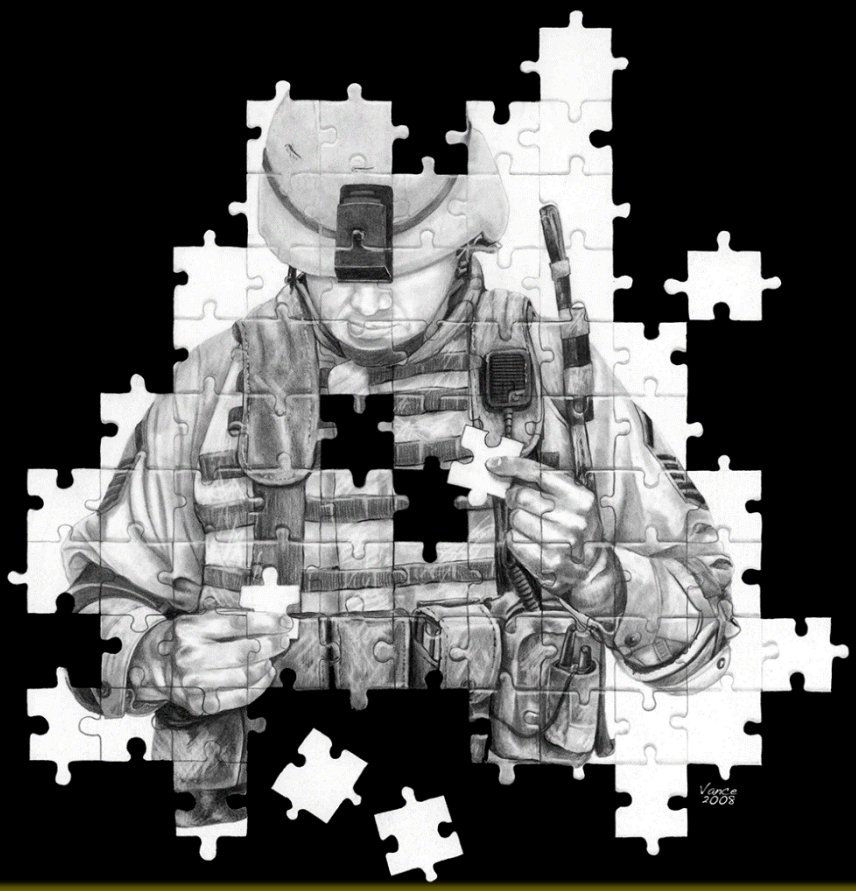
Lessons Learned Manual:

A Framework for Addressing Barriers to Evidence-Based Psychotherapy Utilization in the Defense Department

The Center for Deployment Psychology



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Lessons Learned Manual

This Lessons Learned Manual (LLM) was created as a means of consolidating the experience and knowledge base of Center for Deployment (CDP) staff regarding the challenges involved in expanding the use of Evidenced Based Psychotherapies (EBPs) in the Department of Defense (DoD). This LLM is a formal deliverable under the JIF grant and is primarily intended to inform the Champion-Consultants; however, others involved in efforts to implement EBPs may find these observations useful. The LLM identifies a number of challenges, barriers, and problems we have encountered in efforts to increase effective EBP utilization within the Military Health System (MHS). It is important to note that many of these issues will arise in other public and private clinical settings. In addition to listing the barriers, this LLM provides potential solutions to the problems and barriers that have been identified. Discussions of barriers to EBP utilization often focus on implementation issues, however, barriers can exist at several points along the continuum of utilization, including 1) Dissemination, 2) Implementation and 3) Sustainment, (see Figure 1).

Figure 1: Utilization Continuum

These points in the utilization continuum are defined as:

- Dissemination: The purposeful distribution of relevant information and materials to practitioners.
- Implementation: The adoption and integration of disseminated information and materials into actual clinical practice.
- Sustainment: The promotion and maintenance of programs that enhance mental health in an attempt to bring about meaningful behavioral change at the end of implementation, during which programs are expected to continue in the absence of external support.

In identifying the problems and barriers to EBP utilization, each point along the continuum was carefully considered. This version of the LLM represents CDP's current state of knowledge regarding barriers to EBP utilization. This LLM is considered a "living document" and is expected to grow and transform as additional information becomes available. The LLM will be updated and expanded periodically to provide additional information on barriers and the outcome of efforts to resolve the barriers through the use of tools developed and distributed through Champion-Consultants as well as other solutions that show promise for increasing the effective delivery of EBPs.

Center for Deployment Psychology

Established in 2006 and housed at the Uniformed Services University of the Health Sciences (USU), the Center for Deployment Psychology (CDP) is a tri-service training and education center. The mission of CDP is to train military and civilian psychologists, psychiatrists, social workers, mental health psychology interns/residents and other behavioral health professionals to provide high quality deployment-related behavioral health services to military personnel and their families.

On December 13, 2010, the Office of the Assistant Secretary of Defense for Health Affairs distributed a Memorandum entitled "Guidance for Mental Health Provider Training for the Treatment of Post-Traumatic Stress Disorder and Acute Stress Disorder." This document recommended that Department of Defense (DoD) mental health providers receive training in specific Evidence-Based Psychotherapies (EBPs) for acute stress disorder (ASD) and post-traumatic stress disorder (PTSD) consistent with DoD/Veterans Affairs (VA) clinical practice guidelines (2004, 2010). Military clinics were directed to seek the recommended EBP training and consultation from CDP.

Since its inception, CDP trained more than 1200 military mental health professionals through a two-week course on deployment concerns. This course includes workshops in the use of evidence-based psychotherapies for PTSD.

Additionally, more than 9,000 military and civilian providers have been trained in EBP techniques at CDP workshops throughout the country. The CDP website offers online workshops, schedules of live courses, and resources for providers, and attracts more than 10,000 online visitors every month.

Overview of Integrated Mental Health Strategies

Integrated Mental Health Strategy

Many patient care issues were brought to the forefront of the VA and the DoD's attention in 2007. The DoD and VA established a senior oversight committee, which was co-chaired by VA and DoD deputy secretaries. There were over 400 recommendations, many of which were Congressional mandates that focused on psychological health and traumatic brain injury issues. A joint DoD/VA Summit was held in October 2009 where explicit recommendations for the two agencies were put forward. One output of the Summit was the creation of an Integrated Mental Health Strategy (IMHS), which would serve to convert the broad recommendations into smaller actionable items.

The DoD and VA initiated the IMHS in 2010 and identified 28 Strategic Actions for development of implementation plans. This effort sought to advance an integrated and coordinated public health model to improve the access, quality, effectiveness, and efficiency of mental health services for service members, veterans, and their families.

IMHS Strategic Action #09

Strategic Action (SA) #09 aims to increase the availability of mental health professionals trained to deliver EBPs effectively to service members, veterans, and their families. In addition, it includes training a cadre of consultants within the DoD and VA who can support newly trained clinicians as they learn to deliver these therapies.

CDP has been key in meeting the goals set forth under SA #09. Under funding from the DoD, CDP has researched and developed trainings for multiple EBPs, including Prolonged Exposure and Cognitive Processing Therapy for PTSD, Cognitive Behavioral Therapy for Depression, Cognitive Behavioral Therapy for Insomnia, Suicide Assessment and Prevention, and Cognitive Behavioral Therapy for Chronic Pain. CDP has delivered these trainings to approximately 4,500 providers in the DoD over the last 3 years.

Another core function of SA #09 is the expanded use of consultation for these EBPs. Consultation is seen as important in promoting implementation, including implementation with fidelity, of new treatment

approaches. CDP staff has engaged in multiple lines of effort to increase the access to and utilization of consultation for EBPs.

Champion-Consultant Program

CDP started a new initiative as a follow-up to the work CDP completed under the VA/DoD IMHS, SA #9 effort, called the Champion-Consultant Program. This new program was funded by an award from the Joint Incentive Fund (JIF) supported by resources from DoD and VA. The intent of the JIF-funded Champion-Consultant initiative is to broaden dissemination and promote sustainability of EBPs across the DoD's Military Health System (MHS).

Under this program CDP will place mental health providers at each of 10 Military Treatment Facilities (MTFs) to serve as EBP Champion-Consultants. The EBP Champion-Consultants will champion the use of EBPs and provide ongoing consultation to providers using EBPs for PTSD and other deployment-related behavioral health conditions. The CDP will also train a cadre of decentralized consultants who will support additional providers and provide an infrastructure at these 10 MTFs for ongoing consultation in EBPs for PTSD. The planned roles for these Champion-Consultants are listed in the box to the right.

Besides the recruitment and placement of the 10 Champion-Consultants, the Champion-Consultant Program will develop numerous products designed to increase the utilization of EBPs throughout the DoD. These products will be part of a toolkit for clinic optimization, which focuses on increasing EBP utilization by addressing large and small-scale barriers to EBP utilization in the DoD. A key deliverable for the Champion-Consultant Program is this Lessons Learned Manual, which provides a framework for the development of the toolkit.

Champion-Consultant Roles

- Advocate for EBP Utilization
- Provide Consultation Services
- Perform Program Evaluation/Process Improvement
- Develop Toolkit Contents
- Coordinate with CDP

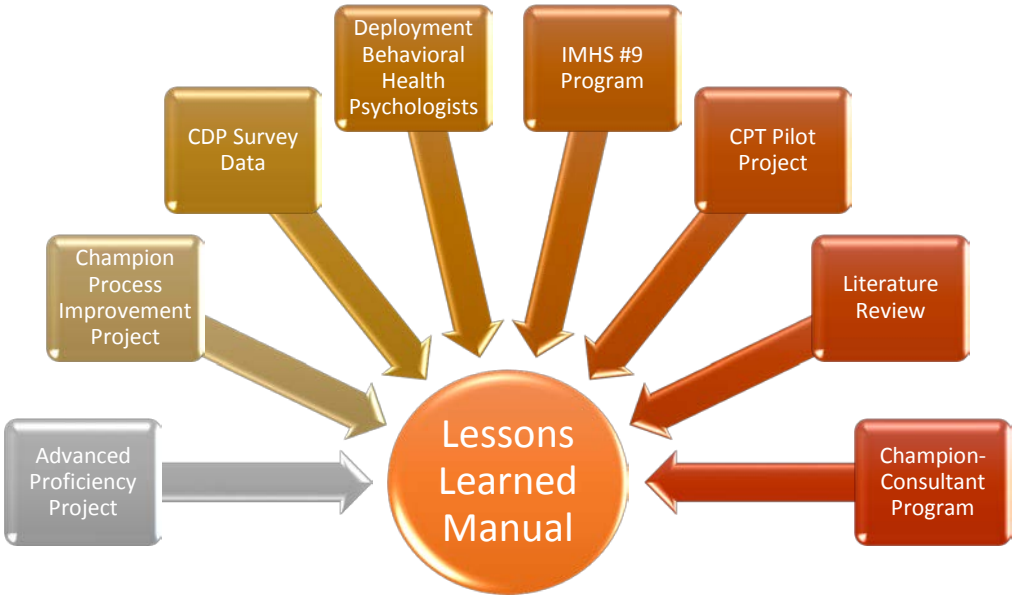
Sources for Lessons Learned

For almost ten years the CDP has been providing training and education workshops to DoD and civilian providers who care for service members, veterans and their families. Since its inception, CDP has initiated multiple programs and projects focused on training providers to use EBPs.

CDP internally classifies its efforts into programs and projects. CDP's programs are intended to be long-standing efforts that are focused on meeting a specific part of its mission over a number of years. The Center has also launched various projects over the last several years. CDP's projects are short-term, targeted efforts that have been employed to meet specific tasks or to provide data to answer specific questions relevant to its mission.

In generating the content for this LLM, CDP staff was able to draw heavily from the wealth of information and experiences accumulated through the various programs and projects that CDP has conducted. Information from all CDP programs and projects were incorporated into this LLM, but certain programs provided more information on the problems and barriers to EBP utilization in the DoD than did others. The primary sources of lessons learned for this manual came from the CDP activities that are depicted in Figure 2 and further described below:

Figure 2: Sources of Lessons Learned



Advanced Proficiency Project: This project involved a sustained outreach to specific DoD behavioral health providers to encourage them to engage in an ongoing consultation relationship. The aim was to determine if a focused effort on a small set of providers would lead to greater engagement in consultation.

Champion Process Improvement Project: This performance improvement project involved interviewing behavioral health providers at several Military Treatment Facilities (MTFs) about the use of EBPs at their sites and the barriers to increased utilization. The project was conducted as part of CDP's program evaluation efforts.

CDP Surveys of EBP Participants: CDP periodically conducts surveys of EBP workshop participants. These surveys reach a significant number of providers, who have supplied data on the degree of utilization of EBPs and barriers to utilization.

Deployment Behavioral Health Psychologist (DBHP) Program: This program is one of CDP's longest standing endeavors and involves placing a Psychologist Subject Matter Expert (SME) at all DoD Psychology internship sites. These DBHPs provide information on how care is delivered across 10 different MTFs.

IMHS #9/EBP Program: This program is conducted in conjunction with the Defense Health Agency (DHA) and the VA and involves providing training on various EBPs to DoD providers. The program also provides a consultation capability to providers who have attended EBP trainings for PTSD, Insomnia, and Depression.

Cognitive Processing Therapy (CPT) Pilot Project: This project was a partnership with a government agency in Montgomery County, Maryland that provides clinical services to trauma victims. The project was an attempt to increase the utilization of CPT within the agency. The project involved training counselors in CPT and providing a system for structured follow-up consultation.

Literature Review: CDP staff conducted a review of the literature on dissemination and implementation science to inform this manual and CDP's larger mission. While this literature review focused on the literature relevant to EBP utilization and military-specific factors, it also examined more general principles and procedures.

Champion-Consultant Program: The newest of CDP's programs, this effort involves the placement of Champion-Consultants at specific MTFs to advocate and facilitate greater EBP utilization. One of the primary inputs from the Champion Consultants was feedback on how the early versions of Clinic Optimization Toolkit items were received at their sites.

Lessons Learned: Barriers and Recommended Solutions

There are many challenges in translating and integrating an intervention into ongoing clinical practice along the continuum of dissemination, implementation, and sustainment. This LLM presents the lessons learned by CDP in the last several years regarding barriers to EBP utilization. Rather than simply listing and describing the barriers that were identified, this Manual also presents one or more suggested solutions to each barrier identified.

It is important to note that in providing these suggested solutions to barriers, CDP is not attempting to dictate policy or suggest that these solutions are the only means for addressing the barriers. The recommended solutions do represent our best ideas regarding how DoD may intervene to expand the utilization of EBPs within the MHS.

Many of the barriers identified are fairly specific and clear-cut, while others are more complex. The more complex problems, which have far-reaching impacts, are referred to in this Manual as "Systemic Barriers," while the less complex issues are simply referred to as "barriers."

The LLM presents at least one recommended solution to all identified barriers, including descriptions of potential products for the Clinic Optimization Toolkit. These suggested products cover a wide range of formats, including factsheets, podcasts, templates, formal trainings, new policies, and online rating tools. Clinics may choose to adopt these tools "off the shelf," modify to fit their specific clinic needs, use as a model for their own tool development, or ignore completely if better solutions are available.

Systemic Barriers:

The following section presents several issues that CDP personnel have identified as Systemic Barriers to EBP utilization. Each of these barriers is described in detail below, with suggested solutions and rationales in a one-page format. Identified Systemic Barriers include:

- There is no formal program for local EBP Champions within the DoD.
- There is a lack of clinic optimization in Military Health System facilities.
- Existing performance measures for most behavioral health services center on process measures and largely neglect objective outcome measures.
- There is no DoD-wide framework or methodology for measuring clinical outcomes, resulting in variation across and within Services in type and frequency of assessment.
- The DoD does not have a defined set of quality benchmarks to gauge performance across MTFs in terms of outcomes to allow identification of best practices.
- The DoD does not have a systematic means to assess fidelity for EBPs.
- There is no mandate for consultation within the DoD.
- DoD providers tend to use *ad hoc* consultation in lieu of systematic consultation.

Barrier: There is no formal program for local EBP Champions within the DoD
The VA has implemented a Champion-type system, with each health care facility having a designated EBP Coordinator. The VA EBP Coordinators have been a key component of the VA's efforts to widen the dissemination and implementation of EBPs for PTSD, Depression, Insomnia, and other behavioral mental health conditions.

	Recommendations	Rationale
1	Create a cadre of providers at MTFs around the nation to champion the use of EBPs. In addition to promoting EBP use, this group will provide data to further guide the adoption and implementation of EBPs throughout the MHS.	Adoption of new practices often requires a local Champion to be present to spearhead the dissemination and implementation of these practices. Local EBP Champions are central to the VA's successful rollout of EBPs at its medical centers. Additionally, creating dedicated time for this activity is deemed critical to success.
2	Translate the lessons and products from this effort into an EBP toolkit that can be distributed throughout DoD.	Having a toolkit of products that have demonstrated effectiveness in MTFs would speed up the adoption of EBPs throughout the DoD. The toolkit could be used by all MTFs. The off-the-shelf templates, forms, procedures, and trainings in such a toolkit would not only help increase the application of EBPs, but also move toward standardization across the DoD.

	Potential Toolkit Items
A	Champion-Consultant positions: CDP placed 10 Champion-Consultants at MTFs to serve as a demonstration for applying this concept in the DoD. Although a recent DoD report (RWTF, DoD, 2013) called for having EBP Champions at all MTFs, placing a full-time Champion at each MTF may not be logistically feasible based on the number of available clinicians. Based on the results from this demonstration program, the number of Champions could potentially be expanded using a variation of the program, such as using a tiered strategy based on a formula that incorporates the patient population and current degree of EBP utilization on site. Some sites may require a full-time Champion, while others may only require a part-time position. The efforts of the Champions should be coordinated by a central office that tracks innovations and ensures systematic dissemination of best practices and creates standardization across services. More specific strategies are expected to emerge as the demonstration project progresses.
B	Toolkit to enhance utilization of EBPs in the DoD: The initial group of DoD EBP Champion-Consultants will develop a toolkit that translates their experiences and lessons learned into concrete tools that can be shared across the DoD. Champions will provide feedback on the tools, tracking which items were useful across MTFs and making improvements to tools. This collection of factsheets, podcasts, training decks, and webcasts could eventually be made available as a web-based toolkit, which will allow access to all DoD and VA providers.

Barrier: There is a lack of clinic optimization in Military Health System facilities
For effective implementation of a large-scale change in practice to EBPs, it is vital to prime the environment. This includes having adequate time and resources to implement the change. The MHS has experienced an influx of new patients due to the high operational tempo of the forces, resulting in backlogs and increasing focus on access to care with less attention on the effectiveness of care provided through the MHS. Additionally, MHS clinics have been negatively affected by the frequent deployment and reassignment of military providers and the high turnover of contract providers at MTFs. Providers report that they do not feel that they have sufficient time to attend EBP trainings or to receive consultation and that their schedules (templates) are often too inflexible to accommodate EBPs. Improving efficiency at clinics and re-focusing on outcome metrics will provide time to adequately support providers as they incorporate EBPs into their practice.

	Recommendations	Rationale
1	Work to optimize the operational functions in behavioral health programs to ensure they are able to support a viable EBP implementation program.	As a result of the requirements that DoD mental health care providers face, the tasks of taking on new training and consultation can seem unmanageable.
2	Efforts to engage mental health providers in Government Service and contractor positions should prioritize candidates with existing EBP experience. Those without such experience should be required to complete EBP training (education plus consultation).	The system has an influx of new therapists that creates a natural opportunity to bring in providers already trained and familiar with EBPs for conditions such as PTSD. Targeting experienced EBP therapists will reduce training costs and ease the enterprise-wide transition to EBPs. DoD should also look to change policies in order to require these skills in contract providers or to allow them to more easily obtain training in EBPs.

	Potential Toolkit Items
A	Training on clinic optimization: This product will serve as a step-by-step guide to improve the operational effectiveness of behavioral health clinics and programs in the MHS. The training will provide the rationale and procedures for a series of changes to clinic practices as well as a business case for using EBPs over treatment as usual. Example topics include: conducting a needs assessment; aligning clinic services with population needs; optimizing the use of behavioral health technicians; implementing EBPs in group therapy; and using outcome measures for treatment planning and process improvement.
B	Supporting materials for clinic optimization: Materials to enable clinic and program leaders to rapidly integrate the changes recommended in the optimization training. Potential products include training for technicians on administering/scoring outcome measures, needs assessment surveys, group therapy tracking sheets/note templates, and templates for Standard Operating Procedures that clinics may adapt to formalize their changes to policies and procedures.
C	Support for enacting changes: A support team familiar with implementation challenges in the DoD care system could be available for discussion and coaching that is related to optimization strategies and procedures, including targeting EBP experienced therapists for new hires.

Barrier: Existing performance measures for most behavioral health services center on process measures and largely neglect objective outcome measures
Currently, many enterprise-wide process improvement projects in DoD behavioral health care center around process measures, including numbers of patients seen/RVUs generated, wait times for new intakes, and no show/cancellation rates. Although these measures are often easy to capture, they only address throughput in a system, not the quality or efficacy of care within the system. A true shift in care will require a shift in focus in order to place an appropriate emphasis on outcome measures.

	Recommendations	Rationale
1	Achieve a balance between process and outcome measures. While recent guidance calls for the Army's Behavioral Health Data Portal to be implemented in other Services, full use of this tool will require a shift in focus and attitude among providers and clinic managers.	While process measures are indicators of the functioning of a clinical service, they do not capture the quality of care received or the resulting outcomes of treatment. When clinics focus only on process metrics, they lack an overall picture of a clinic's functioning. By developing and sustaining a systematic focus on outcome measures, DoD can more easily assess and optimize quality as well as delivery of care.
2	Promote interest in outcome measures at the highest levels of DoD Leadership. The recent Institute of Medicine (IOM, 2014) report of behavioral health conditions in DoD also recommends this shift to outcomes assessment.	To create a culture change in the MHS, it is imperative to have a sustained commitment to and interest in collecting outcome data on patients and utilizing these data by providers, clinic managers, and policy makers.

Potential Toolkit Items	
A	"Off the shelf" process improvement projects: A series of process improvement projects will be developed to facilitate efforts of clinics and programs to systematically implement and improve scores on outcome measures. These standardized packages will include templates for project descriptions, timelines for completion, step-by step instructions for projects, and materials for strategic communications.
B	Business Case Analysis (BCA) for EBPs: This product will document the case for increased use of EBPs, relying heavily on the distinction between process and outcome measures of performance. A central idea behind the BCA is that the current focus on process metrics (patient throughput and wait times) actually costs the DoD money. DoD will reduce costs, as well as improve the lives of service members and their families, by refocusing attention to outcomes. This transition will naturally drive providers to use EBPs in their practice.

Barrier: There is no DoD-wide framework or methodology for measuring clinical outcomes, resulting in variation across and within Services in type and frequency of assessment
DoD mandated the use and tracking of outcome measures in 2013. However, implementation has been slow. As outcome data across all Services are generally unavailable, there is limited on-the-ground evidence for the superior efficacy of EBPs over Treatment as Usual (TAU). Increased visibility of EBP effectiveness is presumed to increase adoption. Each Service has developed initiatives to capture clinical outcomes, but these efforts are disparate in nature and are not universally applied, even within that individual Service. Recent guidance to the Services to adopt the Army's Behavioral Health Data Portal (BHDP) may help correct this issue.

	Recommendations	Rationale
1	Make it easier for MTFs to capture outcome measures by developing a series of tools for collecting and examining patient and clinic level outcomes data.	Although the BHDP will allow collection of outcome measures across the entire MHS in the future, it is not currently being implemented at all sites. To bridge this gap, tools can be developed that are consistent with BHDP reporting practices. This will allow providers to become familiar with the use of outcome measures and facilitate implementation of the BHDP.
2	Provide a framework for aggregating and acting on clinical outcomes data.	It is unproductive to collect data on patient outcomes if no action is taken based on the information. These data should inform and guide individual treatment decisions and be used at the clinic level to identify effective processes/interventions.
3	Use outcome data at the local level to recruit patients and providers into EBP utilization.	A frequently reported barrier to EBP utilization centers on beliefs that EBPs will not work with complex cases seen in the "real world." Such beliefs may be changed through education and training, but more powerful are data from the clinician's own clinic showing that EBPs work with complex cases.

	Potential Toolkit Items
A	Training decks on metrics: Expanding the use of patient and clinic level measures in DoD mental health care will benefit from training that provides an overview of the collection and utilization of outcome measures at the patient and clinic level. Specific guidance will be provided for using patient-level data to guide treatment planning and clinic-level data to guide process improvement projects. This training will recommend that clinics that have not been scheduled to adopt the BHDP begin collecting the same outcome measures as soon as possible.
B	Supporting products for training decks: This group of products will serve as a mini-toolkit for metrics and would include templates for storing data, standard operating procedures on data collection/storage, and competency checklists for administering and scoring outcome measures.
C	Local marketing tools for EBPs: These tools will consist of brochures and briefings for staff meetings that show declines in symptom levels of patients receiving EBPs.

Barrier: The DoD does not have a defined set of quality benchmarks to gauge performance across MTFs in terms of outcomes to allow identification of best practices
The inconsistent use of outcome measures across DoD clinics creates a significant challenge to evaluating the utility of particular programs and comparing effectiveness across programs and clinics. Without benchmarking outcomes, DoD leadership is forced to make decisions about program continuation based solely on anecdotal or process measures.

	Recommendations	Rationale
1	Develop a framework to assess and capture clinical programs' performance on process and outcome measures.	The DoD needs a common framework for assessing the effectiveness of clinical services to allow a comparative analysis of programs and clinics against each other in terms of both process measures (e.g., access to care and patient throughput) and outcomes measures (e.g., symptom reduction and return to duty rates).
2	Use this framework to locate best practices for dissemination to the rest of DoD. The program should have safeguards to ensure that clinics that are at the lower end of the performance spectrum are not publicly singled out, but instead receive necessary support to implement best practices.	Identifying and disseminating best practices across DoD sites will reduce the suffering of patients by providing more effective treatments earlier, and will decrease costs to the DoD in lost work and disability. In order to ensure that clinic/program managers use the system and report honestly, only programs that are achieving very high results should be highlighted and information on which programs are at the middle-to-low end of the spectrum should not be publically available.

	Potential Toolkit Items
A	Algorithm for clinic and program managers: Managers will be able to perform a self-rating of their services against a standardized set of criteria with clear anchors for ratings. This product will form the basis for the web-based system described below (B). Information on the number of patients receiving EBPs, the degree of fidelity to EBP protocols, the use of outcome measures, and similar domains likely would be included in the algorithm.
B	Web-based input system: Clinic and program managers will use this system to perform a self-assessment of clinic functions and outcomes. Clinic leaders will use the site to compare their clinic to their Service's and DoD benchmarks. In order to maximize the confidentiality and honest reporting of all clinics, this system will not allow direct comparisons of one clinic against another.
C	Create a team of personnel who can periodically review benchmark data and identify best practices: New and modified programs/processes arise across DoD sites through the energetic efforts of individuals and clinics. These programs need to be evaluated and improved. The clinics/programs should be officially recognized for creating and/or improving practice. Strategies for enterprise-wide dissemination of these new/improved practices should be developed.

Barrier: The DoD does not have a systematic means to assess fidelity for EBPs
A common finding regarding EBP utilization is that over time, some percentage of providers "drift" away from the protocol. In many instances, a provider may have to deliberately adapt the protocol to accommodate the constraints of the operational environment. For instance, a provider may shorten the time to complete the therapy or stretch out the time between sessions due to environmental limits or barriers. Currently, there is no system in place to assess the fidelity of interventions in the field and whether such variations have any impact on treatment outcomes.

	Recommendations	Rationale
1	Include measures of EBP fidelity in the algorithm for rating clinic/programs and include brief fidelity checks in peer review of charts.	A proven means of fostering adoption and sustainment of new innovations is to have them institutionalized (e.g., written into the organization's policies and incorporated into usual routines).
2	Utilize MTF Champions to periodically conduct fidelity checks as part of process improvement and program evaluation efforts.	MTF Champions will have training and experience in conducting fidelity assessments for various EBPs. Information on treatment fidelity can be used to evaluate programs and identify areas in need of improvement.
3	Relate clinic outcomes data to fidelity assessments.	If regular outcomes data are being collected, these data can be combined with information on fidelity to EBP protocols. This combination would allow DoD to determine the impact of protocol alterations (intentional or unintentional) on the efficacy of the therapy.

	Potential Toolkit Items
A	Rapid and easy-to-use fidelity assessment checklists: Fidelity assessment checklists that can be integrated into the progress notes templates will be available for commonly utilized EBPs, including Cognitive Processing Therapy (CPT), Prolonged Exposure Therapy (PE), Cognitive Behavioral Therapy for Insomnia (CBT-I), Cognitive Behavioral Therapy for Depression (CBT-D). Depending on provider needs in the MTFs, long and short versions of each checklist may be developed.
B	Draft language for incorporating fidelity assessment into chart reviews: This wording will allow a standardized assessment of fidelity to protocols in a rapid and easy-to-score manner.
C	Trainings for Champions on how to conduct fidelity assessments at their sites: This training will cover a variety of topics, such as how to use the standard fidelity assessment, how to address protocol variations, how to gain buy-in from providers on the assessment process, and how to act on the results of the assessments.

Barrier: There is no mandate for consultation within the DoD
The proportion of providers who actively seek consultation for EBPs is much higher in the VA compared to DoD. This discrepancy is likely due to differences in how the agencies have implemented training and consultation. The VA set forth institutional mandates requiring providers to participate in consultation for EBPs. The DoD recommends consultation, but does not mandate it. The absence of a mandate, coupled with additional barriers that DoD providers face, such as the lack of time in DoD provider schedules, has resulted in a low number of providers obtaining consultation.

	Recommendations	Rationale
1	Include measures of EBP fidelity in the algorithm for rating clinicians and programs. Include brief fidelity checks in peer review of charts.	Incorporating fidelity assessments in the evaluation process will encourage providers and clinic managers toward consultation in an effort to improve fidelity.
2	Use MTF Champions to conduct more in-depth fidelity checks as part of clinic/program process improvement and program evaluation efforts.	MTF Champions will have training and experience in conducting fidelity assessments for various EBPs, providing a local resource for supporting fidelity checks. Using a network of well-trained Champions will also serve to standardize the fidelity assessments.
3	Develop certification criteria for providing EBPs in the DoD that include consultation along with periodic re-certification.	Leadership and providers will develop an understanding of the learning connection between training and consultation if it is included in the overall training methodology.

	Potential Toolkit Items
A	White paper on delivering consultation within the MHS: CDP will develop a white paper covering a suggested framework for providing consultation for various EBPs that takes into account the unique operational, staffing and geographic concerns that the DoD faces. This paper will outline the potential for creating on-site "EBP generalist" Champions, as well as a national network of SMEs for the various EBPs who would be available to support the on-site Champions.
B	Factsheets and podcasts that address providers' misconceptions regarding consultation: Numerous mistaken beliefs exist regarding consultation that limit its use and prevent providers from benefiting from this useful training experience. Factsheets and podcasts will be developed to directly counter these misconceptions and help encourage the use of consultation, leading to enhanced patient care.

Barrier: DoD providers tend to use *ad hoc* consultation in lieu of systematic consultation
When DoD providers seek out consultation, it tends to be in an informal, *ad hoc* fashion, most frequently with colleagues at their own sites. Although such *ad hoc* consultation can help providers address specific (perhaps idiosyncratic) challenges in the use of EBPs with particular cases, it is not an adequate substitute for the systematic consultation recommended by the EBP protocol developers, particularly with regard to the goal of ensuring that treatments are delivered with fidelity.

	Recommendations	Rationale
1	Provide guidance and education on the advantages of formal/systematic consultation over ad hoc consultation.	Education on the advantages of systematic consultation and the distinction between this approach and *ad hoc* consultation would be designed to encourage providers to shift towards the use of more formal consultation.
2	Increase time available for systematic consultation by optimizing clinic functioning and including consultation as part of regular clinic activities.	If the DoD can encourage the widespread optimization of clinical care at mental health clinics, it will reduce the burden on provider time. Some of this time can be devoted to training and receiving consultation in EBPs.

	Potential Toolkit Items
A	Model scheduling template: This template will allow time for the correct implementation of EBP practice as well as for consultation. With correct scheduling, more time may be available to seek formal, ongoing consultation, as opposed to ad hoc consultation, which is often sought due to time constraints. By increasing the use of EBP groups within a clinic's weekly template, clinics can create the flexibility to allow for larger numbers of individual EBP sessions, as well as time to receive consultation for these therapies.
B	Webcast and in-person training: This training will outline the distinction between *ad hoc* and systematic consultation. The content for this training/informational briefing will include the value of systematic consultation in which providers benefit from a supportive relationship with their consultant while they are trained to fidelity.

Additional Barriers to Utilization

In addition to the systemic barriers reviewed above, a number of barriers were also identified that tended to impact specific aspects of the continuum of utilization. These more specific barriers are described below under the three headings: Dissemination, Implementation and Sustainment.

Dissemination

In this context, dissemination refers to the targeted distribution of the knowledge and development of skills required to effectively deliver EBPs. The goal of this effort is to move beyond awareness and initial training in the use of EBPs, towards a widespread proficiency in the use of EBPs. Within the DoD, there are barriers to achieving this goal that exist at the individual, clinic and system level. Table 1 outlines the barriers that we have identified and initial ideas for overcoming the identified barriers. The following section details and provides a rationale for suggested solutions and provides example toolkit items designed to facilitate execution of those solutions.

Table 1: Summary Table of Barriers to Dissemination

BARRIERS	RECOMMENDED SOLUTIONS
Providers are unable to travel to trainings due to new DoD travel regulations and limited clinic and program budgets cannot afford to provide toolkits and manuals for EBPs	• Hold EBP workshops on site at MTF clinics and ensure that local embedded providers are aware of the training • Increase availability and awareness of online training opportunities • Raise awareness of free EBP materials such as provider manuals and patient handouts
Clinic staff is not necessarily aware of EBPs or the trainings for them and training agencies do not have information on the training needs of individual sites	• Greater outreach to providers and DoD clinic leaders (potential lines of communication: EBP Champions, social media, newsletters, specialty leaders). This outreach should be coordinated with Service level and local level DPHs. • Develop and regularly update a comprehensive listing of MTF sites that have behavioral health treatment capabilities
Lack of support for EBPs by providers at sites	• Utilize regional consultants to build support for EBPs at sites • Develop a strategic communications plan to reach out to both the provider and patient populations
Competition with other therapies that lack strong evidence base, but are heavily marketed	• Work with DoD leadership to prioritize EBP dissemination over non-EBP therapies • Work with local clinics, commands, and patients to advocate for the delivery of EBPs and caution against potential limitations of using therapies that lack an adequate evidence base as a primary treatment approach
Insufficient time for providers to travel to trainings and receive consultation due to direct patient care, collateral duties, administrative duties, non-count patient care, and stringent training requirements	• Bring EBP trainings to clinics either in person or online • Develop model of training that more effectively fits into the requirements of DoD care provision • Implement the clinic optimization toolkit
Some providers attend EBP trainings and do not intend to practice what they learned	• Target training to providers who are most likely to incorporate the protocols into their practice, including interns and residents who are just beginning their clinical career • Require training participants to sign a training agreement which involves an acknowledgement that the provider will use the therapy in their practice as part of registration

Providers are unable to travel to trainings due to new DoD travel regulations and limited clinic and program budgets cannot afford to provide toolkits and manuals for EBPs
The Office of Management and Budget (OMB) recently enacted travel regulations to reduce spending on travel, conferences, and other agency operations. This set of regulations has created difficulties for many providers seeking trainings in EBPs, as travel requests are often denied. Behavioral Health programs likely do not have the resources to pay for travel and lodging for providers to attend training in EBPs.

	Recommendations	Rationale
1	Hold EBP workshops on site at MTF clinics and ensure that local embedded providers are aware of the training	By bringing the trainings to the MTF clinic, there would be no need for providers to travel. CDP and AMEDD already provide EBP trainings at no cost to MTFs; therefore, mental health program budgets will not be negatively affected.
2	Increase availability and awareness of online training opportunities	Online training allows providers to customize their own training experience. In addition to simply providing workshops in an online format, the training process could be fundamentally redesigned to capitalize on the flexibility of online delivery. Providers will be able to stay up-to-date on EBP trainings at their own convenience, which would significantly reduce disruption to their clinic responsibilities and schedules.
3	Raise awareness of free EBP materials such as provider manuals and patient handouts	Several EBP materials, such as CPT and CBT-D manuals are free to DoD facilities. Electronic versions of some EBP materials would help providers improve the quality of care at no cost to the facility.

Potential Toolkit Items	
A	On site EBP workshops at MTFs: CDP and AMEDD offer dozens of trainings every year in EBPs that are held at MTF sites in order to eliminate the costs of travel and lodging for MTF personnel. Alternative training hours could reduce the impact of the training on clinic services.
B	Listing of Workshops available to DoD providers: Creating a centralized listing of workshops that highlights trainings available both in person and online formats will increase awareness and attendance at workshops. Using platforms such as Adobe Connect and Second Life allows CDP to train numerous providers in a manner that dramatically reduces provider time away from patients and eliminates the need for travel.
C	Listing of free EBP manuals and support documents: A listing of the EBP materials that are available at no charge and where these documents can be obtained will raise awareness at the MTF level of what resources are available.

Clinic staff is not necessarily aware of EBPs or the trainings for them and training agencies do not have information on the training needs of individual sites
A disconnect may occur between training agencies and MTFs. For example, clinics will not request training if they are not aware of the agencies that provide free trainings for EBPs. Furthermore, training agencies may not reach out to locations in need of training if they lack familiarity with the site or cannot access the contact information for staff at a particular site.

	Recommendations	Rationale
1	Greater outreach to providers and DoD clinic leaders (potential lines of communication: EBP Champions, social media, newsletters, specialty leaders). This outreach should be coordinated with Service level and local level DPHs	A consistent, quality relationship between training agencies and clinic providers and leaders will enhance the flow of information needed and delivery of EBP trainings. As a result, identified training needs can be efficiently and effectively met.
2	Develop and regularly update a comprehensive listing of MTF sites that have behavioral health treatment capabilities	Creating and updating a listing of MTF behavioral health clinics with points of contact for these sites would greatly increase the ability to disseminate information about new trainings in EBPs.

	Potential Toolkit Items
A	Multi-center training calendar: A coordinated training calendar between CDP and other training organizations, such as AMEDD, will allow greater awareness of the types of training available. The calendar will also provide information regarding geographic distribution of trainings and can provide guidance to plan future trainings. This calendar will also provide a ready reference for dates and locations of upcoming trainings. The document could be available to POCs for behavioral health clinics/programs in the MHS.
B	Psychological Health Resource List: The list will be a publically available listing of all psychological health treatment venues in the MHS. This list of sites and POCs will allow rapid dissemination of information on obtaining EBP training.

Lack of support for EBPs by providers at sites
Providers may not support the use of EBPs for various reasons. They may have the perception that they are too busy to learn the EBP, lack awareness of the effectiveness and importance of utilizing EBPs, or carry other various misconceptions about EBPs.

	Recommendations	**Rationale**
1	Utilize regional consultants to build support for EBPs at sites	Champion-Consultants can assist with clinic optimization in order to create more time for clinicians to train in and become proficient in EBPs. Champions can also address misconceptions about and advocate regarding the effectiveness of EBPs among colleagues using formal and informal channels of communication. Advocacy efforts should be strongly coordinated with clinic leadership.
2	Develop a strategic communications plan to reach out to both the provider and patient population	Local Champions can raise awareness of the effectiveness of EBPs and help to increase support and demand for EBPs among providers and patients using outcome data and relevant literature. They can encourage command to express explicit endorsement of EBPs and include items related to EBPs on peer reviews.

Potential Toolkit Items	
A	Implementation plan: The Champion-Consultant project involves piloting 10 local EBP Champion-Consultants at MTFs around the country. The implementation plan for the pilot program can serve as a foundational document to guide MTFs should expansion be undertaken in the future.
B	Multiple toolkit items described under other barriers will address overcoming provider and patient barriers.

Competition with other therapies that lack strong evidence base, but are heavily marketed
There continues to be promotion of newly developing therapies that propose to treat conditions such as PTSD and depression. Many of these new therapies have been heavily marketed to providers within the DoD and VA. Typically, promotional efforts fail to indicate that these treatments are not considered first-line interventions and do not provide information regarding the evidence base for treatment efficacy or effectiveness with a military population. While some of these new therapies may eventually attain supporting evidence within the scientific community, at present they are not considered Level A treatment in the VA/DoD Clinical Practice Guidelines (CPG). Given the limited time providers have for training in new therapies, these non-EBP therapies represent a challenge to dissemination of established EBPs.

	Recommendations	**Rationale**
1	Work with DoD leadership to prioritize EBP dissemination over non-EBP therapies	By providing accurate information to DoD leaders on the evidence base of EBPs vs. emerging therapies, leadership would be better informed regarding the demonstrated efficacy of EBPs, which could help prioritize funding for EBP dissemination.
2	Work with local clinics, commands, and patients to advocate for the delivery of EBPs and caution against potential limitations of using therapies that lack an adequate evidence base as a primary treatment approach	Creating training materials and educational information about the therapies that compete with EBPs for interest and training within the DoD will shift the focus at the individual MTF level.

Potential Toolkit Items	
A	Training deck on complementary and alternative and emerging therapies: This training presentation will present information on complementary, alternative and emerging therapies that have been suggested for deployment-related psychological health conditions. The deck will present a balanced account of new therapies.
B	Factsheets on CAM/Emerging therapies: This series of factsheets will present descriptions of popular competing therapies for common behavioral health disorders seen in the military population. The factsheets will outline the origins, supposed mechanism of action, level of evidence, and a recommendation regarding use based on the scientific evidence.

Insufficient time for providers to travel to trainings and receive consultation due to direct patient care, collateral duties, administrative duties, non-count patient care, and stringent training requirements
Insufficient time for training is well documented across DoD facilities. Provider time away from the clinic can be difficult to arrange, especially en masse, due to provider schedules and responsibilities. It is more difficult for providers to attend trainings when there is significant travel time involved. Often, trainings that last two or more days interfere with major clinic activities.

	Recommendations	Rationale
1	Bring EBP trainings to clinics either in person or online	Currently, CDP offers EBP training opportunities to interested MTFs. Opening more training opportunities for EBPs would increase the number of providers able to provide EBPs, aligning treatments provided with recommendations from the DoD/VA. Other methods of learning, such as online trainings provide opportunities for learning and reduce cost and time away from the clinic.
2	Develop model of training that more effectively fits into the requirements of DoD care provision	Explore additional training models that fit better around patient care commitments (e.g. two hour blocks of training split over several days/weeks).
3	Implement the clinic optimization toolkit	By conducting various activities in the clinic optimization process, providers will have more time available in their schedules to attend trainings in new EBPs. This time must be protected from the addition of greater workload to preserve incentive.

	Potential Toolkit Items
A	On-site and online EBP workshops at MTFs: CDP and AMEDD offer dozens of trainings every year in EBPs. These trainings are held at MTF sites in order to eliminate the costs of travel and lodging for MTF personnel. CDP also offers several EBP trainings in an online format, which limits provider time away from patients and eliminates travel time and costs.
B	Draft curricula for new training models: Develop a draft for modifying and splitting currently developed workshops into smaller segments, which can be delivered over a longer period of time using smaller blocks of time (e.g., 2-3 hours per week). These new curricula would be able to leverage the full potential of online platforms to enhance the learning experience.
C	Clinic Optimization toolkit: The primary goal of the Clinic Optimization toolkit is to increase efficiency within MHS clinics. This increased efficiency will free up provider time, creating more opportunities for training in EBPs.

Some providers attend EBP trainings and do not intend to practice what they learned
Providers attend EBP trainings for a variety of personal and professional reasons. For example, some providers may attend solely to obtain continuing education credits, not intending to use the treatment, or simply to get a break from patient care. Some may have been required to attend by their command and may not be interested in learning about EBPs and hence may have no intention of practicing what they learn. This resistance may be due to the misconceptions providers hold about EBP effectiveness. Some providers may have previous learning incongruent with actual EBP practice. Others may believe that they are practicing the treatment to fidelity and would not benefit from refresher trainings.

	Recommendations	**Rationale**
1	Target training to providers who are most likely to incorporate the protocols into their practice, including interns and residents who are just beginning their clinical career	Growing a cadre of interested providers by targeting providers most likely to make a change in their practice will optimize training expenses. Clinics should identify early adopters and target other staff members who would influence fellow providers to adopt the practice after they are trained.
2	Require training participants to sign a training agreement which involves an acknowledgement that the provider will use the therapy in their practice as part of registration	Training agreements would require the provider to use a given EBP with a minimum number of cases after the training.

Potential Toolkit Items	
A	Best practices factsheet for scheduling trainings/selecting providers to attend EBP trainings: This factsheet will provide practical advice on selecting providers for attending EBP trainings.
B	Sample training agreement: A template for a training agreement will be created and made available at MTFs. This agreement would be signed by the provider and supervisor indicating a commitment to utilize the new treatment and actively engage in standardized consultation after the training.

Implementation

"Implementation" means the adoption and integration of disseminated information and materials into actual practice. As an increasing number of individuals are trained in the effective delivery of EBPs, the focus shifts towards making the use of EBPs a regular activity that is supported at all levels of the organization. Barriers to implementation are closely tied to the barriers to dissemination and in many instances grow directly from dissemination barriers. For example, when limited training resources are diluted by non-EBP focused training, it follows that provider time will be shifted to these non-EBP focused interventions. Additionally, at this level of the process, new barriers arise that impede implementation. Table 2 lists the specific barriers and suggested solutions.

Table 2: Barriers to Implementation - General

BARRIERS	RECOMMENDED SOLUTIONS
Insufficient time for providers to conduct EBPs	• Expand the availability of EBP groups and increase utilization of these groups when demand exceeds capacity for individual treatment • Manage high-utilizers and sub-clinical patient populations more effectively • Modify clinic scheduling practices when necessary to accommodate EBP care
Limited number of professionals adequately trained to provide consultation	• Increase awareness of consultation services available. Make remote consultation services more user-friendly to MTF staff in terms of hours and methods. • DoD should mandate having one EBP generalist consultant at each MTF. This person would be knowledgeable about the general principles of EBPs. • Expand the use of Train the Consultant workshops to qualified providers
EBPs often compete with complementary and alternative therapies, emerging treatments and Treatment as Usual (TAU)	• Work with DoD leadership to promote EBP practice as the first line treatment choice • Educate administrators, providers, and patients about the detailed process of obtaining empirical support for EBPs, the importance of such scientific data, and the limited support for alternative and emerging treatments • Collect metrics at the local level to assess the effectiveness of EBPs versus other treatments
Patients may not be interested in EBPs because they hold misconceptions about the treatment	• Provide accurate information to patients to build demand for EBPs • Provide therapists with tools to introduce and explain EBPs that maximize commitment to the treatment and target common misconceptions and concerns • Provide therapists with accurate information on the safety of EBPs while emphasizing the ethical responsibility they have to offer treatments that have demonstrated efficacy
Lack of consistent leadership support at sites due to rotations	• Have EBP use institutionalized into DoD and MTF policies • Create executive briefings for MTF leadership with the goal of making the Senior Leaders strong advocates of EBPs within their MTFs • Incentivize clinics and MTFs that adopt an EBP model for care delivery
Lack of understanding of EBPs from other disciplines (case managers, primary care) perpetuates poor understanding of EBPs with patients and limits referrals	• Target dissemination efforts to these related disciplines to raise awareness so patients will be better informed and prepared for EBP treatments • Disseminate information about EBPs directly to patients via unit briefings and through other sources such as chaplains

Some of the major variables to consider in the implementation of EBPs are the provider's perceptions of and attitudes about the EBP. There are many common misconceptions and attitudes towards the utilization of EBPs that must be addressed in order to gain the full support and participation of the leadership, provider, and patients. Table 3 below outlines these barriers. The following section provides greater details on addressing implementation barriers along with recommended toolkit items.

Table 3: Barriers to Implementation – Provider Beliefs

BARRIERS	RECOMMENDED SOLUTIONS
Some clinicians do not acknowledge Randomized Clinical Trials (RCTs) as the best method to establish efficacy	• Provide accurate information about the methodology used to establish the efficacy and effectiveness of an EBP • Collect and share data at the local level that exhibits the outcomes of EBPs versus Treatment as Usual (TAU)
Providers may feel that protocol-based care is rigid and "cookie cutter" (not customized) ignoring patient differences and compromising the therapeutic relationship	• Educate providers that most EBPs require extensive customization • Give examples of achieving a balance between flexibility and fidelity of treatment delivery, such as skipping/repeating sessions, including non-protocol sessions, etc.
Providers may have the assumption that EBPs are not effective with complex cases	• Educate providers about studies that have found EBPs to be efficacious for single or multiple problems and that symptom reduction for a targeted diagnosis is frequently associated with reduced symptoms of other diagnoses • Encourage providers to share stories about complex cases successfully treated with EBPs (in case staffing meetings or consultation groups)
Providers assume EBPs are too rigid to handle a patient crisis	• Train providers to use agenda setting to handle these situations more effectively • Train providers on how to deal with common crisis situations within an EBP framework
Providers may feel that the non-EBP treatment they already provide produces equivalent or superior outcomes compared to EBPs	• Use local outcomes data to compare efficacy of treatments to counter the subjectivity bias • Educate providers about the biases that can interfere with objectively evaluating therapy approaches
Provider tried the EBP but the patient's condition did not improve or worsened	• Encourage providers to look at the large body of evidence supporting EBPs and not base opinions on a single or small number of cases. Remind providers that if done properly, EBPs frequently prove to be efficacious. • Highlight the importance of seeking consultation • Use local outcomes data to compare efficacy of treatments
Providers may be concerned that positive treatment outcomes associated with EBPs will change disability compensation for their patients	• Educate patients and therapists about the real possibility that improved symptoms will lower the chances for high disability rating • Intervene early with service members to decrease the expectation of disability for conditions such as PTSD and depression
Providers may believe that widespread changes in current practice aren't feasible, particularly within the VA and DoD care systems	• Launch small scale demonstration projects to show that shifts to EBP practice can occur across multiple levels and in various facilities • Educate DoD providers on the successful rollout of EBPs in the VA and leverage lessons learned

Providers may believe there is no cure for PTSD and focus care on symptom maintenance	• Cite evidence demonstrating that service members diagnosed with PTSD have successfully returned to full duty status following EBP treatment • Collect data at MTFs to demonstrate that service members at that site can be successfully treated for PTSD and other mental health issues
Providers may assume that their clients will reject EBPs and will not participate actively in the treatment	• Increase demand for and commitment to EBPs within the patient population • Change the culture of MTF clinics to emphasize the efficacy of EBPs and establish them as the norm for care
Providers may believe that EBPs are not safe or tolerable, leading to sensitization, symptom exacerbation, or drop-out	• Educate clinicians on the studies demonstrating safety and tolerability of EBPs and discuss limitations of studies that suggest symptom exacerbation • Encourage providers to seek ongoing consultation after learning an EBP

Insufficient time for providers to conduct EBPs
Frequently, providers who are motivated to learn and practice EBPs note that a major impediment to starting or continuing these therapies is the lack of time. Sufficient time to learn and practice an EBP is needed to become more comfortable and proficient in the skill. Unfortunately, in most MTF mental health settings, providers are overwhelmed with cases, administrative demands, and other non-clinical responsibilities that limit available time to learn and practice a new therapy. Additionally, some of these therapies require more time than the standard 60 minute follow-up slot allows, making them even harder to adopt.

	Recommendations	Rationale
1	Expand the availability of EBP groups and increase utilization of these groups when demand exceeds capacity for individual treatment	Increasing the number of EBP groups will reduce the burden on provider panels, allowing more time for learning new therapies and seeking consultation. This will also allow for longer treatment protocol sessions.
2	Manage high-utilizers and sub-clinical patient populations more effectively	By identifying and better managing the sub-clinical population, providers can free up time to practice EBPs and seek consultation for their new skills. Group programs should also be developed for high-utilizers that reduce the burden on individual providers.
3	Modify clinic scheduling practices when necessary to accommodate EBP care	Modifying scheduling templates and practices to accommodate 90-minute sessions will support providers in implementing EBPs with fidelity.

Potential Toolkit Items	
A	Best Practices in EBP Groups deck & supporting handouts/templates: A cornerstone of the clinic optimization process will be expanding the use of EBPs in group format. The training on EBP groups and provision of group manuals will give clinic leaders information on how to rapidly expand the number of EBPs delivered within the clinic. Numerous supporting handouts will also be available to Clinic Managers.
B	Managing Patient Throughput deck: A training on how the clinic can manage the sub-clinical population (those who desire therapy, but are not symptomatic enough to require individual therapy) will give practical advice and techniques for handling this population, reducing unwarranted use of limited resources.
C	Draft template for establishing some 90-minute appointments in CHCS: Several clinics in the MHS have successfully implemented 90-minute appointments into their CHCS schedules. An information sheet that explains how these clinics have been able to implement these appointment practices will be made available for other sites to model the best practice.

Limited number of professionals adequately trained to provide consultation
EBP consultation is recommended, but not required within the DoD. The low prevalence of consultation results in many providers trained in EBPs not maintaining treatment fidelity when delivering care. CDP offers remote consultation for several EBPs; however, providers may prefer to utilize a consultant they know who is on staff at their own MTF.

	Recommendations	Rationale
1	Increase awareness of consultation services available. Make remote consultation services more user-friendly to MTF staff in terms of hours and methods.	CDP currently offers remote consultation for several EBPs, including treatments for PTSD, insomnia, and depression. DoD can develop and leverage new platforms such as phone based apps and online message boards to make these services more user friendly.
2	DoD should mandate having one EBP generalist consultant at each MTF. This person would be knowledgeable about the general principles of EBPs.	Having a consultant for EBPs located within each MTF will make EBP delivery more effective. DoD should consider implementing the model of having one consultant who is an EBP generalist rather than having one consultant for each specific EBP at every MTF. DoD could develop a national network of EBP SMEs who provide support to these on-site EBP generalists.
3	Expand the use of Train the Consultant workshops to qualified providers	CDP offers training in how to be a consultant for several EBPs. With additional resources, these trainings can be expanded in size and frequency for DoD providers interested and qualified to become consultants.

Potential Toolkit Items	
A	CDP fact sheet on consultation: Create a summary document that explains the free consultation services available to DoD providers and distribute to MHS providers. This document will list the EBPs that agencies provides consultation on, the times consultation services are provided, and the mechanisms by which consultation can be obtained (e.g., phone and e-mail).
B	White paper on delivering consultation within the MHS: CDP will develop a white paper covering a suggested framework for providing consultation for various EBPs that takes into account the unique operational, staffing and geographic concerns that the DoD faces. This paper will outline the potential for creating on-site "EBP generalist" Champions, as well as a national network of SMEs for the various EBPs who would be available to support the on-site Champions.
C	Implementation plan: The Champion-Consultant project involves placing ten local EBP Champion Consultants at MTFs around the country. The implementation plan for the pilot program can serve as a foundational document to guide future efforts to expand this program.
D	Consultant handbook: CDP runs multiple consultation workshops each year with specific information and materials for each workshop. CDP can create a handbook that consolidates generic information across these various EBP workshops into an easy-to-use introduction to serving as a consultant for EBPs.

EBPs often compete with complementary and alternative therapies, emerging treatments and Treatment as Usual (TAU)
Providers tend to employ the treatments with which they are the most familiar. Often, this is not an EBP and includes supportive counseling with some elements drawn from specific therapies. This is often referred to as treatment as usual (TAU). In addition to TAU, there are complementary and alternative (CAM) therapies such as yoga, reiki, tai chi and numerous emerging treatments, such as Somatic Experiencing, Tension Trauma Release Exercises, and Emotional Freedom Technique that are gaining popularity in the MHS. These other therapies can be appealing for a variety of reasons, but often have limited empirical support.

	Recommendations	Rationale
1	Work with DoD leadership to promote EBP practice as the first line treatment choice	EBPs should be promoted as the existing first line treatment to facilitate adoption. It is expected that providing accurate information to DoD leaders on EBPs and other therapies will lead to additional support for EBPs and prioritization of EBP dissemination.
2	Educate administrators, providers, and patients about the detailed process of obtaining empirical support for EBPs, the importance of such scientific data, and the limited support for alternative and emerging treatments	There is an overwhelming body of evidence that supports EBPs as the best treatment for behavioral health conditions. Educating administrators, providers, and patients about the empirical support for EBPs will facilitate a deeper understanding of the importance of utilizing gold standard treatments and encourage them to learn more about EBPs.
3	Collect metrics at the local level to assess the effectiveness of EBPs versus other treatments	Demonstrating greater symptom reductions and return to duty rates for patients treated with EBPs vs. TAU would help shift clinic practices and leadership attitudes towards the use of EBPs.

	Potential Toolkit Items
A	Training deck on complementary, alternative and emerging therapies: This training will present information on complementary, alternative and emerging therapies that have been suggested for common behavioral health disorders seen in the military population. The deck will cover the actual level of evidence for each of these therapies.
B	Factsheets on CAM/Emerging therapies: This series of factsheets will present descriptions of popular competing therapies for common behavioral health disorders seen in the military population. The factsheets will outline the origins, supposed mechanism of action, level of evidence, and a recommendation regarding use based on the scientific evidence.
C	Metrics I - patient level measures deck: This deck will outline how to start using patient level outcome metrics, largely centering on standardized scales (symptoms and global functioning) to evaluate the utility of a particular treatment with a particular patient.

Patients may not be interested in EBPs because they hold misconceptions about the treatment
Patients may develop misconceptions regarding the effectiveness of EBPs through a variety of sources including social media, peers, and misinformed providers. This represents a significant barrier if providers are not able to respond effectively to counter these beliefs. It is essential that clinicians understand the facts about these therapies and are able to communicate this in terms that patients can understand.

	Recommendations	Rationale
1	Provide accurate information to patients to build demand for EBPs	Providing information on the procedures and success rates of EBPs to patients should encourage patients to inquire about and request EBPs and encourage providers to offer them.
2	Provide therapists with tools to introduce and explain EBPs that maximize commitment to the treatment and target common misconceptions and concerns	As therapists' understanding and acceptance of EBPs grow, they will convey accurate information to counter patient misconceptions and concerns about EBPs.
3	Provide therapists with accurate information on the safety of EBPs while emphasizing the ethical responsibility they have to offer treatments that have demonstrated efficacy	A common misconception among providers is that some EBPs are unsafe. Accurate and credible information must be provided on its safety and benefits.

	Potential Toolkit Items
A	Factsheet on why you should ask your provider about evidence-based treatment: This patient factsheet will describe the importance of asking for EBP care when discussing care options with providers. Once patients understand the efficacy of EBPs, they will be more likely to ask for these therapies by name, creating a demand for the therapy.
B	Factsheet on myths about exposure and other therapies: These factsheets will directly counter the various misconceptions regarding various EBPs, including exposure therapy. Both patient and provider versions will be created in order to build both demand and acceptance for exposure-based therapies.
C	Myths and realities about EBPs deck: This training deck will counter myths about common EBPs, including EBPs that incorporate exposure therapy. It will expand on the factsheet content and is intended for providers who are reluctant to use these EBPs with patients.
D	Example scripts for introducing EBPs to patients: This tool will consist of several example ways of introducing EBPs to patients. The scripts will be drawn from the MTFs where Champion-Consultants have been placed and will represent the most successful introductions for the various therapies.

Lack of consistent leadership support at sites due to rotations
Military personnel rotate every 2-3 years, resulting in a constant flux of incoming and outgoing providers and leaders. This can lead to a lack of continuity in support for EBPs, particularly if requisite clinic procedures and policies are not in place. When a clinic changes leadership, the new clinic manager may or may not emphasize the use of EBPs as much as the prior clinic manager.

	Recommendations	Rationale
1	Have EBP use institutionalized into DoD and MTF policies	Having EBP use institutionalized into DoD and MTF policies can facilitate continued support for EBP use. Individuals within an organization will attend to and work to meet the set organizational standards.
2	Create executive briefings for MTF leadership with the goal of making the Senior Leaders strong advocates of EBPs within their MTFs	Demonstrating the effectiveness of EBP treatments and their impact on readiness issues, such as return-to-duty rates, as well as clinical efficiency/productivity measures will encourage leaders to support EBPs.
3	Incentivize clinics and MTFs that adopt an EBP model for care delivery	Provide incentives for providers, clinics and MTFs that have adopted a model EBP practice in behavioral health.

	Potential Toolkit Items
A	Standard Operating Procedures (SOP): SOP templates and/or written guidance regarding EBPs ensure that implementation and sustainment occur regardless of changes in clinic personnel, even as they become institutionalized. This may also involve developing and fielding a model peer review process that assesses the use of EBPs.
B	Business Case Analysis (BCA) for EBPs: This product will document the case for increased use of EBPs, relying heavily on the distinction between process and outcome measures of performance. A central idea behind the BCA is that the current focus on process metrics (patient throughput and wait times) actually costs the DoD money. The current system leads to large caseloads with little to no attention to recovery, a situation that leads to more time in treatment and poorer outcomes. DoD will reduce costs, as well as the amount of suffering and disability of service members and their families, by shifting its focus to outcome measures.

Lack of understanding of EBPs from other disciplines (case managers, primary care) perpetuates poor understanding of EBPs with patients and limits referrals
Case managers, primary care providers, and other professionals are often the first individuals to identify a mental health problem. They can be strong advocates and disseminators of accurate information to patients to prepare them for referrals for EBP treatment. If these providers hold misconceptions about EBPs, then they could be less likely to refer a patient to a clinic or therapist who practices EBPs.

	Recommendations	Rationale
1	Target dissemination efforts to these related disciplines to raise awareness so patients will be better informed and prepared for EBP treatments	These related disciplines often control access to care for patients needing help for mental health issues. Working to raise their awareness, reduce skepticism, and increase comfort level regarding EBPs will result in more referrals to these treatments.
2	Disseminate information about EBPs directly to patients via unit briefings and through other sources such as chaplains	Directly educating patients can increase referrals to EBPs, as patients who are fully informed will be more likely to ask for the therapies that have been shown to be effective.

Potential Toolkit Items	
A	Introduction to EBPs deck: This item will be a provider introduction to EBPs describing recommended treatments for PTSD and other deployment-related conditions. This training will be suitable for multiple audiences, including referral sources such as PCMs and case managers.
B	Factsheets and brochures for EBPs: Various factsheets and brochures for each EBP will be created to inform patients and providers about these therapies.
C	Factsheet on why you should ask your provider about evidence-based treatment: This patient factsheet will describe the importance of asking for EBP care when discussing care options with providers. Once patients understand the greater efficacy of EBPs, they will be more likely to ask for these therapies.

Some clinicians do not acknowledge Randomized Clinical Trials (RCTs) as the best method to establish efficacy
EBPs are defined as evidence-based largely on the basis of RCTs that demonstrate the efficacy of the treatment in a controlled manner. The fact that these efficacy studies are very carefully controlled leads some providers to believe that they would not have the same effect in a general population. Some clinicians in the MHS believe that RCT studies demonstrating an EBP's effectiveness do not generalize to military populations and others discount these types of studies based on a philosophical outlook that places more value on the individual provider's experience than on controlled studies.

	Recommendations	Rationale
1	Provide accurate information about the methodology used to establish the efficacy and effectiveness of an EBP	Therapists may sometimes practice on the basis of anecdotal evidence and utilize information that confirms their belief. Education regarding "real world" applicability can help counter resistance to RCTs and the concept of following a protocol as an effective means of treatment.
2	Collect and share data at the local level that exhibits the outcomes of EBPs versus Treatment as Usual (TAU)	After understanding the importance of RCTs, the collection and dissemination of data on treatment effectiveness from clinics will further strengthen the case for using EBPs for clinicians.

Potential Toolkit Items	
A	Factsheet on RCT myths: This factsheet will outline some common misconceptions about RCTs and provide corrective information to counter these misunderstandings.
B	Introduction to EBPs deck: This item will be a provider introduction to EBPs describing recommended treatments for PTSD and other deployment-related conditions. This training will educate providers on the scientific rigor of RCTs and how they are used to establish an evidence-base for a treatment.
C	Metrics I - patient level measures deck: This deck will outline how to start using patient level outcome metrics, largely centering on standardized scales (symptoms and global functioning) to examine the effectiveness of a particular treatment with a particular patient.
D	Metrics II - clinic level measures deck: This deck will explain how to collect and track clinic level outcome and process measures such as patient throughput, wait times for intakes, return-to-duty rate, and percentage of patients on limited duty. This deck will also describe how to translate results into changes in clinic procedures and practices.

Providers may feel that protocol-based care is rigid and "cookie cutter" (not customized) ignoring patient differences and compromising the therapeutic relationship
A common misconception among providers is that EBPs are strictly regimented protocols, devoid of any appreciation for the patient's individual presentation or the provider's therapeutic acumen. Hence, providers may feel that they cannot develop a proper therapeutic relationship with their patient since it is difficult to tailor the protocol to the patient's unique characteristics and traits.

	Recommendations	Rationale
1	Educate providers that most EBPs require extensive customization	Clinicians need to be taught that EBPs do actually require customization to fit the idiographic patient's needs, taking into consideration one's presenting concerns, cultural factors, and context.
2	Give examples of achieving a balance between flexibility and fidelity of treatment delivery, such as skipping/repeating sessions, including non-protocol sessions, etc.	Maintaining fidelity or consistency with the session's objectives while being sensitive to the patient's changing condition is key to success. Providing examples such as flexibility to titrate exposure or effectively ending treatment early will encourage providers to use EBPs.

Potential Toolkit Items	
A	Factsheet on myths about exposure and other therapies: These factsheets will directly counter the various misconceptions regarding various EBPs, including exposure therapy. Provider versions will describe how EBPs are not a cookie-cutter approach to therapy, but rather, flexible treatments that accounts for non-specific factors and countless patient presentations.
B	Training on common provider misconceptions about EBPs: This training will address several provider misconceptions regarding the use of EBPs, including the belief that they are inflexible and mechanical.
C	Common misconceptions about EBPs podcast: This podcast will present the information from the training deck described above in a virtual/on-demand format.
D	Treatment customization video: This video will outline the course and treatment of an individual involved in an EBP. The video will focus on how the protocol was adapted to meet the needs of the patient.

Providers may have the assumption that EBPs are not effective with complex cases
Some providers may think that the manualized approach of EBPs is geared towards uncomplicated presentations of disorders such as PTSD and depression. They may believe that EBPs work best for single diagnoses and disorders that have a narrowed symptomatology. Since co-morbidity is the norm rather than the exception within the DoD patient population, this would be a valid reason to avoid using EBPs with these complex cases if it were accurate. The data, however, suggests that EBPs for conditions such as PTSD and depressive conditions are actually efficacious even with complex cases, with the co-morbid conditions often showing improvements as well.

	Recommendations	Rationale
1	Educate providers about studies that have found EBPs to be efficacious for single or multiple problems and that symptom reduction for a targeted diagnosis is frequently associated with reduced symptoms of other diagnoses	If providers had a greater understanding of data supporting EBP's effectiveness for individuals with multiple issues, then they would be more apt to adopt EBP techniques.
2	Encourage providers to share stories about complex cases successfully treated with EBPs (in case staffing meetings or consultation groups)	When military providers hear about the benefits of EBPs in treating military patients from colleagues, there is a greater likelihood of shifting perceptions and utilization of EBPs.

Potential Toolkit Items	
A	Factsheet on myths about evidence based psychotherapy (provider version): This factsheet will directly counter the various misconceptions regarding EBPs.
B	Training on common provider misconceptions about EBPs: This training will address several provider misconceptions regarding the use of EBPs, including the belief that they do not work with complex cases.
C	Common misconceptions about EBPs podcast: This podcast will present the information from the training deck described above in a virtual/on-demand format.
D	Sample case presentations: A set of examples will introduce patients with complex case presentations and cover the use of and effectiveness of an EBP for their conditions. These can serve as a template for local providers who are preparing their own presentations.

Providers assume EBPs are too rigid to handle a patient crisis
Because EBPs follow a set protocol, handling a patient in crisis can be challenging for providers who are new to implementing EBPs. Mental health providers may feel uncomfortable when they have to go "off script" and attend to an individual in crisis during their individual or group psychotherapy session. Providers may believe that the structured EBP protocols do not adequately address patients in crises. Additionally, providers may believe that EBPs cannot be implemented if the patient lacks focus or brings too many issues to address in session while continuing with the protocol.

	Recommendations	Rationale
1	Train providers to use agenda setting to handle these situations more effectively	Agenda setting is a collaborative process between the therapist and patient to ensure that session time is maximized. Without an agenda, therapists may miss out on an important topic or devote too much time to a topic that is not a priority for a patient, leading to inefficient use of time, disruption of the therapeutic alliance, and/or early termination.
2	Train providers on how to deal with common crisis situations within an EBP framework	Individual crises can disrupt progress in individual and group EBP treatment. Training in crisis management can bolster a provider's confidence to meet the needs of the individual in crisis while covering the full session agenda. Setting accurate expectations for patients entering EBP treatment can also help decrease the need to manage these crises.

Potential Toolkit Items	
A	Factsheet on agenda setting: This will covers the benefits of setting an agenda and potential drawbacks of not setting an agenda in individual and group therapy. Tips and techniques on how to set an agenda tailored to the patient and how to incorporate crisis into the protocol will also be provided.
B	Training on common provider misconceptions about EBPs: This training will address several provider misconceptions regarding the use of EBPs, including the belief that EBPs do not allow you to respond to patients in crisis. This information will also be made available in a podcast.
C	Factsheet on what to expect from an EBP group: This factsheet will cover basic information on how EBP groups are run and set expectancies regarding the educational nature of this type of therapy.

Providers may feel that the non-EBP treatment they already provide produces equivalent or superior outcomes compared to EBPs
Behavioral health providers that have not adopted and implemented EBPs may believe that the current therapy they provide is equal or more effective than an EBP. Furthermore, information processing biases may lead providers to remember non-EBP cases that had positive outcomes and discount cases where TAU did not work. Other biases may include minimizing the benefits of standard treatment protocols, believing that the real agent of change is common factors (e.g., client-therapist alliance and therapist empathy).

	Recommendations	Rationale
1	Use local outcomes data to compare efficacy of treatments to counter the subjectivity bias	Regardless of the treatment being provided, outcome measures should be used for all patients to measure efficacy of treatment. This will provide the therapist with direct feedback on his or her treatment practices as well as the efficacy of EBP practices within the clinic.
2	Educate providers about the biases that can interfere with objectively evaluating therapy approaches	By directly explaining common biases in clinical practice and presenting evidence that counters these biases, providers may shift their practice patterns to EBPs.

	Potential Toolkit Items
A	SOP on the collection of clinic level measures: This SOP will describe how clinics might collect, store, and safeguard patient level outcome measures in order to compare EBPs to TAU.
B	Factsheet on the superiority of Evidence-Based Therapies over TAUs: This factsheet on EBPs vs. TAU will include a description of Level A recommended psychosocial treatments for PTSD, Depression, Insomnia, and Substance Use Disorders (SUD).
C	Training on common provider misconceptions about EBPs: This training will address several provider misconceptions regarding the use of EBPs, including those beliefs about the efficacy of EBPs. This information will also be made available in a podcast.

Provider tried the EBP but the patient's condition did not improve or worsened
Some therapists may abandon the use of EBPs too easily after having one or more patients not progress as expected in treatment. There are many reasons why providers can have less than desirable outcomes with patients. One cause may be a lack of experience with the protocol or implementing EBPs without fidelity, especially when first learning the EBP. The provider may also erroneously attribute a poor outcome to the protocol itself rather than considering therapist or patient factors. Poor follow through with consultation services after attendance of a workshop in EBPs may also lead to poor treatment outcomes with patients. Unfortunately, providers may overgeneralize an instance of poor results to all potential patients, even when there is strong empirical support for the effectiveness of EBPs.

	Recommendations	Rationale
1	Encourage providers to look at the large body of evidence supporting EBPs and not base opinions on a single or small number of cases. Remind providers that if done properly, EBPs frequently prove to be efficacious.	Providers new to implementing EBPs may feel disheartened when a patient does not meet his or her goals in therapy, leading to doubts about the overall effectiveness of EBPs. This may also negatively influence the provider's confidence in whether they can effectively implement the EBP.
2	Highlight the importance of seeking consultation	Therapists may overestimate their ability to implement EBPs with fidelity following workshops in EBPs. To fine tune skills and gain competency in EBPs, consultation is highly recommended. Ongoing consultation provides the opportunity to discuss challenges in application, solve problems, and learn from treatment non-responders.
3	Use local outcomes data to compare efficacy of treatments	Outcome measures should be used for all patients to measure efficacy of treatment. Clinics that use outcome measures will have a large body of evidence that EBPs do generally work with cases. This information can be used to counter provider beliefs that the EBP does not work after a clinician has a non-responsive patient.

	Potential Toolkit Items
A	Introduction to EBPs deck: This deck will be a provider introduction to EBPs describing recommended treatments for PTSD and other deployment-related conditions.
B	Barriers to consultation deck: This deck will counter myths about seeking consultation and emphasize the value and need for consultation to increase competencies in EBPs.
C	Training on common provider misconceptions about EBPs: This training will address several provider misconceptions regarding the use of EBPs. It will address the fact that some providers stop practicing EBPs due to past treatment failures. This information will also be made available in a podcast.

Providers may be concerned that positive treatment outcomes associated with EBPs will change disability compensation for their patients
Some providers fear that if they provide EBPs, then their patients' current or future disability compensation will be lowered. It is true that the provision of EBPs may reduce symptoms, resulting in clients no longer meeting criteria for their disorder. This would obviously influence a person's disability evaluation. Hence, some therapists avoid using EBPs in the interest of protecting the patient's ability to receive disability compensation. Encouraging a patient to use a less efficacious treatment in order to maximize a patient's disability level raises ethical concerns and should be discouraged.

	Recommendations	Rationale
1	Educate patients and therapists about the real possibility that improved symptoms will lower the chances for high disability rating	Therapists should have a better understanding of the potential positive and negative consequences associated with the provision of effective EBPs. Through education, patients can make an informed choice regarding the benefits and potential costs of engaging in EBPs before entering into a treatment contract with a mental health provider.
2	Intervene early with service members to decrease the expectation of disability for conditions such as PTSD and depression	Many disorders, such as PTSD and depression, are treatable conditions from which many patients will recover; however, many service members erroneously believe that these conditions automatically lead to permanent disability compensation. Education prior to clinical intervention is essential to decrease the expectation of disability compensation for such conditions.

	Potential Toolkit Items
A	Training on common provider misconceptions about EBPs: This training will address several provider misconceptions regarding the use of EBPs, including the belief that since EBPs should be avoided since they may affect a patient's disability compensation. This information will also be made available in a podcast.
B	Factsheet on asking your provider about EBPs: This factsheet will educate patients on why they should ask providers about the EBPs and discuss the expectation for a full recovery from conditions such as PTSD and depression.
C	Training on informed consent: This training will be on the informed consent process and how it educates clients about the potential risks and benefits of participating in treatment.

Providers may believe that widespread changes in current practice aren't feasible, particularly within the VA and DoD care systems
The task of integrating EBPs into the current practice of behavioral health providers across the DoD is a worthwhile but difficult endeavor. Many providers may believe that the VA and DoD are too large and too bureaucratic to undergo such a systemic change. Many of these providers have seen other attempts to institute change come and go, with little actual impact on the system of care. These providers may look at all efforts to integrate EBPs into regular practice as a pointless exercise and therefore do not support these efforts.

	Recommendations	Rationale
1	Launch small scale demonstration projects to show that shifts to EBP practice can occur across multiple levels and in various facilities	To facilitate widespread adoption of EBPs, smaller scale projects that demonstrate the successful implementation of EBPs into practice are needed to debunk misconceptions that systems are too resistant to change. Demonstration projects will provide an opportunity to identify barriers, learn from mistakes and resolve problems before practices are implemented on a larger scale.
2	Educate DoD providers on the successful rollout of EBPs in the VA and leverage lessons learned	Many DoD behavioral health providers may not be aware that the VA has already successfully rolled out and adopted EBPs in their system. Practitioners may be more open to change if they are aware that other large organizations have been able to successfully adopt EBPs system-wide. Lessons learned from the VA can be leveraged to increase likelihood of success in the DoD.

	Potential Toolkit Items
A	Final report from Champion-Consultant project: The Champion-Consultant program serves as a demonstration project within the DoD. The final report, which will summarize the results of this project, will include information from ten sites that show changes across a range of outcomes and may help to counter the belief that the DoD cannot change.
B	Introduction to EBPs deck: This deck will be an introduction to EBPs for providers and will describe recommended treatments for common psychological health conditions in the DoD. It will also discuss how the VA has successfully implemented EBPs.

Providers may believe there is no cure for PTSD and focus care on symptom maintenance
There are numerous case examples of service members being treated successfully for PTSD, depression and other mental health disorders and returning to full duty status. Despite this, there is a relatively widespread belief that combat-related PTSD cannot improve to the level that a service member can be deemed fit for full duty. There is ample evidence showing that those who actively engage in trauma-focused EBPs for PTSD experience greater symptom reduction and functional improvements than those who do not receive treatment or engage in non-EBP treatments. Unfortunately, when misinformed providers believe that there are no treatments that can effectively treat PTSD, they are more likely to take a symptom maintenance approach to care.

	Recommendations	Rationale
1	Cite evidence demonstrating that service members diagnosed with PTSD have successfully returned to full duty status following EBP treatment	For providers who have relied upon supportive counseling or TAU, it may seem that PTSD does not resolve. Dissemination of evidence that demonstrates that these conditions are treatable with EBPs in a relatively short period of time is needed to increase knowledge and possibly motivation to implement EBPs.
2	Collect data at MTFs to demonstrate that service members at that site can be successfully treated for PTSD and other mental health issues	Tentative clinicians may believe that EBPs do not work with patients in the military or specifically at their clinic. Outpatient mental health clinics can demonstrate the effectiveness of EBPs by collecting outcome data for program evaluation.

Potential Toolkit Items	
A	Training on common provider misconceptions about EBPs: This training will address several misconceptions providers have regarding the use of EBPs, including the belief that PTSD does not resolve with any treatment. This information will also be made available in a podcast.
B	Metrics II - clinic level measures deck: This deck will explain how to collect and track clinic level outcome and process measures such as patient throughput, return-to-duty rate, and changes in symptom levels. Such data can demonstrate that PTSD is actually a treatable condition that patients recover from.
C	SOP on the collection of clinic level measures: This SOP/OI will specifically outline how clinics should collect, store, and safeguard patient level outcome measures. Such information will help to make comparisons between EBPs and TAU.

Providers may assume that their clients will reject EBPs and will not participate actively in the treatment
Providers may believe that there is limited demand for EBPs from their patients. They may also hold the belief that EBPs are too academic for the military; e.g., EBPs requires active engagement and completion of practice assignments outside of the therapy session. In addition, providers may assume that patients do not want to participate in any therapies that involve revisiting traumatic memories or situations, which is a core component of many PTSD EBPs.

	Recommendations	Rationale
1	Increase demand for and commitment to EBPs within the patient population	Patients asking for EBPs by name will directly counter the misconceptions some providers hold regarding the lack of acceptability for these therapies. Educating potential patients about EBPs and encouraging them to ask for these therapies will help increase their use.
2	Change the culture of MTF clinics to emphasize the efficacy of EBPs and establish them as the norm for care	Through advocacy, EBPs can become the standard of practice and the norm of care across DoD mental health clinics, as opposed to something implemented by a few select providers with limited support from leadership.

	Potential Toolkit Items
A	Factsheet on asking your provider about EBPs: This factsheet will educate patients on why they should ask providers about EBPs and the expectation for a full recovery from conditions such as PTSD and depression. Local outcome data can be used in conjunction with this factsheet to communicate the availability and effectiveness of particular treatments available in that setting.
B	Example scripts for introducing EBPs to patients: This tool will include several ways of introducing EBPs to patients. The scripts will be guided by the experiences of Champion-Consultants that have been placed in MTFs and will reflect the most successful introductions for the various therapies.
C	Training on pre-treatment strategies for EBPs: Incorporating training on the importance and application of pre-treatment strategies to help clinicians increase client commitment to therapy.

Providers may believe that EBPs are not safe or tolerable, leading to sensitization, symptom exacerbation, or drop-out
Some mental health providers may mistakenly believe that EBPs are unsafe or intolerable for patients. For example, providers may fear that discussing previous traumas in detail may exacerbate symptoms or lead to increased dropout rates. These misunderstandings may reflect a lack of experience with the treatments or understanding of the theoretical grounding and research supporting EBPs. This misunderstanding may cause providers to be reluctant to engage in trauma-focused therapy with patients.

	Recommendations	Rationale
1	Educate clinicians on the studies demonstrating safety and tolerability of EBPs and discuss limitations of studies that suggest symptom exacerbation	Citing studies that demonstrate the safety and tolerability of EBPs and identifying the limitations of studies that suggest symptom exacerbation will challenge providers' misconceptions about EBPs.
2	Encourage providers to seek ongoing consultation after learning an EBP	Ongoing consultation provides the opportunity to discuss any concerns providers may hold regarding the therapy and also address challenges in application to minimize dropouts from therapy.

Potential Toolkit Items	
A	Training on common provider misconceptions about EBPs: This training will address several provider misconceptions regarding the use of EBPs, including the belief that these therapies may be unsafe or not tolerated well by patients. This will also be available as a podcast.
B	Training on pre-treatment strategies EBPs: Incorporating training on the importance and application of pre-treatment strategies to help clinicians increase client commitment to therapy.
C	Video series on managing distress: Since increased distress is one of the major concerns of the provider, this video series will discuss how to manage distress in session.

Sustainment

Sustainment is promoting and maintaining programs at the end of implementation during which programs are expected to continue in the absence of external support. Barriers from the first two phases accordingly impact the ability to maintain and sustain the program. The rapidly changing environment of a DoD mental health clinic presents unique challenges in encouraging and sustaining the implementation of EBPs. Knowledge and empirical evidence alone about EBPs are not sufficient to promote and maintain their use. Table 4 provides a listing of potential barriers to sustainment and suggested solutions, followed by a detailed review that includes recommended toolkit items.

Table 4: Barriers to Sustainment

BARRIERS	RECOMMENDED SOLUTIONS
Providers who have been trained in EBPs leave the MTFs	• Utilize CDP and AMEDD's free trainings to increase the number of staff with capability to provide EBPs • Expand participation in Train the Consultant model to create a larger pool of experts • Leverage telehealth resources to provide coverage to sites with gaps • Replace providers who leave Government Service and contractor positions with providers who have EBP experience
Support for EBPs can change when a new clinic leader arrives	• Have EBP use institutionalized into DoD and MTF policies • Create executive briefings for MTF leadership, making the Commanding Officer/Hospital Commander a leading advocate of EBPs within their MTF • Train DoD clinic managers in the clinic optimization process and the central role EBPs hold in that process
Sites lose consultation support for EBPs	• Expand participation in Train the Consultant model to create a larger pool of experts • Utilize CDP's phone consultation for EBPs and allocate this time in the providers' templates • Establish a DoD network of consultants for various EBPs, including a pool of consultants for PE, CPT, CBT for Depression, etc. • Establish local EBP Champions who are familiar with the general EBP principles
Clinic shifts away from EBP-focused care to some other model due to competition with emerging models of care with insufficient empirical support	• Have EBP use institutionalized into DoD/MTF policies • Create briefings for Service members and line commanders about the benefits of EBPs • Track outcome measures to determine whether there is a change in results due to a shift away from EBP-focused care • Clinics should approach shifts away from EBP-centered approaches using a process improvement framework
Providers drift away from protocols over time, using only parts of the EBP protocol	• Encourage routine use of protocols via refresher trainings and consultation • Encourage routine use of fidelity assessments and measure impact of changes on outcomes when adapting protocols • Create accountability with MHS-wide outcomes monitoring and reporting of outcomes • Encourage peer review and/or consultation to facilitate fidelity to the treatment protocols as well as periodic review of fidelity with an expert consultant

Clinics do not have the resources (funding, staff) to sustain EBP use and promotion	• Modify the culture/business model for DoD behavioral health clinics to increase the use of EBPs • Place EBP Champions at MTFs to advocate for EBP use, optimize clinics, and provide EBP consultation • Train DoD clinic managers in the clinic optimization process and the central role EBPs hold in that process

Providers who have been trained in EBPs leave the MTFs
Staff turnover within MTFs is an unfortunately common occurrence. While there has always been a steady amount of turnover for active duty military providers, who complete a permanent change of station (PCS) every two to three years, other types of providers leave frequently as well. Contract providers are notoriously subject to turnover. Government service providers were traditionally a steadying influence; however, in MTFs where morale is low, retaining these providers can be quite difficult. When these various types of providers leave, they take their EBP knowledge and experience with them, creating gaps in a clinic's ability to sustain the delivery of EBPs.

	Recommendations	Rationale
1	Utilize CDP and AMEDD's free trainings to increase the number of staff with capability to provide EBPs	CDP and AMEDD offer free on-site trainings in EBPs to interested MTFs. CDP has also developed online EBP trainings. These trainings can be used to expand the pool of providers who are competent in EBPs.
2	Expand participation in Train the Consultant model to create a larger pool of experts	Access to expert consultation can bring newly trained providers up to proficiency in EBP implementation. As the number of proficient providers increases, each loss of a provider will have less impact on the continuity of care and the clinic's ability to provide EBP treatments.
3	Leverage telehealth resources to provide coverage to sites with gaps	Trained and experienced providers in EBPs located in telehealth facilities can provide care at other MTFs, reducing burdens on staff during periods of transition.
4	Replace providers who leave Government Service and contractor positions with providers who have EBP experience	Targeting experienced EBP therapists will reduce training costs for new personnel, reduce interruptions in treatment and facilitate the enterprise-wide transition to EBPs.

	Potential Toolkit Items
A	CDP Site: CDP's homepage will be the main portal for information on upcoming, free trainings and general information on EBPs.
B	Online training: A web-based Train-the-Consultant training will increase the availability of EBP consultants across the DoD.
C	Factsheet on principles of utilizing telehealth: This factsheet will aid providers in delivering EBPs using telehealth.

Support for EBPs can change when a new clinic leader arrives
Personnel rotations can lead to changing support for EBPs, especially when the person leaving is the clinic manager or another key EBP advocate. A new clinic manager may influence EBP use in varying ways from actively discouraging EBP use, to simply not supporting EBPs (e.g., not allowing time for consultation) to (in the positive end) actively seeking to shift the clinic towards greater use of EBPs. Institutionalizing the use of EBPs into DoD and MTF policies will ensure consistency despite changes in clinic personnel.

	Recommendations	Rationale
1	Have EBP use institutionalized into DoD and MTF policies	Having EBP use institutionalized into DoD and MTF policies can facilitate continued support for EBPs. Individuals in an organization will typically attend to and work to meet standards that are set by leadership.
2	Create executive briefings for MTF leadership, making the Commanding Officer/Hospital Commander a leading advocate of EBPs within their MTF	Even when local clinic providers rotate, delivery of EBPs can remain a priority if the Command itself supports EBPs. Demonstrating the effectiveness of EBP treatments and their impact on return-to-duty rates and clinic efficiency will encourage commanders to support EBPs.
3	Train DoD clinic managers in the clinic optimization process and the central role EBPs hold in that process	Creating a workshop on clinic optimization for clinic managers would serve two important functions: 1) Provide clinic managers the skillset to optimize clinics 2) Demonstrate the role of EBPs in improving clinic efficiency and effectiveness

Potential Toolkit Items	
A	Standard Operating Procedures/Operating Instructions: SOP/OI templates and/or written guidance regarding EBPs ensure that implementation and sustainment occur regardless of changes in clinic personnel, as their use has become institutionalized. This will also include a template for reviewing EBP usage in peer reviews.
B	Business Case Analysis (BCA) for EBPs: This product will document the case for increased use of EBPs, relying heavily on the distinction between process and outcome measures of performance. A central idea behind the BCA is that the current focus on process metrics (patient throughput and wait times) actually costs the DoD money. DoD will reduce costs, as well as the amount of suffering and disability of service members and their families, by shifting its focus to outcomes. This transition will naturally drive providers to use EBPs in their practice.
C	Clinic optimization course: This course will be a multi-day workshop for clinic managers to learn how to optimize clinic operations to enhance the use of EBPs.

Sites lose consultation support for EBPs
Gaps in consultation for EBPs emerge when personnel rotate or stop providing consultation due to role changes or loss of interest. Consultation is a critical aspect of learning new EBPs and having on-site EBP consultation has been noted to improve the use of consultation. This becomes challenging as there are multiple EBPs endorsed by the DoD and it is unlikely that any MTF will be able to have an expert in every EBP on site at all times.

	Recommendations	Rationale
1	Expand participation in Train the Consultant model to create a larger pool of experts	Training more consultants will increase access to consultation for providers. Creating incentives to serve as a consultant will also help increase participation and utilization.
2	Utilize CDP's phone consultation for EBPs and allocate this time in the providers' templates	Phone consultation provides coverage when an on-site consultant is not available, but reserving time to obtain consultation is critical. If time is not reserved, it will usually be filled with patient care.
3	Establish a DoD network of consultants for various EBPs, including a pool of consultants for PE, CPT, CBT for Depression, etc.	Organizing a network of DoD providers who have expertise in specific EBPs will allow new EBP providers to easily reach out to experts for help. Such a model would fit nicely into the DoD's current structure where personnel rotate due to mission needs, as opposed to local requirements for expertise in a specific therapy.
4	Establish local EBP Champions who are familiar with the general EBP principles	Having a consultant for EBPs located within each MTF will make EBP delivery more effective. DoD should consider implementing the model of having one consultant who is an EBP generalist, rather than having one consultant for each specific EBP in every MTF. These local onsite champions would also link to a national network of SMEs in various EBPs.

	Potential Toolkit Items
A	EBP Champion handbook: This how-to manual for newly designated EBP Champions will codify the lessons learned from the Champion-Consultant program into practical hands-on advice on procedures for this role.
B	Online training: This web-based Train-the-Consultant training will increase the availability of EBP consultants across the DoD.
C	EBP consultant network: This network will connect DoD providers with expertise in specific EBPs to other DoD providers who have recently begun practicing EBPs. This would require having a well-defined system for reaching out to these groups and for them to respond to individual questions in a coordinated manner.

Clinic shifts away from EBP-focused care to some other model due to competition with emerging models of care with insufficient empirical support
Drift from EBPs can occur when EBP use is not institutionalized or when a strong advocate for new psychotherapy models arrives at the clinic. Unfortunately, many practices advocated by well-meaning therapists lack efficacy studies demonstrating that they are beneficial for patients. Drift from the EBP-focused model of care may also occur when a new department head or program manager changes the focus of clinics/programs.

	Recommendations	Rationale
1	Have EBP use institutionalized into DoD/MTF policies	Institutionalizing EBP use into DoD and MTF policies can facilitate continued support for EBPs. Individuals within an organization will attend to and work to meet the standards that are set by leadership. Additionally, command knowledge of EBP effectiveness will garner support for a time-limited treatment protocol.
2	Create briefings for Service members and line commanders about the benefits of EBPs	Well informed consumers of behavioral health services will ask for EBPs by name. By educating Service members and their leaders, DoD can help sustain EBPs within its MTFs by ensuring that there is a steady demand for these services.
3	Track outcome measures to determine whether there is a change in results due to a shift away from EBP-focused care	Outcome measures help determine patient progress in therapy. Tracking outcome measures can improve the quality of care received and demonstrate the benefit and effectiveness of EBPs over non-EBP approaches.
4	Clinics should approach shifts away from EBP-centered approaches using a process improvement framework	New therapies and models are constantly being developed, and garner enthusiasm from providers and clinic leaders. The process improvement framework provides a ready-made method for evaluating whether shifts away from EBPs are having the intended impact within a clinic.

	Potential Toolkit Items
A	Standard Operating Procedures/Operating Instruction: SOP/OI templates and/or written guidance for commanders regarding EBPs ensure that implementation and sustainment occur even after commanders rotate from their commands.
B	Business Case Analysis (BCA) for EBPs: This product will document the case for increased use of EBPs. A central idea behind the BCA is that the current focus on process metrics (patient throughput and wait times) actually costs the DoD money. DoD will reduce costs, as well as the amount of suffering and disability of service members and their families, by shifting its focus to outcomes. This transition will naturally drive providers to use EBPs in their practice.
C	Training decks on metrics: A training on expanding the use of patient and clinic level measures in DoD mental health care will provide an overview of outcome measures for the patient level (symptoms) and the clinic level (return to duty rates) and explain how these measures can be collected and utilized.

Providers drift away from protocols over time, using only parts of the EBP protocol
Over time, providers may drift away from EBP protocols. Some may adapt protocols to their own experiences or may only use parts of the established protocol. Providers who pick and choose elements of a protocol do not have the same level of assurance compared to providers who use the protocol with fidelity.

	Recommendations	Rationale
1	Encourage routine use of protocols via refresher trainings and consultation	To ensure EBP fidelity, refresher trainings and consultation are needed to review the basics and fine-tune clinical skills. Additionally, these experiences can stress the importance of adhering to the protocol. Straying from the protocol, or therapeutic drift, can lead to therapeutic vagueness and reduced benefit for the patient.
2	Encourage routine use of fidelity assessments and measure impact of changes on outcomes when adapting protocols	Regular assessment encourages the therapist to review the fundamental principles of each session to ensure that all elements are being used correctly. Fidelity assessments can improve patient care by revealing inconsistencies that can prompt a provider to change his or her techniques, conceptualization, or strategy.
3	Create accountability with MHS-wide outcomes monitoring and reporting of outcomes	Providers will be more likely to implement EBPs with fidelity if they are required to report their usage as part of an MHS-wide initiative.
4	Encourage peer review and/or consultation to facilitate fidelity to the treatment protocols as well as periodic review of fidelity with an expert consultant	When providers consult with experts, peers, or a Champion-Consultant, they may become aware of the therapeutic drift and will learn ways to improve fidelity.

Potential Toolkit Items	
A	Refresher trainings: The availability of refresher trainings will allow previously trained providers to review the elements of the protocol.
B	Fidelity checklist (one per therapy): Fidelity checklists will be made available for PE, CPT and other EBPs to allow the therapist to check their adherence to the therapy in real time.
C	Notes template for EBP treatment: The template will allow providers to input their usage of EBPs and patient outcomes. Supervisors can set expectations of these notes in chart reviews.
D	Peer review template: Example language on incorporating fidelity to EBPs into a clinic's existing peer review system will be made available. This will help shift more providers to using the EBP protocols with fidelity.

Clinics do not have the resources (funding, staff) to sustain EBP use and promotion
Despite the increase in the number of providers over the past several years, behavioral health clinics often do not have sufficient staffing levels to see patients in a timely manner. The impact of insufficient resources has overburdened providers, leading to high staff turnover, which has ultimately led to higher costs for the DoD. Promoting the transfer of knowledge and skills of EBPs can actually help alleviate budget concerns since EBPs have a standardized and efficient approach to therapy.

	Recommendations	Rationale
1	Modify the culture/business model for DoD behavioral health clinics to increase the use of EBPs	Shifting the culture towards EBPs increases efficiency, allowing providers to see more patients with less effort. Adopting EBPs within clinics will reduce the burden on personnel and budgets, allowing clinics to have more time for training and consultation.
2	Place EBP Champions at MTFs to advocate for EBP use, optimize clinics, and provide EBP consultation	Adoption of new practices often requires a local Champion to be present to spearhead the dissemination and implementation of these practices. Despite a small loss in patient care by having a designated Champion, the net effect for DoD will be an increase in savings due to increased efficiencies.
3	Train DoD clinic managers in the clinic optimization process and the central role EBPs hold in that process	Creating a workshop on clinic optimization for clinic managers would serve two important functions: 1) Provide clinic managers the skillset to optimize clinics 2) Demonstrate the role of EBPs in improving clinic efficiency and effectiveness

	Potential Toolkit Items
A	Business Case Analysis (BCA) for EBPs: This product will document the case for increased use of EBPs. DoD will reduce costs, as well as the amount of suffering and disability of service members and their families, by shifting its focus to EBPs.
B	EBP Champions: The number of MTFs with designated EBP Champions will be expanded. These Champions should have a portion of their time allotted to EBP advocacy, providing support for clinic optimization and generic consultation on common EBPs.
C	Clinic optimization course: This course will be a multi-day workshop for clinic managers to learn how to optimize clinic operations to enhance the use of EBPs.

Next Steps

This Lessons Learned Manual advances the level of understanding of the barriers to EBP utilization that exist in the MHS. For each of the barriers mentioned in this LLM, one or more suggestions for addressing it have been presented, along with a rationale for the recommendation. Each recommendation has one or more potential tools that could be developed to put these suggestions into action.

Following the completion of this LLM, CDP plans to move forward with two initiatives that will aid the MHS in expanding EBP utilization: 1) completion of the Clinic Optimization Toolkit which was initiated during this project, and 2) develop a Clinic Optimization Course.

Clinic Optimization Toolkit

Concurrent with the Champion-Consultant program, CDP has been developing a toolkit for improving the utilization levels of EBPs. This "Clinic Optimization Toolkit" will provide practical and easily-implemented tools and processes that MHS staff can implement with minimal effort.

A team located at CDP headquarters is coordinating product development while the Champion-Consultants have been piloting the initial drafts of these tools at their sites. The initial dissemination of toolkit items has been limited to the 10 Champion sites, however it is anticipated that the majority of toolkit items will be available for dissemination to a wider audience.

It should be noted that the toolkit items described in this LLM represent an ideal state, based on our current level of understanding. It may not be necessary, or even possible, to develop all of these products based on time and other costs associated with the particular product. It should also be noted that additional products not mentioned in the LLM may also be developed.

Clinic Optimization Course

To further increase the utilization of EBPs in the MHS, the CDP plans to develop a new course for DoD Behavioral Health clinic managers that will build off of the lessons learned from the EBP Champion-Consultant program (JIF-9). This course will offer training and consultation with the goal of optimizing clinic function through the enhanced use of EBPs. The course's curriculum will include content derived from the modules in CDP's Clinic Optimization Toolkit, presented during a multi-day workshop. Sessions will focus on topics such as tailoring the clinic's services to the needs of the patient population, increasing access to EBP treatment in both individual and group formats, utilizing metrics to track patient improvement and clinic function, enlisting support of behavioral health technicians, managing patient throughput, and evaluating program effectiveness. The ultimate goals of the course will be better access to care, higher quality treatment, and reduced cost for the DoD.

Following the workshop, CDP staff will be available for consultation to provide feedback and assistance with troubleshooting issues at individual clinics. This may take the form of regular, scheduled phone calls or ad hoc consultation via telephone, videoconference, or email. Should the DoD decide to add Champion-Consultants at other MTFs at the end of the JIF-9 Champion-Consultant project, this course would be an ideal means for orienting newly designated Champions to the role.

Closing

In summary, the CDP developed this Lessons Learned Manual to describe potential barriers to EBP utilization in the DoD as well as recommendations for addressing said barriers. The content of the LLM was informed broadly by nearly a decade of training and consultation efforts and more specifically by information gained during the development and execution of the Champion-Consultant program. CDP's efforts to enhance utilization of EBPs in the DoD will continue with the planned development and execution of the Clinic Optimization Toolkit and Clinic Optimization Course, both efforts based heavily on the contents of this LLM.

For additional information regarding this Lessons Learned Manual, or the Clinic Optimization Toolkit or Course, please contact one of the Project POCs:

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Appendix A: References & Bibliography

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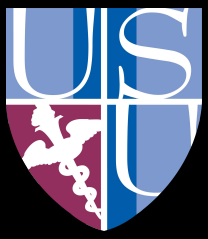


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