PROGRAM EVALUATION

Strategy, Plans, and Functional Integration Directorate

Evaluation of the Comprehensive Soldier Fitness/Army Resilience Program
Disclosure Regarding Data Use Provisions

This program evaluation report is a predecisional document intended to assist leadership deliberations and program manager decisions. Information contained in this document is part of an ongoing effort. As such, the information will be used on a continual basis for program evaluation efforts, and it will not be considered complete until final determinations have been made. Use of this information out of context, or improperly, risks causing deleterious effects toward ongoing program evaluation efforts.

Forwarding the information contained in this program evaluation report should be on a “need-to-know” basis for the purpose of programmatic planning and not for fiscal decision making.
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1 Executive Summary

The Defense Health Agency (DHA) Strategy, Plans, and Functional Integration Directorate (J5) is responsible for responding to various executive, legislative, and departmental directives related to improving the effectiveness of Department of Defense (DoD) psychological health (PH) and traumatic brain injury (TBI) programs. In response to these directives, DHA J5 developed a program evaluation and improvement capability that includes ongoing efforts to evaluate existing programs as well as training and toolkits to enhance program evaluation capabilities across DoD PH and TBI programs.

In fiscal year (FY) 2014, DHA J5 conducted an initial information collection using a telephonic interview process to capture baseline program information. Following completion of that preliminary effort, DHA J5 began comprehensive onsite evaluations to verify the program information collected.

The DHA J5 evaluation team completed a program evaluation (PE) site visit for the Comprehensive Soldier Fitness (CSF)/Army Resilience Program on 15 March 2017. Results of the evaluation indicate the CSF program capabilities fall within the "developing effectiveness" stage. The site visit highlighted several program strengths including: 1) evidence-based goals, objectives, and activities and 2) consistent data tracking and reporting practices. The team also identified recommendations for future program development including to: 1) develop actionable goals linked to the program’s mission; 2) develop specific, measurable, achievable, relevant, and time-bound (SMART) objectives; and 3) track overall program cost and classify cost by resource category. By acting on these recommendations, the program will be able to better demonstrate its outcome and cost effectiveness to facilitate senior-level leadership decision making.

2 Background

Given the more than $2.7 billion spent for the delivery of PH and TBI services between 2007 and 2010, the DoD has been under increased political and public scrutiny regarding the quality of care provided to Service members, veterans, and their families to address these issues. The DoD is accountable for ensuring services are provided in a fiscally responsible manner by conducting evaluations examining the outcomes and cost effectiveness of PH and TBI programs. Toward accomplishing that goal, DHA J5 is conducting effectiveness evaluations of clinical and non-clinical PH and TBI programs across the DoD to generate reliable outcome data for programmatic and resource-related decision making.

In FY 2013, DHA J5 began its PE initiative by examining PH program effectiveness using a web-based information collection format. This effort was expanded in FY 2014 at the direction of the Assistant Secretary of Defense for Health Affairs, to include both PH and TBI programs as well as a more comprehensive process using a telephonic interview to thoroughly capture programmatic data. DHA J5’s data review in FY 2014
established a baseline of program characteristics. DHA J5 subsequently distributed individualized program
reports to each program that took part in the FY 2014 data collection effort. These reports contained feedback
and observations based on the information collected, program evaluation scores across four key areas of
program effectiveness, program strengths, and opportunities for development.

Trends of the FY 2014 data collection indicated that programs were generally able to provide information
concerning the mandates, activities, and outputs of the services they provided. However, a large proportion of
programs were unable to document evidence of program outcomes or account for how program funds were
being used. Data limitations in these areas greatly restricted DHA J5’s ability to generate conclusions about
overall program effectiveness.

In FY 2015, DHA J5 continued PE efforts by conducting program site visits. Site visits are a critical aspect of
the evaluation process in that they:

- Provide the most accurate representation of how programs operate;
- Allow for baseline data collected from programs to be verified;
- Reassure stakeholders that the evaluation’s results are credible;
- Help clarify assessment questions and fill information gaps; and
- Examine fidelity of implementation across primary sites (e.g., headquarters locations) and secondary
  sites (e.g., satellite locations).

Site visit activities consist of interviews with staff and stakeholders, a review of program documentation, and a
structured observation. DHA J5 has also developed general educational offerings (e.g., webinars, program
evaluation guides) to increase knowledge of best practices for evaluation activities, in addition to tailored
consultation services to address program-specific evaluation needs.

DHA J5’s multi-year evaluation effort consisting of baseline information collection and comprehensive site visits
serves to complete the response to various executive, departmental, and legislative directives. This effort lays
a foundation for integration of functional outcomes and financial data that is anticipated to influence key
decisions about resource allocation. The DoD will use findings from onsite activities to inform decision making
by senior leadership, provide detailed feedback to programs and their Service leadership, and as a basis for
standardizing and institutionalizing best practices in program evaluation across DoD-funded PH and TBI
programs.
3 Program Evaluation Approach

DHA J5 employed a rapid evaluation process to assess quality and effectiveness of all identified DoD-funded PH and TBI programs that meet inclusion/exclusion criteria. The onsite evaluations serve to verify information previously collected in FY 2014. This process began with a phone-based structured interview to assess baseline information across five dimensions (Need, Structure, Process, Outcome, and Finance) of the PE framework. A detailed outline of the framework can be found in Appendix A: Program Evaluation Framework. The framework:

- Creates a standardized, evidence-based process for examining program data,
- Is based on an extensive review of existing methodologies, proven models, and assessment tools, primarily Donabedian's Structure, Process, Outcome model (1980),
- Operationalizes broad concepts by using objective definitions for each criterion, and
- Provides comprehensive and transparent assessment criteria applicable to a broad range of programs.

Within the framework, four key characteristics of program effectiveness were identified and structured around established program performance measures as outlined in program evaluation and public health literature. Similar evaluation approaches have been used by government agencies (e.g., the Centers for Disease Control, Health Resources and Services Administration, and the Center for Medicare and Medicaid Services) to assess large service systems containing widely varying programming. The four key areas form the standard upon which DHA J5’s recommendations are based and are defined below.

- **Fidelity:** the extent to which the program was implemented as planned
- **Sustainability:** the ability of the program to deliver its intended activities or services over time
- **Program Characteristics:** the program’s structure and processes
- **Changes:** how the program encompasses changes in participants, practices, and costs

The data collection, analysis, and synthesis process have been incorporated into a standardized, step-by-step evaluation protocol that equips the evaluation team with the tools needed to complete program evaluations using a deductive, top-down approach that can be executed uniformly across DoD programs. Using a standardized method to review collected information, DHA J5 converted qualitative program information into quantitative metrics and determined key areas indicative of programmatic effectiveness. Programs need to meet a threshold on all four indicators (Fidelity, Sustainability, Program Characteristics, and Changes) to demonstrate adequate evidence of overall program effectiveness. Programs are categorized on a continuum ranging from limited demonstration of effectiveness to progress toward sustainment of internal evaluation processes characteristic of effective programs. Stages within the continuum are outlined as follows:
Planning for Effectiveness: The program has met the threshold on one or fewer of the four indicators. Programs at the planning stage will typically require developmental activities in multiple areas to increase their ability to demonstrate and sustain effectiveness.

Developing Effectiveness: The program has met the threshold on two of the four indicators. Programs at the developing stage will generally require developmental activities more narrowly focused than in the planning stage, but structure and process maturation will be necessary to identify and measure outcomes characteristic of effectiveness.

Demonstrating Effectiveness: The program has met the threshold on three of the four indicators. Programs at the demonstrating stage will typically have the majority of necessary effectiveness infrastructure and processes in place, but may require specific developmental activities to robustly demonstrate outcomes characteristic of effectiveness.

Sustaining Effectiveness: The program has met the threshold on all four indicators. Programs in the sustaining stage have the necessary effectiveness infrastructure and processes in place to identify and measure program outcomes, although some technical or strategic assistance may still be required.

Additionally, the results of this evaluation process have been used to identify areas of program strength and opportunities for further development to strengthen the program’s quality and ability to demonstrate outcome and cost effectiveness.

4 Key Limitations to Data Interpretation

Qualitative and quantitative analyses of DHA J5’s evaluation of programs from FY 2015 onward are the result of inputs based upon availability of information to the program and Service points of contact (POCs). Therefore, the information included in this report should not be interpreted in relation to the effectiveness of PH and TBI programs without first understanding the key limitations associated with the site visit process. DHA J5 has documented several common limitations related to this process:

- Given the complexities of federal budgeting, programs measure costs in different formats, including funding allocations, expenditures, and staffing. Jointly held or shared supplies and locations also complicated financial analysis when specific resources could not be broken down into single line items.
- PE teams were only able to capture and analyze data that were readily available to and provided by the program administrators. Evaluation teams may not have been able to access the level of data necessary to determine the effectiveness of programs in terms of intended outcomes or cost effectiveness.
DHA J5 collected information from PH and TBI programs according to predetermined questions within the five dimensions of the framework. As such, DHA J5 was limited in scope to follow up verification of data that were previously captured during the information collection process.

Programs were provided an opportunity to update and clarify the information that was previously collected in FY 2014. Due to traditional staffing fluctuations and rotations in key program leadership positions, the primary POC that provided program data in the FY 2014 information collection may not have been the same individual who participated in the site visit process. Therefore, there may have been inconsistencies in program responses due to subjective interpretation of program activities and operations. Additionally, due to the phased approach of the evaluation process, program information may have changed over time and program POCs typically provided program information that was consistent with current practices.

Lastly, due to institutional review board stipulations, PE teams were not able to directly observe the delivery of client services or review outcome data that included protected health information. As such, the breadth and depth of analysis in DHA J5’s evaluation effort may be limited in some areas.

These limitations should be given serious consideration when the results of the site visit are interpreted. Results may represent the availability of relevant information and the ability of the site visit team to review and verify such information rather than a true representation of program effectiveness.

5 Program Specific Information

5.1 Program Summary

The CSF program was implemented in FY 2010 pursuant to the Department of the Army Ready and Resilience Campaign Plan, Army Directive (AD) 2013-07, and Army Regulation (AR) 350-1, which outlines the training requirements for the broader Army branch of Service. The program serves active duty Army, Reserve Components, Department of Army civilians, and family members. The mission is “to execute the CSF program in order to increase the physical and psychological health, resilience, and performance of soldiers, families, and Department of Army civilians.” The program’s goal is to increase resilience and performance enhancement skills by building on the five dimensions of strength: physical, emotional, social, spiritual, and family. The CSF program’s goal and objectives are based on scientific evidence from numerous research trials conducted by the Penn Resilience Program (PRP) at the University of Pennsylvania.

The CSF program emphasizes the use of hands-on training and self-development tools to enhance an individual’s ability to cope with adversity, enhance performance in stressful situations, and thrive in the military and civilian sector, meeting the wide range of operational demands. Program services focus on providing assessments and trainings related to specific physical, psychological resilience, and performance.
enhancement techniques and skills. Specifically, the program has various components including, the Global Assessment Tool (GAT) 2.0, comprehensive resilience modules (CRMs), master resiliency training (MRT), and schoolhouse and institutional resilience training. All Service members (active and Reserve Components) are required to complete the GAT annually, which is an online survey tool to assess physical and psychological health based on the five dimensions of strength. The GAT assessment is provided on the ArmyFit website, an online environment and social-media platform, providing information, resources, and up-to-date health and fitness information. The GAT combines objective health data with health survey-based questions to provide participants with an individual score and training resources to improve physical and psychological health. The GAT identifies strengths and weaknesses and directs users to the CRMs, a set of online self-development training modules, to address specific resilience skills in each of the five dimensions. Resilience training is conducted at the unit and institutional level, and also for families; Service members are required to receive 16 hours of training at each new duty station, as well as a refresher training at each level of professional military education. Institutional Resilience Training provides resilience training at all major levels of the military from Reserve Officer Training Corps through the War College and Sergeant Majors Academy. The program also provides MRT (a train-the-trainer course), which teaches 12 resilience skills to be provided at the unit level; there are 25 training centers within the continental U.S. (CONUS) and outside the continental U.S. (OCONUS) that offer the 10-day training curriculum for MRTs. MRTs then provide annual training to Service members at the unit level, which is conducted through PowerPoint presentation and practical exercise worksheets. In addition, the CSF program developed and maintains a program website and develops training materials.

The CSF program gathers data on the number of participants completing the GAT, the number of MRTs trained, unit status reports (USRs), and the number of training hours conducted. Units report training totals to headquarters on a monthly basis. Specifically, USRs monitors GAT scores at the unit level; each company reports the frequency and details of the skills training effort to headquarters on a monthly basis. Per the program POC, these aggregated data are located on the CSF website. At the time of the site visit, there were approximately 40,000 trained MRTs. The program gathers feedback from participants, commanders, and staff about their opinion of and satisfaction with the program. In addition, survey feedback is gathered from participants following the MRT course, and via GAT 2.0 and ArmyFit. Feedback data are stored on the CSF website.

The program’s targeted outcomes are increased resilience, optimism, satisfaction with interpersonal relationships, physical activity, and military training performance, as well as improved sleep, nutrition, and participant satisfaction. The program measures participant outcomes via survey feedback and GAT scores. Specifically, changes in GAT scores indicate increased optimism and ability to cope with adversity. Further, trends in GAT scores over time inform senior leadership of identified areas of need (e.g., training targeted to younger soldiers). The program also reported participants are required to pass the training course with a score
of 70 percent or higher, indicating increased knowledge of resiliency factors. In addition, an internal military evaluation analyzed data from three GAT survey assessments of 10,000 soldiers assigned by installation to one of two groups (intervention or control) over a 15-month period; results indicated the intervention group demonstrated changes in resiliency, depression, and fitness as compared to the control group. The CSF program also reported a review of historical student performance in a variety of schoolhouse environments demonstrated positive trends in both graduation rates and test scores for those schoolhouses that included the resiliency program. Post-training surveys also indicate increased resilience and positive self-worth. Measures of performance and effectiveness are provided to senior Army leadership on a quarterly basis.

The CSF program reports adequate staffing and sufficient funding to meet the needs of the target population. The program receives funding for contract staff, while other staff resources are considered “borrowed” from other programs and departments. The CSF program conducts financial tracking related to overall program dollars spent with categorical breakouts for staff, travel, and other discretionary costs on a FY basis; however, breakout totals do not closely sum to total program dollars. The program reportedly monitors costs associated with program activities and makes changes based on cost comparisons. Further, the program calculates a cost per participant at approximately $58.42 and an average cost of $4,322 to conduct MRT. However, it should be noted the program was not able to provide the methodology or resources to calculate cost per participant, and, therefore, the amount was not able to be verified.

5.2 Logic Model

The evaluation team, in consultation with the program POC and staff, created a logic model for the CSF program, which is displayed in Appendix B: Program Logic Model. A logic model is a common PE tool that depicts how a program intends to accomplish its mission using specific activities intended to produce changes in the targeted outcomes. Logic models are intended to be a fluid representation of the program to incorporate changes in policy, evaluation results, funding, etc. A logic model can provide a guide for program evaluation and improvement activities.

Displayed in the logic model are educational and outreach program activities that are conceptually linked to outputs (e.g., number of MRTs conducted). Although program activities correlate to specific short- (less than 3 months), medium- (3 to 5 months), and long-term (6 months or more) outcomes, only some of these were able to be verified from actual program data. Therefore, the program logic model includes both actual and potential components. For example, resilience trainings at the unit level (Activities) are associated with respective participants receiving those services (Outputs). In turn, these participants may report increased awareness and understanding of the relationship between physical and mental health (Short-term Outcome). It remains unclear, however, whether it is feasible for the CSF program to track the same participants’ improved communication within the family and unit (Medium-term Outcome) and decreased mental health diagnosis in
the long term. The logic model illustrates that while the CSF program tracks a considerable amount of data, more opportunities exist to demonstrate changes among the target population as a result of participation in the program.

5.3 Program Strengths

The CSF program exhibits strong programmatic attributes. A particular strength of the program is its documented research to support program goals, objectives, and activities. Specifically, the program is supported by various internal and external organizations, including research from the PRP at the University of Pennsylvania which was used in the development of the CSF program. In addition, researchers from the University of Nebraska conducted an evaluation study of the CSF program, including direct assessments of program activities; results indicated: 1) units with MRTs displayed significantly higher resilience and PH scores than those without MRTs and 2) exposure to CSF’s resilience training improved various aspects of soldier resilience and PH, which appeared to reduce the likelihood of a diagnosis of a psychological problem (Lester, Harms, Herian, Krasikova, Beal, 2011; Harms, Herian, Krasikova, Lester, 2013). In addition, the CSF program has consistent data tracking and reporting practices, and uses its website as a data repository.

5.4 Program Opportunities for Further Development

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<td>Data 1</td>
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The table above shows the data distribution across three columns.

**Additional Text**

Further analysis and discussion regarding the data shown in the table above are provided in the concluding sections of the report.
7 Way Forward
8 Follow-Up and Questions

DHA J5 is available for follow-up and questions via the following POC:

Defense Health Agency (DHA)
Strategy, Plans, and Functional Integration Directorate (J5)
1335 East West Highway
Silver Spring, MD 20910
Silver Spring office: 301-295-3000
E-mail: J5.SS.mil@mail.mil

9 References


## Appendix A. Program Evaluation Framework

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<tr>
<th>Need</th>
<th>Structure</th>
<th>Process</th>
<th>Outcome</th>
<th>Finance</th>
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<tbody>
<tr>
<td>Target Population and Impetus</td>
<td>Strategy</td>
<td>Service Delivery</td>
<td>Resilience, Prevention, and Education</td>
<td>Operating Costs</td>
</tr>
<tr>
<td>Population and Condition Definition</td>
<td>Goals and Objectives</td>
<td>Access and Capacity</td>
<td>Knowledge</td>
<td>Operating Costs</td>
</tr>
<tr>
<td>Prevalence and Incidence</td>
<td>Performance and Effectiveness Measurement</td>
<td>Utilization</td>
<td>Behavior</td>
<td>Change in Cost Comparisons</td>
</tr>
<tr>
<td>Gaps in Existing Services</td>
<td>History</td>
<td>Coordination Across Services</td>
<td>Recovery, Treatment, and Education &amp; Training</td>
<td>Cost-Effectiveness</td>
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<tr>
<td>Services Mandate(s)/ Directives</td>
<td>Ownership</td>
<td>Content/Coverage</td>
<td>Signs and Symptoms</td>
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</table>

| Program Conditions            | Other Evidence-Based Practices | Compliance                  | Reintegration and Readiness                   |                                       |
| Services and Interventions    | Accreditation                | Recordkeeping                | Follow-up Progress                            |                                       |
| Milestone Planning            | Recordkeeping                | Process Improvement          | Performance of Duties                        |                                       |
| Resources                     | Process Improvement          | Social Involvement           |                                              |                                       |
| Staff                         | Data Collection and Interpretation | Satisfaction              |                                              |                                       |
| Research Partnerships         | Evaluation                   | Beneficiary, Staff, and Command |                                              |                                       |
| Budget and Funding            |                             |                              |                                              |                                       |
| Stakeholders                  |                             |                              |                                              |                                       |
### Appendix B. Program Logic Model

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
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</table>
| - Mandates  
- Target population  
- Funding  
- Staff  
- Stakeholders  
- Supplies and equipment  
- Facilities | - Resilience training (Service members)  
- Unit  
- Institutional/schoolhouse  
- Family  
- Master training | Number and type of:  
Service member training events; recipients  
Master training recipients; graduates | **Short**  
- Increased optimism  
- Decreased catastrophic thinking  
- Understanding relationship between physical and mental health  
- Train others on program content (trainers) | **Medium**  
- Improved performance and problem solving  
- Improved physical training and marksmanship  
- Improved PH  
- Improved sleep and nutrition  
- Improved communication with family and unit | **Long**  
- Improved resilience  
- Decreased attrition  
- Decreased substance abuse diagnosis  
- Decreased mental health diagnosis |
| Development of training materials  
Website/The Resource Center | Number and type of:  
Training materials disseminated; accessed  
Website access metrics (hits; downloads) | Use of training resources; website information |  
|

Note: The outcomes represented in the logic model have not been verified; however, they are based upon what the program intends to achieve.

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<tr>
<th>Assumptions</th>
<th>External Factors</th>
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| 1. The CSF program increases the physical and psychological health, resilience, and performance of soldiers, families, and Army civilians.  
2. The program is of benefit to most people, as resilience impacts operational readiness and can be costly to the Army.  
3. Repetitive deployments, time away from home, and limited coping skills contribute to the targeted problem. | 1. The CSF program is mandated under the Department of Army Ready and Resilience Campaign Plan, AD 2013-07, and AR 350-1.  
2. The program is funded under U.S. Army G-1, primarily through Overseas Contingency Operations funds.  
3. Sustained resources, manpower, knowledge, and senior leadership support is required to continue program services. |