



PERSONNEL AND
READINESS

UNDER SECRETARY OF DEFENSE

4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

MAY 22 2012

The Honorable Carl Levin
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This is in response to the Senate Report 111-35, pages 149-150, accompanying S. 1390, the National Defense Authorization Act for Fiscal Year (FY) 2010, which requested the Secretary of Defense to assess the efficacy and cost of case management services for TRICARE behavioral health clients with serious mental health problems. This report summarizes Phase I of the Department of Defense's comprehensive two-phase retrospective review.

The report language requested examination of the following variables: cost of care, crisis and hospital admissions, length of stay, change in mental health symptoms and functioning, use of community behavioral health services, community service drop-out rate, and patient and family satisfaction with care. Using available administrative data from FY 2009, Phase I identified the prevalence and demographics of the TRICARE population diagnosed with mental health conditions potentially characteristic of serious mental illness. This review also computed the frequency with which this population utilized health care services for their mental health conditions, as well as the cost of these services. We also identified the beneficiaries in this study population that had documented case management services and provided a discussion on how the community service drop-out rate is determined.

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Sincerely,

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Jo Ann Rooney
Acting

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member



UNDER SECRETARY OF DEFENSE

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WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

MAY 22 2012

The Honorable Jim Webb
Chairman
Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

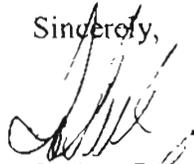
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Jo Ann Rooney

Acting

Enclosure:
As stated

cc:
The Honorable Lindsey Graham
Ranking Member



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PERSONNEL AND
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MAY 22 2012

The Honorable Howard P. "Buck" McKeon
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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Jo Ann Rooney
Acting

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member



UNDER SECRETARY OF DEFENSE

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PERSONNEL AND
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MAY 22 2012

The Honorable Joe Wilson
Chairman
Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

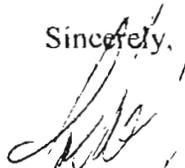
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Jo Ann Rooney
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Enclosure:
As stated

cc:
The Honorable Susan A. Davis
Ranking Member



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MAY 22 2012

The Honorable Daniel K. Inouye
Chairman
Subcommittee on Defense
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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Jo Ann Rootey
Acting

Enclosure:
As stated

cc:
The Honorable Thad Cochran
Vice Chairman



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The Honorable Thad Cochran
Vice Chairman



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MAY 22 2012

The Honorable Harold Rogers
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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Jo Ann Rooney
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Enclosure:
As stated

cc:
The Honorable Norman D. Dicks
Ranking Member



PERSONNEL AND
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MAY 22 2012

The Honorable C.W. Bill Young
Chairman
Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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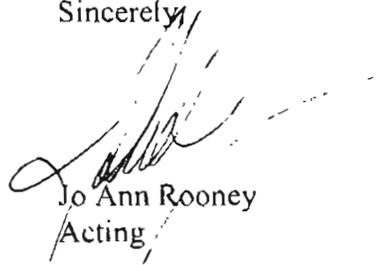
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Jo Ann Rooney
Acting

Enclosure:
As stated

cc:
The Honorable Norman D. Dicks
Ranking Member

Department of Defense Phase I Report on the Efficacy and Cost of
Case Management Services for TRICARE Behavioral Health
Clients with Serious Mental Health Problems

Submitted in Response to Senate Report No. 111-35 (pages 149-
150)



Department of Defense
TRICARE Management Activity

Preparation of this report cost the
Department of Defense a total of
approximately \$2,290 in Fiscal Years
2010-2012

Generated on 20110927
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The enclosed report responds to Senate Report No. 111-35, accompanying S1390, the National Defense Authorization Act for Fiscal Year 2010, that requested the Secretary of Defense to assess the efficacy and cost of case management (CM) services for TRICARE behavioral health clients with serious mental health problems. In response to the above request, a two-phased retrospective review was initiated to assess the efficacy and cost of CM services for TRICARE behavioral health clients who were seriously mentally ill (SMI). This report summarizes Phase I of the review.

BACKGROUND

Senate Report No. 111-35 requested this review to analyze the cost and efficacy of CM services for TRICARE behavioral health clients with serious mental health problems. The Senate report recognized that case managers play an important role in the coordination of complex medical care and dental care for TRICARE beneficiaries. The report acknowledged that CM may improve the effectiveness of mental health care as measured by reduced cost of care; decreased crisis visits and hospital admissions; reduced length of hospital stay; improved mental health symptoms; increased continuity of care from hospitalization to community; enhanced ability to function and increased patient and family satisfaction with care. The report requests the following variables be examined: cost of care; crisis visits (emergency department) and hospital admissions; length of stay; change in mental health symptoms and functioning; use of community (outpatient) behavioral health services; community service drop-out rate; and patient and family satisfaction with care.

Information related to high cost, high utilization, high risk, multiple or complex conditions can be found in administrative data while information related to psychosocial and environmental factors is routinely documented in beneficiaries medical records. Phase I of this two phase retrospective evaluation, examined administrative data to describe the TRICARE SMI population, both those receiving CM services and those not receiving CM services during the specified timeframe. This review identified the prevalence and demographics of the TRICARE population diagnosed with mental health conditions potentially characteristic of serious mental illness. This evaluation also computed the utilization of health care services for each mental health condition and included the cost of these services. The following variables were examined in this Phase I study and are addressed in this report: cost of care; crisis visits; hospital admissions; length of stay; outpatient visits; and community service dropout rate. Phase II of this two phase retrospective evaluation will continue with a further examination not only of administrative data but also beneficiaries' medical records (through chart abstraction) to assess beneficiaries' change in mental health symptoms and functioning level. Patient and family satisfaction with care will also be addressed.

METHODOLOGY

The Phase I review is a descriptive retrospective view that provides a baseline account of the characteristics of the TRICARE SMI population and explores documentation of CM services for the SMI in the administrative data during the

evaluation timeframe. The review conducted is a retrospective evaluation of administrative claims data for Military Health System (MHS) beneficiaries with target mental health diagnoses who presented for care in fiscal year 2009 (FY09). The population was defined as all TRICARE beneficiaries with at least one visit or encounter during FY09 with a relevant diagnosis of a mental health condition. Diagnosis codes used to identify the review population cover a wide range of mental health conditions that may indicate SMI. Conditions targeted for inclusion were derived from various definitions of SMI set forth by: the National Alliance on Mental Illness (NAMI); the Substance Abuse and Mental Health Services Administration (SAMHSA); Access to Disability Data: Chartbook on Mental Health and Disability¹⁰; and the National Institute of Mental Health (NIMH). Based on the definitions set forth by the above, the following categories of conditions and diagnoses were used to define SMI for this retrospective review: schizophrenia disorders, episodic mood disorders, delusional disorders, other nonorganic psychoses, pervasive developmental disorders, anxiety, dissociative and somatoform disorders, personality disorders, special symptoms or syndromes (not elsewhere classified), acute reaction to stress, adjustment reaction, depressive disorder (not elsewhere classified), disturbance of conduct (not elsewhere classified), disturbance of emotions specific to childhood and adolescence, and hyperkinetic syndrome of childhood. While some of these conditions may not be normally included in defining SMI, the Access to Disability, NIMH, and SAMSHA definitions focus on the functional impact of illness on the individual and therefore support inclusion of diagnostic categories such as adjustment reaction.

Administrative files for the Purchased Care System (PCS) and for the Direct Care System (DCS) were searched for visits or medical encounters, operationally defined as a single hospitalization with a relevant primary diagnosis code for the admission or two outpatient visits on separate dates with a relevant diagnosis in any diagnostic category (primary or secondary). The earliest medical encounter during the review period FY09 was identified as the anchor visit date for each beneficiary reviewed. The anchor visit date served as the basis for the measurement period. All visit dates with any mental health diagnosis code (primary or secondary) from the list of relevant mental health conditions were identified for the period of time defined as 365 days prior to and 365 days following the anchor visit date. Data elements were retrieved from all visit dates during the measurement period. Beneficiaries in the anchor visit population were classified according to the major mental health condition occurring most frequently as a primary diagnosis. The total cost for each mental health-related visit was first aggregated over the two-year measurement period for each beneficiary, then across beneficiaries within each major mental health category. This allowed computation of total cost within each major mental health condition and stratification by receipt of CM services.

The aggregated administrative data from this review are unable to confirm dropout rates for TRICARE beneficiaries diagnosed with SMI receiving community mental health services over time. However, beginning in 2010, DoD adopted a new quality of care metric on continuity of care from hospitalization to community services for mental health patients under the Healthcare Effectiveness Data and Information Set (HEDIS) measure. These new measures may provide useful information about follow up

outpatient mental health care after inpatient psychiatric hospitalization in the future. The metric, Follow up After Hospitalization (FUH) provides the percentage of discharges with an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a mental health practitioner within seven as well as within 30 days of discharge. While data were not available for 2009 (time frame of this retrospective review), beginning in 2010, the US Air Force Healthcare Informatics Division (HID) collaborated with the TRICARE Management Activity (TMA) to monitor FUH. This measure is reported by a large number of managed care organizations annually, thus providing DoD a benchmark against which its performance may be compared. The FUH measures are collected monthly from DoD administrative healthcare data and presented as an aggregate for the preceding 12 month period (a rolling year).

RESULTS OVERALL

- The prevalence of diagnosed mental health conditions likely to indicate SMI in the MHS is 391,157 or 5.25% of 7,451,305 eligible beneficiaries age 18 and over. This rate is similar to the general population where results from the 2009 National Survey on Drug Use and Health, reported that among adults age 18 or older 4.8% or 11 million adults have SMI.¹
- The MHS beneficiary population diagnosed with mental health conditions likely to indicate SMI used to obtain the results in this study is 518,649 as this number includes all ages and not just those 18 and older. Included in this review population are 126,470 active duty Service members.
- Larger percentages of the review population were young in age (63.1% were 35 years or younger) or female (55.6%) which are consistent with other epidemiological research on mental illness among the general population: 23% of women reported some form of mental illness as opposed to 15% of men; 30% of young adults (aged 18-25) were identified with mental illness, relative to 13.7% of adults aged 50 and older.
- The mental health conditions found in the largest proportions included: adjustment reaction (30.7%), episodic mood disorders (23.9%), anxiety, dissociative and somatoform disorders (17.2%), and hyperkinetic syndrome of childhood (12.6%).
- Among active duty Service members included in this review (n=126,470), 52% were categorized by the adjustment reaction classification, which includes the diagnosis of Post-Traumatic Stress Disorder.
- Among the review population, 0.91% had documented CM services. (This represents cases where a case manager used a CM code in their documentation in

¹ Office of Applied Studies. Substance Abuse and Mental Health Administrative Services, *Results from the 2009 National Survey on Drug Use and Health: Volume I, Summary of National Findings*, <https://www.osa.samha.gov> (assessed 15 Nov 2010).

the beneficiary's medical record, not all the cases that actually received CM services).

- The rates of documented CM were generally low overall, but higher among the DCS anchor visit population and among the active duty component.
- The active duty component comprised less than one-fourth of the overall study population but accounted for over one-half (58.2%) of the group of beneficiaries with documented CM.
- The rate of documented CM for non-active duty was highest among beneficiaries classified with pervasive developmental disorders (PDD), such as autism and eating disorders. For active duty, the rate of documented CM was highest among beneficiaries classified with schizophrenia (4.94%) and eating disorders (3.41%).
- Analyses of mental health care anchor visits includes crisis/emergency department, inpatient, community/outpatient or inpatient contacts which revealed a pattern whereby the group of beneficiaries with documented CM services had generally higher numbers of visits than beneficiaries with no documented CM services. See Table 1 for summary of these results.
- The median number of hospitalizations, bed days and estimated costs were higher for the group of beneficiaries with documented CM services as compared to the group without documented CM services. See Table 1 for summary of these results.

Table 1 Variable Comparison between Beneficiaries with Documented CM Services and Beneficiaries without Documented CM Services in the MHS Population Diagnosed with Serious Mental Illness who Presented for Care in 2009 (Data collected over two year time period; number in study population (n)= 518,649)

Variable	With Documented CM Services in Study Population (n=4,696)	Without documented CM Services in Study Population (n = 513,953)
Number of Crises (Emergency Room (ER)) visits	988 (4,696)*	33,333 (513,953)*
Number of ER visits	21.0 per 100 beneficiaries	6.5 per 100 beneficiaries
Psychiatric Community/ Outpatient Visits	127,492 (4,667)*	7,173,541 (507,889)*
Median** Visits	25 per beneficiary	9 per beneficiary
Total Full Outpatient Costs in the DCS (includes cost of crisis (ER) visits)	\$35,751,234 (3,882)*	\$948,469,406 (283,647)*
Median Cost	\$4,925 per beneficiary	\$1,673 per beneficiary

Total Amount of Outpatient and Crisis (ER) Costs in the PCS Paid by TRICARE	\$3,471,698 (2,498)*	\$290,591,114 (322,434)*
Median Costs	\$789 per beneficiary	\$516 per beneficiary
Total Full Cost DCS Hospital Claims	\$9,146,505 (397)*	\$130,428,140 (9,593)*
Median Costs	\$14,017 per beneficiary	\$7,727 per beneficiary
Total Amount of Hospital Costs in the PCS Paid by TRICARE	\$31,466,664 (1,287)*	\$278,503,045 (39,080)*
Median Costs	\$13,250 per beneficiary	\$3,326 per beneficiary
Hospitalizations in DCS or PCS	3,703 (1,568)*	67,350 (47,129)*
Median Discharges	2 per beneficiary	1 per beneficiary
Total Hospital Bed Days	59,631 (1,568)*	656,033 (47,129)*
Median Length of Stay	20 days	7 days

*Number of beneficiaries from study population with associated admissions, bed days, costs, or visits for stated variable.

**Median represents the midpoint in the distribution.

The Phase I review provides a baseline snapshot description of the TRICARE beneficiary population with SMIs, to include both those with and without documentation of CM services found in the administrative data. Results from our Phase I review suggest that CM services for the SMI in the MHS cost more than services provided to beneficiaries with mental illness not receiving CM. This is to be expected as CM is utilized for the more seriously ill who will have more complex treatment needs and are higher utilizers of health care services. Larger numbers of community/outpatient visits may indicate that care coordination is occurring as beneficiaries that are case managed keep and attend greater numbers of follow-up appointments.

CONCLUSIONS

- The relevance of adjustment reaction to military populations is supported by the inclusion of Post-Traumatic Stress Disorder (PTSD) (ICD-9 code 309.81) diagnosis in the “adjustment disorder” classification.
- The frequency with which adjustment disorder is diagnosed in both military and civilian communities may represent a tendency to avoid potential stigmas associated with other mental health diagnoses as adjustment reactions are often viewed as “normal” and self-limited.

- MHS CM coding and documentation guidelines were initiated in FY 09 with an emphasis on the Warrior in Transition population. There were other program initiatives such as Re-engineering Systems of Primary Care Treatment in the Military (Respect-Mil) program that targets screening, assessment and treatment of active duty soldiers with PTSD and depression that may have encouraged increased care and documentation for the active duty population.
- Autistic disorder (ICD-9 code 299.0) falls in the PDD classification. Mental health care for autistic dependents has been an important issue within the MHS in recent years and as a result, these patients have been targeted for CM services. Eligible Active Duty family members diagnosed with autism are enrolled in TRICARE's Extended Care Health Option (ECHO) Program (Army and Navy) and Special Need Identification and Assignment Coordination Program (Air Force) and are screened for CM services.
- TRICARE beneficiaries with high risk diagnoses (psychological disorders) and dual diagnoses (medical and mental health and more than one mental health diagnosis) are identified and screened for CM services.
- TRICARE beneficiaries with accumulated high costs and high utilization (frequent crisis/emergency, inpatient and community/outpatient visits) are identified and screened for CM services.
- Beneficiaries diagnosed with schizophrenia, eating disorders, autism, and PTSD are all considered high risk and can accumulate high costs and high numbers of mental health visits.

This Phase I descriptive retrospective review of administrative data for TRICARE beneficiaries diagnosed with mental health conditions potentially characteristic of SMI has not only provided prevalence and demographics for this population but has also addressed the following variables as requested in Senate Report 111-35: cost of care; crisis/emergency visits; hospitalizations; length of stay; and community/outpatient visits. While data were not available to describe community service dropout rate over time, the HEDIS FUH metric was discussed as a new measure that will be utilized in the future to track continuity of care for the SMI population following hospitalization (addresses the immediate dropout rate). Utilization and cost of mental health services was reviewed for this population of beneficiaries who received and did not receive CM services. Evaluation of costs may need to be measured from the perspective of decreased number of hospitalizations, length of stay, and increase in time between hospitalizations for individual patients receiving CM services. While this was beyond the scope of this review, these utilization measures will be considered in the follow-up Phase II review as well as patient and family satisfaction.

WAY FORWARD

Phase II of this review will focus on the same diagnostic group of TRICARE beneficiaries as Phase I who meet criteria for SMI (i.e., complex, high utilizers, longer lengths of hospital stays, etc.). The Phase II review will further analyze the administrative data as well as provide a focused retrospective medical record review. Two groups of beneficiaries (those who received CM and those who did not) will be compared to examine differences in utilization patterns and costs. Change in mental health symptoms and level of functioning information will be collected from the medical records of beneficiaries who received documented CM services. Patient and family satisfaction with CM services will also be addressed. The report for Phase II is due to Congress September 1, 2012.