Integrating Primary Care Behavioral Health in Remote Military Settings

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ABSTRACT

Active-duty military service members experiencing mental illness while stationed at geographically remote bases may encounter barriers to behavioral health treatment. The purpose of this quality improvement project was to increase access to on-site behavioral health diagnostic and treatment services for active-duty military personnel at remote Military Treatment Facilities (MTFs) by implementing and evaluating a variety of process improvements aligned with the Defense Health Agency's (DHA) quadruple aim initiative. Goals included improving individual medical readiness, organizational readiness (specialty behavioral health appointment availability), quality of care, patient experience, and reducing costs. The project followed a one group pretest-posttest design over three months at four military primary care clinics. Primary care behavioral health (PCBH) interventions included training and the use of tools provided through digital platforms for primary care providers and clinical personnel. Primary care providers completed surveys measuring self-efficacy with PCBH. Evaluated outcomes included patient satisfaction, cost, and individual and organizational readiness. Results: Nine providers completed pre– and post-implementation surveys. A paired samples t-test revealed clinically and statistically significant increased self-efficacy scores ($t = -2.612$, $df = 8$, $p = 0.031$); and Cohens $d = 0.87$, indicating a large effect size. Patient satisfaction scores remained unchanged at 100%. Individual readiness measures increased at one clinic and organizational readiness measures improved 8%. Behavioral health referrals, claims, and overall costs decreased by 11%, 26%, and 19%, respectively. Conclusions: PCBH interventions were associated with meaningful increases in provider self-efficacy, organizational readiness, and cost savings. Limitations included small sample size and loss to follow-up due to deployments and the COVID-19 pandemic.

INTEGRATING PRIMARY CARE BEHAVIORAL HEALTH IN REMOTE MILITARY SETTINGS

Compared to those serving in nonremote locations, active-duty personnel serving in geographically remote bases can be exposed to higher levels of occupational stress, social isolation, and extreme environmental conditions.[1] Service members may experience an increased risk of developing behavioral health symptoms while facing more barriers to treatment than service members in nonremote locations.1 Barriers to care occurring more frequently at remote Military Treatment Facilities (MTFs) include service members delaying care due to cultural stigma, scarcity of specialist services, organizational issues, and logistics.[1] Remote MTFs are defined as being in a low-provider-density area or more than a 30-minute drive from behavioral health services.[1]

Access to effective and timely medical and behavioral health services is critical to the national defense strategy of maintaining a military force that is both physically fit and mentally prepared to deploy.[2,3,4] Measures of individual medical readiness determine how physically and psychologically prepared a service member is to deploy for combat duty and measures of organizational medical readiness reflect how promptly an MTF responds to those seeking care.[2,5] An MTF's ability to provide timely behavioral health services for all service members who seek care is essential to individual medical readiness1,[4] Delays caused by barriers to treatment can negatively impact medical readiness at the individual and organizational level as service members are not seen until they have more severe symptoms and MTFs struggle to meet the demand for care with limited resources.[1,4]

MTFs, particularly those in remote locations, are challenged to find solutions to meet the organizational medical readiness standard requiring service members to be seen by a behavioral health specialist within 30 days of referral by a primary care provider.[1,5] Bray et al.[6] reported less than 50% of military personnel who sought behavioral health services were able to receive them, indicating MTFs have struggled to meet demand. Similarly, results from a survey presented to the Department of Defense by the Inspector General in 2020 indicated 53% of active-duty service members referred for behavioral health care by primary care clinics failed to receive them and urgent solutions to address barriers to care were needed to support the mission to maintain individual and organizational medical readiness.[7]

The purpose of this quality improvement project was to increase access to on-site behavioral health diagnostic and treatment services for active-duty military personnel at remote MTFs by implementing and evaluating a variety of process improvements. These improvements align with the Defense Health Agency's (DHA) quadruple-aim initiative

to improve individual medical readiness, organizational readiness, quality of care, patient experience, and reduce costs.[8] Project objectives focused on the patient experience of care, the number and cost of referrals, primary care provider self-efficacy in treating behavioral health symptoms, and individual medical readiness. The time frame for evaluation was three months post – implementation of the interventions. Objectives were stated as follows: (a) a 5% increase in patient satisfaction scores, (b) a 5% reduction in the number of referrals and cost of claims, (c) a 10% increase in behavioral health management self-efficacy scores (as a measure of quality of care), and (d) a 2% increase in individual medical readiness.

METHODS

This quality improvement project followed a one-group before-and-after design to implement and evaluate process improvements. DHA quadruple aim-aligned measures of quality, patient satisfaction, readiness, and efficiency were used to evaluate progress. Approval for the project was obtained from Washburn University's Institutional Review Board. For site approval, the project was deemed exempt due to not qualifying as human subjects research.

Setting and Participants

Four primary care clinics on three remote military bases in rural southern California serving approximately 13,370 active-duty servicemembers participated.[3,8,9,10,11,12] The project team included two psychiatric mental health nurse practitioner doctoral students, an active-duty psychiatrist, and two hospital corpsmen. Participants included primary care provider physicians, flight surgeons, and physician assistants. Independent duty corpsmen trained to practice primary care at MTFs were also included as participants.[13] Specialty providers, mental health specialists, PCBH-certified primary care providers, and non-DHA clinical consultants were excluded.

Primary care providers were identified as participants due to their central role as treatment initiators and gatekeepers for referrals. Though self-referral is an option, most active duty servicemembers seeking behavioral health treatment at MTFs see a primary care provider who provides treatment or places a referral for behavioral health specialty care.[2,14] Due to increased scarcity of behavioral health specialists in remote areas, primary care providers at remote MTFs may diagnose and treat mental illness more frequently, for longer periods of time, and with fewer resources than their colleagues in nonremote locations.[2,6,14,15] The most frequently treated mental illnesses treated in the primary care setting are depression, anxiety, and insomnia.[5]

Interventions

Primary Care Provider Training and Tools. Project interventions included the development and delivery of training sessions for primary care providers at participating sites. These sessions were delivered to primary care providers by the project team leaders during one–hour lunch and learn sessions. The sessions covered content on selecting, titrating, and switching psychotropic medications to treat anxiety and depression and administering non-pharmacological treatment for insomnia in the primary care setting. Didactic content was selected from DHAPCBH guidelines and a similar quality improvement project conducted by Amin and Thomas for Army primary care providers.[2,14,15]

Tools selected for training and implementation included the Primary Care Psychotropic Medication Decision Tool, Cognitive Mental Therapy for Insomnia (CBT-I) Tool, and the Brief Mental Treatment of Insomnia (BBTI) Tool. Vignettes were included during training to give participants the opportunity to practice applying these tools.

Primary Care Psychiatry Psychotropic Decision Tool. This tool was developed by Amin and Thomas in 2020 to assist primary care providers with prescribing medications for depression and anxiety.[15] It is a portable document file (PDF) with Adobe Acrobat-enabled hyperlinking software that guides primary care providers through selecting medications for depression and anxiety that are compliant with DHA PCBH guidelines, are approved by the TRICARE formulary, and provide options to weigh patient comorbid medical conditions and side-effect concerns when making medication selections.[15] Permission was obtained from the authors to use this tool for the project.

Cognitive Mental Therapy for Insomnia (CBT-I) Tool. This tool provides non–pharmacological treatment options for symptoms of insomnia, adapted to the primary care clinical environment.[16,17] It was designed to address cognitive and behavioral issues contributing to insomnia without using medications, as some patients do not want or are unable to take psychotropics for insomnia due to occupational demands.[16,17]

Brief Mental Treatment of Insomnia (BBTI) Tool. This tool is another non – pharmacological treatment tool to guide primary care providers in addressing behaviors specifically contributing to insomnia.[18,19] The BBTI is similar to the CBT-I, however, it requires less time to use and would be a preferred resource for busier primary care providers. It is designed to be delivered during a 30-minute session, over a course of four weeks.[18]

Hospital Corpsmen Training and Tool. The project team also developed a separate 30–minute training session for hospital corpsmen staffed at primary care clinics that covered how to

administer the Behavioral Health Measure-20 (BHM-20) to patients. The two hospital corpsmen members of the project team delivered this training, which included vignettes for staff to practice administering and scoring it accurately. The BHM-20 is a point-of-care screening tool assessing motivation, energy, and emotional distress; symptoms of anxiety, substance abuse, risk of self–harm, and depression; and life-functioning through relationships, work, school, and enjoyment areas.[20,21] The BHM-20 is included in DHA PCBH guidelines as a screening measure of mental wellness to initiate and normalize early discussions of mental health, and as a tool to guide treatment.[2,14] It is a concise and comprehensive psychometric screening and treatment effectiveness measurement tool, taking an average of two minutes to complete.[20,21] When used in three large military primary care settings, scores demonstrated adequate to very good internal validity and interrater reliability as a screening and PCBH treatment response tool.22

Outcome Measures

Data on quality, readiness, patient satisfaction, and efficiency were obtained before and three months after PCBH implementation of process interventions. The following outcome measures were used.

Quality:

Self-Efficacy for PCBH. The project team selected and used The Self-Efficacy for Mental Illness Management Scale, developed by Dr. Danielle Loeb and colleagues, to measure primary care provider self-efficacy with PCBH.[23] After developing and analyzing the scale, Loeb et al.[24] suggested the tool can be used to measure provider self-efficacy as a proxy for quality in managing mental illness and to evaluate the integration of PCBH. To test validity and reliability, investigators reviewed survey data from 402 primary care providers.[23] The Self – Efficacy for Mental Illness Management Scale demonstrated high internal consistency reliability (Cronbach alpha = 0.88), high internal validity, and good construct validity.[23] Dr. Danielle Loeb gave approval for the scale to be used for this project. The scale contains 10 items, using an 11 – point Likert scale, to assess provider confidence levels diagnosing and treating generalized anxiety disorder, depression, and bipolar disorder.[23] It also assesses provider confidence managing acutely suicidal patients, those with comorbid chronic medical and mental illness, and comfort level consulting a psychologist or a psychiatrist for cases of bipolar disorder.[23]

Patient Satisfaction:

Aggregate measures of patient satisfaction were retrieved from the Interactive Customer Evaluation Department of Defense reporting system. The DHA uses this survey to elicit consumer feedback for services.25 Consumer service questions are answered on a 5-point Likert-type scale and satisfaction questions are answered as a "yes or no" response.[25]

Readiness:

Individual Medical and Organizational Medical Readiness. To measure the project's impact on individual medical readiness at participating sites, the project team requested and obtained a percent change in total force medical readiness measures before and after implementation of process improvements. Total force medical readiness is reviewed quarterly by MTF leadership and represents the ratio of service members medically ready for deployment to the total population of service members at an installation.[26,27]

Similarly, the project team requested and obtained the percent change in organizational medical readiness data before and after implementation. Organizational readiness is represented by the number of available appointments for patients each month per mental health provider full–time equivalent and is compared to the total number of actual patient appointments completed.[5] This monthly aggregate productivity measure is reported as a percentage for psychologists and psychiatrists assigned to the MTF.[5]

Efficiency:

A report was requested and received through Health Net Federal Services that tracks measures of provider productivity, payment of claims, and service member use of managed healthcare programs, including TRICARE.[28] This report included the number of referrals from primary care to external behavioral health specialty care, the number of claims utilized, and the costs associated with these claims for external psychology and psychiatry services. A percent change between values before and after implementations was calculated.

Procedures

The PBI Network Model was selected by the project team to process elements of this quality improvement project.[29,30] The PBI Network Model is a framework developed to support implementing best practice in actively operating clinical sites.

Obtain Participant Consent and Assess Primary Care Provider Self-efficacy with PCBH. Written consent was obtained from primary care providers to receive training and take The Self-Efficacy or Mental Illness Management Scale.

Engage Stakeholders and Request Remaining Measures from Data Analytics Team. Primary care providers and leadership (stakeholders) were invited to informal discussions with the project team regarding their experience providing behavioral health services at remote clinical sites. Primary care providers conveyed interest in utilizing time-saving point-of-care resources and remote video teleconference for behavioral health consultation when needed.

Primary care providers also expressed interest in training but preferred brief, informal, and pragmatic presentations. After engaging stakeholders and participants, the project team requested pre-intervention measures of patient satisfaction, readiness, and economic impact data.

Select and Adapt PCBH Treatment and Screening Tools. The project team reviewed policies from the DHA, Department of Veterans Affairs, Psychological Health Center of Excellence, and the Uniformed Health Services University to locate clinical practice guidelines for PCBH treatment for anxiety, depression, and insomnia for implementation. Selected tools included the BHM-20, the Primary Care Psychiatry Psychotropic Decision Tool, CBT-I resource guide, and BBTI resource guide for training. This didactic content was developed into PowerPoint presentations for training primary care providers and hospital corpsmen. Implementation support resources were prepared to be emailed to participants at the conclusion of training.

Develop and Deliver PCBH Educational Sessions for Providers and Hospital Corpsmen. Training for primary care providers was implemented during the first two weeks of September 2021. The training sessions were led by the project team psychiatrist and nurse practitioner in person or remotely via video teleconference at each remote primary care clinic. Vignettes allowed primary care providers to practice using the medication decision tool.

During this time, hospital corpsmen attended one of several 30-minute training sessions offered on using the BHM-20. The sessions were delivered in person or via video teleconference format to all clinics by the project team hospital corpsmen. The goal of educating support personnel in addition to primary care providers was to reduce errors and improve uptake of PCBH guidelines at participating sites.[29]

Reassess Objective Measures Three Months After PCBH Process Improvements. Three months after implementation of PCBH process improvements, participants were invited to complete The Self-Efficacy for Mental Illness Management Scale a second time. The project team requested post-intervention measures of patient satisfaction, readiness, and economic impact data.

Data Analysis. Data were coded, cleaned, and analyzed using Statistical Package for the Social Sciences (SPSS) software. A paired samples t-test was performed to assess for a significant change in primary care provider mental illness management self-efficacy scores. An effect size (Cohen's d) was calculated to determine the magnitude of the mean differences in scores. The effect size was calculated as the mean difference divided by the standard deviation. A value of 0.2 was considered a "small" effect size, 0.5 a "medium" effect size, and 0.8 a "large" effect size. Measures of readiness, cost, patient satisfaction, and self-efficacy survey results were compared pre– and post-intervention assessing for percentage changes in these measures.

RESULTS

A total of 16 active duty primary care providers consented, completed the pre–implementation survey and received training. The sample included six physicians, two flight surgeons, three physician assistants, and five independent duty corpsmen. The mean score on the Self-Efficacy for Mental Illness Management Scale for the 16 participants was 6.3 (SD = 1.75). Nine of the participants completed the post-implementation survey. The remaining seven participants were lost to follow-up due to deployment and the COVID-19 pandemic.

The project objectives set targets for improvements in measures of patient satisfaction, efficiency, quality, and medical readiness at the participating MTF following implementation of process improvements. The first objective, for example, focused on improving quarterly patient satisfaction score by 5%. This objective was not realistic as the team soon learned that the Interactive Customer Evaluation scores measuring patient satisfaction were at 100% prior to the implementation and remained at that level across all sites.

The second objective focused on improvements in efficiency and established a goal to reduce by 5% the number of referrals from the primary care clinic to behavioral health treatment outside of the MTF and costs associated with claims resulting from those referrals. This objective was met. The number of referrals to outside psychiatry and psychology services decreased by 11%, the number of claims associated with referrals to psychiatry and psychology decreased by 26%, and costs related to psychiatry and psychology referrals decreased by 19%.

The third objective focused on improvements in quality with a targeted 10% increase in primary care provider self-efficacy scores in the practice of PCBH. This objective was met.

Mean primary care provider self-efficacy for mental illness management scores increased by 13%. A paired samples t-test (n = 9) indicated that the difference in mean scores was statistically significant ($t = -2.612$, $df = 8$, $p = 0.031$). The effect size (Cohen's $d = 0.87$) was large, indicating that the difference in mean scores was clinically meaningful.

The fourth objective focused on MTF individual medical readiness with a targeted 2% increase in organizational and individual medical readiness scores. The objective for organizational medical readiness was met. Measures of organizational medical readiness increased by 8%. The objective

for individual medical readiness was partially met. While individual medical readiness scores increased by 3% at one site, the scores declined by 8% to 25% at the other three sites.

DISCUSSION

Results of the project exceeded expectations. Quality, measured by proxy as self-efficacy, exceeded the targeted level of improvement at all clinics indicating that primary care providers were more comfortable implementing PCBH. Measures of individual readiness, or Total Force Medically Ready, were mixed, exceeding the goal of improvement at one clinic but not the other three. However, organizational medical readiness, or the availability of specialty behavioral health appointments, improved and exceeded the project's target. Patient satisfaction did not change, though it was at a maximum score prior to implementation of process improvements, indicating lack of negative impact. Data obtained through financial metrics were positive as cost savings occurred due to fewer claims for specialty behavioral health care, and minimal costs to implement the project.

The educational content in this current project was similar to the educational content in a project by Amin and Thomas;[15] however, it was delivered to smaller groups of providers over a shorter duration (one hour) and was implemented remotely via video teleconference in some cases. Like the Amin and Thomas results, provider self-efficacy improved following the educational sessions and training was implemented quickly and effectively in remote, operational environments.[15]

The pre-intervention mean scores of 6.3 on the Self-Efficacy for Mental Illness Management Scale obtained in this study were somewhat lower than the general primary care provider population (n = 402) mean of 7.1 (SD 1.4) obtained by Loeb et al.23 The MTF's lower scores may reflect self-efficacy of younger and less experienced providers as the current sample included six physicians, two flight surgeons, three physician assistants, and five independent duty corpsmen.

There were no studies measuring the impact of PCBH on individual or organizational readiness found for comparison. The measure of organizational medical readiness, as evidenced by mental appointment availability, exceeded the targeted objective level and may have been influenced by fewer referrals to specialty behavioral health.

The United States loses approximately $26 billion every year without the integration of behavioral health and primary care services.[31] The direct cost savings of behavioral health services retained within MTF primary care clinics are realized through the reduction of costs associated with referrals to specialty mental health services. Fewer referrals to mental health were associated with a lower number of claims and decreased costs to pay for those claims. The development and implementation of the educational sessions and the use of existing DHA resources allowed for significant savings to the MTF.

Other cost savings to the command included the potential reduction in emergency room and inpatient admissions.[31] Furthermore, integration of behavioral health and primary care services can improve adherence to preventative health measures, increasing the effectiveness of chronic disease management.[31] Patients with chronic disease and behavioral health comorbidities cost 50% more than patients without the behavioral health condition.[31] Only 25% of patients referred to behavioral health services attend their first appointment, so providing treatment in the primary care clinic likely improved access to behavioral health.[31]

Strengths of this project included stakeholder buy-in, participation, and on-site leadership facilitation of training sessions. Several clinical personnel volunteered to engage with the project and provided training, guidance, and feedback on the project's interventions. Strengths also included a strong theoretical framework developed for the DHA's implementation research network, and the DHA's efforts to provide high quality of care on a global scale, across military branches.

Limitations included the small sample size, lack of a comparison group, and use of a convenience sample which may not support high internal validity or protection from bias. While the sample originally involved 16 primary care providers, seven were lost to follow-up due to deployments and illness related to the COVID-19 pandemic. Poor internet connectivity during one video teleconference may have limited participant engagement during the sessions. The COVID-19 pandemic placed considerable demands on the availability of supplies, staff, and medical resources during the implementation of process improvements and may have also impacted outcomes.

Additional limitations may include the measures selected to target individual medical readiness, patient satisfaction, and provider self-efficacy. While convenient, they may have been too broad to capture the impact of the project's process improvements. For individual service members, a periodic health assessment includes an assessment of physical health, adherence to preventive occupational health guidelines like vaccination, and results from mental health screening tools to provide a comprehensive score of medical fitness for deployment.[3] Additionally, physical health scores may have been influenced by increased illness among service members who were exposed to COVID-19. The Interactive Customer Evaluation survey measuring patient satisfaction was also too generic, and The Self-efficacy for Mental Illness Management Scale did not include treatment

for insomnia, which may have failed to capture that aspect of PCBH.

Findings were disseminated in meetings with site leaders and stakeholders at an MTF hospital process improvement fair in February 2022. Discussions at the fair provided the opportunity for the project team to identify a new project champion and develop recommendations for continued implementation of PCBH at remote sites. The project team recommended that PCBH training be semi-annual and included as part of the orientation process for all primary care providers. They also recommended that PCBH training opportunities be extended to other MTFs, onboard ships, and other austere military operational and training environments. A third recommendation focused on the selection of additional outcome measures to evaluate the impact of PCBH on the utilization of crisis resources at participating sites. A fourth recommendation focused on evaluation of the consistency of providers in implementing PCBH and a fifth focused on the measurement of primary care provider satisfaction with PCBH. The MTF could use data obtained from the electronic health record to track these recommendations. For example, tracking utilization of the BHM-20 would provide insight into adoption of early screening of service members.

Other discussions focused on the measurement of individual mental health readiness scores using the DHA's Mental Health Data Portal,[32] instead of measures of individual medical readiness. This recommendation would provide data more likely to be impacted by these process improvements as well as providing valuable information regarding mental fitness for deployment.

CONCLUSION

In conclusion, PCBH interventions were implemented with a goal of increasing access to on-site behavioral health diagnostic and treatment services for active-duty military personnel at remote MTFs. Most project objectives were achieved. Three months following implementation, mean primary care provider self-efficacy for mental illness management scores increased by 13%, patient satisfaction scores remained stable at 100%, the number of referrals to outside psychiatry and psychology services decreased by 11%, the number of claims associated with referrals to psychiatry and psychology decreased by 26%, and costs related to psychiatry and psychology referrals decreased by 19%. Measures of organizational medical readiness increased by 8%, however, results of individual medical readiness scores were mixed. Individual medical readiness scores increased by 3% at one site, and declined by 8% to 25% at the other three sites. Recommendations focused on sustainability, expansion, and the use of alternative and/or additional outcome measures.

REFERENCES

1. Hepner, KA, Brown, RA, Roth, CP, Ruder, T, Pincus, HA (2021). Behavioral health care in the military health system: access and quality for remote service members. RAND corporation; 2021. Accessed July 30, 2023. https://doi.org/10.7249/RR2788.
2. DHA-PI 6025.27 Integration of Primary Care Behavioral Health into Patient-Centered Medical Home and other primary care services settings within the Military Health System. Defense Health Agency. Published October 18, 2019. Accessed March 10, 2021. file:///Users/DHAPI%20602527%20Integration%20PCBH%20Services%20into%20PC MH%20Signed%20101819%20(1).pdf
3. Rapley J, Chin J, McCue B, Rariden M. Embedded Mental Health: Promotion of Psychological Hygiene Within a Submarine Squadron. Military medicine. 2017;182(7):e1675-e1680. doi:10.7205/MILMED-D-16-00269
4. Curley, JM, Warner, CH. Improving awareness of behavioral health readiness. Military Medicine, 2017;182(7):1738-1746. https://academic.oup.com/milmed/article/182/7/e1738/4158568
5. DHA-IPM 18-001 Interim Procedures Memorandum 18-001, "Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in Medical Treatment Facilities (MTFs). Defense Health Agency. Published February 4, 2020. Accessed March 10, 2021.
6. Bray, RM, Engle, CC, Williams, J, et al. Posttraumatic stress disorder in U.S. military primary care: Trajectories and predictors of one-year prognosis. Journal of Traumatic Stress. 2016;29: 340-348. doi: 10.1002/jts.22119.
7. Inspector General U.S. Department of Defense. Evaluation of Access to Mental Health Care in the Department of Defense. DODIG-2020-112. August 10, 2020. Accessed March 10, 2021. https://media.defense.gov/2020/Aug/12/2002475605/-1/-1/1/DODIG – 2020-112_REDACTED.PDF
8. Defense Health Agency. Quadruple aim performance improvement process: Transforming performance improvement. Presented February 11, 2019. Accessed March 15, 2021. https://health.mil/Reference-Center/Presentations/2019/02/11/Quadruple-Aim – Performance-Process-Transforming-Performance-Improvement
9. Tricare.mil. Branch Clinics:Naval Hospital Twentynine Palms. Accessed February 2022. https://twentynine-palms.tricare.mil/Clinics
10. Militaryonesource.mil. Marine Corps Mountain Warfare Training Center. In-Depth Overview. Military Installations. Updated August 17, 2023. Accessed February 2022. https://installations.militaryonesource.mil/in-depth-overview/marine-corps-mountain – warfare-training-center-mwtc
11. Militaryoncesource.mil. Naval Air Weapons Station China Lake In-Depth Overview. Military Installations. Updated August 17, 2023. Accessed February 2022. https://installations.militaryonesource.mil/military-installation/naval-air-weapons-station – china-lake
12. Militaryonesource.mil. Twentynine Palms (MCAGCC) In-Depth Overview. Military Installations. Updated August 17, 2023. Accessed January 15, 2022. https://installations.militaryonesource.mil/in-depth-overview/twentynine-palms-mcagcc
13. OPNAV INST 6400.1D, MCO 6400.1A, NO93/HQMC HS. Training, Certification, Supervision, and Employment of Independent Duty Corpsman. U.S. Department of the Navy. Issued January 24, 2019. Accessed March 18, 2021. https://www.marines.mil/portals/1/Publications/MCO%206400.1A%20(OPNAVINST%2 06400.1D).pdf
14. DAD-MA 6025.1 Procedures Manual: Primary Care Behavioral Health standards. Defense Health Agency. Published December 20, 2019. Accessed March 10, 2021.

15. Amin, R, Thomas, MA. Effects of brief depression and anxiety management training on US Army division primary care providers. Military Medicine. 2020;185:719-723. https://academic.oup.com/milmed/article/185/5-6/e719/5716508.

16. Manber, R, Friedman, L, Siebern, AT, et al. US Dept of Veterans Affairs. Cognitive Behavioral Therapy for insomnia in Veterans: Therapist manual. Washington, DC: US;2014. Accessed August 10, 2021.

17. Perlis ML, Jungquist, C, Smith MT, Posner D. Cognitive Behavioral Treatment of Insomnia: A Session-By-Session Guide. Springer New York; 2005. doi:10.1007/0-387 – 29180-6

18. Elliman TD, Schwalb ME, Dolan D, Brim W, Adler AB. Brief behavioral treatment for insomnia: Treatment schedule and training feasibility in the military. Psychological services. 2022;19(2):335-342. doi:10.1037/ser0000528

19. Center for Deployment Psychology. Brief behavioral treatment of insomnia in primary care: Handouts. Updated 2019, Accessed August 20, 2021. https://deploymentpsych.org/system/files/member_resource/BBTI_Patient_Handouts_20 19_Revision_0.pdf

20. CelestHealth Solutions. Our Instruments. Updated 2023. Accessed August 15,2021. https://www.celesthealth.com/instruments.asp

21. Kopta SM, Lowry JL. Psychometric Evaluation of the Behavioral Health Questionnaire – 20: A Brief Instrument for Assessing Global Mental Health and the Three Phases of Psychotherapy Outcome. Psychotherapy research. 2002;12(4):413-426. doi:10.1093/ptr/12.4.413

22. Bryan CJ, Blount T, Kanzler KA, et al. Reliability and normative data for the Behavioral Health Measure (BHM) in primary care behavioral health settings. Fam Syst Health. 2014;32(1):89-100. doi:10.1037/fsh0000014

23. Loeb DF, Crane LA, Leister E, et al. Development and initial validation of primary care provider mental illness management and team-based care self-efficacy scales. Gen Hosp Psychiatry. 2017;45:44-50. doi:10.1016/j.genhosppsych.2016.12.005

24. Loeb DF, Leister E, Ludman E, et al. Factors associated with physician self-efficacy in mental illness management and team-based care. Gen Hosp Psychiatry. 2018;50:111-118. doi:10.1016/j.genhosppsych.2017.11.003

25. Defense Logistics Agency. Installation Evaluations: (DLA ICE) Updated 2023. Accessed November 2022. https://www.dla.mil/Installation-Management/Installation-Evaluations/

26. Health.mil. DHA Strategic Plan. Updated August 17, 2023. Accessed March 12, 2021. https://www.health.mil/About-MHS/OASDHA/Defense-Health-Agency/DHA-Strategic – Plan

27. Tanielian T, Farmer C. The US Military Health System: Promoting Readiness And Providing Health Care. Health Aff (Millwood). 2019;38(8):1259-1267. doi:10.1377/hlthaff.2019.00239

28. Health Net Federal Services. Committed to providing quality health care services. https://www.hnfs.com/content/hnfs/home.html.

29. Psychological Health Center of Excellence. Practice-Based Implementation Network Approach to Research Translation and Implementation in the Military Health System. 2019. Accessed March 10, 2021.https://www.health.mil/Military-Health-Topics/Centers – of-Excellence/Psychological-Health-Center-of-Excellence/PHCoE-Research-and – Analytics/Practice-Based-Implementation-PBIN-Network

30. Creason AH, Ruscio AC, Tate KE, McGraw KL. Accelerating Psychological Health Research Findings into Clinical Practice Through the Practice-Based Implementation Network Model. Mil Med. 2019;184(Suppl 1):409-417. doi:10.1093/milmed/usy298

31. Floyd P. Integrating physical and behavioral health: a major step toward population health management. Healthcare Financial Management. 2016;70(1):64-71.

32. Department of Defense. Section 729 of the National Defense Authorization Act or Fiscal Year 2016 (Public Law 114-92) Plan for Development of Procedures to Measure Data on Mental Health Care Provided by the Department of Defense. September 2016. Accessed December 9, 2021. https://health.mil/Reference-Center/Reports/2016/09/13/Plan-for – Development-of-Procedures-to-Measure