Understanding *Who*, *What* and *Where* in Army Mental Health Services Delivery

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Introduction

The United States Army has been engaged in the two wars in Iraq and Afghanistan for over a decade. Mental health conditions such as Post-Traumatic Stress Disorder have been highlighted as signature wounds from these wars (1, 2). The rapid increase in ambulatory service use for mental health conditions from 1.5 million encounters in FY 2003 to 4.7 million encounters in FY 2014 has heightened interest in how services are currently organized, and how they should be organized (3, 4). The increase in admissions for psychiatric and substance use conditions from 12,190 admissions in FY 2003 to 27,622 admissions in FY 2014 has further elevated the importance of examining quality (5), effectiveness (6), and value (7) of services. This paper uses de-identified administrative data on services provided to Army beneficiaries to answer key questions of: *Who* receives mental health services? *What conditions* do they receive services for? and *Where* do they receive services?

Care in the military health system is distributed between direct care services provided in military treatment facilities, and care purchased from providers in the community using TRICARE health plans. This split of services between direct care and purchased care creates unique care management challenges because the Army only has direct control over the direct care system, and relies on the Defense Health Agency to manage the TRICARE health plans. The Army is currently in the process of transforming the organization of direct care mental health services into a standard

system of care (8), making it even more important to answer these *who*, *what* and *where* questions. The baseline established from answering those questions can then be used to examine the effects of the proposed organizational changes on access and utilization patterns in the beneficiary population.

The Military Health System Data Repository (9) serves as a useful starting point as it contains data on all clinical care services provided to Army beneficiaries, including the type of clinic where the service is provided, the procedures performed and the clinician's diagnoses. We used a de-identified subset of all clinical care services provided to Army beneficiaries in the FY 2003 - FY 2014 timeframe to develop the quantitative baseline presented here.

We also carried out thirty-four field research visits to nineteen Army installations from 2010 to 2015, to understand the evolution of service user flows in the direct care system. In these visits we interviewed care team members (providers, case managers, social service assistants, nurses, support staff), gatekeepers (chaplains, command teams, military family life counselors) and installation support services (substance use care, community services) to understand the system of care from their viewpoint. We also walked the care pathways that beneficiaries used in these visits to gain insights on the logistical challenges associated with using mental health services. These field research insights were combined with the quantitative data analysis to identify areas for further study.

Who uses services for mental health conditions?

We first identified all ambulatory encounters and inpatient admissions with a primary mental health diagnosis. The data set was then expanded to include all services provided in a specialty mental health clinic or ward, and all care that involved a privileged mental health provider. Services were provided to ten groups of beneficiaries: active duty soldiers, dependents of active duty, activated guard and reserve soldiers, dependents of activated guard and reserve, retirees, retiree dependents, inactive guard/reserve soldiers, dependents of inactive guard and reserve, dependents of survivors and others (such as foreign military members). The first six groups account for most of the service utilization, as shown in Table 1.

Soldier (active duty and guard/reserve) use of direct care ambulatory services grew from 701,646 encounters in FY 2003 to 1,628,543 encounters in FY 2014. Their utilization of purchased care outpatient services grew from 26,269 encounters in FY 2003 to 356,514 encounters in FY 2014. These numbers include singleton visits such as health screens, but even when we build a smaller cohort of Soldiers who have a psychiatric admission or two outpatient visits with a mental health diagnosis, the % of soldiers using services has grown from 5.7% in FY 2003 to 15.6% in FY 2014 for active duty, and from 2.5% to 7.2% for guard/reserve.

Direct care ambulatory services use by dependents of soldiers (active duty and guard/reserve) grew from 429,612 encounters in FY 2003 to 480,900 encounters in FY 2014. This is a reduction in the share of direct care ambulatory care use from 37.7% to 21.8% that can be attributed to the prioritization of service provision for soldiers in the military health system. Purchased care ambulatory services use by these beneficiaries grew from 323,836 encounters in FY 2003 to

1,367,127 encounters in FY 2014. The % of dependents with more than two outpatient encounters for a mental health condition or a psychiatric admission has increased from 6.3% of active duty dependents in FY 2003 to 11.3% in FY 2014, and from 3.1% to 8% for guard/reserve dependents.

Retiree and retiree dependent beneficiary groups grew from 992 members in FY 2003 to 46, 413 members in FY 2014. The direct care ambulatory services use by these groups grew from 7584 encounters in FY 2003 to 96,820 encounters in FY 2014. Purchased care ambulatory services in the same timeframe grew from 3923 encounters to 622,709 encounters. The purchased ambulatory care utilization rapidly increased from 1.1% of all encounters to 25.1%. The lower increase in direct ambulatory care from 0.7% to 4.36% is a function of care capacity and beneficiary prioritization into purchased care.

Soldiers (active duty and guard/reserve) used 86.2% of all direct care psychiatric admissions in FY 2003, and remained relatively stable over the time period of analysis. Purchased care psychiatric admissions of soldiers on the other hand grew 1858 admissions in FY 2003 to 9600 admissions in FY 2012, and has declined to 6581 admissions in FY 2014. This growth in inpatient utilization shows the increase in acuity in the population due to the high operational tempo. Soldier dependents use in direct care declined from 627 admissions in FY 2003 to 555 admissions in FY 2014, but purchased care admissions grew from 5419 admissions to 9370 admissions. The 4416 purchased care admissions of retirees and their dependents in FY 2014 accounts for 20.5% of all purchased care admissions.

What do beneficiaries get care for?

The change in utilization patterns across direct and purchased care by the various beneficiary groups prompted a deeper examination of the diagnoses driving usage. We counted the primary diagnosis of each outpatient encounter or inpatient visit in a given year for each beneficiary group. The top 15 diagnoses in each beneficiary group were aggregated to create a composite picture of the change in diagnoses over time in both direct care and purchased care. These diagnoses represent 70% of all outpatient encounters in the direct care system, and show the changing disease burden in the beneficiary population. The composite visualizations were developed using the Wordle tool (10), with diagnoses in each fiscal year normalized against total outpatient encounters in FY 2014, and shaded based on the beneficiary group (green for active duty soldiers, blue for active duty dependents, dark orange for guard/reserve, light brown for guard/reserve dependents, deep purple for retirees, and violet for retiree dependents).

In FY 2003, active duty soldiers used direct care ambulatory services for psycho-social education, substance use related counseling, major depressive disorder and counseling for marital problems. Active duty dependents utilized the system for psycho-social education, attention deficit hyperactivity disorder, and major depressive disorder. In FY 2008, the diagnosis portfolio had shifted with health exams becoming the prominent service provided to active duty Soldiers. While active duty dependents continued to receive services, the volume of services provided to these beneficiaries had dropped to 22% of all services. In FY 2014, PTSD had become the dominant reason for service provision to active duty soldiers,

accounting for over 190,000 encounters (which is almost twice the utilization for major depressive disorder). This utilization of services for PTSD has remained relatively stable since FY 2012.

In FY 2003, purchased care ambulatory services were used mostly by active duty dependents and guard/reserve dependents, with major depressive disorder, attention deficit hyperactivity disorder and adjustment disorders driving most of the utilization. Active duty soldier purchased care utilization increased almost 650% from FY 2003 to FY 2008. In this timeframe, active duty PTSD care grew from 484 outpatient encounters to 14,619 encounters. The utilization by dependents increased but the diagnosis profile remained similar to FY 2003, with the exception of autistic disorders. These disorders were the 10th largest diagnosis in FY 2008 consuming 14,474 encounters. In FY 2014, these disorders accounted for 136,026 encounters, the most use by active duty dependents for any diagnosis.

The diagnosis profile for direct care inpatient services has remained relatively stable from FY 2003 to FY 2014. Major depressive disorder and adjustment disorders accounted for a majority of direct inpatient admissions. Active duty soldier admissions for PTSD grew from 137 admissions in FY 2004 to 418 admissions in FY 2014. The diagnosis profile for purchased care inpatient admissions has shifted for retiree dependents and active duty soldiers. Retiree dependent admissions for major depressive disorders rose from 21 admissions in FY 2003 to 952 admissions in FY 2014. In the same period, admissions for bipolar disorders rose from 4 admissions to 560 admissions. Major depressive disorders remained the largest cause for active duty soldier admissions; PTSD admissions

grew at a faster rate from 25 admissions in FY 2003 to 939 admissions in FY 2014, peaking in FY 2012 with 1182 admissions. Unspecified episodic mood disorders supplanted bipolar disorders to become the largest cause of active duty dependent admissions in FY 2010, accounting for 2036 admissions in FY 2014.

The data show that the diagnosis profile in the Army population has changed significantly from FY 2003 to FY 2014. The care provided to these beneficiaries has had to change to focus on function restoration, and in the case of soldiers, ensuring mission readiness.

Where do beneficiaries access services?

The Medical Expense and Performance Reporting System (11) provides greater granularity into the types of clinics in which direct care services are provided. Our purchased care dataset is more limited to just emergency room and other ambulatory and inpatient services in purchased care. The analysis of the clinic types shows the differences between the access patterns across beneficiary groups (Table 2).

In FY 2003, active duty soldiers received 97.6% of all ambulatory mental health services in the direct care system. By FY 2014, purchased care use had grown to 13.65% of all ambulatory encounters. In FY 2014 soldiers access over 95% of all direct care mental health services in four clinics: specialty mental health clinics (83.6%), primary care clinics (5.41%), family medicine clinics (5.55%) and general medical care clinics (2.35%). Even though the actual number of primary care mental health visits grew from 64,443 visits in FY 2003 to 79974 visits in FY 2014, as a share of service utilization, primary care dropped from 10.61% in FY 2003 to

5.41% in FY 2014. Family medicine grew from 27,522 visits in FY 2003 to 82,077 visits in FY 2014. This growth can be attributed in part to the establishment of soldier centered medical homes that incorporate behavioral health providers (12). The sharp growth in surgical care visits in FY 2013 and FY 2014 can be attributed to the implementation of integrated pain management strategies (13).

In FY 2003 active duty dependents received more services in direct care (61.63%) that purchased care (38.37%). In FY 2014, the distribution has reversed, with direct care accounting for only 28.56% of all ambulatory services. Almost half of the direct care ambulatory visits occurred in specialty mental health clinics (48.96%), with family medicine clinics (32.90%), and pediatric clinics (8.68%) accounting a majority of the remaining visits. Primary care clinic use by these dependents dropped from 8.57% of direct care ambulatory visits in FY 2003 to 1.39% in FY 2014. This drop in primary care use coincides with the introduction of patient centered medical homes within family medicine clinics (14). In FY 2014, retirees and retiree dependents got over 86% of all ambulatory services in the purchased care network. This beneficiary group was the second largest user of purchased care ambulatory services, and the largest user of purchased care emergency room services.

Even though emergency room utilization for mental health services is less than 1% of all ambulatory visits, the ER was identified in our field research as an important access point for mental health services for Army beneficiaries. Active duty soldiers use of the ER in the direct care system for a mental health condition grew from 3.1% of all direct care ER visits in FY 2003 (5021 encounters) to 8.04%

in FY 2012 (18383 encounters), before declining to 6.5% in FY 2014 (12,205 encounters). One possible explanation for the decline in ER use is better routing of beneficiaries in the system of care, especially during duty hours. Active duty dependent use followed the same trajectory, but grew at a slower pace, starting with 2.3% of all dependent ER encounters (6,489 encounters) in FY 2003 and peaking at 5.5% of all encounters (16,852 encounters) in FY 2008, before dropping to 2.8% of all encounter in FY 2014 (7,674 encounters). Retiree and retiree dependents use of purchased care emergency room services for mental health grew from 4.37% of all ER visits (54 encounters) to 9.42% of all ER visits (7434 encounters) in FY 2014.

Our field research was critical to understand how beneficiaries entered the system of care. The interviews and focus groups revealed that services were triggered either by a walk-in, self-referral, provider referral, or a command referral. Referrals by some gatekeepers like chaplains, military family life counselors, family members, and in some cases command teams, appear in the data as walk-ins or self-referrals. The interviews surfaced anecdotal evidence of the use non-clinical mental health services provided by military family life counselors, chaplains, and Military OneSource. It is difficult to quantify the volume of these services as these providers do not document in the medical record, and the information they share (if any) are aggregated trend data that are not traceable to a specific beneficiary.

Discussion

The data show clear differences in utilization patterns of the beneficiary groups with active duty Soldiers receiving most of their care in the direct care system and other beneficiaries (dependents and retirees) being sent to TRICARE

providers. This distribution is consistent with the MHS access to care standards that prioritize direct care services for active duty personnel. It does however raise important questions on service equity for beneficiaries sent to TRICARE. The preliminary findings highlight the need for more research on access and quality differences between direct and purchased care.

Guard and reserve soldiers and their dependents actively use mental health services when they are on activated status. We do not have sufficient insight into where these beneficiaries receive services when they are not on active duty. More research is needed into the needs of these beneficiaries as they are increasingly relied upon to augment the active duty population (15).

The nature of services in the direct care system has fundamentally changed from FY 2003 when the focus was on psychosocial education, to the treatment of chronic conditions such as PTSD. The current data provide limited insight into whether the direct care system has the right mix of personnel with appropriate training to meet this evolving disease portfolio. More research is needed to determine whether the staffing models currently used in the direct care system are sufficient to meet the known demand (16, 17). The volume and diversity of diagnoses that are being sent into the purchased care system highlights the need for a deeper examination into the training needs of providers in the purchased care network (18, 19). If the long-term goal is to recapture care from the purchased care network, additional hiring actions need to be executed in the direct care system to meet the growing volume of psychiatric disorders in children, and training programs need to be expanded (20, 21).

Even though a majority of ambulatory mental health services in the direct care system occur in specialty mental heath clinics, services are also provided in other clinics such as family medicine, primary care, medical care, and the emergency room. The behavioral health system of care in the Army relies on provider-level coordination to manage care across these other care locations. Similar challenges exist when care is distributed across direct and purchased care. In our field research, we have seen local practices that focus on managing known high-risk patients through active case management, but the volume of services provided makes it difficult to scale these local solutions. More research is needed into the utilization patterns of beneficiaries when care is distributed across multiple care locations.

ER utilization rates for mental health conditions in the civilian population have been found to vary from 6.3% (22) to 11% (23), with the latter number focusing on uninsured patients. The 9% utilization by retirees and retiree dependents is concerning because they are insured and choosing to access services in the emergency room. Fewer than 3% of beneficiaries with a primary mental health diagnosis seen by a privileged mental health provider in the purchased care ER setting. The direct care system shows a similar pattern prior to FY 2008, with almost 30% of ER encounters involving a privileged mental health provider in FY 2012 and FY 2013. This seeming lack of assessment by a privileged mental health provider is an area of concern that needs to be addressed. One potential explanation is that a large number of these beneficiaries were admitted into inpatient care, but the inpatient admissions data do not provide consistent evidence in support of that

argument. A second explanation is poor data quality because mental health providers who are consulted by the ER doctor are coding the visit as a consultation. This is an area that needs to be examined in greater detail.

The analysis is limited in its focus on utilized services. Our field research surfaced concerns of potential demand suppression due to the stigma associated with seeking care. Providers were also concerned about a potential shadow care system created by providing services under the "non-clinical" label by chaplains (24, 25), military family life counselors (26) and in Military OneSource (27). All the military family life counselors we interviewed emphasized their client engagements as *solution focused problem solving* (28, 29) for subclinical conditions. Some of these providers did highlight the challenges of handing off a client into the direct care system. More research is needed on understanding the volume of these non-clinical services and the handoff between non-clinical and clinical care.

Table 1 Service Utilization by Beneficiary Group

FY	Direct Care Ambulatory Services							Purchased Care Ambulatory Services						
	Total Encounters	ACT	GRD	DA	DRG	RET	DR	Total Encounters	ACT	GRD	DA	DRG	RET	DR
2003	1143718	607216	94430	407878	21734	4009	3575	355201	14905	11364	253923	69913	1449	2474
2004	1240224	650321	145336	398540	25598	6263	7325	472218	17782	18842	305394	115147	3832	8767
2005	1247715	700649	136405	358870	24363	8140	10424	605456	28285	42761	347448	151075	9036	20938
2006	1251327	734718	125768	336248	22048	9329	13585	737211	36287	65357	407742	160568	17354	38627
2007	1357897	818882	120365	358624	21128	11617	16008	853159	57070	69354	472409	156923	26711	55886
2008	1579778	1021277	144193	347895	21711	12667	17334	1054022	96722	80046	558870	175912	37797	79748
2009	1799199	1190710	188105	344690	22001	14426	20182	1290231	134406	94074	663639	200692	50099	107116
2010	2131316	1451549	209556	381188	21786	20071	25090	1556087	171783	118163	772564	229344	68517	139393
2011	2260074	1535198	203858	423780	21213	23179	28450	1856602	210407	137026	912027	238463	93033	180076
2012	2330907	1568735	198561	460776	21455	27313	35011	2199414	255191	154581	1057006	251368	132314	246624
2013	2301531	1531397	177014	476820	21944	30143	44566	2345020	255431	151168	1106891	235198	169730	305291
2014	2221607	1478931	149612	459916	20984	39165	57655	2484307	233757	122757	1150323	216804	231702	391007
	Direct Care Inpatient Services							**Purchased Care Inpatient Services**						
FY	Total Admissions	ACT	GRD	DA	DRG	RET	DR	Total Admissions	ACT	GRD	DA	DRG	RET	DR
2003	4787	3464	664	586	41	4	3	7403	1429	429	4337	1082	38	48
2004	5018	3482	841	610	33	14	14	8571	1577	595	4544	1611	71	132
2005	5007	3580	792	497	48	23	13	9561	2249	709	4387	1746	109	230
2006	5014	3783	643	474	45	14	25	9649	2543	749	4147	1513	139	418
2007	5653	4297	660	535	29	32	26	11408	3760	856	4572	1372	179	507
2008	6068	4721	747	448	31	27	26	13624	4816	980	5187	1494	226	658
2009	6300	5034	733	373	23	39	19	16288	6220	1094	5767	1615	309	813
2010	5570	4254	657	471	19	60	30	18375	6784	1180	6415	1755	476	1086
2011	6160	4893	576	467	17	78	33	20402	7621	1162	7061	1558	645	1445
2012	6165	4863	520	570	19	72	48	23169	8381	1292	8261	1656	734	1851

2013	5923	4626	520	548	14	87	50	22200	6863	1080	8200	1630	881	2398
2014	6102	4823	460	535	20	119	84	21520	5704	877	7917	1453	1148	3268

ACT: Active Duty; GRD: Guard/Reserve; DA: Dependents of Active Duty; DRG: Dependents of Guard/Reserve; RET: Retiree; DR: Dependents of Retiree

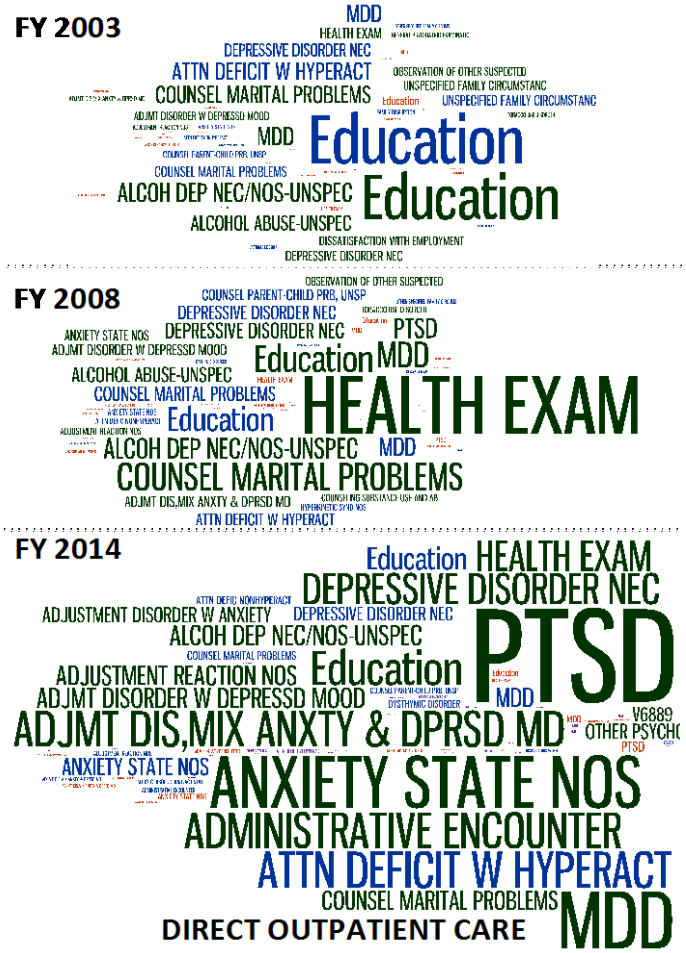

Figure 1 Changing Diagnosis Portfolio in Direct Care Ambulatory Mental Health Services

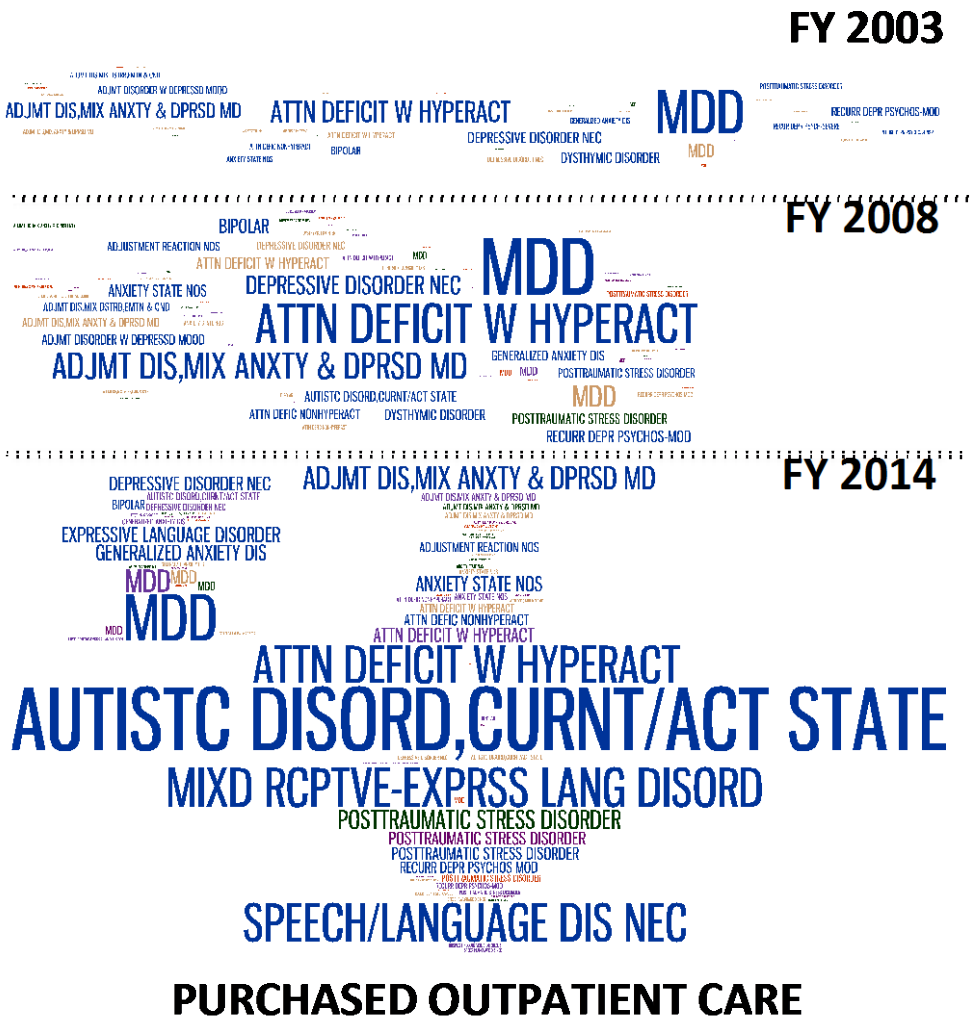

Figure 2 Changing Diagnosis Portfolio in Purchased Ambulatory Mental Health Services

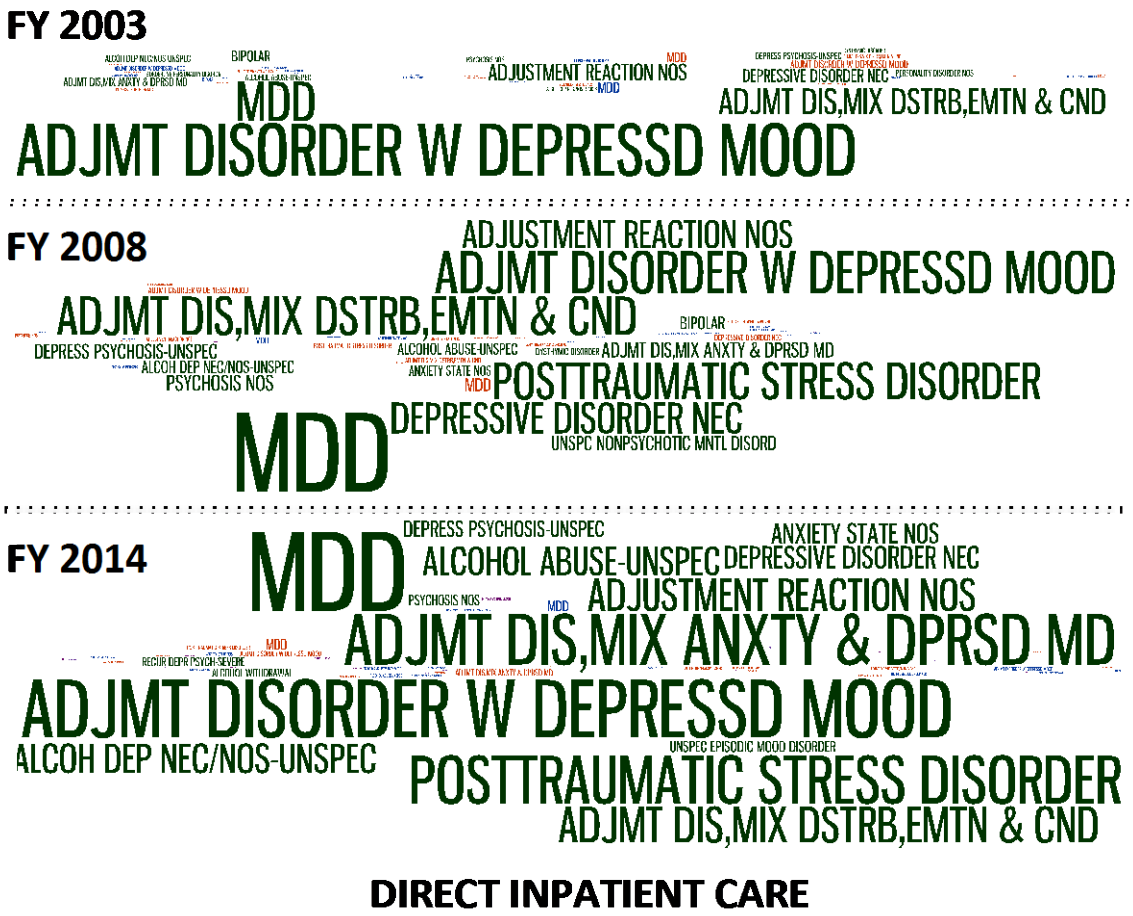

Figure 3 Direct Inpatient Care Diagnosis Portfolio Evolution

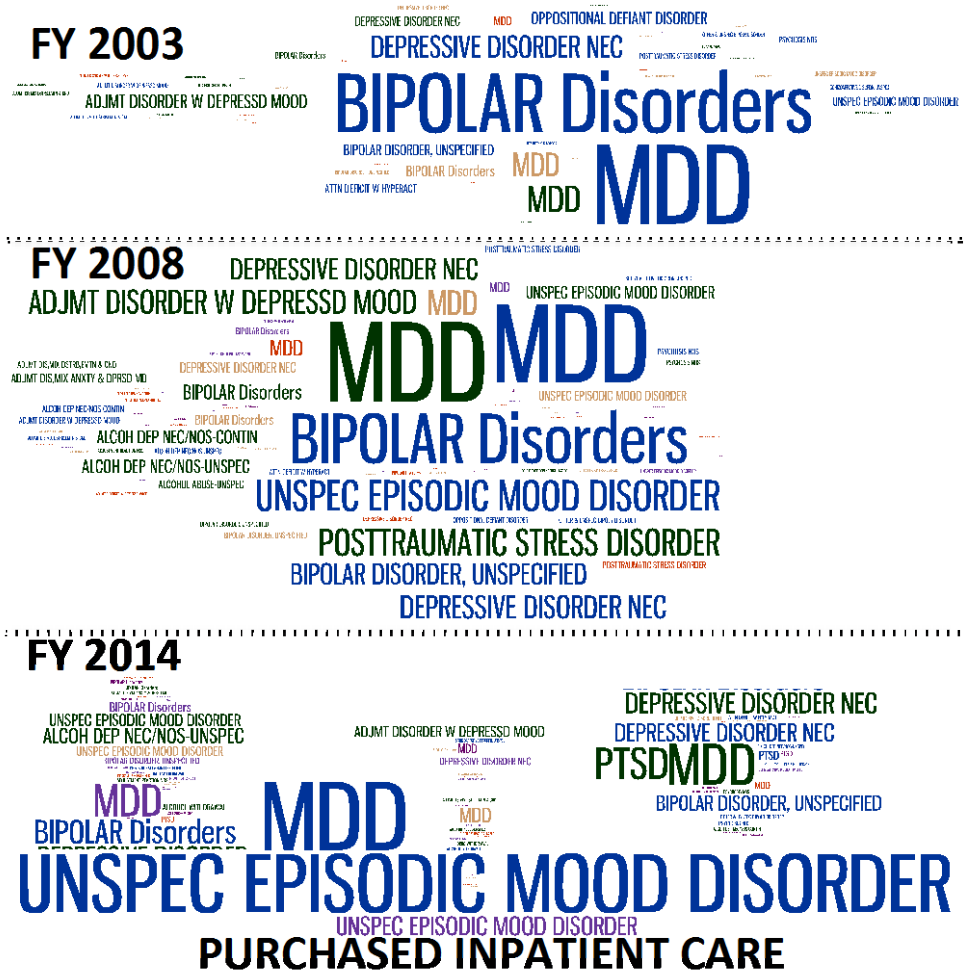

Figure 4 Purchased Inpatient Care Diagnosis Portfolio Evolution

Table 2 Variation in Where Beneficiaries Access Services

ACT				Direct Care					Purchased Care	
FY	*SMH*	*FM*	*PCM*	*MC*	*SC*	*PC*	*OSC*	*ER*	*Non ER OP*	*ER*
2003	473047	27522	64443	11866	3591		21726	5021	14056	849
2004	515702	29108	70103	12406	3176		14610	5216	16790	992
2005	553314	23770	82956	13893	4333		16724	5659	27036	1249
2006	623189	19945	59767	12307	1878		11420	6212	34862	1425
2007	690515	22604	72357	13122	1893		10609	7782	55362	1708
2008	856235	31451	85278	23961	2128		12265	9959	94475	2247
2009	1021999	38574	78119	22740	1926		15638	11714	131739	2667
2010	1270821	45994	76287	25769	1480		17850	13348	169341	2442
2011	1320555	65223	85725	28127	2620		16679	16269	207500	2907
2012	1321847	79595	98252	29966	3581		17111	18383	252132	3059
2013	1274645	88203	89317	34173	9476		19420	16163	252640	2791
2014	1236360	82077	79974	34749	13255		20311	12205	231175	2582
DA				**Direct Care**					**Purchased Care**	
FY	*SMH*	*FM*	*PCM*	*MC*	*SC*	*PC*	*OSC*	*ER*	*Non ER OP*	*ER*
2003	215725	67160	34945	11055	1679	50862	22678	3774	251718	2205
2004	205119	68822	34883	9837	1635	56463	18117	3664	302867	2527
2005	170333	67314	30190	9994	923	54179	22192	3745	344555	2893
2006	176650	59255	25126	6737	593	46149	17739	3999	404665	3077
2007	192476	68844	23749	5809	677	45238	17791	4040	468772	3637
2008	175587	71932	21057	6635	1146	45989	19410	6139	554850	4020
2009	168045	74020	20893	6583	2103	46785	19673	6588	659345	4294
2010	195874	77886	22375	6775	3257	46966	21027	7028	767920	4644
2011	220033	93315	22296	6271	3546	46911	23319	8089	906870	5157
2012	230228	124019	21678	6531	3865	44668	21718	8069	1051448	5558

2013	228397	150678	12516	6929	1591	47064	22032	7613	1101653	5238
2014	225193	151321	6410	7304	1714	39906	22360	5708	1145332	4991
RET+ DR				**Direct Care**					**Purchased Care**	
FY	*SMH*	*FM*	*PCM*	*MC*	*SC*	*PC*	*OSC*	*ER*	*Non ER OP*	*ER*
2003	4219	1434	606	687	47	341	176	47	3869	54
2004	7064	2799	1011	1326	91	848	342	79	12436	163
2005	8574	3896	1468	2186	137	1646	486	134	29644	330
2006	12470	4124	1612	1732	142	2088	497	231	55378	603
2007	14529	5933	2039	1887	182	2334	413	303	81674	923
2008	14394	7617	2083	2192	274	2557	430	435	116407	1138
2009	17596	7781	2507	2433	376	2873	574	449	155843	1372
2010	24584	9806	2686	3053	441	3229	755	601	206067	1843
2011	27592	11557	3343	3289	616	3495	901	809	270442	2667
2012	31687	15331	3842	4598	903	4144	797	972	375556	3382
2013	31996	25276	3377	5721	692	5400	991	1177	470086	4935
2014	42895	35096	2450	7094	1074	5819	1119	1139	615275	7434

ACT: Active Duty; DA: Active Duty Dependents; RET+DR: Retiree and Retiree Dependents

SMH: Specialty Mental Health; FM: Family Medicine; PCM: Primary care; MC: Medical Care; SC: Surgical Care; PC: Pediatric Care; OSC: Other Specialty Care

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