I have too many disagreements at work/school.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
40.	I feel something is wrong with my mind	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
41.	I have trouble falling asleep or staying asleep.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
42.	I feel blue	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
43.	I am satisfied with my relationships with others.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0		☐	
44.	I feel angry enough at work/school to do something I might regret	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
45.	I have headaches.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
							+	+	
							TOTAL =		

AMERICAN PROFESSIONAL CREDENTIALING SERVICES LLC
E-MAIL: APCS@EROLS.COM
WEB: WWW.OQFAMILY.COM
TOLL-FREE: 1-888-MH SCORE (1-800-647-2673)
FAX/VOICE: 1-973-366-8665

ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

Please check the answer that is correct for you.

1. How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ Two to four times a month ☐ Two to three times a week ☐ Four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 or 9 ☐ 10 or more

3. How often do you have six or more drinks on one occasion?

☐ Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

☐ Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

☐ Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

☐ Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

☐ Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

☐ Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

☐ NO ☐ Yes, but not in the last year ☐ Yes, during the last year

10. Has a relative or friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down?

☐ NO ☐ Yes, but not in the last year ☐ Yes, during the last year

NAME _____ RANK _____ SSN _____

UNIT _____ DOB _____

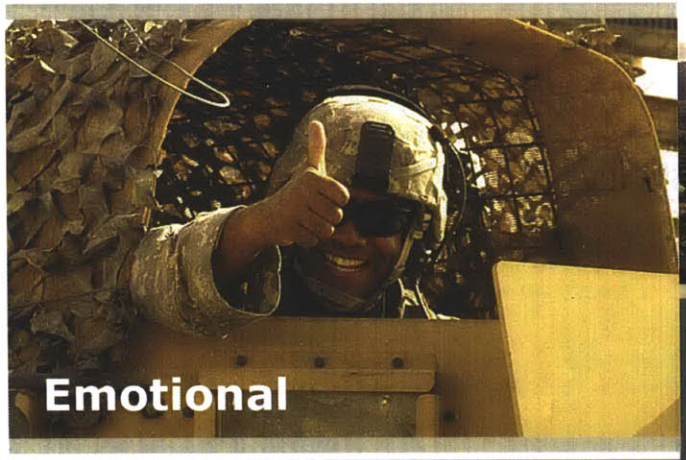
Appendix E – Comprehensive Soldier Fitness Brochure

"The Comprehensive Soldier Fitness program is a well-designed, well-rounded, evidence-based program that focuses on five important dimensions to increase resilience and enhance performance."

MAJ Scott Stokoe,
Master Resilience Trainer

"All Soldiers, Family Members and DA Civilians will reap the benefits of this program, as will anyone with whom they come into contact. This program will help in all aspects of our lives, empowering us to strengthen relationships with our families, our peers and our Soldiers."

SFC Jose Sixtos,
Master Resilience Trainer



COMPREHENSIVE SOLDIER FITNESS

STRONG MINDS ★ STRONG BODIES

2530 Crystal Drive, Rm 5122
Arlington, VA 22202
703.545.4326
http://csf.army.mil

U.S.ARMY

ARMY STRONG.℠

BROCHURE UPDATE ★ VERSION 5

COMPREHENSIVE SOLDIER FITNESS
STRONG MINDS ★ STRONG BODIES

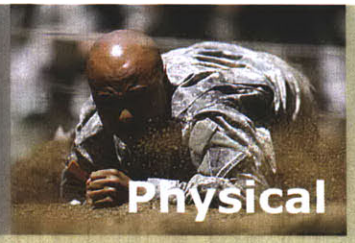
What is Comprehensive Soldier Fitness?

Comprehensive Soldier Fitness represents the Army's investment in readiness of the force and quality of life for our Soldiers, Family members and Civilians by giving the same emphasis to psychological, emotional and mental strength that we have previously given to physical strength. The program uses individual assessments, tailored virtual training, classroom training and embedded resilience experts to provide Soldiers with the critical skills needed to take care of themselves, their Families and their teammates in this era of persistent conflict.

Why is CSF important?

CSF marks a new era for the Army by equipping and training Soldiers to maximize their potential, and face the physical and psychological challenges of sustained operations. We are committed to a true prevention model that enhances Soldier resilience and coping skills by enabling them to grow and thrive in today's Army.

The goal of CSF is to increase resilience and enhance performance by developing the five dimensions of strength:



Physical

Performing and excelling in physical activities that require aerobic fitness, endurance, strength, healthy body composition and flexibility derived through exercise, nutrition and training.

Emotional

Approaching life's challenges in a positive, optimistic way by demonstrating self control, stamina and good character with choices and actions.

Social

Developing and maintaining trusted, valued relationships and friendships that are personally fulfilling and foster good communication including a comfortable exchange of ideas, views and experiences.

Spiritual

Strengthening a set of beliefs, principles or values that sustain a person beyond family, institutional and societal sources of strength.

Family

Being part of a family unit that is safe, supportive and loving and provides the resources needed for all members to live in a healthy and secure environment.

Key Program Elements

Global Assessment Tool
Provides Soldiers with their baseline in four dimensions of strength: emotional, social, spiritual and family; and provides an opportunity to track self-development and growth in these areas over time. Available online at https://www.sft.army.mil

Comprehensive Resilience Modules
Educates and provides tools so that Soldiers can develop their strength in the four dimensions. Available online at https://www.sft.army.mil

Master Resilience Training
A 10-day course designed to train Soldiers in critical thinking that will increase a person's optimism, self-awareness and mental agility.

Sustainment Resilience Training
Builds Soldiers' inner strength to face adversity, fear and hardship with courage and confidence. Training is implemented during pre-deployment, deployment and post-deployment phases (deployment cycle training). Training will be implemented throughout a Soldier's career, even through senior leadership training. Sustainment training is also incorporated into Military life-cycle training through TRADOC courses.

Appendix F – Executive Summaries for Selected Site Visits

Case Study of the Behavioral Health Delivery System at Site A

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Andrea Ippolito
Dr. Jayakanth Srinivasan

Purpose:

The Post Traumatic Stress Innovations (PTSI) team from the Massachusetts Institute of Technology's (MIT) Lean Advancement Initiative (LAI) conducted a week-long site visit to Site A as a part of its data gathering regarding the military's care delivery enterprise for Post Traumatic Stress and related conditions. The team collected information from stakeholders from Forces Command (FORSCOM), the US Army Medical Command (MEDCOM), and US Army Installation Command (IMCOM) at Site A through a series of interviews conducted by the authors. The interviews focused on how each stakeholder participates in care delivery services for Post Traumatic Stress to both service members and their families during both deployment and home station operations. This case study presents the findings regarding the architecture of the enterprise and the processes by which the enterprise delivers care.

Site Demographics:

Site A is home to one of FORSCOM's combat divisions, and two nonconventional Army units consisting of approximately 30,000 military personnel, 8,000 civilian employees, and 51,000 family members. It is located in a rural community with a population around 100,000, approximately sixty miles from the closest major city. The installation is home to an Army Community Hospital with 68 operating beds, and additional medical support is provided by five off-post hospitals within 75 miles.

Deployment History:

The division has deployed twice in the past three years, and is beginning preparations for its next appointment scheduled for the end of 2012. Three of four brigade combat teams are currently at home station with the 4th brigade combat team scheduled for return within the next sixty days.

Behavioral Health Delivery in During Deployment

An integrated, unit-focused Level 1 Care Team delivers behavioral health services during deployments for the soldiers assigned to Site A. The Level 1 Care Team, shown in Figure 1, remain in constant communication and work toward the common goal of ensuring that soldiers remain fit for duty, so that the unit may accomplish its mission.

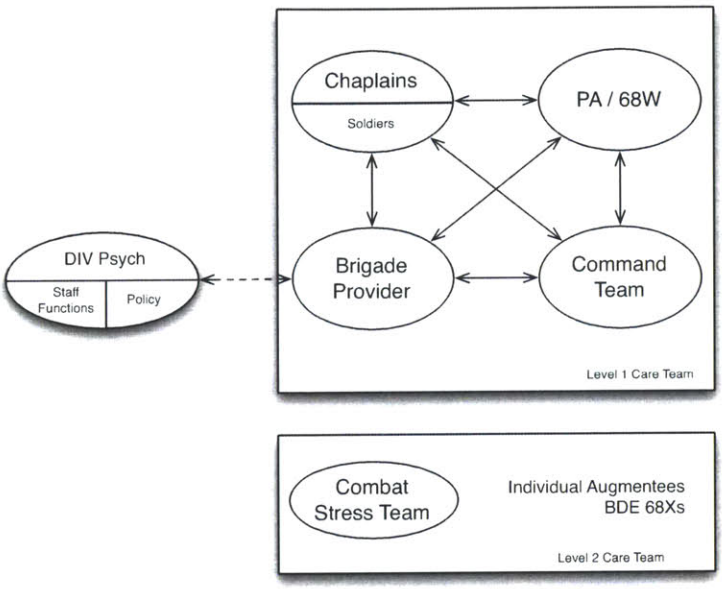

Figure 1. Site A Deployed Behavioral Health Architecture.

The Command Team is highly attuned to the needs of their soldiers as well as the soldiers' living conditions and experiences, which may vary greatly from unit to unit during deployments. Particularly at the junior Non-Commissioned Officer (NCO) level, leaders have a great deal of fidelity of understanding regarding their soldiers' personalities, and are capable of detecting even slight changes in their soldiers' demeanors that may be indicative of problems relating to behavioral health. Officers and senior NCOs at the company and battalion levels rely heavily upon the young NCOs to remain vigilant in caring for junior soldiers, and recognizing when the soldiers need help. Tactical unit leaders need soldiers who are fit for duty for accomplishment of the mission, and they are heavily invested in ensuring that those in their command get the assistance that they require. The command team depends on the battalion's organic medical assets and chaplains to ensure the physical and spiritual wellness of each member of the unit. These three members of the Level 1 Care Team work with the Brigade Combat Team (BCT) psychological clinician to ensure soldiers' emotional wellness.

Medical assets assigned to the fighting battalions, specifically the battalion PA and unit medics, help the commander to understand the soldiers' needs from a medically-trained point of view. Additionally, these personnel have access to protected medical records that the commander does not, and can serve as a front line case manager to ensure continuity of care and also to keep commanders informed of issues that may affect soldier fitness for duty. The unit medical team works closely with the command team to identify soldiers who may

require behavioral health care for command referral to a provider who may administer the required services.

The third member of the battalion's Level 1 Care Team is the unit chaplain who is charged with providing spiritual ministry to the battalion's members and to ensure that all of the unit's soldiers may freely practice their chosen religion. Chaplains additionally serve as nonclinical counselors and advisors to soldiers in their units, and they are generally accepted as the first line of defense for behavioral health care. Most soldiers speak freely with the chaplains because they know and trust these officers who live, eat, sleep, and most importantly, go on missions with soldiers. Because they live the life of a soldier it is easy for the chaplains to make relationships with those for whom they care. Soldiers trust the chaplains and they know that the chaplains care about them.

> *"Soldiers don't care what you know until they know who you are. You have to build a relationship with a soldier before you can help him." – Battalion Chaplain*

The 4th member of the Level 1 Care Team is the BCT's behavioral health clinician, a Licensed Clinical Counselor. This officer is the psychological health specialist in the team, and also lives and works in the same conditions as their patients. With one behavioral health provider assigned for the brigade, this officer is effectively a member of four Level 1 Care Teams, and is responsible for providing clinical care for 4000 soldiers. This ratio of patients to providers creates challenges for care availability, but the provider, in nearly all cases, makes up for the lack of numbers through hard work and constant mobility on the battlefield.

> *"Our brigade psych was outstanding. She was all over the battlefield, all the time, helping soldiers where they were. She wasn't satisfied to stay cooped up on the FOB." – Battalion Commander*

The most remarkable feature of this team is that they provide consistent care under extremely demanding conditions as an integrated unit. These four stakeholders each understand their role and the importance of working closely with the other stakeholders, since none of the stakeholders can individually provide the necessary spectrum of care. They are held together by the shared objective of ensuring soldier fitness for duty, so that the soldiers may accomplish their mission. Key enablers for this team are physical proximity to the other stakeholders, a shared understanding that what affects one affects all, and a common set of experiences that bind them in both spirit and purpose.

For the soldiers for whom the Level 1 care is not enough, Level 2 care is administered by Combat Stress Teams. These teams are composed of Mental Health Specialists (68X) and individual augmentee clinicians who maintain special facilities on the BCT Forward Operating Bases (FOB) in which they provide care in a clinical setting. This allows for the evacuation of a soldier from the Combat Outposts (COP) to a physical location where stress is lower. At the Level 2 facilities soldiers are not only given clinical care, but they also receive resiliency training, nutritional training, and classes on sleep discipline. Soldiers who are evacuated from battlefield are escorted to the Level 2 care facilities by an NCO, and they are typically at the Level 2 facility *for treatment* for three days.

The strength of the architecture for care while deployed is that the first-line providers are located at the point of need and are closely integrated with one another. There is a consistent and a predictable process by which soldiers may seek and receive care, and there is a standardized process for elevating soldiers to an appropriate level of care above Level 1 as necessary.

Weaknesses in the architecture stem from a lack of organic clinicians, and waste while waiting for movement between duty location and Level 2 care facilities. The Army has recognized and begun to address the need for more clinicians at the brigades by modifying the Modified Table of Organization and Equipment (MTOE) to allow for two clinicians per BCT. Waste generated by waiting can keep a soldier out of his place of duty, as well as his escort, for up to two weeks. Whether waiting on aerial transport or a supply convoy to return the soldier to his place of duty, the other soldiers in the unit from which he came have to work harder to make up for the loss of two soldiers, and adds to the stigma associated with seeking care.

> *"You know you have to have to send a soldier for care when he needs it, but it's painful because it takes him and an NCO out of the fight for two weeks. Everyone else has to work that much harder to make up for their absence."*
> *– Company Commander*

Behavioral Health Delivery at Home Station

When soldiers redeploy to Site A, there is a change in the behavioral health model, due to the change in operating environment and an addition of stakeholders to the enterprise for care delivery. MEDCOM providers at the community hospital at both the Behavioral Health Department and the Emergency Room replace the Level 2 Care Team, while the Level 1 Team changes in both composition and mission. Figure 2 shows that the Command Team has been removed from the Level 1 Team as well as the Battalion PA and the unit medics. They maintain relationships with Level 1 care providers, but only for the purpose of generating Command-directed mental health screenings or referrals from the soldier's primary health care provider.

Chaplains at home station continue to provide nonclinical counseling services to soldiers, but also become responsible for providing ministry to families. Additionally, the chaplain is required to execute Chapel Programs, which take away from his time to interface with his unit.

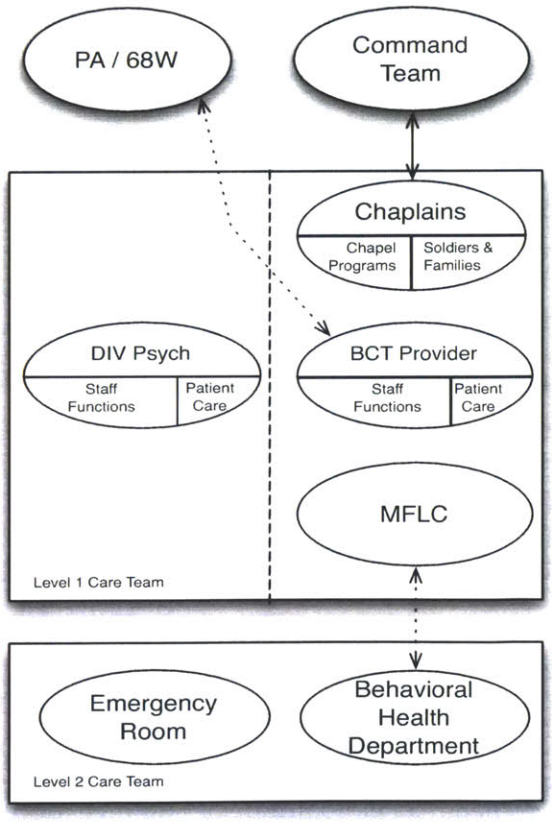

Figure 2. Site A Home Station Behavioral Health Architecture

The BCT's Clinical Provider transitions from exclusively providing care to executing numerous staff functions and administration. The result is that there is a significant reduction in the hours that they can dedicate to care provision. At home station, the Division Psychiatrist also provides clinical care, which contrasts with his wartime mission of staff work and policy creation. Like the BCT providers though, most of the Division Psychiatrist's time is dedicated to duties other than providing clinical care, which minimizes his effect on the mission.

Because the Division's and the BCT's organic providers are required to spend the bulk of their time with other duties, the Military Family Life Counselor (MFLC), who is owned by IMCOM but works for a Battalion Commander, is added to the Level 1 Care Team. This employee, who is contracted for six-month intervals, is a clinical counselor that provides services for soldiers and their families. The addition of one MFLC per battalion offsets the reduction in care provision by the BCT providers, since they are a single provider for one quarter of the number of patients normally seen by the organic provider. It must be noted, however that since the MFLC is not a uniformed service member and has not deployed with the unit, the provider does not have the contextual background on the unit that the BCT provider has. It should not be implied that the MFLC's contribution is not valued, because all commanders at Site A report that the MFLC adds value to the battalions.

> *"I spend over half of my time filling out paperwork and going to meetings. Who suffers for it? My soldiers." – BCT Behavioral Health Provider*

Site A is in the "surge period" for post-deployment behavioral health related events, and there is an overwhelming demand for services. Because of the process flows for soldiers seeking care and providers administering it, weaknesses in the behavioral health system architecture significantly inhibit that system from delivering the value that it should provide.

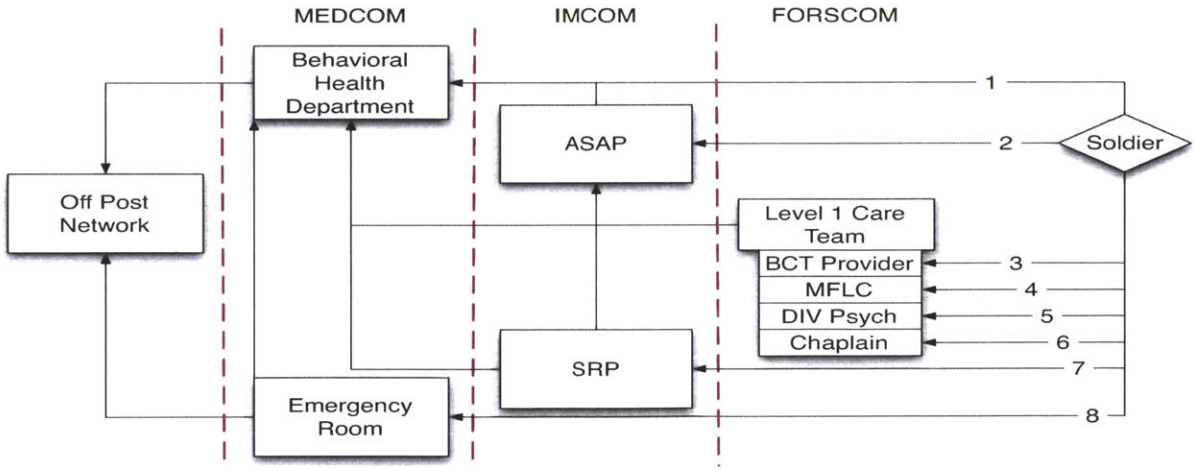

Figure 3. Site A Behavioral Health Process Flow

The existence of eight distinct points of entry into the behavioral health system prevents consistent process flows for care provision. Figure 3 shows that a soldier with a behavioral health need could enter the system through the MFLC, the Battalion Chaplain, the BCT's 68Xs, his BCT provider, through the Army Substance Abuse Program (ASAP), through the Behavioral Health Department at the hospital, the SRP Site, or at the installation's

Emergency Room. Because all these options are available to the soldier there is no consistent or predictable execution of a plan for providing triage, or elevation of the need to the appropriate care provider. Because soldiers routinely enter the system at any and all of the points of entry listed, each of the stakeholders is inundated, often with soldiers who have needs that should be dealt with at a much lower level.

> *"I am the person who should best understand the system, but if I had a behavioral healthcare need, I'm not sure where I would start." – Division Psychiatrist*

Figure 3 also shows the process by which the Site A architecture enables the soldier to get behavioral health care. The first point of entry, the Clinicians in the Level 1 Care team from Figure 2, conducts triage to determine the appropriate level of care, and if they can treat the soldier at that level, then that is what they do. Cases that require more acute care are referred to Level 2, typically to the Behavioral Health Department at the Hospital. At Site A, however, the soldier may also self-refer directly to the Behavioral Health Department or the Emergency Room. For cases that require inpatient care, the Level 2 facilities must refer the patient to off-post providers in order, since there is no inpatient capability on the Site.

Due to the surge in demand, Level 1 care is typically inundated with patients, and soldiers cannot see a provider near their place of duty, so they self refer to Level 2. The Behavioral Health Department at Site A has a typical wait time for appointments of six weeks per visit because this clinic is the overflow for four BCTs worth of Level 1 patients as well as the treatment center for Level 2 patients. The result is that a non-acute patient that self refers to the Behavioral Health Division may wait six weeks for an initial screening and triage, only to find that they need to make another appointment with a provider commensurate with their need, so they must wait up to three full months before receiving care.

Acute self-referrals move to the front of the line and cause the cancellation of appointments for non-acute cases, or they are referred from the hospital to the off-post network of providers. Once the soldier leaves the military reservation, they enter an "information void" since non-military providers do not have access to the Armed Forces Health Longitudinal Technology Application (AHLTA). It must be stated though, that AHLTA is an imperfect system and it is not uncommon for information fidelity to be below the level needed to adequately share information between on post providers. The most prevalent outcome of the information gap is the emergence of poly–pharmacy. Since soldiers can freely enter the system at multiple points there exists the often realized possibility that soldiers can be given multiple prescriptions that have unexpected synergistic effects. This issue is compounded by the chain of command's lack of knowledge and/or understanding of the drugs prescribed to their soldiers.

> *"Poly-pharmacy is my biggest issue right now. Soldiers here can go to three different doctors and get three different prescriptions, and none of us know about it. " - Division Surgeon*

Site A's home-station architecture lacks integration with the chain of command at the battalion and company level. The officers and NCOs who are closest to, as well as charged

with the care of soldiers, are the least informed stakeholder in the enterprise. Company grade and field grade leaders at Site A have a nearly universal distrust of the behavioral health system outside of FORSCOM which excludes them from the care plan and process - a stark contrast to the deployed architecture. MEDCOM and off-post providers do not receive input from the chain of command that may be relevant to the soldiers' psychiatric state even when it is proactively offered by the chain of command. This is less of a problem for providers that are at the BCT level and below due to common experiences with the soldiers and an understanding of the events in soldiers' lives gained through mutual deployments. Providers outside of FORSCOM could and should benefit from this information, but they do not either because of time limitations with the soldier, or in some cases deliberately severing the lines of communication with the chain of command.

Conversely, the chain of command at the battalion and company level does not understand the care plan or the timeline associated with that plan for behavioral health care. Commanders report that the system is an "information void" that their soldiers freely enter and commonly returned to the unit with a "bag of pills" and an ambiguously written profile that all too often takes their soldiers out of the fight. Many of the stakeholders involved in the ABH enterprise report a need for a better behavioral health profile system that informs the unit's organic providers of the medicines that their soldiers are taking, and to give the chain of command a clear Fit for Duty recommendation along with the path forward and timeline for those soldiers who are not declared Fit for Duty.

> *"The [behavioral health doctors] hand my soldiers a bag full of pills, and nobody tells me about them or what they do. Then I hand them an automatic weapon. Tell me how that makes sense." – Battalion Commander*

The system's architecture, which allows unfettered access to all points of entry, coupled with the HQDA-directed systemic response to a soldier who declares himself suicidal or homicidal has precipitated the most damaging emergent property of the system. Company and field grade commanders agree that over 50% of those who self refer to the Behavioral Health Department are overstating the severity of their condition, or they are using the open, unquestioned access to avoid undesirable duty, imminent adverse administrative or legal action, or as a pathway out of military service altogether. It is generally believed among the stakeholders who are close to soldiers, and evidence suggests, that malingering is a significant factor in overwhelming the behavioral healthcare system at Site A.

> *"It's a lose, lose proposition for the units, because nobody wants to be the person who holds someone back from getting the help that they may really need, but you can't tell one person yes, and another person no. Soldiers are in behavioral health treatment, playing the game, and are still on the unit's books, so we cannot get a replacement for them." – Company First Sergeant*

Given the complexity of the system and the challenges presented by the structural makeup of that system, it may be inferred that the solution to the adult behavioral healthcare challenges must be holistic in nature, starting with an examination of the home station enterprise's value proposition and then re-architecting the system so that it best delivers the

proposed value to the enterprises customer, the soldier, who is likewise a system stakeholder.

This re-architecting must begin by moving healthcare providers closer to the point of need in numbers that are appropriate for the numbers of patients. The providers must be integrated with one another and with the chain of command to establish information flow and trust. By moving the providers closer to the point of need, and providing consistent, repeatable processes for care seeking and provision, the ambiguities surrounding the question "where do I go to get help?" will be eliminated. Chain of command involvement, coupled with dedicated providers for the units, will allow identification and treatment of behavioral health problems at the lowest possible level starting with appropriate triage and elevation to a higher level of care as necessary. "Professional malingerers" will be identified early, offered care at the appropriate level, returned to duty, and will not be permitted to create bottlenecks within the system.

Effective Adaptations to meet Emergent System Needs

The behavioral health system of care at Site A was historically not designed to meet the stressors and strains of a decade of war. As a result, there have been a number of local adaptations to support the rapid surges in demand that occur both prior to deployment and during reintegration. These innovative practices have occurred across the system of care at the ASAP, the Behavioral Health Clinic, the Warrior Transition Battalion and the Installation. We will highlight examples from each of the areas.

ASAPs Care Continuity Tracker & Education Groups

The ASAP clinical director at Site A recognized that soldiers that were undergoing therapy for alcohol and substance abuse were being deployed even if they had not completed their outpatient treatment program, and that the system was not designed to ensure effective recapture of those soldiers when they returned from theater. As the clinical director noted,

> *"Once they went into theater, we lost them, and had no means of ensuring that they finished their treatment program."*

The team developed a tracking mechanism wherein every soldier that was being deployed prior to program completion would be placed in a tracking list. The division surgeon working together with the ASAP clinical director would scan the manifest of every returning flight from theater against the tracking list to ensure that returning soldiers were afforded the opportunity to reengage in their treatment plan.

An additional challenge that surfaced in our discussions with soldiers across the chain of command, was the ASAP referral that was triggered when the threshold was exceeded with respect to alcohol consumption during the R-SRP process. The soldiers interviewed universally noted that they routinely prevaricated in response to the question – the most common answer being

> *"I was in an alcohol-free combat environment, and hence I don't drink"*

As one soldier pointed out, "visiting ASAP was like walking down loser's lane". The ASAP team had to figure out an effective means of engaging patients in a process that would enable them to safely reflect on whether they needed to get more focused care. They started an educational group that would allow the soldiers to gather as a cohort and understand the stages of addiction and the impact it had on their lives. If the soldier at the end of the educational group sessions felt that they did not need help, then they were considered to have met the referral requirements, and no further action was necessary on their part.

High Interest Program

One of the critical capability gaps in Site A is the lack of in-patient psychiatric care. As a result all acute cases are being sent into one of four facilities in the civilian care network surrounding the post, and once they are full being sent to locations in neighboring states that are over 150 miles away. While these facilities meet the immediate needs of the Army, the handoff processes when the soldier leaves in-patient care vary significantly from site to site. The major complaints that we heard from both providers and commanders being: the lack of understanding of Army policies on the part of network providers (prescribing inappropriate medication); the lack of understanding of Army culture (return to limited duty with constant supervision); commanders being unaware of their soldier returning to the post; and the provider being unaware of the care that the solider was provided as an in-patient because the medical record was incomplete or not sent. While Site A leadership has been actively engaged with their network hospital partners, they recognized that they needed to develop an internal mechanism to ensure that soldiers did not fall through the cracks.

The High Interest Program was created to identify, track, and manage soldiers who had been admitted to in-patient psychiatric care, and who needed to get continued support as they recovered after their in-patient care. The behavioral health clinic team in collaboration with the division surgeon, ensure that commanders are kept in the loop with respect to the status and care of their soldier. Also, the active case management of the soldier in the program ensures that the soldier receives the care that he/she needs (appointment reminders, progress tracking) until they are assessed to have improved to the point that they can be managed using the regular outpatient process.

WTB Quad Chart

The WTB commander at Site A has developed a tracking tool to assess the progress of the soldiers in the WTB. He realized that there were a number of soldiers that were in the WTB who had been in the unit for over a year, and were in limbo either because the MEB process had stalled, or because the soldier was uncertain about the path forward. The Quad Chart is a tool that synthesizes the soldiers' case into a single viewgraph that provides senior leaders with an overview of the soldier's history, the progress that the soldier had made over the time period, his/her development plan, and duration in the WTB. Every soldier that has been in the WTB over 270 days automatically gets a face-to-face meeting with the WTB commander who reviews the soldier's progress with the soldier, and then follows up with installation infrastructure to ensure that any process hurdles in the MEB process are overcome. As the WTB commander noted,

> *"In some cases, it was just a question of calling the clinic and making sure that the narrative summaries were completed"*

This tool serves as an effective communication tool between the WTB commander and other senior leaders in the division and the installation. It provides situational awareness, and creates a process for reviewing critical cases that may have otherwise lingered.

Community Health Promotion Council

The increased emphasis on behavioral health has resulted in an explosion of programs and services across the installation. This proliferation has led to overlapping and duplicated programs that are not only an ineffective use of scarce resources, but also lead to confusion on the part of key enterprise stakeholders on where to direct a solider who needs help. To address this challenge, Site A established the community health promotion council (CHPC), which was a process for brining together key stakeholders who ran the various programs (ACS, Chaplains, Behavioral Health, MFLCS, ASAP) to first document the programs that were available (they identified 166 programs, and 355 subprograms on post), and identify key gaps that needed to be filled. The CHPC owner pointed out,

> *"CHPC is a process – it brings together key stakeholders to identify where they overlap and support each other, because we are all trying to take care of soldiers. It does not replace the regular chain of command – what it does it provides an avenue to senior leadership to highlight needs and issues."*

The two key outcomes of the CHPC process are: the commander's resource guide, which identifies all of the programs on the installation, and provides points of contact for them; and the community health dashboard, which provides key risk indicators that senior leaders can use to understand the state of the installation.

Appendix: Stakeholders Interviewed & Significant Data Gathered

FORSCOM:

ADC-O

- Human Resources Command is adding stress by moving families at R+90. It is at this time that most behavioral health issues first begin to manifest themselves, and we only add stress (financial and family) by moving soldiers at that time.
- Counterproductive to move ASAP from MEDCOM to IMCOM. ASAP provides medical services, so they should belong to MEDCOM
- Lack of trust between behavioral health providers and the Command; no communication in either direction.

DIV Surgeon

- Polypharmacy is the biggest issue. Soldiers go to multiple, unlinked providers, who each prescribe medicines without knowledge of the medicines that the soldier is already taking. We are working on a tracking tool to eliminate poly-pharmacy for every soldier in the division, but it's a full time job to maintain.
- Wait times for behavioral health appointments are unacceptably long.
- The medical command does not know about the forces command drug policies, specifically the drugs that make soldiers non-deployable.

DIV Psych / BCT Psych

- There is no structure to the behavioral health care system. Distributed care is good, but does not allow for triage and a deliberate plan for care.
- Off post providers do not understand the military, and the environment that the soldiers live in daily. Normal for the soldier is extraordinary for most non-military members. Because their baseline for diagnoses is non-military, the usefulness of their work is reduced.
- Division and BCT providers are insufficient in number to provide the care that is needed. Most of their time is spent fulfilling administrative requirements. They need more people in the BCTs.

BCT Commander

- One of the best tools that we have in theater for treatment of potential behavioral health issues is the Critical Event Debrief Team. This team is composed of a chaplain, the brigade psych, and doctors who rapidly deploy within the theater to visit units who have been involved in a critical or catastrophic event. Because of the composition of the team, death is an issue, but we overcome this challenge with mobility.
- Why don't we give junior leaders authority at home that they have forward? From squad leaders, to medics, to company commanders a great deal of authority is stripped away at home station. The soldiers feel like the only time they really get to do their jobs and utilize their expertise is on

deployments. It is impossible to imagine that a reduction in authority and capability at home station increases the effectiveness of the soldiers on deployments. Likewise, it is likely that this stripping away of authorities inhibits the function of home station systems. For example, a medic in combat can perform life-saving steps, treat severe trauma, and attend to a wide array of medical needs. At home station the same medics are not even allowed to freeze a wart, but are instead relegated to menial tasks below their training and experience.

- Human Resources Command pulls leaders away immediately after deployment, likewise our specialists depart the unit at the same time. This does an injustice to the soldiers to the commanders and to the families because the leaders who know the soldiers best depart before the manifestation of behaviors associated with behavioral health issues arise. New leaders are unable to perceive changes in the soldier's personality because they do not have a baseline for normal for a soldier. Combat is a unifier, we must take care not to break apart our team prematurely.

BN Commander/CSM (x4)

- We do not want our soldiers sent to providers that do not have a baseline understanding of what soldiers have gone through. Embedded psychological care is awesome, but is spread too thin. "Is one or counselors/psychologists per brigade the best that this country can do?"
- Because we have so many programs to help family members with every conceivable problem, we have created an unsustainable Army welfare state. Young spouses have never been in an Army that did not have all of these programs, so they feel that they are entitled to help with every problem that they may have. Families are in the Army too, and they need mandatory training on life skills just like soldiers do, so they can help themselves.
- Does the Army have any helpful risk assessment tool for behavioral health? Yes: Junior leader involvement in soldiers lives. The paper surveys that they give us are absolutely worthless. Most of the time we just throw them in the trash.
- Behavioral health has become a get out of jail free card for soldiers and they know that. If a soldier seeks behavioral health care they cannot be prosecuted under the UCMJ for malingering. The chain of command must be involved and this aspect of their soldiers' lives in order to halt malingering. A commander's business is underwriting risk, and although it is not palatable for some to allow commanders this kind of leeway, it may be the only way to keep the system from becoming overwhelmed so that soldiers who really need help can get help. Our battalion needs an embedded behavioral health capability, to solve soldier problems at the lowest possible level. We need someone who works for the command, not someone who works for someone who was removed from the system.
- Do not, do not, do not take away my FRSA.

CO Commander/1SG (x~20)

- Behavioral Health is seen as an easy escape from impending adversity. There is no punishment for working the system. Commanders have no leeway for telling a person that they need to go back to work. It's a lose, lose proposition for the units, because nobody wants to be the person who holds someone back from getting the help that they may really need, but you can't tell one person yes, and another person no. Easy, no-questions access yields the chronic abuse of the system.
- We need to do a better job screening people for behavioral health issues before we put them in the Army. This should start with recruiters, then MEPS, and should continue through Basic Training and AIT. It should not fall on the combat unit to straighten out a guy who should have never been put in the Army in the first place.
- If the Army takes something seriously, they need to resource it with money and people. One brigade behavioral health provider cannot be everywhere, and even if they were there aren't enough hours in the day for one person to see everyone that needs some help. Brigade is too high [in the organizational structure] for the first providers. Soldiers are anonymous at that level.

FRSA

- There is not enough help available for behavioral health. It takes too long to get an appointment, and families are not allowed to go to behavioral health appointments. This is true even if the servicemember and their family desire family involvement in behavioral health care.
- New spouses seem to have this sense of entitlement that the Army is going to cater to their every need (marital, financial, grass mowing). The army is not a welfare system.
- FRSA standardization and enforcement of those standards is a necessity. Utilization of the FRSA varies from unit to unit with the priorities of the commander. FRSA's are employed to provide a standard set of services and are often underutilized. This occasionally causes confusion for families who are new to a unit because they are used to a certain set of services to be provided by the FRSA at their new unit because they were provided by the FRSA at the last unit. At this time minimum standards for FRSA's are not being enforced.

MRTs

- Leaders should be sent through the resiliency training program. We should push down the training to platoon sergeants and squad leaders, so that they may conduct impromptu training events when time is available.
- In most cases there are more stresses at home station and on deployment. Soldiers come home and try to get help for their problems but they get turned away because the system can't handle the surge. The soldiers get the message that they're not trying to kill themselves, not important enough to be seen for six weeks.
- Commanders need to understand MRT's, their capabilities, and how they align with the Comprehensive Soldier Fitness program.

MEDCOM

Behavioral Health Department Head

- It takes 4 weeks to credential a motivated doctor. Most of this delay is systemic. After credentialing it takes a provider another month of learning how to do the job at this site.
- It is difficult to hire people to come to the rural area at Site A. There are many locations in the Army that are much more desirable.
- It would be helpful if the military entrance processing stations information was readily available. We cannot currently see the history of new soldiers. We do have a good transfer of information from combat theater now.

IMCOM

Installation Commander

- ASAP doesn't follow from post to post, so often the first time you see a soldier's ASAP issue is on the blotter. During high turnover times 200-300 soldiers/month PCS, so how is a commander supposed to know if he's getting a soldier with a dependency issue?
- Commanders and 1SGs get frustrated by the system when they constantly run into the HIPPA wall when they try to get information about their soldiers. We need education on both the behavioral health and the Command side on how to work together.
- No organic inpatient care for suicide risk. High-risk soldiers are sent to programs off post at the cost of ~$1000/day

ASAP

- The transition to IMCOM from MEDCOM has been very difficult. Medical command is into medicine, and ASAP is into medical treatment. IMCOM doesn't have as much money as medical command, so they must plan for budget a year ahead. ASAP is held to the standards of physical health providers for sanitation but because of medical command credentialing. Likewise, MEDCOM credentials the ASAP providers. This means that MEDCOM finds all the problems, but has no stake in fixing the problems.
- No capability or resources to help family members.
- Cannot track down soldiers with known dependency issues after deployments to help them.
    - Contact information changes.
    - Need to catch them somehow.
    - Need coordination of care among providers on the post.

CHPC

- CHPC participation is not mandated for organization leaders, but is mandated for each organization. Relationship building with members of the organization is key to the success of CHPC. Relationship building between organizations reduces the need for resources because friends will always

help friends. Additionally resources are tied to strategic objectives. When resources go away, how do we decide what is most important?

- The organization is not sure why ASAP has moved to the Garrison. They are in medical treatment business.
- The operating environment is not changing. When budgets are reduced we must expect that services will likewise be reduced. All the hard work in the world is not going to replace resources; it will only serve to burn people out. We need to stop making more programs and let people work on the ones that we're already executing.

WTB

- At Site A, all WTB providers are military or former military. This allows the providers to better understand the soldiers.
- The biggest pain point for the warrior transition Battalion is the bulk of paperwork required for interfacing with the other agencies. Most of the Warrior Transition Battalion soldiers just want to get on with their life, but the paperwork drill is slowing them down.
- Warrior transition Battalion entry criteria, dictated by HQDA FRAGO 3 sets the appropriate number of gates for a soldier to enter the warrior transition Battalion. This is good because some soldiers just show up at the Warrior Transition Battalion thinking that they can just join the unit.

Case Study of the Behavioral Health Delivery System at Site C

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Purpose:

The Post Traumatic Stress Innovations (PTSI) team from the Massachusetts Institute of Technology's (MIT) Lean Advancement Initiative (LAI) conducted a week-long site visit to Site C as a part of its data gathering regarding the military's care delivery enterprise for Post Traumatic Stress and related conditions. The team collected information from stakeholders from Forces Command (FORSCOM), the US Army Medical Command (MEDCOM), and US Army Installation Command (IMCOM) at Site C through a series of interviews conducted by the authors. The interviews focused on how each organization, as a stakeholder in the Site C Enterprise, participates in the delivery Behavioral Health services to both service members and their families during home station operations. This case study presents the findings regarding the architecture of the enterprise and the processes by which the enterprise delivers care.

Site Demographics:

Site C is undergoing the final stages of a transition in its primary mission from an installation with a focus on institutional training to a new mission, serving a FORSCOM Heavy Division. Prior to the change in mission, the installation's soldier population was around 8,000; however, with the arrival of the combat division and departure of the TRADOC units, the population has grown to nearly 30,000 soldiers. Although the civil infrastructure on the installation and in the neighboring town has grown to suit the larger population, the service industry, both on and off the installation, are still in a period of transition and growth for accommodating the population change. The Site is home to an Army Community Hospital with 16 beds dedicated to inpatient behavioral health care. Two nearby civilian hospitals provide the balance of the required in-patient care delivery.

Unit History:

The division, at all echelons, has arrived to the Site within the past three years, with all BCTs having arrived prior to the establishment of the Division HQ. This approach has created challenges for the Division leadership to unify the BCTs by common operating procedures, battle rhythms, and information sharing protocols. The Division currently has two BCTs deployed to two separate theaters, with the third scheduled for deployment in the next calendar year. The Combat Aviation Brigade (CAB) is newly arrived to the installation, and has redeployed from combat operations within the past three months.

Behavioral Health Delivery Architecture

Deployed behavioral health care for the units at Site C is similar in nearly every way to the models presented at Sites A and B. All concerned regard downrange behavioral health care as outstanding due to the proximity of the providers to the soldiers, frequent interaction and full integration with both the chain of command and primary care providers. When asked directly about why care is perceived as "better" on deployments, a uniformed provider stated that in addition to the mentioned factors, when the Army is deployed there are no distractions from the mission of providing medical care to soldiers. Further, the provider stated that most uniformed providers joined the military to take care of soldiers, so there is a great deal of job satisfaction while deployed because the doctors are able to what they signed up to do. Jokingly, but tellingly, the provider stated, "when you're deployed, you don't have anything else to do, so you might as well do your job." Soldier satisfaction with downrange care reflects this increase in provider availability, and likewise, all service members report an increase in the quality of care as a result of more time allocated per patient encounter.

> ***"You don't have anything else to do when you're downrange, so you might as well do your job."***
>
> *- Uniformed Health Care Provider.*

At home station the architecture for the delivery of behavioral health care is drastically different from that downrange. The soldier population at Site C is geographically dispersed due to both the size of the installation as well as the necessary concept of Military Construction (MILCON) for accommodation of newly arrived mechanized/armored units and associated equipment. Conversely, Behavioral Health services and facilities are centralized and geographically separated from the soldier population, as it was developed to serve a smaller, centralized TRADOC population. For delivering value to FORSCOM, the architecture eliminates the characteristics of deployed care that are perceived as quality enablers: proximity to patients, and trusted relationships between providers and unit leaders.

From a systems perspective, the MTF behavioral health assets are distributed across four discrete locations on the installation. The first is a triage and assessment clinic, established to see walk-in patients who are in crisis, and executes needs assessments by licensed clinical social workers and psychologists to effectively direct patients to the required level of care. They either refer patients on for regular outpatient care, or for acute cases they refer patients directly to inpatient facilities for supervision and treatment. In addition to This clinic leverages two psychiatric nurse practitioners for medication management. This clinic sees 30 to 40 patients on an average day.

Outpatient treatment is executed by two clinics – one for service members, and one for both service members and their families. These clinics are staffed by licensed clinical social workers, psychologists and psychiatrists, who are capable of providing the full spectrum of outpatient care. Typical wait time for appointments at these clinics is between four to six weeks per appointment. This excessive wait time is a result of an overwhelming need for services and a shortage of providers in the clinics.

The installation executes inpatient care through a 16-bed inpatient psychiatric care ward at the Army Community Hospital. The intent of the facility is to provide oversight and treatment to acute or imminently dangerous patients. Because of insufficient capacity for providing the required number of inpatient beds, two off-post facilities augment the

inpatient capabilities of the hospital. The providers in charge of these facilities stated that assignment to a specific Level 3 facility (ref: Figure 1) is a function of bed availability, not acuteness or condition.

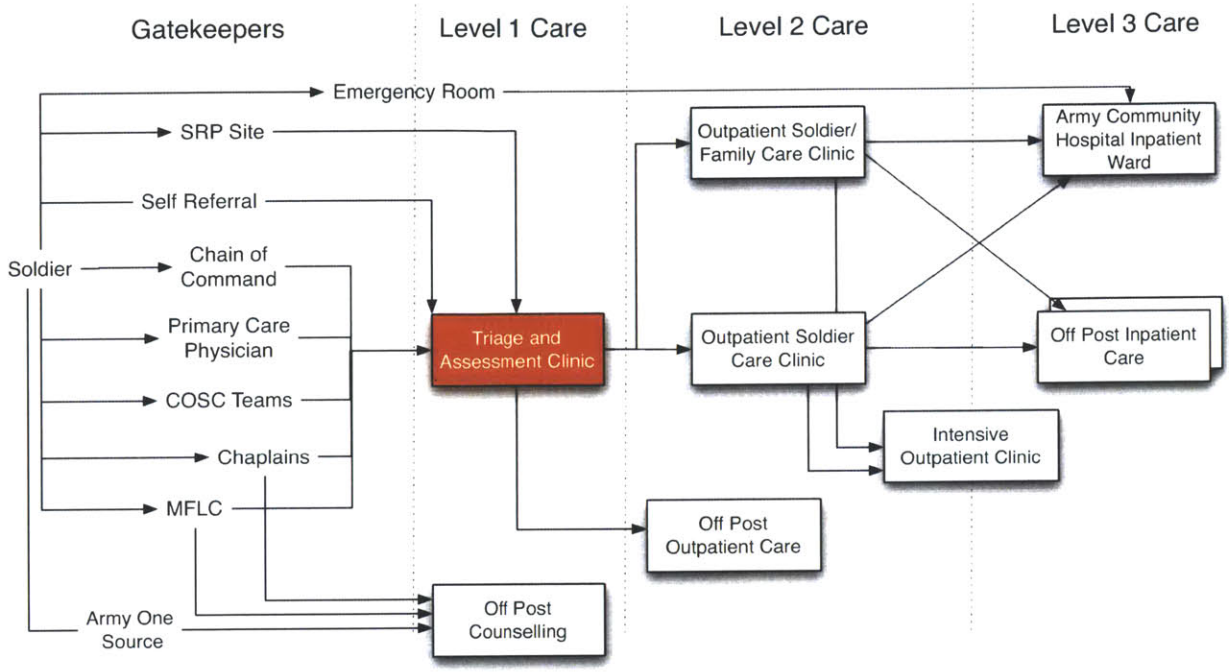

Figure 1. Behavioral Health Architecture - Site C

In addition to the care clinics, Site C is home to a DoD pilot program designed for intensive outpatient care. This center conducts a six-month, program for a cohort of 30 soldiers who are identified as severe PTSD sufferers. Additionally, soldiers admitted to this program must have a minimum of two years remaining on Active Duty and have the endorsement of their chain of command prior to entry. The program executes multiple modes of conventional and alternative therapies, and currently has a 67% success rate, defined as graduates returned to duty at their unit.

In addition to the clinics where Military and DA Civilian providers administer triage and treatment, Figure 1 shows an array of entry points, labeled "gatekeepers" into the behavioral health system. The function of these have been discussed in previous reports, so discussion of these gatekeepers will focus on what is different at Site C.

The first significant difference is a gatekeeper that is unique in our findings to Site C - the Combat Operational Stress Control (COSC) Teams. The COSC team is staffed by licensed clinical social workers, who serve in a variety of roles and functions at the unit level. Their primary purpose is to advise and assist commanders in the identification of treatment options and services for high and medium risk soldiers. Additionally, COSC team members track and work with the high and medium risk soldiers immediately upon redeployment from theater. COSC utilization varies from commander to commander, but is generally accepted as a useful resource for the command. It was reported by the commanders that we spoke to, that the principal people that the three people they could name in behavioral health

were the head of behavioral health, the head of the in-patient care facility, and the COSC social worker who was assigned to their unit.

A second Site-specific attribute of the Site C architecture is the challenge faced by the Chaplain corps. An alarming number of battalion level chaplain positions are unfilled. The worst case is the CAB, in which no battalion has a chaplain, and the brigade chaplain is expected to depart before summer of next year. One chaplain interviewed, who filled a position left vacant for three months prior to his arrival, stated that he was shocked at the state of his unit, and that he was unable to make any good progress in prevention and education programs because he is trying to remedy the myriad of spiritual issues that have piled up with no predecessor to act as the unit's first line of defense in behavioral health matters.

"There wasn't a chaplain in my unit for three months. Problems have been piling up that long, and I'm in damage control mode right now."

- 1LT Battalion Chaplain.

Next, Site C has a unique Soldier Readiness Processing (SRP) station, which was established for the purpose of facilitating smooth mobilization and demobilization for the 20,000 Reserve and National Guard soldiers who are processed annually at the Site. Activated Reservists maintain a permanent facility that assesses the need and generates referrals and consults for follow-on treatment at soldiers' home stations after demobilization. Soldiers with acute needs are retained on Active Duty for treatment within the military system until they are no longer acute, during which time they are assigned to the Warrior Transition Unit. The role of the SRP site has grown significantly from its original intent to accommodate the quarterly SRP for the entire FORSCOM division in addition to its Mob/De-Mob function. Active Duty soldiers assigned to the installation are referred out for treatment on post by the SRP site upon identification of a need. This is shown in Figure 1, above, as a referral to the Triage and Assessment Clinic.

The next peculiarity of Site C's architecture is a seemingly preferred use of off-post outpatient providers by a large segment of the gatekeepers (ref: Figure 1). Figure 1 shows the pathways to these off-post providers beginning with the Military Family Life Counselors (MFLC) and Chaplains. Those interviewed stated that they greatly prefer using off-post providers because they know that their soldiers can get "more immediate and better" care than they can get on post. This perception flows from the overtaxed, under-resourced military system described above and not a function of the quality of the providers in the system.

"If my guys need [behavioral health] care, I send them off post, because they're going to get more immediate, and probably better care."

- Site C Chaplain.

The final site-specific attribute of Site C's architecture is the absence of BCT-assigned psychological providers throughout the division. Two of five brigade-sized elements have had this authorization filled very recently, although the psych-health providers assigned to the units were attached specifically in preparation for, and just a few weeks prior to, impending deployments. The result of these absences, coupled with the very recent addition of a division psychiatrist, is that the FORSCOM behavioral health providers are not yet a functional part of the Site's behavioral health architecture. Further, since the FORSCOM providers are latecomers to an

established system, it is likely that these officers will be forced to overcome significant challenges integrating themselves into the established architecture.

The challenges of the system emerge from medical TDAs and architecture developed and optimized for an 8,000-soldier community with a training mission, and unfilled FORSCOM MTOE positions vital to the proper execution of unit-level behavioral health care. The system did not adapt quickly enough to facilitate the demands of units with a combat mission and multiple deployments. The leaders of the system understand that they need to grow their capability and change their approach to care provision, and they have an appropriate commander's intent and end-state. Execution of the key tasks that will transform the organization from the current state to the desire future state will be difficult since what is needed differs greatly from the current concept.

Other Behavioral Health Stakeholders

The Army Substance Abuse Program (ASAP)

The Army Substance Abuse Program (ASAP) at Site C is fully staffed by substance abuse counselors and a psychiatrist who provide weekly counseling and, as-needed, clinical psychological assessment and treatment to service members enrolled. The program, formerly owned by MEDCOM, was transferred to IMCOM to bring together the education and prevention work with the clinical counseling and treatment. MEDCOM continues to credential both employees and the facilities, and the ASAP psychiatrist is on loan from MEDCOM.

Induction into ASAP is exclusively on a command-referred basis, as there is no self-referral program at the Site. The ASAP employees report that their functional relationships with commanders are highly dependent on the command team with which they engage. This was likewise reflected in meetings with unit level commanders, as some reported that ASAP was helpful (although understaffed), while others reported complete dissatisfaction with the program. These descriptions stand as evidence of the importance of deliberately developed person-to-person relationships created, if for no other reason, to foster cooperative professional functionality in the interest of caring for soldiers.

In addition to treating soldiers ASAP serves the important function of aggregating risk behaviors for the installation. In accordance with the FORSCOM risk reduction plan ASAP collects data on most, but not all, behaviors indicative of underlying behavioral health issues. The aggregated data is used at the installation level to inform commanders of trends and drive reactive, focused, mitigation and education efforts. The data is likewise filtered for individual units, and is briefed periodically down to the company level to serve the same function at the tactical level.

Community Health Promotion Council (CHPC)

The Community Health Promotion Council, an IMCOM activity, is in a nascent stage of development. "The Site C CHPC's mission is to identify and set priorities for community health promotion and wellbeing programs while directing the integration and synchronizing of installation programs and services."[i] Although the program is not mature at this time, the program's director envisions his role as an informal integrator of community health services, serving to build relationships between stakeholders at the personal level. Relationship

building will enable meaningful stakeholder value exchange based on shared strategic objectives where deliberate, policy-driven, relationships do not exist. This is an important need that is best illustrated in a quote from one of an employee of one of Site C's Behavioral Health stakeholder organizations, "We've got 10,000 programs on this post, and none of them are connected."

"We've got 10,000 programs on this installation, and none of them are connected."

- ACS Employee, Site C

The CHPC serves the secondary function of providing information on its members' services to the community. Again, the organization is new at the installation, but work is underway to build a catalogue of programs that is internet accessible, so that service members and their families may have a single point of reference to locate the resources that they require, which include auxiliary Behavioral Health-related activities. Currently the CHPC provides this service by telephone and a growing web site. In addition to direct access for the end user, CHPC will serve the same function for Family Readiness Support Assistants who in turn provide this type of information at the unit level.

Family Advocacy Program (FAP)

JK to ADD

Warrior Transition Unit (WTU)

The Warrior Transition Unit at Site C provides case management and "coordination and synchronization of care, treatment, and services" for the soldiers assigned. The primary group of soldiers assigned to the unit are those who are require complex medical care and is unable to perform his/her duties for six months or longer. Since Site C serves as a mobilization and demobilization site for the National Guard and Army Reserve, the WTU additionally provides a unit of assignment and accountability activity for soldiers from these components who require intensive post-deployment treatment before de-activation.

The commander of this unit is a medical officer who has full access to medical records and can provide organic medical expertise as necessary. The entire WTU cadre is HIPPA trained, and is fully capable of case management on a formal or informal level. This is a great benefit to the soldiers in the unit because there is never an information barrier that would preclude their chain of command from helping their soldiers to get the care that they need. In addition to medical care, the WTU has habitual relationships with nearby colleges and vocational training activities both on an off post that help soldiers make a successful transition to employment outside the military. This activity is far more prevalent at Site C than any other site visited to date, and is a practice that should be transferred to other units of this type.

A second difference in the WTU at Site C is a longer period of time for soldier/patients to be assigned to the unit. Typically, a soldier is expected to be assigned to a WTU for one year or less, after which they leave the service or return to duty. Average time for the WTU at Site C is much greater than one year with some instances of soldier assignment exceeding 1,000 days. These outliers may be a function of the addition of Comp. Two and Three soldiers to the unit, and requires further data collection to determine why this is the case. The outcome of the extended time of assignment is the perception on Site C that the WTU has become a medical holding unit. Again, further study is required to determine the cause, but

leaders should initiate efforts to eliminate the causes and effects of this perceived function of the facility.

Analysis of the Current State Architecture's Performance

The defining artifact of the Behavioral Health Enterprise at Site C is the operational separation of IMCOM and MEDCOM Behavioral Health Stakeholders from FORSCOM units and their organic medical assets and attached Behavioral Health counselors (COSC teams). This fragmentation of institutional Behavioral Health stakeholders and the deployable force is a function of spatial separation that precludes person-to-person information exchange, automated information system shortcomings, and weak accountability policy. When considering the evolution of the system's architecture, growth of the installation's population by the introduction of an effectively new organization, and the effect of the ARFORGEN cycle on subordinate unit integration into the installation's systems, these defining artifacts are not surprising.

Since FORSCOM is a new entity on Site C, and the installation's infrastructure was developed prior to its arrival, pathways for accountability and information sharing are only now being formalized. Behavioral Health organizations developed standards for operational procedures and established themselves in fixed structures that were each suitable for supporting the TRADOC population that they formerly supported. Their procedures and locations, although acceptable for a relationship with a training unit, are not well –suited for supporting a deployable force focused on mission readiness. This manifests itself in a few ways.

The first evidence of this is accountability loss of patients in the handover from the fighting unit to MEDCOM. FORSCOM providers were told specifically not to use a clinical consult when sending their soldiers to the Triage and Assessment Clinic, as the resultant accountable demand for services would overwhelm its capability to conform to access to care standards. The result of this operating procedure threefold. First, the system generates a gap in patient accountability within the medical system. Since no patient is formally referred into the system, then every patient is a walk-in, and prioritized by the front desk at the clinic. Second, since every patient becomes a walk-in, then the system does not consider the patient to be in the care of any specific doctor, and there is a loss of traceability to any unit. Third, the system loses its feedback mechanism for primary care from specialty care. Providers at the unit no longer receive specific, focused feedback, but instead are forced to reference a Behavioral Health provider's AHLTA note, which all providers have acknowledged as having significant limitations for the transmission of Behavioral Health-related data. It must be noted that the Behavioral Health system and the Primary Care physicians have noted this deficiency and at the time of our departure from the Site, were working together to close this gap.

The second evidence of a system that is removed from the population that it supports is the physical separation of the system's entry point from the warfighting units. As discussed above, the Behavioral Health infrastructure was developed for a much smaller installation with a proportionally smaller patient population. When FORSCOM moved an entire division to the site, the BCTs had to be placed in an area that could support the requirement for living areas, offices, motor pools, etc. The combination of these two factors

results in a soldier population on one side of the post, and the entry point for the Behavioral Health system on the opposite side. This physical separation leads to difficulty in accessing the system and a reduction in capability for development of cohesive relationships and standardization of procedures between primary care and specialty care. Once again, the Behavioral Health leaders at the site have recognized this challenge for their system and have developed a future state vision that, if fully implemented, will address these difficulties. This may be made more difficult by the recent upgrades and expansion of the Triage and Assessment Clinic, and leaders should be aware of and plan to mitigate the effects of physical separation from the patient population.

The single point of entry described in this section remains in place, so that the system can execute the necessary identification of urgent patients for immediate care. An unintended consequence of the site's architectural evolution, though, is a structural chokepoint that results in an accountability gap. When accountability is lost at the entry point, the effects resonate throughout the system, frustrating Behavioral Health provider efforts, continuity with primary care, and commander confidence in the system. Nearly all stakeholders at the site remarked that they would benefit from a better relationship with the other stakeholders, but they don't have the time or information to develop them.

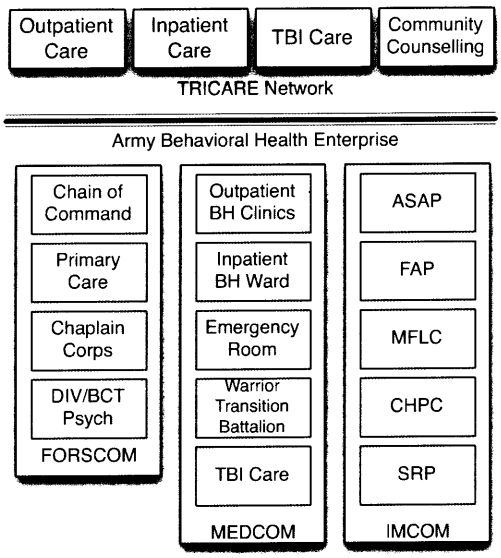

Figure 2. Site C Behavioral Health Enterprise

Figure 2 shows another set of stakeholders in the Behavioral Health enterprise that are likewise separated from the others. Off post providers to which soldiers are referred by TRICARE and One Source are disconnected in terms of accountability and information. Providers and Commanders at Site C (and all other sites) report that when soldiers leave the installation for care, there is no coordination with or feedback to the on-post enterprise. The TRICARE network is essential to close the gap between "care required" and "providers available"; however, the information disconnect results in two significant challenges.

First, since off-post providers do not have access to AHLTA or unit information, they have no clinical history or background information on the soldier/patient for which they provide care. The result is a treatment restart for the soldier each time he/she starts with a new provider, resulting in frustration. Second, the lack of a feedback mechanism from the TRICARE network creates the potential for incidents of poly-pharmacy or prescription of deployment-disqualifying drugs. Prescriptions from off-post providers are not automatically reconciled against existing prescriptions in any sort of med management system unless a provider or pharmacist on post extracts the prescription information from CHCS (the system underlying AHLTA) and manually enters it back into the proper fields in AHLTA. The information is only available in CHCS if TRICARE pays for the prescription; if the soldier pays out of pocket the information is never available. Once the on-post agent enters the prescription into AHLTA, it becomes available to the entire network at the next AHLTA update, which occurs every 72 hours. This means that in the absolute best-case scenario, the

provider on post discovers and enters the data immediately after the prescription is filled and three days later the soldier's provider finds out about it. Any delay between the soldier filling the prescription and the movement of the information from CHCS to AHLTA adds to that number. Additionally, delay is added by the primary/specialty care provider who does not reconcile his patients' medicine at the exact time that AHLTA updates. In a system that is as overwhelmed as that at Site C, some delay in entry and reconciliation is a certainty, and 72 hours to identification of poly-pharmacy is unrealistic. Once again, the Behavioral Health providers at Site C have recognized this deficiency and scheduled a symposium to educate TRICARE network providers on the drugs that they should/should not use with soldiers and to try to develop more efficient means for transmitting prescription information back to the on-post enterprise.

The FORSCOM/MEDCOM information gap is not the only one existent in the system. Unit Commanders within FORSCOM state that there is no deliberate means for transmission of accumulated knowledge regarding soldiers who move from one unit to another on Site C or to/from another installation. Formerly, leaders generated quarterly counseling statements for their soldiers that served to help soldiers sustain desirable behaviors and to improve others. When a soldier moved, all of his counseling documentation would move with him to inform the next unit's leadership on "who they're getting," and what to expect from that person. Leaders report that this practice was abandoned for the purpose of giving each soldier a fresh start at his/her new unit; however, the consequence is that the new commander may get a soldier prone to destructive behaviors that may be the manifestation of a Behavioral Health condition and be completely unprepared. Likewise, if the commander has no documentation of past behaviors that could be evidence that the soldier is unfit for continued military duty.

The Senior Mission Commander at Site C has decided that in order to avoid moving a soldier with a challenge to another commander, no one with a pending adverse action or in Behavioral Health treatment will move from his installation to another. Instead, the soldier will be remediated or treated at Site C, or he/she will be processed for elimination from the service. This generates a challenge on Site C because they "accumulate" soldiers with challenges, and move mission ready soldiers on their normal pace. This behavior, however, is commendable because Site C does not perpetuate a cycle of negative behavior manifestation, re-identification of root causes, and restarting a course of treatment to eliminate those causes.

Misalignment of Incentives

A finding observed at all sites, and is likewise prevalent at Site C, is a misalignment of incentives with desired behaviors. This is present in several of the enterprise's stakeholders, but focus should be placed on MEDCOM and FORSCOM. It is evident in the behavior of the actions of these two organizations that performance measurement drives action. For MEDCOM, measurement of provider productivity and adherence to access to care standards drive behavior. For FORSCOM, the driver is mission readiness requirements within the ARFORGEN cycle. It must be stated up front that individual actors within the stakeholder organizations are not to blame for actions that do not support strategic objectives, but instead the measures of success to which they must conform.

MEDCOM receives funding from Congress through the Military Health System (MHS) relative to the number of Relative Value Units (RVU) generated through individual patient

encounters. This easily measured performance metric allows the organization to ensure that the number of providers employed is appropriate for the demand on the system. If providers do not see enough patients in a month, measured in terms of patient encounters, then the organizations are considered to be underperforming, and funding is adjusted relative to demand. This is necessary to ensure that the military is not employing doctors that it does not need. When queried as to what performance metrics are used to measure the efficacy of health care, specifically in terms of patient outcomes or contribution to collective readiness, no respondent has yet (at any site) cited one. The effect, again with the understanding that performance measurement drives action, is that the medical system incentivizes throughput over quality. It is important to note that this assertion is not to suggest that providers do not want to treat patients, but instead to understand the behavior that the incentive structure promotes.

Second, Military Health Policy dictates adherence to the following access to care standards:

- One day or less for urgent care
- One week for routine care
- One month for specialty or wellness care
- 30 minutes or less in the provider's waiting room
- 30 minutes or less travel time to the primary care provider's office.

Adherence to these standards precipitates a need for immediate triage at the Triage and Assessment Clinic (ref: Figure 1), so that urgent care cases, defined for Behavioral Health as Suicidal/Homicidal/Psychotic may be immediately referred to Inpatient Care. Since Behavioral Health is considered specialty care, the soldier who is a routine patient must wait up to one month before seeing a provider at one of the Outpatient Care Clinics. The providers at the Triage and Assessment Clinic recognize that even those who are not urgent have symptoms that must be mitigated in the month between initial assessment and the next appointment. Evidence suggests that the systemic response is to prescribe psychotropic medications to assuage the patient's symptoms in the interim. The resultant perception among FORSCOM stakeholders is that the Behavioral Health system is a "straight to drugs" system, which is again, a response to systemic challenges on the part of providers who are wearing themselves out to try to provide as much care as they can for the patient population.

If the on-post Outpatient Care Clinic cannot see the soldier within one month, the soldier is referred into the TRICARE network for care off post. Next, since there is no standardization for intakes and assessments, respondents report that each new provider spends his/her first encounter with the patient executing a new intake and assessment. An overwhelmed system, as described below, results in Behavioral Health providers both on and off post having full panels (schedules) for six weeks, which is the limit for provider scheduling. If we consider all of these factors, it is likely that the first time that a patient will see a provider for a full therapeutic session will be ten weeks after entry to the system.

The combined result of action driven by performance measurement for the Behavioral Health system is a course of treatment that frustrates providers because they cannot see patients frequently enough to provide the continuity of care that they desire, and a general impression that drugs are becoming a replacement for therapy. For commanders, the second agency served by the system, there is also frustration due to a perception of focus on throughput instead of care, and a similar perception that if their

soldier goes to Behavioral Health, they will just come back to the unit with "a bag full of pills."

For Commanders in FORSCOM, performance measurement also drives behavior that is not beneficial to the Behavioral Health Enterprise. Mission Readiness in accordance with the ARFORGEN cycle forces deploying commanders to establish a 90% unit readiness rate. This is an understandable and easily measured performance metric, as the commander must deploy to combat with a force appropriate for executing his mission. What is not easy to measure is overall force wellness, which is likely a better indicator of what is needed. The result of performance is the generation of a controlled exchange of deployable soldiers for non-deployable soldiers between BCTs who are close to deployment and BCTs who are not. BCT Commanders who need a 90% readiness rate are able to deploy and perform their mission, but those Commanders who are at home station are left with a high percentage of non-deployable soldiers within their ranks.

The second orders effect of this controlled exchange of soldiers is a population at home station that generates a disproportionally large demand for medical care. Add to this the soldiers in the Rear Detachments who require medical care and those in the WTU, medical providers must support a unit in which almost everyone has some kind of medical issue. As with the assessment of the medical system above, this is not meant to be a poor reflection on commanders who must make these decisions, but instead a description of the system in which they work that drives this behavior.

Leaders must be aware of the incentive structure in their organizations, and must assess whether the behavior that they reward is aligned with the enterprise's strategic objective. Further, senior leaders must evaluate whether the objectives of their subordinate organizations are aligned with one another. A common management misstep is to measure what is easy to measure and not what should be measured. (Ackoff, 1996). Likewise, we should expect organizations to focus on and improve the factors that they report to their superiors. Only when strategic objectives are aligned with stakeholder needs and performance metrics, and enterprise processes support improvement of measured activity should we expect the desired behavior out of stakeholders in the enterprise.

Vision for Behavioral Health Transformation

As indicated throughout the report, Behavioral Health providers at Site C have recognized shortcomings in their system, and have developed a vision for the future that will overcome these challenges. The Director of Behavioral Health Even at Site C stated that even before the Army funded Embedded Behavioral Health for his installation, he and his staff had developed a similar concept to allow him to reference his established clinics in accordance with the Embedded Behavioral Health intent. The Behavioral Health department plans to transform to dedicated Behavioral Health Clinics that would each service a BCT, and an additional clinic to provide care for personnel who are not assigned to a BCT. Likewise, the Behavioral Health department understands that their personnel should be closer to the point of need. They have a long-term construction plan for clinics within the BDE footprints, and have suggested that non-permanent structures may be used to move caregivers closer to their patients.

The Senior Mission Commander at the site has been briefed on this vision and is personally invested in ensuring that the Behavioral Health infrastructure on his installation continues to evolve to meet the needs of the population that is, vice the population that was, on the post. Additionally, the Commander is working with the MTF Commander and the installation commander to deliberately develop information and accountability linkages between all the stakeholders at the site.

Emergent Finding: Soldier Fragility and Junior Leader Skills

At each site that our team has visited, a common theme in the data that we gather is a reference to an Army-wide change in its junior ranks. Commanders, Behavioral Health Providers, Chaplains, and Primary Care Physicians all discuss the reduced aggregate quality of junior enlisted soldiers resulting in a reduction in recruiting standards from 2004-2007.

In this timeframe a great number of junior NCOs left the service, likely due to the increased OPTEMPO and associated stress on themselves and their families. As a response, the Army was forced to promote its junior enlisted soldiers to fill the vacancies. These new NCOs had spent their entire careers in combat, and were excellent in terms of "operations on the objective." Rapid promotion in combat conditions result in a generation of NCOs who never learned to lead soldiers in a garrison environment; never learned to do effective counseling, and do not understand how to lead *soldiers and families*. This is compounded by a reduction in scope and/or indefinite deferment of NCOES courses for these junior leaders, so in addition to the lack of experience, they have not been given the institutional training that they require for home station operations.

To fill the vacancy of junior enlisted soldiers created by the rapid promotions, the Army responded by lowering recruiting standards in order to quickly fill the lower ranks. Stakeholders that we have interviewed that served in Recruiting Command and as Drill Sergeants in TRADOC in that period have stated that they knew that they were creating long-term problems for the Army by enlisting and sending those soldiers to units, but the mission was to grow the Army quickly.

The combined result of these actions is a generation of junior leaders who have never been given the opportunity to lead soldiers and their families who are forced to lead soldiers who never should have been allowed in the service. When discussing this topic, a military provider at another site stated, "the AMEDD is so overwhelmed taking care of people who can't be helped, who should have never been admitted in the Army, that there's nothing left to take care of those who can be helped."

Case Study of the Behavioral Health Delivery System at Site E

MAJ Shane Scott
Dr. Jayakanth Srinivasan

Purpose:

The Post Traumatic Stress Innovations (PTSI) team from the Massachusetts Institute of Technology's (MIT) Lean Advancement Initiative (LAI) conducted a week-long site visit to Site E as a part of its data gathering regarding the military's care delivery enterprise for Post Traumatic Stress and related conditions. The team collected information from stakeholders from Forces Command (FORSCOM), the US Army Medical Command (MEDCOM), and US Army Installation Command (IMCOM) at Site E through a series of interviews conducted by the authors. The interviews focused on how each organization, as a stakeholder in the Site E Enterprise, participates in the delivery of Behavioral Health services to both service members and their families during home station operations. This case study presents the findings regarding the architecture of the enterprise and the processes by which the enterprise delivers care.

Site Demographics:

Site E is a major FORSCOM installation, with six Brigade Combat Teams (BCTs) and one Combat Aviation Brigade (CAB), as well as nine Brigade-sized elements for support of the BCTs. Headquartered at the Site are an Army Corps, a Division HQ, and a Regimental HQ. In total, over 46,000 military and family members reside at the Site with an additional 73,000 family members living and working in the adjacent communities. The civil infrastructure on the installation and in the neighboring town is appropriate for this large population, as Site E has historically been the US Army's largest installation, worldwide. The Site is home to an Army Community Hospital with 128 operating beds, sixteen of which are dedicated to inpatient behavioral health care, although the Inpatient Ward is only staffed to operate twelve beds. The community's civilian hospitals support the installation by providing additional support for service members and their families as needed.

Deployment History:

The BCTs and the CAB at the installation have been deployed or training for deployment to Iraq and Afghanistan for the past ten years. At the time of this report, four of the six BCTs were redeploying from the final rotation of Operation Iraqi Freedom, and in the words of one of those interviewed, "This is the first time in ten years that soldiers are returning to [Site E] when they haven't known exactly when they were going to leave again."

Description of the Site E Behavioral Health Architecture

The architecture of the Behavioral Health system at Site E is characterized by centralized facilities and services that provide care for the entire military population. Centralization of services yields a predictable pathway that all soldiers and leaders may access for Behavioral Health care. The downside of centralization is the susceptibility to inundation in surge periods during which centralized nodes become pacing items for the performance of the entire system. The "Gatekeepers" at Site E (ref: Figure **1**) function in a similar fashion to those at previous sites, and will be discussed on a by-exception basis.

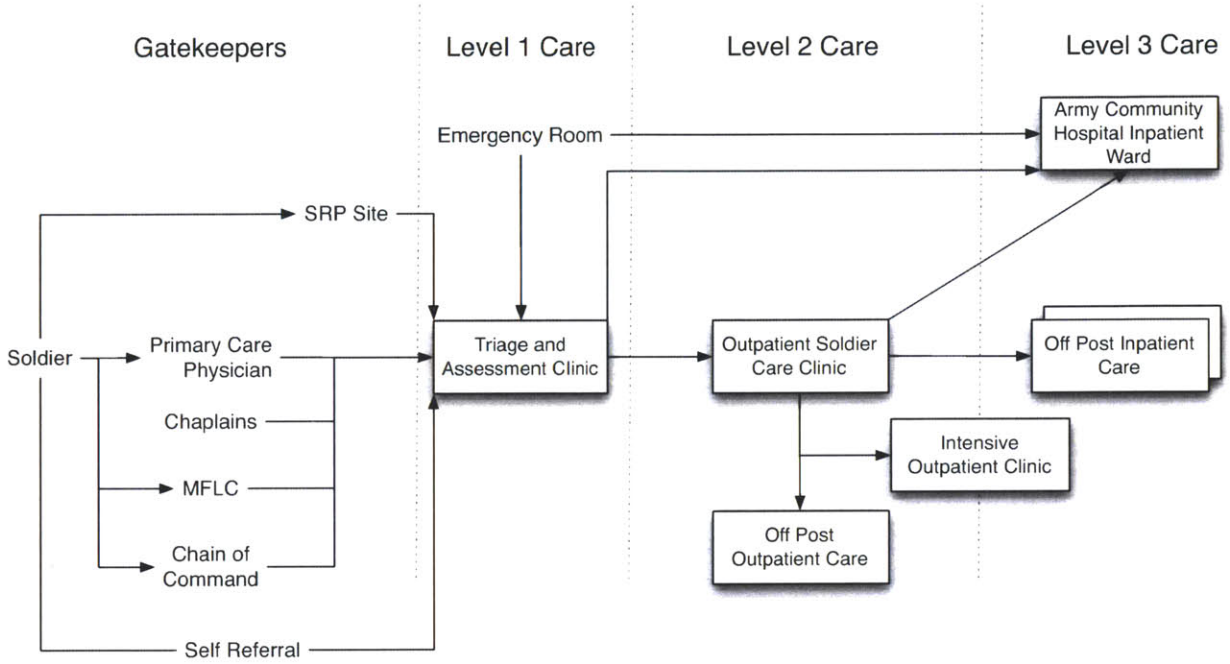

Figure 1. Behavioral Health Architecture at Site E

All soldiers and leaders at Site E report that their point of entry into the Behavioral Health system is the post's centralized Triage and Assessment Clinic. This clinic serves the function of determining whether a patient is Suicidal/Homicidal/Psychotic, in which case they are referred directly to the Army Community Hospital's Inpatient Ward, or if the soldier should enter the queue for intake at the Outpatient Soldier Care Clinic. The current staff for this facility is two (of an authorized four) psychologists who may execute triage for the entire military population of Site E. Wait times for assessment are reported as up to six hours because of the small staff, and during this time soldiers wait on site, supervised by an NCO from their unit. Due to the nature of patients' conditions at this clinic an armed guard is also employed in the waiting room.

If a soldier is assessed as having an urgent need for care, they are referred to the post's outpatient clinic within seven days for assessment and intake. In routine cases, soldiers may be seen for their initial appointment at the Outpatient Clinic up to 28 days after triage and initial assessment. Psychiatrists and Psychologists assigned to the Outpatient Soldier Care Clinic execute an initial assessment and intake for each patient, and schedule

appointments for follow-on treatment. For those patients who cannot be seen within 28 days due to lack of capacity in the on-post clinic, they are referred off post into the TRICARE network for follow-on care.

Soldiers who are assessed as having moderate to severe PTSD may be eligible for the post's Intensive Outpatient Clinic. This clinic executes a 30 day program to which soldiers report as their place of duty for eight hours per day. In this program, clinicians administer multiple and complimentary treatment modalities. At the end of the program, patients may either Return to Duty (RTD), or if the doctors at the clinic determine that they are not well enough to RTD, then the soldiers typically begin a Medical Board.

Patients who require extensive inpatient treatment are typically referred to regional hospitals with the capability to execute that type of care. There is one hospital in the immediate area that is capable of delivering long-term inpatient care, so the majority of inpatient care is executed by hospitals outside of a 50-mile radius of the installation. The Inpatient Ward at the Army Community Hospital is generally utilized for shorter-term mitigation of critical needs, and currently operates only eight beds.

One BCT at Site E is equipped with an Embedded Behavioral Health element that changes the architecture and, to a degree the function, of the Behavioral Health architecture at the Site for that BCT. The Embedded Behavioral Health element is deployed at the BDE level, and serves as a dedicated Triage/Level 1 Behavioral Health node for 4,000 soldiers. The TDA for this clinic authorizes one psychiatrist who oversees Psychologists, Licensed Clinical Social Workers (LCSW) and Behavioral Health Technicians (68X); however, not all of these authorizations are filled at this time. The MEDCOM providers at this clinic work closely with the BCT's Behavioral Health Officer, who integrates the clinical Behavioral Health providers with the BCT's Gatekeepers. The Embedded Behavioral Health Clinic, shown in Figure **2**, only refers soldiers outside the BCT footprint who require more intensive treatment than can be provided by the single psychiatrist in the facility.

Site E Top Findings

Local Successes:

1. Embedded Behavioral Health

a. The model for Embedded Behavioral Health at Site E, if fully staffed, is a DoD-wide best practice. Architecturally, this concept pushes providers forward to the point of need and provides enhanced continuity of care. Primary Care Physicians, Behavioral Health providers, and soldiers maintain habitual relationships that result in increased communication and knowledge management for improved patient care and case management. In effect, the Embedded Behavioral Health model brings what is best about downrange care to home station: it aligns organizations with the Army's Comprehensive Soldier Fitness concept, and it enhances the capability of all actors to optimize outcomes for soldiers and their units. This concept is consistent with Army doctrine, as well as with the concepts of Army Medicine Strategy (Army Medicine Strategy Map – March 2011)

Dedicated providers for the BCT's soldiers enhance continuity of care and case management. In the "centralized" model shown in Figure 1 soldiers see the providers as dictated by the clinic's schedule, and in practice this results in new providers for each visit, and a new start to treatment at every appointment. The Embedded Behavioral Health model enables a patient to see the same clinician throughout his course of treatment. Since the

soldier is treated by a single provider, the patient and provider can build a relationship, the provider can understand patient history and progress, and the patient does not have to tell his story from the beginning with every new doctor. An additional benefit to this model is that the Primary Care Physician and the Behavioral Health provider can work together to manage the patient's case cooperatively and in a holistic fashion.

A common theme in the team's research is the importance of relationship building and cooperation among people and agencies in the military, and in addition to putting providers forward, the Embedded Behavioral Health model enables the synergy of downrange care at home station. Medical providers, commanders, and soldiers at Site E (as well as all other sites) report that downrange medical care is perceived as better than home station care because all stakeholders are collocated, accessible to one another, and share relationships that enable information sharing and enhanced knowledge management despite the lack of sophisticated information systems. Again, all stakeholders at all sites report that person to person contact is a key enabler for information exchange and team building, and placement of Behavioral Health providers in the BCT footprint places the final stakeholder in a comprehensive soldier treatment team with the rest of the stakeholders, and positive

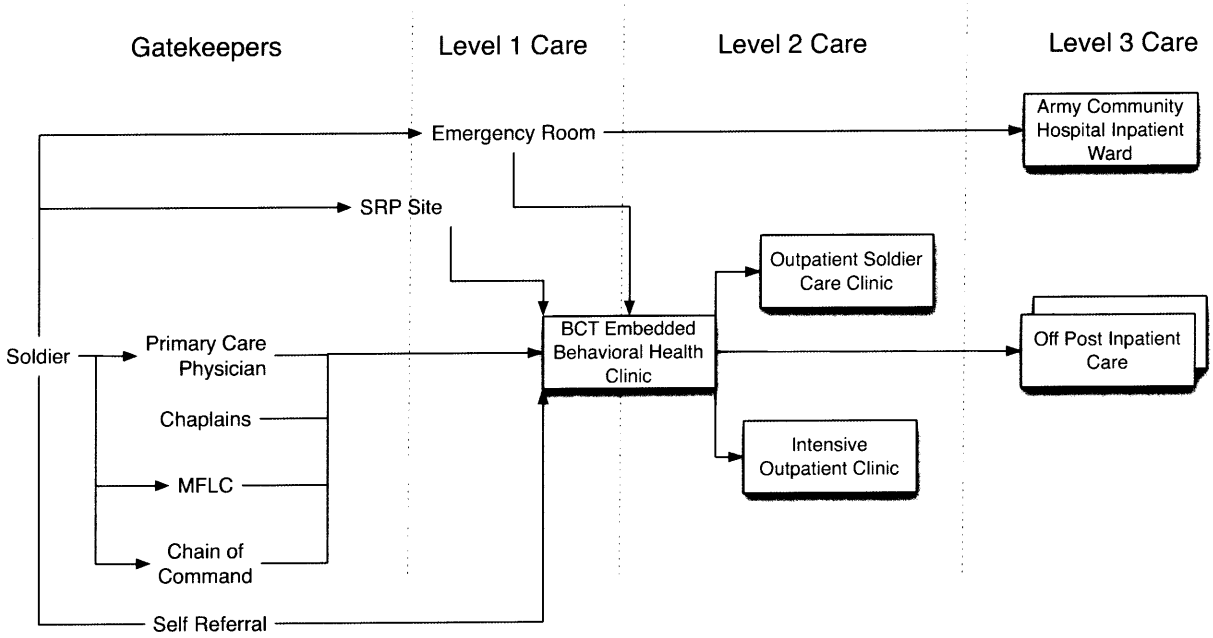

Figure 2. Architecture for Embedded Behavioral Health at Site E.

emergent system behaviors seen on deployments are likewise observed at home station.

The Army's Comprehensive Soldier Fitness (CSF) concept shows that this branch of the DoD has initiated an effort to approach soldier wellness in a holistic fashion, and the Embedded Behavioral Health model dovetails with this program. This architecture places the champions of each CSF pillar at the unit level: Primary Care Providers (Physical), Behavioral Health Providers (Emotional), Chaplains (Spiritual), FRSAs/FRGs (Family), and Battle Buddies/Small Unit Leaders (Social). This structure is consistent with the Unity of Effort principle that is pervasive in military doctrine. The Army's Field Manual 3-24 (Counterinsurgency) states that, "Unity of effort must be present at every echelon of a [counterinsurgency] operation. Otherwise, well-intentioned but uncoordinated actions can

cancel each other or provide vulnerabilities..." Although this publication refers to efforts to safeguard a system against an armed enemy, the principle remains applicable[1]. This unified team is able to cooperatively recognize and care for soldiers who need help, and to prevent those who do not need help from overwhelming the system.

Commanders in the BCT with Embedded Behavioral Health have a significantly higher opinion of the Behavioral Health capability at the Site than those in the BCTs without it because they know the providers by face and name, and they value the relationships and information sharing that is provided by proximity. Additionally, commanders remarked that the focus of the providers is on providing treatment, instead of generating throughput, which is perceived by commanders as the medical system's success criteria in the centralized model. Likewise, Behavioral Health providers at the BDE level report that they prefer this architecture for the reasons listed. The BCT's assigned behavioral health provider and the primary care providers from the BCT stated that everyone in the brigade loves the Embedded Behavioral Health concept, but "we are terrified that someone is going to take it away."

"We all love the embedded [Behavioral Health] capability, but we're terrified that someone is going to take it away."

- BCT Health Care Providers

Of all the Behavioral Health programs and architectures seen across the DoD, Embedded Behavioral Health at the BCT level is a best practice that must be adopted across the services.

Further commentary on Site E's Behavioral Health Architecture will ignore Embedded Behavioral Health, since this model is the exception rather than the rule.

2. **The Army Substance Abuse Program (ASAP):** ASAP at Site E was reported as excellent by all those interviewed. The Site E ASAP is staffed with 30 counselors, including a psychiatrist, provided by MEDCOM. The transition from MEDCOM to IMCOM, although difficult and questioned by providers, has not affected the effectiveness of treatment at the installation. The primary difference in ASAP at this installation, compared with others that the team has visited, is the consistent and deliberate integration with the command.

Each Soldier who enters treatment in the program is in-briefed along with his/her Company Commander and 1SG. In this inbrief, the counselor details expectations, guidelines, and desired outcomes; defines criteria for successful completion; and integrates the command team into the treatment plan. At the end of the program the counselor briefs the soldier and his command team on the outcome, reasons for success/failure, and conducts a "warm handoff" to the command with a plan for sustainment. All parties reported that this deliberate, integrated approach was one of two factors in the program's success at the Site.

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[1] The remainder of the sentence referenced from FM 3-24 is "for insurgents to exploit." One could easily replace this with "...for *service members seeking secondary gain* to exploit." Unit Commanders across the Army recognize that there are many soldiers who truly need Behavioral Health services, and they are encouraged when those soldiers get the help that they need. However, after interviewing over 150 Company Commanders, Battalion PAs, BDE Psych providers, and unit medics we have found that the consistent estimate for the percentage of service-members seeking to "work the system" is between 50%-75%. This is consistent with the percentage assessment by the psychologist from the triage clinic at Site E.

The second factor in the program's success is a focus on results. Each soldier enters the program with a well-defined plan and end state. Likewise, the treatment plan has a timetable for execution, so there are no indefinite enrollments. This is desirable for commanders because they have a reasonable schedule at the end of which they can expect the soldier to be either mission capable or prepared for separation from the service. This is likewise appealing for the clinicians, because they can see measured progress.

3. Intensive Outpatient Program for Behavioral Health.

Site E operates a thirty-day intensive outpatient Behavioral Health program for soldiers who are diagnosed with moderate to severe PTSD. For the month that soldiers are enrolled in the program, their place of duty is the treatment facility in which they engage from 0800-1600 daily in a variety of treatment modalities. The program treats soldiers in cohorts of eighteen, so that in addition to individual therapies, group therapies may also be leveraged and a support network is pre-established for graduates. The downside to the cohort model is low throughput, but positive results, which are the focus of the program instead of throughput, demonstrate that the treatment regimen is effective. 50% of the soldiers admitted into the program are returned to duty successfully, which is remarkable.

The director of the program, a psychiatrist with over 50 years of experience in his field, stated that the program's ability to take the time to focus on treatment with measurable patient outcomes is the reason for the program's success. His only concern for the program is for the soldiers who return to inhospitable units that are focused on his month-long absence rather than his success in getting the help that he needed. Returning to a toxic environment, according to the director, can easily reverse the progress made in the program. Site E's leadership was briefed on the successes of this program and the director's concerns.

4. 68X Training Program

Enlisted Mental Health Technicians at Site E undergo a comprehensive "on the job (OJT)" training program that is different from any program seen across the military. This program allows these soldiers to spend time in a variety of garrison environments. Starting in the Army Community Hospital's Inpatient Ward, the soldier spends around six months learning the job in a hospital setting. Next, the soldier moves to a Behavioral Health clinic on Site E to participate in the outpatient clinic environment. While assigned to this clinic the soldier is able to get out to the combat units to integrate with and educate Commander/1SG teams on the capabilities of the 68X and to engage service members, in their work areas, to enhance junior soldier and leader understanding and to conduct counseling as requested.

At the completion of the clinic/unit time, the soldier returns to the Inpatient Behavioral Health Ward to train new Techs and be available for deployment with BCTs to augment Combat Stress Teams. The result of the OJT program is a well-rounded Psych Tech who can relate and succeed in a wide array of possible operating environments. Both 68Xs and clinical providers see this program as a success, and it should be considered as a possible best practice.

Systemic Challenges

1. **Architectural Weaknesses.** The centralized architecture at Site E is similar in structure in form and function to other Behavioral Health models observed throughout the services. Duplication of Effort is widespread due to unintegrated organizations with overlapping capabilities, poor information sharing/knowledge capture mechanisms, and unintended consequences of a policy that allows unimpeded access/demand on the system's pacing items. The outcome of these combined attributes is a system that performs layers of triage with no continuous care, spends time and resources generating rework, is overwhelmed at structural chokepoints, does not deliberately inform interested stakeholders of necessary information, or allow unified effort for solder/patient case management.

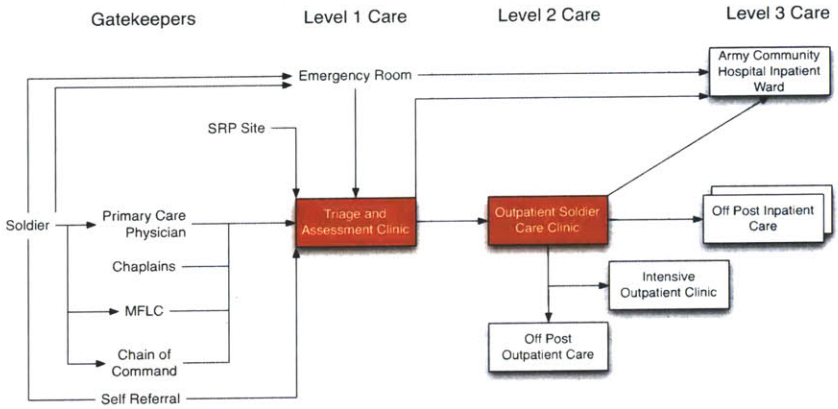

Figure 3. Architectural Choke Points - Site E.

The defining features of the current state architecture is the presence of two structural choke points, highlighted in Figure **3**. The Triage and Assessment Clinic utilizes two psychologists as the entry point into the Behavioral Health system for the 27,000 military members at the installation. This results in excessive wait times for soldiers seeking care. Service members report that the average wait time at the site is two to three hours, but some have reported waiting up to six hours for an initial assessment/intake. The second choke point is the Outpatient Soldier Care Clinic, which is staffed with providers who also perform an initial intake and assessment. Because of the overwhelming demand on this clinic, soldiers must wait up to one month for their intake at this clinic and generally another month before their first full therapeutic session with a clinician, seldom the same doctor that they saw for their initial intake at that clinic. Since there is no common standard for intakes at the clinic, the soldier must start again with each new provider seen. The Armed Forces Health Longitudinal Technology Application (AHLTA) is meant to be the means of transferring information between the clinicians, but this information system has a three-page limit on uploads per entry, and the average for intake forms is around ten pages. This is not meant to be a poor reflection on the providers at this clinic or their clinical methods, but instead an observation on the architecture of the system in which they work.

In the case that the wait time for an appointment for therapy exceeds acceptable standards, the soldier is referred into the TRICARE network in the adjacent town after their initial intake at the Outpatient Clinic. This yields another re-start for the soldier, because off-post providers have no means of information exchange with on-post medical providers. Worse, TRICARE may refer soldiers to a different off-post provider during the course of treatment, forcing another re-start for the soldier. When we consider all of these re-starts, coupled with month-long wait times between appointments, we begin to understand how architecture affects both continuity and quality of care.

Off-post inpatient care is likewise affected by the absence of an effective information conduit between on and off-post Behavioral Health providers. When a soldier requiring long-term inpatient care is sent to a regional civilian provider, that provider has no means of contacting the soldier's unit for background information or the on-post Primary Care or Behavioral Health providers for medical or treatment history. On completion of treatment, the off-post provider has no means of transmitting detailed assessment, clinical notes, or diagnosis aside from a one-page discharge summary.

Most concerning, regarding off-post medical provision (inpatient or outpatient) is the absence of an effective mechanism for sharing prescription data with each other or with military behavioral providers. It is not uncommon for a soldier to be prescribed medication by an on-post provider, receive referrals to multiple off-post providers as described above, with each prescribing additional medication in different types and/or doses. A soldier may unwittingly, or knowingly, take all of these medications, and overdose or be victim of negative synergistic effects that come from mixing medications. A soldier at Site E recently died in a similar scenario. Poly-pharmacy is a systemic issue that must be addressed. On-post medical systems allow pharmacists and physicians to exercise effective med management, but the addition of off-post providers adds a layer of difficulty in pharmacy that requires an extensive amount of work to overcome. TRICARE-filled prescription information is available to on-post pharmacists and clinicians; however, this data must be manually extracted from one information system and added to AHLTA. Since AHLTA requires 72 hours to update, the very best of scenarios would allow a soldier to go three days with unknown medications from off post.

2. Information Systems. Ineffective information conduits and an unreliable or absent feedback structure is the second significant architectural weakness in Site E's Behavioral Health system. Figure **4** shows information pathways and graphically illustrates the strengths of those pathways. The first information system, AHLTA (which acts as an overlay for CHCS), links all on-post outpatient medical providers for clinical assessments, diagnoses, treatment notes, pharmacy data, etc. The system is shown in amber because it is considered,

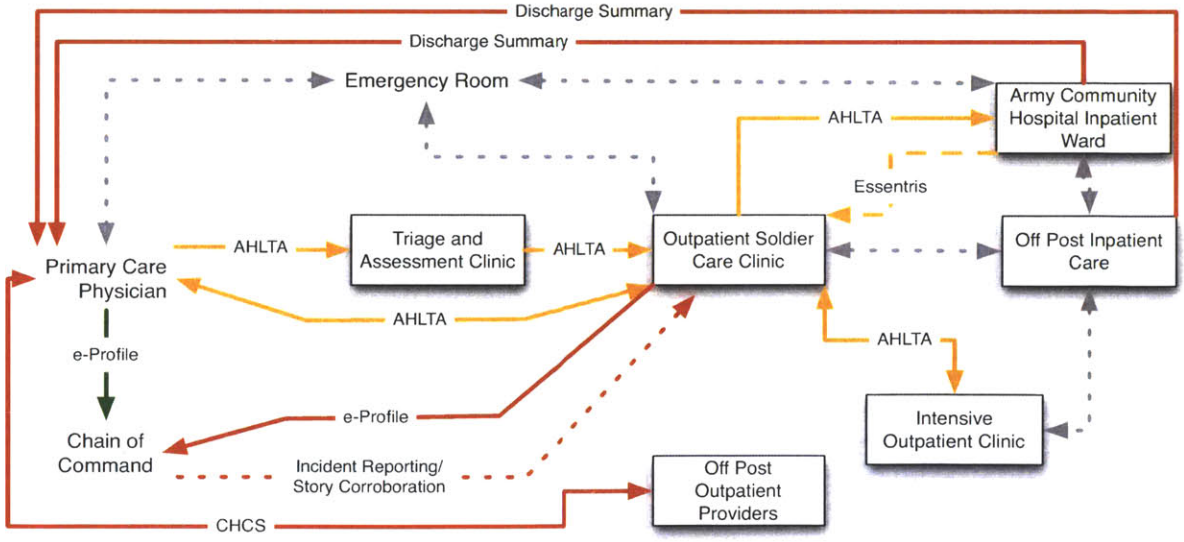

Figure 4. Information Conduits

system-wide, as difficult to use, unreliable, and inadequate for effectively transmitting detailed Behavioral Health information. Providers across the Army have stated repeatedly that they desire a better system because it is a significant source of frustration and an inhibitor, rather than an enabler, for clinical care.

The second conduit for medical information is Essentris, which is the Army's inpatient medical record system. In regards to Behavioral Health, Essentris is the information system that is used in the Inpatient Behavioral Health Ward at the Army Community Hospital [ACH]. This information system is completely federated from AHLTA, and special training is required for accessing this system. The training required for accessing Essentris requires a half day of training at the ACH. This system is shown with a dashed Amber line because it is available, but it is not utilized outside the hospital's Inpatient Behavioral Health Ward. As an illustration of this system's operational isolation, the director of one outpatient clinic at Site E knew that the system existed, but had no idea that it was accessible outside the ACH.

"I know they use Essentris over at [the ACH], but I don't know anything about it, and I cannot access it anyway."

-Director of an Outpatient Clinic at Site E

The third medical information system, eProfile, works well for transmission of Primary Care-related soldier information to Commanders. It is shown as a solid green line between Primary Care Providers and Commanders in Figure **4** because it is used for its intended purpose in this interaction, and weaknesses in electronic communication are strengthened by personal relationships enabled by collocation of these stakeholders. The same system is shown as a red solid line between Behavioral Health providers and Commanders because the system is used, but is inadequate for the transmission of data required to describe information unprotected by HIPPA, but required at the unit level. Commanders at Site E (and all other sites) report that Behavioral Health profiles are generally ambiguous/unusable by command teams or overly restrictive, effectively removing soldiers from the unit's fighting strength. Often cited example is the "may not work for more than 30 consecutive minutes, with no weekend duty," or "may not report to work prior to 0900." These types of doctor recommendations are generated both on and off post.

The final system illustrated in Figure **4** is the Composite Health Care System, which is the system underlying the AHLTA Interface, and is the system that was described above for extracting TRICARE pharmacy data. This system is represented by a red solid line because it is present, but unintegrated, and requires a deliberate unintuitive, burdensome query on the part of the provider to determine offline if there is a poly-pharmacy issue. It is worth noting in this discussion that the Embedded Behavioral Health clinic has a technician who reconciles this information daily for the purpose of preventing poly-pharmacy. The Embedded Behavioral Health providers cited this as a best practice within their clinic.

"In a 20 minute encounter, I spend 10 minutes just trying to make the computer work."

- Site E Clinical Provider.

Finally, Figure 4 shows a number of information pathways with gray dashed lines. These are pathways that should, but do not, exist in the current architecture. Those associated with off-post providers have been covered above; however, according to those interviewed, the Emergency Room remains unlinked from the rest of the system. Although

the Emergency Department is located in the ACH it does not execute inpatient care, so it is not linked to Essentris. Likewise, stakeholders interviewed at Site C report that the ER does not reference AHLTA except for the pharmacy data.

The effects of unlinked information systems are not isolated to ineffective feedback structures and poly-pharmacy. Case management and knowledge capture is made nearly impossible by unlinked stakeholders in a system that services so many patients. Until information systems are integrated or unified, these challenges will remain.

3. **Unintended Consequences of an Open and Unquestioned Access.** An architecturally-challenged and under-manned system with marginal information systems and knowledge management mechanisms struggles to provide continuous and effective Behavioral Health services when operating with a full load of patients. A third challenge, the system's open, no-questions-asked, access policy has generated a state in which demand for the system constantly exceeds its capacity for effectiveness. Open access, which is desirable and necessary for a force as emotionally taxed as combat soldiers, however, is not the root cause of excessive demand. Instead, the benefits available for soldiers who would selfishly leverage the system for secondary gain makes self-referral to Behavioral Health too easy for unscrupulous individuals who may unduly benefit from the system.

In plain terms, soldiers have learned that Behavioral Health is a "silver bullet" that they may use to avoid anything that they want to avoid. Commanders report that it has become the default response for soldiers facing administrative or legal action to self refer to the Behavioral Health clinic, where the soldier cannot be touched until his treatment is complete. Since the system has complete open access, Behavioral Health providers, commanders, and soldiers at Site E stated that any soldier can walk in to the Behavioral Health clinic or the Emergency Room at any time and report that they are suicidal/homicidal, and they immediately enter inpatient treatment. Further, a soldier can spend fifteen minutes on the internet[2] and learn exactly what to say and what to do to start the process for a Medical Board and an Honorable Discharge, or to get out of a deployment or undesirable duty. With this capability so readily available, it is not surprising that such a high number of soldiers self report to the system.

> ***"There's nothing really wrong with me. I just want to get out of the Army, and this is an easy way."***
>
> *-Soldier to a Psychiatrist at the Site E Inpatient Behavioral Health Ward*

The effects of malingering on the Behavioral Health system are staggering. Providers are forced to spend valuable resources unnecessarily, wait times for those who really need help are excessive to the point of being prohibitive, and stigma associated with Behavioral Health is increased because good soldiers who need assistance do not want to be thought of as a malingerer.

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[2] Example websites found on Google in ten minutes. Using the in formation found on these two sites, a soldier can be completely prepared to defraud Behavioral Health providers and get a PTSD diagnosis.
http://www.sovereignwarriors.com/
http://forums.military.com/eve/forums/a/tpc/f/8280047191001/m/9860093991001

It is likely that this problem can be fixed by a three-pronged approach. First, a zero-tolerance policy for Behavioral Health-related malingering should be adopted. In effect, the policy should state that Chapter Action will be initiated for any soldier found attempting to defraud the government using the Behavioral Health system as a means. Second, there must be an effective conduit for Commanders and providers to corroborate soldier claims and/or provide back-story on soldiers after their initial intake at the Outpatient Behavioral Health Clinic. Third, adoption of the Embedded Behavioral Health architecture will place providers closer to their patients, their Primary Care providers, Commanders, and Chaplains, and providers will have better situational awareness regarding the soldier in their office.

4. Alignment of Incentives for Medical Units

According to the Army Medicine Strategy Map (March 2011) the mission of MEDCOM is threefold:

- Promote, Sustain and Enhance Soldier Health
- Train, Develop and Equip a Medical Force that Supports Full Spectrum Operations
- Deliver Leading Edge Health Services to Our Warriors and Military Family to Optimize Outcomes

Although the MEDCOM mission indicates emphasis on Soldier and Family Health, Operational Support, and Optimized Outcomes, there are no metrics to measure success relative to any of these areas at Site E or at any other site visited thus far. Organizations measure and promote what is important to them, and what is measured in the Army's Medical Command is throughput and provider productivity. Providers at Site E, as well as in all other sites, remark that generation of Relative Value Units (RVUs), the performance measurement unit for provider productivity, is the impetus for most clinical action. When asked what metrics are used to track patient progress or outcomes, no provider has yet been able to cite one. Again, this is not a reflection of poor providers or clinical staffs, but instead an assessment of the system goals and incentivized behaviors. When we queried clinicians about their ability to track patient progress, they noted that they do not see patients often enough to be able to provide the care at the frequency they would like to, and lacked the outcome measures to demonstrate and discuss progress with their patients.

"If our clinic doesn't generate the needed number of RVUs for the month, the hospital Business Operations Division hammers our boss."

-Medical Clinician at Site E

If a desired behavior of Army Medicine is to Promote, Sustain, and Enhance Soldier Health, then a large part of the incentive structure for the medical community should be tied to individual and unit medical readiness metrics. Conversely, if current performance metrics are sustained, then the emphasis on throughput and provider productivity should likewise be expected to be sustained.

5. Rear Detachment Task Organization and Training

Rear Detachment Commanders and 1SGs at Site E, report that a high percentage of soldiers are in their units because they have medical or legal complications that prevent them from executing combat deployments. A large part of the Rear Detachment's mission is to work with these soldiers to solve their issues so that they may join their units downrange or to process soldiers who have disqualifying medical or legal conditions out of the Army. The task organization for the rear detachment mission, however, is not consistent with this mission. A Rear Detachment Commander at another site summed up this problem perfectly when he said, "They leave me all the medical and legal problem children, but they take all the medical and legal experts downrange." This sentiment is consistent with the attitudes of the Rear-D Staff at Site E, and all interviewed remarked that they needed dedicated legal and medical assistance for their units and ideally a medical case manager.

"99.9% of my time is spent chasing down the problem children, and I don't have any time to concentrate on getting soldiers ready to deploy."

-Rear Detachment Commander, Site E

Additionally, training for the Rear Detachment is identical to the Commander/1SG course offered to MTOE (Modified Table of Organization and Equipment) command teams, and is a brief overview of the services available on the installation. Rear Detachment staffs interviewed all agreed that the focus of Rear D training should be on three areas: Medical Boards, Chapter Actions, and UCMJ, since these are the areas in which the Rear D Commander focuses the majority of his time.

6. Disconnected Soldier Readiness Processing

The current model for SRP at Site E is a fixed site at which activated Reservists administer the process as their primary duty. Soldier Readiness Processing at a fixed site enables predictability and regularity to the SRP process; however, this model presents two significant challenges. First, information collected/generated by the process has no formal means for transmission to the unit; and second, the absence of unit providers from the process reduces the fidelity in the service that units receive. By maintaining the current cadre, and adding unit providers in both oversight and participatory roles, both of these challenges could be overcome.

Because of the system for generation of referrals and consults to Site E health care services/providers, SRP cadre must informally refer soldiers who need off-site care to the unit providers, so that the unit providers may make the referral. When a referral/consult is created, the formal feedback mechanism returns information to the originating provider, so if SRP providers generate the referral, they get the feedback. If unit providers generate the referral, then the feedback comes back to the unit, which is desirable. Since the SRP cadre do not provide treatment, there is no reason for the information from the referral to come to them. By placing unit providers at the SRP site, the providers may eliminate an additional step for the soldiers in need of care. An alternative solution is to create routing processes/systems to allow information from SRP-generated referrals to route to unit providers; however, this is a resource-intensive solution that is likely impractical.

Next, the SRP cadre use data collected through the Down-Range Assessment Tool (DRAT), the Post-Deployment Health Assessment (PDHA), and the FORSCOM Risk Assessment Tool to identify soldiers who require behavioral health services. Again, the unit

providers are not present in the process, and the SRP cadre are left to depend on instruments that are regarded as extremely poor by all interviewed (at all sites). No SRP cadre-member understands the soldiers' history or unit's culture, so the ability of the process to identify soldiers in need of help is reduced. A soldier may hide his condition on redeployment through lying on the assessments, or he may likewise overstate his condition for the purpose of seeking secondary gain. When unit providers who understand the soldiers' experiences and history are not present at the SRP, no one is capable of augmenting the data-collection instruments with real-world experience. In plain terms, reliance solely on data generated by flawed instruments significantly reduces the fidelity of the process.

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