CAB D0002054.A2/Final
September 2000

TRICARE and Mental Health: Providing the Benefit

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Approved for distribution: September 2000

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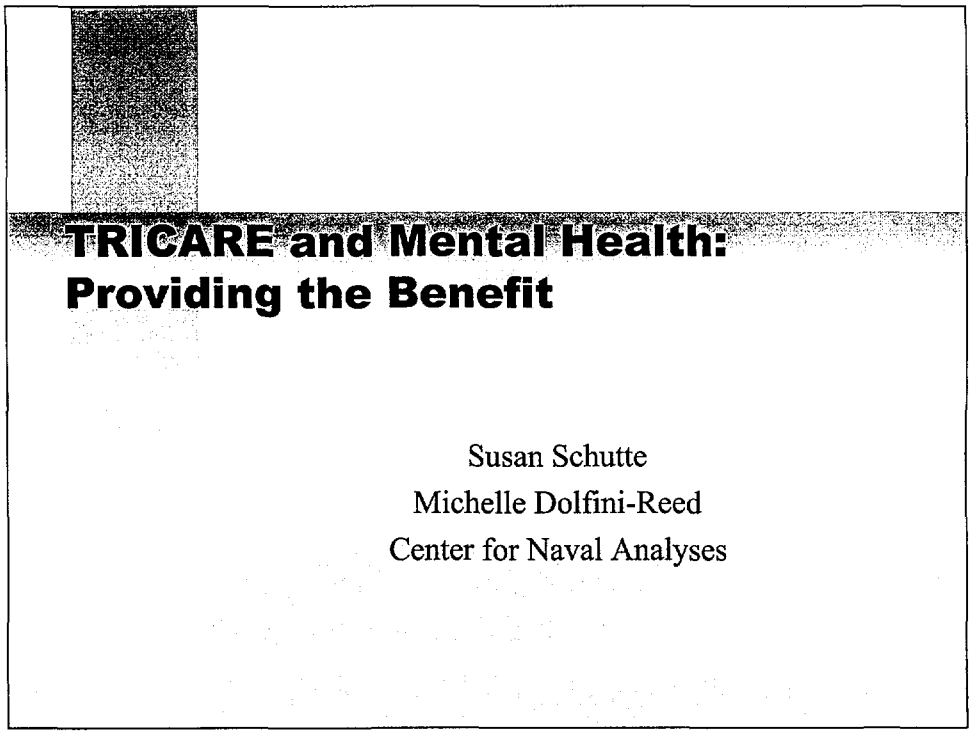
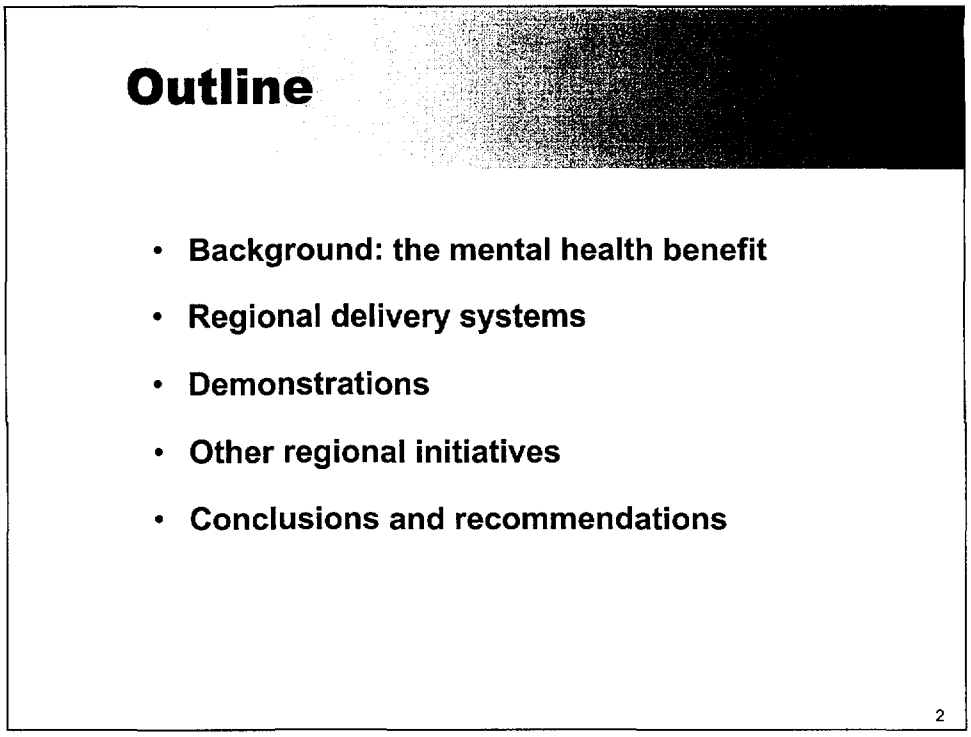


Navy Medicine has identified mental health as one of the major product areas in which it wants to develop a business strategy that supports the effective and efficient provision of these services to the military health system's beneficiaries. To develop this strategy, the Navy Bureau of Medicine has established a mental health product line executive panel. Its members include both medical and non-medical Navy and Marine Corps personnel, reflecting the Navy's diverse mental/behavioral health resources.

Among the many tasks facing the mental health product line executive panel is establishing a comprehensive baseline understanding of mental/behavioral health care services as they currently exist in the Navy and Marine Corps communities. Our purpose in this document is to provide an overview of the regional TRICARE mental health care delivery systems and to identify issues requiring further investigation, thought, and analysis during the course of the executive panel's proceedings. This annotated briefing represents the first in a series of research documents that we will be preparing for the working group during the next several months.



We begin by providing a brief description of the TRICARE mental health benefit. For background purposes, we describe the services covered under the benefit, authorization for care requirements, and annual limits on the frequency of outpatient visits and inpatient bed-days.

Next, we discuss the various approaches that the 12 TRICARE regions have adopted to deliver the mental health benefit to the military beneficiary population. We primarily collected this information in a series of telephone conversations and interviews with a variety of military health care system administrators and providers involved in the delivery of mental health services in each of the 12 U.S. TRICARE regions. In our interviews, we spoke with persons working in the TRICARE Management Activity (TMA) Regional Lead Agent offices, mental health subcontractors, TRICARE mental health utilization and case managers, military psychiatrists, and other military mental health providers. Specifically, we used the following questions to structure our interviews with regional mental health care administrators and providers:

- What is the status of the mental health integration with primary care?
- What are the issues associated with access to mental health services?
- What mental health demonstrations have been completed in your region and what demos are currently in place or planned for the future?

- What other regional initiatives have been tried? Were they successful? Have they been implemented on a permanent basis? What initiatives are planned?
- What are the emerging issues and challenges for mental health delivery?

Note that we did not include primary care providers in our interviews. The information here reflects people's perceptions, beliefs, and informal observations of mental health professionals. In follow-on work, we will be including the primary care viewpoint as well. In addition, this document does not provide complementary analyses using administrative workload, cost, and personnel data to substantiate the abstract, general impressions of our interviewees. However, we will be conducting these complementary, detailed analyses and documenting our results in the coming year.

Background: the mental health benefit

Covered Services	Authorization Required	Annual Limits
Outpatient primary care visits and outpatient psychotherapy	May self-refer for first 8 visits—thereafter requires authorization	Individual: 104 visits per year Group: 104 visits per year
Inpatient psychotherapy	Yes	Age ≤ 18 years: 45 days/FY or /admission Age 19+ years: 30 days/FY or /admission
Partial hospitalization	Yes	60 days per fiscal year or per admission
Residential Treatment Center (RTC)	Yes	Age 20 years & under: 150 days per fiscal year or per admission
Substance abuse	Yes	3 disorder treatment benefit periods in his or her lifetime

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The TRICARE mental health benefit covers both inpatient and outpatient services that are medically or psychologically necessary to treat a covered mental disorder. Individual, group, and family psychotherapy, collateral visits, and psychological testing are available benefits within prescribed frequency and duration limits.

Patients may see various types of providers for diagnosis and treatment of mental health conditions. TRICARE authorized providers include primary care providers, psychiatrists, licensed clinical psychologists (at doctoral level), licensed clinical social workers (at master's level of education), certified psychiatric nurse specialists, certified marriage and family therapists, certified pastoral counselors, and certified mental health counselors. In addition, TRICARE requires physician referral and supervision of pastoral and mental health counselors.

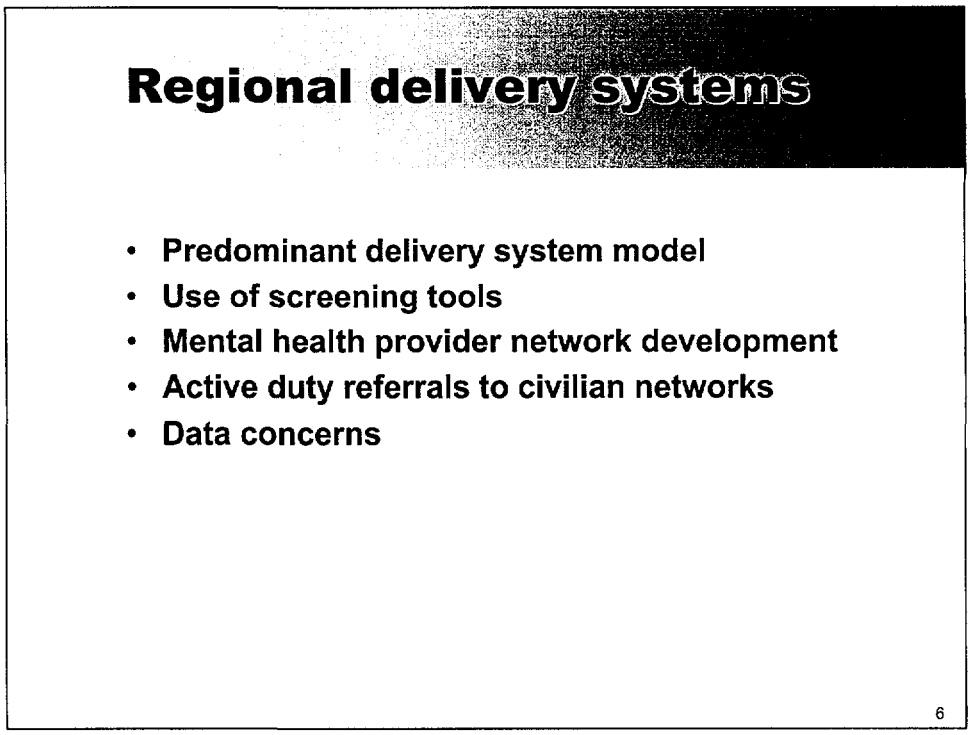
TRICARE covers both individual and group outpatient psychotherapy. Beneficiaries may self-refer for the first eight mental health visits and do not need to receive a referral from their primary care manager or authorization from the local TRICARE service center for coverage of these sessions. After the eighth visit, however, authorization is necessary for continued coverage. The intended goal is to give beneficiaries increased access to care and privacy. As discussed later in this document, however, beneficiary self-referrals to mental health specialists present communication and care challenges to primary care managers responsible for oversight of the patient's care. Examples of potential challenges include a patient receiving conflicting advice from different providers or an internal medicine physician unknowingly prescribing a drug that interacts adversely with a patient's antidepressant.

Acute inpatient mental health services are limited by the patient's age at the time of admission. The limit for patients 19 years of age and older is 30 inpatient days in any fiscal year or in an admission. For patients 18 years and under, the limit is 45 inpatient days in any fiscal year or in an admission. All nonemergency inpatient mental health services require care authorization before the admission.

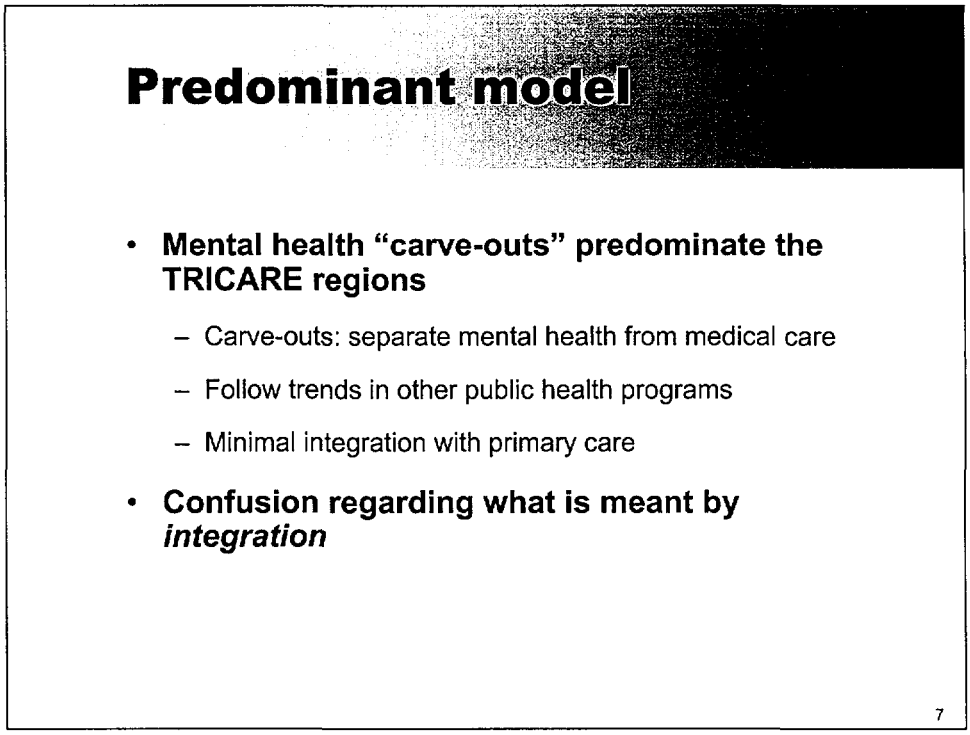
TRICARE also covers expenses associated with care received in partial hospitalization programs. Reference [1] defines partial hospitalization as "a time limited, ambulatory, active treatment, that offers therapeutically intensive, coordinated, and structured clinical services...." Partial hospitalization requires authorization and is a covered benefit when medical or psychological necessity conditions are met. The intent of this benefit is to provide quality care at less expense than the full hospitalization rate and to allow more efficient use of mental health resources.

Residential treatment facilities (RTCs) are another alternative for mental health care under the TRICARE benefit. Established as a benefit in FY 1991 [2], the RTC is viewed as a source of mental health services that is less expensive than inpatient hospitalization. These facilities exist specifically for 24-hour psychiatric treatment of children and adolescents up to age 21. TRICARE regulations require preauthorization of an admission to an RTC.

Emergency and inpatient hospital care for complications of alcohol and drug abuse or dependency and detoxification are covered as for any other medical conditions. Coverage includes detoxification, rehabilitation, and outpatient care provided in authorized substance use disorder rehabilitation facilities. Each beneficiary may receive up to three substance use disorder treatment benefit periods in his or her lifetime. A benefit period begins with the first date of covered treatment and ends 365 days later, regardless of the total services actually used within the benefit period. Effectively, the TRICARE mental health benefit limits beneficiary use to 3 years, regardless of whether the 365-day periods fall consecutively or not. These services are also subject to visit limits and require preauthorization in nonemergency situations.



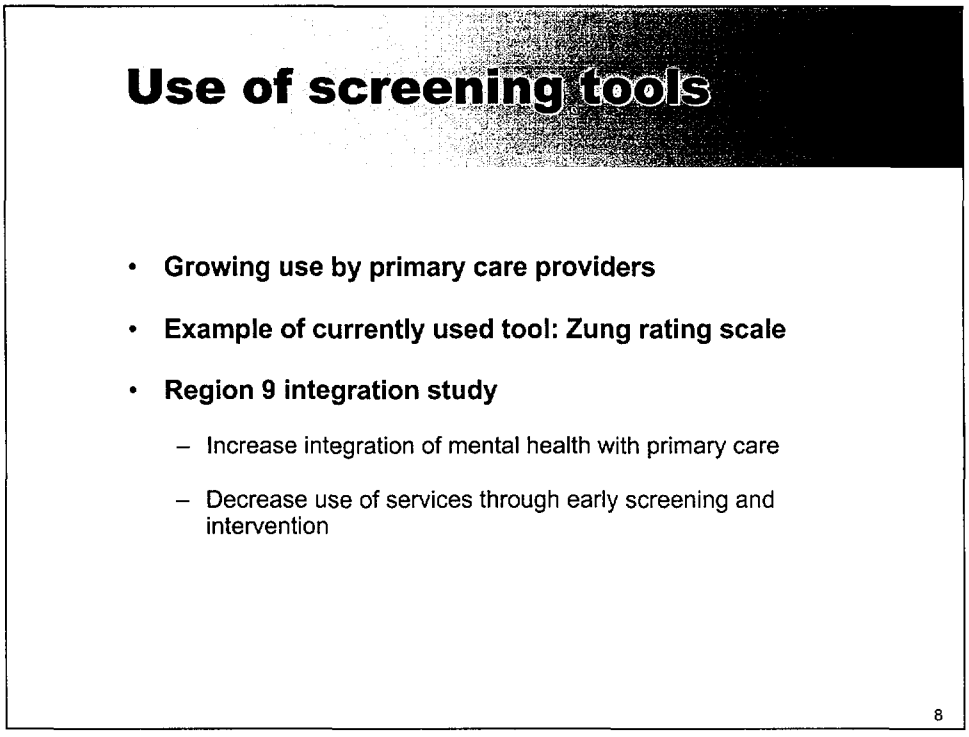
In the section that follows, we describe various regional approaches to mental health delivery in the military health system.



Most regions report little integration between mental health and primary care services. Rather, the use of carve-outs predominates. Carve-outs describe a delivery approach in which mental health services are separated from medical services. Usually under carve-out arrangements, insurers contract with a separate entity to provide oversight, management, and coordination of mental/behavioral health services. During the 1990s, an increasing number of state Medicaid and local community health programs have used carve-outs as a means to containing mental health costs [3].[1] Carve-outs, as implemented under the TRICARE regional support contracts, are responsible for oversight, management, and coordination of civilian mental health specialists who agree to participate in the respective region's TRICARE health plan.

We found that regional administrators and providers were uncertain as to the definition of integration. Is it co-location of primary care and mental health service, common management of the service delivery, or care managed by the primary care provider? Although we found that physicians and case managers did not always agree on the definition of integration, they did tend to agree that a combined approach to mental and physical treatment is a desirable goal.

1. We provide more detailed information on state use of mental health carve-outs in [4].



Many primary care units are using screening tools to identify depression and mental health issues. Several regions reported that they were using the "Zung Self-Rating Depression Scale." Rating scales, such as the Zung scale [5], are used as a complement to an in-depth patient interview. In the primary care setting, the Zung scale can be used to screen patients for depression and to measure progress during therapy. Because the items in the scale are self-administered, providers tend to view the tool as a reliable way to assess patients for depression symptoms without introducing interviewer bias.

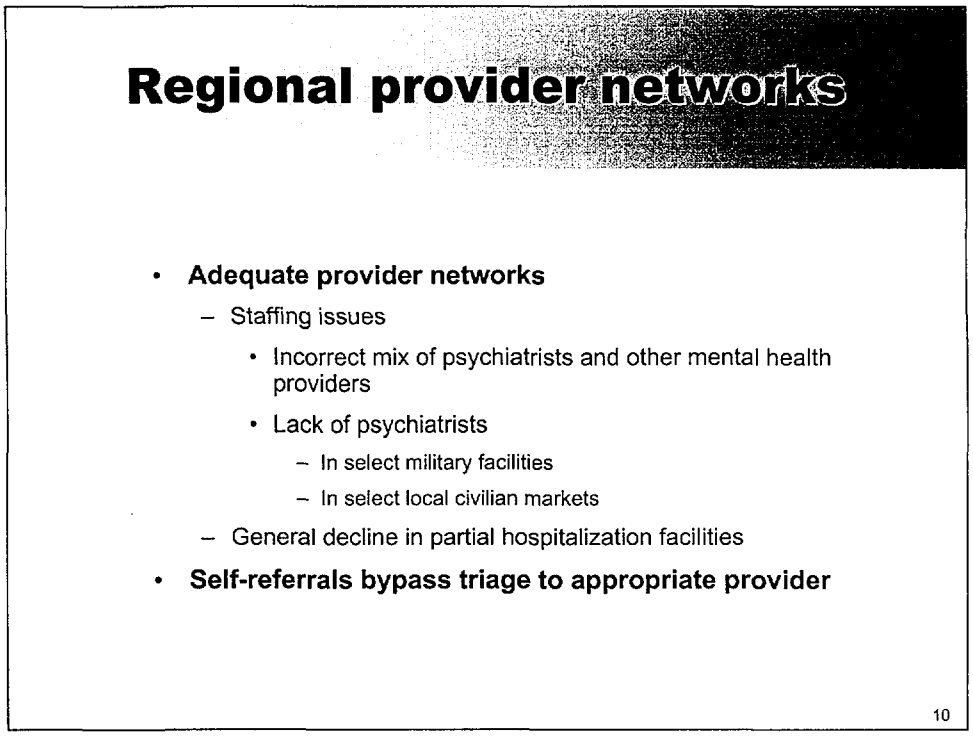
Staff education and training on "trigger diagnoses"[2] and mental health referral processes appear to be ongoing initiatives in most regions. Region 9 has received approval to initiate a study at Naval Medical Center, San Diego to increase mental health integration with primary care. Patients in the internal medicine clinic will serve as the experimental group; patients in the primary care clinic will serve as the control population.

In this demonstration effort, primary care physicians in the internal medicine clinic will administer a survey (similar to the Zung scale) to patients to assist in identifying depression. If the patient meets the criteria for depression, the physician will inform him or her of the different treatment options, including

2. Trigger diagnoses are medical diagnoses that tend to precede and increase the probability of developing comorbid, mental health conditions.

antidepressant therapy, psychotherapy, or some combination of the two. If the patient exhibits signs of suicidal behavior, the primary care physician will immediately refer to a mental health specialist. If the patient warrants drug therapy and is agreeable to antidepressant therapy, the physician will ask the patient if he or she wishes to participate in the study.

Counseling will be provided in the internal medicine clinic but only in a group setting. Patients requiring individual counseling will be referred outside the clinic. Pharmacists who work in the Internal Medicine Clinic will participate in this study as part of the treatment continuum, providing follow-up with patients. The pharmacists will monitor referred patients and be able to adjust medication doses based on lab results. Under this arrangement, pharmacists will take responsibility from the physicians for performing medication checks and follow-up visits. Follow-up visits usually will occur during weeks 1, 4, 12, and 24. At these times, the pharmacist also will readminister the depression survey, referring patients back to physicians when medication changes are required. The pharmacists also will refer patients to the mental health clinic immediately if the patient appears to be at risk to harm himself or herself. The goal of the study is to increase beneficiary satisfaction and decrease utilization of services through early screening and intervention. The experiment will begin November 1, 2000.



Resource issues were a recurring theme in our discussions with facility providers and regional managers. The right mix of staffing at the military hospitals and clinics is a major concern of the TRICARE regional managers and military providers. Most of the available providers in the majority of military hospitals and clinics are psychiatrists. Regional representatives consistently noted that they could provide the appropriate levels of mental health care at less expense with the addition of other health professionals, such as clinical psychologists, psychiatric nurses, licensed practical counselors, and social workers. Several regions[3] also noted a lack of psychiatrists and child psychiatrists within specific military facilities and local civilian markets. The predominant viewpoint among facilities with deficits was that specialists were unevenly distributed among the military facilities—some had more than enough, while others were understaffed.

Half of the regions[4] expressed concerns regarding their civilian networks, particularly with respect to TRICARE certified partial hospitalization facilities. Partial hospitalization facilities are not available in some regions, or regions have such a small number that beneficiaries are often referred to neighboring regions for service. The benefit for partial hospitalization was initiated to provide a less

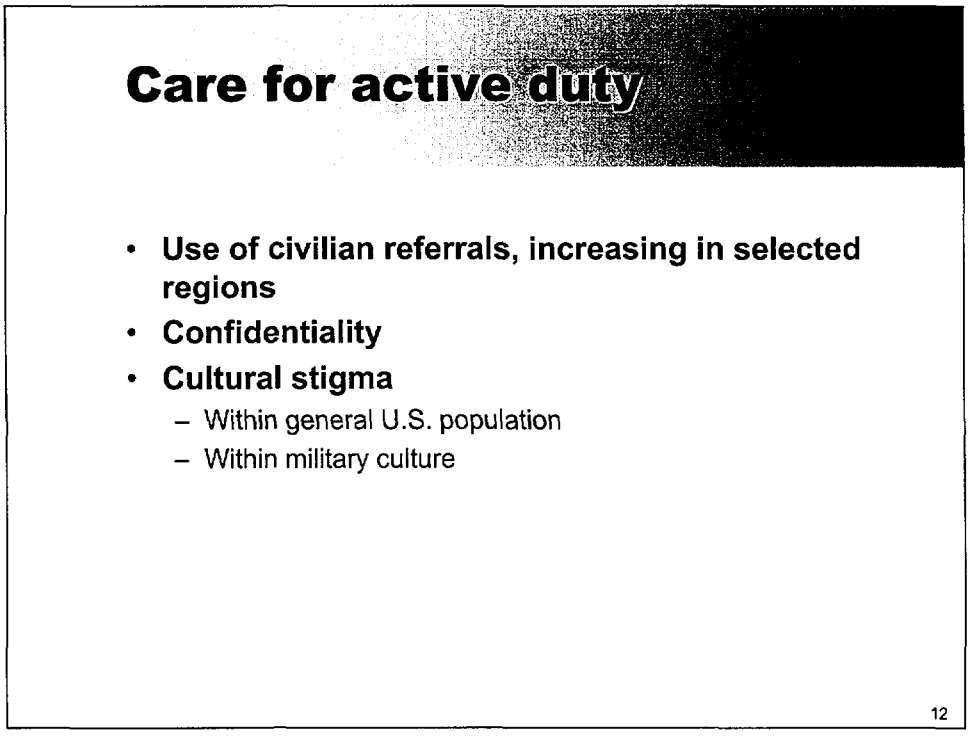
3. In region 5, Blanchfield Army Hospital; in region 9, Twentynine Palms; in region 10, TRICARE Management Activity (TMA).

4. Regions expressing concerns include regions 2, 6, 9, 10, 11, and 12. Members of the TMA staff also noted network development challenges.

expensive alternative to full hospitalization. However, most regional administrators and providers reported a decline in the number of TRICARE-certified partial hospitalization facilities in their regions due to the TRICARE certification requirements. Partial hospitalization facilities must meet the same certification requirements prescribed for inpatient facilities. As the availability of facilities in each region decreases, the beneficiary's alternatives are referral to partial hospitalization facility in another region, inpatient hospitalization, or going without care. We found that most providers viewed these alternatives as more expensive and time-consuming, and as having a negative effect on the continuum of care.

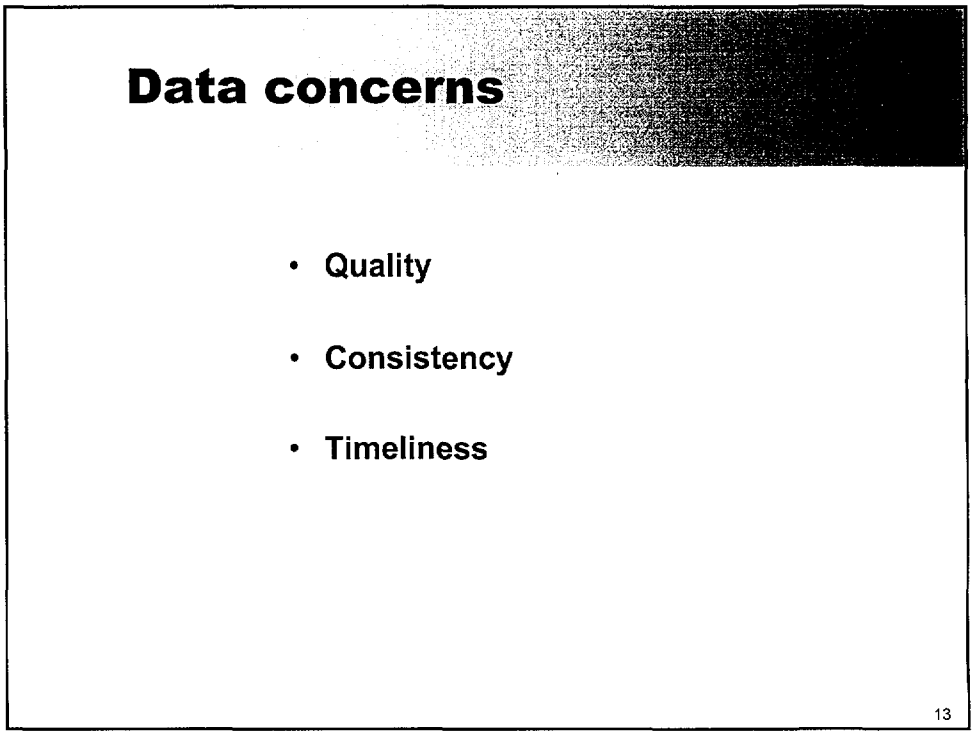
Region 6 reported several concerns with the mental health self-referral option. As noted earlier, the TRICARE benefit authorizes the beneficiary to receive up to eight mental health visits with a civilian provider without obtaining a referral from his or her primary care provider. The widely held belief is that many beneficiaries take advantage of the self-referral option and prefer not to authorize release of their records for review by their primary care provider. Consequently, primary care providers are not aware of all aspects of their enrollee's care, creating the potential for adverse reactions and complications, particularly with respect to care plans and prescribed treatments. The preferred relationship is to require military and civilian psychiatrists to communicate patient care plan information to the primary care provider.

A second self-referral issue involves the type of provider selected by the beneficiary. The concern is that the patient will self-refer to the wrong type of provider or refer to a specialist when his or her primary care physician could treat the condition. At issue is identifying the appropriate source of care that optimizes available military health system resources. As currently designed, the option to self-refer increases the risk of inappropriate use, inappropriate care, and higher costs.



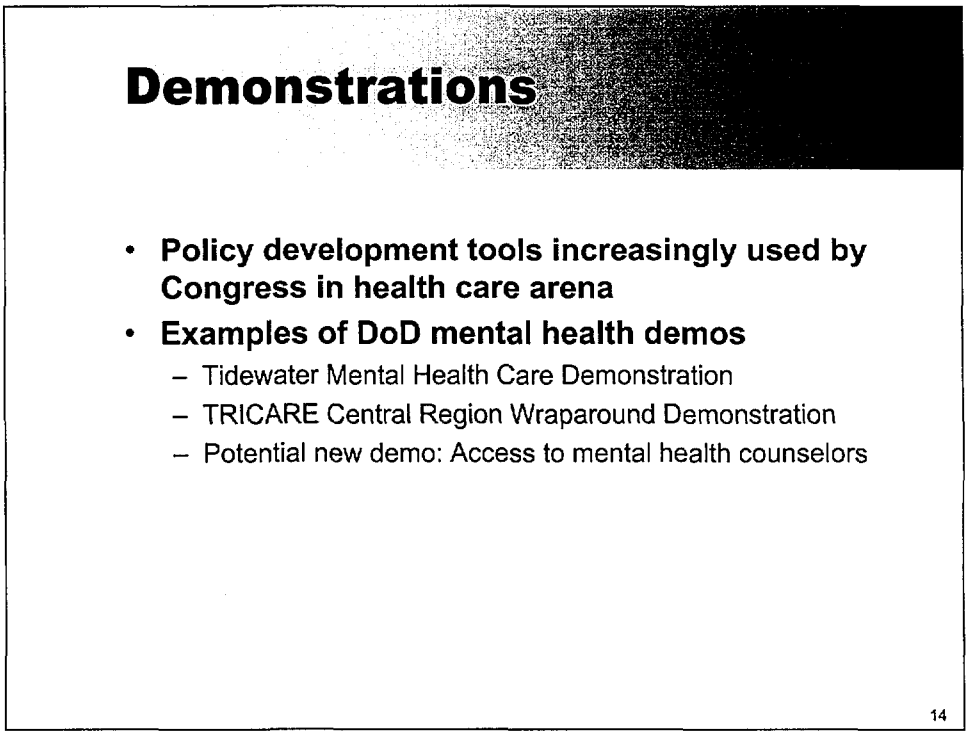
Active duty personnel have first priority for receiving health services in military clinics and hospitals. If mental health issues are identified by the primary care provider and subsequently referred to a military mental health specialist, feedback to the primary care provider occurs. However, when the military facility does not have the appropriate mental health professional available, the primary care provider will refer the active duty member to a civilian network provider. In this instance, communication between the primary care provider and the civilian mental health provider is minimal. In both instances, the patient must sign a release of information before treatment status and diagnosis details are released to the primary care provider.

Most of the regions reported a perceived increase in active duty referrals to civilian networks, although some believed they were treating all active duty demand for mental health services. Region 6, in particular, noted that among its military clinics and hospitals, civilian referrals for active duty members ranged from zero to one-third, depending on the size of the facility and local staffing of military psychiatrists. While region 6 does not support a significant number of Navy beneficiaries, the region's self-reported patterns of active duty referrals support the perceptions of the other regions that referrals to the civilian networks are increasing. Based on these perceptions, we believe that further investigation of this issue is warranted.

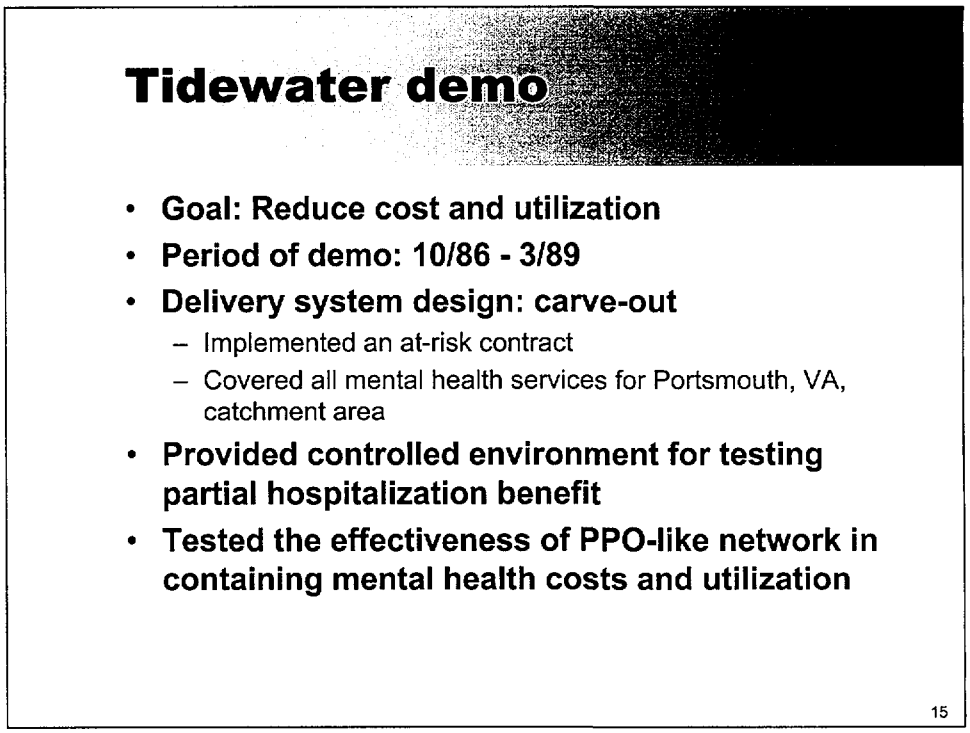


Regions have very different opinions regarding the quality of their data on mental health care available to manage services. Most tend to express the opinion that the current data are not sufficient to support effective management of their regional health care benefit. Regional health care managers noted that the military hospitals' inpatient data are consistently reported but are not tied to outpatient statistics. Claims data tend to be "too old" to support decision-making because the time to file a claim for civilian-based care is one year. Region 10 indicated that its Managed Care Support Contractor had amended the contract to provide Health Plan Employer Data Information System (HEDIS) reports, but the result was production of "HEDIS-like" reports and did not provide enough service detail for resource management.

Ultimately, the quality and usefulness of regional data depend on how much emphasis each military facility places on consistently collecting accurate treatment information and on the reports filed by the Managed Care Support Contractor or as required under contractual agreements. Past research has identified specific issues affecting the quality of military health care data [6, 7, 8, 9]. These studies indicate and we continue to find that there has been little focus on implementing uniform processes that support patient care and data quality. Continuing patterns of not using available data to manage resources reinforce continued poor reporting practices and ultimately undermine the ability of military facilities to optimize their health care operations.



Policy-makers increasingly used program demonstrations in the health care arena during the 1980s and 1990s as a way to test new models of delivering and paying for health care services under Medicare, Medicaid, the Veterans' Health Administration, and the Department of Defense's military health program. In the mental health arena, policy-makers have used demonstrations as a way to test new delivery system designs, evaluating their effects on utilization, ease of access, cost, and quality of care. In the following pages, we describe three DoD mental health demonstrations: the Tidewater mental health carve-out; the Central Region wraparound, and a newly proposed demonstration program involving the use of mental health counselors.

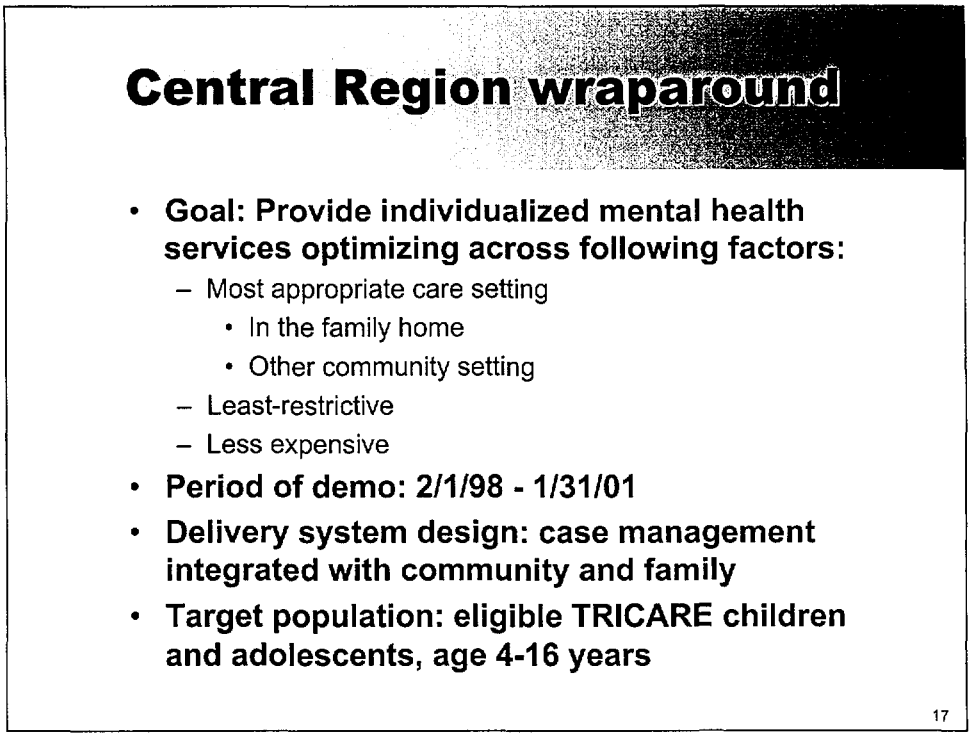


DoD initiated the CPA Norfolk Demonstration[5] in 1985 because of high levels of mental health utilization in the Tidewater, VA, area [10]. DoD awarded Sentara Alternative Delivery System Corporation (doing business as " First Step") a fixed-price contract to coordinate and preauthorize all CHAMPUS mental health and chemical dependency benefits delivered to the nearly 260,000 beneficiaries in the Tidewater area. Under the contract, Sentara established a network of mental health contract providers. Beneficiaries were free to choose contract or noncontract providers, with an out-of-pocket cost associated with noncontract services.

In general, the evaluation of the demonstration conducted by Abt Associates, Inc., found the results of the demo to be positive, confirming the practicality and efficiency of the carve-out model [10]. Over the 2.5-year period, the costs for mental health care under the demo were at least $33.4 million, or 31 percent of the expected costs without the demonstration. Concurrently, over the same period, the utilization of mental health services increased slightly, suggesting that access was not negatively affected. A dramatic change in the mix of services from inpatient to outpatient occurred—inpatient from 75 percent of all mental health costs to 55 percent of all costs by the end of the demonstration.

5. Also known as the Tidewater mental health demonstration.

Although the program did raise some issues related to quality of care, the lack of baseline data measuring quality made it impossible to evaluate these issues. Overall, the evaluation results could not connect observed quality problems with the contractor or cost-control measures. In addition, the use of inpatient utilization, specifically partial hospitalization, was not controlled until late in the demonstration; therefore, the evaluation results did not provide a definitive answer on the cost-effectiveness of this alternate source of inpatient care.



Congress directed DoD to conduct a mental health wraparound demonstration under the National Defense Authorization Act, 1996. Wraparound services as defined under the act refer to "individualized mental health services that are provided principally to allow a child to remain in the family home or other least restrictive and least costly setting, but also are provided as an aftercare planning service for children who have received acute or residential care" [11].

As implemented in this program, the wraparound design combines the use of case management techniques with family and locally available community resources. The assumption of the wraparound approach is that the combined use of such "services...builds support for the patient which enables shorter inpatient stays through comprehensive and continued management of care, while substantially reducing recidivism for the residential phase of treatment; thereby reducing costs of inpatient psychiatric and residential care" [12].

The specific objectives and expected outcomes are as follows:[6]

- *Improved patient outcomes.* Outcomes will be measured through such indicators as use of multiply prescribed medicines, numbers of missed appointments, numbers of Against Medical Advice (AMA) discharges, number of elopements from inpatient or residential treatment center facilities, and the number of patient interactions with the criminal justice system as compared to

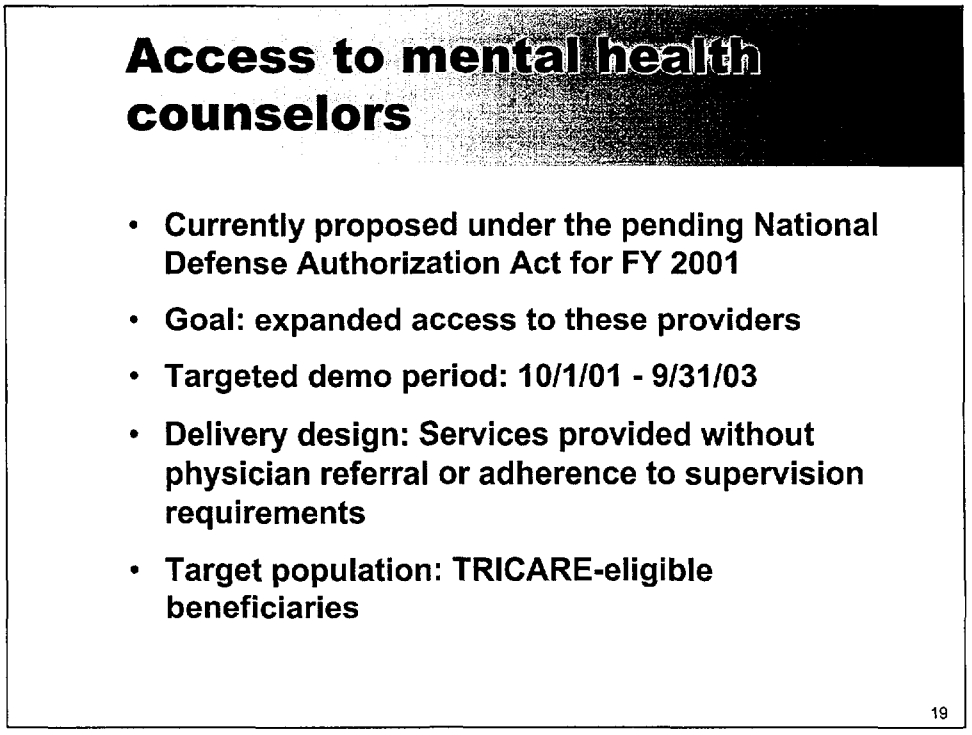
6. We obtained this information from [13].

such indicators in the control group. The expected effect is a significant decrease in each indicator for the demonstration participants.

- *Reduction in family mental health expenditures.*
- *Reduction in patient's length of stay in inpatient psychiatric care or residential treatment.*
- *Reduction in recidivism rate for residential phase of treatment.*
- *Reduction by 15 percent over control group in numbers of days spent in institutions.*
- *Increase of at least 50 percent in compliance in such areas as keeping therapy appointments, medication compliance, and school attendance.*
- *All sentinel events (hospitalizations, self-destructive behavior, expulsion from school, juvenile arrests, pregnancy) will be captured and compared in both groups.*

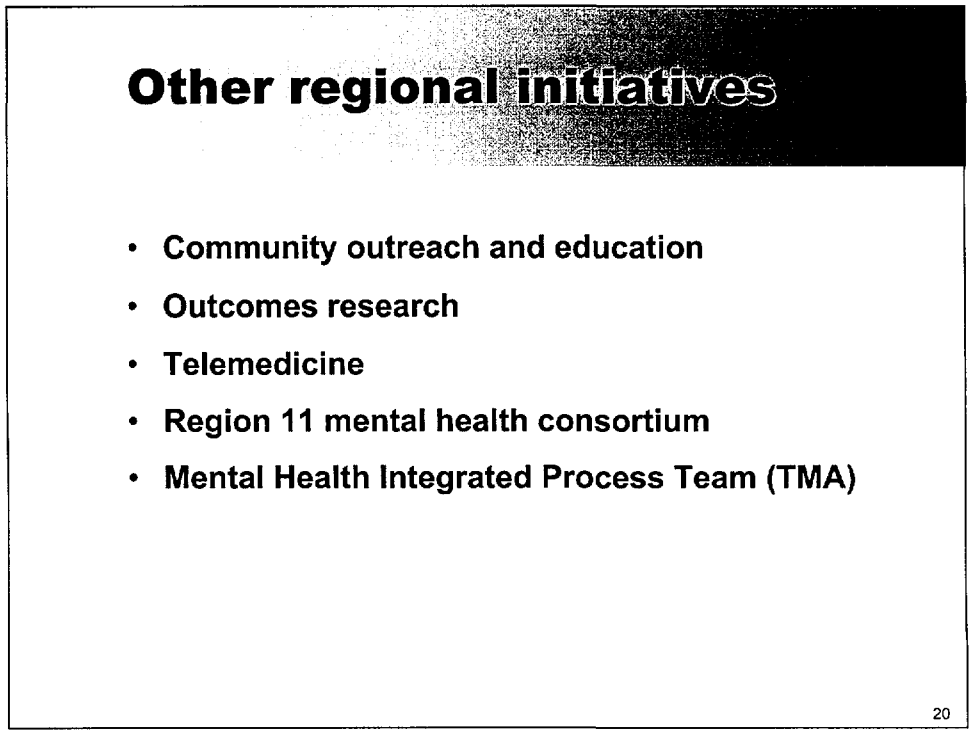
The TRICARE Central Region is the site of the wraparound program, with regions 9 (Southern California) and 10 (Northern California) serving as the control group.

There is widespread interest throughout the regions regarding the programs' outcomes and associated costs. Based on anecdotal evidence, military health care managers anticipate that the program has increased family involvement and reduced recidivism and cost. The evaluation of the program is under way, and DoD should receive the final published result for presentation to Congress in 2001.

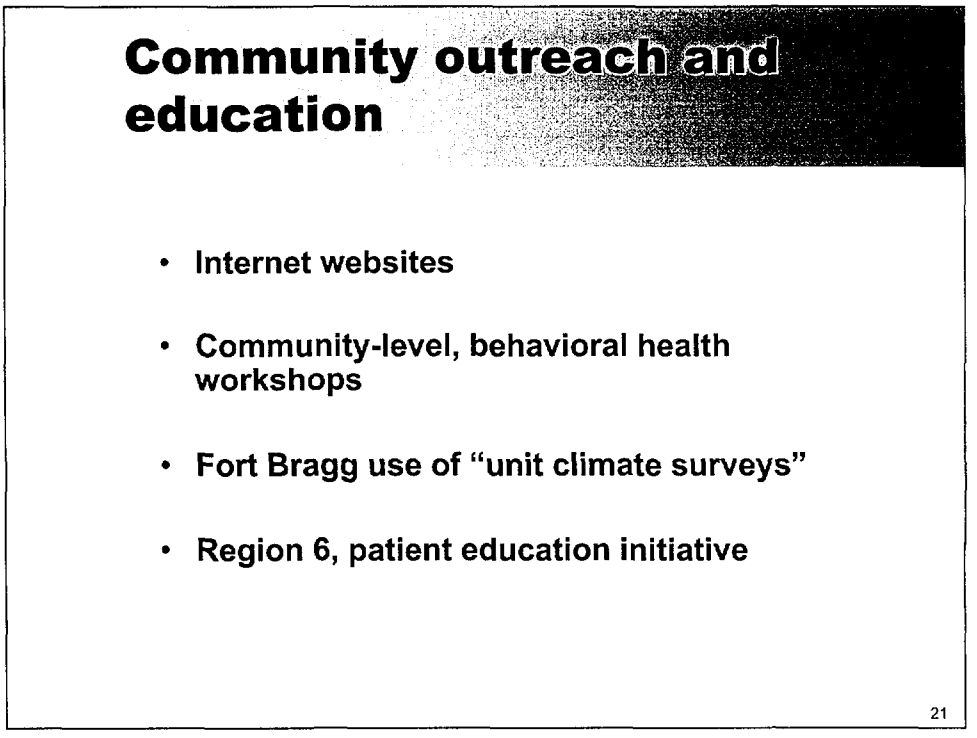


Currently, TRICARE covers mental health care counselor services only if the beneficiary has been referred by a physician and the services are rendered under the supervision of a physician. Physician supervision means the physician provides overall medical management of the case. Under Section 704 of the pending National Defense Authorization bill for FY 2001, Congress is directing the Secretary of Defense to conduct a demonstration project to test the effect of increasing access to certified professional mental health counselors by removing the requirement for physician referral and supervision.[7] This demonstration requires the analysis of the utilization and costs associated with the removal of the referral and supervision requirement and recommendations on future policy changes.

7. As of 27 July 2000, the FY 2001 Defense Authorization bill was still under consideration in the U.S. Senate.



A number of interesting mental health initiatives are taking place at the local and regional levels, as well as at the DoD level in the TRICARE Management Activity (TMA). In this section, we describe several of these initiatives.



Most of the TRICARE regions have developed websites that contain links to or information about mental health services. The Central Region website [13] provides information about clinical depression developed by the Magellan Behavioral Health Division of Magellan Health Services, Inc., a subcontractor to TriWest Healthcare Alliance for mental health and substance abuse services. The online module is a collaborative effort between the TRICARE Central Region Lead Agent and TriWest; it provides an overview of clinical depression, its effects, and treatment. One of the website features is an online, self-assessment questionnaire that beneficiaries may complete to determine whether there is a general indication of a depressed state. Website visitors also may access links to resources, information on available treatments, and how to contact professionals. Examples of other site pages that discuss symptoms and how to recognize them are "Postpartum Depression," "The Depressed Child," "Let's Talk About Depression" (for adolescents), and "Help for Seniors." This online mental health/outreach program provides information and easily accessed resources for people who are initially hesitant to seek care in person.

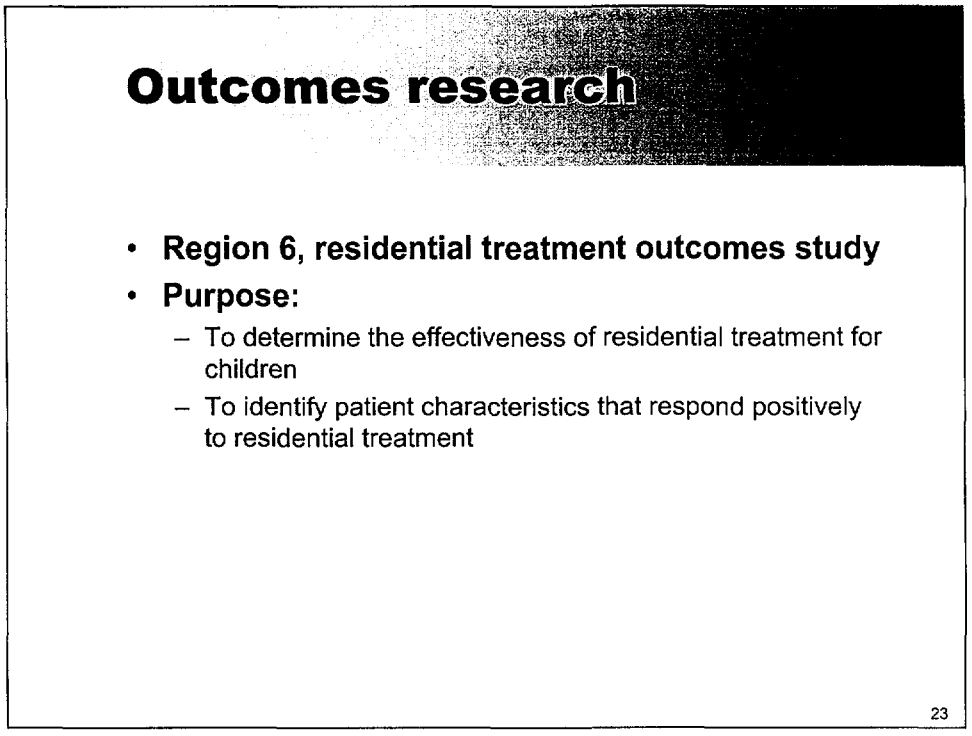
The Ft. Bragg Division of Mental Health, which provides outpatient services for the 82nd Airborne, has adopted a direct approach to mental health education. Staff from the clinic visit the army units to conduct behavioral health classes on site. In addition, clinic staff have developed surveys that they use to evaluate the unit climate as a whole, the results of which they

provide and discuss with the units and their respective command. Clinic staff also are assigned to support each brigade. In this support role, mental health staff train and deploy with their assigned unit. As part of the unit, the mental health personnel become familiar to the soldiers and more approachable. This close relationship fosters communication and an openness that has enhanced ease of access for active duty members and the provision of care.

Most of the regions have initiated workshops or classes designed to increase awareness and develop skills to cope with behavioral health issues. Covered topics include a wide range of areas, such as stress management, anger management, communication, parenting skills, and deployment issues. Educational efforts also include online access to resource information, written materials and self-assessments.

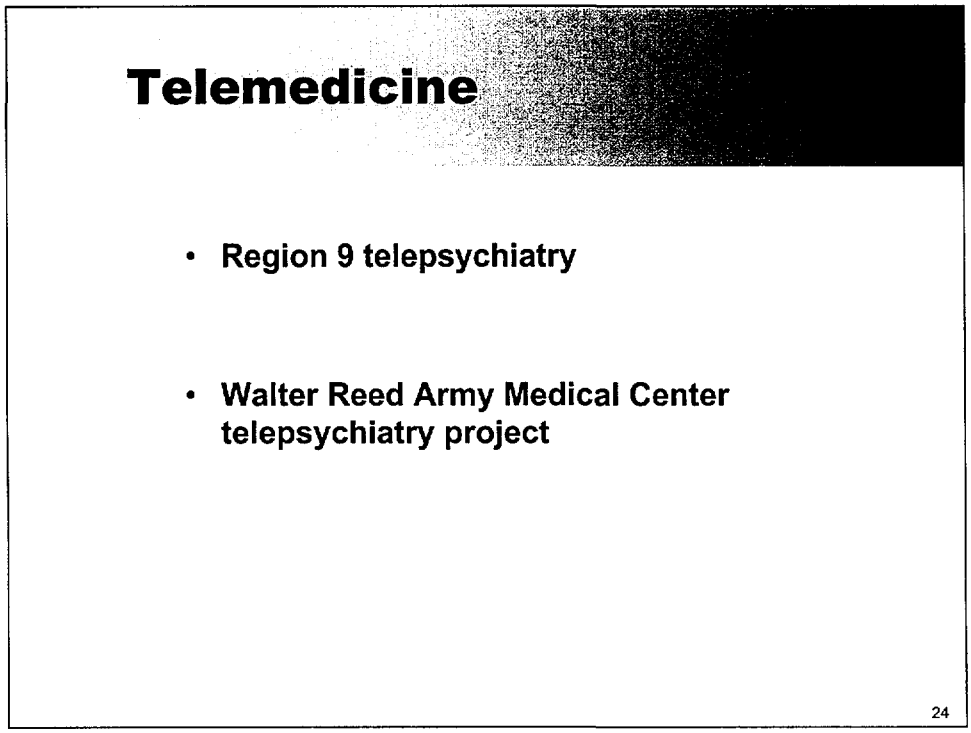
One example of an ongoing initiative is the patient education program in region 6. Initiated by Managed Health Networks, a subsidiary of Foundation Health Services which oversees the management of mental health services in TRICARE regions 6, 9, 10, 11, and 12, the patient education program provides a year of post-hospitalization follow-up for beneficiaries admitted to a hospital for mental health care. Mental health clinicians call each patient after discharge to ensure that they are provided with educational materials about their diagnosis and/or treatment and to monitor and encourage compliance with the treatment plan, including both medication and psychotherapy. Those patients who elect to participate will receive follow-up calls for up to 1 year after discharge. The program is predicated on the premise that patients who understand their illness and get their questions answered are more likely to comply with treatment and, therefore, are less likely to relapse.

The first phase of the program focused on adults discharged with a diagnosis of depression. (Mental Health Network reports that over half of all TRICARE beneficiaries who are discharged from an inpatient mental health stay carry a primary diagnosis of depression.) Because of the high incidence of children and adolescents (two-thirds) using inpatient mental health services, however, the program has recently been expanded to include calls to the parents of these patients. Currently, this program is active only in region 6; however, plans are under way to implement similar programs in regions 9, 10, and 11 by 1 September 2000.



Residential treatment usually is thought to be an effective mode of mental/behavioral health care for children; however, some patients do not respond to this form of treatment, whereas others respond adversely. To determine the patient characteristics that are predictive of a positive response to the treatment, Managed Health Networks (MHN), which provides the network and management for mental health services in region 6, has initiated outcomes research to assess the effectiveness of residential treatment for children.

During the first phase of this study, MHN recently completed enrollment of more than 300 families with children or adolescents who have been admitted to a residential treatment center in region 6 during the past year. These families will participate in a one-year telephone follow-up to collect outcome information. Once the year is complete (approximately September 2001) and all data are compiled, MHN will determine the characteristics of patients who responded the best to residential treatment versus the characteristics of patients who did not respond well. The study also will identify components of the residential treatment program that are most effective.



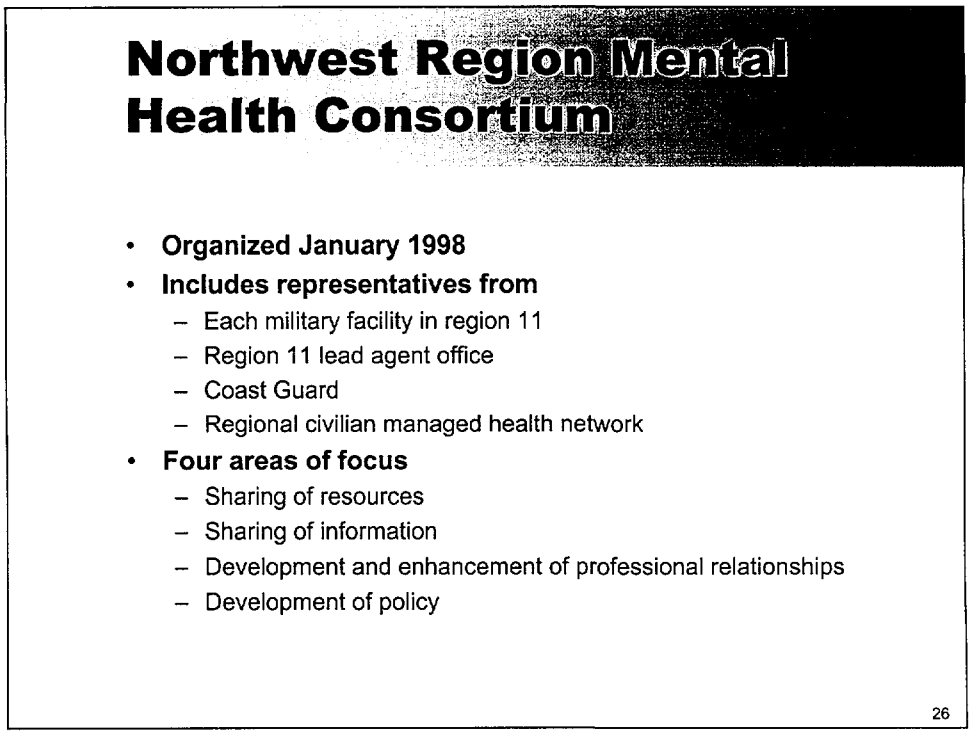
Several regions are attempting to improve access to and management of mental health services through telemedicine or telepsychiatry. Two projects of interest are telemedicine applications for mental health treatment implemented at Navy Hospital, Twentynine Palms, CA, and the Walter Reed Army Medical Center. Both projects involve child/adolescent psychiatry.

Twentynine Palms, with the collaboration of the Department of Psychiatry at Naval Medical Center, San Diego and the Office of the Lead Agent, TRICARE Region 9, established a Child and Adolescent Telepsychiatry Clinic to provide consults and evaluations for patients who were located in areas without the support of a child psychiatrist. Prior to the use of telepsychiatry, dependents in the Twentynine Palms area had to travel up to 5 hours to the nearest MTF for a child psychiatry evaluation.

Under the telepsychiatry program, pediatricians and family practice providers at Twentynine Palms refer patients to the telemedicine clinic and write consults over the internet-based tracking system. Family members complete medical and behavioral history questionnaires, which are faxed to the child psychiatrist at Naval Medical Center, San Diego before the actual consultation. The consult with the child psychologist in San Diego takes place in the telemedicine clinic on low bandwidth equipment using standard telephone lines at minimal cost to the commands. Twentynine Palms receives feedback after the consultation via the internet or faxed report.

Usually, the consults take place once a week with 4 to 6 patients seen a month. The initial feedback is very positive, and family members seem satisfied with the quality of care and convenience afforded by this application of communications technology.

The telemedicine project at Walter Reed also focuses primarily on child and adolescent psychiatry. Walter Reed has an active video-teleconferencing (VTC) consultation and research telepsychiatry program established with Carlisle Barracks. The research protocol involves validation of the VTC to establish therapeutic alliance with the patient's family. Walter Reed is evaluating the development of plans to expand the sites served by this program and to develop the application for adult psychiatry.



The Region 11 Mental Health Consortium was organized in January 1998. Members include representatives from each MTF and Managed Health Networks (the region's mental health subcontractor), the Coast Guard, and the TRICARE Lead Agent. The group meets once each month to examine issues of access to mental health within the region, to share best practices and how to implement them on a region-wide basis, and to exchange information. The consortium is recognized as the expert and advisory panel for all mental health issues within the region by the TRICARE Executive Council and the Lead Agent. The group has provided input to TMA concerning cost-saving measures and restructuring of the mental health benefit.

The consortium has four main areas of focus: sharing of resources, sharing of information, development and enhancement of professional relationships, and development of policy.

Resources: The sharing of resources has occurred in a number of mental/behavioral health programs in place throughout region 11. In particular, the consortium has used memorandums of understanding between military hospitals and clinics to facilitate the sharing of staffing resources. Training and educational materials from the different services represented in the region also are shared, with Naval Hospital, Oak Harbor providing the lead on training initiatives and information throughout the region.

One example of a regional resource-sharing arrangement is the coordination and referral of mental health consults between Naval Hospital, Bremerton and Madigan Army Medical Center. When Bremerton closed its psychiatric inpatient unit, Madigan agreed to provide inpatient care for patients referred from Oak Harbor and Bremerton. As part of the agreement, Madigan has provided Bremerton the use of a military ambulance for transporting Navy patients to Madigan. To date, the process is working well and there have been no problems with the transfer of beneficiaries.

With the closing of the inpatient psychiatric unit, Naval Hospital, Bremerton made the transition to providing an intensive outpatient mental health program covering a wide range of services for area beneficiaries. As part of these expanded services, the Bremerton mental health clinic provides alcohol treatment services for patients referred from McChord Air Force Base. In exchange, McChord sends a counselor to Bremerton three days a month to augment Bremerton's mental health staff. Resource-sharing agreements also have been implemented with VA hospitals in the region. In addition, to expand access to mental health care for active duty members, contracts between Managed Health Networks and regional VA facilities were amended to include active duty admissions.

Information: One of the first projects initiated by the consortium was standardization of the Ambulatory Data System (ADS) worksheet. It reviewed ICD-9 and CPT-4 codes to develop a consolidated list of mental health codes to facilitate the collection of better data. The development of the region 11 mental health ADS form went through several iterations during a year-long process. Upon completion, all the MTFs in the region adopted the uniform ADS worksheet. Using the data collected from ADS, the group has started to identify and analyze the top mental/behavioral diagnoses. Once completed, the next goal is to determine the treatments and the disciplines associated with mental health services. The consortium will use this information to assist regional managers in financial decision-making regarding provider distribution and types of treatment.

Professional Relationships. Most consortium members believe the monthly meetings have fostered a professional respect among members, the military medical facilities, and the armed services in the region. The group has identified common problems and been able to share solutions and roadblocks. The consortium serves as a forum for discussions of resource issues, management concerns, and problem patient cases. Members noted that the experience of the consortium has led to the development of close working relationships both in and out of the group.

Policy. As noted, the consortium is recognized as the expert and advisory group for mental health issues in the region. The panel has provided input to TMA on mental health issues, including certification requirements for residential treatment centers and partial hospitalization. It also has provided feedback to the TMA Mental Health Integrated Process Team on cost-saving initiatives and preauthorization of visits. The consortium continues to play a significant role in the shaping of the mental health product line.

Over a 2.5-year period, the Region 11 Mental Health Consortium has facilitated and enhanced problem solving and communication between and within the region's military medical facilities. The military hospitals and clinics are sharing resources and information, and the consortium believes that this exchange has helped improve access to mental health services. The consortium has worked to identify projects and accomplish goals and has foregone the previous practice of "reinventing the wheel" at each hospital and clinic. Regularly scheduled meetings and brainstorming have allowed the consortium members to identify common issues that can be addressed as a group. The experience has shown that it is easier to initiate change as an integrated group, rather than as separate entities.

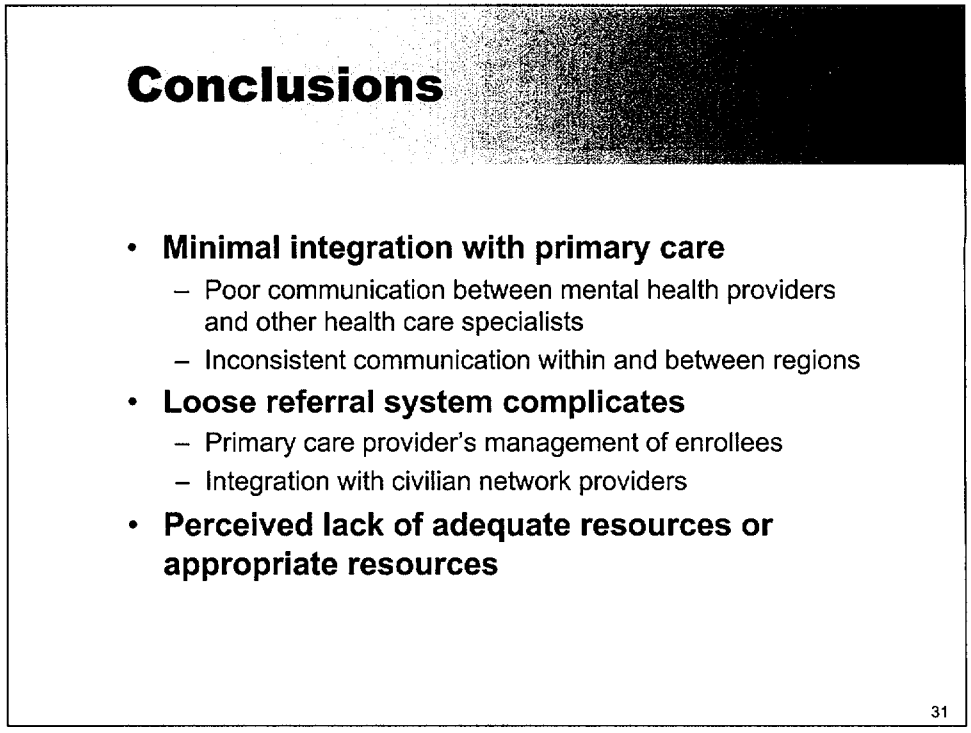
The Region 11 Mental Health Consortium continues to focus on developing regional practice and referral guidelines, addressing the shortage of child psychiatry resource in the region, evaluating the impact of unfilled or deleted positions within the MTF, and continuing to explore all the potential resources, nurturing the integration of mental health with primary care and standardizing data to optimize information and decision-making.

As part of the overall Defense Department focus on population health and optimization, TMA has created a Mental Health Integrated Process Team (IPT), chartered to focus on the redesign of the mental health benefit and identification of cost-saving initiatives connected with the delivery of mental health services. To date, the team has made several recommendations, most requiring legislative or regulatory changes that it would like to see included in the TRICARE program's future. These recommendations are as follows.

- Liberalization of the substance abuse treatment benefit. Currently, the benefit is limited to certified substance abuse centers. Beneficiaries are not allowed to go to a local provider for outpatient care. The IPT has recommended eliminating both the provider limit and the lifetime limit of three benefit periods to achieve parity between outpatient substance abuse services and other types of outpatient care.
- Change the partial hospitalization benefit. The IPT recommends that the certification process for these facilities be simplified. TRICARE requires partial hospitalization facilities to meet the same standards as the inpatient hospital facilities. Partial hospitalization services are not inpatient services, and partial facilities should not have to meet the inpatient requirements. The team also recommended that this benefit be expanded to allow psychiatric nurse specialists to develop treatment plans and provide ongoing assessment for partial hospitalization services. The current process requires that a psychiatrist must certify the services and provide the treatment plan.

- Continue the initial unmanaged mental health visits. The IPT recommends that the first eight visits, which do not require preauthorization, be continued. The team believes that this benefit provides some privacy and increased access.
- Implement of the wraparound demonstration. Based on initial positive feedback of the Central Region wraparound demo, the team recommends that the demo be implemented as a permanent benefit/process of TRICARE.
- Change the level of review for treatment. TRICARE currently requires that certain providers be supervised by a psychiatrist. The team recommends that requirements be changed to allow psychologists to supervise and certify treatment.
- Modify coverage for "V codes." Certain procedure codes, such as marital counseling and partner relationship problems, are not covered by TRICARE. These services cover problems that are big issues in the military because of frequent moves, long absences, and so on. The team believes that these types of service tie in to readiness objectives and should be benefits.
- Carve out mental health benefits. The IPT is analyzing the carve-out of mental health benefits from the TRICARE managed care support contracts. All of the current contracts have subsidiaries or subcontractors managing the mental health benefit and mental health provider network.
- Provide parity for mental health services outside the MTF. If the MTF cannot provide service to a family member, the member is referred to a civilian network and pays more in copay for mental health services than would normally be required for medical care. Mental health services should have parity with medical services.

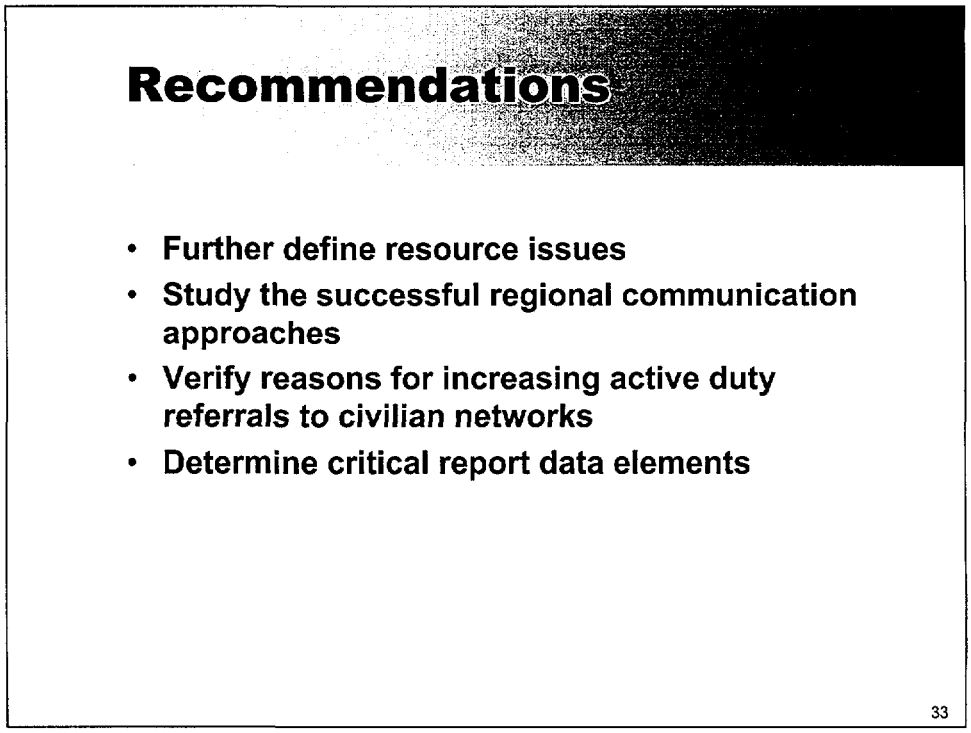
Finally, the Mental Health Integrated Process Team has had input to the pending bill, discussed earlier in this briefing, that would expand the list of providers who can provide mental health services without the supervision of a physician. The bill requires a demonstration to evaluate the impact of this change.



Overall, we found little integration of mental health with primary care in the military health care system. The provision of mental/behavioral health care is fairly separate from the domain of physical medicine. Some experimentation is occurring in several military facilities with the use of screening tools and co-location of mental health providers in primary care clinics; however, these efforts are the exception rather than general practice. Communication is poor between mental health specialists and other health care providers. With the exception of the regional consortiums in the Northwest and Central Regions, the challenge of establishing open channels of communication is an issue within and between facilities, as well as within and between regions.

The current referral system allows beneficiaries open access to mental health specialists, particularly those participating in the TRICARE civilian network. Current regulations support patient confidentiality but do not attempt to address the potential risk factors associated with failing to coordinate care, particularly medications, between mental health and other health care. Ease of access to appropriate mental/behavioral health care for active duty members also is a strong concern among the regions. We find a common perception exists that a growing number of active duty members are receiving such care from civilian network providers rather than the military with limited to no communication back to the referring physician.

Finally, in nearly all our conversations with regional mental health providers and managers, we heard people express concerns about mental/behavioral health staffing and facility resources. Specific issues include staffing numbers, the staffing mix (psychiatrist, psychologists, social workers, counselors, administrative support), and the level of coverage supported by the local civilian network. The Northwest Region was the only region in which we found that the triservice medical community has organized and worked together to optimize resources across services and facilities to expand mental health resources. Otherwise, there seems to be a genuine interest among the other regions in the strategy of integrating mental health with primary care, but concern about whether current resources would support such efforts.



In this report, we have highlighted a number of issues surrounding the delivery of the TRICARE mental health benefit based on interviews with mental health specialists and administrators located throughout the 12 TRICARE regions. We find that issues appear to be consistent across the TRICARE regions. Each region has used different methods to resolve service problems and improve access. Several regions have adopted more aggressive approaches and are improving delivery. The results of the interviews outlined in this briefing, identify the key issues and provide additional information that will help us prepare for upcoming site visits. The following questions are of specific interest:

- How are the regions managing resources and what successful delivery models can be shared with other regions?
- Are patients and providers satisfied with the current delivery of the military health care benefit?
- What do the facilities believe are their primary resource deficiencies? The number of staff? Specialty allocation? Civilian network provider and facility issues?
- Is the facility experiencing an increase in active duty referrals to the civilian network for mental/behavioral health care? How many are referred out?
- Inadequate, poor quality data has been a concern in the regions for years. Are certain data elements missing from reports? Should reports be combined? Is reporting consistent? If not, why?

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