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Enhancing Capacity to Address Mental Health Needs of Veterans and Their Families

The Welcome Back Veterans Initiative

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Key findings

- The Welcome Back Veterans (WBV) Initiative was launched in 2008 to support Iraq and Afghanistan veterans and their families across the United States. In the most recent funding cycle, the program supported several academic medical centers to expand access to high-quality mental health care for veterans and their families.
- Across the initiative, WBV partners designed and implemented a suite of activities to raise awareness, conduct outreach, educate and train providers and organizations, and deliver services directly to veterans and their families.
- WBV sites identified and worked to overcome several challenges to engage veterans, create partnerships with other organizations and agencies, and expand the longevity of their programs.
- WBV sites used various strategies to meet the mental health needs of veterans and their families. Many employed veterans as peer connectors and outreach coordinators, developed referral relationships with other veteran-serving organizations and facilities, and held training events with local community-based providers.
- Building public-private partnerships was a priority for WBV sites. Sites that demonstrated stronger partnerships tended to communicate regularly, have two-way referrals, and have relationships on multiple levels.
- The WBV could serve as a model for other nongovernmental sector initiatives to serve veterans and their families.

Since 2001, more than 2.6 million Americans have deployed to support military operations for Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF) and Operation New Dawn (OND) in Iraq. Many of these individuals deployed multiple times and experienced significant exposure to combat-related trauma. As these service members come home, leave military service, and reintegrate into their families and communities, they may face several challenges. Many empirical studies have documented the nature of these challenges, particularly those related to post-deployment health-related concerns and family readjustment.

While most OIF/OEF/OND veterans have readjusted to civilian life with relatively minimal problems, others have faced difficulty reestablishing relationships with family and friends, seeking work, and continuing their education.¹ Several studies have examined the impact of deployment on the well-being of service members and of their spouses and children. Deployment can have both positive outcomes (e.g., increases in post-deployment earnings for reservists, probability of promotion and career growth) and negative outcomes (e.g., increases in risk of injury and illness (including post-deployment health problems), marital dissolution, lowered military retention).² The Pew Research Center has found that, while many post-9/11 veterans reported positive experiences and outcomes with their military experience, 44 percent said they had difficulty readjusting to civilian life; 48 percent reported strains in family relations since leaving the military; and 47 percent reported frequent outbursts of anger.³

Among the most widely studied deployment-related health issues for veterans are mental health problems. The estimated

Abbreviations

BSC	Breakthrough Series Collaborative
DoD	Department of Defense
FQHC	federally qualified health center
MDD	major depressive disorder
MLB	Major League Baseball
M-SPAN	Military Support Programs and Networks
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OND	Operation New Dawn
PATSS	Program for Anxiety and Traumatic Stress Studies
PMC	Performance Monitoring Center
PTSD	posttraumatic stress disorder
RFP	Request for Proposals
TBI	traumatic brain injury
UCLA	University of California at Los Angeles
V3C	Veteran Culture and Clinical Competencies
VA	Department of Veterans Affairs
VAP3C	VA Patient Centered Community Care
VSO	veteran service organization
WBV	Welcome Back Veterans

prevalence rates of posttraumatic stress disorder (PTSD) and major depressive disorder (MDD) among OEF/OIF service members vary across studies due to differences in diagnostic screening criteria, analytical methods and timing, and study population. The latest estimates of PTSD rates among OIF/OEF veterans have typically varied from 13 to 20 percent,⁴ and those for depression vary from 10 to 15 percent.⁵ Other studies indicate that between 19 and 23 percent of OIF/OEF veterans have incurred a probable traumatic brain injury (TBI) during service and that between 5 and 39 percent have displayed symptoms of problematic alcohol use.⁶

Studies of returning service members and veterans note that relatively few seek help for mental health problems. Among those with a mental health problem such as PTSD, only about half seek any care or assistance; among those who do seek care, only about half receive at least minimally adequate treatment.⁷ Veterans report many barriers to seeking care, including concerns about the confidentiality of care, side effects of medications, and potentially damaging career repercussions.⁸

To ameliorate such negative consequences, the Department of Defense (DoD) and others have expanded support programs for military families across the deployment cycle. In particular, DoD and veterans' agencies have allocated billions of dollars to expand mental health services in support of the significant numbers of returning troops who had experienced wounds, injuries, and illnesses associated with their military service. These programs and services range across the deployment cycle, as well as across the prevention-intervention continuum, and have been instrumental in expanding access for returning veterans and their families. Programs include those that increase military families' abilities to build relationships, increase function and promote resilience both individually and as families, and decrease the risk of psychological and physical health issues.⁹

Despite the existence of hundreds of programs, studies have shown enormous gaps in the provision of high-quality and culturally competent services and programs to support veterans and their families, and concerns about sufficient capacity and quality to meet the needs of all veterans and their families remain. For example, in a recent review conducted by the Institute of Medicine, the Committee on the Assessment of Ongoing Efforts in the Treatment of Posttraumatic Stress Disorder found insufficient data to assess the quality and effectiveness of reintegration programs and prevention strategies for behavioral and mental health outcomes for service members and their families.¹⁰ Reviewers noted that both DoD and the Department of Veterans Affairs (VA) had undertaken efforts purported to enhance capacity and deliver high-quality care but said the lack of data made it impossible to determine whether needs were being met and whether the systems were delivering high-quality care. Moreover, relatively few programs are aimed at some of the key challenges faced by military families (including stress disorders and depression), and many do not address the barriers associated with seeking treatment.¹¹ Reports about appointment wait times, rising suicide rates, and barriers to seeking help continue to dominate mainstream media. While access standards for the federal health systems have been set and communicated, recent concerns indicate the need for even greater capacity to meet the mental health needs of veterans and their families.

With the support of the philanthropic community, several new organizations, programs, and initiatives have sought to create additional capacity since 2001 for supporting military and veteran families and to address the gaps noted above.¹² Many of these efforts have focused specifically on meeting the post-deployment mental health and employment-related needs of

veterans and their families. For example, funding from private-sector and nonprofit organizations has helped create new or adapt existing community-based programs to assist service members, veterans, and their families in the areas of education; physical and mental health; family and community services; and legal, financial, and housing services—with some organizations offering medical services to veterans and their families for free.¹³

Among these efforts is the Welcome Back Veterans (WBV) Initiative, launched in 2008 by Major League Baseball (MLB) team owners through the work of MLB Charities and in partnership with the Robert R. McCormick Foundation (McCormick Foundation) to transform the lives of returning veterans by providing ongoing treatment to them and their families for PTSD and other deployment-related mental health issues. The WBV Initiative sought to complement existing efforts and programs available through DoD and VA by implementing community-based programs at leading academic medical institutions and nonprofit organizations throughout the country.

To help document the activities and facilitate sharing within the Initiative, the McCormick Foundation asked the RAND Corporation in 2011 to serve as a Performance Monitoring Center (PMC) for the WBV Initiative.¹⁴ The goal of the PMC was to provide subject-matter and technical expertise in designing and implementing a monitoring framework and infrastructure for the program. RAND documented activities and examined lessons learned by sites that could inform efforts related to outreach, enrollment, and mental health treatment of veterans and their families, as well as about the development and long-term sustainability of public/private partnerships. The PMC did not evaluate individual programs; instead, it synthesized collective efforts. In this report, we describe the guiding conceptual framework for the PMC and provide details on its activities and approaches. We also describe the services and programs offered under the WBV Initiative and document the impact that these programs are having in creating additional capacity for serving veterans and their families over their performance period between February 2011 and June 2013 (referred to as Phase 1).¹⁵ While the WBV Initiative continues to support several of these programs and their activities, this report focuses on this specific period of activity. In the coming years, RAND will continue to work with the WBV Initiative to summarize activities and lessons learned among the sites that received continuation funding through 2015 and prepare a subsequent report in 2016.

As additional philanthropic efforts are established to serve veterans and their families, and as the call for expansions in the creation of public-private partnerships continues, the experience of the WBV Initiative may provide useful insight and serve as a guide for future endeavors.

THE WELCOME BACK VETERANS INITIATIVE

As the empirical evidence about the challenges that returning veterans face began to grow in 2008, MLB and the McCormick Foundation began a unique partnership and grant-making program to support returning veterans and their families. Through the initial philanthropic efforts of Fred Wilpon, owner of the New York Mets, as well as the work of MLB Charities, the WBV Initiative was launched in partnership with the McCormick Foundation. The objective was to establish a nationwide program of support for veterans returning home from the wars in Iraq and Afghanistan by creating and resourcing programs to facilitate their reintegration into their communities. The WBV Initiative set out to work closely with DoD and VA, as well as other government and nongovernment entities and nonprofit organizations, to provide essential services and support to veterans and their families.

Initially, the focus of the WBV Initiative was to provide assistance to veteran support programs across a number of areas: employment and career development, family support, and treatment for mental health problems. During the early years of the Initiative, 37 nonprofit organizations were funded to implement community-based programs across these three areas, valued at approximately \$6 million. These organizations were resourced to develop and implement programs designed to deliver clinical services (evaluation, treatment, and referral) for mental health problems and wraparound supports for families—as well as employment training, housing and education, research to test innovative models for treating the invisible wounds of war, and raising public awareness. Over the course of the initial grant-making period, many of the supported organizations reported significant challenges to implementing their programs. These challenges were largely due to the difficulty with engaging veterans in their programs and developing relationships with the other veteran-serving organizations, including the federal government.

In 2010, following the initial grant-making, MLB and the McCormick Foundation conducted a review of their existing

approach. They engaged in internal strategic planning, site visits to the funded centers, and consultation with the Entertainment Industry Foundation. During this process, a few key conclusions were reached:

- Best practices in service delivery to veterans involve comprehensive, integrated models that address stigma reduction, navigation support, social services, counseling, and education within a concept of “no wrong door,” meaning that veterans will get effective referrals for services they need regardless of where they begin their search.
- Existing health facilities within communities have the capacity and opportunity to deliver needed services; however, better-trained mental health providers are needed. Thus, these professionals (along with other service providers) should be trained to improve detection, diagnosis, care, and treatment of PTSD and other war-related mental and health care issues for veterans and their families.

Following this review, and in light of these insights, the goals of the WBV Initiative were clarified to focus primarily on mental health issues moving forward in 2011. Currently, the WBV objectives are to

- transform the lives of returning veterans and their families by facilitating ongoing treatment and support for PTSD, depression, suicide prevention, and other mental health concerns
- complement VA, DoD, and community-agency services through the development of public/private partnerships
- raise public awareness about mental health and reentry issues that veterans and their families face.

Guided by a steering committee composed of MLB team owners, former military officials, and representatives from the McCormick Foundation, the WBV Initiative issued a second invitation-only request for proposals (RFP) to design and implement programs addressing the mental health needs of veterans and their families. The RFP called for submissions that would focus on designing and implementing programs consistent with the Initiative’s objectives, previous lessons learned, and new research on social strategies or public policy analysis.

The opportunity to respond to the RFP was offered to academic medical institutions that held a nonprofit status as 501(c)(3) organizations. Eight academic medical institutions were offered the opportunity to apply; these had been hand-selected by MLB and McCormick Foundation from among the top academic medical institutions with reputations for research on the treatment of PTSD and/or depression, including the three

academic medical institutions awarded earlier grants (Stanford University, the University of Michigan, and Weill Cornell Medical College).

Additional institutions were selected because they had exhibited strong public-private partnerships in other service areas in their local communities and experience with tracking participant engagement and success in treatment for mental health problems. While some attention was given to the geographic location of these institutions, proximity to MLB teams was not a requirement for inviting other institutions to submit applications. Of the eight institutions invited, seven submitted formal applications.

Following technical peer review by a group of nationally recognized subject-matter experts in the treatment of PTSD and mental health issues, the WBV Initiative awarded multiyear grants to seven academic medical institutions beginning in 2010: Duke University, Emory University, Massachusetts General Hospital, Rush Medical Center, UCLA, the University of Michigan Depression Center, and Weill Cornell Medical College Department of Psychiatry.¹⁶ Although there was some overlap in the objectives of the WBV-supported programs, each proposed a different constellation of services and activities and filled different gaps where veterans may not have received timely services otherwise. With the exception of the University of Michigan and Weill Cornell, which had been funded by the WBV Initiative in prior grant periods, all the institutions proposed to implement new programs and/or services to address the RFP requirements. Many of these institutions had already been conducting research into treatment for PTSD, implementing family support or resilience programs, or education/training programs for community-based providers; however, these prior activities were not specifically tailored to the veteran community or anchored to the goals of the WBV Initiative for veteran mental health.

As a result, most of the activities initiated by the institutions during the current reporting period were proposed in direct response to the RFP and involved new undertakings. Institutions each proposed a wide variety of programs and services, including delivery of pro bono referrals, clinical treatment, training services to veterans and their families, training/education among the provider community and general public, and the conduct of research on the effectiveness of new interventions or approaches to care. Each institution outlined the intended target audience of the services: members of the affected community (active-component service members, National Guard and reserve personnel, former service personnel regardless of VA eligibility status, and/or family members

of service members or veterans), or members of the provider community (individual providers, provider organizations), as well as the general public. Many of these sites were awarded two- or three-year grants and began their efforts in early 2011.¹⁷ These programs and the nature of the activities, described next, were implemented during “Phase 1,” the funding cycle between February 2011 and June 30, 2013.

BraveHeart Southeast Veterans Initiative: Emory University

Initially funded in February 2011, Emory University’s Trauma and Anxiety Recovery Program and the Atlanta Braves formed the BraveHeart WBV Initiative to serve veterans and their families living in the Southeastern United States (specifically, Alabama, Georgia, and South Carolina).¹⁸ The BraveHeart staff engaged an advisory board consisting of local and national experts from the VA and the Atlanta Braves. The program has five primary objectives:

- educating veterans, families, communities, and health professionals about PTSD and its treatment
- partnering with the Atlanta Braves to raise public awareness and decrease potential stigma associated with PTSD and its treatment
- conducting outreach through community events and primary care practices throughout the Southeast
- linking veterans and their families to treatment options within their communities, including VA treatment services and pro bono services offered at BraveHeart
- creating and maintaining partnerships with other veteran-serving organizations within the region.

In implementing these objectives, the BraveHeart Team uses a clinical care coordinator to serve as a liaison between VA and community resources to link veterans and their families with available services. The coordinator’s role is to facilitate referrals and hand-offs with VA, with other service providers in the community, and with the BraveHeart clinical team to provide services at no cost. The BraveHeart program team specializes in PTSD and anxiety disorders and has been a leader in implementing and documenting the use of Virtual Reality Exposure therapy for psychological disorders, and provides several PTSD treatment interventions to veterans and their spouses and partners, including free individual treatment and support groups for military spouses and partners.¹⁹

BraveHeart also offers web-based access to online PTSD self-assessment tools and referral resources and collaborated

with the Institute for Creative Technology at the University of Southern California to launch SimCoach, an interface for veterans to get information about PTSD, take a self-assessment, and get connected to services. This interface includes an avatar that interacts with the user to pose and answer questions designed to inform and help users find a care setting. The BraveHeart clinical coordinator follows up with treatment referrals for those interested. Website users can find local mental health treatment resources by searching their ZIP code, as well as download other educational materials on PTSD for members of the public and the health care community. Family members can also find resources and tips for transition, coaching their loved one into care, and for helping children understand and cope through the process. In addition, to market their services and raise awareness, BraveHeart staff regularly attend and present at Yellow Ribbon events and other public forums to provide education to veterans and the greater community.

The BraveHeart leadership continues to work with the Atlanta Braves to raise awareness about PTSD among veterans. During this funding cycle, activities included hosting events at Turner Field on Memorial Day and disseminating co-branded education materials (e.g., PTSD screener cards and posters) in primary care offices throughout the region. Patients seeking services at these sites could contact the BraveHeart initiative for screening, referral to VA services, or treatment through Emory University’s Trauma and Anxiety Recovery Program.

Duke University Veteran Culture and Clinical Competencies (V3C)

The Duke University Evidence-Based Practice Implementation Center (EPIC) collaborated with the Center for Child and Family Health to launch the Veteran Culture and Clinical Competencies (V3C) initiative in 2011. Their objective was to develop, implement, and evaluate a two-year capacity-building initiative within a select region of North Carolina. Unlike other WBV sites, Duke V3C does not provide direct screening, referral, or treatment services. Rather, it focuses on training existing community-based providers to implement culturally appropriate and evidenced-based services through the V3C Breakthrough Series Collaborative (BSC). The V3C initiative addresses four specific provider skill domains:

- outreach and access strategies for engaging veteran, National Guard, and reserve members and their families

- competencies in core clinical assessment techniques to identify strengths and clinical concerns
- skills-based learning in core mental health clinical competencies to address the needs of veteran, National Guard, and reserve members and their family members
- strategies to fully integrate, implement, and sustain these techniques within the scope and practice of participating agencies and provider teams.

For this project, V3C specified the intent to build a community network of providers that proactively addresses the mental health needs of military families and children in a manner that is sensitive to military culture, engages the family support system, integrates evidence-based treatments, and is sustainable and scalable beyond the life of the project. With this goal in mind, V3C identified three critical knowledge areas to inform effective practice with the veteran, National Guard, and reserve population: veteran and military culture, childhood development and its interplay with risk and resilience, and community-based barriers to accessing quality care. For each of these knowledge areas, V3C developed specific curricula content for its training series. V3C planned three in-person learning sessions, each followed by action periods that involved significant engagement with the participating provider teams and V3C faculty. The BSC culminated in a final meeting to reflect on accomplishments in 2013. Through the BSC approach, the V3C team focuses not only on improving knowledge and skills of existing community-based providers but also on facilitating long-term sustainable change in practice among participating teams.

Home Base Program: Massachusetts General Hospital and Red Sox Foundation

In 2009, the Red Sox Foundation (RSF) and Massachusetts General Hospital (MGH) founded the Home Base program for post-9/11 veterans and their families.²⁰ Centered in Boston, Home Base provides direct clinical services, peer-to-peer outreach, and community education. Clinical services are provided through a dedicated clinic at MGH; remote services through telemedicine for patients in Massachusetts and teleconsult services for community clinicians. Home Base joined the WBV Initiative in 2011. Unlike other WBV-funded programs, Home Base was initiated at the direction of the Red Sox ownership and thus has a strong connection to the Boston Red Sox through the RSF, which provides significant support for public relations, marketing, fundraising, and outreach. The partner-

ship with the RSF has been critical for helping to build clinic space and hire professional staff.

The Home Base program is governed by a Board of Overseers with equal representation from MGH and the Boston Red Sox. Home Base receives significant financial support beyond that of the WBV Initiative. To the extent possible, we sought to include in our performance monitoring only those activities and services funded in whole or in part by the WBV Initiative. The Home Base program has several outreach initiatives and public awareness events for veterans (including veteran-to-veteran outreach) and their families. It routinely hosts social gatherings and outings throughout New England for veterans and their families (e.g., boat cruises, ski trips), as well as family events at Fenway Park.

In addition, Home Base uses fundraising events (such as the “Run to Home Base”) to build community support and disseminate anti-stigma messaging. Through the Department of Psychiatry and Physical Medicine and Rehabilitation at MGH, it offers diagnostic assessments; evidence-based treatment for TBI, PTSD, depression, and other related conditions; referral services; and training for providers (including first responders and school nurses). With the additional WBV Initiative funding support, Home Base expanded its telemedicine program. Its strategy includes expanding its care and outreach team, as well as its telemedicine capability, and pursuing certification of home-based technology applications.

Military Support Programs and Networks (M-SPAN): University of Michigan

Based at the University of Michigan at Ann Arbor, the Military Support Programs and Networks (M-SPAN) Welcome Back Veterans Core Center provides various clinical, training, and peer-to-peer services for service members, veterans, and their families. Founded by the University of Michigan Depression Center and the Department of Psychiatry in 2008, M-SPAN was one of the original WBV Initiative sites. Its objectives include:

- addressing the special needs and challenges that National Guard and reserve members and their families face
- expanding and improving military-university-VA-community partnerships to bridge service gaps and improve care
- developing integrated service delivery models through peer-to-peer based methods
- expanding provision of prevention-focused services to military families, with emphasis on parenting and spouse interventions

- demonstrating program effectiveness and training providers throughout the state
- developing and administering assessment tools to identify predictive resilience measures
- cultivating credible and well-known representatives to speak on behalf of returning service members and their families.

To meet these objectives, M-SPAN launched several programs: the Buddy-to-Buddy program, Deployment Cycle Support, Support To Restore, Nurture and Grow (STRoNG) Families, Military Family Support Forum, and HomeFront Strong. It also convened meetings to facilitate networking within the state and nationally, and implemented data collection efforts to examine risk and resilience characteristics for National Guard members across the deployment cycle.

The *Buddy-to-Buddy* program operates in collaboration with the Michigan Army National Guard to create a set of trained volunteer veterans that provide mentorship to Iraq and Afghanistan service members and veterans. It is offered for free throughout Michigan on a confidential basis. Participating volunteer veterans assist service members in connecting with financial, legal, benefit, and educational programs.²¹ Veteran volunteers also offer emotional support and can link veterans with mental health providers and other resources for emotional and relationship support. The Buddy-to-Buddy program involves a two-tier training approach; Buddy 1s receive a three-hour training session in communications skills and program logistics; Buddy 2s receive more advanced training, ongoing supervision, conduct armory visits, and provide telephone support to veterans.

Through *Deployment Cycle Support*, M-SPAN works with the Yellow Ribbon Program to facilitate predeployment and reintegration workshops for returning service members, spouses, and families. The workshops provide training on a range of issues, including couple relationships, communication, and parenting.²²

STRoNG Families facilitates family-support groups for service members and their spouses or partners and children up to 8 years old.²³ This attachment-oriented parenting program is ten weeks long and seeks to enhance family resilience.²⁴ The core pillars of the program include self-care, parenting education, social support, parent-child interaction, and connecting to care. The program is offered in cycles and includes pre-deployment, post-deployment, and follow-up assessment among participants.

The *Military Family Support Forum* is a professionally facilitated monthly forum for military families that offers a presenta-

tion on a relevant topic and a facilitated discussion, allowing families and individuals to bond over common experiences and build social networks.²⁵ Topics have included family reintegration; stress management; children and parenting; communication; and understanding PTSD, depression and substance use.

HomeFront Strong is an eight-week support-group program for military spouses or partners who experience stress related to deployment of a service member.²⁶ The program concentrates on resiliency and encourages participants to develop strong social systems, practice self-care and positive coping, and use the range of available resources for military families.²⁷ A simultaneous program for children is offered for families that participate.²⁸ Additional funding support for HomeFront Strong is provided by the Ethel and James Flinn Foundation.

Program for Anxiety and Traumatic Stress Studies: Weill Cornell Medical College, Department of Psychiatry

Based in New York City, the Weill Cornell Medical College's Program for Anxiety and Traumatic Stress Studies (PATSS) first received funding in 2009 as part of the initial WBV grant-making program. It received subsequent funding for the period between 2011 and 2013 to provide services for returning service members, veterans, and their families, focusing on three areas:

- providing education and outreach
- delivering treatment and clinical services to service members deployed to Iraq or Afghanistan and their families
- implementing telepsychiatry.

PATSS activities are organized into a few specific categories, including community education around PTSD and treatment, free mental health screening for service members and their families by appointment or walk-in, and treatment in its Manhattan location. Service members who have deployed to Iraq or Afghanistan and are in need of services are evaluated and screened for potential inclusion in any number of ongoing externally funded research studies for treating PTSD. If they are eligible and consent, they are enrolled in the studies, which cover the cost of their care. If service members are not eligible, they can be served by PATSS clinicians under the WBV funding. PATSS faculty specializes in the use of Virtual Reality Exposure therapy, with and without adjunctive pharmacology. Similar clinical services are also available to family members, although there are no specific outreach and recruitment activities for them. PATSS used a range of outreach activities to

recruit service members and families, including social media and listservs, as well as participation in community events and outreach to organizations, employers, and religious congregations.

Through its partnership with the Weill Cornell Center for Clinical and Translational Science Center, PATSS sought to use telemedicine to provide access to treatment beyond its physical location. Using videoconferencing, PATSS offers Psychological Health and Wellness Workshops to National Guard members in Brooklyn and Queens. The workshops cover a range of techniques and strategies for sustaining health and well-being, including decreasing stress and risky behaviors, anger management, and elevating mood and motivation. They also incorporated content on communication skills and strategies for developing fulfilling relationships and high work performance. Techniques include tips for nutrition, financial management, sleep, hygiene, and yoga poses and practice. Another key objective of the workshops is to reduce stigma surrounding treatment for mental health issues by teaching soldiers about PTSD, trauma, anger, and substance-abuse disorder.

University of California at Los Angeles Welcome Back Veterans Family Resilience Center

Beginning in March 2011 with initial funding from the WBV Initiative, UCLA launched the WBV UCLA Family Resilience Center to enhance available family-centered services and to develop and evaluate a continuum of family-centered interventions for mitigating stress and promoting resilience among veterans and their family members. The center also proposed supporting the dissemination of evidence-based, family-centered care for veterans and their families in partnership with community systems of care. To meet these objectives, the center arranged two interdependent components: a research core and a community core.

The goal of the research core was to develop and evaluate promising family-based interventions for improving the lives of returning warfighters and their families. Two pilot studies were proposed and undertaken:

- Couples Counseling for Combat Veterans: a 12-session, couples-based treatment that employs skills training and joint exposure-based activities
- Families OverComing Under Stress: adapting the existing FOCUS model of trauma-informed family-centered preventative intervention to promote resilience among military

members to veterans and their families affected by combat-related psychological and physical injuries.

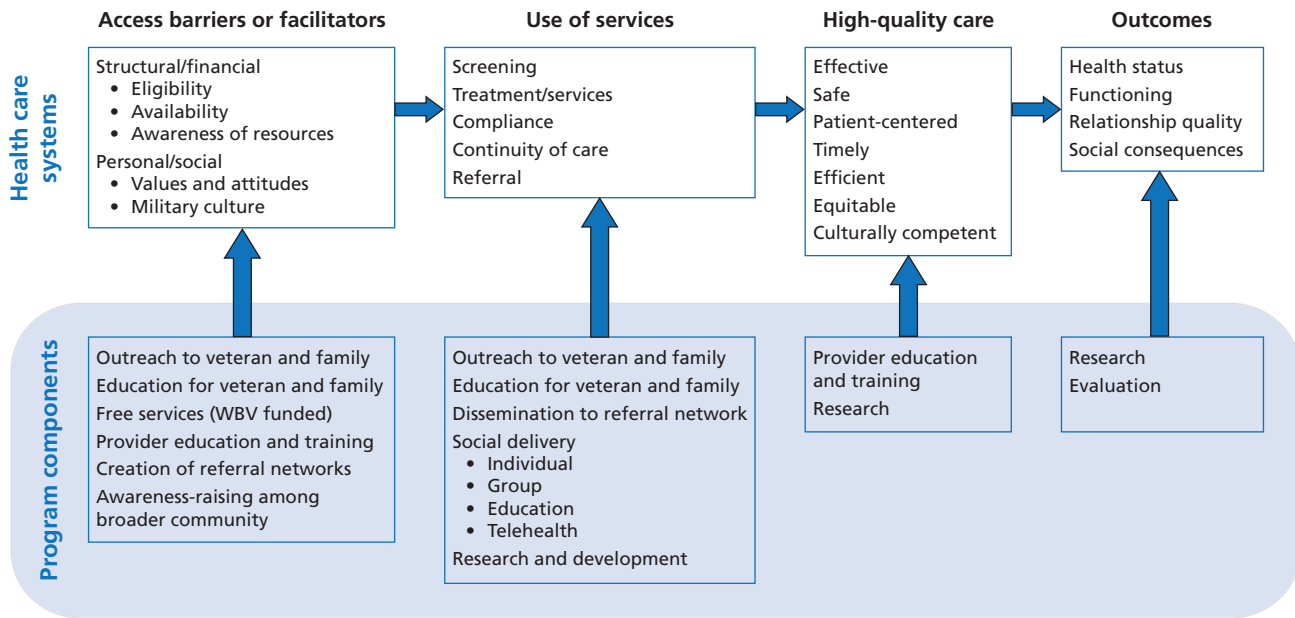
The UCLA Community Core enhances education and services for veterans and their families through community capacity-building efforts designed to adapt and disseminate trauma-informed, family-centered care into different tiers of service settings. The Community Core team proposed the use of mapping techniques to identify gaps in the continuum of care for veterans' families and to identify entry points for community-level engagement. Using these data, the Community Core was also able to develop community partnerships to deliver education services throughout the region. It also works with UCLA's Operation Mend and the Los Angeles County Department of Mental Health, as well as the California National Guard and the Greater Los Angeles VA.

ASSESSING PERFORMANCE AND IMPACT WITHIN THE INITIATIVE

Guiding Conceptual Model

The specific programs implemented by WBV sites represent a diverse mix of approaches to improving the lives of veterans with PTSD and their families. The model below, adapted from a conceptual model commonly used in health services research,²⁹ highlights how specific program components may improve service delivery for veterans and their families. Improving health outcomes for veterans and their families is a function of both *access to care* and *receipt of high-quality care* (see Figure 1). Maximizing the benefits of health care services for veterans and their families requires facilitating access to services by addressing barriers and ensuring that the services received are of high quality. In this context, *high-quality care* is defined as care that has been demonstrated as effective (i.e., evidence-based), safe, patient-centered, timely, efficient, and equitable.³⁰ Each WBV-supported service and program can be linked to facets of this conceptual model. Some WBV program components focus on addressing *access to care* by implementing creative solutions to overcoming barriers to care (e.g., telehealth, virtual worlds, veteran-to-veteran outreach), while other components address the *receipt of high-quality care* by training and educating health care providers, expanding referral networks, or delivering evidence-based treatment services directly to veterans or their families. Equally important are outreach and dissemination efforts conducted to

Figure 1. Programs Improve Health Outcomes by Improving the Effectiveness of Health Care Systems



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ensure that veterans, their families, and the community are aware of program services.

Performance Monitoring Center Activities and Approaches

As the PMC for the WBV Initiative, RAND designed and conducted a wide range of activities to understand the impetus and ultimate goals for the Initiative, to document site activities, and to facilitate dialogue across sites for understanding programs and sharing information and resources to better serve veterans and their families.

Documenting the History and Evolution of the WBV Initiative

Though the RAND PMC for the WBV Initiative was developed in autumn 2011, the Initiative itself had been ongoing since 2008. As a result, there was a significant amount of history and evolution that we needed to document to ensure that the PMC activities accorded with the Initiative's priorities and vision. We conducted semistructured interviews with six stakeholders, including members of the WBV Steering Committee, to document the Initiative's history and evolution, as well as its mission and purpose. These interviews lasted 45 to 60 minutes and covered the impetus for and original goals of the Initiative, how it was developed and supported, how sites were selected,

and how the Initiative and goals have evolved over time toward an emphasis on the development and sustainability of public-private partnerships.

Initial All-Site Meeting

RAND supported an initial, all-site meeting hosted by MLB at its New York headquarters in November 2011. This initial one-day meeting was designed to acquaint sites with one another, introduce the RAND performance monitoring role, and establish relationships with sites. Sites prepared one-page summaries that were shared with all participants before the meeting. During the session, participants gave short presentations about their programs, outlining their mission and approaches, and reviewing accomplishments, while RAND representatives spoke about RAND expertise, as well as its approach and expectations as the PMC (described in more detail later). Sites were encouraged to ask each other questions when sharing information about and progress on their efforts.

Standardized Reports

One challenge we faced as the PMC was determining the best way to collect data from six sites, each with a different focus and approach to activities, so that we could aggregate information and provide a higher-level understanding of the WBV Initiative. To ensure that we collected similar data across diverse

programs, we designed and implemented a standardized, systematic, data-reporting tool on outreach and dissemination efforts, service delivery, partnerships, education, and research and evaluation efforts (Please contact the authors for a copy of the reporting template).

Using structured tables to count activities across these domains, sites provided updates on their varied activities each reporting cycle. In response to open-ended questions, they also provided information on challenges they faced and strategies to overcome them. Initiative sites completed these reports and provided them on a regular basis to RAND, for a total of seven reports covering the activities conducted over the period between their grant start and June 30, 2013. These reports were labeled Reports 1–7 (R1–R7) and each covered three months of activity, except for R1. Since RAND’s data collection began in November 2011, sites were asked to include activities dating back to their start dates (no earlier than February 1, 2011) in their first report. For some sites, the first report represented activity over the course of the prior three-month period; for others, it may have been as much as eight months. RAND summarized performance for each reporting period across these domains for the Initiative as a whole, providing information both about the current performance reporting period and the collective efforts to date. These performance reports were shared with McCormick and the sites.

Regular Phone Meetings

Beginning in December 2011, RAND held conference calls every three months with individual sites to review their completed reports, discuss progress made toward program objectives, glean additional context on activities, understand challenges and lessons learned, and discuss anticipated progress over the coming reporting period. These phone-based meetings lasted about an hour and were scheduled one to two weeks after receiving performance reports. To facilitate the discussion, RAND reviewed each completed performance report and generated a list of specific follow-up questions to focus the discussion where additional clarity was required.

Site Visits

RAND also completed at least one visit to each site with a representative from the McCormick Foundation.³¹ Site visits lasted one to two days and provided an opportunity for the PMC team to engage in more detailed conversations about program activities, meet with all program staff, and see the facilities and

clinics where care and programs were provided. Where possible, our site visits were timed so that we could observe a training session or an outreach event. We scheduled the site visits to occur within the first several months of the PMC so we could become familiar with individual-site activities. Each site had the opportunity to influence the agenda for the site visit and RAND asked relevant questions throughout the activities as appropriate (i.e., RAND observed events without interrupting activities at many sites but later asked project staff in-depth questions about activities, progress toward goals, and challenges experienced).

Cross-Site Communications

Though the six sites had similar goals and objectives, their activities and approaches were distinct. While some sites worked together outside the WBV Initiative, they had little interaction to identify shared challenges or to share lessons learned prior to the establishment of the PMC. In an effort to facilitate more cross-site collaboration, RAND worked closely with the McCormick Foundation to facilitate information-sharing and group discussion.

For example, the McCormick Foundation created and hosted a WBV Initiative SharePoint website where WBV Initiative sites could post information and comments, as well as retrieve and view information posted by other sites, including RAND. To facilitate dialog about specific issues, RAND convened six hourlong teleconferences between May 2012 and June 2013. Topics included use of innovative outreach methods including social media, challenges and opportunities of telemedicine, and developing partnerships with DoD and VA. The agenda and notes from these calls, along with other WBV-related documents, were posted to SharePoint.

In May 2013, RAND hosted an in-person, daylong conference in Washington, D.C., to facilitate sharing and partnerships with the Defense Centers of Excellence for Psychological Health and TBI (DCoE) and the VA Office of Mental Health and Vet Centers. The meeting included a visit with Obama administration officials to discuss the role of the WBV Initiative in facilitating public-private partnerships for mental health care of service members, veterans, and their families.

Summarizing Activities

Data collected from the site visits, the performance reporting form, and the cross-site conference calls were used to assess

performance and document lessons learned. Following each performance report, RAND collated the data (counts of individuals served or trained, outreach events conducted, etc.) in a performance period roll-up. These data were then aggregated across the reporting period to inform the results we present in the next section. Using the unstructured data shared during site visits and cross-site conference calls, as well as the free-text response to open-ended questions in the performance reporting form, RAND collated comments and input to summarize major themes and issues experienced by the sites. These experiences are summarized in the lessons learned section.

MAKING A DIFFERENCE: SUMMARY OF INITIATIVE PERFORMANCE

Over the course of the past three years, the activities implemented by the six academic medical organizations funded by the WBV Initiative have touched the lives of many veterans and their families. Whether their impact was made through direct contact or other service providers, each program has delivered an array of services and programs designed to improve the mental health and well-being of service members, veterans, and their families. We summarize the collective efforts of these in promoting awareness and engagement through *outreach and dissemination*; teaching new skills through *education and training activities*; improving veteran and family well-being by *delivering clinical and nonclinical services*; and expanding capacity by *developing and building partnerships*. To help understand the relative impact of the sites in meeting the WBV objectives, we provide summary statistics for each measure across WBV sites, with detail by individual site where appropriate. Direct site-to-site comparison is challenging given varied start dates, differences in program activities, the relative emphasis placed on each activity (e.g., treatment, training, outreach), and the developmental stage of each program. The following sections describe the cumulative impact of the WBV programs between the start of their most recently completed grant periods (no earlier than February 2011 through June 30, 2013, referred to as Phase 1 in figures and tables throughout this report).

Raising Awareness and Promoting Engagement: Outreach and Dissemination

WBV sites launched a number of activities to educate and inform the public about the mental health issues that veterans

face, as well as to reach out to members of the veteran population in an effort to let them know about programs and services. While many of these were general awareness-raising activities about the needs of veterans and their families (including public service announcements and appearances on television and radio shows), these efforts also specifically sought to recruit veterans and family members into WBV programs through targeted posts on social media sites, advertising in local venues (displays, ads, etc.), and presentations at veteran-attended events.

Despite the documented need of veterans and their families for high-quality mental health services, the philosophy of “If you build it, they will come” did not seem to ring true for the sites. Individual WBV sites reported significant challenges in engaging members of the affected population and many potential barriers that may limit immediate uptake of new services, including a lack of awareness of available services outside the DoD and VA systems; concern that nonmilitary providers do not understand military culture; confusion over where members and families may seek services; and costs. While WBV programs sought to address these barriers, many individual programs struggled with how to do so given the inherent difficulty in identifying where veterans and their families resided. As a result, programs had to use a combination of creative approaches for outreach and engagement. We discuss outreach activities that were designed to recruit participants for WBV-supported program services (clinical treatment or training) or for WBV-supported research activities.

In addition to outreach and engagement activities, we also gathered information about the dissemination activities each site conducted during each performance period. These activities were generally intended to promote greater awareness among the broader community and designed to let members of the public or veteran-serving community know about the WBV program and available services. We classified dissemination activities by intended audience: military-related community, professional audiences, policymakers or military leadership, potential donors, and general public.

Outreach

To encourage veterans and their families to avail themselves of WBV activities, sites used a variety of means to advertise programs and recruit participants. These ranged from posting specific advertisements online or in print (social media, displays in office practices, etc.) or at events (e.g., reunion and reintegration events with the National Guard) to attending specific

community-based events that veterans and their families attended, such as job fairs. We tracked outreach activities in two categories: those that sought to recruit new clients or patients into clinical services or workshop events; and those that sought to recruit participants into new research studies or trials funded by the Initiative.

For Program Services: Sites regularly engaged in outreach activities to increase awareness of their program services in the general and veteran populations. Outreach was often conducted through briefings to target populations; attendance at veteran events (e.g., Yellow Ribbon Reintegration program events); and attendance at public events regarding employment, wellness, or related resources. Sites have also reached out to veteran services organizations by email and in-person meetings. Altogether, sites conducted 278 outreach events designed to increase awareness of their programs and services and to raise general awareness about veterans' mental health challenges during this funding cycle.

For Research: Five sites included research as a core activity. Since the start of the funding cycle, 17 outreach activities have been conducted to increase participation in research. Because research falling within the WBV Initiative was focused on evaluating the effectiveness of the treatment models and programs that had been developed as part of the WBV Initiative, recruitment efforts were similar to those conducted to recruit for program services, with the exception that interested individuals were screened for eligibility. If they were eligible and interested, they entered into the research study. Those who were not were treated as part of the program.

While many sites continue to be actively engaged in research, particularly to assess the effectiveness of their programs and services, the prioritization of recruitment for research diminished somewhat. Sites noted that this was due, in part, to the fact that many of the individuals reaching out to the programs were experiencing more acute needs and needed more immediate services. Given that many of the research studies were rigorous designs that required randomization or recruitment of a full study cohort prior to the administration of the program services, in many cases sites did not feel comfortable having veterans with more acute needs waiting for the study to launch. There was also a desire to redirect energy and resources to other service provision and training activities over time, which were seen as higher priorities.

Dissemination

Sites conducted a number of events, meetings, and activities for sharing information about their programs. Largely, these activities were designed to tell others about the programs being delivered by the WBV Initiative partners. We summarize these by the intended target audience.

Military Community: For many sites, attending military-related events provided an opportunity to promote awareness, conduct outreach, and encourage the seeking of help. Examples of military-related dissemination efforts included seeking inclusion in national and local directories, communicating with veteran service organizations (VSOs) on referral sources, and interacting regularly to share information with the local National Guard. Two also attended university and college events intended for student veterans. Across the funding cycle, WBV sites participated in 217 different activities designed to share and disseminate information about their programs to military-related audiences.

Professional Audiences: Attendance at professional conferences was another common vehicle for sharing information about WBV programs. Sites reported attending professional meetings on a range of related topics, including warrior resiliency, military families, health care for homeless veterans, and caregiver support. During these events, the site representatives often made presentations through workshops or symposia, or used the opportunity to network with other professionals working with veterans and their families. Throughout this funding cycle, WBV sites participated in 256 professional dissemination activities.

Policymakers or military leadership: Engaging policymakers and leadership was essential to individual and collective dissemination efforts. Meetings with these stakeholders helped promote awareness of WBV site-specific activities, seek feedback on needs, and inform efforts to address mental health issues among veterans. Outreach activities included one-on-one meetings (such as with the Commander of the State National Guard Bureau), briefings with key local and federal military personnel from various services, and participation in service-related activities, such as Navy Week. WBV sites reported 85 dissemination activities with policymakers or military leaders throughout the funding cycle.

Potential Donors: Securing and sustaining financial support have been instrumental to WBV-site activities, including 181 donor support-related activities across the sites throughout this funding cycle. In recognition of the need for long-term sustainability beyond WBV, sites have spent time engaging in dissemination efforts with potential funders. Some had access

to development offices at their academic institutions, while others relied more on personal connections to foundations and private donors. Donor-support dissemination activities included meetings with individual donors and large-scale events hosted by MLB and community partners to garner donations and community support and raise awareness of WBV activities and military mental health issues.

General Public: In addition to the activities mentioned above, sites also disseminated messages to the general public to promote an awareness of mental health issues with the hope of reducing stigma and promoting veterans and families who need help to seek it. WBV sites attended or hosted public events (e.g., concerts, baseball games), provided relevant media commentary, and gave informal presentations, for example. Sites conducted 154 activities to increase awareness of mental health concerns.

Teaching New Skills: Providing Education and Training

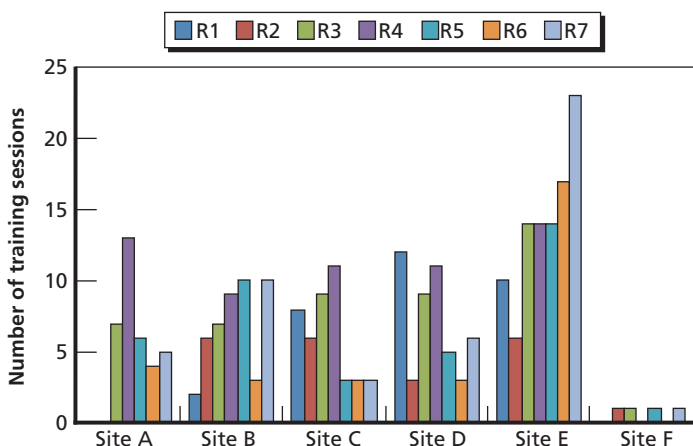
In addition to providing direct services to veterans and their families, many sites designed and provided education, structured training, and ongoing technical assistance to providers, practitioners, and those interested in serving the needs of veterans. Since program inception, WBV sites have conducted 228

training sessions or workshops. The number trained at each session varied greatly, from hundreds per session through virtual training sessions to small groups of fewer than 20. Education and training covered such topics as resiliency and evidence-based practices, including psychoeducation, military culture, and the provision of culturally competent care. They also included skill-building workshops and informational sessions on the signs, symptoms, and longer-term impacts of PTSD and TBI. Sites also provided training and education for community mental health organizations interested in replicating and implementing specific elements of WBV programs, such as peer-to-peer support models. Sites provided training to groups both in person and over the Internet. While these activities varied in topic, mode, and number trained, they all contributed to the Initiative’s shared objectives. Figure 2 shows the number of training sessions per reporting period by site. Figure 3 shows the total number of training sessions across all sites.

Improving Well-Being: Delivering Clinical and Nonclinical Services

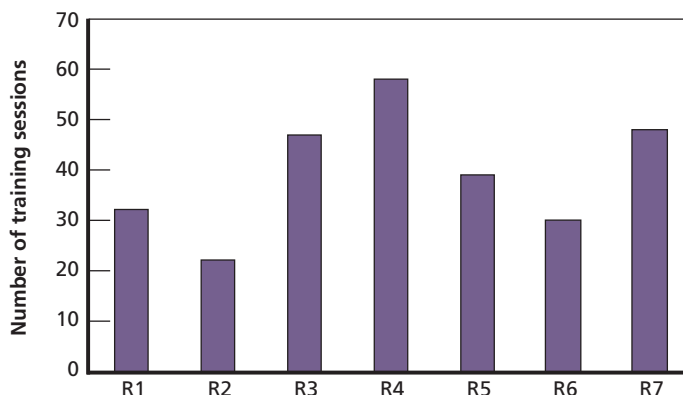
Many sites have resources to deliver clinical care directly to veterans and their families through individual or group therapy. Across WBV sites, there is a stated commitment to using evidence-based or evidence-informed therapeutic interventions for addressing mental health issues among veterans and their family members. Sites are also delivering nonclinical services focused on building skills, resiliency, and wellness. This may include parenting workshops; peer-to-peer mentoring services; and presentations and facilitated discussions for service mem-

Figure 2. Number of Training Sessions per Reporting Period by Site



NOTES: While some of the data presented in the tables and figures present the performance of WBV Initiative partners side by side, care should be taken in interpreting comparisons. Each program had a different level of capacity and emphasis across efforts, and each program’s own performance in prior quarters is the best comparison, not other WBV sites. To minimize making inferences about relative site performances, the names of the programs have been removed. R1 through R7 refer to the reporting periods during which data were collected.

Figure 3. Total Number of Training Sessions per Reporting Period Across All Sites



NOTE: R1 through R7 refer to the reporting periods during which data were collected and aggregated.

bers, veterans, and military families. In addition to serving veterans, many programs offered services to individuals who are still on active duty or who were members of the National Guard and reserve components, and to families (including children) of service members and veterans.

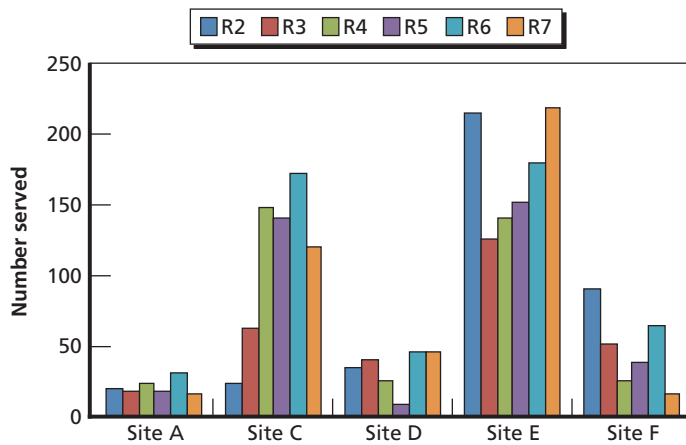
The WBV sites provided screening or precare services for 1,541 individuals and referral for 361 individuals during this phase of WBV funding (see Table 1).³² They treated 1,784 individuals during the current WBV funding phase. The number of individuals treated is higher than those screened because there are various pathways to treatment and some do not include formalized screening and precare activities.

As shown in Figure 4, the number of veterans, service members, and families receiving WBV services varied widely across sites and over reporting periods. Given the rolling start dates of each of the sites, there was a wide variation in the period covered by the first reporting period of fiscal year 2012 with respect to performance monitoring activities. Some of these reports reflected activity over three months, but others were much longer (dating back to the initiation of their funding, which may have been as early as February 2011). This varying period skewed the numbers for the first reporting period. While the number served during this period was captured to ensure a complete picture of site activities, we exclude this report from the figure to ensure accurate comparison over time and across sites. As with the start dates, the end dates for each site also varied. While some continued to treat individuals past the fourth quarter of fiscal year 2013, we again exclude them from the figure, but include them in our totals noted above.

Referral Relationships and Sources

Veterans, service members, and their families come to the WBV Initiative programs through many channels, and the relative emphasis of these sources varied greatly (Figure 5). The distribution of referrals across different channels within the WBV Initiative reflects, to some extent, the specific approaches

Figure 4. Number of Veterans, Service Members, and Families Screened, Referred, and Treated in Phase 1



RAND RR719-4

to outreach and partnership building efforts undertaken by the different sites to reflect the current needs and landscape of their local context. There did not appear to be a single “right way” or formula to apply to increasing the number of referrals, although the majority came from the VA or other medical providers. VSOs were an underutilized source for referrals for most sites during this phase and may present an opportunity for expanding the referral network beyond the more traditional sources.

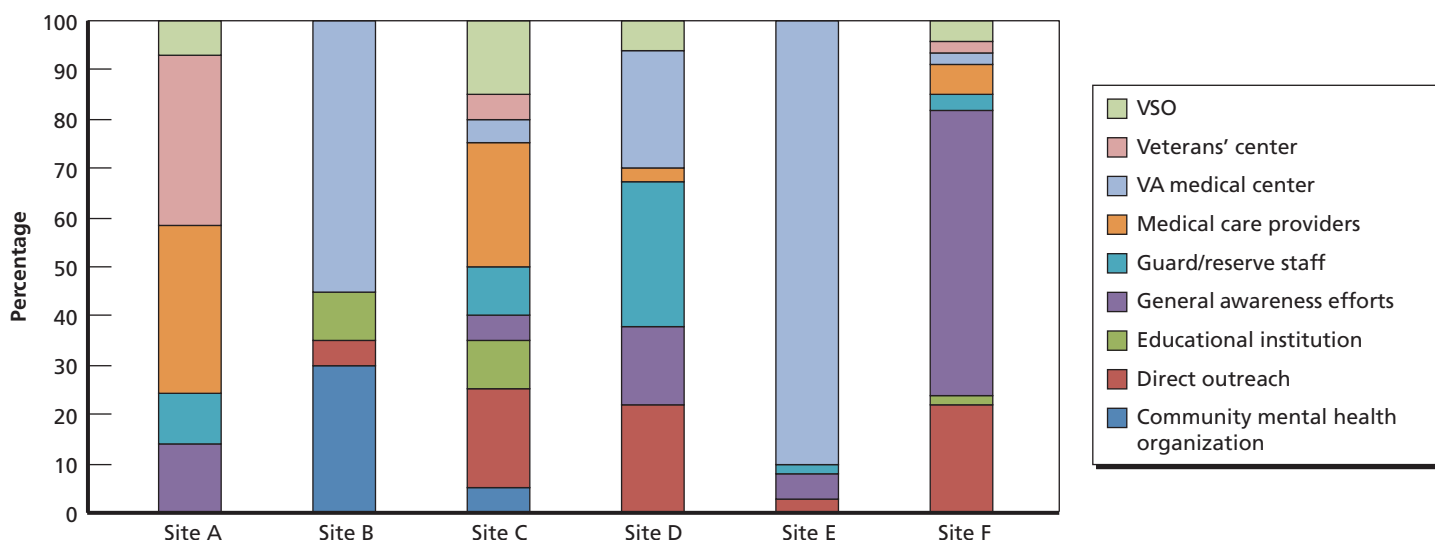
Expanding Capacity: Building Partnerships

The creation and expansion of partnerships has been a critical component of each site’s ability to effectively implement its program. Establishing relationships within the community helps facilitate access and referrals but also enables a wider safety net for veterans and their families. While much of the focus of partnership-building activities among sites was initially to raise awareness about WBV program activities, such activities have expanded to enable bidirectional referrals and longer-term sustainability and replicability of WBV services and programs.

Table 1. Number of Individuals Receiving WBV Services in Phase 1

Individual Group	Screened/Precare Activities	Referred for Services	Treated
Active-duty service members	81	18	139
Veterans (no current military affiliation)	653	230	562
Current reserve/Guard members (even if activated)	198	77	227
Family (members)	609	36	856
Total	1,541	361	1,784

Figure 5. Referral Sources by WBV Site



RAND RR719-5

To examine partnerships within the WBV Initiative, RAND adapted a five-tiered evaluation metric that rates the objective of a given partnership and an assessment of its maturity or strength. This metric was based on a system developed by the UCLA WBV Resilience Center to track and assess its own partnerships across relevant service sectors within Southern California. Next, we list the categories used to define partnerships.

Partnership Level

1. Site has conducted an informal or surface-level conversation with an organization to disseminate information on available program services.
2. Site has conducted a face-to-face formal briefing or meeting with staff of the organization to discuss potential collaboration, partnership, or establishment of referral network.
3. Site has begun a formal process of partnership, investigating potential mutual referral protocols and opportunities

for staff to provide services, education, or training in partnership with the organization.

4. Site has begun getting referrals from the organization, or to provide services, education, or training in partnership with the organization, or at the organization's facility/location.
5. Site has begun to further partner with the organization (building from Level 4) on future program or curriculum development and adaptation.

We observed that site partnerships have been growing over time, both in the number of community partners and in the strength of the partnerships. Table 2 shows the number of partnerships that sites have reported since the second reporting period, when this measure was added to the performance measurement report form. Given the sheer volume of partnerships that were classified as Level 1, we exclude those relatively informal conversations from the table. Sites reported partnerships with 188 organizations in Phase 1. They reported more

Table 2. Number of Partnerships Reported at the End of Phase 1 by Level Across All Sites

Partnership Level	Veterans Affairs/ Government Officials/Agencies	VSOs	Community Health Systems/ Agencies/Universities and Colleges
2	17	12	32
3	10	14	15
4	12	2	8
5	36	5	25
Total	75	33	80

partnerships with government agencies and community health systems and relatively fewer partnerships with VSOs.

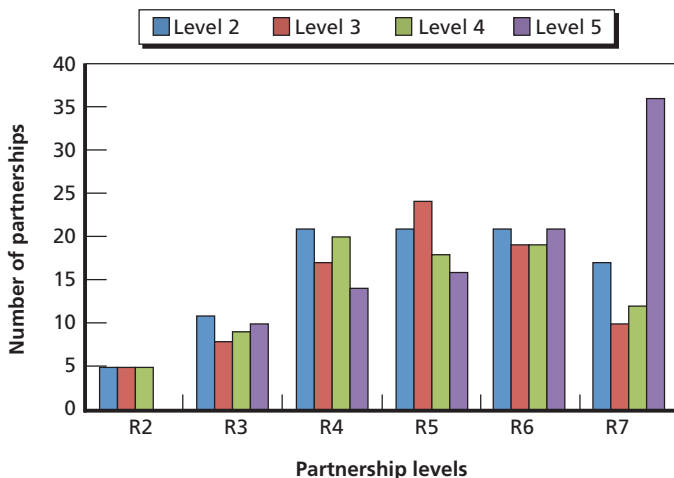
Over time, we have seen a growth in the partnership levels established by WBV sites with all organization types. Below, Figures 6, 7, and 8 show the progression of WBV partnerships through Phase 1. Beyond an increase in the number of partnerships, we would expect to see a strengthening of partnerships over time. Such growth would be represented by an increase in partnerships classified as Levels 4 or 5, with a reduction in the number of partnerships classified as a Level 2 or 3.

By the end of Phase 1, sites had developed strong relationships (designated as Levels 4 and 5) with many government agencies. Figure 6 shows that Level 5 partnerships with government agencies greatly increased in the third reporting period. These government agencies include VA, DoD, and other local government agencies. Sites have also continued to seek and gain official documentation of working relationships, such as memoranda of understanding, with organizations to document and reinforce their partnerships and to develop Level 4 and 5 relationships with many community organizations.

Sites also continually sought to build relationships with national and local veteran serving organizations. The goals of these efforts ranged from trying to secure opportunities for disseminating information, being listed in resource directories, or helping to inform and guide program content. Figure 7 displays the progression of these relationships across the funding cycle.

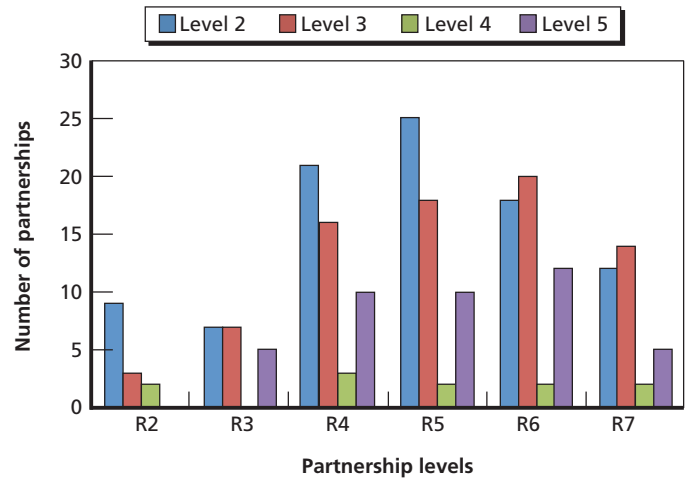
As Figure 8 shows, sites increased the strength of their local or regional community partnerships over time. This was

Figure 6. Government Agency Partnership Progression through Phase 1



NOTE: R2 through R7 refer to the reporting periods during which data were collected and aggregated. R1 is omitted because data were not collected during that period.

Figure 7. VSO Partnership Progression Through Phase 1

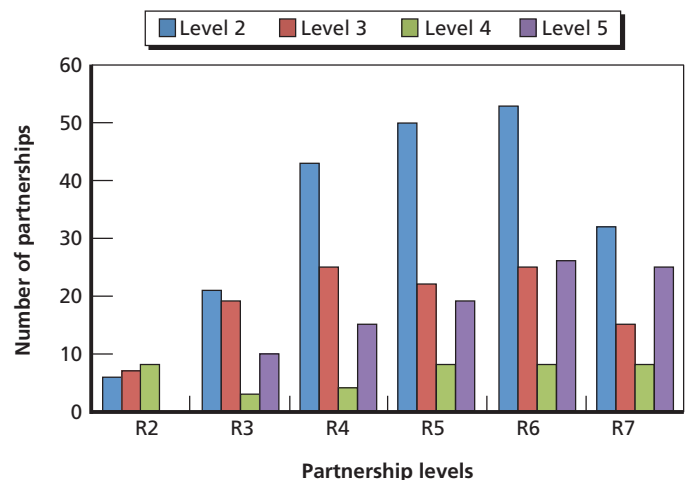


NOTE: R2 through R7 refer to the reporting periods during which data were collected and aggregated. R1 is omitted because data were not collected during that period.

particularly evident through the growth of partnerships with universities and colleges that served as referral mechanisms for training activities and clinical services. Sites also increasingly served as community mobilizers for increasing awareness of program activities and for sustaining and replicating their programs in the long term.

In sum, during Phase 1 (February 2011–July 2013), WBV sites laid a foundation of community connections with a range of stakeholders. As the landscape for public-private partnerships continues to evolve, WBV sites have the opportunity to build

Figure 8. Community Partnership Progression Through Phase 1



NOTE: R2 through R7 refer to the reporting periods during which data were collected and aggregated. R1 is omitted because data were not collected during that period.

on the framework of support by creating and strengthening relationships with community partners. Formalizing service delivery and training partnerships, adapting programs and processes based on lessons learned in the field, and pushing forward the momentum of public-private partnerships through advocacy and building the evidence base for the programs' impact will all be critical factors as WBV sites continue to focus on sustainability and replicability moving forward.

SUMMARY AND CONCLUSIONS

The WBV Initiative was launched to expand access to high-quality mental health services for veterans and their families. Over the course of its lifespan, it has funded several academic medical institutions to design and implement programs to serve veterans and their families within their communities and regions. These programs have provided direct clinical services to veterans, offered workshops and training sessions for members of the National Guard and their family members, trained other community-based providers on delivering culturally competent high-quality care, and raised public awareness of the mental health issues facing veterans and their families. To carry out these activities, individual WBV sites have created partnerships with local, regional, and national service organizations; formed collaborations with each other to share information and best practices; and disseminated information to other organizations and stakeholders. Over the course of their activities, sites identified and overcame several challenges in ways that may inform future efforts to serve veterans and their families. Here, we summarize lessons learned and discuss how these lessons—and the WBV Initiative overall—significantly contribute to the current dialogue around public-private partnerships to better serve veterans and their families.

Lessons Learned

Across the Initiative, there was a great deal of consistency in the types of challenges each site encountered, particularly related to working with the VA and other public agencies, identifying and engaging the veteran community, and ensuring a strong and sustainable funding base that will enable these programs to serve veterans and their families well into the future.

Developing, Expanding, and Sustaining Public-Private Partnerships

The development of effective models of public-private partnerships has always been a core objective of the WBV program. There is a strong recognition that high-quality and culturally competent treatment services and training programs add enormous value and could serve to supplement federally provided care. For example, the WBV sites serve as a source of care and support for veterans who are not eligible for VA care or who wish to receive care outside the VA or DoD treatment systems. WBV sites also complement services offered to veterans at the VA by offering services directly to family members. Site representatives reflected that having a close relationship with local DoD and/or VA treatment facilities improves the quality of care for veterans in that it helps veterans avoid being placed on a wait list for treatment and increases patients' options for treatment modalities and venues within their community.

Over the course of this project period, many sites attempted to establish a strong working relationship with their local VA treatment facilities or DoD installations. However, not all were equally successful. While several sites have established solid relationships with the local VA, Guard bureau, and other public agencies to serve the needs of service members and veterans, other relationships are much weaker, with little to no interaction between sites and their local federal resources.

Sites that established stronger relationships with DoD and VA tended to communicate regularly with the organizations, have two-way referrals, and partner with them on multiple levels and for multiple purposes. For example, some sites provided training to VA providers to expand their knowledge and use of evidence-based practices. These training sessions have not only equipped the VA with tools to better serve veterans, but have also led to several cross-referral relationships between the sites and the VA. Other sites were able to collaborate with DoD and VA on strategic initiatives, on outreach at community events, and on care coordination with providers. One site, for example, spent a significant amount of effort interacting with VA in its region to develop and cofacilitate mental health summits at medical centers within the Veteran Integrated Service Network. The site hosts periodic learning collaboratives with local VA offices as well. In addition, several sites participated in regular meetings with local VA clinical teams to track the status of patients. Other sites were able to offer resources and referral mechanisms for local Guard units, including skills based training opportunities.

Sites also noted that, while they may have been able to build relationships with local VA or DoD facilities, building personal and organizational relationships at the statewide and national level has been more difficult.

Sites reported that strong personal relationships with local VA staff also helped to facilitate frequent interactions and collaboration. For example, some sites have staff members who are affiliated with the VA, and at one site, the spouse of a WBV clinical psychiatrist works for the local VA. These relationships, while in some cases serendipitous, have helped facilitate the development of local public-private partnerships and a stronger two-way referral relationship for the site and VA.

Despite the success of some sites, others are struggling to build and formalize partnerships with VA or DoD. A few sites were able to work with local VA facilities to plan the VA community summits held in the summer of 2013, but others have continued to face difficulty in getting the VA to acknowledge them. At some sites, substantial efforts to build and maintain relationships with local VA staff have resulted in referrals and regular interaction, but more formalized partnerships have not come to fruition despite several attempts to establish memoranda of understanding at various levels of the VA (local, statewide, national). While the personal relationships and shared staff mentioned above may help open the door, the sustainability of these relationships may be at risk if they are largely dependent on ties that were either personnel-specific or driven by preexisting personal connections and collaborations. For this reason, sites have worked hard to solidify their connections

with the VA, local DoD units/installations, and other public entities in the ways described above. Regardless of the strength of their relationships with the federal facilities, the WBV sites have demonstrated a commitment to improve and institutionalize these connections.

Sites also noted that, while they may have been able to build relationships with local VA or DoD facilities, building personal and organizational relationships at the statewide and national level has been more difficult. Some sites were able to achieve state-level relationships, particularly with the National Guard; however, not all sites placed the same emphasis on these types of relationships. This challenge highlights the value of initiatives, such as WBV, that can engage the VA collectively at the national level and discuss the value of local and regional public-private partnerships to better serve veterans and their families.

Veteran, Service Member, and Family Engagement

Engaging veterans and their families in services and research was a notable challenge for most WBV programs throughout the Initiative. Some of the challenge stemmed from difficulty identifying where veterans and their families resided. Without this information, outreach and engagement efforts could not be tailored geographically. Some sites utilized data and mapping technology to identify areas where veterans clustered geographically and worked to ensure that messages were being delivered to those areas and local partners were available to provide services and/or referrals. Other programs did not wait for veterans to come to them but instead proactively went to where the service members and veterans were, including armories and college campuses.

Another lesson learned was that, while the programs may be centered on service provision, outreach to increase individuals' awareness of and engagement in program services took an incredible amount of time and had to be continually sustained. But extensive and frequent outreach efforts are key to success. The most successful sites used a multitude of strategies to address barriers and engage veterans, service members, and families. These included participating in community events to increase general awareness about mental health and program services, as well as conducting more targeted outreach and engagement by working through universities, affinity groups, and community partners. Sites spent a significant amount of time strengthening community networks as a means of promoting cross-referrals and information dissemination about

available services. For example, one site developed a strategy for selecting partners for increasing referrals and disseminating best practices that involved identifying organizations meeting one of these two criteria: (1) the organization serves veterans but lacks expertise in serving families, or (2) it serves veterans in a specific way but seeks referral opportunities for other services for their clients. By strategically engaging with organizations based on their focus and goals, the site positioned itself to complement partner organizations and access the numerous veterans they serve.

Finally, several sites have leveraged technology to ensure that individuals remain engaged in treatment. Through the use of video conferencing connections, social media, and mobile applications, sites are able to engage clients from remote locations. Such technology also helps to overcome logistical barriers related to transportation or other barriers.

Sustaining Program Support

The WBV programs depend on outside funding to remain in operation. The philanthropic, grant, or contract support they have secured has enabled them to provide their services free of charge to veterans and the community. Sites have been creative in piecing together different funding streams to support their efforts. This has included securing private foundation grants, pursuing government research grants or service contracts, and implementing marketing and fundraising campaigns through their universities.

Many of the sites have been working to evaluate more sustainable funding models, including fee-for-service approaches, becoming part of existing VA and DoD preferred provider networks, or developing models to leverage other funding streams within their organizations. As public interest wanes and philanthropic support begins to decrease, sites remain concerned about constrained resources and the resulting vulnerability and potential risks to sustaining these community-based programs for veterans and their families in the future. Many have turned to the role and opportunity of securing government funding through legislative provisions.

Sites have invested significant effort into building greater awareness of their programs within their communities, as well as among local, regional, state, and federal policymakers, with the goal of informing more systematic approaches for supporting these community-based efforts. While some universities have provided in-kind support and even dedicated some of their own endowment funds to these programs, it remains unclear

whether and how long this level of support will continue. The sites that were able to dedicate staff to marketing and public relations appeared to have more polished materials that can be used in trying to gain additional support for their individual efforts. However, not all sites had access to these capabilities. Similarly, some sites have invested in advocacy efforts, scheduling and requesting meetings with local, state, and federal policy officials. At the time of this writing, it is unclear to what extent these sites have been successful in finding legislative solutions for solidifying their funding stream from the government.

Public-Private Partnerships: The Contribution of the WBV Initiative

Since 2001, we have seen a proliferation of support programs and mental health services for military families. In 2012, Berglass reported that there were more than 40,000 organizations operating at the community level to provide a variety of services to veterans.³³ While their existence at the community level may place them more in touch with the needs of local veterans and their families and may expand access to services, the abundance of programs may create confusion among consumers about where to turn for help.

As public interest wanes and philanthropic support begins to decrease, sites remain concerned about constrained resources and the resulting vulnerability and potential risks to sustaining these community-based programs for veterans and their families in the future.

Further, many have been underfunded and lack coordination with other public- or private-sector programs, and few (if any) of the new programs have been evaluated to determine whether they are effective and should be disseminated more broadly. Thus, while more opportunities may be available in communities for serving veterans and their families, without data on whether the efforts are having demonstrable impact, we know little about the value of these philanthropic investments for improving the lives and transition process for veterans. At the same time, the proliferation of these programs in the absence of strategic coordination with existing programs for veterans (such as those operated by DoD and VA or through existing, congressionally recognized VSOs) may further add to the complexities and disorganization of the veteran support landscape.

In 2011, the Office of the Chairman of the Joint Chiefs of Staff recognized this “sea of goodwill” but called for more partnerships between federal institutions and these VSOs in the community.³⁴ In one effort to forge such partnerships, the Joining Forces Initiative was launched by First Lady Michelle Obama and Dr. Jill Biden. Through this initiative, government leaders, service organizations, philanthropic organizations, and the general public are connected via specific activities designed to raise public awareness and educate communities to better support military families; create more employment opportunities for returning veterans and military families; and improve the well-being of service members, veterans, and their families. Now three years old, Joining Forces has served to call greater attention to the sacrifices of military families, secure pledges

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from the private sector to hire more veterans, train additional providers, and fund support programs. This effort has motivated the nongovernmental sector to take and sustain action; however, concerns remain regarding linking and bridging efforts between the VA and nongovernmental sector.³⁵

In an Executive Order issued in August 2012, President Obama called for enhanced partnerships between VA and community providers in an effort to improve access to mental health services for veterans, service members, and military families. Now a key goal within the VA’s strategic plan, the creation and expansion of public-private partnerships has become a major focus and priority for meeting the mental health needs of veterans and their families. In addition to specifying specific goals in their strategic plan, the VA secretary hired several senior-level staff with specific responsibilities around public-private partnership development and public engagement. While these positions may help raise the visibility of these issues within the VA central office, little guidance exists about how these public-private partnerships should be configured and implemented at the local and regional levels.

In response to the Executive Order, the Veterans Health Administration (VHA) and the Department of Health and Human Services established a pilot program to contract (or establish some other formal arrangement) with existing community-based providers, such as existing federally qualified health centers (FQHCs) and community-based mental health clinics. This pilot program took advantage of several existing relationships with FQHCs and forged new ones in such states as Georgia, Iowa, Wisconsin, Tennessee, Nebraska, and South Dakota, enabling veterans to be served at these sites when it is difficult for them to travel to the VHA. The VHA also launched the new VA Patient Centered Community Care (VAP3C) as an additional means of creating greater access to specialty care providers for veterans across the nation. Through these new \$9 billion contracts, the VHA will establish networks of specialty providers that will be allowed to receive reimbursement for services rendered to VHA-enrolled veterans.

At the time of this writing, however, no data were available to document the impact of these new pilot programs, neither are there data on the utilization of services within the VAP3C networks. While the implementation of these partnerships may, in time, demonstrate expanded access and provision of services for veterans with mental health problems, fundamental gaps remain in meeting the needs of family members, in particular. At the same time, the partnerships described have briefly forged greater collaboration across federal government resources

(VHA and DHSS), rather than creating service delivery or training partnerships with community providers supported largely in the nongovernmental and independent sectors.

In an early attempt to facilitate more community-based interaction between the VHA and community-based providers, the Under Secretary of Health called on all VHA facility leaders to convene local VA mental health summits during summer 2013. Local VHA leaders were expected to convene community stakeholders for meetings and public events to discuss areas of shared interest and potential collaboration. Recognizing the continued importance of these local, community-based efforts to create partnerships for expanding support for veterans and their families, the Obama administration called for continued work in this area. In March 2013, the President issued a cross-agency priority goal designed to improve mental health outcomes for service members, veterans, and their families. This goal specifically calls for the evaluation and improvement of existing VA-community pilot collaborations and the expansion of formal arrangements with community providers.

The experiences and accomplishments of the programs implemented under the WBV Initiative serve to highlight the potential contributions and impact that these nongovernmental entities can have at a local, regional, and national scale and to point out the significant challenges that such organizations face in trying to develop meaningful partnerships with federal stakeholders to meet the needs of the affected population.

Through their collective efforts, the WBV Initiative partners have served more than 3,600 military- and veteran-affiliated individuals with clinical services (screening, referral, and treatment), networked with 188 organizations, and conducted 228 training sessions or workshops to build new skills sets and capacity among veterans, veteran-serving organizations, and community-based providers. While they have faced challenges, the sites within the WBV remained focused on and committed to building and expanding access to high-quality services for veterans and their families.

The VA is in the midst of considering the proliferation of public-private partnership models as a means of expanding capacity (through provider-contracting mechanisms and pilot programs with community-based clinics) to augment its own staff capacity. Federal, state, and local agencies are also working with the philanthropic community to create new models that outsource or leverage potential efficiencies from the private sector. In moving forward, consideration and care will be needed to ensure that partnering organizations have the appropriate infrastructure, resources, and partnerships—not only to expand access, but also to deliver high-quality service to all veterans and their families, regardless of their location and choice of provider.³⁶ The WBV Initiative has demonstrated value and can serve as a guidepost for future efforts to improve capacity to meet the mental health needs of service members, veterans, and their families.

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- ¹⁵Each site within the WBV Initiative had an independent grant period based upon its proposed timeline and the date of award. RAND was funded to begin performance monitoring in the fall of 2011.
- ¹⁶Rush Medical Center was not included in the performance monitoring efforts based upon the timing of its project initiation.
- ¹⁷Each site had an independent grant period based in part on its proposed timeline but also its award date. It should be noted that the RAND PMC was not funded until autumn 2011. Once initiated, it began collecting information and data on the sites both retrospectively and prospectively.

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About This Report

In the context of the conflicts in Iraq and Afghanistan over the past decade, there have been a growing number of efforts designed to support service members, veterans, and their families as they cope with deployment and ensure that those who experience mental health problems following their service have access to high-quality care for themselves and their families. Among these is the Welcome Back Veterans (WBV) Initiative, launched in 2008 by Major League Baseball and the Robert R McCormick Foundation. Since its founding, the WBV Initiative has provided funding support to approximately 40 organizations that, in turn, implemented services and programs to support veterans in the areas of employment, education, and mental health care. Following a review of ongoing activities in 2010, the WBV Initiative adopted a narrower focus on the mental health of returning veterans and their families. During 2011–2013, the WBV Initiative issued grants to academic medical institutions around the nation to create and implement programs and services designed to address the mental health needs of returning veterans and their families.

In 2010, the McCormick Foundation asked RAND to join the WBV Initiative in a performance monitoring role. Using a conceptual model to guide its efforts, RAND designed a system of regular data reporting to assess performance and impact of the WBV-funded activities at each site. This report provides an overview of the WBV Initiative, summarizes the impact of WBV-funded programs during their funding cycle between February 2011 and June 2013, and outlines the lessons learned in implementing veteran support programs. It also discusses the role of partnerships and innovative strategies for outreach.

This report should be relevant to individuals and organizations with interest in implementing support programs designed to fill gaps and expand access to high quality mental health care for veterans and their families.

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