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**Joint Base Lewis-McChord (JBLM) Telebehavioral Health Service Program Evaluation**

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Uniformed Service University of the Health Sciences

NURS5330: Doctor of Nursing Program Project

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## Abstract

**Project Title:** Joint Base Lewis-McChord Telebehavioral Health Service Program Evaluation

**Authors:** Githiora, E., & Smith, L.

**Problem:** Evaluation of the telebehavioral health (TBH) services at Joint Base Lewis-McChord (JBLM) was needed to help determine the effectiveness and feasibility of these operations. October 2020 and November 2020 to April 2021. The RE-AIM Framework guided the evaluation of the program to track the program's reach, effectiveness, adoption, implementation, and maintenance over 12 months.

**Methods:** The evaluation consisted of four phases. Phase one analyzed the current program using a RE-AIM-based evaluation plan. In phase two, evaluators reviewed the process, structure, and outcome measures. Phase three involved collecting data and analyzing results. Finally, in phase four, the evaluators generated reports to disseminate findings and recommendations to the stakeholders.

**Results:** We reviewed (N =124) Active-Duty patients' charts. 8% of the charts had two data points for comparison, 14% of the charts had one data point, 20% were deemed non-qualifying due to not meeting the criteria, and 58% of the charts had no data documented using behavioral health (BH) screening tools. BH screening tools and charting methods varied among providers; therefore, objective data capturing was sparse. Overall, TBH services increased access to care 19,537 encounters were performed during April 2020-April 2021 compared to 17,468 encounters before COVID from April 2019 to April 2020.

**Conclusion:** The swift adoption and implementation of the TBH program made data analysis challenging. Overall, the availability of TBH services increased the number of patient encounters by approximately twelve percent. TBH remains an option for care at JBLM Clinics, and a new TBH platform is being implemented.

**Keywords:** Program evaluation, telebehavioral health, RE-AIM, military

## **Joint Base Lewis-McChord (JBLM) Telebehavioral Health Service Program Evaluation**

Mental health remains a significant public health issue worldwide, affecting over 450 million people. Each year, one in five US adults experiences mental illness (CAMH, 2020; NAMI, 2020). Pandemics and infectious disease outbreaks can induce or exacerbate behavioral health disorders. The COVID-19 pandemic has presented a unique stressor by contributing to psychiatric conditions and negatively affecting the ability to seek and provide needed care (Gruber et al., 2020). The provision of mental health care via remote platforms, also known as telebehavioral health (TBH), is a viable, evidence-based process that can alleviate some of the challenges brought about by the pandemic. Recent studies have demonstrated no significant differences between telehealth and in-person care for adults diagnosed with anxiety, depression, posttraumatic disorder, and substance use disorder (Lazur et al., 2020). With the onset of the COVID-19 pandemic, Joint Base Lewis-McChord (JBLM) behavioral health clinics quickly implemented and expanded the use of TBH services to meet the new challenge. The TBH program at JBLM has not yet been evaluated for effectiveness and sustainability. This project uses the RE-AIM framework to conduct a program evaluation of TBH services implementation at JBLM during the first 12 months of the COVID-19 pandemic.

### **Problem Synthesis**

Over the past decade in the United States, the demand for behavioral health services has grown exponentially. However, this rise in demand has not been matched by a commensurate increase in behavioral health resources. As a result, a significant deficit exists between the demand and supply of behavioral health services (Bashshur et al., 2016). The mismatch between the mental health demand and the availability of resources has translated into patients with mental health illnesses not receiving the desperately needed care. In 2016 alone, approximately

35% of adults in the United States with serious mental illness did not receive the mental health services they needed (Shannon et al., 2016).

In the military, mental health disorders account for the highest number of in-patient bed days. Recorded annual bed hours related to mental health disorders rose from 50,000-bed hours in 2005 to over 70,000 in 2015; a further increase followed this in 2016 when over 80,000 annual bed hours were recorded due to mental health disorders (Deployment Health Clinical Center [DHCC], 2017). During that time frame, the top four presenting diagnoses were adjustment disorders, alcohol-related disorders, depressive disorders, and anxiety disorders, respectively (DHCC, 2017). The use of TBH can assist with delivering a multitude of treatment modalities to our military personnel. TBH provides an excellent opportunity to reduce the gap between the need and the availability of mental health services.

### **Relevance to Military Nursing**

Evaluating the implementation of the TBH program at JBLM behavioral health clinics will contribute to the Defense Health Agency's (DHA) "Quadruple Aim" of maintaining great outcomes, a ready medical force, satisfied patients, and fulfilled staff (DHA, 2021). An effective TBH program will increase access to mental health care and reduce costs. Mental health providers can reach Service Members in remote and deployed settings by providing care virtually. Increasing access to essential services enables early recognition and provision of care, leading to a mentally healthier force. The program evaluation will allow the opportunity to objectively compare the JBLM TBH program's performance with recent literature.

### **Clinical question**

At JBLM behavioral health clinics, how did TBH adoption, implementation, and maintenance affect patient outcomes (adherence and symptom severity) during the first 12 months of the COVID-19 pandemic?

## **Literature Review of Solution**

### **Search Strategy and Results**

To guide our literature search, we used the PICO question: do patients with mental health diagnoses (Population) utilizing telebehavioral health services (Intervention) versus standard care (Comparison) have a reduction in symptoms severity (Outcomes) and show increased treatment engagement? We used CINAHL, PsycInfo, and the power search option in the USUHS online library as our search databases and the following search terms: Telehealth OR telebehavioral health, OR telemedicine, virtual health, video conferencing, online care, in-person OR face to face, telehealth AND acceptability OR feasibility, Mental health, OR Telehealth AND adoption OR implementation. Our initial search yielded 213 articles. We refined our search by limiting the results to peer-reviewed literature published within the last seven years, excluding duplicates and articles without access to full text. The number of articles decreased to 27. We excluded another 12 due to having lower than level II evidence; we only included articles and studies with level I and II evidence. From the remaining 15 studies, we excluded seven that did not focus on the primary diagnoses of our project (anxiety, depression, and PTSD). Eight studies met the inclusion criteria for this project: five randomized controlled study articles, one meta-analysis, and two pilot studies. We used the John Hopkins Nursing Evidence-Based Practice (JHNEBP) appraisal tool for evidence level determination (Appendix C).

### **Solution Synthesis**

Current empirical evidence shows that TBH services increase access to mental health care and are positively perceived by patients (Shannon et al., 2016; Bashshur et al., 2015; Yuen et al., 2013). TBH services have been proven effective in filling an essential provider gap in mental health (Shannon et al., 2016). Bashshur et al. (2015) found that 78% of rural patients and 72% of urban patients receiving care via telehealth were "moderately" or "extremely" satisfied

with using TBH services. In 2013, a pilot study was conducted to assess the feasibility, acceptability, and initial efficacy of behavioral intervention through videoconferencing for Seasonal Affective Disorder (SAD) treatment in 26 adults. Upon completion of therapy, based on a patient satisfaction survey, 95% of the patients were completely or mostly satisfied, and 100% of the therapists were completely satisfied with the video conferencing approach for SAD treatment (Yuen et al., 2013).

Empirical evidence shows that TBH is effective in several mental health conditions, specifically depression, anxiety, and PTSD, which are among the most prevalent mental health conditions in the US military. TBH was found effective in improving depression severity (Acierno et al., 2016; Luxton et al., 2016), reducing PTSD symptoms (Acierno et al., 2016; Fortney et al., 2015; Morland et al., 2015;), and reducing anxiety severity (Yuen et al., 2013). Additionally, TBH was found effective in promoting smoking cessation (Bashshur et al., 2016) and stress reduction (Harrer et al., 2018).

Luxton et al. (2016) evaluated the safety, feasibility, and effectiveness of TBH in treating depression and PTSD among active-duty military members at JBLM. This randomized controlled study supported the hypothesis that care rendered via TBH services was effective and non-inferior to care provided in office/face-to-face settings (Luxton et al., 2016).

Panic Disorder is one of the costliest mental health disorders. Patients with this disorder utilize many resources seeking explanations and treatments in somatic and alternative medicine (Nordgreen et al., 2017). In an effectiveness study conducted at three clinics in Norway, Internet-based Cognitive Behavioral Therapy (CBT) was efficacious in reducing panic disorder-related symptoms. Results indicated a significant decrease in symptoms at the end of treatment compared to pretreatment, with sustained symptoms reduction six months after treatment (Nordgreen et al., 2017). Untreated anxiety can lead to maladaptive behaviors and worsening

symptoms; Yuen et al. (2013) demonstrated that an acceptance-based behavioral intervention via Skype significantly reduced anxiety symptoms in patients with a social anxiety disorder (SAD) diagnosis.

Morland et al. (2015) studied cognitive process therapy (CPT) delivered via TBH for PTSD treatment in veterans. The results showed that CPT via TBH was clinically effective and cost-effective for the patients. Patients save resources in terms of transportation costs, time, and missed work associated with office visits.

### **Focus Areas**

This project was a program evaluation of how TBH services were adopted, implemented, and maintained during the first 12 months of the COVID-19 pandemic and the impact on patient outcomes (reach and effectiveness) at JBLM behavioral health clinics guided by the Reach, Effectiveness, Adoption Implementation, and Maintenance (RE-AIM) Model (RE-AIM, 2020). The following were the focus areas.

- 1) Focus area 1: evaluate patient outcomes linked with TBH implementation
- 2) Focus area 2: evaluate implementation, adoption, and maintenance of TBH services from an organizational standpoint.
- 3) Focus area 3: Analyze the results and formulate recommendations for improvements.

Identify strengths and weaknesses of the process through which TBH care was provided during the first 12 months of implementation.

### **Organizing Framework**

RE-AIM is a well-known framework used to guide in planning and evaluation of programs, practices, policies, and environmental changes within organizations (RE-AIM, 2020). Reach was defined as the number of patient encounters via TBH during the first 12 months of the pandemic and the number of patients who did not attend scheduled appointments (No Shows).

Effectiveness focused on the change in illness severity over 12 months. We focused on three of the most prevalent mental health conditions in the military: depression disorders, anxiety disorders, and PTSD. Adoption described the number of providers who used TBH.

Implementation focused on utilization and standardization: the number of TBH appointments provided via TBH during the first 12 months of the program compared to the number of face-to-face appointments provided during a similar period before the pandemic. Standardization demonstrated the level of uniformity in TBH care documentation. Maintenance assessed the sustainment plans for the TBH program at JBLM post-implementation at 12 months (Sweet et al., 2014).

## **Project Design (Part 1)**

### **General Approach**

This project was a program evaluation of TBH adoption, implementation, and maintenance at JBLM behavioral health clinics and its effectiveness (patient reach and outcomes) using the RE-AIM Model during the first 12 months of the COVID-19 pandemic. The goal was to enhance the TBH services and maintain a systematic way of identifying effective solutions.

### **Setting and Population**

JBLM is the second largest medical treatment facility (MTF) in the Military Health System (MHS), one of two designated Level II trauma centers with approximately 220 beds and providing nearly one million outpatient clinic visits annually. JBLM serves more than 100,000 active-duty service members, their families, and retirees (Madigan Army Medical Center, 2020). The JBLM BH department has the largest number of BH providers (psychiatrists, APRNs, Licensed Independent Providers) in the Army, delivering comprehensive BH services in an inpatient unit and eight outpatient clinics (Madigan Army Medical Center, 2020).

The population of interest for this project was active-duty patients diagnosed with at least one of three of the most prevalent mental health conditions; depression, anxiety, and PTSD. We also looked to identify the number of TBH provider users.

### **Procedural Steps**

The first phase of the project was planning and meeting with stakeholders. Evaluators conducted a meeting with the key stakeholders to state the purpose of the program evaluation. The second phase began with an approval request to the Institutional Review Board (IRB) for determination and privacy review. After IRB authorization, evaluators reviewed TBH, and the policies needed to assess the TBH program successfully.

During the third phase, evaluators identified data sources and developed a data collection plan (Appendix B). The evaluators conducted Electronic Health Record (EHR) reviews to collect data on 'Reach' 'Effectiveness' and 'Implementation. The evaluators conducted meetings with key stakeholders to obtain data on adoption and maintenance. The evaluating team abandoned the initial plan to collect providers' and patients' demographics because the provision of care via TBH was not per provider or patient preference; all outpatient behavioral clinics had to operate virtually.

The fourth phase is ongoing; it involves report generation and dissemination. The evaluators will provide a detailed report on the standard operating procedures (SOPs), guidance on the program's adoption, and recommendations to the key stakeholders. Upon completion, evaluators will present to leadership at JBLM and USUHS (Appendix A)

### **Project Design (Part 2)**

#### **Data Analysis Plan Description**

This study's data analysis units were the patient and the events (Outcomes) described in Appendix B (Reach, Effectiveness, Adoption, Implementation, and Maintenance) (RE-AIM,

2020). Longitudinal data were collected at the beginning of the TBH adoption and tracked for 12 months.

***Descriptive statistics:***

**Reach.** The number of patient encounters at JBLM behavioral health clinics before COVID-19 restrictions, compared to the number of encounters during a similar time frame under COVID-19 restrictions

**Effectiveness.** Evaluators tracked depression severity using PHQ-9 screening tool scores during the first half of the study period (six months) and compared those scores to PHQ-9 scores recorded during the second half of the 12-month focus. The same data collection method was used to track GAD-7 scores assessing level of anxiety and PCL scores assessing level of PTSD symptoms. Evaluators did not collect descriptive data on the numbers of providers and patients using TBH due to issues to be discussed further below. The COVID-19 restrictions called for strict isolation measures; providing care via TBH was not based on provider or patient preference.

**Implementation.** Evaluators calculated the number of missed appointments in three leading behavioral health clinics over twelve months (pre-pandemic) and compared them with missed appointments over a similar timeline during Covid-19 restrictions when TBH was the primary platform for outpatient mental healthcare delivery. By multiplying the number of missed visits by the estimated average cost per visit, evaluators identified the financial impact of reducing "no shows."

**Treatment uniformity.** Evaluators gathered data on the treatment SOPs, guidance, and training on TBH use. Reviewed EHR and conducted interviews with providers on the TBH process. Identified similarities and discrepancies during the 12-month study period.

**Maintenance.** Evaluators identified sustainment measures and the future direction for TBH services at JBLM by reviewing the descriptive data from written guidelines (SOPs) and interviews with stakeholders. Evaluators analyzed the collected data on each metric used per the revised data analysis plan (Appendix B).

### ***Barriers and Mitigating Actions***

The project team used both the RE-AIM model and input from stakeholders to anticipate and plan for barriers to the project

- Lack of access to quality data. The project team anticipated that there might be difficulties querying data from the JBLM EHR, MHS Genesis, and the Behavioral Health Data Portal (BHDP) maintained by DHA. The team made early contact with a JBLM biostatistician to develop a plan to best collect the data. Strict DHA data sharing agreements also added to the complexity of data acquisition. The evaluating team provided specific parameters and diagnoses to the biostatistician and maintained close collaboration throughout the process to ensure that data on target diagnoses and patient population (Active duty) were correctly collected. Evaluators required scores for evidence-based screening tools (PHQ-9, GAD-7, and PCL) to establish effectiveness in patient outcomes.
- Interpersonal conflict. Change is difficult; to help mitigate any unforeseen conflict with leadership and staff, the evaluators maintained open communication, trust, and shared expectations with stakeholders throughout the project.
- Lack of adequate resources in terms of human resources and time. The evaluating team created a timeline to mitigate the issue, contacted stakeholders in the early stages of the project, and adjusted the timeline to foster productivity and time management.

### ***Dissemination Plan***

The knowledge phase included a presentation on the project plan to faculty and peers on November 29, 2020. During the persuasion phase, evaluators presented the project and the BCA to stakeholders at JBLM. The dissemination phase will end with a poster/podium presentation to leadership and stakeholders at JBLM on the study findings and recommendations for the adoption and the implementation of the TBH program. Finally, evaluators will conduct a poster and podium presentation on the project to USU faculty, guests, and students in Bethesda, MD.

### ***HIPAA Concerns***

The majority of the work of this project involved retrieving patients' medical records for review and analysis. These records contained protected health information (PHI) for hundreds of patients, which can cause harm if mishandled or shared with unauthorized parties. The evaluating team took all necessary steps to ensure appropriate measures to protect the privacy of personal health information and set limits and conditions on the use and disclosures. Evaluators obtained authorization to access patient data from JBLM's Institutional Review Board (IRB). All PHI data was only accessed through the EHR. In conjunction with the biostatistician, the evaluating team de-identified all data from EHR and assigned unique codes only identifiable by the team. Evaluators used these codes while entering data into other platforms outside of the EHR. Evaluators did not keep any PHI (electronic or paper format) in their electronics or physical storage space. Only de-identified metrics will be included in the dissemination phase of the project. All files were stored on government CAC-protected computers only accessible to project team members.

### **Business Case Analysis**

This project conducted a program evaluation and assessed the implementation and effectiveness of TBH services at JBLM mental health clinics during the first 12 months of the COVID-19 pandemic. This program evaluation compared the JBLM TBH program performance

with literature and other HROs. The results from this project will provide vital information to JBLM leadership as they continue to push for an efficient TBH program. We highly recommend adopting an ongoing system of program evaluation to identify barriers to TBH services in the future. The time invested in a program evaluation such as this one supports continuous process improvement. (Appendices C and E).

The evaluation of the TBH program at JBLM yielded valuable data on patient outcomes, patient and provider experiences, and cost-effectiveness. The project promoted efficacy, sustainability, and improved patient care associated with TBH services.

### **Results: RE-AIM**

**R:** TBH services effectively maintained access to care during the global pandemic. In three behavioral health clinics at JBLM, 19,537 behavioral health encounters were performed from April 2020 to April 2021 (during the pandemic) compared to 17,468 encounters before COVID from April 2019 to April 2020 (pre-pandemic). This was an 11.8 percent increase in patient reach. There was also a decrease in missed appointments during the first year of TBH adoption. The total number of "No Show" visits for a 12-month pre-pandemic period for the same three behavioral health clinics was 2,253. During the 12-month study period with TBH services, "No Show" visits decreased by 522. The cost of missed appointments is estimated at 105 dollars for each primary care appointment and \$265 for each specialty appointment National Defense Act (2017). The decrease in missed appointments translated to approximately \$138,000 in savings ("Standardized system for scheduling medical appointments at MTFs-missed appointments," 2017).

**E:** To assess the effectiveness of TBH services, evaluators required two data points assessing clinically significant changes in patient outcomes over 12 months as measured via PCL, GAD-7, and PHQ-9 scores. To allow comparison, the evaluating team needed at least one

diagnosis screening tool score within the first six months of the study period and another on the same scale in the last six months. The immediacy required to adopt TBH services after the COVID-19 pandemic presented a logistical and planning challenge; there was not enough time for staff training on transitioning to virtual care. Connectivity issues and inadequate equipment lead to a lack of access to the BHDP, a system in which patients electronically take the screening tools. Data capturing on behavioral health screening tools was negatively affected by the abrupt transition to virtual care. The project team found that the vast majority of charts did not contain documented scores. No scores were documented in 58% of the charts and only eight percent had the desired data points for comparison.

The lack of communication between BHDP and the MHS Genesis platforms presented another challenge. Even when patients did have access to BHDP, providers had to manually transfer screening tool scores from BHDP to MHS Genesis. The disconnect between the two systems creates a gap where scores are often not documented at all.

Although the available data was not enough to generalize results or reach a scientific conclusion on the effectiveness of TBH services at JBLM, the charts that met inclusion criteria indicated improvements or no change in measured metrics. Four records showed a one to three-point improvement in PHQ-9 scores. Three patients' charts had a one to three-point improvement, and one chart had a six-point improvement in GAD-7 scores. One chart showed no change in GAD-7 scores. Two charts captured PCL scores with 15 and 10-point improvements in PTSD symptoms. Three charts had a one to three-point worsening of depressive and anxiety symptoms per PHQ-9 and GAD-7 scores.

**A:** After the Centers for Disease Control (CDC) implemented COVID-19 restrictions, leadership at JBLM put outpatient face-to-face BH services on hold and quickly devised a plan to continue mental health care via a triage clinic. The triage clinic was a face-to-face setup

designed to coordinate BH care between the emergency department and the in-patient behavioral health unit. Leadership developed SOPs and disseminated to all clinics the provision of virtual BH services.

**I:** During the primary stages of TBH adoption and implementation, only about 30% of BH providers had the hardware and software capabilities to provide virtual care from home. Three months into the pandemic, BH leadership had provided needed computer equipment to more than 75% of BH providers to allow them to provide behavioral health care virtually. During the transition period, BH providers saw their patients via many platforms. These platforms included Doximity, Google DUO, FaceTime, and phone calls. Six months into the pandemic, per MEDCOM guidance, Adobe Connect, Google Duo, and FaceTime became the only authorized platforms for virtual BH visits. Due to patients' and providers' difficulty with access and familiarity with virtual platforms, many virtual patient encounters took place over the phone. (P. Russel. personal communication, March 21, 2022)

**M:** MHS Video Connect is the future platform designed to streamline virtual care. The goal is to continue refining policies and SOPs to streamline and standardize virtual care and increase virtual care staff training and technical support. The MHS Video Connect rollout is currently in its second phase; 21 providers are now using it.

### **Analysis of the Results**

This program evaluation project demonstrated that the telebehavioral health program at JBLM behavioral health clinics maintained access to mental health care for active-duty service members. The program evaluation at JBLM showed that mental health services were effectively delivered via telebehavioral health. These results are in congruence with recent literature discussed above on the effectiveness of TBH services as a reliable, dependable platform that increases access to care.

Results also indicated gaps in the TBH care documentation process. The recording of essential data on patient outcomes was sparse. Most patients' charts from virtual encounters were missing screening tool scores, as discussed earlier. Failure to capture important metrics led to a small sample size that yielded inconclusive results on the effectiveness of TBH services on diagnostic patient outcomes.

### **Limitations**

Due to the immediacy of the situation presented by COVID-19 restrictions, operational standardization and data capturing became a challenge. These challenges created deficits in data availability and negatively affected data analysis. The sample size that met inclusion criteria was too small to generalize the results. The lack of communication between MHS Genesis and BHDP platforms created a gap that made capturing important data difficult. The conditions presented by a global pandemic did not allow for provider and patient preference between TBH and face-to-face care. As a result, evaluators had to re-design the data collection plan and analysis.

### **Organizational Impacts**

TBH services increased access to care for thousands of service members assigned to JBLM. The program bridged the gap during the pandemic to provide access to mental health care. A program evaluation of the TBH service at JBLM was essential to identify excellence and areas of improvement. The results from the project were well-timed as they showed the need for the MHS Video Connect that is currently being launched. The program evaluation revealed the need for standardization and consistency in documentation and the need for a streamlined platform to support the TBH program better. The results provided data that will be instrumental to JBLM behavioral health leadership in making necessary adjustments to continue to improve

TBH services. Increased access to quality care will have a direct impact on JBLM's medical and mental readiness

### **Future Direction**

TBH is ongoing and remains an option at JBLM Clinics. Introducing MHS Genesis Video Connect for telehealth services will address some of the issues patients and providers encounter using TBH services at JBLM clinics. Leadership will provide clear guidelines on approved methods/platforms, alternatives, and required training. To improve data collection and documentation, individual providers and supervisors must ensure evidence-based measuring scales are recorded on every virtual encounter. Behavioral health services will ensure hardware and software are available to licensed BH providers who can provide care virtually.

### **Conclusion**

The conditions presented by a global pandemic under which the TBH program was adopted and implemented made the adoption and implementation quite challenging. After COVID-19 restrictions, JBLM BH leadership and providers had to quickly initiate remote TBH services to continue providing mental health care.

Despite all the challenges that JBLM behavioral health clinics faced adopting and implementing the program, telehealth services at JBLM Clinics allowed for effective care continuity during a global pandemic. BH leadership quickly reacted to an unforeseen challenge and implemented an effective platform that ensured the continuation of the mental healthcare needs of all service members assigned to JBLM. TBH continues to expand access to care and provides flexibility for patients.

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## Appendix A

### Program Evaluation Timeline

Phase 1	MAY 2021	JUN 2021	JUL 2021	AUG 2021
	<ul style="list-style-type: none"> <li>- Check in</li> <li>- Build rapport</li> </ul>	<ul style="list-style-type: none"> <li>- Meet with the key stakeholders, local leadership, unit leadership, providers and the Information Technology Department (ITD)</li> <li>- Review all written procedures</li> <li>- Meet with ITD to discuss gaining access to specific EHRs identified by parameters and diagnoses</li> <li>- Created data collection sheet based on identified metrics from the data analysis plan</li> <li>- If necessary, revise the original project timeline for the remaining of the phases for this project</li> </ul>		
Phase 2	SEP 2021	OCT 2021	NOV 2021	DEC 2021
	<ul style="list-style-type: none"> <li>- Conduct electronic medical record (EHR) reviews to collect data per the data analysis plan, based on the data source</li> <li>- Conduct meetings with key stakeholders to obtain data per the data analysis plan</li> </ul>			
Phase 3	JAN 2022	FEB 2022		
	<ul style="list-style-type: none"> <li>- Input data entry from the audit checklist (based on the data analysis plan prepared during the planning phase)</li> <li>- Upon completion of the data entry, evaluators analyzed data and synthesized results.</li> </ul>			
Phase 4	MAR 2022	APR 2022	MAY 2022	
	<ul style="list-style-type: none"> <li>- Evaluators report on the initial standard operating procedures (SOP)</li> <li>- Provide guidance on the adoption of the TBH program during the six-month period</li> <li>- Report results using the RE-AIM model</li> <li>- Provide recommendations to the key stakeholders</li> <li>- Upon completion, evaluators will present to leadership at JBLM and Uniformed Services University of the Health Sciences (USUHS)</li> </ul>			

## Appendix B

## Data analysis Plan

	Variable Name	Variable Description and type of measure	Data Source	Possible Range of Values	Level of Measurement	Time Frame for Collection	Statistical Test	Decision Rule
<b>IV</b> (descriptive variable)	JBLM TBH program	A 12-month evaluation of TBH program adoption, implementation, and effectiveness Process measure; Nominal	Evidence-based evaluation form	N/A	N/A	Initiative-completion	None	The goal is to conduct program evaluation at JBLM clinics utilizing TBH services
<b>DV</b> (outcome variable)	<b>REACH (R)</b> R1. # TBH encounters	R. # TBH encounters <b>Process measure</b>  <b>Nominal Data</b>	Electronic Health Record	Based on 0-100% ----- --	R Interval  R2. Nominal	12 months	E1. E2, E3 use Paired t-Test or Wilcoxon's signed-rank test (if issues with normal distribution)	Applies to all DVs Based on the literature, it shows a significant reduction in the severity of symptoms over time through telemedicine. And Improvements in outcomes. The goal is to assess upwards or downwards







	<p>outcome variable)</p>	<p>M2. ORGANIZATIONAL SUSTAINMENT MEASURES</p>	<p>M2. Any provider incentives, guiding SOPs, initial training, ongoing training (obtained qualitatively via interviews with local stakeholders)</p>				<p>Review available SOPs on TBH, Complete interviews with stakeholders, and record data.</p> <p>Key stakeholders and local leadership will determine the ongoing use of TBH at JBLM based on the amount of training required, personnel needed and technical assistance for staff, settings, and patients.</p>
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Variable	Description	Source	Range	Level of measure	Time frame	Statistical test	Decision rule
IV	Program eval	Eval form	—	Nominal	12 months	n/a	Effectiveness based on “REAIM”
DV							
Reach	R1	EHR	-----	Ordinal	12 months	Descriptive	monitor use trends over first 12 months of COVID-19 pandemic
Effectiveness	E1	EHR	0-27	Interval	12 months	Paired t-test	PHQ score severity categories
	E2	EHR	0-21	Interval	12 months	Paired t-test	Mild, mod, severe
	E3	EHR	0-80	Interval	12 months	Paired t-test	5 -point change
	E4	EHR	0-100%	Ordinal	12 months	n/a	Higher or lower
Adoption	A1	EHR/ Interviews	0-100%	Interval	12 months	Descriptive	Report change
Implementation	I1	EHR& Lit	-----	Interval	12 months	Interval	TBH vs Office Cost/visit
	I2	EHR, SOPs, Interviews	—	Nominal	12 months	Descriptive	Care provision discrepancies
Maintenance	M1	EHR, Interviews	-----	N/a	12 months	Descriptive	Official SOP
	M2	SOPs, Interviews	—	N/a	12 months	Descriptive	Established Training and SOPs

(SOP- Standard Operating procedures, LIT- current literature, EHR- Electronic health records, HR- Human resource department)

## Appendix C

### Evidence Table

1st Author Name (Publication Yr.)	Study Purpose/Aims	Research Questions/Hypotheses (If different from/specificationally described separately from study purpose & aims)	Study Design	Total Sample Size (How many initially, how many at final analysis?)	Sampling Plan	Independent Variables and Level of Measurement	Dependent Variables and Level of Measurement
Luxton et al., 2016	To compare the safety, feasibility, and effectiveness of home-based tele behavioral health services to the traditional in-office treatment among active duty service members and veterans.	In-home care through tele behavioral health services was less effective than in-office treatment among active duty service members and veterans.	A noninferiority study design was used for this trial. This showed the comparison of a novel adaptation of established treatments that demonstrated efficacy. That a new treatment is not unacceptably worse than the current standard therapy. The noninferiority margin was identified as a standardized difference of 0.50.	158 assessed for eligibility 121 reported on in the final analysis. Veteran participants in the study (randomized; n=29) TBH 15 individuals and in-person 14 individuals. Active duty service members in the study for major depression (randomized; n=81) TBH 41 individuals and in-person 40 individuals, and minor depression in	Setting: United States military Hospital Joint Base Lewis-McChord clinics. Sample Inclusion criteria: (a) Met diagnostic criteria for minor depressive disorder or major depressive disorder, as determined by the Structured Clinical Interview for the DSM-IV Axis I Disorder (SCID-I/P) (b) High-speed Internet access at home (384 kB/s minimum) (c) If taking psychoactive medications, has maintained a stable regimen for a minimum of 30 days prior to study entry (d) Informed consent read and signed. Exclusion criteria: (a) Currently undergoing psychotherapy for depression (b) 18 or 65 years of age (c) Active psychotic symptoms/disorder as determined by the SCID-I/P	The independent variable is "Home based Tele behavioral Health" (HBTBH) services, it presumes to have an influence on the other variables of interest. The level of measurement here is Nominal.	The dependent variables are behavioral depression by the Hope and the Depression II. The measurement is Nominal. Interventions received an average of 3.91 points. Hope and Beck's Inventory

substance dependence or substance abuse will not be excluded) (h) History of violence or poor impulse control (i) Significant ongoing stressors that require urgent crisis intervention (j) Have a living arrangement that will not permit the use of a private space to participate in the study.

1st Author Name (Publication Yr.)	Study Purpose/Aims	Research Questions/Hypotheses (If different from/specifically described separately from study purpose & aims)	Study Design	Total Sample Size (How many initially, how many at final analysis?)	Sampling Plan	Independent Variables and Level of Measurement	Dependent and Level of Measurement
Morland et al., 2015	To compare the effectiveness of video teleconferencing (VTC) versus in-person individual delivery of a manualized evidence-based treatment (EBT) for Posttraumatic stress disorder (PTSD) through cognitive processing therapy (CPT) in a sample of civilian and veteran women to determine whether reductions of PTSD symptoms in the VTC-delivered psychotherapy were comparable to effects of in person delivery.	The key process indicators would not be significantly different between the VTC and in person conditions.	A noninferiority-designed randomized clinical trial (RCT) was conducted with women veterans, reserves, and guard, and civilian women with PTSD at the National Center for PTSD in the Department of Veterans Affairs (VA) in Honolulu, Hawaii. The VA Pacific Island Health Care System's Institutional Review Board approved the protocol.	Met criteria. Initial n = 149. enrolled in the study n = 126. Assigned to in person condition (randomized; n=63). Assigned to VTC condition (randomized; n=61).	Women with PTSD, including 21 veterans and 105 civilians, were assigned to receive psychotherapy delivered via VTC or in person. Study inclusion criteria were diagnosis of current PTSD established by the Clinician-Administered PTSD Scale (CAPS), and a stable psychotropic medication regimen for a minimum of 45 days prior to study entry for those taking such medications. Exclusion criteria were significant cognitive impairment or history of organic mental disorder, active psychotic symptoms/disorder, active homicidal or suicidal ideation, current substance dependence, and unwillingness to refrain from substance abuse during treatment	The independent variable is treatment delivered via video teleconferencing (VTC) through cognitive processing therapy (CPT). The level of measurement here is Nominal.	The dependent variable is PTSD the Clinician-Administered PTSD Scale. The measure is Ordinal. The civilian conduct is posttreatment 6-month respect

	Fortney et
	To compare the
	Collaborative
	A pragmatic
	Initial n = 275
	11 Department of Veterans
	The independent
	The de

<p>Acierno et al., 2016</p>	<p>To compare relative noninferiority of evidence-based psychotherapies for Posttraumatic Stress Disorder (PTSD) and Major Depression (MD) when delivered via Home Based Telehealth versus In-person delivery</p>	<p>evidence-based psychotherapy and pharmacotherapy for rural veterans compared to usual care (UC).</p>			<p>criteria for current PTSD according to the Clinician-Administered PTSD Scale (CAPS). Exclusion criteria included receiving PTSD treatment at a VA medical center or a current diagnosis of schizophrenia, bipolar disorder, or substance dependence. Two hundred sixty-five veterans were enrolled from November 23, 2009, through September 28, 2011, randomized to usual care (UC) or the TOP intervention and followed up for 12 months.</p>	<p>tele psychiatrists an outreach program for PTSD. The level of measurement is Nominal.</p>	<p>or psy level is Ord</p>
	<p>Behavioral Activation therapy delivered via HBT would produce similar reductions in PTSD and MD symptoms compared to in-person modalities. Reduced</p>		<p>Randomized controlled design powered for noninferiority analysis was used</p>	<p>Initial n = 265; Final analysis was n = 201. Assigned to (In person delivery) n =102; Assigned to usual care (HBT) n = 99.</p>	<p>Combat veterans returning to society with impairing mental health conditions such as PTSD and MD. Inclusion: diagnosis of PTSD established by the Clinician-Administered PTSD Scale (CAPS). Subthreshold PTSD was defined as meeting PTSD Criteria A (traumatic event) and B (re-experiencing), and</p>	<p>The independent variable is Behavioral Activation and Therapeutic Exposure (BA-TE), when delivered via home-based telehealth (HBT). The level of measurement is Nominal.</p>	<p>The de variab impro patient PTSD through level is Inte</p>

Yuen et al., 2013	This is a pilot study that aimed to assess the feasibility, acceptability, and initial efficacy of an acceptance-based behavioral intervention through Skype videoconferencing	Researchers hypothesized that patients and providers would report the videoconferencing modality as acceptable and feasible, and that levels of social	Pilot study	58 subjects contacted, 38 tele screened. 30 completed diagnostic assessment. 27 completed pretreatment assessment. 26 enrolled for	(hyperarousal). Veterans meeting either this subthreshold definition, or full criteria PTSD was eligible for participation. Exclusion: Individuals who were actively psychotic, acutely suicidal, or met criteria for current substance dependence were excluded from participation.	Remote Exposure behavioral therapy through skype video conferencing. Participants and therapists self-rated the intervention on acceptability and feasibility. Nominal level of	The fe accept initial expos therap skype confer phobio invent (SPA)
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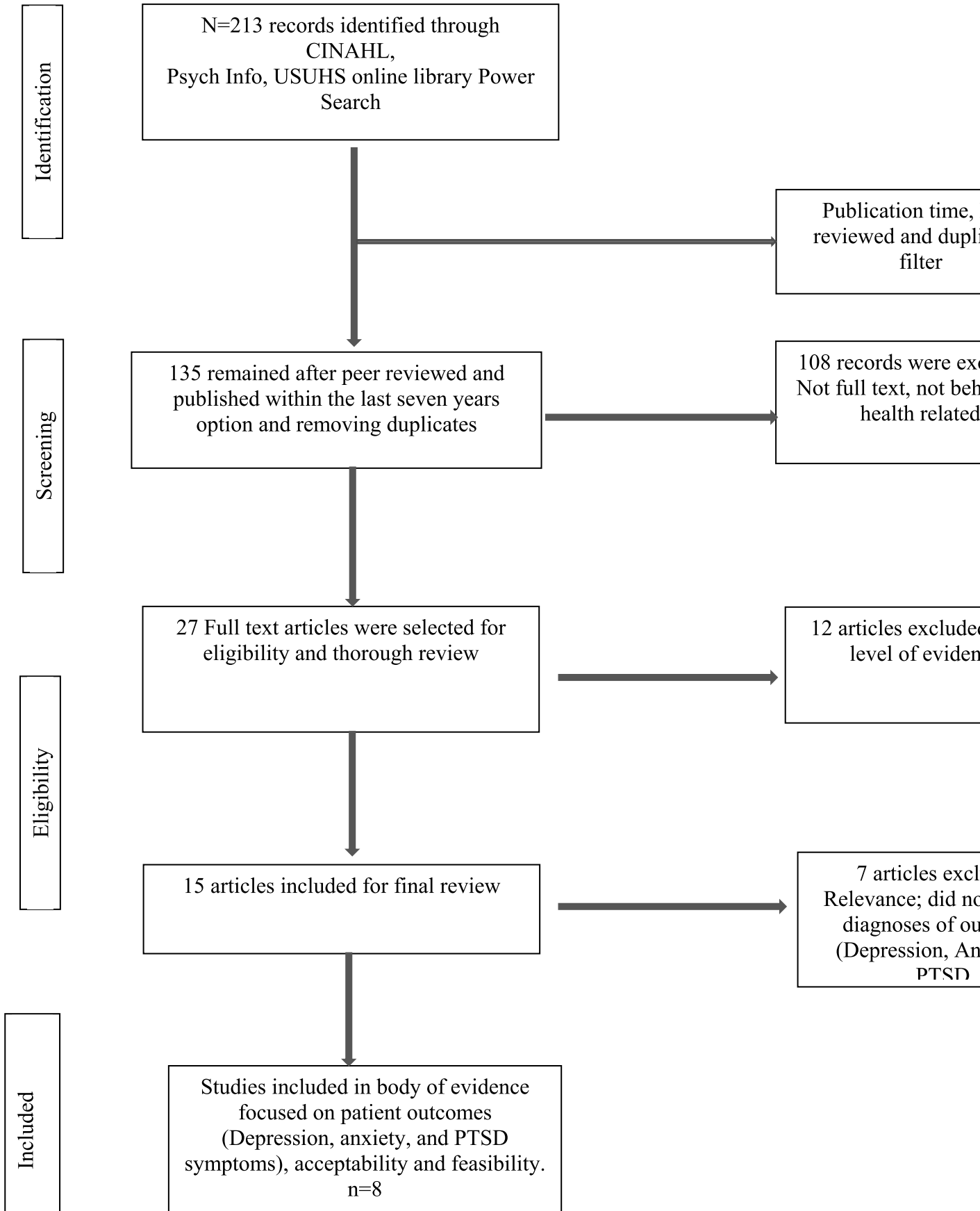
					<p>maintained at stable doses. Exclusion criteria included subjects with psychotic symptoms, acute suicide potential, history of substance dependence within the past 6 months, mental retardation, and serious developmental disorders.</p>		<p>Treatment Questionnaire (RTQ; Nau, Heiml, 2010), Work Inventory (WAI; Green, Tracey, 1989), Behavior Assessment (BAT; of me</p>
<p>1st Author Name (Publication Yr.)</p>	<p>Study Purpose/Aims</p>	<p>Research Questions/Hypotheses (If different from/specifically described separately from study purpose &amp; aims)</p>	<p>Study Design</p>	<p>Total Sample Size (How many initially, how many at final analysis?)</p>	<p>Sampling Plan</p>	<p>Independent Variables and Level of Measurement</p>	<p>Dependent and Level of Measurement</p>
<p>Harrer et al., 2018</p>	<p>The aim of this study is to evaluate the effectiveness of an internet- and mobile-based intervention targeting university students with heightened stress level</p>	<p>Researchers hypothesized Internet and mobile-based intervention to be more effective in reducing symptoms of stress compared with a waitlist control group (WCG) given</p>	<p>A 2-armed randomized controlled trial was conducted comparing an internet app-based intervention with feedback on demand to a waitlist control group (WCG).</p>	<p>150 participants; The sample size allowed to detect effect sizes of <math>d=0.41</math> with a power <math>(1-\beta)</math> of 0.80 with alpha of .05 and was based on a meta-analysis</p>	<p>College students; inclusion criteria (1) elevated levels of perceived stress (Perceived Stress Scale 4-item version) PSS. (2) enrollment in a German-speaking university at the beginning of the training, (3) age 18 years and older (4) internet access, (5) willingness to provide self-report data at all</p>	<p>The independent variable is internet- and mobile-based intervention. The level of measurement is Nominal.</p>	<p>The DV variable is in symptoms stress measurement Ordinal</p>

<p>Bashshur et al., 2016</p>	<p>This article's aim was to assess the state of scientific knowledge on the merit of telemedicine interventions in the treatment of mental disorders (TMH), focusing on feasibility/acceptance, medication compliance, health outcomes, and cost</p>	<p>Researchers suggested that there is increased prevalence of mental health issues across age, social, ethnic, and economic groups, and that there is a shortage of mental health professionals. They suggested that Telemental health (TMH) has the potential to solve these problems</p>	<p>Meta-analysis. Literature search of RCTs. 22 studies investigated the feasibility/acceptance of TMH, 32 studies focused on outcomes, and 5 studies addressed cost issues.</p>	<p>Robust scientific studies (defined as mostly randomized clinical trials [RCTs] with +150) The time frame for the analysis is the decade from 2005 to 2015.</p>	<p>depression outcomes (SMD=0.43) [17]. A sample size of 150 was therefore chosen to also detect significant changes for secondary outcomes in this study such as depression.</p>	<p>elevated risk for suicide were given detailed information about treatment options and were asked to see a physician or psychiatrist as soon as possible.</p>	<p>Independent variable is the use of different platforms of Telemental services</p>	<p>Mental outcomes feasibility accept</p>
<p>Nordgreen et al., 2018</p>	<p>The aim of this study is to examine the effectiveness of a</p>	<p>Researchers hypothesized that the effectiveness</p>	<p>This was a Pilot study conducted at three clinics</p>	<p>A total of 153 patients were eligible for</p>	<p>The sample consists of patients seeking psychiatric care in general</p>	<p>The independent variable is treatment delivered via guided</p>	<p>The dependent variable</p>	

			<p>guided ICBT using a naturalistic, within-group design with repeated primary and secondary treatment outcomes and 6-month follow-up.</p>	<p>treatment. Of those who started, 52 (45.6%) did provide 6-month follow-up data.</p>	<p>antidepressant medication, the dose must have been stable for the previous four weeks, and (5) be able to read and write in Norwegian. The exclusion criteria were: (1) current suicidal ideation, (2) current psychosis, (3) current substance abuse, (4) in immediate need of other treatment, and (5) no access to the Internet. All participants signed an informed consent.</p>		
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Appendix D

Prisma Flow Chart



## Appendix E

### Business Case with Value Based Care

#### BUSINESS CASE with VALUE BASED CARE ASSESSMENT

Proposed Title for Project/Initiative/Opportunity to Improve *Proposed Title*

Program Evaluation of TBH implementation at JBLM mental health clinics during the first 6 months of COVID-19 pandemic using the RE-AIM model.

Opportunity Statement (*Description of proposed project/initiative/opportunity to improve*) *Opportunity statement*

Mental health remains a major public health issue around the world affecting over 450 million people including over 7 million Americans. Currently, the demand for mental health services exceeds the supply due to both resources and provider shortages (Bashshur, Shannon, Bashshur, & Yellowlees, 2016). Pandemics and infectious diseases outbreaks can induce or exacerbate behavioral health disorders to include depression, anxiety, posttraumatic stress, and substance use due to fear and unavailability of resources (Asth.org, 2020). COVID 19 pandemic has presented a unique stressor by contributing to psychiatric conditions and negatively affecting the ability to seek and provide needed care (Gruber et al., 2020). The provision of mental health care via remote platforms, also known as telebehavioral health (TBH), is a viable evidence-based process that can alleviate some of the challenges brought about by the pandemic. Current studies demonstrate the effectiveness (Cost and patient outcomes) and the acceptability of Telemental health (Hilty, et al., 2015). JBLM BH clinics quickly implemented TBH services to meet the COVID-19 pandemic challenge. The implemented TBH program has not yet been evaluated. This project constitutes a program evaluation of TBH implementation at JBLM mental health clinics during the first 6 months of the COVID-19 pandemic using the RE-AIM model.

Business Opportunity/Objectives (*Prioritize listing – macro and micro objectives*) *Business Opportunity*

Macro objective

Contribute to enhanced TBH utilization and access to mental health care

Contribute to enhanced readiness of the warfighter

Contribute to better health for the warfighter

Contribute to better and effective resource utilization

Micro objectives

Evaluate the reach and effectiveness of TBH services at JBLM behavioral health clinics (patient reach and patient outcomes).

Assess provider/organizational TBH adoption, implementation, and maintenance at JBLM at the beginning of the pandemic to track the process for six months.

Potential Impact of the Initiative/Project (*Identify outcome metrics & benchmarks/and how objectives align with Quadruple Aim, Value Based Care, and HRO goals*) *Potential Impact*

This project contributes to the following MHS quadruple aims in the following manner:

**Better Health:** An effective TBH program will increase access to mental health care and reduce cost. Increased access will lead to early recognition, early provision of care leading to a mentally healthier force.

**Enhanced Readiness:** Timely and remote care allows for service members to receive specialized care at their local stations. SMs will spend less time and resources (transport, escorting staff, accommodation, time away from work) This approach will free more time and resources for training and other readiness priorities.

**Better Care:** An effective TBH program creates a safe channel for SMs who may be hesitant to seek care due to the fear of being seen walking into BH clinics/areas. SMs have in the past expressed being seen in BH clinic areas/buildings as a barrier to seeking mental health services (USUHS mental health stigma student and staff panel).

Alternatives (courses of action) chosen for Analysis: *Alternatives*

Provides more time for the current process to prove whether it is effective or not Change can bring conflict	Uncertainty on the TBH process (Both provider and consumers) potentially leading to less utilization
---	--

**Assumptions** *Assumptions*

1. Conducting the evaluation will provide numerical data on how many patients are benefiting from TBH services. Proposed changes will lead to improved reach (more patients utilizing TBH). Evidence and data driven changes and adjustments made to the process will increase the number of patients cared for via TBH.
2. Option one provides an advantage over second option due to the employment of objective quantifying metrics
  - a. PCL-5 for PTSD severity
  - b. GAD 7 for anxiety
  - c. PHQ-9 for depression
  - d. Cost effectiveness
3. A standardized process will increase providers' comfort and utilization of the program. Lack of proper guidance on standard operating procedures (SOP) and processes can cause confusion and variation between individual providers and clinics.

**Recommendation and Rationale** *Make a choice*

**Recommendation** *Make a choice*

We recommend conducting a program evaluation of TBH implementation at JBLM mental health clinics during the first 6 months of COVID-19 pandemic using the RE-AIM model.

**Rationale** *Make a choice*

There have been extensive studies demonstrating the effectiveness and the acceptability of Telemental health, however, there is a need for a practice-focused approach on how to adopt telehealth in mental health (Waltman et al.,2020). This action is necessary to improve the patient and providers experience and to identify key barriers in TBH services (Tuckerson, et al., 2017). This program evaluation will help determine patient outcomes, patient and provider experiences, and cost effectiveness. Compared to socio-demographically matched civilians, military members appear to be disproportionately affected by mental health disorders. This is partially due to exposure to unique stressors that come with the profession (Kessler et al., 2014). This means TBH services must not only be adopted, but the effectiveness must be scientifically and objectively evaluated. JBLM BH clinics quickly implemented TBH services to meet the COVID-19 pandemic challenge. The need for change was urgent. This project will evaluate the adoption of the TBH services at JBLM mental health clinics and track its effectiveness over a six-month period.

*Value Based Care - Investment Required by the Organization and the Associated "VALUE" or \$ GAINED. Below represents two ways to present this information. Depending on the initiative, you may need to alter this outline. Please adjust as appropriate and if need be ... do not hesitate to create this portion on a separate document and then attach to this assignment. Outline the Value Based Care*

The costs associated with this project include:

X= hourly rate is \$50. Y= cost of goods is estimated at 13,330

X: Time the evaluators spent to meet with key stakeholders, local leadership, clinic leadership and Information Technology Department. Templates/charts/evaluation tools and software. Data collection and reviewing patient records, data processing.

Y: The cost of goods; (a)software/templates/evaluation tools = \$5,000  
 (b)office supplies/stationery material =\$3,890  
 (c)printed material/printed charts =\$2,960  
 (d)miscellaneous items =\$1,480

4. Lack of Resources (manpower/limited access to Key stakeholders and leadership)	4. Establish a comprehensive list of required resources and partnership with the Key stakeholders and leadership. Collaborate with the Information Technology department, conduct recurring calendar meetings with Key stakeholders and leadership for updates, planning, to gain access to resources and personnel. Set and state realistic deadlines to the team for a manpower of two.
5. Human factor (interpersonal skills of the evaluators)	5. Maintain open communication, build trust, address barriers and concerns early and as they come. Ensure shared expectations throughout the project

**Implementation Plan** *Implementation plan*

Phase 1: Planning: analyze the current program at the start of Covid-19 with the use of the project-created RE-AIM-based evaluation plan

Milestone Description: Evaluators to meet key personnel and gain access to the mental health clinics at JBLM

Deliverables	Due Date	Accountable Person
<ol style="list-style-type: none"> <li>1. Conduct a meeting with the key stakeholders, local leadership, unit leadership and providers to state the purpose of the program evaluation.</li> <li>2. Review all written procedures at JBLM Mental Health Clinics.</li> <li>3. Conduct a meeting with the Information Technology Department to discuss the evaluation program, and the needed support to gain access to specific records identified by parameters and diagnoses set.</li> <li>4. Create data collection sheet based on identified metrics needed for data analysis plan</li> <li>5. If needed revise the original project timeline for the remaining phases.</li> </ol>	2-3 months	Cpt Githiora, LT Smith, Leadership, Key Stakeholder, Information Technology Department

**Resources Needed**

Access to the eight mental health clinics at JBLM, access to the database, access to the providers and key stakeholders and access to the personnel in the Information Technology Department. Data collection developed to be used.

**Expected Level of Benefit**

A completed assessment, services and support identified, target dates reviewed, Data collection developed to be used.

Phase 2: Implementation Phase

Milestone Description: Implement the program evaluation using the project-created RE-AIM-based evaluation plan

Deliverables	Due Dates	Accountable Person
<ol style="list-style-type: none"> <li>1. Conduct EHR reviews to collect data per data analysis plan, the data source (R1, R2, E1, E2, E3, E4, I1)</li> <li>2. Conduct meetings with key stakeholders to obtain data per data analysis plan, the data</li> </ol>	3-4 months	LT Smith, Cpt Githiora,

# Team Mentor (Committee Membership) Agreement Form



Appendix C: Daniel K. Inouye Graduate School of Nursing  
DNP Project Team Mentor (Committee Membership) Agreement Form

## DOCTOR OF NURSING PRACTICE PROJECT DNP Project Clinical Question and Team Mentor (Committee Membership) Agreement

**Graduation Year:** 2022      **Phase 2 Site(s) Name:** Joint Base Lewis-McChord

### Name(s) of DNP Project Student Team:

- |                        |                                |                              |   |                              |                            |
|------------------------|--------------------------------|------------------------------|---|------------------------------|----------------------------|
| 1. LT Latisha Smith    | AGCNS <input type="checkbox"/> | FNP <input type="checkbox"/> | PMHNP <input checked="" type="checkbox"/> | RNA <input type="checkbox"/> | W <input type="checkbox"/> |
| 2. CPT Edward Githiora | AGCNS <input type="checkbox"/> | FNP <input type="checkbox"/> | PMHNP <input checked="" type="checkbox"/> | RNA <input type="checkbox"/> | W <input type="checkbox"/> |
| 3. _____               | AGCNS <input type="checkbox"/> | FNP <input type="checkbox"/> | PMHNP <input type="checkbox"/>            | RNA <input type="checkbox"/> | W <input type="checkbox"/> |
| 4. _____               | AGCNS <input type="checkbox"/> | FNP <input type="checkbox"/> | PMHNP <input type="checkbox"/>            | RNA <input type="checkbox"/> | W <input type="checkbox"/> |
| 5. _____               | AGCNS <input type="checkbox"/> | FNP <input type="checkbox"/> | PMHNP <input type="checkbox"/>            | RNA <input type="checkbox"/> | W <input type="checkbox"/> |
| 6. _____               | AGCNS <input type="checkbox"/> | FNP <input type="checkbox"/> | PMHNP <input type="checkbox"/>            | RNA <input type="checkbox"/> | W <input type="checkbox"/> |

### The tentative title of the DNP Project Proposal for this student group is:

Joint Base Lewis-McChord (JBLM) Telebehavioral Health Service Program Evaluation

### Committee Approved DNP Project Clinical Question:

Do patients with mental health diagnoses, utilizing telebehavioral health services, versus standard of care have a reduction in symptom severity and remain engaged in treatment?

### Names of DNP Project Team Mentors (type the name and obtain digital signatures):

I agree to serve as a member of the DNP Project Team (Team Mentors) for the above DNP Project Team. As a Project Team Mentor, I agree to the duties and responsibilities outlined in the DNP Project Manual which include but are not limited to the provision of consultation and guidance supporting the entire DNP project journey and to ensure the DNP project is of sufficient rigor and demonstrates doctoral level scholarship to meet the requirements for USUHS GSN graduation.

**NOTE:** You may have 3-4 DNP Team Mentors [committee members including your DNP Senior Mentor (Chair)]. The Phase II Site Director may also be a member of the group, as well as other USUHS faculty or others who may serve as content experts. All non-USUHS faculty selected as Team Mentor must be approved by the DNP Project Director.

Senior Mentor (Chair):	Dr. Nicole Moret	Signature:	Nicole Moret	Digitally signed by Nicole Moret Date: 2022.04.27 17:00:38 -04'00'	Date:
Team Mentor (Member):	LTC Jennifer Fiandt	Signature:	FIANDT.JENNIFER.COREY.162428906	Digitally signed by FIANDT.JENNIFER.COREY.162428906 Date: 2022.04.27 15:54:27 -07'00'	Date:
Team Mentor (Member):		Signature:			Date:

# CITI Training Certificates



Completion Date 05-Apr-2020  
Expiration Date 05-Apr-2023  
Record ID 36098890

This is to certify that:

**Edward Githiora**

Has completed the following CITI Program course:

**OUUSD P&R Human Research** (Curriculum Group)  
**Biomedical Investigators and Research Study Team** (Course Learner Group)  
**1 - Basic Course** (Stage)

Not valid for renewal of certification through CME. Do not use for TransCelerate mutual recognition (see Completion Report).

Under requirements set by:

**Office of the Under Secretary of Defense (Personnel and Readiness)**



Verify at [www.citiprogram.org/verify/?wfd918654-da03-44cb-8c3f-a15b08559ba3-36098890](http://www.citiprogram.org/verify/?wfd918654-da03-44cb-8c3f-a15b08559ba3-36098890)



This is to certify that:

**Edward Githiora**

Has completed the following CITI Program course:

**GCP - Social and Behavioral Research Best Practices for Clinical Research**  
**GCP - Social and Behavioral Research Best Practices for Clinical Research**  
**1 - Basic Course**

Under requirements set by:

**Office of the Under Secretary of Defense (Personnel and Readiness)**

Verify at [www.citiprogram.org/verify/?we7dc26d3-e8ff-44a7-8...](http://www.citiprogram.org/verify/?we7dc26d3-e8ff-44a7-8...)



Completion Date 05-Apr-2020  
Expiration Date 05-Apr-2023  
Record ID 36098894

This is to certify that:

**Edward Githiora**

Has completed the following CITI Program course:

**Good Clinical Practice (U.S. FDA Focus)** (Curriculum Group)  
**GCP for Clinical Trials with Investigational Drugs and Medical Devices (U.S. FDA Focus)** (Course Learner Group)  
**1 - GCP** (Stage)

Not valid for renewal of certification through CME. Do not use for TransCelerate mutual recognition (see Completion Report).

Under requirements set by:

**Office of the Under Secretary of Defense (Personnel and Readiness)**



Verify at [www.citiprogram.org/verify/?w695780d8-706f-44c8-938e-cfda0870597a-36098894](http://www.citiprogram.org/verify/?w695780d8-706f-44c8-938e-cfda0870597a-36098894)



This is to certify that:

**Edward Githiora**

Has completed the following CITI Program course:

**Responsible Conduct of Research (RCR)** (Curriculum Group)  
**Responsible Conduct of Research (RCR)** (Course Learner Group)  
**1 - Basic Course** (Stage)

Under requirements set by:

**Office of the Under Secretary of Defense (Personnel and Readiness)**

Verify at [www.citiprogram.org/verify/?w41d6234d-f74a-401...](http://www.citiprogram.org/verify/?w41d6234d-f74a-401...)



Completion Date 05-Apr-2020  
Expiration Date 05-Apr-2023  
Record ID 36098893

This is to certify that:

**Edward Githiora**

Has completed the following CITI Program course:

**OUUSD P&R Human Research** (Curriculum Group)

Not valid for renewal of certification through CME. Do not use for TransCelerate mutual recognition (see Completion Report).



This is to certify that:

**Edward Githiora**

Has completed the following CITI Program course:



Completion Date 06-May-2020  
 Expiration Date 06-May-2023  
 Record ID 36542900

This is to certify that:

**Latisha Smith**

Has completed the following CITI Program course:

**Good Clinical Practice (U.S. FDA Focus)**  
**GCP for Clinical Trials with Investigational Drugs and Medical Devices (U.S. FDA Focus)**  
 1 - GCP

(Curriculum Group)  
 (Course Learner Group)  
 (Stage)

Not valid for renewal of certification through CME. Do not use for TransCelerate mutual recognition (see Completion Report).

Under requirements set by:

**Office of the Under Secretary of Defense (Personnel and Readiness)**



Verify at [www.citiprogram.org/verify/?w2a8aa610-f9d1-480d-b99c-dcbe6036f9f3-36542900](http://www.citiprogram.org/verify/?w2a8aa610-f9d1-480d-b99c-dcbe6036f9f3-36542900)



This is to certify that:

**Latisha Smith**

Has completed the following CITI Program course:

**GCP – Social and Behavioral Research Best Practices for Research**  
**GCP – Social and Behavioral Research Best Practices for Research**  
 1 - Basic Course

Under requirements set by:

**Office of the Under Secretary of Defense (Personnel and Readiness)**

Verify at [www.citiprogram.org/verify/?w80h17eef-c423-4bac-9cf](http://www.citiprogram.org/verify/?w80h17eef-c423-4bac-9cf)



Completion Date 23-Mar-2020  
 Expiration Date 23-Mar-2023  
 Record ID 36009087

This is to certify that:

**Latisha Smith**

Has completed the following CITI Program course:

**Responsible Conduct of Research (RCR)** (Curriculum Group)  
**Responsible Conduct of Research (RCR)** (Course Learner Group)  
 1 - Basic Course (Stage)

Not valid for renewal of certification through CME. Do not use for TransCelerate mutual recognition (see Completion Report).

Under requirements set by:

**Office of the Under Secretary of Defense (Personnel and Readiness)**



Verify at [www.citiprogram.org/verify/?wed565bec-5271-4ce6-a794-e9dc6abfad6-36009087](http://www.citiprogram.org/verify/?wed565bec-5271-4ce6-a794-e9dc6abfad6-36009087)



This is to certify that:

**Latisha Smith**

Has completed the following CITI Program course:

**OUSD P&R Human Research**  
**Biomed Research Coordinators, Clinical Coordinators, Study Coordinators & Research Administrators**  
 1 - Basic Course

Under requirements set by:

**Office of the Under Secretary of Defense (Personnel and Readiness)**

Verify at [www.citiprogram.org/verify/?w16153c49-11af-4d80-ba0b](http://www.citiprogram.org/verify/?w16153c49-11af-4d80-ba0b)



Completion Date 23-Mar-2020  
 Expiration Date 23-Mar-2023  
 Record ID 36009085

This is to certify that:

**Latisha Smith**

Has completed the following CITI Program course:

**OUSD P&R Human Research** (Curriculum Group)  
**Biomedical Research Support Staff** (Course Learner Group)  
 1 - Basic Course (Stage)

Not valid for renewal of certification through CME. Do not use for TransCelerate mutual recognition (see Completion Report).



This is to certify that:

**Latisha Smith**

Has completed the following CITI Program course:

**OUSD P&R Human Research**  
**Social and Behavioral Investigators and Research Study Team**  
 1 - Basic Course

USU (VPR) Form 3202N

**USUHS FORM 3202N  
DANIEL K. INOUE GRADUATE SCHOOL OF NURSING  
EVIDENCE-BASED PRACTICE/PERFORMANCE IMPROVEMENT PROPOSAL**



**Project Number:** GSN-61-12390 (VPR will assign)

**Project Title:** Program Evaluation of TBH Implementation at JBLM mental health clinics during the first of COVID-19 pandemic

**SECTION A: STUDENT POC INFORMATION**

1. Name (Last, First, MI): GITHIORA, EDWARD Student E-mail: edward.githiora@usuhs.edu  
 2. Home Address: 11217 Bent Creek Ter Germantown MD Cell Number: 763-639

**SECTION B: COMMITTEE CHAIR / SENIOR MENTOR INFORMATION**

3. Name (Last, First, MI): MORET NICOLE  
 4. Telephone: 860-558-7441 Fax: \_\_\_\_\_ E-mail: nicole.moret@usuhs.edu  
 5. USUHS Building/ Room No.: GSN Building E USUHS

**SECTION C: PROJECT INFORMATION**

6. Attach the Abstract for the proposal, including the following sections: Site Location of the Project, Title, Authors, Background, Problem/Issue, Clinical Question/Purpose, Project Design, Anticipated Organizational Impact/Implications for Practice, and Budget. The abstract should include the Proposed Timeline. Single space the abstract and use Times New Roman font, size 12.  
 7. Is this proposal related to an active research project of the Chair/Senior Mentor identified in Section B?  Yes  No  
 If yes, complete below; if no, proceed to Part 8.  
 Project Number: \_\_\_\_\_  
 Project Title: \_\_\_\_\_  
 Project Start Date: \_\_\_\_\_ Project End Date: \_\_\_\_\_

8. Anticipated period of performance: Project Start Date: 1/1/2021 Project End Date: 4/1/2022

9. Performance Site(s): JBLM BH CLINICS

10. Does this project involve any classified information? (Contact the USUHS Security Office for guidance)  Yes  No

11. Do you have a funding source for this project?  Yes  No  NA  
 If yes, specify the funding agency and the amount provided: \_\_\_\_\_

**SECTION D: SIGNATURES**

The following signatures attest to the validity of the above information:

GITHIORA.EDWARD.KABII.1291284929 Digitally signed by GITHIORA.EDWARD.KABII.1291284929 Date: 2022.01.06 07:17:10 -08'00'  
 Student (Project Point of Contact for the Group) (Signature and Date)

Nicole Moret Digitally signed by Nicole Moret Date: 2022.01.06 07:17:10 -08'00'  
 Chair/Senior Mentor (Signature and Date)

OWEN.REGINA.D.1253117423 Digitally signed by OWEN.REGINA.D.1253117423 Date: 2022.01.20 08:32:47 -05'00'  
 Chair/Program Director (Signature and Date)

Chair/Program Director (Signature and Date)

DNP Project Director or PhD Director (Signature and Date)

SEIBERT.DIANE.C.1084932279 Digitally signed by SEIBERT.DIANE.C.1084932279 Date: 2022.01.20  
 Associate Dean for Academic Affairs, GSN (Signature and Date)

WASSERMAN.JOAN.E.1551061066 Digitally signed by WASSERMAN.JOAN.E.1551061066 Date: 2022.01.20 18:00:26 -05'00'  
 Associate Dean for Research, GSN (Signature and Date)

ROMANO.CAROL.A.1032050294 Digitally signed by ROMANO.CAROL.A.1032050294 Date: 2022.01.20  
 Dean, DKI Graduate School of Nursing (Signature and Date)

# Institutional Review Board Letter of Determination



**DEPARTMENT OF THE ARMY**  
**MADIGAN ARMY MEDICAL CENTER**  
**9040 JACKSON AVENUE**  
**TACOMA, WA 98431-1100**

MCHJ-ISI

8 October 20

MEMORANDUM FOR LT Latisha Smith, DNP/Psych Mental Health Nurse Practitioner Student, and CPT Edward Githiora, AN, DNP/Psych Mental Health Nurse Practitioner Student, USU Class 2022

SUBJECT: Determination of Not Research for, "Program Evaluation of Telebehavioral Health Implementation at JBLM Mental Health Clinics during the First 6 Months of the COVID-19 Pandemic Using the RE-AIM Framework". Reference # 222004

1. The Madigan Army Medical Center Human Research Protections Office initially received the above-referenced project on 18 July 2021 to review for applicability to human subjects protections regulations. Revisions were required and the application was resubmitted with all required documents on 30 September 2021.
2. This project aims to evaluate how telebehavioral health (TBH) services were adopted, implemented, and maintained during the first six months of the COVID-19 pandemic and the impact on patient outcomes (reach and effectiveness) at JBLM mental health clinics, guided by the RE-AIM Framework. This process will identify strengths and the weaknesses of the program through which TBH care was provided during the early phase of implementation. It will also identify how many active duty service members utilized TBH services and their outcomes in the first six months of the COVID-19 pandemic protocols were instituted.
3. This study does not constitute research as defined under the human subjects protections regulations, as it is not "a systematic investigation . . . designed to develop or contribute to generalizable knowledge." [32 CFR 219.102(l)] Additionally, per DoD Instruction (DoDI) 3216.02, "activities, including program evaluation, customer satisfaction surveys, user surveys, outcome reviews, and other methods, designed solely to assess the performance of DoD programs where the results of the evaluation are only for the use of Government officials responsible for the operation or oversight of the program being evaluated and are not intended for generalized use beyond the program" are not research involving human subjects, and as such, are not covered under the requirements of DoDI 3216.02.

MCHJ-ISI

SUBJECT: Determination of Not Research for "Program Evaluation of Telebehavioral Health Implementation at JBLM Mental Health Clinics during the First 6 Months of COVID-19 Pandemic Using the RE-AIM Framework" Reference # 222004

4. **This determination should not be construed as approval to conduct this project.** It is your responsibility to identify and obtain any necessary permissions or approvals to conduct the project prior to initiation. This activity may proceed with no further requirement for review by the Madigan Army Medical Center Human Research Protections Office, pending other required approvals.

5. In addition, your project may become research subject to IRB review if it becomes and/or includes a systematic investigation to develop or contribute to generalizable knowledge. In the event there is a change to the above-described project that may affect its determination, please submit a modification form for review and determination. No change to this activity may be implemented until the review is completed and you have been notified that there is no revision to our determination that your activity is deemed not to be research. A request for our review does not need to be submitted if the following changes to your activity: (1) personnel conducting the activity; (2) location or site at which activities will be conducted; (3) number of respondents; or (4) period of time over which the activity will be conducted. You are not authorized to take project data away from the institution.

6. All publications, presentations or abstracts arising from this work must be cleared through appropriate publication clearance procedures prior to publication IAW your institution's local publication clearance policy. Many journals are interested in publishing projects that are not research. If you do decide to publish your findings, please use paragraph headings such as: "issue," "procedures for collecting and evaluating information," "information found," "lessons learned," etc. and avoid using headings such as "research questions or hypothesis," "methods," "results," "study limitations," etc.

7. The Madigan Army Medical Center Human Research Protections Office point of contact for this review is Dr. Mary S. McCarthy in the Center for Nursing Science & Clinical Inquiry at 253-968-3695.

  
Exempt Determination Official  
Center for Nursing Science & Clinical Inquiry

## Public Affairs Office Clearance Letter

# DNP Project Completion Verification Form



Appendix G: Daniel K. Inouye Graduate School of Nursing  
DNP Project Completion Verification Form

## DOCTOR OF NURSING PRACTICE PROJECT Completion Verification Form

The DNP Project titled: Joint Base Lewis-McChord (JBLM) Telebehavioral Health Service Program Evaluation

was completed at Joint Base Lewis-McChord (JBLM) by the following

<i>(type student name)</i>	<i>(signature)</i>	<i>(date)</i>
LT Latisha Smith	Latisha Smith <small>Digitally signed by Latisha Smith Date: 2022.04.27 09:35:21 -07'00'</small>	27APR22
CPT Edward Githiora	GITHIORA.EDWARD.KABII.1291284929 <small>Digitally signed by GITHIORA.EDWARD.KABII.1291284929 Date: 2022.04.27 10:17:14 -07'00'</small>	27APR22

The DNP Practice Project Team verifies that the following components of the DNP project, by the above students, is of sufficient rigor and demonstrates doctoral level scholarship to meet requirements for USUHS GSN graduation:

- Presentation to the DNP Project Team,
- Presentation of DNP project to the leadership at the Phase II Site,
- Abstract/Impact Statement (*Appendix I*), and
- DNP Project Written Report.

Verified by:

<i>(type name)</i>	<i>(signature)</i>	<i>(date)</i>	
Nicole Moret	Nicole Moret <small>Digitally signed by Nicole Moret Date: 2022.04.27 16:59:10 -04'00'</small>	27APR22	Senior Mentor
Jennifer Fiandt	FIANDT.JENNIFER.COREY.1162428906 <small>Digitally signed by FIANDT.JENNIFER.COREY.1162428906 Date: 2022.04.27 15:53:21 -07'00'</small>	27APR22	Team Mentor
			Team Mentor
			Team Mentor & Phase II S