RECORD VERSION

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ON POST-TRAUMATIC STRESS DISORDER AND TRAUMATIC BRAIN INJURY - CLINICAL AND RESEARCH PROGRAM ASSESSMENT

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Chairman Coffman, Ranking Member Speier, and distinguished members of the subcommittee, thank you for this opportunity to provide a perspective on the treatment of Soldiers with behavioral health conditions, including Post Traumatic Stress Disorder, and Traumatic Brain Injury (TBI).

Over the past decade, I have witnessed the profound transformation of the Army's system for delivering behavioral health care to Soldiers and their Family Members impacted by conflicts around the world. I know of no other health care system in the nation that has improved behavioral health access, quality, and safety over a short period of time as extensively as Army Medicine. The Army committed to a multi-year transformation process to identify best practices in the field, incorporate emerging research findings, and standardize clinical operations across the enterprise. This approach has reduced variance between Army hospitals and improved the effectiveness of care. Army behavioral health providers are now positioned closer to the point of need, which reduces barriers to care. Our providers have new insights into the impact of their treatment through the use of one of the nation's leading methods for measurement-based care. While much work remains to be done, Soldiers are more ready to fight the nation's wars than they were several years ago.

Moving Care to the Point of Need

One of the core components of the Army's approach to enhancing behavioral health care delivery has been to eliminate barriers to care by moving teams of health care providers to locations that are more accessible to Soldiers and Family Members and developing working relationships with key stakeholders. For Soldiers, this approach is called Embedded Behavioral Health (EBH). Through the EBH program, Army Medicine aligns teams of behavioral health professionals with specific combat units. In most cases, EBH teams provide clinical care out of a small clinic located close to where Soldiers in that unit live and work. Informed by findings from Army researchers on stigma and barriers to care, EBH was pioneered at Fort Carson in 2009. EBH has been correlated with improved access to and continuity of care, a reduction in stigma to receiving behavioral health care, and fewer high risk behaviors, such as suicide attempts. The Army has adopted this model of care for all combat units and

now operates 62 EBH teams with a total of over 450 behavioral health providers. Leaders in Army combat units have embraced this model of care and partnered with EBH teams to support Soldiers at risk for adverse events and improve the readiness of their units.

In a similar way, Army Medicine identified the need to more effectively provide access to behavioral health care for our Soldiers' children. We partnered with leaders in the civilian community, including the Universities of Maryland and South Carolina, to develop a School Behavioral Health program within Department of Defense schools located on Army installations. Through this effort, Army Medicine has placed behavioral health providers into small clinics in 60 schools and has plans to expand to 40 more in the next two years. School Behavioral Health providers offer convenient access to care and readily partner with school personnel, such as counselors, teachers and principals, to ensure that treatment is tailored to each patient's and enhances the readiness of the Soldier by decreasing the amount of time away from the unit for their child's appointment.

Embedded Behavioral Health and School Behavioral Healthcare are two examples of the innovative and wide-ranging improvements Army Medicine has implemented to better deliver behavioral health care. Soldiers and their Families now engage in outpatient care over twice as often as before changes were made. In 2007, Army beneficiaries participated in approximately 900,000 behavioral health visits. In 2016, that number grew to over two million. As more Soldiers have engaged in outpatient treatment, the need for inpatient care has decreased. Soldiers spent 67,000 fewer days in inpatient behavioral health facilities in 2016 than they did in 2012, which may indicate that behavioral health conditions are being treated before progressing to the point that inpatient care is required.

Measurement-Based Care

In the midst of transforming its behavioral health system of care, the Army recognized the need to measure the true effect of the care being provided to its beneficiaries. Unlike other areas of medicine, which easily lend themselves to objective outcome measures, such as blood pressure readings or laboratory results, behavioral

health care is inherently subjective. To better ascertain the impact of behavioral health treatment, the Army developed one of the nation's leading platforms for measuring patient-centered outcome measures in behavioral health care.

The Behavioral Health Data Portal (BHDP) is an enterprise-wide web-application that enables standardized behavioral health assessments and outcome tracking in behavioral health clinics. Use of BHDP allows for real-time graphing of outcomes measures for clinical care, consolidation of data from multiple sources into one clinician dashboard, and aggregation of data for meaningful program evaluation. It was recently described in the Harvard Business Review as a leading practice for its ability to help providers personalize their treatment approaches to each patient.

The Army initiated BHDP in April 2012 and has since implemented it in all Army outpatient clinics, including virtual behavioral health. BHDP is expanding to include Intensive Outpatient Programs, Child and Family behavioral health, Family Advocacy, and Traumatic Brain Injury clinics. BHDP is now used in over 60,000 behavioral health encounters every month with over 2.2 million surveys collected to date. Each survey contains objective treatment outcome data that enables clinicians to better tailor treatment plans for each patient. BHDP has been endorsed as a best practice by the Assistant Secretary of Defense for Health Affairs and is being implemented across each Service. Finally, Army Medicine is working with Defense Health Agency leaders to include the core elements of BHDP into the new electronic health record.

The State of Treatment for Soldiers with Traumatic Brain Injury (TBI)

Since 2000, more than 357,000 Service members worldwide had a first time TBI diagnosis, of which approximately 58.5% (208,000) were U.S. Army Soldiers. The vast majority (approximately 85%) of those injuries were diagnosed in garrison non-deployed settings. However, due to the nature of combat operations, our Soldiers still have a higher likelihood of sustaining a TBI while deployed. Currently, there are no true diagnostic measures for concussion (also known as mild TBI) and no therapeutic treatments specific to TBI. For these reasons, the Army has invested in advancing the state-of-the-science and clinical care, while simultaneously using event-driven protocols to protect Soldiers from potentially concussive events. Army Medicine achieves this

through a comprehensive program consisting of five essential elements: (1) a mandatory education component; (2) one world-wide standard of care; (3) an expansive garrison clinical care program; (4) baseline neurocognitive testing of deploying Soldiers, and (5) a gap-driven research program.

To complement medical and research efforts, Army Medicine leverages policy to enhance knowledge and standardize management of TBI. One aspect of the policy targets education and training for non-medical Soldiers, and focuses on leadership actions that will protect Soldiers after a potentially concussive event. A second Army policy effort targets the medical community by creating one world-wide standard of care through standardized evaluations and the use of jointly developed algorithms and clinical tools. Clinically, the Army also built an expansive garrison care capability, which is inclusive of 47 validated TBI programs. Additionally, the Army supports the joint force as the manager of the pre-deployment computerized neurocognitive testing program.

Providing optimized treatment is a priority of Army Medicine, however in the case of TBI, our efforts cannot and will not stop there. In 2017 and beyond, the strategic aims of the Army TBI program will be to enhance care, increase the impact of TBI research, and continue to generate a force trained to optimize TBI management.

Translating Research into Policy

The Army has been a leader in behavioral health research and continuously uses findings to inform behavioral health care policy and improve clinical programs. Army research studies that have been published in leading medical journals over the last 10 years include studies of factors influencing barriers to care, natural disease progression, effectiveness and utilization of clinical tools, and studies of the overlap in physical and behavioral health concerns following traumatic brain injury during deployment. Army Medicine has developed and refined policies as a direct result of this research. In particular, guidance to Army health care providers on the assessment and treatment of PTSD has evolved as new insights have emerged. Research has also informed other key areas, such as Army and DoD programs to reduce stigma and improve access, Combat and Operational Stress Control doctrine and training, and BH services delivered in primary care clinics.

The Army's ability to optimize care for Soldiers who have experienced Traumatic Brain Injuries also depends on a sharp understanding of the state-of-the-science. In FY16 alone, the Medical Research and Materiel Command invested $78M towards gap-driven research which includes projects targeting various capabilities including an objective diagnosis of mild TBI, a triage capability for the combat environment, and development of individualized rehabilitation plans. The Army will continue to maintain a strong link between its researchers and clinicians to ensure Soldiers and their Family Members receive the best available care.

Conclusion

Senior Army leaders recognize the direct link between behavioral health care and readiness and remain fully committed to further improving the treatment provided to Soldiers and their Family Members. The enhancements and innovations achieved by Army Medicine could not have been accomplished through the civilian health care system. The Army has tailored its behavioral health care system to the specific needs of Soldiers and their Family Members and is overcoming barriers to care, such as distance and stigma. While major changes have been made and significant progress has been realized, more remains to be done.

The most problematic barrier to continued improvements in behavioral health care is the maintenance of a stable hiring environment for civilians. The large majority of professionals working in behavioral health clinics are government civilians. Approximately 15% of our staff turns over each year. The Army depends on a consistent hiring process to ensure that a sufficient number of providers are available to deliver evidence based care.

We are committed to continuing to improve the health and readiness of our Soldiers and their Family Members. We look forward to continue to work with Congress in this effort. I want to thank my partners in the DoD, the VA, my colleagues on today's panel, and Congress for your continued support.