

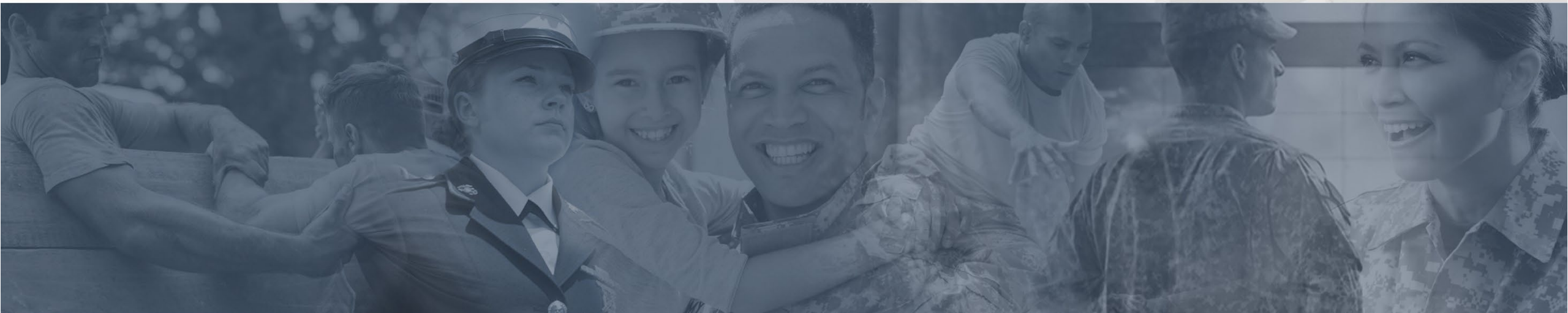


Decision Brief: Mental Health Care Access for Military Health System Beneficiaries

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Chair, Neurological/Behavioral Health Subcommittee

March 22, 2023



Overview



- Members of the Neurological/Behavioral Health Subcommittee
- Tasking
- Subcommittee Activities
- Report Summary
- Proposed Findings and Recommendations



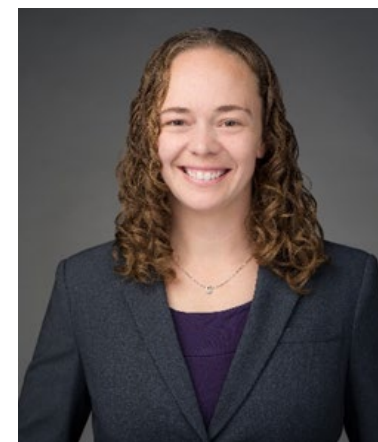
Membership



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Tasking

On May 5, 2022, the Acting Assistant Secretary of Defense for Health Affairs directed the Defense Health Board ("the Board") **to provide recommendations to enhance the Military Health System (MHS) capacity and capabilities to meet beneficiaries' mental health needs.**



Tasking: Background

- Access to mental health care is increasingly a concern for family beneficiaries in the MHS.
- Family member mental health & Service Member mental health are interrelated.
- The supply of military mental health resources (e.g., clinicians and treatment options) has not kept pace with the needs of the MHS beneficiary population.
- The COVID-19 pandemic has widened the gap between demand and supply for MHS mental health care.
- Advances in tele-behavioral health and new therapies offer opportunities to improve access to mental health treatment.



Tasking: Objectives and Scope

- Provide recommendations to enhance MHS capacity and capability to meet beneficiaries' mental health care needs, and to eliminate barriers to accessing and delivering mental health care for both adult and child beneficiaries
- Provide recommendations to promote innovative mental health care research and treatment strategies for PTSD and other behavioral health conditions



Summary of Activities

Meeting Date	Discussion Topics
Mar 30, 2022: DHB Meeting	Child and adolescent mental health crisis
Jun 6, 2022: DHB Meeting	Mental health access from the DoD's perspective
Jun 28, 2022: NBH Kickoff Meeting	<ul style="list-style-type: none"> • 2020 DoD Inspector General's Report on beneficiary mental health access challenges • Blue Star Families' Military Lifestyle Survey
Jul 14, 2022: NBH Meeting	Mental health needs of military families
Aug 10, 2022: DHB Meeting	Update of report to DHB members
Aug 18, 2022: NBH Meeting	<ul style="list-style-type: none"> • TRICARE for Kids Coalition priorities • Mental health care access in the direct care system
Sep 8, 2022: NBH Meeting	Review report outline and Chapters 1 & 2
Oct 13, 2022: NBH Meeting	<ul style="list-style-type: none"> • Army Spiritual Readiness Initiative and Mission-100 to Alaska • Air Force's Targeted Care Initiative

Summary of Activities (cont.)



Meeting Date	Discussion Topics
Nov 10, 2022: NBH Meeting	TRICARE reimbursements for mental health
Dec 8, 2022: NBH Meeting	Substance Abuse and Mental Health Services Administration overview
Jan 12, 2023: NBH Meeting	Report Development: Background
Jan 26, 2023: NBH Meeting	Report Development: Findings and Recommendations
Feb 9, 2023: NBH Meeting	Report Development: Findings and Recommendations, Executive Summary
Feb 23, 2023: NBH Meeting	Report Development: Final Report
Mar 22, 2023: DHB Meeting	Decision Brief



Report Summary

Mental Health of Military Health System Beneficiaries

Mental Health Care Needs and Access

Urgency of the Mental Health Crisis

Meeting the Mental Health Care Needs



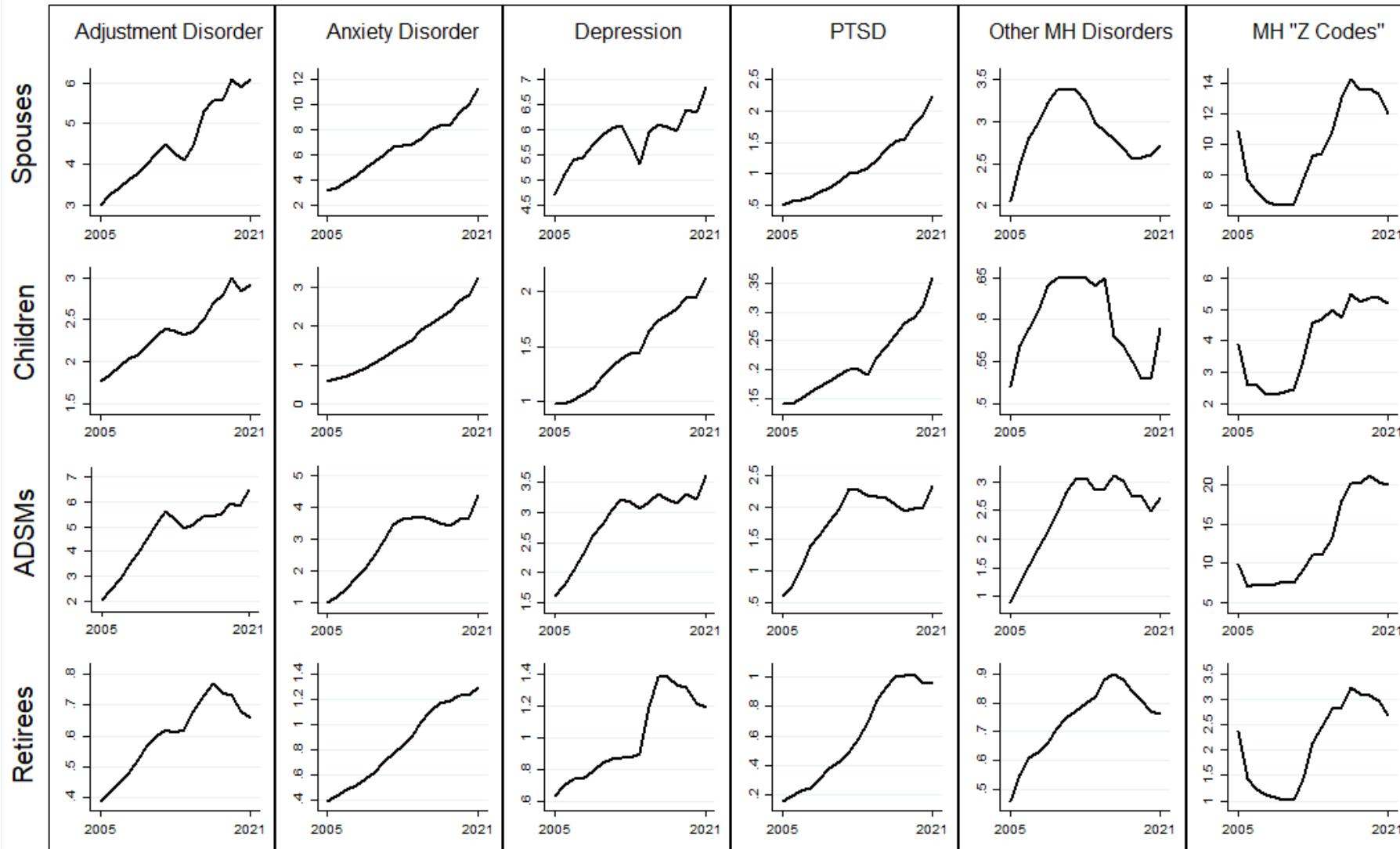


Military Health System (MHS) Beneficiaries

	Number, in millions (%)
Workload	
Direct Care	(40%)
Purchased Care	(60%)
Providers	
Direct Care, Military	0.07 (6%)
Direct Care, Civilian	0.06 (5%)
Purchased Care	1.01 (89%)
Eligible Beneficiaries	
Active-duty Service Members	1.41 (15%)
Active-duty Service Member Families	1.62 (17%)
Guard/Reserve/Inactive Service Members	0.44 (6%)
Guard/Reserve/Inactive Service Member Families	0.64 (6%)
Retirees	2.22 (23%)
Retiree Families	2.73 (27%)
Others (includes Survivors)	0.63 (6%)



Average Rates of Prevalent Mental Health Diagnoses among: Military Health System Beneficiaries



Note. Data from the Psychological Health Center of Excellence, 2022. Y axes display population average prevalent mental health diagnosis rates for Military Health System beneficiaries: military spouses and children, active-duty Service members, and retirees, 2005-2021.



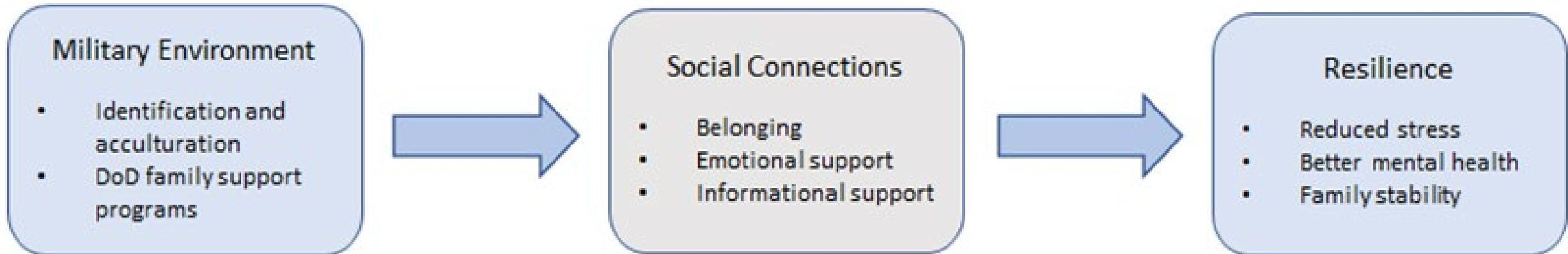
Military Family Life

Challenges

- Frequent Moves
- Heightened operations tempo in non-deployed environments
- Deployments

Benefits

- Family Resilience
- Shared Identity
- Social Connectedness





Mental Health Care Needs and Access

- MHS not adequately meeting MH needs of beneficiaries
- Widespread access barriers for military families seeking MH care
- Barriers that contribute to direct care MH provider shortages:
 - Uncompetitive salaries
 - Excessively long hiring processes
 - Provider billet limits
 - Staffing inefficiencies and provider-patient geographic mismatches
 - Recruiting challenges
- Limited purchased care network capacities due to low provider reimbursement rates

Urgency of the Mental Health Crisis



- Poor mental health increases risk for negative health outcomes
- Significant financial impact of MH conditions
- Reduced Service Member readiness and recruitment
- At the family level, parental MH challenges predict child MH challenges
- Family MH challenges burden Service Members and can distract them from performing their duties

Meeting the Mental Health Care Needs

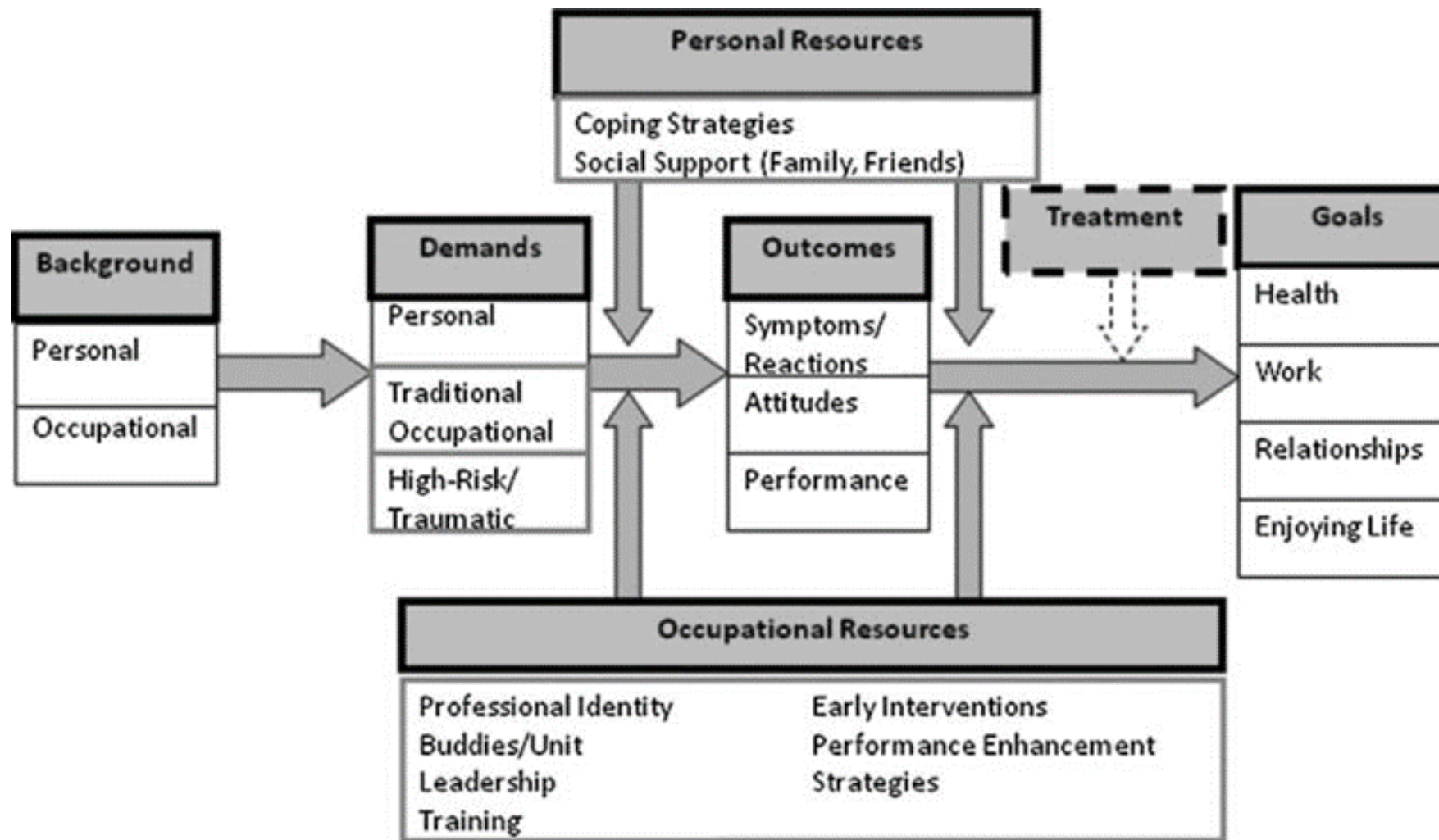


- Increasing the supply of MHS MH Services
 - Address staffing inefficiencies and misalignments
 - TRICARE reforms
 - Group therapy
 - Triaging patients to ancillary MH support caregivers
 - Improve patient booking
 - Developing and Implementing quality of care improvements
- Reducing beneficiary demand for such services by promoting military family MH resilience
 - Occupational Mental Health Model
 - Operational Stress Continuum Model





Occupational Mental Health Model





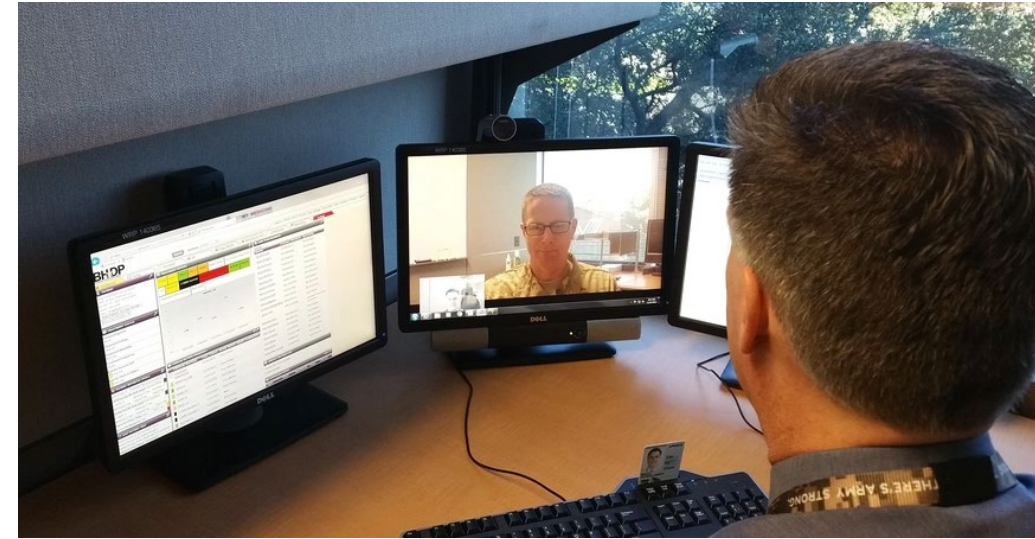
Stress Continuum Model

READY (Green)	REACTING (Yellow)	INJURED (Orange)	ILL (Red)
<p>DEFINITION</p> <ul style="list-style-type: none"> • Optimal functioning • Adaptive growth • Wellness <p>FEATURES</p> <ul style="list-style-type: none"> • At one's best • Well trained and prepared • In control • Physically, mentally, and spiritually fit • Mission focused • Motivated • Calm and steady • Behaving ethically • Having fun 	<p>DEFINITION</p> <ul style="list-style-type: none"> • Mild and transient distress or loss of functioning • Always goes away • Low risk for illness <p>CAUSES</p> <ul style="list-style-type: none"> • Any Stressor <p>FEATURES</p> <ul style="list-style-type: none"> • Feeling irritable, anxious, or down • Loss of motivation • Loss of focus • Difficulty sleeping • Muscle tension or other physical changes • Not having fun 	<p>DEFINITION</p> <ul style="list-style-type: none"> • More severe and persistent distress or loss of function • Leaves a "scar" • Higher risk for illness <p>CAUSES</p> <ul style="list-style-type: none"> • Life Threat • Loss • Inner Conflict • Wear and Tear <p>FEATURES</p> <ul style="list-style-type: none"> • Loss of control • Panic, rage, or depressed mood • Substance Abuse • Not feeling like normal self • Excessive guilt, shame, or blame • Diminished sense of purpose, meaning, or hope in the future 	<p>DEFINITION</p> <ul style="list-style-type: none"> • Unhealed stress injury causing life impairment • Clinical mental disorder <p>TYPES</p> <ul style="list-style-type: none"> • PTSD • Depression • Anxiety • Substance Dependence <p>FEATURES</p> <ul style="list-style-type: none"> • Symptoms persist and worsen over time • Sever distress, social or occupational impairment
<p>Unit Leader Responsibility</p>	<p>Individual, Peer, Family Responsibility</p>		<p>Caregiver Responsibility</p>



Meeting the Mental Health Care Needs (cont.)

- Telehealth
 - Convenient and can reduce transportation costs
 - Mitigate distance-related access barriers
 - Enhanced privacy can mitigate stigma-related access barriers
- Facilitating research in, and beneficiary access to, cutting-edge MH treatments





Proposed Findings and Recommendations





Finding 1

- The MHS does not have sufficient MH providers to manage existing beneficiary demand for MH care, much less projected increases in demand. There is a shortage of MH providers in the civilian sector, as well. In competing with other health systems to recruit and retain MH providers, the MHS is at a competitive disadvantage.

Recommendation 1



- 1a. The Defense Health Agency (DHA) should increase salary and benefits packages for MH providers to meet or exceed salary and benefit compensation rates of MH providers working in regionally similar federally qualified healthcare agencies.
- 1b. The DHA should expedite MH provider hiring timelines to be competitive with those of other federally qualified healthcare agencies.

Recommendation 1 (cont.)



- 1c. The DHA should develop a program to alleviate financial burdens associated with obtaining licensure for allied MH providers who commit to providing care for MHS beneficiaries.
- 1d. The DHA should assess and implement additional ways to facilitate recruitment of allied MH providers.
- 1e. The DHA should work with the Defense State Liaison Office (DSLLO) to facilitate licensure portability for military spouses.



Finding & Recommendation 2

- Finding: Allocating MH personnel efficiently, in alignment with beneficiary demand for MH care, is critical to meeting beneficiaries' MH needs. This task is complicated by the existence of separate direct and purchased care staffing systems that utilize separate estimates of beneficiary demand. The MHS is a dynamic system in which patient demand shifts between direct and purchased care networks. Such shifts can overwhelm existing staffing capacities.
- Recommendation: The DHA should create and staff regional market-level offices tasked with monitoring beneficiary demand for MH care from local direct and purchased care providers and with proactively responding to changes in beneficiary demand.



Finding 3

- MH access barriers pervade the purchased care network. Alongside rising demand and provider shortages, low provider reimbursement rates and regulatory compliance burdens discourage MH providers from enrolling TRICARE patients. Although TRICARE provider reimbursement rates are limited by law, the DHA is authorized to grant locality-based reimbursement rate waivers in cases where access to health care services is “severely impacted.” Additional research is needed to identify factors limiting TRICARE provider participation.



Recommendation 3

- 3a. The DHA should utilize its waiver-granting authority to increase TRICARE provider reimbursement rates in targeted purchased care markets experiencing provider shortages. The DHA should regularly inform Congress of the additional costs associated with this recommendation.
- 3b. The DHA should investigate and advocate for legislative remedies to increase TRICARE provider reimbursement rates.

Recommendation 3 (cont.)



- 3c. The DHA should investigate and address where possible the factors limiting TRICARE provider participation.
- 3d. The DHA should create a single point of contact for providers with questions regarding TRICARE requirements and billing.



Finding & Recommendation 4

- Finding: The scope of purchased care access challenges is difficult to determine due to conflicting reports. A “secret shopper” approach could be helpful in this regard.
- Recommendation: The DHA should contract with 3rd party reviewers to conduct regular assessments of MH performance metrics such as access to evaluation and treatment, patient satisfaction, and the quality of care provided in the purchased care network.



Finding 5

- In addressing MH access challenges for military families, the DHA is constrained by the limits of its authority over the purchased care network, which is the route through which most military families receive MH and other medical care. However, Managed Care Support Contractors (MCSCs) are required to adhere to standards for access to care. The DHA's ability to enforce access to care standards is unclear.

Recommendation 5



- 5a. The DHA should leverage its authority to enforce and enhance access to MH care across direct and purchased care networks.
- 5b. The DHA should review its authorities to determine whether it possesses underutilized mechanisms to enhance access to MH care.

Finding & Recommendation 6



- Finding: Ongoing efforts to address MHS MH shortages, including provisions in the 2023 National Defense Authorization Act (NDAA), do little to address purchased care network-specific MH access challenges.
- Recommendation: The DHA should foster and facilitate collaboration with academic and community partners to develop internship placement opportunities for licensed and allied MH providers in the purchased care network.



Finding 7

- Group therapy can be a force multiplier when clinically appropriate. Triage is critical to maximizing existing and future capacity to meet beneficiary demand for MH care. Given that direct care compares favorably to purchased network care in terms of cost and quality, beneficiaries receiving MH/BH in the direct care system stand to benefit from Targeted Care, as does the MHS. The larger population of military family beneficiaries also stands to indirectly benefit from reduced demand pressure on the purchased care network.

Recommendation 7



- 7a. The DHA should develop evidence-based metrics for assessing the effectiveness of group therapy.
- 7b. The DHA should reduce barriers to the clinically appropriate use of group therapy, including financial disincentives in the purchased care network.

Recommendation 7 (cont.)



- 7c. The DHA should collaborate with academic institutions, issue collaborative grants, and co-sponsor training workshops to encourage the use of group therapy by licensed MH providers in the purchased care network.
- 7d. The DHA should continue efforts to implement triaging procedures for MH patients accessing care through the direct care system.



Finding 8

- Ghost networks frustrate military families seeking MH care in the purchased care networks, which is where most military families access MH care. Better management of provider lists and centralized MH appointment booking and oversight through systems like Integrated Referral Management and Appointing Center (IRMAC) are needed to ensure beneficiary access to care.

Recommendation 8



- 8a. The DHA should assess the feasibility of extending IRMAC oversight to behavioral health (BH) appointments in the purchased care network.
- 8b. DHA market offices should maintain a regularly updated list of purchased care providers for their regions.



Finding 9

- Pilot programs are an effective way to design, implement, and assess evaluation and treatment initiatives. Military families, who are treated primarily within the purchased care network, should benefit from lessons learned through pilot efforts in DoD and other federal health care agencies.



Recommendation 9

- 9a. The DHA should continue to scale up and establish relevant policy to sustain successful pilot programs and implement evidence-based research efforts.
- 9b. The DHA should prioritize the development of new and effective behavioral health integration (BHI) practices.
- 9c. The DHA should develop quality and outcome measurements to support pilot studies and other evidence-based research.
- 9d. The DHA should develop a strategy to disseminate successful treatments identified through pilot studies in the direct care system, Department of Veterans Affairs (VA), and other federal agencies to purchased care network providers.



Finding 10

- Improved resilience reduces demand for MH services and improves quality of life. The Services recognize the importance of resilience to family readiness and mission readiness. Recent, SM-focused efforts to bolster MH have demonstrated some success in building SM resilience.
- Research and experience demonstrate that resilience in military families is enhanced through activities that promote identification with and connection to the military community. Existing DoD family support programs and services make important contributions to military family resilience independently, by supporting military families' health, education, and other needs, and through their impact on social connection and community engagement. Reservist and National Guard families have less access to these social supports than active-duty families.



Recommendation 10

- 10a. The DoD should evaluate the effectiveness of existing family support programs in promoting social connection, well-being, and family readiness and use evidence-based strategies to improve these programs.
- 10b. The DoD should pay particular attention to identifying less socially connected members of the military community when providing support programs. The DoD should consider ways of assessing social connectedness to identify those most in need.
- 10c. Where appropriate and feasible, the DoD should provide "opt-out" programs that foster social connections between military families with special attention to Reserve and National Guard families.



Finding 11

- Stigma is a potent barrier to accessing MH care. Military leadership, including mid-level enlisted leaders, has an important responsibility in destigmatizing MH to promote early access and treatment. This responsibility extends to military families, especially given their importance to readiness

Recommendation 11



- 11a. The DoD should tailor de-stigmatization efforts towards military families.
- 11b. The DoD should tailor de-stigmatization efforts through leadership training for mid-level unit leaders.
- 11c. The DoD should periodically assess military family climate by institutionalizing surveys of military spouses to ensure that military families have a mechanism to inform military family policy.



Finding 12

- DoD has invested heavily in resilience training programs and, in the case of the Army, such training incorporates military families. Military family resilience training is urgently needed; however, evidence demonstrating the effectiveness of current programs is lacking.

Recommendation 12



- 12a. The DoD should identify areas where resilience programs positively contribute to military family resilience and develop Service-tailored military family resilience programs.
- 12b. The DoD should facilitate information exchange among Service resilience training leaders.
- 12c. The DoD should ensure that that the Behavioral Health Clinical Community is made aware of DoD resilience training program resources.



Finding 13

- Sleep disorders are often present as comorbidities in patients with MH disorders and can impact MH treatment outcomes. Adequate sleep is critical to resilience, and sleep impacts every dimension of Total Force Fitness (TFF) and readiness. Training and treatment for providers, SMs, and families must emphasize and address the significance of sleep to MH and well-being. Insomnia and sleep apnea demand special emphasis.



Recommendation 13

- 13a. The DHA should encourage MH and primary care providers to prioritize training on the impact of sleep and sleep disorders on MH treatment outcomes.
- 13b. The DHA should ensure that provider training for Cognitive Behavioral Therapy for Insomnia (CBT-I) is widely available in the MHS.
- 13c. The DoD should develop and implement sleep education and training for beneficiaries, including military families, that emphasizes prioritization of sleep, optimization of circadian alignment, and recognition of symptoms of insufficient sleep and sleep disorders.



Finding 14

- The efficacy of telehealth (TH) is well-established. However, there is a risk of regression towards pre-pandemic TH usage in private-sector medicine. This change could impact healthcare access and continuity of care for TRICARE beneficiaries, particularly families undergoing a Permanent Change in Station (PCS). Potential changes in coverage for audio-only visits may exacerbate access issues for beneficiaries who lack video capability.

Recommendation 14



- 14a. The DHA should maintain and consider expanding COVID-19 pandemic levels of access to TMH in MTFs and in TRICARE by continuing reimbursement for TMH services.
- 14b. The DHA should continue to reimburse audio-only TH care rendered to patients who lack video capability.
- 14c. The DHA should ensure parity in TRICARE reimbursement rates for TMH and in-person services. TRICARE reimbursement rates for these services should be comparable to reimbursement rates of other leading health care plans.

Recommendation 14 (cont.)



- 14d. The DHA should work with the DSLO to promote interstate licensing flexibility for TRICARE providers beyond that allowed by existing interstate licensing compacts.
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- 14e. The DHA should ensure that TMH services are available to patients in purchased care networks whenever in-person MH services are unavailable.
- 14f. The DHA should promote access to TMH for military families.



Finding 15

- There are many novel approaches and emerging therapies that may benefit patients with posttraumatic stress disorder (PTSD) and other BH conditions, including, but not limited to, Schedule 1 substances. The posture of the federal government is that approval of use of these medications will adhere to the same assessments of risk and benefit as for other medications and therapies.
- DoD researchers may face barriers to participating in preclinical and clinical trials of Schedule 1 substances due to interagency and inter-institution administrative processes and due to stigma associated with these substances within the military community.

Recommendation 15



- 15a. The DoD should continue to support research to develop best practices for emerging therapies for MH conditions



Recommendation 15 (cont. 1)

- 15b. The DoD should support its clinical researchers in participating in or leading preclinical clinical trials in novel therapeutics, including psychedelic medications and neurostimulators.

Concurrence with this recommendation would include at least one of the following:

- At least one interagency agreement with the Food and Drug Administration (FDA), the National Institutes of Health (NIH), or the Drug Enforcement Agency (DEA) to participate in ongoing discussions of policy or in preclinical or clinical trials
- Less burdensome multi-site research agreement requirements by DoD medical researchers with civilian academic institutions, such as participation in regional institutional review board consortia like the former DoD infectious disease regional board
- Non-zero-dollar funding specified in at least one of the DoD-controlled medical research budgets

Recommendation 15 (cont. 2)



- 15c. The DoD should actively promote evidence-based novel therapeutics in treating MH disorders, including psychedelic medications and neurostimulators, by eliminating policy and administrative barriers.

Finding 16



- Some MHS beneficiaries may be limited from participating in potentially beneficial trials such as those involving Schedule 1 drugs and therapeutic neural technology devices due to occupational factors and frequent moves.

Recommendation 16



- The DoD should advocate for equal access for its beneficiaries to clinical trials by federal and civilian academic institutions. Concurrence with this recommendation would include at least one of the following:
 - Asking other federal agencies, state institutions, and civilian institutions that receive federal money to grant exemptions to exclusion from studies of emerging therapies for military family members for whom military service requires frequent moves
 - Consideration of family member clinical trial participation by the Exceptional Family Member Program during the assignment process
 - Granting an exemption to federal workplace drug testing for MHS beneficiaries who participate in trials of psychedelic medicines



Questions

